

Japan's Policies on Long-Term Care for the Aged :
The Gold Plan and the Long-Term Care Insurance Program

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The population of Japan is aging at a rate unprecedented in the history of the world. Along with the issues of medical care and pensions, long-term care for older persons is one of the most important issues facing the Japanese. Traditionally, children of older persons provided long-term care. However, dramatic changes have taken place in the social structure. There is a rise in the number of people in need of care at the same time as women, who were the traditional caregivers, are increasingly working outside the home.

In 1989, Japan launched an ambitious ten-year plan with the goal of building a national infrastructure to care for its aging population while at the same time reducing costs. The Golden Plan, as it came to be known, was to be a major shift from long-term institutionalized care in hospitals and nursing homes to home programs and community-based rehabilitation facilities. At the same time, the government formulated a plan to make long-term care services universally available to older persons.

In December of 1997, the National Diet passed a Public Long-Term Care Insurance Law, which will go into effect in April of the year 2000. It was designed to cover the growing expenses of long-term care by reimbursing expenses for facility services and home care services to older persons who are in need of care.

Public long-term care insurance is Japan's fifth social insurance program, coming after medical care insurance, pension insurance, protective insurance against unemployment and occupational accident compensation insurance. As the population ages, all of the developed countries will be forced to deal with the issue of long-term care. Our country's efforts in this area will offer a variety of lessons to other developed countries.

The Status of Long-Term Care for the Aged

The aging of the population and the increase in older people in need of care have had a great impact on long-term care in Japan.

According to data for 1996¹, the average life expectancy was 77.01 years for Japanese men and 83.59 years for Japanese women, making the Japanese the world's longest living people. On the other hand, at the same time the birthrate in our country continues to decline. The total fertility rate, which indicates the average number of children born to a woman in her lifetime, was just 1.43 in 1996. This rate is much smaller than the rate of 2.1 which is needed to maintain the current population².

As a result of these two trends (the increase in average life expectancy and the decline in the birthrate), population aging in Japan has been progressing rapidly. The percentage of the population age 65 and over, was 10.3% in 1985, and is expected to reach 17.2% by 2000, and 27.4% by 2025. As Table 1 shows, the rate of population aging in Japan is much greater than that in other developed countries. Therefore, the various systems which are affected by these changes, such as pensions, medical care and long-term care, need to be revamped.

Along with these changes, we expect that the number of older people who are bedridden, have dementia or other difficulties and are in need of support in their daily lives will sharply increase. This number is expected to rise from two million in 1993 to 2.8 million by 2000 and 5.2 million by 2025. (Table 2)

¹ Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare, Abridged Life Table (1996) .

² National Institute of Population and Social Security Research, Ministry of Health and Welfare,

There are several reasons for the rapidly increasing number of older persons in need of care. One is an increase in the absolute number due to the rise in average life expectancy. Another is an increase in the number of people whose lives have been saved (particularly stroke victims) thanks to advances in medical care.

Table 3 shows the incidence of those in need of care by age group. According to this Table, the risk of becoming bedridden (including those people who are bedridden and have dementia) is 10%, and the risk of having dementia is 1.5% for those in the age group of 80 – 84. The risk is 20.5% and 3.5% respectively for those in the 85 and older age group. The risk of at least one spouse having a condition which requires care reaches about 50% over a person's lifetime in Japan, where the average life expectancy has reached into the eighties.

Back in the 1950s, the main cause of death was cerebrovascular strokes, because many of the aggressive treatment methods which are being used today were unavailable. As a result, many people died relatively soon after suffering a stroke. In these circumstances, even if family members cared for their sick relations, it is fair to say that the duration of care was relatively short -- at most, several weeks³. In those days, we were able to cope with the situation by conventional means of family caregiving, because of the short caregiving period and the greater number children per family than is the case today. However, as access to public medical care insurance has increased, access to medical care has improved⁴. Also, as critical medical care has advanced substantially, such progress has made it possible to increase the number of patients,

Latest Demographic Statistics (1997), Research Series No. 292.

³ Yuzo Okamoto (1996), Medical Care and Social Service for the Older (pp.29-33). Tokyo, Japan :

including stroke victims, whose lives are saved and who then receive rehabilitation and survive for quite a long time.

The second point is that the conventional means of caregiving, that is through the families of these older people, has begun to come up against new societal realities. The common belief has always been that a woman is responsible for the care of her parents or her husband's parents in their old age. It was considered shameful to place parents in nursing homes or make use of external services to care for them at home. It was seen as being akin to abandoning one's filial responsibility.

However, in a rapidly increasing number of cases it is difficult to maintain the well-being of older people predominantly through care given by family members. One reason is the aging of the family caregivers themselves. The majority of older people in need of care are over 80 years old and their caregivers (who may be their spouses or children) are, in many cases, over 60 years of age⁵. When a caregiver is advanced in age, it is difficult to provide physically demanding personal care, such as helping a family member bathe, go to the bathroom or change position day and night. Often, older people who regularly go to hospitals for outpatient care are those who are, in turn, taking care of their parents. There is concern that both parent and child may "fall together."

The second reason that makes family caregiving difficult is the declining ratio of older people who live with their children. It is well-known that Japan's cohabitation ratio (the number of adults living with their aging parents) is higher than in other developed countries. With

Iwanami Syoten.

⁴ Universal coverage of medical care insurance in Japan was realized in the year of 1961.

changing perspectives among both parents and children, however, this ratio has quickly fallen in recent years -- especially in cities. In Tokyo, which has the highest population, the cohabitation ratio has dipped below 50%⁶. Thus, an increasing number of parents who need care live apart from their children..

Other reasons include the rapid increase in the number of women in the labor force and the weakening of the old fashioned belief that a daughter-in-law should take care of her parents-in-law.

We will no longer be able to solve problems through the traditional approach by which family members, particularly women, provide most of the care. Furthermore, we no longer believe such an approach is appropriate.

The third point to consider is the shortage of nursing homes and care workers who provide services. In Japan, as in other countries, care for the aged is provided at special nursing homes and other institutions and through various home care services, in addition to care which is provided by family members. Up until the late 1980s, however, Japan's national policies reflected the basic belief that children should take care of their aged parents. Thus, the government did not try to increase either the number of these institutions or workers to staff them

On the other hand, the medical care insurance system in Japan is relatively generous in covering hospitalization costs. As a result, many older people in need of care are neither being

⁵ According to the Comprehensive Survey of Living Conditions of the People on Health and Welfare by Ministry of Health and Welfare(1997), every other caregiver is 60 years old or older.

⁶ Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare. Comprehensive Survey of Living Conditions of the People on Health and Welfare (1997).

cared for by their family members at home nor being admitted to nursing homes (due to the long waiting lists). Instead, these people remain in general hospitals for long periods of time.

However, general hospitals do not have proper or sufficient facilities for providing long-term care, such as private or semi-private rooms, dining rooms and bathtubs. Also, they do not have enough staff to provide personal care to patients who need long-term care. It has been said that older patients in general hospitals do not improve their activities of daily living (ADL) and that those who are bedridden deteriorate because of an absence of adequate care.

It was not until 1989 that the Gold Plan was formulated, with the objective of promoting the development of facilities and manpower. Later in 1994, the target levels were raised. With 1999 as the target year, efforts are rapidly being made to develop institutions and train workers, but these efforts still lag behind the actual needs created by the rapid aging of the population and the increase in older people in need of care. A new fund, which will be created under the long-term care insurance system after the year 2000, is intended to encourage the entry of the private sector into this market and dramatically expand the service volume. (On the other hand, some governmental officers and economists are concerned about the possibility that spending on long-term care insurance will be substantially larger than expected.).

History of the Policies on Long-Term Care for the Aged : From Welfare Law for the Aged to the Long-Term Care Insurance Law

The Welfare Law for the Aged

Under the Welfare Law for the Aged which was enacted in 1963, homes for the aged , home care aid services, respite care (which is called "short stay program") and other similar

services have been covered by taxes from central and district governments. When this law was enacted, it was designed for low-income aging individuals who had no relatives to care for them. This policy reflected the prevailing belief of the times, that family members should take care of their aging relatives. However, since then, as the demand for long-term care has increased, coverage has gradually expanded as well. Today, any older person who needs long-term care can receive services under the Welfare Law for the Aged.

Partly due to the fact that taxes are used to fund these services as a "welfare" system, however, the fees borne by users are divided into many levels, depending on the individual's income level. Fees range from zero to almost 100% of cost.

In addition, the municipal governments decide who is eligible (whether or not applicants qualify for benefits) and control the content of the benefits, taking into account, among other factors, both the income of the older person and their family members and family relationships. In practice, there still appears to be a strong tendency to provide services to low income earners and people without relatives, while people with middle incomes are given a lower priority.

The Health Service System for the Aged

Facility services in special nursing homes and home care aid services, among other services which are provided under the Welfare Law for the Aged, are funded by taxes. As a result of rigorous pressure from the Ministry of Finance, they have been placed under strict budgetary restraints each year and the volume of services provided has not been sufficient to meet the rapid increase in demand of the aging population .

Under these circumstances, hospitals have stepped in, virtually offering living space to

older people in need of care, in place of special nursing homes. In Japan, all citizens are covered by an insurance plan for medical services. Thus, people have access to the hospital of their choice regardless of their income status. Older people in particular can receive medical services with a lower co-payment than the working population, under a special system for older persons which is called the "Health Service System for the Aging". (Originally there was no co-payment, but a co-payment system was later introduced; the current percentage of co-payment is about 5% of the total expenses.)

Therefore, many aging persons and their family members, have continued to choose admission to readily accessible hospitals, instead of the "welfare" system which involves complex procedures, income checks and details of the family's personal circumstances.

As a result, the average length of stay in general hospitals in Japan is much longer than in other developed countries. It was 33.7 days in 1995⁷ despite a gradual decrease in recent years.

Table 4 shows a comparison between Japan and the United States in terms of the number of hospital beds and beds in homes for the aged per 100,000 of the aging population. You will notice that there are many more hospital beds in Japan and more nursing home beds in the US. It is still fair to say that hospitals are the main facilities offering long-term care in Japan, although this is changing since long-term care facilities have been developed according to the Gold Plan described below.

The Health Service System for the Aged, which was institutionalized in 1982, covers all necessary medical services, including hospital admissions. Services such as health services

⁷ Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare, Hospital Reports (1995).

facilities for older persons (which are a kind of long-term care facility and primarily provide rehabilitation), home-visit nursing care and home-visit rehabilitation have been gradually added. Long-term care is viewed as a part of medical treatment, and is integrated in these medical services.

Long-term care services for the aged have thus far been above, based on two different systems: the welfare system for the aged and the Health Service System for the Aged.

The Gold Plan

Recognizing that family caregiving for older persons was becoming increasingly difficult, the Japanese government developed and implemented the Gold Plan in 1989 which defined specific goals to be achieved over a ten-year period ending in 1999. These goals included numerical targets for facilities and workers in the field of long-term care for the aged. In implementing the Gold Plan, each of the municipal governments conducted a fact-finding survey on older persons living within its jurisdiction, and formulated a specific action plan for the development of a service infrastructure based on the results of the survey. Local governments also drew their action plans based on those of the municipalities within their districts. Making plans at the district and municipal levels increased public interest in the issue of long-term care. It became an opportunity to raise the policy priority of this issue to a higher level, both in the national and district political scenes.

Subsequently, however, while in the process of creating action plans at local levels, it became apparent that the target levels specified in the Gold Plan were not sufficient to meet the needs of the people. So in 1994, the Japanese Government revised the Gold Plan and formulated the New Gold Plan by raising the goals:

* Home care aides	170,000 people
* Respite care (short stay) service facilities	60,000 beds
* Day care centers	17,000 locations
* Home-visit nursing care stations	5,000 locations
* Special nursing homes for the aged	290,000 beds
* Health service facilities for the aged	280,000 beds
* Assisted living facilities (Care houses)	100,000 people

With the ongoing depression in the Japanese economy, however, the fiscal situation at the national and local level is deteriorating. Despite this setback, progress under the New Gold Plan has been relatively smooth, except in the case of assisted living facilities (care houses).

Many localities have experienced more demand than expected since the launch of the New Gold Plan and the supply of home care services and facility services has not kept up with the rapidly accelerating need. It is anticipated that the demand will further expand due to the enforcement of the public long-term care insurance system in April of 2000. The development of a service infrastructure beyond the New Gold Plan is now an important challenge.

Under the system of public long-term care insurance, the national government is expected to set forth basic guidelines on the development of the service infrastructure in order to systematically promote the continued development of care facilities and manpower training. Then, all the municipal and district governments will draw up specific development plans.

Public Long -Term Care Insurance System

While the development of the service infrastructure progressed based on the Gold Plan,

we were faced with the challenge of deciding how to share the burden of the rapidly increasing long-term care expenses in the society. The answer is the public long-term care insurance system.

The major factors in the introduction of the public long-term care insurance system were:

1. The need to ensure a stable revenue source. Since the launch of the Gold Plan, general tax revenue has been used to fund the development of an infrastructure for welfare-related long-term care services under the welfare system for the aged, and insurance funds have been used to fund the infrastructure development for medical care-related long-term care services under the medical care insurance system. However, it was anticipated that ensuring the necessary financial resources to meet the needs of the future increase in an aging population would be difficult, because neither of these systems focus on long-term care. People became more aware that a stable financial source had to be secured for the future, while the issue of elder care was one of the most worrisome factors in post-retirement life⁸.

2. The criticism raised against the conventional allocation system. Today, home care services such as home care aid and day care services, and facility services, such as nursing homes, are provided by municipal governments as a part of the welfare system. When an application is filed by an older person in need of care, the municipal government determines not only the necessity of providing the benefit, but the content of the service, and designates the provider, after taking into consideration income and family condition of the person, among other factors.

Today, when the public has begun to perceive the issue of long-term care as relevant to

⁸ According to the survey conducted by the Prime Minister's Office in 1995, more than 80% of the respondents supported the establishment of the public long-term care insurance system, though the

their lives, they criticize the current allocation system for making services psychologically difficult to use because it stigmatizes people. They also dislike the fact that the input by users is disregarded, and municipalities unilaterally determine the content and providers of services.

3. The deterioration in the fiscal situation of medical care insurance caused by the long-term hospitalization of aged patients in need of care. Many older persons in need of care avoid using the welfare system because a variety of restrictions are imposed on the use and quantity of services. Instead, they often use the more readily accessible medical care insurance system (Health Service System for the Aged), where they opt for long stays in hospitals. In short, those aged who need special nursing homes which are less costly, or who should receive services at home, are staying in more costly hospitals⁹.

With this as the background, the decision was made to integrate the two existing systems that covered the long-term care for the aged -- the welfare system financed by the general tax and the Health Service System for the Aged, which is predominantly funded by premiums -- to create a new long-term care insurance system funded by both premiums and general tax. (See Table 4) Although people often think that the long-term care insurance system was created from scratch, it is actually a product of the reorganization and integration of the existing two systems.

The Contents of the Long -Term Care Insurance System

Basic Principles

system will be predicted to increase their burdens. The results of surveys by others also show the similar response and present people's high expectation to the improvement of long-term care.

⁹ The average cost of a stay in hospital (about \$3,800 a month) is 1.8 times more than that of a stay in special nursing home (about \$2,100 a month) . All dollar values in this article are based on January 1, 1998 exchange rate of 130.62 yen to the dollar.

- To respect the choice made by consumers. Specifically, older persons should be entitled to utilize home care services and facility services according to their own needs and desires without feeling a sense of reluctance, regardless of their income level and family situation.
- To integrate the two existing systems for the aged, the welfare system and the Health Service System for the Aged, removing the wasteful overlap between the two.
- To encourage the entrance of diverse private-sector businesses into this market so as to respond to the rapidly increasing demand for long-term care services. Under the conventional welfare system, a mechanism exists in which municipal governments choose service providers and contract with them to deliver services. Therefore, the municipalities have tended to preferentially choose service providers run either by the municipalities themselves or by organizations funded by the municipalities, instead of private-sector service providers with which the municipalities are not familiar.

In order to guarantee the same competitive situation for public- and private-sector service providers, the long-term care insurance system will abolish the system of contracting by municipalities. Older people and their families will be able to choose freely from among service providers, regardless of whether they are public or private, and private businesses can enter the market freely.

- To introduce the concept of "care management" that provides a variety of services in conjunction with one another to better meet the specific needs of the aged. Many older persons and their families are isolated and lack information about what types of care are available. Even when they do know which service providers to contact, extensive negotiation and formulation of programs are required to actually receive services. This process requires a

great deal of time and patience. As a result, the new system, as shown in Table 6, provides the aged and their families with care plans formulated by a professional of their choice who also coordinates services based on the plan. The system assumes the costs.

Insurers

The municipalities are the insurers. In principle, the medical care insurance system is uniform throughout the country. The need for long-term care services, however, varies greatly according to the percentage of older people still living with their families and the perspective of local residents on family caregiving. Thus, the long-term care insurance system must reflect the characteristics of local communities in its benefit design and to some extent in the level of premium payment.

Municipal governments will not take sole responsibility for this new system. The national and local governments, which have been sharing the costs under the welfare system for the aged and the Health Service System for the Aged, will bear part of the total expenses. Insurers of medical care insurance and insurers of pension insurance will collect long-term care insurance premiums on behalf of the municipalities.

The Insured

All people age 40 and older will be required to participate. For people under 40 years of age who need long-term care, care services will be provided through the existing welfare system designed for people with disabilities.

Those who are insured will be divided into two categories, using age 65 as the

demarcation line. Persons age 65 and older will receive insurance benefits if they have a condition requiring long-term care, regardless of cause. They will pay premiums through the municipalities in which they live. Those between the ages of 40 and 65 will receive insurance benefits only if their conditions are caused by illnesses associated with aging (e.g. cerebrovascular strokes and early-onset dementia) notwithstanding the fact that their condition may require long-term care¹⁰. They will pay premiums through their medical care insurance.

Insurance Benefits

Insurance benefits cover both home care services and facility services, as shown in Table 7. In addition, the cost of care management services (i.e. designing care plans and coordinating services by a care manager) will be reimbursed.

To receive insurance benefits, the insured must be assessed by his/her municipality first, to determine if insurance benefits are required. This determination is based solely on the insured person's physical and mental condition. It differs from the conventional system in that neither the family situation nor the income of the aging person and the family is reviewed for this purpose.

Insured persons who are entitled to receive insurance benefits through this process are classified into five or six categories, according to their need for care or the severity of the condition. The level of benefits varies among these categories. At present, we are considering benefit levels of about \$2,300 per month for the most severe and about 500 dollars for the

¹⁰ The reason the long-term care insurance system covers only those age 40 and older and uses 65 years of age as the demarcation line is that this system was designed to reorganize and integrate the welfare system for the older and the Health Service System for the Older from the perspective of long-term care for senior citizens. There were people who believed that it would be technically difficult and inappropriate to classify the risk of a condition requiring care by age. However, for the reason mentioned above, it was decided for the time being to cover long-term care for the older under the new system. Whether we should lower the age limit of those covered or not will be an important issue after this system is implemented.

mildest. Within this range, the insured can freely combine different types of home care services, such as home care aid services and home-visit nursing care, and may be eligible to receive reimbursement.

Table 8 shows the benefit model example of the new system¹¹.

Example: A person who cannot turn over in bed without assistance, and needs help in some activities of daily living. Home visits are also needed for care at night and medical management. The person is living with a child. In this model, the insured can use some services almost every day. All of these services will be covered by the benefits of the public long-term care insurance.

One characteristic of this model is that it incorporates multiple short (10 to 30 minutes) visits per day around the clock. A conventional home care aid typically visits a patient two to three times a week and assists with housecleaning and cooking. Each visit lasts for approximately 2-3 hours. These services are not very useful for aged persons who need physical assistance. The new system aims to provide truly useful services to those who are in need of care by focusing on the provision of physical assistance such as changing incontinence undergarments and position changes.

The level of services illustrated in the aforementioned example will probably be covered by the public long-term care insurance. Additional services such as meal delivery must be paid for out-of-pocket or paid for by privately acquired long-term care insurance.

Co-payment

Insurers will be reimbursed for 90% of the cost of insurance benefits. Users' co-payment will be 10% of expenses. In addition, insured persons who are admitted to a facility will be responsible for the co-payment for meal expenses.

Financial Scale

In 1995, the total expenses of welfare and Health Service System for the Aged for long-term care of the aged was 16.1 billion dollars. By the year 2000, when the infrastructure development by the New Gold Plan ends and the long-term care insurance system starts, this amount is expected to grow to 32.2 billion dollars¹². Since the numbers of older people in need of care will continue to rise, this amount is expected to reach 52.8 billion dollars by 2010.¹² (See Table 9)

The long-term care insurance system will cover these expenses, excluding the users' co-payment. Fifty percent will be funded by premiums and the remaining 50% by taxes. The national, district and municipal governments will share the expenses at a ratio of 2:1:1.

Insurance Premium

Although the average insurance premium will vary depending on the income of the insured, it is estimated to be 19 dollars per month in 2000 and 27 dollars per month in 2010. See Table 9 Premiums will be two-tiered - one for the aged and another for those ages 40 – 65.

The municipal governments will set approximately five premium levels for those over

¹¹ This model example is shown in the 1998 Annual Report on Health and Welfare, p. 240.

¹² These figures are calculated based on the price index of 1995 without making adjustments for inflation.

65, depending on income level. The appropriate premium will be deducted from the person's pension.

An insured person between ages 40 - 65 will have a slightly different premium level, depending on the medical insurance plan in which the person is enrolled. In the case of medical insurance for employees, half of the long-term care insurance premium will be borne by the employer and in the case of the National Health Insurance, the same will be borne by the national government. Thus, in reality, the amount of the long-term care insurance premium to be borne by the insured will be about one-half that of the aged. All of the premiums collected by medical insurers will be pooled into the Social Insurance Medical Fee Payment Fund, which, in turn, will distribute the funds to the municipalities. The amount distributed to each municipality will be set so that each receives an approximately equal percentage of the total cost of benefits for that municipality. Thus, the gap in funding will not be disproportionately placed on the shoulders of the insurers (such as the aging ratio). (See Table 10).

Significance and Challenges of Recent Policies on Long-Term Care for the Aged

As of the writing of this article, the long-term care insurance system has not yet been implemented, and therefore, it is impossible to evaluate its results. However, the very fact that the two policies (namely the Gold Plan and the public long-term care insurance system) have been adopted since the late 1980s indicates the change in perceptions. It has ceased to be an issue which needed to be resolved within the family and has become an issue which involves the efforts of the society as a whole. On the surface it seems inappropriate to launch a new entitlement

program when budget cuts of social security programs are one of the prominent issues arising from the aging of the population. However, the changes in people's perspectives have created the momentum to carry it through.

The long-term care insurance system reflects the changing perceptions on the part of the Japanese as exemplified by the following changes: the abolition of the conventional allocation system, the adoption of the basic principle of respect for choices made by older persons, and the rejection of the cash benefits system¹³.

The following questions have been frequently raised by foreign researchers: Why didn't Japan introduce the cash benefits system under the public long-term care insurance system? Shouldn't we appreciate family members' caregiving as long as people pay premiums? Don't we expect expenses to balloon, because if family caregiving is not appreciated, everyone will use non-family care services?

These questions appear at the first glance to be reasonable from the viewpoint of maintaining fairness between people receiving family care and people receiving non-family care, or from the viewpoint of concern that expenses may spiral out of control. Indeed, these opinions were expressed in the course of discussions about the creation of the long-term care insurance system. However, at that time, most of those who were in favor of the cash benefits system did not base their opinions on the reasons mentioned above. They believed that ethically, long-term care should be given by family members (especially daughters and daughters-in-law) and that unless these traditions were maintained, all would be lost. These opinions were primarily

¹³ A beneficiary or family member receives cash as a benefit, when the beneficiary chooses care-given by the family instead of services provided by non-family service providers.

advocated by the aged themselves and by rural residents, but they faced strong criticism from feminists and their supporters, who pointed out that this viewpoint excluded men from participating in the delivery of long-term care. Women's organizations asserted that the people who tried to use non-family care services were severely criticized for not caring for their parents. They expressed concern that if the cash benefits system were created, the prevailing concept of family care would persist.

In the end, the cash benefits system was shelved because the opposition to cash benefits became dominant^{14 15}.

Recent Japanese policies on long-term care for the aged have had a significant impact on the national economy. On the one hand, public long-term care insurance increases the public burden mainly shouldered by the current generation of workers. On the other hand, it generates substantial growth of the long-term care service industry through the process of externalizing family labor. The most important factor regarding anxiety about post-retirement life among the Japanese is the issue of who will care for them when they require care. Older persons have saved considerable amounts of money, which is said to be the highest in the world, because of such concerns. It is hoped that long-term care insurance will play a role in eliminating anxiety about post-retirement life. It is expected that long-term care insurance will help older people to feel

¹⁴ The trend toward the burden-sharing of long-term care in society as a whole has been rapidly becoming dominant, as the quantity of long-term care services has been increasing. It is predicted that within a short period after the launch of the public long-term care insurance, prerequisites which deny the cash benefits system will change, and that the negative effects of not having the cash benefits system will gradually expand, as was pointed out by foreign researchers. The issue of having the cash benefits system will be debated again at that time.

¹⁵ Other oppositions include an opinion that providing the cash benefits system would only end up with becoming a mere means of lavishing money without any guarantee of improving the care level for the older and an opinion that the financial scale of the system would further expand, resulting in a heavier cost burden.

more secure about their lives and become better consumers, thereby helping the economy as a whole.

According to Professor Ohmori of Osaka University, the overall economic effect achieved by the creation of public long-term care insurance is expected to be an increase of GDP by 1.3%. He anticipates that the negative effect caused by the expansion of the public burden will be negated because of the expansion of the long-term care service industry and an increase in consumption by the aged.¹⁶

However, a prerequisite exists for realizing such economic expansion; the benefit levels of public long-term care insurance are fairly high so that retired persons can rely on the insurance and thus spend money without worrying. As the aging of the population is in motion, inevitably, the burdens of taxes, pension, public medical care insurance and the like have been rapidly increasing, especially among the current working generation. Therefore, it is impossible to maintain the high benefit levels of public long-term care insurance, if public funds, including taxes and premiums, continue to be distributed in the traditional manner.

A considerable amount of public funds have been spent for public infrastructure programs, such as the construction of roads and ports. These programs, however, are no longer expected to have a greater impact on the Japanese economy than in the past, and the government has been criticized for funding the programs that primarily benefit vested interests and are thought to be useless. Now is the time to start investing these funds in new industries, such as health care, to reflect the aging of the society.

¹⁶ Takashi Ohmori, The Impacts of Long-term Care Insurance on Japanese Economy, Nippon Keizai Shimbun, October 17, 1997.

It is also important to prioritize among social security programs, such as those for pension, medical care and long-term care.

Finally, we must address the challenges of implementing the long-term care insurance system¹⁷.

Currently, various preparatory activities are underway with a view toward implementing the system in April of 2000. They include preparing standards for assessment of eligibility status, manpower training of those who will be involved in assessment, and identification of needs to calculate insurance premiums, in addition to the development of long-term care service infrastructure based on the New Gold Plan.

One concern is the availability of a sufficient quantity of long-term care services once the insurance system is implemented. Although the infrastructure is being developed at a faster rate than that for the New Gold Plan, there are wide variations in the levels of infrastructure developed among different geographical areas. Initially after implementation, shortages will be inevitable in some localities. However, it is anticipated that shortages will disappear in the medium term, as has been the experience in Germany, because the fund pool of long-term care insurance is anticipated to promote the entry of private-sector businesses into this market.

Another concern is that the eligibility status to be done accurately and speedily. In Germany, in some cases people did not receive insurance benefits for a long time due to the delay in the assessment process. This was partly because of the short preparation period prior to the implementation of the system. In addition, many Germans who are insured submitted requests

¹⁷Other challenges which aren't discussed in this article are explained in the following article : Naoki Ikegami, MD, Public Long-term Care Insurance in Japan, JAMA, 1997; 16: 1310-1314

to review their eligibility status, in part because it was said that the decisions varied greatly depending on the assessors. In Japan as well, much remains to be done in order to be adequately prepared within the short time frame of two years. A flawless beginning in the year 2000 is unlikely. We need to establish standards which will serve as the basis for assessing the conditions that require care through clearly defined procedures, and by insuring that the system has well-trained assessors.

Another concern is assuring the quality of long-term care services.

Long-term care services are offered to people who are in need of assistance. Assurance of quality of care is an important issue.

While the entry of many businesses into this market is expected in the future, it increases the potential for abuse. It is necessary to seriously consider how to prevent or minimize these problems and to improve the quality of services provided by businesses.

Care management and regulations of local governments will help assure quality control. However, it is also necessary to develop and introduce more effective methods, including the use of an ombudsman and determining an approach to evaluate the quality of long-term care services by third parties, as seen in the US.

Conclusion

Not long ago, developed nations began to seriously address the issue of long-term care. Indeed, in Japan, we are now facing this historic new challenge through the establishment of such policies as the Gold Plan and the public long-term care insurance system. We address this issue while at the same time facing the challenge of economic stagnation. The future is unclear.

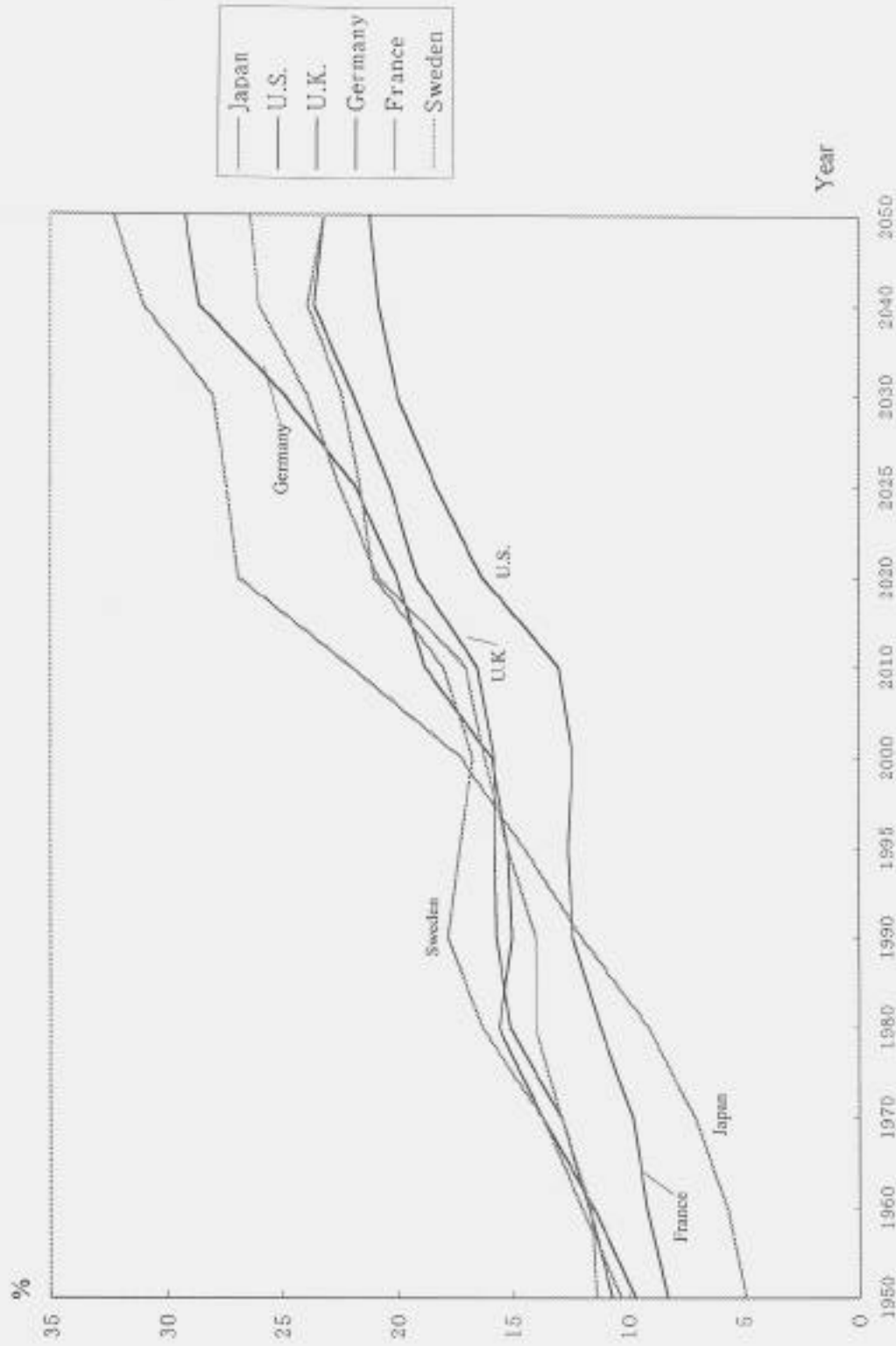
However, there is no way to avoid the need for a social security system in an aging society. We have therefore adopted policies that will help the aged and their family members to cope with the issues of long-term care.

The policies we have begun will require a period of trial and error. However, as a result of these experiences, Japan will be in a position to act as mentor to other countries as they attempt to implement similar programs.

Kazuhito Ihara served for many years in the Japanese Ministry of Health and Welfare. Among his titles was that of Deputy Director of Headquarters of the New Long-Term Care System for the Elderly and Deputy Director of the Bureau of Pharmaceutical Affairs. Currently, he is Director of the Department of Health and Welfare of the Japan External Trade Organization (JETRO), in New York City. He speaks frequently on issues of health care.

Figure 1

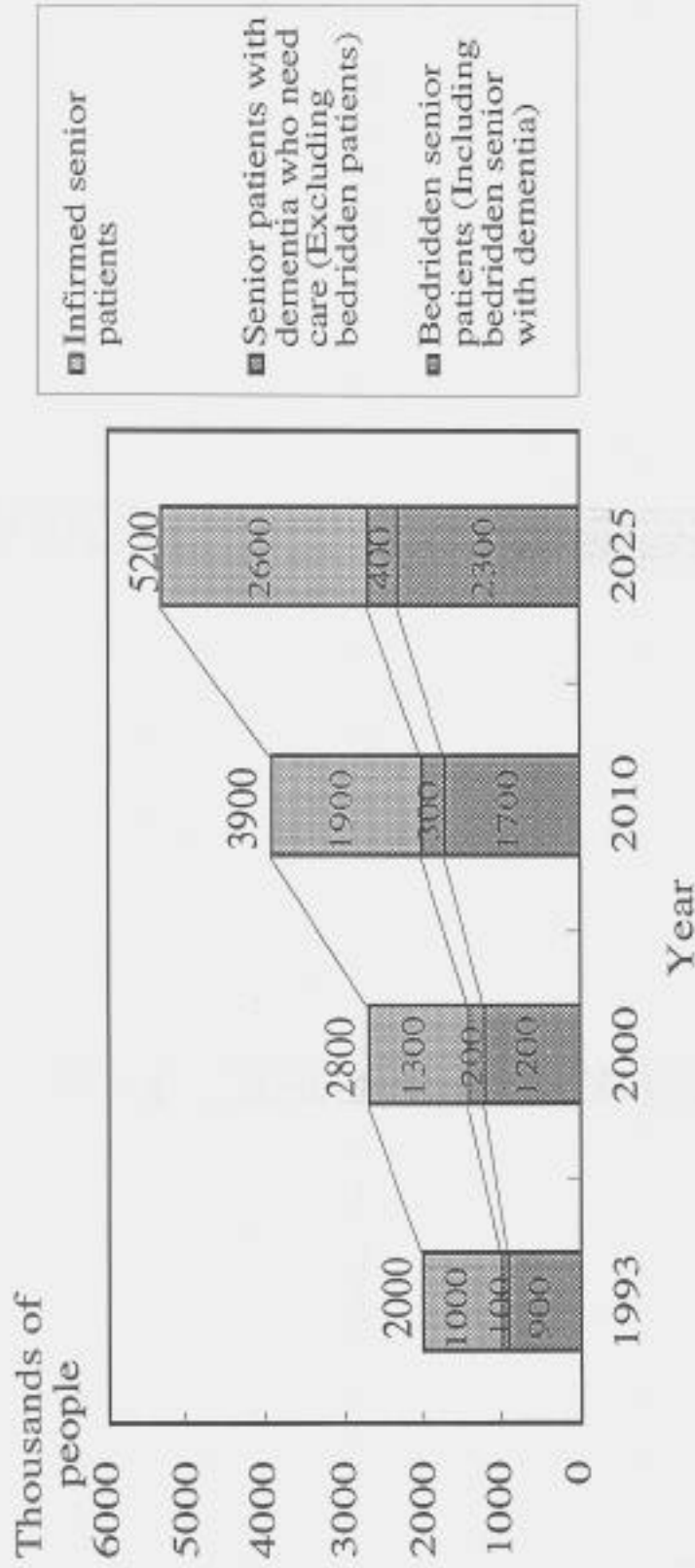
CHANGES IN THE RATIO OF ELDERLY POPULATION (AGE 65 AND OVER)



Source: Management and Coordination Agency, Population Census of Japan; National Institute of Population and Social Security Research, Population Projections for Japan in January 1997; and the United Nations, World Population Prospects (1996).

Figure 2

ESTIMATED NUMBER OF BEDRIDDEN AND OTHER ELDERLY PATIENTS



Source: Ministry of Health and Welfare, Points for Long-Term Care Insurance (2nd ed.).

Figure 3

PROPORTION OF PEOPLE IN NEED OF CARE BY AGE GROUP

	65-69	70-74	75-79	80-84	85-
Bedridden Senior Patients*	1.5	3	5.5	10	20.5
Senior Patients with Dementia**	0	0.5	1	1.5	3.5

Note:

* Include bedridden senior patients with dementia

** Exclude bedridden senior patients

Source: Ministry of Health and Welfare, Points for Long-Term Care Insurance (2nd ed.)

Figure 4

Hospital Beds and Nursing Home Beds
Per 100,000 Population in US and Japan

	Hospital Beds	Nursing Home Beds
US	340 (1996)	5,048 (1996)
Japan	1,112 (1995)	2,084 (1996)

Notes : The data of nursing home beds in Japan include beds of special nursing homes and health service facilities.

Source: US: HCFA-OSCAR data 1/31/97, American Hospital Association, Hospital Statistics and US Bureau of the Census, 1996 Statistical Abstract of the United States

Japan: Ministry of Health and Welfare, Hospital Reports, Annual Report on Health and Welfare(1998) and Current Population Estimates 1996

Figure 5

LONG-TERM CARE INSURANCE

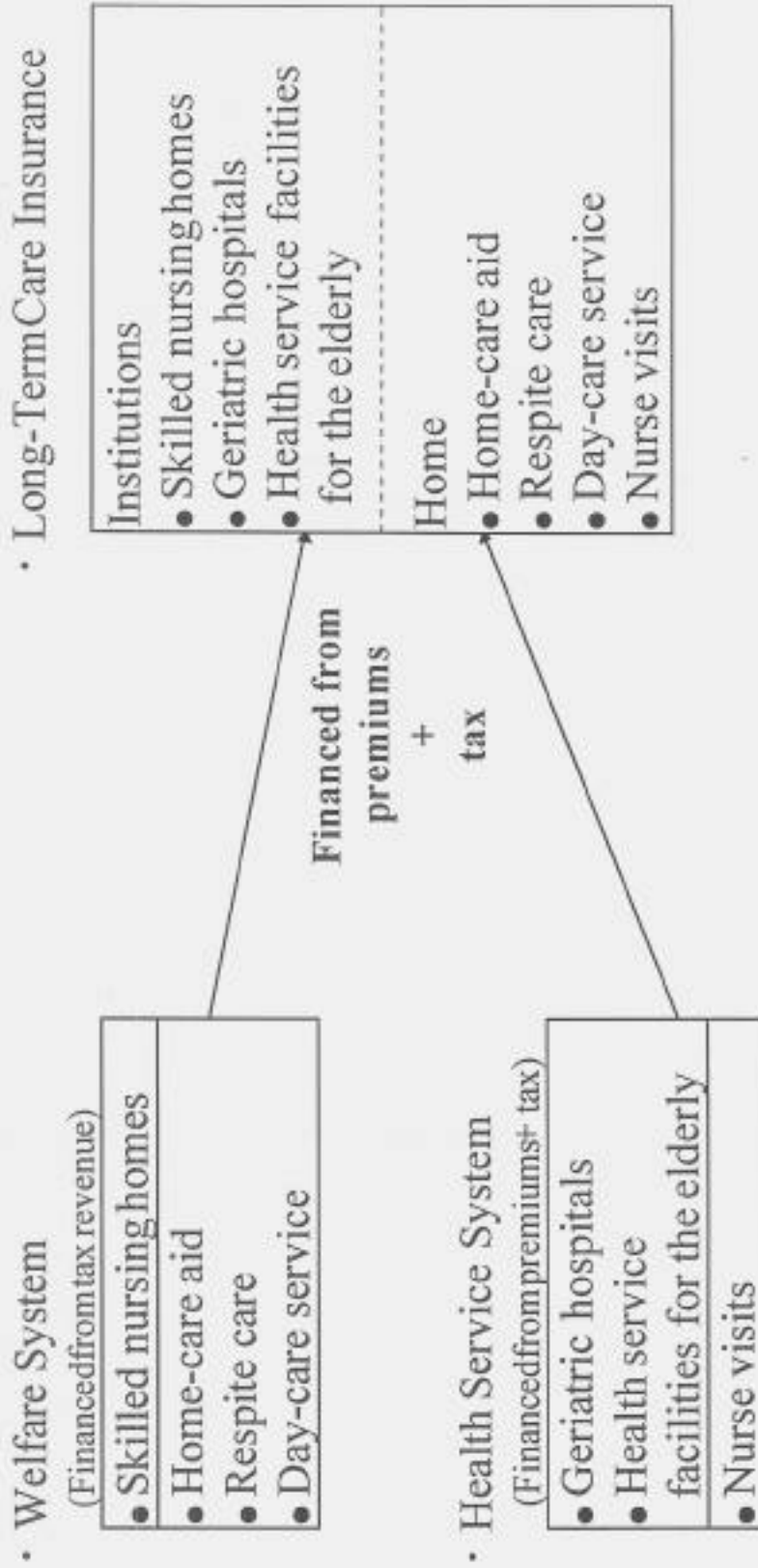


Figure 6

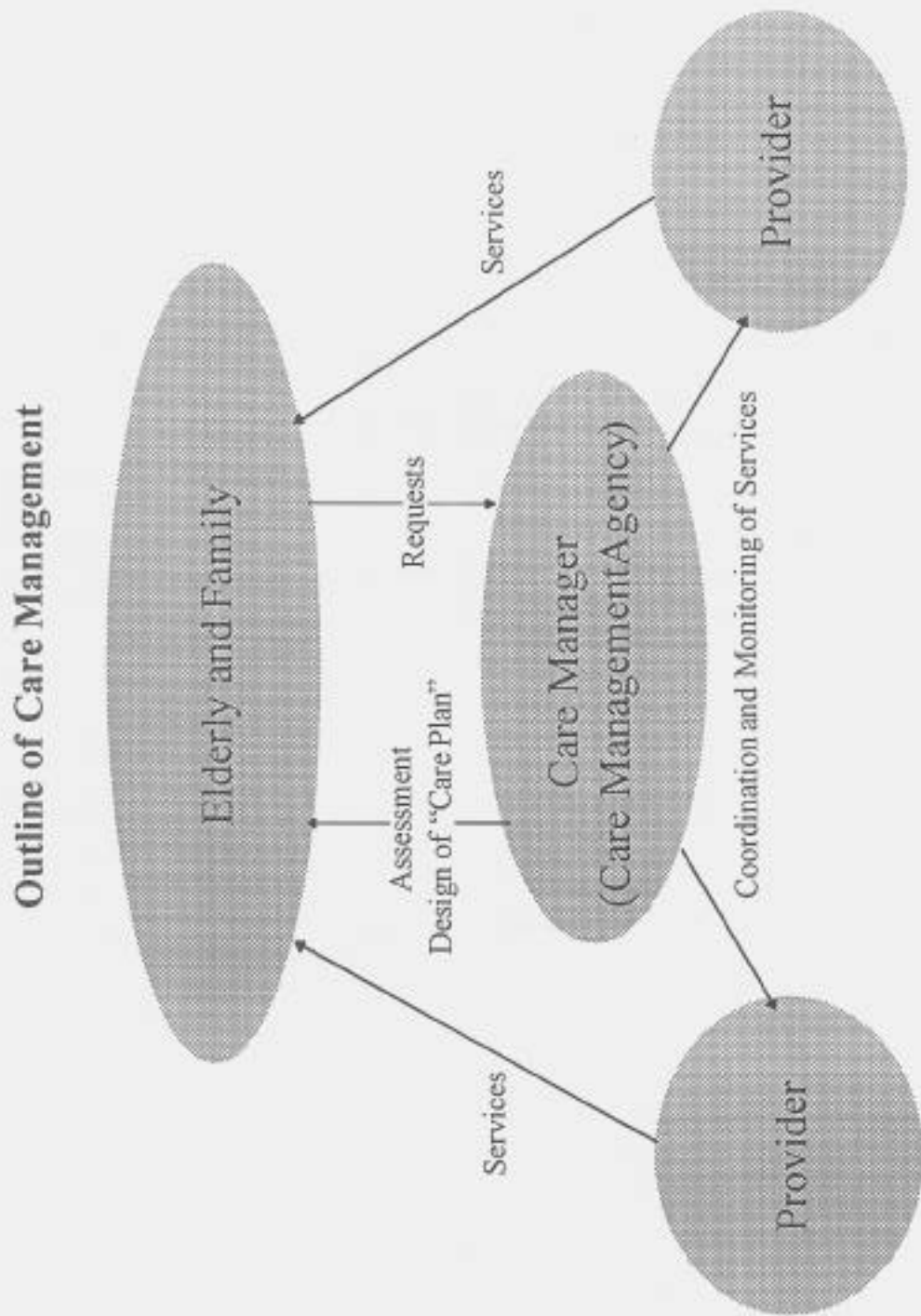


Figure 6

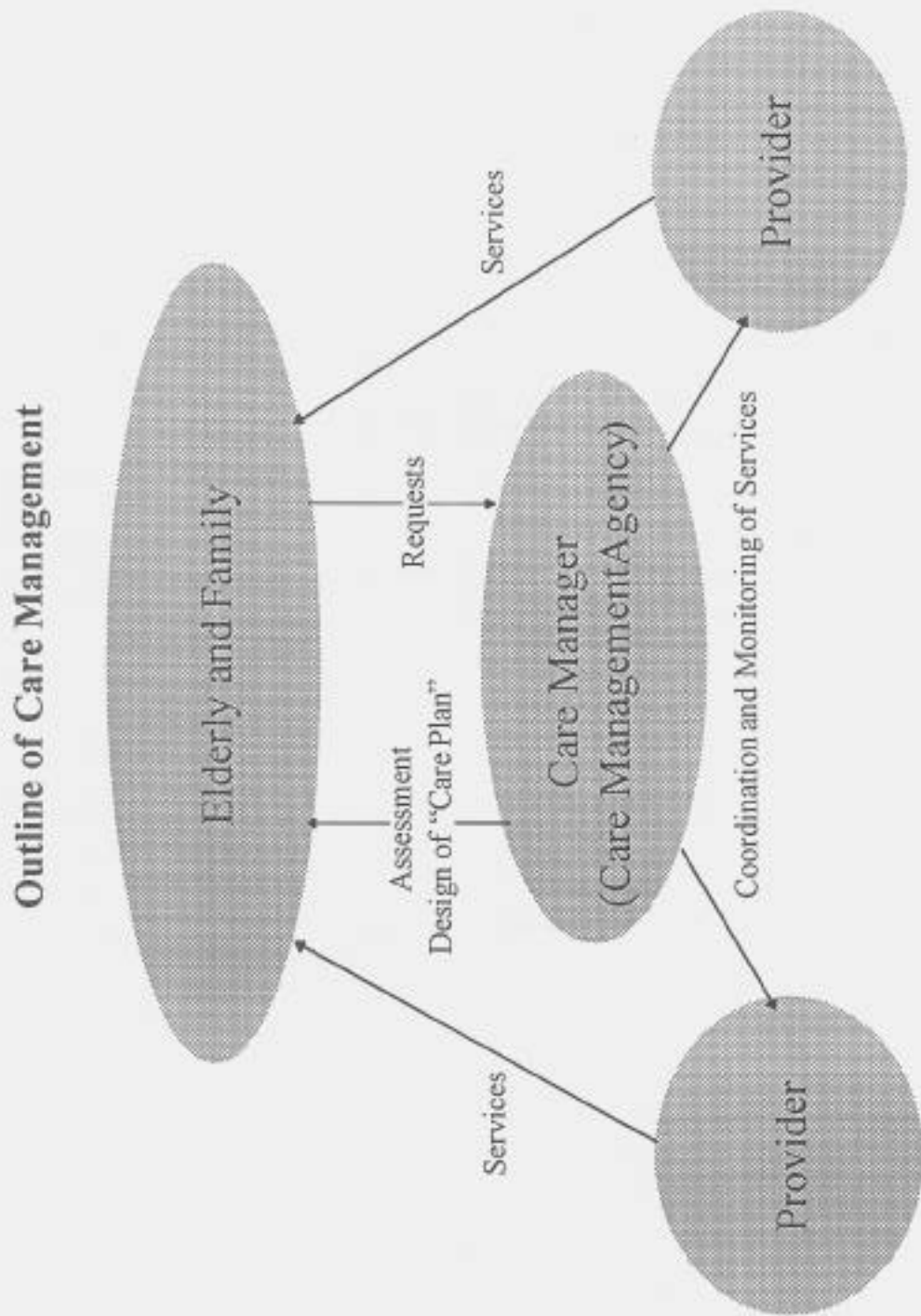


Figure 7

INSURANCE BENEFITS

I. Home Care Services

- Nurse visit and home care aid (24 hours including at night in case of need)
- Rehabilitation service at home and day care center
- Medical management
- Respite care service
- Day care center service
- Group-home service for seniors with dementia
- Home visiting bathing service (mobile bath-tub)
- Home-care devices (wheel chair, special beds, etc.)
- Minor home remodeling (eliminating steps, installing handrails, etc.)

II. Institutional Services

- Special nursing homes for the elderly
- Health service facilities for the elderly
- Geriatric care hospitals (long-term care ward)

III. Care Management Services

Figure 8

AN EXAMPLE OF BENEFIT MODEL FOR HOME CARE

	Morning	Afternoon	Evening	Late Night
Mon.	Home Care Aid	Nurse Visit	Home Care Aid	Patrol Visit
Tue.	Home Care Aid	Day Care Service		Patrol Visit
Wed.	Home Care Aid			Patrol Visit
Thu.	Home Care Aid	Day Care Service		Patrol Visit
Fri.	Home Care Aid	Nurse Visit		Patrol Visit
Sat.	Home Care Aid	Day Care Service		Patrol Visit
Sun.	Home Care Aid			Patrol Visit

Additional services provided are such as...



Source: Ministry of Health and Welfare, 1998 Annual Report on Health and Welfare, p. 240

Figure 9

**TREND OF TOTAL COSTS AND MONTHLY PREMIUMS
OF LONG-TERM CARE INSURANCE**

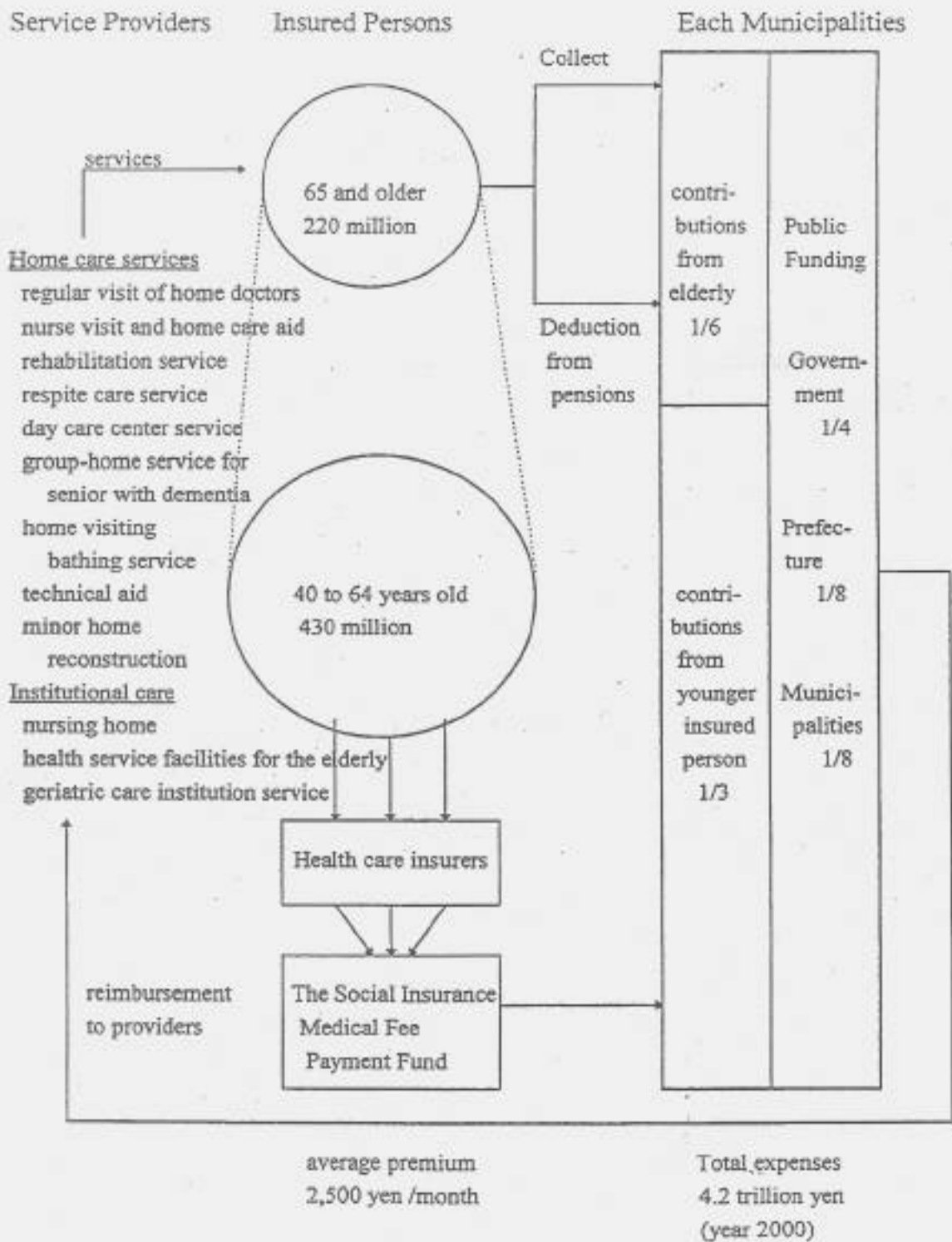
(\$1.00=¥130.62)

Year	2000	2005	2010
Total Cost	\$32.2 Bil.	\$42.1 Bil.	\$52.8 Bil.
Monthly Premium	\$19	\$21	\$27

Source: Ministry of Health and Welfare, Points for Long-Term Care Insurance (2nd ed.).

Figure 10

Outline of the Long Term Care Insurance System (year 2000)



Source: Ministry of Health and Welfare, Points for Long-Term Care Insurance (2nd ed.).