How can effective coordination between Health Insurance and LTC Insurance (including sharing of user information) be achieved in Japan?

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1. The present status of coordination

In Japan, there are two insurance schemes which provide coverage for medical treatment and long-term care for the elderly. Health Insurance is designed to cover medical treatment, and the cross-regional municipalities in each prefecture are the insurers for the medical care which provides coverage primarily to all those 75 years or older. The long-term care insurance system (LTC), on the other hand, aims to provide long-term care primarily to those 65 years or older, and the municipalities are the insurers.

In Japan, the majority of that which in the Netherlands would be covered by the WMO (social support act), a Dutch Municipal Service, is provided by the LTC. However the Japanese national council report this summer indicates that there is intention toward placing some LTC services under the administration of the municipalities, as is done in the Netherlands.

In this way then, the cross-regional federations of municipalities are the insurers for medical treatment for the late-stage elderly, and each municipality is the insurer for LTC: in both instances, the municipalities are key players.

Under the current system of medical treatment for the elderly, most early-stage elderly (age 65 to 74) receive payment from National Health Insurance with the municipality as the insurer. Therefore, there is also potential for a different health insurer however, in order to simplify the discussion, this study will focus on the late-stage elderly.

"Effective coordination" refers to the following:

A: Full system coordination of aggregate level data across the two systems for efficient use of funds, and

B: Coordination of private information at the operational level in order to bring about medical treatment and care that is beneficial for each client.

From the perspective of maintaining confidentiality with regard to B, any exchanges of information between the insurance manager and LTC manager concerning the insured are fundamentally an exchange of information within the same organization, municipalities; however, as a precaution, it may be worth considering legislating to make it clear that this is acceptable.

Concerning A, the Cabinet Office has begun to establish the DPC (Diagnosis Procedure Combination) Project, a National Health Insurance database system that also contains data from many hospitals. This system attempts to assist with cost reduction through analysis of the data of each insurance type, based on the information gathered from the electronic receipts of medical institutions.

According to material from the Cabinet Office, the DPC procedure is already used to accumulate the medical fee data and specific medical checkup data at a national level, based on the

medical insurance receipt data that is kept anonymous. This data is then organized into medical fee data by region, and fee data by hospital. In the future, prefecture-level databases will be created based on this same data, and individual-level data will also be made accessible in an attempt to ascertain the outpatient visit status for each patient and for use in home treatment/long-term care coordination. The "Fukuoka Prefecture Sanitation Medical Nursing General Database" can be given as an advanced example of this type of prefecture-level database.[i]

The All-Japan Federation of National Health Insurance Organizations (Kokuhotyuohkai) have begun gathering the data of LTC payouts and medical insurance for each individual and studying the two sets of data. In accumulating this data the municipalities are attempting to assist in treatments that will reduce care needs, and activities that will prevent patients from becoming long-term care service receivers.

Concerning B, under the current system, both the medical provider and long-term care provider receive the following kind of set remuneration for provision of information to the other party.

(1) Information Provision by Doctors (Health Insurance)

In terms of the medical service remuneration for doctors, there is already a medical service information provision amount included as an accepted part of the medical service remuneration.

Because this provides for information provision between doctors, clinic doctors are eligible for remuneration when they supply information regarding admissions to the hospital. However, more important is information provision by the hospital when the patient is discharged. The hospitals are obliged to make an effort with the information provision at the point of discharge as stipulated for under the Medical Care Act, and the government is attempting to encourage this with the medical service remuneration. There are multiple recipients for this information provision, and the hospitals will be eligible for a one-off addition of 250 points per patient (2,500 yen) per month provided that the hospitals authorized to treat insured patients to which the consent was obtained , and submits it to a) the existing family doctor, or b) the municipality which has jurisdiction over the locality where said patient lives, or a Designated In-Home Long-Term Care Support Provider specified by the prefectural governor pursuant to the provisions of Article 46, Paragraph 1 of the Long-Term Care Insurance Act, attaching a document which indicates the status of the medical treatment to provision of information regarding the health and welfare service needs of said patient.

The content of the information provided at this document is as follows.

- Name of illness
- Degree to which bedridden (four stages)
- Where they present on the ADL scale (mobility, toileting, dressing, eating and feeding, bathing, personal hygiene and grooming)
- The level to which elderly persons with dementia are self-sufficient in daily life (5 stages)

(2) Advice by Doctors (LTC insurance)

With regard to clients who are unable to use outpatient services, the doctor who is responsible for

management of in-home medical long-term care is eligible to receive a maximum twice-monthly 500 points if the in-home medicine management consultancy fees of the medical service remuneration have not been included or 290 points otherwise. Provided that said doctor, based on systematic and ongoing medical management of the client in question, supplies the in-home long-term care support provider with the information required to draft a home service plan, and gives guidance and advice on precautions that will improve the client's QOL in the home, such as the location of the handy toilet. In this instance the doctor is also entitled to add on an in-home medicine comprehensive management fee, and this is dependent on their having conveyed the following information to the care manager in either the service givers conference or in writing:

- The condition of the patient, progress etc.
- Points for special attention, care methods etc.
- Items requiring special attention in the client's daily life

As well as providing information to the care giver, the doctor must also inform the client and client's family of the points for special attention and care methods for use in the long-term care service.

Long-term care support providers are eligible for two kinds of long-term care remuneration The first is available when a client is discharged from hospital or a facility authorized for long-term care of insured patients, if the long-term care support staff member consults with the hospital and requests the information required to enable the client to use the home service, creating the "Hospital/Facility Discharge Information Form", an additional 300 points per month for hospital/facility discharge will be added to the in-home care support fees. (Newly established in the 2009 revisions)

The content of the information is recorded below. This then, constitutes the official understanding of the medical information that long-term care providers require. When viewing a sample form, we would find the following items:

- Condition of illness (name of primary disease, predominant symptoms, medical history, medication, ADL)
- Meals (degree of independence, meal format - shredded food etc.)
- Oral care (degree of independence)
- Mobility (degree of independence)
- Bathing (degree of independence)
- Toileting (degree of independence)
- Condition overnight (sleeping, restlessness)
- Items for attention during treatment

The second is available if a long-term care support staff member provides the staff of the hospital or clinic with information on a client who is about to be admitted and who requires long-term care, adding 150 points per month in long-term care remuneration for medical coordination to the in-home care support fees.

Of these examples of information provision, some are obligatory and some are not. For example the "Hospital/Facility Discharge Information Form" is not mandatory for care providers. Additionally, for some items there is a set information provision format and for others there is none, for example the "Hospital/Facility Discharge Information Form" has a set format, but no such format exists for "In-home Medicine Management Consultancy Fees".

2. Data required by medical staff and long-term care staff

In order to ensure that clients can experience a high quality of life, it is important to define what information is required by those in medical treatment and long-term care, and what kind of information is beneficial to the client.

The information given can be divided into two types: "basic data" and "variable data". Basic data is comprised of the basic information that is obtained when the person applies for long-term care or at the point of change, and variable data is the required variable information such as that which changes time-by-time. Examples of basic information include the client's name, address and date of birth. Variable information is as follows: the name of the primary disease, predominant symptoms, medication, meals, fluid absorption, sleep, toileting, motion, bating, oral care, and degree of care required.

The majority of this information is contained in the "Hospital/Facility Discharge Information Form" introduced in Section 1. The Cabinet Office sets forth the following standardized information as information to be shared.

- Sleep, toileting, meals, fluids
- Primary complaint, information on medicine
- 12 items concerning skin and bodily functions
- Treatment details, prognosis[ii]

Of these, the only item which is not contained in the "Hospital/Facility Discharge Information Form" is fluid. As there has been a lot of feedback to the effect that this item is necessary for workers in the field, it should be added to the form.

As stated in Section 1, the national government has begun creating a macro-system that will extract a number of items from the doctors' electronic receipts, and create a form containing the necessary information. However, looking at the items on the current electronic bill from this perspective there are only the name of the illness, types of medical intervention such as medication, and medical fees. Likewise, the LTC provision fee receipt contains only the degree of care required, and the service details. It is necessary to consider whether these constitute a sufficient level of information for those in the medical and long-term care fields.

The only details recorded on the long-term care authorization application form are the basic information, degree of care required, and attending physician. However the ADL condition such as the locus of paralysis etc. is recorded in detail on the authorization survey form which summarizes

the results of the on-the-spot survey carried out by the municipalities in response to the client application. The variable data is recorded in the form of an actual benefit management report submitted by care-managers monthly.

3. Proposals related to future medical treatment and care coordination

(1) Who initiates coordination?

In some regions, hospitals/clinics and long-term care providers are successfully carrying out direct information exchange. However, there is no rule as to who is to initiate the information sharing. In areas where coordination is successful, it is initiated by a doctor or others who are eager to provide users with a high quality of life.

One local government has a guideline to classify and determine who to provide information to when a patient is leaving the hospital and has no care manager.[iii] It is important to know which of those who actually come in contact with the client is to take responsibility for initiating the coordination. Therefore, a decision must be made on who should initiate coordination between the medical care system and LTC, if such coordination is to take place throughout Japan.

(2) Care manager

In my opinion, it should be the care manager's duty to initiate the coordination, and only those who cooperate with the coordination should be eligible to be designated as home visit long-term care providers and in-home health support clinics. As the coordination with care-giving is the issue, LTC accreditation is a requisite. And as care should theoretically be required for any in-home cases, the insured should be made to appoint a care manager (a role which can be assumed by the insured) thus creating a structure for coordination between medical treatment and care.

Furthermore, it should be made mandatory for doctors of in-home health support clinics, hospitals which accept those who need care, home visit long-term care providers, and home visit nursing service providers etc. to participate in service manager meetings (document-based participation to be accepted). Participation in this meeting should also be made obligatory for attending physicians (document-based participation to be accepted) who are not affiliated within-home health support clinics in order to establish coordination. In cases where there is no care manager (i.e. the users themselves are creating their own care plan), it must then be the obligation of the person receiving in-home treatment to appoint a care manager.

Under the current policy, if an in-home service plan is newly created, the care manager must host a service manager meeting comprised of staff involved in in-home services if a person recognized as requiring care receives either a recognition renewal or changes to the condition classification of the recognition. However, an area that requires improvement is that the doctor is taken out of the role of in-home services and has no obligation to participate in the meeting.

(3) Who is to provide the information?

Ideally doctors and LTC facilities, which hold the most medical information, would provide information to the care manager. However, this would involve placing the obligation to provide treatment information etc. as introduced in Section 1 with doctors and LTC facilities. Therefore, law changes would be required in order to achieve this. And since there is a political issue involved in this, information should be provided in the following way until it is possible to achieve this.

For the medical care system and LTC, receipts go through cross-regional federations and municipality for payment. Therefore, new mandates are not required, and it is possible for the insurer to provide information to the care manager using information technology. The contents of the current receipt must be evaluated for sufficiency from the perspective of medical and long term care, and if it is not sufficient, the receipt format must be changed. As the cross-regional federations, which are the insurers for the medical care system, are aggregates of municipalities, it is necessary to consider whether amendments to the law are required to ensure that municipalities can provide information for the coordination by long-term care staff and medical institutions.

(4) How should the coordination take place?

There are two possible methods for collecting data. One method is to collect the necessary information from doctors' receipt information and long term care providers' invoice information by using DPC logic, which is currently being carried out automatically. Information can be obtained with relative ease if sufficient data is contained in the receipt. To do this, receipt information conversion technology is required. In addition, the format of the receipt may need to be changed to include the required user-related information, as discussed in Section 2 above. The second method is to expand the provision of treatment information etc. by doctors, as stated in Section 1. In order to do this, items that are not currently mandatory must be made mandatory.

In addition, if it is difficult to carry this out within the current municipal structure, it is possible to consider consigning this to the National Health Insurance Organizations of each prefecture, which carry out inspections and payouts for National Health Insurance and LTC.

(5) Obligation of Care Managers

Some doctors are concerned about disclosing patients' personal information to long-term care providers which include profit-making enterprises. It is therefore important to clearly stipulate in legislation the penalties for violating the confidentiality obligation of care managers who were given such personal information.

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[i] 2013. 5. 16. Cabinet Office "The Current Status and Challenges for Social Security" 2013.8.25accesswww5.cao.go.jp/keizai-shimonn/kaigi/…/sankou_01.pdf

[ii] "Survey Research Concerning the Shape of Common Infrastructure for an Information

System for Coordinating Medical Treatment and Care", July 29, 2013, Ministry of Health, Labour, and Welfare, Manager Conference Material 6

[iii] "Guideline for Home Care Support (elderly requiring care)", LTC Insurance Department, Chuo-ku, Tokyo (July 2011)