Long Term Care Insurance for Better Aged Care Services: A New Chapter for Japanese Welfare System in 21st Century

オン・クオック・ライ／渡部律子
On-Kwok Lai and Ritsuko Watanabe

The implementation of Japan's Long Term Care Insurance Scheme in April 2000 was the culmination of some 30 years of policy deliberation on aged care, shaping many changes in service delivery, and much debate between service providers, different levels of government, academic analysts and major media interests. Understanding the policy development of the LTC Insurance scheme and its financing arrangements requires an appreciation not only of rapid demographic and social change, especially in family structures and attitudes to caring for aged parents, but the pressures that population aging and economic downturn are placing on Japan's pension and health insurance systems also need to be recognized. The later part of this paper specifies the major changes in organization of service delivery that have increased opportunities for private sector providers, including large corporations, and restructured contractual relationships between municipalities and providers in all sectors. New arrangements for client assessment, classification, care management and extended service types are then outlined. An interim assessment is then made of the likely consequences of the reform, with the concerns of welfare professionals that the public welfare system is under threat juxtaposed with bureaucratic goals of liberalising the provision of long term care.

Key Words : Long Term Care Insurance, Aging Society, Elderly Care, Welfare Reform, Intergenerational Transfers, Social Policy, Care Management

THE POLICY CONTEXT

The question of caring for the aging population is not a new policy discourse in Japan. For 30 years, academic, business, policy and media reports have generated a substantial amount of knowledge, as well as policy options, for caring for the aged. Yet, because of the lack of political will – resulting from factional fights in the Liberal Democratic Party (LDP), and the political expediency for welfare populism – there has been little action. The expansionary development of health and welfare services enabled by the sustained growth of the Japanese economy until recently has meant that attention has only belatedly been given to the institutional structures and policy developments needed to cope with the aging of Japanese society in general and more specifically, for the provision of long term care (LTC). In policy terms, it has taken more than 30 years to start the implementation of a scheme of long terms care (LTC) insurance in April 2000, and it remains to be seen how long this scheme will last without some modification.

As a reminder of the uniqueness of the Japanese welfare system, we want to specify the nature of the crisis that has arisen in the system. There is no doubt that Japanese economic growth helped to create the belief that there is an alternative, Asian, model of collective welfare as compared to the European welfare state. This view was particularly the case when overseas observers witnessed the very substantial improvement of health, welfare and quality of life achieved in Japan in the last 20 years, plus the undeniably healthy aging population. The story-telling of the Japanese welfare model seemed to go questioned, at least until the economic crisis of the mid 1990s posed fundamental questions of financing and wastage in the health and welfare system. These questions stem from

four areas in which the system has failed to respond to change: the imbalance in the share of social security funding coming from general taxation vis-‡-vis premiums paid by salaried workers in the occupational based welfare system; rapid demographic changes; changes in family structures and attitudes towards caring for the elderly; and a high cost medical system. All these factors have had a bearing on the context in which the LTC Insurance scheme, also known as the Nursing Care Insurance scheme, was planned from 1994 and implemented in early 2000.

The Crisis of the Occupation-Based Welfare Model

After years of lagging behind some other industrial countries in providing properly coordinated social security services, the Japanese government accomplished its goal of ensuring that every member of society had a pension plan and medical insurance with the implementation of the basic framework of a national insurance scheme of social security in 1961. Once the system was established, the government was preoccupied with the task of boosting benefits in these social security programs, and failed to pay due attention to future demographic changes. Gifted by uninterrupted economic growth in 1970s and 1980s, the government was able to make headway in upgrading its social security system, making such improvements as increasing pension payments, ensuring that there was no village without health and welfare services and putting in place a health insurance system for elderly people (Koseisho,1999a/b).The Japanese welfare model seemed to work perfectly well as an accompaniment to the postwar economic miracle.

Yet, the occupational based and labor-market-financed welfare model has its limits and as changes in the global economic climate, regional crises and domestic problems set in, it reached the verge of collapse by the late 1990s. A recent statement by the Health and Welfare Ministry (Koseisho) revealed what is perhaps the true story of the Japanese welfare model, namely that Japanese taxpayers cover a smaller portion of the bill to operate the social security system than their counterparts in the United States and Europe (Koseisho 1999a/b). Hence, social insurance is financed more by the contributory pensions and health insurance schemes than by various forms of general taxation, and contributions are made to all three tiers of the Japanese state-run pension system, which are:

1. The basic pension scheme sets the overall framework; it covers people in all categories of society – the self-employed, spouses of insured people, private-sector salaried workers and government employees.
2. Corporate employees and public servants are also insured under employees' pension and mutual aid pension schemes.
3. Employees at some private-sector corporations receive benefits from funds operated by these companies.

In the late 1990s, the premiums paid by employees for their pension schemes stood at the equivalent of 17.4% of private-sector salaried workers' wages, and an average of 8.6% for health insurance. Taken together, this 25% contribution means that individual corporate workers pay the equivalent of three months' wages in premiums for their pension and health insurance plans each year, although the burden is actually split 23.0% from employees and 27.5% from their companies. Other macro data also suggest that some 65% of social security is financed by the contributory pension and health insurance schemes, and the state's monetary transfer from central and local taxes in this sector is only 25%, with the 10% balance coming from government asset investment and other income. The social insurance burden hence is higher than the taxation contribution.

The sustainability of the occupational welfare model is under great strain due to problems in Japan's corporate sector, including redundant workers and networking of the banking and manufacturing groups, and the need for corporate restructuring in the near future in the face of global competition and the recent Asian economic crisis.

Domestically, many salaried workers already feel that they are too heavily taxed for their pension and health insurance premiums, as well as having income and other taxes deducted from their paychecks every month. The controversial consumption tax has increased from 3% when it was introduced in 1989 to 5% at present to contribute funds to welfare programs. Taxpayers may feel even harder hit if they have to pay higher premiums to meet the sharp increase in social security costs that will result from caring for an aging society in the future. The funding of social security is therefore a political as well as economic question, and the extension of the system to cover long term care had to be done in a way that would not compound the problems of the existing system.

Rapid Demographic Change

Post war economic growth lead to improved standards of living, including improved public hygiene and access to medical science and technology, and the average life span in Japan increased markedly. In 1947, average life expectancy was 50.1 years for men and 54.0 years for women; by 1997, these figures had risen to 77.2 for men and 83.8 for women, increases of 27.1 years and 29.8 years respectively in the 50 year period. Average life expectancy in Japan is now the highest in the world.

The elderly population is increasing sharply as life span increases. The 65 and older population increased from 4.16 million in 1950 to 21.87 million in 2000; the absolute number of older people increased more than four fold over this 50-year period. The increase in the population of the old-old (75 and older) was particularly marked, increasing from 1.07 million to 7 million, a 6.5 fold increase, in the same period (NIPSSR,2000).

Several features of Japan's demographic aging warrant particular note. First, aging is a comparatively recent phenomenon in Japan, beginning only in the 1970s. Second, Japan is the most rapidly aging society in the world; by 2000, it had the highest proportion of population aged 65 and over of any country, 17%, and this figure will reach 22% by 2010, with Japan maintaining its global lead for another 50 years. Third, the number of the old-old will continue to increase ahead of the total aged population; compared to just on a third of the total aged population in 2000, the old-old will account for close to half of the elderly in 2010, 10.5 million out of 28.13 million. Fourth, by 2020, 35.2% of families across the country will be headed by elderly people, and from 2000 to 2020, over 50% of the elderly will be in single person or couple only household (NIPSSR,2000). Finally, based on the medium projections in the Population Projections for Japan of the National Institute of Population and Social Security Research (NIPSSR, 1997), the proportion aged will reach 26% in 2020 (about 32.3 million), and will continue to rise to an initial peak of 28% in 2030, and peaking again at 32.3% around 2050 (NIPSSR, 2000). With one out of every four citizens aged 65 and over, and one in two of these aged 75 years of age, the 21st century in Japan is truly the 'century of the elderly'.

Changing Family Structures and Attitudes Towards Supporting the Elderly

The transformation of the family in post war Japan has had the greatest impact on the elderly. As society has grown increasingly oriented toward nuclear families, the percentage of households where children and the elderly live under the same roof has been decreasing. In 960, over 85% of the elderly lived with children, but this figure is now just over half; conversely, single person elderly households which accounted for only 5.4% in 1960 but have increased to 17%, and another 28% were couple only households in 2000, compared to 7% in 1960.

These changes reflect increasing standards of living of both older and younger people, and rural to urban shifts of younger people, and are made all the more significant by the high rate of marriage, and hence lower rate of single person household due to non-marriage. The decline in co-residence is despite a number of aspects of the Taxation Exemption Allowances and Employment Benefit (Special Allowance) which can influence decision about taking parent(s) or parents-in-law into the Family Account on which taxation is based. Co-residence is also reinforced by the Household Registration System at the local government level, and the multi-generation mortgage arrangement available in the property market for home purchase.

With the demographic trends of fewer children and an aging population, coupled with the economic problems Japan is experiencing, attitudes toward supporting elderly parents and aged relatives are also changing significantly. A nation-wide survey by the Ministry of Health and Welfare in 1994 found that 60% of the care-givers thought their burden were too much. It is becoming increasingly difficult to expect that families will provide full support for their elderly, and the problems of illness and long-term care have been identified as the greatest concern of the elderly (Campbell & Ikegami,1999; Koseisho,1999a/b).

The economic uncertainties that the younger generations have to face, including less secure job tenure, having to be ready for more mobile job locations, and the dual roles of women in the family and the workforce, mean they are beginning to think about living together with their parents and supporting their parents in need of care as separate issues. In the past, living together with parents has implied caring for them, but now many younger people, especially daughters and daughters-in-law, are looking to ways of providing care for their parents that do not involve co-residence.

In addition to the dynamics of population aging

outlined above, a number of other economic and social issues have to be addressed. First, even though some 60% of the elderly are economically dependent on the pension system, there is a large income differential among elderly households, so that low income elderly require more financial support from their family. Second, there is a tension between the trend to early retirement versus the wish to work post-retirement. Third, caring for the elderly is increasingly seen as a shared responsibility of public services and private families, and a responsibility that should be shared more equitably between men and women. Fourth, by 2020, over half the elderly will be living alone or with an elderly spouse only.

High Cost Medical Care

The aging question was well articulated by the Council on Population in a report in August 1969 which highlighted that the world's lowest birth rate would make Japan an 'elderly nation' in 30 years time. Those 30 years have passed since the Council's advisory panel made its recommendations were to the Health and Welfare Ministry, but not much has been done by way of actual policy change and systematic reform. Economic prosperity through the 1960s to early 1980s, the political expediency of holding on to voters' loyalty, and the powerful professional interests such as the Japan Medical Association, which literally blocked any reform initiative for health cost containment, reinforced the further development and expansion of health and welfare programs with little recognition that the system was defaulting on aging.

One of the synergistic effects of the pro-growth approach in health and welfare has been the development of a very high technology, high cost medical system. Clinics and hospital, regardless of private and public funding, all tend to be high technology and high cost based. Overseas visitors are surprised to see newly developed medical equipment being placed in normal clinics. On the other hand, users of in-patient services appear to stay longer than in other countries, but this is in part because of the unclear separation of acute hospitals from long stay and rehabilitation hospitals.

Although health care accounts for a low share of Japan's GDP compared to other OECD countries, the rate of increase has been higher; the 7.5% share in 2000 was up from 6% in 1990, and per capita outlays increased by almost 40% over the decade. Further, internal transfers are now critical to staving off bankruptcy of the health insurance schemes and funds for the health sector from both government and individual household are shrinking. The first attempt at cost-containment in four decades, the Health Insurance Law implemented in 1997 to lower the rate of increase for the overall health care expenditure, was not successful, and the high cost health care sector is still inefficiently run, and the compounding effect of aging on the cost of medical and hospital care is already evident.

Approaching 40% of the total expenditure of •30 trillion will probably go to covering medical and hospital expenses for patients aged 65 and over or older in fiscal 1999-2000 (Mainichi Daily News, 8 February 2000). In age cohorts terms, medical bills incurred by aged people are five times greater than those still contributing and working regularly. The impending growth in medical and hospital expenditures are one of the prime reasons for separating out the costs of long term care and transferring them to the LTC Insurance scheme. As this scheme draws on other sources of funding, it can assist in containing the premiums to be paid for health insurance.

POLICY OBJECTIVES OF STRUCTURAL REFORM

The social security system in Japan covers five major areas of services: medical and health care, social welfare, pensions system, employment and related insurance, and public hygiene. Its main policy objective is to protect the whole population's health and welfare, but it has not until now made special provision for long term care. Facing an aging population with fewer children, and a proportionately smaller workforce, the 1990s has been a period for structural reform of social security programs. That the LTC Insurance scheme has been the first initiative to be implemented indicates both the priority of addressing long term care, and also that it has been easier, or at least less difficult, to introduce a new scheme than to modify the existing schemes in other areas.

The Japanese Model of Financing Social Security

Following interest repayments for national debt, social security is the largest single item in the government's budget; expenditure of ¥16,095 billion accounted for 19.7% of the total budget in 1999. Fully 65% of social security inputs in Japan are financed by contributory premiums for pensions and health insurance. A main policy goal is to reduce this share to 50% and have the other 50% provided by other forms

of taxation.

The Japanese taxation system has three major financial implications for funding social expenditures. First, the tax base and the volume of direct tax derived from salaried workers is relatively small; indirect taxes and the consumption tax thus have an important role to play for funding of new programs. Second, for majority of salary households, the tax contribution is less than the social insurance contributions paid for pensions and health insurance; the ratio between tax and social insurance contributions is about 1:1.3. Lastly, the balance between social insurance and taxation is inversely proportional to income; for lower income households, the social insurance burden is high in proportion to the tax burden, while higher income households contribute more through taxes compared to social insurance contributions.

Turning to outlays, taking fiscal 1996 as an example, the balance of social security expenditure was 52% on pensions and 37% on medical services, with the balance on other areas (Koseisho, 1999a; Ito, 1999). More importantly, payments to the elderly population accounted for 64% of the total budget, with a 3.1 ratio for outlays on pensions to health care. As the aging momentum increases, there will increasing pressure on these payments. Even in the short term, the consumption tax will have to rise to 7% from the present 5% if the existing level of outlays on programs for the elderly program is to be maintained to 2005. The introduction of the consumption tax in 1989 coincided with moves to expand long term care services, especially community care, and facilitated this growth, but only postponed rather than obviated the need for further reform for financing long term care.

The Golden Plan and the New Golden Plan[1]

Concerted action to expand the range of services available for long term care of the elderly was first taken in 1989, with the introduction of the Ten Year Strategy to Promote Health Care and Welfare for the Elderly, known as the Golden Plan. The Golden Plan was established to achieve integrated development of health, medical care and welfare for the elderly over a ten year period, and aimed to implement a long-term care service system that would allow elderly people requiring long-term care to be independent as possible and continue to live in their accustomed homes and communities. Under the Plan, in-home services especially were expanded, but institutional welfare services were also enhanced and rehabilitation services were expanded to prevent elderly patients from becoming bedridden. In 1990, administration of welfare services was shifted to the municipalities, and the establishment of a Local Health and Welfare Plan for the Elderly in each municipality became mandatory. Funding for these long term care services continued to be through the welfare and health components of the social security system, bolstered by the new consumption tax.

In 1994, in order to meet expanded needs arising from the implementation of the Golden Plan, the New Golden Plan was introduced and laid the foundation on which long term care services for the elderly was to be built. Again, there were no reforms to financing.

Financing Reform

Establishment of a social insurance scheme for financing long term care was first mooted in December 1994 in a Report on Nursing Care for the Elderly and a Supportive System for Independence, and was further recommended by the Social Security System Review Council in July 1995. After gaining support from three major political parties, the Bill was tabled for Diet discussion in November 1996. The Nursing Care Insurance Law was enacted on 17th December 1997 (Hiramatsu,1999; Koseisho,1999a/b; Minerva Shobou,1999). The LTC Insurance Law has 14 chapters and 215 rules, and is supplemented by the LTC Insurance Implementation Law which accounts for another 19 rules. The structure of this legislation is similar to the 12 major laws that govern the provision of other welfare services under the Japanese Constitution (Matsui, 1999), and the administration of services at municipal level. These laws and their subsidiary by-laws are very detailed and specify service standards and protocols, staffing and administrative responsibilities of provider agencies. The laws covering the LTC Insurance scheme are thus highly consistent with the existing legislative infrastructure, although the LTC scheme itself has introduced major changes in service delivery and financing.

As a first step towards structural reform of the social security system to cope with rapid population aging, the new insurance scheme is bringing about a large scale reorganization of the LTC system, which until now has been divided into welfare services and medical care services, and it also aims to create an efficient and fair social support system. To this end, the dual key considerations are to build steadily on the foundation of LTC services and create an insurance based financing system for LTC. The goals of the LTC insurance scheme are as follows:

[1] In Japan, both are generally referred to as 'Gold Plan'.

- To provide a care system in which users can freely choose services;
- To offer welfare and medical care services related to long-term care in a unified and integrated manner;
- To provide diversified and efficient services through the participation of entities such as private businesses and non-profit organizations;
- To rectify the long stays in general hospitals for reasons of long-term care (so-called ìsocial hospitalizationî) and create more efficient medical services.

In undertaking these reforms as part of the wider reform of the social security system, it is necessary to maintain consensus among the general public. The overriding considerations that have to be kept in mind in this regard area achieving higher efficiency overall through reorganization across programs, ensuring user-oriented services with higher efficiency and ensuring fairness, equity and equality, across the social divides of generations, gender and income.

These consideration underlie the reforms of each part of the system separately and collectively that have been proposed (Koseisho,1999a/b). The LTC insurance scheme has led the way in implementation, and the other reforms are in the process of implementation or under consideration. Gradual reform of medical insurance has been implemented from 1997 to increase efficiency of medical care while ensuring its quality. Beginning with attempts to control rising insurance premiums and introduce of pricing mechanisms, the reforms have moved into the entire range of the medical care delivery and medical insurance system, while maintaining universal coverage. Comprehensive reform is however yet to come, particularly on the basic issue of who finances medical care and the level of benefits.

In the area of public pensions, the system overall is being reviewed to achieve appropriate levels of benefits without causing the burden to become excessive in the future, while taking into account the balance between the level of benefits and that of real income for the future generations. Proposals with draft legislation are being studied by the Diet, and the related legislative changes will take place from 2000 to 2005.

For welfare services other than LTC for the elderly, a new service delivery system needs to be developed. A Plan for People With Disabilities was drawn up in 1995 aimed at achieving rehabilitation and normalization in the community, and action is needed to promote integration across programs and establish comprehensive measures that will provide a livelihood support system for people with disabilities.

Financing Arrangements for the LTC Insurance Scheme

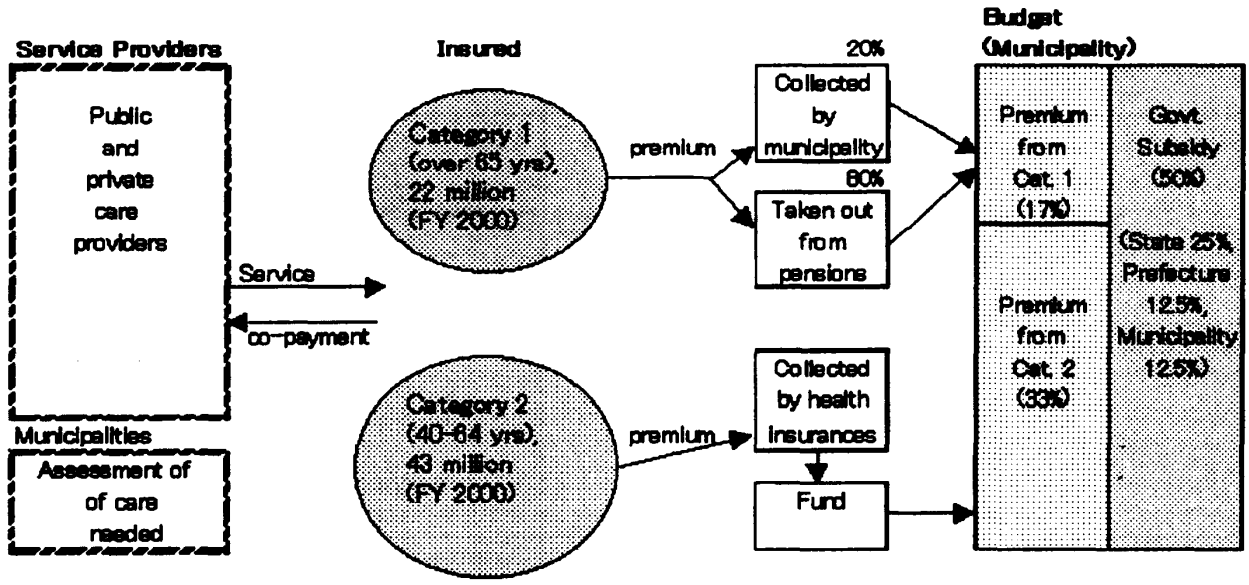
The LTC Insurance scheme is a social insurance scheme in so far as premiums are collected and risks shared across the whole population, but it is not a funded insurance scheme, that is, current premiums pay for current costs rather than providing for the cost of future long term care use on the part of those who now pay premiums. The financing arrangements involve cost sharing and co-payments and so no single source of funding is over-burdened.

Cost sharing: The overall budget of the LTC insurance scheme was estimated at ¥4.2 trillion at the start of the scheme in April 2000, when there were expected to be over 2.8 million certified users. It is jointly funded by policy owners' premium payments and government funds, each making up 50% of the fund.

Of the 50% premium income from the insured population, 17% will come from those in Category 1 (age 65 or above) and 33% from those in Category 2 (age 40 to 64). The remaining 50% will be contributed by all three levels of government: central government will provide 25%, of which 5% is an adjustable contribution to compensate for regional differentials in age-weighting for local municipalities, and prefectural governments and local municipalities will each contribute 12.5%. In addition, there will be a stability fund set up within the tripartite government framework to cope with possible increases in LTC expenditure or to cover unpaid or non-recoverable premium contributions. Each party is responsible for one-third of this fund (Figure 1).

Premiums: The method of premium payments for 70-80% of the elderly in Category 1 is expected to as a deduction from the pension payment they receive, automatically charged through the pension system. The remaining 20-30% will pay directly to the municipal LTC Insurance office. For those in Category 2, those aged 40 to 64 years, the premium payment will be added to their health insurance and then channeled to the municipality (Asahi,1999; Koseisho,1999a/b). Payment of the premiums is integrated with existing social security infrastructure and has achieved efficiencies in not requiring a separate financial infrastructure.

Figure 1: Diagram Representation of Long Term Care Insurance



Source: Kenko Hoken Kumiai Rengokai, 1999, MHW, 1999.
Source: NIPSSR, 2000.

The monthly premium of those 65 and above (Category 1) is estimated at a national average of ¥2,915 at the start of the scheme. The premium payments are set on a 5 step scale following the taxation status of the insured. The standard premium is ¥3,000 per month at step 3, for those with no taxable income per month, with adjustments of 25% up and down. Thus, those who have least income (protected household/welfare pension recipients) will have to pay only 50% of the standard premium, i.e. ¥1,500 per month, whilst there will be two higher steps for those paying tax, either 125% or ¥3,750 per month, or 150%, ¥4,500 per month. It is expected that unless there is major re-categorization, the premium level will stay the same for three years.

Co-payments: Generally, service recipients are charged 10% of the cost of services, plus food costs.

ORGANISATION OF LONG TERM CARE

This section covers the development of the long term care service delivery system in Japan in the lead up to the implementation of the Long Term Care Insurance scheme from April 1st , 2000. The new system commenced on that date, apart from the collection of premiums to be paid by the insured population which was delayed for six months. LTCI is the first of a set of comprehensive policy reforms tackling different issues of population aging in Japan, and focuses on those who need assistance in daily living and particularly those are bed-ridden.

The new scheme covers a wide range of both community care and institutional care services. The scheme is commonly known as 'nursing care insurance' as well as Long Term Care Insurance in Japan, reflecting the need for nursing care as the base requirement for eligibility for all services covered by the scheme. In this paper, we use the term Long Term Care Insurance (LTCI) for the scheme, long term care (LTC) when referring to the wider range of services, and nursing care is reserved for care services provided by nurses.

Service Administration and Selection of Service Providers

The LTCI scheme is attempting to build up a 24-hour and all-round service delivery system at community level, administered by the local municipalities, with local service providers in the quasi-public and private sectors, that is, non-profit and profit making bodies (Asahi, 1999; Komuro & Nagatani,1999). To promote efficiency of the system

overall, there are built-in mechanisms to promote care alternatives to residential care, as well as competition for quality improvement, within a given standardized set of certified services.

While administration of the LTCI scheme builds on existing infrastructure by way of municipal-based service planning and delivery, it has required changes to these arrangements and introduced a number of new features. In contrast to the tripartite funding arrangements that involve central, prefectural and local governments, health and welfare services in Japan are mostly administered and delivered by the local municipalities. The functions of the prefectural level of government in Japan are broadly equivalent to state or provincial governments in other federal systems. The role of municipalities was strengthened from 1994, and they deliver services usually with joint financial and policy coordination with the prefectural government and central government ministerial agencies (Takao,1999).

Although the LTCI system has been centrally developed at the ministry level and is 'top-down' in managerial terms, actual service delivery is more decentralized, and the locally autonomous governance structure allows for local municipalities to develop alternative plans and legal protocols within an overall national framework. (Matsui,1999; Minerva Shobou,1999). The national framework sets some conditions, such as the range of services to be covered by LTCI and the premiums to be paid by those aged 40 to 64 years, but Local Government has to decide the premiums for the elderly and also whether to provide any extra services, such as meals, which are not included in the LTCI scheme. Thus, there will be some variations around a central model in each of the 47 Prefectures, 17 Special Designated Cities (like Kobe and Osaka), and 3,252 municipalities (cities, districts and villages) as they have to develop their own protocols for the LTCI scheme.

The most radical departures from the old system are the entry of new of service providers in the burgeoning nursing care market, and the new contractual relationship between these providers and consumers.

Growth and Differentiation of Service Providers: The total number of registered nursing care providers increased by 55% when the new scheme was implemented, with 196,221 providers registered at the end of April 2000 compared to 126,071 in March 2000. (Kaigohoken Monthly, June 2000, p.22). Most of the increase is derived from private providers seeking to enter the nursing care market as new suppliers, with three main kinds of new providers emerging:

1. Large scale corporations which already had nursing services sending home helpers or visiting nurse to families, were enlarging this type of service knowing LTCI would shortly be in place.
2. Large scale corporations which have never provided long term care services have developed this business and have recently opened many branches in local areas, as well as smaller operating units in remote areas.
3. Volunteer-based not for profit organizations or small scale business enterprises which have provided inexpensive home help service have registered.

There are now four distinct providers groups and their respective contributions in the field in rank order are:

— Medical, nursing and allied health professionals based in clinics and hospitals account for up to 60% of nursing and allied health care for the aged. This group constitutes most of the nursing services in terms of number of organizations, and some have special taxation status.

— Municipal sponsored and funded service providers which grew considerably in the expansionary welfare-populism era remain a major group, are expected to have a decreasing role as their share of provision is seen to be under threat and their survival in light of the recent reforms is a topic of considerable debate.

— Welfare foundations which are legally incorporated bodies are an historic form welfare agency, will play a small role as some will shift to non-profit status if they can attract support under the LTCI scheme. Non-profit organizations that operate under the new law enacted in 1998 governing non-profit organizations can also be included in this group and its role has expanded. The most recent entrants in the field have come from a strong national movement of volunteerism, partly resulting from the Hansin-Awaji earthquake in 1995.

— Private, profit making business providing welfare services are seen as having the potential to gain a larger market share because of their large corporation financing and aggressive marketing. It remains to be seen whether their role does in fact eventuate on a large scale as some of these private business have already withdrawn from home-helper or care-management services as they were not sufficiently profitable and

because clients tended to choose municipal sponsored services more as they had had long history of service delivery before the LTCI scheme.

New Contractual Relationships between Service Providers and Users:

The most important structural change is the new set of contractual relationships between (a) the municipality and the insured, (b) the insured and the care service providers, and (c) the care service providers with the municipality. In the previous arrangements for care service for the aged, the municipalities commissioned the service providers and the latter provided service for the aged. The municipalities mostly assumed the commissioned providers could do the whole job efficiently, from screening and assessment to providing all kinds of services. However, there was the possibility of under or over- provision in relation to the target needs, and cost was less likely contained as the commitment for the aged was open-ended (Komuro & Nagatani,1999).

Under the new scheme, the basic relationship between the municipality and the client is an insurance one, that is, a public contractual relationship governed by the LTCI Law. The insured have a limited entitlement and the insuring agency, namely government, offers a premium-conditioned supply of entitlements; municipal governments also have the assessment / screening function of understanding and planning for the needs of their aged populations, but can shape the demand side of the long term care market by capping the entitlement.

A potentially more significant development is the new private, contractual relationship between the different service providers and the insured clients, who are free to choose their service providers, type and quality of services. This relationship is intended to create a market-oriented system through enhancing customers choice on the demand side, and promoting efficiency of providers on the supply side. In addition, the insuring agency of the municipalities can also influence the standardized costing/pricing of the suppliers; present costing favors the profit making LTC providers as the profit margin between the pricing and cost (labor in particular) is quite large. This margin was intended to attract more private providers and so expand provision, but customers are learning that they cannot afford to use highly-priced services to satisfy their service needs within the limit of LTCI. One way in which customers are making cost-effective use of the LTCI funding is by purchasing only the cheaper services, such as home-making, instead of personal care services.

Further, non-profit providers have benefited from this pricing and have expanded their operations, so making it harder for new private providers to enter the field. As non-Profit providers tend to provide cheaper service to compete with the private providers, more customers are choosing these cheaper services within the given LTCI coverage. The provision of high priced care services by the private profit making providers has not met a good response from the limited LTCI funded customers, and the private sector is not expanding as much as expected, with many of the potential for-profit suppliers now taking a 'wait and see' position. The outcome of the pricing and the limited amount of LTCI coverage has tended to be an increase the supply of low cost, low quality of LTC services.

Classification of Clients for LTCI Entitlements and Pricing

After screening and certification for nursing care needs, service users will be placed in one of the six care levels. These levels are described as 1+5, with a base level of general support and five graduated levels of increasing funding related to care needs. The care ranks, funding levels and typical service mixes at each level are detailed in Table 1.

The quantity and type of recommended services differs according to the category of need, with the service charge (unit costing) usually reflecting the level of service complexity and the time factor. More specifically, the pricing of the 1+5 levels of LTCI entitlement to care services is based upon the standardized time-input for providing nursing care. The lowest level is ¥64,000 per month and the highest is about ¥368,000 per month. In actual operation, the entitlement in terms of the LTCI care rank can be seen as a sort of coupon that gives the certified client a means of expressing their demand in the nursing care market. The client can choose a package of services within the purchasing power of the entitlement, or if they want more services above the entitlement level, they can pay for the excess.

In November1999, a cash alternative to service provision was agreed by the three-parties coalition government. This cash alternative will make it possible to pay up to ¥100,000 a month, plus an unspecified amount of non-cash contribution, to families caring for elders certified as eligible for LTC services on

Table 1: Example of the Certified Care-Rank and Care-Rating System

Care Rank Level	Maximum Fees / LTCI Subsidy (10% paid by service user)	Example of Typical Service Combination and Service Frequencies (No. per Week)
General Support	¥64,000 (less than US$ 640)	2 Day service visits
Care Level 1	¥170,000	1 Home help service visit 1 Visiting nurse visit 3 Day service visits
Care Level 2	¥201,000	3 Home help service visit 1 Visiting nurse visit 3 Day service visits
Care Level 3	¥274,000	2 Home help service visit 1 Visiting nurse visit 7 Rotating visiting nurse visits 3 Day service visits
Care Level 4	¥323,000	6 Home help service visit 2 Visiting nurse visit 7 Rotating visiting nurse visits 1 Day service visits
Care Level 5	¥368,000	6 Home help service visit 2 Visiting nurse visit 1VRPV 14 Rotating visiting nurse visits

condition that they do not receive a nursing service. In some circumstances, it may also be possible for families to cash in the entitlement to care services to take care of their relative who is certified LTCI eligible. While these cash options could offer an alternative in municipalities where services have not developed sufficiently to meet all need, the decision to allow them was not well received by many municipal officers as it could undermine local service development. It is not known how far elderly people and their families will prefer cash to services.

Care Managers and the Care Plan

Before the recipient receives nursing care from the mostly private providers, they will have a professional consultation with an accredited and qualified Care Manager, resulting in a Care Plan detailing the course of action, timing and costing, etc. (Komuro & Nagatani,1999; KK,1999; Yamamoto,1999). Care Manager's Qualification can be obtained, via a state examination, by many professionals and para-professionals who have several years of practice. As well as doctors, nurses, physiotherapists, occupational therapists, and social workers, other groups such as acupuncturists, have qualified and the diversity of backgrounds and training of the qualified Care Managers is now causing many problems. Problems are especially evident in differences in care managers' assessments and decision on services to be provided to LTCI recipients.

The Care Plan will normally be reviewed at six months intervals. The type of care that a recipient will receive is determined by the local government accredited Care Managers, and more often than not, they also assume the role of screening and assessing the elderly for the certification for their Care Rank. The role of Care Manager and the Care Plan are thus both of critical importance; they are instrumental in providing a better information base to help the insured choose among various competing care providers and shop around within the given entitlements on one hand, and enhancing the quality of nursing services on the other.

SERVICE DELIVERY

Target Users

The size of the aged population who need the services to be provided under the LTCI scheme was estimated at 2.8 million in 2000. This estimate means that 16% of the entire senior population are expected to become users of some kinds of long term care service at the start of the system.

The LTCI scheme covers all those aged 40 and above, but this total target population is divided in two groups: Category 1 - aged 65 and above, and Category 2 - aged 40 to 64. Individuals in both groups will be prescribed for long term care services if they have been certified after screening and assessment.

Assessment, Appeal and Regular Review

Either by self-application or referral from the care providers to their local government office, potential service users have to be screened and assessed by the standardized questionnaire. The questionnaire of 85 items is made up of 73 items covering 73 ADL items and 12 items covering mental ability and indicating dementia. The items were based on the study of time taken for service delivery in nursing homes rather than in home settings in the community. The questionnaire is administered by either municipal officials or their commissioned professional representatives.

Following computerized analysis of the responses to these items, the results and doctor's letter are assessed by the local LTCI Assessment Committee for final ranking. In this way, individuals are classified as certified users or not certified, and the Care Rank of certified users and the amount of funding available. Funding is available for the full range of gazetted services community services as detailed below, and for residential care, but if other services beyond these are required, the client or the family has to pay. Qualified care managers and the family of the aged individual are also involved in determining the care plan. Yet, it is not always necessary to involve care managers for care planning. A Care Rank Registry will be kept by the local municipalities for regular review, usually every six months.

If the individual and their family are not satisfied with the assessment outcome, they can initiate a second assessment which is more clinically oriented, mostly with certification from medical doctors, and the case will be considered by the LTCI Assessment Council set up in each municipality in accordance with rules in Chapter 12 of the LTCI Law. The Assessment Council is made up of three by three by three membership appointed from the representatives of the insured, municipality and the public (Ishida & Sumii,1999; Koseisho,1999b; Yamamoto,1999).

Gazetted Service Types

There are two major classes of gazetted LTCI services, for the mostly home based users and for the institution-residential care users. The kinds of services at each care rank are set out in Table 1 above. The 12 types of service for the mostly home and mobile care cover (Table: 2):
Visiting care: home help, bathing, nursing care, rehabilitation
Mobile Care: at day centre/facility, mobile rehabilitation, care equipment rental
Home care management consultation
Short stay nursing care, short stay respite care
Dementia type nursing care
Special allowance for re-designing and upgrading home infrastructure

The three service types for residential care are:
— Homes for the Elderly, which provide residential services for those who need a home because of social/familial difficulties;
— Special Aged Homes, which provide home services for those who have minor physical and/or mental problems but who could not be cared for by their families;
— Paramedical and clinically based residential institutions, which provide residential nursing and allied health services for those who have more severe mental and physical health problems and who could not be cared for by their families. These institutions are now the most equivalent to nursing homes in other countries.

SOCIAL POLICY IMPLICATIONS OF LTCI – AN INTERIM ASSESEMENT

Effect on Cost Containment and Cost Recovery

The implementation of the LTC Insurance scheme will undoubtedly bring a significant improvement for central, prefectural and local governments in the fiscal management of long term care for the elderly as well as others in need of long term care.

At the macro level, the systematic design of the LTC Insurance scheme is obviously aiming for cost containment and shifting costs for long term care from the medical and health care budget to the newly established LTC Insurance budget. It also aims to foster

Table 2: Care under Long Term-Care Insuranc

Service for those staying at home	Service for those who are institutionalized
Home-help	Special nursing homes for the elderly
At-home bathing	Health service facilities for the Elderly
At-home nursing	Care Rehabilitaion Type
At-home rehabilitation	At medical facilities
Day-service rehabilitation	1. Beds for rehabilitation
Medical service (visiting doctor and dentists)	2. Beds for dementia patients
Day-service	3. Beds for care
Short-stay service	
Care for communal living for elderly with dementia	
Group home for elderly with dementia	
homes	
Provision or subsidy for care equipment	
Subsidy for home alteration to meets care needs	

Source: Kenko Hoken Kumiai Rengokai, "Shakai Hosho Nenkan 1999"
Source: NIPSSR, 2000.

quasi-competitive market conditions by admitting more and different suppliers of services, with a view to achieving cost efficiency and innovation. More importantly, in light of the sharp growth in social security costs in the foreseeable future, the government has asked elderly people to shoulder a share of the burden in proportion to their income through the LTC Insurance premiums.

It should be pointed out that the LTC Insurance scheme has not fully addressed the medical needs of the aged, nor the cost implications of medical expenses of acute care for the aged. Among the controversial issues that have yet to be explored are whether the aged will continue to be entitled to the same acute care cover as other age groups, or whether the LTC Insurance is to be complemented by an effort to have elderly people pay a fixed rate of fees for acute treatment and medicines they receive, with an upper limit set on the bill to be shouldered by such patients.

At the meso-level, there are built-in mechanisms to contain the cost of long term care. At the local and regional levels, the insured will have to deal with service providers directly under the terms and conditions laid down by the local authority on the one hand. On the other hand, standardized costing for contracted types of services under the LTC Insurance scheme should give local and prefectural government considerable leverage to adjust the level, quantity and quality of the service supplied.

At the micro level, the means to cost containment lies in the practice of classification of levels of care, using both computerized and professional screening and assessment, and regular review. The gate-keeping or rationing role of the care managers will at the same time guarantee and limit the supply of the classified services. Any services over and above the standardized or recommended levels will have to be paid for by the service users.

Notwithstanding six years of planning and preparation by the Ministry of Health and Welfare, the start of the LTCI scheme was belated and some confusion arose because of the discrepancies between planning and reality. A number of points of contention arose over the period of the development of the LTC Insurance scheme, and especially in the year immediately prior to the planned implementation. The rhetoric of much of the debate over these issues reflects the sparring relationship that exists in Japan between the bureaucracy on one hand and service providers, professional practitioners and academics on the other. Issues that the latter groups saw as threats to the integrity of the public welfare system where seen by the bureaucracy as opportunities for liberalizing the system. The following review of some of the problems identified by welfare professionals in the course of implementation demonstrates the tone of this debate.

The Public Welfare System under Threat

The first, and major issue, concerned the adequacy of service provision that would be realized, and widespread shortfalls were cited. Of the services supposed to be available nationwide by April 2000, the levels actually available were 84% for home help, 72% for day services and 76% for short stay care. In about 10% of all municipalities, some 350 cities, towns and villages, only half the planned level of home help was available, and 30% of municipalities could supply only 50% or less of visiting nurse services. Service providers also pointed out that while it had been envisaged that all eligible clients would have been assessed prior to the commencement of the scheme, by end February 2000, just one month before the LTCI scheme started, only around 1.17 million out of the 2.8 million eligible elderly had been assessed and given a defined care rank.

Service quality was a second widely debated issue. The prospect of private sector providers entering the field gave added force to this debate as no quality control mechanism had been put in place to covering this newly emerging sector. The lack of quality control was also raised as a problem in accreditation of care managers. Professionals made allegations that almost anyone could be accredited and the level of knowledge required to pass the accreditation test would not require professional training. Quite a few Japanese care managers belong to organization and companies that provide services - which is very different from other countries where care managers should keep neutral position. A particular contradiction was also seen in the potential for conflict of interest, as most care managers who had to make fair and independent care plans were actually employed by the service providers. Without a monitoring framework and quality control mechanism in place, the claims that the LTCI scheme would guarantee a better service was derided as just mere rhetoric.

Third, numerous aspects of the content and computerized processing of the schedule used in assessing care needs came under attack. Many of these points of criticism are similar to those raised with other assessment tools and processes, and include the

reliability of assessments involving only single home visits, the way in which the role of family members was, or was not, to be taken into account, and the extent of detail, or lack of it, in the specification of criteria for independent performance of ADL vis-a-vis reliance on care manager judgement. Dementia in particular was not seen to be fairly covered in the assessment. Errors and anomalies in the piloting of the computer program were seized upon by professionals objecting to what they saw as an overly quantitative approach to assessment

Funding arrangements were a fourth area of contention. Variations in the tax base between municipalities, and hence in capacity to contribute to the LTCI scheme, loomed large while the effectiveness of the national government's contribution to equalizing these variations remained untested. Concerns were also expressed about the capacity of users to meet the premiums and co-payments, and that municipalities would be left to pick up the difference.

Last of all, it was claimed that the level of service provided did not amount to effective support for home care and that the actual costs of caring for many elderly who were already receiving welfare services would exceed the funding provided under the insurance scheme. The new scheme was seen as being able only to cover a basic level of support and not promote quality of life more widely, with predictions of negative consequences for the elderly service recipients. The lack of provision of mental health services under the LTC Insurance scheme came under particular attack.

These specific criticisms expressed the more general concern that the scheme was not welfare oriented and it appeared to have been designed by people who were not familiar with welfare practice. Rather, bureaucrats were seen as intent on designing a sales mechanism that shuffled the elderly into one of the various emerging elderly care business, which were to provide a new haven for retiring bureaucrats just as the consumer finance sector had in the 1980s, resulting in new corporate sector care providers under management that had no background experience in or orientation to welfare practice.

This debate added to the sense of insecurity about the new system, not just for the aged population, but also on the part of those responsible at the municipal level. According to a national wide survey conducted by Asahi Shimbun (24. November 1999), 87% of municipal officials responsible for the LTCI scheme expressed some feelings of insecurity. Other studies suggested that most of the elderly who were aware of the new scheme felt more anxiety than about the previous health and welfare systems (Ambo, Lai & Watanabe, 2000).

Not all the problems, whether predicted or newly emerging, had been ironed out prior to implementation. With services still in short supply, the government's efforts to explain how the delivery system was to work were inadequate and increased pressure on providers and their staff, compounding uncertainty and feelings of unease among the aged and their families (Ambo, Lai & Watanabe, 2000). Welfare professionals pointed out that the contracts between service providers and receivers being introduced with new system were alien to Japanese society, especially for the culture of ordinary older citizens and their aging families. They went on to emphasize that with no experience of such contracts, neither the service providers nor the recipients had an understanding of what a good contract was, and further, that limitations of the Japanese legal system meant contracts could give only a nominal guarantee of service, not an enforceable one.

Liberalizing Long Term Care

From the perspective of the central government, the new LTCI scheme changed the relationships between the aged, care providers and the municipalities. Under the old system, municipalities commissioned the service providers to supply services directly to the aged clients. Under the LTCI scheme, there are now effectively three levels of contractual relationships: the municipalities act as an insurance agency, and the aged clients have become the customers of this insurance agency; this relationship is public (Table 3). The relationship between the municipalities and the providers has become a contractual agreement that is conditional upon the terms of payment offered by the municipality, acting as the insurance agency, with reference to the status of the certified level of care need of the insured; it is not yet clear whether this relationship is fully public and open to scrutiny, or protected on grounds of being commercial-in-confidence. The relationship between the insured client and the service providers, which is private in nature though subject to the protection of the LTCI Law; this relationship is the area of greatest change.

The dual contractual arrangements between providers and municipalities on one hand and providers and clients on the other open up the possibility for the providers, whether non-profit or profit-making, to invest

Table 3: Difference Between New and Old Care System

	Old		New
	Welfare for the Elderly	Insurance for the Elderly	Log-Term Care Insurance
Service Target	Low-income, living alone or other requirements	Those aged 70 years old and over and those between 65 and 70 with disabilities	All elderly
Eligibility for Service	Care needs and conditions of family structure, income, etc.	Care needs	Care needs
Co-payment	According to ability to pay	¥530/visit, ¥1,200/day of hospitalization	10% of service fee
Service Providers	Public welfare facilities	Medical facilities	Public or private care facilities, medical faicilities
Freedom of choice by user	No	Yes	Yes

Source: Nihon Iryo Kikaku, "Iryo Hakusho, 1998"
Source: NIPSSR, 2000.

and provide care services, resulting in long term care becoming a more privatized service. At the very least, the private contractual relationships enable negotiation of terms of service beyond the standardized items, such as in the time and volume of services provided.

Other aspects of the LTCI scheme reflect some of the basic features of public management via contractual agreements and a pro-market approach that characterize health care reform in Japan more widely. These features include the standardization of costing and pricing as exercised through the LTCI scheme, the division between policy development at the level of the central Ministry of Health and Welfare, and implementation through municipalities and local service providers, the split of the municipalities' role as service purchasers from the provider role of private and non-profit agencies, and the widening of the choice available for individual households. All these developments are intended to have a positive effect on stimulating a competitive, internal LTC market. More importantly, they will have a very significant impact on the promotion of LTC as an industry, with a business like mode of operation.

To prevent care providers from supplying the insured with more care services than they truly need, including unnecessarily long treatment, and hence charging more, the LTCI scheme has built-in screening and review process for the certified category of service that specify the entitlements and cost/price. All these mechanisms have prepared a level playing field for profit-making agencies to enter the business of long term care.

Initial estimates suggest that the new LTC market will have a turnover of over ¥5 trillion when LTCI scheme starts. The market is believed to be larger as Japanese service recipients do not fully utilize their rights owing to long history of not having chosen services or other access problems. While most existing providers are in the well established, non-profit sector, many large corporations in the private service sector have expressed interest in the business of providing more cost-effective LTC services for the insured. The increase in the number of registered service providers by April 2000 points to the possibility of further liberalization, if not commercialization, of the LTC sector. At the same time as the LTCI Law has made provisions for service standards and quality control for the expanding LTC industry, it remains to be seen how well it can protect the insured aged who are contracted customers of the providers (Kaigohoken Monthly, June, 2000, No.52).

THE INCOMPLETE PROJECT OF LTC: PENSION REFORM AHEAD

Good policy and financing for long term care is not just about enhancing life expectancy for the elderly but is also about ensuring the quality of life they can enjoy. To this end, it is fundamentally important that medical and health care should be anchored on economic and social security, and it is here that the question of stability of the social security system needs to be addressed.

Prospects for Pension Reform

The present arrangements for financing social security for Japan's aging society have an inter-

generational gap with reference to contributions and benefits. To many elderly people, the pension system is a basic financial resource for their remaining days. However, both middle-aged and younger people have become disaffected with the state-run pension system. Middle-aged people are concerned that they may receive less than they have paid, while younger people are reluctant to shoulder a heavy burden in the form of premiums now and in the future.

The greatest challenge facing Japan is to address the normative and ethical issue of policy on aging: the fundamental questions are who should pay, and how much, to finance the pension, medical and long term care insurance systems. As there is every reason to believe that the total cost of these systems will become greater year by year, the more the political delay and indecision, the worse the financial conditions will be. Reform therefore should not just focus on social security, but also on the taxation regime. One proposal has been mooted by the main opposition party (Democratic Party) is to increase the consumption tax to 7% or to use it exclusively for welfare programs for the elderly. While this proposal solves the inter-generational problems of financing, it generates questions of the redistributive justice of indirect taxation.

In late 1999, a government-sponsored bill was submitted to the Diet to reform the pension system. It would increase the ratio of premiums to be covered by state subsidies from one-third to half, after ensuring that the government finds stable means of raising funds. While this bill would address to the risk of the collapse of the pension system, no new policy could be implemented until the end of 2004 at the earliest, assuming there were no more political blockages in the legislative process. So the prospect for pension reform remains uncertain.

Inertia and Administrative-Political Deadlock

In 1997, the Health and Welfare Ministry unveiled five options for reforming the state-run pension system. According to the ministry, the government would have to raise the premiums paid by corporate employees for their pension plans to a hefty 34.3 percent of their monthly salaries by 2025 if they were to receive benefits comparable with the current levels. The five options represented an attempt by the ministry to provide the public with food for thought concerning which they should choose: an increase in the premiums they would have to pay or cuts in benefits they would receive.

But there is inertia and administrative-political deadlock for the overhaul of the crisis-ridden social security system. In the late 1990s, Japanese bureaucrats, their intelligent images tarnished by various scandals, have yet to overcome the problem of the lack of coordination among ministries and over-coordination of intra-ministerial programs; the resultant clannish mind-set limits the capacity of all institutions concerned to work toward mutually shared goals.

In the political arena, few politicians dare take steps to implement cuts in pensions and other social security benefits, or increase the financial burden to be shouldered by the public, for fear of losing votes. Welfare populism becomes the currency for securing political position, particularly in a climate of more multi-party politics. In addition, no organization, such as the Japan Medical Association, health insurance associations, business organizations and labor unions, with a stake in social security programs, stands ready to abandon its vested interests. This has led to a gridlock among the parties concerned, just when the need to take action for reform is most urgent.

Political Compromise and Lack of Political Will

A final twist in the political road to implementation of the LTC Insurance scheme, if not a U-turn, was that an election had to be held before October 2000. The tactic of delaying the introduction of the LTC Insurance premium contribution to be paid by the elderly population did work for the ruling coalition in the Diet Election which was held on June 26th, 2000. Despite losing 60 seats, the Liberal Democratic Party (LDP) still led the ruling coalition of the Liberal Party and New Komeito, and maintains the majority in the Diet.

But the new political packaging of the revised LTC Insurance scheme with the so-called six month 'period of grace' for the premium from the aged and cash options for family carers, coupled with a review six month after the LTC Insurance scheme being implemented, angered the public and many municipal officials, as they feared that the very spirit of the LTC Insurance scheme would be compromised, if not jeopardized, for partisan politics. Even more problematic is building political consensus for further reforms, which will be more difficult to achieve as a result of the Diet election which further strengthened the opposition forces inside and outside the Diet.

The politically fragile ruling parties have neglected the aging question and the funding of LTC needs by their decision to put off collecting premiums in the

hopes of wooing voters. They appear oblivious to the need to improve the foundations of the scheme and come up with stable sources of operating funds - both tasks that should be undertaken from a long-term perspective. Welfare populism has again triumphed over political will to develop policies addressing the basic principles of inter-generational, horizontal and vertical transfers of tax and insurance burdens. In political economy terms, the struggle for sustainable and healthy LTC is just beginning.

DEBATING ON FUTURE DEVELOPMENT

The LTCI scheme represents a kind of safety net of which the public can take full advantage. Although it still leaves much to be desired, the scheme is vital to the struggle to meet the challenges posed by the aging of the population in the future. At a macro level, the LTCI scheme should have a demonstration effect for other reforms in social security and taxation that are in the pipeline, and the provision of a safety net for LTC should regain some of the community's trust in the administrative-political system.

Although some aspects of the LTCI scheme have been controversial, it is seen as one step for coping with the problems of the bedridden elderly especially, and more importantly, it has given increased impetus to rehabilitation for the elderly, thus reducing the number who are bedridden. By doing so, it is certain not only to help give elderly clients a sense of purpose, but also to relieve the strain on the depleted coffers of the health insurance system. At the household and family level, the LTCI scheme should deliver a better alternative than the previous arrangements, with professionally guided care plans for aging kin, notwithstanding the possible increase of insurance contributions and the cost effects on household income. How the care plans will work through the whole system, for the benefits of the elderly and their households, remains to be seen. But at the very least, there seem to be open channels and systematic mechanisms for addressing the 'hidden' social costs of caring for the aged, such as the uneven burden carried by women. The difficulties faced by individual households in caring (or not caring) for the aged have now been rightly responded by social policy initiatives. For this, the LTCI is a new chapter on caring the aging Japanese society in the 21st century.

*Note on currency. Throughout this paper, yen is used because of the fluctuating exchange rate of the yen against the US dollar; the rate was ¥149 in August 1998, ¥102 in December 1999, and about ¥120 in June 2001.

REFERENCES

Ambo, Norio; Watanabe, Ritsuko & Lai, On-Kwok. (2000). *Research Report on Nursing Care Insurance in the Higashi Harima (Hyogo Prefecture).* Kagogawa City: Federation of the Nursing Homes for the Aged in Higashi Harima Area.

Asahi, Kenji. (1999). *Kaigohoken no Point* [Points of Long Term Care Insurance]. Tokyo: Kiri Shobo.

Campbell, J.C. & Ikegami, N. (1999). *Long Term Care for Frail Older People: Reaching for the Ideal Solution.* Keio University Symposium for Life Science and Medicine, vol. 4. Tokyo: Springer-Verlag.

Hiramatsu, Kazuo. (1999). *Kaigohoken Service* [Long Term Care Service] Tokyo: Dental-Medico-Pharmaceutical Publishers.

Ishida, Kazuki & Sumii, Hiroshi. (1999). *Kaigohoken-Assessment* [Long Term Care Insurance Assessment]. Tokyo: Hubunsha.

Ito, Shuhei. (1997). *Kaigohoken* [Long Term Care Insurance] Tokyo: Aoki-Shoten.

Kaigohoken Monthly (Long Term Care Insurance Monthly), various dates.

Komuro, Akiko & Nagatani, Noriaki. (1999). *Kaigohoken, Shakkai Fukushi pou* [Long Term Care, Social Welfare Laws]. Tokyo: Bookman-sha.

Koseisho [Ministry of Health & Welfare]. (1999a). *Kosei [Health & Welfare] White Paper.* Tokyo: Koseisho.

Koseisho [Ministry of Health & Welfare]. (1999b). *Shakai Fukushi no Direction* [Direction of Social Welfare]. Tokyo: Koseisho.

Lai, On-Kwok. (forthcoming). Long Term Care Reform in Japan. *Journal of Aging & Social Policy.*

Mainichi Daily News, various dates.

Matsui, Shigenori. (1999). *Nihonkoku kempou*[Japanese Constitution]. Tokyo: Yuhi-kaku.

Minerva Shobou (1999). *Shakai Fukuishi Shoroppou* [Six Laws on Social Welfare]. Tokyo: Minerva Shobou.

National Institute of Population and Social Security Research [NIPSSR] (1997), *Population Projections for Japan: 1996-2050 and 2051-2100.* Research Series No.291., April 1997. Tokyo: NIPSSR.

National Institute of Population and Social Security Research [NIPSSR] (2000), *Household Projections for Japan by Prefecture: 1995-2050*. Research Series No.298., 31. March 2000. Tokyo: NIPSSR.

Takao, Yusuo. (1999). Welfare State Retrenchment - The Case of Japan. *Journal of Public Policy*,19(3): 265-292.

Watanabe, Ritsuko & Lai, On-Kwok. (forthcoming). Aged Care Service Delivery in Japan – Preparing for the Long Term Care Insurance Scheme. *Journal of Aging & Social Policy*.

Yamamoto, Kazuyoshi. (1999). *Kaigohoken & Rehabilitation*. [Long Term Care and Rehabilitation].Tokyo: Kosei Science Instiitute.

Zenkoku Rojin Fukushi Kyogikai.[ZRFK] (1999). *Hokatsuteki jiritsu shien Program - Kaigo Service Keikaku Sakusei Manual* [Manual and Service Programming for Independent Living]. Tokyo: Shakai Fukushi Pouren ZRFK.

ACKNOWLEDGEMENT

This is an amalgamated version of two separate yet inter-related forthcoming papers to be published in *Journal of Aging & Social Policy*. The authors would like to thank Iris Chi, Anne Howe, Metha Kalanyi and Norio Ambo for their insightful comments and suggestions, collegial, financial and logistic supports from the School of Policy Studies, Kwansei Gakuin University and its Postgraduate Health & Welfare Seminar, as well as the Centre on Aging, and Department of Social Work & Social Administration, both at The University of Hong Kong.