# Enhancing the Long-Term Care Insurance System's Interface with Health Care—Three Themes for the Fiscal 2005 Revision

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## 1. Introduction

In recent years, the social security environment for elderly persons has advanced rapidly, including revision of the health insurance system, launch of the long-term care (LTC) insurance system, and pension reform. Moreover, further changes are being planned, in particular the upcoming revision of the LTC insurance system, and proposed establishment of a health care system for the elderly in 2015.

Article 2 of the LTC Insurance Law provides for a revision of the system after five years of operation. Full-fledged work began in the second half of the current fiscal year to prepare a revision bill for fiscal 2005. The Ministry of Health, Labor and Welfare, which announced at the start its stance to work out problems as they arose, is set to overhaul the system including its legal framework. We expect to see not only adjustments and alterations based on the past three years of operation, but a new role for LTC insurance within the social security structure and new relationship with surrounding systems such as health insurance.

The LTC insurance system was begun with the aim of integrating welfare and health care services for the elderly, the latter of which had been provided separately under the health insurance system (Article 1). However, integration has not progressed as expected; many practical difficulties have emerged due to the low competence of care managers in dealing with medical certificates from physicians, and poor grasp of care plan management among physicians. Attention to these problems is growing because of the widespread recognition that for elderly persons, health care and long-term care are inseparable.

Indeed, from the perspective of elderly users, it is essential to harmonize health care and long-term care, and eliminate gaps caused by arbitrary distinctions. To do this, the revision of the LTC insurance system must not only consider the division of functions with the proposed health care insurance system for the elderly, but find ways to enhance the interface with health care.

This paper discusses the revisions presented by the Subcommittee for Long-Term Care

Insurance of the Council on Social Security, and then examines three key themes from the perspective of designing a better interface of the LTC insurance system with health care.

## 2. Issues in the Fiscal 2005 Revision

Ahead of deliberations on the revision, the Study Group on Long-term Care for the Elderly, an advisory group to the director of the Health and Welfare Bureau at MHLW, compiled a report entitled "Long-term Care in 2015: Toward Care That Supports the Dignity of Elderly Persons" (June 26, 2003).

The report proposes four policy goals for the elderly in the medium to long-term: (1) preventing the need for long-term care and enhancing rehabilitation, (2) a new system of LTC services to maintain continuity in daily living, (3) establishing a new care model for elderly persons with senile dementia, and (4) ensuring and enhancing the quality of services.

Reflecting these goals, on October 27, 2003 the Subcommittee on Long-term Care Insurance presented eight areas of concern in revising the system (Figure 1).

**Figure 1 LTC Insurance System Revision—Eight Areas of Concern**

0. **Overall revision**
1. **Insurers**
   - Size of insurer
   - Functions and authority of insurer
2. **Scope of insured persons**
3. **Benefit content and level (including deductible)**
   - Benefit cost level
   - Benefits for persons needing support, category 1 (including LTC need prevention & rehabilitation)
   - Approach to at-home care and facility care
   - Structure of services (including care for senile dementia)
   - Coordination with health care, etc.
4. **Ensuring quality of services**
   - Care management
   - Third party assessment, protection of rights
   - Training & development of human resources
   - Guidance and supervision of service providers
5. **LTC need certification**
   - Local disparities
   - Quality of certification
   - Procedures, etc.
6. **Distribution of burden**
   - Premiums
   - State's burden
   - Financial adjustment of burden
7. **Relationship to other programs**

Source: Compiled from materials of the Subcommittee on LTC Insurance of the Council on Social Security.

## 3. Trends in At-Home Health Care

As explained above, integrating health care and LTC services is the aim and challenge of the LTC insurance system. We next examine the integration status of health care and long-term care.

### 1. Benefit Trends of At-Home Care Services

LTC insurance services basically consist of two types: services provided to persons living at home, and services provided to persons living in facilities. Service usage and benefit trends are also often divided along this distinction. However, when considering the interface with health care services for elderly persons living at home, it is useful to further divide at-home services into health care and welfare components, and examine their respective infrastructure, usage trends, and benefit trends.

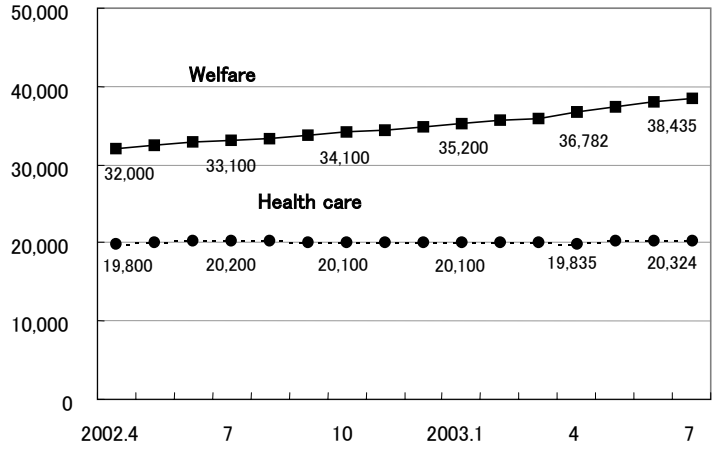
Below we present trends in health care and welfare services by number of establishments, frequency of use, and cost. We focus on at-home services, which include services delivered to the home, as well visits to facilities and short stays by persons living at home (Figure 2).

**Figure 2 Health Care and Welfare Services Provided Under LTC Insurance**

| Health care services | Welfare services |
|---|---|
| Nurse visit to home | Long-term care visit to home |
| Rehabilitation at home | Bathing service at home |
| Rehabilitation at facility | Visit to facility |
| Short stay for medical treatment | Short stay for daily living care |

First, regarding the number of operating establishments, welfare service providers have grown consistently since April 2002, reaching 38,435 establishments in July 2003 (16.1% increase from the previous year). By comparison, health care service providers have remained almost unchanged over the same period, numbering 20,324 (Figure 3). Health care service providers, who consist mainly of hospitals, clinics, and LTC health care facilities for the elderly, have thus not grown consistently compared to welfare service providers, who include for-profit and non-profit corporations.

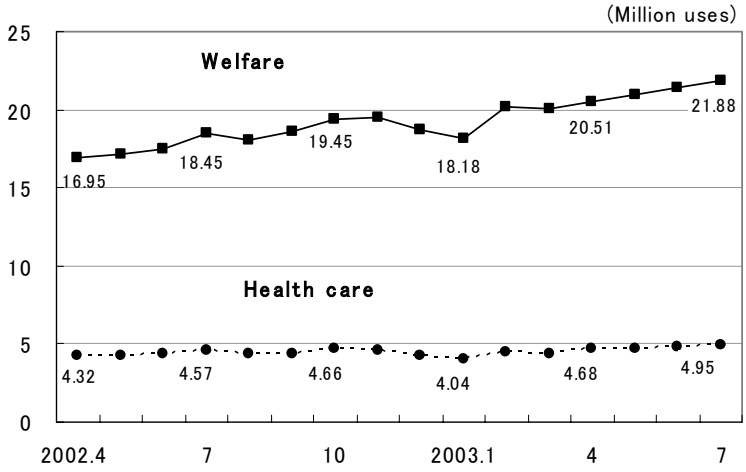
**Figure 3　Trend in Number of Establishments**




Source: Ministry of Health, Labor and Welfare, *Survey of Long-term Care Benefit Costs*.

Next, we find that usage per month (measured by number of uses for services at home or at facilities, and number of days for short stays) increases overall for welfare services, reaching 21,883 uses per month in July 2003, compared to a flat line for health services (Figure 4).

**Figure 4　Use of Services per Month**




Notes: Actual values have been divided by number of days in the month, multiplied by 365, and divided by 12 months.
Source: Ministry of Health, Labor and Welfare, *Survey of Long-term Care Benefit Costs*.

Regarding frequency of use per person, health care services have not changed in the past year: nurse visits remain at 5.4 times per month from July 2002 to July 2003, while rehabilitation visits to facilities dipped from 7.9 times to 7.8 times over the same period. Welfare services are also almost unchanged: nurse visits edged up from 14.7 to 14.8 times per month, and LTC visits to facilities edged up from 7.0 to 7.3 times per month (Figure 5).

**Figure 5　Monthly Use of Services per Person**

(Uses per month)

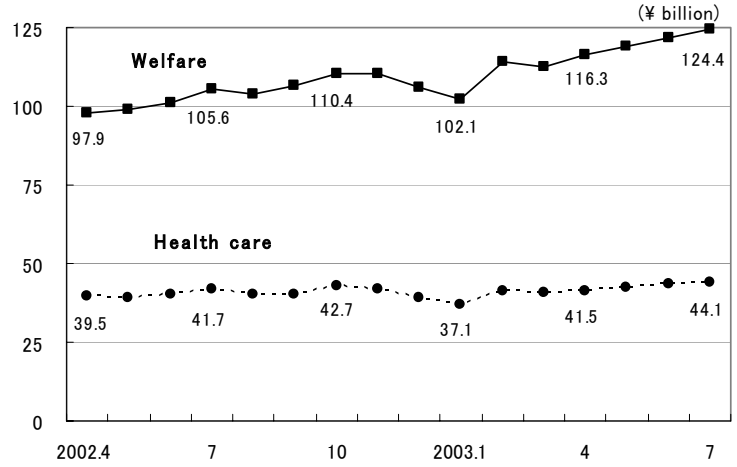
| | Health care | | Welfare | |
|---|---|---|---|---|
| | Nursing at home | Rehab. at center | LTC at home | LTC at center |
| Jul 2002 | 5.4 | 7.9 | 14.7 | 7.0 |
| Oct 2002 | 5.3 | 7.8 | 14.7 | 7 |
| Jan 2003 | 4.8 | 6.8 | 13.7 | 6.3 |
| Apr 2003 | 5.2 | 7.5 | 14.3 | 6.9 |
| Jun 2003 | 5.2 | 7.4 | 14.2 | 6.9 |

Source: Ministry of Health, Labor and Welfare, *Survey of Long-term Care Benefit Costs*.

Thus the rising trend in at-home services can simply be attributed to the growth in benefits associated with the increase in users of welfare services at home.

Looking next at the LTC cost per month (total cost including the user's burden), welfare services have trended upward similar to other indicators, growing ¥18.8 billion per month in the most recent year (17.8% increase from the previous year). On the other hand, while health care services have growth 5.6% in the past year, this growth rate is 8 percentage points below the 13.6% growth rate in users of at-home services (see Figure 2) over the same period (Figure 6).

**Figure 6　Cost of LTC Services**




Notes: See Figure 4 for calculation method.
Source: Ministry of Health, Labor and Welfare, *Survey of Long-term Care Benefit Costs*.

## 2. At-Home Health Care Benefits

From the above trends in number of establishments, frequency of use, and cost, it is apparent that health care services have not grown. Indeed, growth in the usage and cost of at-home services can be attributed almost in entirety to welfare services, while health care services remain stagnant despite the continued growth in number of potential users.

This situation indicates that the supply of at-home welfare services has responded to the strong demand from elderly persons, but raises doubts as to whether adequate health care services are being provided. Although care plans are supposed to integrate the delivery of health care and long-term care, there is concern that care plans tend to favor welfare services due to the number of establishments and availability of services.

We thus need to examine whether the necessary types and amounts of medically valid health care services are available for elderly users at home, and also consider how to build the framework for delivering these services.

## 4. Three Themes for Debate

Given that legal revision to the LTC insurance system will not take effect until 2006, the only way to secure the appropriate at-home health care services under the present system is to improve the quality of care managers. This means elevating care management skills to overcome problems such as biases based on the care manager's previous occupation or affiliation (for example, formulating care plans in which the only service provider is the care manager's own welfare corporation), and lack of collaboration with doctors (for example, delaying the introduction of at-home health care services).

However, benefit trends for at-home health care services indicate that we must examine problems not only at the operational level, but for the system as a whole. Revision of the overall system offers the opportunity to reconstruct how health care is delivered to elderly persons.

In altering the LTC insurance system to enhance the interface with health care, three key themes must be addressed in the revision debate. While financial, systemic, and technical difficulties will inevitably arise, these should be a secondary concern. We must first establish goals and themes—just as the socialization of long-term care was the overriding theme when the LTC insurance system was launched.

### 1. Abolishing Rules That Give Precedence to LTC Benefits

Under present rules, whenever at-home health care services exist under both LTC insurance and health insurance, precedence is given to LTC insurance benefits (Figure 7).

Once elderly persons are certified for support or long-term care, they become eligible for LTC insurance services (even if they do not actually do so), but in doing so lose their health insurance benefits for services such as nurse visits. Since LTC insurance services are

premised on care plan and cost management, health care services are less readily supplied than with health insurance, which is based on the primary physician's judgement. Moreover, elderly persons also suffer when other systems apply, such as the medical expenses assistance program.

**Figure 7　Rules Regarding Precedence of LTC Benefits**

**Health and Medical Service Law for the Aged, Article 34, Section 2**

Expenses will not be paid for medical care or for meals during hospitalization for the aforementioned aging-related diseases or injuries, if equivalent benefits are provided by the LTC Insurance Law.
(The same provision exists in the Health Insurance Law, Article 59, Section 7.)

As long as appropriate insurance premiums are being paid, differences between health insurance and LTC insurance benefits should be clarified, and elderly persons should be empowered to choose for themselves which benefits to use. Unlike other public services, nothing is gained when necessary health care services are withheld due to procedural differences and rules designed to prevent overlapping benefits.

## 2. Redesigning Care Plan Cost Management

In principle, LTC insurance benefits for at-home services are provided within the benefit limits stipulated for each category of care. When care managers formulate care plans, they must also make sure that the total cost of planned services falls within the benefit limit.

At-home health care services are subject to the benefit limit without exception; insurance benefits are not paid out unless care managers include such services in care plans. Unfortunately, considerations such as care plan limitations and the benefit limit are placed before the need for health care services.

Admittedly, the problem might be resolved under the current system by addressing the competence of care managers and price structure of at-home health care services. However, the opportunity now exists to examine the usefulness and effectiveness of care plan cost management itself. For care managers, merits would include not being hindered by the benefit limit when introducing expensive health care services in care plans, and freedom from tedious cost management paperwork. In addition, considering that only about 50% of the benefit limit is actually used on average (due partly to the 10% deductible that users must pay), there is little reason to insist on maintaining the current rules (Figure 8).

Realistic alternatives should be studied, such as (1) separating care plan cost management for health care services and welfare services, (2) excluding at-home health care services from

cost management, and (3) abolishing cost management in principle, and allowing insurers to voluntarily set benefit limits by type of service.

**Figure 8 Benefit Limits and Average Usage Rates**

| | Max. benefit | Average benefit | Usage rate |
|---|---|---|---|
| Need support | 6,150 units | 2,865 units | 46.60% |
| LTC category 1 | 16,580 | 5,787 | 34.90% |
| LTC category 2 | 19,480 | 8,498 | 43.60% |
| LTC category 3 | 26,750 | 12,536 | 46.90% |
| LTC category 4 | 30,600 | 15,092 | 49.30% |
| LTC category 5 | 35,830 | 17,647 | 49.30% |

Source: Ministry of Health, Labor and Welfare, *Survey of Long-term Care Benefit Costs*.

## 3. Designation of Co-Medical Establishments

At-home health care services can also play an important role in the discovery of health care needs. In so doing, LTC insurance can in turn help distinguish and transfer cases that are better dealt with by health insurance.

By administrative order of the MHLW, at-home health care service providers in the LTC insurance system must be hospitals, clinics, or LTC health care facilities for the elderly (Figure 9).

**Figure 9 Service Providers for Health Care at Home**

| | Service provider | No. of estab. | For-profit corp. |
|---|---|---|---|
| Nurse visit | Hospital or clinic | 3,697 | X |
| | Nurse visit station | 5,115 | ○ |
| Rehab. at home | Hospital or clinic | 1,494 | X |
| | LTC health care facility for elderly | 34 | |
| Rehab. at facility | Hospital or clinic | 2,863 | X |
| | LTC health care facility for elderly | 2,920 | |
| Short stay for medical care | Hospital or clinic | 891 | X |
| | LTC health care facility for elderly | 2,765 | |
| Long-term care at home | Unregulated | 17,177 | ○ |
| | Social welfare corporation | 5,214 | |
| | NPO | 777 | |
| | For-profit corp., etc. | 8,281 | |

Source: MHLW, documents of the National Conference of LTC Managers, September 8, 2003.

This is a major reason the number of at-home health care providers has not grown in recent years. While growth would not necessarily ensure delivery of appropriate health care, growth is much needed to expand the infrastructure.

Thus for rehabilitation care services provided at home and at facilities, we propose introducing designated independent rehabilitation centers (including for-profit organizations) staffed with physical therapists (PT) and occupational therapists (OT). Considering the huge success of pioneering nurse visit stations in proliferating nursing services and discovering health care needs, elderly persons at home are more likely to receive needed health care services if we implement medical risk management through directives and reports and increase rehabilitation centers. Since this aim conforms with the proposal of the Study Group on Long-term Care for the Elderly, our proposal should be readily acceptable.

## 5. Conclusion

The LTC insurance system came into being by aggregating health care services and welfare services for the elderly. To preserve this orientation in the revision, rather than relying on health insurance to provide health care for the elderly, the LTC insurance system must pursue its original intent by emphasizing the growing importance of at-home health care services and redefining its relationship to the health insurance system.

Clearly, the themes we raised could be improved and resolved within the present framework. However, the planned overhaul of the LTC insurance system in fiscal 2005 presents the opportunity to address the themes on a large enough scale to eliminate problems that care managers and other frontline participants find insurmountable. No efforts should be spared in searching out all possibilities represented by the themes.

Once the necessary types and amounts of at-home health care services become available, the schism between health care and long-term care can close, and the LTC insurance system can interface with health care in a way that serves elderly persons living at home.

To realize a social insurance system that serves the interest of elderly persons, what we need are not two segregated systems for the convenience of system operation and service providers, but a harmonious interface between health care and long-term care for the sake of users.