The Politics of Japan's Long-Term Care Insurance System

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1. Introduction: The New Long-Term Care Insurance System

In December 1997, the Japanese Diet approved the Long-Term Care Insurance Law, setting in motion what was hoped to be an integration of medical care, nursing care, and welfare services for the elderly. By April 2001, the system had operated for twelve months, and the results were promising, but not yet as complete as intended. Significant barriers to implementation of the original program goals, particularly the division between welfare service organizations, local governments, and medical care providers, and the division of responsibility between local governments and the central government, had not been resolved as much as hoped. Some users could not find enough service providers to use all the services they had been authorized to use. Nevertheless, the new system succeeded in three areas: it created a unified system for home care and facility care for all people over 40 years old with diseases associated with aging, it financed the system with a mix of premiums and public subsidy, it gave more discretion to users in selecting services than in previous programs.

Given the record budget deficits and enormous debt of the central government in the late 1990s, the introduction of such large, new program without budget caps in an era of administrative restructuring and fiscal restraint came as something of a surprise.[1] Under the circumstances, it represented a victory of sorts for Ministry of Health and Welfare[2] planners who had been working on the predecessors of the program since as early as 1989. Final decisions about the shape of the program depended also on coordination between several different configurations of ruling coalitions, particularly the Liberal Democratic/Social Democratic/Sakigake coalition in 1997 when the Long-Term Care Insurance Law passed the Diet, and the Liberal Democratic/Kōmei/Liberal coalition just before

[1] Local government budgets had previously set an upper ceiling on spending for long-term care for the elderly (Ikegami 1997: 1311).

[2] On January 6, 2001, the ministry was merged with the Ministry of Labor in the new Ministry of Health, Labor and Welfare (*Kōsei Rōdōshō*).

implementation in December 1999. Eventually the political benefits of the program outweighed the fiscal costs, but political influence at the last moment threatens to make the system much more expensive than anticipated.

This article discusses Japan's long-term care insurance (LTCI) system (*kaigo hoken*), beginning with the issues it was designed to address and the population (primarily the elderly) whom it is intended to benefit.[3] After outlining the laws establishing the system, and the political process by which original plans shifted at the last minute, it turns to the kinds of benefits and services available, as well as subsidies for service providers. Next it looks at the users, what they pay, and how many users fit in each category of benefits by the end of 2000. Then it turns to financing issues, including where the money goes, and where it comes from. Finally, it addresses recent reforms of the system, and the likely direction for subsequent policy development. At each stage, the system is characterized as an appeal for votes from the elderly, rather than as a compromise to deal with the problems of the aging society.

2. Profile of Japan's Elderly Population[4]

The problems of how to care for the elderly in Japan's rapidly aging society have been raised since throughout the postwar era of Japan's health policy, even as early as 1955 when the Ministry of Health and Welfare was developing plans for universal health insurance (Kokumin Kenkō Hoken 50-nen Shi Henshū Iinkai 1995: 50). Japan's population is aging more rapidly than that of any other country. Although it is not entirely clear that the aging society brings only problems – issues of crowding, high land prices, and unemployment may be somewhat alleviated, particularly in crowded urban areas[5] – the problems of financing existing levels of health care and welfare services without either redesigning systems or developing new sources of funding, or both, cannot be easily ignored.

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[3] For an analysis of expectations about the system after its initial trial period but before implementation, see Ikegami and Campbell (2000: 26–39).

[4] Portions of this section are drawn from Paul Talcott: "Background Paper on Health Care for the Elderly in the United States and Japan", in: Calhoun, Michael (ed.): *The Silver Market: New Opportunities in a Graying Japan and the United States*. New York: Japan Society (forthcoming).

[5] The advantages of a declining population, such as cheaper land and more leisure time, are emphasized by Fujimasa and Furukawa (2000).

2.1 Growing share of elderly and the "older elderly" in Japan's population

Between 1970 and 1994, the proportion of people 65 years old and older rose from 7% to 14% of Japan's population (Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo 1999).[6] In the year 2000, the share of the elderly population is estimated to be 17.34%. The "older elderly" in Japan (people 75 years old or older) are increasing at a faster rate. Between 1980 and 1998 the proportion of these people rose from 3.1% to 6.4% of the population. By 2000 the ratio to the total population was projected to rise to 7.1%. By 2025, the "older elderly" will outnumber the "younger elderly" (between 65 and 74 years old) by 15.6% to 11.8%, and will rise to 18.8% of the population by 2050 (Sōmuchō Chōkan Kanbō 2000: 2).[7] Unless immigration or employment opportunities for women and the elderly expand dramatically, the working age population supporting the elderly in Japan will shrink, just as the number of "older elderly" will reach an unprecedented level. As the next section and discussion of expected system users will make clear, the "older elderly" are the ultimate target of the long-term care insurance system.

2.2 Health status and long-term care[8]

When the long-term care insurance system was designed, the initial number of elderly in the system was estimated to be around 2.8 million, with roughly half of these requiring full-time care due to being completely bedridden. By 2010, numbers are expected to rise to 3.9 million, but the number of bedridden elderly will be reduced to less than half of the total. Based on population data presented above, these figures represent about 15% of the population over 64 in both years. For long-term care, the "older elderly" are the largest group. Of the population requiring long-term care, 85% are 75 years of age and older. Of the people under 80 years old, only 20% are expected to require care (Sōmuchō Chōkan Kanbō 2000: 133). By contrast, far fewer people under 65 years old are expected to require long-term care for diseases associated with aging. Estimates made in 1996 for the fifteen designated diseases associated with aging eligible for LTCI payments were only 140,000 people nationwide.[9]

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[6] Other figures for Japan in this section are also drawn from these projections.

[7] Original data are from Sōmuchō (for 1980: National Census; for 1998: official population projections) and from Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (projections for 2000 and beyond).

[8] For a comprehensive look at the social aspects of caring for the elderly, see Long (2000).

[9] Sum of estimated cases in analysis of Miura Kōji (2000: 384), former director of the Long-term Care Insurance Planning Section, Ministry of Health and Welfare.

In Japan, the seven most frequent conditions for inpatient treatment for the elderly were cerebrovascular conditions, cancer, heart disease (other than hypertension), fractures, schizophrenia, diabetes, and hypertension. For outpatient treatment, the number of visits is highest for hypertension, osteoporosis, cerebrovascular conditions, heart disease (other than hypertension), arthritis, cataracts, and diabetes (Kōseishō 1999). Medical facilities have developed under the medical insurance system to provide both inpatient and outpatient care, but medical treatment is not the only component of the system. The medical system, particularly hospitals, but also clinics with beds, have long provided long-term institutional care at a much lower cost to the elderly than welfare facilities for the elderly owned by local governments. Part of the reason for developing the long-term care insurance system was to reduce use of the medical system for long-term hospitalization, a process called "social hospitalization" (*shakaiteki nyūin*) by the Ministry of Health and Welfare. The cost of this kind of long-term hospitalization was estimated to reach ¥ 1 trillion by 1995, or nearly one-eighth of all medical spending for the elderly (Watanabe 1997: 20–21).

In surveys about their future health status, the elderly in Japan, particularly those living without younger family members (as an elderly couple or by themselves), are quite apprehensive. A *Yomiuri Shinbun* (28.09.2000: 2) survey in September 2000 found that 70% of the elderly had some fear about their future situation, and 54% were worried about their own health or that of their spouse. Yet the elderly also had a certain level of satisfaction with the health care system in general. A 1994 poll of all citizens showed that people 60 and older had the highest level of satisfaction with the way the health care system helped protect them from high medical costs. People 60 years or older were also the most satisfied in general with the health care system (Kōseishō 1995: 10). Some changes in costs for the elderly in the new LTCI system may reduce satisfaction with the costs of care. Home nursing care users in particular, have found the new system to be less satisfactory than the medical insurance system. Under the old system of medical insurance, these visits were basically free after a certain per-month co-payment (¥ 2,200 per month in 1999), but with LTCI, users have to pay 10% of the charges for each visit. Although it is difficult to assess overall satisfaction of users of the new system, since national surveys of satisfaction with the system will not be conducted until June 2001 by the Ministry of Health, Labor and Welfare, a survey of local governments in March 2001 found that 48% of localities felt that the burden for families had increased under the new system (*Yomiuri Shinbun* 03.04.2001: 18). At the same time that dissatisfaction may be rising among the elderly, it is

important to remember that the prior cost was quite low for many services including long-term hospitalization. Still, the costs for low-income elderly and those in remote areas can be expected to rise under the new system.

Although problems with quality, access to advanced technology, and high costs for low-income elderly remain serious, the elderly in Japan find themselves in a decent position relative to younger generations. This reflects the universality of coverage and high public support for public insurance for the elderly. High costs are more of a problem for middle-aged people than for the elderly in Japan: people between 45 and 55 years old pay much larger insurance contributions than do the elderly, because pay is tied tightly to both age and seniority, and insurance contributions for most working people are based on income.

2.3 Elderly income and housing

The social burden of paying for medical care and welfare services for the elderly arises in part because incomes fall after retirement, and health costs are likely to rise. Housing is also an important component in the costs of caring for the elderly. The increased reliance on facilities in the long-term care insurance system reflects shifts in both the life expectancy of the elderly and also the larger number of elderly living independently. Many elderly in Japan live with their children, although not as many as is commonly thought. Despite the common image of multi-generation housing, fully half of the six million elderly households in Japan consist of elderly living alone or as a married couple (*Nikkei Net* 17.05.2001).

Median household income for people aged 65 or older is not that different from that of the active labor force: ¥ 2.07 million per person, or ¥ 3.23 million per household. Total household income is much lower than the figure for all households, which was ¥ 6.57 million, but since non-elderly households are larger (2.95 people compared to 1.56 for elderly households) the average income per household member is nearly the same: ¥ 2.23 million per person (Kōseishō Daijin Kanbō Tōkei Jōhōbu 1999). 64% of income for the elderly came from public pensions, and an average of 27% from other labor-based income. Returns on financial assets provided only 6% of income for the elderly, reflecting interest rates below 1% on fixed-term savings. The relative affluence of the elderly in Japan, on average, has produced calls by the most recent blue-ribbon commission of experts consulted by the Prime Minister on the future of the social security system to rethink the current policy of not collecting premiums for the health services system for the elderly (*Nikkei Net*

25.03.2001). Still, 60% of the elderly rely entirely on pensions and other public support for their income.[10]

Changing family situations also created a sense of urgency for developing a long-term care insurance system. By 2000, the number of households headed by people 65 years or older was estimated to be 10,956,000. By 2002, only 25% of elderly households are estimated to include children; 30% were living alone, and 33% were living as a married couple without children or other relatives (Sōmuchō Chōkan Kanbō 2000: 33).[11] This means that fewer caregivers are available in the family. What has not changed much since 1970 is the percentage of the population over 65 who lived in some institutional setting: 4.5 in 1970, 4.5 in 2000. Of these, 37% were in special welfare facilities for the elderly, 22% were in health facilities for the elderly, and 41% were in ordinary hospitals (Sōmuchō Chōkan Kanbō 2000: 90).[12] Part of the goal of the LTCI system is to reduce reliance on facility-based care, but with multi-generational families becoming less prevalent, the emphasis is on self-reliance as much as on daughters (or sons) as caregivers.

3. Laws and Structure of System Operation

Preparation for the LTCI system began as a bundle of subsidies for facilities and services for the elderly to be provided by local governments and non-governmental organizations. The subsidy component to build new services began life as the Gold Plan in 1989,[13] while the benefits and financing components began to be deliberated by a working group within the Ministry of Health and Welfare excluding non-bureaucrats, in 1994. Final approval came from an advisory council on social security and a new advisory council to review policies for the elderly, the Old Age Health and Welfare Advisory Council (Rōjin Hoken Fukushi Shingikai). But by the time participation broadened to include political parties, the main outlines of the system had become fixed, in part through informal consultations, but in part according to options drawn up by bureaucrats

[10] Results of a survey by the Ministry of Health, Labor and Welfare, reported in *Nikkei Net* (17.05.2001).

[11] Original data are from Kokuritsu Shakai Hoshō Jinkō Mondai Kenkyūjo (1998): *Nihon no setaisū no shōrai suikei (zenkoku suikei)* [The Future Shape of the Number of Households in Japan (Projections for All Japan)].

[12] Original data from Ministry of Health and Welfare.

[13] The origins of the Gold Plan are analyzed in detail in Campbell (1992: chapter 9).

alone.[14] The political process that followed is summarized in this section, and is remarkable for the level of intervention by politicians after the basic outlines seemed to have already been fixed in place. In an era of shifting coalitions, competing reform programs, and intense factional conflict within the Liberal Democratic Party (LDP), long-term care insurance has become one of the tools for appealing to supporters, particularly the elderly.

3.1 Kaigo hoken *Law*[15]

The Japanese Diet established the long-term care insurance system when the Upper House passed the Long-Term Care Insurance Law (*Kaigo hoken-hō*) on December 9, 1997. Beneficiaries of the system were defined in Article 9 to be people 65 years old and older (Type 1) or older than 40 but younger than 65 years old (Type 2). As a social insurance system, Type 1 and Type 2 beneficiaries both pay insurance contributions. Article 3 placed responsibility for operation of the system with local governments: cities, towns, villages, and the wards of Tōkyō.

3.2 Implementation laws and ordinances

As with many laws in Japan, the statutory basis for the LTCI system and its implementation were stipulated in a basic law and an implementation law. The implementation law (*Kaigo hoken shikō-hō*) set out the scope of matters to be stipulated without further review by the Ministry of Health and Welfare in ordinances (*shōrei*). These ordinances established eligibility criteria, placed the funding for the system in the special budget accounts (*tokubetsu kaikei*), set up an oversight committee, and set out other details of system operation. Final regulations for implementation (*Kaigo hoken shikō-rei*) issued on March 31, 1999, and eligibility criteria were further established by ministry ordinance on April 30, 1999.

Although the long-term care insurance system was met with some complaints about such matters as the disparities in availability of service, insufficient payments for services, the principle of taking insurance contributions from pensions, and rising costs, even the citizen groups formed as watchdogs early in the process of developing the system expressed

[14] The definitive study of the steps before LTCI was developed into legislation is Nihon Ishikai Sōgō Seisaku Kenkyū Kikō (1997).

[15] A useful summary of the implications of these laws, along with the text of important provisions, can be found in the *Shakai hoken techō* [Handbook of Social Insurance] (2000).

satisfaction with how smoothly the system was introduced.[16] In the aftermath of implementing the system in April 2000, as before, partisan politics has not played too much of a role in the development of the long-term care insurance system, at least not in terms of one party advocating policies entirely different from another. Even issues on which coalition partners could not agree were pushed off into the future in the form of expected reforms of all social security systems by 2005.

At the same time, partisan disagreement over benefits did occur when the system was being planned, and over funding when implementation was being debated (Ikegami and Campbell 2000: 30–31). Complicating the introduction of the LTCI was the condition that coalition governments have changed three times since the passage of the original LTCI bill in December 1997. Only one of the parties remains in its original form: the Liberal Democratic Party. The coalition partners at the time of initial long-term care insurance legislations, have either disappeared (the Shintō Sakigake [Pioneer] Party) or been reduced significantly through defections to other parties (the Social Democratic Party of Japan; SDPJ). The next coalition government after passage of the long-term care insurance bill formed in October 1998, and along with the Liberal Democratic Party (LDP) which had been in power alone until 1993, and in various coalitions since June 1994, included the Kōmei Party and the Liberal Party, both of which had been part of the opposition Shinshin [New Frontier] Party until its dissolution in December 1997. The Liberal Party left the coalition in April 2000, just after implementation of the long-term care insurance system began, but some of its members resigned and formed a new party, the Conservative Party (Hoshutō) which remained in the coalition.

At each stage, influence on legislation at late stages by politicians reflected not so much long-held policy differences between the different coalition partners, but rather the impending elections for the Upper House in July 1998 and for the Lower House in September 2000, and the changing tactics of the Liberal Democratic Party to reach out to elderly voters. Finally, it was not only coalition governments but also the opposition which had some role in formulating long-term care insurance. In April 1997, at the same time as health insurance reforms were discussed by the ruling coalition and the newly-formed Democratic Party (Minshutō), a four-party agreement was also reached about the content of the Long-Term Care Insurance Law, before the bill was introduced into the Diet.

[16] See the evaluation of the new system by the founder of the "Ten Thousand Citizens' Committee to Realize a Public Long-term Care System ", Ikeda Shozō, in *Banbū* (June 2000: 39–41).

3.3 Delays in passage of Kaigo hoken *Law between introduction in November 1996 and passage in December 1997*

Coalition politics slowed the introduction of the Long-Term Care Insurance Law, but politics within the LDP also played a role in the delay. In spring 1996, when the LDP in coalition with the Social Democratic Party and the Sakigake Party first discussed introducing the long-term care insurance bill into the Diet, disagreement between the LDP and its coalition partners led to the bill's introduction being delayed. The Social Democrats and Sakigake urged quick introduction, and Prime Minister Hashimoto Ryūtarō initially agreed, but Cabinet Secretary Kajiyama Seiroku pointed out that there was no possibility to introduce the bill in the regular session which ended in June, citing voices within the LDP who were not yet satisfied with the vague commitment to new spending without first determining the actual level of burden the public was expected to bear. This illustrates the process of policy-making even within the coalition: first the LDP needed to complete its internal policy review, and only then it would consult with its minor coalition partners.

The first time the LTCI bill was introduced into the Lower House was in November 1996. Unfortunately just after its introduction, a period of scandal paralyzed the Ministry of Health and Welfare: the vice-minister was found to have accepted gifts from a nursing home contractor who received subsidies designed to speed the facilities to be used in the long-term care insurance system, and legislative coordination became problematic under the circumstances. After the LDP/SDPJ/Sakigake coalition initially agreed in April with the Democratic Party to pass the law only after all necessary revision had been made, deliberation continued during the regular Diet Session in spring 1997.

The final review of the bill by the Lower House Committee on Welfare finished in May 1997. Minister of Health and Welfare Koizumi Jun'ichirō (who became Prime Minister in April 2001) delayed introduction of the long-term care insurance bill due to the hotly-debated Organ Transplantation Law that also had to clear the same committee in the regular Diet Session in spring 1997 (*Nikkei Shinbun* 01.04.1997: 2). By this time the LDP and its coalition partners had agreed on the form of the initial law, which would leave much of the details of implementation to the implementation law (discussed below). The Democratic Party, formed in January 1997, opposed strongly a clause that would allow certain local governments that had difficulty developing services for homehelpers to delay implementation of the system, and delay collecting premiums, for a period of up to five years, and even longer if a Cabinet order (not requiring parliamentary approval) could be obtained. The Democratic Party also hoped

to include citizen participation on local government commissions charged with planning and operating local administration of the system. In addition, the Shinshin Party opposed the social insurance system entirely, as well as co-payments for long-term care services. Even the LDP coalition partner, the Social Democrats, looked favorably on revisions to the burden on users. Another complication for the Long-Term Care Insurance Law in June 1997 was the subsequent plan to introduce a bill revising the health insurance system immediately after the LTCI Law, and any delays to the LTCI bill near the June 18 finish of the Diet Session would complicate efforts to raise new revenue to finance the health insurance system (*Nikkei Shinbun* 04.05.1997: 23). Timing mattered as much as the contents of the legislation. The health insurance bill was scheduled to go into discussion in the Upper House Social Affairs Committee on May 23. As a result, on May 22, 1997, the Lower House passed the LTCI bill, with minor revisions (*Nikkei Shinbun* 27.05.1997: 5). Agreement on the health insurance system reforms could not be reached in time for the end of the regular Diet Session, and thus action on the LTCI bill in the Upper House was delayed until the fall (*Asahi Shinbun* 03.12.1997: 1). Final approval came in December 1997 after minor revisions in the Upper House.

3.4 Changes to the LTCI system after passage of the law

The most important changes to the LTCI system came without formal revision of the law or the implementation law. Rather, they came as budget items in a supplementary budget in November 1999 (Gekkan Kaigo Hoken Henshūbu 2000: 18). Once again, the internal politics of the LDP as much as coalition politics brought the impetus for change. The most sweeping changes came with the new partnership between the Liberal Democratic, Kōmei, and Liberal parties that formed a coalition in November 1998. Just before the system was due to be implemented, the LDP, with an eye on upcoming elections proposed the suspension of insurance contributions for the elderly for six months, and a further twelve months of only 50% of the planned contribution for the elderly. They also added a new kind of benefit discarded during the first round of deliberations: cash payments to caregivers under certain, limited circumstances. In late October 1999, the coalition agreed to the proposal, with additional provisions suggested by Kōmei, such as reducing co-payments for low-income seniors for homehelpers.

To finance the suspended premiums, the coalition decided to rely on new public debt. Estimated cost of the suspended premiums for people 65 years old and older reached ¥ 400 billion for the first six months, and a total of ¥ 1.6 trillion for the eighteen month period, which represents over

one-third of all premium revenue anticipated in that period (*Asahi Shinbun* 29.10.1999: 2). The motive for suspending premiums was best captured by an anonymous Liberal Party official: "If we hold a general election right after imposing a new tax on people, it will only help the Communist Party" (*Asahi Shinbun* 30.10.1999: 2). LDP Policy Affairs Council Chairman Kamei Shizuka explained the deal by referring to the lack of an absolute majority of the LDP alone (*Asahi Shinbun* 28.10.1999: 1). New coalition partners brought new dimensions to policies planned by previous coalitions. Other issues, such as another generation of the Gold Plan, a "Super Gold Plan", were easier to agree to, since all parties were interested in expanding the facilities available to use under the new insurance, as well as the subsidies to build them (*Asahi Shinbun* 29.10. 1999: 2).

The new shift was also not without controversy even within the LDP. Deputy Policy Affairs Chief Sakurai Shin and other members of the Social Policy Committee of the LDP criticized Kamei's plans as risking public criticism for increasing social security costs (*Japan Times Online* 27.10.1999). The Minister of Health and Welfare, Niwa Yūya, expressed sharp opposition in public to plans to add cash benefits as an option instead of purely services (*Asahi Shinbun* 23.10.1999: 6). Even though he had served in party office as Assistant Chairman of the powerful Policy Affairs Research Committee in July, which had originally proposed a three-year period of reduced premiums, his position was more protective of the consensus in the ministry (*Asahi Shinbun* 26.10.1999: 2). Niwa's objections demonstrate how electoral concerns did not characterize all political leaders in health care policy. Nevertheless, electoral strategy did dominate the final LDP push for additional benefits on the eve of implementation.[17] Subsidies for the reduced burden on the elderly came through supplementary budget, financed by new debt.

This reliance on public debt to pay for growing health care costs fits into an overall pattern of spending in the hopes of restarting the economy. Since the bubble burst, revenues had stagnated, and by 1999, debt issuance financed 40% of total government spending. At the same time, tax revenue actually fell as a result of tax cut packages (*Asahi Shinbun* 09.11.1999: 13).[18] Coalition leaders brought about expensive policies not only to refloat the economy but also to win votes particularly from elderly voters, regardless of the potential cost for future generations. In long-term care insurance, therefore, the subsidies created a reliance on debt for

[17] On the dominance of electoral factors in other health care reforms, see Talcott (2001).

[18] The ratio of debt to revenue was calculated by Ministry of Finance.

current expenditures on health care, with purposes somewhat different from public spending designed to restart the economy by increasing demand.

3.5 Structure of system operation

Cities, towns, villages, and the metropolitan wards of Tōkyō administer the long-term care insurance system. This paragraph will refer to them as local governments.

Since local governments have varying sizes and administrative capacities, the law also allows new wide-area multi-governmental cooperation organizations (*kōiki rengō*) to administer the system for a number of local governments. And as in the community-based National Health Insurance system (*kokumin kenkō hoken*), payment processing is handled not by the local government but rather by the prefectural association for processing long-term care insurance payments.

Services can be provided by municipal governments directly, by service providers operated by non-profit organizations, or by private sector businesses. In the old welfare system for the elderly, services had to be provided directly by government service providers, and not all local governments could provide all services. Although voluntary non-profit groups do provide some services, especially in suburban areas, most of the non-profit organizations providing long-term care services are run by long-standing social welfare program organizations (*shakai fukushi jigyōdan*), as well as medical corporations (*iryō hōjin*) and other forms of medical service providers who create new divisions to provide services authorized by the long-term care insurance system.

Private sector businesses include special corporations such as Comsn set up entirely to provide long-term care after the insurance system was announced, new divisions of existing care providers, and new entrants into both medical care and personal care, such as Secom, a home-security business, and Nichii Gakken. These companies face strong competition from local government services that provided all services under the old system of welfare for the elderly. Many of these users continue to want to have the same provider, making it difficult for private enterprise to gain as much market share as hoped, or even to hire as many workers as expected (*Banbū* June 2000: 32). Moreover, existing social welfare providers also have access to public subsidies and long-standing contracts with cities to operate public facilities.[19] Other familiar public corporations,

[19] In Okayama one such social welfare group has several former city officials on its board, indicating the level of political connection built into the old system

such as JA, the National Federation of Agricultural Cooperatives, are hoping to turn their local presence and "brand image" into new sources of revenue for the future (*Nikkei Net* 05.03.2001).

The success of private sector providers in long-term care thus hinges on both further deregulation in the health care sector and also changes in the relationships between local governments and care providers for the elderly.

The prospects are not certain for the private sector. The Japan Federation of Employers (Keidanren) has identified long-term care as one of the sectors in which industry requests for regulatory reform have not been reflected in changes in the laws and regulations (*Nikkei Net* 10.04.2001). Existing non-profit organizations providing facility and home-based care may apply for subsidies designed to promote the availability of services. Existing residential care facilities have an even greater advantage if they are organized as social welfare corporations (*shakai fukushi hōjin)* since revenue from the long-term care insurance is not taxable for them. At the same time, private companies may have an advantage in providing home care services, or at least an additional incentive, since even non-profit organizations providing home care such as household chore assistance must pay corporate tax on revenue from the long-term care insurance system. The rationale for this decision by the Ministry of Finance was that private companies should not be at a cost disadvantage in providing long-term care services. The Ministry of Health and Welfare had argued unsuccessfully to make registered non-profit organizations exempt from taxes in order to promote more services, particularly in areas not likely to be profitable for companies, such as remote or sparsely populated areas (*Asahi Shinbun* 20.04.2000: 2). The capital-raising capacity of private businesses stands in sharp contrast to that of local non-profit organizations for home care services, but many barriers to entry in the residential care industry remain.

4. Eligibility, Benefits, and User Contributions

Eligibility for long-term care insurance system benefits is determined in two parts. The first is by age, and the second is by health status. It introduces a higher degree of risk selection into the insurance system than one purely based on occupation category or age alone. Even after eligibility for benefits is established, however, the beneficiary must apply to a

of welfare for the elderly that complicates entry by private companies (*Asahi Shinbun* (20.04.2000, Ōsaka Morning Edition, Okayama Section): A).

local government committee to certify the level of need. The local government first uses a specially-designed computer software package to assess the level of need for care of the applicant. A committee composed of five appointed members then conducts a second review, in which it may overrule the recommendation of the software, but in principle, the system is supposed to be based primarily on the objective, software-based assessment.[20]

4.1 Types of beneficiaries (65 years of age and older, aged 40 to 65)

The two types of beneficiaries for services are the elderly 65 years old and older (Type 1) and those between 40 and 65 years old (Type 2) who have diseases associated with aging. The most frequent conditions of the fifteen officially designated diseases include: strokes (62,000 people), complications from diabetes (22,000 people), chronic rheumatoid arthritis (11,000 people), Parkinson's disease (9,000 people), and early-stage Alzheimer's disease, projected at about 6,000 people.[21]

The original design might have included other disabled people in the plans, since the kinds of services provided (and the service providers) are quite similar for home care. Despite the initial hopes of some groups advocating for the disabled, such as the "Ten Thousand Citizens Committee to Realize a Public Long-term Care System" (Kaigo no Shakaika o Susumeru Ichimannin Shimin Iinkai), however, the system became fixed as one designed to support independent living among those with diseases of aging only (*Nikkei Shinbun* 12.05.1997: 7).[22]

4.2 Types of benefits (facilities, services)

Unlike the German system, Japanese long-term care insurance was not initially designed to provide a choice between cash benefits or in-kind benefits. This point was controversial in the beginning. At the final stages of implementation, Liberal Democratic Party leaders insisted that some benefits be given to families who took care of severely impaired family

[20] At the same time, the problem of running an insurance system in which eligibility and usage are not easily forecast may lead to early reforms, including re-introducing some element of central supervision over eligibility determination (see Doi 2000: 132).

[21] The numbers of patients are estimated based on ministry data by Miura (2000: 384).

[22] The leader of this group, Higuchi Keiko, was also on the Advisory Council that reviewed initial Ministry of Health and Welfare outlines of the long-term care insurance system (see Ikegami and Campbell 2000).

members but did not use any benefits from the LTCI system. A one-time payment of ¥ 100,000 was authorized at the discretion of local authorities, not as an official benefit, but as an "honorarium" (*irōkin*), a category of payments to families that already had a legal basis for local governments. Each would be free to institute this system or not. The additional cost for the national budget was estimated to be ¥ 130 million, a small fraction of the overall budget (*Shakai Hoken Junpō* 2040, 11.11.1999: 19).[23] In fiscal year 2000, 74% of local governments were found to use the system. Moreover, 69% of localities also gave an additional payment of ¥ 10,000 per month to caregivers taking care of the elderly at home, due to the lack of availability of respite care facilities in many communities (*Yomiuri Shinbun* 03.04.2001: 18). The amount of money is nowhere near that in the German system, which in the early stages was designed to pay families cash in amounts up to one-half of the equivalent in-kind benefits.

For Japan, in-kind benefits are the main part of the system. The particular mix of services are chosen and contracted for by the individual seeking care, or their family on their behalf as appropriate, working with a specially-licensed care manager or their family physicians. Care managers work in the private sector on a part-time basis, and in urban areas workloads can be quite heavy, with a fixed payment for case management not based on the volume of work, such as changing care plans frequently (*Japan Times Online* 29.03.2001). In some areas, new non-profit organizations, such as the Setagaya Welfare Support Center in Tōkyō, are developing to support families in discussions with care managers, but these efforts are limited to local initiative (*Yomiuri Shinbun* 26.03.2001: 11). Moreover, care managers and physicians sometimes come into conflict. Managers are faced with time pressure and demands of client families, while the type of care recommended by physicians because of their expertise may be quite different (*Nikkei Net* 23.03.2001).

Care managers build a menu of options in consultation with families for twelve kinds of home care benefits and three kinds of facility care, shown below. Services are then contracted with the service providers. Under the previous welfare system for the elderly, local governments would make the decisions. Contracts are intended to make the obligation of providers and users, and the cost of services, more transparent.

Home care benefits
- homehelp service
- bathing service

[23] This point is discussed in more detail in section 8 on changes to the implementation law.

– home nursing visits
– home treatment management and guidance (by doctors)
– day service (at day care center)
– outpatient rehabilitation (at medical facility)
– respite care
– group therapy for senile dementia
– nursing care services in for-profit nursing homes
– leasing and/or purchase of care-related furniture and implements
– home renovations (small-scale standardized improvements)
– support for home care

Facility care benefits
– long-term care welfare facilities (special nursing homes for the elderly)
– long-term care health facilities (geriatric health care facilities)
– long-term care medical facilities, acute-care beds, beds for treatment of senile dementia, designated long-term care hospitals[24]

The list demonstrates how long-term care for the elderly under the LTCI system incorporates the previous institutions set up under the 1963 Welfare Law for the Elderly (*Rōjin fukushi-hō*) and the medical insurance system. In this way it is more of an additional layer of insurance on top of existing welfare and medical infrastructures, rather than a pure blend of welfare and medical care. Facility care can be based in either medical or welfare facilities. Medical care facilities, including hospital beds for long-term hospitalizations, are usually parts of medical corporations or private foundations operating hospitals for inpatient and outpatient care in addition to specialized facilities for geriatric care. Welfare facilities were previously the option preferred by local governments for long-term residency under the 1963 Welfare Law for the Elderly, and are usually operated by local governments or social welfare organizations. Even under the old law, the costs of living in such welfare facilities were subsidized by local governments, but only under a system of administrative discretion (*sochi seido*). Under both the old and new systems, the costs of living in private for-profit elderly homes are not directly subsidized, except for long-term care services for residents living there. For facility-based care, a monthly fee is paid by the long-term care insurance system, and a certain co-

[24] Based on tables in NATIONAL FEDERATION OF HEALTH INSURANCE SOCIETIES (2000: 72) and *Nichii News* (05.07.1998): Kaigo hoken seido no gaiyō [Outline of the Long-term Care Insurance System]. Online at http://www.med.or.jp/nichinews/n100705f.html (as of April 20, 2001).

payment is paid by the families or the resident, as are charges for food, diapers, and other consumables. The amount of co-payment depends on the level of care, but the charges for food, diapers, etc. are fixed by the facility for all residents.

For home services, user fees are set as a flat 10% of the benefits used. Additional services can be purchased if the user pays the entire cost. Additionally, some services, such as housecleaning, are supposed to be paid for entirely by the user. The budget amount for benefits is set at the same time as eligibility according to Table 1 below, regardless of whether care is in facilities or at home.

Table 1: **Amount of benefits per month and level of care**

Degree of need	Type of needs	Benefit amount (¥/month)
needs support	some assistance in daily life	61,500
care level 1	some long-term care	165,800
care level 2	small degree of long-term care	194,800
care level 3	medium degree of long-term care	267,500
care level 4	large degree of long-term care	306,000
care level 5	highest degree of long-term care	358,000

Source: National Federation of Health Insurance Societies (2000).

4.3 User contributions

People 65 years old and older, or Type 1 beneficiaries, must pay insurance contributions from pensions for the long-term care insurance system.[25] People 40 years and older but younger than 65 years old, or Type 2 beneficiaries, must pay contributions assessed by their local government, in the same way that pension contributions for the public pension system are collected. While the per-capita component of premiums for Type 2 beneficiaries are fixed nationwide, premiums for Type 1 beneficiaries is set according to the expected level of system usage forecast for each local area, adjusted for the reported income of each individual (*Shakai Hoken Junpō* 2071, 21.08.2000: 7). In fiscal year 2000, for the Type 1 beneficiaries, the contribution rate ranged from a low of ¥ 1,533 in Ōiso-mura, Ibaraki Prefecture to a high of ¥ 4,499 in Atsuden-mura, Hokkaidō Prefecture, with a national average of ¥ 2,796 (*Banbū* June 2000: 22–23). Due to a last-minute initiative by the Liberal Democratic Party in November 1999, however, the elderly paid no premiums from April 2000 to October 2000,

[25] Long-Term Care Insurance Law, Article 7, Section 1, part 7.

half premiums from November 2000 to October 2001, and pay full premiums only since October 2001. Once contributions began, local governments deducted contributions directly from pensions for Type 1 users, and sent invoices to the homes of Type 2 residents.

Type 2 users only pay a percentage of their income, just under 1%. Minister of Health, Labor and Welfare Sakaguchi Chikara of the Kōmei Party announced that the per-capita contribution rates for fiscal year 2001 would be ¥ 2,700 per month (*Shūkan Shakai Hoshō* 29.01.2001: 44). There is a cap on combined premiums for health insurance and long-term care insurance, but this amount can be adjusted without legislative action.

For elderly users, some local governments decided to reduce or eliminate premiums for elderly beyond the original six-month free period and twelve-month half-premium period. The Ministry of Health, Labor and Welfare responded with strict instructions not to do so.[26] 78 local governments ignored repeated reminders not to subsidize premiums. It is a small group of localities that can afford to subsidize premiums, but sufficient to demonstrate that consensus on the idea of long-term care insurance as social insurance is not complete, and that at least some local politicians like to use the new system as a way to extend patronage to their residents, to mitigate the delay in building long-term care services, or both.

5. Facility Construction Under the Gold Plan 21

Services under the LTCI are encouraged with subsidies through the Gold Plan 21, the latest version of subsidies that began in 1989. As with the original Gold Plan, the Gold Plan 21 established numerical targets for building new facilities, targeting the number of facilities, or the total personnel of a given type, or the aggregate capacity of all facilities nationwide. Allocation of subsidies requires application and approval at the prefectural level as well as at the national level. Personnel at the prefectural level are appointed on short-term duty from the Ministry of Health, Labor and Welfare, and give a certain level of national coordination to a program that appears to be decentralized to some extent.

In fiscal year 2000, ¥ 230 billion was allocated for investment in infrastructure projects related to LTCI.[27] Public subsidies cover up to three-

[26] Materials from the Meeting of Section Heads responsible for Long-term Care Insurance, February 14, 2001.

[27] Ministry of Health and Welfare F.Y. 2000 Budget, Appendix 1 to Materials for National Meeting of Section Heads Responsible for Long-term Care Insurance, November 16, 2000.

quarters of the construction cost for these facilities. Targets for the Gold Plan 21 for 2004 are listed below:

Table 2: **Gold Plan 21 targets**

TYPE	TARGET
homehelper services	350,000 people
visiting nurse stations	9,900 stations
respite care facilities	26,000 facilities
temporary stay facilities	96,000 people
long-term care welfare facilities for the elderly	360,000 people
long-term care health facilities for the elderly	297,000 people
group homes for dementia	3,200 homes
"care houses" for assisted living	105,000 people
welfare centers for the elderly	1,800 centers

Each of these facilities can be used only after certification of need for assistance or care, as described in the following section. The goals of each type of facility include new facilities created after the LTCI system began, such as the care houses designed to support independent living, to a new source of funding for a much older kind of facility, such as the Welfare Facilities for the Elderly, formerly known as the Special Nursing Home for the Elderly (*tokubetsu yōryō fukushi shisetsu*) operated by local governments for the bedridden elderly.

Other systems, such as the homehelper system, was developed earlier but only allocated through the previous system of local administrative discretion (*sochi seido*) in which benefits depended on individual evaluations of eligibility at the local level under the Welfare Law for the Elderly of 1963. The former system began as an aid to low-income elderly, but soon expanded to be available to even middle-class elderly, although with a lower priority for entering facilities. Under the old system, the level of cost-sharing by the user was determined by the local government on a case-by-case system. The number of homehelpers was dramatically expanded after the introduction of the long-term care insurance system, and entry into facilities became available after a more objective determination of eligibility than under the established welfare system.

In contrast to the welfare system, the health insurance system for the elderly had also provided some services, but on a universal availability basis and at much lower cost than the new LTCI system. The home-visit nursing stations, for example, provided visiting nurses for elderly 70 years of age and older as part of all medical services, which were provided for a nominal monthly co-payment for all medical service. By contrast, with the

long-term care insurance system, first a care plan must be developed, then eligibility certified by the local government, and after services are delivered, a co-payment of 10% must be paid, with no monthly ceiling.

6. Current Data on Long-Term Care Insurance Usage

The first national census of long-term care providers and users is not scheduled to take place until June 2001 by the Ministry of Health, Labor and Welfare. No national statistics have yet been reported to the public, in part because the initial payments under the system to providers were made on the basis of estimated usage and subject to later corrections (*Shakai Hoken Junpō* 2071, 21.08.2000: 3). Even local governments are only beginning to survey usage and user satisfaction. However, some preliminary data have been reported in the advisory councils related to long-term care insurance reporting to the Ministry of Health and Welfare, and the picture of the system resulting from initial reports is one of rapid implementation nationwide.

As shown in Table 3, Type 2 users are mostly enrolled either in community-based National Health Insurance (*kokumin kenkō hoken*) or Small and Medium Enterprise Health Insurance (*seifu kanshō hoken*, directly administered by the government). Total expenditures on Type 2 beneficiaries are projected to reach ¥ 29,000 per person, for a total of ¥ 1.25 trillion.

Table 3: **Fiscal year 2000 Type 2 beneficiaries and long-term care premiums**

Health insurance system	Number of Type 2 beneficiaries	Total long-term care spending (billion ¥)
Small and medium enterprise (government-operated)	13,573,725	393
Large employers	10,850,773	314
Sailors	117,794	0.34
Public employees	3,472,606	100
Community-based health insurance	15,175,711	439
Total	43,190,075	1248

Source: Data compiled by Shakai Hoken Shiharai Kikin (Social Insurance Payment Fund), reprinted in *Shakai Hoken Junpō* 2060 (11.05.2000: 37).

One reason that premiums for Type 2 users are made through existing insurance systems is that employers must split the cost of the insurance premiums with employees. The amount is just under 1%, depending on

employment status. Although it may appear similar to the practice in the medical insurance system, this measure was vigorously opposed, particularly by the Central Committee of Small and Medium Enterprises (Zenkoku Chūshō Kigyō Dantai Chūōkai), the Japan Federation of Employers (Nikkeiren), and the Japan Chamber of Commerce (Nihon Shōkō Kaigijo) (*Nikkei Shinbun* 25.04.1997: 5). For community-based health insurance and the sole proprietors, farmers, and retirees (under 65) enrolled in it, the government pays one-half of the premiums. By contrast, the Democratic Party supported a tax-based system, similar to that favored by many employers (*Nikkei Shinbun* 26.04.1997: 5). In the end, premiums followed instead the social insurance model of premiums for people between 40 and 64 years old.

Table 4: **Type 1 beneficiaries by level of care and facility type**

Level of care						
Requires support	1	2	3	4	5	Total
320,809	670,271	466,664	352,238	364,870	322,931	2,497,783

Home-based care							
Requires support	1	2	3	4	5	Unclassified	Total
212,229	401,175	248,135	158,531	127,627	110,201	39,024	1,296,922

Facility care				
Welfare facility	Geriatric health facility	Hospital bed (long-term care type)	Unclassified	Total
283,513	220,293	102,135	17,984	623,925

Note: Level of care and home/facility care are based on data from December 2000, while the type of facility or home care is based on data from October 2000.

Source: Kōsei Rōdōshō Hokenkyoku Kaigo Hokenka (2001).

According to the Ministry of Health, Labor and Welfare, the number of Type 1 (65 years of age and older) beneficiaries reached nearly 2.5 million by December 2000, or just under 11% of the eligible population. Detailed figures are presented in Table 4. Of the recipients, fewer than one-half were found to require Level 3 of care or higher. The number of people in facilities was 623,925 people, just under one-fourth of the people requir-

ing care. Only 20% of these were in long-term hospital beds, and 40% each were in medical or welfare facilities for the elderly. At the same time, nearly 500,000 people at Level 3 or higher were being cared for at home (Kōsei Rōdōshō Hokenkyoku Kaigo Hokenka 2001). Details are presented only for Type 1 users. More detailed data on usage by Type 2 users (aged 40 to 65) and by facility type should become available after June 2001 when the first comprehensive surveys are planned to be conducted by the ministry.

Although a vast amount of services were provided in the first year of full operation, the system did not reach all of its goals. A *Nikkei Shinbun* survey of local governments found that people used an average of only 74% of the services planned in their care plans in 2000 (*Nikkei Net* 11.03.2000). The reasons for under-use included the lack of availability of services, another reason for the continued popularity of cash benefits in many communities.

7. Budget and Financing

One of the primary goals of the new long-term care insurance system is to reduce spending for the elderly under the old-age health insurance system by replacing costly medical care with more appropriate facility-based and home-based care. Based on the budget reduction for fiscal year 2000 in the old-age health insurance system of 11.1%, the long-term care insurance system has not yet fully achieved this goal, since in April 2000 spending had decreased only by 7.7% (*Shakai Hoken Junpō* 2071, 21.08.2000: 7). Nevertheless, it is still too early to pass final judgment, and the initial reduction, although smaller than expected, suggests that care is beginning to shift into the new system as planned.

Resources for funding long-term care come from individual contributions from the elderly (Type 1 users), people older than 40 but less than 65 years old (Type 2 users), and general revenues. The ratio is 17%: 33%: 50% for the three funding sources. Subsidies from general revenues not only cover part of the cost of services, but also part of the costs of constructing and operating facilities, and of operating costs for public bodies as well including local governments and insurance claims processing public corporations. These general subsidies, however, are split between the central government (50%), the prefectural government (25%), and the local government (25%). Since expenditures for long-term care are not capped, local and prefectural governments are likely to bring pressure for national subsidies to localities facing higher-than-expected costs, a concern ex-

pressed by Akamatsu Yoshinori, mayor of Kagoshima City, in the initial meeting of the Minister's Expert Commission on Social Security Reform in January 2000.[28] Moreover, Type 2 users pay 33% of the costs, but receive only 5% of the benefits of the system.[29] Therefore, some observers are critical that the system is a hidden tax increase on the non-elderly.[30] Future reforms could therefore find support for an increase in general-revenue subsidies for the system, but there is little indication that the Ministry of Finance or the Ministry of Health, Labor and Welfare have any intention of raising national subsidies for the operating costs of the system.

7.1 Facilities

In addition to public subsidy of fees for long-term care insurance, there are significant public subsidies for facility construction to provide services under the long-term care insurance system. These are budgeted through the Ministry of Health, Labor and Welfare directly, and additional loans for long-term care insurance facility construction are available through the Welfare and Medical Program Organization (WAM, Shakai Fukushi Iryō Jigyōdan). Amounts from the ministry budget are financed through general taxation; WAM and other loan programs are financed by loans from the postal savings system. Neither subsidies nor loans to facilities are financed by contributions to the long-term care insurance system. This means that in the public health insurance system, capital costs are not covered by reimbursements under the insurance system. Since reimbursements are calculated without reference to construction costs, public money subsidizes facility owners only at the stage of construction. In this way, facility construction relies on political relationships to license grantors, since a facility cannot recover construction costs entirely through operating revenue that is disbursed as a benefit. The approval of facilities thus becomes a scarce resource allocated by administrators. In the health and welfare administration system, prefectural governments (or major cities) must approve construction plans. These ad-

[28] *Shakai hoshō seido no arikata ni tsuite kangaeru yūshikisha no kaigi gijiroku* [Minutes of the 1st Meeting of the Prime Minister's Expert Commission on Social Security Reform], January 18, 2000. Currently (as of August, 2002) online at http://www.kantei.go.jp/jp/syakaihosyou/dai1/1gijiroku.html.

[29] *Zenkoku kōsei kankei buchō kaigi shiryō* [Materials for the National Meeting of Division Heads responsible for Health and Welfare Administration], January 1, 1997.

[30] A representative criticism of inter-generational unfairness can be found in Itō (2000).

ministrations are usually run by central government Ministry of Health, Labor and Welfare career employees on assignment. This suggests a continued incentive for political concerns to outweigh fiscal restraint in the future, particularly if the services become popular.

Political problems are not the only way the LTCI system may be used for different purposes than simply handling the problems of caring for the elderly. The structure of central control of personnel in charge of licensing contributed to a scandal in 1996 involving former vice-minister Okamitsu Nobuharu. Koyama Hiroshi, real-estate developer in Saitama Prefecture seeking to build nursing homes, provided a condominium and a car to Okamitsu. Koyama also gave money to Chatani Shigeru, a Ministry of Health and Welfare employee who had been temporarily assigned to Saitama Prefecture in charge of approving license and subsidies for long-term care facilities.[31] At the same time, few examples of this kind of behavior have been reported after 1996, and it seems that the negative example, and strict rules enforced on ministry and local government personnel regarding gifts from the private sector, succeeded in discouraging other such attempts to influence the allocation of subsidies. Another avenue for contract troubles comes when subsidies go through social welfare organizations rather than directly through the local government. New instructions issued in 2001 clarify that no "rebates" (kickbacks) are to be taken from contractors building long-term care insurance facilities, in light of several unspecified incidents reported to the ministry.[32] While the administration of subsidies contains the possibility for abuse, incidents seem to be isolated.

By the time long-term care insurance came into full effect in April 2000, many facilities were built by medical corporations that already operated hospitals and/or clinics. One of the reasons cited for the heavy participation by doctors is the predisposition of the ministry to restrain health care spending, which means that doctors expect that the only way to expand revenue is to provide services under the new long-term care

[31] Despite his explanation that the gifts were no more than tokens of friendship, Okamitsu received a sentence of two years in prison. He was the first vice-minister ever to be sentenced and serve time in prison rather than have the sentence suspended. Chatani was also convicted and sentenced to eighteen months in prison but his sentence was suspended. Both had to repay the amounts received from Koyama.

[32] *Zenkoku kaigo hoken tantō kachō kaigi shiryō* [Materials for the Meeting of Section Heads Responsible for Long-term Care Insurance], February 14, 2001. No details of the incidents were published, but their existence was mentioned as an area for caution.

insurance system (Ikegami 1997: 1311). The third category of facilities, hospital beds for long-term care (*ryōyō-gata byōshōgun*) represent administrative efforts to designate beds in certain hospitals with many long-term inpatients for lower payments.

7.2 Services

Contributions to the long-term insurance system (*kaigo hokenryō)* finance the provision of services. Since long-term care insurance spending depends in part on unpredictable demand for services, the amount budgeted for long-term care is adjusted over the year in supplementary budgets as needed. Usage for a fiscal year is estimated and budgeted under the social security section of the special budget accounts. Actual spending, however, is determined in principle by the person seeking long-term care (or their families) in cooperation with the care manager, under the budget amount set by the process of certification of need for care. The spending so far has been less than budgeted in some cases, but the overall amount of spending is on track with expectations. The new tool of monthly benefit budgets resembles a prospective payment system, and may serve to contain the growth of spending better than entitlement-based medical care in which decisions by (mostly) private physicians determine the level of spending. On the other hand, amounts were set to provide a similar amount of services as under the old system, at a cost to the user not out of line with previous out-of-pocket expenses, at least for facility-based care. It remains to be seen whether the new mechanism will be politically feasible.

7.3 Administration

The national government budget for long-term care insurance also subsidizes local government administrative costs, and public corporations which process insurance claims for LTCI (as well as ordinary health insurance). For local governments that are too small to have an effective administrative structure for long-term care insurance, the Ministry of Health and Welfare promoted the development of wide-area multi-governmental cooperation organizations (*kōiki rengō*) to administer the system on behalf of several localities. By May 2001, 58 such alliances had formed nationwide. The restructuring of local government administration was not limited to cooperation on the issue of long-term care insurance. Each local government also has a section responsible for administering the system of health care for the elderly (*rōjin hoken fukushi*), and by the end of 2002, the ministry intends to have each locality draw up plans

to eliminate overlaps and redundancies in personnel between these two sections.[33] These measures concerning local governments are implemented without Diet action, since ministry ordinances are authorized in the implementation law.

In return for compliance with strict oversight and reorganization plans, localities are being given even higher subsidies than first anticipated. By February 2001, an *additional* ¥ 100 billion ($ 0.8 billion at then-current exchange rates) was proposed to smooth implementation at the local level, half for new programs, and half for facilities and salaries for additional officials to administer the system at the local level.[34] This pattern in policy, in which central officials set the direction and provide incentives and penalties for compliance and non-compliance, has come under criticism as not fully involving local communities in planning their own futures. The opposite criticism was also heard from the beginning, however, that without standardization, people nationwide would pay the same premiums, but depend entirely on the discretion of local governments, just as in the previous old-age welfare system.

8. Changes in Long-Term Care Insurance Legislation under Discussion

Reform measures that will not require amending the laws are underway in the area of certification of need for care and the fee schedule for long-term care. The Ministry of Health and Welfare created an expert committee, the Certification of Need for Long-Term Care Discussion Group (Yō-Kaigo Nintei Kentōkai) to report back after surveys in November 2000 and February/March 2001, and possibly to develop a model program to introduce a revised certification system in several localities in fiscal year 2001 (*Shakai Hoken Junpō* 2071, 21.08.2000: 4). For the fee schedule, increases are planned for April 2003. After a study of the operating costs of long-term care providers, the Social Security Advisory Council, which reports to the Minister of Health, Labor and Welfare, will debate increases in certain service areas. Many care providers are complaining that they cannot provide high-quality service at the current level of insurance

[33] Materials regarding wide-area cooperation organizations, presented in the National Meeting of Section Heads Responsible for Long-term Care Insurance, February 14, 2001.

[34] Materials regarding fiscal measures in 2001 for local government LTCI programs, presented at the National Meeting of Section Heads Responsible for Long-term Care Insurance, February 14, 2001.

reimbursements (*Nikkei Net* 02.04.2001). In addition, the Subcommittee on Long-Term Care Fees of the Health Insurance and Welfare Advisory Council (Iryō Hoken Fukushi Shingikai Kaigo Kyūfuhi Bukai) set guidelines for the revision to the fee schedule in an interim report on October 26, 2000. This kind of revision in fees in advisory councils with representatives from business, labor, care providers, and government experts is the same style used for the regular health insurance system. For determining price increases in the fee schedule for the regular health insurance system, however, surveys could not be successfully conducted because of resistance from private hospitals and clinics about the methods and use of information in the surveys. For this reason, the long-term care cost survey could also become politicized.

Assuming the present course of social insurance and consumption-tax funding continues, there are likely to be only increases in the premiums for long-term care insurance, rather than any whole-scale system revisions in the near future. Initial indications of the next direction for reform of the whole social security system, in the form of the Prime Minister's Commission on Social Security report in March 2001, are that no major changes will be made to system financing (*Nikkei Net* 08.03.2001). Under the Japan Medical Association's (JMA) new plan for Structural Reform of Health Care in Japan, the long-term care insurance system for people 75 years of age and older will be integrated into a new health insurance system for the elderly, but no earlier than 2007. The JMA plan would also have a separate LTCI system for people under 75 years old administered separately.[35] But with a full-scale reform (*bappon kaisei*) of health insurance slated for 2002, the prospects of rapid change in the long-term care insurance field are limited, and it is not certain how comprehensive any health-related reforms will be given the challenge of satisfying the powerful groups as well as ordinary citizens in a period of slow government revenue growth.

9. Conclusion

The basic goals of Japan's long-term care insurance system have been achieved: a social insurance system provides financing (along with public subsidies) for a menu of services to care for the elderly (and younger people with diseases associated with aging) at a level appropriate for their need for care through a mixture of public and private providers at

[35] A simplified version of the JMA plan is on their website (in Japanese) at http://www.med.or.jp/nichikara/koso_p.pdf (as of June, 2001).

prices fixed by the Ministry of Health, Labor and Welfare. In each of these areas, there is also room for improvement. The early expectation of some critics that the system would be unavailable or unused seems to be partially fulfilled: a *Yomiuri Shinbun* (01.04.2001: 1) survey found that 80% of localities did not spend their whole budget, due to underuse of services. This echoes the *Nikkei Net* (11.03.2000) finding that 74% of users did not use all the services planned in their care plan. Moreover, private enterprises seeking to provide residential and home care services have not seen as much regulation as they would like, and major companies have dramatically scaled back their operations in light of lower-than-anticipated demand, or over-investment in too many locations at once. Finally, there is some criticism of the process of determining levels of care, particularly for home-bound elderly, that the system does not provide enough services to really free families from the heavy burden of care.[36]

These elements of dissatisfaction may provide material for politicians to make new appeals to elderly voters as they have in the past. At the same time, the higher burdens on younger voters may give opposition politicians grounds to complain that the system has been shifted away from its original purposes for political reasons, at great cost to voters under 65. So far, this kind of confrontation over generational politics has not surfaced as a campaign issue. Alienating older voters is a risky strategy, since they tend to vote in much greater numbers than younger voters.[37] The deep fiscal crisis of the Japanese state in 2001 may place limits on the extent to which new benefits can be extended to the elderly, particularly after Finance Minister Shiokawa Masajūrō's commitment to a ¥ 30 trillion ceiling for new public debt in fiscal year 2002.[38] At the same time, the deep local control over the program may give Diet members and their constituencies an incentive to increase spending if it proves popular. While the Ministry of Health, Labor and Welfare tends to supply personnel to run prefectural government sections responsible for administering and licensing, local governments have their own balances, and unless the ministry is able to place personnel directly in charge of wide-area cooperation organizations, there may be incentives to expand spending wider than anticipated. The system that was designed to overcome so-called "provider-induced demand" (excessive use of resources by revenue-seek-

[36] For a well-documented critique of the system operation and benefits, see NIKI (2000).

[37] This argument is elaborated further in TALCOTT (1999: chapter 6).

[38] Finance Minister Shiokawa Masajūrō announced the ¥ 30 trillion debt ceiling in connection with Prime Minister Koizumi's reform plans (*Nikkei Net* 24.05.2001).

ing physicians) may face instead problems of "political-induced demand" (excessive use of resources by vote-seeking politicians).

Final judgment on the course of future reforms will depend on electoral calculations of the Liberal Democratic Party, both in terms of the timing of the next Lower House election, and in the nature of public spending decisions. If the past is any indication, it can be expected to cost more, not because of negligence, but out of conscious decisions to use the system. This pattern is evident in recent health insurance reforms as well as the long-term care insurance system. Record public debt levels, reaching 115% of GDP by 1999 for central and local government debt combined, may make the system less difficult to expand, but part of the reason the debt grew large was due to a pattern of political intervention without regard to financial consequences. If this tendency to use the system to reward supporters and appeal to voters does not change, the LTCI system may provide better services or cost less for the elderly, but at the same time end up being worse for the nation as taxes, debt, or both must be raised to pay for improvements. The fate of the long-term care insurance system, like so many other issues confronting Japan in 2001, rests in the hands of political leaders.

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