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Japan's healthcare policy for the elderly through the concepts of self-help (Ji-jo), mutual aid (Go-jo), social solidarity care (Kyo-jo), and governmental care (Ko-jo)

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Summary **Elderly care is an emerging global issue threatening both developed and developing countries. The elderly in Japan increased to 26.7% of the population in 2015, and Japan is classified as a super-aged society. In this article, we introduce the financial aspects of the medical care and welfare services policy for the elderly in Japan. Japan's universal health insurance coverage system has been in place since 1961. Long-term care includes welfare services, which were separated from the medical care insurance scheme in 2000 when Japan was already recognized as an aging society. Since then, the percentage of the population over 65 has increased dramatically, with the productive-age population on the decrease. The Japanese government, therefore, is seeking to implement "The Community-based Integrated Care System" with the aim of building comprehensive up-to-the-end-of-life support services in each community. The system has four proposed elements: self-help (Ji-jo), mutual aid (Go-jo), social solidarity care (Kyo-jo), and government care (Ko-jo). From the financial perspective, as the government struggles against the financial burdens of an aging population, they are considering self-help and mutual aid. Based on Japan's present situation, both elements could lead to positive results. The Japanese government must also entrust the responsibility for implementing preventive support to municipalities through strongly required regional autonomy. As Japan has resolved this new challenge through several discussions over a long period of time, other aging countries could learn from the Japanese experience of solving barriers to healthcare policy for the elderly.**

Keywords: The Community-based Integrated Care System, universal health insurance, long-term care, policy reform

1. Introduction

Elderly care is an emerging global issue threatening both developed and developing countries. Worldwide, the number of people over the age of 80 is estimated to double by 2050, with one quarter to one half of them requiring everyday assistance due to their reduced functional and cognitive capabilities. The cost of this long-term care (LTC) is estimated to be a minimum of 1.6% of the worldwide GDP by the Organisation for Economic Co-operation and Development (OECD) and to at least double by 2050 (*1*).

In 2015, 26.7% of the population in Japan was over 65 years of age. Japan's population is aging more rapidly than in other developed countries and has taken only 24 years to move from an aged to an aging society, with the proportion of the population aged 65 years and over doubling from 7% to 14% from 1970 to 1994, compared to more than 100 years in France and almost 50 years in the United Kingdom (UK) and

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Germany (*2*). The main cause for this rapid rise in the aging population is attributed to the low death rate due to improved living standards and medical care (*3*). Likewise, increasing proportions of aging populations are expected to accelerate rapidly across Asia, even in low- and middle-income countries such as Thailand and Vietnam. The aging challenges that most countries are facing include the delivery of appropriate medical and welfare care to the elderly, the human resources required for long-term caregiving, and the funding for such care. In this article, we introduce Japan's medical care and welfare services policy for the elderly. In particular, the lessons learned from Japan's incorporation of self-help and mutual aid into the elderly care policy are elucidated to inform others about possible choices for dealing with their aging populations in the future.

2. Transitions in Japanese health policies for the super-aged society (Tables 1, 2)

2.1. *Universal Health Insurance*

Japan's universal health insurance coverage system was initiated in 1961 and was characterized by compulsory affiliation, free access, low copayments, and coverage by insurance premiums and public subsidies (*4*). Initially, the copayment rate for all was the same when the proportion of elderly requiring many more medical care services was only 5.7% (*5*). Subsequently, medical costs for the elderly became free due to social pressure based on an increasingly aging population combined with rapid economic growth from 1973 onward. However, economic stagnancy led to the implementation of a 10-year limit on free medical care for the elderly. All people over 70 years are now required to pay 20% of the copayment rate, and those over 75 must pay 10% (*4*). Even though Japan has the highest life expectancy in the world, national medical expenses have been constantly increasing as the birth rate declines and the aging population grows. As a result, the Japanese government is now struggling to find the necessary funding to ensure an effective elderly healthcare policy.

2.2. *Long-term Care*

In 1997, LTC was introduced that included welfare services but not medical care services. From the 1980s to the 1990s, many beds in Japanese hospitals were occupied for long periods by disabled elderly because of the absence of post-discharge caregivers and/or a lack of adequate care facilities. This was called "social hospitalization", and the hospitalization fee was paid from medical care insurance. It was evident that elderly care services were not sufficient from the data on the proportion of Japanese receiving formal home care aimed at providing nursing care and welfare assistance for daily living to the elderly, which was lower than that of other industrialized countries in 1995 (*6*). This could be due to the traditional Japanese cultural belief that caregiving for the elderly is the younger generation's obligation (*7*). However, because of the growing nuclear family structure, elderly care provided by the younger generation had already started to collapse even before the World Assembly on Aging in 1982, which defined the primary role of the family in supporting the elderly (*8*). In 2000, LTC insurance was implemented following a nationwide discussion on the national needs of aged care.

LTC services in Japan are now available 24 hours a day, if necessary, and are provided by trained, licensed, and skilled care workers. The number of beneficiaries of LTC services has increased by 2.1 times since its introduction; however, since then, the aging profile in Japan has changed again, and the productive-age population has almost halved compared to that of 2000 (*9*). LTC insurance is funded 50% by taxes and 50% by premiums. Every taxpayer aged 40 or over is obligated to pay LTC insurance premiums based on their public medical care insurance premium rating. Thus, the decrease in the productive-age population is evoking concern over a shortage of financial resources. As this brief history shows, the Japanese LTC system has gone through a paradigm shift and is in need of further review and refinement.

2.3. *The Community-based Integrated Care System*

To this end, the Japanese government is seeking to establish a new care structure called "The Community-based Integrated Care System" (CbICS). This concept originated in the comprehensive social security and tax reforms launched in 2012 through an argument for amending LTC insurance. CbICS comprehensively ensures the provision of five factors: health care, nursing care, prevention, housing, and livelihood support. The primary aim of CbICS is to build comprehensive support and services within intimate communities up to the end of life while preserving the dignity of the elderly and supporting independent living (*10*).

Essentially, CbICS has two dimensions: community-based care based on and driven by community health care needs (*11*) and integrated care that is conceptualized as methods or types that often aim to reduce fragmentation of health care delivery by enhancing coordination and collaboration between health care professionals (*12*). CbICS focuses on community power and the coordination and integration of clinical care and welfare services.

CbICS comprises four main elements: self-help (Ji-jo) provided by the individual or their family, mutual aid (Go-jo) provided through an informal network involving local health volunteers, social solidarity care (Kyo-jo) provided by organized social security

Table 1. Critical events in the history of Japanese national policy regarding the elderly

Year	Event pertaining to Japanese national policy	Proportion of population aged 65+ at the time of the event (%)
1961	Achievement of nationwide full coverage of National Health Insurance – Government's commitment to health for all	5.7
1973	Free healthcare policy for people aged 70+ by public funds	7.1
1982	Conclusion of Health and Medical Services Act for the Aged – Health care for people aged 70+ and bedridden aged 65+ was financed by public funds (30%) and health insurance (70%) with a small co-payment	9.1
2000	Introduction of Long-Term Care Insurance System – Provide institutional-based care, home health care services, and community-based services for those 65+ and those between 40 and 64 years with aging-related disabilities	17.4
2012	Establishment of The Community-based Integrated Care System – Community-based care and integrated clinical care and welfare services	23.0

Table 2. Changes in the copayment rate for medical insurance in Japan

Items	1960s	1970s	1980s	1990s	2000s to present
National Health Insurance					
Insured	30%	→	→	→	30%
Employee insurance					
Insured	Fixed rate	Fixed rate	(1984~) 10%	(1997~) 20%	(2003~) 30%
Dependents	50%	30%	(1981~) Outpatient: 30% Hospitalization: 20%	→	(2003~) 30%
Aged 70+ (including bedridden aged 65+)	Same as for the insured	0%	(1983~) Outpatient: 400 yen/day Hospitalization: 300 yen/day	(1997~) Outpatient: 500 yen/day (max 4 visits) Hospitalization: 1000 yen/day	(2001~) 10% (2008~) Age 75+: 10% Age 70-74: 20%

programs such as LTC insurance, and government care (Ko-jo) provided by public medical and welfare services or by public assistance funded by tax revenues (*10*). Of these four elements, we focus on self-help and mutual aid as we believe that these elements are key to the promotion of CbICS.

We believe that CbICS can be major strategy to achieve healthy aging in Japan due to its exact strategy for maintaining a healthy aging society while reaffirming the elderly's and community's own capital. However, this new policy approach was launched just five years ago, and the first evaluation is yet to be completed. Thus, it is unclear whether this approach will become fully established.

3. New challenges for the elderly health policy

To promote CbICS, Japan should address three challenges, each of which is intricately interlinked: *i*) Accountability for financial benefits, *ii*) Interaction between the four elements of CbICS, and *iii*) Applicability of CbICS to communities.

3.1. *Accountability for financial benefits*

The first challenge to CbICS is accountability for the financial benefits government gains by promoting self-help and mutual aid.

Generally speaking, government spending on healthcare delivery is based on some amount of public assistance usually financed through taxation and social insurance. For example, in the UK, comprehensive health services are provided virtually entirely through the National Health Service (NHS), which is funded through general taxation (*13*); in the Swedish model, both health and welfare service spending is completely covered by taxes (*14*); and in Germany, spending on health care is covered completely by social insurance (*15*). The situation is completely different in the United States as all out-of-pocket expenses including LTC services are provided by private voluntary insurance funds (*16*). Japan currently funds healthcare through a mixture of

taxation and social security. While governments have various options to generate the resources required to fund health care, all are facing a financial sustainability challenge, especially for LTC. In Japan, medical and LTC costs are much higher for those over 65 than for other age groups (*17*). However, the proportion of people over 65 is estimated to be more than 30% in 2025, whereas the productive-age and juvenile populations are expected to continue to decrease (*18*). Medical and LTC costs from 2012 to 2025 are estimated to increase by 1.5 and 2.3 times, respectively, despite a GDP increase of only 1.2 times (*19*). Therefore, it will be hard to maintain the current trend of economic growth as aging in Japan becomes a silent but severe financial burden.

In contrast, self-help and mutual aid are crucial healthcare resources for community-dwelling elderly people (*20*). Active social participation and easy access to assistance from others are associated with good self-help practices (*21*), and paid work also encourages elderly people to maintain their health later in life (*22*). From this viewpoint, healthcare policies targeted specifically toward the elderly should actively include self-help or mutual aid. Therefore, as Japan's first challenge, it is important to balance formal and informal assistance in the healthcare financial framework and show evidence that self-help and mutual aid can bring financial benefits such as a reduction in premiums (*23,24*).

3.2. *Interaction between the four elements of CbICS*

The second challenge for promoting CbICS is the interaction between the four elements of self-help, mutual aid, social solidarity care, and government care. We especially focus on self-help and mutual aid highlighted in the CbICS.

Previous research in some aging countries has shown evidence that well-designed health promotion programs (*25*) and self-management (*26*) can reduce healthcare utilization and related expenditures. Ideally, the government could reduce its financial burden from aged healthcare by not providing funding for the government care element and promoting self-help and mutual aid instead, although these two labels are somewhat controversial as they are abstract concepts (*27*). As well, the actual financial benefits of self-help and mutual-aid in Japan should be identified.

Interaction between the four elements is important in promoting CbICS not only because of its reliance on the financial perspective but also in considering such regional context as cultural background. This system can be flexibly adjusted due to regional contexts such as demographic changes, disease structure, and health levels.

3.3. *Applicability of CbICS to communities*

The third challenge is the applicability of CbICS to elderly care in each community.

The Japanese government is urging all municipalities to establish CbICS by 2025 with strong encouragement of municipal autonomy and independence because situations are quite different and there is no one-size-fits-all approach to establishing CbICS. In Japan, actually, support for preventive care that encourages informal power such as that of individuals themselves or friends and neighborhood networks, that is, self-help and mutual aid, has been spotlighted and strengthened by municipalities authorized by public support. In the UK, for example, self-care is a lifelong component of the LTC model under NHS policy (*28*), and self-help has already led to positive results there. Thus, Japan's national policy is required to interpret the existential value of both self-help and mutual aid.

Japan's proposed CbICS, which is the new challenge in healthcare policy for the elderly, has finally reached common understanding through several dialogues. Japan seeks to reduce excessive health care expenditures by encouraging regional and community involvement through the four elements of self-help (Ji-jo), mutual aid (Go-jo), social solidarity care (Kyo-jo), and government care (Ko-jo). As one solution to the barriers to healthcare policy for the elderly, this model could be applied in other communities and countries in which aging is an emerging issue. As implementation of the policy should be undertaken by each municipality based on its unique social, cultural, economic, and political conditions, it would be our further challenge to clarify the factors that promote the establishment of CbICS in a variety of communities.

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