Reforms of Elderly Long-Term Care Insurance System in Germany and Japan - Focused on the Development of Community Services for the Elderly with Consulting and Support Functions -

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Introduction

Japan entered the 21st century with the prominent social trends of low birth rate and ageing population. The challenge regarding long-term care arose with the increasing number of the elderly who needs medical and social cares, attracted much attention and it became one of the biggest issues to consider in the latter half of the life for every older person in the country. This phenomenon is happening not just in Japan but also globally, especially in most of the developed countries. The governments are trying various ways to deal with this; Germany introduced long-term care insurance in 1995 that focuses on a social insurance model. The United Kingdom and the Northern European countries, including Sweden, employ tax-funded public service as its main provider with NPOs playing a certain roles, while the United States relies heavily on the market mechanism. The techniques and methods for assessment of needs and the care management that meet the needs of the elderly have also been developed against these backgrounds.

The present paper aims to explain and comment on the Japanese long-term care insurance system, its social background, the structure and the features of the services, drawing comparison with the recent trends in Germany. It also attempts to provide the mid-term vision for the Japanese system, based on the sustainability and on-site practical knowledge.

Among others, the revision of long-term care insurance law in 2005 in Japan, as well as the German long-term care reform of 2008 highlighted the need of the systems to function in a sustainable and balanced manner, the need for popularization of comprehensive community services, including dementia care, and collaboration with preventive system. The increase of the elderly population living alone and/or with dementia, along with the rapidly ageing population of large cities are imperative challenges.

In the era of rapid social and economic changes domestically and internationally, including the polarization of society with higher numbers of jobless, these reforms and supports clearly identify the roles of long-term care, medical care, pension, and employment systems in social policies and measures, which will contribute to creating more cohesive social policies.

1. German long-term care insurance reform in 2008 (Pflegereform 2008)

1-1

Preceding Japan, the long-term care insurance law was enacted in 1994 in Germany with the gradual implementation from 1995. The law went through several revisions and in 2008, a major reform (*Pflegereform 2008*), including a gradual increase of benefit payments and provision for more thorough care for dementia, was introduced. As in Japan, Germany faces challenges such as tight budgets for long-term care, increase in the numbers of elderly with dementia, and lack of care services and human resources. Though there are considerable differences, including the collection of contributions, the provision of cash benefit as well as the scope of the benefit recipients, the trends in the German reform provide a valuable suggestion for Japan to investigate its future long-term care insurance system.

As for the running of the long-term care insurance system, the care management function has been playing a significant role in Japan. On the other hand, in the original German system, the function equivalent to the Japanese care management was not clearly defined. Therefore, when applying for the benefits and services including long-term care, the elderly and their families were using the information providing service offered by the local authorities as well as consulting supports offered by care service providers. Several issues were pointed out regarding this situation, and the 2008 reform, which was implemented gradually from July 2008, created a consulting support and service coordinating function within the long-term care insurance system.

In this paper, an overall picture of the German long-term care reform of 2008 is firstly outlined and its issues are discussed. The focus is especially placed upon the newly created consulting support and service coordinating function, the care support centers (*Pflegestützpunkt*). After discussing its notable points and issues, we would like to move on to the investigation that seeks a favorable future of consulting support and service coordinating function in Japan.

1-2 The long-term care insurance reform in 2008 (Pflegereform 2008)

To cater for the ageing population and accompanying increase of the elderly in need of care, a major reform of the long-term care insurance system was introduced in Germany in 2008. The reform is focused mainly on the following areas; (1) benefit payment increase with focus on home care, (2) enhancement of information provision for the elderly in need of care and their families, (3) enhancement of comprehensive support for individuals with dementia, and (4) enhancement of the information provision regarding the quality of care-homes. To achieve these, the contribution rates were raised from 1 July 2008, to 1.95% of income (2.2% for those without a child). Especially notable points of the reform are explained further as follows:

(1) Increase of benefit payments

Monthly payments for care recipients will increase gradually till 2012. Table1 show the amounts given for individuals in need of care but who prefer to stay at home. Increase is most apparent in the benefits in-kind for at-home-care, compared to institutional care, with support enhancement of a shift from

institutional care, such as medical facilities, to homecare as well as an acceleration of benefit eligibility evaluation procedures.

Table 1 Benefit levels for benefits in-kind

Care level（Monthly：€）	Pre2008	2008 *	2010	2012
Ⅰ	384	420	440	450
Ⅱ	921	980	1,040	1,100
Ⅲ **	1,432	1,470	1,510	1,550

*Amount payable from 1 July 2008

** Payment for most severe cases remains the same at 1,980EUR per month

（Bundesministerium für Gesundheit: Gut zu wissen-das Wichtigste zur Pflegereform 2008, Juni 2008)

(2) Measures for dementia patients

Homecare benefits were raised for those with severe incapacity for everyday life, such as severe dementia patients and mentally disabled individuals. It was 460 EUR per year before 2008 but was raised to 100 EUR (basic benefit) or 200 EUR (severe cases) per month, resulting in 1,200 - 2,400 EUR annually. This applies to those dementia patients in institutional care as well, enabling the institutions to provide additional cares and activities with extra staff for the patients.

(3) Establishment of the care support centers (*Pflegestützpunkt*) as the comprehensive consultation provider

This will be discussed in detail in the later sections.

(4) Enhancement of nursing leave

Those who work at a company with more than 15 employees are entitled to nursing leave for up to 6 months. Though the salary will not be paid during this period, the social benefit entitlement will continue.

(5) Improvement of care quality

A federal level of quality improvement measure (Expertenstandards) was introduced and care quality assessment was enhanced.

Every institution is obliged to accept a yearly inspection without notice. The resulting quality assessment report is published on the Internet, at the institution and *Pflegestützpunkt*.

The reform also includes guaranteeing of care workers' wages, support enhancement of self-help groups and volunteer activities as well as enhancing prevention and rehabilitation.

1-3 Notable points and issues of the reform[1]

The most notable and welcome point of the 2008 reform is the strong preference for homecare over

[1]The notable points and issues regarding the German long-term care reform of 2008 sums up the response of a questionnaire, sent to academics and care work practitioners in Germany by the author.

institutional care. Most of the frail elderly, in Germany or in Japan, want to continue living at their own home as long as possible. Promoting home care is also financially favorable compared to institutional care. However, it is not clear at this point whether the care quality and quantity required can be achieved, and further improvement may be necessary.

There is also a positive advancement regarding the benefit amounts for individuals with dementia. However the care service provision in terms of quality and quantity is not sufficient and it is imperative that measures are put in place to train qualified caregivers.

The biggest challenge is the finance. Demographic changes and the increasing number of individuals needing care will certainly reduce the contribution income and push up the cost. The long-term care insurance system in Germany was conceived originally as a partial insurance, rather than intending to cover all the living costs of the recipients. It is not clear at this point to what extent the long-term care benefit can cover the cost in future, and personal provision will become more important.

The possibility of a support system other than the social insurance provision, such as community-led services and volunteering, needs to be investigated as well. The ultimate goal is to make sure the frail elderly stay and receive care at home till the last possible stage, without becoming dependant on the public assistance. This in turn enables a comparative reduction of the cost over institutional care with increased quality of life for the elderly.

1-4 Long-term care insurance in Japan

Though there are considerable differences between the German and Japanese long-term care insurance systems, the German reform in 2008 provides several insights for Japan.

The first point is the issue regarding homecare services. The increase of the benefit amounts demonstrated the preference of homecare over institutional care in Germany, but this should not be taken just as a cost cutting measure to control expensive institutional care. The challenge is to make it a really supportive measure for the elderly to continue to live at home and be cared for as they wish. In order to achieve that, it is necessary to secure the quantity and quality of homecare services as well as to provide various out-of-the system services in order to meet the variety of needs of the elderly. So, establishing a function that collects and provides the information regarding long-term care, that also organizes the actual care effectively and efficiently, combining the services within and outside the official system, will become more important. The comprehensive community support center, which will be discussed in detail later, will be expected to play an important role here.

The second point is regarding the measures to cope with the increasing number of elderly with dementia. The benefits for those who have severe incapacity for everyday life including the elderly with dementia were significantly raised in the German reform. It is a welcome move; however, securing sufficient number of qualified staff is necessary. The issue of the elderly with dementia is becoming widely reported in Japan, but there are still many cases where the burden of caring for such individuals falls solely on the families. It is imperative to improve the dementia care system so that it offers easy-to-use services.

Financing these cares is the biggest challenge for both countries. Increasing numbers of the elderly and the individuals in need of care will put larger pressure on care budgets that both countries need to

address urgently. A reform that takes the cost effectiveness of the services into account is inevitable but the situation where necessary care is no longer provided for the individual in need of such care must be avoided. In the German reform in 2008, both the contributions and the benefit provision were raised at the same time. Its financial outcome as well as the long-term trends such as improvement of the life of the elderly in need to be monitored and analyzed carefully in future.

2. The consulting support and service coordinating function for the elderly in Germany

Under the reform in 2008, *Pflegestützpunkt* (care support center) were newly created as the comprehensive service provider for the elderly in need. Here, the background of establishing such a service and its overall function are summarized and its notable points and issues will be discussed. From there we will further provide some opinions regarding how consulting support organizations such as comprehensive community support centers in Japan should be run.

2-1 Establishment of the *Pflegestützpunkt* (care support center)

Traditionally in Germany, consultation and organizing the services for the elderly in need and their families were offered by municipal information service and care service providers. However, this was deemed to be unsatisfactory. The collaborative link between the municipal information service and the care service providers was weak and there was qualitative variability among the municipalities. The care service providers tend to work for their business interests. And the consultation for support had a too narrow scope. To counter these problems, *Pflegestützpunkt*, a 'one-stop-shop' for information, consultation, and service coordination was established. Following is a summary of *Pflegestützpunkt*. However, being a federal republic with a large part of the power lying at the state level, it is the states which decide matters concerning *Pflegestützpunkt*, including their establishment, thus there are wide regional differences.

(1) Function

Pflegestützpunkt offers comprehensive consultation to the elderly in need of care and their families. It also coordinates, organizes, and arranges long-term care, medical care, and official aid and other support services.

(2) Consulting support service

From January 2009, all individuals in need of care became legally entitled to access the care consultation (*Pflegeberatung*). All the municipalities are now obliged to offer those individuals comprehensive care support service; however, it is up to the individual whether to use this service or not. The care consultation includes provision of information regarding local care services inside and outside the long-term care insurance system as well as organizing and coordinating a comprehensive service package. Consultation is given by a care advisor (*Pflegeberater*) stationed at *Pflegestützpunkt*. The qualifications of a care advisor are not clearly defined, but social workers, geriatric caregivers and nurses are considered appropriate candidates and a senior level case management course is being set up. Related

organizations such as social workers institutes produced a shared guideline that requires the care advisor to have advanced expertise on case management, with on-site experience of at least one year after obtaining a qualification from a specialized higher education course.

(3) Configuration

Pflegestützpunkt makes it a principle to be neutral and independent, but it is allowed to be set up as a part of the existing consultation support organizations and care service providers.

2-2 Notable points and issues regarding *Pflegestützpunkt*

Notable and welcome points for setting *Pflegestützpunkt* are as follows: (1) Individuals in need of care and their family can solve problems regarding the provisions of health, long-term care insurance, and other related services at a one-stop organization. (2) The same dedicated care advisor continuously looks after a care recipient enabling comprehensive planning, coordination, and follow-up of the services, which in turn mitigates the burden of the care recipients and their family. (3) Comprehensive planning for each care recipient is expected to have a positive effect toward rationalizing limited budgets. (4) Care advisers at *Pflegestützpunkt*, in principle, do not belong to any care service providers, enabling avoidance of influence peddling.

With the establishment of care support centers, the support for service activities run by volunteers was enhanced. As a worsening of the insurance finance is expected in the future ageing society, enhancement of variety of services that do not depend on the social insurance is necessary. It is expected that *Pflegestützpunkt* will collect information about and coordinate various services including self-help groups and volunteer services outside the official benefits as well as playing a role in promoting and creating new services.

Meanwhile, problems are apparent too. First, it is up to the users whether they use their care consultation entitlement or not, thus it is unknown at this point how many people would take up the service and how effective it is. Since it is expected that the set-ups and management format of the centers would be varied, it is also difficult to verify the effectiveness of the operation in terms of promoting homecare and lessening the family burden. Though it is expected that enhancing at-home long-term care would reduce cost, setting up the new support centers, as well as increasing provision of the benefits owing to the increasing number of elderly clients would push up the cost considerably, thus financial outlook in future is still severe. And if the take-up of the care consultation entitlement is low, the expected effects, such as the mitigation of care recipients and families' burden and efficient use of services, would be generally low. The challenge is the actual functionality of *Pflegestützpunkt* and promotion of its existence to the would-be users.

2-3 The consulting support and service coordinating function for the elderly in Japan

In Japan, care management/care managers play a core function in consulting support and service coordinating. The German initiatives such as independent consultation, unified provision of information and service coordination, and introduction of a higher qualification path for care advisors with courses that

place importance on interpersonal support techniques as well as basic qualifications, should be watched carefully, since there are considerable benefits that Japan might be able to adopt in realistic ways.

In addition, the German initiative of *Pflegestützpunkt* may also give us some ideas regarding the comprehensive community centers of Japan that is currently functioning as the comprehensive consultation service for the elderly in need. In order to run care services within and outside of the long-term care insurance system efficiently, effectively, and responsively to the needs of the users, it is firstly necessary to form a close collaboration between consultation services, care planning entities, and care service providers. As the independent comprehensive consultation organization, the comprehensive community support centers can play an important role. Since there is a limit as to the extent of services the long-term care insurance system can offer, and since further budget tightening is expected in the long-term care area, it is clear that new services that do not rely on the system, such as volunteering and community specified services, will become more important. Development and coordination of such new services is one of the priorities that the comprehensive community support centers should address.

3. Main points of the Japanese reform of the long-term care insurance system and its development

3-1 Strategic viewpoints of the reform

The basic standpoint of the revision of the long-term care insurance (June 2005, in force from April 2006) is long-term sustainability; to create a system that functions continuously in a stable manner, taking the 2015 problem into consideration8) when the whole baby-boomer generation reaches retiring age. One of the biggest challenges is to change the system toward a more prevention-oriented one, and it is imperative to create a system in which the elderly lead healthy and active lives for as long as they can. At the same time the system needs to be able to cope with new challenges such as the increasing number of the elderly living alone or with dementia and the rapid population ageing of large cities8).

3-2 Shift to a prevention-oriented system

The linchpin of the reform is the ‘shift to a prevention-oriented system’. Looking through the 5 years trend since long-term care insurance was introduced in 2000, prominent increase of the elderly in need of care, who were registered as having relatively mild impairment, is observed 9).

With rapid ageing of the society as the background, the class 1 insured, who are over 65 years old, increased from 21.65 million, when the insurance started, to 25.16 million (as of April 2005). The number of the elderly registered as in need of care or support also increased by about 2 million, from 2.18 million (April 2000) to 4.11 million (April 2005) among which the biggest increase was of those with relatively mild impairment with ‘need of support’ and ‘need of care level 1’ categories. The total number of elderly who use the service doubled from the original 1.49 million to 3.23 million, showing that the system, which started in April 2000, is now well established in the society after 6 years.

With the increase in the use of the service, the cost of long-term care insurance almost doubled from 3.6 trillion yen in 2000 to 6.8 trillion yen in 2005 showing more than a 10% increase every year. The amount of the contributions is revised every 3 years and as the result of the increase in the service users,

the amount of class 1 contribution (contribution collected from those over 65 years old) jumped 13% from the first phase (2000-2002) to the second phase (2003-2005) with the national average of 2,950 yen per month, which further increased in the third phase (2006-2008) to 4,090 yen per month. It was calculated as approximately 4,270 yen per month for the fourth phase but settled to 4,080 yen per month (national average) by digging into the fund.

The definition, service contents and management of the so-called preventive measures benefit, which was provided as a part of long-term care insurance system for those registered as in need of support, was revised. New classification of support level was introduced and those registered as in need of support level 1 and 2 are now eligible to use the preventive measures care services.

3-3 Establishment of comprehensive community support centers and its issues

The elderly who live in a community have a variety of needs and problems. An increasing number of them living alone and/or with dementia (including early onset Alzheimer's and mild cognitive impairment), and new problems such as abuse of the elderly are emerging. The comprehensive community support centers are positioned to combat needs of these varied and complex elderly in order to function as the integrated consultation and support service provider 10) 11).

The main challenges that the comprehensive community support centers face are how to provide the service to those who may need preventive measures; identifying the individuals who may be classified as newly introduced and unique-to-Japan support level 1 and 2, and helping them to maintain and improve their everyday life capabilities. The contents of the support care services are defined from the viewpoint of maintaining and improving everyday life, new programs were introduced and the existing program reviewed. In addition to the existing services such as day center, programs such as motor function exercises, improvement of nutrition, and oral care were included. The widening of the scope of the service recipient is being requested to include not just those registered as in need of support, but also those who are officially 'independent' but may be frail and in need of certain support and care coordination.

Since the enactment of the Elderly Health Law of 1982, the importance of prevention has been pointed out along with treatment and rehabilitation, and it covers a wider spectrum nowadays, such as health promotion and prevention, illness prevention and treatment, and care preventive measures. However, there are large differences between the municipalities in terms of community-based prevention and life support programs, and those municipalities who have traditionally run the care services focused and limited on the elderly in need of real care are now urged to change. Either way, in order that the elderly including those living alone and/or with dementia can continue to live in the familiar environment with individual needs met, the most important is to overhaul and promote the service management system so that it is comprehensive and integrated in the community.

The comprehensive community centers firstly are to establish a prevention management system that is consistent and continual, that provides service to the elderly before they become registered as in need of support or care, and staffed by social workers, public health nurses, and chief care managers. In order to secure independence and fairness for service recipients as well as for the provider, the center management committees will run the service, of which the members are to be the municipality, community service

providers, and the representatives of the insured.

The comprehensive community centers are also to provide comprehensive consultation, work as the advocacy of the rights and entitlement, and create local networks as an independent organization 10)11), and, as with any new organization, such developments need to be monitored.

3-4 New type of approach – introduction and popularization of community-based services

In order for the elderly to continue their life in a community with which they are familiar, it is important that various services be offered at the village/town/city level12). For this reason, community-based services including such initiatives as small-scale multi-functional care, nighttime home-visit care service, group homes that are able to care for dementia patients and specially designated small-scale nursing homes were introduced. In principle, these services are available for the resident of any village/town/city as a rule and price are set at the village/town/city level. Approval procedures of the care care service providers have also been left to the village/town/city since April 2006.

With the introduction of the definition of 'everyday life area' set out in the third phase of the long-term care plan, village/town/city authorities need to enhance concrete measures taking new viewpoints and local needs into consideration.

The focus of the fourth phase plan, that covers the timescale of April 2009 onward, is the popularization of the community-based service, with a part of management criteria regarding small-scale multi-functional care and night-time home-visit care service amended in view of a 24x7 care approach.

3-5 Practical issues and quality improvement of group-home care

Since the introduction of the long-term care insurance, group homes for the elderly with dementia have been rapidly established with 9,800 facilities as of December 2008. They are playing a very effective role as social resources supporting the elderly with dementia and their families, and have been highly praised from several fronts, including overseas specialists, at the 20th Alzheimer's Disease International Conference held October 2004 in Kyoto. However, problems regarding the running of these group homes have become apparent recently, such as misconduct of staff and fire involving loss of lives (Nagasaki prefecture and Sapporo city).

Except for certain areas, the quantity of group homes is being fulfilled, so the improvement in quality, as well as the diversification of management configuration, is the challenge now. One of the examples of quality improvement initiatives is the support for the residents at terminal care stages. From April 2006, payment for such care was increased as well as the pay for the night-shift staff.

3-6 Residential care: promotion of unit care and reorganization of institutions

As a part of the long-term care insurance system reform, a new type of specially designated elderly care homes were introduced from 2003, and the unit care initiative (small scale residential care) is well underway. There are three types of residential care facilities for the elderly within the system and each of them has its own management challenges.

(1) Specially designated long-term care facility: the immediate challenge is to enhance the capability of providing sufficient terminal care, as well as to introduce and implement unit care approach.

(2) Long-term care and health facility: focus should be placed upon enhancement of rehabilitation provision. The challenge for the service providers and related organizations is to establish the preventive measures and short-term intensive rehabilitation services.

(3) Long-term care and medical facility: As the medical care structural reform is underway, the Ministry of Health, Labour and Welfare is proposing to create convalescent wards in general hospitals (December 2005), with a view achieving that by 2012. The basic purpose is to mitigate so-called 'social hospitalization' (hospitalization of the elderly for non-medical reasons), with the introduction of clear classification of medical treatment and long-term care.

As for the fourth phase (2009-2011), one that is drawing attention is the attempt to turn geriatric wards in hospitals into long-term care and health facilities. The challenge is to establish a care infrastructure and to set its direction in the community, including the development of aforementioned small-scale specially designated long-term care facilities as well as housing policies for the elderly.

3-7 Revision on residential care benefit: defrayment of accommodation and food costs by users and supplementary benefit

Up to now, the proportion of residential care users in the long-term care insurance system was approximately 25%, but the cost of financing such care exceeded 50%. In order to balance the burden of the users for homecare and residential care, as well as to adjust the long-term care benefits and pension provision, the costs for accommodation and food (cost of meals including the cost of preparation, and not just the cost of materials) at the long-term care facilities was placed outside the benefit and now users have to pay them. As for the accommodation cost, the revision aimed to redress the difference of the accommodation types (private room or dormitory) and as for the food, the cost of cooking food was added to the cost of materials. These extra costs of accommodation and food are settled between the user and the service providing facility.

As for the elderly who cannot afford to pay this extra cost, detailed measures are provided as a supplementary benefit. For example, those care users (applicants) in the insurance contribution class 1 to 3, the difference between the officially set ceiling, and the actual average accommodation and food cost (standard cost) of the facility is paid from the system as a supplementary benefit (specified long-term care resident service cost). The user cost mitigation schemes by social welfare corporations need to be utilized and popularized.

3-8 New aspects regarding the regulation of the agency service providers

As more and more varied entities come into the care providers' market, problems such as fraudulent claims are also increasing. With this in mind, the revised law includes clauses regarding information disclosure and reviewing of the regulations for the agency service providers, in order for the users to make appropriate choices and high quality service to be provided.

The agency service providers are now legally obliged to publish information regarding the service

contents as well as administrative performance so that the users can choose the appropriate care for themselves. The items to be disclosed include the features of the services, the costs, the physical features of the facility, and staff ratios. The one-way provision of the information can invite the manipulation of information, so the shift to a two-way interaction scheme is desirable where the requests and responses from the users are received and acted upon.

The regulation of agency service providers was tightened as part of the revision. When applying to be an authorized service provider, the application is now not accepted if the applicant or a board member has had his/her authorization withdrawn within the past 5 years. In the past, once the authorization was granted, authorized service providers could continue providing the services without renewal, but now, reapplication must be made every 6 years to eliminate sub-standard agency service providers.

4. Challenge for the future: service quality improvement and system stability

Several points regarding the future challenge of the long-term care insurance system are described below.

4-1 Service quality improvement and cultivation of human resources

Firstly, the issues regarding the cultivation of human resources, and staff education in order to improve the quality of long-term care services, must be addressed. Especially as for the care management, the pillar of the long-term care insurance system, the newly established 5 yearly renewal rule for the care managers and introduction of the chief care manager position is expected to improve the present situation.

Secondly, the issues regarding the home visit care, the central service in the non-residential care, must be addressed as follows in order to improve the quality; (1) identification of clear roles and responsibilities of service providers etc, (2) improvement in the quality of care workers (cultivation of human resources and staff training, positioning qualified care workers as its core), (3) identification of responsibilities and qualifications of managers in agency services providers.

Thirdly, the issues regarding the education and creation of the career path of the on-site care workers, who will play an important role in the promotion of the unit care approach in the facilities. Requirements on education and training to improve care quality have been often talked about in the past but they lacked clear consideration on the conditions of the work. It is essential, therefore, that the whole employment environment improve, including the worker's standard wage, as well as welfare and social security.

4.2 Restructuring of system of the long-term care insurance facilities

There are three types of residential care facilities for the elderly within the system; (1) Social and Nursing care Homes, (2) Nursing-care and health facility, and (3) Long-term care and medical facility. As for (3), with the medical care structural reform underway, the Ministry of Health, Labour and Welfare is proposing to create convalescent wards in general hospitals (21 December 2005), with the aim of achieving that by 2012. The basic purpose is to mitigate so-called 'social hospitalization' with the introduction of a clear classification of medical treatment and long-term care.

As for the fourth phase (2009-2011), one that is drawing attention is the attempt to turn geriatric wards in hospitals into long-term care and health facilities. The challenge is to establish a care infrastructure and to set its direction in the community, including the development of small-scale specially designated long-term care facilities that form a part of the aforementioned community-based care services and other residential facilities (private care homes, care houses, and dedicated rental accommodation for the elderly).

4-3 Sharing the burden in the mid to long-term future

The revision of 2005 also addressed the introduction of new contribution levels, taking into account the payment capability of the contributors, the enhancement of the power of municipalities (insurers), and the establishment of fairer assessments of individuals' care levels.

With the widening range of incomes in the 2nd tier of the contribution levels, it was divided in two to create the new 2nd tier and 3rd tier. It is important to note that the 'pay-as-you-can' approach became clear, with emphasis on the paying capability of the insured.

Also in the revision of 2005, the contribution collection system was improved, with the convenience of the users in mind.

Amalgamation of villages, towns, and cities continued during 2000 to 2010, and that must have enhanced the care infrastructure of the insurers (municipalities). Strengthening of the functionalities of the insurers, the managing entities of the long-term care system, on such issues as designation, guidance and monitoring of aforementioned community-based care services, as well as the stability of the infrastructure, all are of the utmost importance.

The trust in the nation's social security system, which has traditionally leant heavily on the social insurance method for its pension and medical insurance, has been shaken lately and new approach to funding is urgently sought.

Conclusion: From the structural viewpoint of long-term care for the elderly

From the background of the introduction of the long-term care insurance and the recent revision, it is important to raise issues from the structural viewpoint13) that can be summarized as follows.

Since around the time of the introduction of long-term care insurance in 2000, the tendency is emerging to cram all kinds of problems that affect the elderly into the terminology 'care need', especially among the government administrations and care experts. That in turn has created the mindset of creating more and more services for the elderly 'in need of care', that again, in turn, rationalizes the agency care providers' sub-standard behaviors including fee-for-service system and maximization of profit. In order truly to support the elderly socially and generally, with elimination and correction of the sub-standard service providers, as revealed in the 'Comson scandal' in 2007, the following points need to be addressed.

(1) Health promotion as a national value (Healthy Japan 21)
(2) Promotion of preventive healthcare with primary care as its core and streamlining of medical costs (reducing of long hospital stays)
(3) Unification of homecare and community-based care (catering for the everyday life needs of the elderly = introducing the viewpoint of stay-at-home care)

(4) Promotion of concrete preventive measures (development and popularization of health promoting, illness prevention, care-dependence prevention programs)
(5) Limiting and restructuring of residential care facilities (clear classification of care, medical, and residential facilities)
(6) Enhancement of accommodations for the elderly (specialized accommodation units for the elderly and group homes)
(7) Consolidation and localization of related policies based on improving QOL (improvement of residential environment, including the town planning level)
(8) Securing the human resources with care workers as its core and creating a career path for them
(9) Supporting the low income bracket elderly and reducing their charges & premium.
(10) Supporting Victims by Big earthquake of Eastern Japan in March 2011. especially Elderly, Children and Disable persons.

Though the vision for 2015, when the baby boomers enter the age of retirement, is getting somewhat clearer with the securing of the mid-term stability of the long-term care system, we cannot be optimistic for the long-term future. We need to look carefully, along with the reforms of medical insurance and pension systems, into the strengthening of the social security structural reform as well as mid to long-term financing, including the possibility of raising consumption tax rates and restructuring of ring-fenced welfare tax etc. A reform agenda with the keyword, 'constructing comprehensive community care system' will be tabled in 2011, which is expected to be introduced in the fifth phase starting April 2012, following the amendment of the law.

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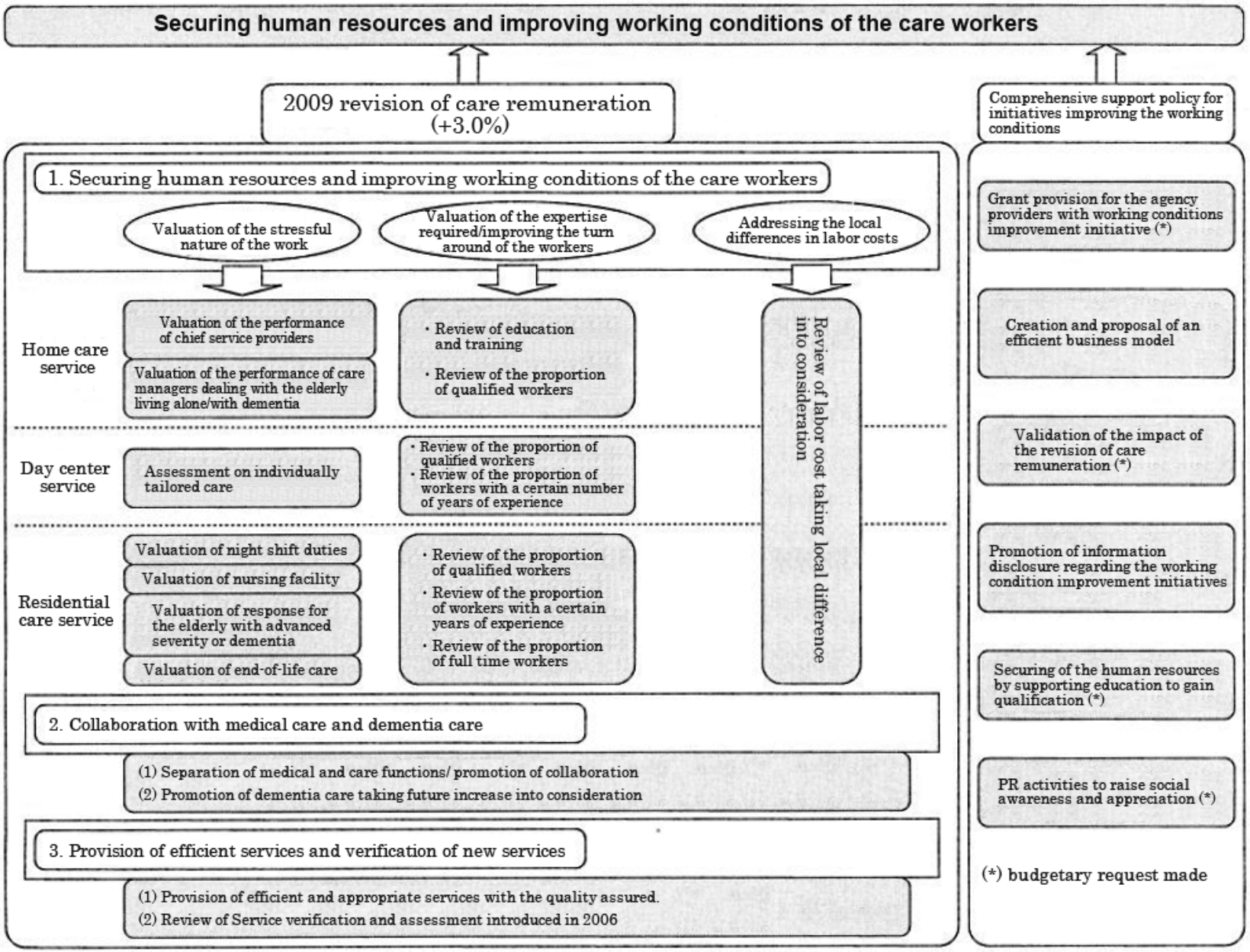

Source: The Ministry of Health, Labor and Welfare, December 2008