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Naoki Ikegami

## The Long-term Care System in Japan



Global Dynamics  
of Social Policy CRC 1342



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# THE LONG-TERM CARE SYSTEM IN JAPAN

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Naoki Ikegami\*

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## 1. COUNTRY OVERVIEW



- » Sub-Region: Eastern Asia
- » Capital: Tokyo
- » Official Language: Japanese
- » Population size: 126,5 million (in 2020) (UN 2018)
- » Share of rural population: 8.2 % (in 2020) (UN 2018)
- » GDP: 5,082 billion US-\$ (in 2019) (World Bank 2021)
- » Income group: High income
- » Gini Index: 32.9 (in 2013) (World Bank 2021)
- » Colonial period and Independence: N/A

Source: D-maps.com (<https://d-maps.com/m/asia/japan/japonryukyu/japonryukyu29.gif> accessed September 2021). Ryukyu islands included at the bottom right. Northern Territories claimed by Japan and occupied by Russia are only partly depicted.

## 2. LONG-TERM CARE DEPENDENCY

### a. Population statistics

**Table 1.** Older population (in 2020)

	Total number (in millions)	Share of total population
Population 60+	43.4	34.3 %
Population 70+	27.5	21.8 %
Population 80+	11.3	9.0 %

Source: United Nations 2019; Ministry of Health, Labour and Welfare 2019, Table 4.27; own calculation.

**Table 2.** Long-term care dependent population in April 2019

	Total number (in millions)	Share of total population	Share of population 70+
Number of recipients receiving preventive long-term care services (MHLW 2019)	0.75	0.6 %	2.5%
Number of recipients receiving long-term care services (MHLW 2019)	4.33	3.4 %	14.8%

Source: United Nations 2019; Ministry of Health, Labour and Welfare 2019, Table 4.27; own calculation.

### 3. NATIONAL DEFINITION AND MEASUREMENT OF LONG-TERM CARE DEPENDENCY

The literal translation of long-term care (LTC) is seldom used in Japan except among experts. The commonly used word for LTC is “kaigo”. “Kaigo” refers to the caring of elders. It came into common use after the government had implemented a “Five Year Strategy to Promote Health and Welfare for Elders (commonly and henceforth to as the “Gold Plan”) in December 1989 for improving the care of elders. By the end of the programme’s completion, the word “kaigo” came to be widely used. The “Five Year Strategy” was extended for another five years during which the “Kaigo Hoken” (Care Insurance, henceforth referred as KH) was legislated in 1997 and implemented in 2000. Since its implementation, “kaigo” refers to the care of elders in general; KH to the public insurance for care services.

Before the implementation of KH, most LTC services were provided, on application, by the municipal welfare offices. Although the fees levied were based on a sliding scale, most did not pay because the services were focused on the poor and those living alone. Instances of ad hoc and seemingly unfair decisions made by government employees (who were seldom trained as social workers) were one reason for adopting a social-insurance-based system. The process was perceived as being ad hoc, unjust and bureaucratic. Some LTC services such as institutional care in LTC hospitals and visiting nurses were also covered by health insurance based on decisions made by physicians. In order to make a clear break with this pattern, in KH, access to LTC services was unified and determined by the following process:

- 1) The applicant applies to the municipal office.
- 2) The municipal office sends an assessor, usually a nurse, to the applicant.
- 3) The assessor interviews the applicant using an 84 (now 74)-item questionnaire on their ability to perform activities of daily living (ADL), such as dressing or eating, and additional open-ended questions on behavioural aspects.
- 4) The responses to the questionnaire are fed into a computer which, in a “primary evaluation”, groups the applicant into one of the six (now seven) levels of eligibility or ineligibility.
- 5) The applicant’s doctor fills in the “Opinion of the Attending Doctor” form. The form includes questions on behavioural aspects and prognosis.
- 6) The Eligibility Assessing Committee established in each municipality makes the “secondary (and final) evaluation” based on further information from 3) and 5). This Committee is made up of experts such as physicians and KH experts.
- 7) Those eligible are entitled to spend from 50,000 to 354,000 Yen per month in community care. In institutional care, the cost of providing care service, which differs according to the type of facility plus some of accommodation and meal costs, the proportion of which differs according to their income level and/or the amount in the bank account for the officially recognized types of facilities. There is a 10% coinsurance for the service costs which was later increased to 20% or 30% for those with higher incomes. However, less than 10% of those eligible pay more than the standard 10%.
- 8) In community care, the beneficiary chooses a care management agency. The care manager then draws up a care plan in which services to be delivered almost always lie within the amount set by the beneficiary’s entitlement level. If the beneficiary agrees to the plan, service agencies are contracted and the services provided. For institutional care, the beneficiary selects the facility. The per diem amount varies according to the type of facility. Facilities that have a higher proportion of licensed nurses have higher rates but there is no process of triaging applicants among the various types of facilities.

### 4. FIRST PUBLIC SCHEME ON LONG-TERM CARE

#### a. Legal introduction

Name and type of law	Kaigo hoken-hō (Care Insurance Law)
Date the law was passed	December 9, 1997
Date of <i>de jure</i> implementation	April 1, 2000

Brief summary of content	The aim of the law was to provide health and social service benefits for the purpose of maintaining dignity and enabling independent living for those who require assistance, nursing care, functional training and medical care in the activities of day living arising from diseases of ageing. The law establishes a long-term care insurance system providing benefits in kind according to the defined eligibility levels.
Socio-political context of introduction	The law was a response to current and future social LTC needs resulting from the ageing society, and to unify the provision of services, which hitherto had been divided into health and social services. The LTC services that had been funded and provided by the municipal government were perceived as arbitrary and unfair, and those provided by health insurance for elders in geriatric hospitals as inappropriate and expensive. Through the new law, LTC services were to be made available on the basis of a transparent process and a new source of funding from LTC insurance premiums.

## b. Characteristics of the long-term care scheme at introduction

The delivery of LTC services expanded after health care had been made “free” in 1973 for elders 70 and over (before, almost all had to pay a 30 %-50 % co-payment). This led to many private hospitals becoming de facto nursing homes. Social services had increased after the “Gold Plan” was launched in 1989, which led to massive increases in public funding. The objectives of the KH lay in integrating these services into one scheme and in strengthening the financial basis by levying a new premium.

The LTC scheme mandates all residents of Japan aged 40 and over to enrol in KH. The parent of an employee may be enrolled as a dependent. Those aged 65 and over are covered for all conditions. Those aged 40 to 64 are covered only if LTC needs resulted from one of 15 designated diseases related with ageing. Originally, LTC benefits were provided according to five “Needs care”-levels and one “Needs support”-level. Benefits are only provided in the form of services from KH providers accredited by the municipality. There are no cash benefits because they were opposed by women’s rights organizations on the ground that it would only increase the pressure on women to provide care to their parents-in-law. Service provision includes care that is delivered at home, in the community and in residential institutions.

All services are officially targeted at elders needing care, not the family. However, day care and respite care de facto mitigates the informal provider’s burden. The municipalities serve as insurers and main actors for making KH services available to the residents aged 65+ living in their jurisdiction. The KH is financed by premiums (about 45 %), tax spending (about 45 %), and user charges (about 10 %). Notably, costs for bed and board are partially covered by the KH for the low-income to avoid applications for public assistance. Those with middle to high income pay 20 to 30 % co-insurance but they represent only about 10 % of the elders. The national government is responsible for oversight, subsidizing municipalities with higher percentages of residents aged 75 and over and lower incomes compared to other municipalities, setting nationally uniform eligibility criteria and benefit levels, staffing and licensing standards.

## 5. SUBSEQUENT MAJOR REFORMS IN LONG-TERM CARE

### a. Major reform I

Name and type of law	2005 Revision of the Kaigo Hoken
Date the law was passed	October 1, 2005
Date of <i>de jure</i> implementation	April 1, 2006
Brief summary of content	The number of eligibility levels was increased from six to seven. Most of those in “Needs Care Level 1” were transferred to the newly created “Needs Support Level 2” (with less benefits). Emphasis was placed on preventing decline. “Hotel service” costs (bed and board) levied for residents in institutional care facilities.

Socio-political context of introduction	The reform was driven by the need to contain KH expenditures. To make the reform politically palatable, the emphasis was placed on preventing decline.
Brief summary of characteristics of the programme	In line with the emphasis on prevention, day care was promoted while access to home-helper services was made more restrictive. The payment of bed and board came to be an explicit obligation of the resident; however, they continued to be fully or partially paid by KH's supplementary benefits (not by public assistance). The proportion paid by KH depends on the resident's income and the amount in his or her bank account. About 60 % of residents receive such benefits due to low income.

## 6. DESCRIPTION OF CURRENT LONG-TERM CARE SYSTEM

### a. Organizational structure

The KH covers all residents aged 65 and over as well as those aged 40 to 64, if LTC dependency is due to an "age-related disease", such as stroke or dementia, or cancer; i.e., not resulting from injury. The 1,700 municipalities, as KH insurers, are responsible for setting the premium level of those aged 65 and over living within their jurisdiction and also for making services available.

### b. Service provision

KH benefits are provided in the form of services, not in cash, with amount determined by the applicant's eligibility level. There are two light care "Needs support" levels focused on preventive services such as day care. Then, there are the five "care needs" levels that provide for services at home, in the community, or in residential care facilities.

Eligibility levels	Percentage of recipients
Needs Support Level 1	5.7%
Needs Support Level 2	9.0%
Needs Long-term Care Level 1	22.3%
Needs Long-term Care Level 2	21.0%
Needs Long-term Care Level 3	16.4%
Needs Long-term Care Level 4	14.9%
Needs Long-term Care Level 5	10.7%

Source: MHLW 2019: Table 4.27, own representation.

In April, 2017, 77 % of KH recipients received services at home such as visits by home-helpers, and/or in the community such as in day care centres, while the remaining 23 % received long-term care in the designated KH facilities for the elderly (MHWL 2018: Table 2). Thus, over three-quarters appear to be receiving services in community settings. However, nearly the same proportion as those in the designated KH facilities live in "private nursing homes with fees", group homes, and "residences with services for elders". The number in the latter has increased rapidly since the implementation of the KH. By making LTC services an entitlement and by levying bed and board costs from residents in the designated KH facilities, the division between "community care" and "institutional care" has become blurred and to have little meaning for the service users (Ikegami, 2017).

### c. Financing

In 2017, Japan spent about 2 % of its GDP on long-term care as defined by the OECD, of which 1.8% were financed by public sources and 0.2% by household out-of-pocket spending (OECD 2021). For the same year, the MHLW reports KH expenditure of 9,897 billion Yen, corresponding to 1.86% of GDP (MHLW 2019: Table 6.3).



User charges make up 10% of the total KH expenditures. Of the remaining 90% that is publicly financed, half is financed by taxes and the other half by KH premiums. Financing starts with the municipal government setting the premium rate of those aged 65+ living within its jurisdiction every three years. These premiums constitute about 20% of the publicly financed KH expenditures and are usually deducted from public pensions. The rate is higher if the municipality's expenditures are higher than the national average and differ by a maximum of threefold. The remaining 30% is financed by premiums from those aged 40 to 64 which are pooled at the national level and distributed to the municipalities. In doing so, the amount is weighted by the ratio of the 65-74 years age group and the 75+ living in the municipality. For those aged 40-64, premiums are collected by the health insurance plan in which the beneficiary is enrolled. These premiums are levied on a per capita basis so that the contribution rates differ for each health insurance plan. In the largest National Health Insurance Association, the KH contribution rate was 1.79% of their wage income (2018-2021).

The other half is financed by taxes, of which the national government finances half, and the local governments finance the remaining half. The amount financed by taxes is distributed to the municipalities. However, municipalities with lower income levels receive more from the national government.

This complex arrangement was designed so that municipalities would be held accountable for their KH expenditures, but at the same time would be compensated for factors beyond their control, namely the age composition and income levels of the elders living within their jurisdiction. However, the municipal governments have little control over expenditures. If the standard conditions are met, a license to deliver services is given to providers. Elders are entitled to receive services up to the benefit amount set by their eligibility level.

Those aged 40-64 only receive 3% of the KH benefits despite the fact the premiums they contribute comprises about 30% of the total KH expenditures. The government justified this imbalance with the argument that when beneficiaries reached the age of around 40, their parents would start using KH services so they would benefit indirectly.

#### d. Regulation

The national government is responsible for oversight, setting the nationally uniform eligibility criteria and benefit levels, staffing and licensing standards. The providers' compliance with the KH fee schedule's regulations is inspected when the claims are filed at the beginning of each calendar month by the Coalition of Municipal KH Insurers at the prefectural level. An on-site "guidance" is made on an ad hoc basis in which the claims data are cross-examined with the clients' records and the staff attendance records. Should there be any discrepancy, the "guidance" becomes an audit. An audit will also be made if there are complaints from users or insurers. If the audit shows that records have intentionally been falsified, the provider may be delisted as a KH accredited facility, which would de facto lead to its closure. Since payment is closely linked to the qualifications of the staff and the level of staffing, these measures have been effective in maintaining the structural measures of quality.

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