Comprehensive Long-Term Care: Affordable, Doable, Controllable (The Japan Case)

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Our Argument

• Comprehensive Long-Term Care is
• Affordable
• Doable
• Controllable
• The first point is “affordable,” via an accounting comparison
• Then the other two, via an account of the Japanese experience
Our Interpretation

• Germany and Japan have comprehensive public long-term care systems, based on mandatory social insurance, covering everyone who needs care
• LTC in the US has much private finance; it is fragmented and inadequate
• Yet the American government spends way more than Germany, and either a bit more or a bit less than Japan depending on definitions
Public Spending on LTC per 65+ Person in 2005
By Function

$ PPP

US
Germany
Japan

Administration
Post-Acute
LTC in Hospitals
Nursing Home
Cash Allowance
HCBS-services
US-Japan-Germany Compared

• This project is by Naoki Ikegami, Mary Jo Gibson of AARP, and me

• It is different from others’ comparisons
  – Public spending only, not total
  – On older people only, not younger disabled
  – Metric is $PPP/65+ person, not %GDP
  – We compare services, not budget categories
  – When precise data are lacking we estimate, not ignore
Look at the United States

- This is public money only, 65+ only
- Bottom two are Medicaid, VA, bit of AOA
- Top is Medicare post-acute, much of which would count in LTC elsewhere
Look at Germany

- Social Insurance
- Aims at 50% of need
- Cash benefit option is much less than that
- 10% of 65+ get benefits
- Therefore much lower cost than Japan
Look at Japan

- Social insurance
- 90% of need
- Services only
- 15% of 65+ get benefits
- Lots of LTC is in hospitals, paid by health insurance
Let’s look at the same data from a different angle: how much of the money is spent on older people who live at home, and how much on those who are in institutions?
Public Spending on LTC per 65+ Person in 2005
For People Living at Home vs in Institutions

$ PPP

US  Germany  Japan

Care in Institutions  Care at Home
Why Different?

- US at-home is higher here because of (expensive) Medicare home health as post-acute
- Germany low on institutions because copays are higher
We Conclude That . . .

• All aging nations must deal with the growing number of frail older people, and the decline in traditional support (i.e. family, i.e. women)

• Two approaches
  – Rely on private care as much as possible, government comes in ad hoc
  – Establish a comprehensive framework with government in the lead

• Our conclusion is, the latter is cheaper
The Case of Japan

• Fastest population aging in the world
• Traditional supports--family caregiving--more problematical than elsewhere
  – 介護地獄 (caregiving hell) for daughters-in-law an emotional issue
• In the 1990s opted for a comprehensive systems on the social insurance model
Kaigo Hoken in Brief

• Social Insurance based on premiums (+ taxes)
• Eligibility by ADL, not income or available support
• Client chooses services (not cash) up to a cap, with advice from a “care manager”
• Two levels of “support” for 800,000 quite light cases at $430-$900 (PPP) a month
• Five levels of “care” for 3,000,000 light to heavy cases at $1430-$3170 a month
• A 10% co-pay and most people use about half of the entitlement
• Providers including for-profits compete in HCBS
• Cost is about $60 billion (PPP)
Doable

• Massive program started up much more smoothly than expected--eligibility process worked, enough providers, etc.
• Management has worked well--in particular, competition, choosing services with CM (at least in urban areas)
• Can say that beneficiaries and their families appreciate it, public supports it. Now seen as normal social policy.
Controllable

- Program grew more quickly than estimated (threshold was too low)
  - 16% of 65+; Germany is 10%; wanted 12%
- Tried to economize
  - Reducing fees
  - Capping institutional beds
  - Picky restrictions and supervision
- Didn’t really work, and caused problems, especially in keeping the labor force
But Could Control

• In 2006, a major reform
  – Light care cases shunted to new “prevention” system, lower costs
  – More “hotel costs” in institutions transferred to beneficiaries
• Succeeded in slowing growth rate—it is not an entitlement program out of control
• Note also controlled institutional growth (but struggling with long hospital stays)
Control Beyond Japan

- Germany imposed tight fiscal controls at the start and kept spending low for years
- Sweden in 1990s redirected community-based care from light cases to the heaviest
- The US famously cut home health care in half, from $18B to under $9B, 1997-1999
- In general governments have been able to control or reform LTC, especially compared to acute health care.
Our Case

• This is really an argument for comprehensive LTC in the US
• The striking finding is how much public money the US spends with its fragmented, partly private system—LTC is similar to health care in that respect
• An interesting finding is comprehensive LTC can be quite inexpensive as in Germany
Thoughts About Japan

• Demonstrates that a large-scale system can work outside of northern Europe
• Funny effect of “culture” . . .
• Japan is usually seen as the epitome of family values
• But its system is formal services only, no cash allowance for family care as in Germany