Japan's Universal Long-Term Care Insurance: Generous, Affordable, Workable

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U Michigan/Tokyo U
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Salt Lake City
Outline

1. Japan is old!
2. Japan’s LTC system
3. Why its distinctive features?
   (1) Services not cash allowances
   (2) Very generous
4. Spending, and controlling costs
5. Problems and successes
6. How well does it work?
1 Japan is old
Population of Japan by Age and Sex, 1950
Population of Japan by Age and Sex, 2000

[Bar graph showing the population of Japan by age and sex in 2000, with bars divided into male and female categories for each age group.]
2 Japan’s LTCI system

• Kaigo Hoken 介護保険
• lit. “Care Insurance;” we say “public mandatory long-term care insurance”
• Law passed in 1997; in effect from April 2000
• Goal: “socialization of care” for the sake of frail elders and their family caregivers
• “Socialization” means that society (government) takes on some of the burdens of frailty, for individuals and families
The basics

• A social insurance system in which everyone 40+ pays premiums, and everyone 65+ is eligible for benefits regardless of means or family situation (age 40-64 if aging-related)

• Premiums age 40-64 about 1% of income to a ceiling; for 65+ average $35/mo (ppp) according to income

• Financing ½ premiums ½ tax revenue

• Management by municipalities.
How is eligibility determined?

- Apply to municipal office; assessment through 73-item questionnaire (mainly ADLs)
- Preliminary categorization into 7 levels by computer algorithm
- Reviewed by an expert committee
- Client selects care manager and/or provider
- Care conference: client and family, physician, and provider(s) produce a care plan
- Services provided, paid by municipality
- Reassessment in 2 years (less if requested)
What services are covered?

• At home: home helper (housekeeping and personal care), visiting nurse, bathing, remodeling, assistive devices
• Outside of home: day care, day care with rehabilitation, short-stay ("night care")
• Institutional: nursing homes, homes with more medical service, chronic hospitals
• "Quasi" institutions: caregiving costs in private nursing homes and "Dementia Group Homes"
How are services provided?

• Providers include semi-public agencies, “welfare corporations,” NPOs, hospitals—and profit-making companies (except for institutional care)

• Licensed and supervised by local government

• Fees for each service set by the national government, revised every three years

• Advice and monitoring by a care manager, some 35 clients, often works for a provider
How much service?

• The allowable amount varies by the level of disability, with seven levels from $400 to $2900/month (ppp) worth of home and community-based services (nursing homes are more)

• Clients pay a 10% co-pay (but free or capped for low income people)

• For home and community based services, most clients do not use up to the ceiling (most use 40-60%)—just what they need.
How is quality protected?

• In home and community services, for-profit companies and NGOs compete for business
• Clients can change providers
• Each client has a care manager for advice and coordination—they can be changed too
• Japan has the usual quality mechanisms—regulations, inspections, complaint desks—but competition and information is the key
Basic LTCI numbers (Dec 2009)

<table>
<thead>
<tr>
<th>Category</th>
<th>65+</th>
<th>(75+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured elderly (=65+ population)</td>
<td>28,766,682</td>
<td>13,560,327</td>
</tr>
<tr>
<td>Certified as eligible</td>
<td>4,652,268</td>
<td>3,999,218</td>
</tr>
<tr>
<td>Proportion eligible</td>
<td>16.2%</td>
<td>29.5%</td>
</tr>
</tbody>
</table>
Service recipients

People living at home 3,041,148
People living in a nursing home 826,439
Total recipients 3,867,587
Recipients as % of eligible 83.1%
Recipients as % of 65+ population 13.4%
(+ 450,000 90 days+ in hospital 17.7%)
3 Japan’s distinctive features

• Most advanced nations have a “comprehensive” LTC program, meaning
  – Ordinary people are eligible (not just poor people or people with no family)
  – Benefits are big enough to matter

• Two main differences in approach
  – Tax-based vs social insurance (or both)
  – Benefits in cash vs in-kind (or both)
How is Japan distinctive?

• Both tax and social insurance financing
  – Because then neither burden had to be too high
• Covers only 65+ people (and a few 40+)
  – Disability is different problems, different program
• It offers only in-kind services, not cash
• It is unusually generous
  – In coverage
  – In benefit levels
(1) Services not cash allowances

• Italy, Austria (cash only), and Germany (both) seek to recognize, reward, and encourage family care by paying cash allowances
• Why didn’t Japan, given that family care has long been cherished?
• At least one reason is cultural—caregiving everywhere is seen as burdensome to women, but in Japan often as oppressive
“Traditional household”

- As recently as 1970, 80% of Japanese elders lived with an adult child
- The norm was with the eldest son’s family, with his wife (yome) responsible for care
- Image: the long, fraught relationship of the in-laws, yome and shutome
- And people project this image to today even though things have changed . . .
Living Arrangements 1960-2005
Proportion of Older People (65+)

With Children
Spouse Only
Alone
Institution
How do older people live today?

• Over 35% live with a spouse
• Under 45% live with an adult child
  – But while healthy, rather independently
  – E.g. often a separate kitchen
  – Most often financially independent
• About 15% live alone
• 5½% live in a nursing home or hospital
Impact on policy

• Clearly there is a great burden on family caregivers, mostly women, of whom many are in the same household

• Feminist groups argued that a cash benefit would not change the basic situation so insisted on services only

• Conservatives (including many women) prefer recognition and encouragement through cash payments, but it is not on the agenda
(2) Very generous

• Although Japan is not known as a big “welfare state,” its LTCI program is one of the biggest in the world.
• True in two senses
  – Its benefits are quite high
  – It covers a lot of people
• Here are some data
Japan and Germany, monthly allowable amounts in dollars (ppp) for home & community services in 2010 (Japanese co-pay not included)

<table>
<thead>
<tr>
<th></th>
<th>Japan</th>
<th>Germany</th>
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<tbody>
<tr>
<td>Assist 1</td>
<td>402</td>
<td></td>
</tr>
<tr>
<td>Assist 2</td>
<td>841</td>
<td></td>
</tr>
<tr>
<td>Care 1</td>
<td>1341</td>
<td></td>
</tr>
<tr>
<td>Care 2 /1</td>
<td>1576</td>
<td>541</td>
</tr>
<tr>
<td>Care 3 /2</td>
<td>2164</td>
<td>1279</td>
</tr>
<tr>
<td>Care 4 /3</td>
<td>2475</td>
<td>1857</td>
</tr>
<tr>
<td>Care 5</td>
<td>2898</td>
<td></td>
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<tr>
<td></td>
<td>Home Care</td>
<td>Institutions</td>
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</tr>
<tr>
<td>Denmark</td>
<td>25.1</td>
<td>4.8</td>
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<tr>
<td>England</td>
<td>12.6</td>
<td>3.5</td>
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<tr>
<td>France</td>
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<td>3.1</td>
</tr>
<tr>
<td>Germany</td>
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<td>3.8</td>
</tr>
<tr>
<td>Japan</td>
<td>13</td>
<td>5.5</td>
</tr>
<tr>
<td>Netherlands</td>
<td>21.1</td>
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Why so generous?

• One reason is that old-age care is a big issue in Japan, and gets a lot of public support.
• Also, the Gold Plan had been generous in providing lots of service to some people with light needs, so hard to take that away.
• Possibly also a technical error—it appears that the government wanted about 12% eligible, but wound up with over 17%.
4 Spending, and controlling costs

- Of course: for 2010, ¥7.3 trillion, 1.5% of GDP
- $60 billion PPP or $90 billion current ExRate
- Actually that is about what the US government spends on old-age LTC ($69B in 2005)
- But gross spending amounts don’t mean too much
- We calculated public LTC spending for 65+ people only, per capita for the elderly population, 2005, in PPP dollars.
Public Spending on LTC (Per 65+ Person)
Japan spends more but . . .

• The Japanese government spent about $1750 per elder person in the population on LTC, while the American government spent $1600.

• But: Japan is providing public LTC to far more people—over 18% of 65+ get public LTC, compared to about 8% in the US. (Of course US has a lot of private pay.)

• Japan looks pretty efficient.
Controlling costs

• In early years, since enrollment was higher than forecast, spending was going up too fast
• Spending in 2005 was 22% above estimate; the growth rate was 11% a year
• Thus, reforms to control costs—less “hotel costs” in institutional care, and light-care people moved into a “preventive care” system
• Succeeded . . .
LTCI expenditures (trillion ¥)  
(Copayment etc. included)
Controlling costs

• Expenditures leveled off from 2005, but then started growing again.

• However, unlike the early years, the growth was because of population change—the number of 75+ people (who use most of the services) expanded rapidly.

• This should be seen as “normal” expansion
LTCl expenditures / 75+ population
(Copayment etc. included) (¥)

Ibid. Population 75 and over from Kaigo Hoken Jigyo Jyoukyou Houkoku
5 Problems and successes
Problem: manpower

• (or Womanpower)
• In early years, easy to hire people
• But labor market improved while wages constrained by the fee schedule
• Hard work, not much chance at career
• Some idealism wore off as well
• So turnover is up and hard to recruit
Solutions for manpower?

• Immigration?
  – Small deals with Indonesia, Philippines
  – But language etc makes Japan hard
  – Opposition to “two-tier” labor force

• Raise wages?
  – 2009 raised fees (but copays go up)
  – New government supplemented wages from taxes

• In the long run, markets adjust
Problem: institutions

- Institutional care is much more expensive than home care
- Gerontologists agree home care better
- Japanese (families) disagree - long waiting lists for nursing homes
- Actually, Japan has one of the higher institutional rates in the world
Solutions for institutions?

• Government will eliminate many chronic hospital beds (LTCI and health insurance) and tighten standards
  – Aim: eliminate “social admission”
• “Care Refugees?”
• Possible answer is to provide more old-age housing of various kinds.
• The public just wants more beds
Problem: doesn’t do enough

• The most often heard complaint is that LTCI leaves big burdens on family caregivers
• One reason is that expectations were unrealistic, partly due to overselling
• And not enough beds for respite care
• In fact, so far have not been able to provide nighttime home visits though intended
Solutions to not enough?

• Government is working on getting 24-hour care in more areas

• More generally, push for more involvement with broader community

• But a large-scale increase is not in the cards; in fact, there will be continual efforts to hold costs down without threatening the core
Success: expanded services

• As we saw from growth in spending, the market for services grew rapidly
• Accepting formal services is now quite normal, even in the countryside
• Most of the growth was in home and community based care
## Expansion of users (1000 people)

<table>
<thead>
<tr>
<th>Service</th>
<th>2001</th>
<th>2009</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Help</td>
<td>518</td>
<td>1,158</td>
<td>2.2</td>
</tr>
<tr>
<td>Day Care</td>
<td>832</td>
<td>1,742</td>
<td>2.1</td>
</tr>
<tr>
<td>Assistive Devices</td>
<td>288</td>
<td>1,047</td>
<td>3.6</td>
</tr>
<tr>
<td>Visiting Nurses</td>
<td>188</td>
<td>258</td>
<td>1.4</td>
</tr>
<tr>
<td>Dementia Group Homes</td>
<td>9</td>
<td>139</td>
<td>15.9</td>
</tr>
<tr>
<td>Nursing Homes Residents</td>
<td>617</td>
<td>844</td>
<td>1.4</td>
</tr>
</tbody>
</table>
Success: Dementia Group Homes

• 9 residents, 5-6 staff, private rooms, big common space with kitchen
• LTCI pays for caregiving; resident pays room & board & copay (~$1200/mo)
• Some quality assurance problems but many give appropriate ad excellent care
• Started late 90s; now ~130,000 people
Success: day care

• 1,600,000 people attend day care—amazing
• This is 6.0% of 65+ (Sweden is 0.6%)
• Many though not all have dementia
• Often it is ~6 hours 3-4 days a week
  – Come and go by van
  – Group games, exercise, crafts, etc
  – Lunch and snack
  – A bath—important in Japanese culture
6 How well does it work?

• LTCI was implemented without major difficulties
• It is popular with the public, and in interviews both older people and caregivers say it makes a lot of difference
• Periodic reviews allowed for correcting problems, including spending
• Possible because it is a coordinated system
LTCI is a real system!

• A national, comprehensive plan
• User friendly
  – Well publicized
  – Information is easy to get
  – Certification is objective, simple and quick
  – Care managers as a crucial link
• It must be making a lot of difference during and after the earthquake-tsunami disaster
Population of Japan by Age and Sex, 2050
Estimated % of 65+ population receiving government-supported LTC, mid 2000s

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</table>
Public Spending on LTC (Per 65+ Person)

- **United States**: Approximately $2,000
- **Germany**: Approximately $1,500
- **Japan**: Approximately $2,000

**Legend**:
- Yellow: Nursing Homes
- Red: Cash Allowance
- Blue: HCBS (services)
Why long-term care?

• We all know—more older people, more of them are frail, traditional family care harder and harder.

• We all see two big problems
  – Quality of life of the frail older person
  – Burdens on family caregivers

• Americans tend to see this as an individual or family problem, not for society as a whole
Why Japan?

• Or better, why are Germany, France, Holland, Scandinavia, and Japan different?

• All have come to see frailty in old age (and being responsible for a frail older person) as a risk that should be shared between the individual and society

• All have public, universal LTC systems
How is LTCI managed?

• Municipalities (1727) are the insurance carriers and oversee the program.
• But national regulations dominate—unlike France, little local autonomy
• For community-based care, providers may be for-profit companies as well as non-profits; they compete for business (at least in cities)
• Prices are fixed so compete on “quality”
Why did Japan do it?

• The general answer: most advanced nations have a fairly comprehensive LTC policy—it is the United States that is the exception.

• Big decision in Japan was back in 1980 as a campaign promise before an election.

• That brought the “Gold Plan” or “Ten-Year Strategy for Health and Welfare of Elderly”

• Expansion of existing programs to extend coverage to ordinary middle-class people
Why LTCI in particular?

• Politicians thought the Gold Plan wouldn’t take (because Japanese believe in family care)
• But it was wildly popular, to the extent that in 1994 the targets for 2000 had to be hiked
• It was all tax money, and politicians feared raising taxes; no system to it, just a bunch of uncoordinated local programs
• So from 1993, the bureaucrats in charge plotted a different approach
<table>
<thead>
<tr>
<th>GOLD PLAN WAS</th>
<th>LTCI IS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility by caseworker decision</td>
<td>Objective standard</td>
</tr>
<tr>
<td>Localities vary greatly</td>
<td>Almost everything the same</td>
</tr>
<tr>
<td>Monopoly providers</td>
<td>Competition including for-profits</td>
</tr>
<tr>
<td>Revenues all from taxes</td>
<td>½ taxes ½ social insurance premiums</td>
</tr>
<tr>
<td>Services and providers by caseworker</td>
<td>Consumer choice</td>
</tr>
</tbody>
</table>
Goals of LTCI

• Explicit: “socialization of care” for the sake of frail elders and their families

• Implicit
  – Transfer burdens from taxes to premiums
  – Save on medical care ("social hospitalization")
  – Rationalize the system through clear eligibility standards and lines of management responsibility
  – Shift toward something like a market, consumer choice and competition, not bureaucracy
1-3 Trends of Population Aging (Population 65 and over, Medium variant) (%)

UN, World Population Prospects: The 2008 Revision