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What can England learn from the long-term care system in Japan?

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nuffieldtrust

About this report

Social care in England is struggling to meet the needs of an increasingly complex and ageing society. Successive cuts to local authority budgets have resulted in fewer people being able to access care and an increasing reliance on informal care to fill in the gaps in state provision. The knock-on impact on the NHS has also been significant. A sustainable and equitable long-term financing and delivery system – while widely acknowledged to be necessary – remains elusive. The government has announced that the long-awaited green paper on adult social care for older people will be published in the summer of 2018.

Within this context, the Nuffield Trust recently undertook a visit to Japan to study the country's social care system. Japan introduced a long-term care insurance system in 2000 which established new models of funding and delivery, and endeavoured to create a positive vision of ageing. Part social insurance, part taxation and part co-payment model, the Japanese system aims to provide comprehensive and holistic care according to need. Over time, the design of the system has successfully created a competitive provider market and facilitated a wholesale shift in care responsibilities, although this has not been without difficulties.

As our government embarks upon its next attempt to grapple with the issues affecting the social care system, this report offers an overview of the Japanese long-term care insurance system and highlights the pertinent points of learning for England, in order to provoke debate and bring new ideas and potential solutions to the green paper discussions.

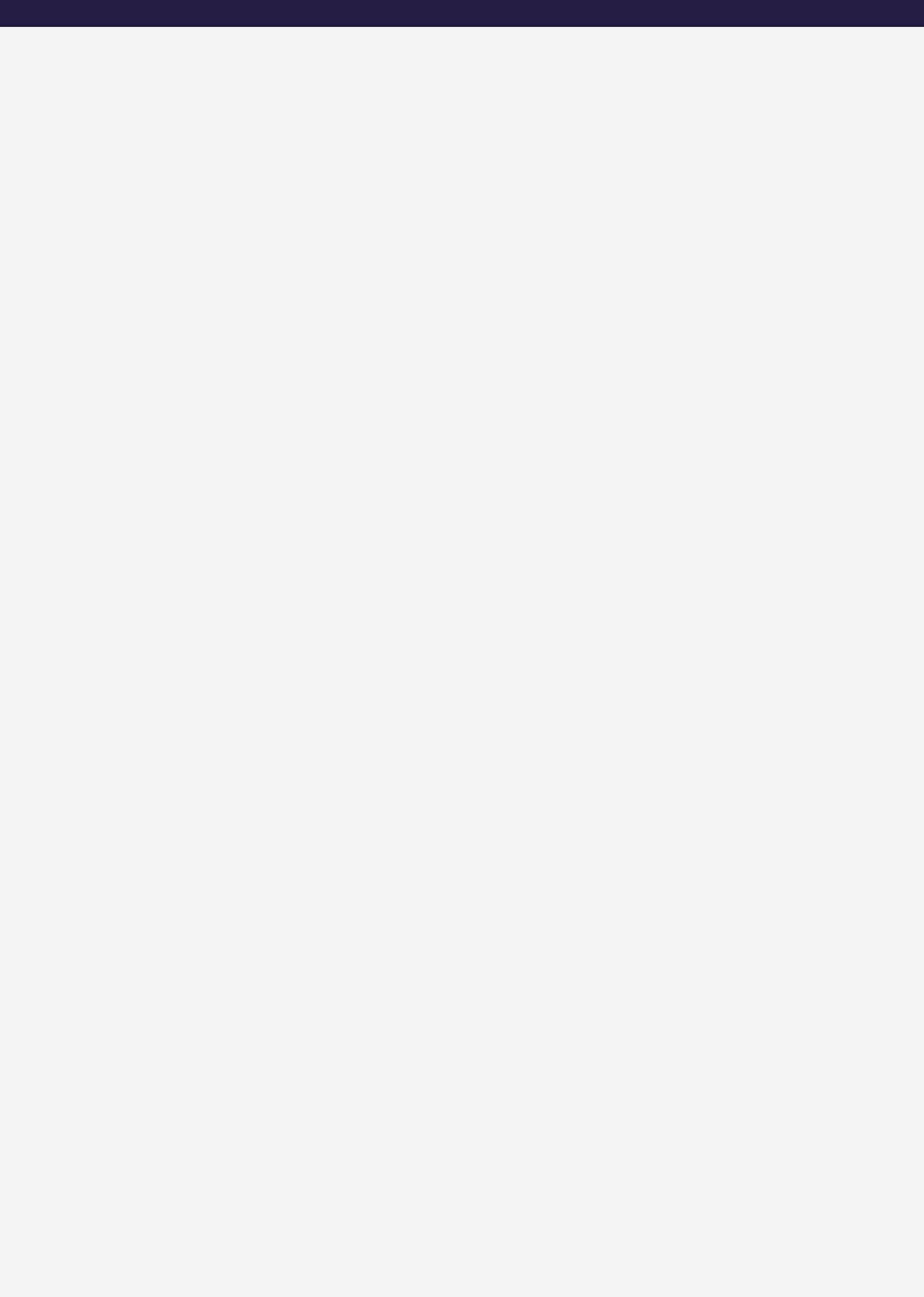
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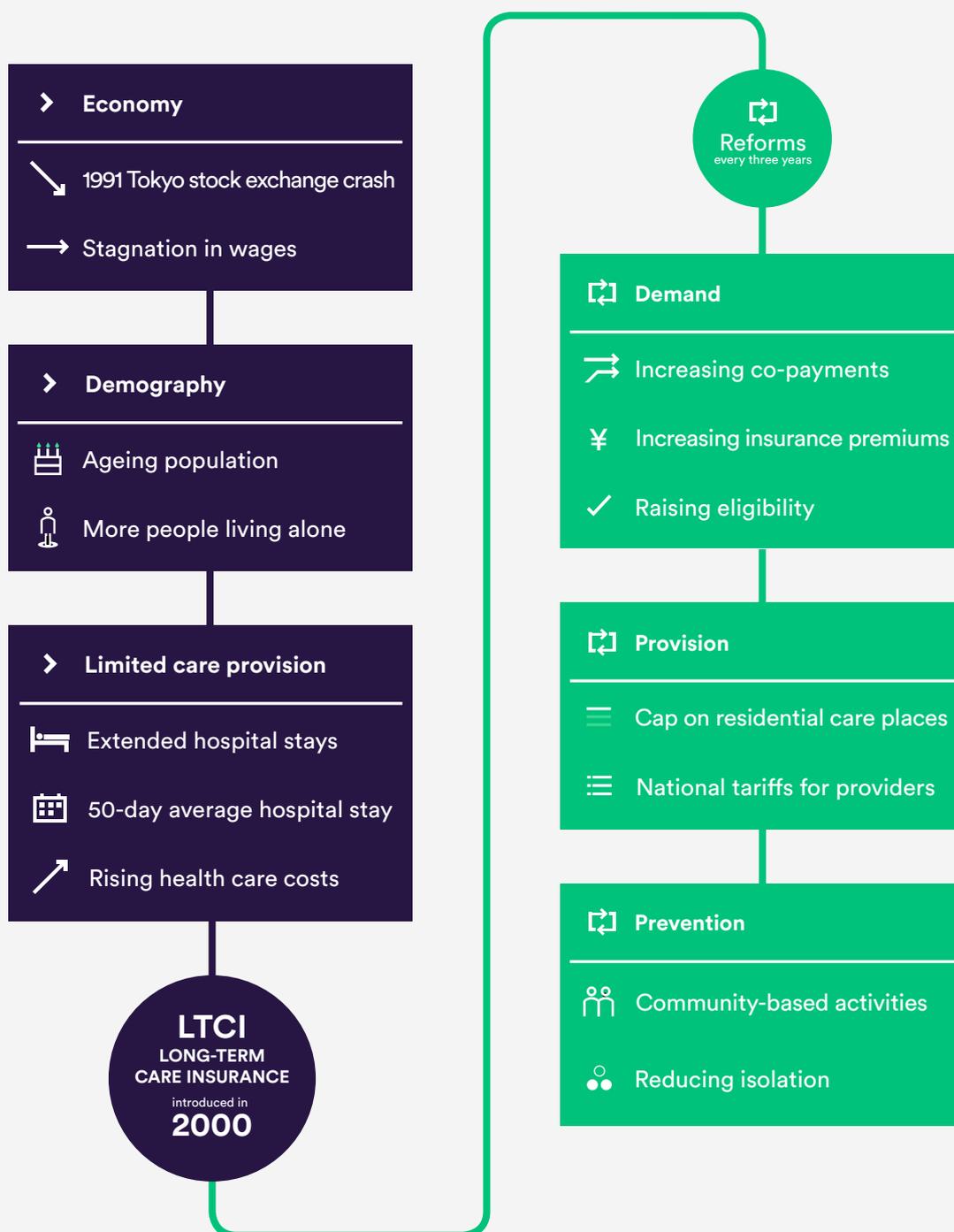
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Drivers for the introduction of long-term care insurance in Japan and summary of subsequent reforms



1 Executive summary

Following years of local authority budget cuts, the English social care system is struggling to provide sufficient care for those who need it. Increasing numbers are forced to self-fund, while others go without. The impact of the social care crisis is also being felt in the NHS, with many people unable to leave hospital as they wait for social care to be put in place. Projections suggest that by 2019/20, social care will be facing a funding shortfall of £2.5 billion (Nuffield Trust and others, 2017). If migration is halted following Brexit, social care faces a shortfall of 70,000 workers by 2025/26 (Dayan, 2017).

While pressures in social care are not a new problem, there is widespread recognition that it is an increasingly pressing priority. A forthcoming green paper is expected to lay the foundations for developing a new system of funding and provision. It is in this context that the Nuffield Trust went to Japan, to consider what lessons may be drawn from the introduction of its comprehensive long-term care system.

Japan's social care system

Japan introduced a long-term care insurance (LTCI) system in 2000 which established new models of funding and delivery, and endeavoured to create a positive vision of ageing. In the 1990s, as a country with a rapidly ageing population, a stagnating economy and decreasing capacity for families to take care of older relatives following high numbers of women joining the workforce, it faced an uncertain future. Health care costs were rising sharply, partly as a consequence of a shortage in affordable care provision.

Part social insurance, part taxation and part co-payment model, the new system aims to provide comprehensive and holistic care according to need. Over time, the design of the system successfully created a competitive provider market and facilitated a wholesale shift in care responsibilities, from families and individuals to society as a whole.

Lessons for England

Although the specifics of the Japanese funding and delivery model may not be suitable for the English context, there are a number of important lessons England can learn from Japan's experience:

- 1 England has so far failed to gain public buy-in or sufficient cross-party support to implement any previous proposals for reform. By making the initial service offer generous, mandating financial contributions from the age of 40 (when most people would see the benefits of the system for their ageing parents), and embedding the principles of fairness and transparency through national eligibility criteria, the Japanese government was able to gain public support and buy-in. However, this did take time. The government in England should be realistic about how much time is likely to be required to ensure genuinely informed public debate is possible. Implementation of any new system should be viewed as a long-term process.
- 2 Intended as a 'living system', LTCI has a high degree of central control with in-built mechanisms for controlling demand and shaping provision. By reviewing the system at three-year intervals, the Japanese government is able to adjust national levers in order to control expenditure and incentivise (or discourage) certain types of provision. In exploring new proposals, the government in England should consider building in flexibility to ensure that the system is able to adapt to changing circumstances and afford some control over expenditure.
- 3 Embedded at the heart of the LTCI system is the care manager, who supports individuals to create care plans that fulfil their needs within an assigned notional monthly budget. Although the roles of care and case managers exist in health and social care in England, there is no single role definition and they demonstrate variable levels of effectiveness. Creating a role that is consistent across the country would help to offer support and clarity about expectations to those navigating the system and to health and care providers.

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- 4 As part of the implementation of LTCI, Japan has sought to embed a positive vision of ageing, where older people are supported by wider communities to remain independent and active in society. By investing in prevention and in community resources, Japan is creating supportive communities that seek to maintain wellness and reduce social isolation in order to prevent or delay the need for state-funded services. Although these services have not yet been independently evaluated, the approach contrasts with the English situation where, despite rhetoric regarding the value of prevention in the 2014 Care Act, financial realities have seen local authorities increasingly make cuts to preventative services in order to direct scarce resources to those most in need.
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Learning from Japan's challenges

Although there are many lessons for us to take away from the Japanese system, there are also cautionary tales. Despite impressive successes in implementing comprehensive long-term care services for 6 million eligible people, the Japanese system is now under significant pressure as a result of its ageing population and shrinking workforce. So far, it has managed to sustain the system by increasing insurance premiums and user co-payments, but it is not clear whether this approach will be sustainable in the long term.

Its depression of provider fees has kept wages low and, as is the case in England, many care workers have left the sector to enter other more lucrative industries. With no history of immigration, Japan has struggled to address this looming crisis. In designing a future system for England, there needs to be a realistic assessment of likely need and the corresponding workforce requirements. In the wake of Brexit, a workable strategy for filling rising numbers of vacancies will be of particular importance. It is crucial that workforce issues are not addressed in isolation and that any reform of social care funding is undertaken in conjunction with a review of workforce.

Conclusion

England, like Japan, faces a very challenging future as both countries grapple with the growing needs of a rapidly expanding older population. It could be argued that England is currently in the situation Japan was in in the mid-1990s, where there was growing consensus that radical reform was necessary. The 2018 green paper represents an opportunity to grasp the thorny issue of social care and to design a viable solution that has so far proved elusive. It will be important that all avenues are explored in arriving at a solution and that, importantly, the debate is taken out of the febrile political environment to allow for informed and genuine public discourse. It will also be essential that the green paper doesn't look at funding options in isolation but that it also considers the wider delivery system and how it interacts with the NHS, and that it has a particular focus on workforce.

As our government embarks upon its next attempt to grapple with the issues within our own system, it will be of utmost importance that we continue to study the experiences and lessons of those countries that are a few steps ahead. Japan is one of a number of countries that have demonstrated that it is possible to achieve fundamental reform. It is our hope that, through consultation and engagement, the green paper will be a significant step on the journey to a solution that is clear, appropriate, equitable and sustainable.

2 Introduction

Social care in England

Social care in England is struggling to meet the needs of an increasingly complex and ageing society. Between 2010 and 2016, successive cuts to local authority budgets resulted in fewer people being able to access care despite a rising older population (Humphries and others, 2016). A 1% real-terms increase in budgets in 2016/17 (NHS Digital, 2017) is unlikely to have reversed this trend. The effects of these cuts are wide-ranging, with people increasingly relying on informal care to fill in the gaps in state provision. The knock-on impact on the NHS has also been significant, with many people being unable to leave hospital as they wait for appropriate social care packages to be put in place (Edwards, 2017).

Despite numerous reviews of social care funding, a sustainable and equitable long-term financing and delivery system remains elusive. Previous attempts to enact reform have become highly political and have failed to gain the cross-party traction, and public support, required. For instance, the 2014 Care

“The need to find a way to fund social care for the long-term has now become urgent”.

House of Commons
Communities and Local
Government Committee (2017)

Act set out the most radical reforms for many years, making commitments to introduce a lifetime cap on care costs, but these were at first delayed and then abandoned. However, there now appears to be a broad consensus that the system as currently configured is unfit for purpose, inequitable and unsustainable.

In autumn 2017, the government announced that a long-awaited green paper on adult social care for older people – originally due to be published in summer 2017 – would be published in the summer of 2018. Although, at the time of writing, the precise details of this paper are not yet known, in March 2018 the Secretary of State for Health and Social Care articulated seven

principles (see Box 1) that the government is considering. These principles suggest that the green paper will cover more ground than just the funding model and will consider the provider market and workforce.

Box 1: Seven key principles to consider for social care reform outlined by Secretary of State for Health and Social Care, March 2018

1. Quality and safety of service provision
2. Whole-person integrated care with the NHS and social care systems operating as one
3. The highest possible control given to those receiving support
4. A valued workforce – an NHS and social care 10-year workforce strategy will be published separately later this year
5. Better practical support for families and carers
6. A sustainable funding model for social care supported by a diverse, vibrant and stable market
7. Greater security for all, including risk-pooling, to ensure greater equity

Source: Department of Health and Social Care (2018)

It was against this backdrop that the Nuffield Trust undertook a visit to Japan in November 2017 to study the country's long-term care insurance (LTCI) system. This report identifies what England may be able to learn from Japan and what we could and should take into account as the next set of reforms develop. It also updates a 2013 report by the Nuffield Trust on the Japanese health and care system (Curry and others, 2013).

Why Japan?

Geographically and culturally, Japan is very different from England. However, the country's demographic, economic and social trends make it a source of valuable policy learning, providing the opportunity to examine in detail the design and implementation of a long-term social care system in the context of macro-level pressures. The Japanese system therefore represents a valuable case for informing policy-makers' thinking about potential reform to the English social care system.

Demography

Japan is a country with stark demographic projections. In 2015, average life expectancy was 84, compared to 81 in the UK (OECD, 2017a). By 2040, the number of people aged 65 or over in Japan is projected to increase to over one third of the total population, compared to nearly one quarter of the population in the UK (UN, 2017). The population aged 80 or older in Japan has also risen sharply, from 0.9% in 1970 to 8.2% in 2016 – nearly twice the proportion in the UK (OECD 2017a) and outstripping the OECD average of 4.1% in 2011 (OECD, 2016).

At the same time (and as with most other developed nations), Japan's population is shrinking, as the birth rate continues to fall. The overall population is estimated to decrease from 127.4 million in 2016 to 124.3 million in 2025 (UN, 2017). As a result, recent projections have estimated that the number of older people (aged 65 or older) per 100 people of working age (aged 20–64) will increase from 46.2 in 2015 to 54.4 in 2025 (OECD, 2017b). In the UK, the increase has been less marked, from 31.0 in 2015 to 35.9 in 2025 (ibid). Wider social changes have also created greater need for care. In 1980, among the population aged 65 or older, 4.3% of men and 11.2% of women lived alone (Cabinet Office, Government of Japan, 2011); by 2015, this had increased to 12.5% and 20% respectively (Census 2015, cited in Yoshida, 2016). This is largely comparable to the current situation in the UK – where in 2016, 32% of the total population aged 65 or older lived alone (Age UK, 2018) – but signals a significant shift in Japanese society (Tamiya and others, 2011).

Economy

Japan's economy has experienced a prolonged period of stagnation. Japan suffered a severe economic setback with the crash of the Tokyo Stock Exchange in 1991. After decades of rapid economic expansion, growth during the 1990s was slow compared with other developed economies and the economy remains sluggish today. Japan's total debt now amounts to over 200% of its GDP, compared to a debt of over 100% of GDP in the UK. It is important to note that the implementation of LTCI was carried out within a context of economic difficulty.

Care provision

Japan has struggled with meeting the care needs of its ageing population, in terms of both provision and financing. Before the turn of this century, Japan's social care system suffered from high levels of local variation, had little by way of choice for service users and was becoming increasingly expensive (Tamiya and others, 2011). State-funded provision was limited to those with very low means and high needs, and most people relied heavily upon informal care by families (Umegaki and others, 2014).

There were attempts to drive up the number of care homes in the 1970s, and further reforms (the Gold Plan) were introduced in 1989 to increase the number of home-helpers and adult day care centres and to further increase the number of care homes. Despite this, provision remained inadequate and increasingly unaffordable (Hayashi, 2011; Traphagan and Nagasawa, 2008; Ikegami, 2007). To address these issues, in 2000 the government implemented the LTCI system (see next chapter for details).

Figure 1: Key comparisons between Japan and the UK

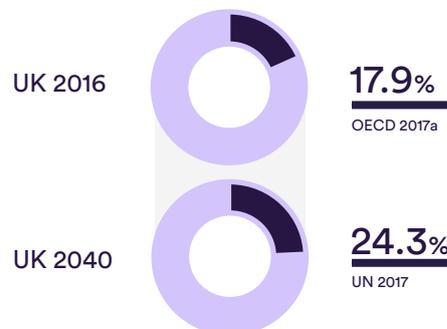
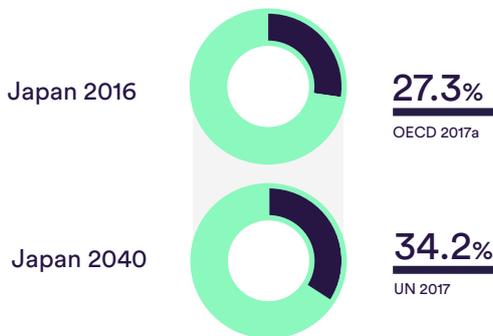
Total population



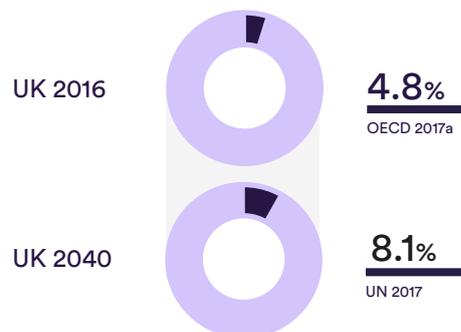
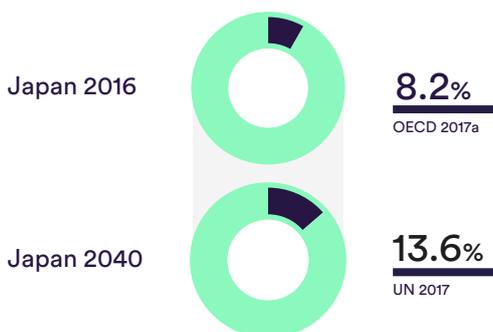
Life expectancy at birth in 2015



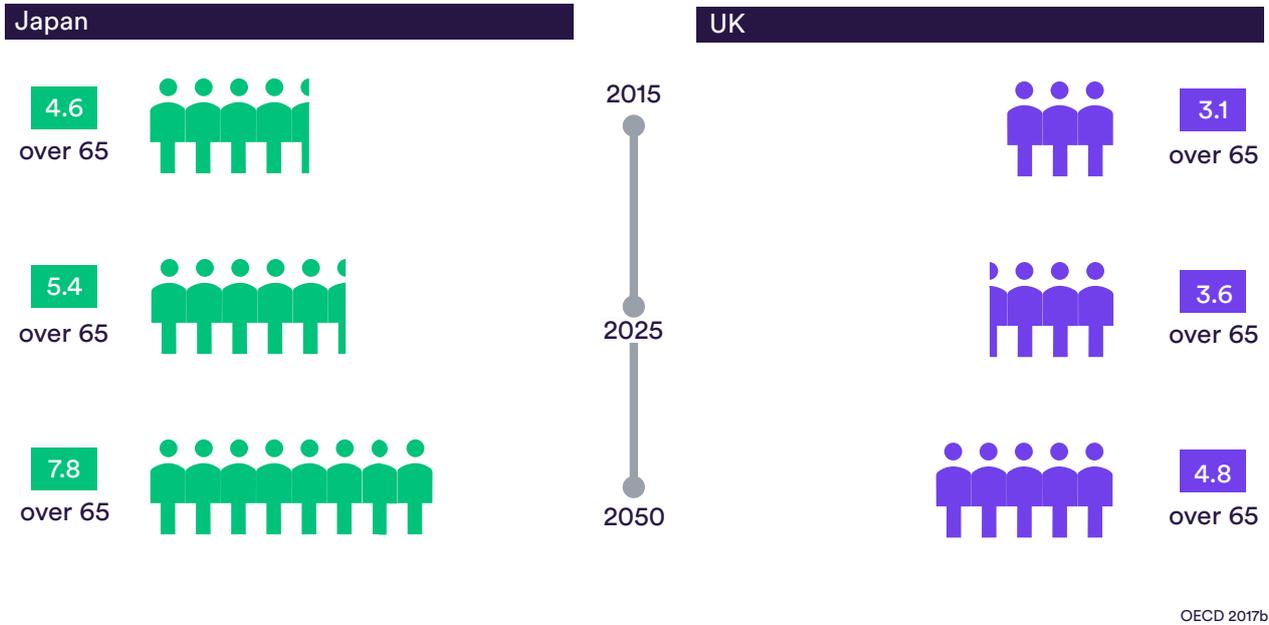
Population aged 65 and older



Population aged 80 and older



Number of dependent older people (over 65) for every 10 working-age adults



General government debt



Note: although this report focuses on the social care system in England, UK figures are presented here as the best available comparable data.

This report and our approach

This report seeks to offer a brief overview of the Japanese LTCI system and to highlight the pertinent points of learning for England. We are mindful of the complexities of international comparisons and the perils of transferring ideas from one context to another. With that in mind, we have not attempted to make direct comparisons between England and Japan. Instead, we have tried to draw out the elements of the Japanese system that we feel could be incorporated into our thinking or that offer cautionary tales. Our intention is to provoke debate and to bring new ideas and potential solutions to the green paper discussions.

Our approach

This report builds on the learning we published from a previous visit to Japan in 2013 that looked more widely across health and social care (Curry and others, 2013). In preparation for our visit in 2017, we undertook an extensive literature search using a range of databases. We also searched grey literature for updated information about the LTCI system and the Japanese context in general.

There is limited published literature in English about the technicalities of the Japanese system, so we engaged with a number of academics and other experts over email and Skype to establish a good understanding of the system.

During our visit to Japan we visited two Tokyo municipalities, five separate care delivery services and the Ministry of Health, Labour and Welfare. We also received a range of background documents from the Ministry of Health, Labour and Welfare and from social care providers. We interviewed the following people:

- three Senior Policy Officers for Elderly Welfare Affairs and Social Security Finance from the Ministry of Health, Labour and Welfare
- the Director General of Elderly Welfare in Setagaya Ward (municipality), Tokyo
- the General Manager of Health and Welfare Department in Musashino City (municipality), Tokyo
- four staff who assess eligibility applications in one municipality

- one care manager
- the managers of five care facilities which provide a group home for people with dementia, a day service, outpatient day long-term care, a multifunctional facility, short-term respite care and elderly living facilities
- three care workers
- a consultant involved in advising the government about reforms to the system.

Our write-up of the visit offers a high-level summary of our key observations. It is not intended as a comprehensive analysis of the Japanese or English system.

3 The long-term care insurance system: a brief guide

The introduction of LTCI

A number of factors and forces drove the development of LTCI during the 1990s. Demographic pressures, coupled with concern over the rising cost of health care, played a central role. The comparatively lower cost of health care, combined with a social stigma attached to the use of what limited social care there was, resulted in high rates of what has become known as ‘social hospitalisation’ (Hayashi, 2011). When families were unable to care for older people, they were often admitted to hospital with little medical justification, where meals and board were included in health insurance payments (Tamiya and others, 2011; Ikegami, 2007). Many hospitals became de facto nursing homes, although they were still designated as hospitals, so still had all the associated staffing requirements (Ikegami, 2007). In 1990, the average length of hospital stay for over-65s exceeded 50 days (OECD, 1990). A further driver of the reforms was a recognition of the care burden on families, and particularly on women who were unable to join the shrinking workforce (Ikegami, 2007).

In response to these pressures, the Japanese government set about designing a system that would provide care to older people that was universal, equitable, affordable and sustainable. By shifting caring responsibilities from individuals and families to society, there was a hope that the impact of the system would be felt widely across society and the economy. Its earlier 10-year reform plan (the Gold Plan) implemented in 1989 was widely felt to be inadequate. Although it successfully increased the provision of home helpers and day centres, access was limited to those with few means and no family support and it did little to alleviate pressures on the health service. Furthermore, provision and access were highly variable, people had no choice over care and access was tightly controlled by local government (Ikegami, 2007).

An opportunity for reform emerged in 1994 when an attempt to raise VAT to fund the existing system failed and brought the government down. At that point, plans for LTCI began to develop (Ikegami, 2007). Legislation was passed in 1997 and the scheme was implemented in 2000. We describe its main features below.

What is LTCI?

LTCI in Japan provides universal, comprehensive care to people over the age of 65 and those with a disability aged between 40 and 65. Based largely on the principles of equality and fairness, this needs-based system provides care to all, regardless of wealth or income (Campbell and others, 2016). It was introduced with an intentionally wide remit that sought to promote wellness, prevention and independence in older adults (Houde and others, 2007). LTCI also includes a large proportion of nursing services. As such, it is markedly different to England’s focus on providing personal care to those with very high levels of need and low levels of income and wealth.

Services that fall under LTCI are listed in Table 1. In addition to these services, 3% of the LTCI budget is spent on prevention services, such as exercise classes and community centres. These are available to all over-65s, regardless of their level of need.

Table 1: Summary of services offered under LTCI

Type of service	Description
Care delivered in a user’s home	<ul style="list-style-type: none"> Includes home visits for nursing, bathing and rehabilitation
Day-care and short-stay services	<ul style="list-style-type: none"> Includes day service for dementia and multi-service packages that combine day care and home help Respite services
Care delivered in a facility	<ul style="list-style-type: none"> Nursing home for severely dependent elderly Institutional rehabilitation Group homes for people with dementia Elderly living facilities

How is it funded?

The LTCI system is administered at municipality level and funded through a combination of social insurance contributions, general taxation and user contributions (known as co-payments). Every member of the population must pay into the system from the age of 40. As the system has matured, contributions and benefits have been adapted. Further discussion about these changes can be found in the chapter ‘What can England learn from Japan?’¹

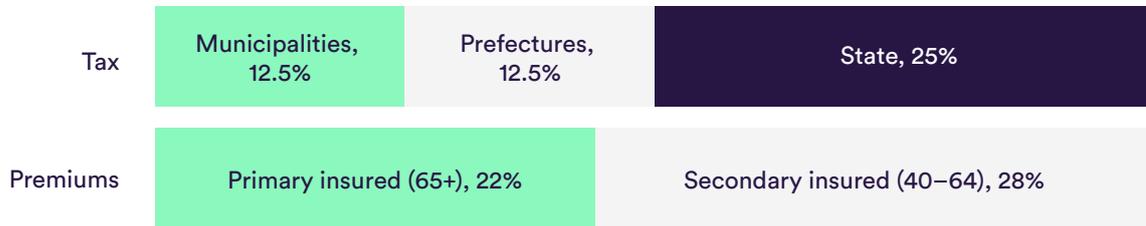
The funding model: premiums and tax

Half of LTCI funding comes from general taxation, collection of which is divided between the three levels of the Japanese state (municipalities, prefectures and national government). The other half of funding is raised through social insurance premiums. People who pay premiums are split into two groups: those known as the ‘primary insured’ are over the age of 65 and their contributions are withheld from their pension payments and collected at municipality level (see Figure 2).

The ‘secondary insured’ are those between 40 and 64 years of age. Their premiums are paid via social insurance funds that were already in place for health insurance prior to LTCI implementation. For those in employment, individuals’ contributions are shared with employers. These premiums are determined and collected nationally and redistributed to municipalities. When redistributing, the municipality’s ratio of the 65–74 and 75+ age groups to the working-age population is taken into consideration to ensure that allocations reflect need.

1 The Japanese state is made up of 1,719 municipalities, 47 prefectures and national government. Municipalities are local public authorities with a strong and direct relationship with local residents. Municipalities have responsibility for most of health and welfare services; prefectures oversee public health (see www.soumu.go.jp/main_content/000295099.pdf). Municipalities are roughly equivalent to local authorities in England.

Figure 2: The basic LTCI funding model



The proportions paid in premiums between the ‘primary’ and ‘secondary’ groups varies according to changes in demographics; these figures relate to 2016/17.

Box 2: A note on the Japanese health system

Japan has operated a social insurance system for health care since 1961 that is similar to LTCI in structure. Social health insurance premiums are based on ability to pay rather than risk of illness (Ikegami and others, 2011). It is compulsory to belong to one of 3,500 insurance plans, most of which are administered by employers. Plans offer the same benefits package, which is determined by national government. On accessing care, individuals are required to pay co-payments, which are typically 30% of the cost of treatment up to a pre-determined monthly cap. Older people, children and those on low incomes pay lower co-payments and annual payment ceilings apply for all. (Matsuda, n.d.).

Table 2: How much (approximately) does LTCI cost the average citizen?

	2000	2016
National average monthly income	£2,000	£2,400
National average monthly premium	£17	£37
Percentage of average monthly income	0.85%	1.5%

Income data taken from OECD average wages indicator (<https://data.oecd.org/earnwage/average-wages.htm>); premium data taken from materials provided by Ministry of Health, Labour and Welfare; contemporaneous exchange rates used.

The funding model: user co-payments

In addition to paying premiums, service users must pay a co-payment (financial contribution) when accessing services, although those on very low incomes are exempt. When the service was first introduced, this was 10% of the total cost of care, rising to up to 30% for some in more recent years (see ‘Controlling demand’ for more on this). Co-payments are paid up to a ceiling. If individuals want to access care beyond their entitlement, they must pay 100% of their costs out of pocket (Rhee and others, 2015). In reality, because provision is relatively generous, only a very small proportion of service users self-fund at all. It is estimated that eligible people take up only around half of the service amount they are entitled to because of concerns over the co-payment (Campbell and others, 2016).

Since 2005, people using services have been required to pay ‘hotel costs’ (for residential care) and a contribution to meals. These contributions are means-tested and capped for people on low incomes (Rhee and others, 2015). Further explanation of changes to the payment model is provided in the next chapter, ‘What can England learn from Japan?’

How do people access care?

LTCI services are provided when people aged 65 or over require care or support. It is also accessible to people aged 40–64 who require care or support as a result of developing age-related diseases, such as terminal cancer or osteoarthritis. The decision to set these parameters of eligibility was not without controversy, as any care needs resulting from an accident, for example, are not covered under LTCI (Ikegami, 2007).

There is a national process, managed by municipalities, through which all individuals wishing to access care are assessed for eligibility. A standard computerised form, consisting of 74 criteria, is administered by a municipality assessor who assigns a level according to seven eligibility levels. The result is submitted, along with a doctor’s opinion, to the LTCI certification committee. The committee alters the level calculated by the algorithm in around a fifth of cases, usually to a more severe level (Ikegami, 2007). The assigned level of need determines the monthly notional budget individuals have available

to them and the services they can access. Income levels and the amount of informal care/family support available are not taken into consideration when making these needs-based assessments. Importantly, there are no cash benefits. This was decided in order to help shift the burden of caring from families – in contrast to other countries (e.g. Germany and England) where cash benefits are available to facilitate family members caring for people with needs (Campbell and others, 2016). People who do not qualify for any care are able to access community support programmes and some long-term care prevention projects (see ‘Mobilising community assets: focusing on prevention’).

How is care delivered?

Once an individual is deemed eligible for LTCI services, they are assigned a care manager who is then responsible for working with the individual to agree a package of care that meets their needs, within the budget available. The allocated budget for long-term care can only be used to purchase services and is not available as a cash allowance. Service users are able to ‘top up’ their care and buy services beyond those provided under the scheme, although few do.

The care manager, in partnership with the individual, is responsible for designing, monitoring and overseeing care plans. Care managers were introduced as part of the LTCI reforms to empower individuals to make choices and decisions about their own care – this had previously been done by bureaucrats (Tamiya and others, 2011). The care management fee is paid by the LTCI system and users are not required to contribute.

Care managers typically have a caseload of around 30 individuals. The majority of care managers are employed by providers of services, although they are obliged to ensure they do not purchase care solely from their employer. If a care manager is found to have purchased more than a pre-specified proportion of care from a single provider (usually 80%), the fee paid to the care manager is reduced. Individual recipients can opt to change care managers at any time. To qualify to be a care manager, five years of prior care work is required. This could be as a nurse, a carer, a social worker or associated profession. A further qualification is then required to become a care manager.

Who provides care?

The introduction of LTCI has resulted in a very active competitive market, comprising thousands of mostly small providers which are a mix of for-profit and not-for-profit companies, social enterprises and charities. The small size of the providers is in line with Japanese convention, wherein over 99% of businesses are classed as ‘small or medium-sized entities’ (Ministry of Economy, Trade and Industry, 2016). Within five years of its inception, the number of home care providers had more than doubled (Ministry of Health, Labour and Welfare, 2011). In order to entice new providers in to the market, they were allowed to make profit (something that had not been allowed under the previous system). However, new providers were not allowed to provide institutional care as the government wanted to incentivise community and home-based provision (Ikegami, 2007).

Providers compete on the basis of perceived quality, convenience and reputation. The market is very lightly regulated, with minimal national standards that focus on staffing ratios and floor size of residential accommodation. There is an inspection regime, but it largely seeks to maintain minimum levels of quality rather than to drive quality improvement (Hiraoka, 2014; Campbell and Saito, 2014). It is not possible, therefore, to compare quality and safety in Japan with other countries.

4 What can England learn from Japan?

The social care green paper is likely to set out various options for reforming the funding and delivery of the social care sector, in line with the seven principles articulated by the Secretary of State. It may consider some of the proposals previously put forward in the reviews and commissions that have come before, such as a lifetime cap on care costs (Jarrett, 2018). What is evident is that any reform will need to go beyond simply increasing budgets and instead introduce a new, sustainable and equitable funding mechanism for providing sufficient care in the long term for our increasingly ageing and complex population. It is also important that any new system of funding and provision works alongside the NHS in order to maximise the efficient use of resources and to ensure that people do not fall between the gaps of care provision. Furthermore, it is crucial that proposals include considerations of workforce requirements across health and social care.

With these considerations in mind, we now draw out what we think are the most pertinent elements of the Japanese system for England, regardless of the funding model it adopts.

1 Getting public buy-in

Despite limited provision and widespread social stigma attached to the use of state-funded social care, Japan managed to implement an entirely new system involving additional financial contributions and take the public along. The government officials we spoke to described the need for social care becoming the ‘number one public issue’ in the 1990s. During this period, there was a growing acceptance that demographic pressures were such that radical reform was required. There was also widespread support for the burden on families to be shifted to the three levels of the Japanese state.

Several factors made the introduction of the system more palatable to the public. First, careful consideration was given to the age at which people should begin to contribute to the system. It was felt that, at the age of 40, most people would know someone who required care, so would see the benefit of the system firsthand and therefore be more willing to contribute. Subsequent attempts to lower the age of contributions (to 20 in 2005) were met with opposition, largely from employers who argued they would be adversely affected (Ikegami, 2007).

To help with the process of public acceptance, the system was made deliberately generous at launch so that contributors felt they were getting value for money. This was also to ensure that those who were already receiving long-term care under the previously variable system did not have any benefits removed (Ikegami, 2007). By designing a universal system with a wide remit that had relatively low thresholds for eligibility, it ensured that a large number of people would benefit from the outset. When compared to Germany (which operates a social insurance system), it is estimated that twice the amount of community-based services are used by those with the same level of need. Because of this low threshold for accessing services, 17% of the 65+ population are eligible for services in Japan compared with just 10% in Germany (Tamiya and others, 2011). This was a deliberate move by the government, which felt it would be more acceptable to reduce the offer at a later date rather than introduce a more limited offer initially (Ikegami, 2007). By ensuring large numbers could be beneficiaries, the reforms engineered a shift in social attitudes that took the shame out of utilising state-run care services.

Second, the system was designed in a progressive way, with those on higher incomes contributing more. To ease the transition to the new system, premiums and co-payments – though adjusted in more recent years (see ‘Raising co-payments’ for more information) – were set at low levels at implementation and were designed to ensure that the largest burden in terms of contributions and co-payments fell on those most able to pay. The monthly co-payment cap was lowered for those on low incomes during the first three years of the system to encourage them to use the system (Ikegami, 2007). However, co-payments are not without their downsides, and it is noted in the literature that recipients typically only take up around half of the services to which they are entitled (Campbell and others, 2016).

Third, the government has sought to be responsive to public concerns. Initially, LTCI was intended to target services only at those with high levels of need. This was seen to potentially disadvantage poorer older people who needed low-level support with activities of daily living. In response to their concerns, LTCI was re-written during the 1990s to emphasise services to support the prevention of decline (Ikegami, 2007). In 2005, reforms that restricted entitlements to those with families and introduced hotel and meal charges for some services caused a public outcry and there was concern that the biggest impact was felt by poorer service users who were discouraged from using services (Hayashi, 2015). The government managed to quell the discontent to some extent by easing some of the restrictions and introducing subsidies for those most affected (Hayashi, 2015).

Fourth, the government was at pains to ensure there was clarity around benefits and contributions and that the system could be easily understood by the public (Campbell and others, 2016). Establishing computerised national criteria for eligibility means that, although the type and range of providers varies between municipalities, the processes of applying and assessing eligibility are consistent across the country. Establishing the system as a partial social insurance system also means there has been a degree of transparency about how much is spent on it. The public were more willing to pay a new premium for LTCI than they were to fund the new system via a higher consumption tax, because the latter is perceived to lack transparency (Ikegami, 2007). Already having a health system based on social insurance meant that the population was familiar with the concept and the mechanisms were already in place.

Finally, the process of public engagement did not happen overnight. Planning for LTCI began in 1994 and negotiations and consultations with different interests groups and the public took place over the subsequent three years. It wasn't until 1997 that legislation was passed to introduce the new universal system. By the point of implementation, there was widespread acceptance (Ikegami, 2007). There is little published work on public perceptions of the system but one poll that was conducted suggested that the system quickly gained popularity: in 2000, 44% of the public gave a 'high' to 'moderate' approval rating of the LTCI system compared with 61% in 2005 (Hayashi, 2013, cited in Hayashi, 2015).

Learning for England

Despite a Royal Commission and multiple independent reviews, green papers and white papers about social care over the last two decades, England has singularly failed to bring about any substantial change to the funding or delivery system. A large part of why it has not happened has been the failure to gain cross-party support for proposals, which have become hugely political. The most recent example of this was the handling and subsequent abandoning of the social care reform proposals (dubbed ‘dementia tax’ in the media) set out in the incumbent government’s election manifesto (Conservative Party, 2017). In the 2010 election, the Labour Party had a similar experience with its proposals being branded a ‘death tax’ in the media. The political climate and negative media coverage of the issues have made it difficult for the public to engage in an informed debate. Research suggests that the public has a limited understanding of the complexities of the social care system and many people do not appreciate that their care costs will not be met by the state (Gregory, 2014).

Although details on the future funding model were unknown at the time of writing this report, the green paper is likely to raise for debate the potential options for means-testing; the level and design of a cap on care costs (Jarrett, 2018); and the appropriateness of risk-pooling and the potential costs of this (Department of Health and Social Care, 2018). As such, the green paper is likely to question whether more of the cost should be met through public expenditure. As outlined in the Barker Commission, increasing costs cannot be avoided, but the question is whether those costs should fall on the individual or on society as a whole (Barker and others, 2014). There have already been a number of calls for a change from our current system where the burden falls almost entirely on individuals and families (see, for example, Ahmad and others, 2018; Dilnot, 2010). There has been some recognition of this by the government, who have suggested that “there has to be a partnership between the state and individuals” and have raised the possibility that the best long-term solution may require different arrangements for different age cohorts (Department of Health and Social Care, 2018).

To ensure the smooth implementation of a new system or (in particular) a reform to funding, it will be imperative that the public are supportive of intended changes and fully understand their individual liabilities under both

the existing system and whatever is being proposed for the future. In order for that to happen, there needs to be genuine cross-party consensus and a healthy and informed public and political debate – something that has been severely lacking in this area. However, any process of meaningful public engagement is likely to take time, and this will pose a significant challenge in addressing this urgent issue.

To help make reform more palatable, careful consideration should be given to who should pay in, who will benefit and – crucially – how those benefits and responsibilities will be communicated to the public. Ensuring transparency over contribution and benefit will be important. Japan made sure that the benefits were highly visible by making the offer relatively generous at the outset. England may wish to take a more cautious approach to entitlements, as reducing an initially generous offer may be less acceptable to the public here. It will be important to ensure that the public understand what they might be entitled to under the current system and how it would compare to a different approach. At present there is limited understanding among the public that social care costs fall upon the individual, so any proposed changes could easily be perceived as services being removed or access being limited (Gregory, 2014).

Part of the challenge with the English system at present is its opaqueness, and the sense of injustice that stems from the complexity of means testing and from national variation in access to services (Wenzel and others, 2018). In particular, the demarcation between social care and NHS continuing care is an ongoing source of confusion. The 2014 Care Act has gone some way to addressing variation in eligibility thresholds, but service provision still varies and the amount spent on care is determined locally (Humphries and others, 2016; Wenzel and others, 2018). Social insurance was selected as the main funding mechanism in Japan because of the clarity it offers for those contributing and because it built upon mechanisms already established for health care. Unlike Japan, England has no precedent of national health insurance, so it may not be perceived to be an appropriate mechanism. Any system involving extra contribution from the public would need to be communicated clearly, be seen to be transparent and, ideally, build upon existing mechanisms.

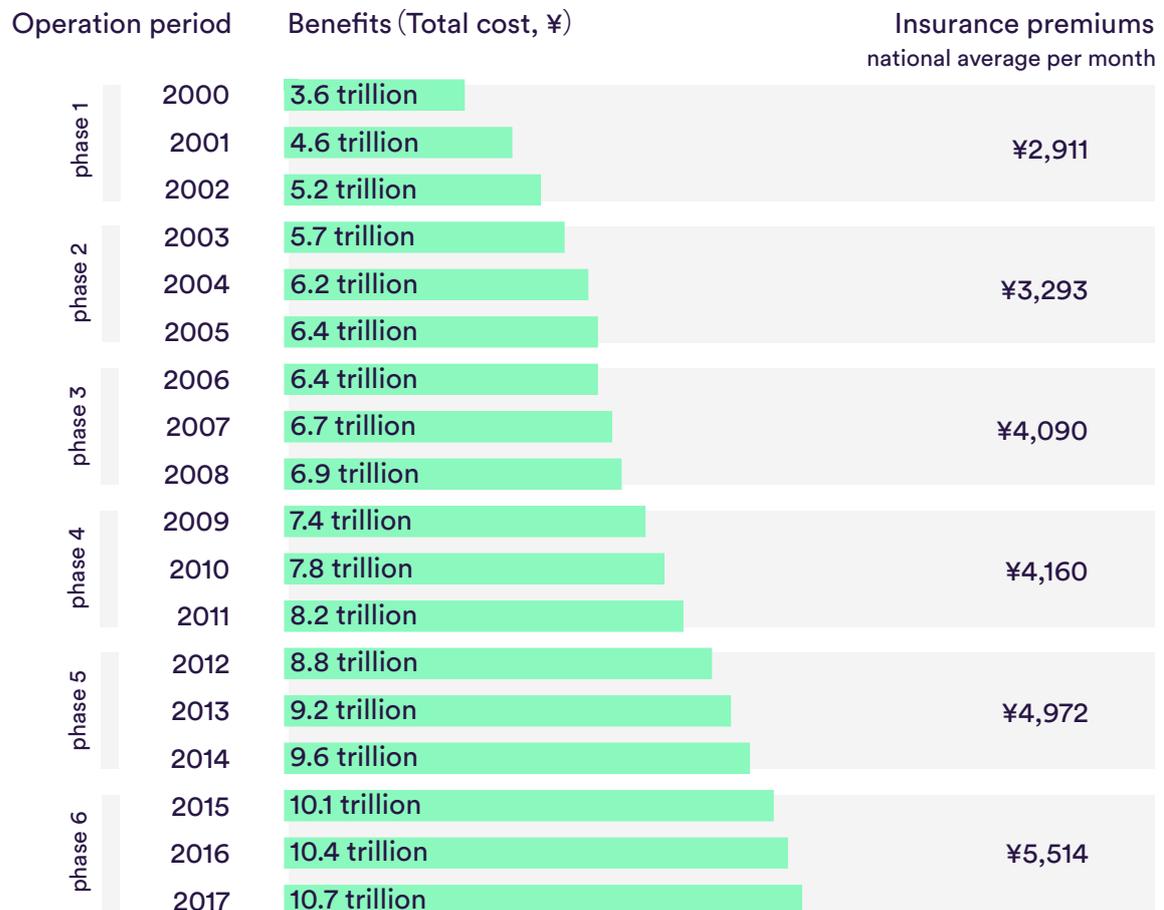
2 Controlling demand: embedding flexibility

Following the implementation of LTCI, demand for services increased sharply – leading to annual expenditure that was roughly 20% higher than originally forecast (Tamiya and others, 2011). The rise in expenditure was mainly because more people were eligible for services than originally anticipated. It was originally expected that 12% of the 65-and-over population would eventually be eligible, but by 2005, 16% were eligible. In absolute terms, the number certified had nearly doubled by 2005 (Ikegami, 2007). In those early years, the fastest rate of growth was among those with low levels of assessed need – this group increased by 138% by 2005, while those with higher levels of need increased by 60% over the same period (Hayashi, 2015). Between 2000 (the year of implementation) and 2017, the number of people in receipt of services increased by approximately 3.3 times (Ministry of Health, Labour and Welfare, 2017). What’s more, the cost of the system increased from 3.6 trillion yen to 10.7 trillion yen (see Figure 3). Using contemporaneous exchange rates, the approximate cost of the system was £21 billion in 2000 and £71 billion in 2017.

When the system was designed, there was an explicit acknowledgement that it would have to adapt and evolve as the population changed, so a degree of flexibility was embedded and change was anticipated. Every three years, the system is reviewed and reforms are made. The health system undergoes a similar process every two years which means that every six years, both systems are reviewed in tandem. As a result, despite the significant demographic and financial pressures, Japan has managed to sustain the health and care systems. Given the challenging demographic projections, there are questions about how sustainable the Japanese system is in the long term. However, significant structural changes in 2005 (see below in ‘Adjusting eligibility’ and ‘Raising co-payments’) appear to have helped to contain rising expenditure.

So far, reforms have focused on adjusting eligibility, raising co-payments and changing insurance premiums. Below we look at each of them in turn, and draw out learning for the social care system in England.

Figure 3: The changing cost of the LTCI system in Japan



Source: Ministry of Health, Labour and Welfare (2017)

Adjusting eligibility

Strict eligibility criteria in Japan ensure that only those with genuine needs are able to access services. Setting these criteria nationally has enabled the government to alter funded provision relatively easily whenever the system is over-stretched. The sharp rise in service users with low levels of need led to the government redefining and reducing their level of entitlement in 2005 (Fernandez and Forder, 2012). Those eligible for the lowest two levels of care were, from that point, limited to accessing preventative care only and the entitlement of people with families who could care for them was further restricted (Bernabei and others, 2009; Hayashi, 2015). As a result, 25% of those in the lowest categories of need were put into preventative 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, 2016) (see ‘Mobilising community assets: focusing on prevention’ below). To reduce expenditure among those with higher levels of needs, the government capped residential care home places at 3% of the population over 65. The 2005 reforms succeeded in reducing expenditure in 2006 and have since stabilised growth in costs (Hayashi, 2015). However, public discontent about changes to entitlement for those with families resulted in those restrictions being eased (Hayashi, 2015).

Raising co-payments

The co-payment acts as a mechanism in controlling demand by discouraging individuals from overusing services. Co-payments for health services existed prior to LTCI, so the public were accepting of them and the administrative mechanisms for collecting them were already established. Once a person’s monthly allowance is spent, they are liable to pay 100% of costs. Although those on very low incomes are exempt from co-payments, there seems to be an impact on uptake of services from this: it is estimated that Japanese people only take up around half the services they are entitled to (Campbell and others, 2016).

The government has made several changes to co-payments over time in order to sustain the system. In 2014, those in the high-income bracket were required to pay a 20% co-payment (as opposed to the blanket 10% required by others). This group makes up around 10% of people receiving long-term care. A second co-payments change was made as part of the 2017 reforms. Those with the highest income (those receiving 3.4 million yen – around £22,500 – or more from pension and other income sources) will now pay a 30% co-payment. This applies to 3% of people receiving services (roughly 120,000 people) and will take effect in August 2018.

In addition to co-payments, service users of residential care must pay a means-tested room-and-board charge, which was introduced in 2005. The introduction of these extra charges was unpopular with the public and there was concern that they accentuated inequalities between service users, with poorer residents only able to afford cheaper, multi-bed rooms (Hayashi, 2015). Raising co-payments for those with greater wealth was, in part, an attempt to try and rebalance that inequality.

Changing premiums

Insurance premiums have been increased at every service review. Average monthly contributions, taking into account taxation and insurance premiums, doubled by 2006 (Ministry of Health, Labour and Welfare, 2017), although average insurance contributions still remain below 2% of average income. To keep pace with rising demand, premiums are expected to continue to rise in future. In 2005, the government also attempted to reduce the age at which people start paying premiums – although employers’ associations vehemently opposed the change as much of the cost would fall on employers, and most groups representing physically disabled people were also opposed, for fear of losing their existing level of benefits. The move was subsequently abandoned (Ikegami, 2007).

In addition to increases in the amount paid, changes have been made to the structure of premiums in an attempt to make the system more equitable. For example, in 2017, the government announced a move from fixed insurance premiums for employers to premiums based on income for people aged 40–64 who are not receiving care. This was partly an attempt to rebalance the burden among employers so that those companies making most profit – and therefore able to pay higher wages – would shoulder more of the burden than less profitable organisations. In 2020, when those changes take effect, approximately 13 million people will be paying more and approximately 17 million people will be paying less, compared to 2017 rates – although it is estimated that the total amount collected will be the same (Ministry of Health, Labour and Welfare, 2017).

Learning for England

The social care system in England is means-tested and people are liable for large sums of money – something that often comes as a shock to people when they find they need care. At present, public funding is available only for those with assets below £23,250. Those with assets below £14,250 are not required to contribute to their care costs. Individuals face a low but meaningful risk of incurring substantial costs: it is estimated that around 10% of people will incur costs of £100,000 or more over their lifetime but it is difficult to predict who will need care and when (Dilnot, 2011). Unlike other insurance risks, it is not possible to buy insurance far in advance to protect against social care needs.

One cautionary tale to take away from Japan’s experience is its underestimation of demand for services. In England, it is estimated that 1.2 million people have needs that are not currently being met – of them, nearly 700,000 receive no help at all (Age UK, 2017). Establishing an accurate measure of likely future demand should be high on the list of priorities for policy-makers in England considering next steps if realistic projections are to inform the design of a sustainable system.

One of the strengths of the Japanese system is the embedded mechanisms that allow the government to respond to demand. It was recognised at the outset that the system would most likely have to adapt to changing pressures and, as such, it was set up as a dynamic system. Appropriate levers for managing demand will be highly dependent on the design of the system and those embedded in the Japanese system may not be suitable for England. What the Japanese experience has shown is that building in an ability to shape the system at a national level can be beneficial. For instance, its nationally determined eligibility and entitlement framework offers a powerful mechanism for controlling expenditure. While the 2014 Care Act has gone some way to establishing some consistency in eligibility across England, these criteria simply set a minimum threshold for eligibility and do not go as far as the Japanese system, which clearly allocates set monthly budgets according to different levels of need. Of course, a centralised approach such as that in Japan would conflict with the autonomy that English local authorities have in determining local priorities and spending, so may not be politically palatable.

Like England, Japan has reduced the service offer to people in order to contain costs. However, rather than shifting people out of the system entirely, Japan has tried to replace care services with preventative programmes. This has reduced costs, but ensured that people were not left on their own, cut off from the system. Prevention now plays a significant role in Japanese long-term care (see ‘Mobilising community assets: focusing on prevention’).

3 Shaping provision

The LTCI system was designed to create a market for provision, with different providers competing with each other on the grounds of quality (Campbell and Ikegami, 2003). By offering choice to service users, the focus became the

direct contract between eligible people and providers (Hayashi, 2015). The government sought to entice providers into the market by allowing home and community-based providers to make profit (something not previously permitted for providers of social care and something that is still not permitted for providers of institutional care except group homes) (Kubo, 2014).

Allowing free entry into a market has the potential to fuel supply-induced demand and, therefore, expenditure (Kubo, 2014). So, in addition to the demand-side levers that are discussed above, the system design included a mechanism to control the supply side, in the form of a national fee schedule. The schedule consists of seven unit-price levels which include an adjustment for cost of living, set according to local civil servant salaries. By tightly controlling what providers are paid for units of care, the government has an ability to both shape the type of provision and to control overall expenditure. For example, in order to stimulate the market in the early days of implementation, the fees available to hospitals were lowered and those available to long-term care providers were raised. This mechanism has been used on a number of occasions to encourage a shift of care out of institutional settings and into home-based services. The three-yearly reviews of the system provide a regular opportunity to review the provider market in order to identify any gaps or over-supply and to adjust the fee schedule accordingly.

While having a national fee schedule offers a degree of overall central control, there are some complex implications. For instance, municipality leaders told us there is sometimes tension between what the municipality and providers want and what service users want. Municipalities want to be designated as a high-level area to attract a higher schedule and therefore to make it easier to attract providers, but that means that the service user co-payment rises in proportion. Issues can also arise in terms of supply if neighbouring municipalities are pegged at different levels, making the one on the higher level more attractive to providers.

A further consequence of keeping the fee schedule low has been that social care providers make relatively little profit (see also ‘Workforce’ below). Average profits among long-term care providers are around 3.3%, compared to 4.7% across all businesses in Japan (Ministry of Economy, Trade and Industry, 2016). Profits among long-term care providers have fallen over the last two

years, largely as a result of rising labour costs, which have not been sufficiently reflected in the fee schedule. Ministers at the Ministry of Health, Labour and Welfare told us that the number of provider bankruptcies is increasing but has not yet reached a level that is concerning. When revising the LTCI fees, the financial conditions of each type of provider are taken into consideration. Types showing increased profits are likely to have their fees decreased, while the reverse will occur for those showing a deficit.

Learning for England

Pressures on local authority budgets mean that social care providers are often unable to provide services sustainably. Downward pressure on funding has begun to affect the largely-private-sector provider market, with 65% of councils reporting provider failure, as the result of financial unviability, by June 2016 (House of Commons Communities and Local Government Committee, 2017). In some areas (particularly rural ones), care home places are very limited and individuals have little choice over providers – either due to a lack of providers in the area, or lack of capacity in existing care homes. One fifth of postcode districts in England have two or fewer different nursing home providers within a 15-minute drive of the centre, and these are mostly in rural areas (Competition and Markets Authority, 2017). Recent rulings on the living wage and sleep-in fees are adding to the pressure that providers are feeling (Care Quality Commission, 2016; 2017b). Because the fees paid to providers by councils are often lower than the actual costs of providing care, providers often cross-subsidise, charging self-funders more for the same level, type and location of care in order to top up the funding they receive from local authorities (Humphries and others, 2016). Not only is this inequitable, it also has implications for the level of care that can be provided in deprived areas with lower numbers of self-funders.

Unlike the health sector, which uses tariffs for some services, there is no national unit price for social care provision in England, allowing local authorities to set or negotiate prices with local providers. While this allows for local shaping of the market, it runs the risk that the most cash-strapped local authorities will attract fewer providers. Budget cuts to local authorities have disproportionately affected providers in more deprived areas with fewer self-funders. A combination of falling fees and pressures arising from the National

Living Wage means that provider failure is of growing concern in the industry (Care Quality Commission, 2016). The recent ruling on ‘sleep-in shift pay’ is likely to have further consequences for providers (Department of Health and Social Care, HM Revenue & Customs, and Department for Business, Energy & Industrial Strategy 2017). In Japan, provider stability appears to be less of a concern, perhaps because the provider fee can be increased if one part of the sector is struggling.

Implementing a blanket national fee schedule (adjusted for local cost of living), as in Japan, has the advantage of offering greater transparency and a level of certainty for providers. It also offers a level of central control to prevent spiralling costs and means that providers compete on the basis of quality and user experience, not price. However, the advantage of that must be carefully weighed against the potential risks: the Japanese experience has demonstrated that depressing the fee schedule offers little opportunity to make profit and has exacerbated the workforce shortage (see section on ‘Workforce’ below). That in turn can limit a provider’s ability to invest in facilities and to take advantage of economies of scale.

Furthermore, taking a national approach would signal a significant shift away from local control and flexibility and may reduce local authorities’ autonomy in identifying and addressing needs. It is important that local authorities conduct accurate planning about future needs for care, and the likely types of care provision needed (whether this is domiciliary, residential or specific technologies), so that additional capacity is in place to meet the expected substantial increase in demand in the future (Competition and Markets Authority, 2017). If local authorities are to succeed in meeting needs, they will require some flexibility to shape provision, so any national initiative would need to allow for some local variation.

4 Workforce

When asked what the greatest challenge facing the LTCI system in Japan is at present, providers, ministers and municipalities alike all replied that the workforce was by far the biggest concern, outstripping affordability. As set out on page 8, the demographic pressures are such that the ageing population

combined with a shrinking working-age population is creating a workforce crisis across all industries. However, workforce pressures are particularly acute in the long-term care sector.

Depressing the fee schedule over a number of years, as described above, has had a knock-on effect on wages in the sector, which now lag behind those in other service industries such as retail. As a result, Japan is facing a shortage of care workers in the order of 300,000 in the next 10 years. With no strong history of immigration, compounded by a significant language barrier, initiatives to attract carers from other countries have progressed slowly. At the time of our visit, there were discussions about the potential for rises in consumption tax to be used for increasing wages in the care sector, although it is not clear how likely that change would be.

Various other initiatives are also being trialled to boost the workforce; for example, offering student loans for new entrants and free refresher training for those who have left the profession. Offering permanent residency to foreign workers who have obtained the national carer qualification has been another solution. It is striking, given the scale of the projected workforce shortages, that the existing schemes are small-scale and there appears to be no long-term strategy in this area.

Learning for England

Workforce pressures are similar in England to those in Japan, with relatively low wages and low status leading to care workers leaving the sector in favour of other industries, such as retail (National Audit Office, 2018). Pressure on fees paid by local authorities have depressed wages. The care sector had a vacancy rate of 6.6% in 2016/17 and the turnover rate for all care jobs in the same year was 27.8% (National Audit Office, 2018).

Currently, England's local authority adult social care workforce totals around 1.3 million workers. What is different to Japan is that a large proportion of England's workforce is from overseas. An estimated 83% of the social care workforce are British; 7% (95,000 jobs) are from other EU countries (up from 5% three years ago); and 9% (125,000 jobs) are from outside the EU (Skills for Care, 2016; 2017). The UK's imminent departure from the EU is likely to exacerbate the shortages in the care workforce. It is estimated that social care

faces a shortfall of around 70,000 workers by 2025/26 if net migration is halted post-Brexit (Dayan, 2017). The International Longevity Centre projects that by 2037, in a worst-case scenario where levels of net migration equal zero, a social care workforce gap of just over 1.1 million social care workers could arise (International Longevity Centre and Independent Age, 2016).

Care workers generally have low salaries and require limited formal qualifications, so there is a risk that future immigration of care professionals will be further restricted under a system that is geared towards highly skilled migration (Dayan, 2017). There is a strong case for care workers to be given special dispensation under such a system. If the immigrant workforce does shrink as expected, there may be a need for wages to rise in order to attract staff – the implications for the affordability of the system would be significant as wage costs already account for almost half of social care spending (Skills for Care, 2016).

A further implication of a shrinking workforce is that (as is already happening), informal carers are increasingly required to step in to fill gaps in provision. Between 2001 and 2015, the informal carer population grew by 16.5% to 6.8 million and the number of people providing 20–49 hours of care per week increased by 43% (Yeandle and Buckner, 2015). The value of these contributions cannot be overlooked, with estimates of the value of informal care being put at between £57 billion and £100 billion (National Audit Office, 2018). This reliance on family provision is unlikely to be sustainable given the projected levels of demand for care, the growing complexity of people’s needs and the widening ‘family care gap’ (McNeil and Hunter, 2014). We also know from Japan’s experience pre-2000 that tying up a large proportion of a country’s potential workforce in unpaid domestic caring duties has implications for the economy. It will be essential that any reform of social care funding and delivery has, as an integral part, a strong and realistic workforce strategy.

5 Navigating the system

Like in England, Japan’s health service operates separately to the long-term care service, with different funding streams and delivery mechanisms. Despite this, the fragmentation of health and long-term care appears to be of less concern and, although some sources in Japan acknowledged the potential for

a lack of coordinated care, most described a largely seamless system. This is for two main reasons.

First, the scope of long-term care is wider than just personal care. The system was established as a wellness service that seeks to maintain independence, rather than just providing care once independence is compromised.

Furthermore, most nursing services for those over 65 – other than those in acute settings – fall under long-term care so the tension between services and funding streams is minimal.

Second, the system has embedded at its heart the care manager. The care manager role was created in order to give a stronger voice to individual users – this was seen as particularly important in the creation of a competitive market where user choice is intended to maintain standards. The care manager is identified at the point at which a person has been deemed eligible for long-term care. This can happen in any setting and appointment of a care manager is swift. So, if an older person has had an acute episode and requires long-term care, the eligibility assessment takes place in hospital and a care manager is assigned (although it should be acknowledged that average lengths of stay in Japan are significantly longer than in the UK (OECD, 2017a)). From that point, the care manager assumes responsibility for supporting the individual to create a care plan, for identifying suitable providers and for coordinating between carers, the individual and the family. Once a care manager is assigned, they generally oversee the individual's care plan for the long term, carrying out regular reviews to ensure that any change in need is reflected in their eligibility level and in their care plan. The care plan is a living document that seeks to knit together a holistic package of care from a choice of providers.

As the holder of the notional budget, the care manager has the power to create a care package that is suitable for the individual, in collaboration with the recipient. The main strength of the Japanese model is that the care manager role is consistently applied across the nation and is therefore well understood by users, families and service providers alike. A weakness of the arrangement is that the majority of care managers are employed by long-term care providers. Although care managers are penalised financially if the proportion of care commissioned from a single agency exceeds a certain level (usually 80%), there is an in-built conflict of interest that, according to some of our sources, has been problematic at times.

Learning for England

Fragmentation between health and social care services continues to be an issue in England, despite continued efforts to overcome it. Although delayed transfers of care are a complex issue with multiple causes, a lack of coordination between health and social care is a significant factor (Edwards, 2017). Tensions between hospitals and the social care sector are increasing at a time when collaboration is more essential than ever (Holder and others, 2018). Ongoing coordination between different parts of the health and social care systems outside hospital is also often problematic for many people with complex multi-morbidity.

The relative complexity of the social care system in England is a compounding factor, with many users and their families reporting difficulties in understanding how and where to seek help (Care Quality Commission, 2017a). This is a particular issue for those choosing care homes – a decision often taken at a point of vulnerability in a person’s life – and people require a high degree of support to make an informed choice (Competition and Markets Authority, 2017). Japan’s LTCI system is seemingly much more widely understood by the public, yet there is evidently a consensus that the care manager role is still required to give people a voice and to help them navigate the system.

Care or case managers are not a new idea. They are established in a number of community health settings in the UK (particularly in mental health), as well as in social care (Ross and others, 2011). The evidence for case management is fairly mixed and there is a lack of evaluation and research regarding the effectiveness of care coordination programmes (Goodwin and others, 2013). Unlike in Japan, there is no single definition of a care/case manager and the terminology is varied and used interchangeably. There is no standard role and individuals with the job title of care/case manager are deployed in different ways.

Despite the existence of care and case managers in the UK, consumer research has found that many people feel they receive little support when navigating the system and making decisions about their care (Competition and Markets Authority, 2017). Many feel rushed when choosing a care home place and there is very little clarity about routes through the system. Many have commented that care managers could have provided more help than they did (Competition and Markets Authority, 2017).

Given the complexity of the English system and the division between health and social care, there is a need for a more consistent coordination role – including for self-funders who are weighing up options for their care – which is defined nationally and better understood by users and providers alike. Having clarity over the role, what powers it has and what an individual can expect from a care manager/coordinator would go some way to helping new entrants and existing users feel they have more control over their decisions. There are many different models of care navigation that have been trialled and evaluated over the years. For instance, a 2014 report by the Institute for Public Policy Research highlighted the potential of ‘local area coordinators’ in Australia, who are based in the community and provide information and support to everyone, across health and social care, regardless of their needs or financial eligibility (McNeil and Hunter, 2014). This is one of many potential models worthy of consideration.

6 Mobilising community assets: focusing on prevention

Following the 2005 reforms in Japan, which restricted access to services to those with low levels of need in order to control demand, there was concern that there would be large numbers of people left vulnerable and without support. These people, it was feared, would be more likely to become socially isolated and develop greater levels of need in the long term, with associated consequences for expenditure. In the intervening years, prevention has increasingly become part of the Japanese government’s narrative around LTCI.

The Japanese government developed a vision for 2025 that aims to put prevention at the heart of society. So-called ‘community-based integrated care systems’ were envisaged that are not only about organising service delivery across health, LTCI and wider welfare services but also about initiating a social movement that seeks to create communities based on the principle of mutual support. The vision is that whole communities are designed to support older people, including those with dementia. Municipalities are given a share of a ring-fenced budget (3% of the total LTCI budget) in order to deliver a locally focused total care strategy for the entire older population (Hayashi, 2015), including those who are not eligible for care. As such, access to services

funded by this budget is open to those deemed ineligible for one of the LTCI care and support levels. In doing so, the government has encouraged over-65s with no care needs to engage in community activities to reduce isolation and deterioration.

Municipalities have begun to invest in communities to help them establish support groups and volunteer-run activities such as exercise or calligraphy classes. They have also offered small grants to renovate empty buildings to transform them into community hubs providing support and advice. One example of this is the ‘Ten Million House’ – see Box 3.

As part of this overall strategy, Japan is seeking to mobilise the ‘well’ older population (i.e. those just over 65 who are in good health) to act as peer supporters to the older, frailer population. The initiative is designed to ensure that the frail elderly receive additional support and the younger group are kept active, engaged in society and independent for longer (Hayashi, 2015).

Box 3: ‘Ten Million House’, Mushashino Ward

The Ten Million House – so named because it was established with a grant of 10 million yen (approximately £66,000) – is located in the ground floor of a local resident’s house. The 90-year-old resident donated the space to the municipality. The ‘house’ offers an informal meeting space along with various activities such as a lunch club, tai chi classes and craft workshops. Most service users are fit and mobile. To use the centre, the only criteria are that you are over 65 and able to get there yourself.

Resources are directed towards this group of people because they generally live alone, far from family and are at risk of becoming isolated. By looping them into the community network before they deteriorate, they are able to create an informal network on which they can rely when their care needs increase.

The centre is well placed to identify issues early, and to ensure that people are enabled to access the formal care system while they can still be supported to live at home.

Despite changes to eligibility in 2005, the Japanese system still offers more services to individuals with lower-level needs than Germany (Campbell and others, 2016). There are high levels of provision of day care services which can be used regardless of whether someone has family support or lives alone: 6.5% of the eligible Japanese population attend a day service, compared with under 1% in Germany and Sweden (Tamiya and others, 2011). As well as shifting caring duties from informal carers to LTCI-funded services, these day care services ensure that those who are most prone to social isolation and deterioration have a support network and do not prematurely lose their independence. One particularly outstanding example (although we understand it is not representative of all facilities in Japan) is described in Box 4 on the next page. Typically, day care services offer activities such as calligraphy, gardening and tai chi alongside lunch and bathing.

Many LTCI facilities have multiple uses, with some space for day care services, space for a nursery and rooms that can be rented by community groups for various activities. Because most providers are very small (some only operating a single small day centre), they are very embedded within the local community and able to build up strong networks of volunteers. Strict staffing ratios mean that volunteers are not able to fill staff vacancies but they enable providers to extend the number of activities on offer.

Box 4: An example of a day centre

Dream Lake Village, Setagaya Ward

In this centre, users (many of whom have dementia) arrive for the day transported by a fleet of minibuses. On arrival, they have to find their name on a board and then pick activities that are displayed on magnetic cards – they use these to design their timetable for the day.

Each person designs their own plan. The only thing they all do at the same time is eat lunch. Staff are present but they are very hands off. The philosophy is that the staff don't do things for people that they can do for themselves.

Once activities are chosen, users have to walk to the opposite side of the sizeable building to put their belongings in lockers. Along the way are games – word games, number games, picture games – and taking part in them earns the users 'currency' that they stow in a purse that they hang from their neck. They need this currency to 'pay' for activities. They also earn currency by setting goals for themselves – perhaps walking upstairs instead of taking a lift – and they earn even more if they achieve those goals.

Some service users also run their own activities, such as painting nails or leading an origami class. Or they can help out with chores – matching up pairs of chopsticks and putting them together with the same colour bowl, for example. Such activities are carefully designed to improve the short-term memory of those with dementia. 'Currency' is then spent on activities like baking, pottery, craft and even woodwork. Or they can spend it on a session in the in-house gym, or watching a film on the large projector screen.

This text is an excerpt from a blog first published on the Nuffield Trust's website (Curry, 2017).

Learning for England

Japan's approach to ageing contrasts with that of England. Although both countries have reduced their state-funded service offer, Japan remains at pains to fill in, through other means, those services that have been restricted to people with only high-level needs. Despite the 2014 Care Act redefining social care as a 'duty to promote wellbeing across a population', the last eight years of austerity in England have resulted in many upstream preventative services and public health initiatives being reduced or abolished as increasingly shrinking budgets are targeted towards those with the most severe needs. Eligibility for social care services has been raised so that only those most in need can now access services (Humphries and others, 2016). Loneliness and social isolation are growing problems with far-reaching implications (Holt-Lunstad and others, 2015). Although there is an active voluntary and community sector providing services in this space, overall budget cuts have led to them struggling to secure funding.

Japan is investing heavily in communities and voluntary sector initiatives as it has concluded that the provision of formal services is unlikely to be able to keep up with demand in the long term. They are seeking to embed a different vision and approach to ageing and are 'pump-priming' initiatives that drive that vision. Prevention is one of its strategies for keeping the LTCI system sustainable, by reducing and delaying the need for long-term care services. There is international evidence that early public health interventions can reduce downstream costs (World Health Organization, 2014) but with no formal evaluation of Japan's preventative interventions, it is not possible to assess the extent to which they will deliver on expectations. However, England's approach of stripping back low-level services to meet short-term budgetary constraints is likely to be merely shifting higher costs into the future as people are more likely to be in higher need, and potentially more socially isolated, when they do come to access services. Any investment in low-level preventative services will need to be weighed against the likely return on investment in the long term. The green paper will need to clearly define social care and, if it is to be conceptualised as a system that promotes wellness, sufficient funding to invest in preventative measures will be required.

5 Discussion

Japan's implementation of a national comprehensive care service has much to be admired. In less than 20 years, the country has transformed the sector from one of variable state provision and a heavy reliance on informal care to one with a very active provider market that provides a range of comprehensive services to almost 6 million eligible people, underpinned by a flexible and clear funding mechanism. Importantly, its set of reforms were not narrowly focused on the funding mechanism but on creating a whole-systems approach to caring for an ageing society. Although not without its challenges, some of which are ongoing, Japan's experience provides a wealth of learning – and cautionary tales – for England as it yet again embarks upon a review of social care for older people.

Firstly, its key success, where England has repeatedly failed, has been in garnering public support through a commitment to transparency and consistency. Secondly, the design of the system, with numerous levers to control demand and supply – and with built-in reviews every three years – has offered a level of control over expenditure with mechanisms to respond to changing circumstances. Thirdly, its strong focus on prevention and investment in the long term has led to a broad vision of ageing, with older people supported by wider communities. Fourthly, Japan has successfully created a highly competitive provider market where providers have clarity over fees, which can be adjusted to influence supply. Lastly, having the care manager embedded at the heart of the system ensures that people are supported to navigate the system and enabled to access care that is personalised, coordinated and regularly reviewed.

The mix of funding sources – part social insurance, part taxation, part direct co-payments – provides a relatively stable and flexible income with an element of transparency. This complex blend of funding mechanisms is unlike any of the proposals suggested by previous reviews of social care in England, which largely focus on lifetime caps and contribution thresholds. There are

advantages and disadvantages to all these different approaches (Rhee and others, 2015). While the Japanese system may provide England with ideas, it is important to note that the particular mix of mechanisms was carefully designed and suited to the context in which it was intended. As such, the suitability of any ideas would have to be carefully considered and adapted to the English context. Although the specific funding mechanisms may not be directly transferable, the pertinent point for England to take away is that the Japanese system is a ‘living system’ and continues to evolve and adapt as circumstances require.

As is often the case, it is the challenges and struggles that provide the most valuable learning for us. One of the main lessons emerging from Japan’s experience is the importance of estimating future demand for services. A question remains about whether Japan failed to correctly estimate future demand or whether it was simply politically infeasible to talk about future potential service reductions when launching the programme (Ikegami, 2007). With the introduction of any expanded service offer in England, demand could rise quickly, so having a realistic idea of the extent of need will be critical. England should be careful not to underestimate the level and value of informal support and care that is currently in place. Regular reviews could be built into any newly designed system to offer flexibility, but any consequent withdrawal of services would need to be handled with great care so as not to jeopardise public buy-in. While demographic change and workforce supply will inevitably drive costs up, social care is not as vulnerable to the inflationary pressures experienced by health care, where rapid developments in treatments and technologies are key drivers. Therefore, projecting social care costs into the future should be comparatively straightforward as long as they are underpinned by accurate estimates of existing levels of unmet need.

Where Japan struggles most is in staffing its services. Its strict staff–user ratios are intended to uphold standards but are putting huge pressure on providers. It is striking that there appears to be no clear strategy beyond a limited number of small-scale schemes. England’s workforce pressures are also increasing and it is vital that we are not complacent about the risks being faced and that we start to create a long-term strategy for the care workforce. With our imminent departure from the EU and likely introduction of minimum income requirements, there is a significant risk that what feels like a very pressured

situation will tip over into a crisis. It is essential that workforce considerations are fully embedded in any plans to reform the funding and delivery system.

Japan's provider market, characterised by large numbers of very small organisations, offers local flexibility and a sense of embeddedness within communities. That can offer potential for them to be more responsive to local needs, but the small scale of providers does mean that they cannot take advantage of economies of scale. It also means that they are less able to withstand reductions in fee schedules. The English market is not altogether different, but does have more larger providers which are more able to operate at scale. However, the fragility of England's care provider market is apparent and policy-makers need to ensure that any changes to the funding and delivery system do not further destabilise the market.

One of the most interesting things about the Japanese approach is its investment in long-term preventative care in the hope that keeping people well will reduce need overall. This is in contrast to our own approach to service planning, which is very much rooted in short-termist annual budget cycles, often leading to the decommissioning of services that don't deliver demonstrable savings in the immediate or short term. In recent years, local authorities have faced a stark choice between investing in prevention and protecting services for those with the highest needs. Although it could be argued that Japan is overly optimistic regarding the impact of prevention on service use – and indeed, there is little evaluation evidence of the Japanese schemes available to demonstrate their impact – its approach is more akin to a social movement aiming to create entire communities based around a positive vision of ageing and less about the narrower activity of service planning.

As the country with the most challenging demographic projections in the world, it is appropriate that we look to Japan for inspiration and lessons. Its government made a bold move in 2000 in implementing an entirely new long-term care system, and in many ways it has been a success. But its challenges should not be overlooked and, as the next decade progresses, the pressures will continue to build.

Our future

England, like Japan, faces a very challenging future as both countries grapple with the growing needs of a rapidly expanding older population. It could be argued that England is currently in the situation Japan was in in the mid-1990s, where there was growing consensus that radical reform was necessary. The 2018 green paper represents an opportunity to grasp the thorny issue of social care and to design a viable solution that has so far proved elusive. It will be important that all avenues are explored in arriving at a solution and that, importantly, the debate is taken out of the febrile political environment to allow for informed and genuine public discourse. It will also be essential that the green paper doesn't look at funding options in isolation but that it also considers the wider delivery system and how it interacts with the NHS, and that it has a particular focus on workforce.

As our government embarks upon its next attempt to grapple with the issues within our own system, it will be of utmost importance that we continue to study the experiences and lessons of those countries that are a few steps ahead. Japan is one of a number of countries that have demonstrated that it is possible to achieve fundamental reform. It is our hope that, through consultation and engagement, the green paper will be a significant step on the journey to a solution that is clear, appropriate, equitable and sustainable.

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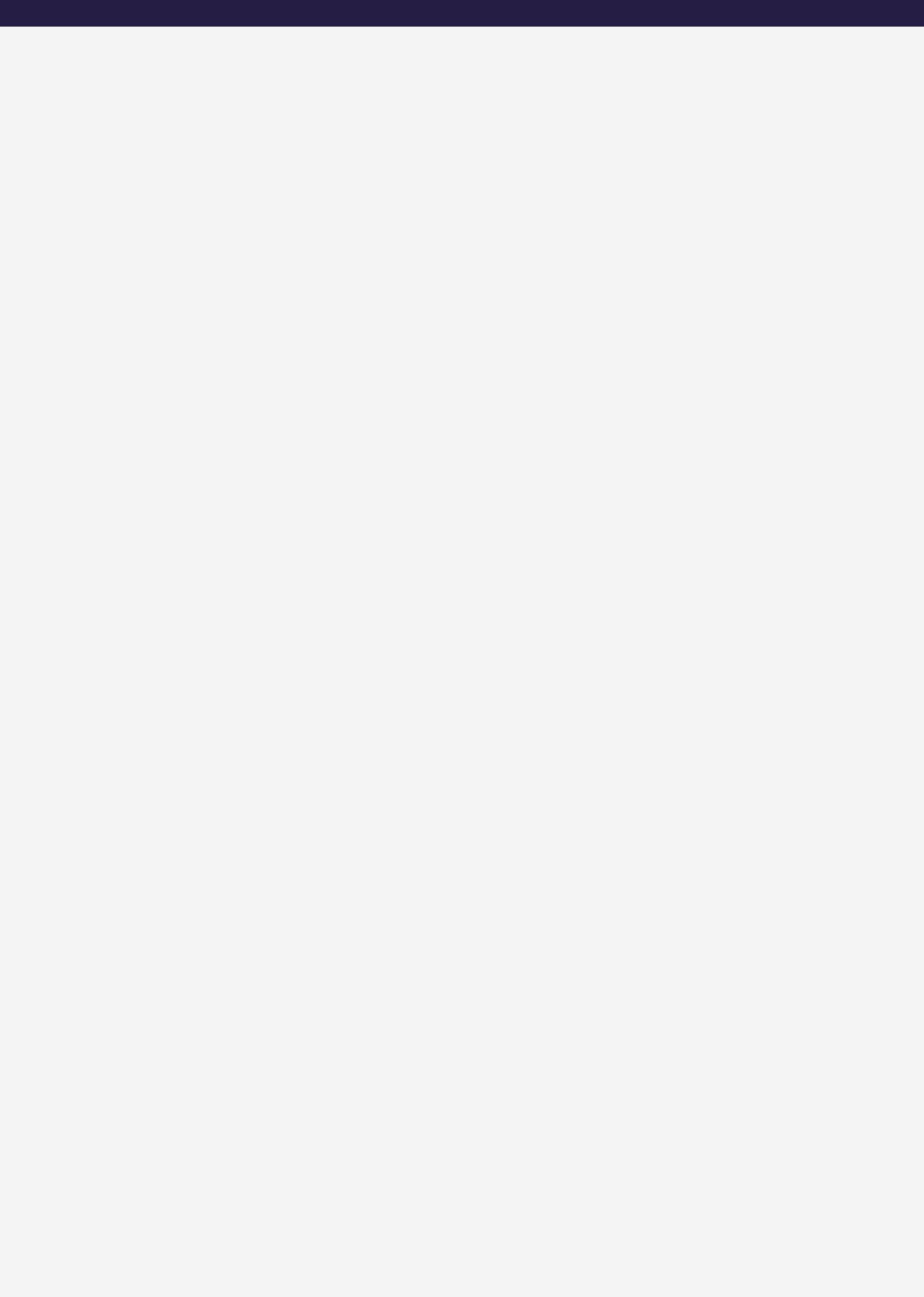
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