

Long-term Care Insurance in Japan

-Understanding the Ideas behind Its Design-

Shuzo Tsutsumi

Japan International Cooperation Agency (JICA)

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Contact

Japan International Cooperation Agency (JICA)
(Social Security Team, Human Development Department)
Nibancho Center Building
5-25, Niban-cho, Chiyoda-ku, Tokyo 102-8012, Japan
TEL: +81-3-5226-6660
URL: <http://www.jica.go.jp>

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Appendix

Overview of the Long-term Care Insurance

Long-term Care Insurance in Japan -Understanding the Ideas behind Its Design-

Introduction

In April 2000, the Japanese government launched its fifth social insurance scheme, the Long-term Care Insurance, to respond to the increasing demand for long-term care. Since then, the Long-term Care Insurance has been established in Japanese society as an essential system for people's lives, while it has various challenges.

In many cases, as it happened in Japan, when a country enters its economic growth stage, and as people's living standards and health standards improve, the average life expectancy increases and the number of elderly persons with long-term care needs increases. At the same time, family's capabilities to provide long-term care for their elderly members decline as a consequence of urbanization and the decreasing size of families. Therefore, it would be inevitable that many developing countries, especially Southeast Asian countries as their economies grow, will face social problems of long-term care for their graying population, although the seriousness of the problem may vary depending on each country's context.

It is true that the Japanese experience may not be directly applied to other countries, because social security schemes as well as socio-economic, historic and cultural conditions, which support the social security schemes, vary across countries. However, whatever the country's condition might be, if they are to introduce a social insurance in order to solve the problem of a growing demand for old people's long-term care, they may find the Japanese experience of establishing a long-term care insurance and the ideas behind the system design somewhat useful.

This paper aims to explain the basic ideas behind the design of the Japanese Long-term Care Insurance, while reviewing the process for establishing the scheme. The outline of the scheme is described in the Annex.

I Process for Establishing the Long-term Care Insurance

1 Situation Before the Establishment of the Long-term Care Insurance

(1) Support for the Elderly Provided by the Relief Schemes for the Poor

In the past, the state's role in providing long-term care was quite limited, and if any, it was for those in financial difficulties with no families and relatives. Because, first of all, people rarely lived to an old age. For example, in Japan, people aged 70 were called "Koki," meaning "old people have been rare since ancient times," which comes from a poem written by a Chinese poet Du Fu. And those who did were normally supported by communities made up of their relatives and neighbors, when they needed long-term care. Therefore, the only state support systems available to them were relief schemes for the poor. In Japan, these schemes included: the Compassionate Relief Regulations put into force in 1874 as an act of charity by the state; the Relief Act put into force in 1929 which stipulated the state's responsibility to help the poor for the first time; and the Public Assistance Act which institutionalized relief for the poor in 1950, based on the right to maintain the minimum standards of wholesome and cultured living stipulated in the Constitution. The only type of relief that these schemes provided to elderly persons requiring long-term care was the provision of protection through admission to institutions. These institutions included old people's homes ("Yoro-in) established under the Relief Act and old people's institutions ("Yoro-shisetsu") established under the Public Assistance Act.

(2) Development of Welfare Policies for the Elderly

After the Second World War, the state's responsibility for social welfare was emphasized in the Constitution of Japan which says, "In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health." In response, the national government and local governments developed policies to provide social welfare services by themselves or by outsourcing the services to other entities. The earliest services institutionalized were welfare services for orphans and children with disabilities, among others, stipulated in the Child Welfare Act (1947) and welfare services for persons with various physical impairments stipulated in the Act on Welfare of Physically Disabled Persons (1949). Those who were subject to the services

had already been recognized as people who needed to be supported by the state even before the laws were enacted. On the other hand, as mentioned above, there were not a significant number of elderly persons who needed long-term care and they were typically helped by their families and relatives. Therefore, it was thought that the state only needed to help them if they had financial difficulties.

However, after the mid-1950s when Japan entered its high economic growth period, it was predicted that the number of elderly persons having difficulties in daily living would increase, and that providing support for them using the relief schemes for the poor alone would cause problems. This led to the idea that elderly persons should become subject to social welfare services instead of relief schemes for the poor which left them feeling stigmatized. Based on this idea, the Act on Social Welfare for the Elderly was enacted in 1963. In this Act, old people's institutions ("Yoro-shisetsu") stipulated in the Public Assistance Act were renamed nursing homes for the elderly ("Yogo-rojin-home", hereinafter referred to as "Yogo")¹. In addition, special nursing homes for the elderly ("Tokubetsu-yogo-rojin-home" or "Tokuyo", hereinafter referred to as "Tokuyo") were institutionalized as facilities where elderly persons who need continuous nursing care in their daily lives are admitted and cared for. The criteria for the admission to Yogo include financial reasons in addition to physical or mental impairments as well as environmental reasons, while the criteria for admission to Tokuyo does not include financial reasons: all elderly persons who need continuous nursing care in their daily lives due to physical or mental impairment are eligible to enter the facilities. Later, the Act on Social Welfare for the Elderly was revised and three types of home-based and community-based services were added to the welfare services for the elderly, namely home-visit care services, daycare services² and short-term careservices³. These services as well as services at Tokuyo became subject to the disbursement of Long-term Care Insurance benefits when the insurance started.

Local governments (municipal governments) paid for long-term care services

¹ Although the literal translation of Yogo-rojin-home is nursing home for the elderly, Yogo is not an institution to provide nursing care. Residents of Yogo generally are independent in ADL, and they live in Yogo for mainly economic and family reasons.

² They are services where old people are given care and physical rehabilitation services at facilities. Transportation services are also provided to and from home.

³ They are services where old people are admitted to facilities for a short period of time and given care and physical rehabilitation services.

stipulated in the Act on Social Welfare for the Elderly using their tax revenues, of which 50% was shared by the state. Social welfare corporations, which are not-for-profit organizations approved by prefectural governor for providing social welfare services, paid for most of the construction costs for Tokuyo, using subsidies and public financing which also came from tax revenues. Due to fiscal constraints on national and local governments, these services could not fully meet the increasing demand for long-term care services. Municipal governments decided who would be admitted to each Tokuyo and old people could not choose the facilities that they wished to enter. Generally, municipal governments tended to prioritize the admission of low-income people.

(3) Support for the Elderly Provided by the Medical Insurance

Under these circumstances, some hospitals supplemented the role of Tokuyo by providing care for the elderly. At hospitals, the costs of services were covered by medical insurance. Japan attained universal health coverage using social insurance in 1961 under which anybody could choose the medical institutions that they wished to receive services at. Through the 1973 revision of the Act on Social Welfare for the Elderly, the majority of elderly persons were exempted from paying patient's co-payment stipulated by the social health insurance. As a result, in the 1980s, an increasing number of elderly persons requiring long-term care entered "geriatric hospitals," which are covered by medical insurance, while others entered special nursing homes. Some families of elderly persons even tended to prefer "geriatric hospitals" rather than Tokuyo because Tokuyo was still considered a kind of relief facility for the poor at the time. Unlike the social welfare scheme for the elderly which charged for services based on income levels, the medical insurance charged a fixed amount co-payment regardless of patient's income level⁴. Therefore, middle- and high-income people had to pay less when using hospitals. This also encouraged the use of "geriatric hospitals" rather than Tokuyo. This phenomenon was called "social hospitalization." Some of the "geriatric hospitals" provided poor quality long-term medical care and it was recognized as a major social problem. In response to the situation, the government added the services provided by facilities which focused on

⁴ In the Health and Medical Service Scheme for the Elderly established by the 1983 Health and Medical Services Act for the Aged, a small fixed amount co-payment was collected from patients. This scheme was jointly run by health insurers and people aged 65 or older were subject to the scheme. In this scheme, old people continued to take part in medical insurance programs and received benefits from their municipal governments. Tax revenues and contributions from medical insurers were used to cover the expenses.

long-term care rather than medical care (that are called sanatorium wards) to the benefit package of the medical insurance. Also added to the benefit package of the medical insurance were geriatric health services facilities (“Rojin-hoken-shisetsu” or “Roken”, hereafter referred as to “Roken”) and home-visit nursing stations. Roken provides rehabilitation services to elderly persons after they leave hospital so that they can restart their lives at home smoothly. These services as well as the services stipulated in the Act on Social Welfare for the Elderly were included in the Long-term Care Insurance benefits when the insurance scheme started.

In short, long-term care services for the elderly had been provided by two schemes: tax-based scheme governed by the Act on Social Welfare for the Elderly; and the medical insurance scheme. These two schemes had different contact points, procedures, user fees and financial sources. In the 1990s, there was a growing concern that it might become difficult to respond to the needs of the increasingly aging population in the 21st century, particularly the increasing number of elderly persons requiring long-term care. The need for a new and comprehensive long-term care system became recognized gradually.

2 Establishment of the Long-term Care Insurance

(1) Growing Interest in Long-term Care Issue and the Development of Service Infrastructure

In the 1990s, aging emerged as a major political issue because the general public’s interest in long-term care grew rapidly. The number of elderly persons with long-term care need was increasing, and the duration of care was extending. In addition, families were less and less capable of taking care of old family members. At the time, the government was planning to introduce a consumption tax (which was the first major indirect tax in Japan) in April 1990. At the end of 1989, just before the introduction of the tax, it formulated the Ten-Year Strategy to Promote Health Care and Welfare for the Elderly (so-called “Gold Plan”), and emphasized to the public that they would use the revenues from the consumption tax to develop Tokuyo and Roken as well as to improve home-based care services. As for the necessary human resources, the systems were already put in place by the enactment of the Certified Social Workers and Certified Care Workers Act in 1987.

The government formulated the New Gold Plan which set higher goals than the ones set in the Gold Plan, just before the consumption tax rate was increased in 1995. Based on the new plan, infrastructure for long-term care services was developed. The infrastructure later supported the services provided by the Long-term Care Insurance.

At the same time, more citizens became involved in efforts to solve the problems concerning long-term care for the elderly. In particular, there was a great interest among women, who had been considered the main workforce for long-term care within the family. Women's organizations including the Women's Association for a Better Aging Society which was established in 1983 (the chairperson: Keiko Higuchi) actively worked towards the establishment of a public long-term care scheme from the mid-1990s onwards. The 10,000 Citizens' Committee for Promoting Public-supported Long-term Care which was established in 1996 (the representative: Tsutomu Hotta) conducted a campaign which specifically aimed at the establishment of a long-term care insurance. This was the first occasion in Japan where citizens became actively involved in efforts to establish a government policy. This shows the high level of interest people had in the issue of long-term care. The Japanese Trade Union Confederation (RENGO), which is the nationwide federation of trade unions, also greatly contributed to the creation of momentum for the establishment of long-term care insurance, by conducting a questionnaire survey of union members and through other activities. As a result, opinion polls conducted by national newspapers showed that an overwhelming majority of people (about 80%) considered a public long-term care scheme necessary.

(2) Planning of a Long-term Care Insurance at the “Headquarters” and Discussions at Advisory Councils within the Government

Around that time, the designing process of the long-term care insurance started in the government, involving a wide range of stakeholders.

In October 1993, the Minister for Health and Welfare (Keigo Ouchi, the Democratic Party of Japan) established the Discussion Group on a Welfare Vision for the Aging Society (chairperson: Isamu Miyazaki), which was a temporary advisory group made up of experts. The minister then asked them to give recommendations on policy directions for the aging society. In March 1994, the discussion group produced a report which emphasized the need to “establish

a system through which all Japanese people can smoothly access the necessary long-term care services close to their home.”

In response to the submission of the report, the Ministry of Health and Welfare established the Headquarters for Measures on Long-term Care for the Elderly in April 1994, where ministry officials served as the full-time secretariat staff. The headquarters established the Study Group on Long-term Care and Independence Support Systems for the Elderly (chairperson: Wataru Omori) which was a temporary study group made up of experts. Through discussion in the study group, a detailed design for a long-term care system was developed⁵. The study group published a report in December 1994, which strongly indicated the need to establish an insurance-based long-term care scheme. The publication of the report effectively launched the designing of the long-term care insurance in Japan.

What were the motivations and circumstances for the Ministry of Health and Welfare to come up with the policy direction toward an insurance-based scheme for long-term care at this time? There are largely two possible factors. One is the financial concern and the use of the private sector as service providers. The other factor is to ease the burden on medical insurance. As for the first factor, in order to increase the provision of services in response to the growing demand for long-term care in the future, the existing welfare systems for the elderly were not sufficient because their main financial sources were tax revenues. Therefore, it was considered that using insurance premiums as the financial sources to meet the increasing demand for long-term care would be appropriate because they would be less affected by the government's fiscal situation. At the same time, it was also expected that the utilization of a market controlled by the insurance system to provide and use the services would realize the effective partnership with private businesses as well as the rights of insured persons to the use of the services. As for the second factor, the cost of long-term care in the medical insurance expense was rapidly growing and was expected to grow further. Therefore, it was expected that the financial burden on the medical

⁵ Normally, policy planning within the government is conducted at each ministry's bureau. When there is a need to discuss a broad policy which requires the involvement of multiple bureaus, a cross-sectoral task force with full-time staff may be established (they are called "XX headquarters"). At the stage of deciding on the policy direction and preparing a draft, the method which is often used is to create a temporary study group or a temporary investigative commission made up of fair and neutral experts who then discuss the relevant matter before it is discussed at the government's council which includes stakeholders.

insurance scheme would be reduced if another scheme was introduced to cover long-term care service costs.

In this context, after the Ministry of Health and Welfare received the report from the above-mentioned study group, the ministry launched discussions on a new long-term care scheme in February 1995, at the Council on Health and Welfare for the Elderly which was a statutory advisory council where the Ministry of Health and Welfare served as the secretariat⁶. The ruling parties were also greatly interested in the establishment of a public long-term care system. In parallel with the discussions at the government's advisory council, the ruling parties also deepened discussions about a public long-term care system, mainly within the Ruling Parties' Welfare Project Team.

This is a list of main points discussed at the Council on Health and Welfare for the Elderly and the Ruling Parties' Welfare Project.

- Which scheme should be adopted: an insurance-funded scheme or a tax-funded scheme?
- If an insurance-funded scheme is adopted, should the scheme be independent from the existing medical insurance or should it be built on the existing scheme⁷?
- If a new insurance independent of the existing medical insurance is to be introduced, the new scheme will be area-based insurance under which local residents become the insured based on their place of residence. In the new system, who should be the insurers, who should be the insured, and who should be eligible to receive benefits⁸?

⁶ A majority of the council members were stakeholders who were involved in health and welfare services for the elderly, including personnel from local governments, women's organizations, senior citizens' organizations, trade unions, business organizations, health professional's organizations, welfare service provider's organizations and health insurer's organizations. The council meetings were open to the public.

⁷ "Building a scheme on the existing scheme" meant using the existing Health and Medical Service Scheme for the Elderly to pay for long-term care services. At the time, old people were receiving medical benefits through this scheme. In this scheme, old people took part in medical insurance programs and paid premiums for the programs, and received medical benefits from municipal governments. However, the Health and Medical Service System for the Elderly did not work well due to conflicts of interest between insurers. Therefore, only a minority of contributors to the discussions believed in using this scheme to cover long-term care.

⁸ At the time, the proposed scheme was that residents aged 20 or older should become the insured and they would be required to pay premiums. Only residents aged 65 or older would be eligible to receive long-term care insurance benefits.

- If premiums are to be collected from elderly persons, how should they be collected?
- What would be the service package (home-based and community-based care services and residential care services)?
- What system should be used to decide the eligibility of benefits payment, and how much should be paid⁹?
- To what extent should various home-based and community-based services be covered¹⁰?
- What system is needed in order to support elderly persons to use home-based and community-based services effectively¹¹?
- What should be the level of user charge¹²?
- How and at what level should tax revenue subsidize the benefit expenses¹³?

The Council on Health and Welfare for the Elderly gave an interim report on “The Establishment of a New Long-term Care Scheme for the Elderly” in July 1995. The Advisory Council on Social Security¹⁴, which was established under the Prime Minister, published a recommendation “The Re-establishment of a Social Security Framework” in the same month and pointed out that the government should consider the “establishment of social insurance on long-term care”. In April 1996, the Council on Health and Welfare for the Elderly produced the final report. In June 1996, the Ministry of Health and Welfare officially asked these two advisory councils to discuss An Outline of the Draft Long-term Care Insurance that had been produced by the ministry. The two advisory councils

⁹ Unlike the medical insurance, it was not considered appropriate for service providers to determine whether the payment of benefits is needed or not. Instead, insurers needed to authorize the payment. Therefore, there was an issue regarding the criteria to be used to authorize the payment.

¹⁰ In the medical insurance, in principle, benefits were paid in accordance with the cost for each treatment service provided (“fee-for-service” reimburse). In the case of long-term care services, it was thought to be necessary to create a ceiling in order to avoid unlimited cost increases.

¹¹ It was the issue of how care management should be institutionalized.

¹² At the time, patient’s co-payment in the Health and Medical Service System for the Elderly was a fixed amount which accounted for less than 10% of the total cost.

¹³ In the Health and Medical Service System for the Elderly, 50% of the benefit expenses for long-term care services were covered by tax revenues (of which, two thirds were paid by the state and one third was paid by local governments). In the welfare systems for the elderly, the costs excluding the amount covered by user fee were covered by tax revenues (of which, 50% was paid by the state and 50% was paid by local governments).

¹⁴ The members included members of the Diet (the Japanese Parliament), representatives of relevant ministries and agencies, experts and representatives of doctors’ association, welfare providers’ association and social insurance providers.

then reported back to the ministry saying that they generally agreed on the outline. The three ruling parties also agreed to “conduct the tasks needed to create a bill based on the draft outline, while striving to solve the pending issue,” which was whether municipal governments should serve as insurers or not. Therefore, the three ruling parties held local public hearings in order to build consensus. They also included measures to mitigate municipal governments’ financial and administrative concerns into the bill. They finally obtained the consent of the relevant parties, and the Long-Term Care Insurance Bill was submitted to the Diet (the Japanese Parliament) in November 1996. The bill was passed in December 1997 and the law was put into force in April 2000.

(3) Political and Economic Environments Which Enabled the Establishment of the Long-term Care Insurance

This section discusses the reasons why a consensus was successfully built on the establishment of the Long-term Care Insurance in the period between 1995 and 1997.

With regard to the political environment, the fact that it was a coalition government consisting of the Liberal Democratic Party of Japan (LDP), the Social Democratic Party of Japan (SDPJ) and the New Party Sakigake had a great impact. In the 1990s, the political situation in Japan was fluid. In 1993, a seven-party coalition government was established, replacing the government led by the LDP which had been in power since 1955. In 1994, the LDP came back to power by forming a coalition with the SDPJ which had been an opposition party to the LDP for many years. The SDPJ, the party of the then Prime Minister Tomiichi Murayama, was enthusiastic about the establishment of a social insurance on long-term care, and it endeavored to create a consensus for the new scheme within the ruling coalition by involving the LDP. Some members of the LDP, which is a conservative party, believed that long-term care by family members should be prioritized¹⁵, but the LDP was relatively cooperative in the establishment of the long-term care insurance because it needed to maintain the three-party coalition. The fact that Ryutaro Hashimoto (LDP) became Prime Minister after Mr. Murayama stepped down also made it easier for the new scheme to be established because Mr. Hashimoto had been enthusiastically involved in welfare policy for many years.

With regard to the economic environment, it was significant that the Japanese economy finally began to show signs of recovery around this time from the collapse of the bubble economy at the beginning of the 1990s. It was also around this time when the need for the decentralization began to be talked about and the first set of decentralization reform policies was established¹⁶. In short,

¹⁵ The Chairman of the LDP Policy Research Council considered that long-term care by family members was a laudable Japanese custom. In fact, just before the Long-term Care Insurance Scheme was implemented, he took the initiative for a budget (although a limited amount) for the payment of cash to families who were providing long-term care for their family members, outside the Long-term Care Insurance Scheme.

¹⁶ In the first set of decentralization reforms, the administrative duties of the state and local governments were clarified, and more authority was transferred to municipal governments, which is the lowest level of local government. The implementation of the Long-term Care Insurance Scheme was considered to be an opportunity to test municipal governments'

there was an environment in place, to a certain extent, in which each government ministry could concentrate on working on various reforms. This was the case not only for the Ministry of Health and Welfare, but also for the Ministry of Finance and the Ministry of Home Affairs. An improvement in the economic environment also made it possible for the business community as well as the labor community to accept the establishment of a long-term care insurance scheme which would entail additional costs.

Now, let us look at the micro-level environments. What were the responses of the health sector and the social welfare sector? People in the health sector, including the Japan Medical Association, supported the establishment of the scheme in principle, provided that the new scheme did not affect the existing medical insurance scheme¹⁷. They believed that the new long-term care would reduce the financial burden on the medical insurance and it would also give medical workers job opportunities in long-term care services. People in the social welfare sector may have had various thoughts, but they accepted the introduction of the new scheme. They believed that a shift to a new system was inevitable. Under the existing system, they provided services on behalf of the government and received fees from the government. In a new system, they would provide services under the contract with service users and receive fees from insurers. They probably knew that the existing system funded by tax revenues would not be able to support ever-increasing long-term care needs and reckoned that the introduction of the new long-term care system would have advantages for them because it would increase financial sources. Their greatest concern was to make sure that medical professionals did not take control of the new system.

Finally, let us look at how municipal governments, which were eventually given the role of insurers, responded to the discussions. In the trend of decentralization at the time, municipal governments were considered as the only obvious choice to become the long-term care insurers. This had some grounds. Municipal governments had been paying the welfare service benefits based on the Act on Social Welfare for the Elderly as well as paying the long-term care

capabilities as the lowest level of local government.

¹⁷ For example, in the Long-term Care Insurance, municipalities certify the level of long-term care needs as well as a ceiling of benefit amount corresponding to each level of care need. People in the health sector were concerned that similar systems could be introduced in the medical insurance.

benefits under the Health and Medical Service System for the Elderly. In addition, municipal governments had been the insurers of National Health Insurance, which is the medical insurance that covers the informal sector population. However, municipal governments remained cautious about assuming the role until the end. This was because municipal governments had many difficulties in administering National Health Insurance. In particular, the assessment and collection of premiums, which are the most important duties of insurers, involved many political and administrative difficulties. Therefore, many municipal governments could not raise premiums sufficiently, and they were covering the National Health Insurance expenditures by using a method not stipulated by law, i.e. using their tax revenues to cover part of the expenditures. For this reason, municipal governments thought it essential to ensure that the assessment and collection of premiums should be conducted properly and the financial management of the insurance scheme should be conducted in a disciplined manner, if they were to assume the role of insurers in the new scheme. Therefore, it took some time for the government to introduce the bill to the Diet, because it had to develop measures to ensure the proper management of the new insurance scheme and to convince municipal governments to undertake the role of insurer.

II Ideas behind the Design of the Long-term Care Insurance

1 Issues in Designing a Long-term Care Insurance Scheme

The above-sections discussed the process for and background to the establishment of the Long-term Care Insurance in Japan. Before explaining this scheme, let us think about the issues that should be taken into consideration when designing a social insurance system in general, in order to ensure people's access to long-term care services, without limiting the discussion to the Japanese situation. These issues include the following. Are there any methods other than social insurance that can be used to respond to the demand for long-term care? Is it appropriate for the risk of needing long-term care to be covered by social insurance? What characteristics does the risk of needing long-term care have, and what impacts do these characteristics have on the design of the system? How should necessary long-term care services be provided?

(1) Are there any methods other than social insurance that can be used to respond to the demand for long-term care?

As already mentioned in the introduction section, the economic development of a country leads to an increase in average life expectancy through better living standards, health and nutritional standards as well as health care, which in turn increases the number of old people requiring long-term care and the prolonged period of time requiring care. The decrease in the size of family leads to a decline in the capabilities of families to provide long-term care for family members. It may be inevitable that societies take this course. Facing these inevitable changes in society, the modern state comes under pressure to take action in order to ensure a stable economy, society and life for the people.

There are two main options available to tackle the problem. One option is that the state or local governments provide the necessary services and support. The other option is that the state provides a legal framework in response to people's wish for a collective system through which people can access the necessary services, in case they come to need long-term care¹⁸. The choice between the

¹⁸ In the second option, social insurance is considered as a way of collective self-help by people. However, social insurance could also be implemented as a policy where the state directly collects premiums and pays benefits using its authority. In that case, social insurance

two options depends on fundamental beliefs concerning the relationship between the individual and the state, i.e. what the role of the state should be. The belief behind the first option is that the government should take responsibility for the provision of necessary care because old people or their families alone cannot support them. The Nordic countries and the UK took this option. The belief behind the second option is that long-term care for old people is basically a problem that old people and their families should take care of, as with becoming sick or getting injured. This option leads to the use of social insurance in which needing long-term care is an insured event, a risk similar to becoming sick or getting injured. When choosing a policy from a practical standpoint, the important criterion would be to consider which option is more likely to meet old people's growing needs for long-term care. In this sense, in a country where social insurance such as medical insurance has been established, choosing the social insurance option may be more realistic because people are familiar with the method of raising funds through collecting insurance premiums and it may be easier to obtain people's support. In addition to this, under fiscal pressure, the option of using tax revenues instead of insurance premiums for the state to provide long-term care services was not even considered in Japan.

(2) Is it appropriate for the risk of needing long-term care to be covered by social insurance?

When creating a long-term care insurance scheme using a social insurance system, the first thing that should be examined at the system design stage is whether or not it is appropriate for social insurance to cover the the risk of needing long-term care. In social insurance where compulsory participation is a basic policy, the nature of risk to be covered is the risk of accidentally getting into a situation where they have difficulty living a normal life. It also has to be a highly probable risk. It would be difficult to convince many people to participate in a social insurance scheme which only covered events that rarely happened to people. Does the risk of needing long-term care due to old age come under this category of risk? Some people come to need long-term care when they become old, and other old people die without needing long-term care. Therefore, people

becomes closer to the state's activity rather than a means of collective self-help by people, and insurance premiums become almost the same as a special-purpose tax. Such a system is probably virtually the same as the first option. On the other hand, the social insurance talked about in the second option puts importance on the autonomous activities of the insured.

probably consider the need for long-term care to be a risk, based on their experience of daily life¹⁹. It can also be said that it is a highly probable risk, because many people will need long-term care, in today's aging society. The problem is that it is difficult to scientifically determine the definition and the scope of "needing long-term care." It should be noted that, if the definition for "needing long-term care" used in the policy is too narrow, it may not be recognized as a risk that many people face²⁰. In addition, as Rosanvallon pointed out, it is true that the possibility of needing long-term care is less likely to be considered a risk, when compared to the possibility of needing medical care. Therefore, when designing an insurance system which covers the risk of needing long-term care, special attention and planning are needed as explained below.

(3) How is the design of the long-term care insurance affected by the characteristics of the risk of needing long-term care?

Even if the possibility of needing long-term care is considered a risk, it is hard to consider it to be the same kind of risk as the risks of becoming sick or getting injured, due to its characteristics. These characteristics become constraints when designing a social insurance which covers long-term care. For example, the risk of needing long-term care tends to increase as one becomes older. This characteristic becomes important when deciding whether mainly old people should be subject to the system (like the Japanese system) or people of all ages should be subject to the system (like the German system). Another characteristic is that, in almost all cases, people fall into the situation where they need medical care, before they need long-term care. When putting importance on this characteristic, it may be a natural course of action to integrate long-term care insurance in medical insurance. In the Japanese case, a scheme independent of the existing Medical Insurance was chosen for political reasons, i.e. in order to avoid inheriting the problems that the existing scheme had, as mentioned above.

¹⁹ On the other hand, P. Rosanvallon said that being under (or in need of) long-term care is not a handicap or a disease, and it is not a phenomenon that meets the standards of accidents, except for cases comparable to the impairment of young people caused by accidents (P. Rosanvallon, *La nouvelle question sociale*, 1995 (translation: *The New Social Question: Rethinking the Welfare State*, 2006).

²⁰ It is believed that "needing long-term care" is relatively broadly defined in the Japanese Long-term Care Insurance. The results in recent years show that 15-20% of people aged 65 or older are defined to be in need of long-term care. One calculation showed that about 50% of people aged 65 or older become in need of long-term care during their lifetime, when integrating the lifespans of the population.

Another characteristic is that once a person needs long-term care, the situation is almost irreversible and fixed because there is little chance that he/she will recover or go into remission. Therefore, it is important to note that the risk of needing long-term care is different from the risk of needing medical care in its nature, in the sense that there is little possibility of those who receive long-term care not needing to receive long-term care in the future. This creates the problem that the policy of covering all the benefit expenses with premiums would be unpopular among the insured who do not need long-term care, because those who receive long-term care services are fixed and the rest do not receive any benefits from the system in the short run. This explains the design of the Japanese Long-term Care Insurance in theory where 50% of the benefit expenses are covered by government contribution²¹. Service users are also charged part of the service costs, in order to strike a balance between the burdens on the insured who need care and the burdens on the insured who do not.

Another important characteristic is that long-term care is needed for all types of everyday activities, and the degree of need varies with no clear boundaries between needing long-term care and not needing long-term care. Therefore, it is not possible to scientifically define what “needing long-term care” means. This is a vital issue because, in an insurance, it is extremely important to decide the scope of “needing long-term care” and determine methods to assess the condition of the person requiring long-term care, as well as determining who and what services should become subject to the disbursement of benefits. Sickness and injuries can be assessed by doctors using medical science. However, in long-term care, there are no experts or scientific basis equivalent to doctors or medical science. Therefore, when creating a long-term care insurance, it is necessary to create a scale for measuring the need for long-term care and a system for assessing the condition of the person requiring long-term care, as the first step. In addition, the fact that long-term care is needed for all types of everyday activities means that the corresponding services are broad and diverse. It is not realistic to cover all the long-term care needs and the corresponding services with long-term care insurance. In medical insurance, there is a strong belief that any medical practice that is necessary for treating sickness or injury should be covered by insurance. On the contrary, due to the characteristics of

²¹ In reality, this is due to a historical reason, i.e. the percentage covered by government contribution was inherited from the systems based on the Act on Social Welfare for the Elderly and the Health and Medical Services Act for the Aged (medical insurance).

long-term care needs, it is inevitable for long-term care insurance to be partial insurance that does not cover all needs and services. In addition, many long-term care services are provided for convenience and comfort, while medical treatment usually causes pain. This suggests that it is essential to create a system which avoids the abuse of long-term care services and ensures the appropriate use of the services.

(4) What are the preconditions for the establishment of long-term care insurance, from a practical standpoint?

The above section discussed the theoretical issues concerning the design of long-term care insurance. In addition, regarding the feasibility of establishing long-term care insurance, there is an issue of whether the long-term care services can actually be provided or not. If a financing system is established before enough services become available, there will be too many people who require long-term care trying to receive services with limited availability, and those who cannot receive services despite them being eligible will be frustrated by the fact that they are paying insurance premiums. Therefore from a practical viewpoint, as a precondition for establishing a long-term care insurance scheme, it is essential to have the prospect of being able to provide a reasonable amount of long-term care services. This is why it is important to take supply-side measures to build enough long-term care service capacity. In Japan, the formulation of the Gold Plan and the New Gold Plan²² prior to the establishment of a long-term care insurance system was significant in this sense. In providing necessary services, there are two ways: one is that long-term care services are provided by insurers (or a third party on behalf of insurers) and the other is that insurers finance long-term care services provided via the market. In either way, long-term care insurance does not function unless services are available. When considering this precondition, it would be more realistic to utilize the market mechanism rather than direct service provision by insurers in order to ensure the necessary services.

2 Basic Design of a Long-term Care Insurance

A social insurance can be compared to a building that is constructed using combinations of parts: insurers and the insured, as well as premiums and

²² For the Gold Plan and the New Gold Plan, see the section I-2-(1).

benefits. With regard to the ideas behind the design of long-term care insurance, this section discusses issues related to the basic design of the “building,” and the section that follows discusses issues related to the detailed design for the construction. Of course, these two designs are closely related to each other because the combination of the two creates one system. Therefore, they are only conceptual divisions created for discussion purposes.

(1) Long-term insurance or short-term insurance?

There are two types of social insurance: long-term insurance which requires the payment of premiums for a specific period of time before the person becomes eligible to receive benefits (such as old-age pension insurance) and short-term insurance where the person is eligible to receive benefits if he/she has paid premiums for the period in which he/she used the services (such as medical insurance). When putting importance on the fact that the risk of needing long-term care notably increases when people become old, it is theoretically possible to adopt a long-term insurance system. For example, people aged 65 or older who require long-term care receive benefits, provided that they have paid premiums for a specific period of time since they were 20 years old. Based on this idea, a long-term care insurance could be integrated into the existing pension insurance (in Japan’s case, this would be the National Pension, which is a basic pension) and premiums could be collected along with the pension insurance premiums. However, in a long-term insurance, the payment of benefits will start only after people have paid premiums for a specific period of time. On the other hand, in a situation where aging has progressed and many old people already need long-term care services, a system with a prompt effect is needed. For this reason, in Japan’s case, using long-term insurance was not a realistic option²³. Therefore, when creating its long-term care insurance, Japan had to adopt a short-term insurance, where premiums paid by current middle-aged and old people are used for people who currently require long-term care. Although this is a short-term insurance, it is also a kind of intergenerational support system, because older people have more risk of needing long-term care. In fact,

²³ The use of a long-term insurance system was not considered an option also because the Health Insurance Scheme was already being used to partially cover long-term care services, and also because the declining percentage of National Pension (basic pension) premiums collected was undermining the pension system and this was a major concern at the time. Further, a long-term insurance system accompanies the creation of a reserve fund. When considering its economic and political risk, it is almost impossible to create a long-term insurance system in the public sector, at Japan’s current stage of economic development.

intergenerational support was integrated into the Japanese Long-term Care Insurance, as explained below. It is probably correct to say that the difference between a long-term insurance and a short-term insurance is the extent an intergenerational support system is explicitly incorporated into the system.

(2) Who receives the benefit? People requiring long-term care or people who care for them?

Who needs long-term care services? Does the need for long-term care services come from people who require care or from the family members who care for them? In other words, should long-term care insurance benefits be paid to the people requiring long-term care or to the family members who care for them? This may seem to be a reasonable question, but when considering the fact that some old people requiring long-term care live alone, the answer is obvious. Those who require long-term care, rather than their family members, should be eligible to receive long-term care insurance benefits.

This brings up an important requirement for the design of long-term care insurance. The principle of social insurance is that those who pay premiums as the insured become eligible to receive insurance benefits. Therefore, in long-term care insurance, old people should be required to pay premiums as the insured in the same way as all the other people who have the possibility of receiving insurance benefits, especially because old people are the main beneficiaries of long-term care insurance. This is one of the institutional reasons why the Japanese Long-term Care Insurance was created as a single-scheme independent of the Medical Insurance. One of the major types of medical insurance in Japan is employee insurance, where only employees are required to pay premiums as the insured and their dependents (including their spouses, children and parents) are not required to pay premiums although they are covered by the insurance²⁴. There are a considerable number of old people who

²⁴ This has been a problem of the Japanese Medical Insurance System. The Japanese universal Medical Insurance System comprises two types of insurance: one is employee insurance where current employees pay premiums as the insured; and the other is area-based insurance where residents who are not covered by employee health insurance pay premiums as the insured, regardless of their age. In order to solve the problem of a considerable number of old people not paying medical insurance premiums, in 2006, the Medical Care System for People Aged 75 or Older was created with the aim of raising funds for medical costs for the elderly. In the system, people aged 75 or older are required to pay premiums as the insured. However, the whole system remained inconsistent because old people younger than 75 who are the dependents of employees covered by employee

are the dependents of employees covered by employee insurance. The complete integration of long-term care insurance into the Medical Insurance would make it impossible to collect premiums from these old people. In other words, old people who are the dependents of employees covered by employee insurance would be given the right to receive long-term care benefits without paying premiums. Of course, if the only purpose of establishing the long-term care insurance was to ensure access for old people requiring long-term care to the relevant care services, it would have been possible to integrate long-term care insurance with the Medical Insurance. However, this option was not chosen and instead, the Long-term Care Insurance was designed to require old people as well as other insured people to pay premiums. This shows the belief that it is of the utmost importance to stick to the principle of social insurance where old people who require long-term care pay premiums as the insured and receive benefits in exchange, in order to create a system that can support an aged society.

As explained above, the long-term care insurance should be designed to provide benefits to people requiring care in response to their needs for long-term care services. However, in reality, families who provide care have demand for long-term care services to substitute their care work. In addition, in the case of old people with dementia for example, it is their family members who decide on the use of long-term care services. This fact effectively makes family members who provide care the beneficiaries of the long-term care service system, which is an important point that cannot be ignored when designing long-term care insurance. As explained below, in the process of establishing the Japanese Long-term Care Insurance Scheme, its effect of reducing long-term care burdens on family members was emphasized, and this probably helped the successful integration of an intergenerational support system into the short-term insurance. At the same time, it should be noted that the needs of old people who require long-term care are not always the same as the needs of their family members who provide care, although the reduction of burdens on family members may be an important effect of long-term care services. It is not easy to find solutions to the differences between what old people who require long-term care want and what their family members want, when long-term care services are actually being used. How to prioritize needs of people who require long-term care while also reducing the burdens on family members who provide care, is a

insurance are still not required to pay premiums.

major issue we face in the operation of the system.

(3) Should the scheme cover only old people, or people of all ages? Should the scheme be independent of medical insurance scheme, or should it be integrated?

The progress in the aging of the population and the accompanying long-term care problems are probably the reasons for most countries deciding to institutionalize long-term care insurance, but the type of systems they choose may differ. If the country focuses on the fact that the risk of needing long-term care increases as one gets old, it may choose long-term care insurance where only old people who require long-term care are eligible to receive benefits. If the country considers the fact that young people also have the possibility of needing long-term care, it may choose long-term care insurance where those who are eligible to receive benefits are not limited to old people. As is the case with private insurance, social insurance functions through risk sharing by people who have various levels of risk. Therefore, it is needless to say that the system would not work if only old people who have a high risk are the insured and only they pay the premiums. This is clear from the fact that no country except Japan has institutionalized medical insurance which only covers old people, who generally have a higher risk of needing medical care. If, similarly to Germany's case, long-term care insurance is to be institutionalized by integrating it into medical insurance, it makes more sense to make people of all ages who require long-term care eligible to receive benefits than limiting the eligibility to old people.

In other words, if a country decides to create long-term care insurance which only covers old people who require long-term care, the system has to be independent of medical insurance. In Japan's case, long-term care insurance was created as a single-scheme independent of the Medical Insurance, because employee medical insurance had many old people who were dependent on employees covered by the insurance, as well as political reasons and policy considerations, as mentioned above. Whatever the reason might be, if a country decides to create a scheme which only covers old people and therefore is independent of medical insurance, it still has to find a way for younger generations to share the costs, because the insurance system would not work if it is only old people with a high risk of needing long-term care who pay the premiums. The problem can be easily solved if the costs can be covered by

government contributions (tax revenues), but if it is difficult due to fiscal constraints on the state, other measures may need to be devised. In Japan, at the initial stage of discussions about the establishment of long-term care insurance, the Ministry of Health and Welfare proposed a scheme where people aged 20 or older should become the insured and they would be required to pay premiums, while only people aged 65 or older requiring long-term care would be eligible to receive insurance benefits. However, the problem with this scheme was that it did not follow the principle of social insurance, because younger people would have to wait to receive benefits until they were 65 years old, while they had to start paying premiums as the insured if they were 20 or older. Therefore, the following solution was adopted. Two types of insured people were created, namely “Primary Insured People” aged 65 or older and “Secondary Insured People” aged 40²⁵ to 64. The former are paid insurance benefits regardless of what made them need long-term care, and the latter are paid insurance benefits provided that age-related diseases caused their need for long-term care. In a way, people aged 40 to 64 requiring long-term care are considered to be equivalent to old people requiring long-term care if the causes which made them need long-term care are age-related diseases. When considering the above design and the fact that all the services covered by insurance are basically designed to support old people requiring long-term care, the Japanese Long-term Care Insurance can generally be called “long-term care insurance for the elderly.”

Some portion of the insurance premiums paid by Secondary Insured People is used to cover insurance benefits paid to themselves, although only in limited cases. Therefore, they essentially maintain the role of insurance premiums. At the same time, a large portion of the premiums paid by Secondary Insured People is used to cover insurance benefits paid to old people requiring long-term care, and therefore it compensates for the financial weakness that the “long-term care insurance for the elderly” has. Therefore, technically speaking, the portion of premiums paid by Secondary Insured People which is used to pay insurance benefits to old people requiring long-term care has the role of a special-purpose tax, rather than an insurance premium. The role of this portion of the premiums was justified by the need for intergenerational support and the effect of reducing

²⁵ Insured people’s youngest age was raised from 20 in the proposed scheme to 40 for the following reasons: 40 is the age when phenomena caused by aging normally start; and the risk of their parents needing long-term care increases around this time, i.e. the risk of them providing long-term care to their family members increases around this time.

long-term care burdens on family members.

As has been discussed above, designing long-term care insurance mainly targeting old people involves some difficulties, when considering the fact that social insurance functions through risk sharing by people who have various levels of risk. Then, if a country is to strictly follow the principle of social insurance and create long-term care insurance which covers the long-term care needs of people of all ages, the following question arises: can the long-term care needs of old people be treated as equal to the long-term care needs of young people (people with disabilities)? As discussed in II-1-(3), long-term care insurance can only be partial insurance which cannot cover all the needs of the people requiring long-term care, because long-term care needs are diverse and it is difficult to measure the needs using a single scale (and, in reality, there is the problem of the limited amount of insurance premiums collected). However, unlike the needs of old people requiring long-term care whose risk can be predicted and preparations can be made to a certain extent over many years, it would not be acceptable to provide only partial insurance for young people requiring long-term care (people with disabilities), such as those who have congenital impairments or those who require long-term care due to accidents at a young age. This means that, even if a country has created an insurance system which covers the long-term care needs of people of all ages, it still needs an additional system where public funds are used to provide the necessary long-term care services that are not covered by long-term care insurance, for young people requiring long-term care (people with disabilities). In Japan, this point was not properly understood in the discussions toward the establishment of long-term care insurance. In addition, organizations representing persons with disabilities had strong concerns that long-term care services for the disabled could be limited to the ones covered by long-term care insurance²⁶ if services for the disabled were included in a long-term care insurance system. As a consequence, the disbursement of insurance benefits to Secondary Insured People was limited to the long-term care needs which are derived from age-related diseases, rather than the long-term care needs of people with disabilities in general. This also made it difficult to lower the youngest age for Secondary Insured People.

²⁶ Currently, public funds are being used to provide a much wider range of long-term care services than the scope of the long-term care insurance, based on the Act on Comprehensive Support for People with Disabilities.

(4) What are the points to consider in designing the long-term care insurance independent of medical insurance?

In Japan, the long-term care insurance was established as a single social insurance scheme²⁷ independent of the Medical Insurance. In the Japanese Medical Insurance Scheme, medical institutions can decide whether or not insurance benefits should be disbursed, and there is no ceiling on the amount of benefits to be disbursed as long as the services provided are needed for medical treatment. There was a concern that this system of medical insurance would be directly applied to long-term care insurance if the two insurance systems were integrated²⁸. This was among the concerns behind the decision to establish an independent long-term care insurance scheme. Now that the long-term care insurance is to be a separate system, the existing framework used in the Medical Insurance, consisting of such elements as insurers, the insured and insurance premiums, could not be used for long-term care insurance; instead, a new mechanism had to be created. The following points were considered when creating the new scheme.

- Who should be the insurer? Considering the fact that it is area-based insurance where residents become the insured, municipal governments may be an appropriate option because they can assess and collect premiums from them, but are there any other options?
- What should be the youngest age of the insured? If age is used to decide who should be insured, premiums should be charged and benefits should be disbursed to individuals rather than households, but does this create any problems? Should old people be treated differently from younger people?

²⁷ Since the Long-term Care Insurance aimed to mainly cover old people, the framework of the Medical Insurance which comprises two schemes (one for employees and the other for those not covered by employee insurance) could not be adopted. Instead, a single scheme covering residents was adopted to create a long-term care insurance scheme independent of the Medical Insurance.

²⁸ The government was concerned that, if long-term care insurance was integrated into the Medical Insurance, interested parties might request that a system similar to the medical insurance be adopted for long-term care insurance. Interested parties, who knew that it would be impossible to directly apply the system used for medical insurance to long-term care insurance, were also concerned that the rules for long-term care insurance introduced by the government (such as the certification of long-term care needs and ceilings on allowances) might also be introduced into medical insurance.

- What criteria should be used to decide on the amounts of insurance premiums and how should the premiums be collected? Should different criteria and collection methods be used for old people and younger people? How should we ensure the setting of appropriate premiums, appropriate assessment and collection, in order to maintain disciplined financial management of the insurance system?
- What should be the composition of financial sources other than insurance premiums (collected from old people and younger people), including user charge and government contributions. How should we ensure the financial sustainability of the system?

Ensuring the sustainability of the system is one of the most important points that should be considered when designing a system. However, an independent “long-term care insurance for the elderly” has many problems concerning its sustainability, as explained in II-3-(6). In the Japanese Long-term Care Insurance, this problem has not been fully addressed.

(5) Should the insurer provide long-term care services, or cover the costs of using long-term care services provided via the quasi-market?

In the Japanese Long-term Care Insurance, the insurers cover the costs of using services rather than providing the services. The difference between these two options might not be obvious to service users in Japan because, in the Japanese system, service providers receive insurance benefits from the insurers on behalf of the insured. However, the theories behind the two options are different and system designs resulting from these two options have some differences.

Firstly, let us look at the option where the insurer provides the services, using medical insurance as an example. In this case, the insurer has to establish hospitals and provide medical services, as a way of providing the services covered by the insurance. Alternatively, it can outsource the provision of services to other medical institutions. In either case, in principle, the insurer is responsible for providing the relevant services. Therefore, when the insurer outsources the provision of medical services to other medical institutions, the insurer decides on the amount of medical fees that it pays to the medical institutions (i.e. the official prices). The Japanese Medical Insurance uses this system. In Japan, anybody can set up a medical institution which treats patients with medical insurance

coverage as long as it meets the statutory requirements. Insured people are allowed to receive medical treatment at any medical institutions which are authorized to treat patients with medical insurance coverage. Due to this, the Japanese medical insurance scheme seems to presuppose the existence of a medical service market. However, theoretically, a medical service market is not necessarily required for the functioning of a system where the insurer provides the medical services.

Secondly, let us look at the option where the insurer covers the costs of using services. For this option to work, there should be a service market where relevant services are traded. The service market in this context is not a complete free market, but it is a market controlled by the insurance system, i.e. a quasi-market, in the sense that, in order for the services to become subject to the disbursement of insurance benefits, the service providers must meet the designated requirements, and they must provide relevant services at a price which does not exceed the set ceiling. In a social insurance scheme where the insurer covers the costs of using services, the insurer is not directly responsible for the provision of services. In Japan, this scheme was adopted for the long-term care insurance, because long-term care services are more suitable to be traded in the market when compared to medical services. For this system to work, the relevant services should be already traded in the market, or there should be the prospect of the relevant services becoming available in the market. For this reason, in Japan, various types of service infrastructure were developed in a hurry before the Long-term Care Insurance Scheme was established. After the scheme was established, appropriate service trade was encouraged through benefit level setting and other measures.

These two options result in different stipulations regarding user charge. In the second option (option where the insurer covers the costs of using the services), the insurer may not cover all the necessary costs depending on the design of the system, and in that case, users are automatically required to pay the rest. For example, in Japan, the long-term care insurance covers 90% of the amount that is set as service cost by the Minister of Health, Labour and Welfare²⁹, and the remaining 10% is paid by users based on direct contracts between the service providers and the users. On the other hand, in the first option (option where the

²⁹ In January 2001, Ministry of Health and Welfare became Ministry of Health, Labour and Welfare as a part of the government reorganization.

insurer provides services), the insurer is required to provide all the necessary services free of charge, in principle. Therefore, in order to be able to charge user fees or patient co-payments, an additional rule must be stipulated in law³⁰.

3 Detailed Design of Long-term Care Insurance

(1) Single-scheme Area-based Insurance Administered by the Lowest Level of Local Government

When Japan decided to create “long-term care insurance for the elderly” independent of the Medical Insurance, it adopted a single-scheme area-based insurance, rather than adopting an employee insurance scheme. This is because the long-term care insurance should cover retired people as well as employees and collect insurance premiums from both groups of people, while the existing Japanese social insurance for employees does not cover retired people. In an area-based long-term care insurance scheme, old people are categorized as local residents. In an insurance scheme which covers residents and collects premiums from them, the insurer must be the state, local government or a public corporation which is given the role of the insurer by the state or local government. This is because, in order to require residents to take part in the insurance scheme and to pay insurance premiums, the insurer must be given the authority in law. In Japan, municipal governments, which is the lowest level of local government, were selected as the long-term care insurers, for the following reasons: municipal governments had been paying benefits based on the Act on Social Welfare for the Elderly as well as under the Health and Medical Service Scheme for the Elderly; they are the insurers of National Health Insurance; and decentralization was a major political trend at the time where importance was placed on the role of the lowest level of local government. The insurer must be able to collect insurance premiums (which is the most important task of an insurer), and conduct the financial management of the insurance scheme in a disciplined manner. In Japan, only the state and municipal governments have the organizational structure and skilled staff needed for the collection of taxes and other contributions from residents,

³⁰ Who should collect patients' co-payment was a major issue for medical insurance in Japan for many years. Medical service providers were not only against the idea of patients' co-copayment, but they also argued that they should not be the ones to collect it in addition to their original role of providing medical services. The Ministry of Health and Welfare might have wanted to avoid this discussion when designing long-term care insurance.

regardless of whether they are workers or not. Under the decentralization policies, making the state the insurer was not an option, and therefore it was in a way inevitable that municipal governments would be selected as the long-term care insurers. It was also encouraged that multiple municipal governments should jointly administer long-term care insurance, if joint administration was needed to improve the operational efficiency of the long-term care insurers. At the time, the Ministry of Home Affairs seemed to have thought it necessary to encourage the merging of municipal governments in order to improve their administrative and financial capabilities, if the individual municipal governments could not administer the Long-term Care Insurance by themselves³¹.

What is the significance of municipal governments (the lowest level of local government) becoming the long-term care insurers, from a welfare administration standpoint? As mentioned above, long-term care is needed for all types of everyday activities, and long-term care insurance cannot cover all long-term care needs. In addition, residents have various other welfare needs and support needs for everyday life. Although it does not mean that municipal governments have to take care of all these needs, they should always have a role to play in responding to these needs as the entities responsible for the general administration of the respective municipalities. Therefore, municipal governments cannot fulfill their administrative responsibilities by just administering long-term care insurance. The Long-term Care Insurance was organized so that insurance is provided at the municipal level (which is also the level dealing with welfare administration) partly because this arrangement would enable municipal governments to administer both long-term care insurance and other welfare programs in an integrated manner.

(2) Determining the Levels of Long-term Care Needs Based on Field Data (the Certification of Long-term Care Needs)

When designing long-term care insurance, the most difficult thing is to determine what level of long-term care need is eligible for the benefit and to assess the level of long-term care needs, for individual people requiring long-term care. Unlike the case of medical insurance where the need is assessed by doctors on

³¹ The Long-term Care Insurance Scheme was launched smoothly with municipal governments serving as the insurers, but the Ministry of Internal Affairs and Communications (former Ministry of Home Affairs) strongly encouraged the merging of municipal governments after the insurance system was launched.

the basis of medical science, there is no similar established academic basis or experts who can make the correct judgment for long-term care needs. Therefore, objective criteria that can be used for all the people requiring long-term care are needed, in order to avoid relying on the subjective judgments of those who conduct the assessments³².

After trial and error, the method eventually adopted was to determine the levels of long-term care needs based on the data of the amount of services provided (the number of hours that actual long-term care services were provided) to users in different physical and mental conditions at long-term care facilities. More specifically, the amount of services provided to several thousand old people at Tokuyo and other long-term care facilities was measured using the one-minute-basis time study method³³ over 48 hours. A database was then created to enter a combination of the amount of services provided and the mental and physical condition of each old person studied. The amount of services provided was divided into several levels, which indicate the level of long-term care needs. When an old person's need for long-term care is to be assessed for insurance purposes, his/her mental and physical condition is surveyed, and the person who has the closest mental and physical condition to him/her is selected from the database using a statistical mathematical method. Then, whether or not he/she needs long-term care and the level of long-term care needs are determined based on the data on the amount of services provided to the person who has the closest mental and physical condition to him/her. His/her level of long-term care needs is assessed by looking at the level that the relevant data on the amount of services provided is in. This is called the primary assessment and it is done using a computer program. This method of determining the levels of long-term care needs based on the field data on the amounts of long-term care services provided is probably a reasonable method when considering the fact that the purpose of assessing the need for long-term care is to decide on the extent to which long-term care services should be provided to individual old people. This method was created in Japan and is highly valued by other countries as a method to objectively process a large number of cases.

³² There were simple criteria for assessing the condition of those requiring long-term care (such as "chair-bound" and "bedbound"), but they still left room for the subjective judgments of those who conduct the assessments. These criteria could not be directly used for long-term care insurance, because the occupational background of a person who conducts assessment (such as nurses or care workers) could cause major bias.

³³ The one-minute-basis time study is a study method where care workers make a record of the types of care they are providing and to whom they are providing it, every minute.

In the Long-term Care Insurance, municipal governments, which are the insurers, certify the need for long-term care, based on judgments made by the Certification Committee of Needed Long-Term Care established in each municipality. This was the first time for Japan to use the system of the insurer certifying the need for the disbursement of benefits as well as certifying the extent to which benefits were to be disbursed, because the Medical Insurance did not have this type of system. Each Certification Committee of Needed Long-Term Care is made up of experts on health, medical care and welfare, and it conducts the secondary assessment based on the results of the primary assessment, the written remarks of the certification investigator as well as the written opinions of the doctor in charge of the person being assessed. The results of the primary assessment can be overturned as a result of the secondary assessment when it is deemed necessary, which often happens. The reason the process for the certification of long-term care needs has two stages (the primary assessment and the secondary assessment) is that the applicants may not be convinced by the results from an automatically conducted assessment alone, when considering the diverse levels and conditions regarding long-term care needs. Therefore, it was considered desirable to make the final decision through mutual consent among experts from the relevant fields. Applicants can appeal the decision to the respective Prefectural Certification Committee of Needed Long-Term Care if they have complaints about the municipal government's decision concerning the certification of long-term care needs.

Although municipal governments conduct administrative work concerning the certification of long-term care needs, it is the Minister of Health, Labour and Welfare that decides on the criteria and operational guidelines for the certification. This is because, although it may be appropriate to leave these decisions to municipal governments from the decentralization standpoint, it is also necessary to maintain the same system across the country in order to ensure fairness, because the scheme uses premiums paid by Secondary Insured People and government contributions as financial sources, which are collected at the national level. Municipal governments also asked for the state to create uniform criteria and operational guidelines, because they were concerned that the use of different certification methods in different municipalities could lead to frequent appeals and lawsuits.

(3) Payment of Benefits for Long-term Care Services in Accordance with the Levels of Long-term Care Needs (with ceilings for home-based and community-based services and fixed amounts for facility services)

The certification of the level of long-term care needs is conducted in order to determine and approve the level of long-term care services needed. Therefore, the amount of benefits for long-term care services is decided based on the level of long-term care needs certified by the municipal government. The certification of the level of long-term care needs has a particularly important role in deciding the benefit amount for home-based and community-based services. Home-based and community-based services include a wide range of services such as “home-visit care,” “home-visit nursing,” “daycare,” “outpatient rehabilitation” and “short-term care” as well as the rent or purchase of equipment. It is not easy for people requiring long-term care to decide on the most appropriate services that they should use. This is because an objective academic framework for deciding on the long-term care needed has not been established, while the treatment of sickness and injuries can be decided based on medical science which has an objective academic framework. When considering the fact that the needs of individual people requiring long-term care vary from both the objective and subjective standpoints, it is not possible to make a top-down decision on the types and the amounts of services that should be used without objective grounds. Therefore, people requiring long-term care should be able to decide on the types and the amounts of home-based and community-based care services that they use. However, since many long-term care services provide convenience and comfort, some people requiring long-term care might want to use more services than they need. For this reason, it is necessary to create a system where ceilings on the amounts of services that can be used are set and users select care services that they want to use within the limits. Of course, such a system should have different ceilings on the use of services depending on the level of long-term care needs.

This idea led to the introduction of a system which sets the ceilings of benefits for home-based and community-based services, for each level of long-term care need. The ceilings were decided using the following method. Firstly, for each level of long-term care need, typical mental and physical conditions of people requiring long-term care were selected from the data in the time study. Then, for each of these types of mental and physical conditions, examples of sets of

services that can be used were created. Based on the set unit cost of each type of long-term care service, the total cost of each set of services was calculated. The benefit ceiling for each level of long-term care need was determined based on these calculations. The examples of sets of services which were used to determine the current benefit ceilings were created through consultations with several experts when the government established the Long-term Care Insurance. However, these examples are not exactly based on objective evidence. So far, there have not been a significant number of cases where the set levels of ceilings caused problems concerning the use of home-based and community-based services. In addition, the creation of sets of service examples is just one step for determining the benefit ceiling. Nevertheless, the fact that the benefit ceilings (which have an important role to play in the system) were determined on an empirical basis shows the difficulties in creating the long-term care insurance before an academic framework has been established to determine what needing long-term care means and what long-term care services are needed. If, in the future, a scientific and academic framework on long-term care is established by utilizing and analyzing vast amounts of data obtained through the implementation of long-term care insurance, it will probably become possible to obtain an objective basis for determining the benefit ceiling, and there might be a possibility of conducting care management based on standard service models.

Certified levels of long-term care needs are also used to calculate the amount of benefits provided for residential services at facilities (“institution-based services”). Unlike home-based and community-based services, services available to users are basically limited to those provided at the facility. Therefore, unlike the benefit ceiling for home-based and community-based services, the benefits paid for institution-based services (90% of long-term care service cost) are determined directly based on the level of long-term care needs, i.e. the amount of benefits is calculated based on the daily cost for each level of long-term care need, which includes all the costs of long-term care services provided at the facility.

(4) Institutionalization of Care Management and the Users’ Freedom of Service Selection

In the Long-term Care Insurance, the care management is institutionalized as a series of activities where care managers assess people requiring long-term care, create care plans about service providers and the types of services to be used by coordinating with the relevant parties based on the wishes of the people

requiring the long-term care, and monitor the use of the services, etc. What is the rationale for institutionalizing the care management?

As mentioned earlier, for home-based and community-based services covered by long-term care insurance, people requiring long-term care can select and use services that they consider meet their own long-term care needs, within the limits of the benefit ceiling. However, there are numerous service providers as well as various types of services. It is not easy for people on their own, who require long-term care, to select the types of services and service providers they need, as well as following the procedures to coordinate with the service providers in order to use the services and create care plans in such a way that service costs do not exceed the benefit ceiling. At the same time, it is not easy for family members to conduct these tasks based on the wishes of the people requiring the long-term care. If they cannot use long-term care services appropriately because of the complicated procedures at the preparation stage, people requiring long-term care cannot fully utilize their right to receive long-term care benefits which is guaranteed by law. This led to the introduction of a care management system.

The work of care managers also includes the submission of care plans written on benefit management forms to the organizations which examine and pay long-term care benefits (the Federation of National Health Insurance Associations established in each prefecture). This makes it possible for the federations to determine whether or not the monthly long-term care benefit expenses (90% of long-term care service cost) claimed by service providers from the federations are within the benefit ceiling for individual people requiring long-term care. Without the prior submission of benefit management forms, the federations would not be able to tell whether or not the amounts claimed by service providers are within the benefit ceiling, and this would make it impossible for the federations to pay the amounts claimed by the service providers. Therefore, if benefit management forms were not submitted beforehand, service users would have to pay 100% of the service cost to individual service providers, and then receive refunds for overpayment (within the benefit ceiling) from their municipal governments. However, the system was designed so that insured people only have to pay 10% of the service cost to service providers, with service providers receiving benefits for long-term care services cost on behalf of the insured in accordance with the law. In order to achieve this system design, the system of care managers submitting care plans (benefit management forms)

to the federations was introduced.

Care management could have been included in the insurers' administrative work. However, care management is essential to guarantee insured people's right to receive home-based and community-based service benefits, and this made it important to involve experts on care management (care managers). Based on the idea that insured people should be guaranteed the use of care management services, care management service was included in the long-term care insurance benefits. Furthermore, unlike other service costs, care management services costs are entirely paid by insurers (no user charge) because it was considered that it might take time for users to understand that they have to pay for the care management service, which is an administrative service and is not included in the existing Medical Insurance scheme.

(5) User Charge and its meaning in the Long-term Care Insurance

As explained earlier, in the Long-term Care Insurance, benefits for long-term care services are disbursed to cover 90% of the total long-term care service costs, and the rest is charged to service users. The role of user charge in the Long-term Care Insurance is not significantly different from that of the patient co-payments in the Medical Insurance. Users effectively pay 10% of the total long-term care service costs, and if the 10% exceeds a specified amount, "benefit for high-cost long-term care services" is paid to the users. For low-income earners, this specified amount, which is the threshold for the "benefit for high-cost long-term care services", is set lower in order to reduce the burden on them³⁴. Later, revised laws introduced a combined high-cost service benefit system where benefits are paid to users if the sum of the amount of patient co-payments in medical insurance and the amount of user charges in long-term care insurance exceeds a specified amount, in order to reduce burdens on people who receive both medical and long-term care services under the two insurance schemes. When the combined system was created, the focus of attention was on the fact that old people's long-term care needs are closely related to their medical care needs and they often receive medical and long-term

³⁴ The rule of low-income earners having a lower threshold for benefits for high-cost long-term care services was modeled after the benefit system for high-cost medical care in the Medical Insurance. However, being a low-income earner is a personal circumstance irrelevant from the need for long-term care. Differentiating the amounts of benefits based on a factor irrelevant to the need for long-term care is an irregular rule when considering the principle of social insurance where benefits should be disbursed in accordance with relevant needs.

care services at the same time. This is one way that a system could be designed to respond to these two types of closely related needs (medical and long-term care needs).

Now, let us think about the particulars of user charges in the Long-term Care Insurance, by comparing them with patient co-payments in the Medical Insurance. Firstly, particular consideration should be given to striking a balance between those who use long-term care services and those who do not. Some people have negative opinions about imposing further burdens on people requiring medical care or long-term care by requiring them to pay patients' co-payment or user charges, but this is probably necessary in order to obtain support from those who have to pay premiums despite them not needing to receive the benefits. This is particularly true for long-term care insurance because, unlike people requiring medical care³⁵, there is little possibility of those who receive long-term care not needing to receive long-term care in the future³⁶. Secondly, particular consideration should be given to ensuring the appropriate and efficient use of long-term care services. In the case of home-based and community-based services, having a benefit ceiling should restrain people from using services that they do not need. However, when considering the fact that many long-term care services provide convenience and comfort, it is essential to have a system which facilitates the efficient use of services, even within the benefit ceiling. This is another important role that user charges have. Another rationale of user charge in the Long-term Care Insurance may be to encourage both users and service providers to prevent further deterioration of users' conditions. Patient co-payments in the Medical Insurance have the role of helping medical service providers select efficient medical treatments because they have to charge patients co-payments for every medical treatment they provide. On the other hand, in long-term care insurance where users decide on the amount of services they want to receive by creating care plans, there is hardly any need to constrain service providers from providing excessive services³⁷. However, if users did not have to pay any fees, they could continue to receive more services without a financial burden when their level of long-term care needs increased, and the service providers would also benefit from the

³⁵ The Medical Insurance Scheme may have a somewhat similar issue these days, due to the increasing number of people who have lifestyle-related illness.

³⁶ Please see II-1-(3) regarding the issue that those requiring long-term care and those who do not, tend to be fixed.

³⁷ User fees probably help stop care managers from encouraging users to use more services for the benefit of specific service providers.

situation because of the higher long-term care service fees. This could discourage service providers from supporting the users so that they do not require higher levels of long term care. In this sense, user charges probably have the role of preventing the users' conditions from deteriorating (prevention of further long-term care).

Some people argue that reducing the financial burdens on the insurance system is the objective of the user charges. It is true that user charges help reduce financial burdens on the insurance system, because the benefits for long-term care services do not have to cover the part paid by users. However, this is just a by-product of a policy which has other objectives. It is unacceptable to discuss user charges from the standpoint of the finances of the system alone. If, in the future, the reduction of the protection level (which is currently 90%) is proposed in order to ease the financial burden on the insurance system, it is necessary to have prior discussions about the appropriate level of user charges³⁸ and possible limits on increases (or decreases) of that level, in light of the objectives of the Long-term Care Insurance. The current level of 10% is equivalent to the target percentage of old patients' co-payment in medical insurance which was to be achieved through the creation and revision of the Health and Medical Services Act for the Aged.³⁹ However, this does not mean that 10% is the only percentage that can be used. Rather, this is an issue that should be decided based on a comprehensive assessment of such factors as the financial situation of the Long-term Care Insurance and the current level of patient co-payments in the Medical Insurance, while prioritizing the original role of long-term care insurance. In this process, it is important to keep in mind the fact that the need for long-term care is irreversible and the use of long-term care services as well as the payment of user charges will continue for many years. Generally speaking, it may not be acceptable to set the user charge percentage used in the long-term care insurance at the same level as the patient contribution percentage in a medical insurance where the patients could be cured or go into remission.

³⁸ This section has been discussing fixed-rate user fees, but it is theoretically possible to use fixed-amount user fees. However, fixed-amount user fees were not mentioned in this document, because fixed-rate fees fulfill the roles expected of user fees more clearly, and also because the problem of people with high levels of long-term care needs having to use more services and to pay high costs can be mitigated by the payment of benefits for high-cost long-term care services.

³⁹ In 1973, the introduction of free medical services to the elderly led to a surge in medical expenses for the elderly. Since then, the reintroduction of elderly patients' co-payment and its increase to 10% had been a long-standing political issue.

(6) Multi-layered Composition of Financial Sources Made up of Premiums Collected from Old People and People Aged 40-64 as well as Contributions from National and Local Governments

Long-term care service costs other than the portion covered by user charges are covered by the Long-term Care Insurance, 50% of which are covered by insurance premiums and the remaining 50% are covered by government contributions. The ratio between the premiums collected from Primary Insured People (Primary Insurance Premiums) and those collected from Secondary Insured People (Secondary Insurance Premiums) changes depending on the ratio between the two population groups. Out of the 50% covered by government contributions, 25% is covered by the state (of which, 5% is the Adjusting Subsidy), 12.5% is covered by prefectural governments and 12.5% is covered by municipal governments⁴⁰. The above-sections already explained the historical reasons for and the institutional significance of the multi-layered composition of financial sources for long-term care insurance made up of premiums and government contributions. Therefore, the following section briefly explains and discusses the methods for collecting Primary Insurance Premiums and Secondary Insurance Premiums and their significance. It also briefly explains and discusses how the multi-layered composition of financial sources influences the operation of the system.

Regarding Primary Insurance Premiums, each municipal government calculates the premiums based on the expected long-term care benefit expenses. Premiums are levied on individuals in accordance with the current levels of the inhabitant tax levied on them (including zero inhabitant tax). Premiums from those who have monthly pension income of 15,000 yen or more are collected using the following method. The organizations which pay the relevant pensions collect insurance premiums under special arrangements by deducting the premiums from pension payments, and then send the collected premiums to municipal governments. As a result, the compliance rate for Primary Insurance Premiums is more than 90%, which is an extremely high level. In the case of long-term care insurance, there is little possibility of those who receive long-term care not needing to receive long-term care in the near future, and those who do not require long-term care may feel strongly that they are paying premiums with

⁴⁰ Concerning benefit expenses for institutional services, a later revision changed the percentages to 20% for the state and 17.5% for prefectural governments.

no possibility of receiving benefits in the short run. Therefore, the collection of premiums using ordinary methods would have been difficult. In this sense, the method of deducting premiums from pension payments is probably one of the factors which enabled the Long-term Care Insurance to be successful. With regard to Primary Insurance Premiums, municipal governments set several different levels of premiums in accordance with the levels of tax levied on individuals. The difference between the lowest level of premium and the highest level of premium is not as large as the difference in medical insurance premiums, which is also probably due to consideration for those not requiring long-term care who feel that they are not receiving anything in return. Primary Insured People include welfare recipients. The lowest level of insurance premium applies to them, and the premium levied on them is covered by welfare payment provided to them which is equivalent to the size of the premium, as part of the livelihood assistance allowances given via the public assistance program. In reality, the relevant welfare offices directly pay the premiums to the long-term care insurance departments in municipal governments. This was the first time for a Japanese social insurance scheme to employ this type of measure for welfare recipients. This was a significant step towards the thorough application of the universality of social insurance.

With regard to Secondary Insurance Premiums (collected from people aged 40 to 64), the insurers of the medical insurance programs that Secondary Insured People participate in are responsible for assessing and collecting long-term care insurance premiums from them. Firstly, the premium per Secondary Insured Person is calculated based on the total expected amount of long-term care benefit expenses nationwide. The Social Insurance Medical Fee Payment Fund ("Payment Fund") allocates the amount that should be paid by each medical insurer (the "long-term care payment"), which is calculated by multiplying the premium per Secondary Insured Person by the number of Secondary Insured People taking part in the medical insurance program. In order to make long-term care payments, each medical insurer collects long-term care premiums from people aged 40 to 64⁴¹ (Secondary Insurance Premiums) that participate in its medical insurance program, using the same method as when collecting medical insurance premiums. This means that medical insurers collect Secondary

⁴¹ Secondary Insured People in municipalities who are the dependents of employees covered by employee health insurance do not pay Secondary Insurance Premiums. Instead, this amount is included in Secondary Insurance Premiums paid by other people aged 40 to 64 who take part in medical insurance programs.

Insurance Premiums on behalf of municipal governments. Medical insurers, who have collected Secondary Insurance Premiums on behalf of municipal governments, make long-term care payments into the Payment Fund using the collected premiums. The Payment Fund then pays the percentage of long-term care benefit expenses that should be covered by Secondary Insurance Premiums to each long-term care insurer (i.e. each municipal government). This percentage is based on the ratio between the Primary Insured People and the Secondary Insured People nationwide. The same percentage applies to all municipal governments (29% in FY2014)⁴². Assessing and collecting premiums by the same method as for medical insurance premium means that, in the case of an employed person, the long-term care insurance premium is a specific percentage of his/her wage, and shared evenly with the employer, and is deducted from wages. In the case of a person in the informal sector insured by National Health Insurance, the long-term care insurance premium is based on the insured person's income, property and the number of family members, in accordance with the assessment method used by his/her municipal government. The premium is then collected along with the National Health Insurance premium. The government contribution to medical insurance benefit expenses also applies to long-term care payments in principle.

Therefore, when looking at the design of the Secondary Insurance Premiums system, this part of long-term care insurance is a uniformed national system. This means that, as long as Secondary Insurance Premiums are collected, the same rights to long-term care insurance must be ensured nationwide although the system is administered by municipal governments. The fact that Secondary Insurance Premiums are collected using the same methods as for the collection of medical insurance premiums means that, this part of the Long-term Care Insurance is built on two schemes developed for the Medical Insurance. In other words, long-term care insurance is supported by the two strong schemes established for universal health coverage, especially the employee insurance scheme which collects insurance premiums very effectively.

⁴² Although the population ratio between insured people aged 65 or older and insured people aged 40 to 64 varies depending on the municipality, the same national average ratio applies to all municipal governments. This gives an advantage to municipal governments which have a less percentage of insured people aged 40 to 64. This system was included in the Long-term Care Insurance in order to prepare for a progress in the aging of the population, along with the Adjusting Subsidy which is allocated to municipal governments in accordance with the percentage of people aged 75 or older, as mentioned below.

As with Primary Insurance Premiums being collected by deducting them from pension payments, the method of medical insurers collecting Secondary Insurance Premiums on behalf of municipal governments was adopted in order to ensure a high collection rate for premiums. As a consequence, welfare recipients, who do not take part in medical insurance programs, lose the opportunity of becoming the Secondary Insured. Considering the fact that welfare recipients cannot be expected to support others, it may be acceptable that they do not pay Secondary Insurance Premiums whose main role is intergenerational support. In addition, they can still receive long-term care services because long-term care assistance was added to the benefits in the Public Assistance Act. However, this will be one of the challenges when considering the possibility of a long-term care insurance system which covers people of all ages.

It was in a sense inevitable for Japan to employ the multi-layered composition of financial sources made up of Primary Insurance Premiums, Secondary Insurance Premiums, national and local government contributions, because the Japanese long-term care insurance system mainly targeted old people. However, when considering the sustainability of the system (i.e. the issue of whether or not the availability of these financial sources can be ensured in order to cover the ever-increasing benefit expenses), this multi-layered composition of financial sources could become a constraint. The heavy reliance on government contributions means that the national and local financial situation can easily affect the system. In addition, it may not be easy to increase Primary Insurance Premiums which cover the risk of needing long-term care; those requiring long-term care and those who do not tend to be fixed, and the idea of “helping each other” does not apply as much as it applies to medical insurance. Furthermore, people consider an increase in Primary Insurance Premiums as just an increase in burdens because the actual amounts rather than percentages are announced. Also, as mentioned below, Primary Insurance Premiums are revised once every three years simultaneously nationwide, and therefore the revision of the premiums tends to be treated as a national institutional issue⁴³ (despite it being a municipal issue). These factors make it difficult to increase the premiums to the levels that meet the increasing benefit expenses. Therefore, it is necessary to continue to deepen people’s understanding about the fact that the

⁴³ In the discussions on a revision of the Long-term Care Insurance in 2010, there was even an opinion that the amount of Primary Insurance Premium for payment should not be more than 5,000 yen per month.

premiums are set so that they match the amount of benefits needed rather than them being just a burden. Continuous efforts must also be made to improve the efficiency in benefit expenses.

(7) Ensuring the Stable and Autonomous Financial Management of the Insurance System

The insurers' biggest concern about the operation of the Long-term Care Insurance is how they can ensure the financial stability. Municipal governments have information about those eligible for receiving long-term care benefits because they conduct the long-term care needs certification process. However, they do not know beforehand the number of people who will apply for the certification of long-term care needs, nor do they know the number of those certified who will actually use long-term care services or the amount of services they will use. In addition, municipal governments cannot refuse to pay benefits even if more people than initially expected decided to use more services than initially expected, because they are entitled to use the services in exchange for paying the insurance premiums.

This is a major difference between a social insurance system and a tax-based system where a government agency provides services using public funds, because in the latter case, it is possible to provide services only within a set budget. Even though those who are eligible to receive benefits may take it for granted that they can use as many services as they need, for the insurers, not being able to control the amount of services used means that they always face the possibility of running short of Primary Insurance Premiums that should cover a specific percentage of benefit expenses⁴⁴. The shortage of revenue from Primary Insurance Premiums occurs not only when the amount of benefits paid exceeds the expected amount, but also when the compliance rate for the premiums falls below the expected level. This could occur due to insufficient efforts being made by municipal governments to collect premiums, as well as

⁴⁴ This problem does not occur for the portions covered by government contributions and Secondary Insurance Premiums, because the specified percentages of the actual benefit expenses are paid to municipal governments without fail. When there is a shortage of government budget, the national and local governments create supplementary budgets. When there is a shortage of Secondary Insurance Premiums that should be granted to municipal governments, the Payment Fund takes out a loan. The shortfall in Secondary Insurance Premiums is added to long-term care payments that have to be paid by medical insurers two years later.

when there are fewer Primary Insured People than expected.

In National Health Insurance administered by municipal governments, the municipal governments have been covering financial shortages by transferring money from their general account budgets, which is a method not stipulated in law. This method not only affected municipal general account budgets, but also damaged the autonomy and completeness of the financial management of National Health Insurance. In order to avoid the occurrence of the same problem in the financial management of the Long-term Care Insurance, a system was introduced to establish a Fiscal Stability Fund in each prefecture.

A Fiscal Stability Fund was created in each prefecture using national and prefectural government contributions and Primary Insurance Premiums from municipal governments as financial sources. At the end of every fiscal year, it lends the amount of the excess benefit expenses (created due to higher expenses than expected by the municipal government) that should be covered by Primary Insurance Premiums, and 50% of the shortage of the revenue from Primary Insurance Premiums (created due to a lower compliance rate than expected), as an interest-free loan. It also grants another 50% of the Primary Insurance Premium shortages. This covers the Primary Insurance Premium shortages and the municipal government can avoid a de facto deficit settlement (i.e. taking out a loan or transferring money from other sources to cover the shortages). The municipal government collects and repays the amount borrowed from the Fiscal Stability Fund by adding it to Primary Insurance Premiums to be collected in the next three-year period. The autonomy and completeness of the financial management of the Long-term Care Insurance Scheme are secured this way.

Another device which was put in place in order to maintain the autonomy and completeness of the financial management of the Long-term Care Insurance is the Adjustment Subsidy given by the state, which is included in the calculation of Primary Insurance Premiums. 25% of total benefit expenses are covered by the state, of which 5% is allocated by taking into account the percentage of people aged 75 or older⁴⁵ in each municipality and the Primary Insured People's collective payment capability in each municipality. The idea behind this is that these two factors should not affect the levels of Primary Insurance Premiums in

⁴⁵ They are also referred to as the advanced elderly.

each municipality. Each municipal government decides on the levels of Primary Insurance Premiums based on the amount calculated by deducting the following amounts from the total expected benefit expenses: the amount expected to be paid from the state's budget, the prefectural and municipal budgets; the amount of Secondary Insurance Premiums expected to be given by the Payment Fund; and the amount of Adjusting Subsidy expected to be paid by the state. This means that the levels of Primary Insurance Premiums are calculated after offsetting the influences of the above-mentioned two factors in each municipal government by giving the Adjusting Subsidy. Therefore, Primary Insured People will be paying fair premiums that must be borne by them, regardless of the municipality they live in.

Therefore, the system's design ensures that municipal governments can fulfill their responsibility for the financial management of the Long-term Care Insurance concerning the setting of Primary Insurance Premiums from the budgeting stage to the settlement stage, which is the most important task for insurers.

(8) Financial Management Method for the Long-term Care Insurance

Section (7) above explained the basic scheme for the financial management of the insurance system by municipal governments. In the Long-term Care Insurance, financial management is conducted on a three-year basis. Each municipal government formulates a Municipal Long-Term Care Insurance Implementation Plan every three years. In this process, each municipal government calculates the expected amount of benefit expenses for the following three years, based on which it sets Primary Insurance Premiums for the following three years. In order to calculate the expected amount of benefit expenses in the plan, each municipal government estimates the amount of services to be provided by estimating the number of certified people requiring long-term care and the number of service users. The creation of the plan is important in the sense that it gives the municipal government, which has granted the right to receive benefits to the insured by certifying the need for long-term care, a way of showing how the right to receive the benefits can be delivered to the insured. In the Long-term Care Insurance, the provision of long-term care services is left to the free trading of services in the quasi-market, while the insurers grant the right to receive services to the insured by certifying the need for long-term care. This involves the tricky issue of how the insurers should

guarantee the right of the insured⁴⁶. In order to resolve this issue, municipal governments' plans play role of bridging these two components in the system.

In this system, the same levels of Primary Insurance Premiums apply to the three consecutive years subject to the plan. The expected outcome from the financial plan is that, the income from Primary Insurance Premiums will exceed the benefit expenses in the first fiscal year of the three years, the income will equal the expenditure in the second fiscal year, and the expenditure will exceed the income in the third fiscal year and the shortfall will be covered by the surplus from the first fiscal year. For municipal governments, the revision of Primary Insurance Premiums involves the risk of political, i.e. arbitrary, decisions being slipped into the process. Revising the premiums every fiscal year might increase the number of decisions that could affect the autonomy and completeness of the financial management of the Long-term Care Insurance. Therefore, the national simultaneous triennial revision of Primary Insurance Premiums was introduced in order to make it clear that it is not a special political event but it is an institutional routine⁴⁷. The state also revises the benefit calculation rules (service fee tables and service operation standards) every three years, when municipal governments create their plans. Therefore, the core of the Long-term Care Insurance is revised every three years. The law is also often revised at this time. In this manner, the current long-term care insurance was developed by undergoing a major transformation every three years.

⁴⁶ This tricky relationship does not surface in the Medical Insurance, where the provision of services is left to the quasi-market and decisions on the granting of benefits are also left to the players in the market (medical institutions).

⁴⁷ Although the introduction of the system succeeded in making the revision of the premiums by municipal governments routine, the system also focused attention on the differences between municipalities and the national average level of the premiums.

III Development and the Limits of the Long-term Care Insurance

1 Revision and the Development of the Scheme after Its Establishment

The Long-term Care Insurance is now well-established in Japanese society. After the scheme was launched in April 2000, daycare service centers opened in various neighborhoods. Home-visit caregivers' cars are often seen on the streets, and the words "care managers" come up in daily conversations among citizens. The scheme has become one of the main pillars of the social insurance in Japan, after going through several revisions (revisions of the law and long-term care service fees).

The first major revision of the Long-Term Care Insurance Act took place in 2005. The primary change among the various changes made was the strengthening of long-term care prevention measures (the provision of services and projects that aim to prevent people from needing long-term care or further long-term care). More specifically, the "needing support" level, which was the one level in the long-term care needs certification system, was divided into two levels. Services which aim to prevent long-term care were added to all types of existing home-based and community-based services. It was stipulated that, in principle, plans for these preventive long-term care services must be created by public health nurses at community comprehensive support centers, rather than by care managers. In addition, those who have not reached the "needing support" levels became subject to long-term care prevention programs conducted by municipal governments, and it was decided that community comprehensive support centers would be responsible for the programs. Community comprehensive support centers are managed by municipal governments directly or the management is outsourced to such institutions as social welfare corporations,⁴⁸ by the municipal governments. In addition to conducting duties related to long-term care prevention, community comprehensive support centers provide general consultation services, respond to elder abuse problems and support the care managers. Through the revision, a system for disclosing long-term care service information was established, and a new service type called the "community-type service" was added. These are services that can only be used by residents in the municipality where the relevant business office is located.

⁴⁸ Social welfare corporation is a non-profit organization specially established to provide social welfare services.

In the 2007 revision that followed the 2005 revision, it was decided that the residents of the institutions covered by long-term care insurance must pay board and lodging costs, in order to reduce the financial burden on the state. At the same time, it was also decided that low-income earners would be given additional benefits from the Long-term Care Insurance in order to reduce the burden on them. The additional benefits are paid to low-income earners using revenue from premiums, although being a low-income earner is irrelevant to an individual's need for long-term care. Therefore, this measure is hard to justify when considering the principle of social insurance.

In FY2003 and FY2006, long-term care service fees were revised. Through the revisions, the fees were reduced because of the financial difficulties that the state was in. The impacts of these revisions gradually surfaced when a large number of care workers started to leave their jobs and it became difficult to recruit care workers, which led to a critical situation in long-term care workplaces. Being alarmed by the situation, the state increased long-term care service fees in the revision of fees in FY2009. In addition, in FY2009 national supplementary budget, the state secured the budget needed to grant subsidies for improving the treatment of care workers up to FY2011, in order to compensate them for past reductions in long-term care service fees.

The next revision of the law took place in 2011. The policy goal of establishing community comprehensive care systems started to be talked about around this time. In the 2011 revision, an outline and the purpose of such systems were given in the provisions which stipulated the responsibilities of the state and local governments in establishing such systems. Services that contribute to establishing such systems were created, including around-the-clock periodic visits and on-demand services as well as composite services. Municipal governments were allowed to designate community-type service providers by inviting public applications, which was a deviation from the principle of allowing the free participation of service providers in the quasi-market.

As seen above, the revisions concerning the Long-term Care Insurance which took place after the establishment of the scheme do not seem to have always been conducted under consistent principles. These might have been inevitable choices when considering the fact that these revisions were largely driven by the hidden motivation of reducing state liability which was required when compiling

the budget. However, despite these inconsistent revisions, the number of people who became certified as needing long-term care and have started to use the relevant services has continued to increase since the establishment of the scheme. This shows the high degree to which people need long-term care services that are guaranteed by long-term care insurance. When considering the still-progressing aging of the population (particularly the increasing number of people aged 75 or older), the important issue is whether or not the current long-term care insurance can continue to finance the costs of long-term care services which are expected to further increase in the future as aging progresses.

2 Limits of the Japanese Long-term Care Insurance and Beyond

In Japan, various institutional circumstances and political considerations resulted in the current long-term care insurance. It is a well-devised system, particularly the “detailed design” part which took into account the lessons learned from the bitter experience in administering the existing medical insurance schemes (especially National Health Insurance). However, whether the Long-term Care Insurance can continue to meet the needs of people requiring long-term care or not (i.e. whether or not the stable management of the system can be ensured into the future), depends on the ability to secure financial resources including insurance premiums and government contributions into the future. Increasing the user charge percentage to 20% might become inevitable in the future. The continuous revision of the Long-term Care Insurance will also be necessary in order to reduce benefit expenses by optimizing and improving the efficiency of the services. Another challenge is reducing the percentage of benefit expenses covered by Primary Insurance Premiums by lowering the age when people become the Secondary Insured, so that Primary Insurance Premiums can be reduced⁴⁹.

Even if these measures are taken, it will not be easy to maintain the system unless premiums (which should be the main income source) are raised and

⁴⁹ Although lowering the age when people become the Secondary Insured will reduce the premiums paid by Primary Insured People, it creates financial constraints because public funds are used to supplement the portion covered by Secondary Insurance Premiums. In addition, the explanation that the signs of aging start to show at age 40 will no longer apply, and therefore it will be necessary to start proper coordination with long-term care services provided to disabled people based on the Act on Comprehensive Support for People with Disabilities.

more government contributions are put into the system. As mentioned in 3-(6), the fact that the Long-term Care Insurance has the multi-layered financial sources could create constraints on the system, as each source faces financial constraints. Constraints coming from the use of government contributions cannot be solved by changing the Long-term Care Insurance alone because they are issues concerning the state's revenue composition and the allocation of financial resources between the state and local governments. However, if the problem is the heavy dependence of the system on government contributions, the questions that must be asked are why such an option had to be taken and what were the other options when the system was designed. There are also constraints coming from the insurance premium system. It is not easy to increase Primary Insurance Premiums because there is little possibility of that those who receive long-term care will not need it in the near future⁵⁰, and those who do not require long-term care may feel strongly that they are paying premiums with no possibility of receiving benefits in the short run. In addition, it is not easy to increase Secondary Insurance Premiums because only a very small portion of them are used to pay benefits to people aged 40 to 64, and most of them are used for intergenerational support. Therefore, the question is why a design which makes it difficult to increase premiums was adopted. If long-term care insurance was institutionalized by integrating it into the Medical Insurance and long-term care insurance premiums were collected by integrating them into medical insurance premiums, the problem of the difficulty in increasing the premiums would not have occurred.

The above-text suggests that, the multi-layered composition of financial sources is in fact the cause of the difficulty in increasing premiums and the government contributions to be put into the scheme. In turn, the cause of the problem can be tracked down to the "basic design" of the scheme which made it inevitable that multi-layered composition of financial sources would be used. Therefore, it can be said that there was a problem with the idea behind the scheme's design, which was to institutionalize long-term care by creating a "long-term care insurance system for the elderly" independent of medical insurance. Of course, new systems tend to be "path-dependent" (i.e. being locked in by the frameworks and the experiences of past and existing systems) and heavily influenced by various political, institutional and financial circumstances as well

⁵⁰ Please see II-1-(3) regarding the issue that those requiring long-term care and those who do not, tend to be fixed.

as stakeholders' interests and intentions. Therefore, I cannot criticize the fact that the Japanese system for guaranteeing the provision of long-term care services was designed as an independent "long-term care insurance for the elderly." It was a realistic decision and other options were almost impossible to take.

However, once long-term care insurance has become institutionalized and the new system has taken root, and we reach the stage of discussing what should be done for the future, we can and should go back to the basics and discuss every possibility. The new systems introduced through the Long-term Care Insurance (the certification of long-term care needs, the benefit ceiling for home-based and community-based services, care management, etc.) have become well-established and they are now considered essential for long-term care insurance. It has become a common view among the relevant parties that these systems are specific to long-term care insurance and they should not be introduced to medical insurance even if the Long-term Care Insurance scheme is integrated into the Medical Insurance scheme. This means that, the dominant motive for separating the Long-term Care Insurance and the Medical Insurance has virtually disappeared. Therefore, one option could be to integrate the Long-term Care Insurance into the Medical Insurance and collect premiums for medical insurance and long-term care insurance together⁵¹, while paying medical benefits and long-term care benefits separately and continuing to use the systems introduced through the Long-term Care Insurance only for the disbursement of long-term care benefits.

This brings us to the question of what the Medical Insurance scheme is, to which the Long-term Care Insurance could be integrated. In Japan, some people argue that the Long-term Care Insurance could be integrated into the Medical Care Scheme for People Aged 75 or Older⁵², after lowering the age at which people become subject to the system to 65. However, this will only create a "medical and long-term care insurance system for the elderly," and it will still have to be

⁵¹ In order to avoid the difficulties derived from independently collecting premiums for insuring the risk of needing long-term care, it is probably realistic to use a method similar to the one used for pension insurance where one type of premium is collected for both the old-age pension and the disability pension.

⁵² The Medical Care Scheme for People Aged 75 or Older is a system for covering medical expenses for people aged 75 or older, all of whom become the insured in the system. The system is run using premiums paid by the insured, contributions paid by the medical insurers which cover people aged 74 or younger, and contributions from the tax revenues of the state, prefectural governments and municipal governments.

composed of multi-layered financial sources. Therefore, the system will continue to face sustainability issues in the future. This leaves us with two options. One is to reorganize the entire Medical Insurance Scheme⁵³ into a single-scheme area-based insurance scheme⁵⁴, before the Long-term Care Insurance Scheme is integrated into the medical insurance scheme. The other is to expand the scope of the current employee insurance scheme to include retired people, and create a long-term care benefit payment scheme within the expanded employee insurance scheme and within the existing National Health Insurance scheme, without reorganizing the two medical insurance schemes into one scheme. In this option, retired people will continue to pay employee insurance premiums as the insured, without them moving from the employee insurance scheme to National Health Insurance or them becoming insured as family members of employees covered by employee insurance. As a result, old people will have to pay long-term care insurance premiums, which is a precondition in order for them to receive long-term care benefits. In this case, municipal governments can administer both the long-term care benefit payment system created within the employee insurance scheme and the long-term care benefit payment system created within National Health Insurance. This will make it possible to continue to utilize the municipal long-term care needs certification system and the other roles of local governments in the current Long-term Care Insurance.

Conclusion

It is likely that many countries with aging populations will need long-term care insurance in the future. The design of the system will be largely dependent on the existing schemes in the respective countries, particularly the design of their medical insurance scheme. This is because the risks and needs concerning medical care and long-term care are closely related or similar to each other. In Japan, long-term care insurance was institutionalized by creating a system independent of the Japanese medical insurance while taking into account and partially using the structure of the medical insurance scheme. However, other

⁵³ For the system of medical insurance in Japan, please see: Shimazaki, Kenji. 2013. *The Path to Universal Health Coverage*. JICA.

⁵⁴ In reality, it is extremely difficult to reorganize the entire medical insurance schemes into a single-scheme area-based medical insurance system where all the people including employees and non-employees are considered “residents,” because it involves the issue of how much of an individual’s income is reported to the insurer as well as issues concerning employer contributions. Please see the author’s article: 2013. *The constitution and function of universal health coverage*. *Bulletin of the Graduate School of Human Sciences, Osaka University*, Vol. 39.

countries may face different choices. Therefore, this document has focused on explaining the options that were available when the Japanese long-term care insurance was designed as well as the option selected and the reasons behind the choice. This is because it is my belief that the process that Japan went through, rather than the conclusion that Japan reached, could be useful for countries which intend to institutionalize long-term care insurance in the future.

Appendix



1. Who participates?

All residents aged 65 or older and all persons aged 40 to 64 participating in medical insurance must participate in the long-term care insurance. Insured people aged 65 or older are referred to as “Primary Insured Person,” and insured people aged 40 to 64 are referred to as “Secondary Insured Person.”

2. Who are the insurers?

The insurers of long-term care insurance are the municipal governments. Public administration in Japan is organized into three levels, with national government at the highest level, followed by prefectural governments, and then municipal governments. As the lowest level of local government, municipal governments have the closest relationship with residents. As of January 2014, Japan has approximately 1,700 municipal governments, which range in population from the most populous one with approximately 3,700,000 residents to the least populous one with less than 200 residents. Every municipality, regardless of its population size, has a responsibility to provide long-term care insurance for its residents.

3. Who is entitled to receive benefits?

Long-term care insurance benefits are available to insured people who have been certified as requiring long-term care by the insurer (municipal government) with whom they are insured. Primary Insured Persons are entitled to receive benefits regardless of the reason why they need long-term care, while Secondary Insured Persons are only entitled to receive benefits if her/his long-term care need is caused by one of the 16 diseases specified as age-related diseases.

The certification process is as follows: The insured person applies to the municipal government to receive benefits, after which a certification investigator is dispatched by the municipal government to survey the applicant’s physical and mental condition. The results of this survey are used to carry out the “primary assessment,” which is done using a computer program. The results of the primary assessment are submitted, together with the written opinions of the doctor in charge of the applicant, for the “secondary assessment,” which is carried out by the relevant Municipal Certification Committee of Needed Long-Term Care, a committee made up

of experts. The municipal government then makes the decision on whether or not to grant certification based on the results of the secondary assessment. If certification is granted, the level of long-term care needs is also decided at the same time. There are a total of seven levels which determine the range and amount of services that the insured person can receive. The seven levels consist of two “needing support” levels, which are for people with relatively less severe conditions, followed by the “needing care” levels, which range from 1-5. As a general rule, the certification and level of care required are reviewed once every six months.

4. What kinds of services are provided?

Persons certified as “needing care” are able to utilize home-based services, community-based services, institution-based services as well as “community-type services”. Home-based services include home-visit care, home-visit nursing. Community-based services include daycare service, outpatient rehabilitation, and short-term care services in which old people are admitted to facilities for a short period of time and given care. Institution-based services are long-term care services provided at nursing homes (“Tokuyo”), geriatric health services facilities (“Roken”) and medical facilities for long term treatment (“Ryoyo”). “Community-type services” include small-scale multifunctional home-based and community-based care combining home-visit care, daycare services and short-term care services provided by small-scale local facilities. Also “community-type services” include nighttime home-visit care provided during the late evening and the early hours of the morning as well as care services for dementia persons living in group homes.

Persons certified as “needing support” are entitled to receive preventive long-term care services and “community-type” preventive long-term care services. Preventive long-term care services include daycare services, outpatient rehabilitation, home-visit care and other forms of care provided with the aim of preventing the person from reaching a condition in which they need long-term care. Likewise, “community-type” preventive long-term care services are also provided with the same aim, and include forms of care such as small-scale multifunctional home-based and community-based care as well as group living care for persons with dementia.

Services which are available to both people certified as “needing care” and people certified as “needing support” include loans of welfare equipment, assistance with home renovation costs, and care management services,

such as the creation of care plans by care managers.

5. To what extent and in which ways are services provided?

The amount of services that can be used differs according to the level of long-term care needs, which is designated in the time of care needs certification. It is possible to use services in excess of the specified amount, but the amount of services received in excess of the specified amount will not be covered under insurance and the user must pay the full cost of the excess themselves.

The amounts of long-term care services provided are given in “units.” In FY2013, the maximum allowances for services were 4,970 units for persons certified as “needing support” Level 1, the level for people with mildest conditions, and 35,830 units for persons certified as “needing care” Level 5, the level for people with the most severe conditions. In the case of services other than institution-based care, the person receives a combination of services within the amount designated based on their need for long-term care. For this reason, there is a system called “care management” in place. Under this system, a specialist in long-term care support, known as a care manager, assesses the physical and mental condition and home environment of the old person and then liaises with care service providers to draw up a care plan which combines the services the old person requires within their maximum usage allowance. The care manager also monitors the condition of the old person and revises the care plan as necessary. Care management is included in the services that are covered under the long-term care insurance system, and, unlike other benefits, the user pays none of the costs (the full cost is covered by long-term care insurance).

6. How are fees for long-term care services calculated?

As described above, the amount of long-term care services provided is given in “units.” Each type of service is designated a specific number of units. For example, in the case of home-visit care, physical care for up to 30 minutes is 254 units, and physical care for 30 minutes to 1 hour is 402 units. The amount of fees is calculated by multiplying the number of units by the fees per unit. The fees per unit differ according to the region and the type of service. For example, fees for home-visit care have five levels, which range from 11.05 yen per unit in the Tokyo metropolitan area, to 10.00 yen per unit in provincial areas. The number of units for each type of service and the cost per unit are decided by the Ministry of Health, Labour and Welfare and are

revised once every three years.

7. How much is charged to the user?

As a rule, the user is responsible for paying for 10% of the costs. However, in the event that this exceeds a specified amount, allowances for high-cost long-term care services are paid to users to cover the excess. Moreover, this “specified amount” is lower for low-income earners than it is for mid- to high-income earners.

In some cases, the necessities of everyday life are provided for as part of care services. For example, meals may be provided during daycare service or outpatient rehabilitation, and meals and housing are provided as part of institution-based services. These costs are not covered under long-term care insurance and the user must pay the full amount. However, for low-income earners, there is a maximum limit on the amount they need to pay themselves, and the excess is paid for under long-term care insurance.

8. Who provides care services?

Care services are provided by service providers who have been approved by the relevant prefectural government (or municipal government in the case of “community-type services”). People who wish to provide services apply to the relevant prefectural government or municipal government for approval. The prefectural government or municipal government then screens the service provider according to the criteria in terms of the number and qualifications of the staff members, the standard of the facilities and the management and operational capacity. Approval is decided based on this screening.

Service providers can be social welfare corporations which are specified nonprofit corporations providing social welfare services, medical corporations which are specified nonprofit corporations providing medical services, other nonprofit organizations and, for home-based and community-based services, commercial companies. As of October 2011, nearly 60% of home-visit care service providers and nearly 50% of daycare service providers are commercial companies.

9. How are the costs of long-term care insurance covered?

As mentioned above, 10% of service cost is covered by user charge. Of the remaining 90%, 50% is covered by public funds from the national, prefectural, and municipal governments, and 50% is covered by insurance

premiums paid by insured people. Of the 50% covered by public funds, on the national basis, 25% is paid by the national government, 12.5% by prefectural governments, and 12.5% by municipal governments. However, in the case of institution-based services costs, 20% is paid by the national government, 17.5% by prefectural governments, and 12.5% by municipal governments. Of the 50% covered by insurance premiums, from FY2012 to FY2014, 21% was covered by Primary Insurance Premiums and 29% by Secondary Insurance Premiums. The proportions covered by Primary Insurance Premiums and Secondary Insurance Premiums are decided according to the ratio of the respective numbers of people paying each.

When we look at each insurer, the proportion of public fund and primary insurance premiums differs because 5% of the 25% covered by the national government is allocated to insurers as an “Adjusting Subsidy.” The proportion of the subsidy allocated to each insurer differs from insurer to insurer and is determined by the proportion of people aged 75 or older and the income of the Primary Insured Persons participating in their insurance scheme. Therefore, for insurers with large numbers of people aged 75 or older and large numbers of Primary Insured Persons with low incomes, more than 25% of the costs are covered by the national government and, as a result, the proportion that needs to be covered by Primary Insurance Premiums is proportionally lower. At the same time, the reverse is true for insurers with lower numbers of people aged 75 or older and lower numbers of Primary Insured Persons with low incomes. These insurers receive less than 25% of the costs from the national government, and as a result the proportion to be covered by Primary Insurance Premiums is proportionally higher.

In the event that the financial management of municipality’s long-term care insurance falls into deficit due to an unexpected increase in the amount of benefits paid out or an unexpectedly lower compliance rate for premiums, the shortfall is loaned or granted by the Fiscal Stability Fund of the relevant prefecture. A Fiscal Stability Fund is established by each prefectural government, using contributions from public funds of the national government, the prefectural government and contributions from municipal governments (insurers), which are paid from Primary Insurance Premiums. The amount loaned to municipal government is returned at a later date by the municipal government from Primary Insurance Premiums.

10. How are Primary Insurance Premiums set and collected?

Every three years, each insurer (municipal government) across the country draws up a Long-Term Care Insurance Implementation Plan, estimating the service expenditures for the next three financial years. Based on the estimation, each municipal government then declares an ordinance setting the amount of insurance premiums, such that the amount that needs to be covered by Primary Insurance Premiums can be paid by the insurance premiums of the Primary Insured Persons of the municipality. The amount of insurance premiums is set as a fixed amount. As a rule, insured people are assigned one of six levels, decided according to the current levels of municipal inhabitants' tax levied on the individual and their household.

There are two collection methods. One is to deduct the insurance premium from insured persons' pension. The organizations that pay out public pensions are informed of the insurance premium amount of each insured person, and for those people whose monthly pension amounts to 15,000 yen or more, the long-term care insurance premium is deducted from that individual's pension and sent directly to the municipal government by the organization that pays out public pensions. The other method is direct payment by the insured persons. People whose monthly pension is less than 15,000 yen, pay their long-term care insurance premiums directly at the counter of the municipal government office, or send their long-term care insurance premiums to the municipal government through a financial institution. Incidentally, more than 90% of Primary Insured Persons pay their insurance premiums by deduction from their pensions.

11. How are Secondary Insurance Premiums set and collected?

The total amount that needs to be covered by Secondary Insurance Premiums is calculated by multiplying the total estimated service costs for each of the next three financial years (this amount is based on the Long-Term Care Insurance Implementation Plan drawn up every three years by each municipal government (insurer) across the country) by the proportion that should be covered by Secondary Insurance Premiums (29% from FY2012 to FY2014). This amount is then used to calculate the amount of premium per Secondary Insured Person on a national basis. Each medical insurer then pays a national organization called the Social Insurance Medical Fee Payment Fund ("Payment Fund") a long-term care payment which is calculated based on the number of Secondary Insured Persons participating in their insurance program. To cover this long-term care payment, each medical insurer collects long-term care insurance

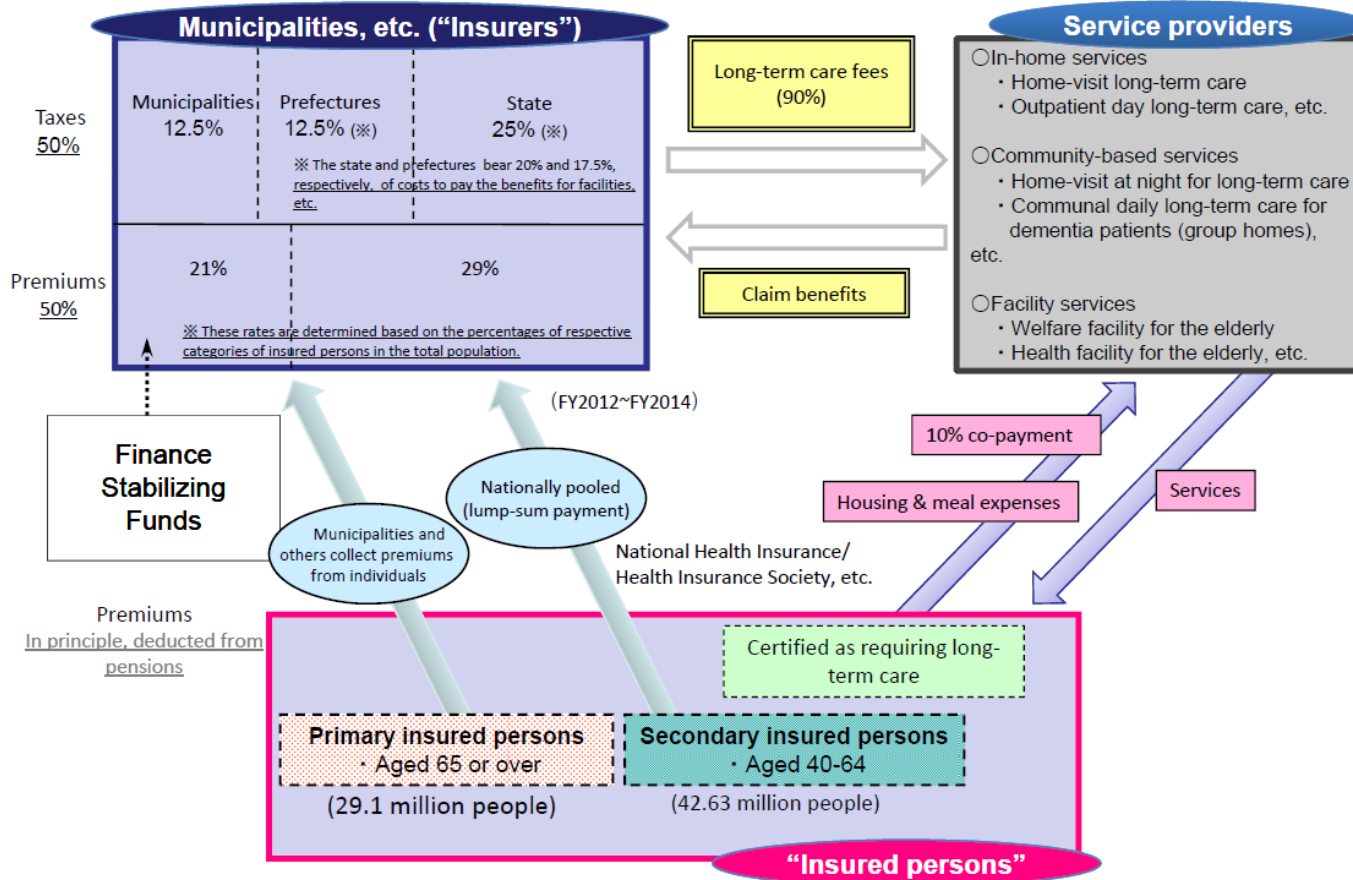
premiums from secondary insured people, using the same system used to collect the medical insurance premiums. The level of long-term care insurance premium is decided as a fixed rate by each insurer. The long-term care payments (Secondary Insurance Premiums) collected from medical insurers nationwide are distributed by the Payment Fund to each municipal government, according to the specific percentage that should be covered by Secondary Insured Persons. The same percentage applies to all municipal governments (29% from FY2012 to FY2014).

12. How are appeals and complaints handled?

There are two cases in which appeals and complaints are made in relation to the implementation of Long-term Care Insurance. One case is that there is a complaint against the results of certification of level of long-term care needs or assessment of insurance premiums by the municipal government. In this case, appeals can be made to the relevant Prefectural Committee on Long-Term Care Insurance, a committee set up by the prefectural government as a third party organization. If the appeal is accepted by this Committee, the relevant decision of the municipal government is revoked.

The second case is that there is a complaint regarding the content of long-term care services. There are several remedies for this type of complaint. Long-term care service providers are obliged to provide a contact point for complaints and to respond promptly and appropriately. The care manager in charge investigates the situation by speaking to both the user and the service provider and reviews possible measures to be taken. Moreover, it is possible to consult with the municipal government, and the municipal government will investigate and provide direction and advice to the service provider as necessary. There is also a complaints and consultation service at the Federation of National Health Insurance Associations established in each prefecture. On receiving complaints, the Federation of National Health Insurance Associations will also investigate and provide direction and advice to the service provider as necessary.

The Mechanism of the Long-term Care Insurance System



(Note) The number of aged 65 or older (primary insured persons) – "Report on Long-term Care Insurance Services in FY2010."
 The number of secondary insured persons – The figure is based on medical insurers' reports (the monthly average of FY2010) used by the Social Insurance Medical Fee Payment Fund to determine the amount of long-term care benefits to be paid to the insurers).

From the website of Ministry of Health, Labour and Welfare

http://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ri_130311-01.pdf

Author's information

Shuzo Tsutsumi has been involved in the development of social security policies of Japan since he joined Ministry of Health and Welfare after graduating from the University of Tokyo in 1971. He is especially recognized as one of the key players in the development and implementation of the Long-term Care Insurance as Director of Planning Division of Health and Welfare Bureau for the Elderly, Secretary-General of the Headquarters of Promoting the Implementation of Long-term Care Insurance as well as Director-General of Health and Welfare Bureau for the Elderly. After leaving the Ministry in 2003 as Commissioner of Social Insurance Agency, he taught at Graduate School of Human Sciences of Osaka University as a professor until 2013. He is the author of many books and articles on social security policies including “The Significance of Long-term Care Insurance” (in Japanese, 2010, Tokyo, Chuo-houki).