

## Chapter 2

# Development of the Long-Term Care Insurance System in Japan

The traditional Japanese value system, which emphasises filial piety and respect for older people, has placed primary responsibility for the support of older people on families. Throughout the 20th century, Japan developed rapidly from an agriculture-based society to a high-value industrial and services-based society. After World War II, rapid industrialisation and urbanisation have produced a steady change in population structure and traditional social patterns in Japan. Rapid population aging was a consequence of this remarkable success. A second consequence was equally rapid change from the social forms of agricultural communities to those of modern, urban social life. These changes have had important implications for health, and welfare policies in Japan.

Major demographic, economic and social changes in Japan, issues such as access, benefits, costs, quality of care and particularly, the respective roles of central and local government, have become crucial factors for creation of an economically and politically sustainable framework for the development and funding of a long-term care system.

## 2.1 Development of Welfare Policies for the Elderly

Social welfare became an important national goal in the late 1940s. During the 1950s and 1960s, new public assistance laws significantly improved the living conditions and welfare of older people. In 1973, a system of free medical care services for older people was introduced. However, to cope with the increasing healthcare demands of older people, a cost-sharing arrangement, along with co-payments by older patients, was adopted in 1983. The public pension system was restructured in 1985 to cater to the projected aging of the population, and retirement benefits were rationalised.

Since the early 1980s, general hospital services in Japan have often been used for ‘*social admissions*’ of older people as a substitute for long-term care. Japan’s Long-term Care Insurance scheme, introduced on 1 April 2000, further developed the mechanism for older people requiring long-term care to be supported in institutional

aged-care environments, and so enabled acute healthcare services to focus on short-term treatment and rehabilitation care. However, as the proportion of elderly people in Japan increased, welfare policies for the elderly began shifting in emphasis from institutional care services to at-home and community care services. A summarised overview of the evolution of the welfare policies for the elderly in Japan will be described for a better understanding of the development of the LTCI system.

### ***2.1.1 Early Welfare Policies for the Elderly (1922–1982)***

Although a ‘poverty’ law (*Jyukkyu Kisoku*) which provided assistance for older, sick persons  $\geq 70$  years who had no relatives to support them, was introduced as early as 1874, the first important milestone in the history of the Japanese welfare state was the introduction of National Health Insurance in 1922 and the foundation of the Ministry of Health and Welfare in 1938. A pension for workers was introduced in 1941. It was not until after World War II, though, that the development of a modern welfare state began. The 1947 Constitution stipulates that all Japanese citizens have a right to enjoy a minimum standard of living. Thus, a Child Welfare Law was adopted in 1947 and a Welfare Law for Handicapped was enacted in 1949 (Karlsson et al. 2004; Maruo 1997).

A government council on Social Security was established in 1950, and a coherent public welfare system began to develop in the next few years, as an Income Support Law (1950) and a Social Service Law (1951) were enacted (Maruo, 1997). In the 1960s, the aim of the welfare policy was to go ‘*from selective to universal*’ measures and ‘*from relief to prevention*’. Accordingly, health and pension insurances were reformed in 1961, after which the national health insurance system covered all Japanese citizens (Maruo 1997).

A brief summary of the history of the welfare policies for the elderly in Japan is shown in Table 2.1. An important step was taken in 1973, when medical care was made free for all aged  $\geq 70$  years; however, social services remained means-tested. As a consequence, the number of hospitalised elderly increased rapidly over the next 20 years, and most stayed in hospitals paid by medical insurance (Campbell and Ikegami 2000).

At the end of the 1980s, there was increased political concern regarding long-term care for the elderly due mainly due to the problem of care for frail older persons in an aging society, which was widely covered by the mass media. Japan already had one of the oldest populations in the world at this time, and there were no signs of a halt in this process. At the same time, the traditional system of informal caregiving, widely viewed as being in crisis, or at least inadequate as a traditional caring arrangement based on three-generation households and obligations on children to look after elderly parents showed signs of breaking down (Campbell and Ikegami 2000). Thus, the Japanese government presented a ‘Gold Plan’ in 1989 that laid down a 10-year strategy to promote healthcare and welfare for the elderly (Karlsson et al. 2004; Campbell and Ikegami 2000).

**Table 2.1** History of health and welfare policies for the elderly in Japan

Time	Ratio of the elderly population (%)	Major policies
1960s	5.7 (1960)	1963 Enactment of the welfare law for the aged <ul style="list-style-type: none"><li>• Setting up of special nursing homes for the elderly</li><li>• Legislation of home helper system</li></ul>
1970s	7.1 (1970)	1973 Free medical care for the elderly
1980s	9.1 (1980)	1982 Enactment of the health and medical service law for the Elderly <ul style="list-style-type: none"><li>• Introduction of partial payment of medical expenses for the elderly</li></ul> 1989 Formulation of the gold plan (The 10-year strategy to promote healthcare and welfare for the elderly) <ul style="list-style-type: none"><li>• Urgent development of facilities and promotins of in-home welfare</li></ul>
1990s	12.0 (1990)	1994 Formulation of the new gold plan(The New 10-year strategy to promote Healthcare and welfare for the elderly) <ul style="list-style-type: none"><li>• Improvement of in -home welfare</li></ul>
Preparation for introduction of the long term care insurance system	14.5 (1995)	1996 Policy agreement of three ruling coalition parties Ruling parties agreements as to the establishment of the long - term care insurance system
2000s	17.3 (2000)	1997 Enactment of the long-term care insurance law
Implementation of the long-term care insurance system		2000 Enforcement of the long term care insurance law
Source Overview of the long-term care insurance system. MHLW 2008		2005 Partial revisions of the same law

Other government policies to deal with problems related to the aging society were considered. The Basic Law on Measures of the Aging Society enacted in 1995 aimed to create a society in which people of all ages could live their entire lives with a sense of security. In 1996, the Government stipulated '*an outline of measures to tackle the aging society*', and released its revised version in 2001. The Government also encouraged employers to hire more senior people. Legislation enacted in 2006 ensured that companies would keep employees until the age of 65 years to promote retention of aged workers in the labour force. However, they were allowed to achieve this goal gradually over a few years and employers were able to cut pay to older workers; indeed, many had their salaries halved when they reached 60 years even if they remained in the same position (Fuyuno 2007). The Government also proceeded with comprehensive aging-society measures to encourage the elderly to be more independent. '*Innovation 25*', Japan's first long-term policy roadmap on innovation, released in May 2007, called for greater working opportunities for women and the elderly and improving productivity over the next two decades with the advent of the aging society. In fiscal 2007, the Government set aside 13.63 trillion yen to support employment, nursing care, education, social participation, living environment, and research into cancer (Fuyuno 2007).

### **2.1.2 Gold Plan (1989–March 2000)**

The Japanese government developed and implemented the 10-year Strategy to Promote Health Care and Welfare for the Elderly, commonly known as the '*Gold Plan*' in December 1989 to cope with increased and expensive '*social admission*' to general hospitals (beginning in 1973 the frail elderly were entitled to free hospitalisation) and the inadequate supply of both home care and nursing homes under social services, and the perceived decline in the capacity of families to provide care for elderly relatives. The Gold Plan defined specific goals to be achieved over a 10-year period ending in 1999 (Campbell and Ikegami 2000; Ihara 1997; Welfare for Older People 2006).

The Gold Plan goals included numerical targets for major expansion of services, such as doubling the number of nursing home beds, tripling the number of home-helpers, and (from a small base) increasing the number of adult day-care centres tenfold. Also added were some new programs, such as local agencies to co-ordinate home care (Ihara 1997; Welfare for Older People 2006). Each municipal government conducted a fact-finding survey on older persons living within its jurisdiction to implement the Gold Plan and formulated a specific action plan to develop a service infrastructure based on survey results. Local governments also developed their action plans based on those of the municipalities within their districts. Making plans at the district and municipal levels increased public interest and became an opportunity to raise the policy priority of the issue of long-term care to a higher level, at both the national and district political levels (Ihara 1997).

The Gold Plan represented a major shift from long-term institutionalised care in hospitals and nursing homes to home programs and community-based rehabilitation facilities. At the same time, the government formulated a plan to make long-term care services universally available to older persons (Ihara 1997). Following introduction of the Gold Plan, Japan experienced rapid growth in the formal care sector, and costs increased by 10–15 % annually (Campbell and Ikegami 2000). Subsequently, it became apparent that the target levels specified in the Gold Plan were insufficient to meet the needs of the people while improving the welfare service infrastructure and creating action plans at local levels. So, the Japanese Government revised the Gold Plan in 1994 and formulated the New Gold Plan by raising the goals regarding the increases in nursing home beds, day care centres, home care services and sheltered housing (care houses) (Campbell and Ikegami 2000; Ihara 1997).

The New Gold Plan had resulted in various improvements by FY1999, including an increase in the number of home helpers for elderly persons, improvements in the capacity of short-stay facilities to accept them for periods of rest and special care, including meals and physical exercise at day-care centres, and expansion of at-home services—such as visits by physicians and nurses who provide special care and guidance of physical exercises for regaining impaired function (Welfare for Older People 2006).

However, existing arrangements (based on the Gold Plan for long-term care published during the 1990s) were proving expensive and unsuitable for the anticipated major expansion in demand. Access to services was controlled by municipal welfare bureaucrats without relevant professional training who were believed to rely heavily on discretionary judgement; access was means-tested, provisions varied among municipalities, and individuals had no choice of service provider (Ikegami 2007).

It became obvious that a new financing mechanism was necessary due to the growing care sector and the reliance of the financing social care system on taxation, and, hence, subject to budget restraints (Campbell and Ikegami 2000). Following a long discussion, a mandatory long-term care insurance policy for the elderly was approved in the Japanese Diet (parliament) in December 1997; the new system became effective in April 2000 and was to be expanded gradually over the next 10 years. This insurance system represented a radical break with Japanese welfare tradition, as it entitles all insured lives to benefits and thus shifted the responsibility for long-term care from families to the state (Campbell and Ikegami 2000).

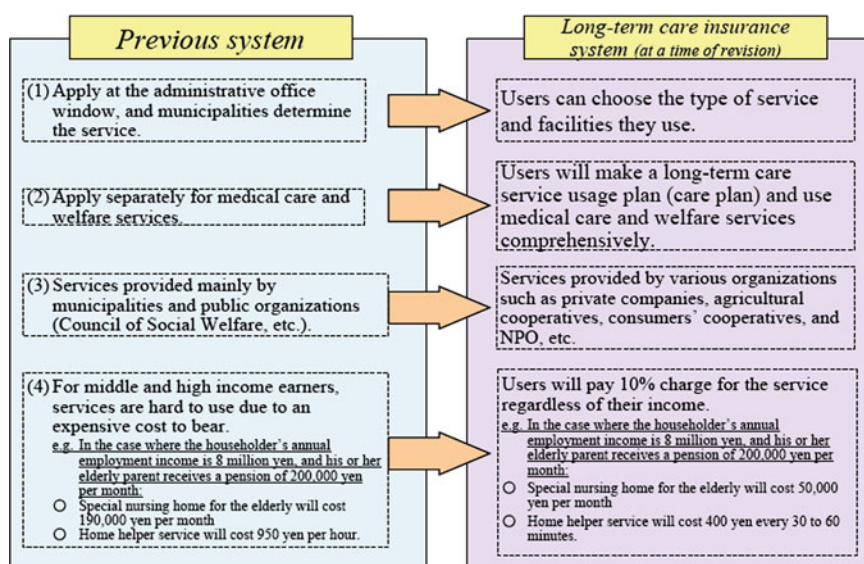
## **2.2 Long-Term Care Insurance System: (*‘Kaigo Hoken’*) (April 2000–June 2005)**

Implementation of Japan’s Long-term Care Insurance System (*‘Kaigo Hoken’* in Japanese) in April 2000 as a third pillar of social security—the other two being pensions and healthcare—was the culmination of a long period of policy deliberation on aged care. Most of the discussion was carried out within a fairly narrow

group of organisations and individuals who had long been active in social policy. At the level of interest-group politics, representatives of physicians and local governments bargained hard and successfully to be sure that their concerns would be reflected in the new system (Campbell and Ikegami 2000). Perhaps the liveliest battle was a ‘*rearguard action*’ by much of the old social welfare establishment to preserve the tax-based and direct-service-provision model. Their arguments, based in part on protecting current recipients of services, lost out to proponents of social insurance. There also was much consideration of what kinds and quantity of services would be provided. The issue that drew the most attention was whether or not cash benefits for family caregivers should be included. This was rejected, although polls showed support for cash benefits (Campbell and Ikegami 2000).

Before the introduction of the LTCI system, Japan was suffering from inequitable welfare care services, as municipalities with different fiscal resources provided different levels of care service according to their local standards. The main differences between LTCI and long-term care provided by the prior systems from the user point of view are shown in Fig. 2.1.

The LTCI system was introduced to supplement the mandatory national healthcare system established in 1961. According to Japan’s Ministry of Health, Labour and Welfare (2002) the new scheme pursued three major goals. It aimed to: (1) shift the burden of elderly care imposed on the families, which was borne mainly by women, to the state; (2) make the relationship between benefits received and cost-sharing via insurance premiums as well as co-payments more transparent; and (3) integrate medical care and welfare services via unified financing



**Fig. 2.1** Differences between the former system and long-term care insurance. *Source* Ministry of Health, Labour and Welfare, 2008

**Table 2.2** Implementation phases of the Long-term Care Insurance System in Japan

	1997	December	Enactment of the long-term care insurance law
1st phase	2000	April	Enforcement of the long-term care insurance law
2nd phase	2003	April	Revision of the Category 1 premium, revision of long-term care fees
		May	Establishment of the long-term insurance subcommittee in the Social Security Council-a start of the “Revision in 5 years after the enforcement”
	2005	June	Enactment of the law to revise a part of the long-term care insurance law
		October	A reviews of facility benefits
3rd phase	2006	April	Full -scale enforcement of the revised law
			Revision of the Category 1 premium, revision of long-term care fees (as for those enforced in April)
	2008	May	Enactment of the law to revise a part of the long-term care insurance law and the welfare law for the aged

Source Overview of the Long-term Care Insurance System. MHLW 2008

(Long-Term Care Insurance in Japan 2002). Authors such as Campbell and Ikegami (2000) emphasised two additional aims: to enhance consumer choice and competition by allowing free choice of providers, including even for-profit companies; and to expand local government autonomy and management capacity in social policy (Campbell and Ikegami 2000).

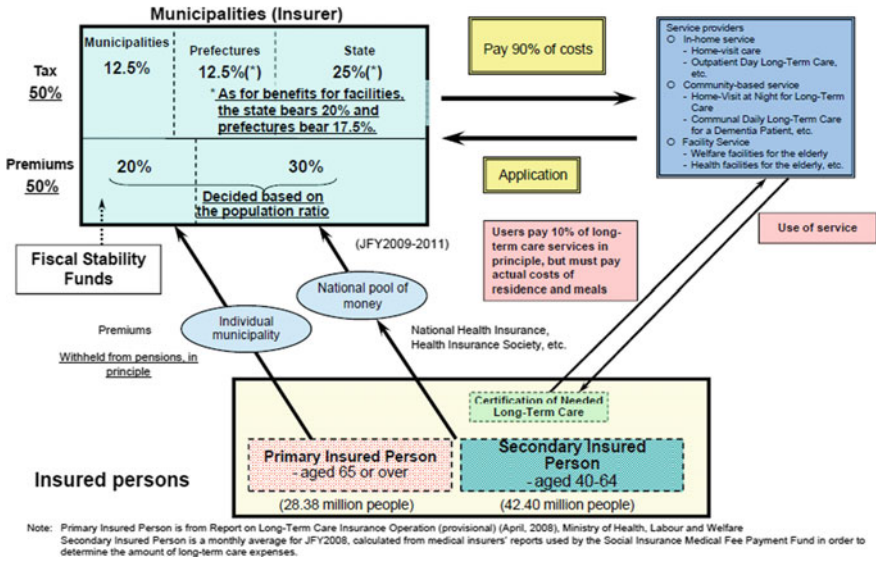
The government planned to expand the new program in three phases gradually over 10 years, leading to a major expansion of community-based care, a fundamental reform of financing and regulation of institutional care, and, more generally, a flexible approach to social policy based on individual entitlement and choice (Table 2.2) (Campbell and Ikegami 2000).

2.2.1 Administrative Structure: Insurers

In contrast to the health insurance system, which has a fragmented structure with different insurers covering different segments of the population, the LTCI system has a uniform structure administered by municipal governments (Fig. 2.2) (Tatara and Okamoto 2009).

Municipal governments insure all registered residents aged ≥65 years (primary insured persons) and all persons covered by health insurance aged 40–64 years who reside in the municipality (secondary insured persons). All municipal governments are required by the LTCI Act to develop a strategic plan with a 5-year time frame to make a sound actuarial prospect. The central government, prefectures, health insurers and pension insurers must provide continuous support and assistance to them (Long-Term Care Insurance in Japan 2002; Tatara and Okamoto 2009).





**Fig. 2.2** Structure of the long-term care insurance system in Japan (after revision in 2005).  
*Source* Health and Welfare Bureau for the Elderly, MHLW 2010

## 2.2.2 Needs Assessment

### 2.2.2.1 Assessment Tool

The needs-assessment tool for LTCI benefits used in Japan is complex. An evidence-based approach was adopted to develop the assessment tool, which was a radical departure from traditional negotiation-oriented policy-making. A field survey was conducted on a sample of residents in selected welfare homes to quantify the care need by means of a 1-min time study, i.e., minute-by-minute records of all their activities, and correlate it with a measurement of activities of daily living (Tatara and Okamoto 2009).

Development of the LTCI required an assessment instrument based on three principles. First, using the standardised instrument, any trained investigator should obtain sufficiently similar results for the same applicant. Second, the results should be strictly based on the response to the assessment questionnaire. Third, needs should be expressed in standardised measurement units. An individual's income, assets, and family care availability are no longer relevant for benefits eligibility because LTCI became an explicit and uniform entitlement for everyone based strictly on physical and mental status (Tsutsui and Muramatsu 2005). The current instrument was developed based on a large-scale time study of professional caregivers in LTC institutions conducted by Tsutsui et al. in 1995. The study sample involved 51 facilities that national LTC facility associations recommended as high-quality service providers, because the government's goal was to make the



quality services of '*ideal*' facilities available in the home. A licensed professional employee of the study institution, who was trained to be the time-study surveyor, followed a peer caregiver for 24 h per day for 2 days and made detailed records of all their activities as well as the name of each person receiving the nursing care service (Tsutsui and Muramatsu 2005).

The data on approximately 10 million minutes of care provided by 2,376 professionals to 3,800 seniors were coded into 328 predetermined care activities, and the amount of time the caregiver spent on each senior was calculated for each activity (Tsutsui and Muramatsu 2005). These data were used to develop tree regression models in which older adults use of services (measured in minutes by nine service categories) was regressed on their physical and mental attributes. Time-study data were also collected for in-home care provided by professionals and families, but these data were not used because in-home care use largely depended on family and housing factors. The tree regression estimation models were pilot-tested on 175,129 seniors in institution and home/community settings in all municipalities in a project funded by the government in 1996–1998. The validity of the models was examined by comparing the computer-aided assessment with a health professional's assessment of each case, with 71.5 and 75.3 % concordance in 1996 and 1997, respectively (Tsutsui and Muramatsu 2005). Feedback from various stakeholders was used to refine the assessment instrument before it was implemented. The product was the assessment tool, which consists of 73 items that predict the care needs of the individual with known accuracy. The tool is fully computerised to facilitate the assessment process and is now used nationwide to determine benefit eligibility.

Training is essential to standardise needs assessments. Thus, the central government developed training videotapes and textbooks at the start of LTCI; these are revised annually according to user feedback. Municipalities are responsible for training assessors using these materials. The training, ranging from 3 to 7 days depending on the assessor's ability, centres on needs assessment role-playing for various situations, including an assessment of demented older people that may involve family caregivers (Tsutsui and Muramatsu 2005).

### 2.2.2.2 The Certification Process

The nationally uniform criteria for long-term-care-need certification in Japan were established objectively. To be eligible for LTCI benefits, the insured or his caregiver (family or professional) must apply to the municipal government for needs assessment. Only after the person is assessed as disabled will they be entitled to benefits. The certification process starts with an initial assessment conducted mainly by a trained local government official or by a private care manager's referral from the government, who visits the home to evaluate nursing care needs using a national standardised questionnaire on current physical and mental status (73 items) and use of medical procedures (12 items) (see Appendix A) (Tsutsui and Muramatsu 2005). The surveyors can record any particular findings to be

considered for final assessment, but they have no authority to make a judgment. The recorded assessment questionnaire is evaluated by computer to provide a preliminary assessment based on the total estimated time of care (independent, requiring support levels 1 and 2, and requiring care, levels 1–5) (Tatara and Okamoto 2009; Tsutsui and Muramatsu 2005).

The municipal governments also ask attending physicians designated on the application form to submit their professional opinions. The physician's opinion is particularly important for '*Category 2 insured persons*', because to qualify for benefits their disability condition must be related to specific and designated aging-related diseases. A municipal board, the Certification Committee for Long-term Care Need, consisting of about five health and welfare professionals, reviews the surveyor's findings and the physician's opinion to decide whether the preliminary assessment should be modified (Tatara and Okamoto 2009; Tsutsui and Muramatsu 2005; Health and Welfare Services for the Elderly. Annual Health, Labour and Welfare Report 2010). The Certification Committee is responsible for evaluation and judgement based on the investigation. The results are based on the insured's mental and physical condition and the family physician's opinions (evaluation and judgement can be entrusted to prefectures). Most commonly, the Certification Committee upgrades the need level to accommodate special needs not captured in the computer-based assessment and reassigns the need level if necessary. The preliminary assessment is final in 80 % of cases. The eligibility decision; *i.e.* the assistance/care need level and the monthly limit of benefits, is then communicated to the applicant within 30 days of applying (Tsutsui and Muramatsu 2007). Approval for LTC benefits is effective for 6 months. If it is desired to continue to receive LTC services thereafter or a change in eligibility status is required, application is made to the municipality within 60 days before the expiration date. Approval for both renewals and/or change in status are subject to the same procedure as the initial needs assessment (Tatara and Okamoto 2009; Health Insurance, Long-Term Care Insurance and Health Insurance Societies in Japan 2008). When the LTCI system was introduced in 2000, six eligibility levels were established: one '*Support level*' and five '*Care need levels*'. Since April 2006 and after of the enactment LTCI law (2005), there have been seven levels of certification under Kaigo Hoken; the two lightest levels are '*assistance required*' ('*yo-shien*' in Japanese) and the remaining five levels refer to '*care required*' ('*yo-kaigo*' in Japanese) (Morikawa et al. 2007; Matsuda and Yamamoto 2011; Igarashi et al. 2009).

### 2.2.3 Financing

Although the LTCI in Japan is considered social insurance, 45 % of funding comes from taxes, 45 % from social contributions, and 10 % from cost-sharing (co-payments) (Fig. 2.2).

Municipalities set up special accounts for their LTCI programs and set budgets that are required to be balanced on a 3-year term. The 3-year period for budget

planning is called the Program Management Period (PMP). When drawing up their budgets, municipalities estimate their LTCI expenditures for the next 3 years. Because LTC prices are set by the central government and are effectively held constant, the expenditure forecasts are directly related to the volume of demand for LTC services (Hayashi 2009; Campbell et al. 2010). Forecasting the volume of institutional care is relatively straightforward as it is capped by the capacity of existing or planned LTCI facilities; however, estimating the amount of home care is rather complicated because it involves forecasting the number of eligible people and the extent to which they utilise their entitlements (Hayashi 2009).

Revenues are considered after expenditure forecasts are obtained. The basic scheme is as follows. First, the central government covers 20 % of the benefit expenses through the Long-term Care Benefits Subsidy. Second, the central government disburses an additional grant called the Adjustment Subsidy (AS), allocating central funds that equal 5 % of the national total of all LTCI benefits to adjust for gaps in municipality finances. The AS grants are distributed with matching rates that depend on the percentage of those aged  $\geq 75$  years, and the average income of those aged  $\geq 65$  years. The minimum value of the matching rates is zero and the maximum value differs from year to year. For example, the percentage was 12.03 in 2003, 11.08 in 2004, and 11.65 in 2005. Third, prefectures cover 12.5 % of municipal benefits in their jurisdictions through the Cost-sharing Subsidy. Finally, another 12.5 % is financed by intra-municipal transfers from the general account to the LTCI account within a municipality. These four factors are financed through taxation, and these tax-financed shares exclude extra benefits that municipalities provide over and above the national standards (Hayashi 2009; MHLW 2008; Overview Financial Status of Long-Term Care Insurance System 2011).

The remaining part of the LTCI benefits is financed from two types of social insurance contributions (premiums) depending on insured categories (Table 2.3). The first type of premium is paid by municipal residents aged  $\geq 65$  years (primary premium) to cover the remaining part of the revenues that vary depending on the size of the AS matching rate. The premiums for this category are set by each municipality based on income level. The second type of premium is paid by those aged 40–64 years (secondary premium) and is calculated based on the calculation standard of the healthcare insurance system to which they subscribe (the average burden per secondary insured is identical). These are nationally pooled in the Social Insurance Medical Fee Payment Fund and then allocated as the Fee Payment Fund Grants to cover 31 % of LTCI benefits in every municipality. Therefore, this grant functions as an equalising device as it favours municipalities in which secondary insured shares are less than the average. The secondary premiums are collected as a surcharge on public health insurance premiums. In fact, this is a payroll tax and is split equally between employers and employees. The rate is 0.95 % of salary for Government-managed health insurance and 0.88 % for association-managed health insurance (Long-Term Care Insurance in Japan 2002; Health Insurance 2008; MHLW 2008).

**Table 2.3** Insured persons, eligible persons, premium burden, levy, and collection method for long-term care insurance in Japan

Covered Eligible	Primary insured		Secondary insured	
	Primary insured		Secondary insured	
Premium burden Levy and collection method	<ul style="list-style-type: none"> <li>• People requiring long-term care (bedridden, dementia)</li> <li>• People requiring support (infirmary)</li> </ul>		<p>People aged 40–64 who are participants of healthcare insurance</p> <p>The case is limited where a condition of need for Long-term care or for a needed support condition is due to disease (specified disease) caused by aging such as terminal cancer and rheumatoid arthritis, etc.</p>	
	<p>Collected by municipalities</p> <ul style="list-style-type: none"> <li>• Fixed premium in accordance with income level (to ease the burden on the people with low income)</li> <li>• Special collection (detection from the pension) for the insured receiving ¥ 180,000 or more benefits from the old-age pension annually. For others, municipalities collect the premiums</li> </ul>		<p>Health care insurers collect the premiums as health care insurance premiums and pay in lump-sum</p> <ul style="list-style-type: none"> <li>• Health care insurance: standard remuneration and standard bonus <math>\times</math> long-term care insurance remittance contribution (bone partly by business operators)</li> <li>• National Health Insurance: Divided proportionally by income or on a per capita basis (borne partly by the national treasury)</li> </ul>	

Source Annual Health, Labour and Welfare Report 2009–2010; MHLW 2010

Those primary insured that receive a pension above a given amount have the premium deducted from their pension, whereas those who do not receive a pension are required to pay the municipal government voluntarily. The premium schedule is progressive and consists of products of a standard rate with adjustment coefficients (Table 2.4). The national guideline sets out six income brackets and applies a set of adjustment coefficients (0.50, 0.50, 0.75, 1.00, 1.25 and 1.50) with larger values for the upper brackets. The standard rate applies to the fourth bracket. The standard rate in each municipality is set so that its budget for the coming 3-year PMP is balanced. As such, the standard rates differ among municipalities. For example, the distribution of the annual standard rates for the 2010–2012 PMP vary from ¥27,180 to ¥69,240 with a median of ¥48,000 (Long-Term Care Insurance in Japan 2002; Health Insurance 2008; MHLW 2008).

Because the premium rates are fixed for 3 years, annually realised budgets do not usually balance. When surpluses occur, they are saved in the Long-term Care Benefits Fund for use against future deficits. If deficits are severe enough to exhaust the funds, loans are made from the Fiscal Stabilisation Fund, which is managed by prefectures (Long-Term Care Insurance in Japan 2002). The loans borrowed in a given PMP are re-paid in the next PMP with funds financed from Category I insured. Receiving loans thus implies a future hike in premiums. Finally, when recipients receive LTC services, a fixed amount of 10 % of the total costs of services is paid directly to the providers as a co-payment (Overview of the Revision of the Long-Term Care Insurance System 2007). After enactment of the LTCI law (2005), housing expenses and meal fees were charged under contract with the facility on top of the 10 % co-payment for those living in a nursing care facility (Tsutsui and Muramatsu 2007; Morikawa et al. 2007; Overview of the Revision of the Long-Term Care Insurance System 2007).

### 2.2.4 Insurance Benefits

Long-term care services are available to all Japanese citizens  $\geq 65$  years, identified as 'primary insured persons', who meet the eligibility criteria. Additionally, LTC coverage is available for the 'secondary insured persons' only if they have one of 15 age-related diseases, including early onset dementia, stroke, Parkinson's disease, and others (Long-Term Care Insurance 2002). Once the eligibility level and limit of the benefits are determined, the system allows consumers a choice of services and providers, and covers both institutional and home-based care. Unlike other LTCI systems in Germany, Netherlands or South Korea no cash benefits are provided in Japan.

Theoretically, people certified as eligible for the LTCI system are free to choose services, but in reality, care-managers certified by prefectures make care plans according to each applicant's certified care needs level, living environment, and requests from the user and family (Tsutsui and Muramatsu 2007; Morikawa et al. 2007; Matsuda and Yamamoto 2011). Care management is a key policy of the

**Table 2.4** Premium schedule for the primary insured category in the long-term care insurance system in Japan

Level	Eligible	Premium	(Reference) Expected number of the insured (%)
Level 1	<ul style="list-style-type: none"> <li>• Beneficiary of public assistance</li> <li>• The insured receiving Old-age Welfare Pension in the municipal-tax exempt household</li> </ul>	Standard amount $\times 0.5$	2.5
Level 2	The insured with the total income including the pension income of ¥ 800,000 or less in the municipal-tax exempt household	Standard amount $\times 0.5$	16.7
Level 3	The insured in the municipal tax exempt household who is not in the level 2 category	Standard amount $\times 0.75$	12.0
Level 4	The insured exempt from municipal tax	Standard amount $\times 1$	31.4
Level 5	The insured subject to municipal tax (total income of the insured is less than ¥2 million)	Standard amount $\times 1.25$	22.2
Level 6	The insured subject to municipal tax (total income of the insured is ¥2 million or more)	Standard amount $\times 1.5$	15.2

Source Annual Health, Labour and Welfare Report 2009–2010; MHLW 2010

LTCI in Japan and defines a professional service to co-ordinate the various services provided by different providers to accommodate geographically dispersed home settings within a limited allocated budget. A care manager is a professional who possesses a health- or welfare-related license and has at least 5 years of clinical experience (Gleckman 2010). Then, a care plan is designed and the process concludes with a contract between a care provider firm and the user. However, as recipients are re-evaluated every 6 months, they may request changes to the care plan and, if dissatisfied, change the manager and/or provider.

Those certified in the *'yo-shien'* levels can use only community care or preventive services to help them to lead self-supporting lives while maintaining their present physical condition as long as possible. Those certified in the *'yo-kaigo'* levels can receive home-based, community-based, or institutional facility services (Morikawa et al. 2007; Someya and Wells 2008). The care plan for those in need of facility services must be created by the facility (Health Insurance 2008).

The benefits provided by the Japanese LTC system after enactment of the LTCI law (April 2006) include services for care prevention benefits and services for long-term care benefits (Gleckman 2010; Health and Welfare Services for the Elderly 2009). Services for care prevention benefits include nursing care prevention services (designated and supervised at the prefecture level) and nursing care prevention support (designated and supervised at the municipality level). Additionally, long-term care benefit services include both at home and facilities services (Table 2.5).

The main categories of at-home care services include home-visit care, home-visit nursing, home-visit bathing service, home-visit rehabilitation, and management guidance for in-home care and allowances for rental of welfare equipment. In-home based services also include commuting services (*e.g.* day services) and short-stay daily-life services. Commuting services in Japan are those delivered in community-based day service facilities for the elderly to which a user commutes and other facilities, where he/she is provided with personal care for bathing, toileting and eating, support for other daily-life activities, and physical exercises, and returns home the same day (Overview of the Revision of the Long-Term Care Insurance System 2007). In contrast, facilities for institutional care are divided into special nursing homes for the elderly, LTC health services facilities for the elderly (geriatric intermediate care), and sanatorium-type medical care facilities (health care facilities for older adults). A user is admitted to a special nursing home for the elderly, where they are provided with personal care for bathing, toileting and eating, support for other daily-life activities, physical exercise, and assistance with health management and recuperation. In contrast, 'geriatric intermediate care' and 'health care facilities for older adults', define LTC institutions where residents are medically stable but require rehabilitation, nursing or personal care. The main difference is that the former is licensed under LTCI law and the second offers LTC services mainly under the National Healthcare System. Other differences are professional staff composition, room sizes and fees (Overview of the Revision of the Long-Term Care Insurance System 2007).



Table 2.5 Long-term care insurance benefits services in Japan

Services designated/supervised by prefectures	Services of care prevention benefits	Services of long-term care benefits
	<div>Nursing care prevention services<ul style="list-style-type: none"><li>• Nursing care preventive home-visit care</li><li>• Nursing care preventive home-visit bathing care</li><li>• Nursing care preventive home-visit rehabilitation</li><li>• Nursing care preventive commuting care</li><li>• Nursing care preventive commuting rehabilitation service</li><li>• Nursing care preventive short-term stay at a care facility</li><li>• Nursing care preventive medical care service through a short-term stay</li><li>• Nursing care preventive daily life care for elderly in specific facilities</li><li>• Lending nursing care preventive welfare instruments</li><li>• Sales of specific nursing care preventive welfare instruments</li></ul></div>	<div>In-home services<ul style="list-style-type: none"><li>• Home-visit care</li><li>• Home-visit bathing care</li><li>• Home-visit nursing care</li><li>• Home-visit rehabilitation</li><li>• Management guidance for in-home care</li><li>• Commuting for care</li><li>• Commuting rehabilitation service</li><li>• Short-term stay at a care facility</li><li>• Medical care service through a short-term stay</li><li>• Daily life care for elderly in specific facilities</li><li>• Lending welfare instruments</li><li>• Sales of specific welfare instruments</li></ul></div> <div>In-home support</div> <div>Facility services<ul style="list-style-type: none"><li>• Welfare facilities for the elderly requiring long-term care</li><li>• Health care facilities for the elderly requiring long-term care</li><li>• Sanatorium type medical care facilities for the elderly requiring care</li></ul></div>

(continued)

Table 2.5 (continued)

Services designated/supervised by municipalities	Services of care prevention benefits	Services of long-term care benefits
	Nursing care prevention support	Community-based services
	<ul style="list-style-type: none"> <li>Community-based nursing care prevention services</li> </ul>	<ul style="list-style-type: none"> <li>Night time home-visit care</li> </ul>
	<ul style="list-style-type: none"> <li>Nursing care preventive small-sized multifunctional in-home care</li> </ul>	<ul style="list-style-type: none"> <li>Commuting care for elderly with dementia</li> </ul>
	<ul style="list-style-type: none"> <li>Nursing care preventive commuting care for elderly with dementia</li> </ul>	<ul style="list-style-type: none"> <li>Small-sized multifunctional in-home care</li> </ul>
	<ul style="list-style-type: none"> <li>Nursing care preventive daily life care in communal living</li> </ul>	<ul style="list-style-type: none"> <li>Daily life care in communal living for elderly with dementia</li> </ul>
		<ul style="list-style-type: none"> <li>Community-based daily life care for elderly in community-based specific facility</li> </ul>
		<ul style="list-style-type: none"> <li>Community-based daily life care for elderly in welfare facilities for elderly requiring long-term care</li> </ul>
Others	Modifying houses	Modifying houses

Source Annual report MHLW, 2009–2010

**Table 2.6** Standard benefits limits for in-home services in the long-term care insurance system in Japan

Level of long-term care need	Benefit limit standard amounts (units/month)
Requiring support 1	4,970
Requiring support 2	10,400
Requiring long-term care 1	16,580
Requiring long-term care 2	19,480
Requiring long-term care 3	26,750
Requiring long-term care 4	30,600
Requiring long-term care 5	35,830

\* 1 unit: ¥10 to ¥11.05 (subject to regions and service types)

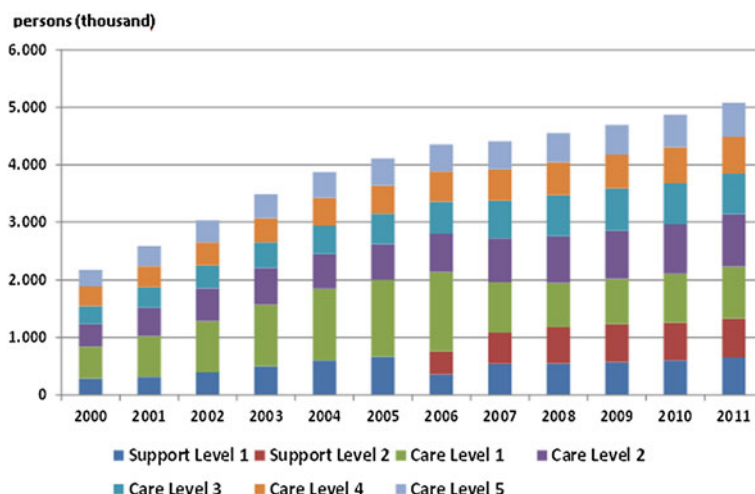
Source Annual Health, Labour and Welfare Report 2010–2011. MHLW Japan

Benefits cover actual costs up to a certain limit. Limits for home care are calculated according to a unit benefits system, in which a number of units are assigned to each type of service. The unit benefits it refers to “minutes of care” required per day. The units are multiplied by a particular number of yen (¥10 to ¥11.05 for 2011), to obtain the actual benefit limit for different levels of need. Table 2.6 shows that the benefit limits for in-home care benefits are approximately 5,000–35,800 units per month according to the long-term care need level (seven levels including the levels of support needed after the 2005 LTCI revision). Costs vary between ¥242,000 and ¥414,000 per month within the institutional sector, depending on the type of facility, room size and the amount of nursing care needed (Karlsson et al. 2004; Overview Financial Status of Long-Term Care Insurance System 2011).

### 2.2.5 Insurance Coverage

As increasing numbers of elderly people obtain more information and become familiar with the LTCI system, the number of insured who apply for need assessment and qualify for the benefit is increasing rapidly. The total percentage of LTCI users in 2000 was 6.9 % of the elderly population, which increased to 13.1 % in 2006 and to 13.5 % in 2008 (Overview Financial Status of Long-Term Care Insurance System 2011).

The LTCI system included 28.954 million primary insured, accounting for 98 % of the total elderly population in Japan in 2010 [95]. Of them, 16.8 % were certified for long-term assistance/care, whereas just 13.9 % chose to receive benefits (Overview Financial Status of Long-Term Care Insurance System 2011). The trend and distribution of the level of care need for 12 years (April each year) are shown in Fig. 2.3.



**Fig. 2.3** Trend in the number of people certified for the long-term care insurance system in Japan, 2000–2008. *Source* Annual report on the status of long-term care insurance, 2010–2012 MHLW

### 2.2.6 Providers

Japan has a healthcare policy known as the “non-profit principle”, which does not permit investor-owned hospitals or clinics. This principle does not apply to welfare services covered by LTCI, with the exception of healthcare services covered by the LTCI. Along with the introduction of the LTCI scheme, the Japanese government allowed for-profit operators to share the provision of at-home care services. For-profit corporations are allowed to provide home help, catering, bathing and day services.

LTCI services are provided by diverse providers; establishments providing in-home services for preventive long-term care, establishments providing community-based preventive long-term care services, establishments providing assistance in receiving preventive long-term care, establishments providing in-home services, establishments providing community-based services, establishments providing assistance in receiving in-home long-term care, and institutions providing long-term care under the LTCI system (The Survey of Institutions and Establishments for Long-Term Care 2008).

Preventive long-term care services and in-home service providers offer a wide array of services. These services vary from assisting people with activities of daily living, such as bathing, eating and using the bathroom, provided by care workers, etc. in people’s homes; nursing care services provided by nurses in people’s homes; functional training provided at day-care service centres; intensive care homes for the elderly; short-term admission facilities for the elderly; and other facilities to which the users commute; rehabilitation services, such as physical

therapy and occupational therapy at institutional centres to which the users commute; nursing, medically managed long-term care, functional training, medical treatment, and assistance in activities of daily living provided in LTC facilities for the elderly, or other facilities to which the users are admitted for a short period of time. These providers lease equipment, as specified by the Minister of Health, Labour and Welfare, that is used to help people perform activities of daily living more independently (The Survey of Institutions and Establishments for Long-Term Care 2008).

The Japanese LTCI system provides institutional care according to definitions prescribed in the Act on Social Welfare Service for Elderly through three types of facilities: Welfare Facility for the Elderly Requiring Long-term Care (WCFE), Healthcare Facility for the Elderly Requiring Long-term Care (HCFE) and Sanatorium-type Medical Care Facility for the Elderly Requiring Long-term Care (MCFE) (Survey of Institutions and Establishments for Long-term Care 2009). The principle differences among these facilities are the type of care supplied, medical conditions of the residents, staff composition, room sizes and fees (Tsutsui and Muramatsu 2007; Campbell et al. 2010).

The WCFE, or as currently named a Special Nursing Home, is defined as a facility with a capacity of  $\geq 30$  residents, offering 24-h services with no limits on residential period and provides assistance with activities of daily living such as care for bathing, toileting, eating, functional training, health control and recuperative care to their residents requiring long-term care based on a facility services plan. In contrast, a HCFE, also called a Geriatric Intermediate, is defined as a facility that provides nursing care, long-term care under control of medical management, functional training and other necessary medical treatment and assistance in activities of daily living to their residents requiring long-term care based on a facility service plan. Finally, a MCFE is a medical facility prescribed in the Medical Care Act, but based on the Long-term Care Insurance Act, that provides recuperative management, nursing care, assistance including long-term care under control of medical management, functional training and necessary medical treatment to their residents requiring long-term care based on a facility service plan (Survey of Institutions and Establishments for Long-Term Care 2009).

As of April 2000, there were 9,143 facilities with a capacity approaching 640,000 persons in the Japanese LTCI system; however, these figures increased to 12,320 facilities and a capacity of  $\sim 838,000$  persons as of April 2007 (Survey of Institutions and Establishments for Long-Term Care 2009). WCFEs represent  $\sim 45\%$  of the total institutional care capacity. Facilities residents accounted for 23 % of the total users of LTC services and for 3 % of the total elderly population in Japan, as of April 2007 (Survey of Institutions and Establishments for Long-Term Care 2009; Population Statistics of Japan 2008). According to 2011 OECD health data, there were 27 beds in LTC institutions and 10 beds allocated for LTC in hospitals per 1,000 people  $\geq 65$  years in 2009. However, the number of

beds in LTC institutions in Japan has increased in recent years. The average annual growth rate in LTC beds in institutions was 3.6 %, and 3.3 % for hospital beds allocated to LTC users, between 2000 and 2009 (Long-term care beds in institutions and hospitals. Health at a Glance 2011).

Furthermore, as the LTCI system offers institutional care with no limit on residential periods, a higher occupancy rate of facilities of ~95 % (98 % in nursing homes) has resulted in a supply–demand imbalance, and a longer waiting list for WCFEs (nursing homes) (Survey of Institutions and Establishments for Long-Term Care 2008). It is estimated that the waiting time for WCFEs is 3–5 times longer than prior to implementation of the LTCI system, particularly in metropolitan areas (Ikegami et al. 2003; Shirasawa 2004). This situation is far from being solved and remains an important challenge.

The LTC providers market has expanded considerably after introduction of the LTCI system. In 2000, there were 20,995 welfare facilities for the elderly requiring long-term care services, which increased to 33,564 facilities in 2011 (Overview Financial Status of Long-Term Care Insurance System 2011). According to the Survey of Institutions and Establishments for Long-term Care (MHLW 2008), a breakdown of establishments by founding entities showed that 55.1 % of a total of 20,885 establishments providing home visit care in 2008 were profit-making corporations, 26.5 % were social welfare and only 5.6 % belonged to a non-profit organization. Local government has marginal participation in this market (0.6 %). In contrast, 84.9 % of short-term stays for long-term care establishments were associated with social welfare juridical persons, whereas 7.7 % belonged to profit-making corporations and 3.5 % to the local government. Additionally, 68.7 % of long-term care for residents of Specified Facilities is related to profit-making corporations, 26.1 % to social welfare juridical persons; the local government does not participate in this market (The Survey of Institutions and Establishments for Long-term Care 2008). However, some publicly owned corporations had a large market share. However, these have been increasingly criticised after various fraud and abuse scandals (Tatara and Okamoto 2009). It was pointed out that the quality of services was not properly secured and ex-post regulation was not functioning effectively.

### ***2.2.7 LTCI Reform 2005 (April 2006–April 2012)***

Concerns about rising costs and anticipated increases in contribution levels predominated by the third year after establishment of the LTCI system. As more people became aware of their entitlement, the number of certified users of LTCI has increased rapidly, and the demand for LTCI services has experienced a remarkable expansion. Because of this, LTCI expenditure is increasing dramatically—this is threatening the financial sustainability of the system (Overview of

the Revision of the Long-Term Care Insurance System 2007; Fukuda et al. 2008). This concern was despite the fact that a majority of people entitled to community-based services did not take their full entitlement; *i.e.* beneficiaries were using less than half the maximum amount of community-based service for which were eligible, possibly because of the disincentive effect of the standard 10 % co-payment and/or cultural legacies of preferring family-based care. However, this under-utilisation is not expected to continue, with beneficiaries expected to use up to 80 % of their entitlements by 2010 (Hiraoka 2006).

The basic purpose of the revision of the 2005 LTCI system was financial sustainability. The total LTC expenditure grew at a 5 % annual rate during 2007–2011 (Overview Financial Status of Long-Term Care Insurance System 2011). It is estimated that if demand continues to rise, LTC expenditures will be ¥19 trillion by 2025 (Health Insurance 2008). The big challenge of this revision was to make the system more prevention-oriented, and so create a system in which the elderly lead healthy and active lives for as long as they can. At the same time, the system needed to be cope with new challenges such as the effect of baby-boomer waves, the increasing number of elderly living alone or with dementia, and the rapid population aging in large cities (Murakawa and Yasumura 2011).

The system was reviewed and revised in 2005 to cope with these problems according to the regulation enacted in the 2000 LTCI Act. The Law to Partial Amendment to the Long-term Care Insurance Law, etc. (Law No. 77, 2005) incorporating the means for solving these problems, was approved in June 2005. The main goals of this reform were to curb LTCI total expenditures and benefit costs and to guarantee its sustainability (Health Insurance 2008). The amended Act concentrated on revising facility benefits, with a shift to a system emphasising preventive measures, establishment of new service programs, upgrading service quality and reviewing the financial burden and system management (Overview of the Revision of the Long-Term Care Insurance System 2007).

The proportion of residential care users in the long-term care insurance system was approximately 25 % during the first 5 years of the LTCI system, but the cost of financing such care exceeded 50 %. A review of facility benefits was implemented to balance the burden of the users for homecare and residential care, as well as to adjust the long-term care benefits and pension provision from October 2005 (Murakawa and Yasumura 2011). For those living at long-term care facilities, meals and accommodation fees were removed from insurance benefits, and charged under the contract with the facility on top of the 10 % co-payment leading to an increase in out-of-pocket expenses for residents (Morikawa et al. 2007; Overview Financial Status of Long-Term Care Insurance System 2011; Overview of the Revision of the Long-Term Care Insurance System 2007). The new out-of-pocket charges for “hotel” costs were income-related, with the poorest paying no increase and extra costs paid by the LTCI system as a supplementary benefit. This varied according to the level of facility (particularly single versus multi-bedded

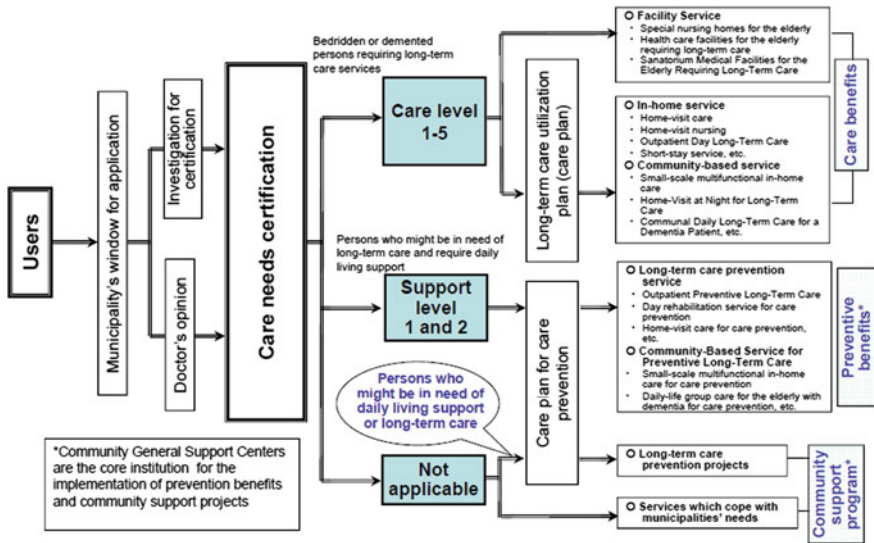


rooms). This measure implied a 4 % reduction in fees for the facility sector and a total reduction in financial burden of 2.4 % for the entire LTCI system (Health Insurance 2008).

The remaining measures were implemented after April 2006. Preventive benefits before the revision were reorganised into New Preventive Benefits (NPB) by re-examining the scope of eligibility of the lowest levels of care, the content of services and care management with the aim of providing services to help people improve and maintain skills for independent living (Overview of the Revision of the Long-Term Care Insurance System 2007; Ito 2005). The NPB program is focused on recognising the importance of disuse syndrome as an important cause of functioning decline in the older population (Okawa and Nakamura 2009). This program states that disuse syndrome can be prevented or improved by actively promoting the use of day-care and limiting home-help services to only tasks that are difficult to perform independently (Fukawa 2007).

In the NPB scheme, Local Comprehensive Care Centres evaluate the needs of persons certified for the two lowest need levels pre-2005 reform (Support Level and Care Level 1) and to recertify them to NPB, which includes “Support level 1” (SL1) and “Support level 2” (SL2) categories. Benefits for these persons were restricted and replaced by preventive health promotion interventions, mainly diet and exercise programmes delivered in day centres (Tsutsui and Muramatsu 2007; Overview of the Revision of the Long-Term Care Insurance System 2007; Murakawa and Yasumura 2011). Those certified in the new categories could use only community care or preventive services to support them while maintaining their present physical condition for as long as possible (Overview of the Revision of the Long-Term Care Insurance System 2007) (see, Fig. 2.4) The recertification process associated with the NPB also had an economic effect on benefit entitlement. The upper limit of the benefits for the “new support categories” was set much lower than the previous LTC insurance scheme (Long-Term Care Insurance in Japan 2002). In contrast, the three principal services—home-help services, day service and outpatient rehabilitation services—had new monthly fixed fees (Tsutsui and Muramatsu 2007). Some authors consider this reform feature as a major change TO the LTCI system (Tsutsui and Muramatsu 2007; Morikawa et al. 2007). Indeed, the NPB program underlies a restriction of the provision of instrumental activities OF daily living (IADL) support services, particularly “home-help services”, which will be provided SO long as the home-helpers do not perform all of the tasks.

The fourth phase of the LTCI plan (2009–2011), introduced community-based services, including such initiatives as small-scale multi-functional care, night-time home-visit care service, group homes that are able to care for dementia patients, and specially designated small-scale nursing homes for the elderly to continue their life in a community with which they are familiar. Group homes for the elderly with dementia have been established rapidly, and 9,800 facilities were operating as of December 2008. They are playing an effective role as a social resource supporting the elderly with dementia and their families and have been highly praised by several fronts. The quantity of group homes is being fulfilled except for a few areas, so the



**Fig. 2.4** Procedure for the use of long-term care services after revision of the law in 2005.  
*Source* Health and Welfare Bureau for the Elderly; MHLW

improvement of quality, as well as diversification of the management configuration, is the current challenge (Murakawa and Yasumura 2011).

Under the 2005 revised LTCI Law, the government introduced a system for renewing care manager qualifications and the eligibility of organisations as a government-designated entity to ensure and improve the quality of welfare services (Measures for Aging Society by Field 2006). The role of care managers was strengthened. They are expected to serve as neutral agents representing client's interests rather than as provider "sales agents" (Tatara and Okamoto 2009). The government has also set a goal of reducing long-term hospital beds to 210,000 in 2011, and no long-term hospitals beds will be financed by LTCI after FY 2012 (Someya and Wells 2008). Another financial measure was coordination between the LTCI benefit and pension benefit, particularly for institutionalised elderly because continuing to pay a full pension to institutionalised elderly is a duplicate benefit (Someya and Wells 2008).

## Appendix A. Questionnaire in the Initial LTCI Needs Assessment

Dimensions (n)	Items
<b>A. Physical and Psychological Status (7 Dimensions)*</b>	
1. Paralysis and limitation of joint movement (11)	Presence of paralysis or limitations of joint movement in various parts of the body.
2. Movement and Balance	Ability to turn over in bed, maintain a sitting position with feet on floor, sit without feet on floor, stand on both feet, walk, and transfer.
3. Complex movement	Ability to stand up from sitting position, maintain a standing position on one foot, get in and out of bath tub, bathe.
4. Conditions requiring special assistance (9)	Presence of bed sore, other skin disease. Ability to swallow, lift one arm to chest, swallow, feel voiding movement, feel bowel movement, manage after voiding, manage after defecation, eat.
5. Conditions requiring assistance with activities of daily living/instrumental activities of day living (13)	Independence/partial assistance/full assistance in personal hygiene (oral hygiene, washing face, hair dressing, nail trimming), dressing (buttoning; putting on and taking off a jacket, pants, socks), cleaning rooms, taking medication, financial management Experience of serious failing memory and indifference to circumstances
6. Communication and cognition (10)	Vision; hearing; communicating will; responding to instructions; understanding daily schedule; short memory; remembering own name, date of birth, the season, and the place.
7. Behavioral problems (19)	Frequency of feeling persecuted, making up stories, visual/auditory hallucination, emotional instability, reversal of day and night, verbal/physical violence, repeating same story, shouting, resisting advice or care, wandering, restlessness, being lost, observation needs, collecting items in appropriately, inability to manage fire, destruction of things/clothes, unsanitary behavior, eating in edible things, troublesome sexual behavior.
<b>B. Use of medical procedures</b>	
Use of medical procedures during the previous 14 days (12)	Management of intravenous infusion, intravenous hyperalimentation, dialysis, care of ostomy, oxygen therapy, artificial ventilator, care for tracheostomy pain care, tube feeding, monitoring (blood pressure, heart rate, oxygen saturation, etc.), decubitus care, incontinence care (condom catheter, indwelling catheter, etc.)

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2014, IX, 138 p. 15 illus., Softcover

ISBN: 978-94-007-7874-0