

Foresight Future of an Ageing Population - International Case Studies

Case Study 9: Long term care insurance in Japan

Foresight Theme: Adapting financial systems

Context

Japan has a declining population size and an ageing population structure. In 2015 Japan had the oldest population in the world with 27% of its population of 126 million aged 65 and over. In 2005 Japan overtook Italy as the country with the highest proportion of its population aged 65 and over and, if present trends continue, this is likely to reach a peak of 42% in 2055. By then the population size will have fallen to 68 million¹. Life expectancy at birth in Japan has increased from 50 years for men and 54 for women in the late 1940s, to 79.9 and 86.4 years respectively in 2012, but the main driving force for both the decline in population size and the ageing population structure is the fall in the number of births. The total fertility rate (TFR) in Japan has fallen from 4.3 in the late 1940s to 1.39 in 2011. In addition, family structures are changing and the proportion of one-person households aged 65 and over, doubled between 1975 and 1995².

These population changes, coupled with increased urbanisation, have created additional pressures on the ability to deliver care for older people through family and informal provision. This has been associated with a change of attitudes within the family to traditional Japanese values of filial piety and household duty, with Japanese women increasingly reluctant to adopt the traditional role of caring for parents and parents in law. A 1994 survey of Japanese women providing care found that 33.6% of wives, 30% of daughters and 46.2% of daughters in law, felt hatred towards the person they were caring for³. Under pressure from public opinion, the Japanese long-term care insurance scheme (LTCI) sought to transfer some of this duty of care from daughters and daughters in law to formal care services⁴.

Japanese older people are better off, on average, than those in the UK, because, although public pensions are less generous than in many European countries, many Japanese (around 30% of men) continue in paid employment after age 65. Japan also has one of the world's highest healthy life expectancies at birth (73 years for men and 78 years for women)⁴.

Japan operates a very hospital-centred health system with, in 2010, average hospital stays of 18.2 days compared with 6.6 days in the UK. In the past, when families were unable to cope with the provision of care at home, older family members were often admitted to hospital. This 'social hospitalisation' led in 1980 to an estimated 4% of the population aged 65 and over 'living' in hospital with an average stay of 103 days⁵. This, in turn, led to pressures on government to reduce health care costs.

¹ ILC-Japan (2013) – *A profile of Older Japanese 2013*

² Kubo (2014) – *Long term care insurance and market for aged care in Japan*, Australasian Journal on Ageing, Vol 33 No 3

³ Hayashi (2013) – *Long-term care insurance in Japan (a presentation by the deputy assistant minister for international affairs, Ministry of Health, Labour and Welfare, Japan)*

⁴ Tamiya et al (2011) – *Population ageing and wellbeing: lessons from Japan's long-term care insurance policy*, The Lancet Vol 378 September 2011

⁵ Curry, Holder and Patterson, Nuffield Trust (2013) – *Caring for an ageing population*

History

Universal health insurance, which has been in place in Japan since 1961, is administered by employers or the municipality (for those without an employer). Premiums reflect the ability to pay and are based either on wages or a per capita per household income and assets based calculation.

Since 1973, medical care has been virtually free for Japanese aged 70 and over and 'bedridden' aged 65 and over. Social services, including nursing homes and home care, were, however, means tested and not usually available for someone who could be cared for at home⁶.

A need for change was recognised and widely accepted by the general public, many of whom had personal experiences arising from the needs of an ageing population

In 1989 the Japanese Liberal Democratic Party introduced a 'Gold Plan' expanding government responsibility for the care of frail older people. The Gold Plan, a 'tax financed' service, was very popular but implementation varied between municipalities and there were significant cost implications⁴. The Gold Plan however set a standard for service delivery which would have to be at least matched by the subsequent LTCI programme⁷.

LTCI was enacted in 1997 and introduced in 2000 with the intention to "maintain dignity and an independent daily life routine according to each person's own level of abilities"⁴. The programme aimed to transfer some of the responsibility for social care from the family to the state⁶ and to give frail older people autonomy at home without family support⁸.

It was hoped that implementation, as a social insurance scheme that was simple to understand, would increase acceptance.

Transitional arrangements were made to ease the burden for those disadvantaged by the change to the new system for example those already in care homes but ineligible under the new assessment criteria.

Implementation

The Japanese long-term care insurance (LTCI) scheme is more than just a way of financing long-term care. It is a complete package covering both the financing and the implementation of social care.

Japanese long-term care insurance is a form of 'social insurance'. Premiums are compulsory for anyone, aged 40 and above, in employment. The premium is split 50-50 between employer and employee. The long-term care insurance premium is typically paid as a supplement of around 1% on health care insurance and is collected by the employee's chosen health care insurer. Individual premium calculations vary with different insurers but should average out the same. The insurer then makes a

⁶ Campbell and Ikegami (2000) – *Long-term care insurance comes to Japan*, Health Affairs Vol 19 No 3.

⁷ Campbell, Ikegami and Gibson (2010) – *Lessons from public long-term care insurance in Germany and Japan*, Health Affairs Vol 20 No 1

⁸ Yamashita (2011) – *Exploring the impact of the Japanese long-term care insurance act on the gendered stratification of the care labour market....* Social Policy and Society Vol 10 No 4

lump sum payment into the Social Insurance Medical Fee Payment Fund which is distributed to the municipalities who pay independent service providers for care and other services.

Older people also pay a premium, deducted from pension, which is linked to income but varies between municipalities, reflecting the level of provision locally. This premium is revised triennially.

The long-term care itself is then financed 50% from LTCI premiums and 50% from general taxation. Thirty percent is from premiums paid by 40-64 year olds, 20% by those aged 65+, 25% from central government taxation, 12.5% from prefectures and 12.5% from municipalities.

In addition service users make a 10% co-payment for the services they use, plus fees for meals and rooms (accommodation costs) for institutional care. These payments are capped at £75 per month for low earners.

UK style general practitioner based primary care is much less well developed in Japan and older Japanese are generally referred to LTCI from a hospital. Self-referral is also possible.

LTCI, as initially set up, is a universally available needs-based service and is not means tested. A key aspect of the Japanese LTCI programme is a very formalised national system for the assessment and certification of care needs. An initial, 74-item questionnaire on activities of daily living is weighted and scored by computer into one of a number of bands which determine eligibility for services. The assessment is then reviewed by a panel of professionals before certification and is also subject to appeal.

Long term care insurance in Japan is used purely to provide agreed services. There is no cash alternative offered to users. This means that the provision of informal care by 'live in' migrant workers, common elsewhere in the world, is virtually non-existent in Japan⁴.

Choice of services

Older eligible Japanese select the services they need from an array of for-profit and not-for-profit providers. Since service prices are set by government and are the same for each region, selection is on the basis of convenience and perceived quality⁷.

The care is organised by a 'care manager', who is commonly employed by a service provider, giving rise to a question of conflict of interest. The care manager was initially envisaged as having a nursing qualification but with relatively low pay and a case load of 50 (later reduced to 30), qualified nurses proved difficult to recruit.

Containing costs

Since the implementation of LTCI the Japanese government has made a number of moves to contain costs. There had been a large increase in the demand for institutional beds following the implementation of LTCI but the Japanese government was unwilling to increase the supply of this higher cost care option by building new nursing homes. This has resulted in long waiting lists for longer term care home places, but short stay respite care places are widely adopted⁴.

In 2005, charges for 'hotel costs' fees for accommodation and food, were introduced in institutional care, and home help services have been restricted to those who live alone or with severe disabilities⁵.

There is no restriction on new providers entering the market and these providers try to stimulate demand. The 10% co-payment by users acts however as a 'weak brake' on costs⁷ and, in 2006, around 25% of those eligible at the lowest level of need were transferred to a preventive care programme with lower benefit ceilings⁷.

Despite this, the total cost of long-term care services in Japan is projected to rise from ¥3.6 trillion in 2000 and ¥6.4 trillion in 2005, through ¥8.3 trillion in 2011 and ¥8.9 trillion in 2012, to ¥18-21 trillion in 2025^{2,3}.

Impact

The long term care insurance scheme (LTCI) in Japan has been generally well received, with 61% saying they appreciate the programme and 23% saying they do not. There has however been a high level of 'mixed response'. Although, for example, 34% felt that the quality of services had improved and 14% thought it had got worse, nearly one half (47%) felt the results were mixed³. However, the majority of older Japanese (70%) still want to receive care at home with 46% wanting that care to be independent of other family members³.

"The programme was set up quickly with few administrative difficulties and it has become an accepted and highly supported component of Japan's social policies"⁴. There is no evidence that employers have favoured younger workers, aged under 40, to avoid paying their share of the premiums.

The Japanese LTCI is a mature system serving around 5 million people. The number of beneficiaries in institutional care has increased by 83% but the number of people receiving home and community based services more than tripled in the first ten years⁴. The implementation of the scheme saw a sharp uptake in the use of formal services by frail older Japanese, rising from around one half (52%) in 1998, to three quarters (76%) in 2001 and 2004. As services are not means tested, the change in take-up was greatest among high income Japanese⁴.

The 10% co-payment has a limiting effect on demand and, on average, recipients of home care take just 40-60% of their entitlement⁴.

Many studies worldwide have demonstrated the physical, psychological and financial effects of family caring, particularly on the ability of the carer to continue in employment⁹. A number of studies in Japan have demonstrated an improvement in the physical burden of care for carers, following the implementation of LTCI, and some studies have shown a reduction in the emotional burden. High income Japanese family carers were substantially more likely to be employed, or spend increased time in employment, following the introduction of LTCI, but for middle and low income groups there was no significant change⁴.

The intention of the LTCI programme to develop a market for social care providers and give older people a choice of services based on convenience and quality rather than price, has been relatively successful but has faced some difficulties. As for elsewhere in the world, low wages for care staff is creating recruitment problems, particularly in Tokyo.

⁹ Centre for Policy on Ageing (2015) - *Older and sandwich generation carers and the impact of caring*.