《研究ノート》

The Effects of Long-Term Care Insurance Revision on Care Management

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The purpose of this study is to address policy revisions intended to maintain and enhance the quality of care management under the Long-Term Care Insurance System (LTCI).

Establishment and Revision of LTCI

Establishment of LTCI in 2000 changed the Japanese care system in several ways. First, the main source of revenue for care services shifted from taxes to insurance premiums. Second, it created a nationwide standard for regulating the amount of care services that one person can access. Third, various providers, especially for-profit providers, have recently become main care providers instead of municipalities and social welfare corporations. Fourth, the government has established the qualification of a care manager as one who supports the choice of care services.

Although LTCI is different from the previous care system, government planners did not have adequate time to prepare for the transition to the new system. Hence, it was mandated that LTCI should be amended every five years to adjust the balance between cost and services. In addition, the remuneration for care services have to be revised every three years.

In 2006, the primary revision was the introduction of new preventive services. These new services were intended to reduce care costs through the delivery of preventive services to the frail elderly in "Support Level 1 or 2" (needing support for daily activities). Newly institutionalized agencies, called comprehensive community support centers, have provided preventive care management services for the elderly. As a result of this amendment to LTCI, providers have had to release their information to enable users to select their services. Care managers must receive training if they wish to renew their qualifications. Simultaneously, the government revised the remuneration for community care services, lowering the remuneration for residential care services and increasing the remuneration for domiciliary services and care management.

In 2009, the government increased the remuneration for care services to address the shortage of care workers and introduced the LTCI-point addition system for care management.

Care Management and Care Manager under LTCI

Establishment and subsequent revisions have

greatly influenced care management in Japan.

LTCI, for example, has institutionalized the concepts of care management and care manager. Prior to LTCI, although some professionals (i.e. case workers in public offices, medical social workers, social workers and nurses of in-home care support centers, and discharged nurses) counseled their users and families, the number of such professionals was insufficient. Establishment of care management has enabled users who access LTCI to follow the guidance of their care managers.

In fact, an overwhelming majority of LTCI users have utilized supports from care managers to make decisions about services. Although some users and their families can manage by themselves, the number of such independent users has been limited. This reduction of independence has given care managers significant power to affect the quality of the individual care system.

The position of care managers in Japan is unstable. In contrast to care managers in the UK, who are generally employed by municipalities, the majority of care managers in Japan are employed by private providers. These private providers expect the care managers to be the intermediary between their services and users. As a result, it is difficult for the care managers to select services based on the wishes of the users.

Furthermore, many people consider care management to be a procedure that ties users to LTCI services. The background to this belief lies in the existence of LTCI system in Japan where the remuneration for care management is not paid when a person does not use LTCI services. This characteristic makes care management in Japan specific to LTCI services.

Little attention has been paid to these LTCI revisions and their effect on the quality of care management. Therefore, this article aims to discuss these revisions to care management since the enactment of LTCI.

Method

This article describes and analyzes the influences of LTCI revisions through the analysis of researches and articles for care managers and care management.

First, changes in the government's policies to maintain and improve care management since the enforcement of LTCI are reviewed. Next, the effects of these changes on care management, especially care managers' activities and their working conditions, will be discussed.

State's Measures for Care Management since the Enactment of LTCI

Since the enactment of LTCI, the government has enforced the following measurements.

Establishment of Care Manager Certification and Training

After the enactment of LTCI, the government established the national qualification of care managers. New categories of "care managers" were created that required the licensing of doctors, nurses, certified social workers, and care workers, with over five years of experience in health and welfare fields, as

well as passing the national examination. These categories were created in order to support LTCI users in selecting care services. So far, over 400,000 professionals have acquired the qualification of a care manager. However, many of them do not work as care managers because working conditions of care managers are worse In addition, to secure competent care managers, the government introduced the continuous training system for those who wish to renew their qualifications.

Increasing the Remuneration for Care Management and Introducing LTCI-Point Addition

Soon after the establishment of LTCI, many care managers had about 50 to 100 users, as the remuneration for care management was too low to make a profit. Their heavy burdens for responsibility and low level of care management became social issues. In 2006, the government raised the remuneration for care management per user (Care Level 1,2,3,4, or 5). However, the remuneration for users certified as "Support Level 1 or 2" that accounted for about 35% of LTCI users was reduced by one third.

Furthermore, LTCI-point addition of care management was introduced; LTC-point addition for special providers, cooperation with medical services, dementia users, users who live alone, and initial care management.

Since 2006, regulations of the remuneration have been tightened. Care managers are limited to 35 users classified as "Care Level 1,2,3,4 or 5" and 8 users classified as "Support Level 1 or 2." In light of this, if a single care manager takes charge of more than 40 users, the remuneration for all users can be reduced. This system, however, was recently changed. Currently, if a care manager takes charge of more than 40 users, the remuneration for users over 40 might be reduced. In addition, if over 90 percent of services are delivered by some fixed providers, such as same groups of care management providers, the remuneration for care management will be reduced.

Standardizing the Care Management Process

Many care managers have been employed by for-profit service providers. These care managers were often forced to persuade their users to apply their providers' care services. Consequently, it has been difficult for care managers to support users' selections for services based on users' actual needs. To address this fact, the government mandated that the remuneration for care management would reduce if care managers excessively mediated some service providers to users without justification.

Influential in this amendment was the "COMSON Scandal," where one of the biggest for-profit providers at the time had applied for the remuneration illegally. In June 2007, the government penalized them heavily and consequently they shut down. Since the "COMSON Scandal" was discovered, municipalities have made on-site inspections and audits intensively. If they discover providers applying for the remuneration illegally, providers will have to pay back the remuneration. In cases of repeating violations, such providers might not be allowed to

deliver care management services as a designator of LTCI.

Organizing the Consultation System in the Comprehensive Community Support Centers

In 2006, the government introduced the comprehensive community care support centers to enhance local residents' health and welfare. The comprehensive community care support centers were established by municipalities for every district with a population of 20,000 to 30,000 people. These centers are staffed with a team consisting of a certified social worker, a public health nurse, and a chief care manager. Their main programs are 1) preventive care management, 2) prevention of abuse for the elderly and protection of right for the elderly and other supportive services, 3) support for comprehensive and continuous care management to supervise care managers in districts, creating networks among care managers, and 4) coordination between various professionals who support seniors. To improve care management, chief care managers supervise care managers employed in private agencies of districts, and give advice against hard-to-support users.

Influences of LTCI System Revision upon Care Management

In this section, I would like to examine how these revisions have influenced care management providers and care managers' activities.

Influences of LTCI system revision upon care management providers

Decrease in Incomes

Since the enactment of LTCI, many people have pointed out that the remuneration for care management has been lower than the remuneration for other care services. Therefore, providers have filled for a deficit that was caused by care management and by delivering other care services.

Although the government raised the remuneration for care management per user in 2006, incomes of many providers have decreased, because comprehensive community support centers took charge of preventive care management for many users certificated as "Support Level 1 or 2" instead of care management providers. Care management providers can take charge of preventive care management for 8 users at the maximum, but the remuneration for preventive care management is less than half of care management.

In 2006 and 2008, the government introduced LTCI-point addition of care management for some classifications of users. This system has enabled providers who can call on medical services from hospitals to ensure stable incomes, because many LTCI-point additions are applicable to support users in critical conditions. In contrast, providers who take charge of slightly handicapped users have been in financial difficulties (Tanaka 2008a: 16-7). Thus, care management has become less profitable than before. As a result, the number of care management providers has been decreasing, and providers

have cut off care managers' wages. While nurses of care managers have decreased from 57% to 29% since 2001 to 2007, certified care workers have increased from 44.7% to 55.2% (Hattori 2008: 38-9).

Providers' Voluntary Control

Municipalities' policies of strict on-site inspections and audits have controlled providers to deliver services at their own discretions (Tanaka 2008b: 17). Providers have felt stronger anxiety about suffering potential damages when insurers order providers to pay back their remunerations. Hence, it is more difficult for providers to respond flexibly and develop new resources to meet the needs of users' and community.

Weinberg et al. (2003: 915) pointed out that financial controls in the UK may have developed serves passively. Similarly in Japan, controls of the remuneration for care services, through the strict on-site inspections and audits, are also inhibiting the development of positive activities by the providers.

Influences of LTCI System Revision upon Care Managers

Standardized Care Management Process

These policies have standardized care management by controlling care managers' activities. Care managers must record users' conditions in detail, for the purpose of giving clear evidences for continuing or changing users' care plans. Even care managers who are not experienced and trained well can work based on the standard.

For example, a care manager must visit the home of a user once a month for monitoring and prepare a record. As a result, procedures for monitoring became clear not only for the insurers (the municipalities) and their users and families, and other care team members.

Increased Care Managers' Workloads and Decreased their Discretion

On the other hand, the standardized care management process has increased workloads while decreasing autonomy.

Care managers must monitor care plans and hold care conferences, but they spend less time on counseling and assessment. Baba (2008: 20-2) clarified that care managers spend much more time monitoring, completing paperwork, and recording.

In addition, the strengthening of regulations by the Ministry of Health, Labor and Welfare has spoiled the care management principle (Fujisaki 2009: 55). When providing services according to individual user needs, in the event that services are mediated that exceeds the limits imposed by regulations, it is required to contact and confirm with the municipalities and clearly record the grounds for their judgment in each case. Consequently, these procedures have been a significant burden for care managers.

Payne (2009: 145-146) revealed that due to each regulation, assessment and monitoring became a routine and the discretionary powers of individual care managers in the UK are being reduced. Unlike care managers in the UK who are employed by the municipalities, care managers in Japan are employed by private providers. However,

they are not free to act as employees of private providers, but rather they face exactly the same situation as in the UK in which their discretionary powers are curtailed by government regulations.

Burn-out and Resignation

There changes may have influenced care managers' psychological conditions. For example, Ochi and Kaneko (2008) used the "Burn-out Inventory" to compare care managers' psychological conditions in 2004 to those in 2007. This research showed that care managers suffered from greater burnout in 2007 than 2004. Their intentions to change their jobs were especially stronger. Ochi and Kaneko speculated that these deteriorating conditions might have been caused by voluminous paperwork, complaint procedures against the new system, and terminating relationships with their users.

In general, care managers wish to establish close relationships with their users and solve their problems from a user-centered perspective, but they have not achieved ideal care management, and their enthusiasms for jobs have been dulled by such stressful conditions. Yuki (2008: 220-1) pointed out that many care managers have worked alone and they have less opportunities to obtain advice from senior care managers. Such severe and lonely working conditions accelerate their burn out. Consequently developing skilled care managers is difficult.

The Merits and Demerits of Certified Care Workers Becoming Care Managers

The aforementioned deterioration in the employment conditions of care managers is causing a change in the basic qualification of care managers. In 1999, when the care manager qualification test was held for the first time, nurses (including junior nurses) constituted the majority of the successful candidates (>30%). Subsequently, the percentage of nurses began to decline and by 2009 they constituted only 10.0% of the successful candidates. Conversely, in 1999 approximately 30% of those who passed the exam were certified care workers, but this percentage began to increase and by 2009 they constituted the largest group at 66.0%. Certified social workers constituted 9.3% and certified psychiatric social workers 1.1% of those who passed the test in 2009 (The Center of Social Welfare Promotion and National Examination 2009).

The basic qualification of care managers in the UK and US is intended for social workers and nurses. Conversely, in Japan there is a perception that becoming a care manager is a method by which certified care workers can advance their careers. This perception is becoming increasingly widespread within society and especially among certified care workers.

From the perspective of supporting users' daily lives, when certified care workers become care mangers, they are able to perform care management. In contrast, care plans created by certified care workers tend to focus on users' physical care needs and in

many cases it is difficult to distinguish them from a home care service plan.

Furthermore, as the majority of certified care workers lack the requisite level of medical knowledge, there are a many instances when they are unable to conduct a proper medical assessment of users. In addition, certified care workers are not accustomed to cooperating with doctors and medical professionals. As a result, it has become difficult for them to cooperate with medical institutions for users who are highly dependent on medical treatment.

From the perspective of social work, certified care workers acting as care managers tend to focus on users' physical needs and neglect their social needs. Furthermore, they often concentrate their energies on users and their families with a micro perspective. Consequently, it is difficult for them to perform care management that includes developing social resources and constructing community networks.

In the current situation, it is problematic for care mangers working for private providers to develop social resources and to construct community networks. Therefore, it is hoped that the comprehensive community support centers that was newly established in 2006 will be able to maintain a care system in communities. Such circumstances will be examined in the following paragraph.

Insufficient Support by the Comprehensive Community Support Centers

As a measure to support care managers under serious conditions, the government established the comprehensive community support centers. One of the roles of these centers' roles is support for comprehensive and continuous care management to supervise care managers in districts. Nevertheless, they cannot adequately support care managers for certain reasons.

First, professionals in the comprehensive community support centers have been overwhelmed with preventive care management and they have not been able to allocate time and effort for the support and supervision of care managers (Tsutsui and Muramatsu 2007: Yamanoi 2007).

Second, some chief care managers in the comprehensive community support centers are not sufficiently competent to supervise care managers. One care manager said the following;

> *This Municipality decided who would manage the comprehensive community support center, examining only a scale of corporation [and did not consider competence of the chief care manager]. The chief care manager was not so experienced, and had not completed a training course for the chief care manager recently. When I submitted her a preventive care plan that the comprehensive community support center had entrusted to us , she described pointless wording as a comment, just like 'Strengthen watching'* (Tanaka 2008a: 15).

Municipalities often entrust administration of comprehensive community support centers to large-scale corporations that own many

facilities and/or have existed for a longer time in the district, without considering care managers' competences.

Gap between the Remuneration and Difficulties in Care Management

The remuneration for care management is higher, as users' care levels are worse. Additionally, the government introduced LTCI-point addition system for the remuneration. Some care managers, however, pointed out that care managers' labors might not be proportional to users' care levels.

Shimonomoto (2006: 16), a care manager and administrator of a stock company, described difficulties in care management for 'Support Level' users;

> *It is good for us to pay much money for care management of severely handicapped, but I'm not satisfied to evaluated slight in preventive [care management] (…) Actually, managing severely handicapped is rather easier. Their needs are fixed and their family members must be prepared for serious situations. We can adequately cope with their problems through delivering services, without intensive social work. For those slightly handicapped, care managers have to coordinate introductions in which each staff member has to deliver their services. That is so time-consuming* (Shimonomoto 2006: 16).

As described above, it is easier for care managers to introduce care services to severe users, because their needs are similar. On the other hand, support level users' needs are diverse and can often consume care managers time for coordinating services with users' needs.

Furthermore, social environmental factors have often affected care management. Yamanoi (2009: 36) pointed out that the extent to which the community is equipped with resources influence care management as well as users' characteristics. Even if users have similar needs, the difficulty of care management depends on whether or not there are organizations and professionals within the community with sufficient capabilities to deal with such users. However, under LTCI-point addition system, conditions of social resources in communities are not being considered.

Conclusion

Revisions to LTCI have standardized care management procedures, through the government's strict control. On the other hand, care managers are frequently unable to do their jobs autonomously, and many of them have suffered from burnout.

As a result, care managers do not stay at their positions for very long, and the quality of care management has been worse.

＊本研究は，平成22年度科学研究費補助金（基盤（B））「福祉サービスの質の確保のための規制・評価・情報システムの総合的研究」（研究代表者　平岡公一お茶の水女子大学教授）の研究成果の一部である.

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