
Overview of the Revision of the Long-term Care Insurance System

Amendment of the Long-term Care Insurance Law and Long-term Care Fee

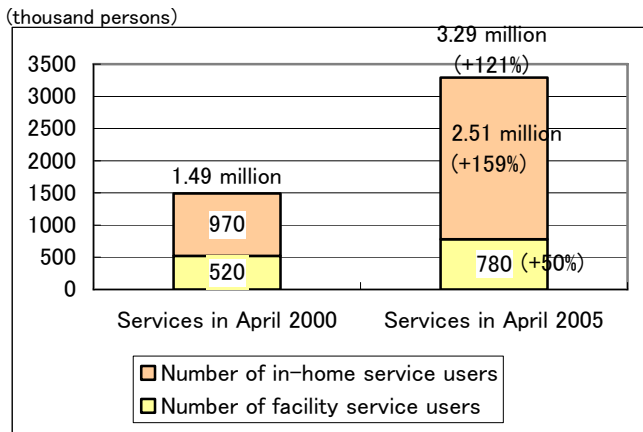
Ministry of Health, Labour and Welfare

Background of the System Revision

I. Steady Development of the System

The Long-term Care Insurance System has been steadily established as a scheme to support needs for care since the start in April 2000; the users of the Long-term Care Insurance have increased rapidly, especially in in-home services.

• Changes in Service Users



Source: Annual Report on the Status of the Long-term Care Insurance Project, Ministry of Health, Labour and Welfare

• Changes in In-home Care Service Providers

The number of long-term care providers has been on the increase, especially in-home care services. Above all the growth in profit-making corporations and non-profit organizations is outstanding.

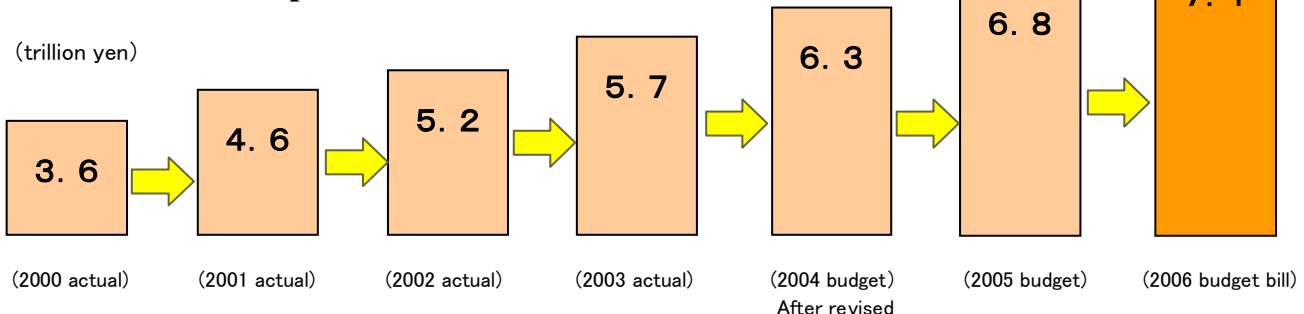
Category of providers		May 2001	May 2005	Rate of increase
Social welfare foundations	Other than Council of Social Welfare	15,134	19,838	31%
	Council of Social Welfare	4,884	5,132	5%
Non-profit Medical corporations		42,907	61,093	42%
Public interest corporations		2,666	3,310	24%
Profit-making corporations		21,882	50,585	131%
Non-profit organizations		682	2,735	301%
Agricultural cooperative societies		952	1,189	25%
Cooperative societies		1,401	1,966	40%
Local governments		5,384	6,416	19%
(Total)		95,892	152,264	59%

Based on WAM-NET(www.wam.go.jp (Japanese only)). As to the number of designation, excluded are other corporations, unincorporated organizations, and care providers certified as designated providers without carrying out application procedure according to a regulation of the Long-term Care Insurance.

II. Financial Condition of the Long-term Care Insurance

As the system is steadily established, the total expense of the Long-term Care Insurance is drastically growing. A steep growth in premiums will be expected in the current system. Thus “sustainability of the system” has become an issue to be solved.

• Growth in Total Expense



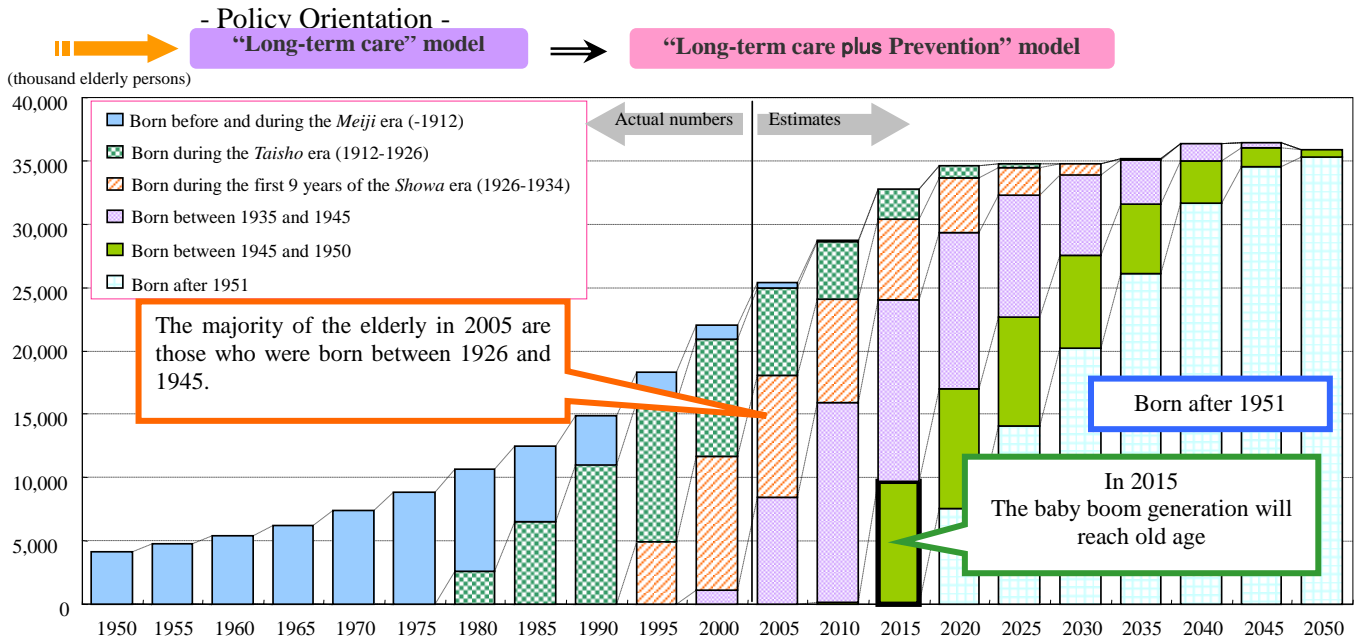
III. Future Outlook -The Elderly in 2015-

“Baby boom generation”* will reach old age after 10 years, in 2015, and further reach later-stage old age in 2025; that will be a peak of aging in Japan.

Additionally, as it is expected that the elderly living alone or with dementia will increase, effort to cope with this new issue is required.

*In Japan, those born in 1947 to 1949

• Rapid Increase in the Elderly



Data: Numbers up to 2000 from the National Census conducted by the Statistics Bureau, Ministry of Public Management, Home Affairs, Posts and Telecommunications and numbers after 2005 from Estimated Future Population in Japan (as of January 2002) by the National Institute of Population and Social Security Research

• Rapid Increase in the Elderly with Dementia

- Policy Orientation -



	Daily life independency level of the elderly with dementia certified as requiring care (As of Sep. 2002)	Those certified as requiring care or support	In-home	Special nursing homes for the elderly	Health service facilities for the elderly	Sanatorium type medical care facilities for the elderly requiring care	Other facilities
Current Status	Total	3,140	2,100	320	250	120	340
	Independent level II or more	1,490	730	270	200	100	190
	Independent level III or more	790 (250)	280 (150)	200 (40)	130 (40)	80 (10)	110 (20)

In parentheses: Older persons with dementia whose physical ability is less declining. (Dementia independency level is “III”, “IV” or “M” and physical independency level is “J” or “A”.)

Estimates	2002	2015	2025
Independent level II or more	1,490 (6.3%)	2,500 (7.6%)	3,230 (9.3%)
Independent level III or more	790 (3.4%)	1,350 (4.1%)	1,760 (5.1%)

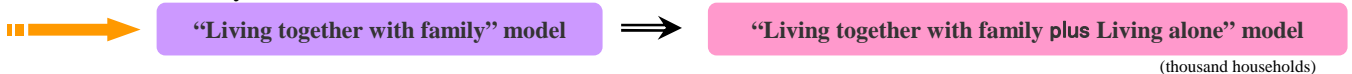
In parentheses: Ratio of the elderly 65+ to the total population

Reference:

Independency level II: Symptom and behavior causing trouble in daily life or difficulty in communication is seen a little; however can be independent with watching. Independency level III: Symptom and behavior causing trouble in daily life is sometimes seen; therefore, care is required.

• Rapid Increase in Elderly Households

- Policy Orientation -



	2000	2005	2010	2015	2020	2025
Single-member households	3,030 (27.2%)	3,860 (28.9%)	4,710 (30.6%)	5,660 (32.2%)	6,350 (34.4%)	6,800 (36.9%)
	3,850 (34.6%)	4,700 (35.1%)	5,420 (35.2%)	6,140 (34.8%)	6,310 (34.2%)	6,090 (33.1%)

In parentheses: Ratio to the households with householder aged 65+

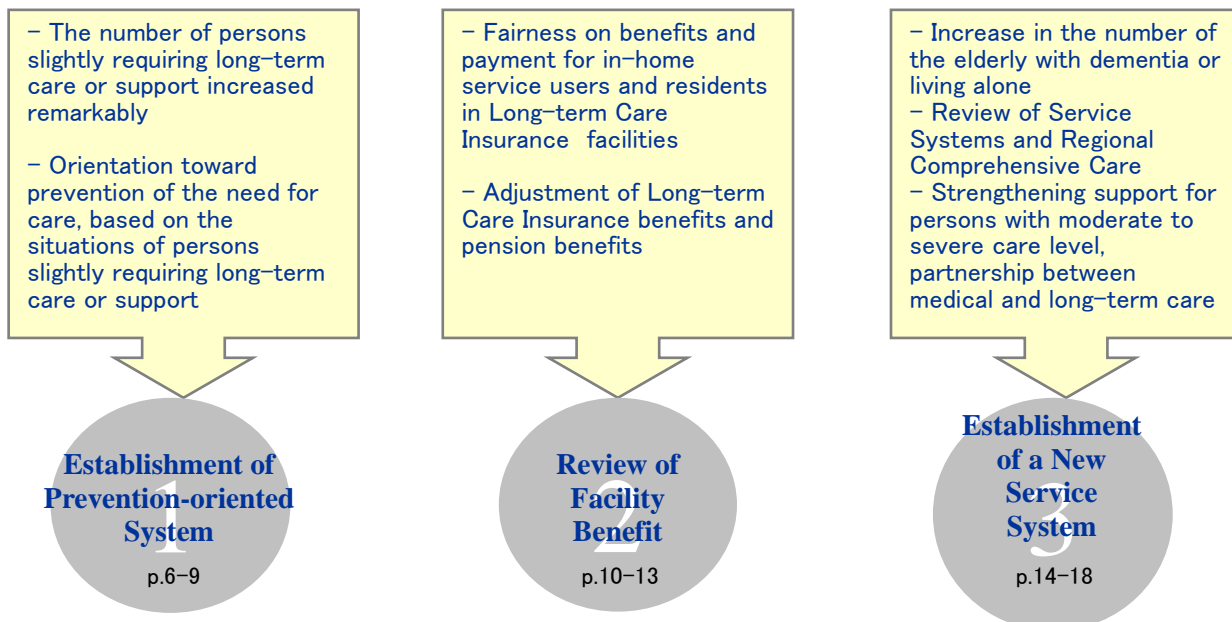
Overview of the System Revision

Basic Perspectives of the Reform

Formation of Productive Aging Society

Sustainability of the System

Overview of the Reform



1) Establishment of New Prevention Benefit

- Based on the situations of persons slightly requiring long-term care or support, persons eligible for prevention benefits, contents of services and care management service are reviewed.
- Regional Comprehensive Support Centers will manage the care management to prevent the need for care in new prevention services.

2) Establishment of Regional Support Projects

- The effective project to prevent the need for care, which is designed for the elderly at risk of requiring care or support, shall be incorporated into the Long-term Care Insurance System.

1) Review of Accommodation Expenses and Meal Expenses

- Insurance benefits for accommodation expenses and meal expenses shall not be provided for residents in three types of Long-term Care Insurance facilities (including short-stays) and users of commuting services.

2) Consideration for People with Low Income

- New supplementary benefits shall be provided in order to reduce payment for people with low income who utilize Long-term Care Insurance facilities.

1) Establishment of Community-based Services

- Community-based Services were established to provide diversified, flexible services reflecting the characteristics of each region.

2) Enhancement of Residential Services

- Expansion of residential care facilities
- Review of for-profit private nursing homes

3) Establishment of Regional Comprehensive Care System

- Establishment of Regional Comprehensive Support Center as a core body in the community

4) Strengthening Support for Elderly with Moderate to Severe Care Level, Partnership and Coordination between Medical and Long-term Care

The Law to Partial Amendment to the Long-term Care Insurance Law, etc.

- Implemented: Apr. 2006 (A review of facility benefits was implemented in Oct. 2005.)

Comprehensive Social Security

- Necessary to secure service quality
- Selection of services by users and improvement of expertise
- Effective rules for regulations
- Problems involved in care management

Maintenance and Improvement of Service Quality

p.19-20

1) Disclosure of Care Service Information

- Obliging nursing care service providers to disclose the information regarding their business

2) Improvement of Expertise in Services and Living Environments

- Improvement of expertise in home-help services and promotion of Unit Care.

3) Review of Regulations for Service Providers

- Review of reasons for disqualification in designation, introduction of the renewal system.

4) Review of Care Management

- Introduction of the renewal system for care manager qualification, obliging the participation in training programs
- Reducing the standard number of the cases each care manager takes charge in, strengthening punishment against unfairness.

- Consideration for people with low income in the insurance premium rate structure
- Impartial and fair certification of long-term care need
- Enhancement of the function of municipal governments as the insurer

Review of Financial Burden and System Management

p.21-22

1) Review of Insurance Premiums for Category 1 Insured Persons

- Creating the insurance premium rate structure that finely reflects the financial ability of each insured.
- Special collection (automatic deduction from pension benefits) shall be additionally applied to the survivor's pension and disability pension.

2) Review of Certification of Long-term Care Need, Strengthening the Function of the Insurer

- Review of subcontracted application services and commissioned surveys
- Strengthening the authority to investigate the office of service providers, developing regulations for outsourcing of clerical work

3) Review of Co-payment Rate, etc.

- Review of the ratio of co-payment of Long-term Care Insurance facilities benefits.
- Review of designation of providers in residential care facilities

Long-term Care Service Plan

1) Enhancement of the Basic Direction of Elderly Care in Future

- Promotion of prevention of the need for care (Community-based Prevention Programs, New Prevention Benefit)
- Enhancement of in-home and community-based services to promote "aging in Place."
- Enhancement of Unit Care and focusing on persons at the severe care levels, concerning living environment in the facilities
- Promotion of extend the choices of residential services according to the increase in elderly households and the progress of aging in urban areas.

2) Preparation for the 3rd Term Long-term Care Service Plan

- Aiming for promoting the fundamental direction of elderly care in future, purposes are established, prospecting for the final year (FY 2014) of the 5th Long-term Care Service Plan.
- Each municipality draws up the 3rd term Long-term Care Service Plan (FY 2006-2008) to attain these purposes.

Scope of Insured Persons and Beneficiaries

Issues on the age of insured and beneficiaries of the Long-term Care Insurance is a future agenda, which will be reviewed and considered by the government by the end of FY 2009.

1. Establishment of Prevention-oriented System

Background of Review

Since the start of the Long-term Care Insurance System, the number of the elderly certified of long-term care has been growing; especially, people slightly requiring support or care (support level or care level 1) has increased steeply, accounting for half of the total.

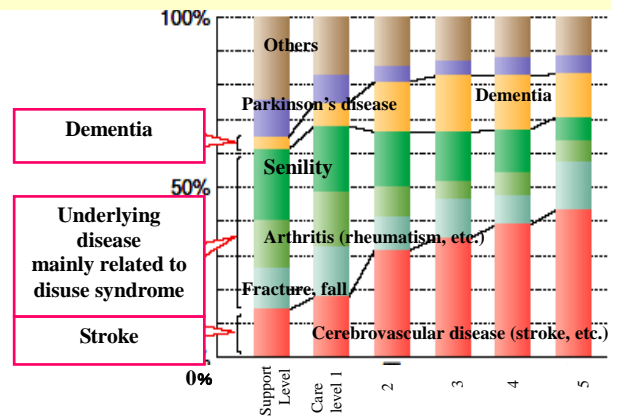
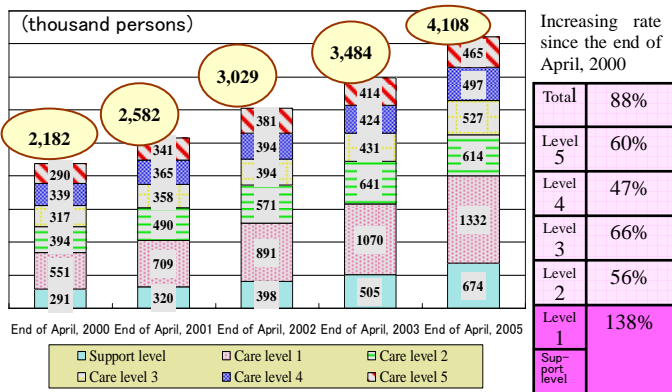
Those slightly requiring support or care have a characteristic that most of them are in the condition of disuse syndrome (inactivity syndrome); their QOL is gradually declining due to falling, fracture, arthritis, etc. or they have its symptoms. It is expected that they could maintain or improve their QOL by appropriate service use.

• Changes of the Number of the Persons Certified of Long-term Care (by Care Level)

• Ratio of Causes of Care Requiring Condition (by Care Level)

The number of the persons certified of long-term care increased by 1.93 million (88%) in 5 years. Especially, those certified at support level and level 1 drastically increased (138%).

Considering the increase in people slightly requiring support or care, it is needed to promote prevention measures against disuse syndrome toward future.



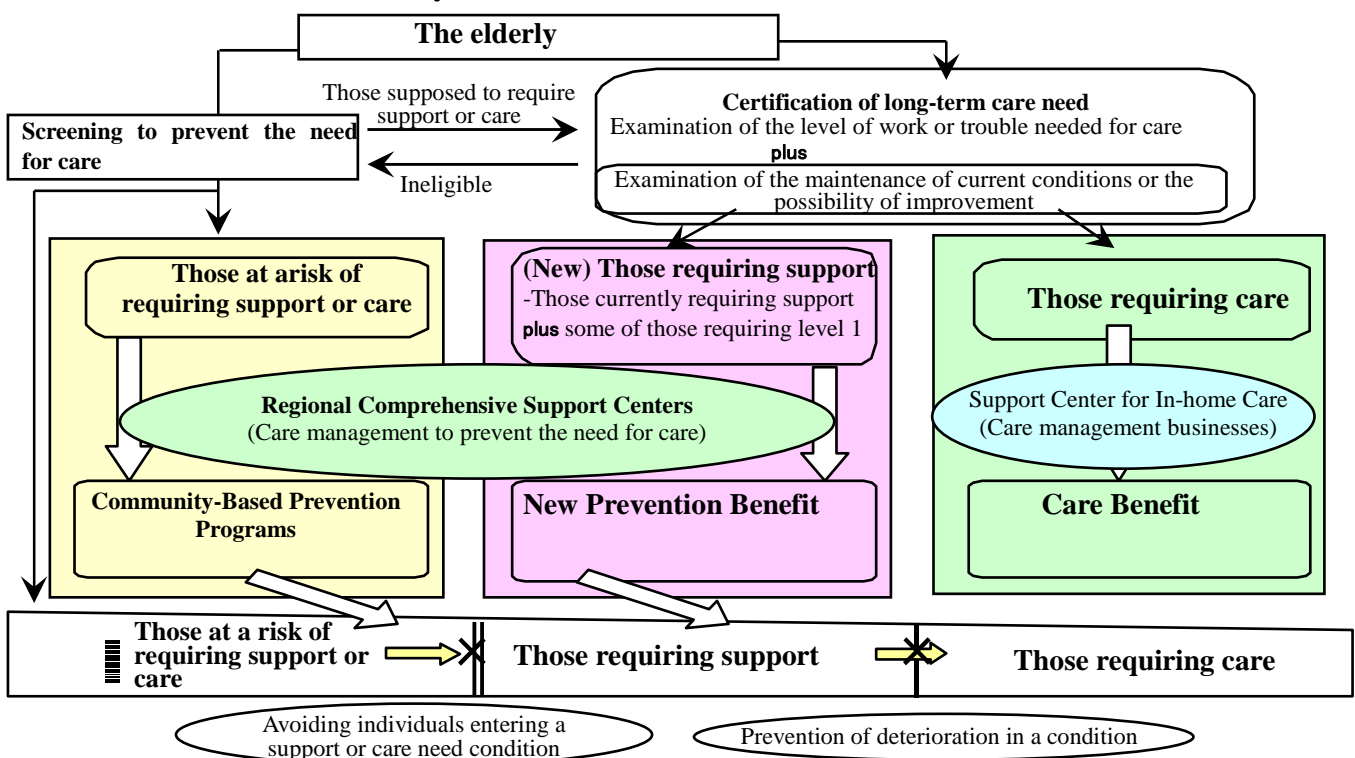
Source: Annual Report on the Status of the Long-term Care Insurance Project, Ministry of Health, Labour and Welfare

Source: Original statistics by Health and Welfare Bureau for the Elderly, MHLW based on the Comprehensive Survey of the Living Conditions of People on Health and Welfare by MHLW (Respondents: 4,534)

Establishment of Prevention-oriented System

The goal of the revision is to establish the system highlighting on “prevention of the need for care” so that people slightly requiring support or care would not assume a condition requiring support or care, or more severe, on the basis of their situations.

• Shift to Prevention-oriented System



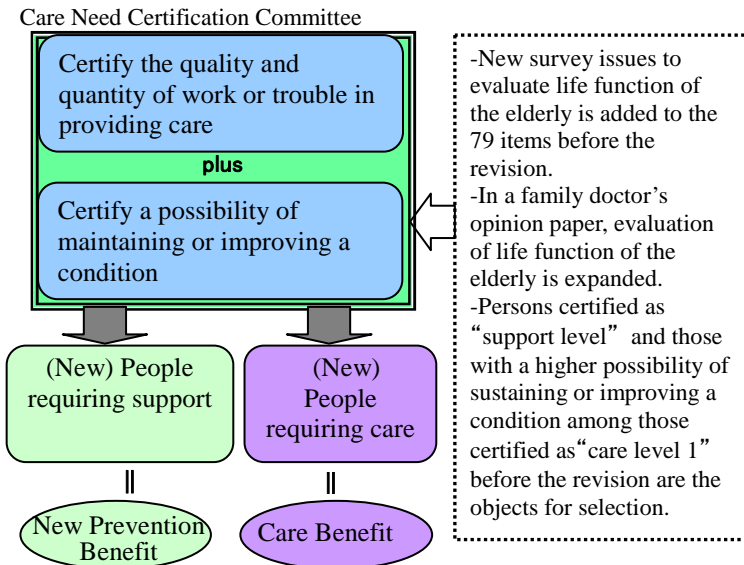
1. Establishment of New Prevention Benefit

From a viewpoint of thoroughly dispersing “supporting independence,” a philosophy of the Long-term Care Insurance, the prevention benefit before the revision, is reorganized into “New Prevention Benefit” by reexamining the scope of eligible persons, the contents of services and care management.

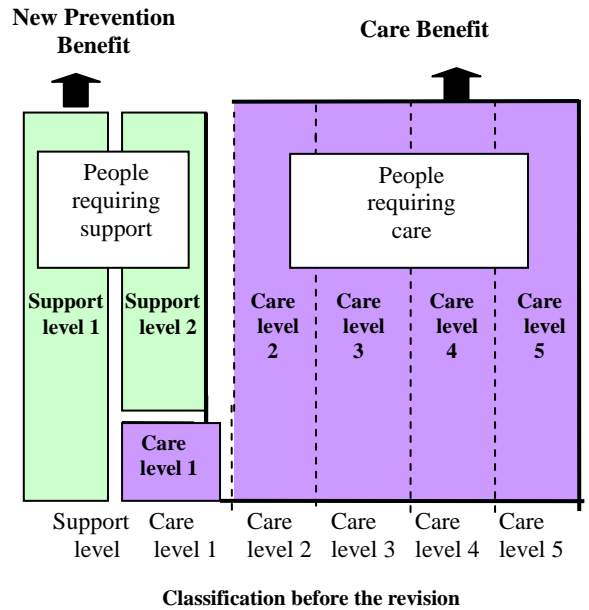
Scope of Eligible Persons / Certification Method

Eligible persons are decided through a process of care need certification by a municipality. Specifically, eligible are 1) persons certified before the revision as “support level” (“support level 1” in a new classification) and 2) people with a higher possibility of maintaining or improving a condition among those certified before the revision as “care level 1” (“support level 2” in a new classification).

• Certification and Decision Process in the Care Need Certification



• Image of Insurance Benefit and Care Requiring Condition Classification Committee



Care Management to Prevent the Need for Care

Municipalities are responsible for care management to prevent the need for care in New Prevention Benefit, attaching greater importance to consistency and continuity with projects to prevent the need for care (p.8), which prevents the condition requiring support or care.

Specifically, assessment is conducted in Regional Comprehensive Support Centers; 1) Goals are established according to users’ conditions, 2) Service plans effective for users’ independence are established in cooperation among diverse experts including the users themselves, 3) Results of services uses are regularly checked out.

Contents of Services to Prevent the Need for Care

Services to prevent the need for care provided as New Prevention Benefit include 15 services such as “day care service,” “day rehabilitation service,” “home-help service,” “rental service for welfare equipments” (except for “care management”).

• Main Contents of Services to Prevent the Need for Care

Day care service/Day rehabilitation services	<ul style="list-style-type: none"> • “Fixed sum system (by month)” of fees • Combination of “common services” and “optional services”* *Optional services: physical exercise, improvement of nutrition and oral function • Introducing assessment of care providers
Home-help services	<ul style="list-style-type: none"> • More closer examination of service necessity • “Fixed sum system (by month)” of fees
Rental and sales services for welfare equipments	<ul style="list-style-type: none"> • Basically, people at support level or care level 1 are not eligible to be provided with a reclining bed, a wheel chair, etc.
Maximum benefits	<ul style="list-style-type: none"> • Established from a standpoint of adjusting prevention benefits

- New Prevention Benefit was implemented in April 2006 in principle. In the municipalities where Regional Comprehensive Support Center has not been established yet, it is possible to postpone the start for up to 2 years (April 2008).
 - People certified in need of care before April 2006 are eligible to receive the benefit as usual during the effective period of care need certification.
 - People placed in the Long-term Care Insurance facilities before April 2006 are able to continue to live in the facility until the end of 2008, even if he/she becomes the object of New Prevention Benefit.

2. Establishment of Community-based Prevention Program

In addition to promote prevention of the need for care before entering the support or care need condition, Community-based Prevention Programs, implemented by municipalities, is established through the viewpoint that enhances comprehensive and continuous care management in the community.

Main Contents of Projects

1) Projects to Prevent the Need for Care

For the elderly in the community, highly likely to require support or care (about 5% of the total elderly population), projects to prevent the need for care (physical exercise, nutrition and oral function, and prevention or support of withdrawal, dementia and depression) are carried out.

2) Comprehensive Support Projects

- General counseling support projects
- Program to protect the right-advocacy projects
- Comprehensive and continuous care management support projects
- Care management projects to prevent the need for care

3) Optional Projects

- Project to stream line long-term care expenditure
- Project to promote family care support projects

Expenses of Community-based Prevention Program

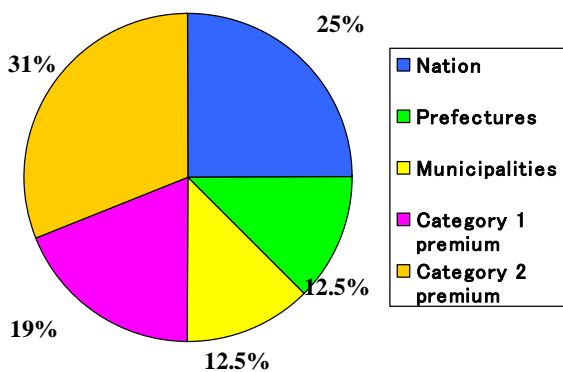
Municipal governments decide the contents and expenses of Community-based Prevention Programs in the Long-term Care Service Plan.

- Decide the maximum by a government ordinance. The standard is less than 3.0% of Long-term Care Insurance benefit of each municipal government. (Temporary measure: less than 2.0% in 2006, less than 2.3% in 2007)

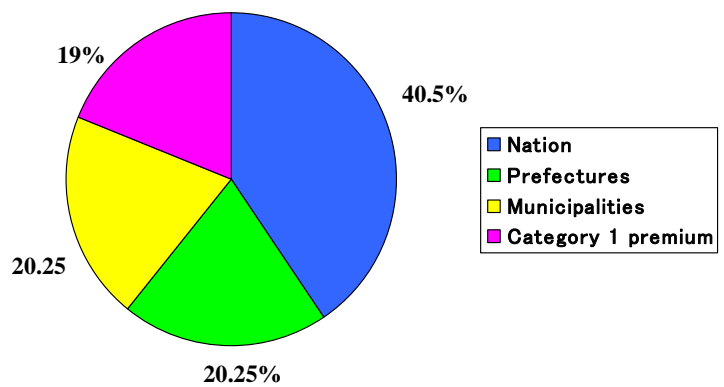
Municipal governments are able to claim users' fee from the users of Community-based Prevention Programs.

• Fund Structure of Community-based Prevention Program

Projects to Prevent the Need for Care



Comprehensive Support Projects/Optional Projects



- The ratios of category 1 & 2 premium are results in the 3rd period (FY2006 to 2008).

Categories of Services after the Revision

	Services in Prevention Benefit	Services in Care Benefit
Services designed and supervised by Prefectures	<p>Services to Prevent the Need for Care</p> <p>[Home-visit services] -Home-help service -Home-visit bathing service -Home-visit nursing -Home-visit rehabilitation -Management & guidance for in-home care</p> <p>[Commuting services] -Day care service -Day rehabilitation service</p> <p>[Short-stay services] -Short-stay for the elderly requiring care -Short-stay for the elderly requiring medical care</p> <p>-Residential care facility for the elderly requiring care -Rental services for welfare equipments -Sales of designated welfare equipments</p>	<p>In-home Services</p> <p>[Home-visit services] -Home-help service -Home-visit bathing service -Home-visit nursing -Home-visit rehabilitation -Management & guidance for in-home care</p> <p>-Residential care facility for the elderly requiring care -Rental services for welfare equipments -Sales of designated welfare equipments</p> <p>In-home Care Support</p> <p>Facility Services -Special nursing homes for the elderly -Health services facilities for the elderly -Sanatorium-type medical care facilities</p>
Services designated and supervised by municipalities	<p>Support to Prevent the Need for Care</p> <p>Community-based Services -Community-based one-stop home care service for small group of users -Day care service for the elderly with dementia -Group home for the elderly with dementia</p>	<p>Community-based Services -Community-based one-stop home care service for small group of users -Night care service -Day care service for the elderly with dementia -Group home for the elderly with dementia -Community-based residential care facility for the elderly requiring care -Community-based welfare facility for the elderly requiring care</p>
Others	-House Reform	-House Reform
Projects by municipalities	<p>Community-based Prevention Programs -Projects to prevent the need for care -Comprehensive support projects General counseling support projects Right-advocacy projects Comprehensive and continuous care management support projects Care management projects to prevent the need for care</p> <p>-Optional projects</p>	

2. Review of Facility Benefit (implemented in October 2005)

Background of Review

In the review of facility benefits, residents in the facilities are claimed to pay accommodation and meal expenses. The revision is carried out in “fairness” to people provided with in-home care, and it is necessary to retain Long-term Care Insurance premium paid by the elderly as well.

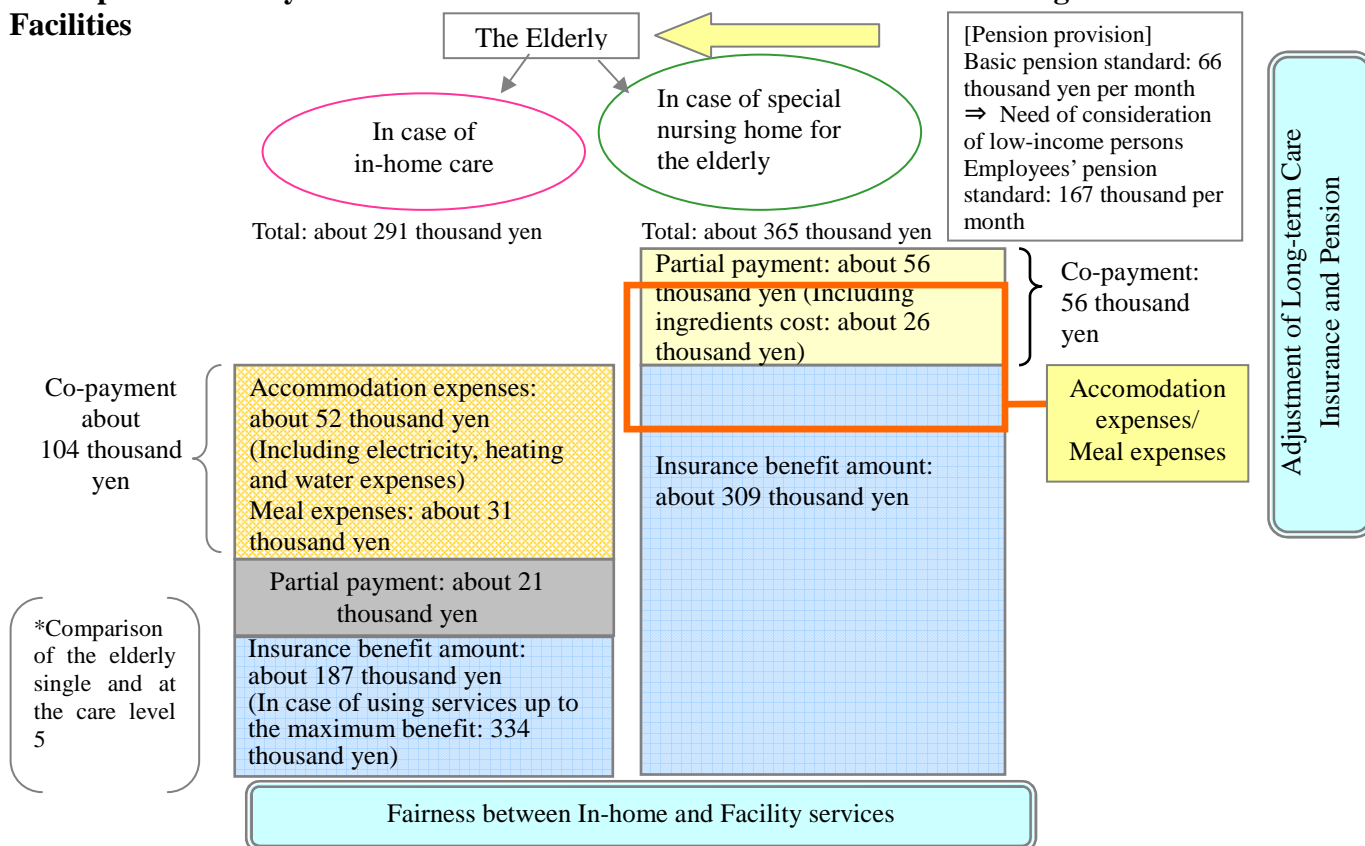
Fairness on Benefits and Financial Burden for In-home Service Users and Residents in Long-term Care Insurance Facilities

In the former system, actual payment of in-home care recipients was about twice of that of facility residents at the same care level.

Adjustment of Long-term Care Insurance Benefits and Pension Benefits

Moreover, despite the fact that basic living expenses like accommodation or meal expenses were covered by the pension system, they were provided by the Long-term Care Insurance also. Therefore it was necessary to adjust such overlap.

• Comparison of Payment for In-home Service Users and Residents in Long-term Care Insurance Facilities



• (Reference) Facility Residents' Payment (US and European Nations)

It is usual in foreign countries that facility residents pay accommodation and meal expenses.

Germany	United Kingdom	France	Sweden	USA
Basically, accommodation and meal expenses and the amount beyond the maximum benefit are residents' co-payment. State social aid (public expense) is provided for low-income persons.	Facility residents with a fixed level of income or asset share all of the cost. Regarding low-income persons, municipalities pay all or partial service expenses for them.	Basically, facility residents pay accommodation and meal expenses. Social aid is provided for low-income persons.	Basically, facility residents pay accommodation and meal expenses. House rent subsidy is provided for low-income persons.	Accommodation and meal expenses are paid by Medicare only for a fixed period of time; after the period residents pay all the cost. In case incapability of co-payment is admitted, it is dealt with Medicaid.

Control of the Increasing Rate of Premiums

Owing to this revision of facility benefit, it is prospected that the increase of insurance benefit is held by about 300 billion yen a year, and that of premium about 200 yen a month.

1. Review Points

Accommodation and Meal Expenses are Excluded from Insurance Benefit. Users and Facilities Make a Contract

In the revision this time, facility and short-stay users are required to pay accommodation and meal expenses as well as in-home care recipients. Day care users also pay meal expenses.

The specific amounts of such expenses are decided by a contract between users and facilities. The nation has suggested “guideline concerning users’ accommodation (including short-stay) and meal expenses,” which defines the need of prior explanation in writing for users and procedure of informed consent, so that an appropriate contract is carried out.

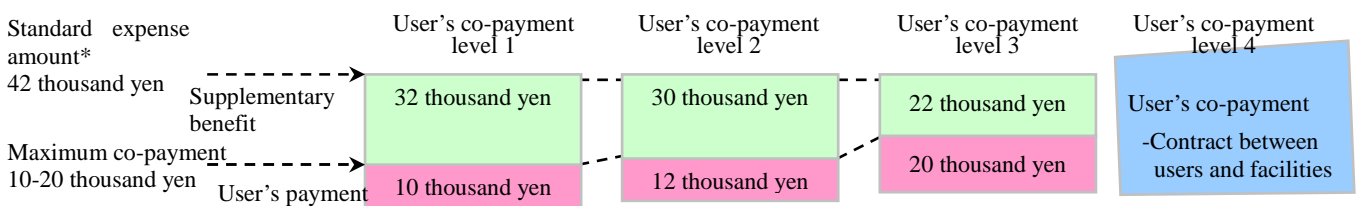
• Guidelines as to the Contract between Users and Facilities

Guidelines for appropriate procedure	<ul style="list-style-type: none"> -Prior explanation in writing for users or their family -Users’ consent in writing (Excluding day care service and day rehabilitation service) -Details of accommodation expenses and meal expenses: Stated in the operation regulation as to monetary establishment or change and also put up on the bulletin board in the facility.
Guideline for a scope of “Accommodation expenses” (including short-stay)	<p>Scope of “accommodation expenses”</p> <ul style="list-style-type: none"> -Established according to living environment <p>Issues to be considered in deciding the standard of “accommodation expenses”</p> <ul style="list-style-type: none"> -Construction cost of the facility (Repair and maintenance costs are included. Whether it receives public support or not also should be considered.) -Average standard of house rent and light, heating and water expenses of similar facilities in the neighborhood, etc.
Guideline for a scope, etc. of “meal expenses”	<p>Scope of “meal expenses”</p> <ul style="list-style-type: none"> -Establish the amount equivalent to “ingredients and cooking cost.”
Others	<p>In collecting “special room charge*1” or “special meal expenses *2,” it must be clearly separated from “accommodation expenses” or “meal expenses.”</p> <p>*1: Living environment based on user’s special request (private room floor space, the location, a view, convenience like access to internet)</p> <p>*2: Menu or ingredients based on user’s special request</p>

Consideration for Low-income Users

Regarding accommodation and meal expenses of low-income users, the maximum payment amount is decided to prevent their excessive burden. In the facilities newly established insurance benefits (=supplementary benefits) make up for the difference between the average expenses (=standard expense amount) and the maximum payment.

• Scheme of Supplementary Benefit (ex. Meal Expenses)



* In case the expenses currently needed is less than the average expenses in each facility, the expenses needed currently is the standard

Levels of users’ co-payment (*)	Level 1	Level 2	Level 3	Level 4
Levels of users’ co-payment (*) (Example of the persons covered)	(Public assistance recipient)	(Pension amount: 0.8 million or less yen)	(Pension amount: over 0.8 to 2.66 million yen)	(Pension amount: over 2.66 million yen)

• Change of Users’ Co-payment

Case of special nursing home for the elderly (multiple-bed room) Total users’ co-payment	Persons covered by supplementary benefit			
	Level 1	Level 2	Level 3	Level 4
Co-payment before the revision	25 thousand yen / month (same as before the revision)	37 thousand yen / month (lower payment than before the revision)	55 thousand yen / month (controlling payment increase)	81 thousand yen / month (**)
Co-payment after the revision	25 thousand yen	40 thousand yen	40 thousand yen	56 thousand yen

*The level of users’ co-payment in Long-term care Insurance Services provided after July 2006 is decided by each taxation condition after revision of the taxation system.

**As to the 4th level of users’ co-payment, the standard is decided by a contract between a user and a facility. An average amount is shown here. It is to be 80 thousand yen in the revision of fees in April 2006.

2. Review Points As to Accommodation Expenses

A scope of “Accommodation Expenses” Is Basically Decided according to Living Environment

Scope of “accommodation expenses”	Multi-bedroom (shared room)	:	Equivalent to light, heating and water expenses
	Conventional-type private room	:	Equivalent to room charge plus light, heating and water expenses
	Unit-type semi-private room	:	Equivalent to room charge plus light, heating and water expenses
	Unit-type private room	:	Equivalent to room charge plus light, heating and water expenses

The Maximum Co-payment of Low-income Users Is As Follows:

(In parentheses: approximate amount per month)

		Maximum co-payment			Standard expenses amount
		Users’ co-payment	Users’ co-payment	Users’ co-payment	
Multi-bedroom (shared room)		0 yen / day (0 yen)	320 yen/day (10 thousand yen)	320 yen/day (10 thousand yen)	320 yen/day (10 thousand yen)
Conventional-type private room	1) Special nursing homes for the elderly, etc.	320 yen/day (10 thousand yen)	420 yen/day (13 thousand yen)	820 yen/day (25 thousand yen)	1,150 yen/day (35 thousand yen)
	2) Health service facilities for the elderly, sanatorium-type medical care facilities, etc.	490 yen/day (15 thousand yen)	490 yen/day (15 thousand yen)	1,310 yen/day (40 thousand yen)	1,640 yen/day (50 thousand yen)
Unit-type semi-private room		490 yen/day (15 thousand yen)	490 yen/day (15 thousand yen)	1,310 yen/day (40 thousand yen)	1,640 yen/day (50 thousand yen)
Unit-type private room		820 yen/day (25 thousand yen)	820 yen/day (25 thousand yen)	1,640 yen/day (50 thousand yen)	1,970 yen/day (60 thousand yen)

- 1) is in case of special nursing homes for the elderly or short-stay for the elderly requiring care.

2) is in case of health service facilities for the elderly, sanatorium-type medical care facilities and short-stay for the elderly requiring medical care.

- As supplementary benefits, the difference between the average accommodation expenses (standard expense amount) and the maximum payment above is provided by the Long-term Care Insurance to the facilities.

- The specific standard of users’ payment level 4 is decided by a contract between users and facilities.

- Additionally, for some private rooms in health service facilities for the elderly and sanatorium-type medical care facilities, extra fee is charged.

The Following Transitional Measures Are Adopted for Residents in Conventional-type Private Rooms

The following transitional measures are adopted for those who have already accommodated or get hospitalized in conventional-type private rooms, so that the payment of them would not rapidly increase.

Scope of Eligible Persons

Current residents: Those who do not pay extra charge among the current residents in the conventional-type private room

New residents: 1) Those who are required to spend in a private room for a certain period (less than 30 days) owing to facility’s circumstances, such as infectious disease or treatment needs.

2) Those whose room is less than a fixed floor space

* Special nursing home for the elderly: 10.65m²

Health service facilities for the elderly: 8m²

Sanatorium-type medical care facilities: 6.4m²

3) Those whose care can be provided only in a private room because they are in such a serious mental condition as to affect mental or physical condition of the roommates.

Long-term Care Fee

Applying the same amount as multi-bedroom

Users’ Co-payment

Amount equivalent to light, heating and water expenses

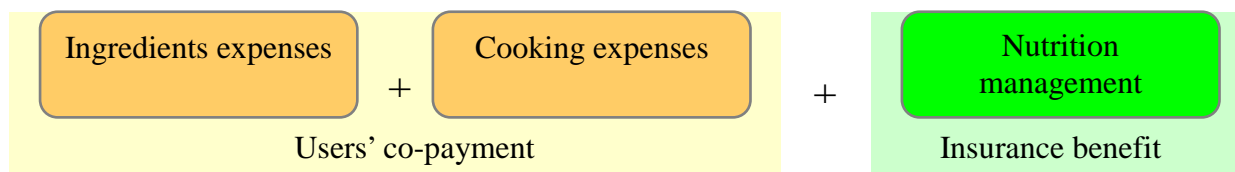
Extra Room Charge

It is not permitted for facilities to ask for its co-payment.

3. Review points as to meal expenses

Scope of Meal Expenses Is Equivalent to “Ingredients Expenses” plus “Cooking Expenses”

Among meal expenses, users’ co-payment is “ingredients expenses” plus “cooking expenses,” while “nutrition management expenses” are provided by Long-term Care Insurance.



The Maximum Co-payment of Low-income Users Is As Follows:

(In parentheses: approximate amount per month)

Maximum co-payment			Standard expenses amount
Users’ co-payment level 1	Users’ co-payment level 2	Users’ co-payment level 3	
300 yen/day (10 thousand yen)	390 yen/day (12 thousand yen)	650 yen/day (20 thousand yen)	1,380 yen/day (42 thousand yen)

- As supplementary benefit, the difference between the average meal expenses (standard expense amount) and the maximum co-payment above is provided by the Long-term Care Insurance to the facilities.
- The specific standard of users’ co-payment level 4 is decided by a contract between users and facilities.
- Additionally, extra meal expenses are charged depending on the situation.

Importance Is Attached on Individual Treatment According to Each User’s Nutritious or Intake Condition, and Low Nutritious Condition Is Improved by Nutrition Care Management

The Following measures are adopted for meal and nutrition management in facilities.

- 1) Users’ health and nutritious condition is checked by weighing users’ weight.
-“Are they not malnutritional?” “How is their swallowing?” etc.
- 2) Users’ individual plan is drawn up based on each health and nutritious condition.
-Meals to prevent or improve malnutrition, eating pattern according to intake or swallow function, etc.
- 3) Regular follow-up checks

These nutrition care management is covered by Long-term Care Insurance benefit. While aiming for “eating by his/her mouth,” devices for diabetic diet are also continuously covered by Long-term Care Insurance benefit.

3. Establishment of a New Service System

To Promote “Aging in Place”

The elderly with dementia or living alone are increasing. In order to promote “Aging in Place,” reviewing services is carried out; for example, establishment of “community-based services,” improvement of “residential services.” In addition, establishing a “regional comprehensive care system” is promoted by establishment of Regional Comprehensive Support Centers.

Moreover, while “support for the elderly with moderate to severe care levels” is further strengthened, a partnership of “medical and care facilities” is promoted and the coordination is clarified.

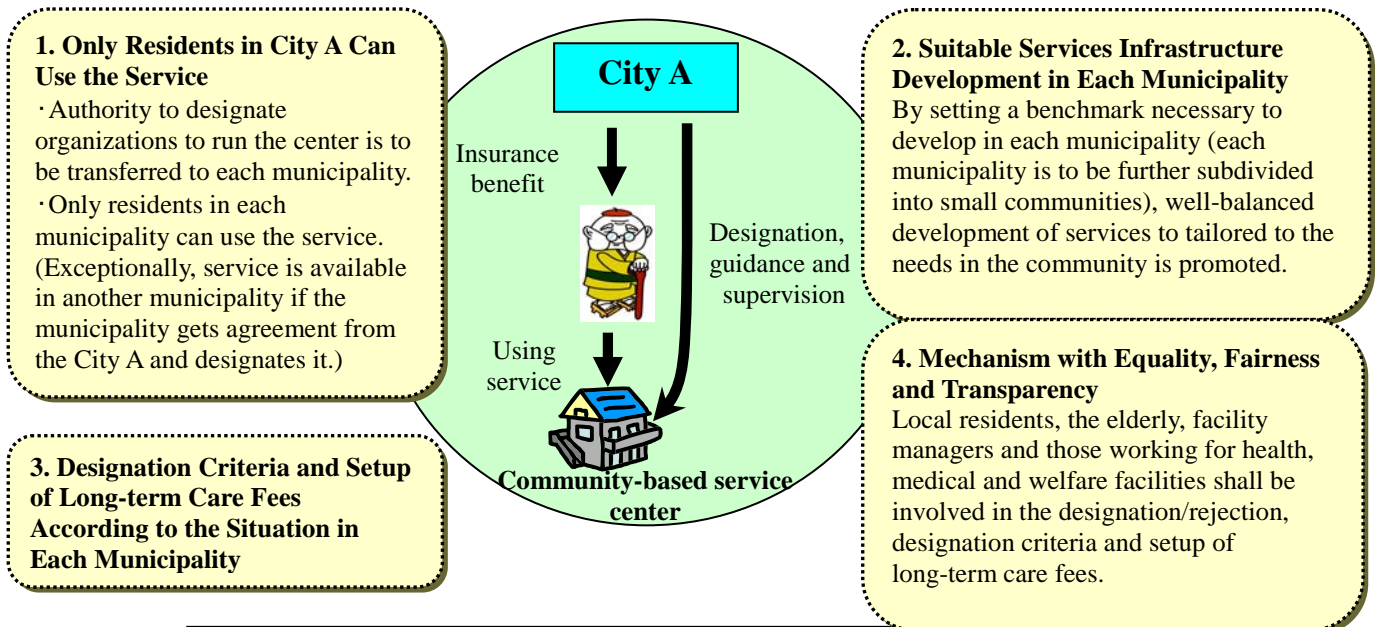
1. Establishment of Community-based Services

While “to retain dignity” is prescribed among the purpose of the Long-term Care Insurance, “community-based services” are created as a new service system. This system will enable diverse and flexible service provision in the community where the users have lived long, depending on regional characteristics.

• Purpose Provided in the Long-term Care Insurance Law (Article 1)

Article 1 This law aims: concerning the people in need of care due to diseases, etc. caused by aging-related mental or physical changes, who require bathing, toileting or feeding care, functional training and nursing care, and medical care including medical treatment management, in order that the government shall provide allowances related to required health care and welfare services for citizens to retain dignity and live independently according to their capacity, the Long-term Care Insurance System is established on the basis of a principle of national common solidarity, the issues required to practice insurance benefits, etc. are defined, and thus improvement of national health, medical care and welfare is realized. (The underlined phrase is revised in this revision.)

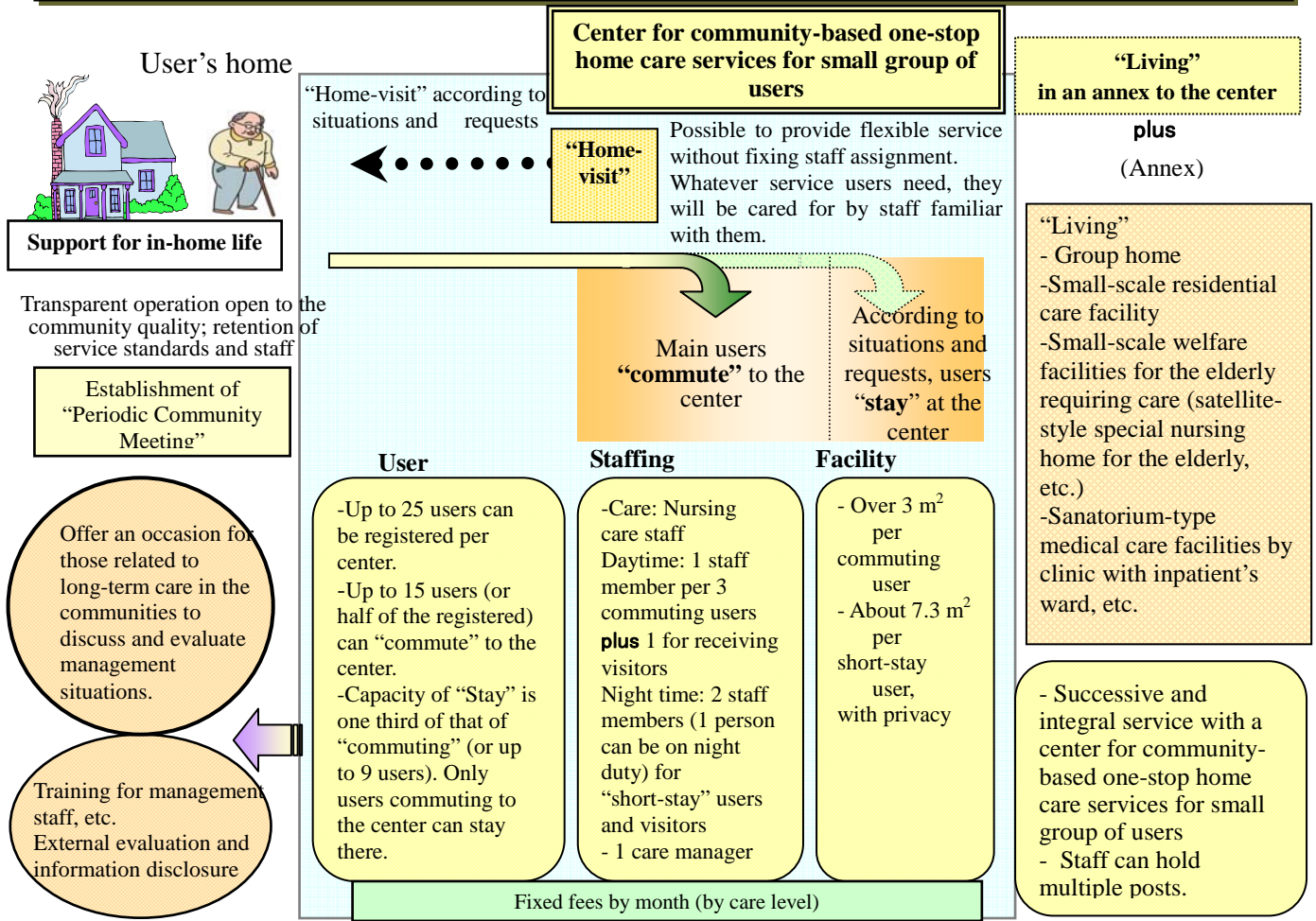
• Scheme of Community-based Services



- Community-based Services**
- 1) Community-based One-stop home care service for small group of users
 - 2) Night care service
 - 3) Day care service for the elderly with dementia
 - 4) Group home for the elderly with dementia
 - 5) Community-based residential care facility for the elderly requiring care
 - Small-scale (capacity: under 30 persons) designated facilities for the elderly requiring care
 - 6) Community-based welfare facility for the elderly requiring care
 - Small-scale (capacity: under 30 persons) welfare facilities for the elderly requiring care

• Image of Community-based One-stop Home Care Services for Small Group of Users

Basic concept: To help users, who will need moderate or severe level care if at all, “aging in place” by having main users commute to a care center and also providing a combination service of “home-visit” and “short-stay” at any time; according to the situations and requests from the elderly requiring care.

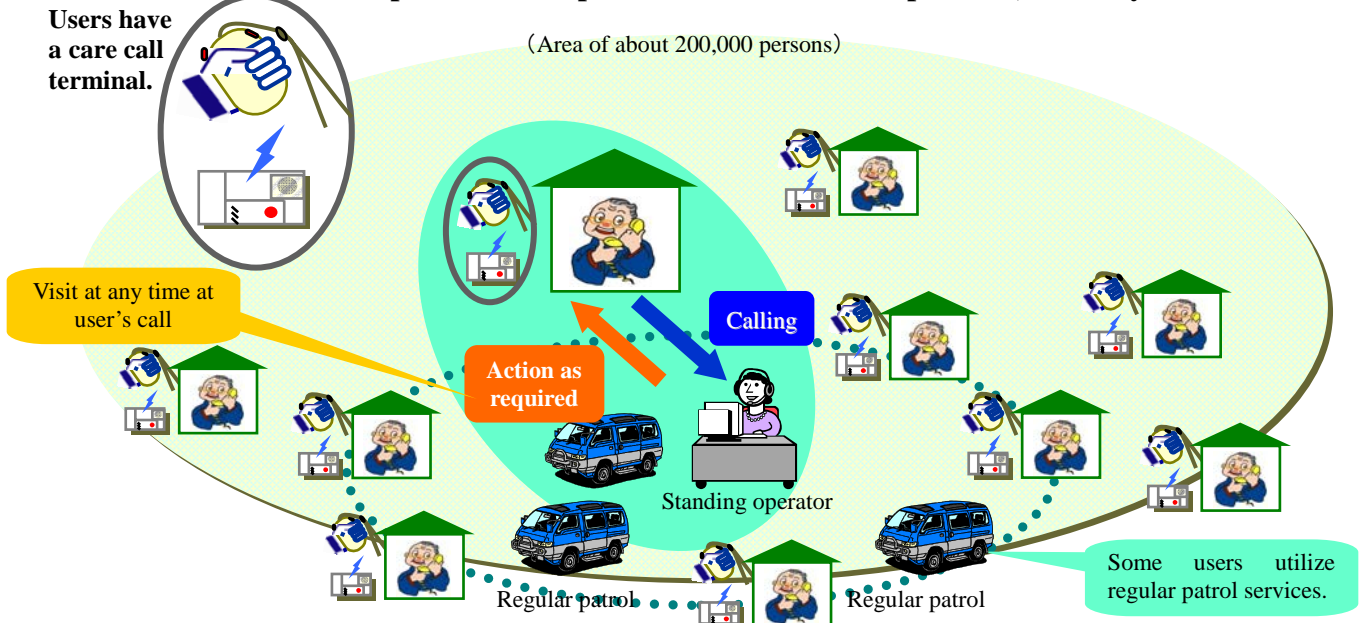


• Image of Night Care Service

Basic concept: It is necessary to develop a system in which the in-home elderly can securely live 24 hours a day, including night time.

→ Establishment of “Night care service” to respond on demand through regular patrols and telephone calls.

About 300 persons are expected to use this service per area, basically.



2. Enhancement of Residential Services

As to residential care facilities providing residential services, a scope of eligible persons is expanded and care service supply system is diversified. Regarding private elderly homes, the definition is revised (abolishing requirements about the number of residents, etc.), information disclosure, measures for keeping a lump sum intact against going bankrupt, etc. are imposed to them from a viewpoint of protecting residents.

Residents in nursing homes for the elderly become eligible to use the Long-term Care Insurance.

Expansion of Needs for Relocating among the Elderly

(Background)

- Difficulty or worry in daily life due to an increase in single-member households or husband-and-wife households among the elderly
- House structure is not suitable for a life of people in need of care.
- Diversification of elderly living style



Relocating to a “House” Where the Elderly Can Lead Safe, Comfortable Lives: A New “House” Other Than Own Home or Facilities

- Barrier-free, and living standard suitable for a house
- Securing continuous living
- Living support service for safety and comfortability
- Provision of care services depending on each pattern of “early relocation of the house” and “relocation of the houses in care requiring condition”

Enhancement of Residential Services

1) Expansion of the Subject of Residential Care Facilities

- Before the revision, only for-profit private nursing homes for the elderly and care houses: Expanded to “houses for rent exclusively for the elderly” which satisfies a certain living standard

2) Diversification of Service Provision Patterns in Residential care Facilities

- Before the revision, care services are provided by staff of residential care facilities: Establishment of “care for residents in designated facilities using external services”

3) Review of For-profit Private Nursing Homes for the Elderly

- Review of the definition of for-profit private nursing homes for the elderly
- Improving security of residents: Obligation of disclosure and measures to keep a lump sum intact)



3. Establishment of Regional Comprehensive Care System

“Regional comprehensive care” is aiming for a “comprehensive and continuous service system” by which required care services are continuously provided according to a change of needs or a condition of the elderly. Establishment of “Regional Comprehensive Support Center” is newly promoted as a core body to support such a system.

Regional Comprehensive Support Center

Regional Comprehensive Support Center is a core body in the community, performing the following 4 functions from the perspectives of ensuring equality and fairness of the center:

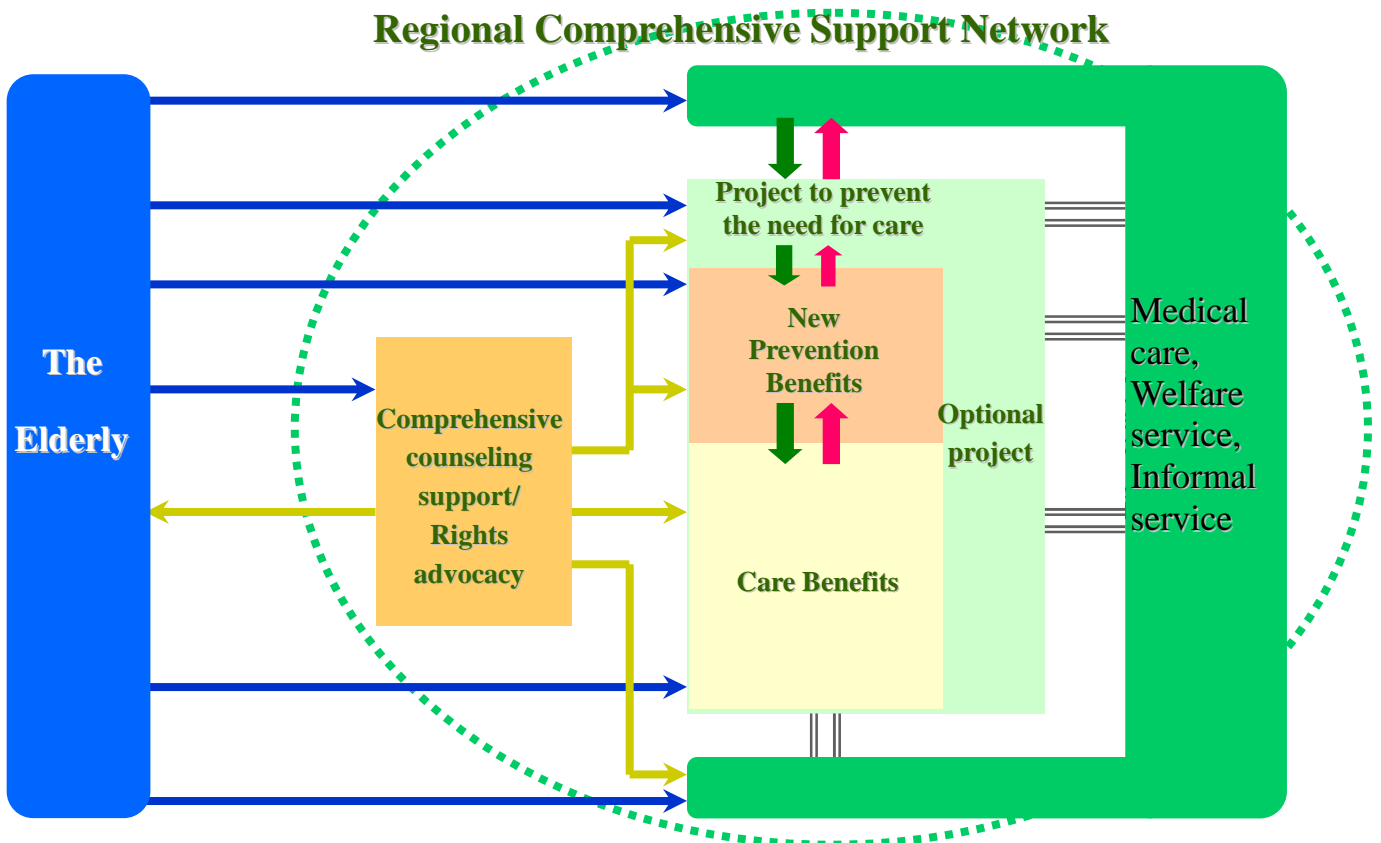
- 1) Total counseling support
- 2) Rights advocacy including prevention and early discovery of abuse
- 3) Comprehensive and continuous management support
- 4) Care management to prevent the need for care

Main management	Municipalities, corporations operating in-home care support centers (social welfare foundation, medical corporation, etc.), and other corporations entrusted by municipalities.
Area	Area in charge is decided by each municipality. Co-establishment is possible in small municipalities.
Staffing	Public health nurses (or nurses who have an experience of community care), chief care managers, and certified social workers or persons similarly qualified * These 3 types of professional workers are placed per 3000-6000 elderly 65+.

Regarding establishment and operation of Regional Comprehensive Support Center, municipalities take a role of a secretariat, while Management Council of a Comprehensive Support Center in a Community, composed of local service providers, associated bodies, representatives of the insured, etc. is involved in it.

• Basic Function of Regional Comprehensive Support Center

Establishment of infrastructure	Establishing comprehensive and multi-layered networking of local resources
Comprehensive counseling	Comprehensive counseling for the elderly, home-visit to grasp the situations and lead to services in need. Striving for rights advocacy such as prevention of abuse.
Comprehensive and continuous	Support establishment of a care management system utilizing diverse social resources in the communities, so that comprehensive and continuous services could be provided for the elderly.
Care management to	Promote appropriate care management, so that care prevention programs and New Prevention Benefits are effectively and efficiently provided.



4. Strengthening Support for Persons with Moderate to Severe Care Levels, Partnership and Coordination between Medical and Long-term Care

Strengthening Support for Persons with Moderate to Severe Care Levels

While strengthening support for persons with moderate to severe care levels to continue their life at home, further efforts are made to cope with deterioration or terminal care in facilities.

Establishment of “Day-nursing Care Service”

Establishment of commuting services provided in cooperation with medical organizations, visit-nursing station, etc. for persons requiring care with an intractable disease or terminal cancer

Enhancement of care for younger people with dementia (day care service, day rehabilitation service)

Care for younger people with dementia is improved by day care service and day rehabilitation service.

Establishment, etc. of urgent short-stay network

Network to cope with users' needs of urgent short-stay is established: coordination windows by multi-providers, 24-hour counseling system; and strengthening the systems of short-stay nursing care and home-visit nursing care for the elderly in home at moderate to severe care levels.

Establishment of the systems of group homes for the elderly with dementia

Oblige to carry out a night shift system/ improve the system for health management and medical partnership

Cope with deterioration and improve practical system for terminal care in health facilities for the elderly, etc.

In order to cope with deterioration of residents, strengthen nursing systems and establish 24-hour response system. Improve practical system for terminal care with the collaboration of various related professions.

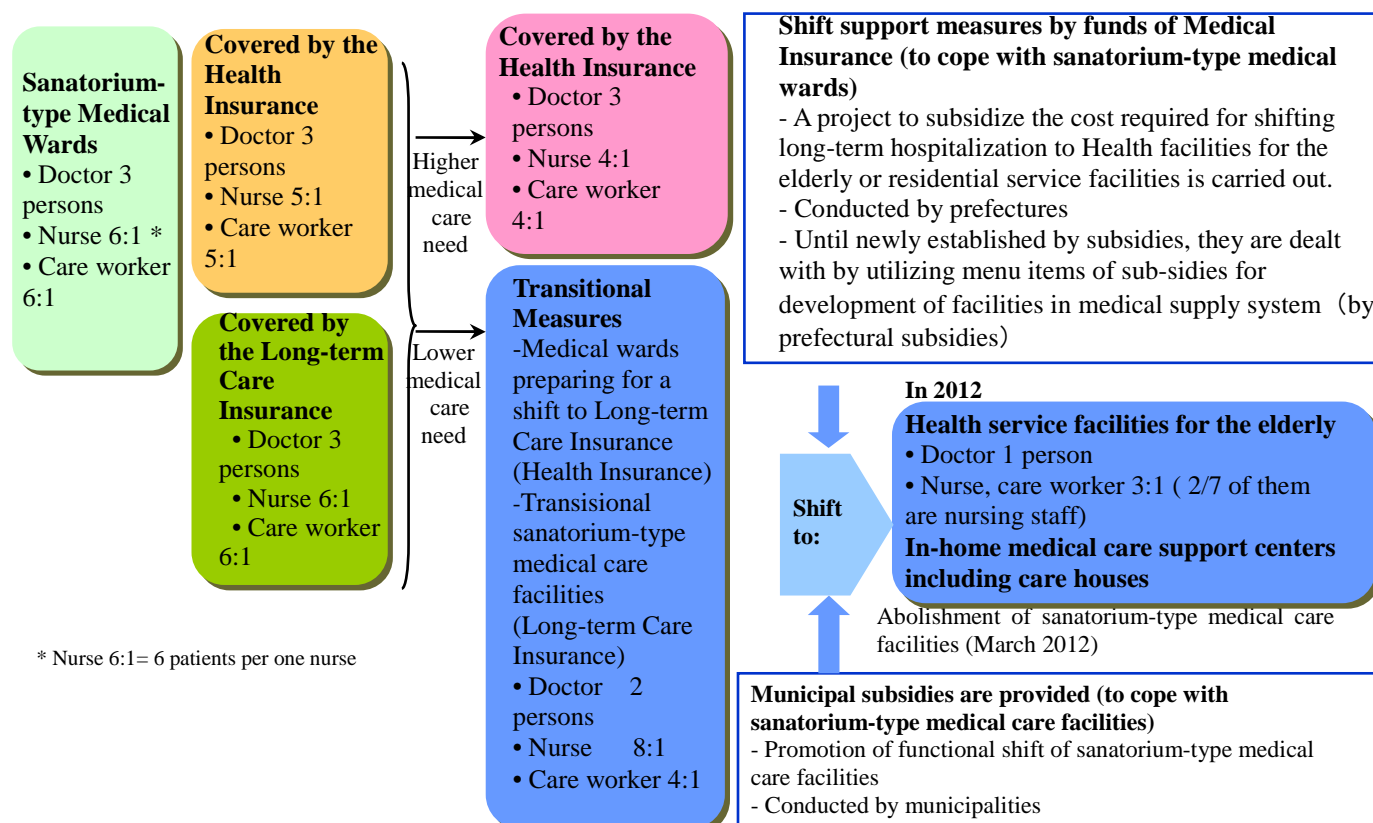
Partnership and Coordination between Medical and Long-term Care

In order to firmly deal with persons in need of care who require partnership with medical care, a connection with a family doctor, etc. in care management is strengthened.

Meanwhile, in sanatorium-type medical wards, reorganization according to medical needs is promoted from the viewpoint of clarifying coordination of Long-term Care Insurance and Health Insurance, etc.

• Reorganization According to Medical Needs

- 1) Sanatorium-type medical wards are limited to patients in higher need of medical care, and covered by the Medical Insurance.
- 2) Patients in lower need of medical care are coped with by in-home and residential care services, or health facilities for the elderly, etc.



4. Maintenance and Improvement of Service Quality

Maintenance and Improvement of Service Quality

Aiming for provision of quality of services under users' appropriate choices and providers' competition, obliging providers and facilities to disclose information about the Long-term Care Insurance Services, improvement of expertise in services and living environment and review of regulations for care providers are carried out.

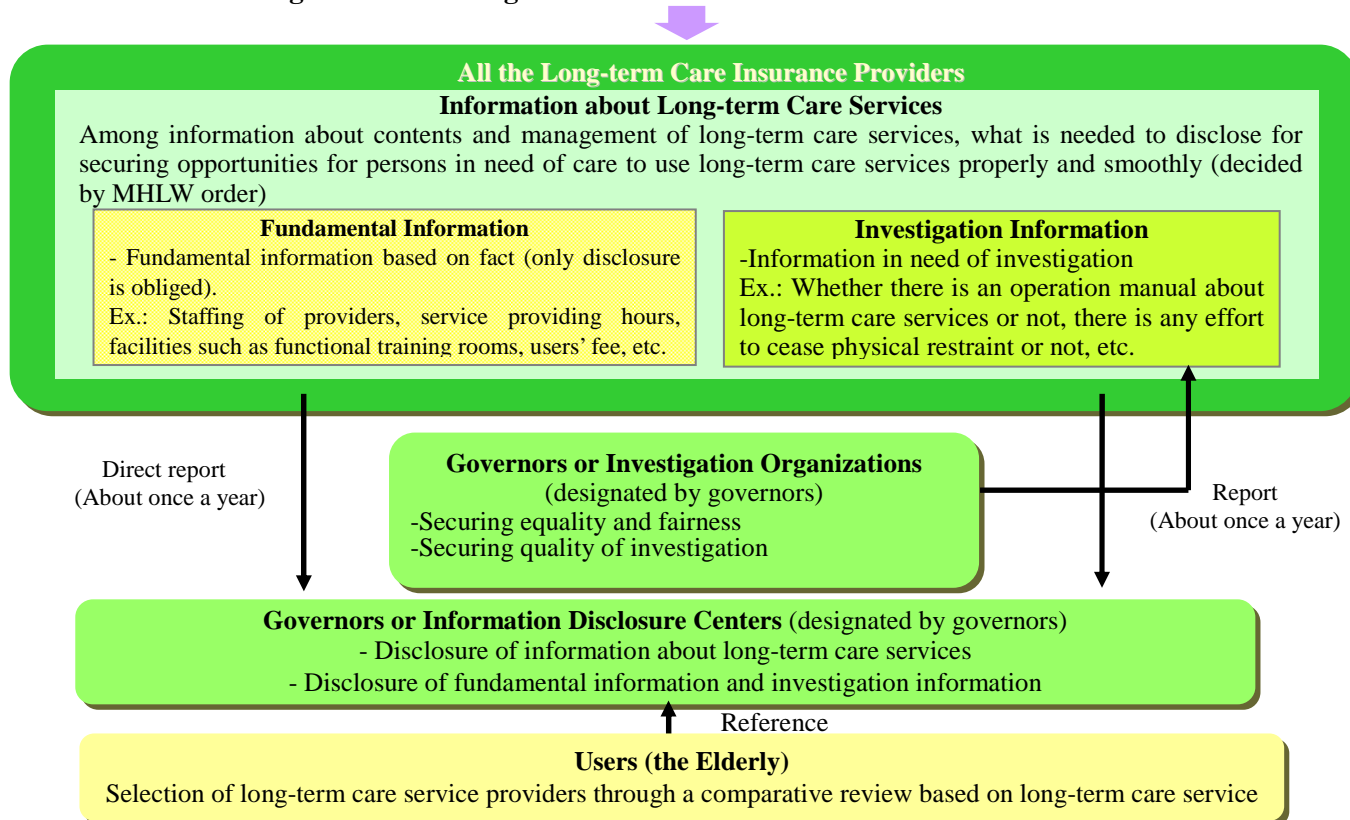
Moreover care management is reviewed from the point of promotion of comprehensive and continuous management, improvement of care managers' quality and expertise, securing fairness and equality, etc.

1. Disclosure of Care Service Information

So that the Long-term Care Insurance Services are properly and smoothly selected and used, a scheme that obliges providers and facilities to disclose information required is introduced.

• Scheme of Information Disclosure System

Obligation of the Long-term Care Insurance Service Disclosure



2. Improvement of Expertise in Services and Living Environments

Aiming for securing and improving the quality of services, expertise of service workers is improved as well as living or medical environments in facilities.

• Efforts to Improve Expertise in Services and Living Environments

Improvement of Expertise in Home-help Services

- Review of education and training systems like introducing "basic training for care workers" aiming for the shift to Certified Care Workers
- Improvement of systems of service provision in long-term care fees, taking account of helpers' activity circumstances
- Strengthening of saving fees for the 3rd level helpers

Improvement of living or medical environments in facilities

- Establishment of infection management, safety management systems and bedsores prevention systems, promotion of ceasing physical restraint
- Promotion of Unit Care, strengthening of reduction in fee payment for improper living environment

3. Review of Regulations for Service Providers

From the point of strengthening ex post facto rules to illegal providers, regulations for service providers are reexamined including reasons for disqualification and revocation in designation, or introduction of the renewal system for designation, etc.

• Contents of the Review of the Regulations for Service Providers

1. Addition of reasons for disqualification and revocation in designation

Aiming for improvement of quality of services and exclusion of vicious providers:

- 1) Add revocation record of applicants and executives, criminal history record, etc. to reasons for disqualification in designation.
- 2) When applicable to a definite case, like in case fixed years have not passed since the revocation in the past, the designation must not be admitted.

2. Introduction of the renewal system for designation

- In designating providers, the term of validity is established (6 years).
- On the renewal of designation, the situation of fulfilling a criteria or the record of improvement orders are confirmed. When admitted it is impossible to execute appropriate management based on the criteria, the designation renewal is rejected. (Before the revision, only new application for designation can be rejected in such a case.)

3. Addition of recommendations, orders, etc.

So that municipalities (comprehensive community-based services) can guide, supervise or punish providers smoothly based on the actual conditions, added are the authority to exert over providers:

- 1) Recommendation to improve operations
- 2) Order to improve operations
- 3) Order to cease designation validity
- 4) Disclosure of the punishment

4. Review of Long-term Care Management

The Long-term Care Insurance system and fees are revised, from the viewpoint of promotion of comprehensive and continuous care management, improvement of quality and expertise of care managers, securing of fairness and equality, etc.

• Overview of the Review of Care Management

1. Promotion of Comprehensive and Continuous Care Management

- Establishment of Regional Comprehensive Support Center
- Strengthening partnership between care managers and family doctors, etc.
- Strengthening care management in leaving hospitals or facilities

2. Improvement of Quality and Expertise of Care Manager

- Introducing of renewal system of care managers (5 years) and new registration system under which both the names of a company and its care managers have to be reported
- Obliging and systemizing education and training for care managers
- Introducing of chief care managers

3. Securing Fairness and Equality/Focusing on Process

- Reducing the standard number of cases care managers take charge in (50 to 35 cases), introduction of a regressive fees system when care managers take in charge of many cases
- Fees by care level reflecting operations/evaluation of care-planning at the first time
- Strengthening management for the elderly with moderate to severe care levels or cases with difficulty in support (Introduction of additional fees for designated providers)
- Strengthening punishment against unfair care managers
- Strengthening reduction of fees relating to inappropriate management

5. Review of Insurance Premium and System Management

Review of a Premium

Methods to set up insurance premiums for category 1 insured persons or levy methods are reviewed.

A method of certification of long-term care need is revised from the viewpoints of fairness and equality in addition to the municipal authority over service providers for strengthening function of the insurer.

Furthermore, along with the reform of subsidies, the ratio of sharing between the nation and the municipalities is reviewed.

1. Review of Insurance Premium for Category 1 Insured Persons

Review of a Method to Set Up a Premium

Before the revision, the insurance premiums for category 1 insured persons included the fixed amounts depending on the 5 income levels. After April 2006, the 2nd level is subdivided in order to reduce the premium for persons with lower income.

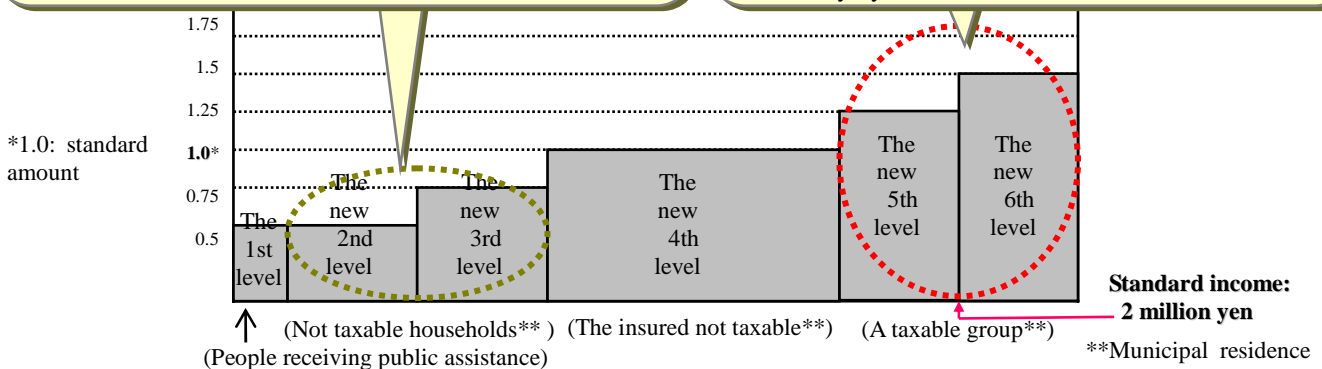
• Review of the Levels of a Premium

Subdivision of the 2nd Stage

There is a great difference in cost sharing ability of the insured on the 2nd level.
The 2nd level is subdivided, and a lower premium is set up for persons with lower cost sharing ability (ex. annual income: under 800 thousand yen).

Flexibility in Setting Up a Premium for a Group Imposed Taxation

Municipalities are eligible to set up more detailed levels of a premium according to the income levels of the insured.
Specifically, regarding taxable persons, municipalities are eligible to set up the number of levels and the premium rate flexibly by a local ordinance.



Improvement of a Premium Collection Method

Survivors' Pension and Disability Pension become subject to special collection, that is, deduction from pensions.

Regarding ordinary collection, paying a premium at convenience stores becomes possible.

2. Review of Certification of Long-term Care Need and Strengthening the Function of the Insurer

Review of Procedure for Certification of Long-term Care Need

In principle, new certification of long-term care need is conducted by the municipalities. (A certain interim measures are adopted.)

Strengthening the Function of the Insurer

So that the municipalities could carry out their function properly, they are qualified to intervene in the providers directly. From the viewpoint of reducing office work and making it efficiently, process like visit survey for certification can be entrusted to a corporation which is well-versed in the Long-term Care Insurance work and able to carry it out with fairness.

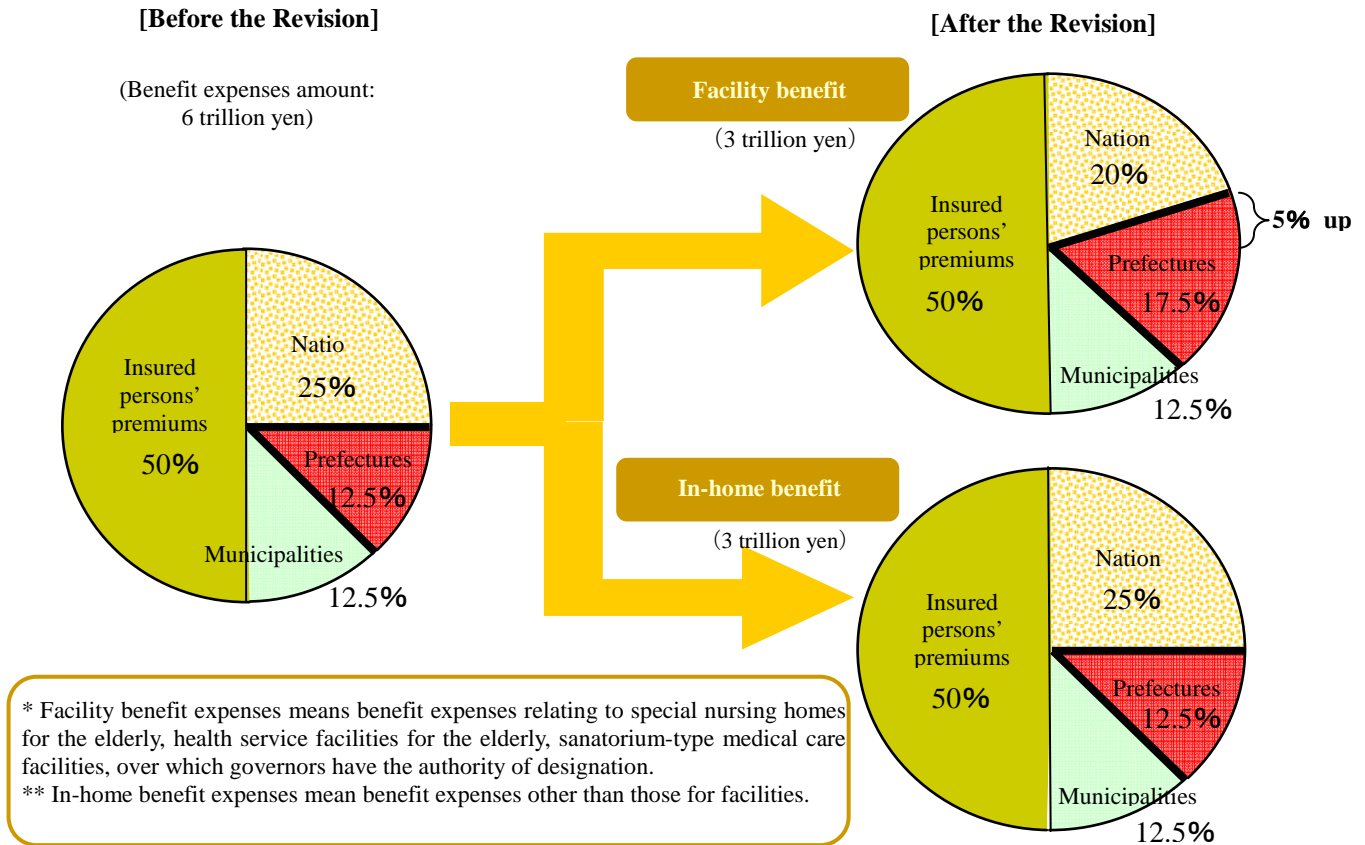
3. Review of Co-payment Rate, etc.

Along with the reform of subsidies, the ratio of co-payments between the nation and prefectures is revised as to the benefits related to the Long-term Care Insurance facilities and designated facilities by prefectures.

Regarding designated facilities other than ones only for long-term care, the total users' capacity in need is defined in the prefectural Long-term Care Insurance support project. Those beyond the capacity cannot be designated and become subject to exceptional rules for location* instead.

* In case of relocation of the insured with need for facility care, municipality before the relocation keeps to be the insurer.

• Benefit Expenses Related to Long-term Care Facilities and Designated Facilities



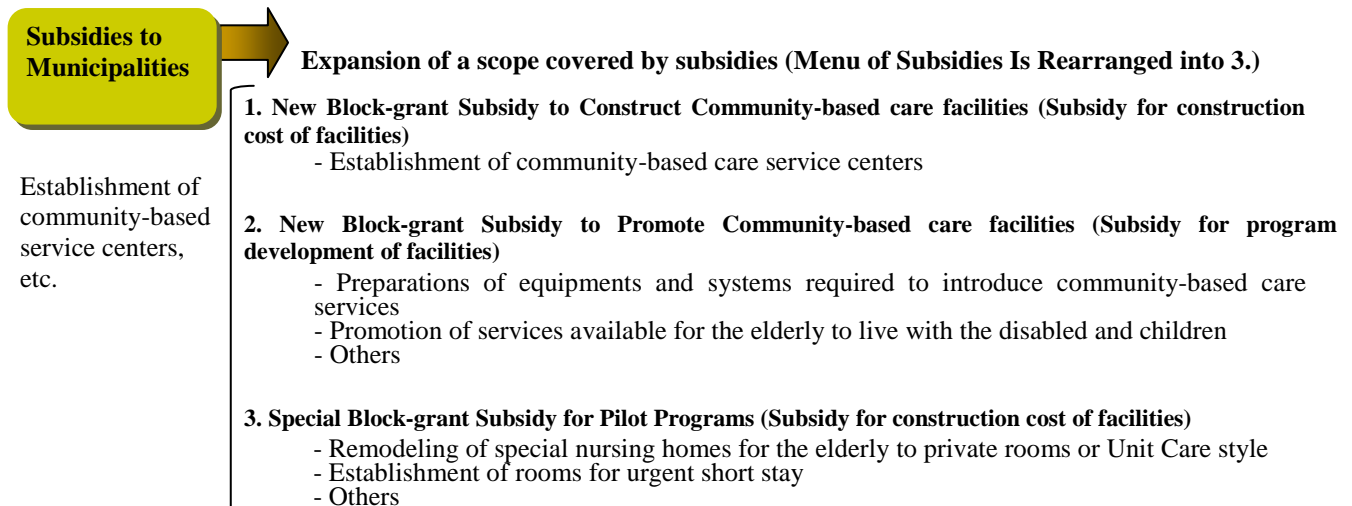
Note) The amount of benefit expenses is estimated based on "Survey on the Status of the Long-term Care Allowance." (Surveyed in August 2005)

4. Review of Block-Grant Subsidies for Community-based Care Facilities

Regarding mechanism of subsidies for development, etc. of care and welfare space in a community:

- 1) Subsidies to prefectures are abolished, transferred to the general account.
- 2) A scope of project covered by subsidies to municipalities is expanded, and improved to a system easier to use.

• Review of Subsidies to Municipalities



Concerning Long-term Care Service Plan

Municipalities and prefectures are required to decide the 3rd term Long-term Care Service Plan, with three years as one term (FY 2006-2008) in line with the national basic principle based on Clause 1, Article 117 and Clause 1, Article 118 of the Long-term Care Insurance Law. This Long-term Care Service plan is an establishment plan of long-term care services as well as a plan for a base to estimate a premium related to those aged 65 or older, who insured the 1st category in each municipality.

The Basic Direction of Elderly Care in Future

In the national basic principle, it is required to present the basic direction of major efforts for future elderly care, in addition to a guideline to decide on Municipal and Prefectural Long-term Care Service Plan.

■ Toward 2015 when the baby boom generation becomes the elderly aged 65, with the purpose of promoting a basic direction for elderly care in future, established are the goals, starting fixedly at 2014, the last year of the 5th term Long-term Care Service Plan.

■ Each municipality sets up the 3rd term Long-term Care Service Plan (2006-2008) to attain those purposes.

• Goals in FY 2014

Proper Establishment of 3 Types of the Long-term Care Insurance Facilities and Residential Services in Exclusive Use for Long-term Care

2004
The ratio of facility or residential service users to people requiring care level 2-5: **41%** (870 thousand persons)



2014
The ratio of users of facilities or residential services in exclusive use for long-term care: **Under 37%*** (1.08 million) *10% lower than in 2004

Promotion of Extending the choices of residential Services

- Increase in the elderly single-member households
- Drastic aging in urban areas
- Need for relocating the house in old age



Extending the choices of assisted living houses aiming for a safe and comfortable life for the elderly

Focusing on the Elderly with Severe Care Level among the Users of 3 Types of the Long-term Care Insurance Facilities

2004
The ratio of the total facility users to people requiring care level 4-5: **59%**



2014
The ratio of the total facility users to people requiring care level 4-5: **More than 70%**, so that the elderly with severe care level could use facilities.

Promotion of "Private rooms" in 3 Types of the Long-term Care Insurance Facilities

2004
- The ratio of private rooms in 3 facilities: **12%**
- The ratio of private rooms in special nursing homes for the elderly: **15%**

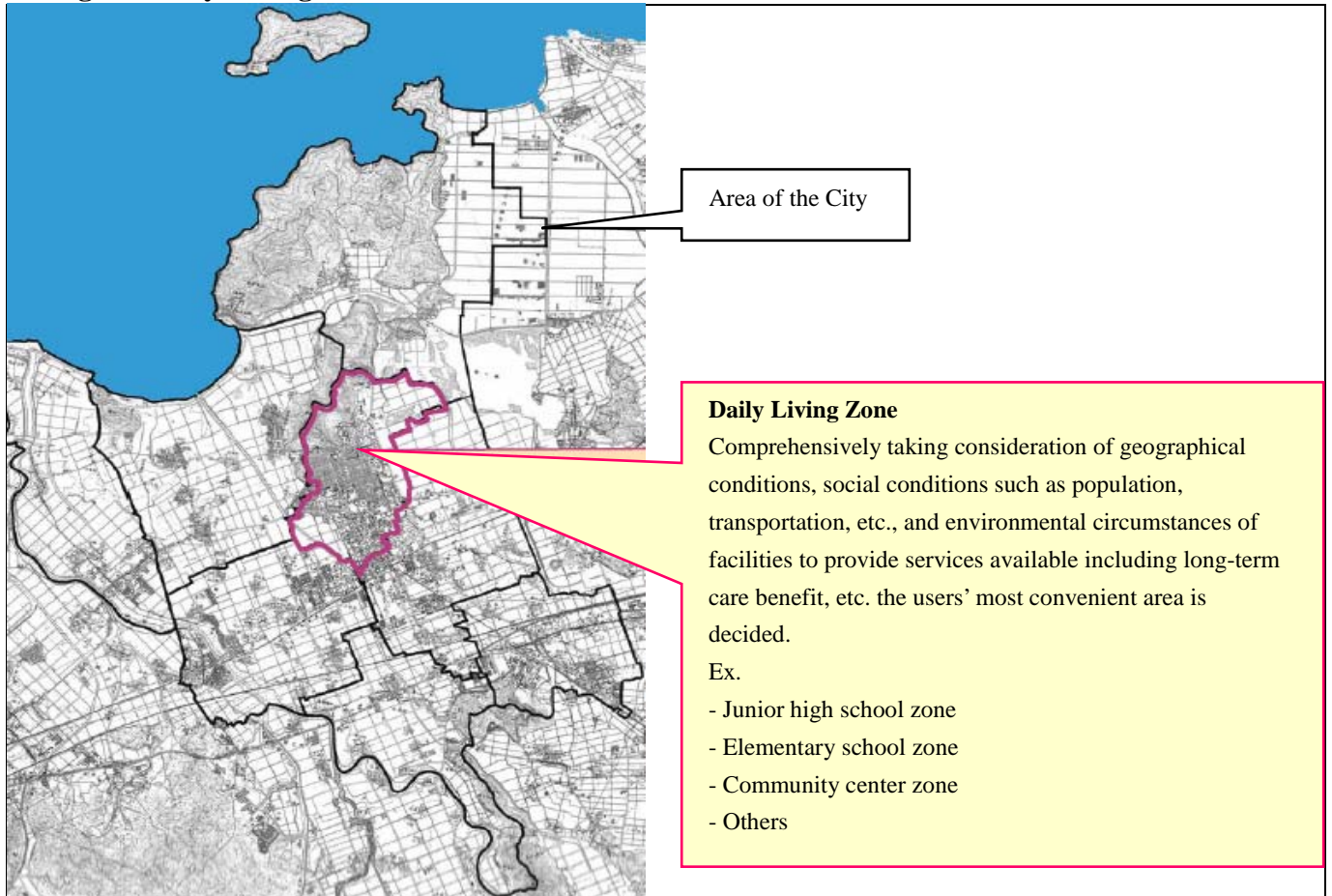


2014
- The ratio of Unit-type semi-private rooms in 3 types of the Long-term Care Insurance Facilities: **More than 50%**
- The ratio of Unit-type semi-private rooms in special nursing homes for the elderly: **More than 70%**

Establishment of Areas of Daily Living

Concerning community-based services newly created by the revision of the Long-term Care Insurance, municipalities are to include the amount of work for 2006 to 2008 in the projects.

• Image of Daily Living Zone



Scope of Insured Persons and Beneficiaries

The Law to Partial Amendment to the Long-Term Care Insurance Law, etc.

Clause 1, Article 2 of the Supplementary Provision

Supplementary Provision Clause 1, Article 2 provides that issues on the age of insured and beneficiaries of the Long-term Care Insurance is a future agenda, which will be reviewed and considered by the government by the end of FY 2009.

Process

The issue of the scope of insured persons and beneficiaries has been one of the main points since the start of the Long-term Care Insurance System.

(Reference) Article 2 of the Supplementary Provision, The Long-term Care Insurance Law (before the revision)

Article 2 Regarding the Long-term Care Insurance System, ...including the scope of the insured persons and beneficiaries ..., they shall be reviewed and considered as a whole in about 5 years after the implementation, and based on the result necessary measures shall be adopted.

“Opinion on expanding the scope of insured persons and beneficiaries” was formed at the Long-term Care Insurance Committee of the Social Security Council in December 2004.

Outline of “An Opinion on the Scope of Insured Persons and Beneficiaries”

- A large majority approved to provide services for all the persons in need of long-term care regardless of the cause or age, and additionally to aim for spreading the system by means of expanding a group required to pay the premium. On the other hand, some others had an opinion that we should cope with the issue much more cautiously.
- The social security systems are required to be reviewed as one body to form a conclusion in about 2 years, FY 2005 and 2006. In the review it is needed to make a prompt reexamination toward forming national consensus or a concrete system revision draft, including for or against it, and reach a conclusion.

Scope of Insured Persons and Beneficiaries

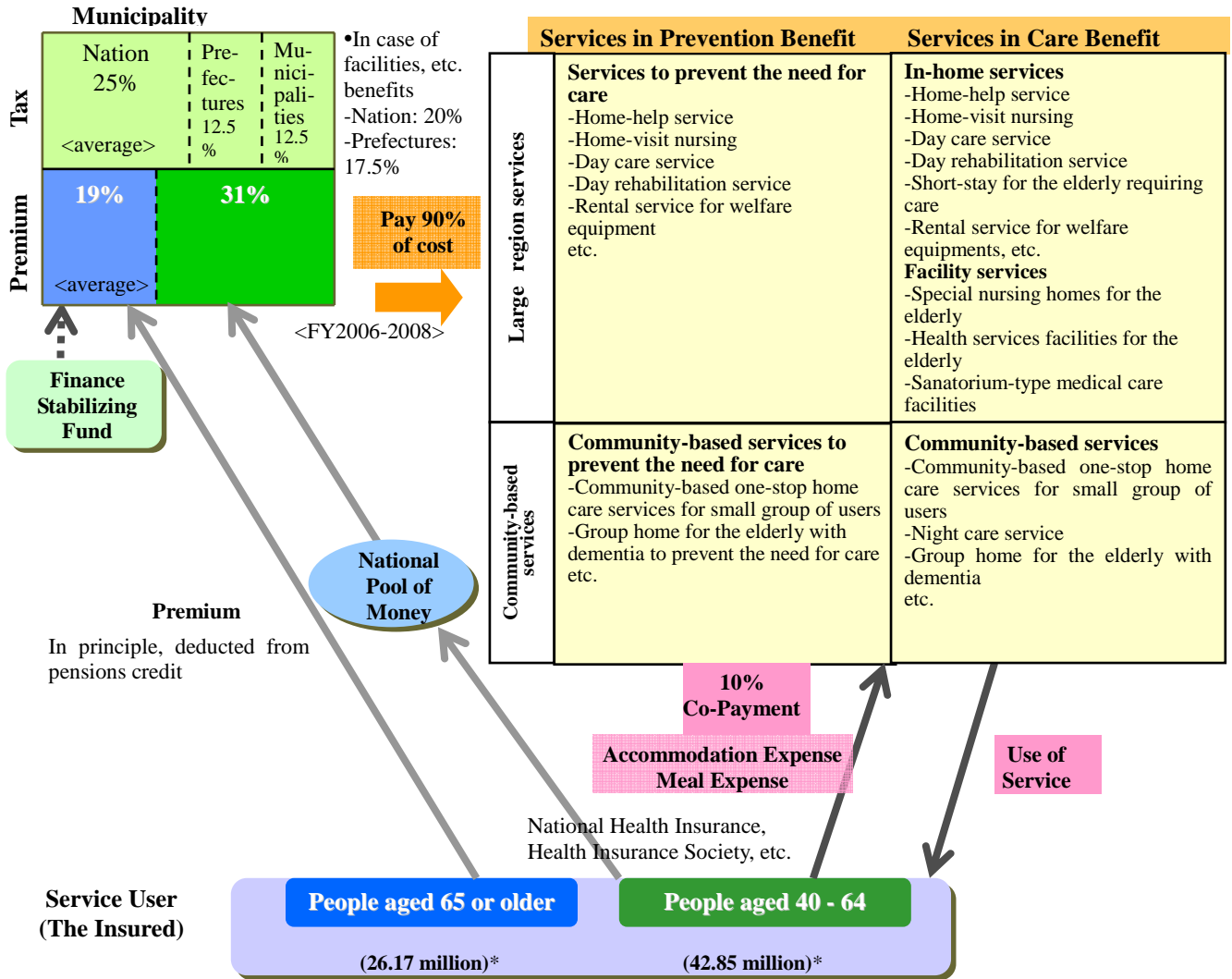
	Eligible persons	Requirements to receive services
The 1st category insured	65 or older	Condition in need of support or care
The 2nd category insured	40-64, who are insured by Health Insurance	Condition in need of support or care with age-related diseases designated by nation*

*Designated diseases: terminal cancer, rheumatoid arthritis, amyotrophic lateral sclerosis, ossification of posterior longitudinal ligament (OPLL), osteoporosis causing fracture, dementia of those past middle age, Parkinson's disease, Spino-cerebellar degeneration, spinal canal stenosis, premature senility, Shy-Drager syndrome (SDS), diabetic neuropathy/ diabetic nephropathy/ diabetic retinopathy, Cerebrovascular disease, Occlusive arteriosclerosis, chronic obstructive lung disease, oteoarthritis causing major deformation to both of the knee-joint or hip-joints

【In case of terminal cancer】

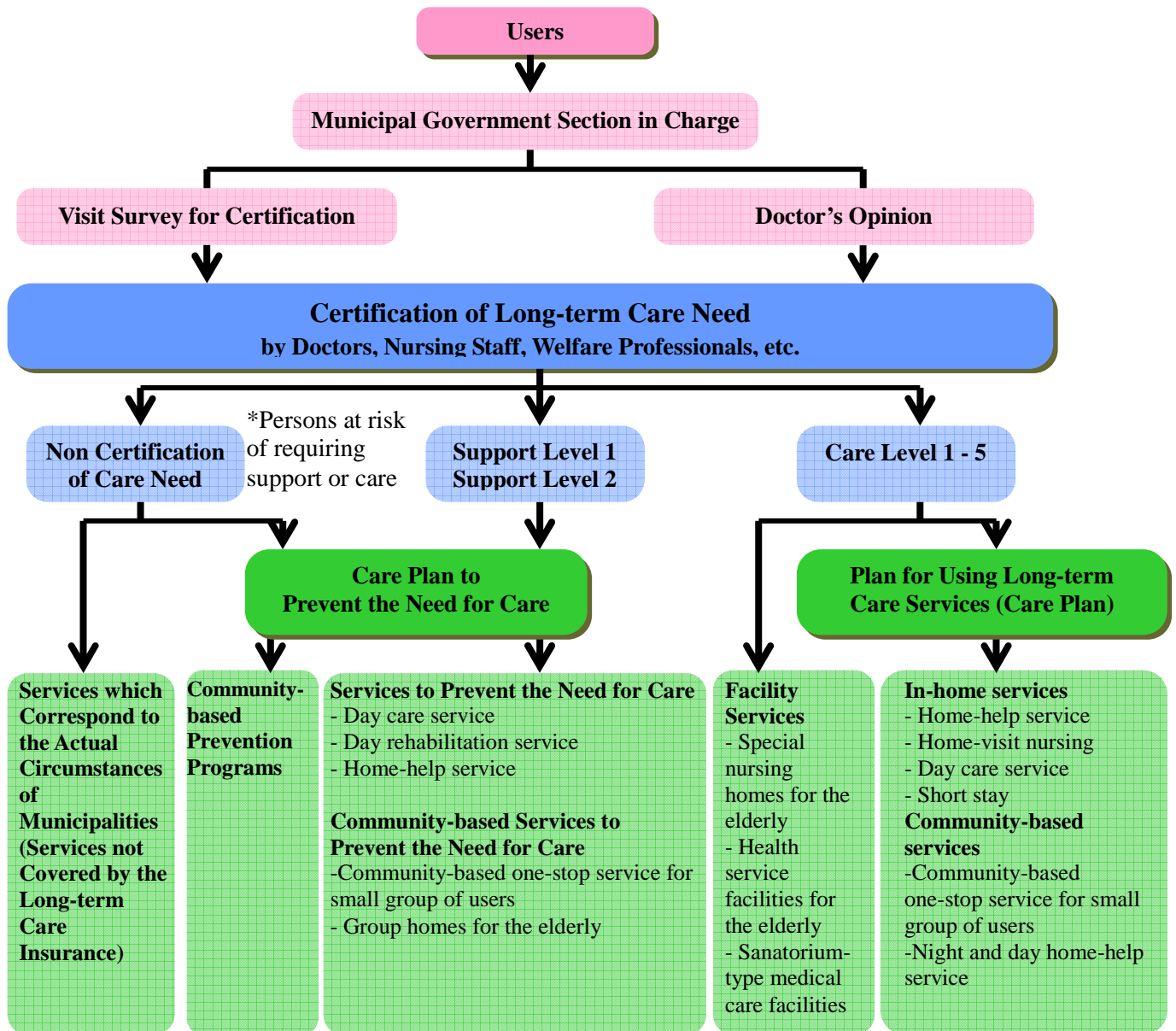
Terminal cancer was added to the designated diseases in April 2006. Consequently, people aged 40-64 in need of care for terminal cancer have become eligible to receive the Long-term Care Insurance services.

(Reference) Scheme of the Long-term Care Insurance System after the Revision



* The number of people aged 65 or older (the category 1 insured) and people aged 40-64 (the category 2 insured) is the estimate in 2006.
Source: Estimated Future Population in Japan (as of January 2002), by the National Institute of Population and Social Security Research

Procedures for the use of the Long-term Care



Development and Schedule

The 1st term	2000	Apr.	The Long-term Care Insurance Law was implemented.
The 2nd term	2003	Apr.	The 2nd term Long-term Care Service Plan started (to 2005). - The category 1 premium was reviewed. The revision of the Long-term Care Insurance Fees was carried out.
		May	The Long-term Care Insurance Committee was established in the Social Security Council.
	2004	Jul.	Report on the Long-term Care Insurance Committee
		Dec.	Report on the Scope of Insured Persons and Beneficiaries at the Long-term Care Insurance Committee
	2005	Feb.	The Bill for Partial Amendment to the Long-term Care Insurance Law, etc. was submitted to the Diet.
		Apr.	Block-grant Subsidies for Community-based Care Facilities were established.
Jun.		The Law to Partial Amendment to the Long-term Care Insurance Law, etc. was enacted.	
Oct.		Facility Benefit was reviewed. The Long-term Care Insurance Fees were revised. (Implementation in October)	
The 3rd term	2006	Apr.	The revised law was implemented. - New prevention Benefit and Regional Comprehensive Support Centers were established. - Community-based services were established. - The disclosure system of care service information was established. The 3rd term Long-term Care Service Plan started (to 2008). - The category 1 premium was reviewed. The revision of the Long-term Care Insurance Fees was carried out.
The 4th term	2009	Apr.	The 4th term Long-term Care Service Plan will start (to 2011). -The category 1 premium will be reviewed. The revision of the Long-term Care Insurance Fees will be carried out. Scope of Insured Persons and Beneficiaries - Required measures will be adopted in about 2009. New prevention Benefit, Community-based Prevention Programs - Reexamined based on actual situations about 3 years after the implementation.