GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Japan

Long-Term Care In-Kind Benefit Plan Details

2000-2022

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

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Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023 – 2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Japan

In-Kind Benefits

Plan details 2000-2022 * †

Long-term care (LTC) services are provided to persons with care needs by municipal governments through in-kind benefits, although family-based care is the dominate form of care. Before 2000, public LTC services were primarily provided to persons of limited means by municipalities through institutional care. Care access and cost were largely determined by the municipal government.

Universal LTC Insurance was introduced in 2000. This system guarantees access to LTC benefits and enables elderly to receive care services of their choice. An assessment of care needs based on an applicant's physical and mental status determines an approved care level. Based on approved care levels, persons may receive care from public and private LTC service providers, up to a maximum benefit level. Support and care services may include residential, semi-residential and at-home care. All LTC Insurance benefits are provided in-kind (i.e., there are no cash benefit options).

Since the introduction of LTC Insurance in 2000, the Japanese LTC system has been subject to two major policy reforms, which included the introduction of preventive LTC benefits in 2006 and creation of municipality operated "Comprehensive Program" systems from 2014 that promote the development of services aimed at keeping persons in the community as they age rather than using LTC insurance services.

Key Dates

First law: 1963

Major changes since 1992: 2000, 2006, 2014

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* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

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Chapter 1: Background on long-term care policy prior to 2000

Editor's Note
The Japanese Universal Long-Term Care (LTC) Insurance system was enacted in 1997 and began in 2000. Prior to 2000, LTC for the elderly in Japan was characterized by family-based care or services provided by Japanese prefectures and municipalities based on need, where availability of government services and costs varied at the local level. Since the Japanese Study for Aging and Retirement began in 2007, well after the introduction of LTC Insurance, and given the difficulty of collecting local policy information from this period, this chapter deviates from the usual design of the *Gateway Policy Explorer Series* and provides historical background on the evolution of LTC services in Japan prior to the creation of the LTC Insurance system. The background provided in this chapter offers important context for the creation of the LTC Insurance system and subsequent reforms.

After the Second World War, Japan broadened eligibility for publicly-provided services for the elderly, first with the introduction of universal medical care insurance in 1961 (National Health Insurance Law, No. 192, 1958) and then with a national framework for an elderly welfare system in 1963 (Law on Social Welfare for the Elderly, No. 133, 1963) [1, 2]. The Health Insurance Act made health insurance coverage compulsory for the entire population, and healthcare for seniors was guaranteed either through the Employee's Health Insurance (EHI) or the National Health Insurance (NHI). The *Law on Social Welfare for the Elderly* created national welfare policies that included commitments to provide services for the aged promoting health and social participation and created options for home care and care facilities for the elderly [3]. These services were financed 50% by national government and 50% by prefectural and municipal governments [4].

The *Law on Social Welfare for the Elderly* provided an institutional framework for elderly home and residential care. It officially recognized three types of publicly financed elderly care facilities [2, Chapter 3]:

- Nursing Homes for the Elderly (養護老人ホーム), also known as *yogo*
- Homes for the Elderly with Limited Cost (軽費老人ホーム), also known as *keihi*
- Special Nursing Home for the Aged (特別養護老人ホーム), also known as *tokuyo*

Eligibility criteria for yogo included an applicant being at least age 65 and an evaluation of their financial situation, physical and mental impairments, and environmental conditions. Yogo facilities did not provide nursing care, and patients were generally independent with respect to activities for daily living (ADL) residing there mainly for economic and social reasons [4]. Keihi offered care services related to activities of daily living at a low fee to persons aged 60 or older. There were two types of keihi. The first type provided accommodations for elderly without families or for elderly who were unable to live with their own family. Their monthly income had to be less than one and a half times the average monthly operating cost per resident. The second type had less strict income requirements and access was guaranteed to those capable of independent living with legitimate financial reasons to request housing [5]. Access to tokuyo was guaranteed for applicants that were at least age 65 on the basis of their physical and mental condition, regardless of an elderly person's financial condition.[1] These services were introduced in an effort to reduce the burden of medical facilities for inpatient elderly care [7].[2]

The *Law on Social Welfare for the Elderly* also included home and community-based services, such as general services like elderly rest homes (老人憩いの家) and welfare centers (老人福祉センター) available to all the elderly to support their physical and mental health by providing them educational and recreational activities [2, Article 14]. Additionally, a home helpers service (家庭奉仕員) was introduced for single low-income individuals [2, Article 12]. The government would determine what service a beneficiary was to receive and assign user fees for facility care and home and community-based services according to the beneficiary's income —beneficiaries had little input in the type of care they received [7].

The steep rise in Japan's elderly population resulted in a significant increase in demand for these services. Municipalities experienced difficulties in securing sufficient financial resources to expand welfare programs resulting in the majority of long-term care services provided by the medical system [7]. This led municipalities to change their eligibility criteria, prioritizing access to nursing care facilities for low income users [8]. Elderly persons that had sufficient income to be precluded from these services turned to hospitals for care [4]. From the beneficiary's perspective, hospitals required a small fixed copayment that did not depend on their income level. After the revision to the *Social Welfare Law for the Elderly* in 1973, small copayments for medical care were eliminated for those at least age 70

[1] Although access was not income restricted, users paid monthly fees proportionate to their or their legal supporters' income [6].

[2] Article 29 of the Welfare Act provided for the creation of another type of facility —a paid nursing home (有料老人ホーム), also known as yuryo homes. Yuryo homes were defined as "facilities which continuously house more than ten elderly and provide them with necessary services for daily living, including meals, and which are not designated as welfare centers for the elderly" as defined by the Welfare Act [2, Article 29]. They were small-scale homes that did not receive public funds and were administered by philanthropic individuals, small groups, or nonprofit charity organizations. They usually hosted elderly with an income level exceeding the upper limit requirement for keihi homes. Since these facilities were not publicly funded, users had to finance their entire stay. No yuryo homes were constructed until the early 1970s. From 1982 yuryo homes were included in the National Retirement Housing Association. The Ministry of Health and Welfare did not recognize yuryo homes as welfare facilities and in 1985 there was no official administrative and management regulation. After 1991, the National Retirement Housing Association and the local authorities were empowered to evaluate yuryo homes' structural feasibility and prefectures attempted to more closely regulate these facilities. Yuryo homes have lost their original meaning over time, no longer reflecting the type of care these facilities initially provided [5].

and these persons were exempted from payment of out-of-pocket expenses [4, 9]. Small or no copayments are widely believed to have led to hospitals providing LTC services for a substantial proportion of the elderly population [10]. In 1980, while the majority of persons over age 65 years or older were cared for by family, hospitals were the second most common care location. The number of bedridden elderly was 438,000 of which 307,000 (70%) received family care, and 131,000 (30%) were hospitalized [11]. Between 1975 and 1990, the proportion of patients admitted to medical institutions doubled from 2% to 4% of the elderly population [7]. Short-term stay and day care services, established in 1978 and 1979 respectively, were still in an experimental phase and available from few providers across the country [11].

In the 1980s, the Japanese government made it a policy priority to reduce dependency on hospitals for elderly LTC. The *Law for Health and Medical Services for the Elderly* (Law No. 80, 1982), effective from 1983, introduced a series of funding reforms aimed at deterring use of hospitals for LTC including copayments for users (¥400/month for outpatient services and ¥300/day for inpatient services) and financial disincentives for hospital operators [12].[3] This law also provided for specific elderly-oriented care services including specific rehabilitation facilities for the elderly [4, 13]. In 1986, "Long-term care health facilities" (老人保健施設) were introduced as transitional facilities to support elderly transitioning from hospitals to their home [7]. In 1987, the Japanese Ministry of Construction and Ministry of Health and Welfare developed the "Silver Housing" project. "Silver Housing" referred to different housing projects providing elderly accommodation along with on-site care. Within "Silver Housing" accommodation, care was managed through the "Life Support System" administered by the "Life Support Advisor" (LSA). The LSA provided elderly "life support services" including assistance in emergency situations, regular health and safety checks, temporary housework assistance and consultation about daily matters [14].

By the late 1980s, it was clear to policy makers that Japan's elderly population was going to increase substantially in the coming decades and with it the age dependency ratio (the number of elderly persons relative to the number of working age persons). This demographic challenge was compounded by a low fertility rate, which meant that there would be fewer children per parent to provide old-age care. Consequently, the demand for elderly services and the financial burden was expected to increase substantially.

In 1989, the Japanese government announced the Ten-Year Strategy for the Promotion of Health Care and Well-Being of the Elderly, referred to as the Gold Plan (ゴールドプラン). The Gold Plan aimed to deinstitutionalize aged people and substantially increase the supply of home care, short-stay institutions, and day-service centers. Home care services became widely available in local communities, providing support centers and at-home nursing care. Short-stay institutions provided respite care and patients could stay up to one week. Day care centers provided meals, bathing and functional training for needy aged or physically disabled people [13]. In this period, the number of "Silver Housing" accommodations substantially increased, reaching 4,369 sites by the end of 1993 (in 1988 there were 131 sites) [14]. Municipalities were the providers of these services receiving reimbursement from user fees, the Social Insurance Medical Need Payment Fund or the Federation of National Health Insurance Associations. Municipalities assessed care eligibility and applicants could not freely choose care services.

In 1994, the Japanese government revised the Gold Plan with the New Gold Plan. This plan further increased the supply of elderly care services and redefined institutional care, short-term facilities, and home care. Three types of institutional facilities were provided [13]:

- Special nursing homes (特別養護老人ホーム): Eligible people were those aged 65 or older needing constant care presenting difficulties in living at home. National and local governments equally finance these facilities. Users paid according to their income level, bearing an average monthly cost of ¥20,000 in 1996 (¥20,827 in 2020, i.e. $190.87).[4]
- Long-term care health facilities (介護老人保健施設): Eligible people were age 65 or older requiring functional training, nursing, or rehabilitation. These facilities were funded by health insurance premiums (50%), the national (30%) and local governments (10% by prefectures and 10% by municipalities). User fees vary across facilities. The average monthly cost was about ¥50,000 in 1996 (¥52,068 in 2020, i.e., $477.17).
- Nursing homes for the elderly (介護利用型軽費老人ホーム): Eligible people are elderly and elderly couples' who can maintain independence with the help of wheelchairs, home helpers and other daily living services.

Home and community-based services provided during this period included [13]:

- Consulting support centers: Provided support to households with home care related problems.
- Short-term stay services (短期入所 系サービス): Provided respite care for households with bedridden elderly. In these facilities, patients could stay up to 1 week at a time, paying a daily fee of ¥2,000 in 1996 (¥2,083 in 2020, i.e., $19.09).
- Outpatient care (通所介護) – day service (デイサービス)/ Outpatient rehabilitation (通所リハビリテーション)- day care (デイ・ケア): Provided meals, bathing, and functional training. Users' fees varied from ¥500 to ¥700 per day in 1996 (from ¥521 to ¥729 in 2020, i.e., from $4.77 to $6.68).

[3] Reviewing multiple sources, we identified inconsistent copayment amounts across service types, potentially owing to when they were measured. Those reported in the text are from [13]. According to [6], patients are responsible for a fixed copayment of ¥800/month for outpatient services and ¥400/day for inpatient services

[4] All the currency amounts in this section are derived according to the World Bank Consumer Price Index for Japan of 101.269 as of 1996) and 105.458 (as of 2020) and converted to US dollars based on IMF-reported exchange rate of ¥109.12 per $1 for January 3, 2020 [15, 16]

- Home-visit long-term care (訪問介護): Provided at-home help assistants to the elderly and their families. User fees ranged from ¥500 to ¥700 per day in 1996 (from ¥521 to ¥729 in 2020, i.e., from $4.77 to $6.68) according to prefecture.
- Home-visit nursing stations (訪問看護ステーション): Consulting agencies that provided nursing assistance to bedridden patients with equipped operators and social workers.

The Gold Plan and the New Gold Plan created the LTC service infrastructure that was the foundation for the launch of the LTC insurance system in 2000.

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Chapter 2: Policy enacted 2000-2005

Policy change in 2000

The Japanese Long-Term Care (LTC) Insurance program was introduced in 2000 with four key objectives:

1. Reduce care burden on families
2. A more transparent relationship between premiums paid and benefits received
3. Greater integration of the systems for health, medical, and welfare services
4. Separation of LTC from health insurance coverage —reduce the number of "social hospitalization" cases where elderly with basic care needs were hospitalized

In order to accomplish these goals, the reform made significant changes to the LTC system. Mandatory participation in LTC insurance made access to LTC services universal and guaranteed. Municipalities became the insurers and collected premiums. The law provided a clear definition of LTC providers, type of services, and the price and coinsurance rate for those services. Additionally, the law created a classification of insured people, defined levels of dependence, and created a standardized eligibility certification process to determine the needs of LTC applicants.

Overview

Japanese public long-term care (LTC) services for the elderly during this time period consist of benefits from the LTC Insurance system that are coordinated by municipalities using a common dependency assessment system.

LTC Insurance (介護保険)

The Long-Term Care Insurance Law (Law No. 123, 1997), passed December 17, 1997 and effective from January 1, 2000, brought universal access to long-term care services. This system consists of two types of insured persons:

- Insured Type 1: Persons age 65 or older
- Insured Type 2: Persons age 40 to 64

Insured Type 1 persons are eligible for all LTC services covered by LTC Insurance. Insured Type 2 persons are only eligible for LTC services covered by LTC Insurance if they require care or support resulting from age-related disease and are covered by health insurance programs. Individuals may apply at any time and eligibility is determined by a two-step assessment system: applicants are first evaluated by an on-site 85-item questionnaire, then the automatic computer assessed level of care is reviewed by a group of specialists and physicians.

There are six levels of dependence in which an applicant can be classified. There is one level (Support Level) aimed at persons capable of living independently with supporting care. The next five levels (Care Levels 1 to 5) correspond to persons incapable of living independently that require assistance in activities of daily living (ADLs). Based on the certified level of care needed, applicants may access home care benefits, semi-residential care, and residential facilities.

The LTC system is financed 50% from mandatory premium contributions of individuals aged 40 and older and 50% by national and local government taxes. Coinsurance rates are fixed at 10%.

Municipalities are LTC insurers. LTC providers are local governments, semi-public welfare corporations, non-profit organizations, hospitals, and for-profit companies all of which are licensed and supervised by the prefectural government. In-kind benefits are not means tested, and are not subject to taxation.

Other LTC support systems

Other welfare policies exist for individuals with care needs that may not otherwise qualify for LTC insurance benefits. These include the Welfare Law for the Physically Handicapped, the Welfare Law for Persons with Intellectual Disabilities, and the Child Welfare Act (only for children with disabilities). The Welfare Support Fee system, introduced in 2003, guarantees access to LTC services for people with disabilities covered by these three laws.

This chapter provides policy details on the Japanese LTC insurance system. Some LTC support services are provided by the Japanese disability support system depending on age. We distinguish when certain types of care are not provided by the LTC insurance system but may otherwise be covered by the disability support system depending on its eligibility criteria. Policy details of disability support systems are not covered.

Statutory basis

Long-Term Care Insurance Law (介護保険法), Law No. 123, December 17, 1997, effective from 2000

Financing

Source of financing

The LTC insurance system is operated as a pay-as-you-go system and is financed 50% from premiums paid by the insured and 50% by taxes. Of the total:

- Premiums: 17% is paid by Insured Type 1 and 33% is paid by Insured Type 2 (Insured types are defined below) —the LTC insurance premiums are reviewed every three years according to the population ratio in order to balance the burden per person
- Taxes: 25% are from national taxes, 12.5% from prefectures and 12.5% from municipalities

Payment of LTC insurance premiums begins at age 40. LTC premiums are progressive and premium rates are revised every three years to maintain fiscal balance. Adjustments are based on each municipality's projection of LTC expenditures over the next period. Premiums vary according to a person's insured type, residence municipality and type of health insurance.

Insured Type 1 LTC Premiums

Insured Type 1 persons are age 65 or older who are covered by the LTC insurance. LTC insurance premiums for Insured Type 1 are collected by municipal governments. The premiums are a fixed amount based on the person's income level. Premium amounts are a multiple of the "basic amount" LTC premium rate. Income levels and Insured Type 1 premiums are displayed in Table 1. The "basic amount" for Insured Type 1 persons is revised every three years and is set based on each municipality's elderly population, the number of people requiring LTC, and the cost of services. Thus, premiums for LTC insurance vary across municipalities depending on how many services are available in each municipality and what services are in high demand.

Insured Type 1 Premium Collection Method

Insured Type 1 premiums are collected and retained by municipalities using one of two methods:

- Special collection: Premiums are deducted from pension benefits of ¥180,000 or more per year
- Normal collection: Premiums are collected directly by municipalities.

Normal collection is used when special collection is not feasible.

Insured Type 2 LTC Premiums

Insured Type 2 persons are age 40-64 who are insured by the health insurance system. Japanese health insurance systems can be grouped into Employees' Health Insurance (EHI) available to employees and their dependents through their employers, and the National Health insurance (NHI) for agriculture, forestry and fisheries workers, students, self-employed, part-time workers, retirees, and unemployed people not covered by EHI. Insured Type 2 LTC premiums are collected with premiums for healthcare insurance by healthcare insurers. For people insured with EHI, the amount of premiums is decided based on a standardized amount of salary multiplied by a long-term care premium rate (employers bears half of the cost). For people insured by the NHI system, the premium is determined by a person's income from the previous year in addition to a fixed per-person amount.

In general, the average annual premium for an Insured Type 2 person is the same as for an Insured Type 1 person.

Insured Type 2 Premium Collection Method

LTC premium is collected with the health insurance premium. Premiums collected for Insured Type 2 are pooled nationwide: they are collected by the Social Insurance Medical Fee Payment Fund, which then distributes them to municipalities. The Social Insurance Medical Fee Payment Fund is a fund to pay for the growth in benefit costs across Japan due to the growing ratio of elderly people and the expected decrease in future tax income. The mechanism to adjust for the financial disparities across municipalities is known as an "adjustment grant."

Premiums for dependents

Dependents' LTC premium collection varies according to their age:

- Dependents age 65 years or older are considered Insured Type 1 persons and pay the LTC premium to the municipality.
- Dependents age 40 to 64 years old are considered Insured Type 2, but the premium collection differs according to the nature of the primary insured person.
  - If dependent on an Insured Type 2 person, then they are covered by LTC insurance through the LTC premium paid by the primary Insured Type 2 person.

- If dependent on an Insured Type 1 person, then their premium collection depends on the primary insured person's health insurance.

LTC premium exemption
Some Insured Type 1 persons may be exempted from municipal taxes if they have very low income, receive public assistance, have a confirmed disability, or are surviving spouses with total income in the previous year of less than ¥1.25 million (as of 2002).

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

LTC insurance covers care needs related to limitations in activities of daily living (ADL), cognitive status and sensory status impairment.

Eligible population

Eligibility is divided into two categories:

1. Insured Type 1: Persons age 65 years or older
2. Insured Type 2: Persons aged 40-64 covered by a health insurance program (EHI or NHI systems). LTC Insurance benefits are limited to cases where a qualifying condition requires care or support resulting from 16 age-related diseases, namely:
    - Early dementia
    - Cerebrovascular disease
    - Amyotrophic lateral sclerosis
    - Parkinson's disease-related conditions
    - Spinocerebellar degeneration
    - Multiple system atrophy
    - Diabetic nephropathy, diabetic retinopathy, diabetic neuropathy
    - Arteriosclerosis obliterans
    - Chronic obstructive pulmonary disease
    - Degenerative joint disease with pronounced deformation of both knee or hip joints
    - Rheumatoid arthritis
    - Ossification of posterior longitudinal ligament
    - Stanochoria of the spinal canal
    - Osteoporosis involving bone fractures
    - Progeria
    - Terminal cancer

Benefit

Home care benefit

- Home-visit (在宅介護)
- Home-vists bathing (家庭訪問入浴)
- Home-visit rehabilitation (家庭訪問リハビリテーション)
- Home-visit nursing care (在宅介護)
- Welfare devices leasing (福祉機器リース)
- In-home medical care management counselling (在宅医療管理カウンセリング)
- Care service for the elderly with dementia (認知症の高齢者を相互支援するケアサービス)
- Care service provided in for-profit private homes for the elderly (老人ホーム等での介護サービス)
- Allowances for purchase of welfare devices (福祉機器購入手当)
- Allowances for home renovation (住宅改修の手すり)

Semi-residential care

- Short-stay services (短期滞在サービス)
- Day care services (デイサービス)
- Medical day care services (医療デイケアサービス)

- Day rehabilitation (一日のリハビリ)

Residential care

LTC facility-based services

People classified as Care Levels 1 to 5 have access to these benefits —

- Special nursing homes for the elderly (特別養護老人ホーム): Facilities where elderly people requiring medium to severe care live with physical care and life support
- LTC health facilities (介護老人保健施設): Facilities that provide rehabilitation to elderly people requiring nursing care and aimed to return to home
- LTC medical facilities (介護療養型医療施設): Facilities that provide medical care LTC services, including sanatorium-type wards, wards for elderly with dementia, hospitals with enhanced long-term care service provision

Medical care is not included in the LTC program but instead is offered under the national healthcare system.

Other benefits

N/A

Provision of care

LTC benefits are provided by local governments, semi-public welfare corporations, non-profit organizations, hospitals, and for-profit companies, all of which are licensed and supervised by the prefectural government. For-profit companies are not allowed to provide institutional care. Seniors with certified needs can use services from providers of their choice according to their preferences.

LTC services' fees are set by the government and revised every three years. LTC services' rates are based on a *units concept*: the government sets a number of units for at-home care, semi-residential and institutional care services, where a unit is equal to ¥10 with some regional variations. The number of units assigned for at-home and semi-residential care does not depend on the dependence level of the beneficiary, while the number of units assigned to institutional care is set according to the type of institution and individual's dependence.

The maximum monthly payment limit covered by LTC Insurance for home-based benefits are provided in Table 3.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

There are 6 levels of dependence according to the required caregiving time needed.

The lowest level of dependence is Support Level (between 25 and 31 minutes of caregiving time required a day). In these cases, the person typically lives independently but requires assistance with instrumental activities of daily livings (IADL).

The lowest level of dependence for people who cannot live independently is called Care Level 1. This level requires 32 to 49 minutes of caregiving time. In these cases, the person typically requires partial care for daily living and care for IADLs.

Duration of benefit

The duration of each care plan is provided by management care agencies. Care managers are expected to coordinate care service for the elderly depending on the dependence level assigned. Eligibility must be re-evaluated every two years or every six months for those with lower dependence levels, or as requested in the event of further decline in health.

Means testing

LTC Insurance benefits are not means-tested. Every eligible person has equal access to services regardless income level. In circumstances where LTC services are not covered by LTC Insurance, these services may be covered by other welfare systems related to disability. These services are often means tested.

Age requirement

There are differences in coverage of services by LTC Insurance:

- People age 40 to 64: Only LTC services required for conditions resulting from an age-related disease

- People age 65 and older: All LTC services are covered

In circumstances where LTC services are not covered by LTC Insurance, these services may be covered by other welfare systems related to disability.

Care needs assessment

Definition of dependence

There are 6 levels of dependence, including Support Level and Care Levels 1 to 5. The levels are based on the needed caregiving time. Individuals classified as Support Level or Care Levels 1 to 5 are eligible for benefits provided by LTC Insurance.

Not certified

People determined to need care less than 25 minutes per day are classified as "not certified." These persons are not eligible for LTC services from LTC Insurance, but may be eligible for preventative LTC services offered by the applicant's municipality such as a care plan for future preventive LTC.

Support Level

Support Level, the lowest level of dependence for Preventive LTC, is a classification for persons needing 25 to 31 minutes of caregiving per day. At this level a person's ability to perform activities of daily living (ADL) is slightly reduced and support is required.

Care Levels

There are five Care Levels. All require the applicant being incapable of living independently, requiring assistance in basic ADLs. The lowest level of dependence is called Care Level 1, which includes people requiring 32 to 49 minutes of caregiving per day. Care Level 1 is defined as needing partial care for ADLs and there is a general decline in comprehension. Care Level 2 includes people needing 50 to 69 minutes of caregiving per day, requiring more help with ADLs in addition to the previously mentioned limitations. Care Level 3 includes people needing 70 to 89 minutes of caregiving per day, thereby requiring additional help with IADLs and ADLs relative to Care Level 2, and the individual requires intensive care. Care Level 4 includes people in need of 90 up to 109 minutes of caregiving per day and Care Level 5 includes people needing 110 minutes or more of caregiving per day. Care Levels 4 and 5 require regular care for ADLs and IADLs, with the distinction between level 4 and 5 being primarily determined by the effort required to provide the needed care. There is typically limited comprehension at these dependency levels.

A brief summary of dependence levels by their eligibility criteria and monthly payment limit for home-based benefits can be found in Table 2.

Evaluation of dependence

An insured person applies for LTC benefits through their municipality. The applicant has a two-step evaluation process: an on-site assessment based on a standardized questionnaire is performed, followed by a review of the on-site assessment by a certification board that considers additional input.

On-site assessment

Applicants for LTC benefits submit an application to their municipality of residence. An on-site assessment is performed based on a standardized 85-item questionnaire. The questionnaire considers ability conduct ADLs, cognitive status, and sensory status. The assessment forms are processed by a computer program that automatically classifies applicants into a dependence level.

Assessment conference (Nursing Care Needs Certification Board)

The computerized care level classification is reviewed and, if necessary, revised by an assessment conference. This group may obtain further qualitative information and the opinion of the individual's physician.

The eligibility decision is communicated to the applicant within 30 days.

Evaluators

On-site assessment

Conducted by municipal staff using the 85 items of standardized questionnaire analyzed by the official computer program to classify applicants into a dependency level or as sufficiently independent to be ineligible for LTC services

Assessment conference (Nursing Care Needs Certification Board)

Board of five experts in health care and welfare (学識経験者構成される合議体) —the board reviews the classification made by the computer program and considers a descriptive statement plus a report from the applicant's doctor.

Benefit limitations

Can you mix LTC benefits?

The LTC Insurance system only provides in-kind benefits. These is no option between cash and in-kind benefits.

Is there free choice between cash and benefits in-kind?

N/A

Can you receive LTC benefits with other social security benefits?

It is possible to receive benefits provided by LTC Insurance along with other welfare benefits, such as disability and survivor benefits.

User costs

User charges

The coinsurance rate is fixed at 10%. A standard charge for meals is imposed on users of facility services (such as special nursing homes for the elderly). There are upper limits on out-of-pocket expenses and meal costs that vary by income level. Coinsurance rate limits and standard charges for meals are provided in Table 4 (as of 2002).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2006-2013

Policy change in 2006

The Act for Partial Revision of the Long-Term Care Insurance Law, Act No. 77, enacted June 29, 2005 and effective from January 1, 2006, introduced preventive LTC to the already existing LTC system. Given the growing aging population, the goal of this reform was sustainability of the LTC system. It shifted towards emphasizing preventive care, including a revised classification of the dependence levels and new preventive care benefits. A second support level was introduced to the previous 6 dependence levels. Support Levels 1 and 2 are preventive care levels, while 5 Care Levels reflect increasing levels of dependency. Additionally, the law introduced a Comprehensive Community Care System (CCCS) to provide community-based services available at any village, town, or city, aimed at supporting people with care needs being able continue their lives in a familiar, non-institutional environment.

Separate from LTC insurance, the Disability Independence Support Law, (Act on Support for The Independence of Persons with Disabilities, 障害者の日常生活及び社会生活を総合的に支援するための法律, Law No. 123 of 2005), effective from 2006 and renamed in 2012 as the "Act on the Comprehensive Support for Persons with Disabilities" (障害者自立支援法), reformed the existing disability support fee system. The reform redefined services, eligibility criteria and evaluation process for people with disabilities. Benefits for disabled people include usage of LTC services.

Reforms during this period include:

- The Law to Partially Revise the Long-Term Care Insurance Law to Strengthen the Foundation of Long-Term Care Services (介護サービスの基盤強化のための介護保険法等の一部を改正する法律), enacted in 2011 and effective from 2012, introduced a 24 hour care benefit and enhanced elderly care provision through the CCCS by strenghthening the cooperation among long-term care, medical care and life support services providers. It also promoted measures for people affected by dementia.

Overview

Japanese public long-term care (LTC) services for the elderly during this time period consist of benefits from the LTC Insurance system that is coordinated by municipalities using a common dependency assessment system. Additionally, there is the Disability Independence Support System that provides LTC services to persons classified as having a disability.

LTC Insurance (介護保険)

This system consists of two types of insured persons:

- Insured Type 1: Persons age 65 or older
- Insured Type 2: Persons age 40 to 64

Insured Type 1 persons are eligible for all LTC services covered by LTC Insurance. Insured Type 2 persons are only eligible for LTC services covered by LTC Insurance if they require care or support resulting from age-related disease and are covered by health insurance programs. Individuals may apply at any time and eligibility is determined by a two-step assessment system: applicants are first evaluated by an on-site 82-item questionnaire, then the automatic computer assessed level of care is reviewed by a group of specialists and physicians. The assessment questionnaire was revised in 2009 to 74-items.[5]

There are seven levels of dependence in which an applicant can be classified. There are two levels (Support Level 1 and Support Level 2) designed to encourage preventive care. The next five levels (Care Levels 1 to 5) correspond to persons incapable of living independently that require assistance in activities of daily living (ADLs). Based on the certified level of care needed, applicants may access home care benefits, semi-residential care, and residential facilities.

The LTC system is financed 50% from mandatory premium contributions of individuals aged 40 and older and 50% by national and local government taxes. Coinsurance rates are fixed at 10%.

Municipalities are LTC insurers. LTC providers are local governments, semi-public welfare corporations, non-profit organizations, hospitals, and for-profit companies all of which are licensed and supervised by the prefectural government. In-kind benefits are not means tested, and are not subject to taxation.

Disability Independence Support System

[5] Further revisions occurred in 2012 and 2015, but they do not concern changes in the number of evaluation items or evaluation items themselves. For this reason, we report the 2009 version of the 74-items questionnaire as reference.

Benefits for disabled persons under the newly established Disability Independence Support System consist of LTC benefits, training benefits, independence support medical care, assistive devices, and community life support projects. Disability welfare services are positioned as "LTC benefits" when using LTC services.

People with disabilities wishing to use LTC services apply to the municipal office to receive a certificate according to the classified degree of disability. Disability is classified into six levels of impairment related to the need of care, from Category 1 (the lowest) to Category 6 (the highest). In order to classify the applicant into one of these 6 categories a 106-item survey is conducted by the municipality. An applicant found to be disabled will be given one of three possible disability certificates, namely the "Physical disability certificate" for body-related disabilities, the "Rehabilitation certificate" if the applicant has an intelligence quotient less or equal to 75, and the "Mental disability certificate" if the applicant is found to be mentally ill. Each disability certificate corresponds to a level of care that will be provided by the Disability Independence Support System.

Municipalities require applicants to submit the "service usage plan." This plan can be created by the applicants' themselves or by a "designated specific consultation support business operator." Consultation support business companies are specific consulting entities for disability services.

This chapter provides policy details on the Japanese LTC insurance system. Some LTC support services are provided by the Japanese disability support system depending on age. We distinguish when certain types of care are not provided by the LTC Insurance system but may otherwise be covered by the Disability Independence Support System depending on its eligibility criteria. Policy details of the Disability Independence Support System are not covered.

Statutory basis

Act for Partial Revision of the Long-Term Care Insurance Law (介護保険法の部分改正法), Law No. 77 of June 29, 2005, effective from 2006

Financing

Source of financing

The LTC insurance system is operated as a pay-as-you-go system and is financed 50% from premiums paid by the insured and 50% by taxes. Of the total:

- Premiums: 22% is paid by Insured Type 1 and 28% is paid by Insured Type 2 in 2016 (Insured types are defined below) —the LTC insurance premiums are reviewed every three years according to the population ratio in order to balance the burden per person
- Taxes: 25% are from national taxes, 12.5% from prefectures and 12.5% from municipalities

Payment of LTC insurance premiums begins at age 40. LTC premiums are progressive and premium rates are revised every three years to maintain fiscal balance. Adjustments are based on each municipality's projection of LTC expenditures over the next period. Premiums vary according to a person's insured type, residence municipality and type of health insurance.

Insured Type 1 LTC Premiums

Insured Type 1 persons are age 65 or older who are covered by the LTC Insurance. LTC premiums for Insured Type 1 are collected by municipal governments and revised every three years. They vary according to each municipality's number of elderly requiring long-term care, amount of LTC service costs and total number of people over 65 living in the region. Insured Type 1 premiums are calculated by multiplying the "basic amount" times the LTC premium rate. The LTC premium rate differs across municipalities according to the insured's income level (e.g. 0.38 to 3 depending on tax status and income). An example using Suginami ward in Tokyo for 2020 is provided in Box 1.

From 2008, LTC Insured Type 1 persons aged 75 or older and people aged 65 to 74 with certain disabilities must be insured by the Medical Care System for the Advanced Elderly which does not provide dependents' coverage.

Insured Type 1 Premium Collection Method

Insured Type 1 premiums are collected and retained by municipalities using one of two methods:

- Special collection: Premiums are deducted from pension benefits of ¥180,000 or more per year
- Normal collection: Premiums are collected directly by municipalities.

Normal collection is used when special collection is not feasible.

Insured Type 2 LTC Premiums

Insured Type 2 persons are age 40-64 who are insured by the health insurance system. Japanese health insurance systems can be grouped into Employees' Health Insurance (EHI) available to employees and their dependents through their employers, and the National Health insurance (NHI) for agriculture, forestry and fisheries workers, students, self-employed, part-time workers, retirees, and unemployed people not covered by EHI. Employees' Health Insurance schemes are the Japan Health Insurance Association, Health Insurance Societies, the Crew Insurance, and Mutual Aid Associations. The Japan Health Insurance Association covers employees of small- to medium sized companies, while large companies are covered by Health Insurance Societies. Mutual Aid Associations are typically insurers for national and local government workers and private school faculty and staff. LTC premiums are collected by a person's health insurance system along with their premium for healthcare.

For people insured with the EHI, premium amounts are based on three elements: the "standard monthly salary," the "standard bonus amount," and LTC insurance premium rate. The "standard monthly salary" is derived according to the insured monthly income level. There are 50 monthly income levels, from less than ¥50,000 to ¥1.39 million or greater. The "standard bonus amount" is the total bonus amount before taxes (intended as wage compensation the insured received from employer other than salary) rounded down to the nearest thousand yen. The LTC insurance premium rates vary according to the person's health insurance company and is adjusted annually.

Insured Type 2 premiums are the sum of the "standard monthly salary" together with the "standard bonus amount" multiplied by the LTC insurance premium rate. Employers bear half of the premium. Premiums for people covered by EHI are not affected by Insured Type 2 number of certified dependents: being calculated on the "standard monthly salary," health premiums vary solely on the income level. An example of a person residing in Tokyo who is a member of the Japan Health Insurance Association in 2020 is provided in Box 2.

For people insured by the NHI system, the premium is determined by a person's income from the previous year multiplied by the LTC insurance premium rate in addition to a fixed per-person amount. For NHI, dependents are insured separately from the primary insured person. The LTC insurance premium rates and fixed per-capita amount vary according to the municipality of residence.

In general, the average annual premium for an Insured Type 2 person is the same as for an Insured Type 1 person.

Insured Type 2 Premium Collection Method

LTC premium is collected with the health insurance premium. Premiums collected for Insured Type 2 are pooled nationwide: they are collected by the Social Insurance Medical Fee Payment Fund, which then distributes them to municipalities. The Social Insurance Medical Fee Payment Fund is a fund to pay for the growth in benefit costs across Japan due to the growing ratio of elderly people and the expected decrease in future tax income. The mechanism to adjust for the financial disparities across municipalities is known as an "adjustment grant."

LTC Premiums for Dependents

Dependents' LTC premium collection varies according to their age:

- Dependents age 65 years or older are considered Insured Type 1 persons and pay the LTC premium to the municipality.
- Dependents age 40 to 64 years old are considered Insured Type 2, but the premium collection differs according to the nature of the primary insured person.
  - If dependent on an Insured Type 2 person, then they are covered by LTC insurance through the LTC premium paid by the primary Insured Type 2 person.
  - If dependent on an Insured Type 1 person, then their premium collection depends on the primary insured person's health insurance —examples include:
    * EHI (Insurer: Japan Health Insurance Association): Dependents' LTC premium is comprised with the primary insured person's health insurance premium
    * EHI (Insurer: Health Insurance Societies): Health Insurance Societies rules for dependents' LTC premium collection vary across insurers. Some of them adopt the "specified insured person system" by which, the primary insured person becomes a "specified insured person" who pays their dependents' LTC premium to the health insurance society. An example is provided in Table 5.
    * NHI: Dependents' LTC premium is paid together with their health insurance premium
    * Other EHI insurers dependent premium rules are not known

LTC premium exemption

Insured Type 1 and Insured Type 2 persons may have reduced insurance premiums and local taxes if they satisfy certain conditions, such as not residing in Japan, living in exempt facilities, or suffering an income loss from a natural disaster. See kaigonohonne.com (2021a) for additional details on premiums and tax exemptions.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

LTC insurance covers care needs related to limitations in activities of daily living (ADL), cognitive status and sensory status impairment.

Eligible population

Eligibility is divided into two categories:

1. Insured Type 1: Persons age 65 years or older
2. Insured Type 2: Persons aged 40-64 covered by a health insurance program (EHI or NHI systems). LTC Insurance benefits are limited to cases where a qualifying condition requires care or support resulting from 16 age-related diseases, namely:
    - Early dementia
    - Cerebrovascular disease
    - Amyotrophic lateral sclerosis
    - Parkinson's disease-related conditions
    - Spinocerebellar degeneration
    - Multiple system atrophy
    - Diabetic nephropathy, diabetic retinopathy, diabetic neuropathy
    - Arteriosclerosis obliterans
    - Chronic obstructive pulmonary disease
    - Degenerative joint disease with pronounced deformation of both knee or hip joints
    - Rheumatoid arthritis
    - Ossification of posterior longitudinal ligament
    - Stanochoria of the spinal canal
    - Osteoporosis involving bone fractures
    - Progeria
    - Terminal cancer

Benefit

Home care benefit

LTC benefits

People classified as Care Levels 1 to 5 have access to these benefits:

- Home-visit service (訪問介護): Help with meals, toileting, bathing, cleaning, washing, shopping, cooking and transportation assistance to hospitals
- Home-visit nursing (訪問看護): Professional help with medical treatments along with mental and physical rehabilitation
- 24-hour care (定期巡回・随時対応型訪問介護看護) —Available from 2012

Preventive LTC benefits

People classified as Support Level 1 to 2 or as beneficiary eligible for service programs have access to these benefits —

- Home-visit LTC preventive benefits (介護予防訪問): Daily support with cleaning, washing, meals preparation, bathing and dressing (equivalent to the conventional LTC system home-visit services)

Community-based services not through LTC Insurance

- Home-visits at night (夜間対応型訪問介護)

Semi-residential care

LTC benefits

People classified as Care Levels 1 to 5 have access to these benefits —

- Outpatient day care services (通所介護)
- Short-stay admission services (短期入所 なと)

Preventive LTC benefits

People classified as Support Levels 1 to 2 have access to these benefits —

- Preventive home-visit nursing (介護予防訪問看護)
- Preventive outpatient rehabilitation (介護予防通所リハビリ)

Community-based services not through LTC Insurance

- Community based LTC in small multifunctional group homes (介護予防小規模多機能型居宅介護): Facilities offering walk-in visits and short-term stays
- Community based daily LTC for dementia patients in group homes (グループホームの認知症患者のためのコミュニティベースの毎日の長期ケア)

Residential care

LTC facility-based services

People classified as Care Levels 1 to 5 have access to these benefits —

- Special nursing homes for the elderly (特別養護老人ホーム): Facilities where elderly people requiring medium to severe care live with physical care and life support
- LTC health facilities (介護老人保健施設): Facilities that provide rehabilitation to elderly people requiring nursing care and aimed to return to home
- LTC medical facilities (介護療養型医療施設): Facilities that provide medical care LTC services, including sanatorium-type wards, wards for elderly with dementia, hospitals with enhanced long-term care service provision

Medical care is not included in the LTC program but instead is offered under the national healthcare system.

Other benefits

N/A

Provision of care

LTC benefits are provided by local governments, semi-public welfare corporations, non-profit organizations, hospitals, and for-profit companies, all of which are licensed and supervised by the prefectural government. For-profit companies are not allowed to provide institutional care. Seniors with certified needs can use services from providers of their choice according to their preferences.

LTC services' fees are set by the government and revised every three years. LTC services' rates are based on a *units concept*: the government sets a number of units for at-home care, semi-residential and institutional care services, where a unit is equal to ¥10 with some regional variations. The number of units assigned for at-home and semi-residential care does not depend on the dependence level of the beneficiary, while the number of units assigned to institutional care is set according to the type of institution and individual's dependence.

The maximum monthly payment limit covered by LTC Insurance for home-based benefits are provided in Table 3.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

There are 7 levels of dependence according to the required caregiving time needed, grouped into Preventive LTC and LTC.

The lowest level of dependence for Preventive LTC is Support Level 1 (between 25 and 31 minutes of caregiving time required a day). The lowest level of dependence for people who cannot live independently is called Care Level 1. This level requires 32 to 49 minutes of caregiving time with an "unstable" condition (the level of stability refers to clinical conditions concerning some diseases or syndromes such as dementia and it is evaluated as part of the dependency assessment).

Duration of benefit

The duration of each care plan is provided by management care agencies. Care managers are expected to coordinate care service for the elderly depending on the dependence level assigned. Eligibility must be re-evaluated every two years or every six months for those with lower dependence levels, or as requested in the event of further decline in health.

Means testing

LTC Insurance benefits are not means-tested. Every eligible person has equal access to services regardless income level. In circumstances where LTC services are not covered by LTC Insurance, these services may be covered by other welfare systems related to disability. These services are often means tested.

Age requirement

There are differences in coverage of services by LTC Insurance:

- People age 40 to 64: Only LTC services required for conditions resulting from an age-related disease
- People age 65 and older: All LTC services are covered

In circumstances where LTC services are not covered by LTC Insurance, these services may be covered by other welfare systems related to disability.

Care needs assessment

Definition of dependence

There are 7 levels of dependence, including Support Levels 1 and 2 and Care Levels 1 to 5. The levels are based on the needed caregiving time. Individuals classified as Support Levels 1 or 2, or Care Levels 1 to 5 are eligible for benefits provided by LTC Insurance.

Not certified

People determined to need care less than 25 minutes per day are classified as "not certified." These persons are not eligible for LTC services from LTC Insurance, but may be eligible for preventative LTC services offered by the applicant's municipality such as a care plan for future preventive LTC.

Support Levels

Support Level 1, the lowest level of dependence for Preventive LTC, is a classification for persons needing 25 to 31 minutes of caregiving per day. In Support Level 2, individuals need 32 to 49 minutes of caregiving per day and have a stable condition (the level of stability refers to clinical conditions concerning some diseases or syndromes, such as dementia, and it is evaluated as part of the dependency assessment). At these levels a person's ability to perform activities of daily living (ADL) is slightly reduced and support or partial care is needed. People belonging to these dependence levels may need daily wellness visits for doing household chores such as cleaning a room and they may need some support for complicated movements such as standing up or standing with both feet and for standing up and walking. People are typically independent in eating and toileting functions.

Care Levels

There are five Care Levels. All require the applicant being incapable of living independently, requiring assistance in basic ADLs. The lowest level of dependence is called Care Level 1, which includes people requiring 32 to 49 minutes of caregiving per day with unstable conditions (the level of stability is evaluated as clinical condition of causal disease and dementia at the assessment conference). Care Level 1 is defined as needing partial care for ADLs and there is a general decline in comprehension. Care Level 2 includes people needing 50 to 69 minutes of caregiving per day, requiring more help with ADLs in addition to the previously mentioned limitations. Care Level 3 includes people needing 70 to 89 minutes of caregiving per day, thereby requiring additional help with IADLs and ADLs relative to Care Level 2, and the individual requires intensive care. Care Level 4 includes people in need of 90 up to 109 minutes of caregiving per day and Care Level 5 includes people needing 110 minutes or more of caregiving per day. Care Levels 4 and 5 require regular care for ADLs and IADLs, with the distinction between level 4 and 5 being primarily determined by the effort required to provide the needed care. There is typically limited comprehension at these dependency levels.

A brief summary of dependence levels by their eligibility criteria and monthly payment limit for home-based benefits can be found in Table 14.

Evaluation of dependence

An insured person applies for LTC benefits through their municipality or their Regional Comprehensive Support Center. The applicant has a two-step evaluation process: an on-site assessment based on a standardized questionnaire is performed, followed by a review of the on-site assessment by a certification board that considers additional input. See Figure 1 for a visual summary of the LTC service application and evaluation process.

On-site assessment

Applicants for LTC benefits submit an application to their municipality of residence. An on-site assessment is performed based on a standardized 74-item questionnaire. The questionnaire is divided into 5 intermediate evaluation groups:

1. Physical function (Table 8)
2. ADL function (Table 9)
3. Cognitive function (Table 10)
4. Behavioural and Psychological symptom of dementia (BPSD) related problems (Table 11)
5. Adaptation to social life (Table 12).

Estimation of the theoretical time required for caregiving is done with 8 decision trees, each of them concerning a care category, namely: eating, toileting, mobility, personal hygiene, indirect assistance, BPSD-related care, functional training related care and, medical service-related care. The estimated caregiving time of the applicant is determined as a sum of the caregiving time estimated through the decision trees (using the scores of each item and the total score of each intermediate evaluation group) and time allocated to each of the 12 medical treatments shown in Table 13. If the applicant receives any of the listed treatments, the corresponding time is added to the theoretical time of caregiving (Matsuda et al., 2011a).

Assessment conference (Nursing Care Needs Certification Board)
The computerized care level classification is reviewed and, if necessary, revised by an assessment conference.

The eligibility decision is communicated to the applicant within 30 days. If dissatisfied with their assessment, applicants may appeal for re-evaluation twice: first at the municipality and second, if still dissatisfied, to the LTC Insurance examination committee at the prefecture level.

Evaluators

On-site assessment
Conducted by municipal staff using the 74 items of standardized questionnaire analyzed by the official computer program to classify applicants into a dependency level or as sufficiently independent to be ineligible for LTC services

Assessment conference (Nursing Care Needs Certification Board)
Board of five experts in health care and welfare (学識経験者構成される合議体) —the board reviews the classification made by the computer program and considers a descriptive statement plus a report from the applicant's doctor.

Note: In 2006 Reform the Ministry of Health, Labor and Welfare introduced a 25-item self-administrated questionnaire, the Kihon Checklist, aimed at identify frail elderly individuals at risk for being certified in need for LTC benefits in the near future. The Kihon Checklist is a screening function and does not provide access to LTC benefits. See Table 6 for Kihon checklist questions and Table 7 for results interpretation.

Benefit limitations

Can you mix LTC benefits?

The LTC Insurance system only provides in-kind benefits. These is no option between cash and in-kind benefits.

Is there free choice between cash and benefits in-kind?

N/A

Can you receive LTC benefits with other social security benefits?

It is possible to receive benefits provided by LTC Insurance along with other welfare benefits, such as disability and survivor benefits.

User costs

User charges

The coinsurance rate is fixed at 10%. A standard charge for meals is imposed on users of facility services (such as special nursing homes for the elderly). There are upper limits on out-of-pocket expenses and meal costs that vary by income level. Coinsurance rate limits are provided in Table 15 (as of 2021).

As of 2012, the coinsurance rate increased to 20% for persons with incomes greater than or equal to ¥2.8 million.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 4: Policy enacted 2014-2022

Policy change in 2014

The Act on the Promotion of Comprehensive Medical Care and Long-term Care (地域における医療及び介護の総合的な確保を推進するための関係法律の整備等に関する法律), enacted in June 2014 and effective from April 2015, developed the Comprehensive Community Care system (CCCS), which devolved long-term home nursing care and life support preventive benefits to municipal governments, including their management and financing. One of the aims of this reform was to place greater responsibility on municipalities for creating a local network of volunteers, community groups, and business partnerships as part of a Comprehensive Program (総合事業) system that promotes keeping aging persons in their own community rather than using LTC Insurance services.

Major changes included:

- Home nursing care and life support preventive benefits are provided and financed by the municipal government through its community care system
- Redefined the care assessment process, adding a preliminary care assessment process using the Kihon checklist
- Expanded the cooperation between the LTC and medical system to improve elderly health and care in their living environment
- Increased the LTC Insurance system coinsurance rate to 20% for high income levels

Other reforms in this period include:

- The Law Partially Revising the Long-Term Care Insurance Law for Strengthening the Comprehensive Community Care System (総合的な地域医療制度を強化するための介護保険法を部分的に改正する法律), enacted in May 2017 and effective from June 2017, further expanded the CCCS and increased the LTC insurance system coinsurance rate to 30% for very high income levels.

Overview

Japanese public long-term care (LTC) services for the elderly during this time period consist of benefits from two main systems that are coordinated by municipalities and share a common dependency assessment system: LTC Insurance and the Comprehensive Program system. Additionally, there is the Disability Independence Support System that provides LTC services to persons classified as having a disability.

LTC Insurance (介護保険)

This system consists of two types of insured persons:

- Insured Type 1: Persons age 65 or older
- Insured Type 2: Persons age 40 to 64

Insured Type 1 persons are eligible for all LTC services covered by LTC Insurance. Insured Type 2 persons are only eligible for LTC services covered by LTC Insurance if they require care or support resulting from age-related disease and are covered by health insurance programs. Individuals may apply at any time and eligibility is determined by a two-step assessment system: applicants are first evaluated by an on-site 74-item questionnaire, then the automatic computer assessed level of care is reviewed by a group of specialists and physicians.[6]

There are eight levels of dependence in which an applicant can be classified. There are three levels (Beneficiary eligible for service programs, Support Level 1 and Support Level 2) designed to encourage preventive care. The next five levels (Care Levels 1 to 5) correspond to persons incapable of living independently that require assistance in activities of daily living (ADLs). Based on the certified level of care needed, applicants may access home care benefits, semi-residential care, and residential facilities.

The LTC system is financed 50% from mandatory premium contributions of individuals aged 40 and older and 50% by national and local government taxes. Coinsurance rates are fixed at 10% for most income levels with higher rates of 20% or 30% (from 2018) for high income levels.

Municipalities are LTC insurers. LTC providers are local governments, semi-public welfare corporations, non-profit organizations, hospitals, and for-profit companies all of which are licensed and supervised by the prefectural government. In-kind benefits are not means tested, and are not subject to taxation.

Comprehensive Program (総合事業, CP) system

[6] Further revisions occurred in 2018, but they do not concern changes in the number of evaluation items or evaluation items themselves. For this reason, we report the 2009 version of the 74-items questionnaire as reference.

The 2006 LTC reform introduced the Comprehensive Community Care System (CCCS) to enhance preventive care provision by local governments. The CCCS is included in the framework of the main LTC system but managed and financed independently by each municipality. One of the aims for creating the CCCS was to place greater responsibility on municipalities for creating a local network of volunteers, community groups, and business partnerships as part of a Comprehensive Program (CP) system that promotes keeping elderly persons in their own community rather than using LTC Insurance services. CP systems are unique to each municipality. As of 2011, use and implementation of a CP system at the municipal level for nursing care preventive LTC benefits and daily life support services was at the discretion of each municipality. Adoption of a CP system was made compulsory for municipalities in the 2014 LTC reform, requiring the transition of most nursing care preventive benefits and daily life support services from the LTC system to each municipality's CP system by the end of 2017. Some preventive home care and semi-residential benefits are still provided by the main LTC system. CP benefits provision is managed by the Regional Comprehensive Support Center, introduced with the 2006 LTC reform as the core agency for preventive care management in each municipality.

Insured Type 1 and 2 in the LTC Insurance system have access to the CP benefits. Benefits covered by the CP include home care and semi-residential services. Individuals classified as Support Levels 1 and 2 by the LTC care assessment process and individuals classified as a beneficiary eligible for service programs by the preliminary care assessment process are eligible for nursing care preventive services and life support services. The CP system also provides general care preventive business services for all Insured Type 1 persons in the LTC system. Individuals may apply at any time and eligibility is determined according to the Kihon checklist in a preliminary care assessment process.

The CP is financed by general tax revenues of municipalities, out-of-pocket expenses and the Regional Support Project Grant, by which the national government support 25% of the costs incurred by municipalities for the CP system. Municipalities may adjust services or eligibility for services provided by the CP system based on budget limitations.

Providers of CP benefits are municipalities or entities sub-contracted by local governments.

Disability Independence Support System

Benefits for disabled persons under the Disability Independence Support System consist of LTC benefits, training benefits, independence support medical care, assistive devices, and community life support projects. Disability welfare services are positioned as "LTC benefits" when using LTC services.

People with disabilities wishing to use LTC services apply to the municipal office to receive a certificate according to the classified degree of disability. Disability is classified into six levels of impairment related to the need of care, from Category 1 (the lowest) to Category 6 (the highest). In order to classify the applicant into one of these 6 categories a 106-item survey is conducted by the municipality. An applicant found to be disabled will be given one of three possible disability certificates, namely the "Physical disability certificate" for body-related disabilities, the "Rehabilitation certificate" if the applicant has an intelligence quotient less or equal to 75, and the "Mental disability certificate" if the applicant is found to be mentally ill. Each disability certificate corresponds to a level of care that will be provided by the Disability Independence Support System.

Municipalities require applicants to submit the "service usage plan." This plan can be created by the applicants' themselves or by a "designated specific consultation support business operator." Consultation support business companies are specific consulting entities for disability services.

This chapter provides policy details on the Japanese LTC insurance system and national details on the CP system (i.e., we do not provide municipal-specific details). Some LTC support services are provided by the Japanese disability support system depending on age. We distinguish when certain types of care are not provided by the LTC Insurance system but may otherwise be covered by the Disability Independence Support System depending on its eligibility criteria. Policy details of the Disability Independence Support System are not covered.

Statutory basis

Law Concerning the Development of Related Laws to Promote the Comprehensive Security of Medical Care and Long-term Care in the Community (地域における医療及び介護の総合的な確保を推進するための関係法律の整備等に関する法律 - Act on the Promotion of Comprehensive Medical Care and Long-term Care), enacted in June 2014 and effective from April 2015

Financing

Source of financing

LTC Insurance

The LTC Insurance system is operated as a pay-as-you-go system and is financed 50% from premiums paid by the insured and 50% by taxes. Of the total:

- Premiums: 23% is paid by Insured Type 1 and 27% is paid by Insured Type 2 in 2019 (Insured types are defined below) —the LTC Insurance premiums are reviewed every three years according to the population ratio in order to balance the burden per person
- Taxes: 25% are from national taxes, 12.5% from prefectures and 12.5% from municipalities

Payment of LTC Insurance premiums begins at age 40. LTC premiums are progressive and premium rates are revised every three years to maintain fiscal balance. Adjustments are based on each municipality's projection of LTC expenditures over the next period. Premiums vary according to a person's insured type, residence municipality and type of health insurance.

Insured Type 1 LTC Premiums

Insured Type 1 persons are age 65 or older who are covered by the LTC Insurance. LTC premiums for Insured Type 1 are collected by municipal governments and revised every three years. They vary according to each municipality's number of elderly requiring long-term care, amount of LTC service costs and total number of people over 65 living in the region. Insured Type 1 premiums are calculated by multiplying the "basic amount" times the LTC premium rate. The LTC premium rate differs across municipalities according to the insured's income level (e.g. 0.38 to 3 depending on tax status and income). An example using Suginami ward in Tokyo for 2020 is provided in Box 1.

From 2008, LTC Insured Type 1 persons aged 75 or older and people aged 65 to 74 with certain disabilities must be insured by the Medical Care System for the Advanced Elderly which does not provide dependents' coverage.

Insured Type 1 Premium Collection Method

Insured Type 1 premiums are collected and retained by municipalities using one of two methods:

- Special collection: Premiums are deducted from pension benefits of ¥180,000 or more per year
- Normal collection: Premiums are collected directly by municipalities.

Normal collection is used when special collection is not feasible.

Insured Type 2 LTC Premiums

Insured Type 2 persons are age 40-64 who are insured by the health insurance system. Japanese health insurance systems can be grouped into Employees' Health Insurance (EHI) available to employees and their dependents through their employers, and the National Health insurance (NHI) for agriculture, forestry and fisheries workers, students, self-employed, part-time workers, retirees, and unemployed people not covered by EHI. Employees' Health Insurance schemes are the Japan Health Insurance Association, Health Insurance Societies, the Crew Insurance, and Mutual Aid Associations. The Japan Health Insurance Association covers employees of small- to medium sized companies, while large companies are covered by Health Insurance Societies. Mutual Aid Associations are typically insurers for national and local government workers and private school faculty and staff. LTC premiums are collected by a person's health insurance system along with their premium for healthcare.

For people insured with the EHI, premium amounts are based on three elements: the "standard monthly salary," the "standard bonus amount," and LTC insurance premium rate. The "standard monthly salary" is derived according to the insured monthly income level. There are 50 monthly income levels, from less than ¥50,000 to ¥1.39 million or greater. The "standard bonus amount" is the total bonus amount before taxes (intended as wage compensation the insured received from employer other than salary) rounded down to the nearest thousand yen. The LTC insurance premium rates vary according to the person's health insurance company and is adjusted annually.

Insured Type 2 premiums are the sum of the "standard monthly salary" together with the "standard bonus amount" multiplied by the LTC insurance premium rate. Employers bear half of the premium. Premiums for people covered by EHI are not affected by Insured Type 2 number of certified dependents: being calculated on the "standard monthly salary," health premiums vary solely on the income level. An example of a person residing in Tokyo who is a member of the Japan Health Insurance Association in 2020 is provided in Box 2.

For people insured by the NHI system, the premium is determined by a person's income from the previous year multiplied by the LTC insurance premium rate in addition to a fixed per-person amount. For NHI, dependents are insured separately from the primary insured person. The LTC insurance premium rates and fixed per-capita amount vary according to the municipality of residence.

In general, the average annual premium for an Insured Type 2 person is the same as for an Insured Type 1 person.

Insured Type 2 Premium Collection Method
LTC premium is collected with the health insurance premium. Premiums collected for Insured Type 2 are pooled nationwide: they are collected by the Social Insurance Medical Fee Payment Fund, which then distributes them to municipalities. The Social Insurance Medical Fee Payment Fund is a fund to pay for the growth in benefit costs across Japan due to the growing ratio of elderly people and the expected decrease in future tax income. The mechanism to adjust for the financial disparities across municipalities is known as an "adjustment grant."

LTC Premiums for Dependents
Dependents' LTC premium collection varies according to their age:

- Dependents age 65 years or older are considered Insured Type 1 persons and pay the LTC premium to the municipality.
- Dependents age 40 to 64 years old are considered Insured Type 2, but the premium collection differs according to the nature of the primary insured person.
  - If dependent on an Insured Type 2 person, then they are covered by LTC insurance through the LTC premium paid by the primary Insured Type 2 person.
  - If dependent on an Insured Type 1 person, then their premium collection depends on the primary insured person's health insurance —examples include:
    * EHI (Insurer: Japan Health Insurance Association): Dependents' LTC premium is comprised with the primary insured person's health insurance premium
    * EHI (Insurer: Health Insurance Societies): Health Insurance Societies rules for dependents' LTC premium collection vary across insurers. Some of them adopt the "specified insured person system" by which, the primary insured person becomes a "specified insured person" who pays their dependents' LTC premium to the health insurance society. An example is provided in Table 5.
    * NHI: Dependents' LTC premium is paid together with their health insurance premium
    * Other EHI insurers dependent premium rules are not known

LTC Premium Exemption
Insured Type 1 and Insured Type 2 persons may have reduced insurance premiums and local taxes if they satisfy certain conditions, such as not residing in Japan, living in exempt facilities, or suffering an income loss from a natural disaster. See kaigonohonne.com (2021a) for additional details on premiums and tax exemptions.

CP system
A municipality's CP system is financed by their general tax revenues, user fees and coinsurance payments, and the Regional Support Project Grant. Through this grant, the national government supports 25% of municipality's costs for their CP system.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

LTC insurance covers care needs related to limitations in activities of daily living (ADL), cognitive status and sensory status impairment.

Eligible population

Eligibility is divided into two categories:

1. Insured Type 1: Persons age 65 years or older
2. Insured Type 2: Persons aged 40-64 covered by a health insurance program (EHI or NHI systems). LTC Insurance benefits are limited to cases where a qualifying condition requires care or support resulting from 16 age-related diseases, namely:
   - Early dementia
   - Cerebrovascular disease
   - Amyotrophic lateral sclerosis
   - Parkinson's disease-related conditions
   - Spinocerebellar degeneration
   - Multiple system atrophy
   - Diabetic nephropathy, diabetic retinopathy, diabetic neuropathy

- Arteriosclerosis obliterans
- Chronic obstructive pulmonary disease
- Degenerative joint disease with pronounced deformation of both knee or hip joints
- Rheumatoid arthritis
- Ossification of posterior longitudinal ligament
- Stanochoria of the spinal canal
- Osteoporosis involving bone fractures
- Progeria
- Terminal cancer

Persons aged 40-64 not satisfying these conditions may still qualify for LTC services through the Disability Independence Support System.

Benefit

Home care benefit

LTC Insurance

LTC benefits: People classified as Care Levels 1 to 5 have access to these benefits:

- Home-visit services (訪問介護): Help with meals, toileting, bathing, cleaning, washing, shopping, cooking and transportation assistance to hospitals
- Home-visit nursing (訪問看護): Professional help with medical treatments along with mental and physical rehabilitation
- Home-visit at night (夜間対応型訪問介護)
- 24-hour care (定期巡回・随時対応型訪問介護看護)

Preventive LTC benefits: People classified as Support Levels 1 to 2 have access to these benefits —

- Preventive home care management consulting (予防住宅経営コンサルティング)
- Community-based preventive small-scale multifunctional home (小規模多機能型居宅介護)
- Community-based dementia preventive LTC group homes (認知症対応型共同生活介護 など)

CP system

Preventive LTC benefits: People classified as Support Level 1 to 2 or as a beneficiary eligible for service programs have access to these benefits —

- Nursing care prevention and livelihood support services (介護予防・生活支援サービス事業)
- General care preventive program services (一般介護予防事業)

CP home care benefits within the nursing care prevention and livelihood support category include preventive LTC services equivalent to those provided by the LTC system and 4 “visit-type” services:

- Home-visit LTC preventive benefits (介護予防訪問): Daily support with cleaning, washing, meals preparation, bathing and dressing (equivalent to the conventional LTC system home-visit services)
- Visit-type service A (訪問型サービス A): Livelihood support visits providing help with cooking, cleaning, garbage assistance, shopping for heavy items, and accompanying services
- Visit-type service B (訪問型サービス B): Daily life assistance with drying futons, cleaning stairs, shopping and cooking, garbage, replacing light bulbs, and writing
- Visit-type service C (訪問型サービス C): Short-term intensive preventive services, providing consulting for LTC prevention through various programs: nutrition, oral functions, cognitive decline, exercise equipment, activities for knee and back pain, depression and general improvement in ADLs and IADLs
- Visit-type service D (訪問型サービス D): Mobility assistance with transportation, shopping, going to hospital, and outing support for outpatient services

Semi-residential care

LTC Insurance

LTC benefits: People classified as Care Levels 1 to 5 have access to these benefits —

- Outpatient day care services (通所介護)
- Short-stay admission services (短期入所 など)

Preventive LTC benefits: People classified as Support Levels 1 to 2 have access to these benefits —

- Preventive home-visit nursing (介護予防訪問看護)
- Preventive outpatient rehabilitation (介護予防通所リハビリ)

- Preventive home care management (介護予防居宅療養管理指導 など)
- Community based LTC in small multifunctional group homes (介護予防小規模多機能型居宅介護): Facilities offering walk-in visits and short-term stay
- Community based outpatient preventive day care for people with dementia (介護予防認知症対応型通所介護 など)
- Community based daily LTC for dementia patients in group homes (グループホームの認知症患者のためのコミュニティベースの毎日の長期ケア)

CP system

Preventive LTC benefits: People classified as Support Levels 1 to 2 or as a beneficiary eligible for service programs have access to these benefits —

- Outpatient services and functional training, similar to those provided by the LTC system (通所介護と同様のサービス、生活機能の向上のための機能訓練を)
- Outpatient service A (通所型サービス A - 緩和した基準によるサービス): Day care services, exercise support and recreation
- Outpatient service B (通所型サービス B - 住民主体によるサービス): Day to day services for exercise and social interaction
- Outpatient service C (通所型サービス C - 短期集中予防サービス): Short-term intensive preventive benefits for motor function, malnutrition, and oral function

Residential care

LTC Insurance

LTC facility-based services: People classified as Care Levels 1 to 5 have access to these benefits —

- Special nursing homes for the elderly (特別養護老人ホーム): Facilities where elderly people requiring medium to severe care live with physical care and life support
- LTC health facilities (介護老人保健施設): Facilities that provide rehabilitation to elderly people requiring nursing care and aimed to return to home
- LTC medical facilities (介護療養型医療施設): Facilities that provide medical care LTC services, including sanatorium-type wards, wards for elderly with dementia, hospitals with enhanced long-term care service provision

As of 2015, access to Special nursing homes for the elderly (特別養護老人ホーム) was restricted to people classifies as Care Levels 3 to 5. Medical care is not included in the LTC program but instead is offered under the national healthcare system.

CP system

No residential care services are provided.

Other benefits

CP system

"General care preventive program" services (一般介護予防事業) are offered to all Insured Type 1 persons in the LTC system. These services include —

- Nursing care prevention grasp program (介護予防把握事業): Regular health check-ups and encouragement to participate to preventative LTC activities —These services are intended to inform the municipality of the current state of the health and well-being of the elderly in its area and are to be used to inform future care prevention efforts
- Nursing care prevention dissemination and enlightenment program (介護予防普及啓発事業): Resources and experiences aimed at informing eligible persons about nursing care prevention, including informational resources and media, as well as lectures/seminars, counseling sessions and exercise classes that contribute to awareness of preventive care
- Community care preventive activity support program (地域介護予防活動支援事業): Supports activities by volunteers, community groups, and residents that promote the creation of an accommodating environment for the elderly, including activities that promote social participation
- Community rehabilitation activity support project (地域リハビリテーション活動支援事業): Integrates rehabilitation professionals into CP system and other community activities, such as home visits, community care meetings and outpatient visits in order to provide their input on the development and evaluation of care plans and promote a focus on rehabilitation and retention of persons in the community
- General care prevention evaluation program (一般介護予防事業評価事業): Evaluates whether the LTC system and the CP system are achieving the goals of LTC prevention

Provision of care

LTC Insurance

LTC benefits are provided by local governments, semi-public welfare corporations, non-profit organizations, hospitals, and for-profit companies, all of which are licensed and supervised by the prefectural government. For-profit companies are not

allowed to provide institutional care. Seniors with certified needs can use services from providers of their choice according to their preferences.

LTC services' fees are set by the government and revised every three years. LTC services' rates are based on a *units concept*: the government sets a number of units for at-home care, semi-residential and institutional care services, where a unit is equal to ¥10 with some regional variations. The number of units assigned for at-home and semi-residential care does not depend on the dependence level of the beneficiary, while the number of units assigned to institutional care is set according to the type of institution and individual's dependence.

The maximum monthly payment limit covered by LTC Insurance for home-based benefits are provided in Table 3.

CP system

Providers of CP services are municipalities, entities sub-contracted by local governments, volunteers and residents. The maximum monthly payment limit covered by CP differs across municipalities. An example of CP benefit coverage in the city of Hiroshima is provided in Box 3.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

There are 8 levels of dependence according to the required caregiving time needed, grouped into Preventive LTC and LTC.

LTC Insurance

The lowest level of dependence for Preventive LTC is Support Level 1 (between 25 and 31 minutes of caregiving time required a day). The lowest level of dependence for people who cannot live independently is called Care Level 1. This level requires 32 to 49 minutes of caregiving time with an "unstable" condition (the level of stability refers to clinical conditions concerning some diseases or syndromes such as dementia and it is evaluated as part of the dependency assessment).

CP system

The minimum level of dependence for people needing Preventive LTC benefits is the classification as a beneficiary eligible for service programs, which is a lower level of dependence than Support Level 1. Additionally, the CP system provides access to some other LTC-related benefits for all Insured Type 1 in the LTC system.

Duration of benefit

The duration of each care plan is provided by management care agencies. Care managers are expected to coordinate care service for the elderly depending on the dependence level assigned. Eligibility must be re-evaluated every two years or every six months for those with lower dependence levels, or as requested in the event of further decline in health.

Means testing

LTC Insurance benefits are not means-tested. Every eligible person has equal access to services regardless income level. In circumstances where LTC services are not covered by LTC Insurance, these services may be covered by other welfare systems related to disability. These services are often means tested.

Age requirement

LTC Insurance

There are differences in coverage of services by LTC Insurance:

- People age 40 to 64: Only LTC services required for conditions resulting from an age-related disease
- People age 65 and older: All LTC services are covered

In circumstances where LTC services are not covered by LTC Insurance, these services may be covered by other welfare systems related to disability.

CP system

There are differences in services based on a beneficiary's age and dependency level:

- People certified as Support Level 1 and 2 of all ages and people certified as a beneficiary eligible for service programs: Nursing care prevention and life support services

- People age 65 or older: General care prevention services (一般介護予防事業, see section on "Other benefits")

Care needs assessment

Definition of dependence

There are 8 levels of dependence, including a beneficiary eligible for service programs, Support Levels 1 and 2 and Care Levels 1 to 5. The levels are based on the needed caregiving time. Individuals classified as a beneficiary eligible for service programs or Support Levels 1 or 2 are eligible for CP system benefits. Individuals classified as Support Levels 1 or 2, or Care Levels 1 to 5 are eligible for benefits provided by LTC Insurance.

Not certified and beneficiaries eligible for service programs (サービス事業対象者)
People determined to need care less than 25 minutes per day are classified as "not certified," but are also considered a beneficiary eligible for service programs if not completely independent in ADLs and IADLs.

Support Levels
Support Level 1, the lowest level of dependence for Preventive LTC, is a classification for persons needing 25 to 31 minutes of caregiving per day. In Support Level 2, individuals need 32 to 49 minutes of caregiving per day and have a stable condition (the level of stability refers to clinical conditions concerning some diseases or syndromes, such as dementia, and it is evaluated as part of the dependency assessment). At these levels a person's ability to perform activities of daily living (ADL) is slightly reduced and support or partial care is needed. People belonging to these dependence levels may need daily wellness visits for doing household chores such as cleaning a room and they may need some support for complicated movements such as standing up or standing with both feet and for standing up and walking. People are typically independent in eating and toileting functions.

Care Levels
There are five Care Levels. All require the applicant being incapable of living independently, requiring assistance in basic ADLs. The lowest level of dependence is called Care Level 1, which includes people requiring 32 to 49 minutes of caregiving per day with unstable conditions (the level of stability is evaluated as clinical condition of causal disease and dementia at the assessment conference). Care Level 1 is defined as needing partial care for ADLs and there is a general decline in comprehension. Care Level 2 includes people needing 50 to 69 minutes of caregiving per day, requiring more help with ADLs in addition to the previously mentioned limitations. Care Level 3 includes people needing 70 to 89 minutes of caregiving per day, thereby requiring additional help with IADLs and ADLs relative to Care Level 2, and the individual requires intensive care. Care Level 4 includes people in need of 90 up to 109 minutes of caregiving per day and Care Level 5 includes people needing 110 minutes or more of caregiving per day. Care Levels 4 and 5 require regular care for ADLs and IADLs, with the distinction between level 4 and 5 being primarily determined by the effort required to provide the needed care. There is typically limited comprehension at these dependency levels.

A brief summary of dependence levels by their eligibility criteria and monthly payment limit for home-based benefits can be found in Table 14.

Evaluation of dependence

An insured person applies for LTC benefits through their municipality or their Regional Comprehensive Support Center. See Figure 1 for a visual summary of the LTC service application and evaluation process before the CP system was implemented and Figure 2 for how it is implemented after the CP system.

Preliminary care assessment
The municipality or the Regional Comprehensive Support Center perform a preliminary care assessment based on the Kihon Checklist to determine if the applicant qualifies for benefits provided by LTC Insurance or the CP system. The Kihon checklist is a 25-item self-administered questionnaire introduced by the Ministry of Health, Labour and Welfare in 2006, aimed at identifying elderly individuals at risk for needing LTC benefits in the near future. See Table 6 for Kihon Checklist questions and Table 7 for interpretation of the Checklist's ratings. The checklist will determine if the person is potentially eligible for LTC, only a beneficiary eligible for service programs, or is not certified for requiring LTC preventive services. Persons potentially eligible for LTC must apply for and undergo an on-site assessment.

On-site assessment
Applicants for LTC benefits submit an application to their municipality of residence. An on-site assessment is performed based on a standardized 74-item questionnaire. The questionnaire is divided into 5 intermediate evaluation groups:

1. Physical function (Table 8)

2. ADL function (Table 9)
3. Cognitive function (Table 10)
4. Behavioural and Psychological symptom of dementia (BPSD) related problems (Table 11)
5. Adaptation to social life (Table 12).

Estimation of the theoretical time required for caregiving is done with 8 decision trees, each of them concerning a care category, namely: eating, toileting, mobility, personal hygiene, indirect assistance, BPSD-related care, functional training related care and, medical service-related care. The estimated caregiving time of the applicant is determined as a sum of the caregiving time estimated through the decision trees (using the scores of each item and the total score of each intermediate evaluation group) and time allocated to each of the 12 medical treatments shown in Table 13. If the applicant receives any of the listed treatments, the corresponding time is added to the theoretical time of caregiving (Matsuda et al., 2011a).

Assessment conference (Nursing Care Needs Certification Board)
The computerized care level classification is reviewed and, if necessary, revised by an assessment conference.

The eligibility decision is communicated to the applicant within 30 days. If dissatisfied with their assessment, applicants may appeal for re-evaluation twice: first at the municipality and second, if still dissatisfied, to the LTC Insurance examination committee at the prefecture level.

Evaluators

Preliminary care assessment
Conducted by municipal or Regional Comprehensive Support Center staff using the Kihon checklist

On-site assessment
Conducted by municipal staff using the 74 items of standardized questionnaire analyzed by the official computer program to classify applicants into a dependency level or as sufficiently independent to be ineligible for LTC services

Assessment conference (Nursing Care Needs Certification Board)
Board of five experts in health care and welfare (学識経験者構成される合議体) —the board reviews the classification made by the computer program and considers a descriptive statement plus a report from the applicant's doctor.

Benefit limitations

Can you mix LTC benefits?

The LTC Insurance and CP systems only provide in-kind benefits. These is no option between cash and in-kind benefits.

Is there free choice between cash and benefits in-kind?

N/A

Can you receive LTC benefits with other social security benefits?

It is possible to receive benefits provided by LTC Insurance and the CP system along with other welfare benefits, such as disability and survivor benefits.

User costs

User charges

LTC Insurance

Coinsurance rates are fixed based on income. There are two coinsurance rates: 10% and 20%. The 20% coinsurance rate is applied to incomes greater than or equal to ¥2.8 million. A standard charge for meals is imposed on users of facility services (such as special nursing homes for the elderly). There are upper limits on out-of-pocket expenses and meal costs that vary by income level. Coinsurance rate limits are provided in Table 15 (as of 2021). As of 2018, the coinsurance rate was increased to 30% for

persons with incomes greater than or equal to ¥3.4 million.

CP system

Coinsurance rates for CP services are equivalent to previous LTC preventive services. Users' fees for general care prevention program services are set independently by each municipality.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Insured Type 1 LTC Premiums Calculation (2002)

Level	Eligibility Condition [1]	Premiums
1	Public assistance receipients	Basic amount x 0.5
	Municipal tax-exempted households and Old-Age Welfare Pension receipients	
2	Municipal tax-exempted households	Basic amount x 0.75
3	Municipal tax-exempted persons	Basic amount x 1
4	Municipal tax-payers (the insured total income is less than ¥2.5 million)	Basic amount x 1.25
5	Municipal tax-payers (the insured total income is ¥2.5 million or more)	Basic amount x 1.5

Source: MHLW (2002)

Notes: The "basic amount" for Insured Type 1 persons is revised every three years. It varies across municipalities and it is derived according to the total cost of LTC services used by people over 65 and the total number of people 65 or over in the municipality of interest.

[1] If an Insured Type 1 person presents two eligible conditions at the same time (for example, being a public assistance recipient and a tax-exempted person), their premium amount is calculated on the basis of the lowest level condition (public assistance recipient).

Table 2: Eligibility Levels (2000-2005)

Dependence Level	Eligibility Criteria	Monthly Benefit Limit Coverage for Home-Based Benefits
Not certified	Under 25 minutes	-
Support Level	25 to 32 minutes	6,150 units
Care Level 1	32 to 49 minutes	16,580 units
Care Level 2	50 to 69 minutes	19,480 units
Care Level 3	70 to 89 minutes	26,750 units
Care Level 4	90 to 109 minutes	30,600 units
Care Level 5	over 110 minutes	35,830 units

Source: MHLW (2006), Tsutsui and Muramatsu (2005)

Notes: 1 unit ≈ ¥10. Ratio differs according to region.

Table 3: Maximum Payment Limit Covered By LTC Insurance for Home-Based Benefits (2003-2021)

Year	Support Level 1	Support Level 2	Care Level 1	Care Level 2	Care Level 3	Care Level 4	Care Level 5
2003	6,150 units		16,580 units	19,480 units	26,750 units	30,600 units	35,830 units
2004	6,150		16,580	19,480	26,750	30,600	35,830
2005	6,150		16,580	19,480	26,750	30,600	35,830
2006	6,150		16,580	19,480	26,750	30,600	35,830
2007	4,970	10,400 units	16,580	19,480	26,750	30,600	35,830
2008	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2009	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2010	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2011	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2012	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2013	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2014	4,970	10,400	16,580	19,480	26,750	30,600	35,830
2015	5,003	10,473	16,692	19,616	26,931	30,806	36,065
2016	5,003	10,473	16,692	19,616	26,931	30,806	36,065
2017	5,003	10,473	16,692	19,616	26,931	30,806	36,065
2018	5,003	10,473	16,692	19,616	26,931	30,806	36,065
2019	5,003	10,473	16,692	19,616	26,931	30,806	36,065
2020	5,032	10,531	16,765	19,705	27,048	30,938	36,217
2021	5,032	10,531	16,765	19,705	27,048	30,938	36,217

Source: MHLW (2003-2021)

Notes: Support and Care required coverage levels are measured in units. One unit ≈ 10 yen. Ratio differs according to region.

Table 4: LTC Coinsurance Upper Limit and Standard Charges for Meals (2002)

Eligibility Condition	Upper Limit of 10% Coinsurance Payment Covered By LTC Insurance	Standard Charges for Meals
Non-low income persons	¥37,200 per month	¥23,400 per month (¥780 per day)
Municipal tax-exempted households	¥24,600 per month	¥15,000 per month (¥500 per day)
Old-Age Welfare Pension recipients, etc	¥15,000 per month	¥9,000 per month (¥300 per day)

Source: MHLW (2002)

Box 1: Insured Type 1 - Premium Example

Insured Type 1 premium definition for 2020 in Suginami ward, Tokyo, based on a person's total income:[1]

Income Levels 1 - 3
Persons in a household fully exempt from municipal taxes and where their total income less pension income and less taxes paid on pension income is between an upper and lower bound:[2]

Income Level	Lower Bound	Upper Bound	Insurance Premium	Annual premium	Monthly premium
1		¥0.8m	Basic Amount $\times$ 0.38	¥28,200	¥2,325
2	¥0.8m	¥1.2m	Basic Amount $\times$ 0.53	¥39,300	¥3,275
3	¥1.2m		Basic Amount $\times$ 0.76	¥56,340	¥4,695

Income Levels 4 - 5
Person is exempt from municipal tax, but another person in the household pays taxes, and where their total income less pension income and less taxes paid on pension income is between an upper and lower bound:

Income Level	Lower Bound	Upper Bound	Insurance Premium	Annual premium	Monthly premium
4		¥0.8m	Basic Amount $\times$ 0.85	¥63,000	¥5,250
5	¥0.8m		Basic Amount	¥74,400	¥6,200

Income Levels 6 - 14
Person is required to pay municipal taxes and his or her total income of the previous year is between an upper and lower bound:

Income Level	Lower Bound	Upper Bound	Insurance Premium	Annual premium	Monthly premium
6		¥1.25m	Basic Amount $\times$ 1.06	¥78,600	¥6,550
7	¥1.25m	¥2.0m	Basic Amount $\times$ 1.19	¥88,800	¥7,400
8	¥2.0m	¥3.0m	Basic Amount $\times$ 1.40	¥104,400	¥8,700
9	¥3.0m	¥5.0m	Basic Amount $\times$ 1.61	¥120,000	¥10,000
10	¥5.0m	¥7.0m	Basic Amount $\times$ 1.89	¥140,400	¥11,700
11	¥7.0m	¥10.0m	Basic Amount $\times$ 2.20	¥163,800	¥13,650
12	¥10.0m	¥15.0m	Basic Amount $\times$ 2.50	¥186,000	¥15,500
13	¥15.0m	¥25.0m	Basic Amount $\times$ 2.70	¥200,000	¥16,667
14	¥25.0m		Basic Amount $\times$ 3.00	¥223,000	¥18,600

Source: Sigunamy City (2021)
Notes

[1] The total income amount is that determined before the basic deduction and personal deduction, and after the public pension deduction, deduction of employment income and deduction of necessary expense.
(a) ¥50 million (maximum) where land etc. for expropriation exchange is transferred
(b) ¥20 million (maximum) where land etc. has been transferred for a specific readjustment project or disaster prevention mass migration promotion project etc.
(c) ¥15 million (maximum) where land etc. has been transferred for specific residence creation project etc.
(d) ¥8 million (maximum) where farmland etc. is sold for rationalization of farmlands in possession
(e) ¥30 million (maximum) where property for residence is transferred
(f) ¥10 million where specific land is transferred (those which obtained in 2009 or 2010 and held in possession for over five years)
(g) ¥50 million of the maximum limit amount (maximum) where among (a) through (f), two or more items are applied.

[2] Persons with low income may be eligible for premium reductions based on the care insurance law.

Box 2: Insured Type 2 - Premium Example

Consider a LTC Insured Type 2 person residing in Tokyo who is a member of the Japan Health Insurance Association (JHIA) in 2020. Suppose their monthly salary is ¥205,000 plus a bonus of ¥405,500. The "standard monthly salary" is derived considering the JHIA's 50 monthly income levels. The insured monthly salary of ¥205,000 corresponds to the 17th JHIA income level, corresponding to a "standard monthly salary" of ¥200,000. The "standard bonus amount" is calculated by rounding down the ¥405,500 bonus to ¥405,000. The sum of the "standard monthly income" together with the "standard bonus amount" are multiplied by 1.79% —the JHIA's LTC premium rate of the reference year (2020). The resulting amount, ¥10,289, is the LTC premium, of which 50% is borne by the employee and 50% borne by the employer.

Source: kaigonohonne.com (2021b)
Note: A complete list of the 2020 monthly salary rates for JHIA in Tokyo are available at the following site: https://www.kyoukaikenpo.or.jp/~/media/Files/shared/hokenryouritu/r2/ippan_3/r20913tokyo.pdf.

Table 5: Tokyo Gas Health Insurance Society - LTC Premium

Primary Insured Person Age	Dependent Age	LTC Insurance Premium
Less than age 40	Less than age 40	LTC premium is not collected for either the primary insured person or their dependent.
Less than age 40	Age 40 - 64	LTC premium is not collected for the primary insured person, who have to pay LTC premium for dependents (LTC Insured Type 2). The primary insured person becomes the "specified insured person" and pays their dependent's LTC premium to the Tokyo Gas Health insurance Society according to the "specified insured person system."
Less than age 40	Age 65 and older	LTC premium is not collected for the primary insured person and dependent has to pay LTC premium to the municipality.
Age 40 - 64	Less than age 40	Primary insured person's LTC premium is collected by the Tokyo Gas Health Insurance society. LTC premium collection does not apply to dependent.
Age 40 - 64	Age 40 - 64	Both the primary insured person and dependent's LTC premium are paid to the Tokyo Gas Health Insurance Society.
Age 40 - 64	Age 65 and older	Primary insured persons pay LTC premium to the Tokyo Health Insurance Society and dependent's LTC premium are paid to the municipality.
Age 65 and older	Less than age 40	Primary insured persons pay their LTC premium to the municipality. LTC premium collection does not apply for dependents.
Age 65 and older	Age 40 - 64	Primary insured persons pay their LTC premium to the municipality and LTC premium for dependents (LTC Insured Type 2). The primary insured person becomes the "specified insured person" and pays dependent's LTC premium to the Tokyo Gas Health insurance Society according to the "specified insured person system."
Age 65 and older	Age 65 and older	Primary insured persons and their dependents pay LTC premium to the municipality.

Source: Tokyo Gas Health Insurance Society (2021).

Table 6: Kihon Checklist

Question Number	Questions	Response Options
1	Do you go out alone by bus or train?	0. Yes; 1. No
2	Do you shop for daily necessities?	0. Yes; 1. No
3	Do you withdraw money?	0. Yes; 1. No
4	Do you visit a friend's house?	0. Yes; 1. No
5	Do you talk to family and friends?	0. Yes; 1. No
6	Do you going up the stairs without railings or walls?	0. Yes; 1. No
7	Can you stand up from a sitting position without grabbing anything?	0. Yes; 1. No
8	Have you been walking for about 15 minutes in a row?	0. Yes; 1. No
9	Have you fallen in the past year?	0. No; 1. Yes
10	Are you worried about falling?	0. No; 1. Yes
11	Have you lost more than 2/3kg in 6 months?	0. No; 1. Yes
12	Body mass index (BMI) = $\frac{\text{Body weight (kg)}}{\left(\text{Height (cm)} \times 100\right)\text{^}2}$	0. If BMI ≥ 18.5; 1. If BMI <18.5
13	Is it harder to eat hard things than six months ago?	0. No; 1. Yes
14	Do you have tea or soup that you can chop up?	0. No; 1. Yes
15	Are you worried about dry mouth?	0. No; 1. Yes
16	Do you go out at least once a week?	0. Yes; 1. No
17	Are you going out less often than last year?	0. No; 1. Yes
18	Do people around you tell you that you have forgetfulness such as "I always hear the same thing?"	0. No; 1. Yes
19	Do you look up phone numbers yourself and make phone calls?	0. Yes; 1. No
20	Are there times when you don't know what month or day today is?	0. No; 1. Yes
	Based on your feelings in the past 2 weeks, do you agree with the following statements:	
21	"There is no sense of fulfillment in everyday life"	0. No; 1. Yes
22	"I can no longer enjoy what I used to enjoy doing"	0. No; 1. Yes
23	"What used to be easy now feels like a big deal"	0. No; 1. Yes
24	"I don't think I'm a useful person"	0. No; 1. Yes
25	"I feel like I've been tired for the last two weeks"	0. No; 1. Yes

Source: MHLW (2009)

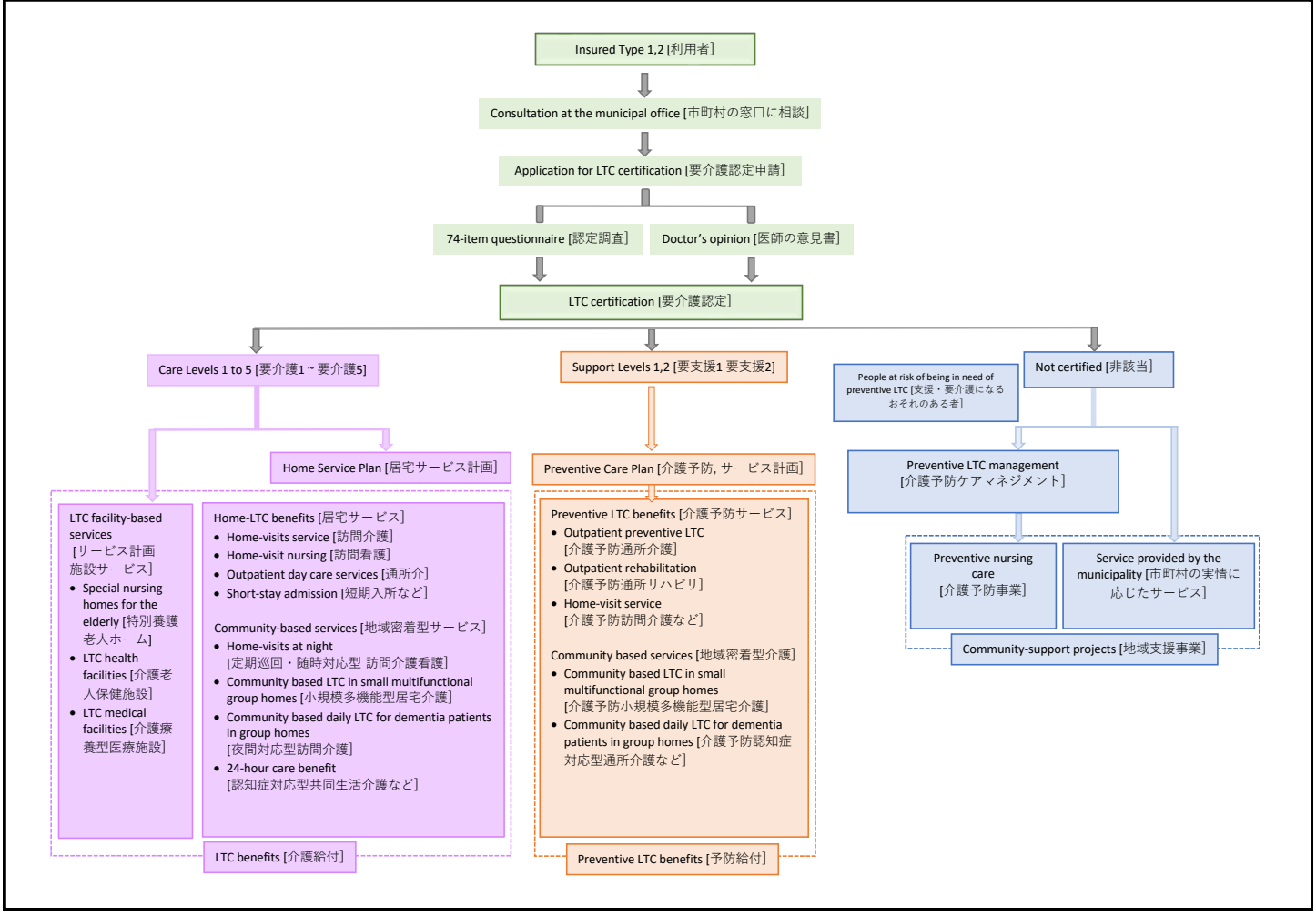
Table 7: Kihon Checklist - Results Interpretation

Category	Description
10 or more positive responses from questions 1 to 20	General difficulty expressed by multiple items
3 or more positive responses from questions 6 to 10	Decrease in mobility
Positive response to both questions 11 and 12	Undernourished
2 or more positive responses from questions 13 to 15	Decline in oral functions
1 or more positive response from questions 16 and 17	Confinement
1 or more positive response from questions 18 to 20	Decline in cognitive functions
2 or more positive responses from questions 21 to 25	Possibility of depression

Source: City of Iwaki (2022)

Notes: A positive response to a question is defined as a value of 1 in Table 6. People satisfying one of the seven categories displayed in the table are eligible for the Comprehensive Program system as beneficiary eligible for service programs.

Figure 1: Procedure for Use of LTC Services Before Implementation of the Comprehensive Program



Note: The figure depicts an applicants' evaluation process before the 2014 reforms become effective. Effective dates vary by prefecture, but all prefecture's had to implement changes no later than 2017.
Source: Authors' interpretation of MHLW (undated).

Table 8: Intermediate Evaluation Group 1 — Physical Function, Sitting, Standing

Item	Status Level 1	Score Level 1	Status Level 2	Score Level 2	Status Level 3	Score Level 3	Status Level 4	Score Level 4	Status Level 5	Score Level 5
Paralysis	Does not exist	6.5	Monoplegia	5.5	Paraplegia	3.9	Hemiplegia	3.3	Quadriplegia	0.0
Shoulder Contracture	Does not exist	2.3	Exists	0.0	-	-	-	-	-	-
Hip Contracture	Does not exist	2.7	Exists	0.0	-	-	-	-	-	-
Knee Contracture	Does not exist	1.1	Exists	0.0	-	-	-	-	-	-
Roll over in bed	Possible	9.0	Using upper limbs	6.5	Impossible	0.0	-	-	-	-
Sitting up in bed	Possible	8.8	Using upper limbs	6.7	Impossible	0.0	-	-	-	-
Keep sitting	Possible	10.0	Using upper limbs	8.4	Needs assistance	4.7	Impossible	0.0	-	-
Hold standing position with two legs	Possible	8.7	Needs assistance	6.2	Impossible	0.0	-	-	-	-
Walking	Possible	7.6	Needs assistance	5.5	Impossible	0.0	-	-	-	-
Standing up	Possible	9.7	Using upper limbs	7.1	Impossible	0.0	-	-	-	-
Hold standing position with one leg	Possible	7.3	Needs assistance	5.4	Impossible	0.0	-	-	-	-
Washing oneself	Independent	6.2	Partially dependent	4.4	Totally dependent	0.0	Not able	0.0	-	-
Cutting nails	Independent	4.1	Partially dependent	2.8	Totally dependent	0.0	-	-	-	-
Acuity	Normal	5.2	Possible at 1 meter distance	4.0	Possible if close to own eye	2.9	Almost blind	0.0	Impossible to evaluate	0.0
Hearing	Normal	10.8	Occasionally difficult	10.6	Possible using a loud voice	9.8	Almost deaf	9.0	Impossible to evaluate	0.0

Notes: Levels range from the least (Level 1) to the most (Level 5) dependent. The number of levels depend on the item and evaluation group.

Source: Matsuda et al. (2011a)

Table 9: Intermediate Evaluation Group 2 —ADL Function

Item	Status Level 1	Score Level 1	Status Level 2	Score Level 2	Status Level 3	Score Level 3	Status Level 4	Score Level 4
Transfer (e.g. bed to wheel chair)	Independent	9.1	Needs watching	6.9	Partially dependent	3.5	Totally dependent	0.0
Mobility	Independent	8.1	Needs watching	6.4	Partially dependent	3.7	Totally dependent	0.0
Swallowing	Independent	10.2	Needs watching	7.2	Impossible	0.0	-	-
Eating	Independent	9.8	Needs watching	6.8	Partially dependent	4.6	Totally dependent	0.0
Urination	Independent	7.2	Needs watching	5.9	Partially dependent	5.1	Totally dependent	0.0
Defecation	Independent	7.2	Needs watching	5.7	Partially dependent	4.9	Totally dependent	0.0
Oral hygiene	Independent	9.3	Partially dependent	5.2	Totally dependent	0.0	-	-
Washing face	Independent	9.0	Partially dependent	5.1	Totally dependent	0.0	-	-
Hairdressing	Independent	7.9	Partially dependent	4.1	Totally dependent	0.0	-	-
Wearing on/off shirt and jacket	Independent	9.4	Needs watching	8.0	Partially dependent	5.7	Totally dependent	0.0
Wearing on/off pants, trousers, and skirt	Independent	8.7	Needs watching	7.3	Partially dependent	5.4	Totally dependent	0.0
Going outdoor	More than once a week	4.1	More than once a month	3.4	Less than once a month	0.0	-	-

Source: Matsuda et al. (2011a)

Notes: Levels range from the least (Level 1) to the most (Level 4) dependent. The number of levels depend on the item and evaluation group.

Table 10: Intermediate Evaluation Group 3 —Cognitive Function

Item	Status Level 1	Score Level 1	Status Level 2	Score Level 2	Status Level 3	Score Level 3	Status Level 4	Score Level 4
Communication	Possible	17.7	Occasionally	12.5	Almost impossible	4.2	Impossible	0.0
Orientation								
Schedule	No problem	7.6	Disturbed	0.0	-	-	-	-
Birthday	No problem	11.3	Disturbed	0.0	-	-	-	-
Short term memory	No problem	7.0	Disturbed	0.0	-	-	-	-
One's name	No problem	16.3	Disturbed	0.0	-	-	-	-
Current season	No problem	11.6	Disturbed	0.0	-	-	-	-
Wandering	Never	9.5	Occasionally	2.7	Often	0.0	-	-
Difficulty returning home	Never	9.9	Occasionally	4.7	Often	0.0	-	-

Source: Matsuda et al. (2011a)
Notes: Levels range from the least (Level 1) to the most (Level 4) dependent. The number of levels depend on the item and evaluation group.

Table 11: Intermediate Evaluation Group 4 —BPSD-Related Problems

Item	Status Level 1	Score Level 1	Status Level 2	Score Level 2	Status Level 3	Score Level 3
Persecutory tendency	Does not exist	7.0	Occasionally	3.2	Exists	0.0
Confabulation	Does not exist	8.2	Occasionally	3.4	Exists	0.0
Rapid changes in mood	Does not exist	5.0	Occasionally	2.5	Exists	0.0
Reversal of the night-day sleep-wake cycle	Does not exist	4.2	Occasionally	1.9	Exists	0.0
Repeat the same story	Does not exist	4.9	Occasionally	3.0	Exists	0.0
Shouting	Does not exist	7.0	Occasionally	2.8	Exists	0.0
Resistance to care	Does not exist	6.1	Occasionally	2.4	Exists	0.0
Restless	Does not exist	7.8	Occasionally	2.1	Exists	0.0
Eager to go out by oneself	Does not exist	8.7	Occasionally	2.3	Exists	0.0
Collection mania	Does not exist	8.3	Occasionally	1.6	Exists	0.0
Violence	Does not exist	10.7	Occasionally	2.3	Exists	0.0
Severe memory loss	Does not exist	4.0	Occasionally	3.3	Exists	0.0
Abnormal muttering and loughing to oneself	Does not exist	6.5	Occasionally	2.3	Exists	0.0
Selfish behavior	Does not exist	6.3	Occasionally	3.0	Exists	0.0
Endless talking	Does not exist	5.3	Occasionally	1.9	Exists	0.0

Source: Matsuda et al. (2011a)
Notes: Levels range from the least (Level 1) to the most (Level 3) dependent. The number of levels depend on the item and evaluation group.

Table 12: Intermediate Evaluation Group 5 —Adaptation to Social Life

Item	Status Level 1	Score Level 1	Status Level 2	Score Level 2	Status Level 3	Score Level 3	Status Level 4	Score Level 4
Taking drugs	Independent	21.2	Partially dependent	9.9	Totally dependent	0.0	-	-
Handling finance	Independent	18.2	Partially dependent	9.5	Totally dependent	0.0	-	-
Daily decision making	Possible	22.5	Possible in ordinary situations	13.7	Difficult	5.5	Impossible	0.0
Difficulty of adaptation to group activity	Does not exist	6.1	Occasionally	1.8	Exists	0.0	-	-
Shopping	Independent	16.6	Needs watching	9.2	Partially dependent	7.4	Totally dependent	0.0
Cooking	Independent	15.4	Needs watching	9.0	Partially dependent	8.6	Totally dependent	0.0

Source: Matsuda et al. (2011a)

Notes: Levels range from the least (Level 1) to the most (Level 4) dependent. The number of levels depend on the item and evaluation group.

Table 13: Intermediate Evaluation Group 6 —Theoretical Time Required for Care Related to Specific Medical Treatments

Treatment	Minutes
Drip infusion in vein	8.5
Intravenous hyperalimentation	8.5
Dialysis	8.5
Stomach care	3.8
Oxygen therapy	0.8
Use of respirator	4.5
Tracheostomy	5.6
Nursing care for pain	2.1
Tubal feeding	9.1
Use of monitoring devices	3.6
Care of decubitus	4.0
Urethal catheter	8.2

Source: Matsuda et al. (2011a)
Notes: If a person receives specific medical care in this table within the last 14 days, the corresponding time is added to expected time for care estimated as a sum of decision trees outputs

Table 14: LTC System - Eligibility Levels (2021)

Dependence Level	Eligibility Criteria	Monthly Coverage
Not certified or beneficiary eligible for service program	Under 25 minutes	-
Support Level 1	25 to 31 minutes	5,032 units
Support Level 2	32 to 49 minutes with stable condition	10,531 units
Care Level 1	32 to 49 minutes with unstable condition	16,765 units
Care Level 2	50 to 69 minutes	19,765 units
Care Level 3	70 to 89 minutes	27,048 units
Care Level 4	90 to 109 minutes	30,938 units
Care Level 5	110 minutes and more	36,217 units

Source: Authors' interpretation of LIFULL (2021)
Notes: LTC service rates are based on the a "unit concept", where 1 unit $\approx$ 10 yen. Ratio differs according to region. The table displays unit amounts converted to yen at a 1 to 10 ratio.

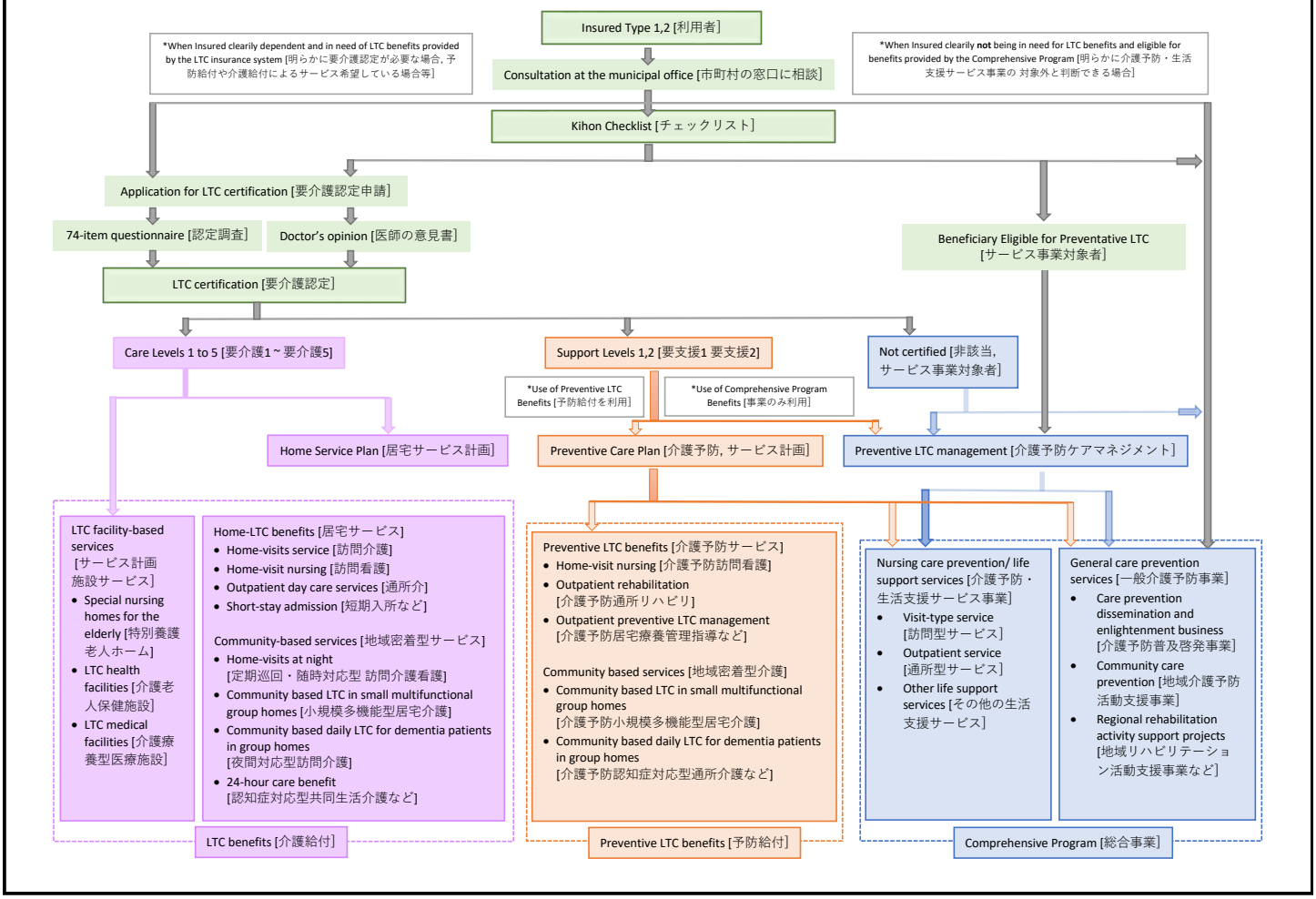
Table 15: Coinsurance Monthly Limits (2021)

Dependence Level	Maximum Benefit Amount	10% Coinsurance Limit	20% Coinsurance Limit	30% Coinsurance Limit
Not certified	-	-	-	-
Support Level 1	¥50,320	¥5,032	¥10,064	¥15,096
Support Level 2	¥105,310	¥10,531	¥21,062	¥31,593
Care Level 1	¥167,650	¥16,765	¥33,530	¥50,295
Care Level 2	¥197,650	¥19,765	¥39,410	¥59,115
Care Level 3	¥270,480	¥27,048	¥54,096	¥81,144
Care Level 4	¥309,380	¥30,938	¥61,876	¥92,814
Care Level 5	¥362,170	¥36,217	¥72,434	¥108,651

Source: LIFULL (2021)

Notes: LTC service rates are based on the a "unit concept", where 1 unit ≈ 10 yen. Ratio differs according to region. The table displays unit amounts converted in yen, at a 1 to 10 ratio. Coinsurance limits are the maximum monthly out-of-pocket cost for home-based benefits.

Figure 2: Procedure for Use of LTC Services After Implementation of the Comprehensive Program



Note: The figure depicts an applicants' evaluation process after the 2014 reforms become effective. Effective dates vary by prefecture, but all prefecture's had to implement changes no later than 2017.

Source: Authors' interpretation of MHLW (undated).

Box 3: Comprehensive Program Benefits - City of Hiroshima (2021)

Monthly coverage in units of the benefits provided by the Comprehensive Program system in Hiroshima city.[1]

Home-visit Preventive Service

Service Frequency	Monthly Benefit Coverage
Once a week	1,176 units
Twice a week	2,349 units
More than twice a week (for Support 2 only)	3,727 units

Livelihood support Preventive Service

Service Frequency	Monthly Benefit Coverage
Once a week	990 units
Twice a week	1,977 units
More than twice a week (for Support 2 only)	3,136 units

Day Care Preventive Service

Service Frequency	Monthly Benefit Coverage
Business target person or Support 1	1,672 units
Twice a week (Support 2 only)	1,672 units
More than twice a week (Support 2 only)	3,428 units

Short-term Stay Preventive Service

Service Frequency	Monthly Benefit Coverage
Business target person or Support 1	1,443 units
Twice a week (Support 2 only)	1,443 units
More than twice a week (Support 2 only)	2,955 units

Source: City of Hiroshima (2022)

Notes

[1] 1 unit ≈ ¥10. Ratio differs according to region.

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of daily living (ADL): A common set of activities related to personal care used to assessed independence. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Beneficiary eligible for service programs (サービス事業対象者): A "Beneficiary eligible for service programs" is a dependency level where a person is determined to need care less than 25 minutes per day but is also not completely independent in ADLs and IADLs. These persons are eligible for services provided by the Comprehensive Program system

Care Levels: Care levels are dependency levels where a person is incapable of living independently, requiring assistance in basic ADLs. There are five Care Levels. Persons classified as Care Levels 1 to 5 are eligible for most LTC Insurance benefits.

Comprehensive Program (総合事業, CP): A LTC care system operated and funded by municipalities that promotes keeping aging persons in their own community rather than using LTC insurance services. CP systems are unique to each municipality. Adoption of a CP system was made compulsory for municipalities in the 2014 LTC reform, requiring the transition of most nursing care preventive benefits and daily life support services from the LTC system to each municipality's CP system by the end of 2017.

Comprehensive Community Care System (CCCS): System for preventive LTC benefits provision managed by municipal governments

Disability Independence Support System: A public Japanese welfare system for people with disabilities that provides some LTC services for persons not qualifying for LTC Insurance benefits.

Employees' Health Insurance (EHI): One of the Japanese health insurance systems that is available to employees and their dependents through their employers. Employees' Health Insurance schemes are the Japan Health Insurance Association, Health Insurance Societies, the Crew Insurance, and Mutual Aid Associations. The Japan Health Insurance Association covers employees of small- to medium sized companies, while large companies are covered by Health Insurance Societies. Mutual Aid Associations are typically insurers for national and local government workers and private school faculty and staff.

Instrumental activities of daily living (IADL): A common set of activities used to evaluate a person's ability to live independently in their community. They include being able to prepare hot meals, shop of groceries, take medication, manage money, use a phone, or use a map.

Insured Type 1: One of two LTC Insurance types. Insured Type 1 are persons age 65 years or older.

Insured Type 2: One of two LTC Insurance types. Insured Type 2 are persons aged 40 to 64 and covered by a health insurance program (EHI or NHI systems). Benefits from LTC Insurance for Insured Type 2 persons are more limited than Insured Type 1 persons.

Kihon checklist: A preliminary care assessment tool for determining if an applicant qualifies for benefits provided by LTC insurance or the Comprehensive Program system. It is a 25-item self-administered questionnaire introduced by the Ministry of Health, Labour and Welfare in 2006, aimed at identify elderly individuals at risk for being certified in need of LTC benefits in the near future.

National Health insurance (NHI): One of the Japanese health insurance systems that is available to agriculture, forestry and fisheries workers, students, self-employed, part-time workers, retirees, and unemployed people not covered by EHI.

Support Levels: Support levels are dependency levels where a person's ability to perform activities of daily living (ADL) is slightly reduced and support or partial care is needed. People belonging to these dependence levels may need daily wellness visits for doing household chores such as cleaning a room and they may need some support for complicated movements such as standing up or standing with both feet and for standing up and walking. People are typically independent in eating and toileting functions. Prior to 2006, there was only one Support Level. Since 2006, there are two Support Levels. Support Levels 1 to 2 qualify for some LTC Insurance benefits as well as benefits from the Comprehensive Program system.

Version information

Current Version: 1.0 (September 2023)

Version History

- 1.0 (September 2023): First version.

Additional resources

The following resources provide additional details for the interested reader:

Ministry of Health, Labour and Welfare (undated). 介護保険三施設の比較 [Comparison of the three long-term care insurance facilities]. Available in Japanese only. As of July 25, 2022.
Available at: https://www.mhlw.go.jp/shingi/2003/12/s1222-4f4.html
Features: Provides further details concerning the different types of LTC nursing care facilities

National Tax Agency (undated). 第 7 節: 社会福祉事業等関係 [Section 7: Social Welfare Business, etc.]. Available in Japanese only. As of July 25, 2022.
Available at: https://www.nta.go.jp/law/tsutatsu/kihon/shohi/06/07.htm
Features: Additional information concerning the changes in the maximum payment limit covered by LTC Insurance for home-based benefits from 2003 to 2021 reported in Table 3

Ministry of Health, Labour and Welfare (undated). 障害者自立支援法のサービス利用について 平成 24 年 4 月版 [About the use of services of the Act on the Independence of Persons with Disabilities April 2012]. Available in Japanese only. As of July 25, 2022.
Available at: https://www.mhlw.go.jp/bunya/shougaihoken/b_shien/pamphlet.html
Features: Additional information about the disability welfare system

City of Nagoya (2006). 認定調査員テキスト 2006: 平成 18 年 1 月 [Certified Investigator Text 2006: January 18, 2006]. Available in Japanese only. As of July 25, 2022.
Available at: https://www.kaigo-wel.city.nagoya.jp/view/kaigo/docs/2007041900014/files/kuni_text2006.pdf
Features: Detailed information concerning the 82-items assessment questionnaire