

---

## Case study

---

# Japan

Naoki Ikegami  
Keio University  
Tokyo, Japan

## Abstract

Health care and long-term care (LTC) services are an entitlement to all older people in Japan. However, the government's responsibility in health care differs markedly from its responsibility in LTC. In health care, social health insurance (SHI) covers and pays all effective services and pharmaceuticals that are available at the point of delivery. The amount paid by the patient is capped to an affordable level. Extra billing and balance billing are strictly regulated. In contrast, in public LTC insurance (LTCI), benefits are restricted to the amount that is set by the individual's eligibility level. This level is based on a computer algorithm that sorts the applicant's responses to a 74-item questionnaire on his or her functional and cognitive performance. There are no cash benefits. Those eligible choose their care manager who draws the care plan and organizes services that would best meet the client's needs. Although users can purchase more services by paying out-of-pocket, very few actually do so. Following its implementation in 2000, services have greatly expanded. In particular, the development of special "housing" that offers 24X7 hour coverage has blurred the difference between care in the community and in institutions.

In both SHI and LTCI, payment is basically fee-for-service. However, not only the fee (price), but also the volume of each item is controlled by setting strict conditions of billing. The Fee Schedule is revised every two years in SHI and every three years in LTCI. The process starts by the prime minister deciding the global revision rate for SHI and LTCI that is based on the amount to be allocated from the general expenditure budget. Next, the fees and conditions of billing are revised on an item-by-item basis following negotiations with provider organizations. Some fees are increased; others are lowered. The conditions of billing are relaxed in some, leading to increases in volume, and tightened in others, leading to decreases in volume. The national claims databases of the SHI and the LTCI are used to calculate the effect of revising each item. The cumulative effect of these revisions must be respectively made equal to the global budget of the SHI and of the LTCI.

In health care, Japan's payment system offers an alternative to the orthodox form of capitation for primary care and DRG (Diagnosis Related Group) for inpatient care. By setting the global revision rate, despite the fee-for-service payment, expenditures are contained to the level set by the government. By revising the fees on an item-by-item basis, providers are nudged to deliver services in line with policy goals. However, the same method has been less successful in LTC because ageing has had a greater impact on costs and because users are more pro-active in choosing services.

## Contents

|                                                         |            |
|---------------------------------------------------------|------------|
| <b>Introduction</b>                                     | <b>169</b> |
| <b>1 Development of health services</b>                 | <b>172</b> |
| 1.1 Historical background                               | 173        |
| 1.2 Regulating the number and function of hospital beds | 174        |
| <b>2 Development of social services</b>                 | <b>176</b> |
| <b>3 LTCI</b>                                           | <b>177</b> |
| 3.1 Basic design                                        | 177        |
| 3.2 Development of LTCI                                 | 179        |
| <b>4 Health Insurance Fee Schedule</b>                  | <b>184</b> |
| 4.1 Basic structure                                     | 184        |
| 4.2 Revision process                                    | 185        |
| 4.3 Outpatient care and home care                       | 187        |
| 4.4 Inpatient care                                      | 188        |
| <b>5 LTCI Fee Schedule</b>                              | <b>191</b> |
| 5.1 Basic structure                                     | 191        |
| 5.2 Revisions: process and impact                       | 192        |
| <b>6 Challenges in SHI and LTCI</b>                     | <b>194</b> |
| <b>7 Lessons for other countries</b>                    | <b>196</b> |
| <b>References</b>                                       | <b>198</b> |

## Introduction

The goals of Universal Health Coverage (UHC) are to make appropriate services available to all irrespective of gender or age and to prevent impoverishment from health care costs (WHO 2018). Services for an “older person” should be developed within this generic context, as it could otherwise lead to stigmatization by age. In Japan, there was a public uproar when the government introduced a consultation fee for discussing end-of-life (EOL) options for elders 75 and over in 2008. The public feared that elders would be pressured to forgo services. This fee was removed from the Fee Schedule only three months after being listed (Ikegami 2017).

However, the context for long-term care (LTC) is different. When the government introduced the public LTC insurance (LTCI; Kaigo Hoken in Japanese) program focused on elders 65 and over, it was welcomed by the public and has since expanded rapidly (Ikegami 2019a). This suggests that social health insurance (SHI) and LTCI have different paradigms and values. LTC has been defined as “a variety of ongoing health and social services provided for individuals who need assistance on a continuing basis because of physical or mental disability. Service can be provided in an institution, the home, or community, and includes informal services provided by professionals or agencies” (IoM 1986). Once LTC services begin, they usually continue until the person dies, which means that EOL care would be included in the final stage of the continuum.

LTC objectives are to promote the individual’s independence and to mitigate the care burden of the family. Unlike the egalitarian standards that are the norm in health services, in LTC, “topping-up” (paying out-of-pocket for more and/or better services) is socially accepted. For example, in Japan, there are no hospitals that provide services exclusively for the rich, but there are nursing homes that do. Because of this normative difference, LTC must be clearly differentiated from health care in the way services are paid and regulated. However, at the same time, the two sectors must also be coordinated as an older person is likely to require services from both sectors (Ikegami and Campbell 2002).

Sections 1 and 2 will respectively describe how health and social services have developed in Japan. Section 3 will describe public LTCI. Sections 4 and 5 will respectively focus on the structure and revision process of the SHI and LTCI Fee Schedules. In both sectors, the Fee Schedule has been the key to controlling expenditures and allocating resources. Although providers are paid on a fee-for-service basis, the government has respectively set a global budget for the services financed by health insurance and for the services financed by LTCI. Within the global budget, the prices and the conditions of billing are revised on an item-by-item basis, not only to contain costs, but also to incentivize providers to deliver services in line with policy objectives. Section 6 will explain the challenges

facing Japan's health insurance and LTCI. Section 7 will distil "best practices" in price setting and regulations to provide possible lessons for other countries. This report will complement last year's report on price setting and price regulations in health care (Ikegami 2019b). Refer to that previous report for details on the payment of acute hospital care and the pricing of pharmaceuticals.

# 1

## Development of health services

### 1.1 Historical background

Payment has historically been made for visits made by physicians to the patients' home and for visits made by patients to physicians' clinics. However, in the West, patients usually did not pay for hospital services because most hospitals were established as charity institutions for the poor. Private practice physicians were willing to provide their services without pay because being appointed to a hospital position was considered to be an honor and recognition of their skills by peers (Starr 1982). These non-monetary rewards have continued to be important in setting payment for physicians.

This distinction between payment for physician services and payment for hospital services did not develop in Japan because, historically, there were no welfare institutions. As a result, hospitals were established from the start as medical institutions when the country opened its doors to the West in the latter half of the nineteenth century. Public sector hospitals were built to serve the military, to teach medical students and to quarantine patients with infectious diseases. Later, they expanded to provide high quality services mainly for the elite. The majority of hospitals developed from clinics established by private practitioners. The family, and not the hospital, provided nursing care, bedding (futon) and meals until reforms were carried out by the occupying forces after defeat in World War II.

However, to this day, there is no clear functional differentiation between hospitals and clinics. Nearly all hospitals maintain large outpatient departments and most of their patients come without referral. The patients' "free access" to health facilities has discouraged the development of primary care. Almost all physicians are trained as specialists and have identity as such (Kato and Ikegami 2019). In 2019, only 2% of physicians completing the mandatory two-year post-graduate training chose general practice as their specialty (Nihon Ijishinpousha 2018). However, once they go into private practice or move towards a small hospital, most tend to focus on primary care because they are not able to use hospital facilities or receive the support of hospital staff.

Historically, private-sector hospitals have been dominant. They compose four-fifths of the total number of hospitals, and

two-thirds of all hospital beds. Within the private sector, physician-owned family concerns compose the majority (MHLW 2019a). Investor-owned hospitals have not been allowed to be established since 1948<sup>1</sup>. Public-sector hospitals tend to focus on high-tech acute services in urban areas and basic services in rural areas. Note that in Japan, the “public sector” encompasses not only the hospitals owned by the national and local governments, but also those owned by designated organizations with “public characteristics” such as the Red Cross<sup>2</sup>.

Payment to virtually all providers has been controlled by the Fee Schedule. The Fee Schedule sets the same rate and conditions of billing for the same procedure, regardless of whether the facility is in the public sector or the private sector, or where the facility is located. All SHI plans have adopted and used the same Fee Schedule since 1958. By paying providers the same amount for the same service, the Fee Schedule has assured all patients would be treated equally.

Population coverage was later achieved in 1961 by making it mandatory for all permanent residents in Japan to enroll in SHI (Ikegami, Yoo and Hashimoto 2009). However, at that time, there still remained financial barriers to access. Most of the population, including nearly all elders, had to pay a 50% coinsurance rate. This situation changed dramatically in 1973 when health care became “free” (no coinsurance) for all elders 70 and over. This led to huge increases in utilization<sup>3</sup>. The number of hospital inpatients 70 and over increased twenty-fold in twenty years (MHW 1995). Many hospitals became or were newly established as facto nursing homes. This is the main reason why Japan has the highest per capita number of hospital beds in the world (OECD 2019). Hospitals have since expanded to deliver not only acute care and LTC, but also post-acute care. The next section will describe the government’s efforts to reform the delivery system.

## 1.2 Regulating the number and function of hospital beds

“Free” medical care for elders not only increased the number of hospital beds, it also exacerbated geographical disparity. This is why the Ministry of Health and Welfare (MHW; from 2001, the Ministry of Health, Labour, and Welfare, MHLW) introduced regional health planning in 1985. The prefectural governors were ordered to implement health planning, designate planning areas and set caps on the number of hospital beds in each prefecture. However, it is doubtful whether these measures have contained the growth of beds. It may even have been counterproductive because many hospitals rushed to

---

1 The decree was issued following the enactment of the Medical Care Act. Hospitals that had been established before 1948 by for-profit companies primarily for their employees and families were allowed to continue. Since then, although for-profit companies have not been allowed to open hospitals, they have purchased hospitals from physician owners and control the board. However, the hospital continues to be legally defined as a non-profit organization and is not allowed to issue dividends.

2 These hospitals do not receive subsidies to cover deficits but they are exempted from taxes that are paid by private sector hospitals.

3 A cap on the coinsurance amount for non-elders was also introduced in this year.

increase beds before the caps were enforced. Hospital beds continued to increase until 1995 (MHLW 2019a). Their subsequent decrease probably owes more to revisions of the Fee Schedule.

Despite, or perhaps because of its limited impact, the government legislated “Regional Health Care Vision” (Chiiki Iryou Kousou) in 2015 (MHLW 2015a). The goal is to set the number of “needed” hospital beds for each of the following functional categories: high-level acute, acute, recovery, and chronic care<sup>4</sup>. The cut-of points that divide beds into the four categories have been determined by experts based on the distribution of per diem inpatient costs. Beds that had per diem costs higher than ¥30 000 were categorized as “high-level acute”, below ¥30 000 but above ¥6000 as “acute”, below ¥6000 but above ¥1750 as “recovery”, and below ¥1750 as “chronic” (the amounts exclude basic hospitalization fees). The number of beds in each functional category was then appropriated to the 341 planning areas based on their estimated population in 2025, adjusted for sex and age composition.

Meanwhile, hospital directors were ordered to classify their units into these four categories based on the clinical conditions of the majority of the patients in the unit. When the numbers reported were added and compared with the “needed” bed numbers in each area, there were too many “acute” and “chronic” beds, and too few “recovery” beds. The government believes this discrepancy has occurred because hospital directors have been too focused on delivering “acute” care and not on “recovery” care that is needed by the ageing population. Pressure has been put on hospitals to change the category of their units from “acute” to “recovery” care.

In 2019, the MHLW expanded the scope of the “Health Care Vision” to promoting the merger of public sector hospitals. For this purpose, the names of the 464 public sector hospitals that had low volume and/or significant duplications of services within each planning area were publicized on September 26, 2019 (MHLW 2019b). They were listed if they were in the lower 33.3 percentile of the hospitals in the planning area for delivering procedures such as cardiac by-pass operations and services such as emergency care<sup>5</sup>. The basis for selecting these particular features and the cut-off point has not been explained. Moreover, the planning areas have been idiosyncratically drawn by the prefectures, and their population ranges from 20 000 to nearly 3 million. For example, Gunma Prefecture and Tochigi Prefecture, which are adjacent and located to the north of Tokyo, both have a population of 2 million, but the former has 10 and the latter has 5 planning areas. Thus, the “Health Care Vision” is not likely to have much impact on the way services will be delivered in the future, but it may facilitate the merging of public sector hospitals by providing funds to build new facilities.

---

4 The “needed” number of beds in each category was adjusted by the projected age and sex composition of the population in 2025.

5 Patients with pneumonia and fractures, which are common conditions for frail elders to be admitted, were not included.

The responsibility of providing LTC has been historically placed on the extended family and the local community in Japan. The government first gave in-kind support to the very destitute, which included elders living alone, in 1874. The first institution, the Elder Protection Institute (Yourouin), for destitute elders was established in 1929 under the Protection Act (Hogohou). In 1963, the Elders' Welfare Act (Roujin Fukushi Hou) established a new type of institution called Special Protective Homes for Elders (SPHE, Tokubetsu Yougo Roujin Houmu)<sup>6</sup>. Although all elders who needed care were eligible, priority was given to the indigent and to those without family. The Elders' Welfare Act also introduced residential homes, i.e. Homes for Elders with Low Costs (Keihi Roujin Houmu), which provide housing, meals and basic support (the extent differs by type), and community services in the form of home-helpers (who were named Family Service Providers; Katei Houshiin in Japanese) for low-income elders living alone without family support (Ikegami 2017).

Social services were expanded by the Five Year Plan to Promote Health and Social Services (referred to as the "Gold Plan"), which was launched in December 1989. The motive of the ruling Liberal Democratic Party lay in winning back votes (especially female) after they had lost the upper house election following the introduction of the unpopular consumer tax. Although the program was named to "Promote Health and Social Services", it was overwhelmingly focused on social services. The three major targets of expansion were SPHE, the day services delivered in them, and the development of "Home Care Support Centers" (Zaitaku Kaigo Shien Centers) that provided consultation and displayed care equipment such as wheelchairs. The Gold Plan turned out to be very popular and was extended for another five years to 1999 (referred to as the "New Gold Plan"). From 1990 to 1999, the number of full-time equivalent home-helpers was planned to increase from 38 945 to 170 000, and the number of adult day care centers from 1615 to 17 000. These targets were generally met in 1999 (MHLW 2001).

However, access to services was controlled by the local government's social welfare office, which made the process slow, bureaucratic and arbitrary. Charges were levied based on a sliding scale with priority given to the poor and to those without any family. This made it difficult for those with means to access services. There was also considerable geographical disparity because decisions to expand services were made by the municipal mayors. Finally, expenditures were consuming an increasing share of the government's budget. To address these issues, a new social insurance scheme for LTC appeared to be the solution.

<sup>6</sup> They were named "special" because care services were provided and to distinguish them from the Elder Protection Institute (renamed Elder Protection Home). Note that the official translation of SPHE is "nursing homes". This is misleading, because nurses are not required to be on duty 24X7 and may be on duty for only a few days per week.

### 3.1 Basic design

Public LTCl was established as the fourth pillar of social security following employment, health and pensions. From the health sector, about half of the designated LTC hospital beds, Health Facilities for Elders (HFE, facilities providing intermediate care), respite care, day care, visiting nurse services and rehabilitation therapy services were transferred<sup>7</sup>. From the social welfare sector, SPHE, respite care, day care, home-helper services, loan of assistive devices (such as wheelchairs) and home renovation (such as installing ramps) were transferred. However, the services from the two sectors were not integrated. For example, the day care facilities that were transferred from SHI had a slightly higher staffing ratio of therapists and had a physician within the facility, but their function was similar to those transferred from social welfare.

LTCl services became an entitlement for all elders 65 and over and for those aged 40 to 64 whose needs had resulted from age-related diseases such as stroke or Alzheimer's. LTCl premiums are paid by all those 40 and over together with SHI premiums. For those employed, employers contribute half. The municipalities (the 1717 cities, towns and villages) are the insurers. The premiums levied from those 40 to 64 are pooled at the national level and redistributed to the municipalities. When doing so, the differences in the income level and the proportion of elders from 65 to 74 and those over 75 among the municipalities are equalized. The benefits are in kind and restricted to the services delivered by certified LTCl providers. There are no cash benefits. The services available are listed in the MHLW's LTCl Fee Schedule.

Figure 1 shows the process for receiving LTCl services. First, the applicant must have his or her eligibility level assessed by the municipal government. The assessor, usually a nurse, uses a 74-item questionnaire concerning the applicant's functional and cognitive performance. A computer-based algorithm then groups the responses into one of seven eligibility levels or as ineligible. The final decision is made by the expert committee established in each municipality. In doing so, it reviews the additional written statements from the assessor and from the applicant's attending physician. All must be recertified once every five years, but they could ask to be recertified earlier if their condition was to decline.

---

7 There were two reasons why not all LTC hospital beds were transferred to LTCl. The first was that the insurers of LTCl plans, i.e. the municipalities, opposed their transfer because it would increase costs which they would have to finance by increasing their premium rates. The second was that the hospital physician directors preferred to be paid by health insurance and not by LTCl.

**Figure 1**  
Flow chart for receiving LTCI services



Currently, about one sixth of the population 65 and over has been certified as being eligible (MHLW 2019c). Among those who were certified for the first time, only about 2% to 5% have been certified as ineligible (MHLW 2009). About one fifth of those certified are currently not receiving any benefits (MHLW 2019d). They may have wanted to be sure they would be able to receive services without any delay, or they could currently be hospitalized.

There are seven eligibility levels: two “Youshien” (Need Support) light levels and five “Youkaigo” (Need Care) heavier levels<sup>8</sup>. In home and community-based care, benefits range from ¥50 030 to ¥360 650 per month<sup>9</sup>. Those eligible can purchase more services out-of-pocket, but only 1.3% actually do so (Niki 2016). These benefit amounts were determined by experts based on the services that would be appropriate for that level and the fees for these services. The benefit amounts have not been revised, but fee increases have been marginal (see Section 5.2). Those eligible use only about half of the amount to which they are entitled, perhaps because of the coinsurance and/or simply not having the need. The coinsurance rate was initially 10% for all, but has been increased in 2015 to 20%, and again in 2017 to 30% for those

<sup>8</sup> The number of eligibility levels was initially six. Most of those in “Youkaigo 1” were transferred to the newly created “Youshien 2” in 2006.

<sup>9</sup> Home renovation benefits are not included. This benefit is available once in a lifetime for up to ¥200 000.

with high income. There is a cap on the monthly coinsurance amount that varies according to the income level.

In community care, the services are not directly purchased by those who are eligible but by the care manager agency chosen by the beneficiary. The care manager draws a care plan based on the client's preferences and needs and the services available. If the client agrees to the plan, the care manager contracts providers and coordinates services for her client. In complex cases, the care managers are responsible for organizing care conferences attended by all providers, but in practice, they are seldomly held. Care managers were newly created by LTCI. They have received their certificate by passing a multiple-choice examination and then undergoing a short training course. Initially, most used to be nurses but now most are former care workers.

If the applicant's eligibility level is Eligibility Level 1 or higher, they can opt for institutional care at the facility of their choice<sup>10</sup>. There is no process for triaging admissions to the four types of facilities despite the fact that the per diem rate differs by nearly two-fold between SPHE and LTCI hospital beds. The fee also differs according to the eligibility level of the resident. The per diem rate ranges from ¥208 500 to ¥397 720 per month.

Hotel costs (room charges, utilities and meals) charges were introduced in 2005. The amount is ¥135 000 per month for a private room, but about half this amount for a room with four beds. These hotel costs are reduced up to a third of the amount for residents in the lowest income level for the "official" institutional care facilities of SPHE, HFE, LTCI hospital beds and LTCI medical facilities (Kaigoiryuin)<sup>11</sup>. The balance is paid by LTCI, not by public assistance. The average amount paid by residents is lowest in SPHE because SPHE have the lowest fee and tend to admit those with low income who would have more of their hotel costs covered by LTCI. In theory, providers can set their own charges for hotel costs since they are not listed in the LTCI Fee Schedule.

### 3.2 Development of LTCI

LTCI was planned to expand as services developed and as the population aged. Cost containment was initially NOT a major issue. The MHW's priorities were first to expand services. Because people now have to pay LTCI premiums and since there was no option of cash benefits as in Germany, services had to be expanded to make them available to all in need (Ikegami 2007). To expand services rapidly, for-profit providers were allowed entry into the market<sup>12</sup>.

---

<sup>10</sup> Except in SPHE, where admission is limited to those in Eligibility Level 3 or higher. This was introduced in 2015 to shorten the long waiting list.

<sup>11</sup> LTCI hospital beds are being converted to LTCI medical facilities, which were established in 2018. They basically have the same level of staffing, function and payment as those of the former. The number of LTCI hospital beds decreased from 120 700 in 2006 to 36 574 in 2017.

<sup>12</sup> However, they were not allowed into the three "official" types of institutional facilities because of the opposition from providers.

Their second priority was to have no one disadvantaged as a result of the transfer of services to LTCI, especially vulnerable elders who had been receiving services from social welfare. This meant that low-income, relatively functionally independent elders living alone who had been receiving home-helper services or who had been admitted to SPHE would continue to receive the same amount of services as before the implementation of LTCI<sup>13</sup>.

**Table 1**  
**Expansion of LTCI**

|                                        | 2000             | 2018              | 2018/2000 |
|----------------------------------------|------------------|-------------------|-----------|
| 65+ Population                         | 22 million       | 35 million        | 1.6       |
| No. certified eligible                 | 2.18 million     | 6.44 million      | 3.0       |
| No. of service users                   | 1.49 million     | 4.74 million      | 3.2*      |
| Average premium (in yen)/month for 65+ | 2911 yen         | 5869 yen          | 2.0       |
| LTCI expenditures (in yen)             | 3.6 trillion yen | 11.1 trillion yen | 2.9       |

**Table 2**  
**Increase in LTCI users and the ratio of for-profits**

|                           | 2000    | 2016      | 2016/2000 |
|---------------------------|---------|-----------|-----------|
| Home help users           | 446 679 | 906 508   | 2.0       |
| Percent by for-profits    | 30.3%   | 64.1%     | 2.1       |
| Day care users            | 616 967 | 1 054 418 | 1.7       |
| Percent by for-profits    | 4.5%    | 44.9%     | 10.0      |
| Visiting nurse users      | 203 573 | 422 400   | 2.1       |
| Percent by for-profits    | 6.0%    | 47.2%     | 7.9       |
| Institutional care users* | 518 227 | 921 117   | 1.8*      |

\*For-profits are not permitted in designated institutional care facilities

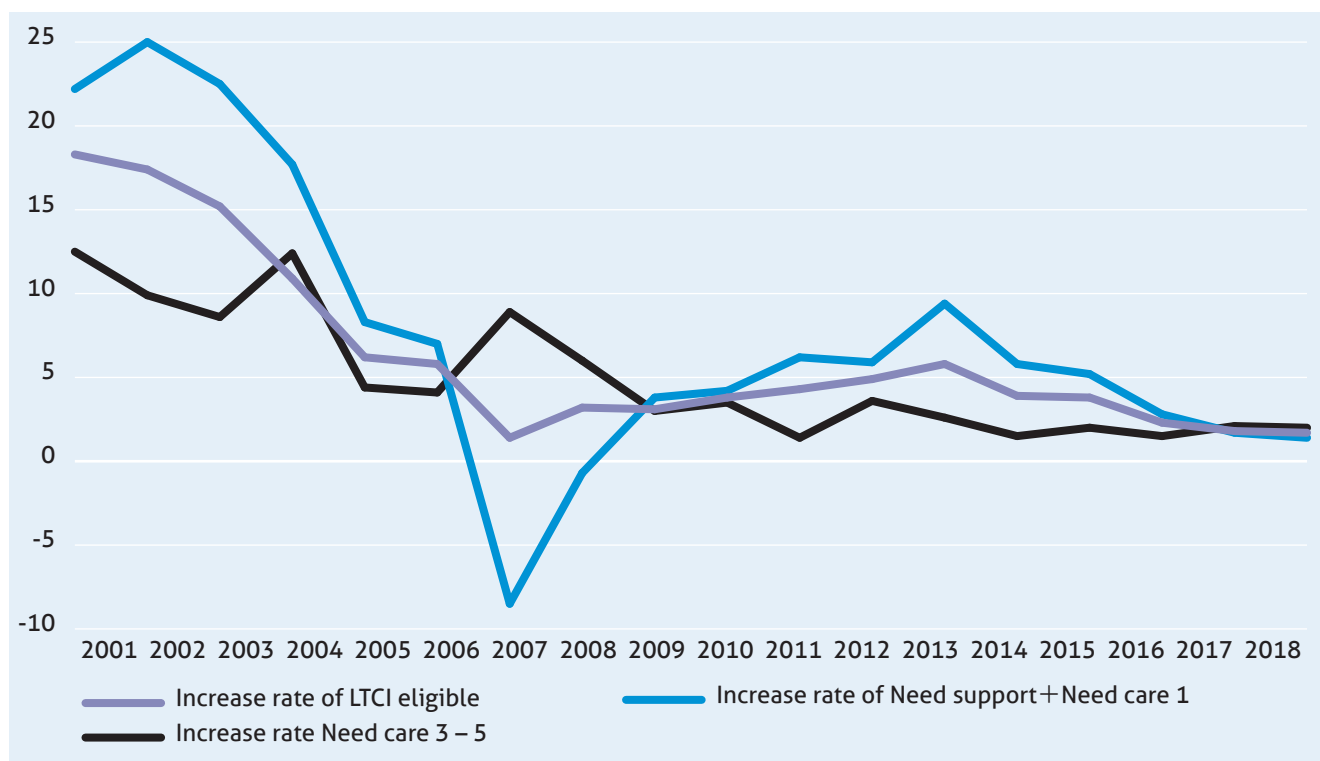
These two priorities led to setting generous benefits for LTCI<sup>14</sup>. When services became available based on their functional level and not on their income or the amount of family support available, LTCI expanded rapidly. The number of services users and costs tripled from 2000 to 2018, which was twice the growth rate of the population 65 and over increased (Table 1).

<sup>13</sup> This was one reason why those in Eligibility Level 1 or higher were able to choose between institutional care and community care when LTCI was implemented.

<sup>14</sup> The programs for those with physical, intellectual and mental disabilities remained separate. Each had developed independently, but their benefits were harmonized in the Support Independence for those with Disability Act in 2005.

Most of the expansion came from an increased number of for-profit providers (Table 2). Among users, the increase in the lighter levels of “Needs support” and “Need care, Level 1” were initially greater than in the heavier levels of “Need care, Level 3-5” (Fig. 2). The growth rate declined in 2007 following the lowering of the benefits in 2006.

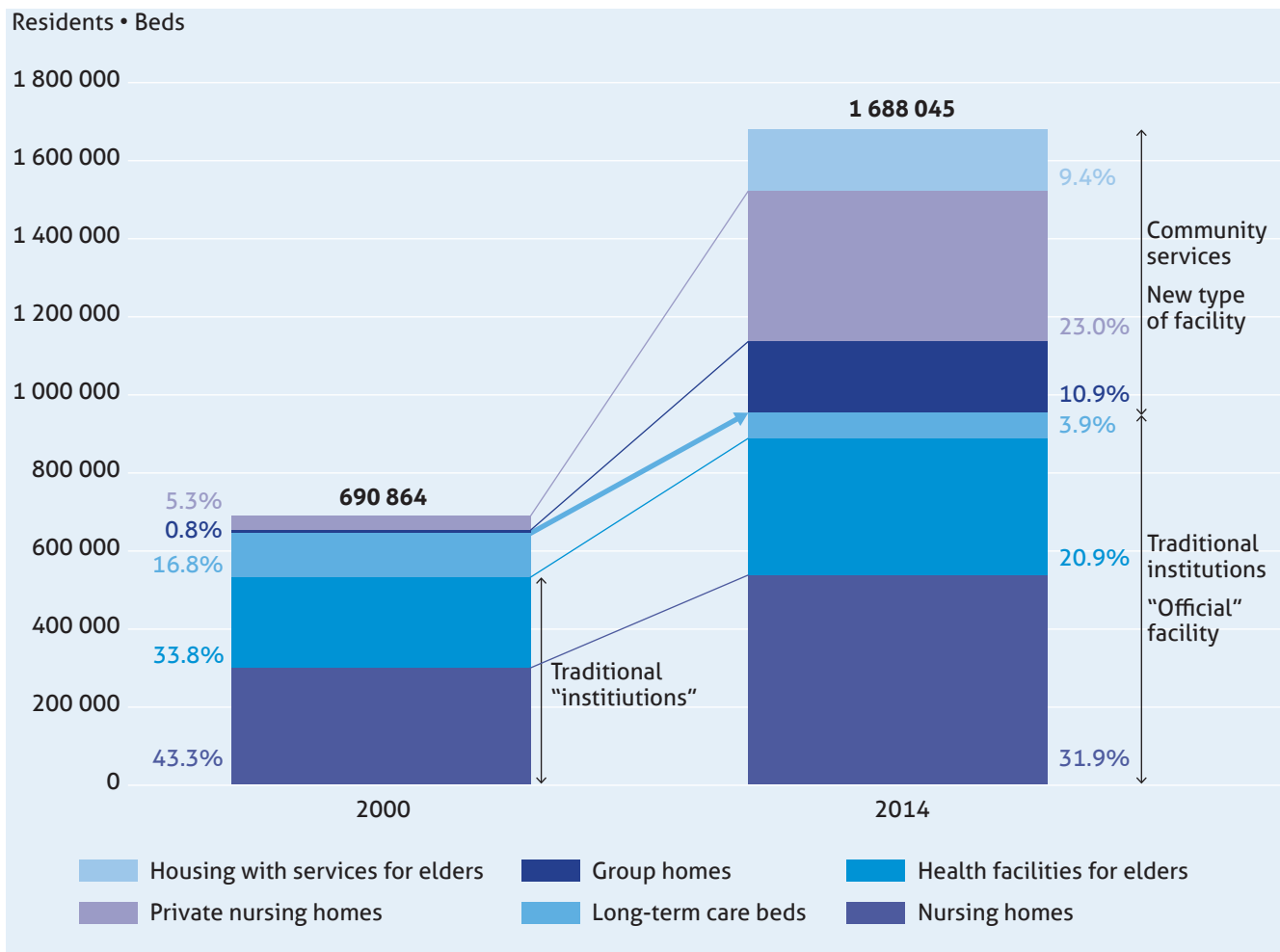
**Figure 2**  
Increase rate among those eligible for LTCI: Total, heavy, light care level



The expansion of home care services has not led to decreasing the demand for institutional care: the waiting list for SPHE numbers 366 000 (MHLW 2017). Many of those waiting could be residing in the quasi-institutional care facilities (their residents are officially included in “community care”) that have developed rapidly after LTCI had been implemented (Fig. 3). These facilities were of two types: the Homes for Elders with Charge (Yuryo Rojin Houmu) and the Group Homes for Elders with Dementia (GH). The former increased because most of their care costs became covered after LTCI had been implemented. The latter also grew rapidly after its introduction in 1997, but the increase slowed down after the maximum number of units (nine residents in each unit) became limited to two, and admissions were restricted to those who had been residing in the municipality where the GH was located. This restriction was introduced because the municipalities did not want outsiders moving into a GH within its jurisdiction because it would lead to increases in their LTCI premium rate<sup>15</sup>.

<sup>15</sup> GH have since been categorized into Services Closely Attached to the Community. The other services in this category include 24X7 scheduled and on demand home care visits by home-helpers and nurses.

**Figure 3**  
Increase in LTCI facility beds



Source: MIAC (2017)

The latest type of quasi-institutional care is the Housing with Services for Elders (Sabisutsuki Koureisha Muke Jutaku), sponsored by the Ministry of Land, Infrastructure, Transport and Tourism, in 2012. The name "Housing with Services" is misleading: the facility's services are limited to consultations and to an emergency alert system. The care services are contracted to "community" providers. However, these providers may be located in the same building so that it would be de facto "institutional care". The floor space per resident must be more than 18m<sup>2</sup> per unit (25m<sup>2</sup> after the common space for dining and so forth has been appropriated), and the floor must be barrier free. Being classified as pure "housing" has meant that providers need not obtain approval from local governments. They have increased to 247 664 units in September 2019 (Satsuki-jutaku, 2019).

The reasons why institutional and quasi-institutional care have increased despite the expansion of community care services are the following. First, 24X7 care, which is especially needed by those with behavioral problems, is not available in community settings. Moreover, in Japan, the family is legally responsible for the elder's behavior should they cohabit. In 2007, a 91-year-old man with dementia walked into a railway

crossing and was hit by a train. This led to the suspension of train services. The Japan Railway Tokai sued the family for the costs of diverting passengers to other railway companies. The Supreme Court dismissed the case on the grounds that the family could not be held responsible: his spouse had been certified as being eligible for LTCI services and his son had been living apart for more than twenty years (Bengoshi Dotcom News 2016). However, this means that if the son had been living together, the family would have had to pay for the damages.

Second, the standards in institutional care facilities have greatly improved after the MHLW issued a directive that required all newly built or renovated facilities to be of “unit care” type. In “unit care”, all rooms must be single and be more than 13.2m<sup>2</sup>. The number of rooms per unit must be ten or less. Each unit must have its own dining and living room (MHLW 2017).

Third, compared with “community care”, the out-of-pocket amounts are likely to be lower in “institutional care” facilities, especially in SPHE which has the lowest care service fees. If the resident is of low income and pays only about half the full amount of the hotel costs, the out-of-pocket amount would definitely be less.

Thus, from the user’s perspective, the best option would be SPHE, which is why they have long waiting lists, especially for rooms with four beds that have the lowest hotel costs. The excess demand has been met in quasi-institutional care facilities. Elders and their families have found it difficult to make informed choices because the conditions and the amount they have to pay differs according to the facility. The amount levied would be composed of the following: the coinsurance for the care services, the charges levied for bed and board, and in the new type of facilities, the balance billed for a higher staffing level and sometimes an entrance fee. Moreover, elders and their families must often make decisions at short notice after being told they will be discharged from hospital.

### 4.1 Basic structure

The Fee Schedule set by the MHLW is enforced on all SHI plans and virtually all providers. Physician services and hospital services are not differentiated and are listed in one manual. There are also manuals for grouping patients into DPC (Diagnosis Procedure Combination) groups in acute inpatient care, and for pharmaceutical and device prices. Payment is made to the facility and not to individual physicians. In hospital settings, physicians are employed and usually paid fixed salaries that reflect their seniority, not their clinical specialty or the revenue they generate. In clinics, most are solo-practices so that the earning would effectively be the physician's income less expenses.

The Fee Schedule manual is over 1500 pages in fine print. There are more than 4000 items listed together with their conditions of billing. For example, an initial consultation (which is four times the repeat consultation fee) may only be billed if the patient had either not made a visit within the last 29 days or has not been told by the physician when to make the next visit. To bill rehabilitation therapy for a patient who has had a stroke, the facility must employ three or more full-time therapists and the patient must have had the stroke within the last 180 days. Compliance to these conditions is inspected when claims are reviewed, and when the regional offices of the MHLW make on-site visits. If the latter finds that claims have been purposely falsified, then both the physician and hospital could be delisted from a SHI contracted service provider, which would de facto mean not being able to operate in Japan.

The fee is the same for the same item throughout Japan. Paying the same amount has contributed to a more equitable distribution of physicians and nurses. Although big city hospitals have higher operating costs and must pay their nurses higher wages to cover the higher cost of living, the wages of their physicians are lower because they are able to offer more non-monetary rewards in the form of peer prestige, access to high-tech equipment and support of trained staff. In the public hospitals established by big cities (over 700 000 inhabitants), annual wages were ¥13.6 million for physicians and ¥5.1 million for nurses. In the public hospitals established by towns and villages (less than 30 000 inhabitants), they were 30% higher at ¥17.9 million for physicians and 10% lower at ¥4.6 million for nurses (MIAC 2017). Although there are no data for private sector hospitals, these differences are likely to be greater because their wages tend to be less seniority based.

The restrictions on balance billing and extra billing were specifically stipulated in 1984. The payment from delivering services based on the fees set in the Fee Schedule composes

more than 95% of the providers' revenue. Balance billing (charging more) is mostly restricted to beds with more amenity that compose about one fifth of all hospital beds; extra billing (charging for items not included in the benefits package) to new technology being tested for its efficacy and safety (Ikegami 2006). Direct subsidies from the government to public hospitals compose about 2% of total medical expenditures (Koushi Byoren News 2019). Thus, the Fee Schedule effectively controls the flow of money in the Japanese health care system.

## 4.2 Revision process

The Fee Schedule is revised every two years. The revision is divided into the following processes. The first is deciding the global revision rate, which is the cumulative volume-weighted revision rate of all services and pharmaceuticals listed in the Fee Schedule. In setting the rate, increases in costs from population ageing (per capita costs increase as the age group becomes older) and increases due to shifts to higher-priced items resulting from advances in technology (such as from CT scan to MRI) are projected from the past three years' trends. Since these two factors have increased health expenditures by 2.4% per year in the past ten years (Asahi Shinbun 2019), if health expenditures are to remain budget neutral for the next two years, the global rate must be set at -5%.

The second step is setting the revision rate of pharmaceutical and device prices. For established products, prices are reduced based on the results of the market survey conducted by the MHLW. Market prices are almost always found to be lower than their Fee Schedule price because providers are able to negotiate discounts from wholesalers. The extent of these discounts is surveyed by the MHLW's Survey of Pharmaceutical Prices. The price of each product will then be revised so that it would be 2% higher than its volume-weighted average market price. For newly launched products, the price is reduced if its sales volume is more than the amount predicted by the manufacturer. The rationale for lowering the price lies in the fact that the manufacturer would then be able to recover R&D costs from the increase in sales.

The third step is setting the overall revision rate of medical service fees. A survey of the providers' revenue and expenditure is conducted by the MHLW in the year before the revision. If their profits have increased or are stable, there would be pressure to decrease the rate. On the other hand, if their profits have decreased or they have deficits, there would be pressure to increase the rate. However, the results are seldom clear cut, because margins differ by the type of provider. Large public hospitals tend to operate at a deficit, and small private hospitals at a small profit. The revenue of the clinic, which is de facto the income of the physician, tends to be stable. Thus, the revision rate is basically a political decision made by the prime minister who must balance the need to contain costs with the need to maintain services and to retain the political support of the providers. This decision can only be

made by the prime minister, because it has a major impact on the general expenditure budgeted amount allocated to health care composing one tenth of the total. This one-tenth, in turn, composes one quarter of total health expenditures. These proportions have been stable.

**Figure 4**  
Annual increase rate of national medical expenditures, medical service expenditures, and fee schedule revision rates (in %)

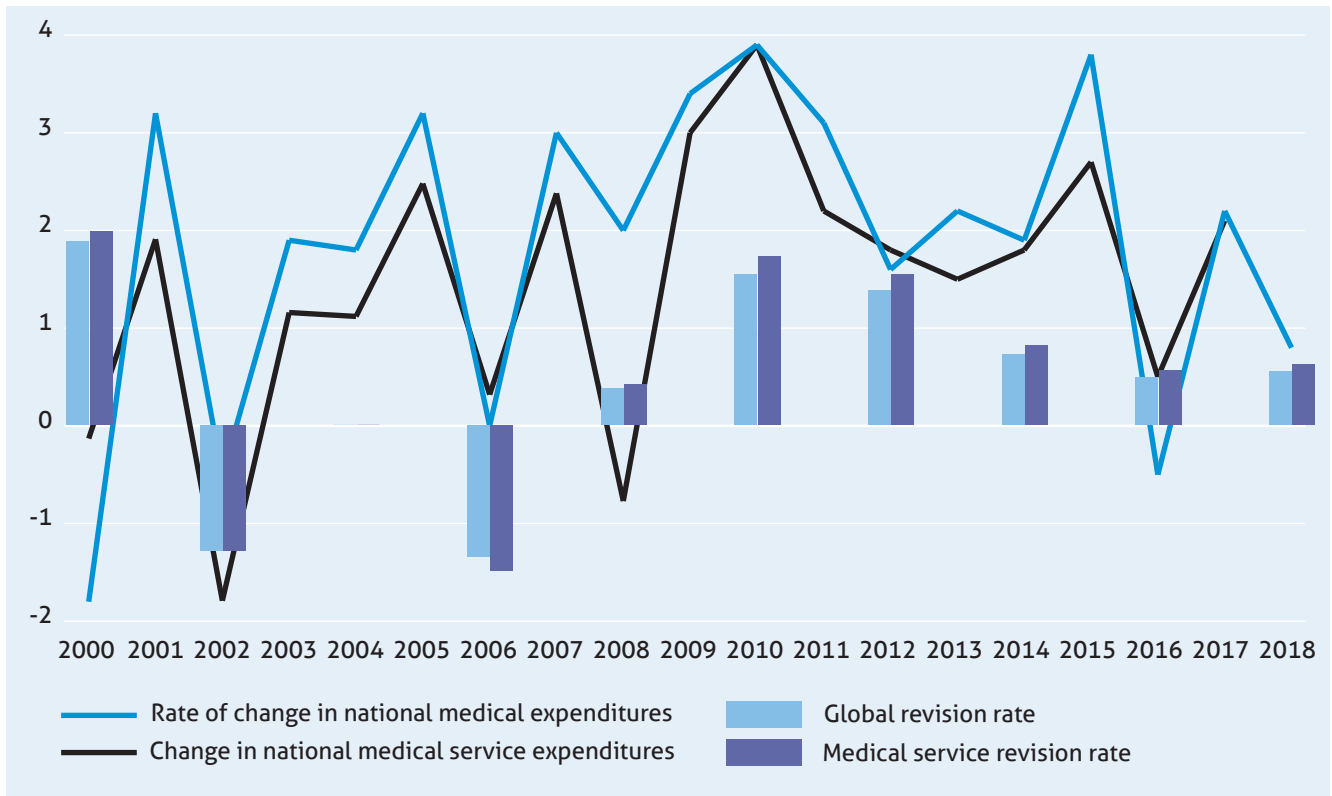


Figure 4 shows how the global revision rate and the medical services revision rate have impacted national medical expenditures and medical service expenditures (MHLW 2019e)<sup>16</sup>. In general, revision rates are reflected in changes in expenditures. However, the estimates for the next year's government's expenditures are not necessarily 100% accurate. For example, in the 2016 revision, the global revision rate was set at -1.45%, which would have increased expenditures by 0.55% in 2017 if expenditures had increased by 2.0% as they had in the past three years. However, the actual increase from increases in volume and shifts to higher priced items was only 0.95% (MHLW 2018), which led to national medical expenditures decreasing by 0.5%.

Finally, the fees and conditions of billing are revised on an item-by-item basis. In some items, the fees are increased, while in others they are decreased. The conditions of billing are tightened in some, which would decrease volume, and relaxed in others, which would increase volume. The impact of revising

<sup>16</sup> The MHLW's national medical expenditures (NME; Kokumin Iryouhi in Japanese) are composed of medical service expenditures (Ika Iryouhi), pharmacy dispensing expenditures and dental expenditures. Medical service expenditures compose about 80% of the total. The method for calculating the expenditures was revised in 2008, which was why the expenditures appeared to decline despite the increase in the global revision rate.

each item on medical service expenditures is calculated from the National Claims Database, which lists the volume of every item in the Fee Schedule. The cumulative effect of these revisions must be made equal to the amount set by the global budget.

The item revisions are deliberated in the MHLW's Central Council on SHI, which is composed of representatives from payers, providers and public interest. Based on its decisions, the minister of the MHLW formally revises the Fee Schedule. However, because the details are very complicated, the actual negotiations are made by the MHLW officials in charge and provider organizations. Among the latter, the JMA (Japan Medical Association) has played a dominant role because it is well organized and has been a major contributor to the Liberal Democratic Party. This party has been in almost continuous power for the past 65 years. Moreover, the JMA's interests are generally in line with the MHLW because its main constituents, the private practitioners delivering primary care, are in a better position to meet the needs of Japan's ageing society than hospital specialists. As a result, private practitioners generally have higher incomes compared with specialists in tertiary hospitals, who tend to have fixed salaries based on their seniority. Monetary rewards and professional rewards tend to balance each other in Japan.

#### 4.3 Outpatient care and home care

This sector has been of paramount importance to the JMA, because it directly impacts the income of private practitioners. The overriding goals of the JMA have been to maintain "free (uncontrolled) access" of patients to all providers and for providers to be paid "fee-for-service". It has opposed gate-keeping and capitation payment, because these would violate the principle of physicians being compensated for all medically necessary services they deliver and the principle of being able to open practice should they wish to do so. Only a fee-for-service would allow physicians to earn income on the day they opened practice. Because of their opposition, the basic form of payment has remained fee-for-service. However, fees have been contained, and the conditions of billing have restricted increases in volume. The below shows some examples.

- Fees to promote home care were first introduced to provide guidance for diabetic patients to self-inject insulin in the 1981 Fee Schedule revision. These instructions fees have been expanded to oxygen therapy, total parental therapy, elimination (from artificial bladder or anus), injections (opioids) and peritoneal dialysis.
- A "comprehensive consultation fee for bed-bound elders at home" was listed in the 1998 Fee Schedule revision for physicians to make scheduled and on demand visits. As of 2018, the physician must visit the patient two or more times for a monthly fee of ¥8330. Should the patient die at home, the physician would receive an additional fee of ¥55 000.

- A fee to provide comprehensive primary care services was listed in the 2014 Fee Schedule revision. To bill the fee, the physician must monitor all pharmaceuticals prescribed (including those prescribed by other physicians), and the patients must have two or more of the following conditions: hypertension, diabetes, hyperlipidemia and dementia. The fee is ¥250 (¥350 if dementia is included) per month. If billed as a bundled fee including pharmaceuticals and laboratory tests, it would be ¥15 600 (¥15 800 if dementia is included). If the facility meets these conditions, it will be able to bill an additional ¥800 to the first consultation fee.

The conditions of billing have become more complicated. For example, to bill the scheduled home visit fee, the clinic now must have had three or more patients who have transferred from outpatient care to home care in the past year and have two or more full time equivalent physicians (among which one must be full time). To reflect the shorter travel time for the physician if the patients were to live in congregated housing for frail elders, the visit fee is reduced by 80% if more than 80% of the patients visited by the physician on the same day reside in the same building. To bill the bonus payment for providing EOL care to a patient dying at home, the physician must have visited the patient two or more times within the past 14 days. There is an additional bonus fee of ¥10 000 if the visit is made from a designated “palliative care facility”.

Physicians who make scheduled visits must arrange for and give instructions to visiting nurses. The fee for visiting nurse services was first listed in the 1992 Fee Schedule for Elders for bedridden elders 65 and over. The objective was to provide support and advice to the patient and family<sup>17</sup>. The visits became available to non-elders in the 1994 Fee Schedule revision, but they continue to be focused on chronic patients and not on post-acute patients discharged from acute hospitals. Seventy one percent of visiting nurses’ patients are financed for by LTCI and not by SHI (Japan Visiting Nurse Foundation 2018). SHI financed services are for patients with cancer and other designated diseases such as Parkinson’s.

#### 4.4 Inpatient care

Two policy goals have been consistently pursued. The first is to improve the level of basic inpatient services. As noted, before the post-World War II reforms, the family had provided care. Bonus fees were first introduced in 1951 for hospitals that met basic standards in nursing, bedding and meals. Since then, conditions have become increasingly complex. For example, in order to bill higher rates, registered nurses must compose more than 70% of the total, and the night shifts must compose less than 72 hours per month. These conditions have been promoted by the Japan Nursing Association. The second policy goal has been to shorten lengths of hospital stays and

<sup>17</sup> There was another Fee Schedule for all elders 70 and over (and elders 65–69 with disabilities) from 1984 to 2009, which differed in minor details. <https://www.mhlw.go.jp/file/06-Seisakujouhou-12200000-Shakaiengokyokushougai-hokenfukushibu/0000123638.pdf>

functionally differentiate hospital beds into acute care and LTC. In order to bill the higher hospitalization fees, the hospital must not only have higher staffing levels, but the average length of stay must be 18 days or less.

The conditions of billing for LTC have become increasingly complex. As noted, the demand for inpatient care increased dramatically after “free” (no coinsurance) inpatient care was introduced in 1973. The fee-for-service payment led to over-medication and the excessive ordering of diagnostic tests. There were also not enough nurses. Care was mainly delivered by private attendants who were hired 24x7 by the patients. Their presence exacerbated the over-crowding in the units: most hospitals had only the minimum floor space per patient that was set at 4.3m<sup>2</sup> (this level was set in 1948, reflecting housing conditions at that time).

In response, a new type of facility, the HFE, was established in 1986. The ostensive purpose was to deliver intermediate, step-down care after the patient had been discharged from the hospital. Admissions were initially restricted to those who were expected to be discharged home within three months. However, this restriction came to be flexibly interpreted. Payment was a flat per diem amount inclusive of medications and diagnostic tests. The staffing level was set relatively high, and the hiring of private attendants was prohibited. The floor space per bed had to be 8m<sup>2</sup> or more, which made it difficult for hospitals to convert to HFE, even though this had been the intention of the government.

This was why the government decided to introduce a new form of inclusive payment for hospital LTC units from 1990 (Nishiyama 2019). The payment was inclusive of all services and similar to that of the HFE, but without the physical facility requirements. This form of payment was widely adopted by hospital LTC units. Parenthetically, physical facilities have since been improved by introducing a bonus payment in 1992 if the unit met the standards for “convalescent” (ryoyougata) beds. These units must have a floor space of more than 6.4m<sup>2</sup> per bed, a dining room attached to the unit and so forth. Most hospitals delivering LTC eventually converted to this type of unit by 2003.

However, the flat per diem payment quickly led to a new problem: hospitals were given a perverse incentive not to admit patients with high medical needs. To rectify this situation, case-mix-based payment was introduced in 2006 that was based on the patient’s medical acuity and the activities in daily living (ADL) level (Ikegami 2009). The fees for patients with the lowest medical acuity level were set below costs. The MHLW thought that this would force hospitals to discharge patients and close some of their chronic care units. However, a survey made one year after the introduction revealed that hospitals appeared to have up-coded their patients to higher medical acuity levels. Problems in the quality of care and data were also revealed: in one hospital, over 80% of patients had been

checked for urinary infection that would have grouped patients into a high medical acuity level.

Some of these issues have been resolved by on-site audits of patient records. The conditions of billing have also been made more complex. In the 2012 Fee Schedule revision, to bill higher fees, the hospital must have a higher nurse staffing level and more than 80% of the patients in Medical Acuity level 2 or higher. The pressure on hospitals not meeting these conditions to convert to LTCI facilities has increased.

There have also been reforms in post-acute care with the Kaifukuki (recovery) Rehabilitation Units, which were first designated in 2000. The conditions of billing were as follows: the number of therapists per patient must be more than the prescribed level; the patients receiving therapy must have had a stroke within the past 180 days or an injury within the past 90 days. Pay for performance (P4P) was introduced in 2012 using FIM (Functional Independence Measure) scores. Targets for measuring improvements have since been refined.

Next was acute care. Inclusive per diem rates were introduced by the DPC for the 82 Special Function Hospitals (university main hospitals and two national centers) in 2003. A per diem rate was set for each DPC group that differed according to the four hospitalization periods. Following its introduction, many hospitals opted to be paid by DPC rather than fee-for-service because it gave them more status (to be recognized as an acute facility), and because it also generally enabled them to earn more revenue. Hospitals paid by DPC transferred services such as MRI to before and/or after admission (from which they can be billed fee-for-service). Moreover, each hospital was given a specific conversion factor that compensated for the difference in the amount paid by DPC and the amount paid by fee-for-service. This factor began to be phased out from 2012 and was completely eliminated in 2018. About 80% of acute care units are now paid by DPC.

Lastly, Akyuseiki (sub-acute) beds were introduced in the 2004 Fee Schedule revision. The policy goal was to reduce the number of patients in acute care DPC units by transferring them to these units and by directly admitting patients from the community requiring less care to these units. However, the latter function has not developed because the hospitals feared there would be a deficit if the patient needed more resources than the amount paid per diem. The sub-acute units have been renamed "Chiki Houkatsu Kea" (Comprehensive Community Care) beds in 2016, having basically the same functions. In the 2018 Fee Schedule revision, bonus fees were introduced if 10% or more of their patients had been directly admitted from the community and had not been transferred from acute units.

The MHLW has made these revisions to functionally differentiate hospital units so that patients would be transferred from acute to more cost-effective units. However, hospitals have lobbied for more flexibility on the conditions of billing on the grounds that each patient is unique and

physicians must have professional autonomy. The heated negotiations have made the Fee Schedule increasingly more complex.

## 5 LTCI Fee Schedule

### 5.1 Basic structure

The Fee Schedule of LTCI has basically the same structure as that of health insurance. The fees and the conditions of billing are precisely defined. When first set, the services covered by SHI such as most visiting nurse services, LTC hospital units and HFE were transferred at the same amount and with the same conditions of billing. For the services transferred from social welfare, the fees were newly set based on their unit costs in the social service budget.

The LTCI Fee Schedule differs from the SHI Fee Schedule in the following aspects. First, unlike health care, providers are, in principle, allowed to extra bill and balance bill. However, in community care, they seldom do so. Only 1.3% of users have purchased services beyond the amount set by their eligibility level (Niki 2016). The proportion of those who pay more for services of better quality probably compose even less. In contrast, in institutional care, “hotel” costs are in principle not covered, and most quasi-institutional care facilities balance-bill for amenities.

Second, the conversion factor of units to yen differs according to the geographical area. Metropolitan Tokyo is highest: up to 11.4% (the extent differs according to the type of service) than the national base rate, reflecting the higher cost of living and wage levels. Note that, unlike health care, the higher wages of nursed and staff in big cities cannot be compensated by the lower wages of physicians in LTC. Thus, fees must reflect the local labor market.

Third, users are more cost conscious in LTCI services, because they are much more tangible and easier to evaluate than in health care. For example, the fee for a home-helper visit is higher in agencies that have a higher proportion of experienced home-helpers (to provide incentives for agencies to hire them so as to improve quality), but users may prefer an agency that has a lower proportion, because they would pay less as coinsurance. Thus, the bonus incentives on providers are likely to be less effective than in health insurance.

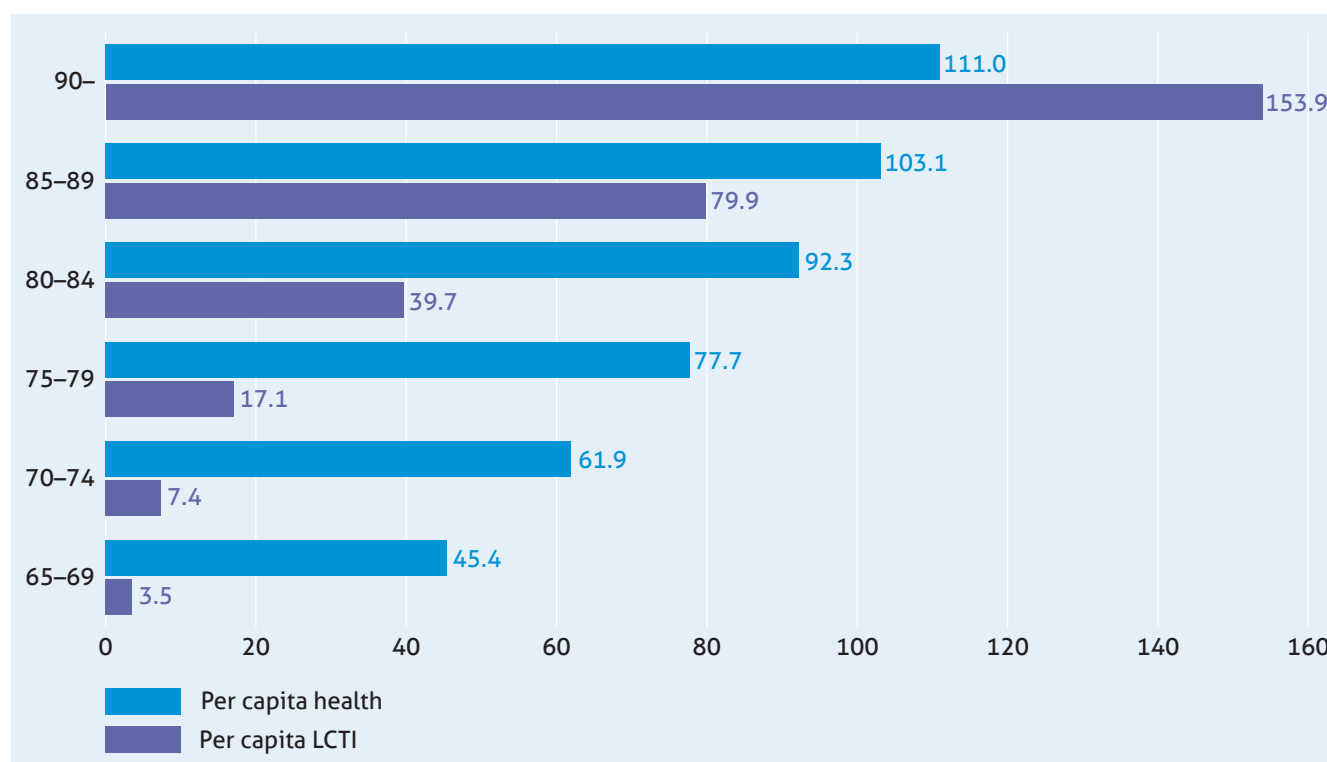
The LTCI Fee Schedule has become increasingly complex. When first implemented in 2000, it had only about one hundred pages. The current 2018 version has 1000 pages in fine print. For example, in home and community services, day care fees differ according to the number of hours spent at the facility, the type of facility and the number of users coming to the facility (bigger facilities are paid less because they have lower costs).

The user's care managers should offer them the best option, but they may steer users to purchase services from their affiliated providers. In institutional care, as noted, it is difficult to evaluate the cost and benefits among the various types of facilities that are available.

## 5.2 Revisions: process and impact

The revision process is similar to that of SHI except that the LTCI Fee Schedule is revised every three years, and not two years as in SHI. As in SHI, the prime minister first sets the global budget by deciding the global revision rate. Future expenditures are estimated based on the average increase rate in the past three years and the increases that would arise from population ageing. In making his decision, the financial condition of the providers is surveyed. If profit margins have declined, then it is likely to lead to a positive revision. In 2003, 2006 and 2015, the global revision rate was negative, but expenditures declined only in 2006, which was due more to the decision made in October 2005 to basically stop covering hotel costs. In 2003, expenditures increased because services were rapidly expanding as new providers entered LTC. In 2015, the negative revision was compensated by subsidies from general revenues to providers so that they could pay higher wages to the care staff in order to mitigate their shortage.

**Figure 5**  
Per capita expenditure by age groups: Health Insurance and LTC Insurance (in ten thousand yen)



Source: Per capita health and LTCI expenditures by age groups. (jeiu.or.jp, 2017)

LTCI expenditures have increased at a faster pace than SHI because the ageing of the population has had a greater effect. Figure 5 shows that per capita expenditures are higher for the older age groups in LTCI: whereas SHI expenditures for those 90 and over are only 2.4 times that of those between 65 and 69, in LTCI, expenditures are 44 times more (Cabinet Office 2016; MHLW 2016; Statistics Office 2016). Parenthetically, although there are no increases due to advances in technology in LTCI, there are also no savings from the reduction of pharmaceutical prices.

Next, the global budget is allocated to service items. As in health care, fees are individually increased or decreased, and/or their conditions of billing tightened or relaxed. The impact of making these revisions is calculated from the national LTCI claims database. The revisions are deliberated in the MHLW's Committee on LTCI Fee Schedule, which has members from providers, payers and independent academics. As in health insurance, the details are negotiated between the MHLW officials in charge and the provider organizations. The LTCI Fee Schedule has rapidly become as complex as that of health insurance, mainly because both the MHLW and the provider organizations have the same mentality. They have also become complex because revisions are a convenient way of dealing with questions raised in the Diet by showing that the MHLW has responded by taking due actions.

To illustrate the complexity of the LTCI Fee Schedule, the following example describes how bonus fees were set in 2006 to promote EOL care in SPHE facilities (Ikegami and Ikezaki 2012). The fee was ¥800 from 4 to 30 days before the date of death (2018 fee revised to ¥1220), ¥6800 for 1-3 days before the date of death, and ¥12 800 at the date of death on top of the daily rate of about ¥8000 (standard rate). The conditions for billing this fee were, first, SPHE must meet the standards of a designated EOL care facility: employing a full-time registered nurse, having a 24 hour on-call service for nurses employed either by the nursing home or contracted to hospitals or visiting nurse agencies, having a policy on EOL care that is explained to the resident and the family on admission, holding seminars on EOL care for the staff, and having a private room available for EOL care. Following its introduction in 2006, two-thirds of SPHE have met these conditions (MHLW 2009).

Second, the resident must be in an unrecoverable condition and have an EOL care plan that is drawn after discussion among the nursing home staff, physician and, whenever possible, the resident and family. This bonus can be retrospectively billed for the 30 days prior to death if the resident was physically in the SPHE (death could have occurred at a hospital). Additional bonuses to augment the EOL care bonus were introduced in 2009: a bonus for having a nurse always on duty during night shifts and a bonus for having more care staff than the prescribed minimum level (MHLW 2009). These bonuses are billed across-the-board for all residents if the facility meets the standards. This focus on the structural aspects of quality,

especially on the staffing level of nurses, has long been the government's policy for assuring quality in Japan (Ikegami, Ishibashi and Amano 2014).

These bonuses appear to have had the desired effect. The number dying in SPHE doubled from 16 788 in 1999 to 36 814 in 2009. This is more than the 50% increase in the number of SPHE beds from 291 631 to 432 284. When the annual number of deaths in nursing homes is divided by the number of nursing home beds, the annual rate of increase was 0.2% between 1999 and 2005, and 0.7% after the introduction of the EOL care bonus in 2006. The latest data show that the number of deaths in SPHE has doubled to 100 523 in 2017<sup>18</sup>. A similar bonus payment to provide EOL care has been introduced to other LTCI facilities.

Other bonus incentives have been introduced to encourage and pay for the additional costs of having more staff on night duty, more therapists, and more staff trained to care for residents with dementia, to deliver enhanced dietary management, to promote oral feeding, to improve dietary patterns, to treat pressure ulcers and to support improvement in elimination and transitions into home care. It is difficult to evaluate their impact, because government data are limited to claims and eligibility levels.

## 6 Challenges in SHI and LTCI

The greatest challenge is fiscal sustainability. Health and LTC expenditures compose 10.9% of the GDP, the sixth highest among OECD countries (OECD 2019)<sup>19</sup>. The number of elders 65 and over has been increasing while the working age population has been decreasing. In SHI, increases in expenditures are due to advances in technology and ageing of the population. The impact of the former has been balanced by reducing the Fee Schedule price of pharmaceuticals and devices. In LTCI, expenditures have increased 1.5 times faster than SHI, because the ageing of the population has had a greater impact. These trends will not change. Containing public expenditures by increasing the proportion paid by elders would not be a practical solution, because their income is usually low and limited to public pensions.

The fiscal problems have been aggravated by the way SHI and LTCI are structured. In SHI, there are over 3000 SHI plans. About half are employment-based and enroll those who are currently employed and their dependents. The remaining half are community-based and enroll the self-employed, the irregularly employed and elders retired from the workforce. From the start, the latter had difficulties in financing the health care costs of

---

<sup>18</sup> The Vital Statistics do not differentiate deaths in SPHE from those in Homes for Elders with Charge, but they exclude deaths in HFE.

<sup>19</sup> OECD's Total Health Expenditures (THE) include both health and LTC. Japan's THE percentage to GDP jumped from 9.2% to 10.6% in 2011, when LTC expenditures came to be fully included in the THE.

the enrolled. Population coverage in 1961 was achieved by the government increasing subsidies to community-based plans. However, these subsidies were not enough to cover the costs of elders when “free” medical care was implemented in 1973. To mitigate the burden on the government, employment-based plans were ordered to contribute towards the costs of elders from 1983. Since then, their contributions have steadily increased so that they now amount to nearly half their premium revenue. Employment-based plans have protested that contributions of this magnitude are unfair and argued that funding should be increased from taxes. However, the government is unwilling/unable to do so, because the national debt has increased and now composes twice the GDP. Financing health care for elders has become the source of intergenerational conflict.

In LTCI, since all insurers are the municipalities, the cross-subsidization across plans is not a problem. However, it is difficult to increase premiums of those 65 and over who live in the municipality. One solution would be to expand coverage to all ages and levy premiums from all ages. However, expenditures for those between the ages of 40 to 64 currently compose only 3% of LTCI expenditures. This percentage is not likely to increase significantly even if the current rules that restrict benefits to those caused by age-related diseases were to be removed. Moreover, those 64 and younger who are currently receiving benefits from disability programs would oppose the transfer to LTCI, because the level would be less generous.

As the above illustrates, there are no easy solutions. Currently, the government has focused on the non-controversial policy of promoting prevention. In health insurance, penalties are imposed on health insurance plans in the form of contributing more towards the health care costs of elders if the percentage of their enrollees who undergo annual check-ups is below 45% (MHLW 2012). In LTCI, from 2020, bonuses will be given to municipalities (insurers) that show improvement in the eligibility levels of their beneficiaries (Cabinet Office 2019). However, the effect of these preventive measures is likely to be at best marginal.

The first lesson is that, in SHI, providers must strictly adhere to the fees and conditions of billing set by the government. In Japan, it took more than twenty years after population coverage had been achieved to impose explicit restrictions on balance billing and extra billing. These rules are pre-conditions for the Fee Schedule to function effectively because unless they are strictly adhered, patients would continue to be at risk of being impoverished from health care costs. As a quid pro quo, the government must guarantee that all services and pharmaceuticals that have been demonstrated to be effective and safe are covered by SHI.

The second lesson is that fee-for-service payment does not necessarily escalate costs. Costs can be contained by setting a global budget and by regulating fees and setting conditions of billing. In Japan, the prime minister decides the Fee Schedule's global revision rate after evaluating the fiscal space and political situation. In making his decision, the extent to which increases in costs from population ageing and advances in technology would be mitigated by reducing pharmaceutical and device prices are estimated. Next, within the global budget, the fees and the conditions of billing are revised on an item-by-item basis. The impact of revising the fee and the conditions of billing each item on the global budget is calculated from the claims database.

The third lesson is that fees can be set and revised so that providers would be nudged to deliver services that are in line with policy goals. In Japan, physicians have clinical autonomy, but they will be paid only if they adhere to the fees and the conditions of billing in the Fee Schedule. The revisions have made physicians more focused on monitoring and advising patients who have lifestyle diseases such as diabetes and on providing home care, including EOL, to frail elders. Hospitals have developed services to provide post-acute rehabilitation care and sub-acute care for frail elders. The coordination of services between clinics and hospitals has been promoted by establishing fees for providing information to the hospital referred and from the referred hospital back to the clinic. However, in LTC, incentives have worked less well because services are chosen basically by the user and not by the physician. This basic fact has not been fully recognized in Japan. Some of the incentives introduced have led to only making the LTCI Fee Schedule excessively complex.

In SHI, Japan's regulated fee-for-service payment offers an alternate method to the dichotomized model of DRG for acute inpatient care and capitation for primary care. This classic model might be appropriate if patients were to be discharged as "cured" and not requiring further treatment. However, it is not appropriate for frail elders who will compose an increasingly larger share of patients and who need seamless

care from acute to post-acute and from post-acute care to LTC. In Japan, their needs have been mainly met by small to medium sized private sector hospitals that deliver both SHI and LTCI services. These hospitals have quickly responded to the revisions made in the Fee Schedules to pursue policy goals.

The last lesson is that public LTCI should be established separately from health insurance because their basic principles fundamentally differ. In health insurance, all effective services must be made available, with strict restrictions on balance billing and extra billing. In contrast, in LTCI, the government is only responsible for providing services up to the amount set by the eligibility level. The dividing line between institutional care and community care also differs between the two sectors. In health insurance, patients are admitted to the hospital by the physician based on their medical need. In LTCI, it is the person needing care who decides whether to opt for community care or institutional care, and, moreover, the dividing line between the two has become blurred as special housing has developed. It would be better to establish LTCI earlier than later to avoid creating ad hoc pockets of entitlement and resulting cost escalation.

In health care, the behavior of physicians and the expectations of patients are difficult to alter. Physicians have professional autonomy and patients tend not to be proactive consumers. Thus, payment reform must be made incrementally. In LTC, the market has a greater role because users, as consumers, are able to choose services and the government's responsibility is limited to providing a basic level of services. Once established, LTC is likely to develop more rapidly than health care because population ageing will have a greater effect.

## References

- Asahi Shinbun (2019). Personnel costs and others +0.55%. *Asahi Shinbun*. 17 December.
- Bengoshi Dotcom News (2016). Cognitive disease lawsuit: When does the family become “de facto guardian?” Summary and explanations of the Supreme Court verdict. *Bengoshi Dotcom News*. [Accessed 14 May 2016] ([https://bengo4.com/other/1144/1280/n\\_4363/](https://bengo4.com/other/1144/1280/n_4363/))
- Cabinet Office. LTC Insurance Expenditures. [Accessed 15 September 2019] (<http://www5.cao.go.jp/keizai-shimon/kaigi/special/reform/wg1/280323/shiryoku4.pdf>, 2016.)
- Ikegami N (2006). Should providers be allowed to extra bill for uncovered services? Debate, resolution, and sequel in Japan. *Journal of Health Politics, Policy and Law* 31(6):1129-1149.
- Ikegami N (2007). Rationale, design and sustainability of Long-Term Care Insurance in Japan: In retrospect. *Social Policy & Society* 6(3):423-434.
- Ikegami N (2009). Games policy makers and providers play: Introducing case-mix-based payment to hospital chronic care units in Japan. *Journal of Health Politics, Policy and Law* 34(3):361-380.
- Ikegami N (2017). *Japan's Health and Long-term Care*. Nihon Keizai Shinbun Shupansha, Tokyo.
- Ikegami N (2019a). Financing long-term care: lessons from Japan. *International Journal of Health Policy Management* 8(8):462-466. doi:10.15171/ijhpm.2019.35.
- Ikegami N (2019b). Japan. In: S.L. Barber, L. Lorenzoni, and P. Ong (editors). *Price setting and price regulation in health care: lessons for advancing Universal Health Coverage*. Geneva: World Health Organization, Organisation for Economic Co-operation and Development. (<https://apps.who.int/iris/bitstream/handle/10665/325547/9789241515924-eng.pdf>)
- Ikegami N and Campbell JC (2002). Choices, policy logics and problems in the design of long-term-care systems. *Social Policy & Administration* 36(7):719-734.
- Ikegami N, Yoo BK and Hashimoto H (2009). Japanese universal health coverage: evolution, achievements, and challenges. *Lancet* 378(9796):1106-1115.
- Ikegami N and Ikezaki S (2012). Japan's policy of promoting end-of-life care in nursing homes – Impact on facility and resident characteristics associated with the site of death. *Health Policy* 105:303-311.

Ikegami N, Ishibashi T and Amano T (2014): Japan's long-term care regulations focused on structure – rationale and future prospects. In V. Mor, T. Leone and A. Maresso (editors): *Regulating long-term care quality – An international comparison*. Cambridge University Press, Cambridge.

IoM (Institute of Medicine) (1986). *Improving the Quality of Nursing Homes*. Washington DC: National Academy Press.

Japan Visiting Nurse Foundation (2008). *Explanation of Our Activities 2018*. [Accessed 2 October 2019] (<https://www.jvnf.or.jp/2018/homecare-web.pdf>)

Jeiu (2017). *Per capita expenditures by age for health and LTC expenditures*.

Kato T and Ikegami N (2019). How specialists become primary care physicians in Japan. *Health* 11:322-331.

Koushi Byoren News (2019). Main results of Hospital Management. *Koushi Byoren News*. June.

MHW (1995). *1993 Patient Survey*. MHW, Tokyo.

MHLW (2001). *1999 Survey of Social Welfare Facilities*. Kousei Tokei Kyokai, Tokyo.

MHLW (2009). *Document 3 from the 2nd Meeting for Issues Related to Reviewing and Revising Eligibility Criteria*. [Accessed 15 December 2016] (<http://www.mhlw.go.jp/shingi/2009/07/s0713-6.html>)

MHLW (2012). *Support to the Health Insurance for Late Elders*. [Accessed 16 December 2016] ([https://www.mhlw.go.jp/bunya/shakaihoshou/iryouseido01/pdf/h240806\\_2-1-3.pdf](https://www.mhlw.go.jp/bunya/shakaihoshou/iryouseido01/pdf/h240806_2-1-3.pdf))

MHLW (2015a). *Regional Health Care Vision (Chiiki Iryo Kousou)*. [Accessed 15 December 2016] (<https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000080850.html>)

MHLW (2015b). *Home care documents for the Central Social Health Insurance Council*. [Accessed 16 September 2019] (<https://www.mhlw.go.jp/file/05-Shingikai-12404000-Hokenkyoku-Iryouka/0000074433.pdf>)

MHLW (2015c). *Regional Health Care Vision 2015*. [Accessed 21 December 2019] (<https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000080850.html>)

MHLW (2017). *Sub-committee on LTCI Benefits. For reference. Special Protective Homes for Elders*. [Accessed 21 December 2019] (<https://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu-Shakaihoshoutantou/0000171814.pdf>)

MHLW (2018). *Latest news on the LTCI*. Methods to strengthen LTCI insurers. 622. [Accessed 13 December 2019] (<http://hssk.gr.jp/wp/wp-content/uploads/2018/03/vol622.pdf>)

MHLW (2019a). *Hospital Report*. [Accessed 13 December 2019] (<https://www.mhlw.go.jp/toukei/list/79-1a.html>)

- MHLW (2019b). *Working Group for the Regional Health Care Vision, Actual Policies*. [Accessed 1 December 2019] ([https://www.mhlw.go.jp/stf/shingi/other-isei\\_368422.html](https://www.mhlw.go.jp/stf/shingi/other-isei_368422.html))
- MHLW (2019c). *Report on the LTCI Activities*. [Accessed 13 December 2019] (<https://www.mhlw.go.jp/topics/kaigo/osirase/jigyo/m19/1901.html>)
- MHLW (2019d). *Monthly report on LTCI benefits*. [Accessed 13 December 2019] (<https://www.mhlw.go.jp/toukei/saikin/hw/kaigo/kyufu/2019/01.html>)
- MHLW (2019e). *National Medical Expenditures*. [Accessed 13 December 2019]. Available from: <https://www.mhlw.go.jp/content/12400000/000550870.pdf>
- MIAC (Ministry of Internal Affairs and Communication) (2017). *2015 Annual Bulletin of Local Government Enterprises*. MIAC.
- Nihon Ijishinpousha (2018). Japan Specialist Association discloses number of residents according to specialty. *Nihon Ijishinpou* 4902. [Accessed 13 December 2019] (<https://www.jmedj.co.jp/journal/paper/detail.php?id=9634>)
- Niki R (2016). Reviewing health care by President Niki (143). *Bunka Jyohousha* 464:18-22.
- Nishiyama M (2019). *Historical review of the present fee schedule*. Shakai Hoken Kenkyujo, Tokyo.
- OECD (2019). *OECD Health Statistics 2019*. [Accessed 25 November 2019] (<http://www.oecd.org/els/health-systems/health-data.htm>)
- Satsuki-jutaku (2019). *Registered number of Housing with Services for Elders, 2019*. [Accessed 18 September 2016] ([https://www.satsuki-jutaku.jp/doc/system\\_registration\\_01.pdf](https://www.satsuki-jutaku.jp/doc/system_registration_01.pdf))
- Starr P (1982). *Social transformation of American medicine*. Basic Books, New York.
- Statistics Office (2016). Population Estimates of Oct 1, 2014. [Accessed 20 May 2016] (<http://www.stat.go.jp/data/jinsui/2014np/#a05k26-b>)
- WHO (2018). Health Financing for Universal Coverage 2018. [Accessed 20 December 2019] ([https://www.who.int/health\\_financing/strategy/dimensions/en/](https://www.who.int/health_financing/strategy/dimensions/en/))