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The Formation and Reorganization of the System of Long-Term Care Services in Japan: From the 1980s to the Present

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Japan is one of the few countries that have adopted a social-insurance-based approach for financing long-term care (LTC) services for the elderly. The shift in the approach to financing LTC services from tax-based to social-insurance-based occurred with the launch of the long-term care insurance (LTCI) scheme in April 2000. This shift in LTC financing was concomitant with an overall reform in the system for providing LTC services. The Japanese system for providing LTC services, which was developed in the 1980s and 1990s with the expansion of LTC services, was reorganized in order to incorporate quasi-market mechanisms and realize an integrated provision of health and social care services within the framework of "mixed economy of care."

This paper aims to analyze the process of the formation and reorganization of the system of LTC services in Japan and to discuss the implications of the results of this analysis for comparative studies on health and social care.

Shift in the Government Policy for LTC Services

Japan experienced a rapid aging of population in the 1980s and 1990s. The proportion of those aged sixty-five years and over increased from 9.1 percent in 1980 to 12.1 percent in 1990 and 17.4 percent in 2000. This rapid aging of population resulted in the increase in the needs for LTC services; however, the former was not the sole cause of the latter. With the decline in the proportion of three-generation households, changes in family values, and increased participation of married women in the labor force, the capacity of the family to care for its aged members gradually diminished. Advances in medicine, improved access to health care, and a rise in the standard of living lengthened life expectancy; at the same time, however, they increased the number of frail elderly persons in need of intensive support over long periods.

The government response to the growing needs for LTC services was generally slow in the 1980s, although those aged seventy years and over were guaranteed access to inpatient and outpatient medical care at no charge (until January 1983) or for a small co-payment (February 1983 onward). The growth in the number of nursing home beds was simply unable to keep pace with the rapid increase in the demand for nursing home care. At the time, community care services were at an early stage of development. Therefore, the number of frail elderly persons in need of lengthy hospitalization increased rapidly. The majority of these persons did not need intensive medical care but stayed in the hospital because adequate family care was unavailable. This phenomenon was called "social hospitalization."

The 1980s witnessed a growing recognition among LTC professionals, policymakers in the fields of health and social care, and those campaigning for the welfare of the aged that drastic measures should be taken to solve the problem of social hospitalization for the following two reasons. First, the growth in social

hospitalization caused an upsurge in medical care expenditure. Second, the quality of care for those hospitalized for "social" reasons was generally regarded as low, because hospitals lacked appropriate facilities for social care and were unable to employ a sufficient number of care workers for this purpose.

In addition, these professionals, policymakers, and campaigners were concerned about the growing number of elderly persons for whom adequate care was not provided in their homes due to a poor housing environment, the family caregiver's lack of knowledge or poor health, or emotional conflict with the family caregiver. According to them as well as many citizens, the traditional Japanese model of long-term care for the elderly, which depended heavily on family care, appeared no longer sustainable.

A radical policy shift occurred at the end of 1989. The Japanese government published an ambitious ten-year plan (which was later called the "Gold Plan") for the rapid expansion of LTC services, giving priority to community care services. The main service targets of this plan are shown in Table 1. The government declared that the implementation of this ten-year plan was secured with sufficient funds in the form of a government subsidy to prefectures and municipalities.

Regarding the factors that caused this policy shift, in addition to the demographic and social factors mentioned above and political factors that will not be detailed here[1], two important factors are worthy of note: the influence of the Scandinavian LTC system and the development of new programs and skills for elder care in the care facilities.

In the 1980s, a considerable number of Japanese policymakers (in the central and local governments), professionals and academics working in the field of LTC, as well as journalists visited Scandinavian countries to directly examine the LTC facilities and agencies in these countries. They were impressed by the scale of the provision of care services (e.g., the number of home helpers), the high quality of care (e.g., "service houses"), and innovative programs (e.g., around-the-clock home care and group homes for those suffering from dementia) in these countries, particularly in Sweden and Denmark, and began to explore the possibilities for "importing" some of these programs and practices into Japan.

Another important factor in the policy shift was the development of new programs and skills for elder care in the front line of LTC. Several care facilities in Japan were keen to involve health professionals, social workers, and care workers to develop new programs and skills, such as those that help the frail elderly to maintain their physical independence or caregivers to cope with the behavioral problems of elderly people suffering from dementia. This led to changes in the views about the purpose and function of formal care services, which were no longer seen as a substitute for family caregiving. As positive effects of formal care services on the physical and mental

[1] See Campbell (2002), Eto (2000), and Hiraoka (2005) for an analysis of these factors.

functioning of the elderly could now be expected, the difficulties in procuring support from politicians, financial authorities, and eventually tax payers for the augmentation of public spending on LTC could be overcome.

Formation of the System of LTC Services in Japan in the 1980s and 1990s

In accordance with the expansion of LTC (and other social care) services, a series of reforms was conducted in the latter half of the 1980s and the first half of the 1990s. The Japanese system of LTC services was established through these reforms. We will describe below the basic characteristics of this system.

Welfare mix LTC services were directly provided by prefectures or municipalities in this period, albeit only in a limited number of cases[2]. The majority of institutional and community care services were provided by governmentally approved nonprofit organizations that had the legal status of "social welfare corporations" under "commissioned placement" (Hiraoka, 2001) or similar contract arrangements with municipalities. The organizations were protected from market competition under the *de facto* long-term contract.

Independent sectors showed a tendency to diversify during this period (Hiraoka, 2001). Mutual-aid organizations of a new type that aimed to provide community care services appeared early in the 1980s and grew rapidly in number in the 1980s and 1990s. They bridged the gap between the growing demand for these services and the availability of public or contracted-out services. A considerable number of nonprofit organizations that run hospitals also began to make inroads into the field of LTC services in the 1990s.

In the mid-1980s, the government began to promote the development of for-profit service providers. The for-profit sector in the field of LTC services expanded in the 1990s, but not to the extent expected. The main reason for the limited expansion of the for-profit sector was the lack of financial assistance to those who utilized services provided by independent organizations outside the framework of contracted arrangements between municipalities and governmentally approved nonprofit organizations. This problem was addressed in the policymaking process of the LTCI scheme in the mid-1990s.

Central role of municipalities In the system for LTC service provision that the central government attempted to establish in the latter half of the 1980s and the first half of the 1990s, municipalities were expected to play a central role in the overall management of LTC services (as well other fields of social care), particularly in assessing the needs of the elderly; securing resources for meeting these needs; allocating the resources to different services, agencies, and service users; and

[2] According to a survey conducted in 1995, only 9 percent of nursing homes were directly managed by local governments, and only 15 percent of home helpers were employed by them (Hiraoka, 2005).

coordinating the activities of different agencies.

A series of reforms for the devolution of authority in the management of social care was conducted from the mid-1980s to 2000. As a result of the revision in the Law for the Welfare of the Aged and the Health and Medical Care Law for the Aged in 1990, municipalities as well as prefectures were legally obliged to publish a "Health and Welfare Plan for the Elderly" and include in it service targets to be achieved during the planning period.

Rationing of services After the implementation of the series of reforms mentioned above, municipalities were vested with the authority to set eligibility criteria for social care services in accordance with the laws and government regulations and to make decisions on who should be provided with what type of service and how much. Municipalities had discretionary powers in making these decisions. Individuals in need of care or support had no legal entitlement to utilize social care services.

Strict division between institutional and community care Another feature of the system of service provision in the 1990s was the strict division between institutional and community care. Care facilities were established and managed either in the traditional model of large-scale social welfare institutions or hospitals. Most of the LTC facilities established in the 1980s and 1990s had four or more people in one room. Group homes for elderly persons suffering from dementia began to be established in the 1990s, but the number of these homes did not exceed 100 until 1999. Intensive home care services were not normally available even after the implementation of the Gold Plan. The around-the-clock home care service was introduced in the mid-1990s on an experimental basis and, after a few years, was established as a government-subsidized program. However, it was not available nationwide in the 1990s.

Care planning and coordination In developing community care services late in the 1980s, the government recognized the need for a mechanism to coordinate the services provided by different agencies. Hence, it decided to promote the establishment of an "aged-care service coordinating team" in each municipality. In addition, in drawing up the Gold Plan, the government included in it a plan to establish 10,000 home care support centers all around the country. These centers, established by municipalities but mostly managed by social welfare corporations (governmentally approved nonprofit organizations), were basically "information and referral" centers, but they gradually became responsible for some or many aspects of the care management function.

Reorganization of the System of LTC Services in 2000

With the launch of the LTCI scheme in April 2000, the system for providing LTC

services was extensively reorganized[3].

Marketization and welfare mix With the launch of the LTCI scheme, quasi-markets were created for LTC services. In the case of community care services, restrictions on entry into the LTC services market were considerably relaxed. For-profit agencies and new types of nonprofit agencies could make inroads into the LTC services market and compete with each other and with social welfare corporations on an almost equal footing. Consequently, the supply of community care services by for-profit agencies and new types of nonprofit agencies expanded rapidly. In the case of home care services, based on the result of a nationwide government survey, we estimate that 25.6 percent of the total number of service users were receiving services from for-profit agencies in October 2000, six months after the launch of the LTCI scheme (Hiraoka, 2005). On the other hand, in 1996, only 6.6 percent of those using home care or home help services were using services provided by for-profit agencies.

In contrast, the extent of marketization in the institutional care sector is limited. Even after the introduction of the LTCI scheme, for-profit agencies and new types of nonprofit agencies were prohibited from providing institutional care services within the framework of the LTCI scheme. In addition, the supply of institutional care services remained under the control of the government and prefectures through the mechanisms of authorization and planning. As a result, ever since the introduction of the LTCI scheme, there has always been a considerable undersupply of institutional care services; this means that the elderly have little scope to choose between different care facilities. However, from a different viewpoint, it can be said that after the introduction of the LTCI scheme, even this protected sector came to be in competition in one form or another with group homes for those suffering from dementia or the "fee-charging homes for the aged"[4]. The number of these two types of homes, which were regarded as providers of community care services within the framework of the LTCI scheme, was not under government control and therefore grew rapidly with the increasing length of the waiting lists for admission to care facilities.

Shift in the balance of care The abovementioned differences between institutional and community care services in the extent of marketization and government control over the amount of services provided were intended to function as an effective device for shifting resources from institutional to community care. During the first five years (Fiscal Years 2000 to 2004) of the implementation of the

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[3] See Hiraoka (2005), Campbell and Ikegami (2003) and Ikegami & Campbell (2002) for an outline of the LTCI scheme and an analysis of this reorganization.

[4] Fee-charging homes for the aged are independent old people's homes that were operated, before the start of the LTCI scheme, outside the contracted arrangement between municipalities and nonprofit agencies; its residents received no financial support from the central or local government. Since the introduction of the LTCI scheme, these homes are provided a remuneration by the scheme for providing care services, so long as they meet the criteria set by the government.

LTCI scheme, the total amount of benefits for community care services increased 2.26 times. On the other hand, the monetary value of the benefits for institutional care services increased only 1.20 times. As a result, the proportion of benefits for community care services increased from 33.9 to 49.0 percent during this period (Hiraoka, 2006).

This may appear like a resounding success of the policy in shifting the balance of care from institutional to community care, but its adverse effects should not be overlooked. During the first few years of the implementation of the LTCI scheme, the waiting lists for care facilities for the aged became increasingly longer all over the country. The only measures adopted by the government were an alteration in its regulations on admission to care facilities and instructions to local governments and care facilities to jointly set criteria for determining admission priorities.

Central role of care managers With the launch of the LTCI scheme, a comprehensive care management system was introduced. Every service user became entitled to use the care management services free of charge. Care management was expected to play a central role in the planning and coordination of care services and was regarded as the cornerstone of the entire LTCI system. Care managers are normally employed by for-profit and nonprofit agencies, and remunerations for care management services are on a per capita basis under the LTCI scheme.

Diminishing role of municipalities With the launch of the LTCI scheme, municipalities assumed full responsibility for the financial and administrative management of the scheme. However, their role in the overall management of the system for providing LTC services diminished substantially. Frail elderly persons, once assessed to be in need of care according to the criteria set by the central government, became entitled to utilize community or institutional care services within the limits set by the government in accordance with the degree of their dependence, and can directly contact service providers to enter into a contract with them. Normally, the care managers they select have a strong influence on the care seekers' choice of service provider, but municipalities cannot intervene in the planning of care or the choice of service provider apart from exceptional cases. Municipalities have lost their discretionary power in the delivery of LTC services and the establishment of eligibility criteria.

Reform of the LTCI scheme on the basis of the Revision of the LTCI Law in 2005

In June 2005, the Diet approved a bill for a partial amendment of the LTCI Law. Some of the amended clauses came into force in June and October 2005, and the others in April 2006. The contents of the bill to reform the LTCI scheme were multifaceted and complex[5]. The bill's most controversial aspects were measures to contain the

[5] See Hiraoka (2006) for an analysis of the background and the contents of this reform.

rising benefit expenditure (e.g., an increase in user charges for institutional care services) and the introduction of "preventive services." However, we would like to focus specifically on the revision in the system for providing LTC services established in 2000.

Inclusion of new community care services From the viewpoint of the advancement of community care in Japan, the most important aspect of the reform is the inclusion of a new category of services called "locally based services" in the list of care services that are eligible for LTCI benefits. One of these services, called "small-scale multifunctional care facilities"—a flexible combination of day care, short stay, and home care services—was originally developed by volunteers in various places and spread throughout the country by virtue of its flexibility. Some others were small-scale facilities, which formerly had not been eligible for benefits on the grounds that their small size renders them economically inefficient.

Reestablishing the role of municipalities It is noteworthy that some measures were taken to reestablish the role of municipalities in the overall management of LTC services. First, for the abovementioned locally based services, the responsibility for accrediting and regulating the care agencies and setting the schedule of remunerations for these agencies was devolved to municipalities. Second, municipalities were given the responsibility of establishing and managing the "Community Total Care Support Center" in each locality so that the LTC services could be more effectively coordinated. Third, municipalities also took over the responsibility of managing newly created preventive services, including the care management process.

New measures for improving the quality of care Several measures have been taken to improve the quality of care. First, all the service providers are now obliged to disclose as specified by the government information concerning the services they provide and their organizational management. The government hopes that this will help service users to select their service providers based on more adequate and reliable information than before. Second, the regulatory power of municipalities has been strengthened so that corrupt agencies such as those that make fraudulent claims for remuneration or provide improper services capitalizing on service users' ignorance can be more effectively expelled from the market. Third, a new schedule for the payment of remuneration to care agencies has been introduced for some services, whereby the amount of remuneration varies with the quality of care, judged either by input indicators such as the staff-client ratio, proportion of qualified staff, or fidelity to a certain desirable process model, or by outcome indicators such as the proportion of clients whose level of dependence had decreased.

Discussion

In concluding this paper, we would like to discuss three issues that seem to have implications for the comparative study of the social care regime.

Market and quality of care The marketized system of service provision created with the launch of the LTCI scheme was modeled on the system introduced in Britain with the implementation of the "community care reform" early in the 1990s. There are, however, some important differences between these two systems. In the Japanese system, it is not the municipalities that purchase LTC services from for-profit or nonprofit providers but individual service users that enter into contracts with them. As mentioned above, municipalities are not responsible for the rationing of services among those in need of such services, nor can they intervene in the individual care plans or choice of service provider. In our earlier paper, we compared the Japanese and British systems using the typology of a pluralistic system of service provision comprising the "service-purchasing type" and the "user-subsidizing type" (Hiraoka, 2001).

In the Japanese system, which is similar to the user-subsidizing type, users have more freedom of choice and service providers can compete with each other with less intervention from local governments than in the British system, which is basically the service-purchasing type. However, it can be said that owing to the "asymmetry of information," Japanese service users are in greater danger of being abused or deceived by corrupt providers or of choosing an inappropriate care plan or service provider, unless effective measures are taken by the central or local governments to provide them with adequate information and advice and to protect their rights through care management or other appropriate systems.

Almost every year since the introduction of the LTCI scheme, the Japanese government took additional measures to improve the quality of care. As these measures—including a complaints procedure, a support system for care managers, and a computerized system for the inspection of benefit claims—did not necessarily prove effective, the government, with the revision of the LTCI Law in 2005, as noted earlier, took several additional measures, including the large-scale and costly scheme of obligatory disclosure of service provider's information. However, this new scheme seems to be still in the "trial and error" stage and its effectiveness is yet to be determined.

Role of the municipality and markets In designing the system of service provision in the legislative process of the LTCI Law, policymakers in the government appear to have attached greater importance to introducing a market mechanism in the system rather than to strengthening the municipalities' capacity for planning and coordinating services in the direction pursued by the government in the 1990s. Consequently, the planning and coordinating function of municipalities has shrunk substantially. One of the main causes of the rapid expansion of LTC services, particularly community care services, was the entitlement given to elderly persons in need of care and the loss of power of municipalities to control the supply of LTC services. A number of mayors who were responsible for the financial management of

the LTCI scheme were naturally discontented with this situation.

As a result of the reform conducted based on the revision of the LTCI Law in 2005, municipalities regained the power to control the number of care services in the limited area of locally based services. In addition, they took over the responsibility of managing preventive services that were expected to contain the future expenditure under the LTCI scheme if these services were effectively provided.

These facts appear to indicate that in comparing the roles of municipalities and markets in different countries, we need to closely examine the institutional design of the system for providing LTC services. The devolution of authority or the introduction of a market mechanism may have different effects on the provision of LTC services depending upon its institutional design.

Familialism and the gendered nature of care Familialism was, and may still be, an important feature of the Japanese welfare regime, and the manner in which it has influenced the LTC policy may not be as straightforward as is often argued. Familialism in the government policy aggravated the problem of social hospitalization in the 1970s and 1980s. The graveness of this problem, however, had paradoxical consequences. As J. C. Campbell (2002) pointed out, the universal availability of social hospitalization since the 1970s has made it politically impossible to introduce a more targeted and less generous type of LTCI scheme such as those found in Germany. We would call this phenomenon "the paradox of familialism" in the Japanese LTC policy.

Regarding the gender dimension of the Japanese LTCI scheme, we would like to point out that the LTCI scheme has both strengthened and weakened the gendered nature of the Japanese regime. The services provided under the LTCI scheme have had a more or less "defamilializing" effect. Under this scheme, LTC services are available regardless of whether or not the elderly person has family members to care for him or her. On the other hand, the establishment of the LTCI scheme has increased the proportion of low-wage and irregular jobs in the LTC sector, most of which have been taken by female workers.

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Table 1. Main Service Targets of the 'Gold Plan' (the Ten-Year Plan for the Promotion of Health and Welfare Services for the Elderly)

	Number in 1989	Service Target (in 1999)	
		"Gold Plan"	"New Gold Plan"
		(1989)	(1994 revision)
Home helpers (persons) (a)	31,405	100,000	170,000
(per 1,000 elderly population)	(2.2)	(4.7)	(8.0)
Short-term stay services (beds)	4,247	50,000	60,000
(beds per 1,000 elderly population)	(0.3)	(2.4)	(2.8)
Daycare centers	1,080	10,000	17,000
(per 1,000 elderly population)	(0.1)	(0.5)	(0.8)
Homecare support centers	---	10,000	10,000
(per 1,000 elderly population)		(0.5)	(0.5)
Visiting nurse stations	---	---	5,000
(per 1,000 elderly population)			(0.2)
Nursing homes ('*Special care homes for the aged*') (beds)	162,019	240,000	290,000
(per 1,000 elderly population)	(11.3)	(11.3)	(13.7)
Geriatric healthcare facilities (beds)	27,811	280,000	280,000
(per 1,000 elderly population)	(1.9)	(13.2)	(13.2)
Care houses (persons) (b)	200	100,000	100,000
(per 1,000 elderly population)	(0.0)	(4.7)	(4.7)
Elderly population, aged 65 and older (1,000)	14,309	21,156	21,156
	(c)	(d)	

Notes:

(a) includes part-time home helpers

(b) sheltered accommodation for the elderly

(c) *Source*: Statistical Bureau, Management and Coordination Agency, *Population Estimates of Japan*

(d) *Source*: National Institute of Population and Social Security Research, 1998 .