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International Survey on Integration of Medical and Social Care for the Elderly

Canada, Germany, France, Norway

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(The following are excerpts of the report)

Summary of the Survey (from Chapter 1)

1. The background and aims of the survey

In Japan, medical care and long-term care have been offered until recently by different providers, that is, by hospitals/clinics and by long-term care service providers, respectively. But with the so-called “super aging” society in the offing, it is increasingly likely that nursing care will be required in continuum of medical care, especially for the elderly, because they often need physical and mental care continuously even after intensive medical care. On the other hand, patients with chronic diseases receiving long-term care also require routine observation and check from the medical viewpoint. Under the circumstances, it is now increasingly desirable that medical and long-term care be provided in a more coordinated way.

Under the present Japanese legal system, medical care is provided chiefly by non-profit medical organizations, while non-medical long-term care services are provided by welfare organizations and/or private businesses. With some exceptions, the law prohibits the single provider from providing both services at the same time, unless he organizes separate legal corporations for medical and long-term care services. Moreover, the procedures and requirements for establishing medical organizations are very strict under the current law, forming high barriers for new entry into the medical business. There do exist a number of "complex" institutions providing both medical and long-term care services, but they are mostly formed with medical organizations as the core. With the introduction of the public long-term care insurance system in the year 2000, however, long-term convalescent care and home nurse-visits, which was considered part of medical care, began to be regarded as a function between the former medical and long-term care. This did contribute to coordinating medical and long-term care, and making it easier for private businesses to enter the home nursing service.

With these Japanese situations in the background, we made researches about the relevant legal systems and actual situations in some of the other countries in this area, including field and case studies, to see how medical/long-term care services are provided there in comprehensive/combined manners. The findings of our researches have been put together in a report form (114 pages in Japanese).

2. Contents of the research

(1) Legal restraints against integrating medical and long-term care services:

We researched about the relevant foreign legal systems and actual practices to see how their legal systems, etc. restrain or separate medical and long-term care services in providing these

services in an integrated manner.

Moreover, we tried to find out what processes they had to go through before arriving at the current systems, also attempting to analyze any issues and problems still existing in their present systems and practices.

(2) Analysis about forms of coordination:

Based on the legal systems found out in the above, we tried to grasp actual ways of integrating medical and long-term care services in these countries, and to see what kinds of organizations provide such integrated services with what kinds of staff arrangement.

3. Selection of target countries

For the purpose of this research, we chose several countries known for their unique approaches or reformed legal systems for well combining medical and long-term care service. We also picked up countries that have seldom been taken up in this kind of Japanese studies in the past. Some of the characteristics and reason of selection are as follows:

(1)Canada:

In Canada, they have started to adopt a one-stop service window system, staffed by professionals such as nurses, where elderly patients can choose to use hospital, nursing home, and home care services in a preferred combination. In Canada, medical and long-term care services are unified, which makes it easy to build integration between hospitals, nursing homes and home care services, providing consumers continuous services without division.

(2)Germany:

In Germany, a single organization is allowed to provide plural complex services. However, because hospital divisions cannot provide other services than medical, they create other divisions to provide other needed services. Of note is that the so-called six great non-profit organizations all provide medical, nursing, and rehabilitation services in a coordinated way.

(3)France:

The legal system of France requires medical and long-term care to be provided separately, so homes for the elderly that provide medical care have to acquire official approval for both medical and nursing services. On the other hand, some hospitals have long-term care beds. While in Japan patient's payment for hospital care is less expensive than for long-term care facilities, the French system requires patients in hospital to pay an equivalent to "rent" if they stay a prolonged time. The country has a public medical insurance that covers medical services and a Personal

Autonomy Allowance (APA) that support payment for long-term care for the elderly.

Homes for the elderly with medical services have hitherto been administered, approved and budgeted by the prefecture's nursing system and the public medical insurance system, but a reform is being reinforced to unify the budget and the system.

(4)Norway:

In Nordic countries, there has been a sharing system in which the province provides medical services and the city provides long-term care services. The budget is also divided between the two and there has been many attempts in order to integrate the two services. More recently, they had a medical system restructuring, like the transfer of hospital authority to the national government in January 2002, and how these changes affect the medical/nursing picture is being monitored with much interest.

4. Methods of the research

(1)Reference investigation

We made research with previous reports about integration of medical and long-term care service and surveyed the situation of foreign coutries.

(2)Interviews and Case study

We conducted interviews with the ministries and government offices, and medical/nursing care institutions. During the field study, we picked up actual cases of integration and analyzed merits and demerits for both the service provider and its user.

Executive Summary

Descriptions of Situations in Surveyed Countries and Suggestions for Japan

1. Integration of Medical Care and Long-term Care in Other Countries

Aspects of medical and long-term care integration could be broken down as the following::

(1) Integrated infrastructure for medical care and long-term care services
(2) Complexes that provide both medical and long-term care, or long-term care facilities that reinforce medical function
(3) Intermediate facilities for transition period between hospital discharge and return home
(4) Coordination among staffs involved in medical care and long-term care

This chapter describes the situations in other countries based on these four perspectives.

《Integration of medical care and long-term care infrastructure》

In Canada, financial resources for both medical treatment and long-term care were transferred to the provinces in 1995, enabling each province to plan and establish medical treatment and long-term care facilities. Each province is divided into regions. Each region has a Regional Health Board that promotes locally developed health care and social welfare policies. When a senior citizen needs both medical treatment and long-term care services, the services are selected and coordinated by a single customer service organization. Typical of such organizations are the Community Care Access Centres (CCAC), which conduct assessments in response to inquiries from patients (or their families) who are about to be discharged from hospitals regarding appropriate medical treatment and long-term care services.

In Germany, plans for building hospitals and/or rehabilitation facilities are made by each state, while long-term care is planned at the municipal level. Thus, the plans are not totally integrated. Financial resources are divided into health insurance and long-term care insurance, both of which are handled by the same sickness funds. The physician (private practice physician or family doctor) determines from which insurance provides the fee. If the doctor determines eyeglasses, wheelchairs, and long-term care equipment, for example, are used for medical needs, they will be provided under medical insurance. However, once services are provided under long-term care insurance (in other words, once the patient is certified as needing long-term care), the sickness funds is usually

unwilling to switch back the patient to medical insurance.

In France, medical facilities are administered by the national government, while long-term care services are administered regionally. Financial resources for medical treatment and long-term care are also separate. The former is covered by medical insurance, while the latter is provided by regional public funds, national government funds, subsidies from the senior pension fund, etc. France is similar to Germany for they both manage medical service at a central government and long-term care at a local level. In 1991, France created Committee for Health and Social Organizations at both national and regional level (CNOSS & CROSS) in order tot integrate medical treatment and care services.

In Norway, nursing services (nursing homes and home-visit nursing) and long-term care services (care facilities and home help) are offered by each commune, which means that such services are provided in an integrated way. While the communes are responsible for primary medical care, the national government provides public hospitals and five health care regions administer them .

《Medical care and long-term care complexes》

A single management entity (or affiliated/group facilities) providing both medical care and long-term care are called complexes. All of the surveyed countries have some hospitals with adjoining nursing homes. While there is cooperation within these complexes, such as doctors of the medical care facilities examining patients at the long-term care facilities or offering advice to the long-term care staff, the patients themselves seldom move between the facilities within the complex. Instead, the complex attempts to liaison with other facilities in the region. There are almost no examples of the type of relationship often seen in Japan, in which long-term care facilities function as undertaker for the discharged patients from hospitals.

In Canada, the CCACs are organizations that assess both facility and home care services for the elderly. Though they were set up to ensure continuity in care services, they also impede the coordination of medical care and long-term care. When transferred from a rehabilitation hospital to a convalescent hospital within the same complex, a patient receives seemless and continuous services as a transfer from a hospital to another. When a patient leaves the convalescent hospital and enters a long-term care facility, however, he/she must undergo a CCAC review, making it difficult to achieve the same level of continuous service. In particular, because the CCAC are public institutions, they give priority to patients who are currently receiving no care at all. As a result, people who are currently receiving care in a convalescent hospital have lower priority for admittance to a long-term care facility, and there is no guarantee that they will be

admitted to a facility within the same complex.

Propriety of complexes differs among each country. In Canada, both providers and users evaluate the advantages of complexes. In Germany, however, there are concerns that complexes will turn into "ghettos" in which all senior citizens are confined in a single place.

《Medical care services at long-term care facilities》

While medical and long-term care complexes administered by the same entity were seldom seen in other countries, some long-term care facilities provided medical care services within the facility itself. In Germany, for example, some long-term care facilities have a resident doctor who provides primary care within his/her area of specialty. In France, there is a move to provide medical care at long-term care facilities. Medical care beds are provided in the homes for the elderly or the service apartment for the elderly to enable residents to receive not only long-term care but also medical care (nursing). These facilities are staffed with nurses and other nursing personnel, enabling them to provide more intensive care for the elderly. In Norway, nursing homes are required to employ both doctor and nurses (though they are not required to be resident), enabling them to provide medical care. Similarly, in Canada, nursing homes and elderly homes provide both long-term care and medical care.

《Intermediate facilities for medical treatment and nursing care》

In an effort to contain medical expenditure in every country, patients tend to be discharged from acute hospitals earlier than before. Convalescent hospitals and other facilities are becoming intermediate facilities for patients who have been discharged from hospitals but are unable to return home yet. These serve as transitional care facilities for patients moving from intensive medical care to long-term care. The developed countries are dramatically reducing the duration of hospital stays. As a result, there is a steady increase in the number of the aged who are discharged while still needing medical treatment, or who need rehabilitation in order to be transferred to a long-term care facility or to return home. All of the surveyed countries recognize the importance of having intermediate facilities to receive these senior citizens. Typical of such facilities are rehabilitation hospitals/facilities and convalescent hospitals that offer care with a strong emphasis on medical treatment.

Canada, for example, has facilities that combine the functions of rehabilitation hospitals and convalescent hospitals. Staffed with doctors, these facilities permit longer stays than ordinary hospitals do.

Germany also has prevention and/or rehabilitation facilities. An increasing number

of these facilities accept patients for recovery and rehabilitation after they have been discharged from hospitals. However, such facilities target all age groups, and they do not specialize in senior citizens. As eldery illnesses and treatment periods are unique, Germany now recognizes the need for geriatric care. Although still few in number, the number of medical treatment institutions specializing in geriatrics is increasing.

In France, hospitals offer medium-term stays and rehabilitation is provided during the recovery period. As in Japan, long-term convalescent beds are available for senior citizens whose chance of recovery is slim but who still need medicalcare. Moreover, some regions provide facilities known as recovery period facilities, which specialize in rehabilitation. All of these are categorized as medical treatment facilities.

In Norway, the commune governments are responsible for long-term care. A patient who is discharged from a hospital but still requires rehabilitation must be placed in an appropriate facility by the commune. If the commune is unable to quickly locate such a facility, and hasn't made an additional contract with the hospital, the commune pays a certain amount to the hospital according to the duration of the patient's stay. In order to meet the demand of those discharged patients who are still in need of care, communes have rehabilitation centers, care hotels, and other similar facilities as well as providing short stays at some nursing homes.

《Coordination between medical care and long-term care staff》

Sharing patient information is a key factor for a smooth transfer from medical care institutions to long-term care facilities. This information includes the patient's medical history and current status, what care the patient has received, and what care is needed in the future.

In addition, senior citizens in long-term care facilities will need an increasing amount of care as they grow older. Both the long-term care side and the medical care side must maintain close contact with each other in order to provide advice to ensure proper care.

The common thread among all of the countries in this survey is coordination. Each senior citizen in a care facility has a personal physician who visits him about once a week and confers with the nursing and long-term care staff. While such coordination exists, it is not possible to provide adequate and precise advice during a brief weekly visit. It was often said that the doctor only prescribed the medicine, and it is the nursing and care staff members who could notice the daily changes.

Complexes and other facilities with a resident physician or with adjoining medical care institutions enjoy close coordination between the medical staff and long-term care staff. When the facilities are physically separated, however, close coordination is not always possible. In France, the contract physicians at elderly homes are in charge of

the medical management of the facility, and not the care of the residents. The role of the contract physician and that of each resident's personal physician is divided and there appeared to be little coordination between the personal physician and the contract physicians at these facilities.

However, as seen in the Canadian example, some countries have introduced case management concepts and case conferences wherein an assessment is conducted that includes a discussion of the best type of both medical and long-term care for each senior citizen.

《Conclusions》

Every country offered the same reason for promoting cooperation: to hold down the increasing expenditure of medical care. For this purpose, these countries are adopting such measures as shortening the duration of hospital stays and reducing the number of hospital beds. They are also encouraging the transfer of patients to care facilities or home care. Due to a drastic reduction in the number of hospital beds, Canada now has a long waiting lists of patients for hospital admittance. This has caused a problem of increasing elderly people who are forced to be discharged, still in need to be cared. Norway also has few hospital beds and long waiting lists for hospital admittance. Long-term care services are now expected to handle the overflow caused by the shortage of hospital beds.

Due to the shorter hospital stays and the smaller number of available hospital beds, many of the countries surveyed currently do not have enough hospital beds for all the patients seeking hospital admittance. This creates an even greater need for intermediate facilities and care services to handle the overflow from the hospitals. These countries are now increasing the number of their intermediate facilities and the quantity of long-term care services.

These efforts, however, seem inadequate to ensure the continuity of services from medical care to long-term care. For example, in the countries surveyed, not all long-term care facilities have a resident physician. Neither is a full-time physician present at the nursing homes that function as intermediate facilities. The "personal physician" that had been in charge of the patient prior to admittance visits the facility once in a while, but medical care is not provided on a daily basis. In most cases, the facility's registered nurse, if there is one, handles most of the medical care. The patient's daily status is reported to the doctor and the doctor only provides care-related advice.

2. Current Situation in Japan and Future Prospects

As noted earlier, from a patient-oriented perspective, the medical services and

long-term care services in the countries surveyed may not have adequate continuity between them. These countries are seeking better coordination between the two services. Let us examine the current situation and future prospects in Japan.

《Efforts to establish an integrated infrastructure for medical care and long-term care》

Similar to the surveyed countries, Japan has separate financial resources for medical care and long-term care; medical insurance and long-term care insurance. Moreover, hospital planning is under the jurisdiction of the prefectures, while long-term care services fall under the jurisdiction of the municipalities. In this sense, the Japanese system is similar to that of Germany. However, home-visit nursing, elderly care facilities, and other long-term care services are covered by long-term care insurance, so they are under the jurisdiction of the municipalities. As a result, nursing and long-term care are provided in an integrated manner.

《Coordination between medical and long-term care at complexes》

In general, medical and long-term care complex is formed from a hospital, intermediate facility, and/or long-term care facility that are located nearby. In some cases, clinic (which is a part of this complex) is located remote from this complex but be conveniently located in terms of public transportation for the outpatient. For the clients, complexes offer the advantage of one-stop service, as well as the feeling of security of receiving a full range of services from the same service provider. For the provider side, a full range of services is attractive in terms of marketing. Also they could provide a wide variety of positions for doctors, nurses, physical therapists, occupational therapists, and other specialists. They could also efficiently operate since they are able to purchase necessary materials jointly. Most complexes in Japan have relatively good coordination among the facilities within the same group, and seamless care is being provided to some degree*.

It has been pointed out that Japan has many more hospitals and hospital beds than other developed countries, but fewer medical staffs. Complexes allow limited personnel to efficiently operate large facilities. Moreover, complexes are able to provide a full range of services, from medical care to long-term care, which is reassuring and appealing to patients. This enables these facilities to survive in local community markets.

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* For further information about coordination between medical care and long-term care at complexes in Japan, see our report, "Research Concerning the Integrated Deployment of Long-term Care and Medical Care Services (May 2001)," an autonomous research project of the JRI, as well as the "Report of a Survey on Medical Care and Long-term Care Complexes (March 1999)" and the "Report of Research for Medical Care and Long-term Care Providing System (March 2000)" research projects undertaken on behalf of the Institute for Health Economics and Policy (IHEP).

《Medical treatment functions at care facilities》

One kind of care facility in Japan, the special home for the elderly (*tokubetsu-yogo-rojin-home*), is required by law to have a resident physician. In other countries, each resident is visited by a personal physician. However, there is no requirement that a physician be present at assisted living, or service apartment for the elderly where elderly people that are self-sufficient or who have comparatively minor long-term care needs stay. If the patient's care needs become heavier, these homes may have a problem providing medical care. Facilities that cannot provide in-house medical care need to maintain close coordination with nearby medical care institutions.

In many cases in Japan, when it becomes difficult to provide care within the long-term care facility, the patient is transferred to a hospital or other medical care facility. When the end is near, the patient is usually transferred to a hospital to breathe his/her last. However, making it possible for patients to return to long-term care facilities when medical treatment is no longer needed or to spend their last days at these facilities, as is the case in most developed countries, will not only hold down medical costs but also increase the patients' level of satisfaction.

《Intermediate facilities (long-term care facilities for the aged, and convalescent beds)》

As in other developed countries, the population in Japan is aging, and medical expenditures containment is necessary. Like the countries surveyed, medical institutions must differentiate their functions and acute hospitals try to shorten their length of stay. On the other hand, as in the other countries, Japan needs intermediate facilities to receive senior citizens who require rehabilitation or other care after they have been discharged from the hospital. These functions are currently being provided by nursing homes for the elderly (*kaigo- rojin- hoken- shisetsu)* or convalescent hospitals *(ryoyo- gata hospital)*.

《Personnel coordination in medical treatment and care》

As in Canada and some other countries, Japan provides long-term care management. Almost all the services assessed by this caremanager are paid from long-term care insurance, and medical care services provided from hospitals are not included. In Japan, however, long-term care insurance also covers home-visit nursing, nursing homes for the elderly (*kaigo- rojin- hoken- shisetsu)* or convalescent hospitals *(ryoyo- gata hospital)*, and other services. Thus, long-term care insurance services are intertwined with medical care services.

《Future prospects for Japan》

As this chapter has shown, compared to the other countries in this survey, Japan is

comparatively advanced in terms of the coordination between medical care and long-term care. One reason for this is that, as part of the effort to hold down medical expenditure, many of the hospitals in Japan are being converted into long-term care facilities such as nursing homes for the elderly (*kaigo- rojin- hoken- shisetsu)* or convalescent hospitals *(ryoyo- gata hospital)*, which serve as undertaker for discharged elderly people in need of care. On the other hand, Japan has few medical care professionals and lags behind the other developed countries in terms of medical care quality.

In order to contain medical expenditure, efforts are underway to reduce the number of hospitals and hospital beds and to convert hospitals into care facilities. A large reduction in the number of hospitals and hospital beds in Japan, however, may result in elderly patients being discharged even though they still require medical care. This is now happening in other developed countries. Moreover, as in other countries, the number of elderly couples or singles living on their own is increasing, while the number of households in which the children live together with, and care for, their elderly parents is declining.

In order to make effective use of limited resources, Japan should make effort to seek for its own way of integrating medical care and long-term care with the hints from other countries.

There is concern that integrated management may monopolize the patients within the complex or may create "ghettos" of abandoned senior citizens. Coordinating with other community resources, opening up the facilities to local residents and local senior citizens who live at home, or disclosing information can avoid these concerns. Residential facilities are already providing day services and day care for the elderly. In France, local private physicians are occasionally invited to the facility. These visits increased trust from the community and also served as a means of recruiting new residents for the facility. At some facilities in Norway, disabled persons were eagerly recruited as employees or volunteers. This type of social commitment to the local community is strongly needed in Japan.