

Promoting human rights and equality through care and support

Professor Manami HORI

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Is it possible to promote human rights through care and support? The answer is “Yes”. While it is difficult to clearly define “human rights”, they can be viewed as the right to “live with human dignity”. From this viewpoint, human rights are not respected if people live without the necessary care and support. Also, from the standpoint of wellbeing and normalisation, it is desirable for people to be able to receive the necessary care and support to maintain activities of daily living. On the other hand, is it possible to promote equality through care and support? The answer could be “yes” or “no” depending on the definition of equality. This article discusses these issues based on experiences in Japan.

Who provides care and support?

In Japan, care and support were long considered personal issues and were believed to be the responsibilities of families. Care and support are gender issues too, and it has been generally expected that daughters-in-law would take care of parents, and wives would care for their husbands. However, as the elderly population is growing at an unprecedented pace, it has become difficult to rely solely on families to provide care and support.

In 2000, Japan introduced Long-Term Care Insurance (LTCI). This is the result of perceiving elderly care and support as social risks. This perception relates to the unprecedented growth in the elderly population that has not been seen in other advanced countries. Average life expectancy increased by more than 30 years from 1947 to 2005, and Japan has the world’s highest longevity. While longevity is desirable, it has resulted in a new phenomenon called “elderly-to-elderly care” where the elderly have to care for one another. Moreover, the duration for which care is required has increased markedly. Since the latter half of the 1970s, household composition has also changed considerably, and the average number of people per household has decreased. More elderly people live on their own, and more elderly couples live on their own than previously. Additionally, the total fertility rate has decreased and birth rates have declined, and this has further exacerbated the problem of a shrinking labour force. Thus acceleration of women’s entry into the workplace is socially expected and the current social thinking is

that it is undesirable for women to quit work to take care of family members.

Because of these changes in social environments, the idea that care and support for the elderly is a social issue has been widely accepted. Unrealistic expectations placed on family care can have negative effects on not only the elderly recipients, but also on those providing care and support. From the viewpoint of human rights, the wellbeing of both caregivers and care recipients is important, and care and support should therefore include assistance to caregivers.

Who receives care and support?

When conventional elderly welfare systems were compared, the introduction of LTCI has succeeded in markedly increasing the number of elderly people eligible for care and support. Before the introduction of LTCI, elderly people could only receive services if their needs were proven by a household means test, conducted by the municipality. Because the resources were limited, only high-priority, low-income elderly people were able to receive services. Moreover, municipalities decided the content and level of services, and users could not choose which services to receive. Since services were funded by local taxes, they varied markedly among municipalities. Fee structures were based on income levels, and services were mostly provided free to low-income earners. However, the need for care and support arises regardless of income. Some elderly people, who could not qualify for welfare services because of income restrictions, underwent lengthy hospitalisation as hospital care is easily accessed in Japan. Compared to other countries, Japan has many more hospital beds per capita, and “social hospitalisation” (a sort of delayed discharge) became a social issue. “Social hospitalisation” refers to patients who stay in hospitals for a long period, not for the purpose of medical care, but because they have nowhere else to go due to family issues or a shortage of social care and support. One of the reasons for introducing LTCI was to reduce escalating medical expenditure for the elderly by lowering social hospitalisation.

In light of the above-mentioned circumstances, LTCI provides services irrespective of income level and family situation, and care needs are certified based on the individual care requirements. The upper limit of service benefits is set based on a care needs assessment, and after certification, users can choose services from available care plans and sign a contract with service providers. Users pay a flat 10% of the expenses incurred. Because users have a choice, and sign a contract with providers, they become more aware of their rights.

Since the introduction of LTCl, the number of service providers (including for-profit companies) has steadily increased, and the number of users has markedly increased. There is no guarantee that all providers offer high-quality care and support. In terms of quality assurance, measures were put in place to evaluate quality, accredit providers, and process complaints. Although there is still room for further improvement, LTCl has been received mostly favourably in Japan, and the majority of users are satisfied. In particular, improving access to and choice in care and support for people who did not qualify for welfare services, or could not afford private nursing care services, has led to human rights being secured for many individuals.

Equality in benefits

A system that evaluates the need for care and support based on individual circumstances is neutral. However, for low-income earners who generally did not have to pay for services, the introduction of a 10% co-payment increased the burden on them for receiving the same service. Although there are measures to reduce the financial burden on low-income earners according to levels of income, some people decline care and support for financial reasons. As a result, equity may suffer under these circumstances.

From the viewpoint of gender roles, LTCl: 1) reduces the care-related burden on women (families); and 2) facilitates the use of external services provided by health and social care professionals. However, in terms of guaranteeing the freedom of individual choices, it may be unfair not to compensate for services provided by family members. For instance, in less-populated areas with fewer external services, when families provide care and support to their elderly members without utilising outside services, families are not compensated monetarily. It has been pointed out that this penalises families who decide to take care of their elderly family members on their own.

However, it is not easy to define family care in terms of equality and distribution of family responsibilities, and there is much room for debate. Also in recent years, the proportion of unmarried people has been on the rise, and the number of single-person households is increasing. Hence, benefits based on family care may not be realistic in the future.

Who pays? Burden equality

LTCl is a form of social insurance and is funded 50% through insurance premiums collected from the insured and 50% from general taxation (national and municipal taxes). LTCl is completely independent of

national medical care insurances. People aged 40 or older and the elderly (65 years or older) are covered, and these two groups pay for their insurance premiums differently. There are two reasons for setting the cut-off age at 40 years. Firstly, to correct the potential generation gap in burden when the system was introduced, so that younger people who would benefit the least at that time were not asked to contribute the most. This was seen as necessary to secure their support for the introduction of LTCI. Secondly, to promote equitable burden-sharing among the generations, as people in this age group are more likely to have parents who require care or to require long-term care themselves for diseases associated with aging.

At present, the system to help disabled people to live independently and LTCI are independent of each other and combining the two systems and eliminating the age classification has been suggested. However, because disabled people receive higher levels of care and support in the present circumstances, detractors of a joint approach state that combining the systems could markedly penalise the disabled.

Since being able to live with dignity has nothing to do with age, the age classification of the present system may be unfair. Therefore, it appears desirable to eliminate the age classification and combine the systems so that the elderly and disabled can receive care and support based on needs. However, because the two systems have different merits, some groups will be disadvantaged in the short term. This is similar to the above-mentioned problem facing low-income earners. When changing any system, it is necessary to minimise the number of users who suffer negative consequences as a result of that change.

Unfortunately, it is very difficult to design a system where all groups are 100% satisfied. As I noted first, the answer to whether it is possible to promote equality through care and support depends on the definition of equality. Equality for all is an ideal but it is not easy. Putting importance on some people's equality may sometimes sacrifice for other's equality. Priority setting based on national consensus is needed for policy making. However, in terms of human rights, it is not desirable to abandon a small group of unfortunate people. All humans have inherent rights. In any case, it will be important to establish a system where people can receive the necessary care while striving to live independently.

Please note: The views expressed by the author may not necessarily reflect the views or policies of the Department of Health.