

Japan's Elderly Medical Care Crisis and Comprehensive Community Care Solution

The following notes are actually the words that were spoken by Dr. Suzuki as each slide was displayed. The Slide numbers match the Note numbers.

Note 1. Good afternoon. I am Gaku Suzuki, and I run a medical clinic in Kiyota Ward, Sapporo. I sincerely appreciate your taking the time to attend my presentation today.

Note 2. The presentation today will cover the following four points. I will tell you about the social conditions affecting medical care and nursing care, the current situation due to the declining birthrate and rapidly aging society, and the worsening financial problems. As a result, the cost of medical care and nursing care must become more stringent and more efficient. I will introduce the outline of the proposed comprehensive community care system. Then, I will explain what our hospital is doing as a concrete example of the comprehensive community care system.

Note 3. These are the reference materials that I used to prepare for today's talk. I am sorry that both books are only available in Japanese.

Note 4. Let's look at some of the social conditions surrounding medical and nursing care.

Note 5. With regard to the rapidly progressing super-aging society, we need to look at the reality of the data and the impact this will have on everyone.

Note 6. This graph shows the population trend of Japan. Currently, 1 person in 4 is aged 65 and over. The age group of production, which is shown in blue, has already peaked and is projected to steadily shrink. In 2025 the primary baby boomer generation will join the group over 75 years old. From this point, one in four people will be latter-stage elderly, entering a rapid aging era. Social security benefits and financial sharing of the burden will become very difficult. The current basic policy is to increase taxes, increase the self-burden and reduce benefits, and further improve the efficiency of the medical care system.

Note 7. The need for more human resources in medical and welfare care has already arrived. Talent competition for all occupations has begun. In 2025, the primary baby boomer generation will be included in the late elderly. However, this is just the beginning of the medical care crisis. Furthermore, the declining birthrate and aging population results in the continued shrinking of the base of productive workers. To make matters worse, the aging of the second layer of baby boomers will arrive

shortly thereafter. Please note that the future period projections could fluctuate depending on the actual birth rate from 2007 onward.

Note 8: This graph shows the ratio of the worker population supporting the elderly. The blue line shows the ratio of the population aged 65 years old and up, when the workforce population includes those 20 to 64 years old. The orange line shows the ratio of retirees from 70 years old, when the population of the workforce would include those 20 to 69. Currently, with those 65 and above considered to be retired, the ratio is 2:1, or double that of the retired population. However, if only those from 70 years of age and up represent the retired population, the worker population base would then be 3:1 or triple that of the retired population group.

Note 9: Japanese medical care and nursing-care insurance are allowance systems that support elderly people by insurance premiums and taxes paid by the working population. If people from 65 years old are considered to be retirees, as it is now, it takes 2 workers to support one elderly person at this time. In 2050, which is about 30 years from now, approximately one worker would be supporting one elderly person. This is probably unsustainable. For that reason, measures are needed to keep elderly people healthy, in order to continue their work and have the ability to contribute to the support of all elderly people.

Note 10. Summary: An abnormal declining birthrate and an aging population in Japan is rapidly progressing. It is very difficult to steer the benefits and burden of social security. How will the government cope with declining tax revenues, recession and increasing social security expenses? Because the average number of household members has decreased, family caregiving ability cannot be expected. Elderly people who live alone, the elderly couples who are caring for each other and middle-aged people who must care for their parents is increasing. Because the decrease in the population of the production age group has been remarkable, the number of people providing medical care and nursing care has also decreased, and competition for limited human resources is ongoing.

Note 11. Our elderly home sign board.

Note 12. Fiscal Resource Problems

Now let's take a look at the Fiscal Resource Problems of Japan, in order to understand the gravity of the situation we are facing.

Note 13: This figure illustrates the reality of the workforce burden providing welfare support for the elderly. What can be realized in the future is whether to choose high

welfare with a high burden or low welfare with a low burden. It seems that current Japanese society is longing for a low burden and high welfare, but that is impossible.

Note 14: Japanese debt outstanding increased by 600 trillion yen from 1990 to 2014. The current debt balance is equivalent to approximately 15 years of general account tax revenue. The debt outstanding in fiscal year 2015 is about 807 trillion yen, which is equivalent to debts of about 6.38 million yen per citizen. For a family of four people it is equivalent to about 25.5 million yen in debt. By the way, the average annual income of workers' households is about 5.11 million yen. So, in an average household, each household is in debt five times the annual income.

Note 15: The ratio of outstanding debt to GDP is on the same level as it was immediately after World War II. As it was then, it is a situation of extreme crisis.

Note 16: The gap between tax revenue and expenditure has been expanding since 1992. This gap is referred to as the mouth of the crocodile. The peak of tax revenue was 1990. From 1992, the mouth of the crocodile begins to open wider. In other words, expenditures continued to increase, but tax revenues did not increase. Issuance of public bonds continues to be offered as the primary measure to fill the gap, but it cannot keep pace with rising expenditures.

Note 17: In order to ensure fiscal sustainability, a policy is needed to reduce the proportion of outstanding debt to GDP. The following three policies have been devised. 1. Suppression of expenditures and expansion of revenues. 2. Focusing on social security and improve efficiency. 3. A strategy to secure economic growth while the population is decreasing. However, as the population continues to decline, feasibility is not high.

Note 18: When thinking about suppression of expenditures, the biggest expenditure are expenses related to social security. Please look at the red line in this graph. Social security expenditure in 2011 accounted for about 53% of general expenditures. It is obvious that political pressure to reduce the largest expenditure was inevitable.

Note 19: Besides reducing social security related expenses, the following four are devised as measures to secure financial resources. What is greatly expected is a consumption tax increase, which will resolve a large part of the deficit, like a cleanup batter hitting a home run to bring the team back from behind. Others include raising social insurance premiums, strengthen income tax progressiveness, and stopping the corporate tax rate reduction policy. Among them, the consumption tax increase is the most powerful source to secure financial resources.

Note 20. (Picture only)

Note 21. For these reasons, integrated reforms to curb the cost of medical care and nursing care are being implemented rapidly.

Note 22. Now I would like to explain about the numerical targets for suppressing social security expenses that the Abe administration presented in 2015. The goal is to reduce the national treasury burden by 1.9 trillion yen over the five years from 2015. Together with the local burden, the reduction scale will increase to 6.5 trillion yen. The basic policy for 2015 is the most severe medical cost control plan in history.

Note 23. This policy launched four years ago as a part of tightening the social security expenses is to further strengthen the function differentiation of the hospital and the clinic and to urge the public to do medical care and nursing care at home.

Towards 2025, when the falling birthrate and aging of the population peaks, the government has launched a plan for the comprehensive community care system to rebuild the medical provision system.

Positively speaking, these plans will promote further efficiency. In other words, the medical institution will not have the ability to respond to the individual circumstances of the patient.

Note 24. From the government, promotion of home care, NOT hospital treatment, has been required. All hospitals will generate less income unless they rush to discharge patients for home care. It is no longer possible for a patient to stay in one hospital for a long period of time. Until 20 years ago, in Japan, patients could stay in one hospital until they were discharged after acute and chronic phases.

Note 25. Differentiation and cooperation of outpatient services are underway. Large hospitals are required to focus on professional medical treatment and leave the outpatient to small and medium hospitals and clinics. The clinic is also required to focus not only on their specialty, but also work for comprehensive medical care, collaboration with special hospitals, collaboration with nursing care, and function as the initial contact point in the community physician and medical care system.

Note 26. Let me summarize the medical care reform bill. The burden on patients and nursing care users will increase, while social security benefits will shrink.

The self-burden ratio of those with annual income of 2.8 million yen or more increases from 10% to 20%.

In terms of services, commuting care and visiting nursing care are not included in nursing-care insurance for recipients with a relatively low need for nursing care, certified as "need support".

There are 520,000 people waiting for entry into a special nursing home for the elderly, so in principle, new residents are limited to those with "Nursing care 3" or higher, who need care all the time.

In the medical field, review of the role sharing of medical institutions is most important. Continue reforms to reduce medical expenses, bring medical care and nursing care services for the elderly closer to "usually staying at home, but sometimes hospitalized."

Reduce hospitals for "acute phase" only. As a result, after the patient's symptoms have recovered slightly, improve cooperation with home care and nursing care.

Note 27. Stockholm

Note 28. In the next section we take a closer look at the comprehensive community care system.

Note. 29 What is the comprehensive community care system? The Japanese government's definition is as follows. When the system is applied, in accordance with local circumstances, elderly people are able to live their daily lives independently in the area where they are accustomed to living, according to their capabilities. And, to do so, support for medical care, nursing care, nursing care prevention, housing and an independent daily life is comprehensively secured.

An increase in elderly people with dementia is rapidly increasing. Therefore, it is important to build a comprehensive community care system to support the lives of the elderly with dementia in local areas. This system is now a policy that can be said to be a national policy which has become the central pillar of medical and nursing care reform.

I think that it is difficult to understand by words alone, so I hope the next slide will illustrate the concept of the system.

Note 30. Here is the image of the regional comprehensive care system which MHLW shows. Elderly people who receive medical care and nursing care are in the center of the image. Their residence is not only their own home, but elderly housing and nursing homes are also defined as their home. In terms of nursing care for them, home care and commuting care services provide support. In addition to that, volunteer activities of local community associations, such as neighborhood associations, local government bodies, elderly clubs, etc. are expected for healthy living support and care prevention.

Regional comprehensive support centers and care managers of local governments will collaborate to provide multiple services. In other words, the regional comprehensive care system considers elderly people to be supported not only by medical and nursing care, but also by networks of administration, local governments, and local communities.

Note 31. Here is a diagram showing the concept of regional comprehensive care. The point of notice here is that the government presented to the people that mutual aid and self-help are necessary, in addition to public assistance and mutual assistance, in order to live peacefully in the area where one has lived for a long time. Until now, we have lived by public assistance composed of public support by the government and administration, and cooperation made up of medical and nursing care systems. The government had not requested self-help efforts of its citizens nor did they demand mutual assistance of volunteer organizations and neighborhood association activities. However, now the government has declared that mutual help from neighborhoods is important for care prevention and living support, asking individuals for self-help, and encouraging everyone to prepare by accepting responsibility for living to an old age.

What is meant by "individual family choice and attitude" that the government considers to be "self-help" as indicated in the diagram? Although the number of households with low nursing care capacity will increase in the future, public aid will be reduced. In order to prepare for such a situation, the government recommends that a life plan for old age is necessary. It seems to me that the government is demanding that people prepare for the end of their lives, without depending on public assistance.

Note 32. In the next two slides, I would like to address two factors, other than the financial problems, which provide the background for the introduction of the comprehensive community care system. The first, which can be seen in this graph, is the advent of the multi-death society, as the number of deaths in Japan has been increasing year by year for the past 50 years. You can see that in 1966, there were

only 670,000 deaths annually. In 2015 that figure had almost doubled to 1.29 million people. It is currently predicted that it will continue to increase until it peaks at 1.67 million in 2039.

Looking at it in terms of the mortality rate, you can see that in 1966 with a total population in Japan of around 100 million, 6.7 out of every 1,000 people died, that rate will soon double, and is projected to almost triple by 2060. This dire trend has certainly contributed to the decline in the caregiving capacity of each household as life expectancy keeps on rising and the birthrate stays low.

Note 33. As illustrated in this second background chart, the number of dementia patients in Japan has increased dramatically. Even now, one in 180 people already has dementia. The proportion of patients with dementia increases rapidly as shown in this bar graph every 3 years, and the projection is for an upward climb, as more people continue to enter the expanding elderly population group. In 2025, it is written that nearly 20% of all people age 65 or over is expected to have some kind of dementia symptoms.

Although it is necessary to promote self-help efforts, based upon the two background trends alone, one can expect a dramatic increase in the number of people and families who will experience a long elderly life filled with misery. The reality of this social situation has forced the government to improve the comprehensive community care systems, enhance social networks, and strengthen mutual help, cooperation, and public aid.

Note 34. Here is a graph of trends in the number of deaths and the composition ratio of deaths by location of death. Until around 1960, Japan had not achieved universal health insurance, unlike the present day. Therefore, old people without insurance could not afford to visit a hospital, so it was the majority who died at home being watched by children.

The period when the universal insurance system was introduced and the period of high economic growth overlapped, and together with the advancement of a highly educated society that the trend changed. At the same time, since people were more likely to visit a hospital, the number of caretakers and home nursing decreased. Such a background seems to have been the cause of a rapid increase in the number of people who died in hospitals.

Currently, the home death rate, combined with the nursing and other facility death rate, seems to be increasing slightly, in conjunction with the promotion of home

medical care. However, it is troubling to know that 40% of this increase in the home death rate is attributed to an increase in solitary deaths.

Note 35. This slide reflects the reality of the comprehensive community care system. The actual state of an inclusive regional care system involves a network. In the past, patients and users had individual exchanges with medical, nursing care, and administration, but in this system medical care, nursing care, administration, will provide local neighborhood support for patients and users in collaboration.

Regions requiring this system are mainly in the urban areas. In the suburbs, until recently, there had been very few options. Medical care had been solely focused on treatment and curing of one's illness. However, from now on, it will be necessary to switch to medical care that will both treat, cure and provide support, namely, nursing care and administrative cooperation.

It is also aimed at supporting the extension of the period during which the patient stays at home or in elderly care facilities, as long as possible, within the comprehensive community care system. Therefore, hospital admission rates at the terminal phase, as well as, the entry rate into nursing homes and the period of stay will be suppressed.

It is unlikely that the aim of the comprehensive community care system is to increase the rate of death at home. The majority of places where one dies in the future will still be hospitals, although the proportion will gradually decline. In addition, the number of deaths taking place at homes for the elderly and other elderly facilities will surely increase. A major objective of the new system is to prevent the solitary deaths of those individuals who are not taken care of by anyone, in order to prevent them from creating a social problem.

Note 36. By the way, some experts have pointed out that medical care and nursing care costs will not be reduced by switching to the comprehensive community care system. There is no proof that the cost of community and home care is cheaper than acute facility care. In the case of at least severe care recipients and patients, it is internationally considered to be common sense that community and home care costs are higher than that of facility care.

A Swedish scholar, Anna-Karin Edberg, who is an expert on home care, criticized this notion, as a "myth that home helper is cheap and nursing home is expensive" and said that the cost of home care for late-stage elderly by home helpers is 30% higher than the cost of nursing care at nursing homes with private rooms. In the discourse of

proponents of the idea that home care is cheaper, the calculation of the total cost is missing.

Note 37. Bergen, Norway

Note 38. Finally, allow me to introduce our medical group which operates a small regional comprehensive care system within Kiyota Ward. Our facility which was established by my father has been in business for 39 years. Beginning with a local practitioner who is closely connected to the local community, as the residents have aged, I felt the need to engage in the nursing care industry, and gradually expanded the nursing care business ahead of the administration plan. I have managed this group since 2011. I noticed that it was a business that was responsible for much of the comprehensive community care system that has been proposed and is now being implemented.

Note 39. Our philosophy is represented by the motto, Love and Care. We wish to contribute to the health and happiness of the community through thoughtful management and by providing loving medical and nursing care.

Note 40. The comprehensive community care system requires the local practitioner to serve as a family doctor or general practitioner. In Japan, various practices are allowed for medical practitioners. There are also many of these doctors who are qualified in specialized fields. I will introduce the definition of local practitioners that the government is now seeking in the comprehensive community care system. By definition, the doctor can respond to any consultation, be familiar with the latest medical information, and introduce specialists and specialized medical institutions when necessary.

Moreover, the local practitioner has comprehensive ability to be responsible for community health and welfare. So, he/she becomes a reliable and dependable person in the community. This has always been the image of a general practitioner in the US or the EU.

Note 41. Certification requirements as an authorized home doctor are as shown in this slide. Respond to health consultation. Respond to consultation on the nursing care insurance system. Operate a nursing care business. Participate in nursing care training. Prepare statements as a home doctor for certification of long-term nursing care. Run a clinic that strengthens the function of home care support. Respond to emergencies outside of normal working hours.

Note 42. In addition to the general comprehensive work of a doctor, I also conduct ultrasonic examinations and endoscopic examinations taking advantage of my specialty. This is a carotid ultrasound examination, showing plaque inside artery.

Note 43. Digestive endoscopy is one of my specialties. This is a flat mucosal cancer discovered during a routine colonoscopy. This was an extremely early cancer, it was cured with outpatient treatment.

Note 44. Now let me introduce the rehabilitation center of a care facility. In addition to physical rehabilitation at this facility, it is also a place of socialization for elderly people. Socialization is also very important to maintain cognitive function. In many facilities, events such as volunteer concerts are also held.

Note 45. Inside that building we can get an idea of the facilities in these images. The upper left is the living room, the upper right is the rehabilitation room, the lower left is the bath, and the lower right is the nap room.

Note 46. Here we have some photos which show some of the activities that take place there. In the upper left we see a vital health check being given, and the upper right is a kind of collective recreation basketball activity. The lower left shows a rice cake event on New Year's Day, and the last image proves that the staff can have fun too.

Note 47. Next is an example of a residential care facility, which is a group home for those with dementia. It was rebuilt from my parents' home.

Note 48. People with dementia are less confused when living in homes than in large facilities, thereby preserving a sense of calm in their lives. The group home is a house where dementia is assisted so that residents can live an independent life each day, according to their remaining ability, with an exchange between the home environment and people in their neighborhood. Bathing, drainage, nursing care such as meals, and other care in their daily life and function training are carried out together. If you want to enter our home, we are ready to take care of you.

Note 49. In a book left behind by a tenant was written, "This is my home, indicating the room, dining table and living room."

Note 50. (Photo) This home for the elderly opened in 2013.

Note 51. It is the purpose of this project. When the necessity for elderly medical care is high, we hope our project will provide housing in an environment similar to their previous life at home. There are many people who would like to greet the end of life at home rather than in hospitals and hospices. However, I think that there are many cases where I had to give up because of poor caregiving power at home. I would like those people to use a facility like ours as a substitute for their real home. I always wanted to practice the nursing care business by creating the ideal elderly living environment that is written about in textbooks.

Note 52. Suzuki medical facility and staff

Note 53. Courtyard in June (Photo only)

Note 54. This is an in-home nursing care support office.

Note 55. Care managers and municipal regional comprehensive centers are medical and nursing care coordinators. If you have a problem, they are the first ones you should contact.

Note 56. This is our position in the regional comprehensive care system. I am engaged in a business enclosed in a black frame in this image. Although it is a small business, I think that the comprehensive care of residents in Kiyota Ward has been done to the best of our abilities. We will continue to strive to fulfill our obligation to those who need our care in the community.

Note 57. In this Aging Era, smooth cooperation from medical care to nursing care and also nursing care to medical care is required. We are doing our best to make this a reality through our facilities and service in Kiyota.

Note 58. I deeply appreciate Ken, Megumi and Chihiro for their translation of my materials. It must have been hard work. Thanks also to Stuart for encouraging me to do this presentation in English for the foreign residents. Thank you all for your attention.