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The Future of Long-term Care Insurance

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More than ten years have passed since the public long-term care (LTC) insurance program was introduced in Japan in April 2000. LTC expenditures, which stood initially at just under 4 trillion yen (in fiscal 2000), had increased to 8 trillion yen ten years later (in fiscal 2010). According to the latest government forecast issued by the National Council on Social Security, expenditures on LTC will increase to between 19 trillion yen and 24 trillion yen by fiscal 2025, the year in which the number of elderly people will peak.

The original motivations for the introduction of public LTC insurance were to keep down the medical bills of the elderly (which had increased sharply from the 1970s onward), in particular by reducing hospitalization for non-medical reasons (so-called "social hospitalization"); and to attempt to "socialize" LTC in light of the decline in the family's ability to provide such care, due to the aging of the population, the declining birthrate, and the trend towards nuclear families.

The question arises of whether public LTC insurance has been a success by those standards. It is highly meaningful to review the experiences of the past decade from a number of different angles—both for the purpose of imagining the form that LTC insurance should take in a future in which the population will age even further, and for the purpose of passing on the lessons learned to Western and Asian countries that will likewise face the aging of their populations.

The supply shortages once feared when the system first commenced have essentially been resolved in terms of home care, and the utilization of LTC insurance has progressed satisfactorily. Since then, against a backdrop of rapidly increasing long-term costs, the policy is focusing on cost control. However, in order to accomplish the policy objectives and advance effective reform, it will be necessary both to assess (from the micro perspective) whether or not the initial policy aims have actually been achieved and, if not, how they can be realized, and (from the macro perspective) to expressly analyze future trends in overall LTC costs and the factors in detail that affect them.

There were three objectives in introducing LTC insurance. The first was to support self-reliance. The idea was to go beyond simply providing personal care for elderly people who require it and to support self-reliance in the elderly—the point being that doing so would assuage the greatest anxiety in old age (the issue of LTC) and alleviate the family's burden of providing informal care, which had traditionally been borne by women. Although it has not yet been empirically verified that the introduction of LTC insurance has had a positive effect on the state of health of the people requiring LTC, it has been confirmed that it has had a beneficial effect in terms of alleviating the physical and psychological burdens on caregivers and reducing the time that they need to devote to giving care. However, it will also be necessary to clarify why the time devoted by family members to care-giving still accounts for a significant proportion of the total time required for LTC of those who need it, and whether this is due to systemic factors or to personal motivation in the form of the strategic bequest motive. A number of empirical studies have also verified that one external effect of the introduction of LTC insurance has been an increase in the female labor supply—women having traditionally

borne the burden of caring for family members—and that this has been particularly striking in the middle- and high-income brackets.

The second objective was to provide a user-friendly service. A switchover took place in which hitherto compartmentalized medical, long-term, and welfare services were integrated to create a system in which the user could receive comprehensive health care and welfare services from various different organizations based on his or her own choices. One revolutionary aspect of this was an easing of regulations, which permitted for profit organizations to enter the home care market. In fact, the wealth of new entrants to the market meant that home care supply shortages never materialized. There is abundant evidence which clearly demonstrates that the quality of the services provided by new entrants to the market—most of which have been for profit institutions—is in no way inferior, and that, given the level of quality involved, their services are also cost-efficient. Although user choices are not being biased solely towards non-profit organizations, there are still some outstanding issues that ought to be resolved. For example, for profit organizations and non-profit organizations are not competing on a level playing field, as demonstrated by the way in which non-profit organizations that also operate hospitals "corral" patients, and by the way in which for profit organizations are as yet still barred from providing institutional care services.

The third objective was to introduce the social insurance system. The intention behind the introduction of a social insurance system in which there is a clear relation between benefits and premium was to separate the medical care and LTC systems and to reduce medical costs for the elderly by lowering the number of patients undergoing "social" (non-medical) hospitalization, who take up costly medical resources simply because they have no relatives. So far, however, there has been precious little empirical research that verifies any major reduction in such social hospitalization. With regard to the shift from institutional care to home care, it has been verified that LTC services exhibit low price elasticity. This further suggests that improving these services should be a top priority.

Thus, slowly but surely, evidence is accumulating regarding the quantitative effects of the introduction of the public LTC insurance system. There is still not enough evidence to constitute a macro-level blueprint for LTC policy, however. Meanwhile, the macro-level policy debate over LTC has thus far been marred by three flaws. The first is that it clings to the notion of a typical individual (the "archetypal elderly person") and completely disregards the diversity (which is plain to see in reality) in the individual circumstances of people who require LTC, in terms of their finances, health, and family relationships. The second is that the debate is essentially based on assumptions, such as the routine reduction of user numbers, and makes insufficient use of motivating factors, such as the change in the expense to the individual. The third is that the discussion is based on the tacit assumption that nothing will change. It disregards variations in the financial situations and health of different generations and takes no account of factors such as improved prognoses due to future technological innovation and the future introduction of revolutionary rehabilitation techniques.

Recent reforms that are particularly worthy of note were the introduction in fiscal 2006 of preventive care for the elderly and the introduction of community-based services. As the effectiveness of the former has not been verified through empirical research, more efficient allocation of resources will be required, since, for example, it is less likely that those receiving such preventive care services will lapse into requiring

LTC. Whether or not the latter will work in reality will be affected in large part by the characteristics of the area in question. In light of such uncertainties, it could not be claimed that an evidence-based blueprint for LTC policy is being drawn up, and it will be essential to conduct more precise analysis, making use of globally sourced inter-disciplinary, longitudinal, and universal micro-data, such as the Japanese Study of Aging and Retirement (JSTAR).

As the population ages, the increased utilization of LTC services is, to some extent, inevitable. However, effective containment efforts will require more than just the financial arguments that have been made thus far. A fundamental shift will be required to allow a constructive policy debate based on objective data sets that are accessible to researchers, with particular regard to the following three points: whether the design of the system should focus on the national level, the regions, or the individual; the extent to which factors such as diversity in the organizations providing family LTC and services should be taken into account; and how incentives for users and providers should be utilized. With regard to LTC services in particular, it will, at the same time, be necessary to consider the future nature of the family and the community. Regarding these issues, too, scientific policy formulation based on both micro-level and macro-level evidence is becoming a matter of urgency.