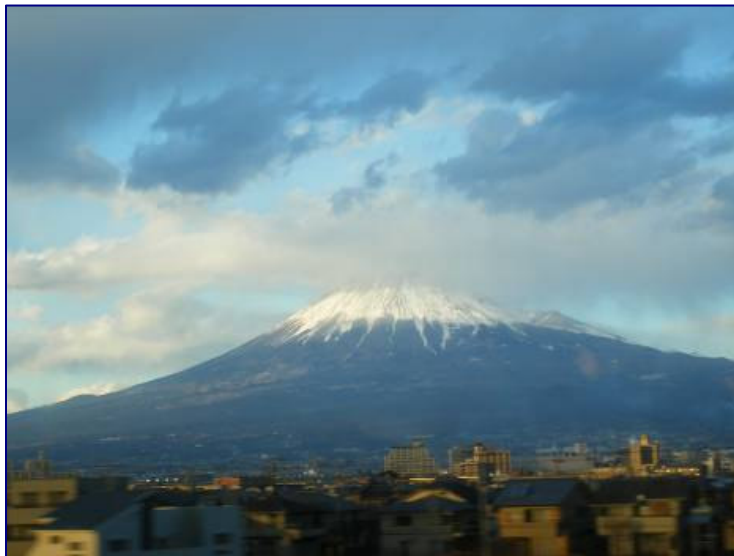


Reforming care and support – learning from Japan

Counsel and Care policy paper

By Anna Passingham



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Introduction – why Japan?

To ensure the success of the debate about the future of care in England, it is important to turn our minds to how care for older people works across other countries and continents, not just on our own island. It is vital as part of the consultation process to open our eyes to the wider global context and consider how other countries in our global economy, also experiencing rapidly ageing populations, have chosen to react to the increasing demand for and cost of care. We are all experiencing the same dilemmas, and must face up to these worldwide challenges if we are to ensure that the new way forward for social care and health will be the best and most appropriate.

In particular, lessons can be learnt from the implementation of a publicly administered national long-term care insurance system in Japan. Japan has the world's fastest ageing population and highest life expectancies (79 years for men and 85.8 for women in 2006ⁱ). It also has the highest proportion of over 65s in the world – currently 21% of the population, but predicted to increase to almost 30% by 2025 and 40% by 2050ⁱⁱ. As in the UK, just under a third of Japanese people aged over 85 have a form of dementia, and the number of the 'older old' people is also increasing fast. Again as in England, there is considerable concern about how, with a declining birth rate (28.1 per thousand in 1950, and only 9.7 in 1996ⁱⁱⁱ), a diminishing 'working population and tax base'^{iv} can successfully support the requirements of such a rapidly ageing population.

The Japanese government's adoption of the mandatory long-term care insurance scheme in 2000 demonstrates a strong governmental response to tackling this ageing 'problem' in a way that is economically sustainable, while also providing equality of access and entitlements for all citizens who need it regardless of income. This social insurance scheme involves contributions from everyone of 40 years and over, and those over 65 can receive services. In Japan, long-term care insurance was 1.4% of GDP in 2005 (6.8 trillion yen), predicted by some estimates to rise to between 3 and 4% of GDP in 2050^v. Healthcare spending is 8% of GDP. This compares with 1.1% of GDP spent on social care in 2002 and 9% on healthcare in the UK in 2008.

In February 2008, the author was part of a delegation that travelled from the UK to Japan to learn about their social care system, and experience how it works in practice. Funded by the Japanese Cabinet Office, the *FY2007 Young Core Leaders of Civil Society Groups Development Programme* provided unique insights into how care for older people can compare at an international level,

encouraged discussion about possible new approaches, good practice case studies, and more innovative solutions to current issues in England.

By examining the experiences in Japan, we can encourage radical reform in England. It is clear that any new system adopted must provide a coherent vision and a universal entitlement for all, promoting equality of access in society, regardless of geography, social class, education and income, but recognising all levels of need. The success of the scheme is reliant on the introduction of a new funding method that is affordable and sustainable regardless of politics and across generations so people will agree to contribute financially to the scheme over a lifetime.

Reforming care and support – learning from Japan is made up of six sections, bookended with an introduction and conclusions and recommendations:

- Following on from the introduction to the policy context provided above, Section One looks at the issue of 'accessibility' and how people can enter the new care system in Japan and have access to services that can meet their needs.
- Section Two covers the thorny but vital issue about who pays what and when, and who decides, with Section Three giving more background to the culture and society which accepted such radical reform.
- Section Four considers the extent to which the introduction of the long-term care insurance model in Japan can be regarded as a 'success' in practice, while Section Five extends this to examine how far long-term care insurance results in quality care for Japanese older people, with comparisons made in Section Six to similar success stories systems in Europe.
- Lastly, some conclusions and ambitious recommendations for the future of the care and support system in England are made. Counsel and Care will encourage ministers to renew their commitment to transforming the care and support system with clear actions and firm resolutions, despite current global financial concerns.

Section 1 – Access

Introduced in April 2000, Japan's public long-term care insurance programme (*kaigo hoken*) was conceived and implemented as a way of substituting formal state services for a long cultural tradition of primarily informal care. Designed to reduce reliance on and the pressures of family care by making community-based services more accessible to all older people, their families and carers, this was major system-wide change in Japan, with the principles of equity and universal accessibility at its heart.

Whereas in England, as we know, care at home or in a care home is only provided by local councils for older people who require an intensive level of support. Care home placements are funded by councils for older people with savings of under £22,250 (2008-09 figures), and care at home is provided to those with a similar savings threshold, although councils have more discretion here. Care often only starts for older people in England when the situation reaches crisis point. However, under the care insurance programme in Japan, older people can be assigned a wide range of support (according to seven different levels of need), with more low-level support given at an earlier time. Therefore, the care insurance programme provides a universal entitlement to services if you meet the criteria based on needs and age, not income, savings, the area you live or administrative selection.

Access by people over 65 to the benefits of the scheme depends first on an application to their local municipality (council) for a 'long-term care requirement certification'. After certification, a qualified social worker or care manager carries out an assessment of their health and social care needs, with a standardised questionnaire of some 80 questions, covering both their physical and mental health. The outcome of the assessment results in allocation to one of seven levels of need, ranging from *jintsu*, when the older person can live independently, *jo-shien* where they require assistance with instrumental daily living tasks, to five increasing more intensive levels for care and nursing for basic daily living activities (*jo-kaigo*)^{vi}. Such daily living activities would include bathing or showering, dressing, eating, getting in and out of bed or a chair and using the bathroom^{vii}.

As in England, each older person is entitled to a 'care plan' developed by a care manager, where the older person can choose to combine various services within the budget allowed for their particular level of needs. It is important to recognise, however, that during the assessment, neither the older person's level of income nor the degree of family support available is taken into account when establishing their level of need, and the services that the older person can receive.

Depending on the level of need the older person is assessed as meeting, they will have access to a wide range of health and social care services streamlined into one assessment, including community nursing, intermediate care, rehabilitation, physiotherapy, personal care at home, support with daily living activities, daily living equipment and adaptations, day care, short breaks, care in a 'group' home, nursing home or hospice care.

Section 2 – Funding

Who pays?

In 2000, a new national system of long-term care insurance was added to the existing health insurance system in Japan. In order to finance the scheme, mandatory monthly contributions are raised from *all* of the working population between the ages of 40 and 65, and the taxpayer subsidises the contributions of those aged over 65 or those on low incomes. In this way, everybody has a stake in the system as everybody contributes towards it. About half of the system is funded in this way by these 'mandatory but means-tested' premiums, with general taxation from central government and top-ups from users of the system (see below) funding the rest^{viii}; people over 65 pay for 18% of the total cost; people under 65 pay 32%, central and prefectural government together contribute 37.5% and 12.5% from local municipalities' own budgets^{ix}.

Who benefits?

Only those aged 65 and over who meet the eligibility criteria based on need are entitled to receive 'benefits' or services (referred to as category 1 insured). So people aged 40 to 65 pay premiums (category 2 insured), but are entitled to receive services only if they have one of 15 age-related diseases, including early onset dementia, stroke, Parkinson's disease and so on. Support for adults with disabilities is currently separate from long-term care insurance.

The state pays 90% of care and support costs through the care insurance, with individuals over 65 in need of care paying a 10% 'top-up' in addition to their monthly insurance premiums. The amount set for each level of long-term care insurance ranges from 49,700 Yen to 358,300 Yen a month (£250-£1,790). The total amount paid varies according to income and tax status, and is capped at a certain level (3,900 Yen in 2006-08 and 5,200 Yen in 2009-12^x).

Each care level has a budget ceiling ranging from 61,500 yen to 358,000 yen per month^{xi}. Older people have access to care services up to the budget ceiling of the particular care level they have been assessed as meeting.

In spring 2006, legislation was introduced which added 'hotel' costs in care homes to that which is paid for by individual older people, and a short-term rehabilitation programme was substituted in place of support to those people with lower (sixth and seventh level) needs^{xii}.

Who decides?

The reform emphasises decentralisation and deregulation from central to local

government (*kisei kanwa*) in terms of decision-making about what services are provided. While a universal level of entitlement is set by central government by determining the prices and types of care and services provided^{xiii}, each Japanese 'prefecture' or municipality can establish the insurance premiums and how many people are able to access the scheme through the certification and assessment process. Providers can compete locally for customers on the grounds of quality of provision, but not prices.

Section 3 – Culture

Such a new approach to funding and providing care for older people can be regarded as revolutionary, as it seems to support both feminist and economic perspectives, by opening up private Japanese homes to access support from the state so women can work and pursue meaningful careers in addition to providing a caring role.

Traditionally, prior to the introduction of the new reforms, the way care and support was provided to Japanese older people relied on ingrained cultural practices and a conservative sense of filial duty and family obligations. These obligations were inherently gendered, traditionally falling to the female members of the family to carry out. In particular, the expectation was that the eldest son and his wife would live together with the parents/parents-in-law, and the daughter or daughter-in-law would provide support and care for them as they aged^{xiv}.



The family

Central to this tradition was the concept of the patriarchal family operating as a harmonious private household living together as three generations, independent of any intervention from the state or 'public sphere'. Coupled with this strong principle of family care as the best type of care for an older person was the principle of 'self-help'^{xv}. This principle had stemmed from a cultural history of voluntary and charitable work by individuals or small groups in Japan rather than reliance on the responsibility of the state to intervene to support the poor and the vulnerable.

However, this idealised image of the traditional Japanese family was easy to undermine if informal care alone was unable to cope as the older person's needs increased. If an older person had to move into a care home it was considered that the family had failed in their duty or that their relatives had abandoned the older person. Such shame and stigma meant that families moved their older relatives into long-stay geriatric wards in private hospitals that were completely inappropriate for their needs rather than endure the loss of face incurred if the older person moved into a care home.

Gender and care

With the rapid modernisation of Japan after the Second World War, traditional ways of living have started to alter to mirror the swift demographic and socio-economic changes. With the significantly ageing population and a decline in birth rate, and as more women participate in the paid labour market, it is no longer realistic for women alone to bear the burden of caring for older people at home without external support either from the voluntary or private sector or the state. Caring has started to move away from a completely female dominated role, with Japanese men representing 15% of informal carers in 2000^{xvi}. As the 'long hours' culture in Japan has discouraged support by sons for older parents, there has been gradual recognition by government of the need for a 'work-life' balance.

The shape of households also have begun to alter, with an increase in single occupancy households from 3.5% in 1985 to 6.8% in 2000, and for older people increasing from 1% to 3%^{xvii} of the total population. While Japanese older people are still more likely to be living with a child than in many other countries, the amount of people over 65 who no longer do so has risen from 28% of all households in 1980 to 46% in 2000^{xviii}. Rural areas of Japan face a significant growth of an isolated ageing population as many sons and daughters now chose to move to the cities^{xix} and their 'punishing work commitments'^{xx} prevent them from regularly returning home to visit their older parents.

Challenging tradition

Long-term care insurance was introduced with the key aims of reducing the social pressure on families to care for their older relatives and also to reduce long hospital stays (similar to *Community Care Act 1990* aims). As Professor Caroline Glendinning from the University of York argues, the introduction of the new social care system saw the 'transformation of social care from a private good to a public commodity'^{xxi}. The new system also questioned the traditional premise that care provided for older people by their family members was necessarily the best that they could receive. A new 'social contract'^{xxii} was drawn up which looked to share the 'burden'^{xxiii} and responsibility of caring for older people amongst all members of Japanese society and the state. There was a great need

to 'commodify' care and also increase its 'diversity'^{xxiv} in Japan, so older people, their families and carers, could have a range of support options from the private and public markets to choose from depending on their individual needs and preferences.

Innovation

The significant increase of the power of the 'silver yen' is shown through the development of technological advancements specifically aimed at older people and their carers. These include the 'I-Pot', an intelligent kettle that monitors the habits of an older person, human airbags to prevent injury from falls outside, brain training games, light-up slippers designed to prevent falls at night, intelligent beds that encourage an older person to get up in the mornings and so forth^{xxv}.

Section 4 – Success

It is important to consider the extent to which the introduction of the long-term care insurance model in Japan can be regarded as a ‘success’ in practice. We could measure this by taking into account a number of factors: the level to which the services offered are used; the level of acceptance of the scheme by the general public; the increase in quality of care received by older people; the benefits experienced by carers and the level to which the scheme looks to be financially sustainable in the future.

Take-up

Professor Naoki Ikegami, a leading health economist in Japan argues that ‘their long-term care insurance [can be considered] a success by widening access’ to social care’. As a result of its introduction, there has been a significant increase in use of care services, especially those older people requiring lower levels of support. In 2005, the number of people with the ‘long-term care requirement certification’ was 4.32 million – an increase of 60% since 2000, and the number of people actually in receipt of services through the insurance scheme was 3.37 million, an increase of 83%^{xxvi}. Use of home care services in particular, has increased by almost 50% in comparison to 5% for use of care homes^{xxvii}.

Acceptance

Debate is currently underway in the UK as to how the responsibility of paying for and providing care to older people should be balanced fairly between the individual, the family and the state and across generations. The Commission for Social Care Inspection’s latest report, *Cutting the cake fairly*^{xxviii}, recommends a ‘clear, simpler framework for deciding who is a priority for publicly-funded support’ and a ‘single, national formula’ for determining personal budgets. A national care fund has been suggested by the International Longevity Centre-UK^{xxix}, which would be limited to those aged 65 and over, in an attempt to balance the wealth disparity between the generations.

However, despite the work of the Social Care Strategy Unit at the Department of Health in promoting the issues raised in *The case for change* consultation, and public awareness raising campaigns, such as It’s Everybody’s Business by Right Care, Right Deal (a coalition of Carers UK, Counsel and Care and Help the Aged) concern remains in England that the general public is not fully engaged in the issues.

Therefore, it is important to look at how far public engagement was achieved prior to the introduction of the long-term care insurance system in Japan, especially when such drastic changes were made. It seems that the Japanese

population accepted the scheme due to a number of factors, but most significantly, due to a strong recognition of the ageing population as the 'number-one'^{xxx} social policy issue in the country. Secondary to this was a change in values towards the rights of people to better care in older age alongside the rights of women to a life outside the home. Ultimately, though, there is something to be said for the fact that the scheme was introduced with low start-up costs and reduced co-payments from individuals, even if it would prove more costly in the future.

Simplicity?

The insurance scheme combines funding for and access to some health and all social care services, such as rehabilitation or home care, so creating a more streamlined and integrated system.

Any new system in the UK must be flexible enough to provide for individual needs and to enable older people to have choice and control over how their needs are met. One potential drawback of the Japanese system is whether the seven different levels serve to limit flexibility and actually increase complexity. Also, while a care manager decides the level of care an older person's needs fit into, there does not appear to be the equivalent of an independent advocate or advice worker that could support an older person if they had concerns about standards and wanted unbiased information and advice.

Choice?

More older people in Japan have had the choice to remain in their own homes with care and support due to the promotion and expansion of home care services and the emphasis on preventative care through the long-term care insurance programme. However, currently, the Japanese system does not offer cash payments in lieu of services as the norm in many countries, including the UK, which champions personal budgets as the best way forward for ensuring choice and control for people with care needs. A note of caution about this approach comes from the recent findings of the IBSEN project^{xxxi}, which evaluated how the personal budgets pilots worked in practice, and demonstrated that despite the popularity of personal budgets, older people must have support, in the form of good information, advice and advocacy, in order to take control of their care successfully.

Japan is slower to initiate similar policy changes, however. Only services, not cash, can be provided to meet the needs of the eligible older population through long-term care insurance. However, recent changes have allowed municipalities to make one-off cash payments of £600 per year to carers of older people instead of direct support. Still, this is a small amount of money and depends on the cared-for person having high needs.

Costs

Government costs for social care have increased since the scheme's implementation in 2000 while health care costs have reduced as less older people remain in long-term hospital stays and the costs are covered in nursing homes. In October 2005, the cost of providing care services for 3.37 million people through the insurance scheme was 5.8 billion yen (a 79% increase since 2000)^{xxxii} and the total expenditure of the long-term care insurance was 3.6 trillion yen in 2000 (0.7% of GDP) and 6.8 trillion yen (1.4% of GDP) in 2005^{xxxiii}.

These costs indicate how popular the services are with the public, but also raise significant concerns about how the services can continue to be funded in the future. This is especially significant when one considers that by 2030, there is predicted to be only two working age people for each retired person^{xxxiv}. Older people in Japan are relatively wealthy mostly in part due to the fact that 20.7% of the over 65s remain in the workplace, compared to 8.7%^{xxxv} in the UK. However, there is evidence of rising poverty amongst Japanese older people, and concerns that the 10% fees for users may discourage some from taking up services.

In 2005, legislation was passed to attempt to restrict increasing costs by adding 'hotel' fees in care homes to that which is paid for by individual older people, and substituting a short-term rehabilitation programme only instead of support to those people with lower (sixth and seventh level) needs^{xxxvi}. This programme of preventative services consisted of exercise training, nutrition and social interaction (see Hot Rehabili Systems in the Quality section as an example).

Ikegami highlights some key potential developments for the future of the care system, in particular the possibility of reducing the amount of services provided under the scheme if costs increase or to introduce stricter eligibility criteria for the services to ensure that system remains sustainable for the long-term. However, adding in short-sighted 'cost-containment mechanisms'^{xxxvii} may serve to undermine the principles of equity and the focus on prevention as the way to reduce need/cost, which underpins the scheme's very design.

Two other policies currently being debated are firstly to merge the insurance system for older people with the current welfare system for adults with disabilities, and also, controversially, to include financial contributions from the working population aged between 20 and 39. Additional methods of funding could include development of the private insurance market and equity release schemes – see Counsel and Care's policy paper, *Lifelong*^{xxxviii} for more details.

Support for Carers

With the introduction of long-term care insurance, older people have access to alternatives to how their care is funded and, in theory, aren't so reliant on the support of family carers. It is important, therefore, to examine the impact of these new policies on the role of family carers and their caring responsibilities.

As the assessment process looks at an older person's needs without reference to the potential support available at home, there are concerns that this approach may actually work to disregard the support families provide while trying to relieve the pressure they are under.

Families still continue to provide a significant amount of informal care and support for their older relatives regardless of the increase in available public services in Japan. Such support does now involve more shared responsibility and negotiation within families as to who is the most appropriate person to be the main carer. As daughters-in-law are much more likely to be working full-time away from the home, more often now, the older partner or spouse is seen to be the best person rather than the children. In such cases, the services available through long-term care insurance work to support older carers, such as day care, home care and short breaks.

Viewing the state as intervening to 'liberate'^{xxxix} women from the burden of caring for their older relatives can be positive in so far as it works to reduce the stress that informal carers were experiencing, but it also works to reinforce a negative view of caring for and supporting an older person as a feat of endurance.

Still, by removing the stigma that families felt if they asked for outside help, carers now can much more easily access support as their right, although they are not entitled to an assessment of their own needs. As highlighted in the 'choice' section above, with recent revisions to the insurance model, municipalities now make one-off cash payments of £600 per year to carers of older people instead of direct support.

However, while this is a step in the right direction, the actual number of carers benefiting from this direct payment is quite small as eligibility is restricted to those who are caring for an older person with the highest levels of need (fourth or fifth levels), and it cannot be regarded as a realistic financial recognition of the support they provide. It appears that if an older person ultimately chooses to remain at home cared for by family only, they will still be required to pay into long-term care insurance. And, despite the long cultural tradition of honouring family support in Japan, it seems strangely neglected by the new insurance system^{xl}.

Section 5 – Quality

It is vital that any care system adopted in England is structured so as to support 'improved quality'^{xli} of care and improved quality of life for those using its services. The long-term care insurance system was not a magic elixir to solve all problems with the provision of care to older people in Japan. It did not include any 'financial incentives'^{xlii} to prevent deterioration amongst older people. But the private care market experienced a huge surge in supply and demand as a result of the system's implementation^{xliii}. The number of older people receiving home care support was 1.52 million between April 2006-March 2007, an increase of 530,000 within a five year period^{xliv}. The number of people employed by care providers increased from 720,000 in 2000 to 1,000,000 in 2004; a 38% increase over the period^{xlv}. One can argue that this surge would have encouraged quality and professionalism of service due to greater competition in the marketplace.

During the author's visit to Japan, she visited Fukui prefecture, which has a high proportion of older people, numbering 190,400 or 22.9 per cent of the total population. Of those 190,400, 29,298 older people were receiving care services under the long-term care insurance (15%). To support these older people, the prefecture has 2,870 domiciliary care workers, 2,195 licensed 'nursing' care workers, and 922 care managers.



The ethos of care for older people in Japan is based on *ikigai*^{xlvi}, or the importance of ensuring life worth living or a meaningful existence. The author visited services for older people that have been developed to recognise older people's needs in the round with activities that preserve social and cultural traditions important to older Japanese people, particularly those with dementia.

See the photograph for an example of traditional Japanese calligraphy being practiced in a day centre the author visited in Fukui. Other traditional practices we saw included the tea ceremony, practicing playing music instruments and sleeping on the floor on mats in the traditional way around a warm heater.

Matsubara Hospital in Fukui prefecture was an impressive example of a day centre, a care home and a hospital for older people with dementia. The photograph below shows older residents in the group care home working together with the care workers to prepare lunch.



Matsubara Hospital had a high staff to older person ratio, and people's rooms were extremely personalised, with their own pieces of furniture, mementoes and treasured items showing their individual identities.



The author also visited Hot Rehabili Systems, a rehabilitation centre, which was heralded as 'one of its kind' in Japan. It demonstrated how keen the Japanese were to invest in technology and preventative care.



The technology on display demonstrated how while they were keen to share innovation, they also recognised the importance of remaining in keeping with the country's cultural and social traditions.



But problems do continue with quality of care for both home care and care homes in Japan and this sustainability of the high staff-older person ratio, in particular due to the treatment of the social care workforce, which is still regarded more as an extension of volunteering and not a formal career, and as a

result given low pay, low social status and low respect. Formal quality assurance mechanisms are more developed with only approved organisations able to provide services. Still more needs to be done in terms of government regulation, particularly with regards to consistency of care standards, regulation of care and monitoring of outcomes across Japan as a whole, not just prefecture-wide. As the care services provided under the insurance system are developed, national care standards would be invaluable to the sector in order to ensure that all care homes and domiciliary care services meet a certain quality and older people have access to up-to-date information as customers in the social care market to choose those services that provide the best care and encourage a 'climate of competition'^{xlvii}.

Home care agencies rely heavily on training to assure quality. Safeguards also need to be put in place to ensure that older people are protected from the risk of abuse when receiving care services in Japan. Introduction of rigorous employment and police checks as occur in the UK would help to ensure that nobody who has been convicted of an offence against vulnerable adults in the past is allowed to work with older people. Demand for care home placements has also increased more than supply in some areas, resulting in long waiting lists that work to reduce the need for providers to compete for consumers with high quality care. As Japan continues to develop its care market in response to the implementation of the long-term care insurance system with more consistency of care, higher staffing levels and better provision across the country, it is to be hoped that the ethos of *ikigai* – the strong sense of quality and respect for a meaningful life as you grow older – can still be retained.

Section 6 – A European approach

Much research has been done on the social care systems in Europe that have also implemented social insurance models of funding long-term care. Here, it is worth focusing on the model in Finland as a useful addition to the debate.

Finland, in particular, is interesting as it has been successful in providing a universal social care system to its older population, combined with the benefits of local flexibility in implementation^{xlviii}. Since the 1950s, there has been an emphasis in Finland on the entitlements of citizens of the country. Each individual is eligible for state provided care and support both as a child and in older age, which are rights completely independent of family support and based on their citizenship.

Rights as citizens to care in older age could work to remove the stigmatism of accessing home care or undergoing a means test. Also, the system in Finland has been successful in removing artificial barriers between health and social care, as well as breaking down class barriers. The system does not distinguish in terms of funding and needs between health and social care.

Conclusions

Prior to 2000, Japan's welfare position echoed the UK in the 1990s in terms of a huge use of care homes and hospitals. The social insurance scheme has funded a move away from providing care for older people primarily in such institutions and to community-based support, which no one can deny is a positive change. However, the workforce needed to provide such care must be better supported, trained and developed. Problems with staff shortages, high turnover and long waiting lists for care, echo the difficulties we face in the UK when attempting to ensure our older population receives high quality, personalised care. While personalised care is provided in Japan, this is not the case across the board, and the assessment process seems to be lacking in flexibility in terms of levels of need/services offered. A key issue also needs to be addressed: how the financial burden of paying for the care of the older population can be shared fairly across the generations if costs continue to increase, while also ensuring that the focus remained fixed on preventative services and providing for a person's low-level needs, where possible.

Despite this, both the scale of major system-wide change introduced and the principles of equity and universal accessibility for all citizens that underpin the care insurance programme in Japan are impressive. While a care insurance model may not be the perfect answer to all the current difficulties in the social care system in England, it has certainly shown that radical reform rather than piecemeal change can be successfully implemented without negative political implications.

Recommendations

- Japan has a universal and equitable care system that was accepted cross-government and by the public, helping to allay society's fears about uncontrollable costs for care in the future. If radical reform is to become a reality in England, **central government** must provide a strong lead that sets out a **national framework for local delivery** and a clearly defined way forward for the public to buy into.
- A similar level of cross-government agreement must also be achieved to ensure that any new system is long lasting regardless of any political changes. Like Japan, a **single funding stream** must be established rather than the multiple and fragmented funding mechanisms that currently exist in England. Such a funding model must include contributions from government, individuals and employers in a combination of 'social insurance, private insurance and personal savings'^{xlix}, in order to ensure involvement from all sections of society.
- Reform has to be about creating a system which everyone has a stake in and which enables people to live fulfilling lives. Any new system adopted must provide a coherent vision and a **universal entitlement for all**, promoting equality of access in society, regardless of geography, social class, education and income, but recognising all levels of need. Counsel and Care's new vision for the wellbeing of all older people, their families and carers attempts to learn from these international experiences. *Lifelong* is an ambitious proposal that aims to tackle the current problems and build a system to meet the growing expectations and demands of our ageing population in England.
- The success of any new system is also reliant on the introduction of a **new funding method** that is affordable and sustainable regardless of politics and across generations so people will agree to contribute financially to the scheme over a lifetime. Asking people to pay contributions towards their care in the future is challenging for politicians. Introducing such a massive change, both socially and politically in how care and support for older people is funded is brave, especially in these difficult financial times. However, Counsel and Care urges the government to hold its nerve on social care reform, despite the current concerns about how it could be funded in this chaotic global financial climate. And we would encourage ministers to renew their commitment to transforming the care and support system with clear actions and firm resolutions.

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Counsel and Care
Twyman House
16 Bonny Street
London NW1 9PG

telephone: 020 7241 8555
email: advice@counselandcare.org.uk
www.counselandcare.org.uk
ADVICE LINE: 0845 300 7585 (local call rate)