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＜ Review ＞

The Current State and Future Development of the Long-term Care Insurance System in Japan

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Abstract

The Long-term Care Insurance System (LTCIS), a societal system of mutual assistance for elderly care, was established in Japan in 2000 in response to the increasing number of elderly requiring care. In this system, each municipality acts as an insurer and calculates long-term care insurance premiums by investigating the number of elderly requiring care and the total cost of service. However, as the number of service users increases and that the number of younger insured decreases, the financial burden on municipalities and citizens, particularly on the younger generation, has increased dramatically. Therefore, the system is currently being reformed in terms of optimization of benefits, certification, and care management; the improvement of long-term care quality; and the promotion of prevention measures to secur stable revenue sources. On the other hand, problems such as changes in the beliefs of insurers (i.e., local governments), service providers, and care managers, combined with a decline in service quality from providers and care managers, have complicated the matter. A fundamental reform is required, and concrete reform measures for the improvement of integrated community care and its service supply are being considered. This paper an overview of a Government-sponsored report on the community-based integrated care system in Japan. The future outcome of the LTCIS will also be discussed in this paper, leading hopefully to an interesting insight for other Asian nations facing similar challenges concerning long-term care for the elderly.

Keywords : long-term care insurance; care needs certification; community-based integrated care system

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Ⅰ. Introduction

As the population ages, the number of elderly requiring care has increased and the overall period of care has been prolonged. In Japan, long-term care needs will only continue to grow. A change in family structure has promoted the establishment of the Long-Term Care Insurance System (LTCIS). Family members used to provide care, but the increasing number of nuclear families has necessitated the use of outside caregivers [1)-3)]. Before the introduction of the LTCIS, all public services were provided by agencies or charitable organizations designated by the government, and individuals had limited choices, if any, between providers. Many recipients also felt a “stigma” attached to these services, because their use implies poverty of the absence of family members able to act as carers.

The LTCIS was introduced to overcome such problems and is characterized by the following three points. First, it aims not only to provide personal care to the elderly, but also to support their independent living through the provision of appropriate home-based nursing services and household assistance. Second, it is a user-oriented system, where users can choose their care services directly from many providers. Third, it employs a social insurance system in which the balance of benefits and expenses are made clear.

Ten years have passed since this system was founded, and there are still a number of problems to be resolved. For example, each municipality acts as an insurer who calculates long-term care insurance premiums by investigating the number of elderly requiring care and the total cost of service. However, as the number of service users increases and the number of younger insured citizens decreases, the financial burden on municipalities and citizens, particularly on the younger generation, increases dramatically.

Therefore, to meet the growing care needs and maintain the care-supply system in the community, it is important

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to secure stable funding sources. Also, for efficiency and fairness to the municipalities (i.e., the insurers), as well as to the citizens, it is necessary to realize the appropriate administration of the Long-Term Insurance Project Plan, Long-Term Care Benefits, Care Needs Certification, and Care Management. In addition, a central concept of the system is the citizens' responsibility to follow preventive services for the elderly in the Community Project for Long-Term Care and preventive care benefits in the LTCIS, which differs from the health care policy in Britain, where the use of public consciousness about self-care is maximized[4].

The government has not reached a national consensus on preventive services yet, which has resulted in alimiteduse use of them [5,6]. Additionally, preventive care benefits in LTCIS are provided to the elderly who have been certified to be in Support Levels. However, these preventive care benefits, different from care benefits (designed for the elderly in Care Need Levels), are to be actively undertaken by the elderly so that they can change their life patterns and prevent their physical conditions from deteriorating. Thus, the preventive care benefits require the elderly to change their behavioral patterns by, implementing, for example muscle training and by eating balanced meals. On the other hand, with care benefits such as home-based nursing services, service users are passive and no positive involvement is required. Thus, there is a clear difference between receiving preventive care benefits and care benefits. Unfortunately, the elderly who wish to use LTCI does not necessarily agree with the concept of an autonomic decision in order to improve life patterns. Therefore, they usually prefer care benefits to preventive care benefits. In the beginning, Japanese government aimed at promoting the kind of self-care that can be found in British health policies; however, such an orientation has not necessarily been accepted by the public.

Despite the great amount of fund injection, the system has failed to yield results, and this seems to reflect citizens' lack of awareness. The government is currently promoting a project to rationalize Care Needs Certification[5], but this program has not achieved adequate results because the willingness of insurers to participate in such programs is not homogeneous. Care Needs Certification has been designated as an administrative requirement of local governments[9]. However, the quality of the certification varies substantially according to the locality. For example, the incidence rate of Leg Paralysis, one of the Care Needs Certification items, is 90% in one city versus 20% in another[9].

In the interest of fairness, the government has reconsidered the certification items, has attempted to clarify the process of decision-making involved in the Care Needs Certification system, and has promoted a series of new texts about Care Needs Certification in 2009. However, service users and care managers still do not completely understand the Care Need Certification system or the items considered during the certification process. Poor communication from the government, whose duties have been extended to include the national elderly care insurance, combined with political pressures toward the government in charge at the time, have led to a revision of the new texts in favor of the old ones[10]. The incompatibility between the new Result Certificates issued from April to September 2009, and the measures concerning the validation process of the certificate that was implemented one year before, has created a potentially catastrophic situation.

The LTCIS is an insurance that covers the risk of needing long-term care, and therefore it provides services especially to the elderly requiring care. The provision of long-term care services through insurance benefits is an attempt to reduce the burden on families who used to provide all the care to the elderly. However, some research have indicated that the use of such services doesn't reduce the burden on the family [11),12)] and that the impact on the family was really different according to the type of services used by the elderly [13)-16)].

The main expectation for this system is the possibility to enable -through the global assessment of the users physical and mental condition, as well as the evaluation of the family care resources and the living environment- the implementation of a care management program that allows the user to be more independent. However, it seems that some difficulties remain regarding the monitoring of the system and the satisfaction of the users' family [17]. Also, there is a problem in Japan regarding the care managers' lack of competence and some problems of objectivity towards the system [18),19)]. Between 2000 and 2005, 328 providers abuse the system by submitting false reimbursement receipts, which represented a loss of 5.5 billion Yen[20].

Although this situation was problematic for the National Diet, it was advantageous to the Democratic Party of Japan. From the Democratic Party of Japan's point of view, increasing the awareness regarding fairness issues may potentially result in a loss of support for their party. Hence, the new Democratic Party-led government of Japan started cash-based allocation reforms including an increase in April 2010 of the 'child allocation' [21], even though financing prospects are still uncertain in terms of financing [22]. The self-centered doctrine of the pursuit of one's own happiness without any consideration for others is called me-ism. It seems that many users of the LTCIS are followers of this me-ism doctrine. Indeed, The elderly and their families who ask care managers to provide them with a higher level of care need than they require, receiving better benefits, and care managers who falsify results in response to their

requests, are becoming too common.

In Japan, the government intended to provide a fairer Care Needs Certification system and certification items, but critics of the system were not silenced. The main explanation is that the newly elected Democratic party of Japan showed an ochlocratic attitude toward this me-ism and made what some may consider a poor judgment regarding the insurance system. Japan was the first country computerize the primary decision on Care Needs Certification to a computer (System of Primary Decision) [3]. This was supposed to result in a political closure that would earn everyone's approval, particularly by making citizens understand, for the first time, the scientific basis underpinning the decisions. The system of primary decision-making gathers data directly from the field. By placing this information into a logical structure, Japan built an unprecedented evidence-based care system[23].

Event though this system is highly considered worldwide, the Japanese citizens' understanding of the system is still remarkably poor[24]. Moreover, irrespective of how reasonable the system is, if the data, which are thought to provide a direct window into the health conditions of the elderly, are distorted from the start by the me-ism of care managers, who are the investigators for the Care Needs Certification (commissioned by the local government), it is not surprising that fair results cannot be obtained. For the proper functioning of this system, citizens should possess a strong sense of ethics and realize the importance of obtaining fair results. This sense of ethics is precisely what we are aiming for. The LTCIS, which was founded on this philosophy, has earned the citizens' recognition and provides more universal services. However, after 10 years, a new issue has arisen: the necessity to make people understand the implications of establishing a long-term care insurance system as a social insurance. The goal here is a drastic transformation of the citizens' understanding of the long-term care insurance and the social security system. This drastic transformation was promoted from 2006 following revisions of the long-term care insurance system in a new report on community-based integrated care. This report notably predicted the outcomes of the LTCIS in 2025. The report also contained many suggestions, such as establishing a grant for research in the field of community-based integrated care, which have been accepted by the Ministry of Health, Labour and Welfare. A set of concrete measures regarding the current state of community-based integrated care and the services provided by this system are detailed in this report and are currently under consideration. The content of this report will now be presented, reviewed, and observations on the future of the LTCIS will be drawn.

Ⅱ. The current situation of the LTCIS in Japan and predictions for 2025

In this section, the current situation in Japan in terms of population demographics, and the changes anticipated by 2025 will be discussed. The second topic will concern the possible implications of the current and future sustainability of the LTCIS.

A sharp increase in elderly individuals needing care

Approximately 4,847,000 people have Care Needs Certificates (or have a support level), which is about twice as high as it was at the time of the introduction of the system (2,180,000 individuals)[25),26)]. This increase is particularly significant for elderly with a low Care Need (support level and Care Need level 1). In other countries, individuals with these lower levels of care needs are not qualified to receive benefits, but in Japan they are covered by the long-term care benefit system. This huge population of low-level care recipients is becoming a threat to the long-term sustainability of the LTCIS.

In 2025, the elderly population over the age of 65 years is predicted to exceed 36,000,000 individuals (30 % of the entire population). This is also the year in which the majority of the postwar generation of baby-boomers will reach the age of 75 years or older (The National Institute of Population and Social Security in Japan Research 2009). The increase in the number of elderly obviously means an increase in the number of individuals with Care Needs Certificates. Indeed, 4.7 % of the population aged 65－74 years have received Care Needs Certificates, a rate that doubles to almost 29.0 % among those aged over 75 years (see Figure 1) [27].

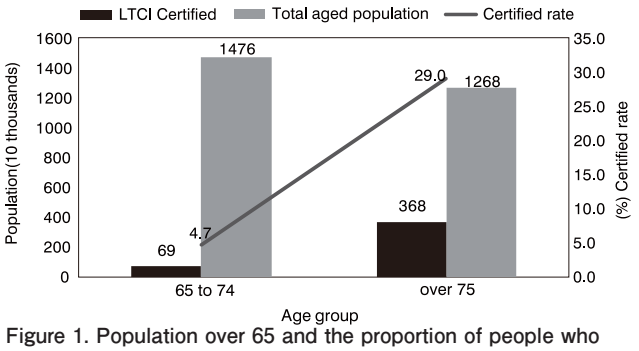


Figure 1. Population over 65 and the proportion of people who received Care Needs Certificates27).

Correction of intra-regional disparity

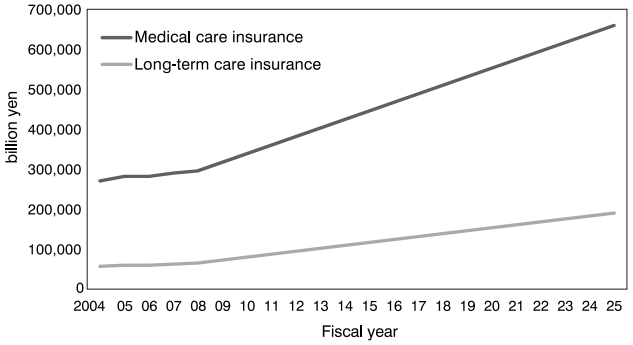
According to the Estimation of the Population's Evolution in Municipalities published by the National Institute of Population and Social Security in Japan Research (2009) regarding the evolution between 2005 and 2025 of the population over 75 years old, the following statements are true: in 6.4 % of the municipalities, this population

will decrease; in 46.8 per cent of the municipalities, it will increase by 1–1.5 times. Moreover, regarding the more urban regions, in 12.1 % of these municipalities this population will increase by 2.5 times; in 6 % of them, this population will increase by 2.5 to 3 times; in 2.5 % of the municipalities, this population will more than triple[27].

In 2025, even though the total population will mostly remain unchanged, the facts that the population over 75 years old will increase considerably within urban regions, that this population will eventually decrease in some municipalities, and that in all of the other places between these two extremes, the aging of the population will evolve at a different pace, can only lead to an era in which policies and measures are not national but are adapted to the diversity of each municipality. In other words, maintaining the stability of the LTCI system (which has already become an insurance system adapted at the local community level) at a uniform and national level would be very difficult.

The need for service assessment

According to the estimation of the national assembly on social security, depending on whether the benefit amount is revised or maintained in its current state, long term care will require between 19 and 24 trillion yen in 2025 (presently 7 trillion yen are required)[28], while the total medical care expenditures are predicted to increase to 66 trillion yen (see Figure 2).



Data between 2004 and 2008 were obtained from Japan National Institute of Population and Social Security33). Estimates for 2025 are derived from the Japan Cabinet Secretariat28).

Figure 2. Predicted changes in social security benefits, including medical care and long-term care insurance in Japan between 2004 and 2025.

If we intend to maintain long-term care expenses at a constant level, reducing the amount of the benefit is a necessity; however, as stated above, the government's attempt to create a more fair system has failed because of the practitioners' associations: most of their clients being in a low level of care need, any decrease in the benefit amount would mean a considerable loss of profit. Making these associations recognize the necessity of lowering the amount of the benefit seems difficult.

Even though the concept of an insurance system that covers the needs and expectations of everyone is largely promoted during the establishment of any system based on social solidarity (such as social insurance), it is not feasible, even theoretically. Thus, it seems necessary to examine carefully the efficiency and contents of the long-term care services. The only solution is to establish a system that does not cover services of poor quality. The government has tried to suppress services of poor quality by creating a quasi-market for long-term care services. However, the actual situation has led to the need to check and monitor the market in order to detect problems such as false claims for reimbursement using the long-term care insurance and to assess the quality of services.

Ⅲ. The current state of the new Japanese care system

Community-based integrated care system

Even with market supervision and the non-reimbursement of poor quality services, the increasing long-term care expenses are still very high. To foster understanding among the population and make them behave more responsibly, it was necessary to build a system that answers the needs of the service users and that treats every individual with dignity. The system that arose from these ideas was the Community-based Integrated Care System, established 5 years ago[5].

The goal of this system is to allow a person who needs long-term care to stay at home as long as possible, and to provide an environment that allows such individuals to preserve their own lifestyle for as long as possible. This system was built for the safety of the citizens, to provide individualized and appropriate services (i.e., medical and social care) inside a community and to allow the provision of these services in any circumstances within approximately 30 minutes. Of course, in order to build such a system, drastic reforms of the services, human resources, remuneration of long-term care, and the LTCIS are necessary, but the greatest reform concerns the transformation of the citizens' perception of life at old age[29].

Creating and administering the new system

The state promoted a system in which the social solidarity transcends generations, is focused on coordination within the medical system, and which is aimed at the development of a continually administrated LTCIS[19]. However, the state is now supporting and rebuilding the system of mutual care, such as volunteer activities and services between residents

of the same area, which has always existed in Japan. This does not mean that the design of the system is based on an unrealistic and nostalgic vision where neighbors help each other, but it is rather the result of citizens no longer being able to be the main caregivers to an increasing elderly population. From one point of view, we might say that choosing this system was an agonizing decision.

Before establishing the LTCIS, the neglect of elderly individuals was an important social issue. Therefore, only 10 years ago, Japan started a publicity campaign for the implementation of the LTCIS entitled, 'From care by family to care by society.' Promoting a system of integrated community care based on self-care and social solidarity care just a few years after this campaign was a political move which, although it may appear to be similar to the German approach, actually has a very different foundation: Germany chose from the beginning to establish a public insurance system that would not replace, but complete, the old system of care provided by the family. In this system, the care-recipient can choose to receive care from a health provider, or from their family. Even if family care is chosen, they still receive an allowance. In contrast, in Japan, there is no allowance for the family carer because social insurance is only available for care provided by a care provider, and not for care provided by a family member[2]. In terms of financing, the German model is funded entirely by insurance premiums, whereas in the Japanese model, half of the financing is derived from taxes at the national, prefectural and municipal level (accounting respectively for 50%, 25% and 25% of the tax funding).

In a Japanese society that could no longer afford to cover all the long-term costs of care, relying upon family care again did not offer much choice. To achieve this major overhaul toward an insurance system in which family carers fill a crucial position, Japan would have to implement generously the kind of measures that can be found in Germany to support family carers: provide nursing allowances, secure a possible rotation of nurses, pay the pensions of family carers, and provide advice and opportunities for learning and consulting.

However, winning the population's approval for this major overhaul will likely be a difficult task. It is interesting to consider the situation in the United States, which became a reference for these reforms in all kinds of fields. The self-care system provides a basis for nursing and medical care. For this reason, in some states, the long-term care services available to the public actually exceeded the demand.

On the other hand, the population of Japan probably does not want a strong but expensive welfare state such as those in the Nordic countries. Neither would they agree to implement a system that is based on family carers, as used in Germany. It is also likely that they would refuse a system based on self-care as is found in the United States. This may explain why Japan would prefer a restructured social solidarity care system.

Ⅳ. Prelude to the reform of the LTCIS

Elements and functions of the community-based integrated care system

The prelude to the drastic reforms that will break the continuity of the LTCIS started in 2006. At this time, the Chiiki Houkatsu Shien Center (Community-based Integrated Care Support Center), the cornerstone of the community-based integrated care system, was founded, and many reforms for the realization of care in the community system were implemented. These reforms opened a path that led to the actual structure of the community-based integrated care system. Until now, the Chiiki Houkatsu Shien Center has been building a support network with formal and informal care resources in order to integrate health and social services so that users receive seamless and comprehensive care. However, the amount of care resources varies greatly between municipalities. Therefore, an integrated care system, which should provide continuous and comprehensive care, and the roles of volunteers in these systems also differ. However, the approach to building such a network is still unclear from the perspective of government-backed schemes. The center was unable to deliver service that was adequate for an integrated care system. Accordingly, the government started a model project in 3 municipalities in 2009 and 57 municipalities in 2010 to evaluate new ways of building such networks. The aim of the project was to ensure that the centers understand the care and support needs required by the elderly in their region by surveying each household about factors such as composition and income, whether the citizens live alone, prevalence of diseases such as dementia, Activities of Daily Living scores, support needs, and residential amenities[30] At the policy level, the actual reform represents a drastic political change because it involves re-discovery of the individual's capacity, which hardly exists at present, to help each other inside a community (mutual care)[31].

The definition of the terms 'self-care,' 'mutual care,' 'social solidarity care,' and 'public care' mentioned in this paper can be found in 'Chiiki Houkatsu Care Kenkyukai Houkokusho (Research Report of Community-based Integrated Care in Japan)[27]. Briefly, self-care represents the idea that one can work by oneself or live by oneself on one's own retirement income, and that one can maintain good health by one's own means. Mutual care refers to the mutual care delivered by informal carers. Social solidarity care is also a kind of mutual

care, but delivered in a system similar to social insurance. Public care is the kind of care delivered to individuals in great distress, when self-care, mutual care, or social solidarity care is ineffective, and only after fulfilling several conditions regarding income, living standards and familial situations.

Broadly speaking, the United States may be considered to represent a system based on self-care. On the other hand, in France, Italy, and more recently England, self-care and mutual care are the core of the system. Germany and neighboring countries are slightly more dependent on a social solidarity care system, while countries in northern Europe use a sophisticated public care system.

Aim of the community-based integrated care system in Japan

Recently, along with the promotion of care by family members, it seems that in countries like France or England, the system of self-care and mutual care is being reviewed (self care)[32]. If we classify generally, we can say that Japan used to be close to the German model but is now, through expressions like 'support of mutual care,' aiming to replicate the model used in the Nordic countries.

From now on, we can expect numerous studies on the possibility of earning the comprehension and support of the population toward this new system, and at the same time preserving peace and safety in the community. However, without waiting for the results of these studies, the community-based integrated care support center, which is actually the core of the system, was founded in 2006. According to recent evaluations, far from reaching the goal of the government to support and re-structure the mutual care system, it appears that the new long-term care services, such as that provided by small-sized institutions and group homes specializing in dementia, are not adequately functional.

These results illustrate the difficulty in structuring a community care system in which the government (state or local) interferes publicly. The core of this system is supposed to be the spontaneous and natural activities of community residents acting on their own free will. The old system of mutual help that used to exist in the community has been replaced by a social solidarity care system based on social insurance. The actual attempts to reverse the process through an interference of the state does not seem very appropriate, and certainly does not match the original concept of natural and spontaneous mutual care.

After accomplishing an unprecedented nationwide project with the implementation of a long-term care insurance system, it is important to consider whether the next core of the system will be "self-care", "mutual care", " social solidarity care" or "public care"[31]. This decision will be of high consequence for all countries.

Ⅴ. Conclusion

This paper summarized the current state and future development of different parts of the LTCIS. Japan is actually confronted to financial issues of public funding because the LTCIS is becoming an integrated care system where needs for care (in quality and quantity) are gradually increasing. Japan is aiming at community-based care that includes the fields of medical care, public health, and welfare; however, in order to succeed, it is necessary to consider training human resources to be flexible to the variety of care needs and to adapt to the structural transformations of services. Japan and other Asian countries that are also influenced by Confucianism probably have common issues when they face the problem of an aging population. The studies that are being conducted in Japan regarding the implementation of political measures, as well as the structural transformation of human resources in the field of long-term care, are very useful for Japan itself, and may be a valuable experience for other Asian countries.

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日本では，高齢者の介護を社会全体で支え合う仕組みとして，2000 年に「介護保険制度」が創設された．この制度では，介護保険料は，保険者である市区町村が地域内での介護を必要とする高齢者の数や介護サービスの利用料から算出することとされてきた．

しかし，昨今は，サービス利用者の増加や少子化に伴う若年の被保険者の減少によって市区町村，住民，若年層の負担が激しいことから，この制度の安定的な運営と財源の確保が課題となっている．このため，日本では「給付，認定，ケアマネジメントの適正化」や,「介護サービスの質の向上」,「介護予防施策の推進」といった視点からの制度改革が実施されているが，被保険者ならびにサービス供給事業者，ケアマネジャーの質やモラル低下の問題，サービス供給体制上の連携の問題等が発生しており，改革は難航している．

これらの問題の抜本的な解決を図るため，政府は，これからの日本が目指すべき地域包括ケアシステムと，これを支えるサービス等の在り方を記した報告書を発表した．

本稿では，この報告書を概観しながら，日本の介護保険制度の現状とこれらからの展望について考察した．なお，この内容は，高齢者の介護という，同様の課題に直面しつつある，他のアジア諸国にとっても有益な内容となるものと考える．

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