Japan's Long-term Care Insurance Program: An Overview

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Even compared with other developed countries, Japan's population is aging at an exceptionally high rate and the proportion of those aged 65 and older already exceeds 20 percent of the total population. The rapid aging of the population is inevitably accompanied by a growing demand for long-term care, resulting in increased pressures on the current social insurance scheme. This abstract provides an overview of Japan's long-term care (LTC) insurance program and the related empirical literature to evaluate how the program measures up to its goals.

The LTC insurance scheme was introduced in April 2000 to supplement the mandatory national health care system established in 1961. According to Japan's Ministry of Health, Labour and Welfare, the new scheme pursued three major goals. First, it aimed to address widespread concerns related to aging, in particular the burden caring for the elderly imposes on families. In effect, the introduction of the scheme signals the recognition that the responsibility of care is shifting from the family to the government and the measure tries to address the supply shortage in the care for the elderly. Second, the reform sought to make more transparent the relationship between benefits received and premiums paid. Until 2000, under the "distribution system", the provision of care for the elderly was part of the government's tax-financed welfare policy and those eligible were assigned to nonprofit providers. As a result of the reform, there is now a clearer relationship between the financing of care services via premiums and eligibility. A third aim of the new scheme was to integrate health, medical and welfare services, which in the past were vertically divided and operated independently. The objective of integration was to encourage the provision of comprehensive

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services to meet the need of care users and to allocate resources in these services more efficiently. Closely related to this issue are attempts to tackle the problem of "social hospitalization".

The following is an overview of the LTC system, focusing on program benefits, eligibility criteria, financing, and co-payments. First, looking at the *benefits* provided by the program, these include services both at home and at facilities. The main categories of at-home care services include home-visit/day services, short-stay services, care for the elderly with dementia, and allowances for the purchase of welfare devices and home renovation. In contrast, facilities for institutional care are divided into LTC welfare facilities for the elderly (special nursing homes), LTC health facilities for the elderly, and LTC medical facilities for the elderly. Medical care *per se* is not included in the LTC program but offered under the national healthcare system.

Second, *eligible* for care services under the program are all persons aged 65 and above as well as people age 40–64 with health-related disabilities. Eligibility is determined based on applicants' health condition rather than their income and/or assets and is reviewed every six months. An eligible person must first undergo an information-intensive application process before receiving LTC benefits. The standards for certification of eligibility are uniform across the country. Once individuals are certified to be eligible for long-term care, they are assigned one of six health categories, and benefit entitlements are allocated according to each person's level of required care. When care recipients use services through the program, they are referred to a care manager who draws up a care plan in consultation with the patient's doctor.

Third, turning to *financing*, the Japanese LTC system is operated as a pay-as-you-go program, financed by premiums levied on insured persons and by general tax revenues. The insured are residents aged 40 and above. Premiums paid by the elderly (aged 65+) cover about 17 percent of the cost of the scheme, while premiums from those aged 40 and above cover about another third. The remainder is borne by the central government (25 percent), prefectures (12.5 percent), and municipalities (12.5 percent). The LTC premiums depend on income level. The insurers of the program are municipalities and premiums vary from one municipality to another.

Fourth, as regards *co-payments*, in addition to regular premiums, LTC users must pay out-of-pocket fees in order to receive care. The co-payment rate for services covered by the insurance scheme is set at 10 percent. In addition, patients in nursing homes are also responsible for meal charges. Services are reimbursed up to a certain threshold after which patients are responsible for 100 percent of any additional costs until a stop-loss ceiling, which is reduced for low-income

patients. Charges for covered LTC services are set by the government. Each type of service is assigned a specific number of units (e.g., a home visit for the provision of physical help not exceeding one hour is equivalent to 402 units). The value of a unit varies depending on the service provided and by region to adjust for regional wage differentials. The value of a unit is currently set at between 10.00 and 10.72 yen and is to be revised every three years.

Japan's LTC insurance is characterized by what might be labeled a "decentralized yet centralized" approach. The overall insurance scheme, eligibility and certification, prices for each care service, and co-payments are centrally determined and uniformly implemented. On the other hand, the insurers are municipalities and insurance premiums vary by municipality. Moreover, most care services are provided privately. While only nonprofit providers are allowed to offer institutional care services, for-profit providers were allowed to enter the at-home care market as part of the deregulation measures introduced along with the LTC insurance scheme. Since fees are set centrally, providers are supposed to compete based on quality of care. Similarly, the scheme combines means-tested insurance premiums, with a flat 10-percent co-payment rate.

Keeping these institutional characteristics in mind, we now turn to the evaluation of the insurance scheme and examine whether the three objectives set out by the government have been achieved. As indicated, the first goal was to expand the supply of care services and to "socialize" the family care burden. Looking at the number of establishments providing at-home care services, a large increase from 9,833 in September 2000 to 17,295 four years later can be observed. Thus, although there continue to be waiting lists for institutional care, there is no shortage in the supply of at-home care. Deregulation, allowing for-profit providers to enter the market, seems to have borne fruit. Noguchi and Shimizutani (2005a) report that in 2003, 40% of home-care providers were for-profit operators. Better-informed households were in fact more likely to choose for-profits, and a bias of preferences towards nonprofit providers, which the contract failure hypothesis predicts, is not observed. Shimizutani and Suzuki (2005) confirmed that the quality of services supplied by providers that entered the market after deregulation in 2000, most of them for-profits, was not worse than that supplied by older, nonprofit providers. Turning from quality to costs, Noguchi and Shimizutani (2005b) found evidence of a nonprofit wage premium in the LTC labor market and showed that nonprofit providers were more costly. Shimizutani and Suzuki (2005) found that for-profits were more efficient than other types of providers after adjusting quality of care. These findings confirm that competition, stimulated by deregulation, has contributed to improvements in the quality and efficiency of the market for at-home LTC services.

Yet, even though the quantity of care supply was successfully expanded, the achievements in terms socializing family care are mixed. SHIMIZUTANI and NOGUCHI (2005) found that two-and-a-half years after the introduction of the LTC scheme, about 10 percent of households with a care receiver spent more than twelve hours a day providing family care and another 10 percent spent at least eight hours per day. Nevertheless, even though the burden of caring for a family member remains heavy in a significant number of households, SHIMIZUTANI, SUZUKI and NOGUCHI (2004) suggest that the introduction of the LTC scheme had a large and positive effect on labor market participation by women in households with a care receiver.

The second objective of the LTC program was to replace the welfare scheme in the provision of care with a public insurance scheme. One of the major issues related to an insurance scheme is how to prevent moral hazards, and a widespread suspicion regarding the remarkable expansion of long-term care use since 2000 is that it was driven partly by the creation of unnecessary needs. Suppliers of care for the elderly may be tempted to exploit information asymmetries regarding patients' true care needs and persuade patients' to use services they do not actually need. NOGUCHI and SHIMIZUTANI (2005c) found little evidence of supplier-induced demand in the LTC market. Another often voiced concern is that consumers utilize unnecessary care services since the co-payment rate is only 10 percent. Unfortunately, the few empirical studies on this issue in Japan's LTC market are unreliable. Another concern regarding the insurance program is the emergence regional disparities. Since the insurers are municipalities and the number of elderly and the capacity of care services vary from one municipality to another, there is a growing divergence in insurance premiums.

The third goal of the insurance scheme was to provide comprehensive services to meet the need of care users and to reduce the number of "socially-hospitalized" patients. As far as we know, available empirical studies on Japan remain silent on this topic. The most important reason is the lack of longitudinal data containing information on the use of medical and long-term care and on patients' economics status and family situation which would make it possible to determine the availability of family care. NOGUCHI and SHIMIZUTANI (2002) is an exception to find that elderly patients with relatively minor ailments tend to be re-hospitalized if they lack family members with whom they can live.

In sum, whether Japan's long-term care insurance scheme succeeded in the objectives that the government set is a question that remains mostly unanswered. Japan's Ministry of Health, Labour and Welfare has warned that the amount of expenditure on elderly care may rise to some 20 trillion yen in 2025, the

equivalent of 3.5 percent of national income and 11.4 percent of social security expenditure. Designing a sustainable and efficient LTC program thus is of utmost importance, and what is needed are policies that are based on clear and detailed evidence. Constructing a large panel data set similar to the HRS, ELSA and SHARE would be a major step forward.

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