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**Topics: Recent topics in public health in Japan 2025**

## ＜ Note ＞

# Policies toward coordinating acute medical care and long-term care in Japan

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**Abstract**

Japan's demographic structure is changing dramatically. Due to an increase in the number of older adults, there is a growing need for acute medical and long-term care services. As a result, even after completion of treatment in acute care facilities, patients who have difficulty living independently may be transferred to long-term care facilities, facing the risk of developing pneumonia and other acute illnesses that require hospitalization at an acute care facility. If a patient in a long-term facility experiences a fall or another medical safety event, they must be promptly diagnosed and treated at an acute care facility. Consequently, collaboration between acute medical and long-term care is essential, and the Japanese Ministry of Health, Labor and Welfare is promoting various initiatives to address this issue. The medical service fee, revised every two years, and the long-term care fee, revised every three years, will be used to achieve this goal. June 2024 presented a rare, once-every-six-year opportunity for these fees to be revised simultaneously, enabling the implementation of policies to promote coordination between acute medical care and long-term care. However, a significant challenge is the decline in the working-age population, which must be addressed. The details are presented in this study.

***keywords***: coordination, acute medical care, Long-Term Care, community health care vision, demographic structure, training

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## I. Background: Why is coordination between acute medical care and long-term care needed?

### 1. Demographic changes

Japan's total population, which includes both Japanese nationals and foreign nationals, declined below the previous year's level in 2005 for the first time since World War II, peaked in 2008, and has been declining for 11 consecutive years since 2011[1]. On October 1, 2021, the total population of Japan was 125,502,000, a decrease of 644,000 (-0.51%) in the one-year period from October 2020 to September 2021. This decline has been the largest since 1950 when comparable data were available. Additionally, the population of Japanese nationals was 122.78 million—a decrease of 618,000 (-0.50%) from the previous year, and the rate of decline has been increasing for 10 consecutive years.

By 2025, the population of older adults, especially those aged 75 years and over, will rapidly increase and then slow down. However the population aged 65 years and over is estimated to continue increasing until approximately 2040, peaking. In contrast, the decline in the working-age population will be estimated to accelerate from 2025 onward (Figure 1).

Considering the population of seniors aged 65 years and older, many areas are already experiencing a downward trend; however, looking at the population of those aged 85 years and older, many areas are still growing.

Approximately 60% of those aged 85 and over are certified as requiring long-term care. Therefore, the main targets for future acute medical and long-term care coordi-

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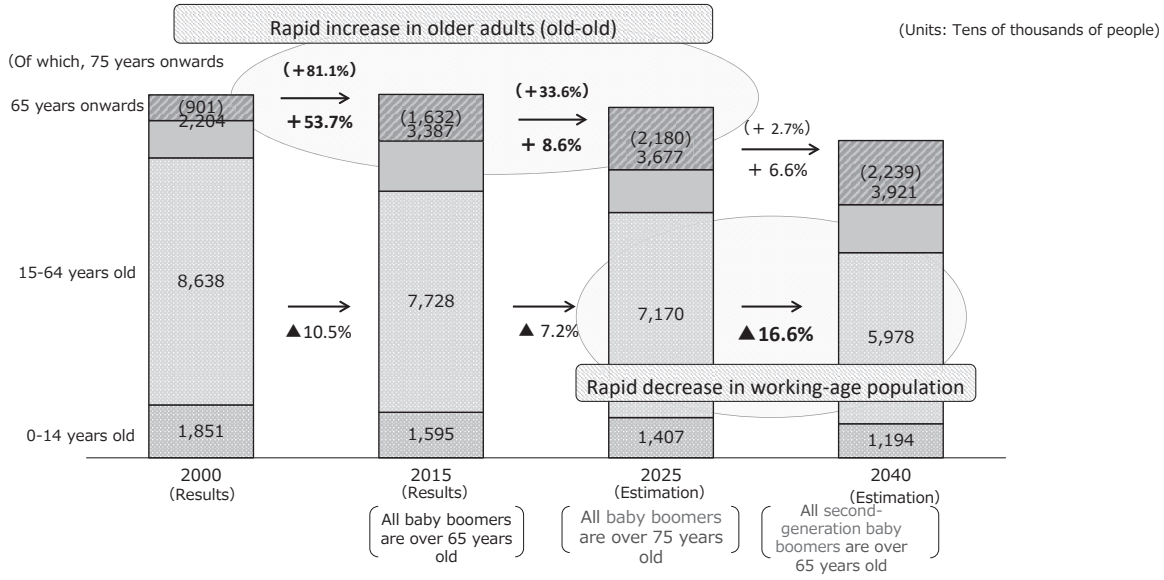


(Source) Ministry of Internal Affairs and Communications "Population Census" and "Population Estimates," National Institute of Population and Social Security Research "Population Projections for Japan, 2017 Estimates"

**Figure 1 Changes in demographics – Demographic structure**

nation will be those aged 85 years and older.

**2. Characteristics of older adults**

Older adults aged over 85 years of age have both acute medical and long-term care needs. It is well known that facility users contract pneumonia, and many of them are admitted to acute care hospitals, after which their activities of daily living (ADLs) decline and their cognitive functions deteriorate. This phenomenon has also been reported in new cases of coronary artery infection. According to statistical data, approximately 60% of those aged 85 years and older are certified as needing long-term care. In some areas, the number of people over 65 years of age is already declining, but in many areas, the number of people over 85 years of age is still increasing. The main target for future acute medical and long-term care coordination is the group comprising individuals aged 85 years and older. Very often, for these individuals, the place of death is a long-term facility as well as a home. Providing medical end-of-life care at home or long-term care facilities remains a major challenge. Thus, users are admitted from medical facilities to long-term facilities and from long-term facilities to medical facilities. In long-term care facilities, the number of patients requiring a certain level of medical care is increasing, with approximately 30% of the patients in medical categories 2 and 3. (The medical classification is a three-level classification of medical necessity established by the Ministry of Health, Labor and Welfare, and takes into account diseases, conditions, medical treatment, etc.). Specific illnesses include pneumonia, aspiration pneumonia, urinary tract infections, and heart failure, which often result in patients being transported to medical facilities. Approximately 75% of these patients are transported to acute care hospitals. If hospitalization is prolonged without much rehabilitation or care focused on daily life after hospitalization, ADLs and cognitive decline occur, and the level of care required increases. However, rehabilitation is not often implemented in acute-care hospitals.

## II. Policies to promote acute medical and long-term care coordination

**1. Strengthening requirements for acute medical and long-term care coordination**

Long-term facilities traditionally require the establishment of cooperative medical institutions at the time of their opening. For example, approximately 10% of cooperating medical institutions in special long-term care facilities are university hospitals, referred to as hospitals with specific functions. However, considering that aspiration pneumonia and urinary tract infections are diseases in which patients are admitted to hospitals from long-term care facilities, they may not be originally targeted by hospitals with specific functions. Approximately half of the aged care facilities and long-term care hospitals also reported that they had little communication with their cooperating medical institutions since the facilities were established. The most recent survey showed that the cooperation, so to speak, had become a formality. Therefore, the Ministry of Health, Labor and Welfare (MHLW) held meetings to exchange views with the concerned parties. Specifically, the MHLW held discussions three times with members of Chuikyo, which is in charge

of medical fees, and with members of the Subcommittee on Long-Term Care Benefits, which is in charge of long-term care fees. The major messages of the revisions are as follows:

- In medical care, we aim to provide high-quality services with greater consideration for life.
- Care management includes a more medical perspective in long-term care.
- Consideration will be given to the content of the information provided and the nature of collaboration to achieve these goals.

Specific revisions included the following mandatory requirements for elderly care facilities (special nursing homes for the older adults, rehabilitation facilities for older adults, and integrated facilities for medical and long-term care) [2]:

- Consultation: In the event of a sudden change in a resident's medical condition, a physician or nursing staff will provide a consultation system. The elderly care facilities are required to establish, maintain, and ensure such a system.
- Diagnosis: A system to provide medical care when needed.
- Hospitalization: In the event of a sudden change in a patient's condition that requires hospitalization, a system that accepts the patient's hospitalization will, in principle, be secured.

Long-term care facilities must include medical facilities that meet these three requirements. Although there have been provisions for cooperation with hospitals in the past, their roles have been clarified and made mandatory. According to the MHLW, it wasn't easy to make this mandatory. It is challenging for elderly facilities to request various things from medical institutions, and sometimes, they are afraid to tell the director. However, during the COVID-19 pandemic, we had experience working with medical and long-term care facilities and managed to make this mandatory.

Nevertheless, we believe that it will be challenging to achieve this immediately; therefore, we included a three-year transitional period. At least once a year, it is necessary to confirm with cooperating medical institutions how to respond to sudden changes in medical conditions and properly notify the local government. Importantly, suppose a resident is admitted to a cooperating medical facility, and their medical condition becomes less severe and no longer requires hospitalization. In that case, the senior care facility promptly accepts the person. Without this, medical institutions would not have been able to manage acute care. In terms of reimbursement for medical services, an additional fee was added on the first day of hospitalization, and an additional house call fee was established when a house call was made to the user. Hopefully, these efforts will result in a win-win relationship between medical institutions and long-term care facilities.

**2. Strengthening rehabilitation coordination**

Stroke patients are rehabilitated at medical institutions under medical insurance until the convalescent stage, and rehabilitation continues at home or in elderly care facilities after discharge.

However, according to the report[3], approximately 70% of the respondents started in-home rehabilitation within two weeks of discharge from the medical institution; that is, 30% of the respondents took more than two weeks to start in-home rehabilitation (Figure 2). It has been noted that this delay results in less effective rehabilitation (Figure 3). Regarding the rehabilitation of long-term care facility patients, only 44% of the respondents reported obtaining and viewing disease-specific rehabilitation plans that had been implemented at medical facilities. There was a discontinuity in the information between medical and long-term care regarding rehabilitation. Therefore, in the current revision, it is mandatory to obtain and understand the contents of the rehabilitation plan prepared by the medical institution during hospitalization when providing day rehabilitation or home-visit rehabilitation after discharge. In other words, it is impossible to calculate long-term care fees for day

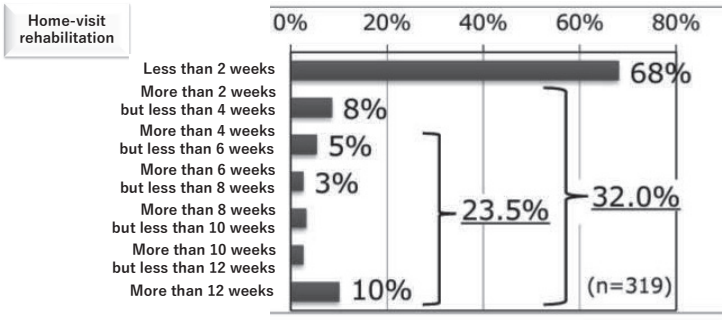


**Figure 2 Period to start rehabilitation use after discharge from the hospital**

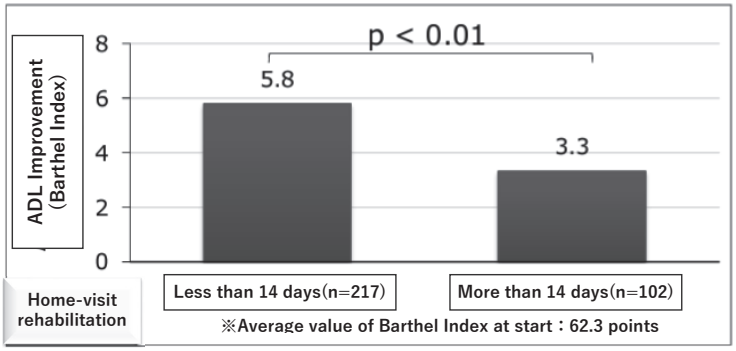


**Figure 3 Frequency of functional recovery by period to start rehabilitation after discharge from the hospital**

rehabilitation or home-visit rehabilitation at a long-term care facility without obtaining a written plan from a medical institution.

Because there was no transitional period for this matter, it was necessary to implement it immediately starting this June, which was a bit of a harsh response. However but the field reported that this effort had made progress as a result of the mandatory implementation.

### 3. Future Community Health Care Vision

To date, the community health care vision has focused on functional differentiation and coordination of hospital beds at each medical institution[4] [5]. However, in the future community health care vision, the entire medical care delivery system, including coordination with long-term care, should be considered. Coordination between medical care and long-term care is a significant issue for the vision of future community health care. In addition to defining the functions of medical institutions (such as highly acute, acute, and convalescent phases), special attention should be given to the functions within the community health care system, especially the coordination with long-term care, as an essential aspect for consideration.

## III. Voices from the field

Various experts dealing with patients, users, and their families in the fields of acute medical and long-term care, especially patient safety, were interviewed. In promoting acute medical and long-term care coordination, we asked for their opinions on what new or transforming patient safety issues arose from the aging of the population and other factors and on the acute medical and long-term care coordination systems needed to address these issues. The interviews included physicians and nurses working on patient safety at acute medical and long-term care facilities, consultants involved in risk management projects at long-term care facilities, and attorneys on the patient or user side. Comments and other information obtained from the hearings are described below.

With the aging of the population, the number of people with combined acute medical care, long-term care, and life-style support needs is increasing. There is a greater mix of acute medical care in long-term care settings and injuries caused by extended daily routines that cannot be handled solely under the medical care umbrella, including dementia care in the medical setting. In this context, safety-first measures are becoming more common in the acute medical field, including restricting patients to sitting or wheelchair use, limiting the range of activities due to dementia, or using sedative medications.

It is increasingly necessary for patients/users/families and acute medical/long-term caregivers to collaborate and plan in advance on how to provide care that does not overly restrict a person's life and considers their personality based on the shared understanding of risks in life due to physical functional decline and cognitive level.

Rather than focusing too much on avoiding risks in hospitals, it is necessary to accept the risks and take as many safety measures as possible, taking into consideration care that makes the most of the individual's personality and then ensuring that patients, families, acute medical care staff, and long-term care staff have a common understanding of what may occur in the future. Simultaneously, it is necessary to ensure that patients/families, acute medical, and long-term caregivers share a common understanding of possible future events.

To this end, in the field of safety, rather than one-way cooperation from medical care to long-term care, it is important to have two-way cooperation based on mutual respect and mutual understanding, for example, by having the medical side learn about care practices in the long-term care field. Even in the event of an injury, it can be expected to improve quality and provide economic benefits, such as

preventing unnecessary time and economic losses for both parties, without causing disputes.

- Two particular patient safety issues are falls and aspiration/choking.
- A multidisciplinary approach that includes physicians, nurses, various rehabilitation professionals, and others is needed.

At this time, a "psychologically safe" place is needed where hospitals can exchange opinions with long-term care facilities, not from a "top-down" perspective but rather with each other. Some medical institutions are implementing a system whereby hospital rehabilitation specialists also work in long-term care facilities (collaboration).

- Unlike hospitals, long-term care (facilities) are places where people live, and it is desirable to be able to pass the baton to the long-term care field quickly and safely when intensive medical care is no longer required. This will help ensure that medical-care facilities focus on treatment. To this end, it is necessary to focus on the following in care settings (not only in residential care facilities): efforts to improve safety (use of accident reports, exchange of experience between facilities and medical institutions), strengthening rehabilitation to maintain daily living skills (e.g., swallowing training), and increasing the number of staff with the ability to judge the need for medical care, and so on. Developing the ability of staff to make decisions on medical needs, increasing the number of personnel capable of making accurate decisions, and so on.
- Advance Care Planning (ACP) is important for older patients, but it is difficult to implement appropriate ACP practices in busy healthcare settings. Therefore, human resources, education, and training are required. As patients move from medical care to long-term care and from long-term care to medical care, information about ACP should also be shared and coordinated appropriately.
- The various care systems are complex and challenging to understand, and it is not always easy for a patient's family to make the best choices. Patients' families need to be better equipped to supplement their knowledge and support decision-making to use healthcare successfully. Medical dialogue promoters at medical institutions and care managers in the long-term care sector play an important role. However they seem to depend mainly on individual qualifications, in addition to a shortage of personnel, and it is necessary to improve their quality as a system.
- The shortage of human resources is a pressing issue in the care sector, with the existing care workforce aging and the number of foreign care workers increasing. For this reason, it is also important to make the systems and procedures for cooperation with healthcare less complex and less burdensome for the field.
- Regarding unknown infectious diseases as a change in the external environment, many establishments are still struggling to deal with new coronavirus outbreaks, as they have to work with medical care with fewer staff in the event of a cluster outbreak.

## IV. Human resource development for promoting health care coordination

The National Institute of Public Health trains personnel involved in medical, long-term care, and other fields[6]. Several training courses are provided to develop human resources that can contribute to promoting cooperation between acute medical care and long-term care in regional medical cooperation management training.

The primary target audience for the courses includes hospital executives, such as hospital directors and nursing directors. First, before participating in the training, participants sort and share the various issues related to cooperation with other medical institutions, care facilities, and the government at their respective medical institutions. These issues are discussed and exchanged on the first day of the training. Throughout the five-day training program, participants attend various lectures (delivered by MHLW personnel, experts, and so on.) and take part in group exercises and other exercises to obtain hints on how to solve these problems. This includes a simulation of older individuals' experiences to help participants better understand what "patient-centered" means with regard to this population, who is the target of healthcare coordination. Although healthcare professionals regularly work with older patients, this simulation provides them with a renewed understand-

**Figure 4 a simulation of older individuals' experiences**

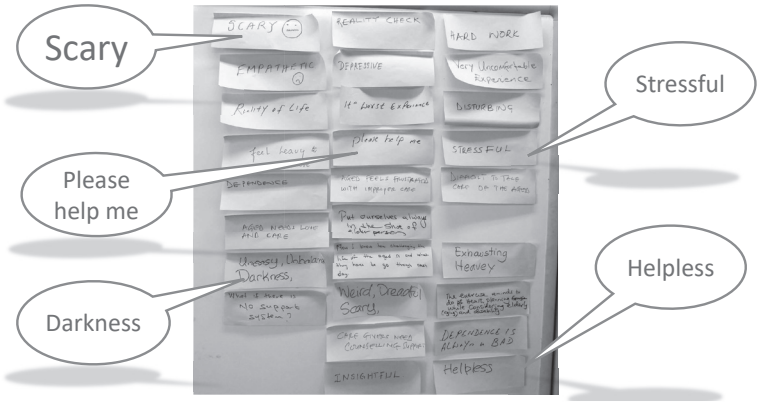


**Figure 5. Reflections after the simulation**

ing of the situation and an opportunity to reconsider patient care and cooperation (Figure 4, Figure 5).

The National Institute of Public Health (NIPH) also provides training for senior administrators in developing countries. In its training, this simulation of the aging population aims to deepen our understanding of the aging challenges facing Japan. The participants' countries are young in terms of their overall national population. However they have a better understanding of the older people close to them, learn about patient-centeredness in a meaningful way, and have the opportunity to consider aging, which will be an issue in their countries shortly.

## V. Expectations for the super-aging society

Aging is a challenge faced by several countries. Many older adults have both medical and long-term care needs, and coordination between acute medical and long-term care services is considered an essential issue that needs to be addressed in all countries. In Japan, in addition to the challenges of an aging population, a decline in the working-age population is a key feature that makes it even more challenging to address. Beyond each medical institution and long-term-care facility, the whole community must work as one big team to provide "people-centered" health and care.

The author concludes with an African proverb learned during his time working for the WHO (2012-2015):

"If you want to go fast, go alone; if you want to go far, go together."

Coordinating acute medical care and long-term care is challenging, but it is achievable through the collaboration of the various stakeholders.

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＜解説＞

# 医療介護連携政策の動向

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**抄録**

日本の人口構造は大きく変化し，高齢者の増加によって医療及び介護のニーズが高まっている．この結果，急性期医療における治療が完結しても自立した生活が困難で介護の必要な患者は介護施設に転院し，また介護施設の利用者は肺炎等の急性期疾患を容易に併発し急性期医療機関への入院が必要となる．さらに介護施設の利用者に転倒など医療安全上の出来事が起きれば，速やかに急性期医療機関において，診断と治療が必要となる．これらの結果，医療と介護の連携は必須であり，これに対応すべく日本の厚生労働省は様々な取組みを推進している．とくに取組みを実現すべく活用されるのが，2年に1回の診療報酬改定と3年に1回の介護報酬改定である．2024年度はこれらが同時に改定される6年に1度の貴重な機会であり，医療介護連携を推進するための新たな政策が実施された．一方で，これに対応すべき生産年齢人口の減少は大きな課題の一つである．これらの詳細について，当該論文で紹介する．

**キーワード**：医療介護連携，人口構造，地域医療構想，研修