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Caring for an ageing population

Points to consider from reform in Japan

Research report
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November 2013

About this work programme

Social care is crucial to the welfare of many older people, disabled adults and children, but meeting the need for it is set to become more challenging in the decades to come as public expenditure is constrained and the population continues to age.

There is almost universal agreement that the social care system needs urgent and fundamental reform, but despite this consensus various attempts at reform over the last 20 years have all stalled.

Against a backdrop of concerns about the implications of an ageing population for the affordability of long-term care, the Coalition Government announced new measures in February 2013 for funding care to ensure that older people and those with disabilities get the care they need without facing 'unlimited costs'. The legislative framework that will make it possible to introduce these new measures forms part of the 2013 Care Bill. The suggested reforms, to take effect in 2016, include a higher means-test threshold and a cap on the amount any adult eligible for local authority assistance will have to pay for care.

We are active in the debate about how to finance and deliver good-quality, accessible social care and are undertaking a range of activities. This includes providing analysis of the government's draft legislation and examining how other countries are trying to address the issue of providing health and social care services to an ageing population. This analysis of Japan's approach to social care forms part of this programme.

Find out more at: **www.nuffieldtrust.org.uk/our-work/social-care**

Acknowledgements

We are very grateful to the Great Britain Sasakawa Foundation for part-funding this project. We would also like to thank John Creighton Campbell, Mayumi Hayashi, Naoki Ikegami and David Walden CBE for their detailed review of this report. Particular thanks also go to Mayumi Hayashi for providing translated statistics and information where they were only available in Japanese. We are also grateful to colleagues at the Nuffield Trust for their support throughout, in particular to Andy McKeon.

This report expresses the views and observations of the authors alone and any factual errors remain their responsibility.

With support from:

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Executive summary

Finding a sustainable and fair model of funding for social care for our growing older population is a matter of significant political and policy attention in England. We looked beyond our own system to examine how Japan has tried to address the conundrum of providing sufficient and appropriate services for an increasing number of frail older people in an affordable and equitable way.

Japan has the oldest population in the world with 23 per cent of its population over 65; this is set to rise to 40 per cent by 2050 (compared with an estimated 30 per cent in the UK by 2051; Office for National Statistics (ONS), 2011b). Japan's economy has performed poorly since the early 1990s and the country is now grappling with substantial government debt that amounted to over 200 per cent of gross domestic product in 2011 (compared with 85 per cent in the UK and 103 per cent in the US; Trading Economics, 2012).

Japan has traditionally operated a highly hospital-centric system. In order to address the shortage of social care, to ease burdens on informal carers and to relieve pressure on health services, a new insurance system for long-term care – Long Term Care Insurance (LTCI) – was introduced in 2000 and is widely supported. A compulsory scheme for those over 40, it offers access to social care to all those over the age of 65 on the basis of need alone; income and wealth are not taken into consideration in the assessment process. Those who use services are required to make co-payments of up to ten per cent of the costs of care, although raising this for wealthier older people is currently being debated. LTCI provides older people with access to a variety of community-based services, and residential and nursing care.

Finance and coverage

Japan made a bold decision to introduce LTCI as a compulsory scheme benefiting all older adults in need. The system has done well to address much unmet need, to provide support on a universal, needs-alone basis and to support informal carers. However, the financial sustainability of the model is questionable under current cost and eligibility arrangements. The number of users, and therefore spending, has increased far beyond expectations.

In England, eligibility criteria for social care are being tightened and the number of older people being provided with publicly funded care is falling. Moreover, the proposed cap on self-funders' lifetime costs of £72,000 will only benefit a small proportion of people (estimated at one in eight). It seems likely that continuing pressure on public funds coupled with a high lifetime cap on costs will leave many people having unmet needs or still having to incur relatively high social care costs.

In both countries, the governments stepped in to address market failure to provide commercial private insurance. The UK government intends its reforms to stimulate the development of new products to insure individuals against care costs. However, as yet, the sector response to this is uncertain.

Clarity and equity of the system

Japan's adoption of national eligibility criteria using predominantly a computerised assessment process (although clinical judgement is still required) provides clarity over eligibility and service provision to individuals. In England, there is significant variation in locally applied eligibility thresholds and assessment outcomes (although there is a national eligibility assessment framework). The Care Bill goes some way to addressing this by establishing national eligibility thresholds, however, implementation of the criteria will continue to be subject to local decisions, including on funding, and in practice may be less equitable than intended. Personalisation of services, although a positive move, will add to an already complex picture. So too will the operation of the cap on lifetime care costs. As yet, there is no strategy for explaining to the public what will become an even more complex system.

Creating a diverse provider market

Japan has created a diverse and large provider market relatively quickly through additional funds, individual choice about how they are used and financial incentives on the supply side. The last of these have intentionally skewed the market towards domiciliary care, but left the Japanese public with extremely long waits for residential care. Care managers are important in guiding individual choices but the government needed to enforce financial sanctions to ensure that the advice given remained independent and not biased towards the provider who employs the care manager.
In comparison with Japan, the social care market in England is already diversified. Personal budgets could lead to further diversification, but users need to have genuinely independent guidance to exercise their choice effectively.

Tackling the rising number of older people with dementia has been a particular focus in Japan. Group homes offer an interesting model of care for people with dementia, with each 'unit' providing care for around nine people within a home-type environment.

Ensuring quality

Japanese quality monitoring has largely focused on staffing numbers and other similar measures, with central government specifying detailed requirements. Inspection of institutions has been described as 'rather formalistic and paperwork oriented'. Quality monitoring for the home and community-based sector relies heavily on choice and competition. There is debate about how effective this is, particularly as the choice given to users may be restricted by their care managers. England has a similar approach to ensuring quality, although regulation and inspection incorporate ideas of wellbeing, user experience and achieving better outcomes. However, striking the right balance between these different mechanisms is difficult and may not always be effective (as recent care homes scandals have shown). The Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) has advocated greater government regulation of staffing levels for hospitals.

The role of competition and integration

Japan has seen the development of large-scale integrated delivery systems alongside smaller providers of services. Much of the integrated provision appears to have emerged out of existing acute providers who have taken advantage of their established status in the community to attract clients, extend their range of services and make a profit. The focus in the new system in England is commissioner-driven innovation – which in

social care is intended to be driven by individuals acting as their own (micro-) commissioner using personal budgets – where commissioners shape and specify services for which they will pay providers. The Japanese experience (although contextually different) suggests that established providers, if given the right freedoms and incentives, could also lead the development of new models of care.

Mobilising the community

England has already begun to learn from Japan in its care for older people with dementia and recently implemented a 'dementia friend' initiative (Department of Health, 2012) partially based on the similar programme in Japan (Ministry of Health, Labour and Welfare, 2012a). Japan has also managed to harness the support of a large number of volunteers and raise public awareness of dementia, a condition about which little was known previously.

> "The Japanese experience suggests that established providers, if given the right freedoms and incentives, could also lead the development of new models of care

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The role of care managers

Care managers in Japan provide a central point of access for individuals in need of care. They act as brokers, negotiators and commissioners, matching appropriate care to available budgets. They also monitor the services received. Many current integrated care initiatives in the UK and elsewhere place importance on having a single person with oversight of a person's care, but there is debate about the skills and background required by that person. Some argue that the person must have the skills to negotiate with medical and social care staff and to organise care across two sectors (Goodwin and Lawton-Smith, 2010). Experts we met in Japan expressed concern that non-clinical care managers might not have the appropriate skills to manage individuals with complex medical needs, but also that many non-complex individuals may not need a care manager. However, it is important to note in England that only those who qualify for state support will have access to a similar individual to help choose services, although those who pay privately may receive advice and guidance.

1. Introduction

Changing demography and the rising prevalence of long-term conditions has fuelled the debate about how we should best care for an increasing number of frail older people. Around 80 per cent of people who are 65 now will require some form of care in their old age (Department of Health, 2012) and the number of those with severe disabilities is projected to rise by 32 per cent (Wittenberg and others, 2012). To keep pace with this growing need, it is estimated that public expenditure on social care will need to rise by between 37 and 56 per cent to £12.7 to £14.4 billion by 2022 (Wittenberg and others, 2012). This is despite the fact that while health care in England is free at the point of use, access to publicly funded social care is tightly restricted.

Although very different from England in cultural and historical terms, there are certain similarities between the English and Japanese context that make these systems suitable for comparison. First, Japan's economy experienced a sustained period of stagnation following a financial crash in the early 1990s. England is experiencing a prolonged recession and pressure on public funding looks set to continue for a decade (Roberts and others, 2012). Second, with the oldest population in the world, Japan can offer insight into how to meet the needs of a rapidly growing older population. Last, Japan introduced an entirely new system of social care (known as 'Long Term Care Insurance' – LTCI) in 2000, which runs parallel to its established health care system. Proposed changes to the social care system in England are currently being debated in Parliament and there is ongoing debate about how these should be implemented and there are still concerns to be addressed. Comparing the two countries instigates a useful discussion about the type of social care system we are trying to create in England.

There are significant differences in the way the Japanese and English systems work, which it is important to understand. First, individuals in England who are trying to access publicly funded social care are subject to a means-test. The result is that a large proportion of people who use social care end up paying for it completely out of pocket (the exact figures are not known because of a lack of data around self-funded domiciliary care). Importantly, the publicly funded system is becoming more rationed and, for example, 45 per cent of care home places in England are completely self-funded (Institute of Public Care, 2011). In Japan, all users (with some income-related exceptions) are required to pay co-payments, but LTCI is comprehensive and all those in need receive some financial support.

Second, England's eligibility thresholds that determine whether a person's care needs are sufficient enough to accept them into the system are currently decided locally (although the assessment takes place within a nationally set framework). As a consequence, the system is widely perceived to be unfair (Commission on Funding of Care and Support, 2011). New proposals outlined in the Care Bill will mean that these thresholds will also be set at a national level, as they are in Japan.

The third point relates to the services that an individual who qualifies for support receives. In Japan, there is a single national assessment process that is computerised so

that people with similar needs receive similar support wherever they live. The system is understood to be fairly transparent. In England, however, although the government is trying to bring a greater sense of clarity to access to publicly funded social care (as was also important in Japan), local decision-making remains. Personalisation and wellbeing are part of the assessment process, and necessitate greater flexibility in deciding how needs should be met. This also means greater complexity and uncertainty for individuals, and potentially much more local variation.

Purpose of this report

This research report explores how Japan has tried to continue to meet the needs of its ever-growing older population and what models of care provision have developed as a result of the introduction of its new social care system. By providing a brief overview of a small number of issues and case studies, this report aims to generate discussion about the approach taken in England to providing services for our older population and the principles underlying them. We also hope it will generate an interest in further international comparisons.

The report is based on a study visit to Japan in 2012, during which time a variety of organisations, policy-makers, clinicians and academics were visited. The data collected have been supplemented by relevant literature.

2. The Japanese system of health and care

Context

At the end of the Second World War, life expectancy at birth in Japan was 50 years for men and 54 years for women (with the UK at 63 and 68, respectively). By 1970, this had risen by such an extent that Japan overtook Sweden as having the world's longest life expectancy at birth, and by 2009 it had reached 79.6 years for men and 86.4 for women (Reich and others, 2011). Life expectancy in the UK has not risen so sharply, being calculated as 78.1 years for men and 82.1 years for women in 2009 (ONS, 2011a). However, it is not simply life expectancy that has put pressure on the Japanese health and social care system but, more significantly, the proportion of older people in the population. Over the 50 years that universal health insurance has operated, the percentage of the population aged 65 years or older has increased almost four-fold, from six per cent to 23 per cent (Reich and others, 2011). Continued ageing coupled with a declining birth rate means that this figure is projected to rise to 40 per cent by 2050 (Reich and others, 2011). Following the same trend as Japan but at a slower rate, projections for the UK suggest that 30 per cent of the population will be 65 years old and over by 2051 (ONS, 2011b).

Japan's economic situation is also of significance here. Japan has been in a prolonged economic slump since the crash of the Tokyo Stock Exchange in the early 1990s. After decades of rapid economic expansion, growth during the 1990s was slow compared with other developed economies and the period is often referred to as 'the lost decade'. The economy remained sluggish during the past decade and Japan is now grappling with substantial government debt, which amounted to over 200 per cent of gross domestic product (GDP) in 2011 (compared with 85 per cent in the UK and 103 per cent in the US; Trading Economics, 2012).

The health and care system

Japan operates a system of social insurance for both health and social care. With some exceptions, the public are required to pay insurance premiums for both systems (although only those above the age of 40 pay for social care).

Health insurance

Universal health insurance has been in operation in Japan since 1961. Under the Japanese model of 'social health insurance', premiums are based on an ability to pay rather than the risk of illness (Ikegami and others, 2011). Both Japan and the UK spend 9.6 per cent on health as a percentage of GDP (figures for 2010; Organisation for Economic Co-operation and Development (OECD), 2013). While expenditure has continued to rise in Japan, figures for the UK have declined since 2009, with 9.4 per cent of GDP being spent on health in 2011 (figures for Japan are not available). See Table 1 for more comparative data.

Table 1: Overview of health systems in Japan and the UK

	Japan	UK
Population (millions), 2010	128	61
Total spending on health as a percentage of GDP, 2010	9.6	9.6
Per capita government expenditure on health (purchasing power parity, US$), 2010 (World Health Organization country statistics, 2013)	2,644	2,919
Out-of-pocket expenditure as a percentage of total health spending, 2009	16%	9%
Doctor consultations, per capita, 2009	13.1	5
Total number of hospital beds per 1,000 of the population, 2010*	13.6	3.0
Average length of stay (days): acute care, 2010 (note that 'acute' in Japan includes post-acute and rehabilitation beds)	18.2	6.6
Practising physicians (head count) per 1,000 population, 2010	2.2	2.7
Practising nurses (head count) per 1,000 population, 2010	10.1	9.6

Source: OECD, 2013 * This figure includes long-term care beds.

It is compulsory in Japan to belong to one of 3,500 insurance plans, most of which are administered via employers. The self-employed, unemployed and retired belong to a scheme administered by their local municipality and a specific scheme – Late Elder Insurance – covers those over 75 years of age and those over 65 with certain disabilities. Premiums paid by the latter group are calculated on a per capita, per household, income-related and asset-related basis (Matsuda, 2012). In contrast, employer-based insurers decide upon premiums based on wages. Large employers pay part of the insurance premium for employees and employee contributions typically range from between three and ten per cent of their salaries. Those working for a small or medium-sized employer contribute ten per cent of their salary, administered by a sole, national insurer (Matsuda, 2012). All insurance schemes must include the statutory benefits package, which covers hospital care, ambulatory care, approved prescription drugs and most dental care. The majority of the adult population have additional private health insurance, which is often used to cover 'hotel costs' that are levied on a hospital stay. Research conducted in 2005 suggested that 57.9 per cent of adults in Japan had private health insurance, with that figure rising to over 70 per cent for those in their 30s and 40s (Suzuki, 2005).

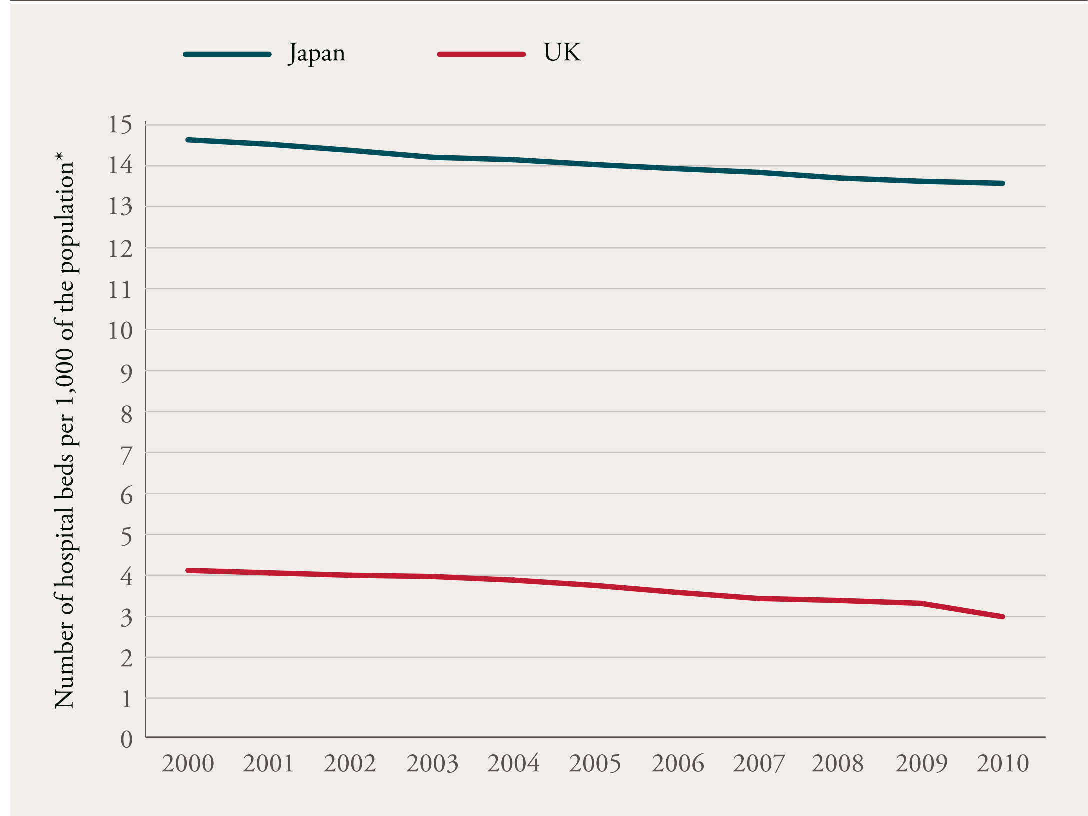
In addition to insurance premiums, patients are required to pay co-payments, which, for most people, are 30 per cent of the total cost of treatment up to a pre-determined monthly cap. People over 70 with low incomes pay ten per cent and children pay 20 per cent.

In terms of access, individuals have free choice over which services they access and most health care is reimbursed on a fee for service basis (Bernabei and others, 2009). Primary and specialist care are not divided into distinct areas of health care in Japan. Specialists often operate from community-based clinics, providing many primary care functions. With only a fledgling system of general practice and no system of gate-keeping, patients can self-refer to hospital for inpatient or outpatient care, although some hospitals charge a fee to patients not referred by a physician. However, hospital-based professionals in Japan told us that patients must pay a similar fee for a physician referral, so the hospital charge does little to control demand. With few mechanisms

to control demand, the main mechanism for controlling costs is the provider fee schedule, which is reviewed every two years. In addition, review committees in each region monitor claims and can deny payment for services deemed to be unnecessary (Matsuda, 2012).

Japan has traditionally operated a highly hospital-centric health system. Around four per cent of the population over the age of 65 is estimated to be hospitalised at any one time (Bernabei and others, 2009), which is similar to the estimated proportion of older people living in residential care in England (ONS, 2013b). Lengths of hospital stay are also known to be long when compared with other countries, as shown in Table 1. The average length of stay for acute care in 2010 was 18.2 days, compared with 6.6 days in the UK. However, 'acute' beds in Japan include post-acute care beds such as for rehabilitation therapy. Figure 1 shows a decrease in the number of beds in hospital in both Japan and the UK, although the decrease in Japan has been relatively limited.

Figure 1: Total number of hospital beds, per 1,000 of the population



Source: OECD, 2013 *Includes long-term care beds.

Long Term Care Insurance

The LTCI system, introduced in 2000, runs parallel to the health care system. It provides the over 65s, and those over 40 with an age-related disability, with what we would term 'social care', although it is in fact wider in that it includes some nursing and rehabilitation care for those with long-term conditions. Interestingly, the approach taken in Japan appears to be very medically focused compared with England, where there are attempts to take a 'whole-person' perspective and consider wellbeing in addition to health needs (see Box 1).

Box 1: The aims of the LTCI system

- To facilitate a system in which society as a whole supports those who are facing the need of long-term care, society's major cause of concern in terms of becoming old.
- To establish a system in which the relationship between benefits and burdens are made clear, by way of introducing a social insurance approach, which can easily gain public understanding.
- To reconstruct the present vertically divided system between health, medical and welfare services, and to establish a system by which service users can receive comprehensive services from a variety of institutions of their choice.
- To separate long-term care from coverage of health care insurance, and to establish a system that aims to decrease cases of 'social hospitalisation' as the first step toward restructuring the social security system as a whole.

Source: Ministry of Health, Labour and Welfare, 2002

Introduced in response to a range of social, economic and demographic pressures, the main aim of the LTCI policy was to promote the independence of older adults with functional disability (Houde and others, 2007). It was intended that promoting the independence of the growing numbers of older people would relieve the increasing pressure on health services. It was also intended that the scheme would stimulate the market for the provision of care for older people, as a shortage of nursing facilities and home care services had been identified as a key reason for the long lengths of hospital stay (Matsuda and Yamamoto, 2001).

The first comprehensive study of the care of older people in Japan conducted in 1968 found that four per cent of people over the age of 70 who were living at home were bedridden; twice the European rate (Hayashi, 2011). Although the study highlighted the limitations of family care, attempts to increase the number of nursing homes in the 1970s remained inadequate (Hayashi, 2011). There was also widespread stigma associated with the use of what social care did exist. As a result, social care has traditionally fallen to the family. When families were unable to look after older members, they tended to be admitted to hospital with little medical justification (Campbell and Ikegami, 2000) and a lot of long-term care continues to take place in hospitals today. In 1980, it was estimated that four per cent of the population over the age of 65 years old were seemingly 'living' in hospitals, as the average length of stay was 103 days – this has now greatly reduced (Hayashi, 2011). The situation has become known as 'social hospitalisation', and despite reductions in the number of long-term beds, commentators recognise that the phenomenon still exists. Further pressure on both health and social care services came from the growing number of older people living alone. In 1980, 4.3 per cent of men and 11.2 per cent of women lived alone; by 2005, the figures were 9.7 and 19.0 per cent, respectively (Cabinet Office, Government of Japan, 2011).

In 1989, the government began the long process of reforming social care provision by launching the ten-year 'Gold Plan', which resulted in an increase in home-helpers and adult day care centres. However, access to services continued to be means-tested, without choice of provider and controlled by local government (Bernabei and others,

2009), and waiting lists for nursing homes were typically several years' long (Traphagan and Nagasawa, 2008).

By the mid-1990s, it was recognised that the hospital-centric approach to caring for older people was unsustainable and that a centralised social care system was needed. The result is that Japan now has a universal, comprehensive, long-term care system based on the principles of social insurance (Campbell and others, 2010). This strictly needs-based system, accessible to all regardless of income or wealth, covers the following services:

- home care, including home help, visiting nurse services, visiting bathing services and visiting rehabilitation services
- respite care, including day care, medical day care and short stay services
- institutional care, including nursing homes, rehabilitation services and geriatric wards. (List adapted from Matsuda and Yamamoto, 2001).

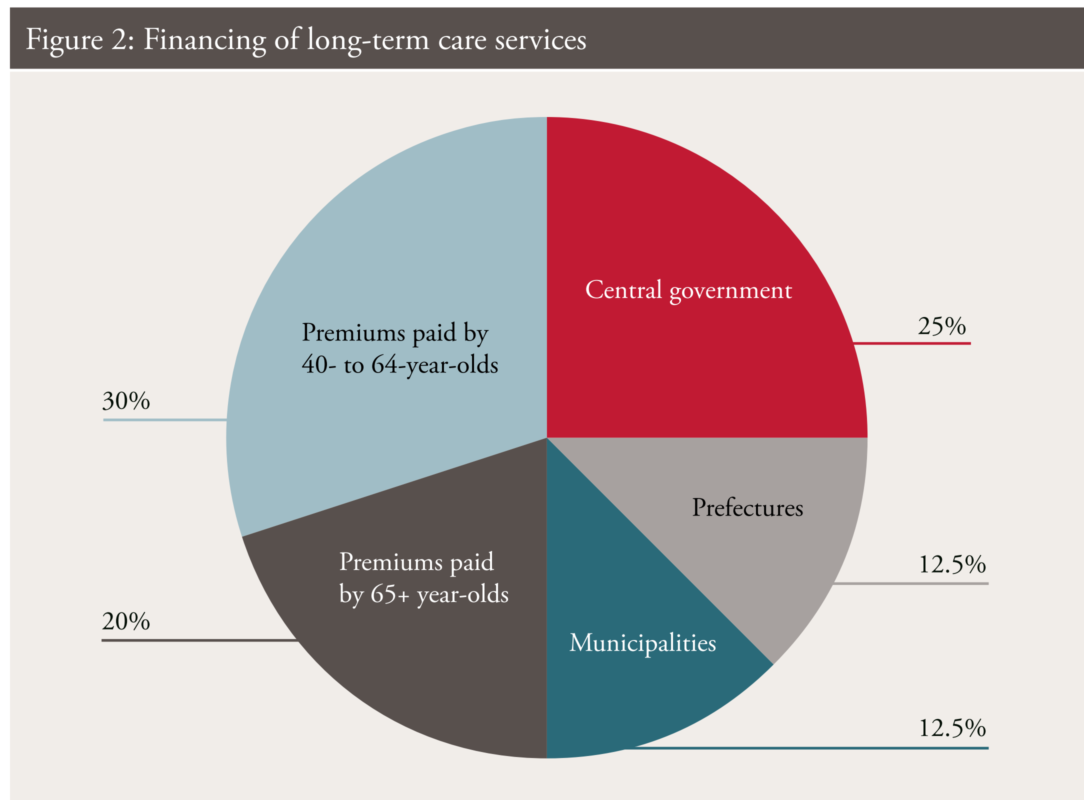
Japan now has a universal, comprehensive, long-term care system based on the principles of social insurance

Financing long-term care insurance

Half of all services provided under LTCI are funded out of employee and pensioner premiums and half out of general and local taxation (Traphagan and Nagasawa, 2008). It is a compulsory scheme where all those over the age of 40 are required to pay insurance premiums. Those who use services are also required to make co-payments of up to ten per cent of the costs of care, although raising this for wealthier older people is currently being debated.

The other half of the funding comes from all three levels of Japan's government: national; 47 prefectures; and 1,719 municipalities (see Figure 2).

Figure 2: Financing of long-term care services



Source: Ministry of Health, Labour and Welfare, 2011a

Japan spends 1.5 per cent of GDP on long-term care (Bernabei and others, 2009), compared with 1.2 per cent in England (Commission on Funding of Care and Support, 2011). On a per capita basis, public expenditure in the two countries is similar (see Table 2). Table 2 provides additional detail on the amount spent per service type for the population over 65 years old. The most striking observation here is that the Japanese government spends more than double that which England spends on institutional care, whereas the majority of expenditure in England goes on supporting people to live independently in their own home[1].

Table 2: Public long-term care expenditure, per the population aged 65 years old and over, US$, 2010

	Japan	England
Administration (including case management)	108	186
Institutions	1,478	581
Cash	–	1,382
Home and community-based services	889	403
Total	**2,474**	**2,552**

Source: Provided by Campbell, 2013

Note: These data differ from figures available from the OECD and other sources. They are based on calculations from official reports in each country, covering all public long-term care spending regardless of accounting category, for people aged 65 and over only. The amounts are in US$ Purchasing Power Parity and are per capita for the 65+ population.

1 Cash payments in England – comprised mainly of Attendance Allowance and Disability Living Allowance – may be used by the individual to purchase their own home or community-based services, but cannot be used to cover the cost of NHS-funded institutional care.

Key points

- Japan operates a system of social insurance for both health and social care. With some exceptions, the public are required to pay insurance premiums for both systems (although only those above the age of 40 pay for social care) and co-payments when services are used. In addition to the insurance premium revenue, social care is also part-funded through general and local taxation.
- Although operating different systems, Japan and England spend a similar amount on health and social care.
- In Japan, users have free choice over which services they access and most health care is reimbursed on a fee-for-service basis. There are few mechanisms to control demand; the main mechanism for controlling costs is the provider fee schedule, which is reviewed every two years. Review committees in each region monitor claims and can deny payment for services deemed to be unnecessary.
- Social care is provided under the LTCI system introduced in 2000. It provides support to people over the age of 65 and those over 40 with an age-related disability. It was introduced to promote the independence of older adults with functional disability and therefore relieve pressure on health services and stimulate the provider market. In contrast to England, access to services is on a needs basis only; income and wealth are not taken into consideration.

3. Long Term Care Insurance: organising and providing care for older people

The introduction of Long Term Care Insurance (LTCI) was a bold move by the Japanese government and not without its difficulties. It has continued to face significant challenges as it has developed. Some of the successes and challenges most pertinent to England are discussed in brief below.

Public support for change

Persuading the public of the value of major policy change is challenging for governments, particularly when they are being asked to make financial contributions to a new system on top of contributions already made to health care. The introduction of LTCI in Japan appears to be an example where the government and the public were in agreement about the need for change. Japanese officials and academics suggest that because of the demography of Japan, many citizens had direct experience of the existing system's shortcomings via elderly parents or friends. Also, because LTCI was the product of longstanding efforts to reform the welfare system for older people that began in the late 1980s (Eto, 2001), by the time LTCI was introduced in 2000, there was widespread public acceptance that social care needed to be reformed. This is in contrast to the current situation in England where the financial implications of the social care system are poorly understood by the public (Commission on Funding of Care and Support, 2011).

"The introduction of LTCI in Japan appears to be an example where the government and the public were in agreement about the need for change

As in England, previous long-term care systems in Japan had targeted people with low incomes, providing them with free or inexpensive services (Eto, 2001). Clearly a shift to a universal coverage requires significant investment. The final decision to structure the scheme as a part-insurance, part-taxation system, rather than funding it solely via general taxation, was seen to be helpful in engendering public support as it was perceived as more transparent. In addition, the population was familiar with paying premiums for health care so it was felt to be more easily understood (Campbell and others, 2010). During our study visit, we found that the decision to require only those aged 40 and over to contribute helped to quickly engage the wider public, as many people could see immediate benefit for their parents or someone they knew. Initially generous eligibility and access criteria ensured that individuals who were already receiving care under the former system did not lose out on benefits. As a result, rapid increases in uptake of services were observed (see Figure 4 on page 20).

Points of interest for England

- Public support for change was aided by the decision to adopt an insurance scheme, which was felt to be more transparent than increases in general taxation.
- Public support was facilitated by initially generous eligibility criteria and the requirement for only the over 40s to pay premiums.
- Although it was implemented in a different cultural context and during a period of relative economic and political stability, the Japanese experience illustrates that public pressure can induce radical system change.

Determining eligibility

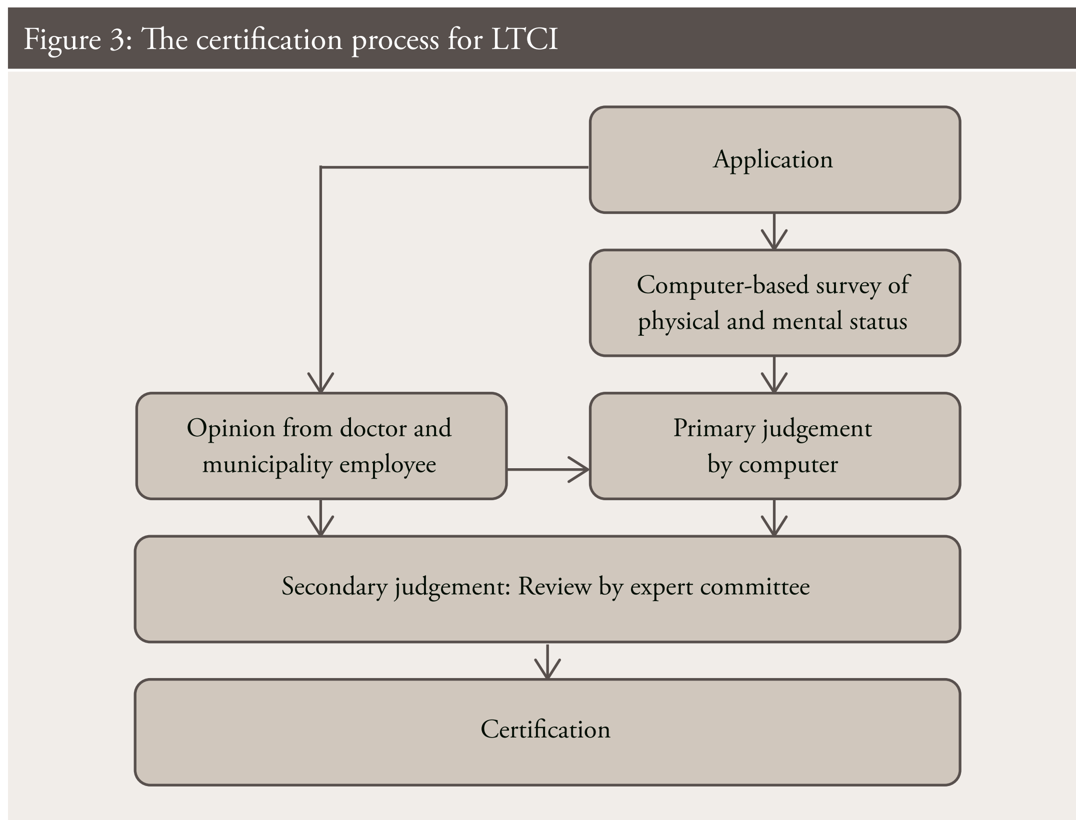
Eligibility for LTCI is determined according to a standardised national process. This is in marked contrast to social care in England, where at present, although there is a national eligibility assessment framework, eligibility thresholds are determined locally and often give rise to concerns about inequity in access (although this is due to change with the Care Bill currently being debated in Parliament). However, while more standardisation could be brought to the English system in terms of determining eligibility, the personalisation agenda – with professionals and users working together to decide how best to meet needs once eligibility is determined – means that variation in terms of the care package is inevitable. In Japan, a highly structured computer-based assessment of eligibility for social care is supplemented by medical opinion. The Japanese government made the deliberate decision to use an objective computer-based test rather than to base eligibility upon the decision of a doctor because it was felt that, by adopting a rigid objective approach, the issues experienced in the health system (that is, high levels of hospital admissions for non-medical reasons) could be avoided (Campbell and others, 2010). Another reason was the perceived lack of a suitably trained social care workforce (Bernabei and others, 2009).

Individuals can refer themselves for an LTCI assessment or be referred from hospital or by a community-based health care provider. Qualifying for services entails a three-part process (see Figure 3):

1. A 79-part standardised questionnaire is administered by a municipal employee in the home, and then analysed by an official computer programme, which determines the level of need among seven levels (Ikegami, 2008).
2. The applicant's main doctor submits an opinion about the individual's health problems, and there is a short comment from the official who administered the questionnaire.
3. Classification is made by the computer programme and the two additional statements are reviewed by a multidisciplinary panel who may adjust the care level up or down. The decision is communicated to the applicant within 30 days of applying. Those deemed to be eligible for any level of care – over 95 per cent of applicants – are said to be 'certified' (Ministry of Health, Labour and Welfare, 2011b).

There is an appeals process at prefecture level for those unhappy with the outcome (Matsuda and Yamamoto, 2001).

Figure 3: The certification process for LTCI



Those who are 'certified' are assigned to a support or care level, which defines the maximum financial contribution the government is willing to provide per month. The higher the level of certification, the greater the contribution (see Table 3 for an indication of the care levels). Those who are not certified are still able to access preventive long-term care support and other community-based services (Ministry of Health, Labour and Welfare, 2011c).

Importantly, on introduction, LTCI services were not means-tested and qualification was based on need alone. During the assessment process, a person's personal circumstances (for example if they had a carer or if they owned assets) were not taken into account. This was felt to be the most equitable approach, although it was subsequently changed (see below 'Reforming eligibility').

The allocated budget for long-term care can only be used to purchase services and is not available as a cash allowance. Individuals are able to 'top up' their care and buy services beyond those provided under the scheme. Users are required to contribute ten per cent of the cost of care as a co-payment, to a maximum monthly cost, which is set at a maximum of £75 per month for people on low incomes (Ikegami, 2008). Since 2005, in addition to the co-payment, users are required to pay for meals and 'hotel' costs in institutional facilities – these charges are means-tested and vary according to the type of facility. The care levels and financial entitlements are outlined in Table 3 (although current proposals being debated in Japan suggest reducing the number of care levels able to receive support).

Table 3: Assessment of care needs, benefits available and user contributions

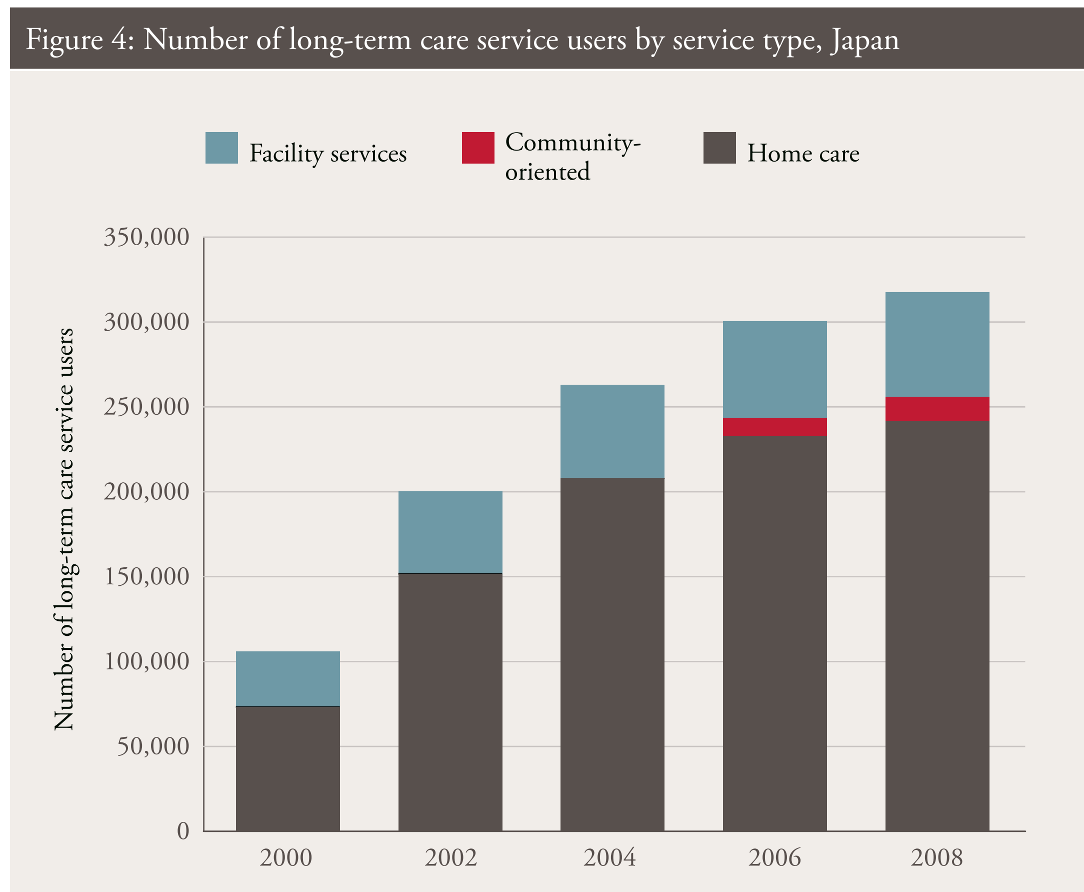
Level	Benefit ceiling per month for government funding*	Description of typical needs
Support level 1	¥49,700	Almost independent; may need some assistance to maintain independence and prevent deterioration
Support level 2	¥104,000	Needs some support with activities of daily living (ADLs)
Care level 1	¥165,800	Requires support with ADLs and some care
Care level 2	¥194,800	Requires care at level 1 and support with more ADLs
Care level 3	¥267,500	Needs substantial support with ADLs and almost comprehensive care
Care level 4	¥306,000	Cannot live without comprehensive care. Almost bed-bound
Care level 5	¥358,300	Bed-bound. Needs comprehensive care

Source: Adapted from Tokyo Metropolitan Government, 2012. At the time of writing, £1 = ¥127.
*The individual is required to pay ten per cent of this.

Reforming eligibility

Initially generous benefits led to rapid uptake of LTCI services and put pressure on budgets. Figure 4 shows the rapid increase in the number of people accessing long-term care services during the eight years following its introduction. In 2000, ten per cent of the over 65 population were found to be eligible (Bernabei and others, 2009). By 2005, this had risen to 16 per cent (4.3 million) with 13 per cent (3.3 million) actually accessing services (Ministry of Health, Labour and Welfare, 2011d). Correspondingly, expenditure rose from the expected ¥5.5 trillion to ¥6.8 trillion (1.5 per cent of GDP; Bernabei and others, 2009). Interestingly, the greatest increase in use was among those on the lower levels of care (an increase of 142 per cent by 2005), while those accessing the most intensive level of support had almost doubled by 2010 (Ministry of Health, Labour and Welfare, 2011d). Part of the explanation was that, previously, people with means would pay for support with everyday living (for example cooking and cleaning) but under the new system, they were entitled to such services provided by the state for only a ten per cent co-payment (Izuhara, 2003).

Figure 4: Number of long-term care service users by service type, Japan



Source: Ministry of Health, Labour and Welfare, 2011d. Note that community-based services include group homes.

In an attempt to contain spiralling costs, the government has undertaken a number of reforms to the system. In 2005, hotel costs (fees for accommodation and subsistence) were introduced in institutional care (Bernabei and others, 2009). In addition, home help services were restricted to those who lived alone or who had severe disabilities (Hayashi, 2013). In 2006, those eligible for the lowest two levels of care were limited to accessing preventive care only (Bernabei and others, 2009). As a result of this latter change, 25 per cent of those in the lowest categories of need were put into preventive care programmes, which meant that they were not pushed out of the system altogether but their cost to the system was reduced (Campbell and others, 2010). One unintended consequence of rising user contributions in the form of co-payments and hotel fees is that fewer poorer people are taking up their full eligibility, giving rise to concerns about equity (Hayashi, 2013).

Despite these restrictions on benefits, the financial challenge is far from overcome as the number of people requiring the most intensive and costly care continues to rise. By 2025, the Japanese Ministry of Health, Labour and Welfare estimates that maintaining existing levels of long-term care provision could require an additional ¥15 trillion, approximately 2.6 per cent of GDP (Hori, 2012). The situation is further exacerbated by the country's large fiscal deficit (amounting to twice the GDP), which has restricted the scope for tax increases by the government (Ikegami and others, 2011). The government will have to decide how it raises money to fill the funding gap, and whether further reducing benefits would be politically palatable. At the moment, it is considering raising the co-payment from ten to 20 per cent for wealthier older people, and raising the eligibility threshold to care levels three and above.

Points of interest for England

- Japan's structured approach to eligibility has offered a number of advantages. In contrast to the more localised approach in the English social care service, setting national thresholds for eligibility offers the public clarity as to their entitlement and is perceived to be relatively transparent. This is particularly important in an insurance-based system. In England, although the Care Bill partly addresses variations in eligibility, the government is yet to detail how it will communicate the complexities of the new system to users (in particular the tapered means-test threshold and the cap on lifetime costs). The means-test in England also means that a large proportion of the older population who require support will have to fund it themselves. The Care Bill also intends to introduce a lifetime cap of £72,000 for how much an individual will have to spend on their care. However, the rules attached to this mean that only an estimated one in eight people will receive state support. Throughout this (even once the cap has been reached), individuals will still be responsible for paying their hotel costs, to be set at £12,000 per year.
- In Japan, initially generous benefits, while important for strengthening public support for the new system, have meant that costs have been greater than first estimated. Benefits have been tightened and new hotel charges introduced, but cost pressures are continuing to mount. It is likely that further adjustments may need to be made.

Developing a market: competition and integration

On establishing the new social care system, the Japanese government faced a significant challenge in attracting new providers to what was a very limited market. It succeeded in stimulating demand for services by designing a system where individuals pay for a small part of the cost rather than for the total amount. It stimulated the supply side by allowing for-profit companies and other providers to compete for the business and (in the case of community and home care) to make a profit. With the help of a care manager (explained more fully in the next section), beneficiaries are able to choose the services and providers they want and, since prices are fixed by the national fee schedule, providers are meant to compete on the basis of convenience and perceived quality (Campbell and others, 2010).

In recognition of the fact that the cost of institutional services is around 1.4 times that of community care (Matsuda and Yamamoto, 2001), the government encouraged greater uptake of the latter and discouraged use of institutional care by allowing providers of community and home care to make a profit. This means that institutional services remain restricted to the public and not-for-profit sectors. Furthermore, in order to reduce demand for institutional care, a reform to the system in 2006 transferred hotel and meal charges to the residents (Tsutsui and Muramatsu, 2007). The result of this policy has been partially successful: Bernabei (2009) reports that there are no longer waits to access community services. However, a parallel policy to cap institutional beds at three per cent of the older population (along with a withdrawal of capital investment subsidies previously used to cover around 75 per cent of the construction costs of nursing homes) has meant that there remains a shortage of nursing homes and people can expect to wait several years (Hayashi, 2013).

> Through a mix of additional funds and regulation, the Japanese government has created a busy market with a mix of for-profit and not-for-profit community-based provider organisations

Through a mix of additional funds and regulation, the Japanese government has created a busy market with a mix of for-profit and not-for-profit community-based provider organisations (Campbell and others, 2010). Services expanded and multiplied rapidly post-2000. For instance, the number of home help service providers increased from just over 11,000 in 2000 to almost 28,000 in 2010 (Ministry of Health, Labour and Welfare, 2011d). As well as the emergence of new providers, many established health care providers have expanded into community-based social care provision, taking advantage of the opportunity to make a profit.

The original vision was for a market of multiple providers competing for clients. In some senses, that has happened and there are many small providers offering a single service, or a limited range of services. However, in some areas, different forms of provision have arisen that aim to provide comprehensive and integrated care across all health and long-term care services. The government's policy on competition has been relatively permissive, allowing some considerable integration and merging to take place. We were told during our study visit that many hospitals saw the provision of long-term care as an opportunity to attract patients in a competitive system by offering a comprehensive set of health and social care services within one organisation. Some have sought to provide much-needed specialist services to those with particular needs, such as group homes for people with dementia (see pages 28 to 30 for examples).

Points of interest for England

- The Japanese government has attempted to control costs and to stimulate community-based care through a combination of a tightly controlled fee schedule and by allowing profit-making among providers of community services but not in residential care. This has incentivised the growth of certain types of services and may result in the regulatory environment being a stronger force in shaping the market than demand from service users.
- Japan has successfully created a busy and diverse community-based provider market over a relatively short period of time. There is a varied market of provision ranging from small single-service providers to large integrated delivery systems that span health and social care.
- Acute providers, alongside existing and new community providers, were incentivised to join this emerging market. This has resulted in some interesting new provision stemming from acute providers. Japan appears to have struck a balance between the role of integration and competition.

The role of the care manager

At the heart of the LTCI system is the care manager, who is responsible for developing a package of care and advising the individual of their options. Care managers also have the potential to commission care from a range of providers. The individual chooses a care manager once they have been certified as eligible for care. Each individual is given a care plan that is, in complex cases, developed and reviewed by a multidisciplinary team. The individual, their carer and their family can choose to be involved in the care planning process.

Once a care plan has been developed, the care manager administers the individual's budget – acting as adviser, commissioner and broker – and monitors the services that are provided (Campbell and others, 2010). Plans can be adapted according to the changing needs of the individual (Matsuda and Yamamoto, 2001). A care manager is 'like a travel agent' who matches the available budget to the most appropriate services for the client (Ikegami, 2008). Individuals are able to change their care manager if they are dissatisfied.

Individuals can, theoretically, purchase their care from any of the care providers accredited by their local government. Care managers are supposed to represent the interests of their clients, but a majority of care managers are employed by provider organisations so, while a user can request services from a range of providers, there was a tendency for them to access the services provided by their care manager's organisation (Wiener and others, 2007). This gave rise to concern about the ability of an individual to access an optimal package of care. The government responded to this in 2011 by increasing fines for providers whose care managers were found to be designing care plans where more than 90 per cent of services were provided by their organisation.

Care managers are funded out of the LTCI scheme. Payment depends on the level of care: ¥4,120 (support level), ¥10,000 (support levels 1–2), ¥13,000 (care levels 3–5) per person per month (Ministry of Health, Labour and Welfare, 2011e). When first introduced, many thought the role would best be filled by trained nurses. At this point, around 80 per cent of care managers were qualified nurses. However, in recent years, it is estimated that only around 20 per cent are now qualified nurses. It has been reported that care managers often suffer from low morale, considering themselves underpaid and overworked (Wiener and others, 2007). Efforts to address this situation in 2005 involved reducing caseloads from 50 to 30, mandating training and better distinguishing the care manager role from that of service providers (Wiener and others, 2007).

At its introduction, Matsuda and Yamamoto (2001) commented that LTCI should encourage a shift in balance of authority from doctor to care manager but that, in order to execute such authority, the role requires skill in conflict management as the care manager negotiates with, and coordinates care across, different care providers. Discussions with Japanese academics on our study visit suggest that there is some concern about how an individual with no clinical background could fulfil such a role, particularly as service users present with increasingly complex medical and social care needs. Despite government interventions and financial sanctions to improve the situation, care managers' independence remains a concern due to their employment by a single provider.

Points of interest for England

- Care managers play a central role in the Japanese LTCI system, acting as advisers, monitors, commissioners and brokers on behalf of the individual. As such, they are key to the delivery of a coordinated package of care.
- Care managers provide a single joint assessment process, initiated before hospital discharge if the individual has had an admission.
- At the outset, there was an assumption that a qualified nurse would be able to fulfil the care manager duties more effectively than a non-clinical worker. As a result of low pay, however, the majority of care managers are now non-clinical and there are concerns that these managers may not have the right skills to coordinate the care of those with increasingly complex needs.
- Care managers are usually employed by a provider organisation so, while individuals can theoretically commission their care from any provider, some were found to be only referring service users to their employer. Despite financial sanctions applied by the Japanese government to ensure users are able to access a range of providers, there are still discussions about whether an independent care manager would be better placed to pull together a more optimal package of care, and facilitate greater choice and competition between providers.
- The Japanese experience highlights the potentially central role of the care manager in an integrated system but raises questions for England as to who the care manager should be, what their role should be, which service users need one and what skills are required. It may be that only the individuals with the most complex needs require a care manager with a clinical background.

Quality of provision

Quality of provision is a very pertinent issue at present in England with numerous stories emerging about poor and, at times, inhumane care in nursing home and other care settings (for example the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013, and the Commission on Dignity in Care for Older People, 2012). Quality and regulation are issues that are also increasingly debated in Japan in both health and long-term care.

Until 2005, beyond compliance with basic legal, administrative and financial rules, Japan did not explicitly emphasise quality in the delivery of services. In 2005, the focus shifted and 'from quantity to quality' became a specific policy goal (Wiener and others, 2007). A central focus of quality assurance in Japan is on staffing. As such, much of the effort to drive quality centres on monitoring staffing levels and bed-to-staff ratios, and on training and motivating staff. Guidance from central government specifies detailed requirements for staffing, which vary according to the facility type and size. Institutions are inspected annually in principle but, in reality, submission of documentation every other year is sufficient unless a serious issue is identified. When inspections do occur, they focus on the physical space, staffing levels, financial management and accuracy of data returns that include, for example, the number of procedures undertaken (Wiener and others, 2007). Besides closing down a facility, the main sanction available

to government is to reduce reimbursements by up to 30 per cent (Matsuda, 2012). Patient or carer experiences are not routinely collected as part of this assessment.

The other mechanisms used to drive quality are choice and competition. This is particularly true in community services where formal oversight of community-based provision is less strict than for institutions (Wiener and others, 2007). By giving individuals control over the funds with which to purchase services, the intention was that providers would compete on quality. While some data are in the public domain to aid choice, Japanese academics and government officials told us during our study visit that it is not widely used and that patients generally choose providers based on reputation and word of mouth. There is mixed evidence about the extent of competition in the market (Wiener and others, 2007).

Our discussions with academics and government officials in Japan revealed a growing sense that quality monitoring should be more extensive and there is considerable interest in the metrics and patient-accessible information used, and being developed, in the UK, particularly around patient experience.

Points of interest for England

- Japan has pursued a regulatory system of monitoring. However, the system – particularly in terms of provision of community and home care – relies largely on choice and competition to drive quality. But, because service users do not have access to cash payments and the care managers who guide their decision-making are employed by individual providers, there is potential for choice and competition to be limited.
- Formal quality monitoring and inspection focus largely on staffing levels and training. Strict requirements are set at national level and, where minimum standards are not met, the main sanction available to the government is to reduce reimbursement rates. In comparison to England, measures of quality are more narrowly defined and fewer in number. Patient and carer experiences are not routinely collected for example.
- There is interest among some Japanese academics and officials with whom we met about how quality is measured in England and what data are used. Because of the lack of comparable data in the two nations, it is not possible to assess the relative quality of services.

4. Models of provision

Although it is important to acknowledge the challenges faced by the Japanese system, it is also important to recognise the innovative approaches that have developed in response to the LTCI programme. This chapter reflects on two models of provision that we witnessed during our study visit. The first describes a model that has arisen in an attempt to provide comprehensive and integrated services to whole populations; the second describes how the system has responded to the specific needs of people with dementia.

Integrated delivery systems

The Japanese government's permissive approach to competition policy has allowed a small number of large integrated delivery systems to emerge. These integrated delivery systems are not dissimilar from some of the US-based models of integrated care in that they operate either as a single organisation or as a series of networked organisations in order to provide a range of care that typically spans health and long-term care (Thorlby and others, 2011).

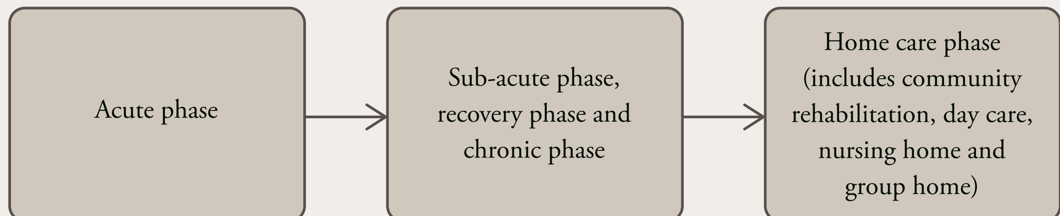
“In contrast to integrated systems in the US that have tended to grow out of physician groups, Japanese integrated delivery systems have tended to develop out of acute hospital providers that are already established and trusted by their communities

In contrast to integrated systems in the US that have tended to grow out of physician groups, Japanese integrated delivery systems have tended to develop out of acute hospital providers that are already established and trusted by their communities. Acute hospitals are paid according to a tariff schedule that, like in England, discourages long lengths of stay through a marginal rate beyond a certain number of days. Matsuda and Yamamoto (2001) suggest that it was this reduced payment that first incentivised hospitals to develop long-term care facilities in order to maximise efficiencies. A further incentive came in the form of profit; as explained in Chapter 3, providers of institutional care are not permitted to make a profit, but providers of community-based long-term care services are. Many institutions have responded by developing home and community care services such as visiting nursing services, visiting rehabilitation services and day care (Matsuda and Yamamoto, 2001).

Box 2: Integrated delivery system at Eisei Medical and Health Care Group

Eisei Medical and Health Care Group is a health care provider located on the western outskirts of Tokyo. The Hachioji area in which it is based covers a population of just under 600,000. Twenty per cent of the population is over 65 and that rises to 40 per cent in the immediate vicinity of the hospital.

The Eisei model is based on phases of care, the services for which are all provided by the same organisation and coordinated across its various sites, facilities and the patient's home:



However, a patient can access the home care component without having previously experienced an acute phase. A care planning centre ensures that patients who qualify for LTCI have access to a care manager who will then coordinate their care across the various facilities. Although the health care and LTCI budgets remain separate, they can both be administered by a single umbrella organisation. Patients can choose to buy services from other providers should they wish to, but most tend to use the facilities provided by the Eisei group.

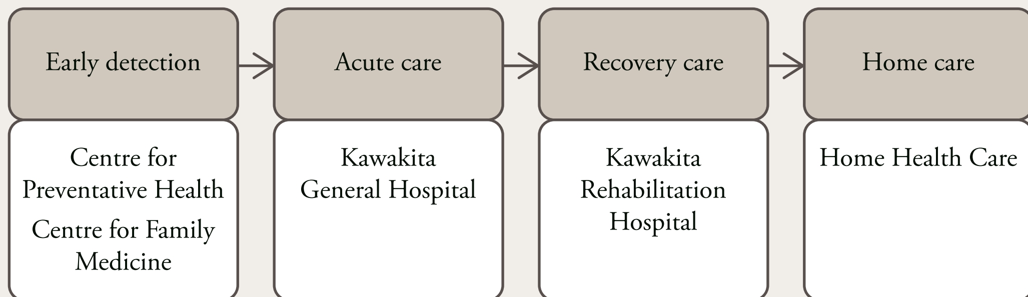
Doctors who work in the hospital also visit patients at home post-discharge. This offers continuity of care and further helps to integrate care.

A central priority of Eisei is prevention and health promotion, which it pursues via healthy eating groups, increased community care and working with volunteers. The organisation is developing a 'whole town development concept', which is attempting to fully integrate health, long-term care, education, employment, housing and the wider community (including business) by forging an overall vision for the area.

Box 3: Integrated delivery system at Kawakita Medical Foundation

Established as a private hospital for tuberculosis in 1928, the Kawakita Medical Foundation has evolved and developed into an integrated delivery system serving a population of 520,000 people, with almost 1,500 staff. With a vision around improving community-based health care, it is seen as a pioneer in the field of general practice and primary care.

The Foundation seeks to provide residents in the area with 'a coherent system from prevention to home care' by coordinating services, as illustrated by the figure below:



In order to provide integrated services, Kawakita brings together the discharge nurse and care manager before the person leaves hospital. A case conference is held, including all the clinicians and health professionals involved with the person's care.

The Kawakita network also includes an outpatient clinic, a dialysis centre, residential homes for older people, a training centre and a nursing school. Because of its commitment to out-of-hospital care, the number of hospital beds in the area it serves is much lower than the Japanese average – around 4.5 beds per 1,000 population, compared with an average of 13.4 beds per 1,000 people (the UK average was 2.95 beds per 1,000 population in 2011; OECD, 2013).

Kawakita has built up a strong network of volunteers who offer a sitting service to people living in the community. It states that this is particularly valuable for families living with an older relative with dementia, as the volunteers are able to give carers a break.

Dementia group homes

One of the more innovative models of care that has been supported by the LTCI scheme is the group home, which provides a form of residential care for people with dementia. Designed to provide for the rising number of older people with dementia, and modelled on a Swedish concept, Japan piloted a small number of these in the mid-1990s (Janicki and others, 2005). The number of people with dementia in Japan increased from 1.5 million in 2002 to 3.05 million in 2015, and is set to rise to 3.73 million by 2017 (Ministry of Health, Labour and Welfare, 2012a). The increase is partially explained by a redefinition of dementia, which has raised public awareness of it as a specific diagnosable condition and not just functional decline associated with the normal ageing process (Traphagan and Nagasawa, 2008).

Box 4: Changing attitudes to dementia

In 2004, the Japanese government changed the term used to describe dementia, seeing it as derogatory. The new term 'ninchi-sho' means cognitive dysfunction. Around the same time, a ten-year nationwide public campaign was launched. The campaign included a travelling caravan that aimed to train one million dementia supporters, promotion of the idea of dementia friendly communities, assistance to support groups for people with dementia and their families, and promotion of new care management processes that more fully involve individuals and their families. The campaign has exceeded expectations and after only four years had already trained over one and a half million dementia supporters. There are now plans to reach six million trained supporters by 2017 (Ministry of Health, Labour and Welfare, 2012a).

The government has also tried to increase the detection and diagnosis of dementia. Since 2005, specialist training for doctors and nurses has been given and memory clinics have been introduced (with 590 registered in 2010).

(Nakashima and others, 2011)

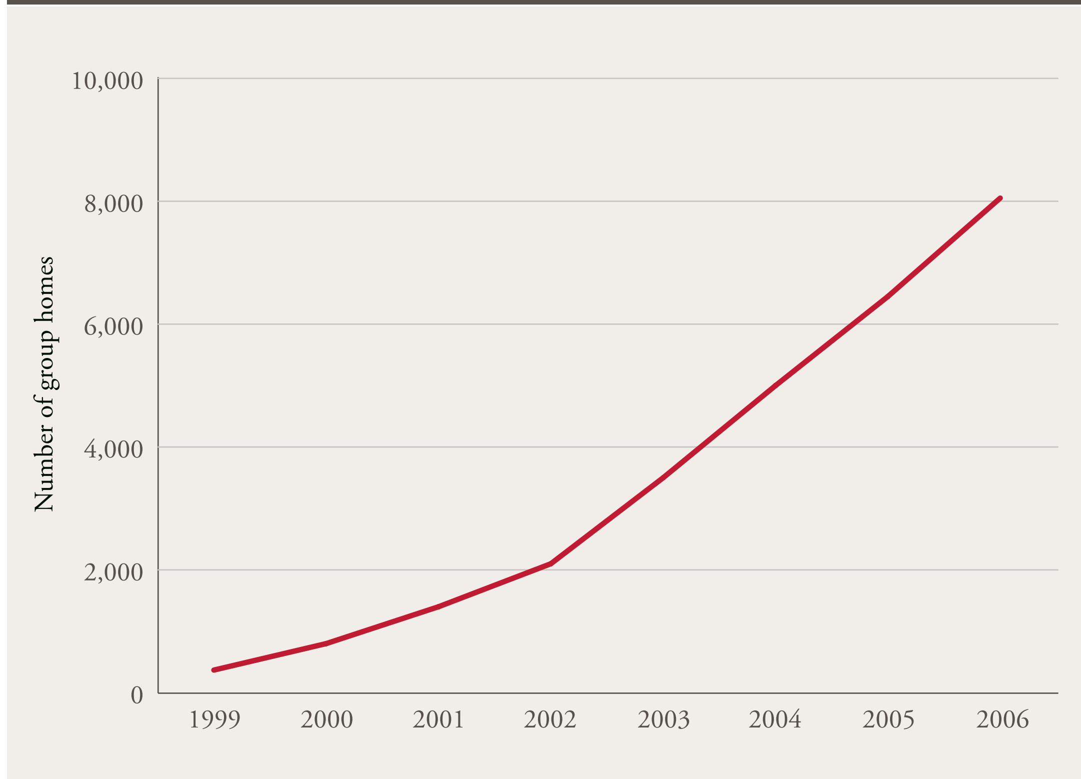
Group homes were established in response to a recognition that traditional institutionalisation of people with dementia can lead to decline in physical, social and psychological functions (Bowie and Mountain, 1997; Uehara, 2008). In contrast to traditional institutions, group homes are intended to be small-scale facilities that should create a home-like atmosphere and facilitate autonomy and activity, while being safe and secure (Uehara, 2008). Residents are seen as 'family members' within the group home (Morozumi, 2007). Although there are few guidelines as to how a group home should provide services, the emphasis of the concept is on support rather than provision of care (Uehara, 2008).

Group homes in Japan can vary in size and set-up, but they typically provide a home-like setting for groups of around nine people who have been diagnosed with dementia but who are not bedridden (Kobayashi and others, 2008). Group homes often house more than one 'unit' and a survey in 2011 indicated an average size of homes to be 15.1 individuals (Ministry of Health, Labour and Welfare, 2012b). Residents each have a private room that they must furnish themselves and the staff (around four) undertake activities with them. Residents are encouraged to participate in food preparation and other chores where possible. Residents tend to stay until death, or until they require more intensive medical or palliative care. A place in a group home costs around ¥240,000 per month (2008 figures), which is around £1,700 at the current exchange rate. Residents are required to cover ten per cent of this cost; the rest being funded by the LTCI programme. In addition, residents must pay for room and board and any other extras, at prices set by the provider. There is some public assistance for these charges for those on low incomes (Traphagan and Nagasawa, 2008). There is some evidence that group homes can reduce the behavioural and psychological symptoms of dementia and enable older people to maintain activities of daily living (Kobayashi and others, 2008).

The introduction of LTCI in 2000 stimulated greater provision of such homes and an original target was set of 3,000 (Janicki and others, 2005). As a result of private

providers being able to enter the market and the fact that group homes are not classified as institutional care, meaning that providers are permitted to make a profit, there was a rapid increase in their numbers over the subsequent decade (Morozumi, 2007; see Figure 5). In early 2005, there were over 5,000 group homes established (Shinbun, 2005). In 2007, around half of group homes were operated by private, profit-making providers and half by non-profit providers (Morozumi, 2007). By 2010, just over 10,000 group homes were registered (Nakashima and others, 2011).

Figure 5: Number of group homes in Japan from 1999 to 2006



Source: Adapted from Traphagan and Nagasawa, 2008

5. Points to consider from the Japanese experience

The social care funding and provision debate continues apace in England. The recent announcement capping individual contributions to care at £72,000 over a lifetime (Department of Health, 2013) has been welcomed by some as representing progress. Others, however, argue that it is a small step that does little to address the fundamental challenges associated with social care affordability, provision or quality (see, for example, Charlesworth, 2013 and Humphries, 2013). What is certain is that the issue has far from gone away and that, due to the rising proportion of older people in our society, a significant overhaul is required not just of how social care is funded, but also of how it is delivered. Of growing importance is the need to integrate social care provision with health care, as people grow older and develop a greater range of complex needs.

Japan's experience over the past two decades provides insights for the next phases of the debate in England. In many respects, the introduction of LTCI can be considered a success. The Japanese government has succeeded in harnessing public support for an entirely new insurance system; in moving from a situation where provision of social care outside the family was extremely limited, to one where public provision is widespread; and in creating a diverse provider market with some innovative models of care. However, the LTCI scheme has not been without difficulties and it faces a number of challenges as it moves into a new period of global financial austerity. As well as continued financial pressures, the system also faces challenges around quality, equity and the workforce. While undoubtedly a significant achievement in many ways, the absence of a formal evaluation or readily accessible data makes assessing its key aim of reducing hospitalisation difficult. Lengths of stay and bed days have fallen, but only gradually, and they are still greater than those in England. So, while the new system may have improved the provision of services, it has seemingly not had the anticipated impact on hospital services that, it was intended, would yield financial savings. It has also not delivered the hoped-for boost to the economy as provision has not been sufficient to eliminate the pressure on families (Campbell and others, 2010). Concerns about equity and quality also appear to be increasing as policy-makers and academics consider how best to monitor and regulate the system. Below we consider some of the pertinent points for England arising from our research.

Of growing importance is the need to integrate social care provision with health care, as people grow older and develop a greater range of complex needs

Finance and coverage

By the late 1990s, there was widespread public acceptance of the need for a reformed social care system in Japan. This acceptance was facilitated by the adoption of a part-taxation, part-national insurance system, rather than a solely tax-funded approach, as it was considered more transparent. It was also felt that at the point at which people were being asked to contribute (40 years old), they were likely to experience the benefits of the system via elderly parents and so were more likely to be accepting of making contributions. The result was a bold decision to introduce LTCI for all.

The Japanese system has done well to address much unmet need, to provide support on a universal, needs-alone basis and to support informal carers. However, the sustainability of the model is questionable under current cost and eligibility arrangements. Accurate projections of likely need and demand over the long term are essential for ensuring that realistic eligibility thresholds and/or realistic premiums and co-payments are agreed.

In England, eligibility criteria are being tightened and the number of older people being provided with publicly funded care is falling. Moreover, the cap on self-funders' costs will only affect a small proportion of people – estimated at one in eight – who have exceptionally high costs over their lifetime. It seems likely that continuing pressure on public funds coupled with a high cap will leave many people with unmet needs or still having to incur relatively high social care costs. The proposed transfer of funds from the NHS to social care, which is intended to achieve better service integration, may have little impact on these issues, and it is uncertain how viable any further transfers will be.

In both countries, the governments stepped in to address market failure to provide commercial private insurance. The UK government intends its reforms to stimulate the development of new products to insure individuals against care costs. However, as yet, the sector response to this has been uncertain.

Clarity and equity of the system

The deliberate adoption of a standardised computerised test in Japan was partially due to concern about the lack of suitable training in the social care workforce. However, it has the advantage of offering the public some clarity over eligibility. In England, there is significant variation in locally applied eligibility thresholds and assessment outcomes (although there is a national eligibility assessment framework). The Care Bill goes some way to addressing this by establishing national eligibility thresholds; however, implementation of the criteria will continue to be subject to local decisions, including on funding, and in practice may be less equitable than intended. Personalisation of services, although positive, will add to an already complex picture. So too will the operation of the cap on lifetime care costs. As yet, there is no strategy for explaining to the public what will become an even more complex system.

Creating a diverse provider market

Japan has created a diverse and large provider market relatively quickly through the use of additional funds, individual choice about how they are used and regulator financial incentives on the supply side. But the last of these have skewed the market, albeit in some cases intentionally. The ban on profit-making in institutional care has

resulted in significant growth in the domiciliary care market. The limits on the number of institutional places has also meant that there are now extremely long waits for residential care and the failure of hospital lengths of stay to fall as hoped may also be due to insufficient supply of these places.

In England, although the market for social care is already varied, the market for health care providers is slowly diversifying. Personal health budgets were intended to have an impact, but the number in receipt of these budgets is small. Patient choice was also expected to bring about change in the market, but the impact has been relatively weak. The experience in Japan indicates that diversification of the market can be stimulated by the injection of funding, financial incentives and giving users some choice over how it should be spent. However, how those choices are guided can be an important factor, with the independence of a care manager being crucial.

Tackling the rising number of older people with dementia has been a particular focus in Japan. Group homes offer an interesting model of care for people with dementia, with each 'unit' providing care for around nine people within a home-type environment.

Ensuring quality

In recent years in Japan, there has been greater attention paid to quality monitoring. This has largely focused on staffing numbers and other similar measures, with central government specifying detailed requirements. While there is a system of inspection for institutions, it has been described as 'rather formalistic and paperwork oriented' unless a significant issue is identified (Wiener and others, 2007). The system relies heavily upon choice and competition, particularly for the home and community-based sector where quality monitoring is less strict than in institutions. There is debate about how effective this is, particularly as the choice given to users may be restricted by their care managers. England has a more varied approach to ensuring quality through a combination of regulation, inspection that incorporates a view of user experience, wellbeing and outcomes, and individual choice. But striking the right balance between these different mechanisms is difficult and may not always be effective (as recent scandals in care homes have shown). The Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) has advocated greater government regulation of staffing levels for hospitals.

The role of competition and integration

Perhaps one of the most striking achievements to result from the Japanese experience is the emergence of a highly diverse provider market based on differing degrees of integration and competition, stimulated by the creation of demand for services. The development of large-scale integrated delivery systems has offered an opportunity for existing providers to extend and expand their range of services and to offer residents comprehensive care within one organisation. Alongside these large providers are smaller providers of services. Much of the integrated provision appears to have emerged out of existing acute providers, which have taken advantage of their established status in the community to attract clients, extend their range of services and make a profit. The focus in the new system in England is commissioner-driven innovation – which in social care is intended to be driven by individuals acting as their own (micro-) commissioner using personal budgets – where commissioners shape and specify services for which they will pay providers. The Japanese experience (although contextually

different) suggests that established providers, if given the right freedoms and incentives, could also lead the development of new models of care.

Mobilising the community

England has already begun to learn from Japan in its care for older people with dementia and recently implemented a 'dementia friend' initiative (Department of Health, 2012) partially based on the similar programme in Japan (Ministry of Health, Labour and Welfare, 2012a). Japan has also managed to harness the support of a large number of volunteers and raise public awareness of dementia, a condition about which little was known previously.

The role of care managers

Care managers in the Japanese system provide a central point of access for individuals in need of care. They act as brokers, negotiators and commissioners; matching appropriate care to available budgets. They also monitor the services received. Many current integrated care initiatives in the UK and elsewhere place importance on having a single person with oversight of a person's care, but there is debate about the skills and background required by that person (Ross and others, 2011). It is often argued that the person must have the skills to be able to negotiate with highly skilled medical and social care staff and to organise care across two sectors (Goodwin and Lawton-Smith, 2010). Experts who we met in Japan expressed concern that non-clinical care managers might not have the appropriate skills to manage individuals with complex medical needs, but also that many non-complex individuals may not need a care manager. However, it is important to note that in England only those who qualify for state support will have access to a similar individual to help choose services, although those who pay privately may receive advice and guidance.

Conclusion

Japan made a bold move in the late 1990s in pursuing the introduction of an entirely new social care system. Its issues were clear: it urgently needed to address the growing number of older people and the increasing pressure on families by increasing access to social care. In many ways, the scheme has been a success, but it has not achieved all that was intended. It has also not been without controversy and perhaps its greatest test is yet to come as it grapples with an older population that already accounts for nearly one quarter of its population. It is useful for England to reflect on the Japanese experience, for its challenges and difficulties are as valuable as its successes in helping shed light on options for social care in England.

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ISBN: 978-1-905030-72-9