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REFORM OF LONG-TERM CARE IN JAPAN: FROM ADMINISTRATIVE PLACEMENT TO MARKET

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Workshop 3 – Health, Assistance and Social Security

1- INTRODUCTION

1. This report aims to make clear the meaning of the recent reform of the long-term care system for elderly in Japan from the point of view of marketisation of public sectors and their influences. In April 2000, Japan's long-term care insurance system started. This reform started rather late compared to other OECD countries, but it has very large financial resources of almost 4 trillion yen (about 32 billion dollars) per year. Japan studied systems of many advanced countries to establish the adequate long-term care system.

2. Community care reform including long-term care for elderly has become a main political subject during 1980--90s in OECD countries. Formerly the burden of long term care fell heavily on the family members, especially women.

3. There are two types of funding for long term care, one of which is a tax-system and the other, an insurance-system. The former type is adopted by the UK. and Nordic countries, the latter is used by Germany, Netherlands, France and Japan. From the observance of these countries, we recognize that these contrast came mainly from the different existing funding for the health care system, for example UK is famous for its NHS and German and Japan's health care fund mainly come from health insurance. When these funds are used, certain social organizations will be composed. Local governments are especially important to manage the whole system. Moreover, there are many kinds of social environments and resources including informal sectors like neighborhood, charity and volunteer groups to support the aged generation. We must watch these funds, market, local governments and informal sectors work in cooperation together for elderly.

4. The long-term care for elderly has very complicated problems. Formerly, social conditions like big family and community relationship could have supported the frail old people because there have been a small number of old people and normal conditions of their living like extended family where there were many kind of carers. It can be said there are no nations who could have performed the complete systems of long-term care from the point of view of users' satisfaction and social, financial burden as well.

5. The newly established Japanese long-term care insurance system adopted radical change in supply of care service and contract with users which means to transfer from public direct placement to market system. Moreover, it collected one half of total expenditure from the new insurance, collecting about 2 trillion yen. It caused a big impact to the traditional public sector. This report will examine the meaning of such transformation and focus its influence to users and suppliers as well as the role of public sectors and NPO.

6. In order to analyze the whole influences of such newly established long-term care system on the traditional public sector in Japan, it will be indispensable to prepare some methodological framework, because if we only describe simply the facts of users' number or financial supply or working of the system, we will not be able to grasp and evaluate the whole meaning of reform or make any proposal to improve the reform. Here, we adopt the complex theory which will become very powerful instruments to analyze the social behavior of many agencies from the point of view of self-organization.

7. Supply of public services in old welfare states had the standardized orders to limit peoples' demands by many kinds of regulation including restriction of financial conditions. Deregulation and marketisation of public sector could bring efficiency and diversity of public supply which has the tendency to meet peoples' demand through the price mechanism. In the theory of complexity, "Edge of Chaos" and "Edge of Order" have the most fruitful realms to realize the optimal behavior of agents (**1**). When we adopt price mechanism to match demand and supply in the social welfare system, it is necessary to be cautious that it should not be in pure market but in "bounded market" which is working in a complex environment. In a social welfare field, there has been a lot of mismatching between over-simplification of targets in public side and diversification of users' necessity. So, market will become " bounded instability" (**2**).

8. In these situations, the role of collective action adopted by public sector will change completely. It is necessary to establish some rules to new system for tax and social insurance payers to certify their demands when necessary. Private sector may supply insurance for the long-term care, but only by asking all the people to join, moral hazard risk could be avoided. As to service supply, certified standard of service level and favorable combination of services targeted for users' demand should be established by highly qualified specialist or public sector.

2 - FROM HEALTHCARE TO LONG-TERM CARE

When they did research to reform the British community care system in the middle of 1990s, they anticipated that Japan should accept in principle a social insurance model for the long-term care cost. And it explained that in Japan this was seen as a matter of urgency, as there were many elderly people in hospitals receiving chronic care (**3**) .

Before the establishment of long-term care insurance system, there were two kind of social care institutions for frail elderly in Japan. One was a nursing home which was a part of social welfare institution where old people who would not get family or informal care entered by administrative placement. This institution has been thought as

a kind of substitute of hospital care, where part-time doctors and nurses took care for "inpatients". The other was a hospital where outstanding length of inpatient stay had been found compared with other OECD countries. We shall show some characteristic data about these features.

2.1 Unhealthy highest life expectancy at birth in Japan

Some scholars report at the international meeting that Japanese health care system has been successful judging from the fact that life expectancy at birth especially for women being the longest in the world which is 84.0 and for men 77.2 in 1998. But at the same time, we must mention another important data from OECD report which shows health status by morbidity (health status). Mortality data can be estimated from life expectancy at birth, but morbidity data will be collected from self-reported indicator. In Table 1, I will show relation of ratio of aged (65above) female and male and ratio of good health or better response for 20 nations of OECD. (**4**)

Table 1/a - Ratio of aged and health conditions. (female.)

14 countries						6 countries		
	Aged	health		aged	health		aged	health
USA	14.7	90	UK	18.3	75	Korea	7.5	41
Canada	13.9	89.70	France	17.1	85	Poland	13.7	40
Netherlands	15.8	73.5	Spain	18.2	65	Check	16.5	50
Finland	17.6	70.0	Germany	19.464		Hungary	17.0	39
Denmark	17.5	75.6	Belgium	18.8	75	Portugal	16.8	27
Switzerland	17.9	80.4	Italy	19.4	51	Japan	18.6	42
Austria	18.7	70.1	Sweden	19.9	76			

Table 1/b - Ratio of aged and health conditions. (male.)

14 countries						6 countries		
	Aged	health		aged	health		aged	health
USA	10.7	91.4	UK	13.0	75.3	Korea	4.4	48.7
Canada	11.9	91.2	France	11.9	90.5	Poland	9.9	48.2
Netherlands	10.9	80.8	Spain	13.6	72.4	Check	10.6	57.7
Finland	11.0	82.9	Germany	11.8	68.3	Hungary	11.2	48.1
Denmark	12.6	82.9	Belgium	13.2	81.6	Portugal	12.6	38.5
Switzerland	12.6	86.2	Italy	14.8	61.0	Japan	13.8	47.2
Austria	11.5	72.5	Sweden	14.9	80.1			

Aged= ratio of aged persons above 65. aged; UN. Demographic Yearbook.
Health= ratio of answered persons to the questionnaire that they are in good health or better health condition.
(OECD, Health at a Glance, 2001, and others. For male and cross section graph, see additional report.)

Here we can find two separate groups in both side of female and male. If we try to get correlation between these 20 countries as a whole, correlation will be very weak of -0.197 for female and -0.238 for male. Such correlation only shows that the longer people live, the better health response will appear, which means rich countries have healthy conditions. When we separate these countries into two groups (14 high healthy group and 6 low healthy group), correlation become improved as following; female14= -0.715, male14= -0.481, female6= -0.058, male6= -0.267. We could not find significant correlation between the ratio of aged and good and better health response in the 6 countries. Japan belongs to the latter 6 nations which means that though he has the most high life expectancy at birth, people's health evaluation is extremely low.

2.2. Hospital played role of nursing home

From middle of 1980s to 90s, many countries seemed to have separated long-term care from medical care. This is reflected to the decrease of inpatient care. Owing to the improvement of medical treatment and increase of medical cost, duration of hospital inpatient has decreased amazingly in many advanced countries. It also means to improve the situation of medical cost and to normalize the patients' life style as well.

Table 2 shows the trend of number of beds per 1000 population. Here, we can find that Japan show a different behavior among OECD countries who did not decrease number of hospital beds in this period. So, the number of beds are almost twice compared with others.

Table 2 - Number of beds in hospital per 1000 populations

	1960	1970	1980	1990	1998
Austria	10.8	10.8	11.2	10.2	8.9
Canada	6.2	7.0	6.8	6.3	4.1
Denmark		8.1	8.0	5.6	4.5
Finland	11.5	15.1	15.6	12.5	7.8
Germany	10.5	11.3	11.5	10.4	8.5
Italy	8.9	10.5	9.7	7.2	5.5
Japan	9.0	12.5	13.7	16.0	16.5
Netherlands	11.0	11.4	12.3	11.5	11.3
Sweden	14.2	15.3	15.1	12.4	3.8
UK	10.7	9.6	8.1	5.9	4.2
USA	9.2	7.9	6.0	4.9	3.7

(OECD, Health Data.)

Moreover, from OECD data we can find that average duration of inpatient stay is very long and the numbers of inpatient admission per 1000 population were small. So, we can compare de facto duration of inpatients' stay in hospital (dd) and calculated it (dc) (Table 3).

Calculated duration of stay=dc, Bed per 1000=b, Admission Number=a.

Hospital beds' occupation ratio: 300 nights per year. So, we can get dc=300 x b/a.

Our assumption of bed occupant rate may have been almost correct. In most countries, dd comes just near dc except Japan. This means while there are so many unused hospital beds and small number of inpatient admission, a long duration of hospital stay has happened in Japan.

Table 3 - Compare of length of hospital stay between fact and calculated days

	1980 Stay	Calcu.	1990Stay	Calcu.	1998 Stay	Calcu
Japan	55.9	68.5	50.5	58.5	40.8	52.1
UK	19.1	19.4	15.6	12.2	9.8	8.4
Denmark	12.1	13.1	8.2	8.4	6.9	6.8
Netherlands	34.7	31.5	34.1	31.7	33.7	30.8
France	16.7	17.3	13.3	12.5	10.7	11.0
Germany	19.0	18.3	17.2	15.6	12.5	12.7
USA	10.0	10.5	9.1	10.9	7.3	8.8
Sweden	23.2	24.8	18.0	19.1	6.6	6.6 (1997)

(OECD, Health Data.)

2.3. Contradictory results of health insurance reform

In these periods, Japanese health insurance system was reformed to supply medical cares almost for free to elderly. From its establishment in 1960s, there has been five separate health insurance funds composed of four kinds of employees and one public health fund which has been managed by local governments. As public managing health insurance funds contain self-employed sector and retired families, most elder people belong here. So, central government's subsidy pays half of their cost, but owing to increase of elderly members and cheap medical cost policy for them as a part of welfare policy, old ages' medical cost became almost free. As a result, hospitals and clinic became full of aged people. Ministry of Health and Welfare reformed health insurance fund to separate the old peoples' fund and created redistributing formula.

Owing to this reform which created Elderly Health Insurance in 1982, all funds have been supposed to have the same ratio of old people and employees' funds should have

paid to this fund more than public health insurance funds because the former has rather young membership. Formerly, employees' health insurances had surplus and they built many resort facilities or distributed some goods to congratulate members' health. But after this reform to separate elderly funds to save the public health insurance by increasing the employees' burden, funds fell in deficit, and it also increased high medical cost for aged.

For example, in 1997, public health insurance funds' ratio of aged membership was 216 per 1000, but aged ratio in employees' funds was 30, and government managed funds' aged ratio was 55. After readjustment the average ratio became 104. One of the reasons for this reform is said that retired senior members of employees' funds will join to public health insurance, so it may be reasonable for it. But, after such calculation, employees' funds insist that they must pay more, because many funds burden more than 30% of their expenditure to Elderly Health Insurance.(Table 4)

Table 4 - Increase of Medical Cost for Aged

Year	medical cost for all	medical cost for elderly	ratio
1983	¥14543.8 billion	3318.5	22.8 %
88	18755.4	5159.3	27.5
93	24363.1	7451.1	30.6
97	29065.1	10278.6	35.4

As a result, medical cost for elderly increased from ¥3.3 trillion in 1983 to ¥10.3 trillion in 1997 compared with ¥14.5 tri. of total cost to ¥29.0 tri. in the same period. It means the share of medical cost for elderly increased from 22.8% to 35.4%. These data contain both acute and inpatient care, including chronic care. They did not separate such necessary difference to establish the long-tem care for elderly.

So, we can say that in 1980s Japanese health policy continued to increase inpatient care and to add the financial support through reform of health insurance system. It may have resulted some contradiction that there happened unhealthy inpatient and long life expectancy at birth ironically.

2.4. Increase of nursing home and chronic care beds

Nursing home and residential care home were supplied to aged persons who could not get family support or physical, mental handicap by administrative assessment and placement. When they construct these facilities, central government's subsidy is one half and prefecture's subsidy are 1 fourth. But to get such subsidy, central government must admit their proposals. After construction, they employ a part-time doctor and nurses to supply medical care paid by public. In 1980s, the number of nursing home increased very rapidly. In the era of speculation, there were almost bubble to supply nursing homes. (Table 5).

Table 5 - Increase of Nursing Home (1000sites)

Year	1980	83	86	89	92	95	98	99
Sites	81.3	106.2	126.9	152.5	181.1	221.2	266.1	287.9

3 - SPECIAL CHARACTER OF JAPANESE LONG TERM CARE SYSTEM (5)(6)

3.1. Number of insured person 65 million

Japanese long-term insurance has very special feature about insured membership.

Insured persons refer to all such individuals aged above 40. As we can see in table 6, there are two categories according to the ages for insured persons. It might be difficult to explain why people above 40 has been included as insurers. We think it came from the point of view of consent and convenience to collect premium as well as financial condition. So, 65 million joined to pay and got right to receive benefit. There are two kinds of insured persons to have the same standard duty to pay certain amount of money according to insurers' decision.

Table 6 - Two Kinds of Insured persons

Member	Age	Benefits
Primary insured persons (No.1)	People aged 65 and over (22 million people)	● all those in need of care (those who have already reached such a condition) ● all those in need of support (those who are in a condition where it is feared they will require long term care services in the future)
Secondary Insured persons (No.2)	People aged 40 to 64 who subscribe to health insurance (43 million people)	● Benefit eligibility is restricted to those for whom long term care in necessary due to illnesses accompanying aging such as middle-aged dementia, strokes and the like.

3.2. Insurer is the municipality ; financial resources are supported by insurance premium, subsidy from tax and 10% user charge

1. Insurance premium is decided every three years according to total amount of payments for services by each insurer. This system has very clear accountability which claims tight relationship between charge and benefit. In Japan, owing to big subsidy from central governments, local authority is apt to hesitate to adopt such

   financial system until now. Though No.1 and No2 insured people have the same standard of premium, the premiums for No.1 insured persons will be adjusted by each municipality based on income level. In the case of No.2 insured persons, the premium will be calculated according to the method employed by the health insurer to which he or she subscribes and then lumped together with the health insurance premium.

2. Users who receive service must pay 10% of total cost. This system is quite different from the means-tested. Users who receive service must pay 10% even if their incomes are low. So, some elderly who receive small amount of pension find it difficult to pay to insurer.

Table 7 - Burden of premium for No.1(adjusted by their income)

	Income Levels	premium	ratio
1	Person with no income who receive social benefit	Standard x 0.50	2.2%
2	families who do not pay local tax	Standard x 0.75	29.0%
3	Person who does not pay local tax	Standard x1.00	42.8%
4	Person who pay local tax(below certain level)	Standard x1.25	16.0%
5	person who pay local tax(above certain level)	Standard x1.50	10.0%

3. Public subsidy.
   Apart from the premiums and a 10% cost-sharing paid by people who use the services, 50% of the expenditure for the long term care insurance system will be financed from the public purse. This breaks down as 25% from the state, 12.5% from the prefectures, and 12.5% from the municipalities.

3.3. Procedure for Receiving the Services

1 Application

The elderly person in need of long term care or his or her family makes application to the department. of municipality.

2 Investigation and approval

A care manager pays a visit to the person's home and completes a form covering 85 questions concerning that person's physical and mental condition. The data in the form is input into a computer and a preliminary decision is reached. The opinion of the physician in charge and any special points noted down by the care manager at the time of the visit are then included for the long term care approval board to decide as to whether care is necessary and if so to what extent. As a result the applicant is ranked as "self-reliant", "needing assistance" or "needing long term care 1-5".

Table 8 - Degree of Need of Long Term Care and Maximum Monthly Amounts for Home Services

Rank of care need.	Condition	Entitled Payment:
Needing assistance	Not deemed to need long term care, but needing assistance in everyday life	61,500 yen/month
Needing long term care 1	Needing some long term care	165,800
Needing long term care 2	Needing small degree of long term care	194,800
Needing long term care 3	Needing a medium degree of long term care	267,500
Needing long term care 4	Needing a large degree of long term care	306,000
Needing long term care 5	Needing the highest degree of long term care	358,000

3 Decision on degree of need

Notification of the decision as to the need for long term care is given by the municipality within 30 days of the application being made. Persons designated as "needing assistance" can benefit from the domiciliary services under the program, while those classified as "needing long term care" have a choice of either domiciliary services or facility services.

4 Drawing up the care plan

*Home long term care: In consultation with the care manager, a care plan can be provided free of charge compatible with factors which would include the extent of care required, the wishes of the elderly person concerned and the family's situation. Alternatively, the elderly person and the family can themselves draw up the plan. There is a limit to the amount that can be expended for home long term care, so the services used must be combined to be within this range.

*Facility long-term term care; The care plan must be drawn up by the facility.

5 Deciding on the care plan and implementing the services

The type of services to be used and the operator to supply them are determined and these services are then implemented in accordance with the plan. The user is liable for 10% of the costs to be paid during the period the services are supplied.

Approval for long term care is effective for six months. If it is desired to continue to receive the service thereafter, application is to be made to the municipality within the period from 60 days before the day of expiration of validity to the day of expiration.

3.4. How to buy service from market

Care manager and entitled user will decide to buy necessary service from market until the decided amounts every month, when exceed the limit user must pay without payment from insurance.

4 - LONG-TERM CARE INSURANCE; USERS' BEHAVIOR

4.1. How many people were entitled as Users by certification procedure

Long-term care insurance system started from certifying the classification of users according to their level of necessary care. It means a kind of entitlement to receive caring services from supplier according to care plan. When users were certificated as a certain level of necessary care, care-manager of private sector makes a care-plan for him/her. Until this procedure, administrative placement of limited numbers has meant how many people want to receive care services, it was almost supply decided demand, so, there were no objective data for frail aged who want care in Japan.

After beginning of long-term care insurance, we can get the number how many frail aged people are there in the country, and how many of them want to receive services. At first, we will compare the number of certificated aged persons by rank of age in 2001. Recent national census of 2000 (prompt report), made it clear there are 22.27 million aged people which means 17.54% of total population in Japan.

Before the start of insurance payment, Certification Committee for Long –term Care needs will assess and decide the level of necessary care. Among 22.27 million elderly, 2.75 million(12.3%) elder people were certified and got entitlement to be paid from the fund to buy care services. Table 9 show the relation of care level and year ranks of man and woman. Under the rank of 75 year, ratio of certificate is near 5%. But above 75 year rank, this rate increases very rapidly.

Table 9 - Ratio of certified elderly as long-term care need (%)

Age	male	female	total		male	female	total
below 65				80-85	18.1	27.5	24.3
65-70	2.5	2.3	2.4	85-90	31.5	44.7	40.7
70-75	5.0	5.8	5.4	90-95	49.3	65.8	61.5
75-80	10.2	13.7	12.3	above95	70.1	78.0	76.8
				Total	8.6	15.0	12.3

(% shows the ratio of entitled elderly;)

4.2. Difference between entitlement and receiving

It is important to know that in this insurance entitlement does not necessarily mean the payment proposal this system. For some reasons, people who were certified as candidates to receive payment from insurance funds did not receive their payments. Table 9 shows the number of receiving their payment according to age rank. Total number of certification was 2.75million but 2.16 million persons (78.3%) received care service. Here, we can find parallel tendency which latter goes below about 10 % under than former.

In order to compare these data more precisely, we will make Table 10. This data show the receiving rate of certificated users by age rank and caring level.

According to the table, we can find some special features which mean that low care level and young people show low receiving rate, female show higher receiving rate than man, level 4 and level 5 show almost the same rate, sometimes level 4 comes above level 5. One of interesting tendency is that female high aged rank become to show lower receiving rate. This means that the most of them are in hospital.

Table 10 - Ratio of elderly receiving long-term care payments (%)

Age	male	female	total		male	female	total
below 65				80-85	13.7	22.2	19.3
65-70	1.8	1.7	1.7	85-90	24.3	37.0	33.1
70-75	3.7	4.3	4.1	90-95	38.9	55.2	50.9
75-80	7.6	10.7	9.5	above95	56.6	66.4	64.5
				Total	6.5	12.1	9.7

(% shows the ratio of receiving elderly;)

Table 11. Ratio of receivers compared to certificated persons; 2001.10 (%)

	Total	below64	65-69	70-74	75-79	80-84	85-89	90-94	above95
Male	74.3	59.3	71.4	73.7	74.9	75.8	77.0	78.8	80.8
Female	80.0	67.0	72.5	74.9	78.0	80.6	82.7	83.8	85.1
Total	78.3	62.9	72.0	74.4	77.0	79.4	81.4	82.6	84.4

(Report from Health Insurance Board. 2001.10 Service data.)

This problem of restrain of care entitlement problem has some reason. When they enter nursing care facility, their cost to pay 10% become certain amount. And when they receive home care from helpers and use other services, they can consult care manager to make care plan in the extent of certificated amount by the 10% charge. Sometimes this charge will be felt so heavy to their income that some users choose not to receive care services or decrease them. Some questionnaire "why your service decreased after long-term care insurance system" made it clear that "contents of service does no fit "=22.5%, "difficulty to pay user charge"=20.6%, "former service exceeded the limit of care insurance services"=16.1% etc. There are some reasoning to this as "in order to promote homecare, extent to supply home care service should be planned wider than before".

When A city did research of questionnaire to entitled families about receiving services, they found there were 24.5% did not receive the services which was a little less than national average. They asked the reason for not to receiving services. The answer was as follows.(7)

1. Inpatient at Hospital: 31.4% (7.8% of total)
2. Family care will do: 30.9% (7.7%)
3. User charge is heavy: 11.7% (2.9%)
4. Trouble procedure: 9.6% (2.3%)
5. No suitable service: 9.0% (2.2%)

Here is some people who do not use service owing to temporary reason, but some people will find inconvenience to the system itself.

4.3. Recognition of right as consumers

Among purposes of long-term care insurance, there were recognition of the right as tax (insurance) payers. Insurers of public insurance system must pay every month certain amounts to municipality fund or they will lose the right to receive payment for their entitled services. This is important point to make citizen aware of their right.

But, at start of Japanese long-term care insurance in April 2000, some populist politicians claimed to postpone the charge for above 65 years persons' premium, (for half year free and for more half year 1/2). They were afraid of losing seats at the election of National Diet. For this one year, only 40--64 year rank people paid as formerly mentioned. This policy may have made above 65 year rank people misunderstand they need not to pay insurance premium. After one year, they became to pay due premium. Some local governments try to decrease their due of low income group at the expense of taxpayers.

We think that during this period of free or decreased premium, elderly people may have not recognized insurance or their behavior has been prudent to receive their services. Some NPO says when they became to pay premium, their attitude to use service became active.

5 - HOW DID SUPPLIER BEHAVE TO SELL SERVICES?

5.1. Long-term care bubble; extreme case

In Autumn, 1999, Goodwill Group's opened their stock (50 thousand yen) at 7 million yen at the stock exchange market. This company was the headquarter of small person-delegation business. They announced to begin home-care business from April 2000, when long-term care system have started, he was the president of one of the famous entertainment company, he advertised at TV commercial explaining how his company developed in this chance and extended their caring business. "Comson (the name of company) will start 800 stations at next April, and every year it increases 1000 stations to supply home care service for 1 million people. When we can get 120 thousand yen per month for each user, our annual sales will achieve 1.5 trillion yen per year". This strategy attracted big reputation to make his company's stock price to 74.99million yen per one stock. President were proud of its result, and became billionaire. Ironically, this company was most prosperous before beginning of long-term care. "Until March 2000, they were very uplifted, number of care station reached more than 1,200, and employed 4,400 full employees and 15,000 part-timers. But, in April they found there were very limited number of users. They missed to count market scale."(**8**)

One regional manager writes this process, but in this case, if president will sell his stock at high price, other financial group would have lost money. Even after burst of bubble (a half year later, stock price became 130 thousands yen), Comson still continued care business using some profitable care stations.

This is the extreme case of private company who joined from private sector. We will discuss character of suppliers of nursing home and home care.

5.2. Increase of care supply by start of long-term care system

Before start of long-term care law system, there existed New Ten Year Strategy to promote the health care and welfare for elderly (so called The New Gold Plan). But, owing to budget restriction and limited administrative placement, the quantity of service supply did not increase so much. When we pick up some categories of care of institutional services, we can get the following table. Here we find increasing process of institutional care service, nursing home, health care facility and medical care house. For these institutional facilities, as already mentioned, special and nursing home has been supplied in 1980s by the public private sectors. When long-term care insurance plan was opened in the middle of 1990s, medical sectors began to change their beds into chronic care for bedridden aged for whom new insurance pay for their stays. So, as shown in table 12-a, we can find rapid increase of these sectors including medical care house.

Table 12/a - Change of care service supply (Institutional Facility) 10 thousands

	1995	1996	1997	1998	1999	2000	2001
Special nursing home	23.4	24.9	26.3	28.9*	30.0*	29.9	31.7
Health care facility	12.0	14.7	18.0	24.9	28.0	23.1	24.7
Medical Care House	1.7	2.3	2.9	7.3	10.0	10.6	11.2

*budget, 2000,2001=number of cases

Table 12/b - Change of care service supply (In-home care services) thousands

Main Category	1995	1996	1997	1998*	1999*	2000+	2001+
Home care visit	95.5	118.8	136.7	167.9	178.5	509.0	709.0
Short stay	33.0	38.6	43.6	56.8	63.0	117.0	158.0
Day care	6.4	7.9	9.6	15.0	15.0	555.0	661.0

Real number. * means budget, + different counting

To promote home care was one of the important purposes of the long-term care reform, radical deregulation to use many kinds of resource, organization etc. They wrote as following. “Municipalities have been promoting the efforts to contract with a variety of organizations including private-sector companies for home-visit care (home help services), and in February 1998 they were permitted to contract with private-sector companies for commuting care service facilities (day-services) and for short-term stay care facilities (short stay) ”(**9**)

5.3. Who are suppliers of care services?

Generally speaking, insurance system is closer to market contract than tax one. So, service supply should be prepared for entitled insured person to be users whenever and wherever they live. It should be avoided that "though there has been insurance, there is no care when necessary". Here is one contradiction that market will work to supply the necessary services, but service price for each hour is predetermined. Market must adapt in such bounded situation. But market must act in very different working spaces like urban area, depopulated area etc. When there is no price mechanism working, service supply system will behave in very complex style. We will examine next.

Table 13a - Supplier of three kinds of care facility

Kind of facilities	Total	Prefecture	Municipal	Private Sector	M A*	No. of Sites	(%)
Special Nursing Home	4463	79	487	3892	---	298912	46.2
Health Care Facility	2667	6	140	422	2003	213216	32.9
Medical care house	3862	3	159	---	2774	102996	15.9
Total	10992	88	786	4314	4677	648559	100

MA*=medical agency (Ministry of Health, Welfare and Labor)

Health care facility is supplied mainly for rehabilitation after medical care or chronic disease. Medical care house is almost a part of hospital to supply beds for care after acute treatment for elderly. These parts are newly supplied facility services for long-term care service. Supplier of these facilities comes from almost medical field. They can use their beds for medical purpose and long-term care use to get insurance as well. As a result, owing to start of long-term care insurance, sites of care facility increased twice, but most new sites came from medical sector. So, one of purpose of introduction of long-term insurance may have been to secure the surplus beds to be burdened by new system.

5.4. Home care service made progress?

To promote home-care service is the most important target of long-care insurance.
As to home care service supplier, we can show in the following table. (Table 13-b). One of the main purpose of long-term care insurance was "to create user-oriented system in which necessary services are received through an unified comprehensive procedure by reorganizing the current inconvenient system in which welfare services and medical care services require different procedure for receiving services.

Formerly, such kind of home care has been supplied by each municipality's policy and financial support. They have been ad hoc existence, and service standard were very different according to municipalities" (**10**). As to the facility services, supply has increased according to join of medical facilities as we looked at table 13-a, but, the most big impact and change by this reform came for the home care side.

Table 13/b - Supplier of the main home care services (%)

Services	No. of facility	municipality	SWA*	Medical	NPO	CO-OP	Private Co.
Home Help	9833	6.6	43.2	10.4	2.1	4.6	30.3
Home visit Bathing	2269	8.6	63.5	2.6	0.4	0.9	23.1
Home visit Nursing	4730	5.1	10.4	53.3	0.3	4.3	6.0
Day Care	8037	22.2	66.0	4.2	1.3	1.1	4.5
Medical Day Care1	2538	5.4	15.7	73.2	---	---	3.6
Medical Day Care2	2273	2.0	---	70.3	---	---	0.2
Short Stay Care	4515	13.5	84.3	0.8	---	---	0.6
Medical Short Stay1	2616	5.5	15.5	73.3	---	---	3.7
Medical Short Stay2	2035	4.8	---	72.3	---	---	0.3
Service for Dementia (Group homes for elderly)	675	3.6	37.5	31.1	5.5	0.3	21.2
Rental and Purchase of allowance for welfare equipments	2685	1.6	8.3	2.6	0.5	3.6	82.6

SWA*=Social Welfare Association; Third sector which municipality supports financial conditions.
Medical1=service to be supplied by health care facility, Medical2=service by medical care house.
(Ministry of Health, Welfare and Labor; "Overview of Long term care service facility. Dec. 2000")

New system made it possible to choose some kind of services combining for user's sake, and buy through contract with suppliers. Moreover entitled payments for home care services are more expensive to attract private sectors here. Market mechanism works mainly in the urban areas because transport cost for service supplier is cheaper, on the contrary, in depopulated areas where ratio of aged is high and live separately, private sector find difficult to work efficiently. Social Welfare Association which has been the third sector to support welfare administration works in such areas. After long term care insurance, private sector, SWA, medical institute and NPO, Cooperation increased their activities on care market. Their fields are different according to kind of services as well as environmental conditions. As table 13-b show, character of their suppliers is different. Newly appearing NPO shows that they are trying to promote group home for dementia. So, we can look that such organizations as NPO or informal sectors find their activities in the newly appearing areas.

5.5. Towards diversification of Supply

We can compare financial trends between the first year of 2000 and the second year of 2001 using some estimation. In 2000 fiscal year, total expenditure was 3.95 trillion yen in which two thirds were used for facility care and one third was used in home care purposes. (Table 14) In 2001 former half fiscal year, this ratio shifted a little to home care, which increased its ratio from 32.7% to 36.6%.

In order to estimate the yearly growth, we will use half years' average monthly number plus latter halves' 5 % increase number. So, growth rate index will be (2001 half year number x 2.05) / 2000 year number. We can guess total account of service supply in 2001 will become 4.58 trillion yen.

Table 14 - Supply of the home care services and facility services (billion yen ,%)

Services	2000year supply		2001(half year)		growth rate
	Total	ratio	Total	ratio	index *
Home Help	290.1bil¥	7.3%	199.9	9.0	141
Home visit Bathing	40.7	1.0	23.5	1.1	118
Home visit Nursing	101.3	2.6	55.4	2.5	112
Day Care	311.0	7.9	191.4	8.6	126
Medical Day Care	249.4	6.3	138.7	6.2	114
Short Stay Care	75.3	1.9	51.4	2.3	140
Medical Short Stay1	21.8	0.6	15.2	0.7	143
Medical Short Stay2	2.4	0.1	2.0	0.1	171
Service for Dementia (Group homes for elderly)	15.8	0.4	16.2	0.7	210
Rental & Purchase for welfare equipments	33.5	0.8	31.8	1.4	194
Total (home care)	1294.1	32.7	816.8	36.6	129
Special Nursing Home	1167.2	29.5	621.5	27.8	109
Health Care Facility	928.8	23.5	486.3	22.2	109
Medical Care House	563.4	14.2	298.8	13.3	109
Total (facility service)	2659.4	67.3	1416.4	63.4	109
Total	3953.5	100	2233.2	100	116

* 2001half:x2.05/2000year

Here, we can find that though for this one year, facility care's supply increased about 9%, but home care service increased about 30 %. Growth index shows that many kinds of menu show different growth rate. Especially, supply to get allowance for rental and purchase of welfare equipments increased 194, and service cost of group home for dementia is one of most increasing items. Through market mechanism, such diversification appeared in home care services. It will become important for public sector or NPO to evaluate whether it will mean to promotes users' welfare and carers' well being.

6 - CONCLUDING REMARKS

New Japanese long-term care reform includes many kind of social experiments which will be able to transform the whole social, economic, administrative systems. Here , we would like to point out some examples to suggest future society including elderly to be respected. When Japanese people has made effort to pursue mainly economic purpose, they adopted “unconscious neglect” or “ignorance as something which is part of the constitution of policy”) for the long-term care problem as policy issues (**11**). Family and hospital took care of them in traditional manners. But after start of the long-term care insurance, society became aware of it and decided to share certain percent of GDP (now near 1%) for new system. Such emerging field has a lot of possibilities to activate various kind of agencies. We examine some examples as concluding remarks.

1) From vested interest to frontier employment; recently Japanese construction industry kept serious depression owing to decrease of public works. I introduce here two reports from newspapers; one is titled as “builders reluctant to be nurses”(**12**) which inform that cut-back of public-work programs in rural areas obliges construction workers to serve for welfare sector; another informs that one big construction company which recently bankrupted decided to change their employees’ job to serve elderly and began training for service. These cases suggest that role of public sector at recent depression is quite different from Keynesian era. It must become enabler to promote workers’ empowerment for new environment.

2) To promote the home care services was the main target of long-term care reform in Japan. We found that many kind of home care services already appeared and increased in care market. Such diversification may have brought some convenient situations for users and carer to improve their life. Market works very fiercely to attract resources through economic and financial motivations. (Moreover, it succeeded in exploring care works open from private stigma.) By freeing care works from administrative placement to market system using price mechanism, so many kind of agencies have joined that public sector could not grasp total process for the users and in the regions. Because, when care manager admit care plan and users buy services from market, market claims payment from central health fund using computer network.
   Recently, one group home are suspected as claiming injustice payment, it collected 50 dementia elderly and only gave meals. They said it was extension of home care (**13**).

Entitlement of payment of insurance is bigger than residential care and sites of care home have a lot of waiting list. Even if user or user's family decided to use such imperfect "facility", local government has no information and finds difficulty to order improvement. Some NPO are making evaluation of care suppliers. They are substituting public function of local governments by making clear information of care facilities. (Though care managers are key person for users, their role are very limited in Japanese system).

3) We think the role of market system is important to utilize resources efficiently in many fields, so it works even in bounded conditions in which payment for care has rigid standard according to certificated need of care. But, when we combine such external condition with "the positive dynamics of internal self-organization"(**14**) . We can achieve more effective results for users and their families. Lastly, we would like to introduce one example of home care service which started at a local city. There has been a deteriorated shopping zone in central area, one doctor rented formerly famous store and opened day care center. They leave traditional architectures which elderly have been familiar with from ancient time (**15**). If such flexible fields are combined with care system of users, society will be able to achieve respect to the aged people.

Notes

(1) Stuart Kauffman, *Investigations*, Oxford U.P. 2000.

(2) Philip Haynes, *Complex Policy Plannning, The Government strategic management of the social care market*, Ashgate, 1999.

(3) Royal Commission, With Respect to Old Age; Research Volume 1, Chapter 6.

(4) OECD, *Health at a Glance*, 2001.

(5) Ministry of H.W.L., Annual report on Health and Welfare, 1999.

(6) National Federation of Health Insurance Societies, *Health Insurance, Long Term Care Insurance and Health Insurance Societies in Japan 2001*, 2001.

(7) Kaigo-sa-bisu Toukei-chousa Nenpou (Annual Report of Long-Term Care Service), 2002, p121.

(8) M. Nakao, "Kaigo-baburu--Komusun no kyosyoku" (Bubble of long-term care, vanity of Comson). BUNGEI-SYUNZYU, 2000. 12.

(9) National Federation of Health Insurance Societies, *Health Insurance, Long Term Care Insurance and Health Insurance Societies in Japan 2001*, 2001.

(10) Ministry of H.W.L*., Annual report on Health and Welfare*, 1999.

(11) Will Medd, Making (Dis) Connections: Complexity and the Policy Process? SocialIssues, No.2 .Nov. 2001.

(12) Financial Times, Sept. 25, 2001.

(13) Nihon Keizai Shinbun, Jan. 7, 2002.

(14) Tim Blackman, Complex theory and the new public management, Social Issues, No.2,Nov. 2001 (e-magazine).

(15) Nihon Keizai Shinbun, April 28,2002.