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Long-term care insurance in Japan: expanding services, increasing costs and developing new forms of institutional care

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Context

Japan implemented public long-term care insurance (LTCI) in 2000. LTC services became an entitlement for all people 65 years and over, and for those 40-64 years with a disability that resulted from an age-related disease. The number of eligible people and expenditures have tripled between 2000 and 2020. Fifteen percent of the population 65 years and over receive services.

LTC became an entitlement for all people 65 years and over.

LTCI unified LTC services in the health and social welfare sectors. In 1973, with free health care for people 70 years and over, some hospitals became de facto nursing homes. The health insurance fee schedule was not appropriate for delivering LTC services and initially led to the excessive use of drip infusion and laboratory tests. Later, when a flat per diem payment was introduced, hospitals admitted light care patients. In social services, access was limited by the rigid administration of the local government's welfare office and the targeting of services to those with low income.

LTCI introduced a new way of accessing and providing services. There are no cash benefits. As in health insurance, services are delivered by fee-for-service with the fee schedule set by the Minister of Health, Labour and Welfare following the deliberations of the LTCI Benefits Sub-committee of the Social Security Council. Benefit levels are determined through eligibility criteria with seven levels. In community care, benefits range from US$ 500 to US$ 3500. Beneficiaries choose a certified care manager agency who draws a care plan based on the clients' needs and wishes, and subsequently providers are contracted. In institutional care, the amount is set to cover all service costs with the exception of hotel costs. There is a 10% coinsurance fee; the exception is 10% of older persons who pay 20% to 30% because their incomes are higher than the average worker.

Institutional care is broadly divided into three categories.

Institutional care is broadly divided into three categories. Only facilities in the first category are officially designated as "institutions" (including hospitals specializing in LTC, health facilities for elders (HFE) delivering intermediate care, and special homes for elders (SHE) that were established as welfare institutions). The fees and the level of health care staffing differ for each. In hospitals, physicians and qualified nurses are available 24/7. In the HFE, they are available only on weekday working hours, and in the SHE, they are unavailable on workdays. These differences are reflected in their fees. However, there are no mechanisms to triage admissions among these three types. The hotel costs were initially all covered by LTCI except for food. Although the coverage for hotel costs became more restrictive in 2005, residents with low income do not have to apply for public assistance. This is why the first type, especially the SHE, is popular, and has led to long waiting lists. The number of those waiting exceeds the number of those residing in the SHE.

The second category includes "older people's homes with fees that have care services", and some facilities that are categorized as "services that are closely linked to the community" such as the "small-size nursing homes" and facilities that combine night care and day care. In government statistics, they are not classified as institutions, but they deliver de facto institutional care. The number of their beds has increased close to the level of the first type. The second category differs from the first in relatively higher staffing levels and room sizes. Unlike the first category, their higher charges are in principle not reduced or waived for those with low income.

The third category is "housing with services", which is only required to have a barrier-free environment and to provide "consulting" on the services that residents could contract. However, about half have home care service agencies that are located in the same or adjacent building, and/or have strong links, so that their residents (and families) regard them as institutional care. The third category has had the highest growth rate and now comprises about 10% of those in institutional care.

In government statistics, only the first is categorized as "institutional care". However, the above definitions facilitate comparisons across countries. The growth in new types of facilities indicate that, although the official goal may be "aging in place", decreasing the care burden would be the priority from the family's perspective.

Key findings

- LTCI services have expanded so that people in Japan have come to regard them as an integral part of their lives.
- The proportion of the population covered by LTCI has increased to 15% of the population 65 years and over.
- LTCI expenditures have tripled from 3.7 trillion yen (US$ 34 billion) in 2000 to 12 trillion yen (US$ 110 billion) in 2020. The growth rate has been about double the rate of health expenditures.
- The division of services into community care and institutional care has become blurred.

Lessons for other settings

- **Ensuring sustainability**. The share of people 65 years and over is steadily growing in Japan and was already 29% in 2020. It is projected to be 37% by 2050. Furthermore, the proportion of those 75 and over will increase with the ageing of the baby-boom generation. The sustainability of LTCI funding should be carefully considered in its design.
- **Setting the eligibility criteria and regulating the fee schedule are key elements that should be monitored and evaluated.** The eligibility criteria control access to services. The LTCI fee schedule controls the way services are delivered. The two control the flow of money in the LTC system.
- **Providing information so that informed choices can be made.** In community care, LTC services and out-of-pocket payment (usually a 10% co-payment) are usually easier for users to evaluate than in health care. In institutional care, hotel costs compose a greater proportion.
- **Monitoring equity.** The eligibility criteria must be transparently applied and monitored so that all those having the same level of need will be entitled to the same amount of benefits.

The WKC and the OECD have produced a report summarizing key findings from nine country case studies on *"Pricing long-term care for older persons"*. The cases represent a range of health care systems and experiences in organizing and financing long-term care (LTC) for older persons. The report identifies best practices and policy lessons, which demonstrate the benefits of investing in quality LTC in the context of ageing populations. The summary report and case studies can be found here: https://extranet.who.int/kobe_centre/en/project-details/pricesetting2