

Kaigo-Jigoku (LTC Hell) and What Japan's Doing About It:
Valuable Lessons for the U.S. and Vice Versa
by
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If you think the United States has a problem with aging demographics, pay-as-you-go social programs, and long-term care financing, consider what Japan is up against. On almost any measure, the Japanese face bigger challenges than we do and they have taken stronger action than we have to meet them. Understanding Japan's problems and corrective actions won't make our challenges go away, but it sure puts them in context. Specifically, studying Japan's creative, activist approach to long-term care service delivery and financing is a great way to put our unimaginative, bogged-down LTC policy in perspective. In the end, maybe both countries have something to learn from each other. This article will explore all those points.

A high and growing life expectancy combined with a rapidly declining birthrate, have made Japan one of the oldest and most quickly aging societies in the world. "For the last three decades, Japan has been going through a very rapid aging process in its population: in 1970, the proportion of 65 years old or older in its total population accounted for 7.1%, in 2004, it reached 14.1%, and in 2005, it is estimated to be 19.6%. Furthermore, according to the mid-range fertility scenario of the official population projection, the proportion will reach 28.7% in 2025, and 35.7% in 2050."¹ Numbers like those forebode serious difficulties for government pension, health care, and long-term care programs that depend on a declining population of working-age people to support an increasing population of older aged dependents.

Consider the pressure and problems long-term care needs have already imposed in Japan. Historically, the country offered long-term care benefits through a means-tested welfare system as the United States still does. In 1963, Japan's Welfare Law for the Aged provided funding for homes for the aged, home care, respite care, and other services paid by taxes collected through central and local governments. These services were targeted to low-income elderly who had no relatives to care for them. Municipal governments determined eligibility. Such a system seemed to fit perfectly with the country's cultural proclivity toward family responsibility for long-term care. According to one commentator: "It was considered shameful to place parents in nursing homes or make use of external services to care for them at home. It was seen as being akin to abandoning one's filial responsibility."² A strict means test discouraged utilization of publicly financed services and encouraged continuation of the traditional model in which care was provided by family members, mostly women, often daughters-in-law.

But time and changes in cultural mores soon caught up with Japan's welfare-based long-term care system. Population aging produced more and more older and feebler elders in need of

¹ Wataru Suzuki, Yanfei Zhou, and Seiritsu Ogura, "Long-Term Care Insurance of Japan after Four Years: How It Has [*sic*] the Way the Japanese Take Care of their Elderly," revised version of a paper originally presented at the 2004 World Congress, International Health Economic Association, Barcelona on July 11, 2004, p. 3, http://www.ecom2.i.hosei.ac.jp/~aging/conf/2005/article/5_1_Ogura_Suzuki_Zhou.pdf.

² Kazuhito Ihara, "Japan's Policies on Long-Term Care for the Aged: The Gold Plan and the Long-Term Care Insurance Program," in *Long Term Care Insurance: The Experience of Two Nations - Reports from Germany and Japan*, International Longevity Center-USA, New York, NY, 2000, <http://www.ilcusa.org/pub/books.htm>, p. 5.

care. Spousal caregivers were aging themselves and less able to provide care safely. Wives and daughters-in-law, often overworked, depressed or tempted by the formal workplace, rebelled against providing long-term care. Mental and physical abuse of the frail elderly increased. "In fact, in a well-known private survey on the informal long-term care, more than half of the family care-providers reported that they had engaged in some acts of abuses toward the one they had been caring."³ What came to be known as Kaigo-Jigoku, or "long-term care hell," became worse and worse.

Furthermore, perverse incentives in the welfare-financed long-term care system impacted Japan's social-insurance-funded health care system severely. Unable to get government help for long-term care without meeting a means test, more and more people turned to Japan's "free" health care system for relief. In other words, they hospitalized their frail elders at government expense.⁴ "Therefore, many aging persons and their family members, have continued to choose admission to readily accessible hospitals, instead of the 'welfare' system which involves complex procedures, income checks and details of the family's personal circumstances."⁵ Experts also worried that acute care facilities that focus on cures, recovery and discharge would give too little attention and resources to rehabilitation and restoring bedridden elderly people to more active lives.⁶

"By the late 1980's, a national consensus had emerged on the need for a public long-term care service that guarantees a general access for everyone in need of the service."⁷ Japan's next step into the complex field of long-term care service delivery and financing was "the Gold Plan." Implemented in 1989, the ten-year Gold Plan "was to be a major shift from long-term institutionalized care in hospitals and nursing homes to home programs and community-based rehabilitation facilities. At the same time, the government formulated a plan to make long-term care services universally available to older persons."⁸ Home and institutional care would be free to all who met the means test. Eligibility for services was determined by the municipal social welfare agencies, which also, along with non-profit organizations, arranged delivery of services. Not surprisingly, costs skyrocketed. "Gold Plan programs did grow rapidly, with expenditures rising by 10 to 15 percent a year for a decade—in fact, the targets had to be raised in the New Gold Plan of 1994."⁹ The Gold Plan did much to develop Japan's long-term care infrastructure for home and institutional care, but it also raised expectations and costs.

³ Suzuki, *op. cit.*, p. 4; their source is "Research Institute of Alliance of Labor Union, 'Survey of Long-Term Care.'"

⁴ "According to an MHW [Ministry of Health, Labor and Welfare] estimate based on Patient Survey, there were 270,000 such patients in 1999, costing the public health insurance system around 2 trillion yen." (Suzuki, *op. cit.*, p. 4)

⁵ Ihara, *op. cit.*, p. 9.

⁶ "The health care system in Japan is not appropriate to the needs of the elderly. There is an excess of acute care hospital-based facilities and a shortage of chronic care nursing home-based facilities. Furthermore both hospital and nursing home facilities tend to assume that the condition of the elderly can only remain the same or deteriorate. They fail to promote rehabilitation and as a result they lack the necessary human and physical resources needed to restore bedridden elderly to a more active state." (David E. Horlacher, "Aging in Japan: Causes and Consequences, Part III: The Elderly," International Institute for Applied Systems Analysis, Laxenburg, Austria, January 2002, <http://www.iiasa.ac.at/Admin/PUB/Documents/IR-02-002.pdf>, p. iv)

⁷ Suzuki, *op. cit.*, p. 5.

⁸ Ihara, *op. cit.*, p. 2.

⁹ John Creighton Campbell and Naoki Ikegami, "Japan's Radical Reform of Long-term Care," *Social Policy & Administration*, Vol. 37, No. 1, February 2003, p. 23.

Faced starkly with the question of "how to share the burden of the rapidly increasing long-term care expenses in the society,"¹⁰ Japan turned in April of 2000 to its radical, new long-term care social insurance system, or "Kaigo Hoken." Among the new system's objectives, as articulated by experts interviewed and published sources reviewed for this article were the following:

- to ensure a stable revenue source not dependent on taxes alone
- to change the system of welfare eligibility determination and service allocation by municipalities, which stigmatized users
- to make services available based on needs and preferences irrespective of income or the availability of family caregivers
- to reduce "social hospitalization," the use of hospitals funded by universal medical insurance for long-term care, and to increase the use of home care and nursing home services
- to replace welfare financing of long-term care as much as possible with social insurance funded half through taxes and half through premiums collected by pension or payroll deduction
- to encourage private sector companies and organizations to enter the field of long-term care service delivery and thus enhance quality through competition
- to make "care managers" routinely available to help beneficiaries of the program and their representatives find and choose the most appropriate service providers
- to relieve the public's anxiety about saving for retirement and old age in order to increase current consumption and thus improve Japan's economy
- to relieve families of LTC burdens and encourage female labor force participation

Foremost, Japan's new government-funded long-term care insurance system was aimed at making the most appropriate long-term care services universally available to all aging Japanese citizens regardless of their ability to pay and based solely on their objective medical needs and personal preferences. For the first time, publicly funded long-term care services would be available to the middle class and not just to the poor who qualified for welfare. But long-term care is "Japan's fifth social insurance program, coming after medical care insurance, pension insurance, protective insurance against unemployment and occupational accident compensation insurance."¹¹ That's a big load to place on taxpayers and mandatory premium-payers. Let's turn next to the question "How does the system work?" and finally to "How has it turned out?" and "What is likely to happen next?"

The Japanese LTC system covers all people over the age of 40 but no one under that age. Younger people remain covered by the existing welfare system. Those 65 and older receive insurance benefits for conditions requiring long-term care regardless of the cause. Those 40 to 64

¹⁰ Ihara, *op. cit.*, pps. 11-12.

¹¹ *Ibid.*, p. 2.

receive benefits only if their illnesses are associated with aging, such as stroke, early onset dementia, etc. Municipalities (of which Japan has about 3500) are the insurers. They determine tax and premium rates (averaging \$30 per month, with half the premium paid by employers for the age 40 to 65 group) based on geographical differences in number and financial status of older people. The municipalities also determine service eligibility based--at least in theory--only on physical and mental condition, without regard to income or family members' availability to provide care. The system is funded half through taxes (25 percent from national taxes; 12.5% from prefecture (cf. state) taxes; and 12.5% from municipal taxes) and half through premiums, 18% from people 65 or older (withheld from their pensions) and 32% from people aged 40-64 (through payroll deduction).¹² The system funds six levels of care depending on need and severity ranging from "support" and "home help services" to nursing home care and varying from \$500 to \$3,300 per month.¹³ The insurance pays 90 percent of the cost to service providers who are selected by beneficiaries. Users pay 10 percent. The government decides reimbursement rates based on a difficult, time-consuming cost-allocation system with readjustments every three years. The indigent have their 10 percent co-pay funded by the traditional welfare program, based on eligibility at roughly \$800 per month of income. Whether or not assets are considered in determining eligibility for welfare assistance depends on whom you ask, but a Ministry of Health, Labor, and Welfare official interviewed for this study said "There is a limit on assets; they don't have a right to keep all assets. If they have a house, they have to sell it; if they have a car, they have to sell that. The municipalities investigate."¹⁴

This sounds very attractive. For thirty dollars a month (on average) in payroll- or pension-deducted premiums starting at age 40, you get unlimited access to a full range of long-term care services from the provider of your choice for ten cents on the dollar. Furthermore, the system seems to be working very well. On a recent trip to Japan (November 2005), I visited three long-term care facilities in urban, suburban and rural areas that offered home health care, adult day care, independent living, assisted living, nursing home care, and special units for Alzheimer's Disease patients. Without exception these facilities were immaculate, odor free, and full of active, happy residents and staff eager to talk about their experiences. In one case, a group physical therapy class was underway as we entered the facility. In another, a group sing along with piano accompaniment, greeted us. In a third case, residents of a special small LTC unit cheerfully met us as a group when we toured their section. Frankly, these experiences were very different from the often depressing, olfactory-offending visits I've made to some nursing homes in the United States. Besides visiting LTC facilities in Japan, we also stayed with a family and met their 93-year-old

¹² "LTCI in Japan is currently financed in several ways. Citizens pay ten percent out of pocket for most services, with taxes and insurance respectively covering half of the remaining 90 percent. There are two stages of participation. Citizens aged 65 or older pay on average \$30 per month, depending on where they rank on a five-tiered personal income scale. This fee also varies based on the local area and service type. Citizens aged 40 to 64 pay on average \$31 per month through employers' payment of their health insurance premiums. The employer pays half of the amount." Andrew M. Saidel, "Japan's Long-term Care Insurance System Faces Overhaul: Straining to Meet Demand, Lawmakers Set to Make Changes," AARP Global Aging Program, May 2004, <http://www.aarp.org/research/international/Articles/a2004-04-01-JapanLTCI-Saidel.html>.

¹³ Campbell and Ikegami, *op. cit.*, pps. 21-22. "The services provided are specified in the legislation, categorized as institutional (residential) care, visiting services (home help, visiting nurses, bathing service), institutional services for people living at home (day care, 'respite' short stay), physical goods (home renovation, provision of equipment like wheelchairs), and some idiosyncratic items such as residential group homes for demented people." *Ibid.*, p. 27.

¹⁴ Personal visit and interview with Hidero Kuroda, Deputy Director, General Affairs Division, Health and Welfare for the Elderly Bureau, Ministry of Health, Labor and Welfare, Tokyo, Japan on November 1, 2005.

loved one who receives twice-weekly home health care visits funded by the LTC insurance system. Here again the services were efficient, helpful, much appreciated and very affordable. On all these measures, it is hard to conclude otherwise than Japan's new social insurance program for long-term is a rousing, popular success.

But before you jump to the conclusion that we should import the Japanese LTC system in its entirety to the United States, consider these clouds on the program's horizon. In a nutshell, here's how one commentator evaluated the program recently: "This insurance . . . has changed significantly how we take care of the elderly not only at home, but also in institutions as well. The first stage of the new insurance has been a solid success: all available indices of LTC market outputs have literally doubled. At the least, a substantial portion of the family burden has been replaced by LTCI benefits, and the LTC institutions are admitting high care level individuals. This success in the first stage, however, immediately creates a far more difficult problem for the second stage: namely, how can we control the costs and make the system sustainable in the long-run?"¹⁵ He goes on: "The benefits are growing too fast. The waiting-line for institutional care is getting longer. There are some signs of moral-hazards in the system. The financing mechanism is still very shaky. The regional imbalance may be expanding. These are the problems that need to be solved to make LTCI sustainable for the future."¹⁶

Following is a list of financial and substantive challenges facing Japan's LTC insurance system as compiled from various sources:

-- Overall program costs are growing at an alarming rate according to several analysts and a member of the Japanese Diet's upper house (House of Councillors) interviewed for this article.¹⁷ "For 2005, 5.5 trillion [yen] projected, 6.8 trillion [yen] actual."¹⁸

-- A major factor driving cost increases is much heavier utilization than expected of the lowest levels of care provided by the system.¹⁹ "Government views with alarm: too many people without much need are getting services."²⁰

¹⁵ Suzuki, *op. cit.*, p. 1.

¹⁶ *Ibid.*, p. 2.

¹⁷ Interview with Keizo Takemi, Member, House of Councillors, on November 2, 2005. Example of an analyst's opinion: "Japanese leaders are grappling with stark budget numbers. In Japan fiscal year (JFY) 2001, the nation's annual social welfare expenditures, including pension, health insurance and LTCI, topped \$800 billion for the first time. This figure also set a record as a percentage of national household income, reaching 22 percent. According to MHLW documents, 3.74 million citizens were enrolled in the LTCI system as of November 2003. LTCI outlays in JFY 2004 will reach over \$50 billion, an increase of 1.7 times over the first four years of the program. By 2025, based on current projections, the cost will increase to just under \$200 billion per year." Saidel, *op. cit.*, p. 1. According to Ministry official Kuroda, *op. cit.*, the LTC insurance paid benefits amount went from 3.2 trillion yen in FY2000 to 5.5 trillion yen in FY2004. "Along with growing users, total expenses and insurance benefits amounts are increasing rapidly."

¹⁸ Naoki Ikegami, "Social Policy and Society: Rationale, Design and Sustainability of Long-Term Care Insurance In Japan — 5 Years On," outline for an article Dr. Ikegami is writing, provided in an email October 17, 2005.

¹⁹ Lower levels of support and care have increased much faster than the higher levels of care, according to Hidero Kuroda of the Japanese Ministry of Health, Labor and Welfare. The lowest, support level was up 85% from 2000 to 2003, Care Level 1 was up 108%, Care Level 2 was up 58% compared to an overall increase of 67% in all levels and increases of Care Levels 3, 4 and 5 respectively, up 44%, 32%, and 51%. (Kuroda, *op. cit.*)

-- Premiums that were only expected to average \$27 per month by 2010 have already reached \$30 on average and are expected to increase seven percent a year from now on.²¹ Because premiums are based on income, "many citizens are now paying closer to \$50 per month."²²

-- Demand for nursing home services has increased despite the system's emphasis on home care because the eligibility screening role of municipalities was decreased at the same time that the system paid "hotel costs" in nursing homes but not for home care.²³ This has led to a high demand for and a shortage of nursing facility beds.

-- On the other hand, demand for and expansion of private-pay assisted living facilities is increasing rapidly, because their cost to consumers has plummeted now that the LTC insurance system pays for most care costs and residents are only responsible for "room and board" expenditures.²⁴ This raises a question of whether the assisted living facilities can provide for the care needs of residents as adequately as nursing homes.

-- Despite a large increase in available professional LTC services at all levels "[t]he average number of hours spent for LTC care per day [by family caregivers] was 5.2 hours, a mere 0.2 hour reduction Thus it is clear that LTCI has not removed all, nor replaced most, of the burdens of family care-givers."²⁵

-- "Information to select care service providers is not sufficiently provided. A number of complaints are filed about quality of care services. Improving quality of care workers and fostering human resources are problems to be solved. Effective means to eliminate the providers with poor quality from the market are insufficient."²⁶

-- Long-term care services provided by hospitals and funded by Japan's medical insurance system have been reduced by LTC insurance, but only to about half the extent hoped for and intended.²⁷

²⁰ John Creighton Campbell, "Long-Term Care: in Japan and in General," PowerPoint presentation to the International Seminar on Reforming Health Social Security, Tokyo, June 27-29, 2005, as provided in a 10/19/2005 email from Dr. Campbell.

²¹ Source for 2010 premium estimate is Ihara, *op. cit.*, p. 18. Source for estimate of seven percent annual increases is an interview with Shigeru Tanaka, Professor and Associate Dean, Graduate School of Business Administration, Keio University, November 1, 2005. Professor Tanaka serves on the committee which sets provider reimbursement rates for Japan's LTC insurance system.

²² Saidel, *op. cit.*, p. 1.

²³ "The system will reimburse 90 percent of cost, including food [*sic*] and board, if an LTCI user is living in a registered long term care facility. However, if that same user is residing at home and receiving home care services, the system will only reimburse for the cost of the care itself. It is cheaper for the user to check in to a facility, even if there is only a low level of care needed." *Ibid.*

²⁴ Interview with Naoki Ikegami, MD, MA, Professor and Chair, Dept. of Health Policy & Management, School of Medicine, Keio University, October 31, 2005.

²⁵ Suzuki, *op. cit.*, p. 14.

²⁶ "Long-term Care for Older Persons in 2015: Toward the Establishment of Long-term Care to Sustain Dignity of Older Persons, October 24, 2003, A Study Meeting on Long-term Care for Older Persons," document supplied by the International Longevity Center in personal correspondence between James Nyberg and the author on December 15, 2003.

²⁷ Ikegami interview, *op. cit.*

-- Municipalities continue to apply eligibility screens based on families' ability to provide care as a means to control program costs. This occurs less often than before but is increasing once again.²⁸

-- The number and quality of care managers to help people find and retain the most appropriate services have not increased as much as was hoped for and intended.²⁹

To address these major and many other minor concerns, Japan's social-insurance-financed long-term care long-term care system underwent a major review resulting in significant modifications of the program which took effect in October 2005. Among the options considered to reform the system were:

-- cutting or changing benefits

-- raising premiums

-- expanding the program to include collecting premiums from and providing services to citizens under 40 years of age

In the end, the idea to expand the program to include all ages was deferred due to strong political opposition. Benefits were not cut, although access to IADL³⁰ support services for people in the lowest two care levels has been somewhat restricted. In fact, new benefits were actually added. The new services include measures, such as "strength training," counseling, and encouraging social participation, that are intended to prevent people from becoming in need of the lower level program services which have been rising in utilization and cost the most. By far the most important change to the system, however, is the elimination of the induced incentive for institutional care by requiring nursing home residents to pay part of their own "hotel" or room and board costs. The goal of these reforms, which will be phased in between now and 2008, was to contain the increase in the average basic premium rate from the projected amount of \$37 per month (without reform), to \$34 (with reform), the current rate being around \$30 to \$31 per month.

According to Dr. Naoki Ikegami, a leading, local expert on Japan's system, "By themselves, these measures are not likely to sufficiently contain costs but they could pave the way for a stricter curtailment of benefits in the future."³¹ Clearly, a process has begun to rein in the expenditure growth of Japan's long-term care social insurance program. Nursing home beneficiaries who will now have to pay their hotel costs will feel the pinch. They, and their families, will bring political pressure to bear. As premiums increase for everyone, there is a risk that political support among premium payers not currently receiving benefits will increase. Serious questions have been raised whether it will be feasible to retain the highly utilized lower level of care paid for by the system, especially IADL support services. It is difficult to deny services to people in the future who have been receiving them in the past or who anticipated receiving them based on the original structure of the program. Will measures implemented in the 2005 reform successfully curtail program

²⁸ *Ibid.*

²⁹ Tanaka interview, *op. cit.*

³⁰ IADLs are instrumental activities of daily living such as preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

³¹ Ikegami outline, *op. cit.*

expenditure growth? The people I interviewed seemed dubious that new costs for new services (prevention) could significantly reduce ongoing costs for existing (care) services. In the meantime, the Japanese public remains very happy with the long-term care system's services and much less concerned about its costs than about the cost of their medical and pension insurance systems, which are much larger. Thus, dismantling the system in the face of increasing costs is unlikely, but constricting benefits and increasing premiums and co-payments is virtually inevitable. And every step in that direction invites more and graver political challenges for the party in power.

So, what is the bottom line? One cannot help but be reminded, when considering Japan's long-term care system, of America's experiments with social insurance, to wit, Medicare and Social Security. Both programs are enormously popular but totally unsustainable fiscally. Medicare has a \$60 trillion unfunded liability and Social Security carries a \$10 trillion long-term deficit. Has anyone run the numbers for the difference between promises made through Japan's social insurance programs (5 at latest count) and the country's economy's ability to keep those promises? Sure, in Japan, as in the United States, governments can keep tweaking taxes, premiums and benefits to bring them into balance with expenditures. But as they get closer and closer to a condition in which citizens are paying too much and getting too little from government programs, they will reach a limit to how far they can raise the cost and reduce the benefits of programs and still retain political control. Furthermore, in the absence of a private market for services in which supply and demand set prices and determine priorities, governments are hopelessly at a loss to decide what are the best services to offer and the proper prices to charge for them. Over time, economic drift caused by subjective prices and bureaucratic control inevitably leads toward inefficiency, consumer discontent, and ultimately to political shoals.

One Japanese politician who is struggling with questions like these is Keizo Takemi, a member of the Diet's upper House of Councillors. He has a portfolio that includes medical and foreign affairs. Mr. Takemi told me that he is worried about the interaction between Japan's pension, medical and long-term care insurance systems. In principle, I believe his concern is that by taking on the responsibility for these costs, the government has lifted a burden of personal accountability from the individual that could create perverse incentives. For example, Japanese citizens are among the biggest savers and wealthiest populations in the world. "Compared to the elderly of other OECD³² nations, the elderly of Japan are in a very strong financial position. For those over age 60, average household savings is about 200,000 Euros [approximately \$234,000] and their annual income of those households was about 45,000 Euros [approximately \$52,650]. Relative to that of all Japanese households, the average income of elderly households rose rapidly in the decade between 1975 and 1985 and since that time has remained at about half that of all households. As a result there has been a marked decline in the incidence of poverty among the elderly."³³ Mr. Takemi told me that Japan's social insurance programs have allowed Japanese citizens to set aside large amounts of money in savings that are not consumed for their living or long-term care needs, thus devolving the whole burden for such needs onto government programs which are already faltering for reasons discussed above.

This set of conditions--short-range popularity and long-term insolvency risk of Japan's social insurance programs--leads me to wonder if Japan might have something to gain from

³² OECD stands for Organization for Economic Co-Operation and Development.

³³ Horlacher, *op. cit.*, p. iv.

considering private sector alternatives, which although foundering in the United States, are at least still legally possible here. For example, private medical insurance is not permitted in Japan because it is considered socially unacceptable to allow a person's wealth, including the ability to purchase insurance, to buy them a higher level of medical care than others with fewer resources are able to obtain. The same restriction does not apply for long-term care, however. The principle accepted in Japan for LTC is that the government should offer a minimal level of services, but those who can afford to do so should be allowed to "top off" by purchasing additional services, albeit at prices set by the government. This leaves open a possible role for private long-term care insurance in Japan if and when someday the public perceives that services under the publicly financed program are inadequate to their needs. Similarly, if the government someday finds that funding adequate long-term care services under the current structure is infeasible politically due to opposition by the public to further tax and premium increases or benefit decreases, public officials might consider implementing an estate recovery program, similar to the one mandated (if unenforced) in our Medicaid program. That could generate substantial new resources for Japan's long-term care system without burdening the broader population of taxpayers and future beneficiaries.

In the meantime, I acknowledge that based on my first-hand, albeit limited, observations, Japan's long-term care service delivery system is very impressive and probably excels our own. Japan's social insurance system for financing long-term care leads me to believe, however, that combined with its other four social insurance systems, Japan is on a dangerous trajectory toward major economic decline as the Age Wave crests and crashes. There is no denying that Japan deserves praise for tackling the challenge of long-term care early and that the United States deserves blame for ignoring the same challenge so doggedly. But just as, compared to other industrialized nations, America minimized our vulnerability to the impending collapse of pay-as-you-go social insurance programs for health and retirement security, maybe our tardiness in addressing long-term care is a blessing in disguise. While losing some of the short-term benefits of early participation in other countries' popular social insurance Ponzi schemes, we may dodge their worse long-term consequences in the end.

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Interview with Naoki Ikegami, MD, MA, October 31, 2005, Professor and Chair, Dept. of Health Policy & Management, School of Medicine, Keio University, Tokyo, Japan

Charts and graphs provided by Hidero Kuroda, Deputy Director, General Affairs Division, Health and Welfare for the Elderly Bureau, Ministry of Health, Labor and Welfare, Tokyo, Japan to the author during an interview on November 1, 2005. Mr. Kuroda's office oversees the LTC system and sets limits on reimbursement levels and establishes regulations for the service providers.

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Interview with Keizo Takemi, Member, House of Councillors, on November 2, 2005. Mr. Takemi belongs to the Liberal Democratic party currently in power in Japan. He is one of 50 delegates proportionally representing the whole country rather than a geographic district. His portfolio includes both medical and foreign affairs.

Interview with Shigeru Tanaka, Professor and Associate Dean, Graduate School of Business Administration, Keio University, Yokohama, Japan on November 1, 2005. Dr. Tanaka serves on the committee that sets reimbursement rates for long-term care providers in Japan and he has been intimately involved in every step of the development and implementation of the LTC system.

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