



ELDERCARE POLICIES IN JAPAN AND SCANDINAVIA

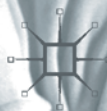
AGING SOCIETIES EAST AND WEST

Edited by John Creighton Campbell, Unni Edvardsen,
Paul Midford, & Yayoi Saito



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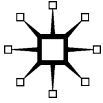
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PREFACE

Paul Midford

This is the second Norwegian University for Science and Technology (NTNU) Japan Program Policy Study. It is hoped that this study; the one that precedes it, *The Political Economy of Renewable Energy and Energy Security: Challenges and National Responses in Japan, China and Europe*; and the subsequent studies in this series will contribute to understanding the major policy issues that face Japan and their relevance for other advanced industrial democracies, and indeed for the global community as a whole. Japan faces a number of policy challenges in common with other advanced industrial democracies, especially those in Europe. The focus is on using common values and shared experiences as the basis for overcoming common challenges.

The NTNU Japan Program originated in the 1980s and early 1990s, when a number of NTNU scientists and engineers conducted research at Japanese universities as visiting scholars. Based on very favorable experiences and interest from Norwegian industry, NTNU established its Japan Program in 1998. Since the Program's establishment it has offered courses on Japanese language, society, and politics, and also on East Asian politics. Another hallmark of the Program is its annual Japan Seminar, which has become a leading venue for presenting and promoting the latest research on Japan and East Asia in North Europe and beyond. It also is a cross-disciplinary Seminar, and especially promotes cross-disciplinary cooperation between engineering and natural sciences on the one hand and the social sciences on the other.

The present volume grew out of the 2007 NTNU Japan Seminar entitled "Eldercare in Japan and Norway: Organization and Quality," held in Trondheim Norway, September 2007. We assembled a high-caliber group of scholars and practitioners from Europe, Japan, and North America to address this truly timely topic. In the broader sense it was and is an exceptionally timely topic, because both Japan and Norway, indeed most industrialized countries, and even some still

developing countries such as China and Mexico, face the challenge of aging societies, brought on by a combination of increasing longevity and declining fertility rates. In the narrower context of Japan our seminar was timely because this challenge is especially acute for Japan, which has one of the most rapidly aging societies.

With a fertility rate just over 1.35 in 2010, and the rate of 2.02 considered the minimum necessary level to prevent population decline, and exceptional longevity, Japan already has the oldest population in the world, with approximately 23 percent over 65 years old. In Norway, the fertility rate was 1.88 in 2011, and only 13 percent of the population was above 65 years of age, but this is projected to grow to 18 percent for Norway by 2020, by which time 29 percent of Japan's population will be over 65 years of age. In short, such long-term trends made this seminar, and make this book, highly timely, especially for Japan.¹

September 17, several days before our 2007 Seminar on eldercare, was the 60th anniversary of *Keirou no hi*, or Respect the Elderly Day, in Japan. Although Japanese society, under the influence of Confucianism, has long prized respect for one's elders, this holiday is actually a postwar tradition. It started in a small village in Hyougo prefecture in 1947, when a gathering was held to show respect for the elderly and ask for their wisdom and life experiences. At that time life expectancy in Japan was approximately 50 years for men and women. Now, Japan is in the top rank globally for longevity, with 79 years being the expected life span for men and 85 for women (Asahi Daily News 2007). Norway is not far behind, with average life expectancy at 82.5 years for women and 77.7 years for men. As discussed above, both societies are aging. Japan is aging faster, with a fertility rate of about 1.35. Norway is aging more slowly with a fertility rate of nearly 1.9, but aging nonetheless.

Perhaps one way to pose the larger question asked by this volume is how does respect for one's elders, a traditional virtue in Japan, translate into care for the elderly at a time when the number of elderly citizens is exploding, many family structures are weakening, and individualism is growing? How can Japan care for the rapidly growing number of seniors over 65 who live alone, a number that by 2007 had already surpassed 4 million (Asahi Daily News 2007)? What can we learn from Japan's still seemingly new and innovative, or at least distinctive, long-term care insurance system (introduced in 2000), or *kaigo hoken*? On the other hand, how does Norway's adherence to the values and institutions of the Scandinavian welfare state model translate into care for its elderly? What can we learn from

Norway's experience? And what can these two models, with very different ideational roots, learn from each other? These are some of the larger themes that this volume addresses.

Although this book's subtitle is eldercare in Japan and Scandinavia, in fact it only focuses on Norway, with only a few limited references to one other Scandinavian country, Sweden. Nonetheless, Norway is a good representative of Scandinavia and its other welfare states. There are of course important differences between these states when it comes to the provision of eldercare, but these are by and large outweighed by the commonalities. For example, the centrality of municipalities in providing eldercare in Norway is largely paralleled in Sweden,² and both stand in contrast to Japan, where the central government's role is more pronounced.

The editors and I would like to sincerely thank the Japan Foundation, and especially its intellectual exchange program, for very generous support of the seminar and this project. We would offer special thanks to Kristin Løkke, for her stimulating presentation during the Japan Seminar. Furthermore, we would like to thank Christine Hassenstab, Professors Anne Saetnan and Ola Listhaug of the Department of Political Science and Sociology, NTNU, for valuable comments on several of the early chapter drafts contained in this volume.

NOTES

1. Japanese statistics and projections come from Soumushou toukei kyoku. 2012. Norwegian statistics and projections come from Statistics Norway (2012).
2. See for example Saito and Yamanoi 1994.

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INTRODUCTION

*John Creighton Campbell and
Unni Edvardsen*

As population aging proceeds around the world, advanced nations have confronted the problem of what to do with frail older people—those disabled enough by physical or mental deficiencies that they need assistance to maintain anything like normal life. The relatively small numbers of people who lived long enough to need such assistance used to be cared for by their children—usually daughters or daughters-in-law—but social changes have meant fewer children, more women working, and new attitudes. The latter might be called liberation from traditional strictures or weakening of a sense of responsibility, but the effect is the same: although families still provide most of the care for frail older people in all countries, governments shoulder more of the burden than earlier.

Beyond this generalization, applicable to all advanced nations, there is a lot of diversity in how governments have approached the problem. One distinction is quantitative: how much of the responsibility the government takes on. Some countries, including the United States, provide a “safety net” of a narrow range of services (usually mostly in nursing homes) for poor people, but leave others to fend for themselves with only personal or family resources. Other countries provide more services to a broader range of the population. A program that covers a substantial portion of need for all or most of the population can be called “comprehensive long-term care.”

The number of nations that offer comprehensive long-term care has been increasing in the last two or three decades—this sector has been called the last challenge of the welfare state. There are two “ideal type” approaches in this sector, though some countries have aspects of both. One is where services for frail older people are decided and provided directly by government, usually local government, paid for from tax revenues. The other depends on financing from social insurance, with beneficiaries able to choose their services up to some set amount

depending on their objectively measured extent of need (regardless of income or availability of family support).

Norway is close to a pure case of the first ideal type, which indeed is often called the Scandinavian model. The purest form of the second type, the social insurance type, is Germany, where virtually all spending comes from social insurance premiums, and recipients can choose to take their benefits in cash, which they can spend as they wish. Japan is closer to the social insurance model, but half of the financing comes from taxation, and recipients do not have a cash option. Still, in Japan all beneficiaries are entitled to a certain level of benefits, and services come from nongovernmental organizations, including for-profit companies.

Japan and Norway are different in other respects as well. First, in terms of the population, Japan is a very large country and Norway a small one—a population of 126 million versus five million. Second, Japan has the oldest population in the world whereas Norway is moderately old—the percentage of the population aged 65 and over is 25 percent versus 16 percent. However, both countries are aging rapidly, with the share of the 65+ population projected for 2020 rising to about 29 percent in Japan and 18 percent in Norway.¹

Another difference is more subtle. Anyone who studies Japanese society and policy is used to thinking of population aging as an issue at the very top of the public policy agenda. In 2013, a poll of residents of 21 countries revealed that 87 percent of Japanese see aging as a national problem.² Care for rising numbers of frail older people has been written and talked about constantly as a quite special problem. The big jumps in public responsibility for long-term care—the “Gold Plan” of 1990 and long-term care insurance in 2000—were regarded as major departures from what was widely perceived as a severely underdeveloped welfare state.

Norway has had a highly developed welfare state for many years, and care for frail older people was taken up fairly gradually as part of municipalities’ responsibility for quality of life at all stages of life. It has not been seen so much as a special problem as it has in Japan. In fact, long-term care programs serve the younger disabled population as well as older people in Norway, while in Japan (with small exceptions) they are exclusively for people 65 and over.

In policy terms, there is much to be said for an age-blind approach, where eligibility is determined simply by the degree of physical or mental disability. On the other hand, younger disabled people often have different needs, such as vocational training and interaction with general society, that are not as important for the typical elderly client in

long-term care (say, an 85-year-old with Alzheimer's as well as physical disability).

A by-product of this difference in perception and policy is that Norwegian and Japanese long-term care programs are difficult to compare at the macro level. Official Norwegian statistics rarely separate out spending for older and younger people (a further problem is that unlike Japan and most other nations, which use age 65 as the dividing line for old-age policy, Norway uses 67).

All these differences make Japan and Norway interesting (and challenging) countries to compare. Still, at the most basic level, long-term care programs are not so different in the two countries. People must be evaluated to assess eligibility and to devise a reasonable plan for care. They are served in nursing homes, while living at home, or (the in-between case) in some form of special housing. A mixture of workers including those with minimal training and those with more professional qualifications perform hands-on care, and they are all part of some kind of organization. Those organizations are regulated by government and monitored for quality. Money to pay for all this flows from households via taxes or social insurance contributions and proceeds through some channel to the organizations and workers. Families provide "informal" care alongside organized or "formal" care. All countries do these things, and looking for similarities and differences helps us understand how they work. These perspectives informed the NTNU Japan Seminar in Trondheim in September 2007, and this resulting volume. For the most part, the same topics were addressed by experts from each country.

Part I is devoted to public policy. Campbell describes the evolution and current operation of Japan's mandatory, public Long-Term-Care Insurance (LTCI) system. Aarheim does the same for Norway. The differences between the two policies noted above show up clearly in these two chapters. Inevitably, the authors' choice of themes reflects the sense in each country of what is interesting and problematical. Japan's program is big and new and completely aimed at frail older people as a distinct group. Norway's program treats frail older people (and disabled younger people) as one among several types of people in need that fall within the responsibilities of municipal government.

Part II turns from the overall system to examine the organizations that actually provide care in both countries. Here, the main difference between the two countries in home and community-based care is that much care in Japan is provided by for-profit companies (though it should quickly be added that they operate under heavy regulations and their fees are fixed). This was one of the important new developments

with LTCI. In Norway, care was traditionally provided directly by municipal government agencies, but in recent years, contracting out services to nongovernmental organizations is also done, mainly in the larger cities. However, the basic principle in Japan that clients can select the service provider that they wish, so that competition will ensure quality, is fairly rare in Norway.

The question of which kind of provision is best is a lively one in Norway, as can be seen in the chapter by Barstad. He describes the kinds of agencies that operate side by side with direct public provision of services, including charitable organizations and a few commercial firms. He also discusses how management of agencies varies across municipalities. Saito similarly focuses on agencies. After reviewing the range of providers in Japan, Saito focuses on the role of “social enterprises,” nonprofit organizations that grew out of community concerns.

Part III takes up family and informal care. After a detailed look at survey data on provision of care by relatives and how it has changed over time, Solheim finds that formal and informal care are complementary in Norway, with the family’s role probably increasing even as the public role expanded. Ruth Campbell shows that the number of older people living with an adult child has declined sharply; interviews with care providers and care recipients since the advent of LTCI reveal the complex interplay between family care and formal service use.

Part IV turns to the entry point into the system for clients, the process of assessment. This too is quite different in Japan and Norway. In Japan, as described by Kurube, the same “objective” questionnaire is filled out for all applicants. A committee then decides what level of care is warranted, based mainly on the score from the questionnaire (as analyzed by a national computer program), but also on the personal physician’s opinion and a brief evaluation by the person who filled out the questionnaire. In Norway, as described by Edvardsen, a new system of registering care needs was implemented in 2006. Since then, municipalities are to fill in a formal scheme, giving scores on a number of need variables. Also taking into consideration any advice from medical doctor, and their own overall evaluation of the person, the municipal administration then makes a decision on the type and amount of services to be allocated. Thus, the nature of the decision following the assessment is different in Japan and Norway (in Japan they decide on the level of need, while in Norway about the type and amount of services).

Finally, Part V looks at quality in services. Hiraoka recounts the evolving approaches to quality control since LTCI began. As in other

Japanese public services, there is a big emphasis on certification and training of workers, but attention to regulation, inspection, and even third-party evaluation has increased. In Norway, assuring quality is seen as a normal part of administrative oversight in the municipal government system. Edvardsen looks at mechanisms for ensuring and controlling quality of care services in Norway. Legal provisions and government policies constitute the basis for a certain standard of quality. The certification of care personnel and systems of supervision and control are measures to ensure this quality of services.

These essays by no means cover all areas of interest in long-term care programs, but they offer new insights (and intriguing questions for future research) about how differently policies in this important area can be carried out in different countries.

NOTES

1. Japanese statistics come from Soumushou toukei kyoku (2012); Norwegian statistics come from Statistics Norway (2012).
2. Unfortunately, no Scandinavian nation was included, but the figure was 55 and 45 percent for Germany and France, respectively, and 26 percent for the United States (Pew 2014).

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PART I



LONG-TERM CARE FOR THE
ELDERLY IN JAPAN AND NORWAY

CHAPTER 1



JAPAN'S LONG-TERM CARE INSURANCE SYSTEM

John Creighton Campbell

Japan's mandatory, public Long-Term Care Insurance (LTCI) program, or Kaigo Hoken, provides care for frail older people in institutional settings or in the community. By world standards it is generous in both its coverage and its benefits.

The program is universal. Everyone from age 40 is insured under LTCI and pays premiums. People 65 and over are eligible whatever the cause of their disability, and regardless of income or whether family help is available (a few aged 40–64 with an aging-related condition are eligible as well). Certification is by an objective test (See Chapter 7 by Noriko Kurube in this volume); the threshold is low and few applicants fail—17 percent of the 65+ population has been certified as eligible (far higher than the 11 percent in Germany's somewhat comparable LTCI program). Or specifically, although only 4 percent of “young-old” people aged 65–74 are certified, over 30 percent of the true elderly who are 75 and older have been certified.

As for benefits, depending on the extent of disability (with seven levels of need), the program allows from \$500 to \$3,500 per month for community-based care (with 10 percent paid by most recipients). These benefits are 70–160 percent higher than in Germany at comparable need levels (Germany has no co-pay). The level of services available may be exceeded by some Scandinavian nations and the Netherlands, but is certainly among the highest in the world.

Japan's LTCI program is a mixture of two basic approaches to care for frail older people. Similarly to Norway and other Scandinavian countries, but unlike most others, only formal services are provided, not cash allowances to reward informal care by family members or to purchase non-professional care. However, similar to Germany, it operates on social insurance principles: financing from premiums (although in Japan half is covered by taxes), national uniformity with little local discretion, and eligibility determined by standardized criteria that excludes income tests or living situation (Campbell 2002).

The official purpose of LTCI is to help frail older people "to maintain dignity and an independent daily life routine according to each person's own level of abilities" (Ministry of Justice 2002). Just as important was the goal of relieving family caregiver stress. Other goals included introducing consumer choice and market competition into LTC services, and moving toward more home- and community-based care and away from institutional care in nursing homes and—a particular Japanese problem—hospitals.

HISTORICAL DEVELOPMENT

Japan had some provision for older people, mainly a few old-age homes, even in the pre-World War II era, but specific programs to care for frail older people date back to 1963 when the Welfare Law for the Elderly was passed (Campbell 1992). It included provision of both nursing homes and home helpers, but at very low levels. The first sizeable government commitment to long-term care came almost inadvertently. In 1973, under severe political pressure from progressive opposition parties, the ruling Liberal Democratic Party (LDP) offered "free" medical care to the elderly by covering the co-pays under public health insurance for everyone aged 70 and over. An unanticipated effect was that older people started moving into hospitals, even if they did not particularly need medical treatment, and in response physicians opened many new small hospitals that in effect operated as nursing homes. When spending ballooned, the government started a long series of reforms aimed at restraining so-called "social admissions," but even today many older people are residing in hospitals, paid from medical insurance, for months if not years.

"Social admission" to hospitals was not only expensive care, but also poor care. In Japan as elsewhere, experts on aging in and out of government believed that nursing homes and in particular community-based care, within the "social welfare" (*shakai fukushi*) field rather than health care, would be better for frail older people as

well as less costly. However, social welfare was covered by tax revenues, and provision for older people lacked the support from politicians and interest groups needed to succeed in the annual budget scramble. Social programs for the elderly did expand, but slowly, barely enough to keep up with demographic change.

Ordinary people were increasingly worried about caring for elderly family members at the individual level, and about the problem of the “aging society” (*koureiika shakai*) at the national level. The breakthrough came with the campaign for the January 1990 general election. The Liberal Democrats were again under severe pressure from progressive opposition parties, in particular for having passed the deeply unpopular consumption tax earlier in 1989. The party needed a compelling reason for the new tax, and found it in a campaign promise to expand public provisions for old-age care dramatically.

This was the “Ten-Year Strategy for Health and Welfare of the Elderly”—the “Gold Plan” for short—which called for doubling and tripling the number of nursing-home beds, home helpers, day centers, and other public provisions for frail older people. Such programs had been restricted to poor people or those who had no family available, but now they were to be available to ordinary middle-class people. Although in Japan as elsewhere election promises are often soon forgotten, the Gold Plan turned out to be very popular. In fact, demand for services increased so rapidly that in 1994 the ten-year targets had to be substantially hiked and a “New Gold Plan” issued (Campbell 2002).

At the same time, the officials at the Ministry of Health and Welfare (MOHW) in charge of old-age welfare were concerned about how the Gold Plan was working. On the one hand, it was consuming more and more of the Ministry's budget at a time when the economy was slow and revenues constrained. On the other hand, administratively the program was increasingly fragmented, confused, and irrational. Responsibility essentially lay in the hands of municipal governments, which lacked the experience and human resources for such complex management tasks; moreover, criticism was growing that people in different localities were being treated quite differently.

The Gold Plan was essentially the Scandinavian model of long-term care imported to Japan. The reason was less cross-national “policy learning” than a matter of expanding and building on the social welfare programs already in place. This was really the only option given that the ruling party needed a concrete plan immediately. However, an approach that had worked passably well for a relatively small number of low-income recipients could not simply be extended to large

numbers of middle-class people. Specifically, the Scandinavian model requires both a high level of taxation and large, skilled local government organizations. Neither was really possible in the Japanese context.

Enactment of LTCI

The MOHW therefore proposed that Japan get off the road to Scandinavia and instead take the road to Germany. Long-term care had reached the policy agenda in Germany in 1989, the same time as in Japan, and for similar motives—attracting votes to the ruling conservative party. However, with Germany’s long social-insurance tradition the Scandinavian model was not even an option. In 1995 Germany initiated its *Pflegeversicherung* (literally nursing insurance) program that strictly followed social-insurance principles: revenues were limited to premiums paid into a new fund, with nothing from taxes; and although in-kind services could be chosen, most benefits for people in the community were paid in cash.

Japan did not go so far. Financing for LTCI would be half from premiums and half from taxes, and the benefits were all in services, not cash. The former was non-controversial, but the latter provoked the biggest arguments of the process since many thought Japan should emulate Germany in encouraging and rewarding family care through a cash allowance. This approach was rejected for three reasons. First and most important, as feminists argued, cash payments would not really relieve the burdens of family caregivers (notably *yome*, daughters-in-law), an issue that had gained wide currency in the general public. Second, if most people chose cash, the market for care services would be too small to ensure that providers would be available throughout the country. Third, allowing cash payments would bring too sudden a surge in spending, difficult to accommodate from tax revenues.

The new LTCI plan was proposed in 1994. After negotiations with a variety of interested groups, including physicians and local governments, plus tricky party maneuvers within two successive governing coalitions, it was submitted to the Diet and passed in 1997. Several conservative politicians later tried to derail the program shortly before its implementation in 2000, claiming that it threatened the sanctity of the Japanese family system, and objecting to the new premiums that would be resented by employers, workers, and older people themselves (who would also have to pay). Nonetheless, the government could not turn its back on its now decade-old commitment to deal with the long-term care problem, and the difficulties with the Gold

Plan were piling up. Moreover, LTCI had been extremely popular among the general public since it was first suggested. It thus was put into effect with just slight cosmetic modifications.

The task of getting so large and complex a program under way was daunting. It was not that the actual volume or variety of service provision suddenly exploded, given that Gold Plan programs had already been expanding rapidly. However, under the new system almost 3,000 municipalities had to set up as insurers, over 20 million older people enrolled to pay premiums, two and a half million were examined for eligibility, 3,200 providers were brought into the new payment system, thousands of care managers were appointed, and so on. Press coverage in Japan talked of “mountains of problems” that could never be overcome, and the dire predictions were even echoed abroad: an April 2000 article in *The Lancet* was titled “Chaos greets birth of insurance system for Japan’s elderly” (Watts 2000). In the event, however, everything went remarkably smoothly in the first year, and the LTCI program was quickly accepted as a normal and important component of Japan’s welfare state.

Since Enactment

This is not to say that the LTCI system has been free of problems and controversies in the decade plus it has been operating. It has been modified several times, usually when the fiscal review of the system is carried out every three years, as specified in the law. The review consists of each municipal government drawing up a detailed plan for program operations over three years, resulting in a budget that includes the monthly premium for elderly residents. This local planning process for the first period (2000–2002) was very lively, with extensive community participation and debate over better services versus higher premiums. Over time, however, it became clear that the national guidelines for what services had to be provided and how the calculations must be carried out were so detailed and strict that municipalities had little scope for truly autonomous decisions, and the process became routinized.

More significantly than the municipal-level review, the review provides a convenient cycle for the national government to evaluate the program and carry out course corrections. The most important of these reforms was decided in 2005 and implemented in 2006. This reform is worth a detailed look because it dealt with the most important problem for policymakers: public spending and sustainability.

The problem was that more people were applying for LTCI than had been anticipated. In 2000, the first year of the program, 2.6 million were certified, 11 percent of the 65+ population, but by 2005 the number certified had soared to 4.3 million or 16 percent. At the same time, the amount of services per recipient kept growing, from ¥145,000 in 2000 to ¥224,000 in 2005. Rising numbers of eligible people plus growing costs per person meant that total spending grew sharply over that six-year period, by nearly 80 percent to almost six trillion yen (Kousei Roudoushou, 2010). Everyone knew that expansion at that rate was unsustainable. Most immediately, this would be reflected in higher premiums for older people themselves.

The Welfare Ministry's first proposal was to expand coverage to include younger disabled people as well as the elderly, as in Germany and elsewhere. The premiums that would newly be paid from age 20 rather than from age 40 would be a much larger amount than the benefits due to younger disabled people, so the financial base would be secured. However, employers balked at the cost of the new premium (they would pay half), and several of the groups that represented the disabled were opposed as well. The proposal was dropped and the Ministry turned to a remedy directly related to the cause of the problem.

That is, from its start the LTCI program had six levels of need. Those in the bottom two levels had relatively low levels of impairment, levels that would not qualify for benefits at all in many countries including Germany. The numbers of low-need recipients had more than doubled in the first six years of the program, while recipients at the four higher levels of need grew by just 42 percent, so the lower-need group had gone from 40 to 50 percent of all those eligible. If spending on them could be reduced, or at least controlled, substantial savings would be possible without threatening the core of the program, services for the heavier-need cases.

Nonetheless, from the government's point of view, cutting back straightforwardly by tightening eligibility standards or arbitrarily reducing benefits—let alone just dropping half the beneficiaries—was politically impossible. Instead, it adopted a clever strategy. It renamed the program for the lower-need group from care provision to “care prevention” (*kaigo yobou*). In principle, services were to be aimed at keeping people from deteriorating or becoming more dependent. In practice, provision did not change that much, but the new goal allowed a small reduction in the ceiling for services and moved the authority for care planning from the client's individual care manager to the municipal government—a little cheaper and somewhat less attractive.

The results were substantial: despite continued rapid growth in the old-age population, the number of lower-need beneficiaries was leveled off—they were now put in three levels rather than two, helpfully for the politicians, obscuring what was happening. By 2009, this group had fallen from 50 to 43 percent of eligible people. Owing to this change, plus some smaller reforms, such as a shift of some room-and-board costs to nursing-home residents, total spending on LTCI leveled off briefly. When spending resumed growing, it was only at the same pace as the growth of the 75 and over population (by far the main users). In short, the 2005 reform was quite successful substantively, and at very little political cost—most saw it as a slight redirection of the LTCI program rather than a cutback.

In the years since 2006 the triennial reforms have not been so drastic. Efforts to control spending have continued, but by manipulations of regulations and the fee schedule rather than structural changes. A new emphasis on community involvement in long-term care was developed, along with efforts to make at-home care more attractive (e.g., by providing visits at night) in order to decrease the demand for institutional care. Moreover, recognizing the difficulties service providers faced in retaining and recruiting staff, in 2010 the new Democratic Party of Japan (DPJ) administration ordered a short-term salary supplement outside of the LTCI structure, and then in the reform that took effect in 2012, the fee schedule was raised slightly in order to have more money to pay careworkers.

There have been four scheduled reforms of LTCI since it began in 2000: the fact that all except the one in 2006 were characterized by incremental, little changes here and there indicate how solidly the program is entrenched in Japanese social policy. Despite constant dire warnings about how the Japanese welfare state cannot be maintained in the face of continued anemic low economic growth and the aging and shrinking population, there are no serious proposals to privatize or cut back on care for the frail elderly.¹

The 3–11 Disaster and Long-Term Care

In the earthquake and tsunami of March 11, 2011, the LTCI system was said to be helpful in important respects (Ootani 2012). First, many clients were in day-care centers, which typically were located in the hills above the coast, so were saved. Second, the names and addresses of frail older people were listed, facilitating finding those at home in the immediate aftermath of the tsunami. Third, although there was a lot of variation among localities, most services were

resumed within two or three weeks and were a source of assistance and comfort to many clients living in the community.

Of course, such efforts were dwarfed by the magnitude of a disaster in which 55 percent of the 19,000 killed and missing were aged 65 and over. An estimated 280 older people died within three weeks of the event due to exposure and the stress of terrible living conditions. In LTCI, although the government quickly relaxed the usual regulations and encouraged providers to help people regardless of where they were registered and what documents they had, it was acknowledged that services delivered to shelters were inadequate for some weeks. For the most part, services were back to normal within two or three months, except that the destruction of some nursing homes required residents to be transferred away from their home towns. Around the nation various projects were started to work on preparing the LTCI system to deal with the next disaster more effectively.

SERVICES FOR OLDER PEOPLE IN THE COMMUNITY

LTCI brought a substantial expansion of services. In most countries, the basic service in long-term care is regular visits by home helpers to provide personal (or “body”) care as well as housework. The number of people using home helpers more than doubled, from 518,000 in 2001 (the second year of the program, when it was fully under way) to 1.16 million in 2009.² In Japan, uniquely, adult day care is even more popular than home help, partly because a higher proportion of older people live with their children. The number using day care also more than doubled, from 832,000 in 2001 to more than two million people by 2012.³ That amounts to 7 percent of the entire 65+ population.⁴ Respite care, spending a few nights in a nursing home to give caregivers a break, was used by 360,000 people that year. A still greater expansion was seen in the provision of assistive equipment, such as wheelchairs and hospital beds; the number of people using any of these items grew from 288,000 to almost 1.4 million people in the same period. These services are all within what is seen as the welfare (*fukushi*) sector.

The boundary between the welfare and medical sectors is a difficult structural problem in LTC systems everywhere. In Japan, LTCI provides several health-related services that in other circumstances are covered under the public health insurance system. These include visiting nurses, physical rehabilitation either at home or in a day-care center, and a monthly fee paid to family doctors to keep an eye on the client’s health. Here the doctor is obliged to see the client once

a month, and to be available around the clock at least by telephone; examinations, procedures, and medications are then covered by health insurance.

The client has the right to choose the services they want, the agencies to provide them, and their quantity. A care manager—also chosen by the client—gives advice, draws up a care plan, handles the paperwork, monitors performance, and generally coordinates services and people. There are specialized agencies that only do care management, but most care managers work for direct service providers. This creates a possibility of conflict of interest, such as pushing the employer's service, or not being receptive to complaints, but in general care managers do seem to look out for their clients' well-being. Indeed, many complain they do not have time to provide all the help they would like, because they normally have 30 clients (it used to be 50) and the administrative duties are burdensome.

A notable point about LTCI in Japan is that the municipal government, which serves as the insurer and so bears the financial responsibility, has very little influence over the key decisions. Admission to the program and classification into levels of need are done by computer analysis of the standard questionnaire, reviewed by a fairly independent expert committee. Local officials do not supervise care managers; they can give care managers general advice, but this is not enforceable, much less applicable to individual cases.

This point is a key difference to Scandinavian LTC. There, frail older people have a legal right to receive necessary care, but not any particular type or amount. That decision is mainly the responsibility of case workers employed (directly or indirectly) by municipal government and so ultimately governed by a budget restraint. Famously, the early 1990s' austerity regime in Sweden led to substantial cutbacks in services to lighter-need people, a matter of individual decisions at the municipal level forced by shrinking resources (Szebehely 2005). Japanese municipalities have no way to do that.

It might be assumed that when clients decide what they want, advised by care managers often employed by service-providing agencies, the result will be unneeded and wasteful usage and soaring expenditure. Of course, there is a ceiling on the value of services depending on the level of assessed need, but as noted it is generous, roughly double the limits in Germany.

However, most people do not use all the services to which they are entitled. Those at the lowest and highest ends of the needs scale use more of their entitlement, averaging about 60 percent, and those in the middle are lower at 40–45 percent. Actually not a few people apply

and are certified, but then use no services at all—20–25 percent in the low-need “prevention” category (where the available services are not so attractive) (Ikeda 2011).

Why do people not use all that they are entitled to? The obvious reason is the co-pay. Although 10 percent might not seem to be a lot of money, adding an extra hour of body-care home help a day would cost \$80–100 more a month. Another reason is that LTC services are not necessarily very desirable unless there is a real need, a need that clients and their families feel competent to judge. Perhaps those who decline all services take the trouble of applying (not very burdensome) just to be ready when they really need them, or to get on the waiting list for a nursing home.

Of course even 10 percent co-pay can be a substantial burden for people with heavy needs, as much as \$350 a month (or more for a household in the increasing number of cases where both husband and wife are getting care). However, the poorest recipients, those on public assistance, do not have a co-pay, and there is also a ceiling that varies by income on the total amount of the co-pay for both LTC and medical care in a household. Judging from survey research, the LTCI co-pay is not seen as a significant constraint on getting the needed care in the vast majority of cases (Tamiya et al. 2011).

In Scandinavia, it is likely that decisions about the amount of care are taken after careful discussion with the client and family before the case worker decides. In contrast, Germany has a free choice between cash and services, wholly or in part, so eligible people always take the entire entitlement. The Japanese approach has the advantage of allowing much more service at a given level of need than is possible in Germany, and allowing the client to make the decision rather than having to persuade a case worker as in Scandinavia.

Japan has clearly succeeded in providing substantial amounts of services to frail older people living in the community. However, from the point of view of recipients and particularly their families, it is still widely seen as insufficient. For an older person living alone or a couple when both are relatively frail, even the maximum of home help leaves many hours in the day and night without assistance. A family caregiver—a spouse, child, or daughter-in-law (the traditional norm)—is certainly greatly helped by, say, three days a week in day care and four nights a month in short-stay respite care, but will still be burdened by many hours of work and more of responsibility (See Chapter 5 by Ruth Campbell in this volume). They ask for more help—not so much larger quantities of the services that are available, but different services.