Long-Term Care Insurance Comes To Japan

A major departure for Japan, this new program aims to be a comprehensive solution to the problem of caring for frail older people.

by John Creighton Campbell and Naoki Ikegami

PROLOGUE: Would-be Medicare reformers regularly emphasize the fact that population aging is expected to put severe stress on the Medicare budget over the coming decades. So familiar are the statistics on aging baby boomers that it is often lost on Americans that many other industrialized nations face even more dire predicaments. For example, while nearly 17 percent of U.S. citizens are expected to be over age sixty-five by the year 2020, Japan has already surpassed this figure and expects a staggering one-fourth of its population to be over age sixty-five in twenty years. U.S. policymakers should take heart that other nations have already been down this road, and, as in the case of Japan, are even aggressively attacking the problem.

John Campbell and Naoki Ikegami chronicle the development of Japan's new mandatory long-term care insurance program, in this paper written just before its implementation. Campbell, a political scientist with a long-standing interest in Japan and its institutions, is a professor at the University of Michigan. He earned his doctorate from Columbia University. Ikegami is professor and chair of the Department of Health Policy and Management at Keio University’s School of Medicine in Tokyo, where he received his medical and doctoral degrees. He is a board member of interRAI, an international organization committed to developing and promoting care planning instruments. Campbell and Ikegami have been collaborating on Japanese health policy research for nearly a decade.
ABSTRACT: Japan has moved decisively toward “socialization of care” for the frail elderly by initiating public, mandatory long-term care insurance (LTCI) on 1 April 2000. The LTCI program covers both institutional and community-based caregiving. Everyone age forty and older pays premiums. Everyone age sixty-five and older is eligible for benefits based strictly on physical and mental disability, in six categories of need. Benefits are all services, with no cash allowance for family care, and are generous, covering 90 percent of need. Long-term costs seemed not to be a major consideration in program design. Consumers can choose the services and providers they want, including use of for-profit companies.

On 1 April 2000 Japan started the biggest and most radical program of public, mandatory long-term care insurance (LTCI) in the world. This event is quite surprising: Japan has long had a reputation for being laggardly as a welfare state and is famous for its tradition of family care for the elderly. Although the rate has been dropping, more than half of persons over age sixty-five live with an offspring, and daughters-in-law are the typical caregivers for bedridden or frail older persons.

The new program, called Kaigo Hoken (literally, “care insurance”), is aimed at the “socialization” (shakaika) of care through mandatory social insurance: Everyone age forty and older with an income must contribute, and all older persons with even a relatively mild disability are eligible, regardless of income or family situation. The program will cover nearly the full cost of institutional or community-based care (formal services only), depending on the level of disability. Estimated spending is ¥4.7 trillion ($43 billion) in the first year, rising to more than ¥7 trillion ($70 billion) at maturity eight or ten years later. Most of this spending is to be offset by reductions in the health insurance and social services categories that now support long-term care, and since the program is just getting started, these spending figures are speculative. In particular, the early estimates of long-range spending are clearly outdated, but they have not been publicly updated by the government.

Why was the program enacted? In recent years Japanese leaders have been calling for restraints or cutbacks on welfare-state spending; given Japan’s decade-long economic doldrums, the passage of so large a new program seems particularly unlikely. Asked about this anomaly, Japanese decisionmakers always point to two distinctive social facts: First, Japan has the most rapidly aging population in the world and soon will have the largest percentages of the elderly and of the oldest old in its population. The Japanese media have covered this story widely during the past twenty years. Second, with fewer children, more women working, and changing attitudes toward family responsibilities, the traditional system of informal caregiving is widely viewed as being in crisis, or at least inadequate.
These two “facts” (or social perceptions) help to explain why Japan might be more likely than other nations to emphasize programs for long-term care. Still, social perceptions do not translate automatically into governmental policy. The decision to enact LTCI should be understood in the light of past attempts to deal with what has often been viewed as Japan’s most pressing policy dilemma—the “problem of the aging society” (kôreika shakai mondai)—and within that the problem of care for frail older persons.

**Background**

The first modern programs for older people in Japan date back to 1963, but the major expansion came in 1973, when, in response to rising public concern, medical care was made virtually free for persons age seventy and older (and the bedridden age sixty-five and older). At that time social services, including nursing homes and home care, were still means-tested and not usually available to anyone who could be cared for in the family. From 1963 to 1993 the number of hospitalized older persons increased tenfold, and they occupied nearly half the hospital beds (about one-third of these for stays of more than a year). Japan’s rate of institutionalization is about 6 percent of the population over age sixty-five, similar to other rich nations, but most are in hospitals paid from medical insurance even though many do not require much medical supervision (a situation unique to Japan).

**The Gold Plan.** These inappropriate, expensive “social admissions” and the inadequate supply of both home care and nursing homes under social services were seen as serious problems in light of Japan’s rapidly aging population and the perceived decline in families’ capacity to provide care. In response, the ruling Liberal Democratic Party came up with the Gold Plan in December 1989 as its major campaign promise for the Lower House election early the next year, after a stinging defeat in an Upper House election. The Gold Plan, more formally called the “Ten-Year Strategy to Promote Health and Welfare for the Aged,” set targets for major expansions of services, such as more than double the number of nursing home beds, triple the number of home helpers, and (from a small base) ten times the number of adult day-care centers. Also added were some new programs such as local agencies to coordinate home care.

The political significance of the Gold Plan was that this was the first time that care for frail older persons had become a major public issue. The policy significance was that the government had now taken on a big new responsibility to provide long-term care to all frail older persons, not just the poor or those without families.

The significance of the Gold Plan was not immediately apparent.
Progressives attacked it as too little, too late and as not really relieving family caregivers’ burdens. Indeed, in Japan, as elsewhere, campaign promises and big-government plans often are left to wither and die. However, in the early 1990s public demand for services exceeded even the rapidly growing supply. Many municipal governments, which had been given a new role in planning health and welfare programs for the elderly, were converted from unwilling agents of national policy to supplicants for program expansion, even though they had to bear a share of the cost. In 1994 the government raised its ambitious targets greatly in the “New Gold Plan.”

The road not taken to Scandinavia. However, serious problems were emerging. Although more by default than by explicit choice, Japan was actually moving toward a Scandinavian-type system of broad entitlement to extensive social services provided by local government (directly or by contract to monopoly nonprofit suppliers), financed by a mixture of national and local taxes. User fees could be charged on a sliding scale based on income, but this was a small portion of costs and was inconsistently applied.

On the one hand, this system was getting expensive, at a time when Japanese were seen as unusually sensitive to tax hikes. On the other, the administrative apparatus for deciding eligibility and providing services was still the old placement system (sochisei) derived from public assistance. It might work fairly well to provide small-scale services to a limited population (by income and especially, in practice, availability of family support) but not for large-scale services to many people. Criteria for eligibility were particularly problematical and would be unless Japan were in effect to move to northern Europe and simply give benefits to anyone who asked for them.6

These and other considerations motivated Japan to search for a different way. In essence, Japan turned from the road to Scandinavia and opted for a social insurance model similar to the program initiated in Germany in 1995.7 Passage of the legislation took until late 1997, and then some two years were needed for intensive preparations, particularly at the municipal level, before eligibility screening started in October 1999 and the program itself, in April 2000.

The Debate

Although space precludes a detailed analysis of the decision-making process leading up to LTCI, it is interesting to look at the main issues raised (and not raised) in the debate. Most of the discussion was carried out within a fairly narrow group of organizations and individuals who had long been active in social policy. At the level of interest-group politics, representatives of physicians and local governments bargained hard and successfully to be sure that their con-
cerns would be reflected in the new system. Perhaps the liveliest battle was a rear-guard action by much of the old social welfare establishment to preserve the tax-based, direct-service-provision model. Their arguments, based in part on protecting current recipients of services, lost out to proponents of social insurance. There also was much consideration of what kinds of services would be provided in what quantities.

The issue that drew the most attention was whether or not cash allowances for family care should be included. Although polls showed support for a cash allowance, it was rejected. There were three arguments against it. First, welfare professionals said that the top priority should be a rapid expansion of formal services, which would not occur unless demand was high. Second, feminists maintained that the allowance would just go into the household budget, and family caregivers would continue to be exploited, unless there were a radical change in the system (contrary to most expectations about Japanese politics, feminists’ concerns were widely and sympathetically heard). Third, as some sober-minded officials pointed out, even if the cash allowance were of less value than the services option, everyone even remotely eligible would likely apply immediately (subsequent German experience bore this out). Although a cash allowance would be cheaper in the long run, full financing for LTCI would be required immediately, whereas the government’s intention was to phase the program in gradually by counting on a low initial level of applications.

One might think that a debate over cash allowances, or over the larger notion of “socialization of care,” would motivate social conservatives to defend the traditional Japanese family system. In Germany the use of cash to express “appreciation” for a family caregiver had been widely heralded. However, in Japan such criticism of LTCI was not much heard prior to enactment. Still more notable was the lack of opposition from fiscal conservatives. In Germany great attention had been given to the overall cost of the program, how to limit future cost increases, and how the costs would be apportioned (in particular, whether employers should pay). Cost issues received remarkably little notice in Japan during most of the process.

However, both sets of concerns burst forth in fall 1999, when the first stage of implementation was just beginning. LTCI suddenly got caught up in complicated interparty and factional politics surrounding the formation of a new three-party governing coalition and an upcoming general election (the worry was that voters might react strongly against having to pay a new social insurance premium).

This political tempest activated both fiscal and social conservatives at last—the former calling for a switch to tax financing, with
talk of means-testing; the latter for cash family-care allowances. There was even talk of postponement. The Ministry of Health and Welfare (MHW), politicians who supported the program, and particularly the municipal officials who had worked so hard to prepare all fought back vigorously. The result was a compromise: a short-term freeze on premiums paid by the elderly, to be made up by extra budget money (about ¥1 trillion, almost $10 billion), and provision of a small means-tested family allowance outside the LTCI framework. These new provisions do not appear to have disturbed program fundamentals too much, although they may foretell a major shakeup even before the scheduled full-scale review five years hence.

The Program

The new LTCI program departs from past Japanese practices in several important respects. It aims to (1) shift a major responsibility for caregiving from the family to the state; (2) integrate medical care and social services via unified financing; (3) enhance consumer choice and competition by allowing free choice of providers, including even for-profit companies; (4) require older persons themselves to share the costs via insurance premiums as well as copayments; and (5) expand local government autonomy and management capacity in social policy. The government plans to expand the new program gradually over ten years, leading to a major expansion of community-based care, a fundamental reform of financing and regulation of institutional care, and, more generally, a flexible approach to social policy based on individual entitlement and choice.

Financing. Although the new LTCI program will operate mainly on social insurance principles, half of the money is to come from general revenues—50 percent national, 25 percent each from prefectures and municipalities. This pattern essentially extends the current pattern for health insurance, which partially relies on subsidies from general revenues. The social insurance half of total LTCI spending will come from two new premiums. First, persons ages forty to sixty-four will pay a supplement to their health insurance premium, which for employees is initially estimated to be 0.9 percent of monthly income up to a ceiling, shared with the employer. Anticipated savings to health insurance by transferring costs to the LTCI program should have offset this new premium by more than half, but since health expenditures have been rising, the decrease
will be partially offset. Second, persons age sixty-five and older will have premiums deducted from their public pensions. The amount will depend on income, at five levels, with the average in the first year to be about ¥2,800 (≈$26) per month.

In total, LTCI is budgeted to spend ¥4.3 trillion in fiscal year 2000, the initial year; the official calculation is that this figure represents only a 13 percent increase from the corresponding budgets in health insurance and social services for FY 1999. Since annual growth of long-term care spending had been in the 10–15 percent range for the decade of the Gold Plan, it is clear that the government was trying to minimize the fiscal impact of the start-up; in fact, spending from general revenues was supposed to decrease slightly as new premiums would be levied. That is no longer true after the last-minute political decision mentioned earlier, which provides national general revenues to subsidize the premiums paid by the elderly (in full for the first six months and then half for another year).

The long-term care insurance carriers are Japan’s 3,200 villages, towns, and cities. This choice is logical in that municipalities were already responsible for social services and for health insurance covering retired persons and other nonemployees (about one-third of the population). However, many municipalities are too small to manage an insurance program very well, in terms of both risk-pooling and administrative capacity, and great disparities exist among municipalities in age distribution and resources. The government has tried to compensate for these deficiencies by encouraging joint management schemes and by fiscal mechanisms for risk adjustment. The premiums paid by persons ages forty to sixty-four are pooled at the national level and allocated to municipalities according to a formula based on demographics and income, and there is an additional fund to help municipalities with severe deficits.

The insurer—the municipal government—has the formal responsibility to determine how much it will spend on LTCI statutory benefits for its eligible residents. Although the procedures and formulas for this calculation were drawn up by the MHW, local officials do have some leeway. They draw up a budget for LTCI based on estimates of supply and demand. One-sixth of this budget is covered by premiums to be paid by local residents age sixty-five and older. The municipality then receives twice this amount from the national pooling fund of premiums paid by those ages forty to sixty-four. The remaining half of the budget comes from general tax revenues at the national, prefectural, and municipal levels. If the municipality wants to provide more services, it can charge a higher premium, and in any case is responsible to its voters. This explicit linkage of decisions about costs and decisions about benefits at the local level
is seen as an important innovation in Japan.

**Beneficiaries, eligibility assessment, and case management.** Everyone age sixty-five and older, plus anyone ages forty to sixty-four with an aging-related disability (such as Alzheimer’s disease or stroke), is eligible for LTCI. Eligibility for the younger group is designed to provide a tangible payoff so that all who must pay premiums have access to benefits. Eligibility is strictly a matter of age and of physical and mental condition; income and family situation do not matter. This is another policy innovation.

An estimated 2.7 million older persons, 12.4 percent of the elderly population, are eligible for benefits in 2000. It is assumed that the 705,000 of them who live in institutions will apply for coverage, but of those in the community, the official estimate is that only about a third (650,000) will do so right away. Thus, in the initial year there should be 1.35 million elderly beneficiaries (6.2 percent of the elderly population); this will rise gradually until about 80 percent of eligible persons in the community will have signed up after eight to ten years. However, there is no mechanism to inhibit applications or to deny eligibility, so the government’s expectation of relatively low demand in the early years may not come true.

After individuals (or their families) apply to the municipal government, an on-site assessment is conducted of each applicant’s physical and mental status. The assessment form contains eighty-five items, each with a choice of three or four levels, plus space for descriptive statements on particular aspects. These items are analyzed by a government computer program to classify each applicant into one of six levels (or to reject—about 3 percent in the first round). The lowest level, called “assistance required” (yôshien), is intended for preventive services; the other five levels are called “care required” (yôkaigo). An expert committee reviews the classification by taking into account the descriptive statements plus a report from the applicant’s doctor. The eligibility decision is then to be communicated to the applicant within thirty days of applying. If dissatisfied with the decision, applicants may appeal to an agency at the prefectural level and ultimately to the courts. Eligibility is to be reevaluated every six months.

Each eligibility level entitles the applicant to an explicitly defined monetary amount of services. The amounts are quite generous, ranging from ¥61,500 to ¥358,300 ($560–$3,260) per month. The recipient is to cover 10 percent of this amount as a copayment and can purchase additional services out of pocket if desired. In theory, the applicant can choose any certified providers and any listed services. In practice, a major role is played by a “care manager” who writes a “care plan,” a weekly schedule of service provision. Care managers
are persons with experience in the field who have passed an examination and undergone brief training. Most of them are to be employees of the organization that provides most, if not all, of the services to that client. However, the care plan must be approved by the client or family, who can change their care manager at any time.

The various decisions about eligibility and services are not made by the municipal government, even though it is the insurer and bears the financial responsibility. The expert committee is named by the mayor but includes no municipal representatives; it usually has five members: two physicians plus social workers, nurses, and others. Also, in many municipalities even the initial assessment is carried out by one of these care managers who works for a provider organization. This pattern raises the question of whether eligibility determination will have a built-in upward bias or whether care plans will have a tendency to favor providers’ rather than clients’ interests.

Municipal governments do have considerable autonomy in these arrangements, and some have already decided to have their own employees do the assessments or serve as care managers for difficult cases, to prevent undue provider influence. They cannot, however, go so far as the British pattern, where the care manager is a local official who controls a set budget and apportions it among clients in accordance with some definition of their needs. In the new Japanese program the amount of the benefit is decided strictly on the basis of physical and mental condition, by a relatively objective process, and the client has ultimate control over how that benefit is spent.

Service provision. The services covered by the LTCI program are divided into institutional and community-based care (which may be either delivered to the home or provided in institutions to persons who live in the community). Both categories have hitherto been covered under both social services and health insurance, an exceedingly complicated situation that should be simplified in the long run by unified financing under the new LTCI program. Transitional problems will be difficult, particularly in dealing with current recipients who might be disadvantaged by the new system.

Institutional care. It is estimated that 705,000 persons will be covered by LTCI, in three types of facilities: nursing homes (43 percent of beds), previously under social services; and two types previously covered by health insurance—health facilities for the elderly (29 percent of beds) and designated long-term-care beds in hospitals (28 percent of beds), which are mostly upgraded from ordinary hospital beds by providing somewhat more floor space per bed. The intention is eventually to merge the three types, which makes sense given that neither the characteristics of the residents nor the actual care they get differs very much. Incidentally, only a portion of
the hospital beds providing long-term care will be transferred to LTCI; the rest, perhaps some 400,000, will continue to be covered by health insurance. Thus, the widely announced savings to be made from preventing “social admissions” to hospitals should be much less than anticipated.

Community-based care. Community-based services covered by LTCI include some former social services such as home help for caregiving or housekeeping, bath service, loan of devices such as wheelchairs, and home reconstruction; some former health insurance benefits such as visiting nurses, rehabilitation, and “medical management” (supervision of care plans by physicians); and some services that had been available from both sectors, such as adult day care and temporary “respite” stays in an institution. To give an idea of the scale of community-based service provision in the first year, it is estimated that 200,000 persons will receive visiting nurse services with an average of 5.6 visits per month, and that there will be eighty million home-help visits, thirty hours per month per recipient.

Transitional Problems

■ Eligibility for services. Many current recipients of long-term care services are not frail enough to qualify for LTCI benefits, at least not at a high level, and these persons also face the 10 percent copayment (most had been paying little or nothing). Various steps have been taken to ease this situation, such as allowing residents classified as noneligible (about 3 percent so far) to remain in nursing homes for five years and lowering the copayment to 3 percent for persons who had been receiving community-based social services. Also, many municipalities will continue to provide services to those not qualifying for LTCI under their own social welfare programs.

■ Provider competition. On the supply side, the big change is with the former social services such as home care, which had been dominated by monopoly providers (local government, highly restricted types of nonprofit organizations, or contracted-out private services), but which are now open to for-profit companies and voluntary groups (subject to licensing by the prefecture, which is supposed to be liberal). Traditional providers are worried about their ability to compete, while potential new entrants are hungrily looking toward what they hope will be a vastly expanded market.

Competition is supposed to be on the basis of quality, since services are all regulated by a fee schedule established by the national government. As with institutional care, price levels have been set to minimize disruption for providers, based on current social service budgets and reimbursement under health insurance. Various distinctions will be maintained. For example, day care in medical facili-
ties will have fees about 20 percent higher than those for social service providers, presumably reflecting more rehabilitation services given. For home care, the prices reflect time per visit (thirty, sixty, or ninety minutes) and providers’ qualification (nurses get up to triple the fee of home helpers).

**Balancing supply and demand.** The most important transitional problem will be balancing supply and demand. Municipalities have a generalized responsibility to plan for the supply of services, but they now must do so indirectly, by encouraging providers and perhaps selectively investing in new facilities, rather than through a routine budget process. For the entire nation, it appears that the current available supply of home-care services roughly matches up to the government’s estimate of initial demand under LTCI. However, great variation exists both across local areas and across types of services. If more persons than expected apply and become eligible, the municipality must either ration services among beneficiaries (politically quite difficult) or somehow scramble to increase services. Or if beneficiaries make choices that are different than anticipated—in particular, if many now in the community opt for institutional care—local officials might be faced with severe complaints from dissatisfied frail older persons and their families.

**Moving Forward**

One might well ask, Why has Japan embarked on such an expansive program when its economy has notoriously been so feeble? First, as already noted, the macroeconomic or even the fiscal impact of LTCI was rarely brought up during the decision-making process. Germans and Americans will find it difficult to believe that this major program could be enacted without careful estimates of future costs by the government and detailed critiques from fiscal conservatives, but cost simply was not a major consideration. Second, most LTCI spending, particularly in the early years, will just be replacing spending from health insurance and social service budgets. In fact, Japan had already been spending so much on long-term care, because of the rapid growth of both institutional and community-based care in the 1990s under the Gold Plan, that the increase in the first year of the new LTCI program is likely to be marginal.

The key to low initial spending levels is the assumption that only about a third of eligible persons living in the community will apply in the first year, because of their unfamiliarity with the program or reluctance to accept care from outside the family. Early reports on the number of applications indicate that this assumption may not be far off target, but no one knows how people will respond to the program as it develops, especially as they start paying premiums.
The key point, perhaps not yet quite realized by many in Japan, is that LTCI is an entitlement program, and under the present legislation neither the national nor the municipal governments have any effective control over who will apply, whether they are eligible, the amount of entitlement, or what kind of services will be chosen (except, in the last case, by influencing the supply of various services through differential investment, or by manipulating the price schedule to make provision unprofitable).

In our view, the government’s assumption that demand will increase only gradually rests on shaky ground. When services became available with the Gold Plan, there was a huge increase in demand. Equally problematical is that the majority of long-term care hospital beds, the key to savings in health insurance, will be left untouched.

If early spending turns out to be higher than these estimates, there might be attempts to stem the tide, as by tightening eligibility criteria, cutting benefits, or even eliminating the lowest “assistance required” category. The excuse would be insufficient availability of services or too high costs. However, particularly if the public can see that the potential supply is expanding rapidly with the entry of new providers, and if these services come to be perceived as an entitlement, the political reaction could be intense. The uproar that occurred when postponing the implementation of LTCI was suggested in 1999 indicates that politicians will think twice before tampering with this high-profile program.

Our guess is that revenue shortfalls will lead the government to change the law and start collecting premiums from everyone, not just those age forty and older, and in exchange expand LTCI coverage to everyone with disabilities. Since usage would be fairly low among younger people, the financial picture would brighten considerably, and the result would be a disability-based rather than an age-based program, which many believe is better public policy. Another plausible reform would be to introduce disincentives for choosing institutional care, as by requiring residents to pay out of pocket for their room charges (as is now done for meals) to make the costs more compatible with those of home care.

The new LTCI program has been one of the most publicized policy issues of the past decade in Japan. Politicians and bureaucrats, current and hopeful providers, and older persons and their families all over Japan had been wondering what will happen after 1 April 2000. All of the problems—no doubt more than have been suggested here—may force some substantial modifications, but it is quite unlikely that Japan can reverse direction as it moves toward “socialization of care” for frail older people.
The authors thank the Abe Fellowship Program of the Social Science Research Council and Japan Foundation, and the Keio University Medical Service Fund, for their support of research leading to this paper.

NOTES

1. The official estimate for the first year is ¥4.3 trillion, for an eleven-month year because of the billing cycle. Dollar equivalents are at the current exchange rate of about ¥110 to the dollar. For some purposes converting by the purchasing power parity (PPP) rate is more useful; the most recent (1998) is ¥163 to the PPP dollar, at which spending in the first year would be about $29 billion. Organization for Economic Cooperation and Development, OECD in Figures 1999, available online at www.oecd.org/publications/figures/index.htm.


6. That is an oversimplification, but until fairly recently Sweden and Denmark were extremely generous in both eligibility and services provided. See J. Baldock and A. Evers, “Innovations and Care of the Elderly: The Cutting-Edge of Change for Social Welfare Systems—Examples from Sweden, the Netherlands, and the United Kingdom,” Aging and Society 12, no. 3 (1992): 289–312.

7. See A.E. Cuellar and J.M. Wiener, “Can Social Insurance for Long-Term Care Work? The Experience of Germany,” Health Affairs (May/June 2000): 8–23. Although in the past Japan had often borrowed its social policies quite directly from foreign countries, that was not really the case with LTCI. Serious planning started at about the same time as in Germany, and the main features of the Japanese plan were pretty well decided by the time the German program was enacted.


9. The MHW had also earlier made a grudging and small-scale concession on family care by authorizing rural villages where formal services are scanty to hire a relative as a home helper, so long as only half of her work time is spent at her own home and she has basic qualifications as a home helper.

10. For employees, since bonuses (usually some 40 percent of remuneration) are not included, the actual rate is below 0.6 percent. Nonemployees receive health insurance from their municipality, and their premiums are expected to
rise by about ¥1,000 per month at the start. See N. Ikegami and J.C. Campbell, “Health Care Reform in Japan: The Virtues of Muddling Through,” Health Affairs (May/June 1999): 56–75.

11. This takes into account the eleven-month year mentioned earlier. Figures for LTCI do not include additional spending on investment in facilities, some municipal service programs such as meal delivery to homes, and especially the large number of older people still getting long-term care in hospitals covered by health insurance.

12. Prefectures always pay 12.5 percent of the total; the national government covers 20–25 percent, and the municipality, 12.5–17.5 percent—the lower amount when its residents are relatively old and poor. An important difference from health insurance is that these payments are decided prospectively on the basis of a budget, rather than retrospectively based on actual spending.

13. Maintaining the same eligibility ratio, with the rapid rise in the old-age population, the number of eligible elderly persons five years into the program in 2005 will be about 4.3 million. It is estimated that something over half of the 3.1 million of these in the community will apply for benefits in that year. About 100,000 younger persons are estimated to be eligible in 2000. These figures were presented by the MHW in a meeting of the municipal directors in charge of LTCI, 29 November 1999.

14. This initial classification is made by a computer algorithm derived from studies of care costs and resident characteristics in institutional settings. The results of demonstration projects using the algorithm have been criticized as not reflecting the actual care burden. Although revisions have been made, the delineation of levels remains problematic.

15. Regional variations add a maximum of 7.2 percent to these amounts to make up for the equivalent higher prices set by the fee schedule for services.

16. At the first examination given in 1998, 230,000 nurses, home helpers, physicians, pharmacists, and others applied, and 90,000 passed. In the second exam in 1999, 165,000 applied and 68,000 passed. Consumers who directly purchase services without going through care managers must first pay the entire amount and get reimbursed later, instead of just paying the copayment.

17. Japan is also reforming its adult guardianship (or “durable power of attorney”) system to regularize decision making for the disabled.

18. LTCI benefits are about 50 percent higher for designated hospital beds and 10 percent higher for health facilities for the elderly than for nursing homes at the various levels of eligibility. However, nursing home capital costs are financed from a public subsidy, and their physician services and drugs will continue to be covered by health insurance. Since medical costs and capital investment have to be financed from LTCI payment for the other two types, the effective reimbursement rates for nursing homes and health facilities for the elderly are about the same.

19. The decision about whether or not to upgrade to “long-term care beds” has been left to each hospital administrator.

20. Because home-care providers are allowed to charge fees lower than those scheduled (which would allow for more visits), some price competition may emerge. Higher unit fees may not be charged, but the consumer can purchase additional services out of pocket.

21. In the current economic situation, Japan requires high deficit spending to stimulate the economy, and the new wages provided via LTCI should be a better use of money than the current pattern of wasteful public works. Moreover, the fundamental economic problem in Japan is oversaving by consumers, motivated in part by worries about care in old age. If the LTCI program alleviates such worries, it could lead to higher consumer spending.