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The Public Long-Term Care Insurance System in Japan

Background

Public long-term care insurance is the youngest social insurance system in Japan. Before its initiation, long-term care in Japan was fairly fragmented: (1) facility care provided both by hospitals and nursing homes, resulted in growing health care costs for the elderly; (2) home care relied heavily on family, especially wives and daughters-in-law. These "traditional" frameworks, however, began to weaken with an upsurge of the aging population, a growing number of women in the labor force and rapidly increasing health care expenditures for the elderly. This prompted policy makers to establish a more coordinated system for long-term care, and led them to launch the "Gold Plan" in 1989, a 10-year national strategy to expand long-term care services for the elderly. The planning and coordination authority for these services was transferred from prefectures to municipalities. This decade-long endeavor paved the way to the introduction of public long-term care insurance in April 2000.

Outline

Public long-term care insurance (LTCI), like public pension and health care insurance, is based on a social insurance model. It mandates participation of all Japanese aged 40 and over and provides benefits primarily to seniors aged 65 and over. Benefits for people aged 40-64 are limited to physical and mental disabilities caused by illnesses like Alzheimer's.

The insurer is each municipal government and the insurance is financed by (1)contributions by seniors aged 65 and over, (2)contributions by participants aged 40-64 collected through the public health care insurance system, and (3) the subsidy from general revenue (50% of the total benefit expenditure). The contribution level by seniors varies among municipalities and is revised every 3 years in line with service volume estimated by each municipal government. This explicit linkage of decisions on costs and benefits at a local level is viewed as one of the important characteristics of the system.

The benefits of LTCI are provided in kind, and unlike the German system, cash benefits are excluded within the framework of LTCI. Benefits include a variety of services such as facility care, home care, preventive care, rental devices such as wheelchairs and so on. The fee payment rule is unified nationally and the Ministry of Health, Labour and Welfare sets and revises the reimbursement price list. The co-payment is 10% of the total service costs plus fees for meals and rooms.

To apply for these services, seniors must go through nationally standardized "long-term care certification" procedures, which are managed by municipal governments. There are seven "care levels" depending on the severity of disability. For seniors certified at lower care levels, municipal governments prepare service plans primarily focusing on preventive care. For those certified at higher care levels, care managers from the private sector draw up care plans. The service planning process involves seniors, their families and service providers.

Challenges

The number of service users increased significantly after the introduction of LTCI, almost doubling for the first 5 years. Like public pension and health insurance, sustainability when faced with demographic challenges has become the focal point. The revisions made in 2006 emphasizes preventive care, community-based care and quality of care particularly in respect to caring for those with dementia. And that reform has also clearly devided institutional care into those financed by the health care insurance system and by the long-term care insurance system. Measures addressed recently included recruiting and retaining qualified human resources.