Overview of Talk

- Background and theory
- Elements of LTCI system in Japan
- Political context for LTCI and reform in Japan
Section I

Background and theory
Demographic Transition and Challenge for Social Security Systems: More Older People, Fewer Younger People

Source: National Institute of Population and Social Security Research, Japan
http://www.ipss.go.jp
Increasing number of elderly needing long-term care

## Comparison of German and Japanese Long Term Care Insurance Systems

<table>
<thead>
<tr>
<th></th>
<th>Germany</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insurer</strong></td>
<td>LTC Insurers</td>
<td>Local Governments</td>
</tr>
<tr>
<td><strong>Insured</strong></td>
<td>All health insured</td>
<td>All citizens 40+</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Cash or in-kind services</td>
<td>In-kind services</td>
</tr>
<tr>
<td><strong>Subsidy</strong></td>
<td>Cross subsidy among LTC Insurers (c. 20%)</td>
<td>Public budget subsidy (50%)</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td>Home care more private, residential more</td>
<td>Mostly medical facilities and private sector</td>
</tr>
<tr>
<td></td>
<td>established health providers</td>
<td></td>
</tr>
</tbody>
</table>


MHLW 2002 (Japan). Cited above.

Main Questions

- What does politics have to do with LTCI?
- Why is the Japanese LTCI system such a hybrid between social insurance and a public benefits system?
- Why does Japanese LTCI use local governments as the point of interaction with users?
- What must be considered when assessing whether Japanese LTCI features are portable to other systems?
LTCl in Japan

- **When?**
  - 1997: Long Term Care Insurance (1999 implemented)
  - 2005: Reform of Long Term Care
  - Underway: Planning for next reform round 2008

- **Why?**
  - Long-term strategy for caring for elderly (Okamitsu 1993)
  - Incremental decision process (Ikegami and Campbell 1998)
  - Coalition politics (Talcott 2002)


Theoretical approach

● Historical institutionalism
  – Initial policies create distribution of interests (Knight 1992)
  – Institutions shape subsequent stakeholder interests and constrain reform options (Pierson 1993)
  – Older approaches to social policy shape strongly the focus in new policy areas (Skocpol 1992)

● Strategic action
  – Political actors can choose between different options
  – Institutions can shift during reforms (Thelen 2004)

Main Explanations by stakeholders in Japan

- Part of broad strategy to meet needs of aging society with fewer children (MHLW 1998)
- More efficient care for conditions of aging (Okamitsu 1993)
- Controlling costs of health care in an aging society (Niki 2000, Kawabuchi 2005)
- Socializing burden of care and liberating women from full-time care-giving (Women’s Committee to Improve the Ageing Society 1997)

Kawabuchi, Koichi (2005). *Nihon no iryō ga abunai* [Japan’s Health Care is in Danger]. Tokyo: Chikuma Shinsho.
Comparative questions from Germany

- Why only aging as LTCI focus in Japan? Why not for other disabled persons needing care?
- Why is there no cash benefit option?
- Why is there such a high subsidy from central, prefectural, and local governments in a social insurance system?
- Why are there three different facility types for residential care?
Section II

Major features of LTCI System in Japan
LTCI Financing

- Social insurance system
  - Type I 65+: Pension deductions
  - Type II 40-64: Contributions collected health insurance system (employer- or community-based)

- National, prefectural, local subsidies
  - 50% of total costs of system

- 10% copayment
  - Caps for maximum for fulltime nursing home care

- Fixed benefits for each level of care after which user pays 100% for optional services

- Public subsidies for construction of LTC facilities (Gold Plan)
LTCl Insured Persons
Japan 2006 (July)

- Type I Insured persons: 26,105,495
  - 14,234,002 65-75 years old (1)
  - 11,871,293 over 75 years old (2)

- Type II Insured persons:
  - 43,000,000 40-64 years old (2000) (3)

Source:
(3) MHLW 2002. Cited above
LTCI: Distribution of System Finance

Source: MHLW 2002, cited above
LTCl Eligibility

- Type I: Age 65+ needing care
- Type II: Age 40-64 with aging-related disability or disease
  - Senile dementia
  - Early Alzheimer's
  - Parkinson's
  - Defined by MHLW
- Emphasis on aging, not disability
- Assessment by family, doctor, decided by local committee with software aid
- 2005 Reform changing benefits at lowest levels of care need toward preventative measures and community care
LTCLI Registration

- Local government commission
- Physician reference
- Self or family assessment of ADLs
- Software-based evaluation
- 2 levels of “needs support”
- 5 levels of “needs care”
- 1 transitional grade
  - for transition between levels after 2005 reform
## LTCI Beneficiaries
### Japan 2006 (July)
#### registered persons

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Type I Insured Persons (65+)</th>
<th>Age 65-74</th>
<th>Age over 75</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Support 1</td>
<td>219,053</td>
<td>41,078</td>
<td>177,975</td>
<td>223,083</td>
</tr>
<tr>
<td>Needs Support 2</td>
<td>191,898</td>
<td>37,252</td>
<td>154,646</td>
<td>199,588</td>
</tr>
<tr>
<td>Under review (downgrading)</td>
<td>462,041</td>
<td>78,796</td>
<td>383,245</td>
<td>469,377</td>
</tr>
<tr>
<td>Level 1</td>
<td>1,201,261</td>
<td>198,463</td>
<td>1,002,798</td>
<td>1,243,498</td>
</tr>
<tr>
<td>Level 2</td>
<td>646,337</td>
<td>108,946</td>
<td>537,391</td>
<td>676,888</td>
</tr>
<tr>
<td>Level 3</td>
<td>562,232</td>
<td>86,675</td>
<td>475,557</td>
<td>585,303</td>
</tr>
<tr>
<td>Level 4</td>
<td>515,539</td>
<td>71,752</td>
<td>443,787</td>
<td>533,774</td>
</tr>
<tr>
<td>Level 5</td>
<td>452,737</td>
<td>66,394</td>
<td>386,343</td>
<td>473,082</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,251,098</strong></td>
<td><strong>689,356</strong></td>
<td><strong>3,561,742</strong></td>
<td><strong>4,404,593</strong></td>
</tr>
</tbody>
</table>

Source: MHLW (2006). *Yō kaigo (yō shien) ninteisha sū* [Number of persons registered as needing care/support].
## LTCI Beneficiaries
### Japan 2006 (July)
registered persons per 1,000 in age cohort

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Type I Insured Persons</th>
<th>Type II Insured Persons</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 65-74</td>
<td>Age over 75</td>
<td></td>
</tr>
<tr>
<td>Needs Support 1</td>
<td>8,36</td>
<td>2,89</td>
<td>14,87</td>
</tr>
<tr>
<td>Needs Support 2</td>
<td>7,33</td>
<td>2,62</td>
<td>12,92</td>
</tr>
<tr>
<td>Under review (downgrading)</td>
<td>17,64</td>
<td>5,54</td>
<td>32,02</td>
</tr>
<tr>
<td>Level 1</td>
<td>45,85</td>
<td>13,95</td>
<td>83,78</td>
</tr>
<tr>
<td>Level 2</td>
<td>24,67</td>
<td>7,66</td>
<td>44,89</td>
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<tr>
<td>Level 3</td>
<td>21,46</td>
<td>6,09</td>
<td>39,73</td>
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<tr>
<td>Level 4</td>
<td>19,68</td>
<td>5,04</td>
<td>37,07</td>
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<tr>
<td>Level 5</td>
<td>17,28</td>
<td>4,67</td>
<td>32,28</td>
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<tr>
<td>Total</td>
<td>162,27</td>
<td>48,45</td>
<td>297,56</td>
</tr>
</tbody>
</table>

Source: MHLW 2006 (cited above), population data from [http://www.ipss.or.jp](http://www.ipss.or.jp), own calculation
LTCl Services Provided

- **Service at home**
  - Personal care
  - Bathing assistance
  - Nursing visits
  - Care Coordination

- **Ambulatory services**
  - Personal care
  - Rehabilitation

- **Other**
  - Short stay
  - Group homes for elderly persons with dementia

- **Nursing home service**
  - Welfare, Medical, and Nursing Home Care Facilities
  - Maximum monthly payment for room & board
  - Maximum monthly copayment

- Care manager plans care plan with family budget
- More need = more services (fixed budget)
### LTCI Provider Stakeholders and legal framework

- **Welfare facilities**
  - 1963 Law for Old Age Welfare

- **Health care facilities**
  - 1949 Medical Corporation Law
  - 1961 Universal Health Care

- **Nursing homes (LTC)**
  - Largely operated by medical corporations

- **Private contractors for care services**
  - 1997 LTCI Law
  - For-profit nursing homes

- **Local governments providing care services directly**
  - 1963 Law for Old Age Welfare

- **Other quasi public providers**
  - Agricultural cooperatives (prewar)
  - Consumer cooperatives (postwar)
  - Other operators of public interest corporations

- **Non governmental organizations (NPO)**
  - 1998 NPO Law
## Number of LTC providers by facility type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care at home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting Personal Care</td>
<td>11.644</td>
<td>12.346</td>
<td>15.701</td>
<td>17.274</td>
<td>20.588</td>
</tr>
<tr>
<td>Visiting Bathing Service</td>
<td>2.457</td>
<td>2.316</td>
<td>2.474</td>
<td>2.406</td>
<td>2.402</td>
</tr>
<tr>
<td>Visiting Nurses</td>
<td>4.825</td>
<td>4.991</td>
<td>5.091</td>
<td>5.224</td>
<td>5.310</td>
</tr>
<tr>
<td>Support Services for Care at Home</td>
<td>19.890</td>
<td>20.694</td>
<td>23.184</td>
<td>24.331</td>
<td>27.272</td>
</tr>
<tr>
<td><strong>Ambulatory</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory rehabilitation</td>
<td>5.441</td>
<td>5.568</td>
<td>5.732</td>
<td>5.869</td>
<td>6.092</td>
</tr>
<tr>
<td><strong>Residential</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Welfare Facilities</td>
<td>4.651</td>
<td>4.870</td>
<td>5.084</td>
<td>5.291</td>
<td>5.535</td>
</tr>
<tr>
<td>Medical Facilities</td>
<td>3.792</td>
<td>3.903</td>
<td>3.817</td>
<td>3.717</td>
<td>3.411</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>2.779</td>
<td>2.872</td>
<td>3.013</td>
<td>3.131</td>
<td>3.278</td>
</tr>
</tbody>
</table>

# Number of LTC providers by ownership type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local gov</td>
</tr>
<tr>
<td>Visiting Personal Care</td>
<td>0.7%</td>
</tr>
<tr>
<td>Visiting Bathing Service</td>
<td>1.2%</td>
</tr>
<tr>
<td>Visiting Nurses</td>
<td>4.4%</td>
</tr>
<tr>
<td>Support Services for Home Care</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Ambulatory</strong></td>
<td></td>
</tr>
<tr>
<td>Day care</td>
<td>1.8%</td>
</tr>
<tr>
<td>Ambulatory rehabilitation</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Residential</strong></td>
<td></td>
</tr>
<tr>
<td>Welfare Facilities</td>
<td>9.2%</td>
</tr>
<tr>
<td>Medical Facilities</td>
<td>5.2%</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

# Number of LTC users by facility type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care at home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting Personal Care</td>
<td>600.313</td>
<td>728.974</td>
<td>899.167</td>
<td>972.266</td>
<td>1.097.769</td>
</tr>
<tr>
<td>Visiting Bathing Service</td>
<td>69.340</td>
<td>66.525</td>
<td>70.948</td>
<td>67.208</td>
<td>67.443</td>
</tr>
<tr>
<td>Visiting Nurses</td>
<td>221.005</td>
<td>244.475</td>
<td>262.925</td>
<td>274.567</td>
<td>279.538</td>
</tr>
<tr>
<td>Support Services for Care at Home</td>
<td>1.447.436</td>
<td>1.656.794</td>
<td>1.909.598</td>
<td>2.083.382</td>
<td>2.266.869</td>
</tr>
<tr>
<td><strong>Ambulatory</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day care</td>
<td>689.721</td>
<td>790.365</td>
<td>920.869</td>
<td>995.903</td>
<td>1.121.125</td>
</tr>
<tr>
<td>Ambulatory rehabilitation</td>
<td>336.302</td>
<td>383.259</td>
<td>419.510</td>
<td>439.754</td>
<td>464.390</td>
</tr>
<tr>
<td><strong>Residential</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare Facilities</td>
<td>309.740</td>
<td>326.159</td>
<td>341.272</td>
<td>357.891</td>
<td>395.319</td>
</tr>
<tr>
<td>Medical Facilities</td>
<td>109.329</td>
<td>126.865</td>
<td>129.365</td>
<td>129.111</td>
<td>123.662</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>223.895</td>
<td>233.740</td>
<td>245.268</td>
<td>256.809</td>
<td>272.588</td>
</tr>
</tbody>
</table>

Section III

LTCI reform and its political context in Japan
LTCI Reform Issues in Japan

- Overall system cost
- Eligibility
  - Benefit levels
  - User costs
  - Expanding preventative services
  - Service quality
  - Access to services in rural areas
  - Provider & care manager training
  - Public subsidy level and revenue situation
  - Employer cost
Parties and Platforms on LTCI: Japan

GOVERNING COALITION

- New Komei Party: protection for low-income
- Liberal Democratic Party LDP (PM, ministers): limited social insurance, no employer contribution, some tax subsidy
- LDP (traditionalist wing): cash benefits

OPPOSITION

- Democratic Party Japan DPJ (liberal wing): taxes, not social insurance
- DPJ (welfare activists): higher benefits, employer contributions
- Japan Communist Party: employer taxes, higher benefits
Political environment change since 2001 in Japan

- PM Office decisions not internal party review
  - Fiscal and Economic Reform Committee reviews all policy reforms (2001-6)

- Fiscal policy targets affect all decisions
  - Highest debt in OECD (300% of GDP and rising)
  - New debt ceiling of 30 trillion yen (€192 billion) annually

- Coalition government (1999-) coordinates between Liberal Democratic Party and New Komei Party

- Nearly 2/3 majority in Lower House (2006-)

- Critical election in July 2007 for Upper House
Broader political context for private sector promotion in LTCI

- Shrinking the size of the public sector
  - Cut costs to increase competitiveness
  - Reduce tax increases
  - Remove organizing opportunities for public sector unions

- Cutting public health facilities and employees
  - Reducing overall cost of public health care spending
  - Reducing communist union organizing opportunities
Comparative findings

- Japan’s LTCI focus on the elderly, local governments, in-kind rather than cash benefits, and the mix of providers comes from larger context of earlier political decisions and coalition politics.

- Determining whether individual strategies are portable to other countries requires careful attention to institutional setting of particular policies and practices in addition to other aspects of policy evaluation.