
Japan

Highlights from *A Good Life in Old Age? Monitoring and Improving Quality in Long-Term Care*, OECD Publishing, 2013.

- Japan has the highest projected share of the population aged over 80 years in the world for 2050. Despite that projection, Japan has thus far succeeded in containing long-term care (LTC) expenditure – at 1.2% of GDP in 2010 – to levels well below that of other comprehensive LTC systems, such as Sweden (3.58% of GDP in 2010) or the Netherlands (3.7% of GDP). Yet Japan public spending on LTC is projected to more than double, and could even reach 4.4% of GDP in 2050 based on the 2011 OECD projection.
- LTC quality assurance of Japan centres around ensuring skill levels of LTC workers. Japan is one of a few OECD countries imposing high skill requirements for LTC workers. The training duration for a certified care workers in Japan is the minimum of 130 hours to become an entry level care worker, compared to two weeks for home health aide in the United States. Japan also offers financial incentives for providers to provide care workers with continuous training opportunities.
- Japan has fewer LTC workers than most OECD countries. In institutions, Japan 15 LTC workers per 1000 people aged 65 years old and over is about the OECD average of 3.2. In home care setting, Japan has 39 LTC workers compared to an OECD average of 3.1. The majority of long-term care workers are personal carers (85%) and nurses represent a small share (15%) (OECD Health Data 2012).
- Japan lags behind other OECD countries in efforts to develop and collect indicators on quality of care services. National surveys collect information on utilisation; however the focus has been on administrative information, benefits, utilisation and structural indicators, with little information on safety, care effectiveness, and user experience. Japan could look at the experience of other OECD countries such as Canada, the United States and Finland that are measuring clinical quality outcomes for LTC services, for example on things such as pressure ulcers, use of physical restraints and malnutrition. Information collected from the standardised assessment tool to evaluate elderly care needs could be developed into a set of quality indicators.
- Accreditation of all LTC facilities in Japan is compulsory, and a condition for public reimbursement. Japan is one of the few OECD countries that has accreditation for home care providers, along with Australia and Germany.
- Japan single-entry assessment and case management system is a good way to encourage service integration. Case managers have the responsibility for creating care plans and monitoring conditions, from assessment to referral and end of care, which covers both LTC and health care.
- While the 2009 LTC reform introduced an annual public reporting system on LTC services in Japan, information regarding quality and the use of third-party agencies for evaluation is limited and the voluntary nature of this reporting systems means that less than 8% of the facilities participate in the assessment and public reporting procedure.
- Japan is one of the few OECD countries, along with the United States and Korea that has been seeking to use payment incentives for improved outcomes. Providers are entitled for financial rewards for successful rehabilitation of LTC recipients, discharge from institutions to home, or for improvements in physical functions.

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Key facts

- In 2012, 24.1% of the Japanese population was over the age of 65 (OECD average 15% in 2010) and 7.0 % of the population was over the age of 80 (OECD average 4% in 2010). By 2050, 39% of the Japanese population will be over the age of 65 and 16.5% of the population will be over the age of 80 (OECD Historical Population Data and Projections Database, 2013).
- LTC spending as a share of GDP is relatively low in Japan comparing the average of the OECD countries. Japan's public expenditure on LTC was 1.2% of GDP in 2010 (OECD average 1.6%). The growth in public expenditure on LTC (health component) was 1.1% over the period of 2000 and 2009, about the same as the OECD average (OECD Health Data 2012)
- The number of elders receiving care at home – compared to institutions – is high. In total of 12.6% of the population over the age of 65 received long-term care, of which 2.8% in institutions (4% OECD average) and 9.8% at home (OECD average 7.9%) in 2011 (OECD Health Data 2012).

Background

Japan introduced a Long-Term Care Insurance (LTCI) programme in 2000, similar to the systems found in Germany, the Netherlands, Luxembourg, and, most recently, Korea. The source of funding is mixed: 45% of the funding comes from taxes, 45% from social contributions, and 10% from cost-sharing. Social insurance contributions are paid for by people aged 40 years or older, allowing funding from a broad pool. The Long-Term Care Insurance programme is managed by individual municipalities. Eligibility is determined by uniform standards across Japan. Providers can be both for-profit and non-profit in home, while institutional care remains mainly non-profit. Private insurance (critical illness insurance) is available but plays a minor role. Public contributions vary by category of insured persons and income level. Each municipality determines the ratio of the fee collected from insured persons. The contribution is reviewed every three years (Colombo et al, 2011).

The Long-Term Care Insurance Act was revised in 2011, adding in the law some aspects of quality, a focus on promoting comprehensive support throughout LTC, medical care, prevention, and housing; the revision also introduces 24-hours regular visiting/on-demand services and extend the scope of care plans to cover all aspects of social care and activities. Certified LTC workers are allowed to perform certain medical services such as aspiration of sputum.

Monitoring of LTC services

National surveys collect information on LTC services and utilisation; however the collection of quality information and user satisfaction is limited. These surveys are carried out on a regular basis and each of them has different objectives. *Survey of Institutions and Establishments for Long-term Care* aims to capture the status and contents of services provided to people receiving LTC services. Other surveys such as *Survey of Long-term Care Benefit Expenditure*, *Fact-finding Survey on Economic Conditions in Long-term Care* and *Survey of report on Long-term Insurance project* mainly collect information on benefits and fees associated with LTC services. In Japan, providers can self-assess their services and submit information on available services and management, while prefectural governors or contracted agencies monitor other information from external reviews or inspections (JPHA, 2009).

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Quality assurance mechanisms

Care quality and elderly protection legislation

The Act on Prevention of Elderly Abuse and Support for Attendants of Elderly Persons was established in 2005 to protect the rights of people requiring LTC and protect the elderly from abuse. The purpose of this law is to reduce the guardian's burden, as well as to prevent guardians and LTC workers from abusing the elderly. Under this programme, anyone who thinks that an elderly person is being abused by a guardian should report this problem to the municipality. The municipality then confirms the details, offers temporary protection to the affected elder and conducts an on-the-spot investigation.

Accreditation and certification of providers and organisations

In Japan, accreditation of facilities is compulsory, and a condition for reimbursement. Japan is one of the few OECD countries that has accreditation for home care providers. The prefectures give certifications to providers and the municipalities supervise and audit LTC providers to ensure proper management. There are regulations on the standard of providers, facilities and managements for each LTC service. All service providers whose LTC fees are reimbursed by LTCI should be accredited by the prefecture of each municipality. The standards for certification related to human resources, complaints handling procedures and elderly protection, management and administration, and care services provided.

The government sets a fee schedule for each LTC service. Since 2009, a financial incentive for high-performing LTC providers has been added to the fee-for-service payment schedule. This is set to reward providers that exceed minimum requirements on certain criteria such as improvements in physical functions. Providers are entitled for financial rewards when a certain percentage of their LTC users experienced improved condition after ambulatory long-term care and ambulatory rehabilitation. For instance, there are additional payment for nursing homes that are successfully discharge elderly people from institutions to home, above a given threshold (JPHA, 2011). Additional payments can be given to community-based care services (*houmon-tsuusho-related-services*) when a certain proportion of users successfully improves their physical functions. A bonus payment is granted to nursing homes that recruit staff with a particular expertise (such as nutritionists, staff trained in dementia care, work experience of staff, etc), or have comprehensive care planning for end-of-life care and rehabilitation.

Qualification and certification of workforce

Japan has emphasised educational and workforce standards as the principal quality-assurance mechanism in LTC. The government also offers financial incentives for providers to hire more certified care workers and to provide them with continuous training opportunities.

Workforce standards are higher than in most OECD countries. Every LTC worker should be certified by a State Examination as Certified Social Worker. The examination is taken by care workers after completing a combination of theoretical and practical training for two to four years or college/university education in care-related subjects. The training required to undertake the State Examination test can consist of two-year programme at a training facility (1650 hours), a training programme in high school (1190 hours) or more than three years of experience in a personal care-related occupation. Some "medical care" for everyday life issues have been added to the trainings (such as suctioning of phlegm and tubal feeding in homes). Certified care workers can now carry out certain "medical care procedures.

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Monitoring and standardisation of processes

Needs assessment, care planning

To access LTC, there is a single-entry system, offering a way to encourage service integration. The single entry point is combined with a case management system. In Japan, case managers have the responsibility for creating care plans and monitoring conditions, from assessment to referral and end of care.

Each municipality ascertains the need for LTC services. Municipalities establish a “Municipal Long-Term Care Insurance Service Plan” once every three years based on the Long-Term Care Insurance Act. In the process of drawing the plan, municipalities assess the elderly care needs and make estimates of the volume of services. Based on the plan, prefectures and municipalities set up LTC insurance premiums and plans for improving the infrastructure of LTC services. When municipalities draw up the plan, they refer to “Basic guidelines for ensuring the efficient implementation of benefits by long-term care insurance projects”.

At the individual level, people can receive LTC insurance services after going through a needs’ assessment process that is adjusted to individual needs and circumstances. Every individual can apply and is eligible to have their LTC needs assessed. The needs assessment process combines a standardised needs assessment survey (an 85-item questionnaire, used to assign each applicant to one of seven needs levels) with information coming from other sources, such as from case workers, volunteers, as well as community residents. Care managers are responsible for making individual care plans. When providing services in very difficult situations or requiring collaboration with other sectors, the support policy is decided and co-ordinated through a multidisciplinary team, a local independent committee of physicians, care managers, and academics, hosted by a “Community General Support Center” set up by municipalities.

Practice guidelines

In Japan, the development of practice guideline is not mandatory, but each provider and organisation produces their own set of internal (non clinical) guidelines and monitors care workers’ compliance.

System improvement through incentives

Public reporting

The 2009 LTC reform introduced an annual public reporting system on LTC services (JPHA, 2011). The system has three types of public reporting. The first is mandatory for all service providers; the second is mandatory for small-scale multifunctional home care, daily group care for the seniors with dementia and community-based LTC prevention providers, while the last is a voluntary procedure for welfare facilities for the elderly. Municipalities are responsible for public reporting in the first two cases, while contracted agencies are responsible for voluntary reporting (JPHA, 2009). Under the mandatory reporting system, all service providers are required to submit information on staffing registration, vacancies, and a list of available services, as well as results of investigators’ surveys. This information is available through each prefecture, and reporting criteria are standardised. Each prefecture can also require service providers to report on additional information, in which case each prefecture decides criteria for evaluation and methodology. For community-based LTC services and prevention services, the reporting process starts with the collection of information from self-assessment and external assessment. The questions seek to examine the governance, management, community relationship, compliance to policies against abuse and human rights, training of staff, quality of life of users, and care management. The assessment is based on open-ended questions and no quality indicator is drawn, nor are providers ranked or graded. Rather, the information supports consumer decisions and helps provider self-improvement efforts. For welfare

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facilities for the elderly, the assessment process involves open-ended questions about quality of services and a few items evaluating achievements (JPHA, 2012). Each designated external agency sets their quality criteria. Assessment procedures are composed of paper investigation and on-site visits. There is no quality indicator or rankings. The government has prepared national guidelines for evaluation, and the process is annual or biannual. Because of its voluntary process, only 7.5% of the special nursing homes for the elderly and 3.2% of the total number of group homes for the elderly people with dementia underwent the assessment in 2011.

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