# A Comprehensive Analysis of Japan's Long-Term Care Insurance (Kaigo Hoken) System

### 1. Introduction: The Genesis and Philosophy of Japan's LTCI

Launched in April 2000, Japan's Long-Term Care Insurance (介護保険制度, *Kaigo Hoken Seido*) system represents a fundamental pillar of the nation's social security framework. Conceived in response to the country's rapidly aging population, its primary objective is to provide societal support for elderly individuals requiring care and their families. The system is built upon core principles emphasizing the maintenance of dignity for the elderly, enabling them to live independently for as long as possible (*jiritsu shien*, 自立支援), and alleviating the burden on family caregivers. This marked a significant paradigm shift, moving away from a model where care was predominantly a private family responsibility (often falling on women) towards a system based on social solidarity and shared responsibility.

The concept of "support for independence" (*jiritsu shien*) is central, focusing not just on assisting with daily tasks but on maximizing the elderly individual's existing capabilities to maintain and improve their autonomy. Furthermore, the "user-centered" (*riyousha hon'i*, 利用者本位) principle empowers individuals to choose from a diverse range of health, medical, and welfare services offered by various providers, tailored to their specific needs and preferences. The introduction of the LTCI system was a national response to profound socio-economic shifts, aiming to establish a sustainable care infrastructure. However, it inherently involves navigating the balance between promoting independence and providing necessary support to those certified as needing care or assistance. This balance is constantly evaluated during the eligibility assessment (Chapter 4) and care planning (Chapter 5) processes.

### 2. Background and Societal Context: Why LTCI Was Necessary

The creation of the LTCI system was driven by dramatic demographic and social changes in Japan. Key factors included:

- **Unprecedented Aging:** Japan experienced population aging at a speed unmatched globally.
- **Shifting Family Structures:** The rise of nuclear families led to smaller household sizes, reducing the traditional capacity for in-family care.
- **Aging Caregivers:** The phenomenon of "rōrō kaigo" (老老介護), where elderly individuals care for even older family members, became increasingly common.
- **Caregiving-Related Job Departure:** A growing number of people were forced to leave their jobs to provide care (*kaigo rishoku*, 介護離職), impacting both

individual finances and the national workforce.

These converging pressures overwhelmed the capacity of traditional family care structures and existing welfare and medical systems to meet the escalating demand for long-term care. Recognizing this impending crisis, the Long-Term Care Insurance Act was enacted in 1997, leading to the system's implementation in 2000. This was a proactive (though some argue belated) policy response, establishing a new framework – a mandatory social insurance model covering all citizens aged 40 and over – rather than merely adjusting existing programs.

### 3. The Social Insurance Model: A Foundation of Shared Contribution

The LTCI system operates on a social insurance model, clearly linking contributions (premiums) and benefits (services). All citizens aged 40 and above are enrolled as insured persons (*hihokensha*, 被保険者) and are required to pay premiums. When an individual is certified as needing long-term care or support, they can access a wide array of services by paying a co-payment, which is typically 10% of the service cost (though it can be 20% or 30% depending on income).

This model differs from tax-funded welfare systems by emphasizing the relationship between contributions and benefits. The requirement for individuals to start paying premiums from age 40 underscores the system's nature as an intergenerational contract: the working-age population supports the care costs of the current elderly generation, with the expectation that they will receive similar support from future generations when they age.

### 4. Operational Structure: A Tripartite Division of Responsibilities

The administration of the LTCI system involves a coordinated effort among national, prefectural, and municipal governments.

- **Municipalities (市町村, *Shikuchoson*):** These are the primary insurers, responsible for the residents within their jurisdiction. Their key roles include collecting premiums from Category 1 insured persons (age 65+), conducting the needs assessment (certification) process, issuing LTCI insurance cards, designating local and community-based service providers, and managing the system according to local circumstances.
- **Prefectures (都道府県, *Todofuken*):** Prefectures act as intermediaries, providing financial support (e.g., grants) and guidance to municipalities. They also play a role in developing the care service infrastructure (especially facility construction), registering and training care managers (*kaigo shien senmon'in*), and designating providers for services that operate across wider areas.

- **National Government (国, *Kuni*):** The central government establishes the overall legal framework (including the LTCI Act), sets national standards, determines service fees (care remuneration), and provides financial support (including adjustment grants) to ensure the system's financial stability.

This three-tiered structure aims to balance local flexibility and responsiveness (municipal level) with national consistency, equity, and financial stability (national and prefectural levels). The national adjustment grant is particularly important for mitigating disparities in service levels and premium burdens between municipalities with varying financial capacities and aging rates.

**5. Funding the System: Premiums and Public Funds**

The costs associated with providing LTCI services are financed equally by premiums paid by insured persons and public funds (taxes). The standard split is **50% Premiums and 50% Public Funds**.

- **Premiums (50%):**
  - Category 1 Insured Persons (age 65+): Contribute 23% of the total premium pool (based on FY2021 budget figures).
  - Category 2 Insured Persons (age 40-64): Contribute 27% of the total premium pool (based on FY2021 budget figures).
  - This ratio (23:27) is based on the relative populations of the two groups and is reviewed every three years.
- **Public Funds (50%):**
  - National Government Subsidy: 25% (standard rate). This includes the aforementioned adjustment grant (approx. 5% of the national share) to support financially weaker municipalities.
  - Prefectural Government Subsidy: 12.5%.
  - Municipal Government Subsidy: 12.5%.
  - (Note: For facility-based services, the public fund ratios differ slightly: National 20%, Prefectural 17.5%).

This 50/50 funding structure reflects a policy choice to share the cost burden between direct beneficiaries (current and future insured persons) and the broader public (taxpayers). The national adjustment grant serves as a critical fiscal mechanism to ensure a degree of equity across the country despite varying local conditions.

**6. Insured Persons (Hihokensha): Categories and Eligibility**

All Japanese citizens aged 40 and over are insured under the LTCI system. They are

divided into two categories based on age:

- **Category 1 Insured Persons (第一号被保険者, *Dai-ichi-go Hihokensha*):** All individuals aged 65 and over.
    - *Service Eligibility:* They can receive LTCI services if certified by their municipality as being in a state requiring care (*yo-kaigo*) or support (*yo-shien*), regardless of the cause of their condition.
- **Category 2 Insured Persons (第二号被保険者, *Dai-ni-go Hihokensha*):** Individuals aged 40 to 64 who are enrolled in Japan's public medical insurance system (e.g., employees' health insurance, National Health Insurance).
    - *Service Eligibility:* They can receive LTCI services *only if* their need for care or support is caused by one of the 16 specific age-related diseases designated by the government (see below), and they are certified by their municipality.

This age-based distinction reflects the system's primary focus on age-related care needs. For those 65 and over, frailty and care needs are considered a general risk associated with aging, making the specific cause less relevant for eligibility. For the younger 40-64 age group, care needs might arise from various causes (accidents, non-age-related disabilities). Therefore, eligibility is restricted to conditions deemed medically linked to aging processes, ensuring the system targets its intended scope while providing a safety net for specific early-onset, age-related conditions.

**(a) The Role of Specified Diseases (特定疾病, *Tokutei Shippei*) for Category 2**

For Category 2 insured persons (age 40-64), eligibility for LTCI services hinges on their condition being caused by one of 16 "Specified Diseases". These diseases are selected based on criteria set by the Ministry of Health, Labour and Welfare (MHLW):

1. Conditions where prevalence or incidence shows a relationship with aging, and which can be clearly medically defined.
2. Conditions highly likely to result in a state requiring care or support for 3-6 months or longer.

This requirement acts as a crucial gatekeeping mechanism, limiting access for the 40-64 age group to cases related to the system's core purpose – addressing age-related care needs. Needs arising from accidents or non-age-related illnesses are generally covered by other systems, such as disability welfare services. It's important to note that simply having a diagnosis of a Specified Disease does not automatically grant access to services; the individual must still undergo the formal Needs Certification process.

**(b) The 16 Specified Diseases (Tokutei Shippei)**

The 16 Specified Diseases eligible for LTCI coverage for Category 2 insured persons are listed below:

1. **Terminal Cancer** (がん（末期）)
    - *Notes:* Limited to cases deemed medically incurable (approx. 6-month prognosis目安); palliative care included.
2. **Rheumatoid Arthritis** (関節リウマチ)
    - *Notes:* Autoimmune disease; diagnosed based on symptoms (e.g., morning stiffness), clinical findings.
3. **Amyotrophic Lateral Sclerosis (ALS)** (筋萎縮性側索硬化症)
    - *Notes:* Motor neuron disease; progressive.
4. **Ossification of the Posterior Longitudinal Ligament** (後縦靱帯骨化症)
    - *Notes:* Ligament in spinal canal ossifies, compressing nerves; requires causal link between X-ray findings and neurological symptoms (numbness, motor deficit).
5. **Osteoporosis with Fractures** (骨折を伴う骨粗鬆症)
    - *Notes:* Requires fragility fracture due to bone density loss.
6. **Early-onset Dementia** (初老期における認知症)
    - *Notes:* Dementia onset between ages 40-64 (e.g., Alzheimer's, vascular, Lewy body); excludes dementia from trauma, toxins, endocrine/nutritional causes.
7. **Parkinson's Disease related disorders** (進行性核上性麻痺、大脳皮質基底核変性症及びパーキンソン病【パーキンソン病関連疾患】)
    - *Notes:* Includes Progressive Supranuclear Palsy, Corticobasal Degeneration, Parkinson's disease.
8. **Spinocerebellar Degeneration** (脊髄小脳変性症)
    - *Notes:* Group of disorders where nerve cells in cerebellum or spinal cord degenerate.
9. **Spinal Stenosis** (脊柱管狭窄症)
    - *Notes:* Narrowing of spinal canal compressing nerves, specifically due to age-related degeneration.
10. **Progeria** (早老症)
    - *Notes:* Group of genetic disorders causing premature aging symptoms.
11. **Multiple System Atrophy** (多系統萎縮症)
    - *Notes:* Neurodegenerative disorder with combined Parkinsonian, cerebellar, autonomic symptoms.
12. **Diabetic Neuropathy, Nephropathy, and Retinopathy** (糖尿病性神経障害、糖尿病性腎症及び糖尿病性網膜症)
    - *Notes:* The three major complications of diabetes.

13. **Cerebrovascular Disease** (脳血管疾患)
    - *Notes:* After-effects of stroke (infarction, hemorrhage, subarachnoid hemorrhage).
14. **Peripheral Artery Disease** (閉塞性動脈硬化症)
    - *Notes:* Arteriosclerosis causing narrowing/blockage of arteries (e.g., in legs); criteria include intermittent claudication, ulcers, necrosis.
15. **Chronic Obstructive Pulmonary Disease (COPD)** (慢性閉塞性肺疾患)
    - *Notes:* Includes chronic bronchitis, emphysema; diagnosed by airflow limitation.
16. **Osteoarthritis of Bilateral Knee or Hip Joints with Marked Deformation** (両側の膝関節又は股関節に著しい変形を伴う変形性関節症)
    - *Notes:* Age-related osteoarthritis with significant deformation in both knee or hip joints.

Understanding this list is crucial for grasping the specific scope of LTCI coverage for the 40-64 age group.

### 7. Financial Base: Premiums (保険料, *Hokenryo*)

Approximately half of the LTCI system's funding comes from premiums paid by insured persons aged 40 and over. The method of determining and collecting these premiums differs between the two categories.

#### (a) Category 1 Premium Determination (Age 65+)

Premiums for Category 1 individuals are set by their municipality of residence. The process involves:

1. **Calculating the Standard Amount (*Kijungaku*, 基準額):** Each municipality creates a three-year "Long-Term Care Insurance Business Plan" estimating the total cost of care services needed during that period. Based on this estimate, they calculate the portion to be covered by Category 1 premiums (currently 23%) and divide it by the number of residents aged 65+ to determine a standard monthly premium amount (*kijungaku*). This amount varies significantly between municipalities due to differences in service needs and elderly populations.
2. **Setting Income-Based Tiers:** The calculated *kijungaku* serves as a base. Individual premiums are then adjusted based on the insured person's income from the previous year and their household's resident tax status. Premiums are set across multiple tiers (the national standard model for the 9th plan period, 2024-2026, has 13 tiers, but municipalities can adopt more). Lower income tiers pay a fraction of the *kijungaku*, while higher income tiers pay multiples. This

ensures premiums are levied according to the ability to pay.

3. **National Average and Regional Variation:** The national weighted average *kijungaku* for the 9th plan period (2024-2026) is ¥6,225 per month, up 3.5% from the previous period's ¥6,014. However, regional disparities are substantial, with the lowest premium in Ogasawara Village, Tokyo (¥3,374) being about 2.7 times less than the highest in Osaka City (¥9,249) during the 9th period.
4. **Income Threshold Adjustments:** Recent adjustments have slightly raised income thresholds for some lower tiers (e.g., Tier 1 threshold from ≤¥800k to ≤¥809k) to account for increases in the basic old-age pension amount.

This system results in a progressive premium structure based on individual income but also means premiums can vary significantly depending on the municipality's specific fiscal situation and demographics, posing potential geographic equity challenges.

**Category 1 Premium Tiers Example (National Standard 13-Tier Model, 9th Period)**

Here is an example based on the national standard model for the 9th plan period (2024-2026), using the national average standard amount (*kijungaku*) of ¥6,225 per month:

- **Tier 1:**
  - *Target Group:* Public assistance recipients; Old-Age Welfare Pension recipients in non-taxable HH; Non-taxable HH & Income ≤ ¥809k.
  - *Premium Rate:* 0.285 x Standard Amount
  - *Example Monthly Premium:* ¥1,774
- **Tier 2:**
  - *Target Group:* Non-taxable HH & Income > ¥809k to ≤ ¥1.2m.
  - *Premium Rate:* 0.485 x Standard Amount
  - *Example Monthly Premium:* ¥3,019
- **Tier 3:**
  - *Target Group:* Non-taxable HH & Income > ¥1.2m.
  - *Premium Rate:* 0.685 x Standard Amount
  - *Example Monthly Premium:* ¥4,264
- **Tier 4:**
  - *Target Group:* Individual non-taxable (taxable person in HH) & Income ≤ ¥809k.
  - *Premium Rate:* 0.9 x Standard Amount
  - *Example Monthly Premium:* ¥5,603
- **Tier 5:**

    - *Target Group:* Individual non-taxable (taxable person in HH) & Income > ¥809k.
    - *Premium Rate:* 1.0 x Standard Amount
    - *Example Monthly Premium:* ¥6,225 (Standard Amount)
- **Tier 6:**
    - *Target Group:* Individual taxable & Total Income < ¥1.25m.
    - *Premium Rate:* 1.2 x Standard Amount
    - *Example Monthly Premium:* ¥7,470
- **Tier 7:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥1.25m to < ¥2.1m.
    - *Premium Rate:* 1.3 x Standard Amount
    - *Example Monthly Premium:* ¥8,093
- **Tier 8:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥2.1m to < ¥2.9m.
    - *Premium Rate:* 1.5 x Standard Amount
    - *Example Monthly Premium:* ¥9,338
- **Tier 9:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥2.9m to < ¥3.2m.
    - *Premium Rate:* 1.7 x Standard Amount
    - *Example Monthly Premium:* ¥10,583
- **Tier 10:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥3.2m to < ¥4.2m.
    - *Premium Rate:* 1.9 x Standard Amount
    - *Example Monthly Premium:* ¥11,828
- **Tier 11:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥4.2m to < ¥5.2m.
    - *Premium Rate:* 2.1 x Standard Amount
    - *Example Monthly Premium:* ¥13,073
- **Tier 12:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥5.2m to < ¥6.2m.
    - *Premium Rate:* 2.3 x Standard Amount
    - *Example Monthly Premium:* ¥14,318
- **Tier 13:**
    - *Target Group:* Individual taxable & Total Income ≥ ¥6.2m.
    - *Premium Rate:* 2.4 x Standard Amount
    - *Example Monthly Premium:* ¥14,940

*(Income definitions: Taxable Pension Income + Other Total Income Amount. Specific*

*thresholds and tier structures may vary by municipality.)*

**(b) Category 2 Premium Determination (Age 40-64)**

Premiums for Category 2 individuals are calculated and collected by the public medical insurance provider they are enrolled in (e.g., Health Insurance Societies, Japan Health Insurance Association (JHIA/Kyokai Kenpo), municipal National Health Insurance (NHI), Mutual Aid Associations) alongside their regular health insurance premiums. Calculation methods vary:

- **Employee Insurance (Health Ins. Societies, JHIA, Mutual Aid):** Premiums are typically calculated by multiplying the individual's standard monthly remuneration (salary bracket) and standard bonus amount by the specific LTCI premium rate set by their insurer. The premium is usually split equally between the employer and employee (*rōshi seppan*, 労使折半). Rates vary by insurer and may be revised annually. For example, the nationwide JHIA (Kyokai Kenpo) rate is set at 1.59% for FY2025 (applicable from March 2025 premiums), down slightly from 1.60%.
- **National Health Insurance (Municipal NHI):** Calculation methods differ by municipality but often combine factors like income (income-based levy), number of insured persons (per capita levy), household basis (flat household levy), and assets (asset-based levy). Premiums are calculated per household, and the head of the household is responsible for payment, even if they are not a Category 2 insured person themselves.
- **National Health Insurance Associations:** Premiums are determined according to the association's rules.

Collecting Category 2 premiums through existing health insurance systems avoids the need for separate collection infrastructure, contributing to administrative efficiency.

**(c) Premium Payment Methods**

Payment methods vary by category:

- **Category 1 (Age 65+):**
  - **Special Collection (特別徴収, *tokubetsu choshu*):** The primary method. If an individual receives ¥180,000 or more per year in eligible pensions (old-age/retirement, disability, survivor), premiums are automatically deducted from their pension payments (usually 6 times a year).
  - **Ordinary Collection (普通徴収, *futsu choshu*):** Used if annual pension amount is less than ¥180,000, or temporarily for those newly turned 65 or recently moved municipalities. Individuals pay directly using payment slips

sent by the municipality (at banks, convenience stores) or via bank transfer.

- **Category 2 (Age 40-64):**
  - Premiums are collected together with their medical insurance premiums.
  - For employees, this is typically via payroll deduction.
  - For NHI members, the household head pays the combined premium (e.g., via bank transfer, payment slips).

These collection methods are linked to the primary income sources for each group (pensions for elderly, salary/business income for working age), with Special Collection being a highly efficient method for the majority of those 65+.

### (d) Consequences of Non-Payment: Benefit Restrictions (給付制限, *Kyufu Seigen*)

Failure to pay LTCI premiums by the due date, without special circumstances like disasters, results in restrictions on accessing services, acting as a penalty. The severity increases with the duration of non-payment:

1. **Over 1 Year of Arrears:** Payment method changes to "reimbursement payment" (*shokan barai*, 償還払い). The user must first pay the *full* (100%) cost of the service to the provider and then apply to the municipality for reimbursement of the insured portion (70-90%). This creates a significant temporary out-of-pocket expense.
2. **Over 1.5 Years of Arrears:** The municipality may temporarily withhold part or all of the reimbursement amount due under the *shokan barai* system. These funds might be used to offset the unpaid premiums.
3. **Over 2 Years of Arrears:** The right to collect the premium expires due to a 2-year statute of limitations. If premiums remain unpaid beyond this period, the user's co-payment rate for future services increases from the standard 10-30% to **30%** (or potentially **40%** for higher incomes). Additionally, they lose eligibility for the "High-Cost Long-Term Care Service Benefit" (which caps monthly out-of-pocket expenses).

These escalating penalties aim to ensure fairness in premium contributions and incentivize payment compliance to maintain the system's financial viability.

## 8. Accessing Services: The Need Certification (要介護認定, *Yo-Kaigo Nintei*) Process

To use LTCI services, an individual must first apply to their municipality and be officially certified as needing care (*yo-kaigo*) or support (*yo-shien*). This certification

process follows nationally standardized criteria to ensure objectivity and consistency.

**(a) Initiating the Process: Application**

- **Applicant:** The individual needing services, or their family members, can apply. If the individual cannot apply themselves, proxy applications can be made by Community General Support Centers, In-Home Care Support Providers, or LTCI facilities.
- **Where to Apply:** The application is submitted to the LTCI counter at the municipal office where the applicant is registered, or through a local Community General Support Center.
- **Required Documents:** Typically include:
  - Application form for Yo-Kaigo/Yo-Shien Certification (available at the counter or municipal website).
  - The applicant's LTCI Insurance Card (*Kaigo Hoken Hihokensha Sho*).
  - Information identifying the primary care physician (name, clinic/hospital, e.g., consultation card).
  - For Category 2 applicants (age 40-64), their public medical insurance card is also needed.
  - My Number confirmation documents, applicant ID (plus power of attorney, proxy ID, seal if applicable).

Access to services begins with this active application step; certification is not automatic.

**(b) Assessment Phase: Home Visit and Doctor's Statement**

Once the application is accepted, the municipality gathers information about the applicant's condition through two main channels:

1. **Home Visit Assessment (認定調査, *Nintei Chosa*):** A certified investigator (municipal staff or contracted professional) visits the applicant's home (or hospital/facility) to conduct an interview with the applicant and family. Using a nationally standardized checklist (including 74 core items), the investigator assesses physical functions, activities of daily living, cognitive function, behavioral issues, social adaptation, and more. They observe the applicant's abilities and record specific details in a narrative section (*tokki jiko*). The visit usually takes about an hour.
2. **Primary Care Physician's Statement (主治医意見書, *Shujii Ikensho*):** The municipality requests a formal medical statement from the applicant's designated primary care physician. The doctor provides information on diagnoses,

symptoms, the progression of conditions causing functional decline, treatment details, cognitive status, physical capabilities, functional limitations, and any precautions needed for service use. If the applicant doesn't have a regular doctor, the municipality may designate one for an examination. The cost of preparing this statement is fully covered by LTCI; there is no charge to the applicant.

This phase combines a standardized functional assessment by a trained investigator with a medical evaluation from a doctor familiar with the applicant's condition, providing a multi-faceted view.

**(c) Review and Decision Phase: Computerized Assessment and Expert Panel Review**

The collected information is then reviewed in two stages:

1. **Primary Determination (一次判定, *Ichiji Hantei*):** Data from the 74 core items of the home visit assessment and some information from the doctor's statement (e.g., presence of dementia) are entered into specialized computer software. Using a nationally uniform logic, the software estimates the amount of care time required (calculating the "Standard Time for Needed Care Certification") and assigns a provisional level: Support Needed 1 or 2 (*Yo-Shien 1-2*), Care Needed 1 to 5 (*Yo-Kaigo 1-5*), or Not Applicable (*Higaito*). This provides an objective, standardized initial assessment.
2. **Secondary Determination (二次判定, *Niji Hantei*):** The final decision is made by the municipality's "Certification Committee for Long-Term Care Need" (介護認定審査会, *Kaigo Nintei Shinsakai*). This committee comprises experts in health, medicine, and welfare (doctors, dentists, pharmacists, nurses, therapists, social workers, certified care workers, etc.). The committee reviews the primary determination result, the detailed notes (tokki jiko) from the home visit assessment, and the *entire* primary care physician's statement. Based on this comprehensive review and discussion, they make the final judgment on the appropriate certification level (*Yo-Shien 1-2*, *Yo-Kaigo 1-5*, or *Higaito*).

This two-stage process combines objective, standardized computer assessment with individualized, holistic expert judgment, aiming for both national consistency and consideration of specific circumstances and medical factors. The committee uses the primary result as a reference but is not bound by it, often placing significant weight on the investigator's notes and the doctor's detailed opinion.

### (d) Notification of Results

Based on the Certification Committee's decision, the municipality finalizes the certification and notifies the applicant.

- **Timing:** Officially, notification should occur within 30 days of application. However, delays are common due to factors like obtaining the doctor's statement or the committee's meeting schedule. The national average processing time in FY2023 was 39.3 days, with some municipalities averaging nearly two months.
- **Content:** The notification letter specifies the certified level (*yo-kaigo-do*) and the period for which the certification is valid. A new LTCI Insurance Card reflecting the certified level is also issued.

The time taken for certification is critical, as it represents a waiting period before services can commence. Shortening this period is an ongoing policy focus.

### (e) Understanding the Certification Levels

The outcome of the certification process falls into one of the following categories:

- **Not Applicable (非該当, *Higaito*):** Assessed as independent and not requiring LTCI services. While ineligible for LTCI benefits, they may access municipally run preventative programs (under the Community Support Project).
- **Support Needed (要支援, *Yo-Shien*) Levels 1 & 2:** Able to perform basic daily activities but need some support with instrumental activities like housekeeping or personal grooming. Eligible for "Long-Term Care Prevention Services" (*Kaigo Yobo Sabisu*) and Community Support Projects aimed at preventing deterioration into a state requiring more care. Level 2 indicates a slightly higher need for support than Level 1.
- **Care Needed (要介護, *Yo-Kaigo*) Levels 1 to 5:** Require some level of nursing care to carry out daily life. Eligible for "Long-Term Care Services" (*Kaigo Sabisu*). The level indicates the intensity of care required:
    - **Yo-Kaigo 1:** Some instability in standing/walking; partial assistance needed with toileting/bathing; potential cognitive issues/behavioral symptoms.
    - **Yo-Kaigo 2:** Support needed for standing/walking; partial or full assistance with toileting/bathing/dressing; potential cognitive issues/behavioral symptoms.
    - **Yo-Kaigo 3:** Unable to stand/walk independently; full assistance needed for toileting, bathing, dressing; often cognitive issues/behavioral symptoms. (Generally the minimum level for admission to Special Nursing Homes for the Elderly - *Tokuyo*).

- **Yo-Kaigo 4:** Daily life largely impossible without care; full assistance needed for personal care; significant cognitive issues/behavioral symptoms likely.
- **Yo-Kaigo 5:** Requires comprehensive care for all aspects of life; communication often difficult; frequently bedridden or near-bedridden state.

This certification level is critically important as it directly determines the *type* of services available (prevention vs. care) and the *volume* of services usable within a monthly budget determined by the level (known as the *Kukyū Shikyū Gendo Kijungaku*).

**(f) Validity Period and Renewal**

Certifications are granted for a limited time:

- **New or Re-assessment Applications:** Typically valid for 6 months initially, though municipalities can set it between 3 and 12 months based on condition stability.
- **Renewal Applications:** Typically valid for 12 months, but can be adjusted from 3 months up to a maximum of 48 months (4 years) depending on the individual's condition.

To continue receiving services beyond the expiry date, individuals must apply for renewal before the current certification ends. If an individual's condition changes significantly (improves or worsens) during the validity period, they can apply for a re-assessment (*kubun henko*) at any time. This system ensures that the level of support provided is regularly reviewed and adjusted to match the individual's current needs.

**(g) Recent Efforts to Expedite and Streamline Certification**

Recognizing that delays in certification hinder timely access to care, national and local governments are implementing measures to speed up the process while maintaining accuracy:

- **Target Setting and Transparency:** The national government has set target timeframes for each step (e.g., home visit within 7 days of request) and publishes municipal performance data to encourage improvement.
- **Digitalization:** Promoting electronic creation and submission of doctor's statements, use of tablets for direct data entry during home visits, and paperless/online Certification Committee meetings to reduce administrative burdens and delays.
- **Procedural Reviews:** Exploring options like allowing applicants to obtain the

doctor's statement before applying.

- **Inter-municipal Cooperation:** Encouraging smaller municipalities to collaborate, for instance, by holding joint Certification Committee meetings.
- **COVID-19 Measures:** During the pandemic, temporary measures allowed for extending validity periods when assessments were difficult due to infection control concerns.

These efforts aim to improve user convenience by shortening the time from application to service initiation, with digital technology seen as key to future efficiency gains.

### 9. Services Provided under LTCI

Individuals certified as *Yo-Kaigo* or *Yo-Shien* can access a diverse range of services based on a personalized Care Plan. Services are broadly categorized according to where and how they are delivered.

#### (a) Overview of Service Categories: In-Home, Institutional, and Community-Based

1. **In-Home Services (居宅サービス, *Kyotaku Sabisu*):** A wide array of services designed to support individuals living in their own homes. This includes services *delivered to* the home (e.g., home help, nursing visits), services attended *outside* the home (e.g., day care, day rehabilitation), short-term *stays* away from home (respite care), rental or purchase of assistive equipment, and subsidies for home modifications.
2. **Institutional Services (施設サービス, *Shisetsu Sabisu*):** Provided within specific residential facilities, offering 24-hour care, medical support, and rehabilitation. These include Special Nursing Homes for the Elderly (*Kaigo Rojin Fukushi Shisetsu* / *Tokubetsu Yogo Rojin Homu*, often called *Tokuyo*), Geriatric Health Services Facilities (*Kaigo Rojin Hoken Shisetsu*, or *Roken*), and Sanatorium Medical Facilities (*Kaigo Iryoin*). These are generally for individuals with higher care needs for whom living at home is difficult.
3. **Community-Based Services (地域密着型サービス, *Chiiki Mitchaku-gata Sabisu*):** Designed to enable older adults to continue living in their familiar communities for as long as possible, these services are tailored to local needs and characteristics. Typically operated on a smaller scale, they are generally restricted to residents of the municipality that designates and supervises the provider. Examples include specialized dementia care (e.g., group homes), flexible combinations of visiting, day, and overnight support (e.g., small-scale multifunctional services). This category was introduced and expanded in past

reforms to promote the "Community-based Integrated Care System" (*Chiiki Hokatsu Kea Shisutemu*).

The structure of these services reflects the system's underlying goal of supporting independent living at home whenever feasible, with institutional care positioned as an option when home-based support is no longer sufficient.

**(b) Examples of Major Services within Each Category**

The following table lists some key services available under LTCI:

**Table: Major LTCI Service Types and Examples**

| Category | Service Type | Japanese Name | English Name / Description |
|---|---|---|---|
| **In-Home Services** | Visiting Services | 訪問介護 (Homon Kaigo) | Home Help / Home Care (personal care, household assistance) |
| | | 訪問入浴介護 (Homon Nyuyoku Kaigo) | Visiting Bathing Service (portable bathtub brought to home) |
| | | 訪問看護 (Homon Kango) | Visiting Nursing |
| | | 訪問リハビリテーション (Homon Rihabiriteshon) | Visiting Rehabilitation |
| | | 居宅療養管理指導 (Kyotaku Ryoyo Kanri Shido) | Home Care Management Guidance (medical advice from doctor, dentist, pharmacist, etc.) |
| | Day Services | 通所介護 (Tsusho Kaigo) | Day Service / Day Care (at a center, includes activities, |

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| | | | bathing, meals) |
| | | 通所リハビリテーション (Tsusho Rihabiriteshon) | Day Rehabilitation / Day Care (at a clinic/hospital, focus on rehab) |
| | Short Stay Services | 短期入所生活介護 (Tanki Nyusho Seikatsu Kaigo) | Short Stay for Daily Life Support (Respite care in a welfare facility) |
| | | 短期入所療養介護 (Tanki Nyusho Ryoyo Kaigo) | Short Stay for Recuperation (Respite care in a medical-type facility, e.g., Roken) |
| | Other | 福祉用具貸与 (Fukushi Yogu Taiyo) | Welfare Equipment Rental (e.g., beds, wheelchairs) |
| | | 特定福祉用具販売 (Tokutei Fukushi Yogu Hanbai) | Purchase of Specified Welfare Equipment (e.g., portable toilets, bath chairs) |
| | | 住宅改修費の支給 (Jutaku Kaishuhi no Shikyu) | Subsidy for Home Modification (e.g., handrails, ramps) |
| **Institutional Services** | Welfare Facility | 介護老人福祉施設 (Kaigo Rojin Fukushi Shisetsu / 特養 Tokuyo) | Special Nursing Home for the Elderly (Long-term residential care) |
| | Health Facility | 介護老人保健施設 (Kaigo Rojin Hoken Shisetsu / 老健 Roken) | Geriatric Health Services Facility (Focus on rehab & returning home) |
| | Medical Facility | 介護医療院 (Kaigo | Sanatorium Medical |

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|---|---|---|---|
| | | Iryoin) | Facility (Long-term care with significant medical needs) |
| **Community-Based Services** | Dementia Care | 認知症対応型共同生活介護 (Ninchi-sho Taio-gata Kyodo Seikatsu Kaigo) | Group Home for People with Dementia |
| | | 認知症対応型通所介護 (Ninchi-sho Taio-gata Tsusho Kaigo) | Day Service for People with Dementia |
| | Small Multifunctional | 小規模多機能型居宅介護 (Shokibo Takino-gata Kyotaku Kaigo) | Small-Scale Multifunctional In-Home Care (Combines day service, home visits, short stays) |
| | | 看護小規模多機能型居宅介護 (Kango Shokibo Takino-gata Kyotaku Kaigo) | Nursing Small-Scale Multifunctional In-Home Care (Similar, but includes nursing) |
| | Other | 定期巡回・随時対応型訪問介護看護 (Teiki Junkai / Zuiji Taio-gata...) | Regular Home Visits & On-demand Support (24/7 visiting care & nursing) |
| | | 夜間対応型訪問介護 (Yakan Taio-gata Homon Kaigo) | Night-time Home Help |
| | | 地域密着型特定施設入居者生活介護 (Chiiki Mitchaku-gata Tokutei...) | Community-Based Care for Residents of Designated Facilities (e.g., smaller private homes) |
| | | 地域密着型介護老人福祉施設入所者生活介護 | Community-Based Special Nursing |

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| | | (Chiiki Mitchaku-gata Kaigo...) | Home (Smaller capacity, usually ≤29 beds) |

This wide variety reflects the highly individualized nature of aging and care needs, allowing for tailored support packages.

**(c) The Crucial Role of Care Plans (介護サービス計画, *Kaigo Sabisu Keikaku*)**

After receiving certification, an individual must have a "Care Plan" created before they can start using services. This plan details the specific types, frequency, and providers of services the individual will use, based on their certified needs, living situation, personal preferences, and family input.

The Care Plan is more than just paperwork; it's an essential coordination tool that translates assessed needs into a concrete service package. In a complex system with numerous services and providers, the Care Plan guides service delivery and facilitates communication and collaboration among all involved parties.

**(d) Care Plan Creation: Process and Cost**

The process and personnel involved in creating a Care Plan depend on the certification level:

- **For Yo-Shien 1 or 2:**
  - *Plan Type:* Long-Term Care Prevention Service Plan (*Kaigo Yobo Kea Puran*, 介護予防ケアプラン).
  - *Creator:* Generally created by staff at the local Community General Support Center (e.g., public health nurse, social worker, chief care manager).
- **For Yo-Kaigo 1 to 5:**
  - *Plan Type:* In-Home Service Plan (*Kyotaku Sabisu Keikaku*, 居宅サービス計画書, often called *Kea Puran*) or Institutional Service Plan.
  - *Creator (for In-Home Services):* Created by a **Care Manager (介護支援専門員, *Kaigo Shien Senmon'in*)** affiliated with an "In-Home Care Support Provider" (*Kyotaku Kaigo Shien Jigyosho*) chosen by the user. The Care Manager conducts an assessment, coordinates a "service planning conference" involving the user, family, and service providers, develops and adjusts the plan, and monitors service delivery afterwards.
  - *Creator (for Institutional Services):* Created by a Care Manager employed by the facility the person is entering.

- **Cost of Care Plan Creation:**
  - The cost associated with creating Care Plans (both *Kea Puran* and *Kaigo Yobo Kea Puran*) is fully covered by the LTCI system (paid as *Kyotaku Kaigo Shienhi* or *Kaigo Yobo Shienhi*). **There is no direct co-payment required from the user for care planning services**.

Especially for individuals receiving care at home, the Care Manager plays a vital role, not just in planning but also in navigating the complex system and connecting the user with appropriate providers. The quality of service access often depends heavily on the Care Manager's expertise and coordination skills.

However, the fact that care planning is fully funded by insurance has been a subject of ongoing policy debate. While eliminating user fees lowers barriers to access, critics argue it may reduce users' awareness of the cost and value of this professional service and contributes significantly to overall system costs (estimated around ¥400 billion annually). Discussions about introducing a co-payment for care planning continue, balancing access against sustainability, but no such fee has been implemented to date.

### 10. User Costs (利用者負担, *Riyosha Futan*) and Reduction Measures

Users of LTCI services pay a portion of the service cost as a co-payment. However, various measures exist to prevent the financial burden from becoming excessive, particularly for those with lower incomes or high service utilization.

#### (a) Co-payment Rates: 10%, 20%, or 30% Based on Income

The standard co-payment rate is **10%** of the service cost covered by insurance. However, for Category 1 insured persons (age 65+), this rate can increase to **20%** or **30%** based on their income.

- **Co-payment Rate Criteria (Category 1, Age 65+):**
  - **10%:** Applies if not meeting the 20% or 30% criteria below.
  - **20%:** Applies if the individual's "Total Income Amount" (*Gokei Shotoku Kingaku*) is ¥1.6 million or more **AND** their "Pension Income + Other Total Income Amount" is ¥2.8 million or more (for single-person households) or ¥3.46 million or more (for households with two or more Category 1 insured persons).
  - **30%:** Applies if the individual's "Total Income Amount" is ¥2.2 million or more **AND** their "Pension Income + Other Total Income Amount" is ¥3.4 million or more (single) or ¥4.63 million or more (two-person+).

- **Other Groups:** Category 2 insured persons (age 40-64), individuals exempt from resident tax, and public assistance recipients generally have a **10%** co-payment rate.
- **Co-payment Rate Certificate (*Futan Wariai Sho*):** Each user receives an annual certificate from their municipality clearly stating their applicable co-payment rate (10%, 20%, or 30%). This must be shown to service providers. Rates are recalculated each year based on the previous year's income, with new certificates typically issued around July.

The 20% co-payment was introduced in August 2015, followed by the 30% rate in August 2018. This reflects a policy shift towards greater "ability-to-pay" (*ōnō futan*, 応能負担) contributions from higher-income seniors to enhance system sustainability and fairness.

**Table Example: Category 1 Co-payment Rate Thresholds (Single Household)**

| Co-payment Rate | Individual's Total Income Amount | AND | Pension Income + Other Total Income Amount |
|---|---|---|---|
| 10% | < ¥1.6 million | | (Cases below) |
| | ≥ ¥1.6 million | AND | < ¥2.8 million |
| 20% | ≥ ¥1.6 million to < ¥2.2m | AND | ≥ ¥2.8 million |
| | ≥ ¥2.2 million | AND | ≥ ¥2.8 million to < ¥3.4m |
| 30% | ≥ ¥2.2 million | AND | ≥ ¥3.4 million |

*(Thresholds differ for multi-person households. Income definitions follow tax law.)*

### (b) Food and Accommodation Costs in Facilities (*Shokuhi*･*Kyojuhi*)

When residing in an LTCI facility (*Tokuyo*, *Roken*, *Kaigo Iryoin*) or using short-stay services, the costs for **food (食費, *shokuhi*)** and **accommodation (居住費, *kyojuhi*; or 滞在費, *taizaihi* for short stays)** are, in principle, **paid entirely by the user**, separate from the 10-30% co-payment for the care services themselves.

This is based on the rationale that food and lodging are fundamental living expenses that would be incurred even if living at home, and thus fall outside the scope of "care" costs covered by insurance. However, reduction measures exist for low-income individuals.

**(c) Reduction Measures for Low-Income Users: Burden Limit Certification (負担限度額認定, *Futan Gendogaku Nintei*)**

To ensure affordability of facility stays, a system reduces food and accommodation costs for users with limited income and assets.

- **Overview:** Individuals (or households) with income and assets below certain thresholds can apply to their municipality for a "Burden Limit Certificate" (*Futan Gendogaku Ninteisho*).
- **Effect:** Presenting this certificate to the facility sets a maximum daily amount (*futan gendogaku*) the user has to pay for food and accommodation. The difference between the actual cost and this limit is paid to the facility by the LTCI system as a "Supplementary Benefit" (*hosoku kyufu*, 補足給付) or "Specified Facility Resident Service Cost" (*tokutei nyushosha kaigo sabisu hi*).
- **Tiers:** The burden limits are tiered based on the user's income status (e.g., resident tax exemption status, income/pension levels, savings/assets – typically 3-4 tiers) and the type of room (e.g., multi-bed room, private room).

This targeted subsidy for normally out-of-pocket expenses acts as a vital safety net, enabling low-income individuals to access necessary facility-based care.

**(d) High-Cost Long-Term Care Service Benefit (高額介護サービス費, *Kogaku Kaigo Sabisu Hi*)**

This system provides refunds when the total monthly co-payments (10-30% portion) for LTCI services become high.

- **Overview:** If the sum of an individual's (or household's, depending on the income tier) co-payments for LTCI services used in a single calendar month exceeds a predetermined monthly ceiling, the excess amount is refunded as the High-Cost Long-Term Care Service Benefit. An application is often required to receive the refund.
- **Eligible Costs:** Only the co-payment portion (10%, 20%, or 30%) of insurance-covered services is counted towards the ceiling. Costs like food and accommodation in facilities, co-payments for welfare equipment purchases or home modifications, and the full cost of services used beyond the monthly

allowance (*kukyū shikyū gendo kijungaku*) are *not* included.

- **Monthly Ceilings:** The ceilings vary significantly based on the household's income and tax status. As of the 2021 revision which raised limits for higher earners:
  - Public assistance recipients: ¥15,000 (individual basis)
  - Non-taxable households (low income/pension): ¥15,000 (individual) or ¥24,600 (household)
  - Other non-taxable households: ¥24,600 (household)
  - Taxable households (up to ~¥3.83m annual income equiv.): ¥44,400 (household)
  - Taxable households (~¥3.83m to ~¥7.7m income): ¥44,400 (household)
  - Taxable households (~¥7.7m to ~¥11.6m income): ¥93,000 (household)
  - Taxable households (over ~¥11.6m income): ¥140,100 (household)

This benefit serves as a crucial financial buffer, particularly for those with high care needs or lower/middle incomes, preventing monthly costs from becoming prohibitive. The tiered structure again reflects the ability-to-pay principle.

**Table: High-Cost Long-Term Care Service Benefit Monthly Ceilings**

| **Income Category (Household Basis unless noted)** | **Monthly Ceiling** | **Basis** |
|---|---|---|
| Equivalent to Active Worker Income (Taxable Income ≥ ¥6.9m / Ann. Inc. ~≥¥11.6m) | ¥140,100 | Household |
| Equivalent to Active Worker Income (Taxable Income ¥3.8m-¥6.9m / Ann. Inc. ~¥7.7m-¥11.6m) | ¥93,000 | Household |
| Equivalent to Active Worker Income (Taxable Income ¥1.45m-¥3.8m / Ann. Inc. ~¥3.83m-¥7.7m) | ¥44,400 | Household |
| Other Resident Tax Taxable Households | ¥44,400 | Household |

| | | |
|---|---|---|
| All Household Members Resident Tax Exempt | ¥24,600 | Household |
| All HH Members Exempt & Income below threshold (*1) | ¥24,600 | Household |
| | ¥15,000 | Individual (*2) |
| Public Assistance Recipients, etc. | ¥15,000 | Individual |

*(1: e.g., previous year's public pension + other total income ≤ ¥800k.)
*(2: Individual cap for non-taxable households; household cap of ¥24,600 also applies.)

**11. Related Support Systems and Key Considerations**

The LTCI system doesn't operate in isolation. It functions as part of a broader network of local support organizations and integrates with other relevant systems to provide comprehensive care for the elderly.

**(a) Role and Function of Community General Support Centers (地域包括支援センター, *Chiiki Hokatsu Shien Center*)**

These centers are pivotal local hubs established by municipalities (or entrusted corporations) to provide integrated support, enabling older adults to continue living safely and securely in their communities. Their key functions include:

1. **Comprehensive Consultation (総合相談支援, *Sogo Sodan Shien*):** Acting as a "one-stop shop" for inquiries from seniors, families, and residents regarding care, welfare, health, medical issues, and daily life concerns. They connect individuals to appropriate services, systems, or agencies.
2. **Rights Protection (権利擁護, *Kenri Yogo*):** Working to safeguard the human rights and assets of older adults. This involves supporting the use of the adult guardianship system, early detection and response to elder abuse, and preventing consumer fraud.
3. **Care Prevention Management (介護予防ケアマネジメント, *Kaigo Yobo Kea Manejimento*):** Developing and coordinating prevention care plans (*kaigo yobo kea puran*) for individuals certified as *Yo-Shien 1 or 2*, and for those identified as being at risk of needing care ("business target persons").
4. **Comprehensive and Continuous Care Management Support (包括的・継続的ケアマネジメント支援, *Hokatsuteki・Keizokuteki Kea Manejimento Shien*):**

Providing back-end support to community Care Managers (*kaigo shien senmon'in*). This includes offering advice on complex cases, facilitating networking among Care Managers, and organizing training to improve the overall quality of care management in the region.

To fulfill these diverse roles, centers are typically staffed by a core team of three types of professionals: **Public Health Nurses** (or experienced nurses), **Social Workers**, and **Chief Care Managers** (*Shunin Kaigo Shien Senmon'in*), who collaborate using their respective expertise. These centers are the "command towers" for local elderly support, essential for the Community-based Integrated Care System, and often the first point of contact for care-related concerns.

**(b) Linkage with Dementia Policies**

With dementia prevalence rising with age, it's a major focus within the LTCI system.

- **Eligibility:** Early-onset dementia (age 40-64) is one of the 16 Specified Diseases making Category 2 individuals eligible. For those 65+, dementia causing care needs naturally qualifies them for certification.
- **Specialized Services:** LTCI offers services tailored for dementia, such as Group Homes (*Ninchi-sho Taio-gata Kyodo Seikatsu Kaigo*) and Dementia Day Care (*Ninchi-sho Taio-gata Tsusho Kaigo*), usually under the Community-Based Services category.
- **Policy Emphasis:** Recent policies stress early detection and intervention, strengthening collaboration with primary care physicians, and promoting initiatives like Dementia Initial Intensive Support Teams. Community support is also bolstered through programs training "Dementia Supporters" and fostering local watch-over networks like "Team Orange". The 2024 care fee revisions included measures enhancing dementia care, such as revised additions for specialized dementia care in visiting services and a new addition for promoting team-based dementia care in facilities.

The LTCI system, in coordination with national dementia strategies, forms a critical social infrastructure supporting individuals with dementia and their families from diagnosis through care and community living.

**(c) Coordination with Medical and Disability Services (連携, *Renkei*)**

Elderly individuals often have multiple chronic health conditions or pre-existing disabilities, making seamless coordination between LTCI, medical insurance services, and disability welfare services essential.

- **Medical Linkage:** Collaboration with healthcare providers is vital across the spectrum – from routine health management and rehabilitation to acute care response and end-of-life care. The concurrent "triple revision" of medical, long-term care, and disability service fees in 2024 prioritized strengthening medical-care linkage. Key measures included:
    - Improved information sharing between hospitals and care providers during admission/discharge (e.g., evaluating participation in pre-discharge conferences, nutritional info exchange).
    - Enhanced capacity of care facilities to handle routine medical needs (e.g., mandatory collaboration with designated medical institutions, revised evaluations for on-call physicians, incentives for deploying specialized nurses, expanding scope of medical procedures).
    - Promoting integrated medical and care services at home (e.g., new additions for specialized management by visiting nurses, new evaluations for pharmacists' home visits).
- **Disability Services Linkage:** Individuals using disability welfare services often transition to LTCI priority upon turning 65. Coordination is needed to ensure service continuity and respect user choice. Community General Support Centers and disability support specialists collaborate to facilitate appropriate transitions.

Lowering barriers between these systems and improving information sharing and role clarification are increasingly crucial for providing seamless, person-centered support to meet the diverse and often complex needs of older adults.

### 12. Challenges, Reforms, and Future Outlook

While firmly established as essential infrastructure over two decades, the LTCI system faces significant challenges driven by Japan's accelerating super-aged society. Ongoing reforms aim to ensure its sustainability and the continued provision of quality care.

#### (a) The Critical Shortage of Care Workers (介護人材不足, *Kaigo Jinzai Fusoku*)

The widening gap between the growing demand for care and the availability of care workers is arguably the most pressing operational challenge.

- **Scale of Shortage:** MHLW projections estimate a shortfall of roughly 320,000 care workers by FY2025 (another estimate suggests 377,000), rising to potentially 570,000-690,000 by FY2040 when the elderly population peaks. Even by FY2026, a deficit of around 250,000 workers is anticipated. The ratio of job openings to applicants in the care sector consistently outpaces the all-industry

average (e.g., 3.71 vs. 1.16), highlighting chronic recruitment difficulties.

- **Underlying Factors:** Reasons cited include the demanding nature of the work (physical and emotional strain), lower wage levels compared to other industries, issues of social perception, unclear career progression pathways, and stressful workplace dynamics. Poor relationships with colleagues/supervisors and dissatisfaction with organizational philosophy/management are top reasons for leaving the sector. Additionally, the increasing number of people leaving jobs to care for family (*kaigo rishoku*) further reduces the potential workforce.
- **Countermeasures:** A multi-pronged strategy is underway:
    - **Wage Improvement:** Successive care fee revisions have included funds for wage increases (e.g., +1.59% overall in 2024, with +0.98% earmarked for wages), alongside consolidation and enhancement of specific wage improvement allowances.
    - **Recruitment and Training:** Supporting care worker training programs, initiatives to bring back inactive certified workers, encouraging entry from middle-aged/older individuals.
    - **Improving Working Conditions:** Promoting efficiency and reducing burden through technology (robots, ICT - e.g., new 2024 addition for promoting productivity), flexible work arrangements (e.g., relaxed rules for part-time staff calculations, clarifying telework applicability), mandatory harassment prevention measures, and support for creating attractive workplaces.
    - **Foreign Workers:** Utilizing frameworks like Economic Partnership Agreements (EPAs) and specific visa categories ("Specified Skilled Worker," "Nursing Care").
    - **Diverse Workforce:** Encouraging participation from active seniors and local residents.

These measures address both attracting new workers ("entry") and retaining existing ones ("exit"), recognizing that solving the shortage requires a comprehensive approach.

**Table Example: Projected Care Worker Supply and Demand Gap**

| Fiscal Year | Estimated Required Workers | Increase from FY2019 | Estimated Shortfall (vs. FY2022 Pace) | Estimated Shortfall (vs. FY2019 Pace) |
|---|---|---|---|---|
| 2019 | ~2.11 million | - | - | - |

| | | | | |
|---|---|---|---|---|
| 2025 | ~2.43 million | ~320,000 | - | ~320,000 |
| 2026 | ~2.40 million | ~290,000 | ~250,000 | - |
| 2040 | ~2.72m to ~2.80 million | ~610k to ~690k | ~570,000 | ~690,000 |

*(Note: Estimates vary based on methodology and timing. Shortfalls indicate the projected gap if current supply trends continue.)*

**(b) System Sustainability: Finances, Rising Costs, and the 2025/2040 Problems**

The paramount structural challenge is ensuring the long-term financial viability of the LTCI system.

- **Fiscal Pressure:** As the number of elderly, particularly those 75+ (*kōki kōreisha*) with higher care needs, increases, both the number of service users and the total system cost (care benefit expenditures) have consistently risen. In the first 20 years, the 65+ population grew 1.6x, while service users increased 3.3x. This drives up both public expenditure (taxes) and premiums for insured individuals (average Category 1 premium roughly doubled between the 1st and 9th plan periods).
- **Demographic Hurdles (2025 & 2040 Problems):**
  - **2025 Problem:** All members of the large post-war baby boomer generation (*dankai no sedai*) will be 75 or older, causing a sharp spike in the late-stage elderly population and projected demand for medical and care services.
  - **2040 Problem:** The 65+ population is projected to peak around 39 million, while the working-age population (who pay premiums and taxes) shrinks significantly. Crucially, the proportion of those aged 85+, who have very high care needs, will increase, along with individuals requiring both medical and long-term care. This creates an extremely challenging demographic structure with fewer contributors supporting more beneficiaries.
- **Balancing Benefits and Burdens:** Maintaining the system requires constantly recalibrating the balance between what the system provides (service scope, eligibility) and how it's paid for (premiums, co-payments). Options regularly debated include making benefits more efficient or targeted (e.g., reviewing services for those with mild needs, examining the role of lifestyle support services) and increasing burdens based on ability to pay (e.g., expanding the pool of users subject to 20%/30% co-payments, introducing fees for care planning, implementing charges for multi-bed rooms in facilities). However, such changes

face significant political and social hurdles due to concerns about access and affordability.

Japan's demographic trajectory poses a fundamental threat to LTCI's stability, necessitating continuous adjustments on both the benefit and burden sides, alongside broad societal understanding and support.

**(c) Recent Reforms and Future Directions: Analysis of the 2024 Revisions**

The LTCI system undergoes regular reviews and revisions, typically aligned with the 3-year planning cycle, to address emerging challenges. The reforms implemented in FY2024 (including care fee revisions) represent a significant step in responding to current pressures.

- **Key Points of the 2024 Revisions:**
  - **Workforce:** Top priority, with significant wage improvements targeted, allowance systems streamlined, and productivity enhancement (ICT/robots) promoted.
  - **Community-Based Integrated Care:** Deepening this system through stronger medical-care linkage (information sharing, facility medical capacity, end-of-life care), enhanced dementia care, and measures supporting integrated local support systems.
  - **Independence Support & Prevention:** Evaluating integrated approaches (rehab, oral care, nutrition), promoting use of the LIFE (Long-term care Information system For Evidence) database with revised related incentives, and valuing specific interventions like bathing assistance and medication reviews.
  - **Sustainability & Stability:** Implementing efficiency measures (e.g., revised deductions for services in congregate settings, addressing long-term respite stays), simplifying the fee structure, mandating financial statement disclosure for providers, and deciding to introduce room charges for multi-bed units in *Roken* and *Kaigo Iryoin* from August 2025.
  - **Other:** Mandating Business Continuity Plans (BCPs) and elder abuse prevention measures (with penalties for non-compliance), and moving towards digital-first requirements for information disclosure.

**Table: Summary of Key 2024 LTCI Revisions**

| Area | Main Revision Content | Related Measures/Additions (Examples) |
|---|---|---|

| | | |
|---|---|---|
| **Workforce/Work Reform** | Care worker wage improvement | Consolidated/Enhanced Care Worker Treatment Improvement Addition |
| | Promotion of productivity (ICT, robots, etc.) | Productivity Improvement Promotion Addition (New); Flexible staffing standards (specific facilities); Mandatory committee |
| | Improving work environment | Flexible calculation of full-time equivalents; Clarification of telework |
| **Deepening Community Integrated Care** | Strengthening medical-care linkage | Specialized Management Addition (Visiting Nurse, etc. - New); Joint Discharge Planning Addition (Rehab - New); Mandatory collaboration w/ medical institutions; Revised additions for emergency physician response; Expanded additions for continuous care in facilities |
| | Enhancing end-of-life (terminal) care | End-of-Life Care Coordination Addition (Visiting Bathing, Short Stay - New); Increased Terminal Care Addition (Visiting Nurse, etc.); Expanded Terminal Care Management Addition |
| | Enhancing dementia care | Revised Dementia Specialized Care Addition; Dementia Team Care Promotion Addition (New) |
| | Promoting community co-living | Revised Comprehensive Management System Enhancement Addition (New tier) |

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|---|---|---|
| | Information infrastructure / DX | LTCI information platform development (by FY2026); Mandatory financial disclosure; Revised rules for posted notices (online principle) |
| **Independence Support/Prevention** | Integrated promotion of Rehab/Oral/Nutrition | New tiers for Rehab Management Addition; Oral Care Linkage Enhancement Addition (New); Discharge Nutritional Information Linkage Addition (New) |
| | Promoting LIFE data utilization | Revisions to Scientific Care Promotion Addition, Independence Support Promotion Addition, ADL Maintenance Addition, Excretion Support Addition, Pressure Ulcer Management Addition |
| | Other initiatives | Revised Bathing Assistance Addition; Revised Collaborating Physician Medication Adjustment Addition |
| **System Stability/Sustainability** | Benefit efficiency/appropriateness | Revised deductions for Home Help in same building (New tier); Fee adjustments for long-term Short Stay use; Deductions for In-Home Care Support in same building |
| | Simplification of fee structure | Motor Function Improvement Addition incorporated into basic fee; Abolition of some minor additions |
| | Review of user burden | Introduction of room charges for multi-bed units (Roken, Kaigo Iryoin - from Aug 2025) |

| | | |
|---|---|---|
| **Other** | Ensuring safety/security | Mandatory BCP formulation & elder abuse prevention measures (with penalties for non-compliance) |

The 2024 revisions represent a comprehensive attempt to tackle multiple pressing issues simultaneously, prioritizing the workforce crisis while advancing medical linkage, dementia care, data utilization, and efficiency. This reflects a strategy of gradual adaptation within the existing framework rather than radical overhaul.

- **Future Directions:** Discussions are already underway for the next major revision cycle (targeting FY2027). Key themes likely include:
  - Further deepening the Community-based Integrated Care System (addressing regional disparities).
  - Strengthening preventative care and health promotion.
  - Exploring new service models (e.g., combined visiting/day service types).
  - Greater use of technology (AI, robotics, data platforms for care planning support, information sharing).
  - Enhancing care provider productivity and encouraging larger scale/collaborative operations.
  - Revisiting benefit and burden issues (potential expansion of 20% co-pay threshold, renewed debate on care plan fees).

**13. Conclusion**

Since its inception in 2000, Japan's Long-Term Care Insurance system has evolved into a fundamental social infrastructure supporting older adults in a rapidly aging society. Its social insurance model, funded by premiums from age 40+ and public funds, aims to uphold dignity, promote independence, and reduce family burden. Featuring municipal insurers, national/prefectural oversight, needs-based certification, diverse services (in-home, facility, community-based) accessed via care plans, and income-related co-payments with safety nets, it is a complex and finely tuned system.

However, the system faces profound structural challenges stemming from hyper-aging and population decline. The dual pressures of escalating care costs threatening financial sustainability and a severe shortage of care workers pose significant risks to its future.

In response, Japan has pursued continuous reforms, exemplified by the

comprehensive 2024 revisions that tackled workforce issues, medical linkage, dementia care, data use, and efficiency simultaneously. This reflects an ongoing process of gradual adaptation to complex, interwoven challenges.

Looking ahead towards 2025, 2040, and beyond, Japan will continue to grapple with deepening community-based care, promoting prevention, leveraging technology, and navigating the difficult but necessary discussions around benefit scope and cost burdens. The core challenge remains: how to deliver high-quality, efficient, and sustainable care while upholding the founding principle of social solidarity in supporting the elderly. The evolution of Japan's LTCI system will undoubtedly offer valuable lessons for other nations facing similar demographic futures.

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