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Frameworks for Term Geriatric Care Insurance Plans That Are Sustainable

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Abstract

The world is currently facing rapid aging population growth which has escalated the need to have sustainable long-term care funding mechanisms. This paper examines the framework, issues and possible reforms of the elderly care insurance programs taking into consideration the need to balance between financial sustainability, social equality and accessibility of the services. The research emphasizes the need to combine both public and private sources, improve the risk pooling and use innovative care delivery practices by studying the international models and policy frameworks. The results indicate that resilience to demographic pressures in older care insurance requires the future to focus on preventive care, community-based care, and integration of digital health through the system. The research will help in policy formulation as it will offer strategic information on how to establish an effective and inclusive nursing insurance model in the long run.

Keywords: ***Long-term care insurance, Elderly care systems, Sustainable financing, Health policy, Aging population, Social security, Risk pooling, Preventive care, Digital health, Community-based services.***

1.Introduction

One of the most important social changes of the twenty first century is the demographic change in the ageing population. Countries all over the world are struggling with the economic, socio-political, and policy issues which are caused by the rise of the life expectancy, the decline of the fertility rates, and the erosion of the traditional family-centered activities of the caregivers. These changes have been most progressive in Japan, whose pace of population aging started to rise in the 1990s and has since outpaced any other developed economy. With a fall in birth rates and a rise in longevity, the percentage of aged citizens elevated sharply and led to a need of total care systems that was not limited to the old household structure. Industrialization and migration to the urban area also put pressure on the support systems of families and old citizens were at risk of being isolated and lacked adequate care. Over time, to solve these mounting pressures, the Japanese government came up with Long-term Nursing Insurance (LTCI) system in 1997 which was formally introduced in 2000. The reform was a turning point in the social welfare policy where the state-dominated and family-dependent model was replaced with a collaborative one that incorporated the state, local municipalities, the actors and community. Japanese LTCI system has since been an international reference point on which other countries deliberated on how they can fund and sustain the long term care of their aging population(1).

Historical Foundations and Early Experiments

Prior to the inception of LTCI, Japan already made incremental measures in tackling the elderly care. The Welfare Law for the Elderly in 1960s recognized that the state had a role to play in taking care of the older citizens, whereas in 1980s, the Health Care Law for the Elderly provided facilities that supported the elderly not only by giving them medical attention but also a place to live. Early efforts to alleviate the mounting household strain were small-scale. In 1989, the Golden Plan was initiated to increase the number of short term care and daily-service facilities in towns and cities, and the idea was to enhance accessibility and coverage. The speed at which the demographic change was happening soon outpaced its provisions no matter its lofty aims. In 1994, the New Golden Plan was aimed at adding more caregivers and facilities, however once again the demand was by far outpacing the supply. This prompted Japan to analyze foreign experience, especially the long-term care insurance system in Germany which was the model of the Nursing Insurance Law in 1997. Its introduction in 2000 was a structural change: long-term care ceased to be an issue of charity or ad hoc welfare, but a right of a special insurance scheme.

Design of the Long-Term Care Insurance System

The Japanese LTCI was intended to be a social insurance system that incorporated the elderly care in the social security system. Contrary to the previous programs that strongly depended on the government subsidies, LTCI was founded on the principle of shared responsibility among people, communities, and the state. Coverage was

designed in terms of two groups of insured people. First, the aged 65 plus group could receive services due to any reason that they needed care. Second, aged persons aged 40-64 were qualified should they have been diagnosed with aging illnesses like cancer, dementia or rheumatoid arthritis at an advanced stage. This dual arrangement was both indicative of the a-priori universality of aging and acknowledgement of particular conditions that can necessitate intensive long term support even prior to the age of old age.

Financing and Cost Sharing

Among the more remarkable innovations of LTCI is its financing model. The system is not funded entirely by the government alone but is funded equally by individuals and the government. It is divided between local municipalities (cities and townships), 12.5% of which, prefectures, another 12.5% and, finally, individuals, through insurance premiums (remains 25 percent). As a way of deterrent to overdepending, there is also co-payment of 10-20 percent of the cost of services by the beneficiaries, after which the balance is paid by the insurance. Individuals incur extra costs in the form of accommodation and meals(2). This cost-sharing system does not only help in the sharing of the financial burden among various stakeholders, but also allows sustainability through avoiding the unregulated increase in the amount of spending by the government.

Administration and Governance

Applicability of the LTCI is under the mandate of the municipalities that are the statutory insurers. They handle funds, collection of premiums and the organization of service provision. This decentralized system provides this to ensure that elderly care is within the community that they serve and both flexible and responsive to the needs of that community. Overall policy direction is given by the Ministry of Health, Labour and Welfare, with a fair amount of freedom given to the municipalities in implementation. Such a mix of national direction and community implementation has played a significant role in the success of the program, encouraging the development of innovations and covering the entire country.

Services and Operational Process

LTCI services offer a range of home-based and facilities based services that incorporate the variety of needs of the elderly. They are broadly classified into five categories including home-visit services, day services, short-stay programs, residential care and facility based long-term services. These are further further divided into 14 home care services and 3 institutional services starting with rehabilitation and ending with housing modification support. An operation process starts with the application of the insured in his or her local municipality. In consultation with physicians, trained investigators assess the physical and mental state of the applicant and sort them into one of the various levels of care, such as support to care level 5. According to this evaluation, individual care plans are made. Prevention is prioritized among the lower levels and more intensive services are given to people of higher needs.

Reforms and Adjustments

Although it has strength, LTCI system has had its challenges. Increasing beneficiaries and increasing costs required reforms. In 2006, the government amended the system thus laying more emphasis on prevention of diseases and encouraging independence rather than emphasising solely on treatment and care. The classification system was narrowed down to eight levels with the introduction of a support level 2 which was a combination of the preventive and rehabilitative measures(3). The reforms also enforced a higher level of eligibility requirement minimizing the chances of over exploitation and making the allocation of resources more precise. The system became more financially sustainable by focusing on prevention and light-care services, which would delay or decrease the need of intensive and expensive care required by the people of Japan.

Public-Private Collaboration in Service Provision

The other innovation that the Japanese model introduced was the involvement of the private providers in service delivery. Compared to the previous systems of welfare that were dominated by the state, LTCI allowed competition between the companies and nonprofit organization. This increased the quality and the range of services and allowed beneficiaries more choice in the care providers. The movement towards mixed-market model encouraged efficiency and consumer orientation which are consistent with wider trends in welfare reform that puts an emphasis on flexibility, accountability, and personalization of services.

Impact and Global Significance

The LTCI system since its introduction has helped greatly in lowering the burden of eldercare in Japan. The number of insured persons aged 65 years and above increased to more than 33 million between 2000 and the end of 2010s, as compared to 21.65 million, and the number of service recipients had increased to over 5 million as compared to 1.49 million. LTCI developed a whole system of accessibility and sustainability by encompassing financing, service delivery and governance. Significantly, it changed the care giving as a family obligation to the

community. Japanese model has been followed by other countries which were experiencing similar demographic pressures such as South Korea, China and various countries located in Europe, as they designed their own long term care systems.

2. Historical Context and Policy Evolution

The change in the policy of eldercare in Japan can be described as a gradual appreciation of the inefficiency of the traditional family-based care systems to deal with the issues of rapid demographic aging. The policy of eldercare in Japan has gone through a series of phases which are also distinguished by the various assumptions that surrounded the roles and responsibilities of those who have to take care of the elderly citizens, namely families, communities and government. The awareness of this historical development also offers a necessary background to the appreciation of the revolutionary character of the systems of the Long-Term Care Insurance and the reasons that made its implementation a necessary and a politically viable event(4).

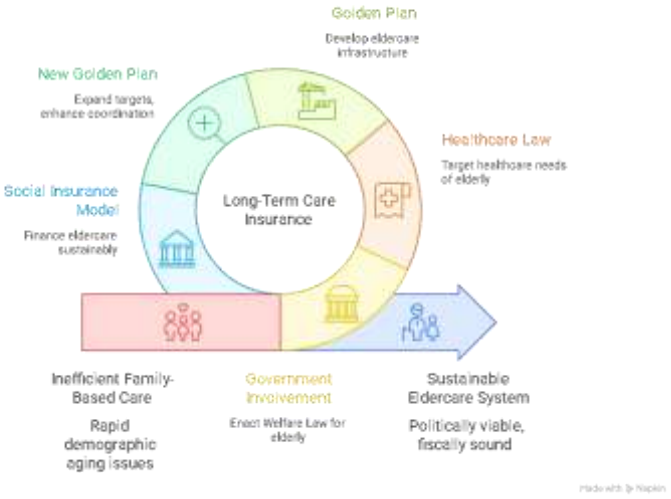

FIGURE 1 Reforming Eldercare in Japan

The first years of the post-war Japan were marked by the extreme lack of resources and orientation to the development of economic, but not social welfare. Eldercare was still a family duty in this period with cultural beliefs rooted in Confucian ideals of filial duty and duty between generations being strong in the culture. Japanese extended family set up, the so-called "ie" system, created strict hierarchies and duties in the extended family, where the senior sons took the main responsibility of looking after their aging parents and daughters-in-law assumed the main role of care giving. This system worked well in the times when the majority of families resided in the countryside, were involved in farming activities that had the capacity to host more than one generation and the extended family structure that could ensure duties of care when the need arose or when there was a crisis.

As the economy of Japan modernized and urbanized in the 1960s and 1970s, the social basis on which conventional eldercare arrangements had been founded started to weaken. The large-scale rural to urban migration of young adults also destabilised the extended family and lowered the number of family members who could offer eldercare. The transition of employment to the industrial sector implied that the work schedules and working locations were not as flexible, thus, it became harder to balance employment and caregiving duties among family members. Nuclear family housing arrangements, when implemented in cities, had the effect of eliminating physical room in which elderly family members could have been accommodated, and the shift in social values started to give a challenge to the traditional belief that women should serve mainly as primary caregivers(5).

The initial involvement of the government in the area of eldercare was through the enactment of the Welfare Law of the Elderly in 1963 which laid down the principle that the government had a role to play in taking care of the elderly citizens. Yet, this act was mostly symbolic, setting some general principles without designing significant new programs or financing systems. The implementation of the law was confined to offering basic services to the elderly citizens who are not supported by their families as it was still presumed that family care was the practice, and government help was only relevant in extreme cases. The practice mirrored the larger shift in the Japanese

social policy around this time that focused on economic growth and industrial development but with very low levels of social welfare spending.

The oil crisis of 1973 and the economic difficulties after that stimulated a more orderly analysis of social welfare policies, of eldercare programs. In 1973, when the government declared its intention to provide free medical care to the elderly, it was a vital increase in the number of the aging population supported by the government but in this case, it was more of medical care than holistic eldercare services. This was a policy shift due to rising political pressures by an ever more powerful voting bloc of the elderly and an understanding that insufficient access to healthcare by the aging population posed more widespread social and economic issues. Nevertheless, the introduction of the free medical care among the aged elderly also indicated the constraints of the extension of the coverage without impacting on the structural issues relevant to service provision and funding.

The Health Care Law for the Elderly was the first effort in 1982 to deal directly with the specific healthcare requirements of aging citizens, using policy interventions that specifically targeted those needs. This law created specialized medical homes meant to offer both healthcare and daily lives services since it was observed that the elderly usually needed services that were not covered by the normal medical care, or the social welfare services. Another idea that the law brought is that of community-based care, which promoted the emergence of day-care facilities and home-visits which might assist the old citizens to stay in their communities instead of being institutionalized(6). These inventions were manifestations of increasing knowledge about the variety of the needs of older adults and the necessity to preserve their independence and social ties as much as possible.

In 1989, the Golden Plan served as a landmark in the Japanese eldercare policy by setting challenging targets on the development of the eldercare infrastructure and the services during the decade. It was the first organized effort to measure the requirements of elderly care and come up with an integrated approach of addressing them using a unified effort by the government. The plan set clear goals of adding more nursing homes beds, day-care facilities, home helpers and other eldercare facilities, and also recommended the significance of community-based services that may assist aging in place. Implementation of the Golden Plan necessitated dramatic increases in government expenditures and constituted a substantial growth of the role of the government in the provision of eldercare.

Although the Golden Plan had very high ambitions and high investments of its kind, its application exposed inherent shortcomings in the current policy towards eldercare. Such speed of demographic aging implied that the number of elderly people requiring eldercare services increased more rapidly than the government was able to increase supply, which resulted in constant shortage and waiting lists of the key services. Service planning and provision was centralized and therefore, it lacked flexibility and responsiveness to the local differences in needs and preferences and lack of user charges posed a moral hazard and inefficient use of resources. In 1994, the New Golden Plan tried to overcome at least part of these drawbacks by expanding targets again and enhancing coordination machinery, but the structural issues were not eliminated completely.

In the mid-1990s, it was now apparent that this incremental reforms of the current policy framework of eldercare would not be enough to tackle the scale of the demographic problems facing Japan. The economic downturn of the early 1990s had stretched government budgets and diminished political willingness to fund new social programmes of expensive benefit, and the ongoing acceleration of the ageing of the population placed growing strategic strain on the need to develop more effective and sustainable policy solutions. The establishment of the Long-Term Care Insurance model in Germany in the year 1995 had been a strong example of how the concepts of social insurance could be utilized in the financing of eldercare without losing fiscal sustainability and social solidarity. This foreign precedent, together with the intense domestic demand to reform eldercare, made the political climate in which the radical policy innovation embodied by the Japan Long-Term Care Insurance system could succeed.

3.System Structure and Coverage

The Long-Term Care Insurance system in Japan is a brilliantly shaping social insurance system that walks the fine line between being comprehensive and sustainable, developing a groundbreaking way of looking at the multifaceted issue of eldercare in a fast-growing ageing society. The architecture of the system shows that a thorough evaluation of the various needs of stakeholders, financial limitations, and administrative abilities has been taken into account, which leads to the multisided design that spreads risks, costs, and responsibilities on multiple levels of society without losing harmony of purpose and effectiveness of operations. The provisions of the LTCI system have an excellent knowledge of the diverse needs of elderly citizens evidenced in their coverage

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provisions which acknowledge that aging has multiple pathways and tracks and that it demands a versatile and individualized approach to solutions as opposed to a generalized one.

The population coverage of the LTCI system is based on two different types of insured individuals with different eligibility parameters, contributions and benefits coverage, that are indicative of different risks and needs at different life stages. The main target of LTCI services is primarily the elderly aged 65 and above who constitute the weaker segment of the insured category since they are the ones most at risk of developing the long-term care needs because of the deterioration of physical and cognitive ability as they age. The fact that the automatic eligibility of this group to receive LTCI benefits, independent of the specific cause of their need of care, is indicative of the fact that as people age they generate legitimate claims to social support and that to attempt to draw lines between the deserving and undeserving cases would be both administratively cumbersome and socially divisive(7).

The secondary insured individuals (those aged 40-64), have more restrictive eligibility requirements, which restrict access to benefits of LTCI to a limited set of circumstances related to age-related conditions, including dementia, stroke, Parkinson, and other degenerative disorders. Actuarial calculation of the likelihood of incurring long-term care services, political calculation of whether middle-aged workers are willing to pay to a system where they are not likely to receive immediate benefits reflects this age-based difference. Inclusion of the 40-64 age group into the LTCI system, even though they have minimal right to benefits, has a few valuable purposes: it expands the contribution base, increasing financial sustainability; it creates a stakeholder investment in the system success among a demographic group with significant political power; and it protects against the catastrophic care expenses of those who develop early-onset conditions that necessitate long-term care.

The benefit structure presented in the LTCI system demonstrates a high level of sophistication by considering the continuum of care needs that are faced by elderly citizens as they include the lowest levels of support, which are essentials of daily living, and the highest levels of support, that would be provided to the persons with severe cognitive and physical disabilities. Seven-level classification scheme, that is, Support Level 1 to the Care Level 5 system, offers the framework of the matching benefit entitlements to the assessed need levels, and the fiscal control is ensured by the graded benefit caps. This system of classification is much more appropriate than binary eligibility decisions which defined previous eldercare efforts and permits more complex evaluations that are capable of supporting the unique situations and paths of older adults.

The levels of support under the LTCI system are to offer preventive services that can be used to ensure that the functional capacity can be maintained and the stages of care dependency advanced or averted. The Support Level 1 and 2 individuals will get services that deal with functionality and loss of effectiveness such as exercise, nutritional counseling, social services, and a little housekeeping. This preventive mindset is indicative of the increased awareness that services to be provided to preserve functional capacity may prove less expensive than providing intensive care services when the decline has already become substantial, as well as more supportive of the interests of older citizens, who desire to retain their autonomy and status in the community.

Levels of care in the LTCI system offer increasingly intensive services to the people whose functional impairments include the significant assistance in activities of daily living, medical and social support. The graduated nature of care levels permits the matching of services to needs in an appropriate way and gives clear channels through which the level of benefits can be adjusted over time in response to changing circumstances of individual life. Care Level 1- includes simple help with personal care and home management and Care Level 5- includes a wide range of support of those with severe cognitive and physical disabilities that need intensive supervision and care. The ability of the system to increase or decrease the levels of benefits according to the periodic reviews is a guarantee that the individuals will be provided with the right amounts of support as their needs change and determines the avoidance of both under-provision and excessive supply of services.

The services portfolio of the LTCI system represents in-depth knowledge of the various support needs encountered by the elderly citizens, including home-based services, community-based programs, and the availability of institutional care that may suit various preferences, family situations, and care needs. Home-based services encompass personal care services, nursing services, rehabilitation therapy, and respite services that can help elderly citizens stay in their own houses and be assisted in the process. Structured programs like adult day care homes, short-term residential homes, and group homes are community-based services that allow the elderly citizens to receive care and social life albeit with some level of independence and social affiliations.

The focus of the system on home and community-based services is representative of cost-saving and appreciation of the wish of elderly citizens to age in the context of surroundings, family, and friends. The institutional care options in the LTCI system are to provide care to individuals whose care needs could not be adequately addressed by home or community settings, offering specialized environments with the right staffing, equipment, and programming to people with complex medical needs, severe cognitive impairments, or intensive care needs. The integration of the various modes of service in the LTCI system enables the development of a holistic system of care that would be flexible in addressing the evolving needs but would not violate the preference of the individual and family situation.

The administrative system of the LTCI assigns responsibilities to various levels of government and has well defined accountability mechanisms and coordination protocols which facilitate proper service delivery. In the LTCI, municipal governments act as insurers and the governments assume the role of collecting the premiums and administering benefits, assessing the needs, authorizing service and overseeing providers in their areas. Such a decentralized system enables the provision of local-level responsiveness and responsiveness to local preferences and circumstances, with national standards and coordination systems providing equity and quality in various regions.

4.Funding Processes and Sustainability.

Financial structure of the Japanese Long-Term Care Insurance programme is one of the most original and well-balanced methods of financing the eldercare services in the developed world and building a sustainable system that is able to distribute costs fairly throughout society, yet is both fiscally responsible and politically viable. The financing mechanisms of the system portray advanced knowledge of the economic dynamics of demographic aging, the political limitations of tax-based funding, and the behavioural incentives developed through the various cost-sharing arrangements. The financial design of the LTCI system tackles the major problem of financing elderlycare costs that are quickly increasing but still continuing to be publicly supported and eliminate the fiscal crises that have bedeviled other social insurance schemes in aging societies(8).

TABLE 1 Financing Mechanisms and Sustainability

Funding Source	Contribution %	Details	Purpose
Public Sector (50% Total)			
National Government	25%	General taxation	Fiscal stability, national standards, redistribution
Prefectures	12.5%	Regional taxation	Regional coordination, resource equalization
Municipalities	12.5%	Local taxation	Local administration, service delivery
Individual Premiums (50% Total)			
Primary Insured (65+)	~25%	Income-adjusted, paid to municipalities	Direct beneficiary contributions
Secondary Insured (40-64)	~25%	Income-based, collected with health insurance	Broader contribution base
User Cost-Sharing	10-20%	Of service costs (income-dependent)	Prevent overuse, maintain sustainability

The guiding principle of the LTCI financing is the equal share of expenses between the contribution of the public sector and individual premium payments, which makes a system that will maintain social solidarity and individual responsibility and guarantee that sufficient revenue should be collected to cover extensive benefits. Such a 50-50 cost-sharing plan represents a thoughtful political calculation regarding the limit on the amount of contribution different stakeholder groups would take, as well as establishing incentives to use services efficiently and provider behavior. The contribution of 50 percent by the public sector is further divided into the national, prefectural, and municipal governments with distribution of the fiscal load to different levels of government and guarantee of sufficient resources to run the system and the avoidance of excessive loads to a single governmental structure.

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The contribution of the national government of 25 percent in the funding of LTCI plays several significant roles in the overall architecture of the system, which are fiscal stability, guaranteeing national standards, and redistribution between the jurisdictions with various demographic profiles and capabilities to meet the various economic demands. Federal government subsidies are used to even out the balance of demographic aging in various areas so that areas with high populations of older adults do not experience the burden of demographic aging disproportionately and this may lead to service quality or care being compromised. Such a redistributive role is especially relevant in Japan, where rural districts generally possess larger shares of elderly population and of tax base than urban ones, and where there may be an imbalance in the capacity to provide sufficient eldercare provision(9).

The contributions of the prefectural and municipal governments, which amount up to 12.5 percent of LTCI total costs, generate stakeholder investment in system efficiency and effectiveness without losing the local governments a lot of influence on service planning and delivery. This multi-tiered system of government financing is indicative of the complex intergovernmental relations that Japan has and the traditional functions that the various levels of government played in the provision of social services. The local governments participation in LTCI funding provides the motivation of effective administration and proper service delivery since the local governments have the direct financial liability of excess costs or inefficient operations in their areas.

The amount of individual premium contributions in the LTCI system are not set up in the same way to cover the two classes of insured persons, since they have varying benefit eligibilities, risk profiles and paying abilities. Primary insured individuals (65 years and above) make income-adjusted payments directly to the municipal governments and the levels of the premium depend on the individual income as well as the systemic cost of delivering LTCI services in each municipality. This income-adjustment system will make sure that premium load is allocated on a progressive basis, with better off, elderly citizens paying more premiums but still ensuring that the poor in society can afford the premiums. The local difference in the level of premiums is based on demographic composition, service utilization model, and local-cost frameworks, which may be appropriately adjusted to local conditions without compromising national policy frameworks.

Those aged 40-64 (the secondary insured) pay LTCI premiums by using already existing social insurance programs, where the amount paid is collected with health insurance premiums and as a percentage of earned income. This collection mechanism can take advantage of the current administrative systems and minimizes the cost of compliance and also the wide inclusion in the LTCI system(10). The progressive distribution of costs in the income-based premium structure of secondary insured persons maintains the insurance principle of contributions having some relationship to the benefits which can be enjoyed by contributors, but because of the limited benefit eligibility of the age group the majority of the secondary insured persons are not making contributions to directly benefit themselves but to contribute to the current beneficiaries.

The LTCI system integrates user cost-sharing conditions that fulfill several key purposes in the overall financing system, such as to regulate moral hazard, to assure adequate use of services, and to promote financial sustainability and to provide price signals that can promote efficient provider behavior. The clients are expected to pay 10 percent (and in the recent reforms 20 percent) of the cost of covered services, and the rest of approved service costs is paid by the insurance system. This cost sharing mechanism balances access to services and avoiding excessive use of services and the income-based adjustment in cost-sharing rates, respectively, serve to ensure progressiveness in the financial architecture of the system.

5.Conclusion

The innovation of the Long-Term Care Insurance system in Japan is a pioneer in the history of social policy development that illustrated that complex, sustainable answers to the problems of population aging can be made by means of calculated systems of social insurance that strike a balance between conflicting goals both without compromising the wide support of stakeholders and economic accountability. The fact that the system has been successful in its work over twenty years already constitutes strong grounds to believe that demographic aging does not necessarily increase the likelihood of fiscal crisis, intergenerational conflict, or even worse quality of eldercare when implemented with careful policy design and implementation. The success of the LTCI system is hardly limited to Japan alone, but it presents many useful insights and inspiration to other countries facing the same demographic changes and aiming at creating their own models of providing elderly care in a sustainable way.

The underlying innovations inherent in the LTCI system such as its ability to integrate social insurance principles with market-based service provision and its multidimensional approach to meeting the needs of diverse elders, its complex financing system that equitably spread costs throughout the society, and its focus on consumer choice in proper regulatory contexts are valuable additions to the body of knowledge in the world on effective social policy design. Such innovations show that the old borders between the public and the private sector can be reimagined in a manner that brings the best of both worlds to the fore, and avoids the worst of both, forming new hybrid solutions that outperform either a fully public or a fully privatized model.

What the system has been able to achieve in terms of sustaining fiscal viability and achieving rapid expansion of service coverage and service quality offers important insights to policymakers in other nations where they are under pressure to make tradeoffs between coverage expansion and cost control. The LTCI system shows that these aims do not necessarily have to be conflicting provided that they are backed by the proper financing system, the efficient cost-sharing schemes, and the proper regulation systems that would promote efficiency without deterioration of the quality level. That the system could absorb such dramatic changes in the service demand and at the same time ensure that the cost growth remained within manageable limits, provides optimism that other countries are capable of overcoming their respective demographic burdens without necessarily hurting other more vital societal and economic goals.

The fact that the LTCI system focuses on aging in place and other institutional care options offered to the elderly who require them is a balanced solution that has the tendency of honoring the choices of elderly citizens without compromising cost-effectiveness and quality of service. This has been done by advanced service delivery schemes that incorporate home based, community based and institutional services into coherent care continuum that can respond to the evolving needs of individuals without the need to become unnecessary institutionalized. The success of this balance in the system leaves valuable lessons to other countries that aim to come up with their own eldercare systems in a manner that takes into consideration individual preferences without compromising on fiscal responsibility.

As the LTCI system looks into the future, it is still challenged by the trends of on-going demographic ageing, service demands, and technological developments as well as the fiscal pressures that will necessitate further adjustment and innovations of the system. The further rise in prevalence of dementia and other complex conditions that demand special care methods will require further building of service capabilities and staff training programmes. The introduction of emerging technologies, such as robotics, artificial intelligence, and telehealth systems, presents a chance to increase the quality and efficiency of services provided and resolve workforce shortages in the areas of eldercare.

The history of the LTCI system of a regular reform process indicates the necessity of incorporating adaptive capacity into social insurance systems at their inception and developing adjustment-based mechanisms that can react to the evolving conditions without necessitating the total overhaul of the systems. The governance mechanisms that exist in the system such as the frequency of review, stakeholder consultation mechanism, and evidence-based evaluation mechanisms offer examples to other nations that may wish to establish sustainable social insurance programs that may be developed effectively as time goes by.

The global impact of the LTCI system in Japan is expanding due to the international awareness of the applicability of the Japanese experience to the demographic issues and policy-making processes of other countries. Varying nations of Asia, Europe and other regions have examined different facets of the LTCI system in the prospect of adopting the system to meet their own demands and the international bodies have pointed at the system as the most pioneering scheme of new strategies in the face of population aging. This transnational awareness has helped to inform wider knowledge of the possibility of social insurance institutions to tackle complicated social problems whilst remaining economically viable and democratically acceptable.

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Conflicts of interest

The authors have no conflicts of interest to declare

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