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Summary

Japan's demographic profile is rapidly changing due to its low birth rate and its unsurpassed longevity. On the other hand, the family's caring capacity for the elderly is weakening because of a changing of household structure, a change of consciousness for supporting parents, and an increase of working women. In response to these problems, the Ministry of Health and Welfare is constructing a new nursing care system which focuses on promoting home health care through the New Gold Plan and the establishment of a public nursing care insurance system. In Northern Europe and the U. S., senior housing with home health care services is playing a significant role as an efficient and effective long-term care option for the elderly. In the U.S., CCRCs (Continuing Care Retirement Communities) has been evaluated as a new senior housing program. In Japan, the preparation of senior housing has been far behind the need and more senior housing is needed in order to deliver quality of care and control health care costs. CCRCs should be a significant model in preparing senior housing programs which will be key for home health care for the elderly in the future of Japan.

Key words : Long-term Care, Continuing Care Retirement Community, New Gold Plan, Health Policy

Introduction

Japan's demographic profile is rapidly changing due to its low birth rate, 1.50, and its unsurpassed longevity, 76.57 years old for men and 82.98 for women in 1994[17][18]. An unprecedented number of people have entered and are continuing to enter the 65 and over age bracket. No other country has experienced such phenomenal growth in this sector of the population. At the same time, as the number of dependent elderly increases, it has strained the government's financial burden for long-term care[17]. As a consequence, the government has been focusing its attention on issues related to access, cost, and quality of services for long-term care.

Traditionally care for the elderly has been a family responsibility and specifically housewives have been the main care-givers. However, this trend is changing. The family's caring capacity for the elderly is weakening because of a changing family structure and consciousness for supporting parents. In addition, the number of working women is increasing[6][25]. As this trend towards a decreasing care-giving capacity rises, the problem of nursing care for the elderly is a serious social problem in Japan[17].

In response to these problems of the elderly, a Ten-year Strategy for Promotion of Health and Welfare of the Elderly, so called Gold Plan, was established by the Ministry of Health and Welfare in 1989. The Gold Plan was revised as the New Gold Plan in 1995 after a comprehensive investigation in which over 3,000 local governments were surveyed about elderly care needs. Even if the New Gold Plan is accomplished, however, the capacity to provide elderly care is insufficient[10][18]. Furthermore, because of great concern for elderly nursing care, a public nursing care insurance plan is being discussed to finance the increasing health care cost of the elderly[6][12][27].

There are two ways to approach elderly nursing care services. The first way is to construct a supporting system for the elderly to encourage independent living as

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long as possible with quality care. The second is to make efficient and effective use of finite social resources for health care delivery.

In order to construct a new elderly nursing care service system, senior housing and home health care services should be promoted as they have been effective and efficient in the U.S. and Northern Europe. Both the U.S. and Northern Europe have experience with an aging society and have provided health care infrastructures and systems for the elderly ahead of Japan[13)23)]. Moreover it is also important for the system to provide continuing care services in response to the changing needs of the elderly.

In the U.S., there are various senior housing programs which can be divided into three functions[4)20)]. First is independent living which provides minimum living support services. Second is assisted living which includes helping residents with bathing, dressing, taking medications and other daily activities. Third is a CCRC (Continuing Care Retirement Community) which provides the full continuum of services from independent living to nursing care.

The research for this paper was accomplished by reviewing the literature on CCRCs and long-term care and interviewing various specialists such as developers, health care consultants and financial specialists. The current status and problems with the introduction of CCRCs in Japan have previously been introduced by these associated authors[14)]. In this paper, health care conditions and long-term care facilities in the U. S. and Japan are compared. Then features and trends of CCRCs including financing, marketing, and management of CCRCs are discussed. Finally, a Japanese style CCRC model with continuing care services centering around a "Care House" is proposed.

Health Care Conditions in the U.S. and Japan

The U.S. population aged 65 and over exceeded 10% of the total population in 1975 and was 13.1% in 1995[26)]. (Table 1) The ratio of the U.S. medical expenditures to the GDP was over 12%, nearly double that of Japan's 6.5 % in 1990[24)]. Moreover, the ratio of the U.S. medical expenditures for the elderly to total expenditures was about 30% in 1976, and it is estimated that the ratio will be 43% in 2030[5)].

Japan's population in the 65 and over bracket was 10.3 % of the total population in 1985 compared with it's current 14.5% in 1995. This is nearly four times the growth rate of the U.S. population in this same category for the same period. It is expected to be 25.8% in 2025[17)] (Table 2). There are two noteworthy features in Japanese population changes : One is that proportion of the aged at its peak is expected to be higher than any other country and the other is that the rate at which society is aging is much faster than any other country. If we compare the length of years for the proportion of the population aged 65 and older to grow to 14% from 7%, it will take 130 years in France, 85 years in Sweden, 70 years in the U.S., and only 25 years in Japan[11)]. Therefore, Japan's time is limited to prepare for its aging society.

The matter is more serious in Japan because of the increase of the so-called "old-old" or frail elderly population, who tend to be sick and need more social support. The proportion of the population over 75 years was 3.9% in 1985, is projected to be 14.5% in 2025. Therefore, the number of dependent elderly people will

Table 1. Population Changes in the U. S. Elderly

	Population (million)			% to Total Population	
	Total	65≦	75≦	65≦	75≦
1980	227.8	25.7	10.1	11.3	4.4
1985	239.3	28.5	11.5	11.9	4.8
1990	249.7	31.7	13.7	12.7	5.5
1995	259.6	33.9	15.4	13.1	5.9
2000	268.0	34.9	17.2	13.0	6.4
2010	284.0	39.2	18.8	13.8	6.7
2020	296.6	51.4	21.7	17.3	7.3
2025	300.6	57.6	25.5	19.2	8.5

Source : Noguchi and Wise[26)].

Table 2. Population Changes in the Japanese Elderly

	Population (million)			% to Total Population	
	Total	65≦	75≦	65≦	75≦
1980	117.1	10.6	3.7	9.1	3.1
1985	121.0	12.5	4.7	10.3	3.9
1990	123.6	14.9	6.0	12.1	4.8
1995	125.5	18.2	7.1	14.5	5.7
2000	127.4	21.7	8.7	17.0	6.9
2010	130.4	27.7	13.0	21.3	10.0
2020	128.3	32.7	16.0	25.5	12.5
2025	125.8	32.4	18.2	25.8	14.5

Source : Ministry of Health and Welfare[17)].

more than double from 200 million in 1993 to 520 million in 2025[17] (Table 3).

In Japan, the medical expenditures in 1993 were more than 24 trillion yen, 7.3% of the GDP. However, the medical expenditure rates are exceeding national income and the GDP. In addition, the medical expenditures for the elderly were over 30% of total expenditures and the rate is still increasing with the rapid aging of Japan[17].

In terms of Japanese care patterns for the elderly, it has been quite common for family members to take care of the elderly at home. This is still a prevalent pattern in rural regions. However, during last half of the century, especially after the beginning of Japan's rapid economic growth, there have been several changes. One is the change of household structure. The number of single units has increased. On the other hand, extended family units, which is the immediate family unit plus either grandfather or grandmother or both, have decreased. The problem is that the elderly, especially elderly single households, have increased to 13.3 % of the total units in 1994 from 4.9 % in 1975 and are expected to continue to increase[17]. The other change is that many housewives, who have been the main care-givers for the elderly, are increasingly finding employment. Another problem is that there is not enough space to take care of the elderly at home, especially in urban areas[16][17]. Therefore, since the role of the extended family in caring for the elderly has deteriorated, more comprehensive support services for the elderly will be needed in Japan.

Long-term Care Facilities in the U.S. and Japan

In the U.S., almost 20% of the dependent elderly are institutionalized and the nursing homes dominate institutional long-term care services and are most closely associated with the dependent elderly[9] (Table 4). About one out of twenty elderly aged 65 and over reside in nursing homes at any one time although most of the elderly live outside institutions. For those over 75, however, the ratio increases to one in ten. In addition to nursing homes, there are two chief types of institutional care services for the elderly : hospital-based services and senior housing.

Nursing Homes

Until 1989, nursing homes were classified as either skilled nursing facilities (SNFs) for Medicare or Medicaid reimbursement or intermediate care facilities (ICFs) for those covered by Medicaid. The SNFs were designed to provide a higher level of care to sicker patients and therefore required a licence nurse on duty 24 hours a day and a registered nurse on day shifts. ICFs were considered to provide a lower level of care, more custodial than clinical, and were required to have a licensed nurse on duty only during the day. In practice, the distinctions between SNFs and ICFs always have been artificial because both types of facilities have served persons with a wide range of needs that often fluctuated between the definition of the two levels of care. When the Nursing Home Reform Act passed, it eliminated the difference in staffing levels and mandated that ICFs provide the same range of services as SNFs. In 1990, all nursing homes were referred to as nursing facilities (NFs)[4].

Although nursing home care is most closely associated with long-term care, only a small minority of the elderly

Table 3. Ratio of the Number of Nursing Home Beds to the Dependent Elderly People in Japan and USA

	A	B	C=A/B	D	E
	Polulation		% of Dependent	Number of	% of Nursing Home
Year	65≦	Dependent Elderly	to 65≦	Nursing Home Beds	Beds to Dependents
	(in thousands)	(in thousands)		(in thousands)	
Japan[a]					
1995	18, 226	2, 000	11. 0%	194	9. 7%
2000	21, 699	2, 800	12. 9%	290	10. 4%
2010	27, 746	3, 900	14. 1%	290	7. 4%
2025	32, 440	5, 200	16. 0%	290	5. 6%
USA[b]					
1985	28, 500	6, 909	24. 2%	1, 505	21. 8%

[a]Source : Ministry of Health and Welfare[17].

[b]Source : Allen[9].

are in nursing homes. In 1985, of the 28.5 million people aged 65 and over, 5% or 1.3 million lived in nursing homes. In 1986, there were 16,388 nursing homes with 1,504,683 beds and 1,380,777 elderly living in the U. S[9] (Table 5).

Hospital-Based Services

Because of the national decline in the U. S. hospital occupancy rates, hospitals began looking for new services or conversion of existing facility space to more profitable use than general acute care. A 1985 survey found that 24% of hospitals owned SNFs, 12% owned ICFs, 33% provided home health services, and 14% provided homemaker services[4].

Senior Housing

Housing is increasingly recognized as playing a significant role in the continuum of long-term care services. For example, the availability of affordable and appropriate housing for the elderly, particularly for those who are dependent, determines the need for institutional long-term care services in the community.

Housing programs and resources for the elderly can be at either end of the continuum. At one end are programs that are geared toward enhancing independent living and keeping elderly people in their home such as home equity conversion plans, home repair, and shared housing. At the other end are semi-independent and shared arrangement such as congregate housing and board-and-care homes and nursing home care. A newer approach, CCRCs, provide the full continuum of services from independent living to SNFs. CCRCs are discussed later in detail[3][4].

In Japan, the government has taken a more active role in encouraging the development of facilities for the long-term care of the disabled elderly people under the New Gold Plan than the Gold Plan[28]. There are currently three types long-term care facilities other than geriatric

Table 4. Projection of Daily Volume of LTC Assistance, by Source of Assistance in USA

	Source of assistance (in thousands)					Dependent
	Instituition	Spouse	Offspring	Other relative	Non-relative	Elderly Total
1980	1, 187	1, 442	1, 436	1, 213	655	5, 933
	(20. 0%)	(24. 3%)	(24. 2%)	(20. 4%)	(11. 0%)	
1985	1, 411	1, 612	1, 701	1, 414	771	6, 909
	(20. 4%)	(23. 3%)	(24. 6%)	(20. 5%)	(11. 2%)	
1990	1, 623	1, 801	1, 950	1, 610	880	7, 864
	(20. 6%)	(22. 9%)	(24. 8%)	(20. 5%)	(11. 2%)	
1995	1, 861	1, 953	2, 232	1, 814	1, 003	8, 863
	(21. 0%)	(22. 0%)	(25. 2%)	(20. 5%)	(11. 3%)	
2000	2, 081	2, 049	2, 484	1, 989	1, 110	9, 713
	(21. 4%)	(21. 1%)	(25. 6%)	(20. 5%)	(11. 4%)	
2020	2, 805	2, 976	3, 392	2, 728	1, 530	13, 431
	(20. 9%)	(22. 2%)	(25. 3%)	(20. 3%)	(11. 4%)	

Source: Allen[9].

Table 5. Nursing facilities in USA, 1986

Number of nursing and related care homes, beds, and residents, by type of home

Type of home	Homes	Beds	Residents
		Number	
All homes	26, 380	1, 767, 497	1, 609, 419
Nursing homes	16, 388	1, 504, 683	1, 380, 777
Hospital-based facilities	734	60, 983	56, 166
Residential facilities	9, 258	201, 831	172, 476

Source: Allen[9].

Table 6. New Gold Plan and Results

	Gold Plan	New Gold Plan	1994	
	Targeted#		Attained #	Attained %
Special Nursing Home	240, 000	290, 000	210, 000	72%
Health Facility	280, 000	280, 000	109, 000	39%
Care House	100, 000	100, 000	6, 853	7%

Source: Ministry of Health and Welfare[18].

hospitals : special nursing homes, health facilities for the elderly, and care houses[10)17)] (Table 6).

Special Nursing Homes (Target : 290,000 beds)

A special nursing home is a government recognized and controlled residential care facility for the elderly and provides nursing care to bedridden persons 65 and older who need 24-hour care because of mental and physical handicaps but cannot obtain proper care at home. Users are admitted to an institution by the heads of municipalities respecting the will and physical and mental conditions of the elderly. There were about 210,000 beds in 1994. Less than 75% of the development budget for these special nursing homes is sponsored by the central and local government.

Health Facilities for the Elderly (Target : 280,000 beds)

A health facility for the elderly has been introduced only in the past seven years and is an institutional category between special nursing homes and geriatric hospitals. These are rehabilitation facilities with stays limited to three months for patients who need functional training and nursing care but not medical treatment. There were about 109,000 beds in these facilities in 1994. However, this type of institution is targeted for expansion. Less than 30% of the budget is sponsored by the government.

Care Houses (Target : 100,000 units)

In 1989, in order to accept the elderly after rehabilitation or nursing care from a health facility for the elderly, a "Care House", a senior housing, was establish -ed. Less than 75% of the development budget is sponsored by the government. Care houses function to meet emergencies as well as counseling, bathing and meal services. Home care services such as accepting home helpers from outside will be introduced as the countermeasure to cope with the weakening or worsening of residents' ADL (Abilities of Daily Living). There were 6,853 units in 1994.

Continuing Care Retirement Community (CCRC) in the U.S.

A Continuing Care Retirement Community (CCRC) is an organization that provides housing, residential services, and health care services to retired people. A CCRC is distinguished from other retirement options since it offers a long-term care contract that provides for housing, services, and health care, including long-term nursing care. The contract is a legal agreement that secures the housing and services over the long term, usually for the rest of the life of the resident. For these services, the resident pays an initial entry fee and an on-going monthly fee[2)3)14)].

Since the elderly plan to live in the CCRCs until the end of their life, CCRCs must be financially successful to keep its continuous quality services. A chief executive officer in a CCRC development company said that his job is like a long-term care insurance company because of the importance to provide all life long services to residents.

These continuing care contracts have been classified into three basic types : all-inclusive, modified, and fee-for-service. First, an all-inclusive contract includes shelter, residential services, and amenities. It also offers long-term nursing care for little or no substantial increase in monthly payments, except normal operating cost and inflation adjustments. Second, a modified contract includes shelter, residential services, and amenities. However, only a specified amount of long-term nursing care is provided for little or no substantial increase in monthly payment, except normal operating cost. Finally, a fee-for-service contract includes shelter, residential services and amenities, and emergency and infirmary nursing care. Access to long-term nursing care is guaranteed, as it may be required, at full fee-for-service rates[1)].

There were twelve U.S. states that had some form of

regulation on CCRCs in 1984, and twenty-one states in 1987. Today, thirty-five states regulate CCRCs. More states are expected to implement regulations affecting the level of board and care that must be provided. Therefore, the CCRC regulations are undergoing rapid changes and being implemented at a fast pace[1].

In general, there are three arguments for this type of regulation : First, the type of regulation appears more suited to state administration than to federal supervision because of the detail required and the nature of this matter. Second, CCRCs are still relatively new and it would be advantageous to encourage the variety of regulation programs that would develop at the decentralized state level. Third, jurisdictional problems exist whenever the federal government attempts to regulate local institutions.

Most states require certification prior to contracting with residents. The certification requests adherence to basic standards and the application by the CCRC to some state authority. Statutes also govern the regulation of financial aspects of continuing care, such as escrow provisions and reserve requirements. Some states also request reserve requirements that are designed to be maintained for some emergency conditions. Many states mandate that full financial disclosure must be made to prospective residents. Financial statements and annual reports must be made available to interested customers as a minimum requirement.

Trends of CCRCs in the U. S.

It was estimated that there were about 900 CCRCs and more than 200,000 elderly people living in CCRCs in 1991. The entrance and monthly fees for retirement housing depends mainly on the type of agreement and the breadth of independent living[14].

CCRCs have to respond to increased regulation and greater competition. CCRCs that had planned to gradually increase residents' fees are facing increased competition from home health care companies and from formerly distressed facilities that have been acquired at bargain rates.

An increase in CCRC rentals is expected, which bypasses the need for residents to pay a hefty entrance fee and avoids problems with amortization. In addition, more CCRCs are unbundling packages of services so they can better match the needs and budgets of potential residents.

According to the survey and analysis by American Association of Homes for the Aging(AAHA), there are about seven emerging trends[1)3)]. First, as to contracts, new CCRCs and some established CCRCs are blending the all-inclusive and fee-for-service concepts into a modified continuing care plan that covers some services and care and makes others available for a fee. These CCRCs retain the case management approach associated with continuing care to keep health care costs down for everyone.

Second, the style of new CCRCs is a combination of single-level and low-rise buildings generally located in suburban settings. Newer CCRCs are building fewer studio units, about the same number of one-bedroom units, and the same number or slightly more two-bedroom units.

Third, on special features and amenities, new CCRCs have retained many of the special features one expects from continuing care, including an activities director, barber shop, beauty salon, cable TV, crafts program, guest accommodations, library, and resident association. New CCRCs are less likely than older ones to have a chapel or to conduct religious services. They are also less likely to have exercise programs, game or billiards facilities, a master TV antenna or a pharmacy. On the other hand, they are more likely to provide a coffee or snack shop, fireplaces, a private dining room and catering, a sauna, spa, or whirlpool, and indoor or outdoor swimming pools.

Fourth, concerning entrance fee refunds, new CCRCs are shifting away from declining refundability plans toward refundable entrance fees fully or partially and unconditionally. They are more likely to require a deposit to reserve an independent living unit ; typically, that amount is 10 percent of the entrance fee, although other percentages and dollar amounts are also reported by some.

Fifth, in terms of residential services, monthly fees in new CCRCs typically include one meal daily and usually include apartment cleaning, laundering flat linens, kitchen appliances, and extra storage. These fees are more likely than fees in older CCRCs to include carports or garages and personal laundry facilities.

Sixth, as for assisted living units, the majority of CCRCs are not initially building personal care or assisted living units. However, new CCRCs are more likely than those opened during 1974-1984 to include personal care in the independent living units. New CCRCs plan to add assisted living units as their resident populations age.

Finally, as to nursing care units, new CCRCs tend to have more nursing care beds than older CCRCs. For the most part, health-related services are available for a fee and not included in the continuing care contract. This represents a general shift away from all-inclusive contracts to modified and fee-for-service contracts among new CCRCs.

Finance, Marketing, and Management in CCRC

In terms of finance, CCRC developers in general are financing from charitable contributions, short-term and long-term debts, and taxable or tax-exempt bonds. However, in order to access the tax exempt bond market, the owner of a retirement community must be a not-for-profit organization unless the proposed project qualifies for tax exempt "housing bonds" by incorporating the required number of residential units specifically set aside for individuals who qualify as having low or moderate incomes[2)3)].

The governing body of a not-for-profit corporation, usually a board of trustees, must have broad knowledge and experience in health care services to the elderly, and the development and construction of real estate projects.

In addition to a high quality board, the project should be formally affiliated with a sponsor organization. The sponsor organization must be an existing provider of similar services that has a favorable reputation and sound financial history, and have a specific constituency from which it can draw residents. Some examples of appropriate sponsors are a religious group, a fraternal organization, the military, and a hospital or health care system.

Generally residents finance entrance fees by selling their houses. Therefore, in pricing, it is important for a CCRC to set the price at the average value of houses targeted in a market region.

As for marketing, in every developing plan of a CCRC, a feasibility study is imperative. The feasibility study must include financial projections and a comprehensive market study which forecasts residential and health care center occupancy levels[1)2)]. Marketing would be a very difficult concept or methodology for Japanese because the definition of marketing is generally restricted solely to promotion and advertising. Marketing is an integrated planning and decision-making process that involves finding out what the customer wants and needs, and fulfilling those needs better than anyone else, while meeting financial objectives[2)].

Marketing is a complex combination of marketing key decisions. In order to introduce a new service, marketers must make at least a dozen key marketing decisions. These include : (1) market target, (2) positioning, (3) product design, (4) pricing, (5) distribution type and level, (6) advertising message, (7) media spending, (8) media mix, (9) media schedule, (10) promotion spending, (11) promotion mix, and (12) promotion schedule.

As to management, CCRCs developers must learn two management issues; first is how to develop a CCRC and second is how to run a CCRC. Accordingly, management of a CCRC might be considered a two phase operation with pre-opening and post-opening activities. Pre-opening activities include recruitment of staff, coordinating project readiness in terms of construction-related items, maintaining marketing activities with a focus on occupancy, preparing manuals and resident handbooks, establishing budgets and accounting policies, and coordinating with state and local officials to ensure that the project obtains all required permits, licenses and approvals.

Post-opening activities include employment of staff, maintaining financial controls and accounting services, providing administrative services, implementing housekeeping, maintenance, dietary, and laundry services, coordinating and supervising including the provision of health care.

Among the various characteristics of management, quality is especially important because almost all services in a CCRC are provided through human resources. Therefore it would be necessary to maintain the quality of management. It would mainly depend on education and training, so they are especially important.

For example, a traditional CCRC in Pennsylvania has long been committed to the development of its staff. Throughout 1991-1992, the employee education

department coordinated a comprehensive program of offerings including those inservices mandated by the State Health and Labor Departments as well as those that are required by itself. Over five hundred programs were conducted with the number of attendees recorded at 5,931 employees. A wide variety of other programs were also available providing additional training such as wellness, health, and safety information, resources for daily living, and enrichment opportunities.

Discussion

Through the networking and integration with preventive health care, medical, and welfare services, high quality health care services can be provided effectively and efficiently by cutting duplicated and unnecessary services[7)19)].

CCRCs provide the full continuum of services from independent living to nursing home care and are getting results as a new senior housing program for the elderly in the U.S. Currently CCRCs cover only about 1% of those 65 and older. However there is a prospect that CCRCs will cover about 10% of those 65 and over in the future[3)22)].

In Northern Europe, senior housing programs are important for the elderly, too. For example, in Denmark the elderly can live independently at home by utilizing a variety of rich home care services. This is because the home care in Denmark depends on senior housing with home care services. The purpose of senior housing with home care services in Denmark is not only to deliver quality of care but also to control of health care costs. In Sweden, "service house", a senior housing with a day service center, was constructed in place of nursing homes in the 1970's and it is playing a significant role in an efficient home care delivery system[13)15)23)].

In this way, senior housing is playing a significant role in health policy for the elderly in the U.S. and Northern Europe. Although about 5% of those 65 and over are living in senior houses in the U.S. and North Europe in 1990's, only about 0.1% were living in senior houses in Japan in 1990[13)] (Table 7). Even if the target for care houses in the New Gold Plan is accomplished, they will

Table 7. Housing Conditions for the Elderly (%)

	Nursing Home &Hospital	Senior Housing	Other Houses
USA	5.0%	5.0%	90.0%
UK	3.0%	5.0%	92.0%
Sweden	3.0%	5.6%	91.4%
Denmark	5.0%	3.7%	91.3%
France	1.6%	3.9%	94.5%
Japan	4.3%	0.1%	95.6%

Source: Sonoda[13)].

Table 8. Applicant and User of Welfare Services

	User (A)	Applicant (B)	Ratio of Demand (B/A)
	(in thousands)	(in thousands)	
Visiting nursing care service	222	2029	9.1
Home help service	218	2638	12.1
Bath service	91	1098	12.1
Meal service	103	1409	13.7
Care instrument rental service	110	1221	11.1
Emergency response service	33	1573	47.7
Day service	176	605	3.4
Short temporary stay service	51	545	10.7
Information & counseling service	94	1317	14.0
Senior housing service with care	9	1269	141.0

Source: Ministry of Health and Welfare[16)].

cover only 0.5% of the population of those 65 and over.

Senior housing is desirable in Japan. According to a survey, the ratio of the applicants to users for senior housing services is 141 and there is a great deficiency comparing with other services[16] (Table 8).

In order to build an new effective and efficient health care system, therefore, more senior housing should be prepared as an option for long-term care programs for the elderly. It would be difficult for Japan to build independent living, assisted living, and nursing care units in one place because of narrow land space and financing problems. Therefore, close networking of housing with preventive health care, medical, and welfare services will be essential. In this case, a care house should be centered in a community since the preparation of senior housing should be led by the public sector because of the necessity of close connection of public home care services and the planned public nursing care insurance system, and the problems of social trust and so on.

CCRCs give useful suggestions for preparation of a new CCRC model on the basis of a care house. The following should be considered. First, the access to nursing care should be secured since the anxiety of how and where the elderly should live is the greatest concern when they need nursing care services. Second, the networking with medical services and preventive medicine should be strengthened. Third, local government can control management and has the temporary right to run it in case there are financial problems in a CCRC[8)22)]. This type of system should be considered in Japan for sound financing. Fourth, more senior housing should be prepared in order to respond to the needs of the elderly. In that case, there is a financing problem. From the financing viewpoint, Japan is suffering a deficit and the elderly should share the costs on the basis of payment ability. But it would be difficult for the elderly to finance the construction costs all at once. Therefore, a new financing system, such as a bond system or long-term loan system, should be promoted as an initial investment. Fifth, from a management viewpoint, the procedures for case management need to be established in order to deliver effective and efficient health care services. Training programs should be offered since case management depends on the networking of various types of specialists and managers. Sixth, marketing is a critical issue in the development of CCRCs. In addition, a quality assurance system should be established and services need to be evaluated through feedback of customer and providers of care. In this case, customer-driven marketing is imperative and customer satisfaction would be a proper index for evaluation of needs for the elderly.

In conclusion, CCRCs should be a significant model in preparing senior housing programs which will be key for home health care for the elderly in the future of Japan.

References

1) American Association of Homes for the Aging (AAHA), Ernst & Young : An Industry in Action ; Continuing Care Retirement Communities. AAHA, Washington, D.C., 1993.

2) American Association of Homes for the Aging (AAHA) : The Consumers' Directory of Continuing Care Retirement Communities. AAHA, Washington, D.C., 1993.

3) Anne R. Somers, Nancy L. Spears : The Continuing Care Retirement Community. Springer Publishing Co., New York, 1992.

4) Anthony R. Kovner et al. : Health Care Delivery in the U.S. Springer Publishing Co., New York, 1990.

5) C. Carl Pegels, Yuzo Okamoto : America no Roujin Iryou (Medical Care for the Elderly in the U. S.). Keisou Shobou, Tokyo, 1985 : p.1-10.

6) Go Miyatake. Kaigohoken toha Nanika (What is Public Nursing Care Insurance?). Hoken Doujinsha, Tokyo.1995, p.70-82.

7) Hideyasu Aoyama : Roujin Hoken Jigyou no Saikinn no Doukou ; Kenkou Kyouiku Gaidorain (Current State of Health Care Service Projects for the Elderly ; Guideline for Health Education). Social Security. 1750 : 22-25, 1993.

8) Howard E. Winklevoss, Alwyn V. Powell : Continuing Care Retirement Communities ; An Empirical, Financial, and Legal Analysis. Richard D. Irwin, Inc., Illinois, 1984.

9) James E. Allen : Nursing Home Administration. Springer Publishing Co., New York, 1992.

10) Japanese National Council of Social Welfare (JNCSW) : Overview of Social Welfare Services in Japan '94. JNCSW, Tokyo, 1994.

11) Jinkou Mondai Kenkyujyo : Jinkou no Doukou ; Nihon to Shakai (The State of Population in Japan). Kousei Toukei Kyokai. Tokyo, 1990.
12) Kenji Satomi et al. : Kaigo Hoken ni Igiari ; Mouhitotu no Teian (Different Opinion for Public Nursing Care Insurance). Mineruva Shobou, Tokyo, 1996.
13) Mariko Sonoda : Sekai no Koureisya Jyutaku (Senior Housing in the World). The Building Center of Japan, 1993.
14) Masayuki Kubota, Akira Babazono : Hoken Iryou Hukushi wo Tougousita Beikoku no Koureisya Syusin Care Community no Genjyou (Current State of CCRC integrated with Preventive Health Care, Medical, Welfare Services in the U. S.). Public Health 59 : 560-565, 1995.
15) Ministry of Finance : Economic White Paper '96. Tokyo, 1996.
16) Ministry of Health and Welfare : Health and Welfare White Paper '95. Tokyo, 1995.
17) Ministry of Health and Welfare : Health and Welfare White Paper '96. Tokyo, 1996.
18) Ministry of Health and Welfare : Kokumin Eisei no Doukou '96 (Health State of the Nation, Annual Report). Kosei Tokei Kyoukai, Tokyo, 1996.
19) Nobuo Maeda : Hoken Iryou Fukushi no Tougou (The Integration of Preventive Health care, Medical, and Welfare Services). Keisou Shobou, Tokyo, 1990.
20) Rosalie A. Kane, Robert L. Kane : Long-term Care ; Principles, Programs, and Policies. Springer Publishing Co., New York, 1987.
21) Sheldon Rovin et al. : Managing Hospitals. Jossey-Bass Inc., San Francisco Publishers, 1991.
22) Silver Service Shinkoukai : Silver Service Fukushi Tekigou Kijyun Sakutei Kiso Kenkyu Tyousa Houkokusyo ; Yuuryou-Roujin-Home (Report for Making a Standard of Health Care Services for the Elderly ; Yuuryou-Roujin-Home). Tokyo, 1990
23) Tadashi Toyama : Klippan no Hitobito (The Elderly in Klippan). Domesu Shuppan, Tokyo, 1990.
24) Yoshinori Hiroi. Iryou no Keizaigaku (Medical Economics). Japan Economic Newspaper Co., Tokyo, 1994.
25) Yuji Ogasawara, Norio Ebie : Long-term Care. Tyuou Houki Shyupan, Tokyo, 1994, p.2-33.
26) Yukio Noguchi, David A. Wise : Koureika no Nichibei Hikaku (Comparison of Aging between Japan and U. S.). Japan Economic Newspaper Co., Tokyo, 1995.
27) Yuzou Okamoto et al. : Kouteki Kaigo Hoken no Subete (Everything about Public Nursing Care Insurance). Asahi Culture Center, Tokyo, 1995.
28) Yuzou Okamoto : Koureisha Iryou to Fukushi (Medical Care and Welfare for the Elderly). Iwanami Shinsyo, Tokyo, 1996.