

# Comprehensive Long-Term Care: Affordable, Doable, Controllable (The Japan Case)

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Aging Asia: Economic and Social  
Implications of Rapid Demographic  
Change in China, Japan, and Korea

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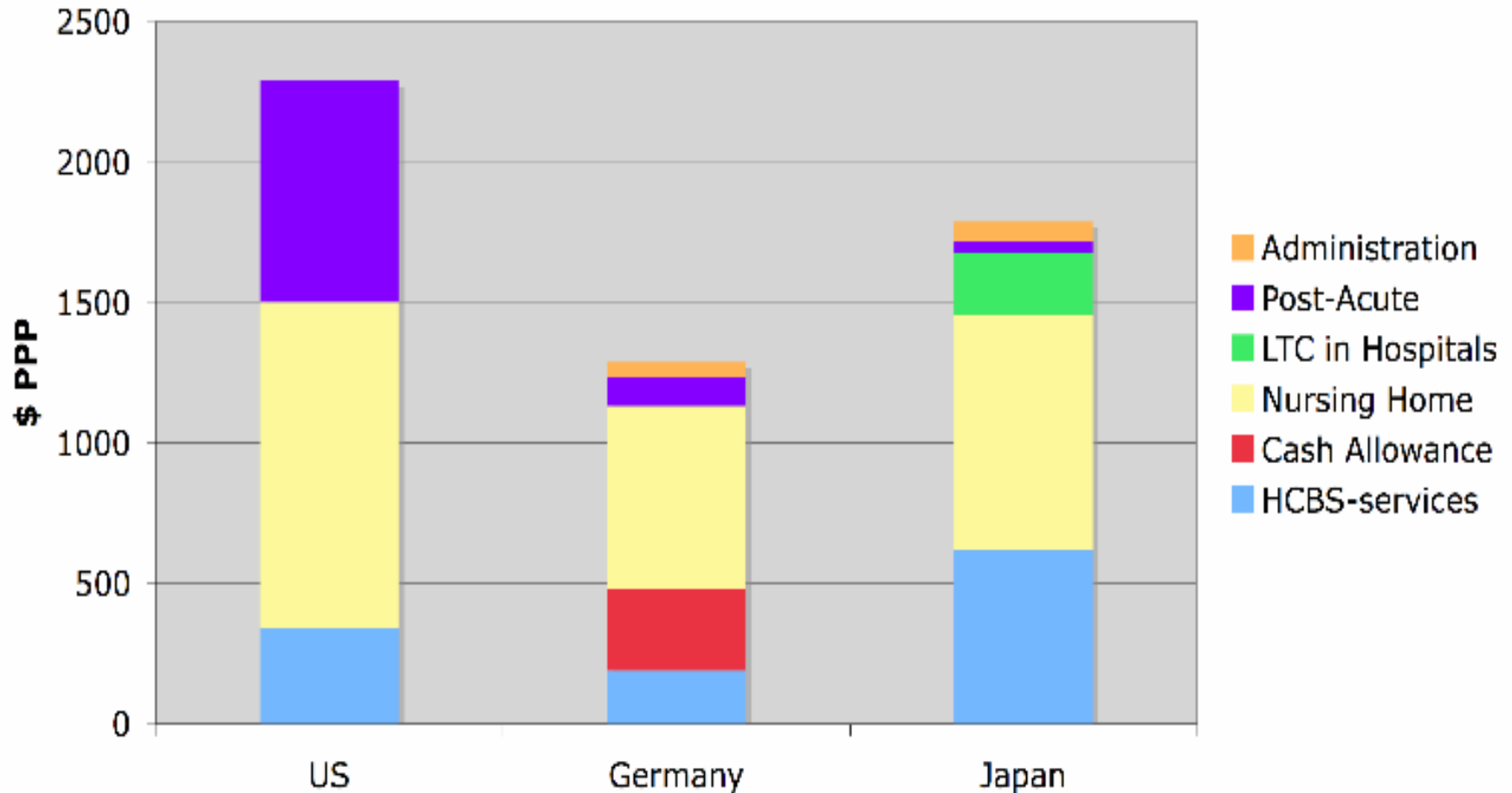
# Our Argument

- Comprehensive Long-Term Care is
- Affordable
- Doable
- Controllable
- The first point is “affordable,” via an accounting comparison
- Then the other two, via an account of the Japanese experience

# Our Interpretation

- Germany and Japan have comprehensive public long-term care systems, based on mandatory social insurance, covering everyone who needs care
- LTC in the US has much private finance; it is fragmented and inadequate
- Yet the American government spends way more than Germany, and either a bit more or a bit less than Japan depending on definitions

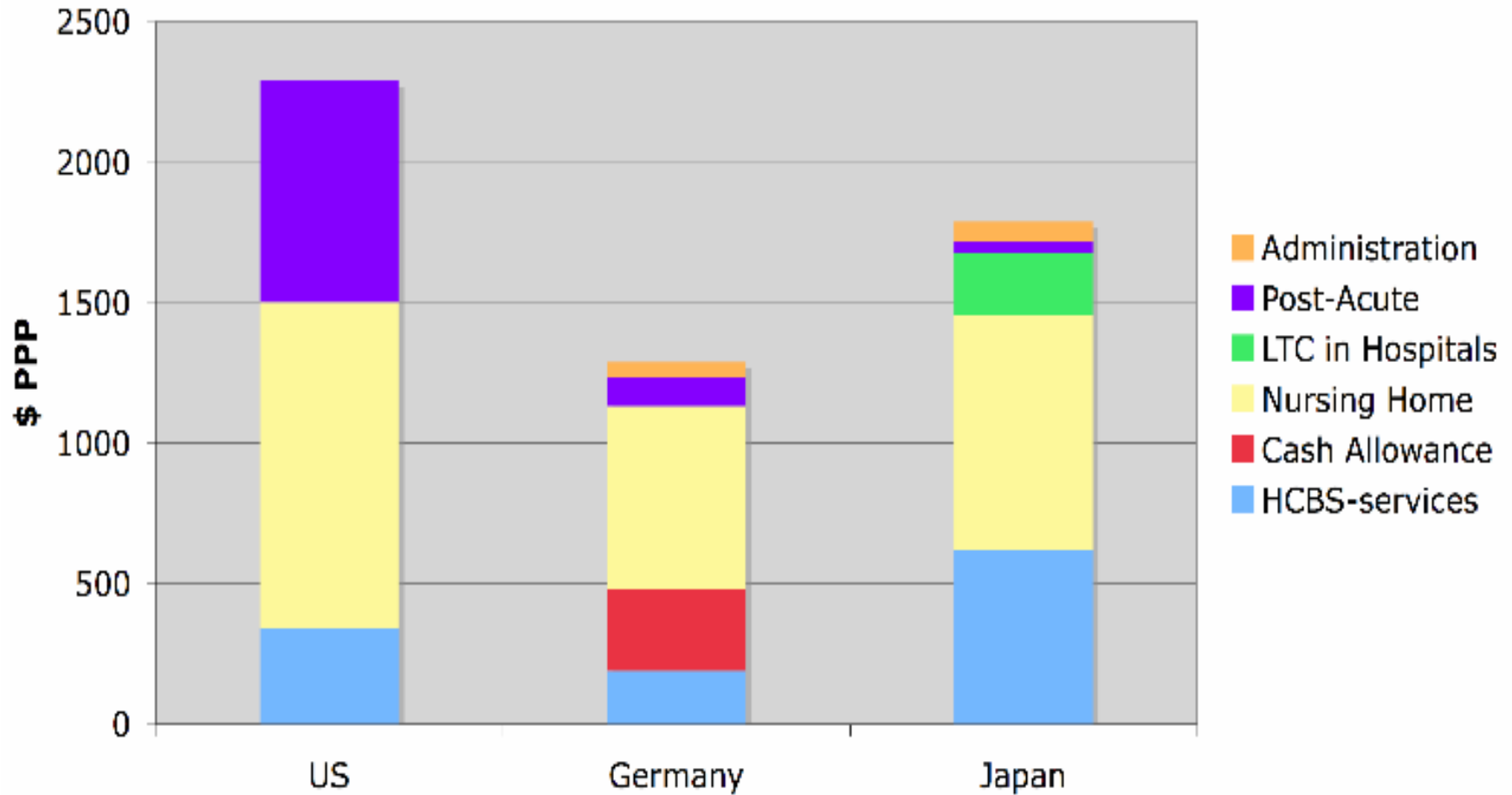
## Public Spending on LTC per 65+ Person in 2005 By Function



# US-Japan-Germany Compared

- This project is by Naoki Ikegami, Mary Jo Gibson of AARP, and me
- It is different from others' comparisons
  - Public spending only, not total
  - On older people only, not younger disabled
  - Metric is \$PPP/65+ person, not %GDP
  - We compare services, not budget categories
  - When precise data are lacking we estimate, not ignore

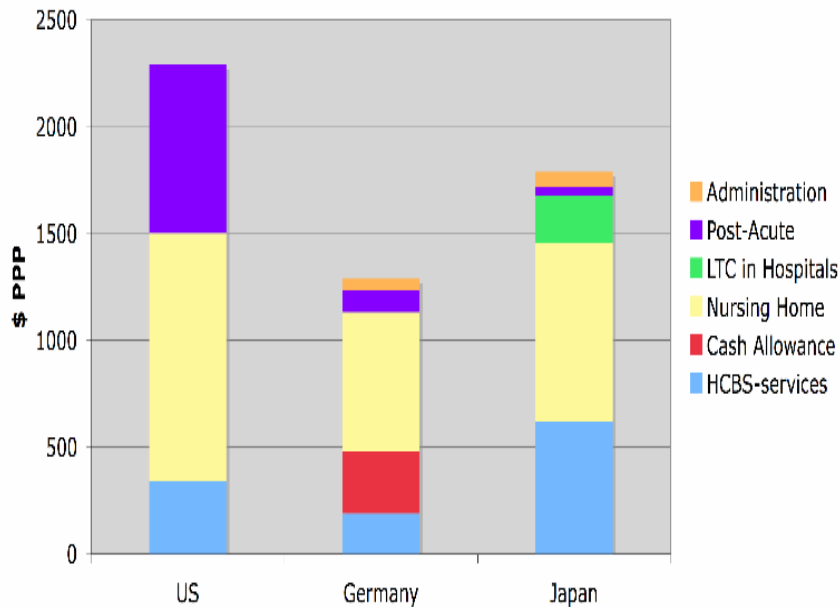
## Public Spending on LTC per 65+ Person in 2005 By Function



# Look at the United States

- This is public money only, 65+ only
- Bottom two are Medicaid, VA, bit of AOA
- Top is Medicare post-acute, much of which would count in LTC elsewhere

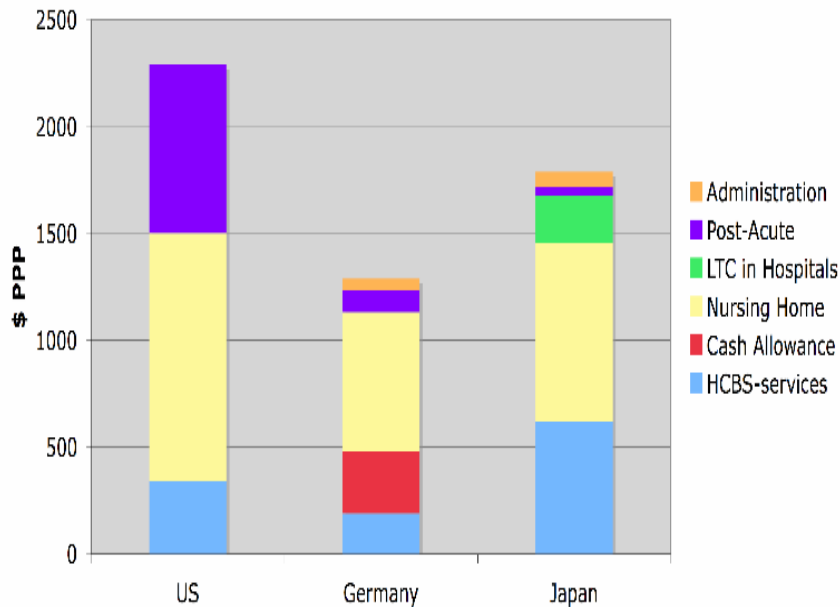
Public Spending on LTC per 65+ Person in 2005  
By Function



# Look at Germany

- Social Insurance
- Aims at 50% of need
- Cash benefit option is much less than that
- 10% of 65+ get benefits
- Therefore much lower cost than Japan

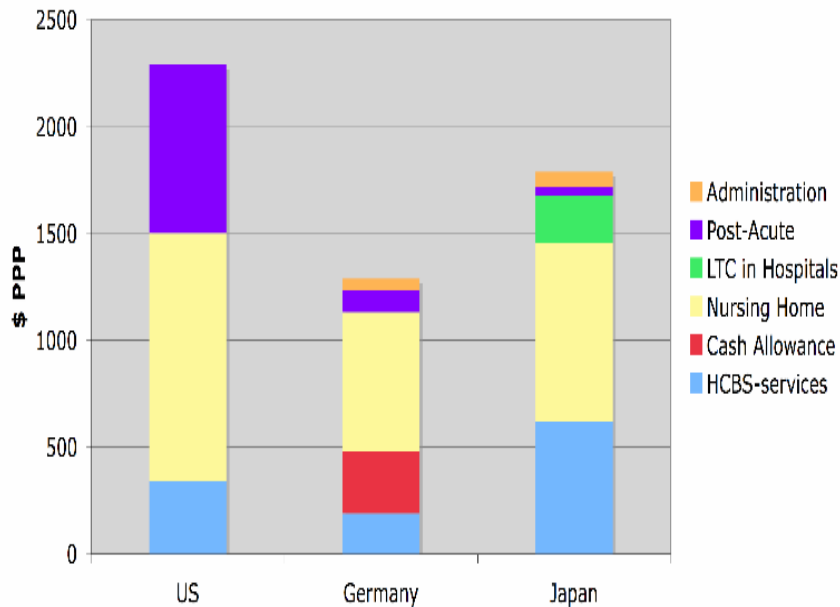
Public Spending on LTC per 65+ Person in 2005  
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# Look at Japan

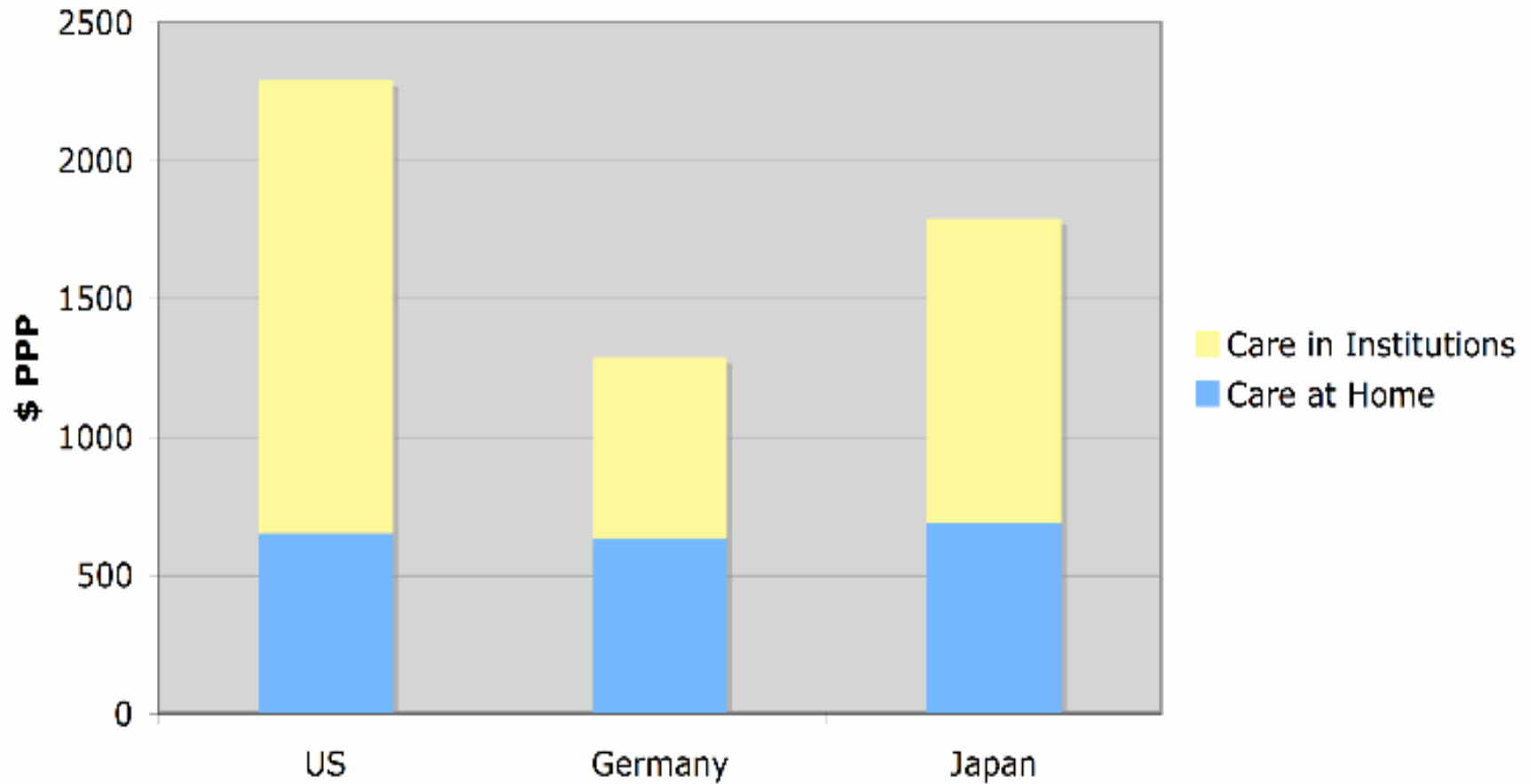
- Social insurance
- 90% of need
- Services only
- 15% of 65+ get benefits
- Lots of LTC is in hospitals, paid by health insurance

Public Spending on LTC per 65+ Person in 2005  
By Function



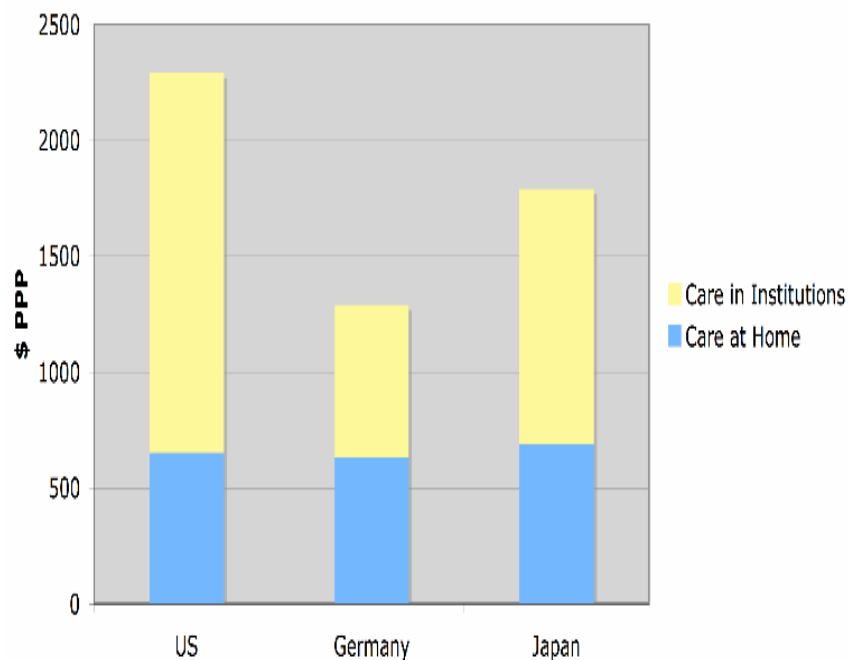
Let's look at the same data from a different angle: how much of the money is spent on older people who live at home, and how much on those who are in institutions?

## Public Spending on LTC per 65+ Person in 2005 For People Living at Home vs in Institutions



# Why Different?

Public Spending on LTC per 65+ Person in 2005  
For People Living at Home vs in Institutions



- US at-home is higher here because of (expensive) Medicare home health as post-acute
- Germany low on institutions because copays are higher

# We Conclude That . . .

- All aging nations must deal with the growing number of frail older people, and the decline in traditional support (i.e. family, i.e. women)
- Two approaches
  - Rely on private care as much as possible, government comes in ad hoc
  - Establish a comprehensive framework with government in the lead
- Our conclusion is, the latter is cheaper

# The Case of Japan

- Fastest population aging in the world
- Traditional supports--family caregiving--more problematical than elsewhere
  - 介護地獄 (caregiving hell) for daughters-in-law an emotional issue
- In the 1990s opted for a comprehensive systems on the social insurance model

# Kaigo Hoken in Brief

- Social Insurance based on premiums (+ taxes)
- Eligibility by ADL, not income or available support
- Client chooses services (not cash) up to a cap, with advice from a “care manager”
- Two levels of “support” for 800,000 quite light cases at \$430-\$900 (PPP) a month
- Five levels of “care” for 3,000,000 light to heavy cases at \$1430-\$3170 a month
- A 10% co-pay and most people use about half of the entitlement
- Providers including for-profits compete in HCBS
- Cost is about \$60 billion (PPP)

# Doable

- Massive program started up much more smoothly than expected--eligibility process worked, enough providers, etc.
- Management has worked well--in particular, competition, choosing services with CM (at least in urban areas)
- Can say that beneficiaries and their families appreciate it, public supports it. Now seen as normal social policy.

# Controllable

- Program grew more quickly than estimated (threshold was too low)
  - 16% of 65+; Germany is 10%; wanted 12%
- Tried to economize
  - Reducing fees
  - Capping institutional beds
  - Picky restrictions and supervision
- Didn't really work, and caused problems, especially in keeping the labor force

# But Could Control

- In 2006, a major reform
  - Light care cases shunted to new “prevention” system, lower costs
  - More “hotel costs” in institutions transferred to beneficiaries
- Succeeded in slowing growth rate—it is not an entitlement program out of control
- Note also controlled institutional growth (but struggling with long hospital stays)

# Control Beyond Japan

- Germany imposed tight fiscal controls at the start and kept spending low for years
- Sweden in 1990s redirected community-based care from light cases to the heaviest
- The US famously cut home health care in half, from \$18B to under \$9B, 1997-1999
- In general governments have been able to control or reform LTC, especially compared to acute health care.

# Our Case

- This is really an argument for comprehensive LTC in the US
- The striking finding is how much public money the US spends with its fragmented, partly private system—LTC is similar to health care in that respect
- An interesting finding is comprehensive LTC can be quite inexpensive as in Germany

# Thoughts About Japan

- Demonstrates that a large-scale system can work outside of northern Europe
- Funny effect of “culture” . . .
- Japan is usually seen as the epitome of family values
- But its system is formal services only, no cash allowance for family care as in Germany