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Lessons For Aging-Related Policy

Key Lessons

- Japan has experimented with various approaches to address the challenge of its aging population, but community-based integrated care has been the most effective solution from the perspectives of equity and sustainability.
- Community-based integrated care leverages existing community resources to support older people and allow them to age in place in their chosen community.
- It also provides a safety net that can address disaster prevention, poverty, and the rebuilding of communities that have disappeared due to urbanization and industrialization.
- Preventive medical care is critical in creating a system to support the needs of older people and to limit the medicalization of care.
- Japan's universal health coverage (UHC) and long-term care insurance system—although still undergoing growing pains—are critical components, ensuring stable, affordable fees for medical care, and improving the quality of and access to care for Japan's older residents.

Lessons from Japan's Policy on Aging: The Path to Community-Based Integrated Care

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A Front-Runner in Population Aging

Japan has been on the leading edge of population aging, as its aging population ratio (i.e., percentage aged 65 and older) rose from 4.9 percent in 1950 to 29.1 percent as of 2021, which is the highest in the world. According to the United Nations definition, when that ratio reaches 7 percent, a country is considered to be an "aging society," 14 percent and above is an "aged society," and 21 percent or higher is a "super-aged society." Japan became an aging society in 1970, an aged society in 1994, and is now a super-aged society. Even among the industrialized nations, the rate at which Japan underwent this transition is by far the fastest, as France took 115 years to go from 7 to 14 percent, and Germany took 40 years, while Japan went from "aging" to "aged" in just 24 years. Today, however, we see a number of countries in Asia that are aging with even greater velocity. Quite naturally, then, many view Japan as a case study from which they hope to gain some insights as they make this transition.

Japan's experience in dealing with its aging population, however, is a history of trial and error in which Japanese society has grappled with various challenges, such as how to construct an effective social security system and how to structure its national budget. During the period of high economic growth in Japan, the country moved toward medicalization and institutionalization of aging at an accelerated pace, but when the economy slowed and stabilized, the limits of that approach became evident. Now, having gone through a period of declining birthrates, increased urbanization, and a shift toward nuclear families, Japanese society

as a whole has once again become aware of local community resources and networks and is now trying to replace the previous social safety net with the concept of community-based integrated care.

In this policy brief, I would like to examine the types of challenges that Japan has overcome and how its systems to address its aging population have been built and improved over time. It is my hope that this will offer suggestions for how we, together with the Asian countries that are expected to follow Japan's aging trajectory, can think about sustainable development.

The Path to Aging—Japan's Characteristics and the Baby Boomer Generation

Based on a country's demographic structure, it is possible to forecast the rate at which the population will age to a certain extent. After World War II, the birth rate increased in many countries around the world, producing what is called the "baby boomers," a generation that includes a large population. In the United States, this refers to a broad range of people born from right after the war up until around the Kennedy administration, but in Japan's case, it is called the "*dankai no sedai,*" or literally the clump generation, which includes those born from 1947 to 1949. During those years, 2.7 million people were born annually. This generation, now in their 70s, witnessed significant improvements in the social environment, such as medical advances and improved public hygiene and nutrition, which in turn led to a decline in mortality rates. The large scale of this population group has continued to have an impact on Japan's social systems in various ways.

It is no exaggeration to say that this generation has always been on people's minds when planning the systems to deal with older people. In 2003, immediately after the introduction of long-term care insurance, an Elder Care Study Group established by the Ministry of Health, Labour and Welfare put together a plan on "Eldercare in 2015" in anticipation of the year when Japan's baby boom generation would all be aged 65 or older. That was the first time that the concept of "community-based integrated care" was proposed. There are also ongoing discussions on how to deal with the challenges expected in 2030, when that generation will be among the "oldest-old" (75+), and the challenges of 2040, when Japan will reach the peak of being a high-mortality-rate society.

There was in fact a doctor who predicted Japan's aging society and sounded the warning very early on, just 10 years after the war. In 1955, Dr. Taro Takemi, who later led the Japanese medical community as chair of the Japan Medical Association, contributed an article to the monthly literary magazine, *Chuo Koron,* on "How Can We Cope with the Growing Number of Senior Citizens?" in which he noted, "It goes without saying that the structure that we have had in the past of having health insurance only for young people will not be able to keep up, and interventions for chronic diseases will lead to an increase in medical expenses." He further stressed the need for preventive medicine based on gerontology, pointing out, "Japan should be wary that its measures for the elderly are moving in completely the opposite direction than those in the rest of the world. These measures will eventually lead to the construction of old folks' homes that are increasingly isolated from society, or they will become nursing homes, which will give the impression that geriatrics is needed only in that isolated world." But despite that warning, the subsequent political and economic conditions did indeed create a tendency to "go in the opposite direction," and it was not until after having undergone numerous twists and turns that Japan may finally have caught up to the strategy Dr. Takemi advocated so long ago.

Making Medical Care Free for Older Persons—From Small-Scale Villages to Nationwide

A major starting point for Japan's social security system was the introduction of universal health insurance in 1961. In addition to employer-based insurance, national health insurance for self-employed people and farmers was introduced in municipalities

nationwide. With that, universal health coverage was achieved so that anyone could receive medical care anywhere and at any time. In September 2011, the leading medical journal, the *Lancet*, published a special edition focused on Japan to commemorate the 50th anniversary of Japan's universal health coverage. It pointed out the importance of Japan's commitment to global health, saying, "Japan's experience and knowledge of health insurance and long-term care will also be a huge asset in the post-MDG movement towards long-term care in societies where the proportion of elderly people is increasing."[1]

However, universal healthcare was not immediately effective as a measure to help older people in Japan. It ensured that there would be stability in terms of medical fees being paid, which led to an increase in the number of medical institutions and the quality of medical care. But at the time, the individual contribution (copay) for National Health Insurance was 50 percent, so not everyone could afford it. Even though the system was in place, medical care for older people was frequently deferred due to the cost, and it was even commonplace for doctors to be asked to make house calls after a person had died just to be able to write the death certificate.

It was against this backdrop that one local government decided on its own to make healthcare free to its older residents. It was a snowy little village in the Tohoku region of Japan with a population of around 7,000 people. The harshness of daily life there meant that many elderly people did not seek medical care, and so the village mayor resolved, "If the country isn't going to do it, I will." He was able to implement free healthcare for the elderly because the implementing agencies for the National Health Insurance plan were the municipalities, which had a degree of discretionary authority over spending. At first, the availability of free care resulted in lots of people going to see their doctors—indeed, it turned into a sort of social outing—and people received a lot of medicine because it was free. However, because this initiative also included preventive activities, the consciousness of the residents began to change. A doctor at the National Health Insurance Hospital at that time was appointed as the chief of the health management section of the village, and that doctor worked with public health nurses on efforts to improve residents' eating habits and living environments. Health data for all villagers was collected in one place, medical care and health activities were integrated, and health management became easier as a result. Per capita medical costs in the village, which previously had been much higher than the prefecture average, subsequently dropped to much lower than average thanks to these efforts.

The move to make healthcare free of charge wherever possible in rural mountain villages began to spread to local governments all over the country. In 1973, the national government decided to provide free medical care to people aged 70 and above. The prime minister at the time, Kakuei Tanaka, boasted that the necessary financial resources could be secured if economic growth continued. That was said to be the first year of Japan's welfare system. Many people expressed the opinion that there is nothing as scary as making things "free," but there was no way to resist the trends of the times or the political demands. Unfortunately, a key component of the success was overlooked: the preventive activities by public health nurses were left behind, and measures were put forward that instead led to increased medical expenses for older people.

The Medicalization of Care—From Dying at Home to Dying in Hospitals

As medical care played an increasingly substantial role in the government's measures to address its aging population, the rise in the number of older people became a hindrance to the general healthcare system. The graph on the following page shows the progress of medicalization. In 1975, the number of people dying in medical institutions surpassed those dying at home for the first time.

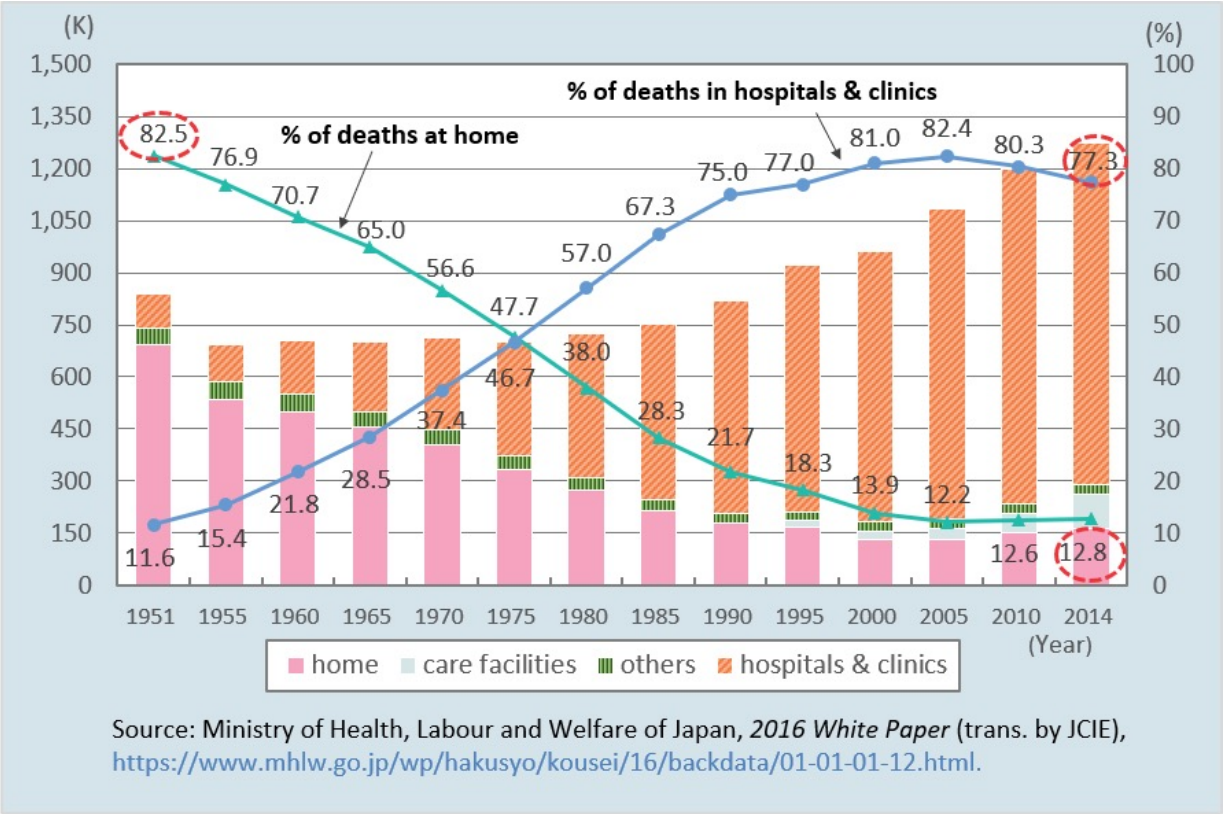
1. R. Llano, S. Kanamori, O. Kunii et al., "Re-invigorating Japan's Commitment to Global Health: Challenges and Opportunities," *Lancet* 378 (2011): 1255–64, https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(11)61048-9.pdf.

During this period, as medical expenses for older people became free, geriatric hospitals were built one after another. Many were built in places where the land was cheap, which meant that they were not convenient to transportation. Older people in need of full-time care, such as people who had suffered cerebrovascular damage and were partially paralyzed, often ended up spending their final days and passing away in this type of hospital facility. As nuclear families had become the norm, it was difficult for children to look after elderly parents in need of nursing care at home, and thus hospitals were relied upon to handle long-term care. Geriatric hospitals require fewer medical staff than regular hospitals and are more focused on long-term care than medical care. There were frequent reports, however, of cases in which older patients in such facilities received insufficient care, and that became a social issue.

The government could no longer sit by and watch this situation. In 1982, with the enactment of the Health Law for the Elderly, a fixed medical fee for older people was introduced, and the era of free care came to an end. However, when it came to charging people for things that had once been free, it was impossible to revert all at once to the previous fee-based system. For about 10 years after that, the fixed amount for hospitalization was only ¥300 a day (just over a dollar at that time) and outpatient care was ¥400 a month, and it was not until 2001 that a fixed 10 percent copayment could be introduced.

Moreover, once a facility has been put up, it cannot be easily torn down, so there was still a need to utilize the geriatric hospitals. Guidance measures were thus introduced that sought to promote efforts to provide older people with rehabilitation and then return them to their homes. But while the names changed from

Figure 1 . Yearly change in number and percentage of deaths by location of death in Japan



Source: Ministry of Health, Labour and Welfare of Japan, *2016 White Paper* (trans. by JCIE), https://www.mhlw.go.jp/wp/hakusyo/kousei/16/backdata/01-01-01-12.html.

geriatric hospital (*rojin senmon byoin*) to things like geriatric health services facilities (*rojin hoken shisetsu*), long-term care beds (*ryoyo byosho*), and integrated facilities for medical and long-term care (*kaigo iryoin*), they remained facilities that provided 24-hour care for older people in various forms. There was no change to the habit of calling an ambulance immediately when something went wrong with an older person, and the reality was that home medical care was not widely available.

Shifting to a Home-Based Care System—The Socialization of Long-Term Care and Its Limits

The concept of home care as part of government measures for older persons came into play around the time that the period of high economic growth was nearing its end. Up until then, there had been municipalities that would dispatch "helpers" (home-visit care) and nurses to the homes of impoverished older people as a welfare measure, but this new concept marked a move to position such care as a home-based service.

In 1989, the government formulated a 10-year strategy, the Gold Plan, to promote health and welfare for the elderly. In order to expand the three pillars of home-based services—home helpers, day-service centers, and short-term care facilities—the national government set numerical targets and provided financial support to encourage municipalities to introduce these options. By doing so, it was trying to shift the current away from institutional care and toward home care. Previously, long-term care at home was considered to be women's work, and so they were seeking to provide as a service those tasks that generally speaking had been expected to be provided by a wife or daughter-in-law. At the same time, the door was opened to private businesses, and in 1985, an office to handle the promotion of the long-term care industry (the Shirubaa Saabisu Shinko Shidoshitsu) was set up in the Ministry of Health and Welfare as the government started to promote measures for the elderly as a business.

In addition, the government began to consider separating out long-term care from medical care and introducing a new insurance system. As the Japanese population continued to age, the number of elderly people who were bedridden or living with dementia increased, and the traditional reliance on families to provide long-term care began to reach its limits. The new keyword became the "socialization of long-term care." In 1994, the government established the headquarters for the promotion of long-term care (Koreisha Kaigo Taisaku Honbu) in the Ministry of Health and Welfare and began considering a new long-term care insurance system, whereby new premiums would be collected from those aged 40 and over, and companies would also bear a certain share of the burden. However, there were those who opposed the idea, believing that it would destroy the traditional Japanese way of thinking that children should naturally be the ones to care for their older parents, and this led to ongoing heated debates. But in light of women's advancement in society, there were many proponents of the socialization of long-term care, and the heads of local governments who were enthusiastic about promoting access to home-based services formed a municipal welfare unit (Fukushi Jichitai Yunitto, now part of the Community-Based Co-operation Policy Alliance of Local Governments) to support the introduction of long-term care insurance. It was thus against this background of great expectations that Japan's long-term care insurance system was introduced in 2000.

The idea of socializing long-term care was to improve care so that even those who live alone can remain in their own homes until the end if they so wish. But it did not go according to plan. Long-term care insurance alone was not sufficient to allow people to age at home, and either family members had to quit their jobs to provide care or they had to pay additional costs out of their own pocket for others to provide that care.

The development of the long-term care insurance (LTCI) system continues to be one of trial and error. Taxes fund 50 percent of the LTCI system (split evenly between national and local taxes) and insurance premiums paid by people aged 40+ cover the other 50 percent (usually covered by employers until the employee reaches the age of 64). Originally, the average monthly premium paid by people 65 and older was ¥3,000 (then about US$28), but it has now doubled to ¥6,000 (over US$50) and it is already clear that this rate will not be sufficient to fund the system under the current division of costs going forward. On the other hand, the number of people recognized as needing long-term care has tripled since the launch of the system in 2000, and this number is only expected to grow as the baby boomer generation enters the later stages of old age. With providers and users at the mercy of a system where care fees must be revised every three years, the system for long-term care insurance is still very much a work in progress.

There is also a serious care worker shortage. It has always been difficult to attract care workers due to the low pay, and the increasing workloads have made it an even more challenging work environment. Efforts are being made to bring in foreign care workers, but this has not had a significant impact on the labor shortage due to systemic issues, such as immigration statuses and other challenges.

Introduction of Community-Based Integrated Care

Immediately after the start of LTCI, a research group at the Ministry of Health, Labor and Welfare introduced the concept of community-based comprehensive care as a new way of providing long-term care for the elderly. This was seen as a critical issue as they looked ahead to 2015, the year when the baby boomer generation would turn 65, which was rapidly approaching. The report published by the group stressed, "While maintaining long-term care insurance services at the core, in order to provide long-term care services and also be able to deal with other issues, we must provide integrated care (community-based integrated care) that draws on various community resources, including cooperation among health, welfare, and medical professionals, and with volunteer workers and other types of resident initiatives."

The hint for this new direction came from a conference on community care that was held in a local municipality. The focus of that discussion was how municipalities can provide care for older people who wish to remain at home by having the family doctor play a central role and bringing together various actors, including nurses, caregivers, care managers, and sometimes civil welfare officers. Busy specialists speak with the older person and family, and after preparing the key points, everyone gathers to discuss it in a brief face-to-face meeting, which should be done in a short span of about 10 minutes. It was an effort to utilize all the local resources available, share information with everyone, and cooperate to support the elderly living in the area.

Similarly, various municipalities were carrying out their own initiatives well ahead of the national government. A number of best practices were introduced. One example was the integration of day-care systems for older people and for people with disabilities, which had previously been handled separately. Another was the establishment of multifunctional centers that handled adult day-care services, short-term nursing home stays, and the dispatch of home helpers. These initiatives had been developed centered on a key point person in each location, and each initiative has a unique local history and resources. Subsequently, there were also mechanisms that were institutionalized nationally through long-term care insurance. However, due to national-level rules and regulations, what worked well at the community or regional level could not always adapt to the national scale, leading to the loss of some of the original values of the care system—such as the utilization of local resources and cooperation for supporting older people in the community.

The current community-based integrated care, as called for in Japan's national policies, is a municipality-based system that unifies healthcare and long-term care and promotes mutual support among members of the community. While this offers a degree of freedom to local governments in terms of how to implement the system, the flip side of that is that it creates a great deal of regional variation in the status of these efforts.

Toward Community Revitalization

In the city of Kunitachi, located in the western part of Tokyo, the regional medical plans that are usually formulated by the prefectures are formulated from the city's distinct perspective instead. This is because it is necessary to think about medical care for older people at the city level, taking into account the local nursing and welfare systems and the opinions of city residents. In this city with a population of just under 80,000, the initiative is centered on a clinic that was opened 30 years ago and provides home medical care. The doctor at this clinic has emphasized the need to shift the focus from "medical care that cures" to "medical care that cures and supports," noting that it is important to consider the lifestyle and motivation of older people rather than just their medical care in order to ensure that they can live with peace of mind in their communities. In addition, as part of its work to promote community-based integrated care and to encourage the active participation of its citizens in the program, Kunitachi hosts a senior college where retirees and others can take a wide variety of courses on topics such as preventive care, dementia, and measures for people requiring assistance during a disaster. More than 50 people have already taken the course and are further contributing to community building by creating spaces where community members can gather.

There are still many places where community-based integrated care has yet to move forward in a concrete fashion. However, there is now a common understanding that utilizing community resources to their fullest and working together is critical to ensure that people can continue to live in the places with which they are familiar. This kind of community building not only supports older people but is also the foundation for a safety net that can address disaster prevention, poverty, and infectious diseases such as COVID-19.

Community-based integrated care is also helping to rebuild communities that were decimated by urbanization and industrialization. Restoring these communities is not an easy task, but there has been a new movement by individuals who have recognized the potential of community-based care—including those in NPOs, academia, and municipalities—to use this concept as an impetus for the rebuilding process.

As a leading example of an aging society, Japan has undergone many ups and downs, but in the end, community-based care is the solution it has settled on to address this challenge. From the perspective of sustainability and ensuring no person is left behind, this perhaps seems like a natural solution, but it has taken Japan many decades to learn this lesson. By examining Japan's path, hopefully other aging nations can leapfrog over this country's growing pains and design policies that build on the most successful elements of Japan's system, namely UHC, an emphasis on healthy aging and prevention, and community-based care.

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