Available Online: 17 November 2026 DOI: 10.54254/2977-5701/2026.39011

Medical insurance financing and payment methods for hospice and palliative care services: a comparative study of China and Japan

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Abstract. Objective: As population aging accelerates, China and Japan share the challenge of developing sustainable medical insurance financing and incentive-compatible payment for hospice and palliative care. This study compares the two countries to inform improvements in China's financing and payment systems. Methods: A comparative institutional analysis was conducted using a "value orientation–financing model–payment method" framework. Institutional arrangements, financing channels, cost-assignment rules, and payment-rate design were systematically reviewed, and the effects of payment incentives were examined using macro- and micro-level evidence from Japan. Results: China has pursued incremental expansion centered on basic medical insurance and dominated by per-diem payment, but faces a single financing channel, fragmented payment standards, and weak incentives for home-based services. Japan's dual-insurance framework assigns end-of-life costs by service type and uses nationally uniform medical and long-term care fee schedules to enact "payment as governance". Add-on payments decline with length of stay but increase as death approaches, shifting care toward homes and communities. Macro- and micro-level evidence supports the effectiveness of these incentives in changing service provision. Conclusion: Japan offers lessons in containing single-pool risk through cost sharing, exercising aggregate control through uniform fee schedules, and promoting service decentralization through explicit add-on payments. However, its long-term care insurance deficits and the conflict between declining per-diem payments and end-of-life care needs should be avoided. China should standardize per-diem payment, establish cost-assignment rules between basic medical and long-term care insurance, and use explicit add-ons to promote home- and community-based hospice and palliative care.

Keywords: hospice and palliative care, palliative medicine, financing model, payment method, China—Japan comparison

1. Introduction

As population aging continues to accelerate, the financial and ethical pressures associated with end-of-life medical care are rising in tandem. During the final stage of life, aggressive curative treatment often entails

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high costs but limited survival benefits. Overtreatment not only increases the burden on patients' families and medical insurance funds but also constrains the scope for hospice and palliative care centered on symptom control, comfort, and humanistic care. Establishing sustainable financing mechanisms and payment methods for hospice and palliative care has therefore become a common challenge for health and social security policy in China and Japan.

2. Current medical insurance arrangements for hospice and palliative care services in China and Japan

In 2017, the former National Health and Family Planning Commission launched the first national hospice and palliative care pilot program. Following the launch of the third cohort in 2023, the pilots covered a cumulative total of 185 cities (districts)[1]. On the payment side, the 2017 *Guiding Opinions of the General Office of the State Council on Further Deepening Reform of Basic Medical Insurance Payment Methods* (State Council General Office Document [2017] No. 55) explicitly stated that "per-diem payment may be adopted for conditions requiring long-term hospitalization with relatively stable average daily costs, such as psychiatric disorders, hospice and palliative care, and medical rehabilitation"[2,3]. In November 2024, the National Healthcare Security Administration issued the *Guidelines for Establishing Price Items for Comprehensive Diagnostic Medical Services (Trial)* (NHSA Price and Procurement Letter [2024] No. 230). "Hospice and palliative care" was incorporated for the first time into the nationally standardized management system for medical service price items. Its price covers physical, psychological, and spiritual care as well as humanistic support; it is charged on a per-diem basis and may not be billed concurrently with inpatient consultation fees or graded nursing fee[4]. In March 2026, the General Office of the CPC Central Committee and the General Office of the State Council issued the *Opinions on Accelerating the Establishment of a Long-Term Care Insurance System*, accompanied by an implementation plan jointly issued by eight government departments. These documents established diversified financing channels and a benefit-payment framework for long-term care insurance[5,6]. China's financing and payment system for hospice and palliative care is thus at a critical juncture in the transition from local experimentation to nationally unified standards.

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1 General Office of the National Health Commission. Notice on Launching the Third Cohort of National Hospice and Palliative Care Pilots: NHC General Office Aging Letter [2023] No. 128 [EB/OL]. (2023-07-12) [2026-08-06]. http://www.nhc.gov.cn/ljks/c100158/202307/709d1b1220914f1f8f1750a63bbfebf8.shtml.

2 General Office of the State Council. Guiding Opinions on Further Deepening Reform of Basic Medical Insurance Payment Methods: State Council General Office Document [2017] No. 55 [EB/OL]. (2017-06-20) [2026-08-06]. https://www.gov.cn/zhengce/zhengceku/2017-06/28/content_5206315.htm.

3 National Healthcare Security Administration. Reply to Proposal No. 2790 (Social Administration No. 193) of the Second Session of the 13th National Committee of the Chinese People's Political Consultative Conference [EB/OL]. (2019-12-03) [2026-08-06]. https://www.nhsa.gov.cn/art/2019/12/3/art_110_6780.html.

4 National Healthcare Security Administration. Guidelines for Establishing Price Items for Comprehensive Diagnostic Medical Services (Trial) [EB/OL]. (2024-11-19) [2026-08-09]. https://www.nhsa.gov.cn/art/2024/11/19/art_201_14753.html.

5 General Office of the CPC Central Committee, General Office of the State Council. Opinions on Accelerating the Establishment of a Long-Term Care Insurance System [EB/OL]. (2026-03-25) [2026-08-09]. https://www.news.cn/politics/zywj/20260325/99d8d232178f45209261a27895f70557/c.html.

6 National Healthcare Security Administration, et al. Implementation Plan for Accelerating the Establishment of a Long-Term Care Insurance System [EB/OL]. (2026-03-26) [2026-08-09]. https://www.nhsa.gov.cn/art/2026/3/26/art_104_20039.html.

Japan was the first country in East Asia to achieve universal health coverage and to establish an independent long-term care insurance system. Universal health insurance was achieved in 1961, and the *Long-Term Care Insurance Act* was implemented in 2000. After more than two decades of operation, the system has largely matured [1]. Japan has not created a separate insurance program for hospice and palliative care. Instead, within a dual-insurance framework comprising medical insurance and long-term care insurance, nationally uniform medical and long-term care fee schedules serve as the core governance instruments. Adjustments to fee-schedule points and to the eligibility criteria for billing enable aggregate cost control and resource reallocation for end-of-life medical care [2]. According to Japan's *FY2024 Annual Report on Long-Term Care Insurance Operations*, approximately 35.84 million Category 1 insured persons aged 65 years or older were enrolled as of the end of March 2025, and 7.207 million people had been certified as requiring long-term care or support [3][7]. Japan's experience of operating this system in a super-aged society offers a distinctive reference for China, where population aging began later but is following a highly similar trajectory.

Hospice and palliative care has both medical and care-related attributes, and its costs therefore inherently span the two funding pools of medical insurance and long-term care insurance. Financing and payment are consequently central to institutional design. Existing research has focused largely on service-delivery systems, ethical issues, and the experience of individual countries; systematic comparisons of China and Japan from the perspective of financing and payment remain limited [4, 5]. Using "value orientation–financing model–payment method" as its analytical framework, this study compares medical insurance financing and payment methods for hospice and palliative care services in China and Japan, with the aim of informing improvements in China's relevant institutions.

3. Value orientations of medical insurance systems for hospice and palliative care in China and Japan

3.1. China's institutional orientation

China has adopted an incremental approach to hospice and palliative care, characterized by pilot programs followed by wider implementation. At the national level, the policy emphasis has shifted from establishing service-delivery systems to improving payment mechanisms. The early pilots concentrated on building institutions, establishing clinical departments, and training personnel, while payment was addressed only in principle within the broader framework of medical insurance payment reform. As the pilots progressed, payment issues—including the calculation of per-diem rates, definition of eligible conditions, and rules for fund oversight—gradually became policy priorities. A quantitative evaluation of 38 policy documents from the three pilot cohorts using a PMC index model found that the overall quality of China's hospice and palliative care policies was relatively high, but that indicators relating to payment security remained underdeveloped [6].

Local practices vary markedly in eligible conditions, per-diem rates, and oversight rules. In July 2019, Dalian became the first city in China to pilot per-diem settlement of hospice and palliative care through pooled medical insurance funds. The pilot incorporated admission based on Karnofsky Performance Status (KPS) scores, informed consent, and medical-record oversight. During its first year, 198 patients with terminal cancer were admitted, pooled-fund expenditure reached CNY 1.77 million, and the maximum pooled-fund payment

[7] Ministry of Health, Labour and Welfare. FY2024 Annual Report on Long-Term Care Insurance Operations [EB/OL]. (2026-08-27) [2026-09-02]. https://www.mhlw.go.jp/topics/kaigo/osirase/jigyo/24/index.html.

for an individual patient was CNY 31,000[8]. Zhuhai's per-diem payment rates range from CNY 331 to CNY 432 per day[9], while Shenyang has introduced a special policy of per-diem payment for terminal malignant neoplasms[10]. Overall, China's policy orientation is one of incremental expansion led by basic medical insurance. Its central concerns are the sustainability of medical insurance funds and cost containment, and coverage for hospice and palliative care remains limited to services of a medical nature [7].

3.2. Japan's institutional orientation

Article 1 of Japan's Long-Term Care Insurance Act states that the Act aims, through social insurance, to provide insured persons requiring long-term care with the necessary health care, medical services, and support for daily living, thereby preserving their dignity, promoting independent living, and reducing the burden of family caregiving. *Article 2* further establishes the principles of respecting the dignity of insured persons, providing continuous support from prevention to severe long-term care, and coordinating with medical insurance and related systems[11]. The core principles of Japan's end-of-life care coverage are therefore support for independence and the preservation of dignity. Policy covers the entire continuum from prevention and rehabilitation to nursing care and dying, with an emphasis on seamless integration between medical care and long-term care.

Of particular importance, Japan uses nationally uniform medical and long-term care fee schedules as central instruments for achieving policy objectives, creating an institutional logic of "payment as governance". The medical fee schedule is revised every two years. Adding or subtracting points for particular services and tightening or relaxing billing requirements guide resource allocation by medical institutions. In pursuit of community-based integrated care, Japan has continually encouraged the relocation of care from hospitals to communities and homes by establishing explicit add-on payments for home-based end-of-life services.

4. Medical insurance financing models for hospice and palliative care in China and Japan: a comparison

Financing mechanisms underpin the sustainable operation of hospice and palliative care systems. Financing concerns not only the amount of funding but also the composition of financing channels, the assignment of costs among insurance schemes, and the distribution of responsibilities across generations and income groups.

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[8] Liaoning Provincial Healthcare Security Administration. [Dalian] First in the Province! A New Medical Insurance Payment Reform in Dalian—Full Implementation of Per-Diem Settlement for Hospice and Palliative Care [EB/OL]. (2020-10-22) [2026-08-27]. https://ybj.ln.gov.cn/ybj/zxzx/gddt/7AD7A3D5A821482AA36228D993C0B877/index.shtml.

[9] Yangcheng Evening News. Zhuhai Launches National Hospice and Palliative Care Pilot and Plans to Develop a Sustainable, Replicable, and Scalable Service Model by 2025—Hospice and Palliative Care Illuminates the Final Journey of Life [N/OL]. (2023-07-20) [2026-08-29]. http://ep.ycwb.com/epaper/ycwb/html/2023-07/20/content_6_587682.htm.

[10] Shenyang Municipal Healthcare Security Administration. Reply to a Proposal by a Member of the Municipal CPPCC on Payment Policy for Hospice and Palliative Care [EB/OL]. (2025-03-25) [2026-08-29]. https://ybj.shenyang.gov.cn/zwgk/fdzdgknr/jytabljggk/szxwyta/202503/t20250325_4826597.html.

[11] Long-Term Care Insurance Act: Act No. 123 of 1997 [EB/OL]. (1997-12-17) [2026-09-03]. https://elaws.e-gov.go.jp/document?lawid=409AC0000000123.

4.1. Medical insurance financing for hospice and palliative care in China

China currently relies predominantly on the single channel of basic medical insurance to finance hospice and palliative care. Covered medical services are reimbursed according to the existing medical insurance catalog, and family sickbed expenses are included in the benefit package in accordance with applicable rules. Pilot cities generally use pooled funds to settle inpatient hospice and palliative care expenses on a per-diem basis. In Dalian, for example, the average pooled-fund payment per case during the first pilot year was approximately CNY 8,939, calculated from pooled-fund expenditure of CNY 1.77 million and 198 admissions. Applying the tiered per-diem rates for employees covered by medical insurance—CNY 420 per day at tertiary institutions, CNY 380 at secondary institutions, and CNY 340 at primary institutions and hospice and palliative care centers—the implied average reimbursed length of stay was approximately 21–26 days[12].

The long-term care insurance channel in China remains at an early stage of development and coordination. The system-building opinions issued in 2026 established diversified financing channels, with a benchmark contribution rate of approximately 0.3%. For employees, employers and individuals each contribute approximately 0.15%; retirees contribute approximately 0.15% individually; and for residents, individual contributions and government subsidies are shared at a ratio of approximately 1:1. No deductible applies to benefit payments. Some early-adopting regions have already included hospice and palliative care and end-of-life care in their long-term care insurance service catalogs. Qingdao, for example, explicitly includes hospice and palliative care within the scope of coverage under its long-term care insurance measures[13]. Overall, however, financing during the pilot phase has shown substantial path dependence on transfers from medical insurance funds, and an independent financing mechanism has yet to be established[14].

China does not yet have well-developed financing channels for nonmedical hospice and palliative care services. Emotional support, companionship, and assistance with daily living are not managed as medical service price items; instead, institutions set their own prices and individuals pay out of pocket. Complementary mechanisms involving fiscal investment, charitable donations, and commercial health insurance remain underdeveloped [8]. Table 1 summarizes medical insurance financing and settlement methods for hospice and palliative care services in selected Chinese pilot cities.

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[12] Average pooled-fund payment per case was calculated from pooled-fund expenditure of CNY 1.77 million and 198 admissions during the first pilot year, as published by the Liaoning Provincial Healthcare Security Administration. The average reimbursed length of stay was estimated by dividing CNY 8,939 by the tiered per-diem rates of CNY 420–340 per day.

[13] Qingdao Municipal People's Government. Measures of Qingdao Municipality for Long-Term Care Insurance [EB/OL]. (2026-04-30) [2026-09-03]. https://www.qingdao.gov.cn/zwgk/xxgk/bgt/gkml/gwfg/lsyg_bgt/202604/t20260430_10583023.shtml.

[14] The Opinions on Accelerating the Establishment of a Long-Term Care Insurance System specify a benchmark contribution rate of approximately 0.3%, with employers and employees each contributing approximately 0.15%; retirees contributing approximately 0.15% individually; and residents' individual contributions and government subsidies shared at a ratio of approximately 1:1. The contribution rate starts at 0.15% and transitions to 0.3% over approximately five years. Near-universal national coverage is to be achieved by the end of 2028, and no deductible applies to benefit payments.

Table 1. Medical insurance financing and settlement methods for hospice and palliative care services in Chinese pilot cities

City	Financing channel	Settlement unit	Payment standard	Admission and management
Dalian	Basic medical insurance pooled fund	Per-diem payment	For employees, CNY 420/380/340 per day, tiered by institution level; 80% of the applicable rate for adult residents; average pooled-fund payment of approximately CNY 8,939 per case (estimated); maximum of CNY 31,000 per person	Admission based on KPS score; informed consent; medical-record and fund oversight; payment period generally not exceeding 90 days
Zhuhai	Basic medical insurance pooled fund	Per-diem payment	CNY 331–432 per day	Tiered management by condition and institution
Shenyang	Basic medical insurance pooled fund	Special per-diem payment policy under development	Per-diem rates calculated according to the pricing guidelines	Transitional management of 28 pilot institutions
Shanghai	Basic medical insurance + long-term care insurance	Multiple mixed payment methods under a global budget; a "hospice and palliative care fee" price item added in 2026	Price items managed under Categories A and B; applicable cases temporarily excluded from diagnosis-based payment	Citywide pooling
Qingdao	Long-term care insurance	Per-diem/service-package payment	Paid according to long-term care insurance benefit standards	Management of designated long-term care insurance providers
Changde	Basic medical insurance pooled fund	Bundled per-diem payment	Unified standard for patients with advanced cancer; initially implemented at Changde Second People's Hospital	"Unified standards, bundled payment, and standardized services"

Note: Compiled from public documents and reports issued by local medical insurance authorities. Average expenditure per case in Dalian was calculated from data published by the Liaoning Provincial Healthcare Security Administration.

4.2. Medical insurance financing for hospice and palliative care in Japan

The costs of hospice and palliative care in Japan are shared by medical insurance and long-term care insurance under a dual-insurance framework. Medical insurance is financed through premiums, national treasury subsidies, and individual cost sharing. The High-Cost Medical Expense Benefit system caps individual out-of-pocket payments, and medical insurance covers medically oriented expenses such as analgesia and symptom control. Long-term care insurance is financed equally by public funds and premiums. The national government, prefectures, and municipalities share public funding at a ratio of 2:1:1. Of premium revenues, Category 1 insured persons (aged 65 years or older) contribute 23% and Category 2 insured persons (aged 40–64 years) contribute 27% in principle. Operating on a pay-as-you-go basis, long-term care insurance covers end-of-life services associated with daily care [9].

Rules for assigning end-of-life costs are central to the dual-insurance system. For example, home-visit nursing for patients with terminal cancer may be covered by medical insurance rather than long-term care insurance, depending on applicable rules [10]. Research using linked medical and long-term care data for the final 24 months of life shows a structural shift from medical to care-related expenditure among older Japanese patients at the end of life [11]. Assigning costs according to service type limits the risk exposure of either insurance fund.

5. Medical insurance payment methods for hospice and palliative care in China and Japan: a comparison

5.1. Payment methods and their characteristics in China

Local medical insurance payment practices for hospice and palliative care in China take several forms. The Dalian model combines tiered per-diem rates, KPS-based admission, and fund oversight. Rates are tiered by institution level, and the payment period generally does not exceed 90 days[15]. Shanghai uses multiple mixed payment methods within a global budget. In 2026, it added a "hospice and palliative care fee" price item, introduced Category A and B management, and temporarily excluded applicable cases from diagnosis-based payment[16]. Beginning on 1 September 2026, Changde introduced bundled per-diem payment for hospice and palliative care for patients with advanced cancer under the principles of "unified standards, bundled payment, and standardized services", initially at Changde Second People's Hospital[17].

5.2. Payment methods and their characteristics in Japan and comparison with China

Japan applies bundled per-diem payment to specialist palliative care institutions through the Palliative Care Ward Hospitalization Fee system. This system has two distinctive features. First, payment rates are linked to facility conditions. Facility standards—including ward staffing, completion of specialist training, and the institution's record of end-of-life care—determine the applicable rate, thereby using payment to purchase service quality. Second, payments decline in steps as length of stay increases. Under the latest standards effective from June 2026, Hospitalization Fee 1 has three tiers: 5,277 points per day for days 1–30, 4,724 points for days 31–60, and 3,515 points for day 61 onward. The corresponding rates for Hospitalization Fee 2 are 5,025, 4,555, and 3,449 points. An additional payment for the initial phase of emergency admission compensates for the costs of acute intake. The design of lower daily payments for longer stays is intended to

[15] Liaoning Provincial Healthcare Security Administration. Reply to Proposal No. 13040499 at the Fourth Session of the 13th Liaoning Provincial CPPCC on Improving Liaoning's Medical Insurance System, Achieving Universal Basic Medical Insurance Coverage, and Guiding Commercial Insurance toward Higher Quality and Broader Coverage [EB/OL]. (2026-07-03) [2026-09-11]. https://ybj.ln.gov.cn/ybj/zfxxgk/fdzdgknr/jyta/szxta/szxssjschy2026n/2026070215374947956/index.shtml.

[16] Shanghai Municipal Healthcare Security Administration, Shanghai Municipal Health Commission. Notice on Adding a Hospice and Palliative Care Fee to the Medical Service Price Items in Shanghai [EB/OL]. (2026-07-10) [2026-09-11]. https://www.shanghai.gov.cn/gwk/search/content/ef28dd7bbc9144e1a2c65f605e9e2413.

[17] Li B, Peng C W. Changde Implements a Medical Insurance Pilot of Per-Diem Payment for Hospice and Palliative Care [EB/OL]. Changde Daily (republished on the Changde Municipal People's Government portal), (2026-09-07) [2026-09-11]. https://www.changde.gov.cn/cdzx/cdyw/content_78217467.

discourage the use of hospitalization as a substitute for residential elder care and to promote bed turnover[18]. The Japan Hospice Palliative Care Association's FY2025 self-evaluation program covered 394 full-member facilities and received 4,837 responses from staff; approximately 79% of evaluation items received scores of 3 or higher. The report nevertheless identified a structural problem: declining payments by length of stay impose financial constraints on the care of long-stay patients[19].

For home-based end-of-life care, Japan has established a clearly tiered system of add-on payments. First, the home end-of-life care add-on applies when a physician makes at least two house calls or home visits on the day of death and during the preceding 14 days (15 days in total) and the patient dies at home. Depending on institution type and response arrangements, 3,500–6,500 points may be billed. Second, an add-on of 3,000 points is payable for end-of-life procedures performed by a physician on the day of death, together with an add-on of 200 points for issuing a death certificate. Third, a 24-hour response-system add-on compensates providers for the costs of round-the-clock availability[20].

Beyond medical insurance, Japan's long-term care insurance also provides special add-ons for the end-of-life stage. In the FY2024 revision, the home-visit nursing end-of-life add-on increased from 2,000 to 2,500 units per month. It is paid monthly for care recipients who receive home-visit nursing on at least two days during the day of death and the preceding 14 days[21]. The end-of-life care add-on for institutional services, including special nursing homes for older adults, increases in tiers as death approaches: 144 units per day for days 4–30 before death, 680 units per day on each of the two days before death, and 1,280 units on the day of death. Payment requires an end-of-life care plan, informed consent from the individual and family members, and staff training[22]. Linking payment rates directly to proximity to death explicitly recognizes and adequately compensates the sharp increase in caregiving intensity during the end-of-life stage. The major payment items and rates for end-of-life medical and long-term care in Japan are shown in Table 2.

These features of Japan's medical insurance payment system for hospice and palliative care have produced observable effects. At the macro level, the 2025 Survey of Medical Institutions reported an average length of stay of 114.7 days and a bed occupancy rate of 85.4% in long-term care beds, clearly differentiated from 15.3 days and 74.7%, respectively, in general beds. Nationwide, 3,290 hospitals had long-term care beds, accounting for 41.1% of all hospitals and providing the facility base for patients with chronic conditions and

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[18] Japan Medical Association ORCA Management Organization. Japan Medical Association Standard Receipt Software: Response to the June 2026 Revision of the Medical Fee Schedule (Inpatient Services) [EB/OL]. (2026-05-21) [2026-10-09]. https://ftp.orca.med.or.jp/pub/data/receipt/outline/revision/pdf/202606-kaisei-taiou-010200_20260521.pdf.

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[20] Medical Affairs Division, Health Insurance Bureau, Ministry of Health, Labour and Welfare. Overview of the FY2024 Revision of the Medical Fee Schedule: Home Care (Home Medical Care and Home-Visit Nursing) [EB/OL]. (2024-03-05) [2026-10-09]. https://www.mhlw.go.jp/content/12400000/001226864.pdf.

[21] Health and Welfare Bureau for the Elderly, Ministry of Health, Labour and Welfare. Items Revised in the FY2024 Long-Term Care Fee Schedule Revision: Reference Material 1 for the 239th Meeting of the Subcommittee on Long-Term Care Benefit Expenses, Social Security Council [EB/OL]. (2024-01-22) [2026-10-09]. https://www.mhlw.go.jp/content/12300000/001213182.pdf.

[22] Ministry of Health, Labour and Welfare. Remuneration and Standards for Special Nursing Homes for Older Adults: Material 1 for the 151st Meeting of the Subcommittee on Long-Term Care Benefit Expenses, Social Security Council [EB/OL]. (2017-11-15) [2026-10-09]. https://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000184781.pdf.

those at the end of life[23]. Micro-level research further shows that medical expenditure is significantly lower among patients with terminal cancer who receive palliative care than among those receiving aggressive anticancer treatment [12]. Physician-led home-visit end-of-life care also costs less than inpatient care [13], and financial incentive policies are significantly associated with increased use of home-based end-of-life care [14]. In other words, explicit add-on payments not only compensate providers for their costs but also change the structure of service provision, offering firsthand empirical evidence that payment levers can shift the setting of care.

Table 2. Major payment items and rates for end-of-life medical and long-term care in Japan

Care setting (insurance scheme)	Payment item	Payment standard	Design and billing requirements
Palliative care ward (medical insurance)	Palliative care ward hospitalization fee	Fixed per-diem payment declining with length of stay: 5,277 points per day for days 1–30, 4,724 points for days 31–60, and 3,515 points for day 61 onward; Hospitalization Fee 2, which applies less stringent facility standards, is 5,025/4,555/3,449 points per day (effective June 2026)	Explicitly excluded from fixed per-diem payment under the Diagnosis Procedure Combination (DPC) system; paid according to actual length of stay; an additional payment applies to the initial phase of emergency admission
Home medical care (medical insurance)	Home end-of-life care add-on	3,500–6,500 points per case	Billable only when at least two house calls or home visits are made on the day of death and during the preceding 14 days (15 days in total), and the patient dies at home
Home medical care (medical insurance)	End-of-life procedure and death certification add-ons	3,000 points and 200 points per case, respectively	Billed separately when a physician performs end-of-life procedures and certifies death on the day of death
Home-visit nursing (long-term care insurance)	End-of-life nursing add-on	2,500 units for the month of death (increased from 2,000 units in 2024)	Home-visit nursing provided on at least two days on the day of death and during the preceding 14 days
Special nursing homes and similar facilities (long-term care insurance)	End-of-life care add-on	Tiered increases as death approaches: 144 units per day for days 4–30 before death, 680 units per day on each of the two days before death, and 1,280 units on the day of death	Requires end-of-life care guidelines, consent from the individual and family members, and completion of staff training

Note: Compiled and excerpted from Ministry of Health, Labour and Welfare materials on revisions to the medical and long-term care fee schedules. One medical fee-schedule point equals JPY 10; one long-term care fee-schedule unit is generally equivalent to approximately JPY 10, with slight regional variation. Unless otherwise specified, points and units refer to FY2026 standards.

[23] Ministry of Health, Labour and Welfare. Overview of the 2025 Survey of Medical Institutions (Dynamic Survey) and Hospital Report [EB/OL]. (2026-09-29) [2026-10-09]. https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/25/.

An "add-on" is an additional payment made above the base fee when specified conditions are met. Additional items for home medical care, such as the 24-hour response-system add-on, are omitted from the table.

6. Conclusion

Japan's payment system for hospice and palliative care has been refined through repeated revisions over more than two decades. Cost sharing between two insurance schemes contains single-pool risk, uniform fee schedules enable aggregate control, and add-on payments guide services toward homes and communities. Japan nevertheless faces challenges, including long-term care insurance expenditures exceeding revenues and shortages of care workers. Although the stepwise reduction of payment rates by length of stay in palliative care wards is intended to promote bed turnover, it conflicts with the practical needs of terminally ill patients, who often require hospitalization until death. Japan's experience offers useful lessons, but its difficulties must also be avoided. China's financing and payment system for hospice and palliative care is at a historic juncture marked by the establishment of service price items and a national long-term care insurance system. China should further standardize per-diem payment, establish rules for assigning costs between basic medical insurance and long-term care insurance, and use explicit add-on payments to promote service provision in homes and communities. Because this study focuses primarily on institutional comparison and publicly available micro-level claims data are limited, it does not conduct a causal test of payment-incentive effects. As claims data from pilot cities accumulate and become publicly available, future research should use micro-level data to conduct more rigorous empirical analyses of the incentive effects of per-diem payment, thereby providing evidence to support the dynamic optimization of the system.

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