

Japan's Long Term Care Insurance (LTCI, Kaigo Hoken)
John Creighton Campbell (jccamp@umich.edu) 2/09

A public, mandatory social insurance system, enacted in 1997 and started in 2000. Preceded by the "Gold Plan," which started as a campaign promise for the 1990 election; it had rapidly expanded tax-based social services, and induced a sharp upturn in public demand.

Reasons for LTCI: more and more older people (Japan is the fastest "aging society"), a long-term decline in traditional family care, and financial and administrative problems with the Gold Plan.

Everyone 40+ pays premiums, scaled to income, averaging \$50/month for 65+. Covers half the spending, taxes the other half. Municipalities are the insurers and managers.

Anyone 65+ (40+ for aging diseases) can benefit. Eligibility is determined by physical or mental disability level; income and family situation are not considered. Certification by a questionnaire based mainly on ADLs, scored by computer and then reviewed by an expert committee.

The main program has five levels of need, providing services worth \$1430 to \$3170 a month (PPP) worth of services.* Lighter-need people get "preventive support" services at \$430-900 a month.

Covered community-based care: day care (most popular), home helpers for personal care or housekeeping, respite care in a facility, rehabilitation, bath service, visiting nurse, home reconstruction, appliances, etc. Service fees are fixed. Clients freely choose which services and which providers, aided by a care manager. A 10% co-pay limits overuse—most clients are well under the ceiling.

Community-care providers can be governmental, traditional service agencies, new non-profits, or for-profit companies. Competition is lively in cities, and clients do switch providers and care managers.

Clients can also choose a nursing home or LTC hospital. Demand for institutional care outstripped expectations, leading to waiting lists and admittance by priority for nursing homes.

Also "residential" coverage—the caregiving portion of expenses in Alzheimer Group Homes (there are now almost 9000) and private for-profit assisted-living or nursing facilities (about 2500).

In May, 2008, about 4.6M people (16.5% of the 65+ pop.) were certified, of whom 0.9M had not started benefits, 2.9M received community-based care, and 0.8M were in LTCI institutions (note that another ~0.4M older people receive LTC in hospitals paid under health insurance). In all 13-14% of the 65+ population receives public LTC services.

Unlike Germany, there is no formal cap on spending under this program, but mayors have a strong incentive to control costs because additional spending would require a higher premium for their 65+ residents (this is 1/6 of the budget but it determines the rest by a formula).

Costs in 2008 were \$57 billion PPP, going up annually at about the rate of population aging.* When program growth appeared too rapid, a reform in 2006 ("preventive support" for lighter needs, a higher resident's share of room-and board in institutions) slowed the growth rate.

In 5th year review, a switch from caregiving to "preventive support" for lighter cases, and charging "hotel costs" in nursing homes—both partly to save money by reducing demand. Also strengthening care management and opening community multiservice centers.

Public spending on old-age LTC in Japan was actually at about the same level per 65+ person in the population as in the United States, even though public spending is a much smaller share of LTC costs in the US, and Japan provides comprehensive services to all who need them.

*Purchasing Power Parity (PPP) is an estimate (by OECD) of currency values based on a common "market basket" of goods. In 2008 it was \$1=¥116. At the market rate, \$1=¥91, monthly benefits were \$550-\$3900 and public spending in 2008 was \$73 billion.