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The Aging Population and Health Care: A Japanese Perspective

This past summer, with my colleague Takao Saito, MD, PhD, I had an opportunity to meet with faculty members of the Jefferson School of Population Health and executives of Thomas Jefferson University Hospital. We are very appreciative of the invaluable information they provided. I learned that health care experts in the US are very concerned about the increasing elderly population and the magnitude of their healthcare issues. The population aged 65 years or older was 12.9% of the US population in 2009, but that's expected to grow to be 19% of the population by 2030.[1] It is quite reasonable for Americans to be anxious about future care problems for the elderly. I would like to introduce the public, mandatory long-term care insurance (LTCI) system used in Japan.

Japan is a country whose aging population is growing the fastest among developed countries. People aged 65 years or older represented about 12% of the population in 1990, but that figure had increased to 23% by 2010, owing to the aging baby boom generation (8 million who were born from 1947 to 1949) and the recent decrease in the birth rate.[2,3] It is projected that the proportion of the elderly will continue to increase to 40% of the population by 2050.[3] The care for the elderly in Japan has been a family responsibility and traditionally it has been provided by women. However, the custom is no longer sustainable because of a changing family structure and increasing number of working women.

The Japanese Government implemented public, mandatory long-term care insurance (LTCI) in 2000, although half of it is financed by taxes. People aged 40 years and older have to pay premiums because they are eligible for benefits. The eligibility is evaluated by items based on activities of daily living and categorized into one of seven levels according to their needs. The ceiling for the amount of benefits per month is decided by the level of care and clients have to pay 10% copayments. The insurance covers home services; non-institutionalized outside services including day care, day care with rehabilitation, short-stay or respite care; and institutional services including nursing homes and healthcare service facilities. However, it does not provide cash benefits. Interestingly, day care has become the most popular service, and is now used by 1.9 million or 6.5% of people aged 65 years and older.[4] It might be because 40% of the elderly live with their families.[5] It has been reported that LTCI has decreased physical, mental and financial burdens on their families. In addition, women living with the elderly have more chances to work outside with the help of LTCI.

There are two main problems in LTCI. First, expensive institutionalized care has been favorably used. However, we cannot increase institutions for elderly care because of governmental finance limitations. Secondly, workers are underpaid with the consideration of working conditions under LTCI. Therefore, there is a shortage of human resources. We will have to increase premiums of LTCI and taxes to protect the dignified lives of the elderly. In addition, we need to create reasonable senior citizen caring facilities such as small-scale, multifunctional group homes.

In the US, huge public resources are spent on medical care for the elderly through Medicaid; while respectively little public funds are spent on non-medical care. Most residents in assisted living facilities pay for care out of their own funds. Although some elderly care facilities including continuing care retirement communities (CCRCs) provide assistance with daily activities as well as healthcare to contribute to their qualified lives, there are many senior citizens who are not able to access this standard of care in the US. *New York Times* reporter, Jane Gross suggests Medicare pays for useless and harmful acute care while not paying for long-term care in a supervised , safe place for frail or demented elderly people, or for home aides to help with stopping, transportation, bathing and using toilet[6] I agree that there is a mismatch between what is covered and what is actually useful in Medicare today.

I believe that non-medical spending is an important factor for health outcomes as well as quality of life. If available resources are limited, spending too much on medical care for the elderly is not effective in improving health outcomes. Balancing medical care spending with non-medical care spending is important.

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It is a common problem for us to cope with aging populations among developed countries. We would therefore like to exchange experiences and knowledge with each other. ■

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REFERENCES

1. US Department of Health and Human Services. Administration on Aging. Aging Statistics. September 1, 2011. http://www.aoa.gov/aoaroot/aging_statistics/index.aspx. Accessed December 29, 2011.
2. UN Population Division. World population prospects: the 2010 revision population database. Country profiles. Japan. http://esa.un.org/wpp/unpp/p2k0data.asp. Accessed December 29, 2011.
3. National Institute of Population and Social Security Research (IPSS). Population statistics of Japan 2008. http://www.ipss.go.jp/p-info/e/psj2008/PSJ2008-02.pdf. Accessed December 29, 2011.
4. Ministry of Health, Labour and Welfare (MHLW). Monthly report on long-term care benefit expense. http://www.mhlw.go.jp/english/.
5. Ministry of Internal Affairs and Communications, Statistics Bureau, Director-General for Policy Planning (Statistical Standards) & Statistical Research and Training Institute. A Bulletin Board from Census 2010.
6. Gross J. How Medicare Fails the Elderly. *New York Times.* October 15, 2011.