

# Overview of the Amendatory Law to the Related Acts for Securing Comprehensive Medical and Long-Term Care in the Community

## Purpose

To promote provision of comprehensive medical and long-term care in the communities, through the establishment of the integrated community care system and an efficient and high-quality medical care provision system, take necessary measures concerning relevant provisions in the Medical Care Act, the Long-Term Care Insurance Act, etc., based on the Act on Promotion of Reform for Establishing a Sustainable Social Security System.

## Outline

### **1. Establishment of a new fund and enhancement of coordination between medical and long-term care (related to the Act on Promotion of Systematic Establishment of Public Long-Term Care Facilities in the Community)**

- ① **Consumption tax increase revenues are used to set up new funds in prefectures** to finance medical and long-term care projects (e.g. roll allotment of medical institutions, promotion of in-home medical care and long-term care) stated in prefectures' plans.
- ② To **enhance coordination between medical and long-term care**, the Minister of Health, Labour and Welfare sets out basic principles.

### **2. Ensuring an efficient and effective medical provision system in the communities (related to the Medical Care Act)**

- ① Medical institutions **report medical care functions of their hospitals (advanced acute, acute, recovery, and chronic phases), etc.** to prefectural governors and, based on such reports, the prefectures formulate **Community Health Care Visions** (how the future of the medical care provision system in the regional communities should be) in their Community Health Care Plans.
- ② A prefectural center for **securing medical practitioner** is stipulated in the Medical Care Act.

### **3. Constructing the Integrated Community Care System and sharing the fair burdens (related to the Long-Term Care Insurance Act)**

- ① **Improve community support projects**, such as the promotion of in-home medical and long-term care. In addition, **home-visit services for preventive long-term care and outpatient long-term care, formerly covered by care prevention benefits, are now positioned as the community support projects. These revisions make the community support projects more diverse.** ※ A community support project : A municipal project run on funding from the long-term care insurance system
- ② **The Facility Providing Long-Term Care to the Elderly** focuses its function on supporting persons requiring long-term care rated from moderate to severe, who have difficulty living at home.
- ③ **Strengthen measures to reduce long-term care insurance premiums for low income earners**
- ④ **Raise copayments of long-term service users above a certain income level to 20%** (however, the monthly cost-bearing limit for general households is kept).
- ⑤ **Add property, etc. to the conditions of the payment of an “allowance for long-term care service to persons admitted to specified facilities”** to cover food and residence costs of low-income facility service users.

### **4. Other**

- ① **Clarify specific medical acts (part of medical assistance)** and establish a new training system for nurses who perform them according to procedure manuals.
- ② Insert a provision on **a mechanism to investigate matters concerning medical accidents**
- ③ Measures to promote merger between associations of medical corporations and medical corporation foundations and transfer to medical corporations without equity ownership
- ④ Consider measures for securing the sufficient number of long-term care personnel (postpone the implementation period of the revision of the qualification acquisition method for certified careworkers from FY2015 to FY2016)

## Dates of enforcement

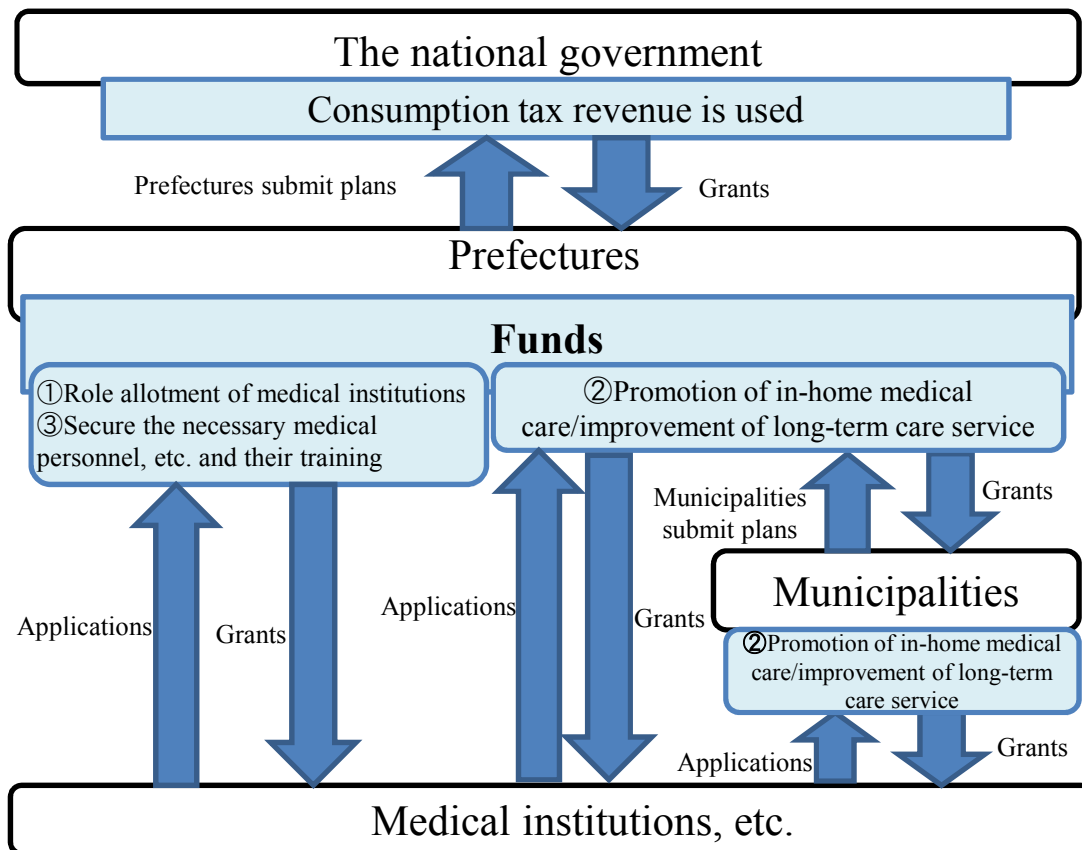
The date of promulgation (June 25, 2014). However, parts related to the Medical Care Act (in or after October 2015), the Long-Term Care Insurance Act (in or or after April 2015), etc. are enforced sequentially.

# A New Financial Support System for the Reform of the Medical and Long-Term Care Service Provision System

FY2014: ¥90.4 billion in public funds

- As the post-war baby boom generation reaches 75 or older in 2025, “reform of the medical and long-term care service provision system” is an urgent issue. Under the reform, we implement, among others, role allotment of medical institutions, promotion of in-home medical care and long-term care, securing the necessary medical staff such as medical practitioners and nurses as well as improving their working environments, and building the integrated community care system.
- To promote the medical and long-term care provision system reform, together with institutional measures to be implemented through the amendment of the Medical Care Act, etc., a new financial support system is established by using the consumption tax increase income.
- The consumption tax increase revenues are allocated for establishment of funds in each prefecture and finance the reform projects according to plans prepared by each prefecture.
- ◇ The amendment of the "Act on Promotion of Systematic Establishment of Public Long-term Care Facilities in the Community" provides the legal basis for the funds.
- ◇ This financial support system is first applied to medical care in FY2014, and to long-term care in FY2015. Regarding the role allotment of the medical institutions, in FY2014, the funds can only be used for challenges that are already indicated, such as conversion to recovery phase hospitals, and in FY 2015, long term care will be added to the fund use list. In FY2015, after the Community Health Care Visions are formulated, further coverage of the funds will be discussed.

## 【The proposed new financial support scheme】



## A mechanism to properly and fairly allocate the budget to projects necessary for the community

- ① The national government develops basic principles based on laws and clarifies projects to be funded.
  - ② Prefectures submit plans to the Ministry of Health, Labour and Welfare.
  - ③ A consultation mechanism will be set up in order to ensure fairness and transparency in the formulation of basic principles /plans by the State, prefectures, municipalities.
- ※ Plan to take necessary measures, including instructing prefectures to distribute the funds to public and private organizations in a fair manner in the national government's basic principles and grants guidelines (for ensuring fairness and transparency)

## Projects to be covered by the new financial support system

1. Projects necessary for roll allotment of medical institutions
  - (1) A project for promoting establishment of facilities and equipment for medical institutions to achieve the Community Health Care Visions etc.
2. Projects necessary for improving in-home medical care and long-term care services
  - (1) Projects to promote in-home medical care (including dentistry and pharmacies) etc.
  - (2) Projects to promote establishment of facilities and equipment for long-term care service etc.
3. Projects to secure necessary medical personnel and their training
  - (1) Projects to secure the sufficient number of medical practitioners
  - (2) Projects to secure the sufficient number of nurses
  - (3) Projects to secure the sufficient number of long-term care staff
  - (4) Projects to improve the working conditions of medical and long-term care staff etc.

■ The national government and prefectures shall cover the two-thirds and one-third of the subsidy, respectively.

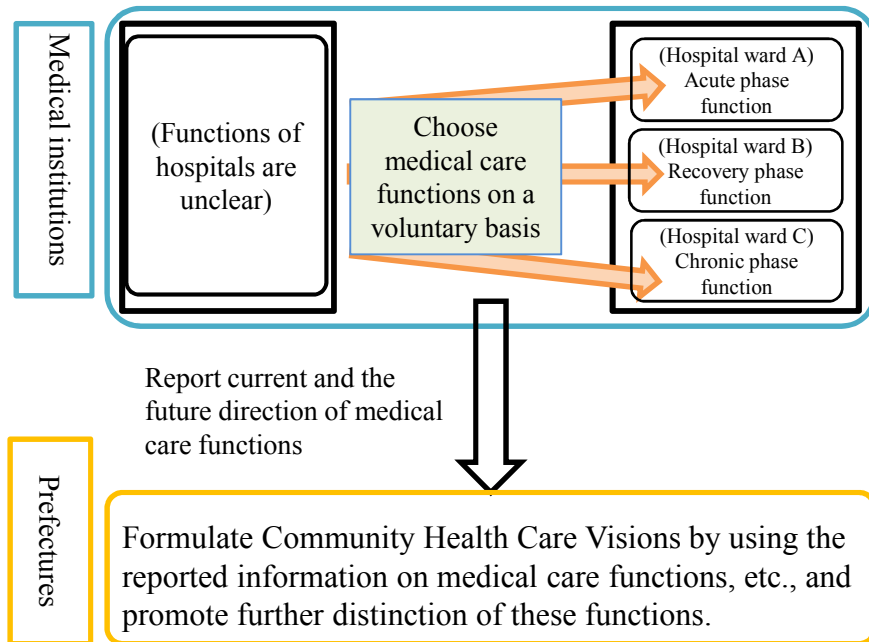
## Reporting System for Functions of Medical Institutions and Formation of Community Health Care Visions

### ○ Reporting system for functions of medical institutions (FY2014~)

Medical institutions have an obligation to report their current and future direction of medical care functions to be served according to each hospital ward to prefectural governments.

### ○ Formulation of the Community Health Care Visions (FY2015~)

Prefectures—by using estimates of future demands for medical care and information reported by medical institutions—formulate Community Health Care Visions which include total estimates of medical care demands in each secondary area for medical service providing system, etc. in the future. These visions properly promote balanced role sharing and coordination for the community health care. The prefectures incorporate those visions in their Community Health Care Plans and promote further role distinctions among hospitals. The national government establishes guidelines for drawing up the Community Health Care Visions in the prefectures (FY2014~).



#### (The Content of the Community Health Care Visions)

1. Demand for health care in 2025  
The number of patients (inpatients/outpatients/types of diseases), etc.
2. Health care service provision systems which should be attained by 2025  
Necessary amounts of medical functions in each area for medical service providing system (in each municipality, with regard to the medical functions of in-home medical care and the integrated community care)
3. Measures to attain the above health care service provision system  
e.g. Installation of facilities and equipment necessary to implement the role allotment of medical institutions, securing and training necessary medical staff, etc.

# A Mechanism to Achieve the Community Health Care Visions

## **(1) Holding conferences for Community Health Care Visions**

○ Prefectures set up conferences where they can discuss with medical personnel, health insurers, etc., how to achieve the Community Health Care Visions.

The Community Health Care Visions are promoted through the consultation among medical institutions, but if they fail to reach an agreement, prefectural governors may take the following measures.

## **(2) Measures to be taken by prefectural governors**

### **① Response to the establishment of new hospitals and increase in the number of hospital beds**

○ The prefectural governors may make conditions on the approval of the establishment of new hospitals to provide insufficient medical functions.

### **② Response to conversion of medical functions by the existing medical institutions**

#### **[In case medical institutions try to convert to excessive medical functions]**

○ Prefectural governors may demand explanations, etc. to the medical institutions at the Prefectural Council on Medical Service Facilities. If they find no compelling reason to do so, the governors may request (or order, in the case of public medical institution.) for suspension of the conversion after hearing the opinions of the Council.

#### **[In case discussion at the conferences fails, and the roll allotment of medical institutions does not proceed only with the medical institutions' voluntary actions]**

○ Prefectural governors may request (or instruct, in the case of public medical institutions.) that they provide certain medical functions which are insufficient in their community, after hearing the opinions of the Council for Medical Service Facilities.

### **③ Request for reducing non-operational beds**

○ Prefectural governors may request medical institutions except for public medical institutions that they reduce hospital beds laying idle after hearing the opinions of the Prefectural Council on Medical Service Facilities, if it is especially necessary to do so in promoting the achievement of the Community Health Care Plans.

※ According to the current Medical Care Act, the governors can order public medical institutions, etc. to cut down the number of non-operational beds.

## **[Measures to be taken when medical institutions disobey the above requests, orders, or instructions]**

○ If medical institutions do not comply with the above requests, prefectural governors may make recommendations. If the medical institutions attempt not to follow such recommendations (or for public medical institutions, if they disobey the abovementioned orders and instructions) then, the below measures may be taken, in addition to the current measures provided for in the Medical Care Act (e.g. orders to change administrators, instructions for public medical institutions on matters related to their operation).

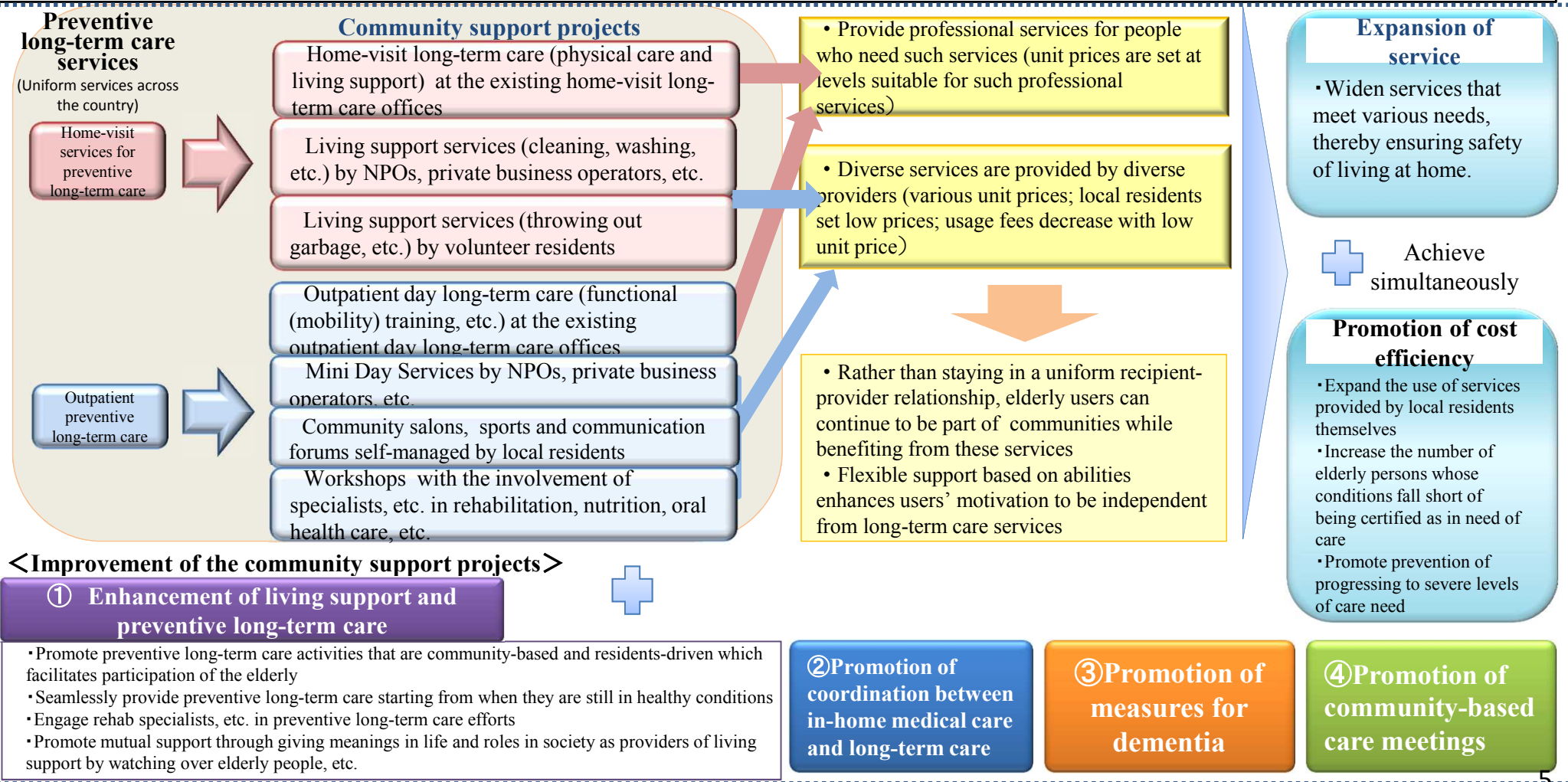
A. Disclosure of the names of the medical institutions

B. Exclusion from various subsidies including those offered by the Welfare and Medical Service Agency

C. Cancellation of non-approval/approval of Regional Medical Care Support Hospitals and Advanced Treatment Hospitals

# Revision of Preventive Long-Term Care and Expansion of Community Support Projects

- Home-visit service for preventive long-term care and outpatient preventive long-term care are moved from care prevention benefit services to community support projects under the long-term care insurance system, to enable municipalities to take measures according to the actual situations in the regional communities (until the end of FY2017). The financial structure for these services will be the same as that for the long-term care benefit services (the national government, prefectures, municipalities, and insurance premiums for primary insured persons, and secondary insured persons)
- In addition to the existing services offered by long-term care offices, the elderly are supported by various actors in the communities, such as NPOs, private enterprises, and volunteers (care management based on the conditions of the elderly, etc.) The elderly persons may sometimes play the supporter's role.
- The ceiling on expenses for the community support projects is reviewed in order to pay for the projects transferred from preventive long-term care services.
- The national government establishes guidelines and support smooth implementation of the municipal projects.





# The Facility Providing Long-Term Care to the Elderly Focuses Its Function

○ In principle, limit admission to the elderly rated as long-term care needs level 3 or higher and focus the function of the facility providing long-term care to the elderly as a facility that supports persons with medium-to-high care need levels and who have difficulty living at home. 【Except for those already admitted at the facility providing long-term care to the elderly】

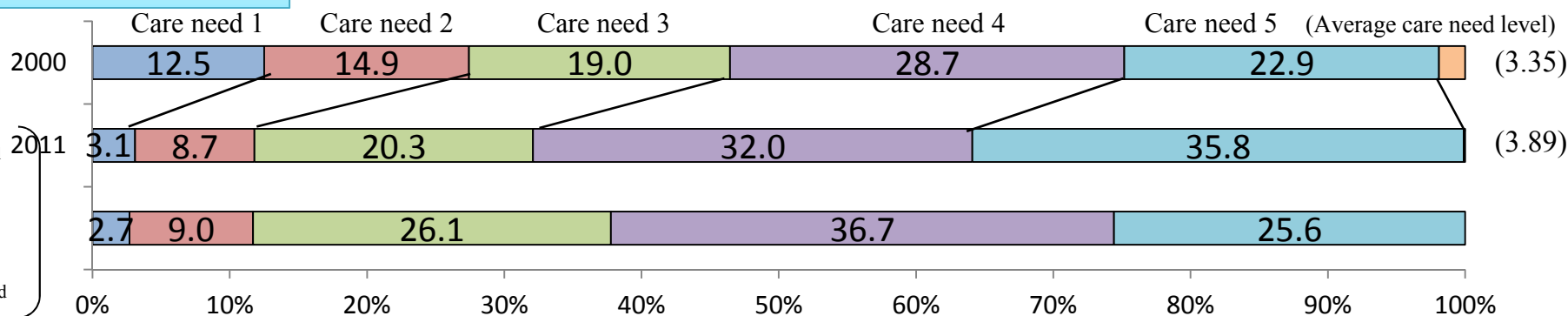
○ On the other hand, for those rated mild (care levels 1 and 2), if there are inevitable situations that make them extremely difficult to live in places other than the facility providing long-term care to the elderly, their admission is allowed on an exceptional basis and under the municipalities' involvement.

【cf.: Cases considered necessary for persons rated 1 or 2 to be admitted to the facility providing long-term care to the elderly (details to be considered later)】

- Intellectual or mental disabilities, etc. make it difficult to live stable life in the community
- Serious abuse from family members, etc. makes it absolutely necessary to secure mental and physical safety and security
- The elderly has dementia and needs proper protection and long-term care constantly

## The ratios of persons admitted to the facility providing long-term care to the elderly by care need level

◀ The number of facilities: 7,865    The number of service recipients: 516,000 (Oct. 2015) ▶



【cf.】  
Persons newly admitted to the facility providing long-term care to the elderly  
※Of about 140,000 persons in total, about 16,000 are rated care need 1 and 2.

## The status of applicants for admission to the facility providing long-term care to the elderly

(Unit: 10,000 persons)

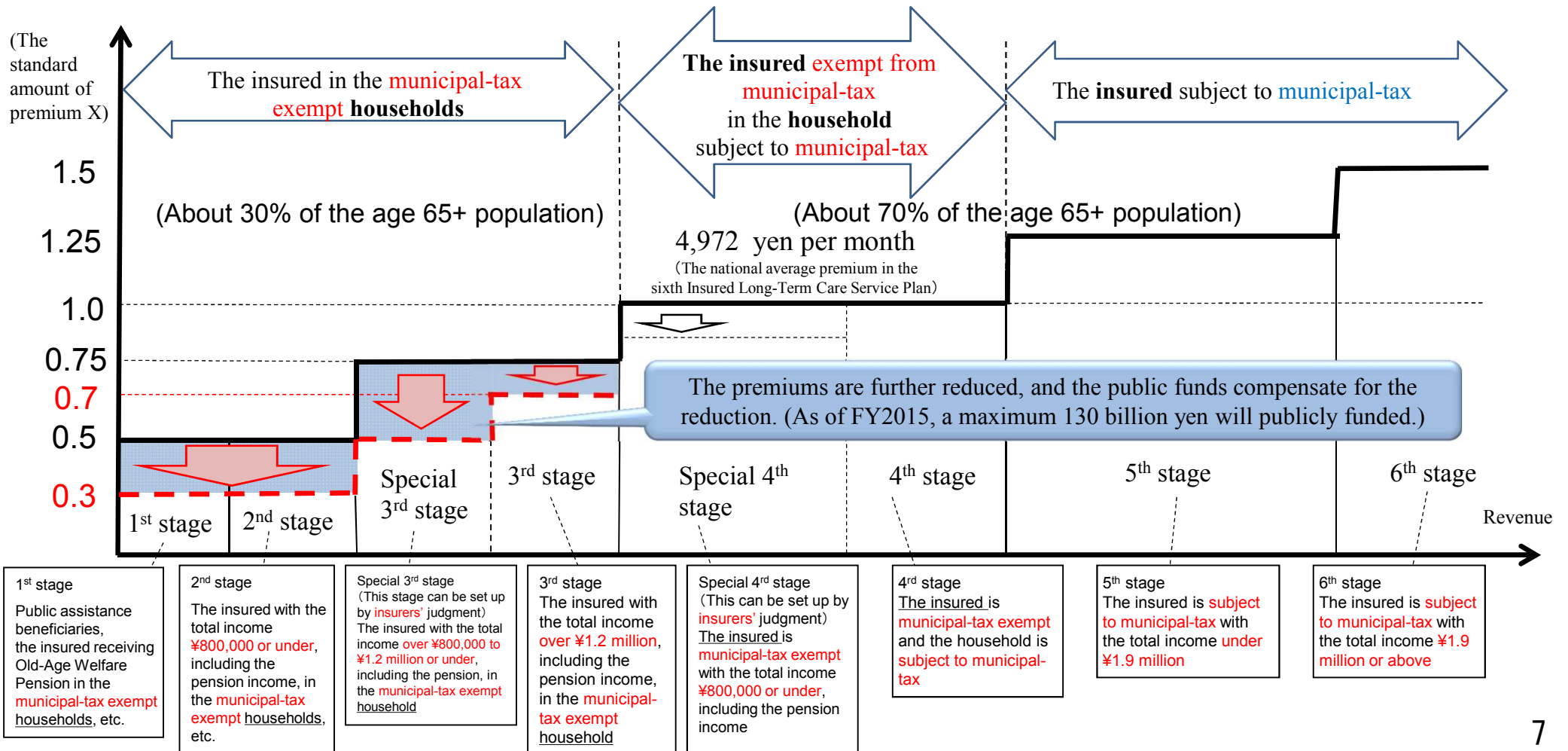
	Care need 1~2	Care need 3	Care need 4~5	Total
Total	17.8 (34.1%)	12.6% (24.1%)	21.9 (41.8%)	52.4 (100%)
Of which who stay at home	10.7 (20.4%)	6.6 (12.7%)	8.7 (16.5%)	26.0 (49.6%)

※Based on prefectures' statistics on the application status of the facility providing long-term care to the elderly (March 2014 data. Time of surveys conducted differs according to prefectures.)

# Further Reduction of the Primary Premiums for Low-Income Earners

To further reduce the premiums of low-income elderly persons, public funds will be injected separately from those used to finance 50% of the long-term care benefit expenses.  
 (The burden bearing ratios of the public funds:  
 The national government 1/2, prefectures 1/4, municipalities 1/4)  
 ■ This reduction is implemented starting in FY2015  
 (The sixth Insured Long-Term Care Service Plan)

	Now	FY2015~
The first and second stages	0.5 →	0.3
The special third stage	0.75 →	0.5
The third stage	0.75 →	0.7



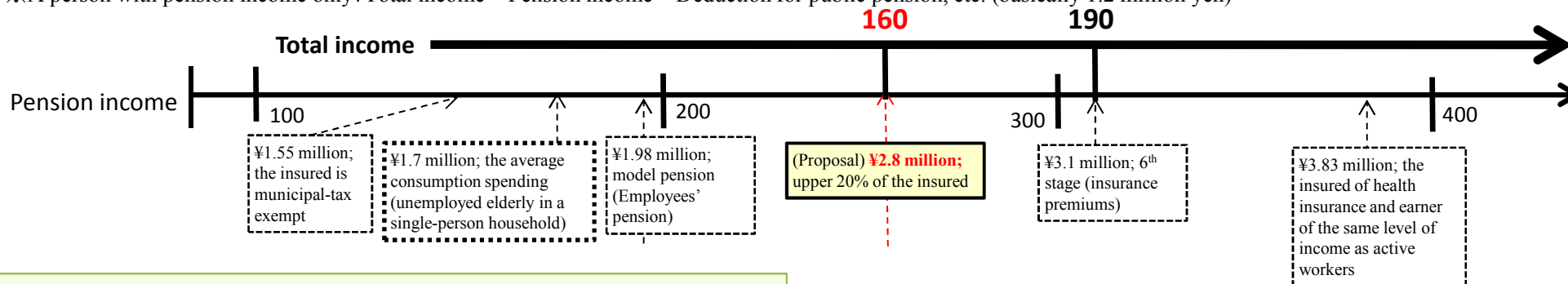
# Review of Copayments for Service Users Above Certain Income Levels

## Increasing the copayment

- While suppressing premiums' rise as much as possible, in order to enhance the sustainability of the long-term care insurance system, the fixed 10 percent copayment across all users will be raised to **20 percent for those with relatively higher financial capacity and above certain income levels**. However, because of the monthly cost-bearing limit, not everyone's burden subject to the revised rate doubles.
- The total income levels to which the 20% copayment applies exceed the amounts of model pensions and the average consumption spending. The standard total income of those deemed capable of shouldering 20% of long-term care service costs will be 1.6 million yen or above (2.8 million yen or above in the case of single persons whose income sources are only pensions) and those who belong to **the upper 20% of the insured** (a point to be included in the Cabinet Order).
- Because the service users' income distribution is lower than that of the total insured population, even among the upper 20% group, the users affected by the 20% copayment are estimated to be restricted to around 15% of in-home service users and 5% of those admitted to the intensive care homes for the elderly.

### Total income levels to which the 20% copayment applies (in the case of single persons with pension incomes only)

※A person with pension income only: Total income = Pension income - Deduction for public pension, etc. (basically 1.2 million yen)



## Raising the maximum copayments/copayment limit

The copayment limit (an allowance for high-cost long-term care service) is raised only for those earn the same level of income as active workers under health insurance.

Reference: The copayment limit related to the high-cost medical care allowance for those 70 or above under health insurance	
	The copayment cap (Current amount/per household)
Income equal to active workers	80,100 yen + medical cost 1% (Reduced payment for multiple high-cost medical care benefits: <b>44,400 yen</b> )
General persons	<b>44,400 yen</b>
Municipal-tax exempt, etc.	24,600 yen
Pension income 800,000 yen or below, etc.	15,000 yen

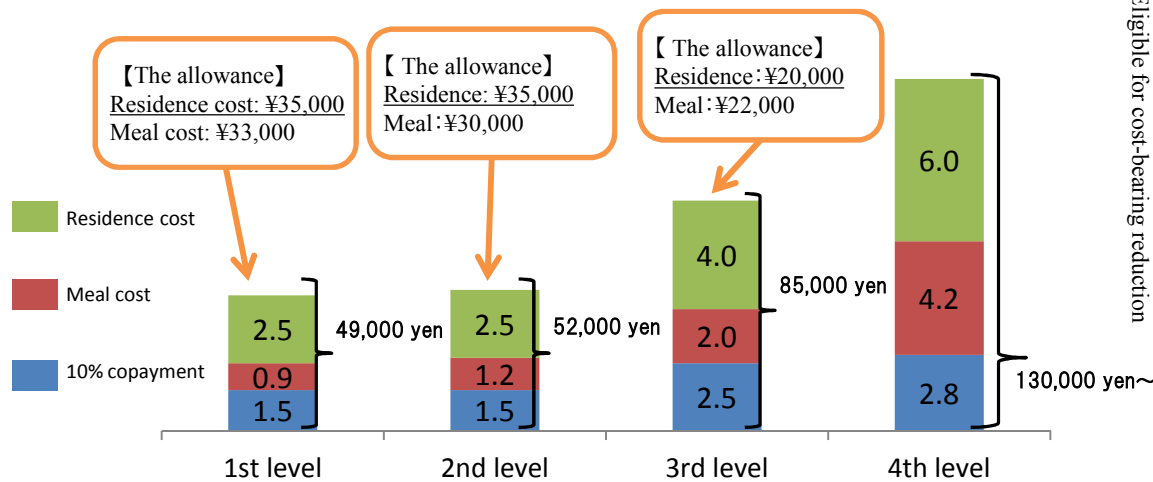
〈Now〉		〈Proposed revision〉	
	The copayment cap (monthly amount)		
General persons	37,200 yen (per household)	Income equal to active workers	44,400 yen
Municipal-tax exempt household, etc.	24,600 yen (per household)		
Pension income 800,000 yen or below, etc.	15,000 yen (per individual)	General persons	37,200 yen



# Review of the Allowance for Long-Term Care Service to Persons Admitted to Specified Facilities (Consideration of Property, etc.)

- For facilities use expenses, in principle, users pay for meal and residence. However, the allowance for long-term care service to persons admitted to a specified facilities is paid for those in municipal-tax exempt households upon application to relieve their cost-bearing loads.
- Because this system is humanitarian and transitional in nature, it would be unfair to pay the benefits from insurance premiums for those who have balances in their bank accounts and savings. Therefore, revisions will be made to the system to take into account the facility users' property and others.

## <The current allowance payments and the costs borne by facility users>



Eligible for cost-bearing reduction

First level	<ul style="list-style-type: none"> <li>Public assistance beneficiaries</li> <li>The insured receiving Old-Age Welfare Pension in the municipal-tax exempt household</li> </ul>
Second level	<ul style="list-style-type: none"> <li>The insured with the total income ¥800,000 or below including the pension income in the municipal-tax exempt households, etc.</li> </ul>
Third level	<ul style="list-style-type: none"> <li>The insured in the municipal-tax exempt household and not in the Level 2 category</li> </ul>
Fourth level~	<ul style="list-style-type: none"> <li>The insured exempt from municipal-tax and the household is subject to the residence tax</li> <li>The insured subject to municipal-tax</li> </ul>

(※) The number of persons certified for supplementary benefits: 1.03 million  
The amount of supplementary benefits: 28.44 billion yen[FY2011]

※ In the case of the unit type facilities with single occupancy

## <Proposed revisions>

### Deposits & savings, etc.

If facility users' deposits and savings, etc. exceed certain levels (above 100 million yen and 200 million yen are supposed for single persons and married couples, respectively), they are ineligible for **the allowance for long-term care service to persons admitted to specified facilities**. →Judged based on the users' declarations. Incorporate provisions on inquiries for financial institutions and penalties (refunds) for wrongful benefit receivers.

### Incomes of spouses

Although households are often separated upon admission to long-term care facilities, the incomes of spouses will be taken into account after the separation, and if the spouses are subject to income taxes, they are ineligible for **the allowance**.

### Tax-free pension incomes

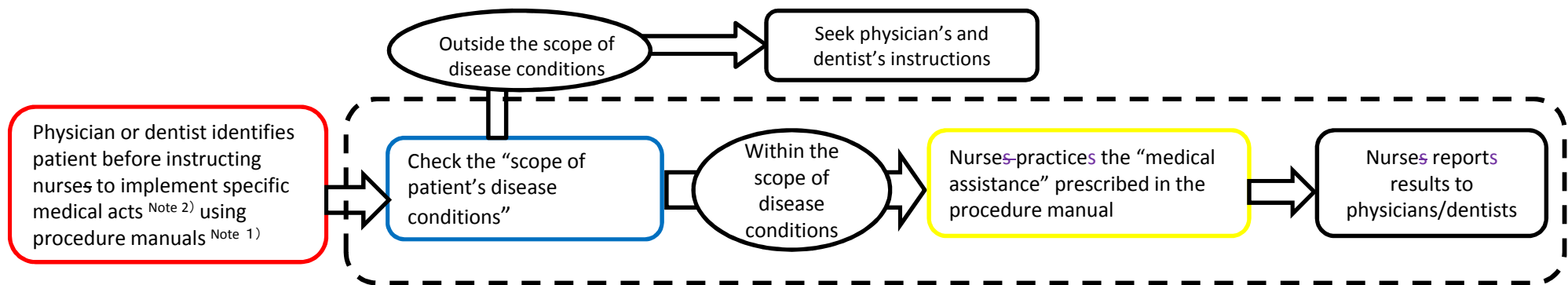
In assessing the levels of the allowance, tax-exempt pensions (Survivors' Pension and Disability Pension) will be taken into consideration.

# A Training System on Specific Medical Acts for Nurses

## The need for the establishment of the training system

- To further promote in-home medical care, etc. by 2025, individually skilled nurses are not enough. There is a need to train and secure the necessary number of nurses responsible for provision of certain medical assistance (for instance, intravenous rehydration (assessment of the level of dehydration and administration of intravenous fluids) in accordance with assigned procedure manuals without physicians' judgments.
- So the purpose of the establishment of the training system is to specify such medical acts, create a training program on the performance of such acts by using procedure manuals, standardize its content, and systematically nurture nurses who support the future in-home medical care, etc.

## The flow of specific medical acts which needs designated training



Note 1) **A procedure manual**: A document prepared by physicians/dentists to instruct nurses to provide medical assistance. It specifies the "scope of patient's disease conditions" for which nurses give medical assistance, "content of the medical assistance," and other matters.

Note 2) **Specific medical acts**: Medical assistance. Practical understanding, thinking, and judgment abilities as well as high-level and professional knowledge and skills are especially required when nurses perform these acts using procedure manuals.

- As under the current system, no restrictions will be placed on nurses carrying out specific medical acts without procedure manuals under the instruction of physicians/dentists.
- Even after this training system is adopted, however, there will be no change in the fact that physicians/dentists decide whether they directly provide patients with medical acts or under what instructions they make nurses provide medical assistance, by considering the patient's medical conditions and the nurse's abilities.

## Information on nurses who completed designated trainings

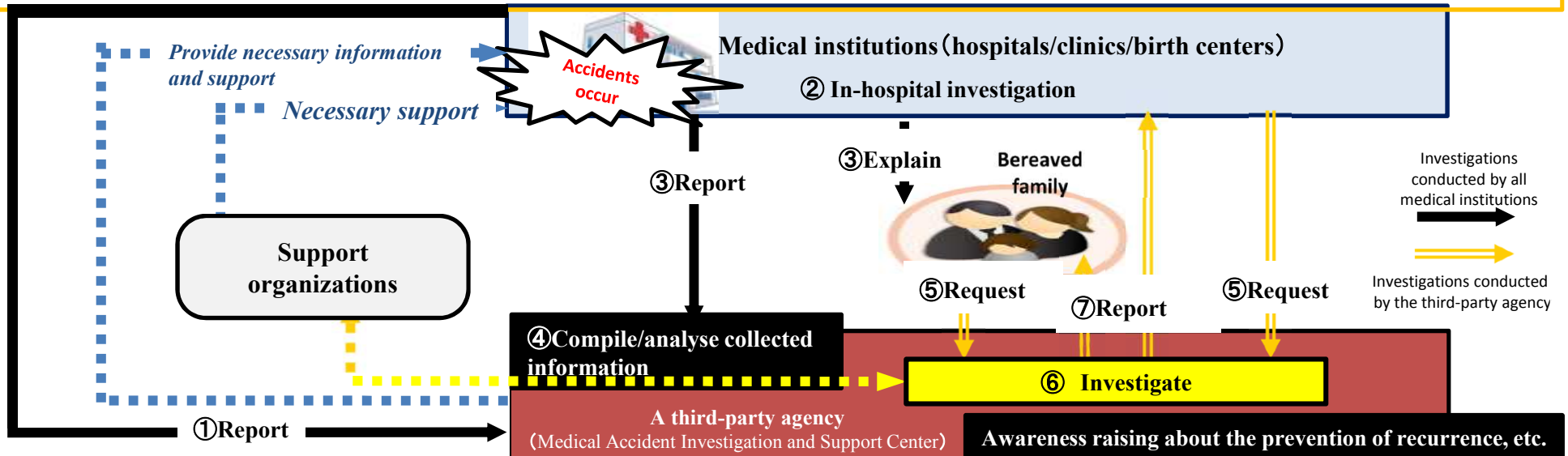
The Ministry of Health, Labour and Welfare receives name lists of nurses who completed training from designated training institutions (it is supposed that the submission of such name lists will be stipulated in a Ministerial Ordinance).

# A Medical Accident Investigation System

- When medical accidents happen, internal investigations are conducted by medical institutions, and a private third-party agency (the Medical Accident Investigation and Support Center) collects and analyzes reported investigation results. This medical accident investigation system, whose aim is to prevent recurrence, will be **stipulated in the Medical Service Act** to ensure medical safety in medical institutions.
- **The medical accidents subject to investigations** are those caused by medical treatment provided by medical practitioners working at medical institutions or are deaths or fetal deaths suspected to have been caused by it, and not foreseen by the administrators of the medical institutions.

## The flow of the investigations:

- When the above medical accidents occur, the medical institutions **report them to a third-party agency (①), carry out necessary investigations (②), explain to the bereaved family and report to the third-party agency** about the investigation results (③).
  - The third-party agency compiles and analyzes the reported results of investigations conducted by the medical institutions (④), and raises awareness for preventing the recurrence of such medical accidents.
  - At medical institutions or **bereaved families' requests (⑤), the third-party agency conducts investigations (⑥) and reports to the medical institutions and the bereaved families (⑦)** regarding the results.
- ※Designate a **new private organization** responsible for proper and steady implementation of, such as, (1) support for medical institutions; (2) compilation and analysis of the results of the in-hospital investigations; (3) investigations as requested by bereaved families or medical institutions; (4) awareness raising on prevention of recurrence of accidents; and (5) training for persons involved in the medical accident investigations.



(Note 1) The support organizations are registered in the Ministry of Health, Labour and Welfare and perform part of work commissioned by the third-party organization.

(Note 2) Requests for investigations to the third-party agency may be filed before the results of the internal investigations are obtained.