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

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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. If migration is halted following Brexit, social care faces a shortfall of 70,000 workers by 2025/26.

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 this summer 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 in autumn 2017, to consider what lessons may be drawn from the introduction of its comprehensive social care system.

Why did Japan need to address its social care system?

As a nation, Japan has stark demographic projections

- In 2016, Japan had a population of 127.4 million compared to 66.1 million in the UK (UN data).
- In 2015, average life expectancy was 84 compared to 81 in the UK (OECD data).

- 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 data).
- The population aged 80 or older in Japan has risen sharply, from 0.9% in 1970 to 8.2% in 2016, nearly twice the proportion in the UK (OECD data).

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. The economy remains sluggish today.
- Japan's total debt now amounts to over 200% of its GDP – in the UK it's a little over 100% of GDP.
- Japan's shrinking population in the 1990s meant that the number of working-age adults was decreasing. There was an imperative to provide social care to allow those delivering informal care at home to join the workforce.

In the 1980s and 1990s, Japan was struggling to meet the care needs of its ageing population, both in provision and financing

- 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.
- State-funded provision was limited to those with very low means and high needs, and most people relied heavily upon informal care by families.
- Many hospitals had become *de facto* nursing homes for people over the age of 65. In 1990 the average length of stay in hospitals was over 50 days.
- A further driver for reforms was a recognition of the care burden on families, in particular women who were joining the workforce in large numbers.

What is the Japanese long-term care insurance system?

Introduced in 2000, long-term care insurance (LTCI) in Japan provides universal, comprehensive care to people over the age of 65 and those with an age-related disability aged between 40 and 65. Based on the principles of transparency and fairness, this needs-based system provides care to all regardless of wealth or income. It was introduced with an

intentionally wide remit that sought to promote wellness, prevention and independence in older adults.

The Japanese state is made up of:

- **1,719 municipalities**, which are local public authorities with responsibility for most health and welfare services. They are roughly equivalent to local authorities in England
- **47 prefectures**, which oversee public health and other functions, such as some parts of the education system and transport networks
- A national **government.**

How is LTCI funded?

Premiums and taxes

- The LTCI system is administered at municipality level and funded through a combination of social insurance contributions, general taxation and user contributions.
- Every member of the population must pay into the system from the age of 40.
- Half of the LTCI funding comes from general taxation, collection of which is divided between the three levels of the Japanese state (see above). The other half of the funding is raised through social insurance premiums. People who pay premiums are split into two groups:
    - Primary insured – people over the age of 65 whose contributions are withheld from their pension payments and collected at municipality level
    - Secondary insured – people aged between 40 and 65 whose premiums are paid via social insurance funds that were already in place for health insurance prior to LTCI being implemented.

- For people in employment, individuals' contributions are shared with employers. These premiums are determined and collected nationally and redistributed to municipalities according to need.

User co-payments

- In addition to paying premiums, service users must pay a co-payment when accessing services, although those on very low incomes are exempt. Most people pay 10% of their care costs, although this rises to 30% for those on high incomes.

- Co-payments are paid up to a ceiling. If the individual wants more services beyond their entitlement, they must pay 100% of their costs out of their own pocket. In reality, few do because the state provision is relatively generous.

How do people access care?

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 of need on a seven-point scale. The result is submitted, along with a doctor's opinion, to a multi-disciplinary long-term care certification committee (comprised of health and care experts), which reviews and adjusts the eligibility level if required.

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.

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.

- 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.

Who provides care?

- The introduction of LTCI has resulted in a very active competitive market, comprised of thousands of mostly small providers which are a mix of for-profit and not-for-profit companies, social enterprises and charities. The small nature of the providers is in line with Japanese convention, where around 99 per cent 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 into 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).

What can England learn?

The cultural differences between the two countries, the very different funding systems for healthcare in both, and differences in the political setup mean that the Japanese system is not a 'silver bullet' to solving the crisis in social care in England. But as the Government begins to ask difficult questions about the future of social care, the Japanese experience in reforming long-term care for the elderly offers some important lessons for policymakers as they seek to bring about much-needed reform in England.

Get public buy-in

- In Japan, it was felt that if contributions started at the age of 40, most people would know someone who required care so would see the benefit of the system first-hand and, therefore, be more willing to contribute. Subsequent attempts to lower the age of contributions (to 20 in 2005) were met with opposition.
- The system was deliberately generous at the launch so that contributors felt they were getting value for money.
- The LTCI, its benefits and the contribution system were clearly communicated with the general public and people understood that the new system would be a better option than what currently existed.

Be flexible

- The Japanese government has been responsive to public concerns as the LTCI system has evolved since it was implemented
- Every three years, the system is reviewed and reforms are made. The Japanese health system does the same, so every six years both systems are reviewed in tandem, offering an opportunity to adjust premiums, eligibility levels and co-payments
- It is estimated that in England 1.2 million people have needs that are not currently being met. Japan initially underestimated demand for care services and saw 20% higher usage in the first five years than expected. As a result, eligibility was raised in 2005 to control expenditure.

Actively shape provision

- Japan has a fee schedule for providers, where each unit of care has a price fixed at a national level. This is similar to the tariff we have in England for health services.
- The fee schedule means that the national government has been able to shape provision – for example by raising the fees it pays to providers of home-based care and reducing the fees paid to providers of institutional care in order to try to shift care closer to people's homes. It also means that if one type of the provider market is struggling financially, fees can be increased to ensure stability of provision.
- Many local authorities in England have reported provider failure in recent years as fees paid to them have been squeezed and there are concerns over the stability of the market.

Address the workforce challenge

- The workforce is the biggest challenge for the LTCI system. Like in England, wages in social care in Japan lag behind other professions and Japan faces a shortage of care workers of about 300,000 in the next 10 years.
- England faces similar shortages but, unlike Japan, it employs a large proportion of its social care workforce from overseas. Brexit risks exacerbating England's shortage of social care workers and there is a strong case for care workers to be given special dispensation once Britain leaves the EU.
- It is important that any reform of social care funding and delivery includes a realistic workforce strategy.

Make the system easy to navigate

- The LTCI 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. 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.

Focus on prevention

- Municipalities are given a ring-fenced budget to invest in communities to help them establish support groups and volunteer-run activities such as exercise or classes to keep people active and to reduce social isolation.
- Japan hopes that by focussing on prevention and promoting wellbeing for those who do not yet need care, it will reduce or delay people's need for formal care services and enable LTCI to be sustainable in the long term.

Read the full report and findings on the Nuffield Trust website: www.nuffieldtrust.org.uk

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