Managing Integration of Long Term Care for Elderly and Policy Implication

高齢者医療・介護統合モデルの構築と政策への適用

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高齢者医療・介護統合モデルの構築と政策への適用

Date : 28 September 2014
Venue : Shinagawa GOOS, Tokyo, Japan

2014年9月28日（日）12:30～17:30 シナガワグースにて

学校法人成城学園・科研費基盤研究（A）（課題番号24243039）共催

Index

Executive Summary

（日本語：Japanese）

Ⅰ. セッション 1

第1報告

「The role of primary health care in controlling the cost of specialist health care.」 Professor Peter Smith, Emeritus Professor of Health Policy, Imperial College London

1.第1報告の問題意識

(1)発表内容の概要

第一セッションでは、インペリアル大学ロンドンのピーター・スミス名誉教授より、「専門(病院)医療費をコントロールするためのプライマリ・ケア分野の役割」について発表が行われた。発表の最初に、スミス教授は以下のような留意事項を丁寧に説明している。つまり、プライマリ・ケアが高齢者医療費増加に対する完全な解決策ではないし、英国の制度を丸写し(copy)することはお勧めしない。但し、プライマリ・ケアのいくつかの要素(elements)は、どの医療制度においても非常に有効であると考えている。このような、観点から英国の経験をみていこう。

本発表では、以下の4点が報告された。まず、①プライマリ・ケアと総合診療医(General Practitioner; 以下GP)において、医療制度におけるプライマリ・ケア分野の位置づけやGPの役割について解説が行われた。ついで、英国ではGPが担当している慢性期疾患に対する②疾病管理(Disease Management)の成果に関する説明があった。これらの結果から制度設計上最も重要と考えられる、③プライマリ・ケア分野における経済的誘因に関する考察が行われた。最後に、④2つのプライマリ・ケア政策として、基金型予算制度(Fundholding budget)及び成果に応じた償還方式(Pay for Performance、以下 P4P)について英国の経験から以下のように論じた。

(2)プライマリ・ケア分野の医療制度における基本的役割

スミス教授は、プライマリ・ケア分野の基本的役割として、①多様なケアのコーディネーション、②健康促進と疾病予防の実施、③薬剤の処方及びその服薬管理、④軽症患者への治療の4つを挙げている。さらに、潜在的な役割として医療制度の効率化や医療費制御(無駄な二次医療の抑制)なども期待されるとしている。

2.プライマリ・ケアでの疾病管理は病院医療費を抑制したか

(1)GPの疾病管理による無駄な二次医療の抑制

今回のスミス報告の焦点は、GPによる疾病管理により、慢性期患者の健康状態の改善や無駄な病院医療を抑制することが可能かどうかである。英国におけるGPが行う疾病管理の内容としては、①心臓疾患患者のコレステロール値などの「モニタリング」、②心臓発作経験者への抗血小板療法などの「二次(重症化)予防」、③禁煙指導などの「生活指導」がある。この①~③から慢性期疾患患者の健康状態の改善と重症化の防止による二次医療の抑制が期待されている。

では、英国ではどのような問題が起きているのであろうか。コーディネーション問題に関するOECD調査によれば、「検査結果の連絡遅れ」「専門の異なる医師からの相反する指導(conflicting information)」「検査の重複」などの問題が起きる割合は、慢性疾患の有りの場合では32%となり、他国に比して大きいことが判明している(残念ながら、この調査には日本は参加していない)。

次に、無駄な二次医療(病院)の抑制は可能だろうか。英国では、この点に関する実証研究としてDusheiko et al(2011)[1)]が、5百万人の患者におけるデータを用いて、プライマリ・ケア分野の疾病管理の品質向上により二次(病院)医療の利用を抑制できるかを検証している。

この結果、10の慢性期疾患（Asthma, chronic heart disease, chronic kidney disease, COPD, dementia, diabetes, hypertension, hypothyroidism, mental health, stroke）のうち、strokeのみで費用抑制が確認された。これにより、1億3千万ポンドの年間医療費（病院医療費の0.2%）を削減可能としている。これらの費用抑制のほとんどは、救急医療の利用率低下によるものである（いくつかの分析モデルのうちRandom Effect Modelでは、全費用の回帰係数-0.266に対して、救急医療のみで-0.245、専門外来のみで-0.058となっている）。

3.プライマリ・ケア分野における経済的誘因

(1)経済的誘因は直接誘因と間接誘因の2種類がある

直接的な経済的誘因としては、①サービス毎の出来高払い、②成果報酬P4Pがある。また、間接的な経済的誘因としては、①評価指標（performance reporting）、②評判（reputation）、③予算配分権限（プライマリ・ケア組織に予算配分を委任する）がある。

(2)P4Pかゲートキーピング予算方式か2つの政策の検討

①GPによるゲートキーピング予算方式は、病院費用抑制に一定の効果を挙げた

プライマリ・ケアにおけるgate keeping方式では、①住民がGPを事前登録（義務方式・保険料軽減などの誘因方式）し、②GPによる専門（病院）医療への推薦（義務方式、直接専門医療に受診した場合の自己負担方式）の2点がある。このGate keeping制度は、国によって義務や経済的誘因の程度が大きく異なっている。日本にはない一方で、独では医師の41.0%がGPであり、家庭医の登録制度が存在している。英国のGP組織に病院医療費の予算を与えたGP Fundholding (1991-1998年に実施、以下GPFH)による費用抑制効果を、Dusheiko et al (2006)が検証している[2)]。その結果、GPFHは4.9%の病院医療費を抑制しており、その差はGPFH制度の廃止により速やかに解消された。同論文では、病院医療費の抑制全体の約60%がNHSからGPへの支払方式の変更によるincentive effectで、残りの約40%がunobserved differencesのためと結論づけている。但し、分析方法として差の差分分析（DID）を用いているが、介入群と制御群にセレクション・バイアスによる異質性が残存しているという問題点があるかも知れないとされている。

1）Dusheiko et al(2011)“Does better disease management in primarily care reduced costs ? Evidence from English primary care” Journal of Health Economics Vol.30 pp919-932では、病院医療費を被説明変数とし、プライマリ・ケア分野のQoF制度における評価指標を点数化した説明変数の影響をパネル・データで分析している。具体的なデータとしては、patient-registration data（住民と登録したGP）, patient hospital use data（住民と入院医療データ）, GP quality data（GP毎のQoF結果)を連結したデータ・セットを利用している。これによって、GPによるdisease managementの品質を示す変数としてQoF点数と病院費用の関係を検証した。その結果、10の慢性期疾患のうちstrokeのみで、品質上昇により病院医療費が減少する頑健な関係を確認できた。

但し、費用抑制効果は単年度のみを補足し、QoF導入による費用増加を考慮していない。

2）Dusheiko et al (2006)は、英国で1991-1998年に導入されたGPFHの効果を評価している。分析方法としては、導入期間及び導入前後の2年間をカバーするパネル・データを用いて、GPFHとnonGPFHの入院率の違いを差の差分分析（DID）で推定している。その結果、GPFHではnonGPFHに比して、入院率が3.5%～5.1%低く、GPFHが廃止された1998年以降には入院率の差が縮小している。一方で、救急医療分野の入院率は、2グループに違いがなく、1998年以降も変化が見られない結果となった。但し、GPFHへの移行はvoluntary方式のため、DIDの前提条件となる、2つのグループが同質的であるという条件を満たしていない可能性が残っていることに留意が必要である。

②英国GPによるP4P導入は、小幅の品質向上の割に費用がかかりすぎた

英国におけるPay for Performance（P4P）導入の経緯については、Smith and York (2004)が詳しい[3)]。導入の成果については、評価指標の水準は改善し小幅の品質向上が認められている（但し、導入以前から品質改善のトレンドがある）。一方、P4P導入後にGPによるゲーミング（制度を利己的に利用するような戦略を取ること）の証拠が認められ、品質指標に含まれなかった分野の品質は低かった。総体的に見て、P4Pの費用に対して効果は少なかったと結論づけられる。また、P4P導入に伴う二次的効果として、GP組織のコンピュータ化や品質情報が豊富になった点があげられている。

これらの英国の経験から言えることは、P4P制度の設計において重要な点は、①対象範囲が包括的か、②経済的誘因が十分強いか、③目標水準の達成のしやすさ、④担当住民のリスク調整の実施、⑤（制度を悪用する）ゲーミングの排除と（測定されない部分の）品質の低下回避である。

結論として、プライマリ・ケア分野は費用抑制と品質向上の鍵であると言える。但し、その効果は依然として不透明な部分が多い。この分野の成功のためには、いくつかの必要条件（prerequisite）が前提となる。例えば、①整合的な償還制度、②情報収集制度及び監査制度、③効果的なガバナンス、モニタリング及び評価制度の存在である。

以　上

3）Smith and York (2004)は、英国でGPに対する支払制度であるQoFの導入経緯やその仕組みを解説した論文である。英国NHSは、1990年代から“primary care-red”の医療供給体制を構築してきた。QoFの実証実験が東ケント州で実施され、不透明だった品質の「見える化」が評価された。これを元に、2004年の契約からGPの品質に対する報酬であるQoFはGPの全所得の18%（支払総額は1.3百万ポンド）まで増額された。

また、QoFの仕組みについては、①どの評価項目を優先して点数を得るかは、地域のニーズに応じてGPが判断できる、②GP個人の所得としてではなく、実施したサービス毎に報酬が支払われるため、誰がサービスを供給しても良いため、チーム・ワークとピアー・レビューが強化される、③QoFの評価項目・点数の改訂にGPがcommitmentをもつ、の3点の特徴を持つ。

QoFは英国のプライマリ・ケア分野に導入された成果報酬制度（Pay for Performance、P4P）である。この導入により、DMの品質を向上させ、病院医療費を抑制することを目的としている。具体的には、①150の評価指標の達成水準に応じた点数を設定し、②外部監査付きの自己申告方式により、③収入の約2割をQoFにより提供する。例えば、「臨床指標（76指標）」の「高血圧（5指標）」のBP5（高血圧患者の血圧コントロールが成功した割合）場合、最低値20%から最高値70%の間の実績値に応じて比例的にポイントが付加される。

Ⅱ. セッション2

第2報告

「KOTITORI : The Service Integrator Model for Home Care」 Professor Paul Lillrank,
Department of Industrial Engineering and Management, School of Science, Aalto University; Chairman of the Board, Nordic Healthcare Group, Co. Ltd.

1.第2報告の問題意識

(1)発表内容の概要

KOTITORIのKOTIとはフィンランド語で「家」の意味で、TORIとは「市場」という意味である。従って、KOTITORIとは在宅で利用される医療・介護・福祉サービスを購入する人向けのサービス市場を意味する。KOTITORIについては既にOECDワーキング・ペーパーで紹介されている。[4)] 今回は基本的な情報を紹介するのではなく、より深いHealthcare organization managementの観点から議論したい。

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4)OECD (2012) "The Kotitori Integrator of Home Care Services in Finland" の概要は以下の通りである。

フィンランドでは基礎自治体(市町村)がLTCの供給責任を担っている。20年前から careの市場化政策が実施され、primary health careやelderly careが民間組織と自治体との契約により供給されてきた。KOTITORIを導入したTempere市(以下、テンペレ市)はフィンランド第三の都市で、人口21.3万人である。そのうち、稼働人口(30-65歳)が43.0%、高齢化率は16.3%である。

KOTITORI社はケース・マネジャー(case manager)を多職種チームの管理者として雇用し、様々なサービス提供者のサービスの統合(integration)を管理する。これらのサービスは市がサービス購入者として対価を支払うが、顧客が別途私費で購入することも可能である。多職種チームのケース・マネジャーは、相談業務、ニーズ把握、ケース・マネジメント、ケア・プラン作成を行う。

テンペレ市がKOTITORIを導入した理由は、①高齢化によるニーズ増加、②地域における担税力の低下、③独居高齢者の増加により、住宅サービスなどの民間のサービス供給者への住民のアクセスを容易にする必要が増加、④これまでテンペレ市では外部環境の変化に対応する改革を実施しようとしたが、これまでのやり方や文化を内部から変えることは困難だった。そこで、外部から変革を行うため新たな仕組みを導入したかった、⑤雇用確保のために自治体は地元の小規模事業者に業務委託を行いたかったが、契約手続きの負担などにより、大規模事業者に頼らざるをえなかった。

KOTITORIはMawell Care社により経営されており、テンペレ市と4年契約を締結している(2009-2013年、但し2年間の延長オプションあり)。Mawell Care社はNordic Health Care Group(Lillrank教授がトップのヘルスケア専門のコンサルタント会社。ベンチマーキングや品質管理を行う)と業務提携し、支援を受けている。

KOTITORIモデルの要諦は在宅向けLTCのone-stop shoppingの市場という点である。KOTITORIは102のサービス提供者と契約しており、そのうち28事業者とはケア・プラン情報をweb上で共有し、サービス指標の設定水準を満たすことを契約しているpartner providerである。

在宅ケアに関するperformance indicatorによれば、KOTITORIの担当地域は他の地域に比較して、①救急医療サービスの利用率が14%低い、②プライマリ・ケアの利用率が15%低い、③在宅からシェルターハウスへの転送が29%低い、④入院医療費が30%低い。一方で、利用者(患者)満足度に関しては、KOTITORI担当地域の方が低いが、有意な差ではない。

上記データについては、より信頼性の高いデータでさらに検証する必要がある。

（2）Healthcare organization managementにおけるVMOの概念

Healthcare organization managementの観点では、医療・介護サービスの提供体制をservice machineとみなす。例えば、ノート PC を例にとると、ディスプレイ・キーボード・CPU・メモリー・電装品の全てが1つのフレームとして統合して稼働する必要がある。サービスの場合にも、様々なサービス供給者・資金調達制度・規制当局・サービス利用者が1つのフレームにおいて、統合して稼働することになる。但し、サービスの場合には、これらの利害関係者を統合するのは相互の契約・経済的誘因である。さらに、契約は不完全な面を含み、様々な関係者のモラル・ハザードが発生する。

この基本的な考え方を前提に、外部委託（Outsourcing）における Vender Management Organization（以下、VMO）を紹介したい。この VMO とは、外部委託に関するマネジメントを含めて受託する（Outsourcing of outsourcing）組織を指す。この VMO の利点は、多数の外部委託先をネットワーク化して全体を service machine としてマネジメントできる点である。KOTITORIの仕組みも、このVMOの概念を用いればシンプルに理解できる。OECD（2012）によれば、KOTITORIの要諦は、在宅向けLTCのone-stop shoppingの市場という点であるとされている）。

2.フィンランドの政策目標と問題点

（1）施設ケアから在宅ケアへのシフト政策

フィンランドでは、未だに 28,000 床の高齢者向け病床が残存しており、在宅比率も低い。人口規模で2倍のスウェーデンでは同種の病床は3,000床まで削減されている。これらの病床は死亡前1年～2年に利用され、非常に費用が高い。このため、フィンランド政府は施設ケアから在宅ケアへの転換を重要政策として推進している。しかし、在宅ケアでも供給主体は公的セクターであり、高コストであった。

（2）民間会社への外部委託の問題点

このため、フィンランドでは在宅ケアを民間会社に外部委託することにより、在宅ケアを拡大させ施設ケアを削減しようとした。次に問題になったのは、民間大企業による地域独占 (local monopoly) である。フィンランドには、主にスウェーデンの大企業が在宅ケアを供給している。外部委託先が大企業1社であると、地域独占を利用して価格の引き上げを行うため、費用がかえって増加する。この問題は既にスウェーデンの小規模自治体で起きている。しかし、地域独占を避けるために、小規模な地元企業と多数の契約を締結することになると、公開入札や契約のための交渉・手続きに膨大な時間と費用がかかってしまうことになる。

テンペレ市が KOTITORI を導入した理由は、自治体が VMO1社と契約し、その VMO が多数の地元の小規模企業と契約することにより、上記の問題を回避することができるからである。併せて、VMO は高度な専門知識を持つ人材を柔軟に雇用できるため、外部委託先を十分に監督できない自治体職員の能力不足の問題にも対応することができる。

3.KOTITORIの仕組みと費用抑制効果

（1）VMOの一種としてのKOTITORI

KOTITORI は、事務所・インターネットのホームページ及び電話で、ケアが必要と考えている人に対応する形を取っている。また、VMO の概念を拡張して、低所得で重度の介護が必要な公費利用者に加えて、高所得で若干歩行に支障があるような私費利用者に対して民間企業（private service provider）のサービスを紹介する業務を追加している。尚、公費利用者はテンペレ市の公務員による公的サービスを利用することも、バウチャーを利用して民間企業からサービスを購入することも可能である。かねてから公的セクターの生産性に不満を持っていたテンペレ市は、KOTITORI モデルの中に公費負担の利用者が公的サービスを利用した場合と民間企業のサービスを利用した場合のパフォーマンスの比較をすることができるように明示的に依頼していた。

KOTITORIには15社のサービス提供の核となるサービス提供者がおり、さらに100社の純粋な民間会社で主に私費利用者を対象とする会社（主に小規模な地元企業で、配食や整髪などもある）がKOTITORIネットワークに加わっている。

（2）KOTITORIのサービス利用状況

KOTITORIがサービスを開始した2009年から数年が経過した。利用希望者のうち12%がサービスを利用する必要がないとアドバイスされ、27%が公的セクターのサービスを利用し、13%が公的セクターと民間企業のサービスの両方を利用し、20%が民間企業のサービスを利用し、11%がボランティアのサービスを利用した。これらの全ての利用者のうち 17%が、従来から利用しているサービスを継続して利用することをKOTITORIからアドバイスされた。

（3）パフォーマンス評価の概念整理

それでは、公的セクターに比して民間企業のサービスはどのような評価を受けたのであろうか。この時、評価には様々な視点があることに留意が必要である。例えば、生産工程が効率的かについては technical efficiency（技術的効率性或いは生産性），費用も含めた資源配分については allocative efficiency（資源配分効率性），その結果として全体の効率性としては economic efficiency（経済効率性）がある。生産の結果として得られた生産量としての output（出力）とその利用者への影響を outcome（結果）として評価することも行われている。さらに、利用者からみて outcome がどの程度の価値があるかも value(subjective value) という概念もある。このようにパフォーマンスを評価するのは非常に複雑かつ困難さを伴うが、いくつかの評価指標で比較をしてみよう。

例えば、最も重要な生産性の評価指標は、介護者（care giver）が直接ケアを供給している時間の全体の労働時間に占める割合である。これは稼働率(capacity utilization rate)と呼ばれているが、フィンランドの場合には公的セクターでは40-45%で、民間企業では 70%程度であった。但し、人間は必ずトイレや休憩の時間が必要なため、最高の場合でも 75%～ 85%に止まると考えられている。

（4）KOTITORIにおける公民の比較結果

2012年には、KOTITORIは360人の利用者を抱え、総費用は3.2百万ユーロ（1ユーロ150円として、4.8億円）となり、うちKOTITORIのケア統合の手数料が0.9百万ユーロ（1ユーロ150円として、1.35億円）になった。75歳以上の在宅利用者一人あたりの費用は、KOTITORIを利用しない公的セクターで1,958ユーロに対して、KOTITORIでは1,287ユーロまで低下した。逆に一人あたりのケースマネジメントの費用は、公的セクターで553ユーロに対して、KOTITORIでは813ユーロと逆に高くなっている。これはKOTITORIではケースマネジメントに充分な費用をかけることにより、適切なケアを適時に提供することを重視しているためである。1人当たりの費用では、公的セクター2,511ユーロに対してKOTITORIで2,100ユーロのため、全体で1.5百万ユーロ（1ユーロ150円として、2.25億円）の費用低下となっている。併せて、KOTITORIでは施設ケアの利用率が低下（入院日数も短縮）した点も認められ、施設ケアから在宅ケアへの移動という政策目標においても良い点が認められる。

更に、KOTITORIと比較された公的セクターでも、稼働力利用率(capacity utilization rate)が45%から52%に上昇し、緊急通報サービスの利用回数が低下したことから、2.7百万ユーロ（1ユーロ150円として、4.05億円）の費用節減が認められた。

結論として、KOTITORIは新しい統合ケアのモデルとして一定の成功を収めたと評価して良いと思う。ただ、まだプロトタイプで、改善や発達が必要と考えられ、一般化するのは早計である。特に、既に要介護の状態にあり、症状の悪化が予想される利用者については、効果的であると考えられる。

以　上

Ⅲ. セッション3

第3報告

「Long-term care in the Netherlands: Towards managed competition?」Professor Richard van Kleef, Institute of Health Policy and Management, Erasmus University Rotterdam

1.第3報告の問題意識

(1)オランダにおける公的医療制度と管理競争の仕組み

オランダでは、公的医療保険は2つに分かれている。一つはlong-term care(以下LTC)を保障する部分で、もう1つは急性期医療(short-term care)を保障する部分である。前者のLTC部分は、ケア・アセスメント・センターがニーズを認めた場合に、現金又は現物で給付が実施される仕組みである。後者の急性期医療部分には管理競争(managed competition)という、民間保険者が基礎的な給付の保険プランを全国民に提供し、その財務リスク(financial risk)を負担するという仕組みが導入されている。 この管理競争による資源配分の効率化の誘因としては、被保険者の保険選択(よりよい保険を選択)と保険給付内容の標準化(保険を選択しやすくする)が必要となる。さらに、国民のアクセスの公平性のために、強制加入・地域保険料方式・リスク調整・低所得者補助金などの条件が必要となる。[5)]

(2)オランダにおけるlong-term care保険の問題点

オランダにおいて、LTCは現状では最も重要な政策的及び政治的課題である。その理由は、社会保障費用の制御において深刻なボトルネックになっているからである。具体的には、以下の3点が挙げられる。

第一に、LTC分野の保険者間に「競争」も「財務リスク」もないため、LTC費用を抑制するという経済的誘因がない。第二に、保険者間競争及び財政リスクがある急性期医療保険からLTC保険へコストシフト(費用のつけ回し)をして、保険者が費用を抑制する誘因があることも懸念されている。第三に、急性期ケアとLTCでは保障制度もサービス供給者も異なるため、LTCと急性期ケアの統合が困難な仕組みになっている点である。その結果、オランダでは高コストの施設ケアへの依存度が高く、本来はLTCが必要ない高齢者にケアが給付されている例が見られる。

(3)管理競争は急性期保険で費用抑制の成果を上げた

このような状態に対して、「管理競争(managed competition)をLTCに適応できるか」が政策課題になっている。私と同僚が近年行った研究によれば、管理競争は徐々に機能が強化されてきており、特に2010年以降薬剤費の増加率抑制のみならず薬剤費全体の抑制に成功している。さらに、2012年に導入された、民間保険者が病院と個別に年間予算を交渉できる仕組みにより、保険者は病院医療費の増加率の抑制に成功している。この結果、2012年の医療費増加率は0.5%で、ほぼ前年と同額であった。

このため、つい2週間前にオランダ政府は、LTCの一部(訪問看護)を第一のLTC保険から管理競争(managed competition)を導入した第二の急性期保険に2015年から移管することを決定している。しかし、このような政策は管理競争の成否を費用抑制の面から見たためであり、利用者側の立場で、サービスの品質が改善されているかの面から見ると違った結論になる。

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5)管理競争の仕組みや導入に必要となる前提条件については、Kleef (2012) “Managed competition in the Dutch Health Care system: Precondition and experience so far” Public Policy Review 5(2) pp171-190に詳しく記載されている。本論文の日本語版として「オランダの医療制度における管理競争ー前提条件と現在までの経験」『フィナンシャル・レビュー』111号(2012.9)がある。本論文にはオランダの医療制度に関する説明もあるが、一部は既に変更されている。

（4）急性期医療保険での管理競争は全ての前提条件を満たしているわけではない

管理競争においては、満たされるべき前提条件が重要であるが、急性期ケア保険においても依然として以下の点が十分に満たされていないと考えられる。第一にリスク調整制度により民間保険者がリスク選択を行う経済的誘因を持たないことが必要である。しかし、現状でも特定のグループに属する被保険者はリスク調整の後も割高な医療費がかかることが分かっている。この部分が十分に調整され、差額が実質的に0円にならない限り、民間保険者はリスク選択の誘因を持ち続けることとなる。

第二に、サービスの品質を「見える化」して品質改善を促す品質指標と、その評価の仕組みが十分に整備されていないことである。このため、管理競争の導入に費用抑制が認められたが、品質が低下しているのか改善しているのか不透明である。

第三に、サービス提供者（急性期病院やその医療従事者）に対する効率化の誘因が不十分である。例えば、セッションIで報告されたPay for Performanceやoutcomeをベースにした償還制度が考えられる。

2.LTC保険にも管理競争を導入するべきか

（1）LTCの場合に問題となる3つの基礎的問題

LTCに管理競争を導入した場合に、以下の3点の基礎的な問題がある。第一にLTCで充分なリスク調整の制度を構築できるか、第二にLTCの利用者は自分で選択する（foot voting）ことが可能か、第三にLTCの未利用者がLTC保険の選択に興味を持つかの3点が挙げられる。

第一に、LTCのリスク調整制度の構築は困難である。これはLTCは急性期ケアに比して、①罹患確率が低く、②費用集中度が高いため、少数のグループがかなり高い費用を消費することになる。さらに、保険者側はこれらのグループを特定することが急性期ケアの場合よりも容易である。例えば、今年施設ケアを利用している高齢者は、来年も同様に利用することは容易に予見できる。また、リスク調整制度で用いるための変数が未知であり、③保険者が容易に予見できる少数のグループをリスク調整制度でより精緻に説明できる可能性が低いと考えられる。

第二に、LTC利用者は自分でLTC保険を選択したり、不満がある場合にはLTC保険を変更することが困難である。これは、高齢者の場合には認知機能が低下したり、精神疾患を有している可能性があることなどから、熟慮した判断ができないためである。このvoting by footがないと、保険者が利用者にとってベストなサービスを給付する経済的誘因が機能しなくなってしまう。

第三に、未利用者はLTC保険の選択にあまり興味がないと考えられる。これは、LTC利用者になる確率がかなり低いため、多くの被保険者は予め利用者になることを想定して行動しないためである。例えば、若者は自分が要介護になることを想定できず、それに対して保険者は若者が興味を持つ別の給付を充実することにより、選択してもらおうとする可能性が高い。上記の3点の理由から、管理競争の下でもLTC保険者は、保険給付内容や品質改善を行う経済的誘因を十分に持たないと考えられる。

3. 管理競争の代替案にも問題が多い

（1）基礎自治体にLTC費用を移管する案

次に代替案として、自治体にLTC費用を移管する場合と、現状（非管理競争）を維持する場合の二案を検討する。

第一に、基礎自治体にLTCを移管する案の利点は、①他の自治体サービス（特に福祉サービス）とLTCの統合が容易になることである。併せて、②リスク選択の問題や利用者がLTC保険を選択する必要がなくなる。代わりに、地域毎の民主的なプロセスにより給付水準や給付内容が決定されることになる。

逆に不利なのは、①急性期ケアとの統合が容易でなくなることや、②LTCの給付水準や品質が地域や自治体によって大きく異なる可能性が高いこと、③利用者の選択肢が特定の自治体内の供給者に限定されるなどにより狭まる可能性が高い、などの点である。地域住民はより良いLTCを求めて、居住地を変更することも可能だが、これがどの人でも可能な方法ではないことは明らかである。この案の場合には、自治体側がLTCのための新たな制度に対応する必要が生じ、そのための投資が必要となる。さらに、限られたLTC予算を配分するという別の目的のために、自治体間のリスク調整制度が必要になる可能性がある。

（2）現状（非管理競争）を維持する案

現状（非管理競争）を維持する案の利点は、リスク選択の問題がなくリスク調整制度の創設や利用者によるLTC保険の選択も不必要である点である。一方で、不利な点は効率化の誘因がなく、急性期ケアとの統合が困難な点である。

（3）これからの方向性と検討課題

実は、現状を維持しながらLTCの一部を自治体に移管することが、現実的な案かも知れない。2007年にLTC保険からホームヘルプ・サービスが自治体に移管された。このサービスは在宅医療・介護とは異なり、シャワーを浴びさせたり、お茶を入れたりというものである。自治体はこの一部のLTCのための予算をnon-earmark（特定の使途に限定していない）の形で受け取り、費用を抑制することにより、他の使途に利用できた。これにより、移管前に比して1時間当たりのホームヘルプの価格は20％低下し、12億ユーロの総費用のうち1.5億ユーロを節減することができた。

私の個人的な意見として、LTCに管理競争を導入するべきかと言われれば、少なくとも今は良い機会ではないと考えている。もう2～3年は現在の急性期保険における管理競争制度の進展を注視する必要がある。

以　上

（文責：成城大学経済学部　河口洋行）

Introductory Remarks

Prof. Hiroyuki Kawaguchi, proffessor, Seijo University: Thank you for coming, everybody. I would like to start the symposium. First of all, I would like to have some opening remarks from the president of Seijo University, Professor Yui.

Prof. Yuji Yui; Chancellor Seijo School; President, Seijo University: Good afternoon ladies and gentlemen. I am delighted to welcome all of you to this international symposium on healthcare and long-term care for the elderly.

I would especially like to express my great gratitude to the three distinguished scholars, Prof. Peter Smith from the United Kingdom, Professor Richard van Kleef from the Netherlands, and Professor Paul Lillrank from Finland for sparing their very busy time and coming to present papers at this symposium.

It is my great pleasure for me to give an opening address. This conference is the outcome of a funding program for granting aid for scientific research. Also, this is partly sponsored by Seijo School. As the chancellor of Seijo School, and the president of Seijo university, I would like to take this honorable opportunity to introduce Seijo School.

Seijo School consists of a kindergarten, elementary, junior and senior high school, and university. It was established in 1917, 97 years ago. Seijo University was established in 1950 by Seijo School. We are going to celebrate the centennial anniversary in 2017. We are now planning a series of events which commemorate the centennial anniversary. This symposium is a part of the commemoration events, and Seijo School has financially supported this event a little bit.

Regarding the theme of the conference, acceleration of aging and rapid increase in expenses of social security, have been a big issue, not only in OECD (Organization for Economic Co-operation and Development) countries, but also in Asian countries. In order to provide health care and long-term care for the elderly efficiently, each country has various policies and system management. So, we can learn important lessons from international comparison and exchange of ideas with experts from different countries. In that sense, I am strongly convinced that this symposium will contribute to deepening our mutual understanding on this issue.

Finally, on behalf of all participants, I would like to express deep appreciation for Professor Kawaguchi's excellent

preparation and management of the symposium. I hope all participants will enjoy this symposium.

Thank you very much.

Prof. Hiroyuki Kawaguchi: Thank you Professor Yui.

I would like to explain about this symposium and our research group in a very short time. I am the chairperson, and your helper. My name is Hiroyuki Kawaguchi, and if you have any problems, please ask me anything. At the start of my comment, I would like to explain about this research project. In this research project, we will make a policy proposal for the healthcare system of long term care for the elderly population in Japan, on both the delivery side and the financing side.

In the delivery side, we will try to develop the care model to integrate and coordinate long term care. In this process, we will consider not only quality of care, but also budget constraints of the Japanese government. Financially, it is a very hard time in Japanese government. In the financing side, we will try to develop a financial scheme for public financing for long term care. On the ground, we will focus on the test of the "red herring hypothesis," and whether this hypothesis is valid in Japan. To answer this question, we will try to evaluate the pressure on health care expenditure by the aging population in Japan.

Let me introduce out members. There are eight members in the research team: Professor Ii from Hitotsubashi University, Professor Ogata from University of Tokyo, and Mr. Kikuchi from the National Institute of Population and Social Security Research, Professor Tajika from Hitotsubashi University, Professor Hashimoto from University of Tokyo (he will attend later), Professor Moriyama from Hiroshima University, Professor Yui from Seijo University, and me.

The introduction of the three invited guest speakers is the most important part for me. Let me present Professor Peter Smith from Imperial College, London; Professor Paul Lillrank from Aalto University in Finland; and Professor Richard van Kleef from Erasmus University, Rotterdam in the Netherlands. Thank you to all the guest speakers from your participation in this symposium.

Time is limited, so I would like to move to session one. The first session is about the primary care field as the basement of the health care system. The presentation will be forty minutes. After the presentation, we will have thirty minutes for discussion.

Session 1

Session 1, Presentation:

The role of primary health care in controlling the cost of specialist health care.

Emeritus Professor of Health Policy,
Imperial College London

Professor Peter Smith

[slide 001]

Hello. Thank you very much indeed, Professor Kawaguchi. I am very honored to be invited here. I would also like to thank Seijo University for inviting me. It is a very great honor to be here. I am very grateful to all of you for giving up your Sunday to come and listen to us. I know Sundays are very precious.

When I was researching for this talk, one of the first things I came across was this report made by one of our think tanks in London called The Nuffield Trust. It is called "Caring for an aging population," and it included "Points to consider from reform in Japan." So, it is lessons for the UK from the Japanese experience. We in the UK are listening very hard to what you say, because we to have real concerns here. I think it is important to say that none of us have any complete answers to this real problem that is beginning to arise in all of our countries.

I am going to talk specifically about the role of primary care, and possible future reforms to improve the quality of care for older people, and control the costs of that care. Right at the beginning, I must underline that I don't think primary care is a complete solution to this problem. I think there are elements of primary care that may be very useful, and very good, for any health system. There are also elements of primary care, certainly as it is practiced in the UK, that I would not want any other country to copy. It is important to take the good things, try to build on those, and avoid the traps and the bad things that have happened.

[slide 002]

I will start my forty minute presentation by talking about primary care, in particular its role in disease management for chronic disease, which is the major concern for older people. Incentives play an incredibly important part in the way that primary care functions, so I will talk a bit about those. Then I will look at two policies, which I think are particularly interesting, that have been tried in the UK but may have relevance to all health systems. I will explain those policies later in the talk, but they have been major experiments in the UK.

Contents

- Primary care and general practitioners
- Disease management
- Role of incentives in primary care
- Two primary care policies
  - Fundholding budgets for general practice
  - Pay-for performance in primary care

[slide 003]

Primary care

- Fundamental role in:
  - Coordinating care
  - Health promotion and disease prevention
  - Prescribing and drug monitoring
  - Minor specialist treatments
  - Gatekeeping
- Also, potential role in:
  - Promoting efficiency
  - Cost control (especially unnecessary use of secondary care)

So, what is primary care? It has a fundamental role in coordinating care of individuals, promoting health and preventing disease. It also has important roles in drug prescription and monitoring. In addition, many primary care organizations do minor specialist treatments, which reduces the burden on hospitals. Also, in most primary care systems, and certainly those in the UK, primary care physicians act as gatekeepers to secondary care. Therefore, we cannot get access to specialist care unless our primary care physician makes a request. Of course, I exclude emergency care from that statement.

There are also arguments that primary care can improve efficiency in the healthcare system, and control costs. Those are things that I will talk about a bit later.

[slide 004]

Specifically in the UK, we have a particular organization of primary care. I am not convinced that this is the best organization of primary care, but it has evolved since the creation of our National Health Service in 1948. Most general practices are small businesses with a contract from the public payer (the National Health Service). They are funded by a mix fixed capitation payments per head of population that they look after. Then on top of that, there are some fee for service payments. They can employ staff and services according to their requirements. About 20% of their income comes through performance-related reward.

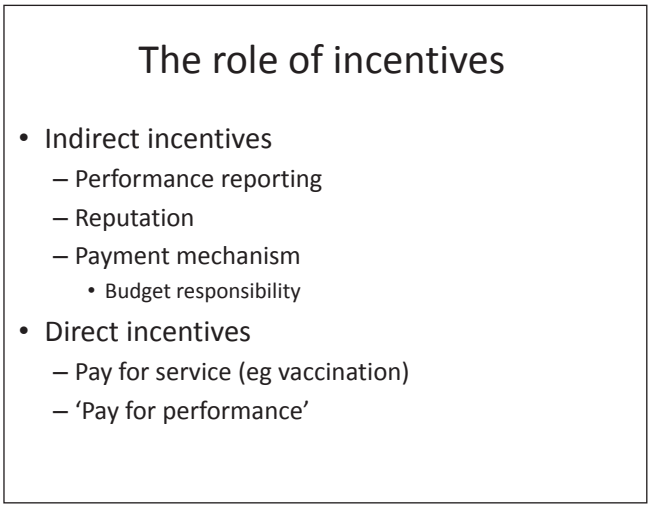
Primary care in the UK

- Average general practice serves a population 7,000 with 4.7 general practitioners (GPs)
  - Most are small businesses with a contractual relationship with the NHS
  - Funded by a mix of capitation payments and fee-for-service
  - Some freedom in employing staff and organizing services
- About 20% of income through pay-for-performance (see later)
- All non-emergency referrals for specialist care must be authorized by the GP
- Fundamental role in the administration of the NHS
  - Implementing national and local policy.
  - Primary care physicians play a leading role in local 'clinical commissioning groups'

I will talk about this later in my presentation. I mentioned already that non-emergency referrals must be authorized by the general practitioner. Increasingly, our primary care physicians are taking a fundamental role in organizing the local services, such as hospital services. They have control of local budgets for much of the health system.

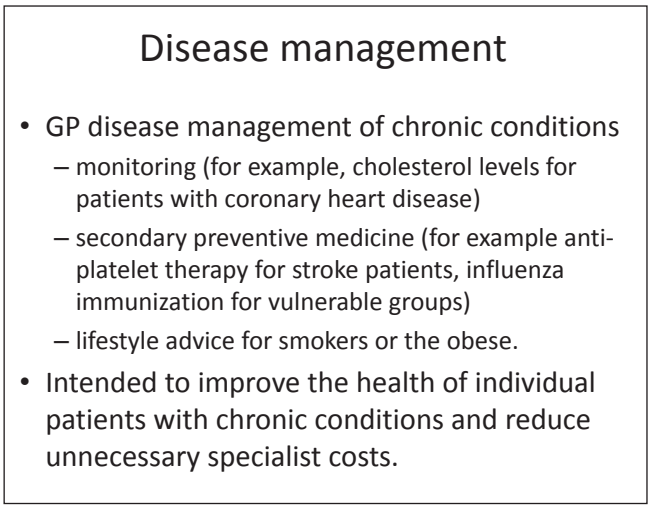
[slide 005]

Incentives play a big part in how our primary care system works. There are indirect incentives, because it is important to note that patients can choose which general practitioner they register with, so there is some competition between them. Therefore, the indirect incentives arise from that competition. There are performance reports, and even a website, like TripAdvisor, where you can see what patients say about general practitioners. Not all general practitioners are pleased with that development – reputation has become an important element. In addition, general practitioners are given budgets to manage. They don't get rewards from those budgets, but it is their duty to look after the budgets for their patients.



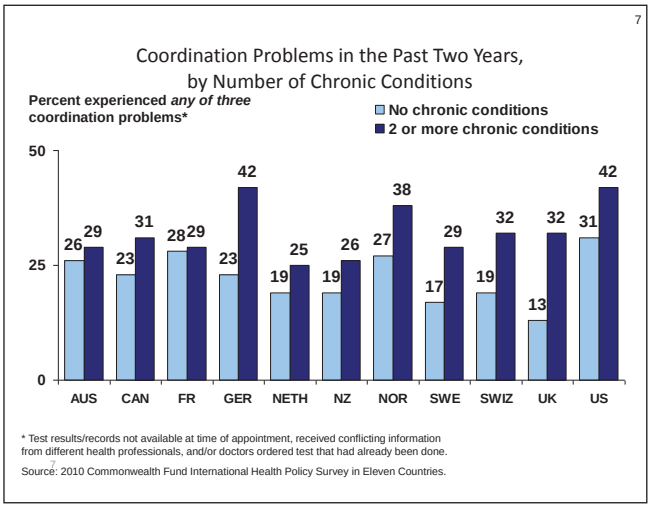
General practitioners also have direct incentives, which I will talk about later.

[slide 006]



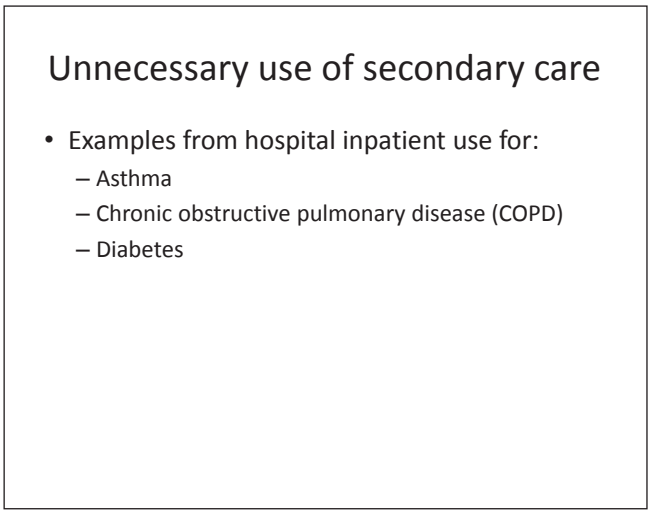
One fundamental role of general practitioners is disease management. "Disease management" is a rather vague term, originally coming from the United States, but roughly speaking, it can be described as monitoring chronic disease to ensure that it is under control, and that any requirements of the patients are met, and also that prevent unnecessary use of secondary care. It is intended to improve the health of the individual and reduce unnecessary specialist costs. However, it is certainly not completely successful in that.

[slide 007]



This is a survey done by the Commonwealth Fund every three years of ordinary citizens in eleven countries. It is unfortunate that Japan does not join in this survey at the moment, but I hope it will in the future because I think it is a very useful "snapshot" of health systems, and what people think of those health systems. This slide is one of many you can get from the Commonwealth Fund. It asks people about problems they have experienced in the coordination of their care over the last two years. The light blue shows patients with no chronic disease, and the problems they have had with car coordination. As you can see, there is quite a lot of variation from country to country. The UK has quite good results in that area. Generally speaking, the countries that have good primary care tend to get better results than other countries. The US, as with so many of these, is a outlier. On the other hand, for patients with two or more chronic conditions, the results are not so good for the UK – or for most countries. Overall, one-third of people with chronic diseases feel there are coordination problems.

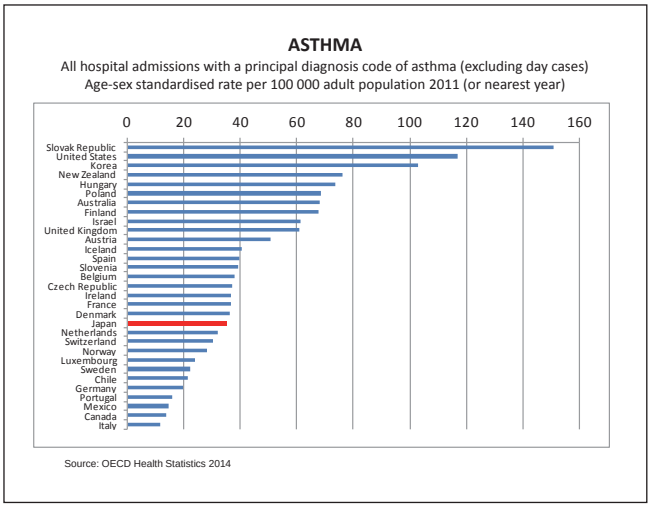
[slide 008]



The second issue was unnecessary use of secondary care. We have some data on this from the OECD for three chronic diseases. They show the number of avoidable admissions for these chronic conditions in OECD countries.

[slide 009]

This is the picture for asthma. Japan is towards the bottom is pretty good, especially compared with the countries at the top, which includes Korea, as having particularly high rates for asthma.



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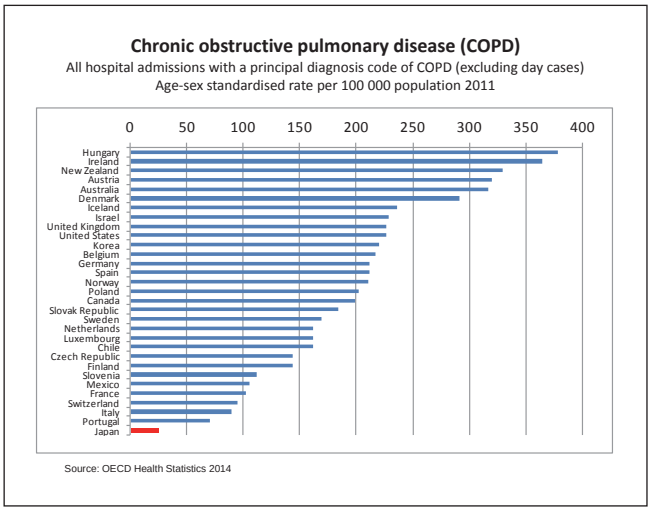
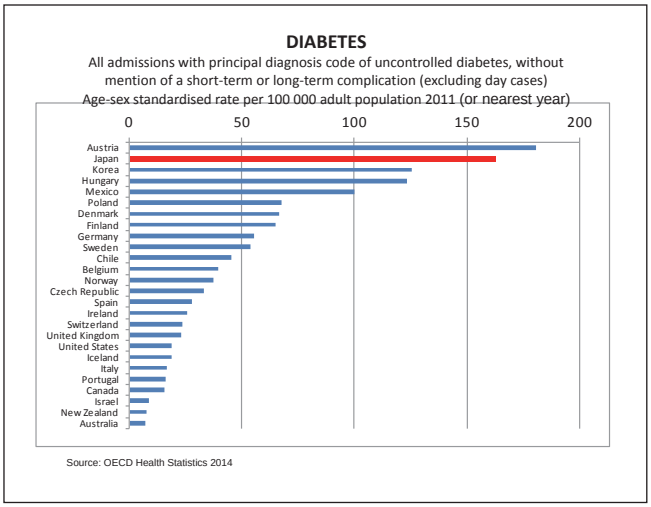


For chronic obstructive pulmonary disease (COPD), Japan is has the lowest rates across the developed world. There may be a different story here – it may be because of the epidemiology, or the care of this disease in Japan. I would be interested in your comments on that.

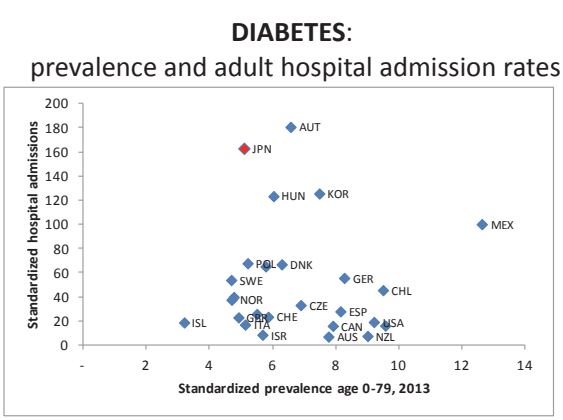
[slide 011]

At the other end of the spectrum is diabetes, where it appears from the data that Japan has particularly high levels of avoidable admissions. It may well be that there is a very good reason for that. I believe that Professor Ii may talk about that a little later on when she replies to my presentation. This demonstrates that this sort of data is very interesting, and useful, but they have to be looked at carefully.



[slide 012]

This is simply a slide on that diabetes issue to show that it is not the prevalence of diabetes in Japan [that is driving admissions rates high]. Along the horizontal axis is prevalence. Japan actually has quite low prevalence compared to most countries, but it has a high admission rate, with only Austria higher. I'm not sure if you are aware, but Austria has a very hospital-dominated health system.



[slide 013 & 014]

We have done a bit of work on whether disease management actually does improve costs or improve health. This is a recent article we published, and what we find is rather mixed is that high levels of performance in managing certain chronic diseases does not seem to improve health of people in the short term. We couldn't examine the longer term, but what we did find was that disease management of people who have had a stroke had a very distinct impact. Good disease management of stroke patients – people who have had a stroke in the past – is associated with reduced future mortality, and reduced future care costs. We think that the improvements over the last five years in stroke care in the UK have saved about 7,000 deaths per annum, and annual expenditure has reduced 0.2% of all hospital costs. That may not sound like a lot, but actually it is very hard to find any interventions which have a major impact on hospital costs. This is one kind of intervention that does have an impact, but we need to find many more to be successful.


Journal of Health Economics 30 (2011) 919–932

Contents lists available at ScienceDirect

Journal of Health Economics

journal homepage: www.elsevier.com/locate/econbase

Does better disease management in primary care reduce hospital costs? Evidence from English primary care

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ARTICLE INFO

Article history:
Received 13 September 2010
Received in revised form 1 August 2011
Accepted 1 August 2011
Available online 7 August 2011

JEL classification:
I12
I18

Keywords:
Disease management
Primary care
Hospital costs
Ambulatory care sensitive conditions
Preventative care

ABSTRACT

We apply cross-sectional and panel data methods to a database of 5 million patients in 8000 English general practices to examine whether better primary care management of 10 chronic diseases is associated with reduced hospital costs. We find that only primary care performance in stroke care is associated with lower hospital costs. Our results suggest that the 10% improvement in the general practice quality of stroke care between 2004/5 and 2007/8 reduced 2007/8 hospital expenditure by about £130 million in England. The cost savings are due mainly to reductions in emergency admissions and outpatient visits, rather than to lower costs for patients treated in hospital or to reductions in elective admissions.

Quality of disease management and hospital costs

- Examined link between incentivized performance in chronic disease management and hospital costs
  - Asthma; chronic heart disease; chronic kidney disease; COPD; dementia; diabetes; hypertension; hypothyroidism; mental health; stroke.
- Only clear link is between improved GP performance and reduced hospital costs for stroke patients.
  - Annual expenditure reduced by £130m (0.2% of all hospital costs), mainly in emergency admissions
  - Saved approximately 7,000 deaths per annum

- Dusheiko, M., Gravelle, H., Martin, S., Rice, N. and Smith, P. (2011), "Does disease management reduce hospital costs? Evidence from English primary care", *Journal of Health Economics*, 30, 919-932.

[slide 015 & 016]

So, let me go on to the two policies aimed at primary care which are trying to improve efficiency in the area of chronic disease and care of the elderly. First of all, this is a policy called fundholding. It was implemented more than 20 years ago. What it essentially did was give general practitioners an annual budget with which they were expected to look after their patients' secondary care needs. They were expected to pay for all the secondary care – not the emergency costs, but the routine care – out of this budget.

Two policies aimed at improving health system efficiency • Gatekeeping budgets – GP fundholding • Pay-for-performance (P4P) – Quality and outcomes framework	**POLICY 1: FUNDHOLDING**

[slide 017]

Gatekeeping in primary care

- Citizens register with a general practitioner (GP)
  - Compulsory, or incentives such as reduced insurance premiums
- Access to (non-emergency) specialist care only through referral by GP
  - Compulsory, or incentives such as a patient fee for direct access to specialist
- Strength of incentives and compulsion varies greatly between systems of gate-keeping

I have talked a little bit already about primary care in the UK. This fundholding role, which I will talk about here, is actually a very extreme form of gate keeping. This is the OECD again. They have done a survey of which countries actually use gate-keeping across the developed world. The horizontal side is whether primary care physicians are required to make a referral for secondary care. As you see, for the majority of countries there is that gatekeeping requirement. So, in Denmark, Finland, and so on. The vertical axis is whether the patients are required to register with a primary care physician. That is less relevant for this particular talk.

[slide 018]

As you see, Japan has no gatekeeping to secondary care, and there are some countries in the middle – Belgium, France, Switzerland, and Mexico – with some gatekeeping incentives. In France for example, one has to pay extra if one goes to a specialist without getting a referral from a primary care gatekeeper. So, those are the different systems in place around the world.

OECD Survey of Health System Characteristics 2012

Gatekeeping system

		Primary care physicians referral to access secondary care		
		Required	Incentives	No requirement, no incentive
Are patients required or encouraged to register with a primary care physician?	Required	Denmark, Finland, Ireland[1], Italy, Netherlands, Portugal, Slovenia, Spain		Czech Republic
	Incentives	Australia, New Zealand, Norway, Poland,	Belgium, France, Switzerland	
	No requirement, no incentive	Canada, Chile, United Kingdom	Mexico	Austria, Germany, Greece, Iceland, Israel, Japan, Korea

Source: http://www.oecd.org/els/health-systems/organisation-health-care-delivery.htm

[slide 019]

Fundholding

- General practitioners were given an annual budget with which they were expected to purchase certain secondary health services for their patients
  - Includes routine ('chargeable') non-emergency surgery (about 37% of all hospital episodes)
  - Excludes 'non-chargeable' elective procedures (more complex, about 16% of all episodes)
  - Excludes emergency admissions (about 46% of episodes)
- Participation of GPs voluntary
- Introduced in 1991, abolished in 1998
- About 50% of patients covered by a fundholder by 1998
- Budgetary surplus could be retained by the practice for 'extra services for patients' (not personal gain)
- Weak sanctions for overspending.

This is the fundholding experiment in the UK. They were given this budget, and it meant that certain routine, or chargeable, procedures, were paid for out of that general practitioner budget. It excluded certain elective procedures that were not chargeable – more complicated ones generally – so, the chargeable were about 37% of all hospital episodes, and the non-chargeable ones were about 16%, and then there were emergency admissions, which were not charged to the general practitioner and made up about 46% of all admissions.

Very importantly, general practitioner (GP) participation was voluntary. In the end, only about 50% of GPs took part in it. It was started in 1991, and abolished in 1998. About 50% of patients were covered by 1998. What happened to the surplus on the budget was that the GP could retain that surplus, not for their own personal wealth or income, but for investing for patient services. They could provide a new service for their patients, and make their practice more attractive in some way.

It is also important to note that the penalties for overspending were quite weak. The worst that could happen to a fund holder was that they would have permission taken away, and they couldn't be a fund holder in the future. They didn't actually have a great deal of personal money at stake.

[slide 020]

The interesting thing with this experiment was that we had a very natural experiment, because we could look at the impact of abolition of fundholding in 1998. Incidentally, it was abolished not because it was considered to be a failure, it was abolished for political reasons – a new government came into power, and they wanted to do something different. I'm sure you don't have things happening like that in Japan! But we have things happening like that in the UK all the time, and it has a very unfortunate impact on our health system.

A natural experiment: the abolition of fundholding

- An opportunity to observe the impact of the *end* of a policy on fundholders vs non-fundholders
- Two years either side of abolition
- Difficult to disentangle *selection* effect from *incentive* effect
- Difference-in-difference econometric techniques
- Results: fundholders made 4.9% less use of the relevant non-emergency hospital treatments than their non-fundholding counterparts, a difference that quickly disappeared after abolition.

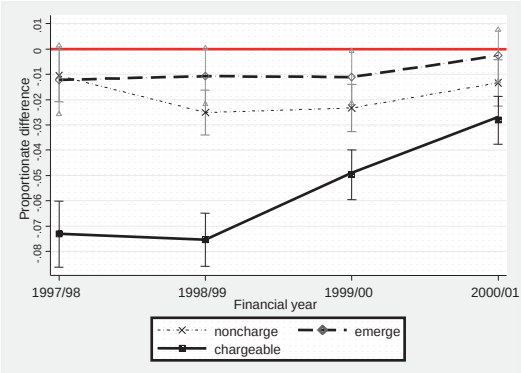
- Dusheiko, M., Gravelle, H., Jacobs, R., Smith, P. (2006), "The effect of budgets on doctor behaviour: evidence from a natural experiment", *Journal of Health Economics*, 25, 449-478.

What we did was look at two years on either side of abolition. We used some advanced econometrics techniques. However, in the end, what we were able to show was that fund holders, after you corrected for everything else, seemed to use about 5% less of those chargeable treatments than non-fund holders. There was quite a large impact on secondary care caused by fund holding. This is the diagram that tries to show it. Here are the two years before abolition, and these are the fund holders here. It is relative to the red line – the fund holders were quite low in their referrals. When fundholding was abolished, which was in this period, in the first year, the fund holders started approaching all the others, and then in the second year, they got very close to the others. So, there was a very distinct impact when the experiment was abolished.

[slide021 & 022]

I haven't got time to go through all of our conclusions, but we concluded that fund holders, and fundholding, had a significant impact on hospital costs. We think, again, that it was a saving of about 0.6% of all hospital expenditure. And this reduction would be permanently reduced, with this system in place. We could find no evidence that fund-holder patients had poorer health. There was an interesting finding, that they actually seemed to be less satisfied with their doctors, than non-fund holding patients. There may be an issue that patients may think that their doctor is more concerned about the money, than about their health.

Differences between fundholder and non-fundholder admission rates for chargeable, non-chargeable and emergency admissions



Fundholding: conclusions

- Voluntary gatekeeper budget-holding secured material reductions in referrals, even with very modest incentives
  - Approximately 5% of referrals; 50% of GPs; 25% of hospital costs. This implies annual savings of 0.6% of all hospital expenditure.
- Earlier fundholders secured larger reductions than later fundholders:
  - More scope?
  - More enthusiasm?
  - Learning behaviour?
- Fundholding regime had no effect on emergency admission rates for FHs
- Fundholders secured distinct waiting time advantages:
  - At expense of non-fundholders?
  - To benefit of non-fundholders?
- Fundholders' patients were less satisfied than their non-fundholding counterparts
- No evidence of unmeasured health costs of fundholding.

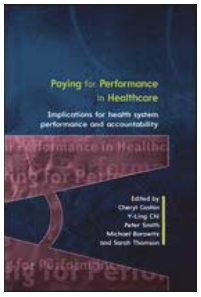
[slide 023]

The second initiative that I would like to discuss is the issue of Pay-for-Performance. This is the notion of paying physicians a reward for securing improved quality. It is rather strange that we should think this is revolutionary. In fact, there is a story that the Chinese first invented this type of reward. I expect you have all heard this story about the Chinese villages only paid their physicians while they stayed healthy. If the villagers became sick, then they stopped paying their physicians. This is an early form of pay-for-performance.

POLICY 2: PAY-FOR-PERFORMANCE (QUALITY AND OUTCOMES FRAMEWORK)

[slide 024]

Paying for performance in healthcare, August 2014



- Cashin, C., Chi, Y., Smith, P., Borowitz, M. and Thomson, S. (eds)
- *Paying for performance in healthcare: implications for health system performance and accountability*
- Maidenhead: Open University Press.

This is just a little advertisement. We recently published a book on this topic, which is now available. It has 16 case studies from across high-income countries for paying for performance, not just for primary care, but also for secondary care.

[slide025]

There are big questions about what should be rewarded when you do pay for performance. Should it be the structure of care? There are some arguments that it should just be having certain things in place – do you actually provide the service. This is actually a big issue in low-income countries. Their first concern is to make sure the clinicians turn up for work. The first aspect of performance is to have the workers in place, and to reward attendance. However, of course we hope we can get more sophisticated than that. So, the next level is the processes of care. Do the physicians, or the providers, adhere to certain types of guidelines, which are expected to lead to better outcomes? Finally, should we reward the outcomes of care in terms of better health? It turns out that these outcomes are very difficult to measure, and they take a long time to

What should be rewarded?

- Structure
  - Provision of service
  - Accreditation
  - Information provision
- Process
  - Adherence to guidelines
- Outcomes
  - Early cancer diagnosis
  - Biomedical status
  - Avoidable admissions
  - Health status

materialize sometimes. Also, they are vulnerable to influence beyond the control of the healthcare provider. So, we find that most systems in place look at the processes of care as being what is rewarded. It is important that those processes are known to be related, eventually, to good outcomes.

[slide 026]

From the book, this shows the countries that are using pay-for-performance, in three columns: Primary care, Specialist care, and Hospitals. You will see that those countries that are doing pay-for-performance are mainly doing it in primary care. There are some in specialist care, and some in hospitals. And of course, the Japan line is empty. I ought to say that this table was compiled by a survey of government officials in the various countries, and I have complete respect for government officials, but certainly in the UK it is quite difficult to find a government official who knows everything about all aspects of the healthcare system. I expect that is true in some other countries as well.

P4P programs and measures in OECD countries.
Source: Borowitz, Cashin, Chi, Smith, and Thompson (2014) for European Observatory and OECD

Country	*Primary care*	*Specialist care*	*Hospitals*
Australia	X		X
Austria			
Belgium	X		
Canada			
Chile	X	X	
Czech Republic	X		
Denmark			
Estonia			
Finland			
France	X	X	X
Germany	X		
Greece			
Iceland			
Ireland			
Israel			
Italy			
Japan			
Korea	X	X	X
Luxembourg	X		
Mexico	X		
Netherlands	X	X	X
New Zealand	X		
Norway			
Poland	X		
Portugal	X		X
Slovak Republic			
Slovenia			
Spain	X	X	X
Sweden	X		X
Switzerland			
Turkey	X		X
UK	X	X	X
US	X	X	X

[slide 027]

Some examples

- France Contract for Improved Individual Practice
- Germany Disease Management Programme
- Australia Practice Incentive Programme
- UK Quality and Outcomes Framework

These are some examples from the book. France has done a lot in prescribing, and retaining prescribing costs. Germany has an interesting disease management program. Australia has a program that is less successful. The one I am going to talk about is called the Quality and Outcomes Framework (QOF) in the England.

[slide 028]

So, what is QOF? QOF is still in operation, it tries to incentivize actions with high quality care, and reduce the need for specialist care. It was first implemented in 2004, and it measures about 150 performance indicators in primary care, and up to 20% of primary care practices' income is determined by their performance. It was quite difficult to evaluate this because there was no control group. Everyone participated in this – it was voluntary, but of course if you didn't participate, you didn't get any reward, so with about 20% of their income at stake, almost every general practitioner participated in the QOF.

P4P: the quality and outcomes framework (QOF)

- Seeks to incentivize actions associated with high quality care and reduced need for specialist care
- Implemented 2004, with a major emphasis on clinical quality
- Measurement uses about 150 performance indicators, yielding a points score for each general practice
- Up to 20% of income determined by quality incentives
- Major reliance on self-reporting (with external audit)
- No control group, so evaluation difficult.

- Smith, P. and York, N. (2004), "Quality incentives: the case of UK general practitioners", *Health Affairs*, 23(3), 112-118.

[slide 029]

GP Contract: Indicators and points at risk

Area of practice	PIs	Points
Clinical	76	550
Organizational	56	184
Additional services	10	36
Patient experience	4	100
Holistic care (balanced clinical care)	–	100
Quality payments (balanced quality)	–	30
Access bonus	–	50
Maximum	146	1050

So, what is the shape of this scheme? It involved 146 performance indicators across a variety of areas – clinical, practice, and aspects of the organization, which had 56 performance indicators. There were some additional service and other things. And then there were points in each area. I will explain how they accumulated, but in the clinical area, there were 550 points, and the maximum point score, which determined your bonus, was 1050 points. It has changed a bit recently – this is the original – but the structure is still the same.

[slide 030]

So, let me look at the clinical area here in some detail here. These are the clinical areas. You can see all the chronic disease areas you would expect. In each area, there were a number of performance indicators. You will notice incidentally that in terms of mental health, one of the biggest areas of expenditure in the UK by a long way, there are only 41 points at stake. But a general practitioner will tell you, that about one-third of their time is spent on aspects relating to mental health. However, for illustrative purposes, I will point out the hypertension area, with 105 points at stake. These are the indicators.

GP Contract: Clinical indicators

Domain	PIs	Points
CHD including LVD etc	15	121
Stroke or transient ischaemic attack	10	31
Cancer	2	12
Hypothyroidism	2	8
Diabetes	18	99
Hypertension	5	105
Mental health	5	41
Asthma	7	72
COPD	8	45
Epilepsy	4	16
Clinical maximum	76	550

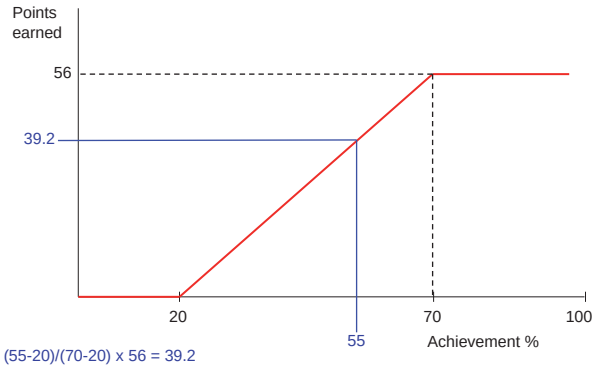
[slide 031 & 032]

You get nine points just for saying you have a register of patients with hypertension. However, the more interesting one, at the bottom here, is the percentage of patients with hypertension in whom the last blood pressure in the last nine months was 150/90 or less. There are 56 points at risk there, and you get all of those 56 points if you have got 70% of your patients with this blood pressure under control. This is how it is calculated, so there is your achievement. At 70% you get all the points. If you had only 20%, you start earning points then. If you have 55% of your patients successfully controlled then you would get 39.2 points.

Hypertension: indicators, scale and points at risk

Records	Min	Max	Points
BP 1. The practice can produce a register of patients with established hypertension			9
Diagnosis and initial management			
BP 2.The percentage of patients with hypertension whose notes record smoking status at least once	25	90	10
BP 3.The % of patients with hypertension who smoke, whose notes contain a record that smoking cessation advice has been offered at least once	25	90	10
Ongoing Management			
BP 4.The % of patients with hypertension in which there is a record of the blood pressure in the past 9 months	25	90	20
BP 5. The % of patients with hypertension in whom the last blood pressure (in last 9 months) is 150/90 or less	25	70	56

Threshold indicator BP5



(55-20)/(70-20) x 56 = 39.2

[slide033 & 034]

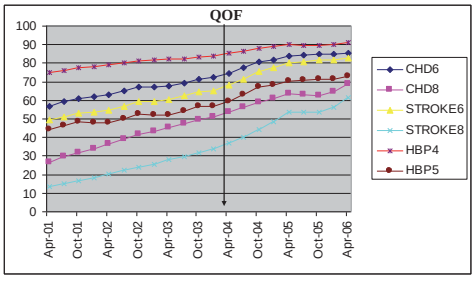
The average points score in each year since it was established has been very high indeed. It looks like the requirements were set too easily, quite frankly. We have seen improvements in all of the areas – this is just six of the performance indicators. That one I showed you, HBP5, or the blood pressure 5, is the brown line on the graph. As you can see, it is improving. And then QOF was introduced, the improvement continued. However, you will notice that all of the performance levels were improving even before this was in place. A large part of this may have been due to computerization, because of course to participate, every general practice needed to be computerized and linked in.

Achievement in England

	2004 /05	2005 /06	2006 /07	2007 /08	2008 /09	2009 /10	2010 /11	2011 /12	2012 /13
Average points score (%)	91.3	96.2	95.5	96.8	95.4	93.7	94.7	96.9	96.1
Practices achieving full marks (%)	2.6	9.7	5.1	7.5	2.0	1.0	1.3	2.4	3.7

Source: NHS Information Centre http://www.qof.ic.nhs.uk/

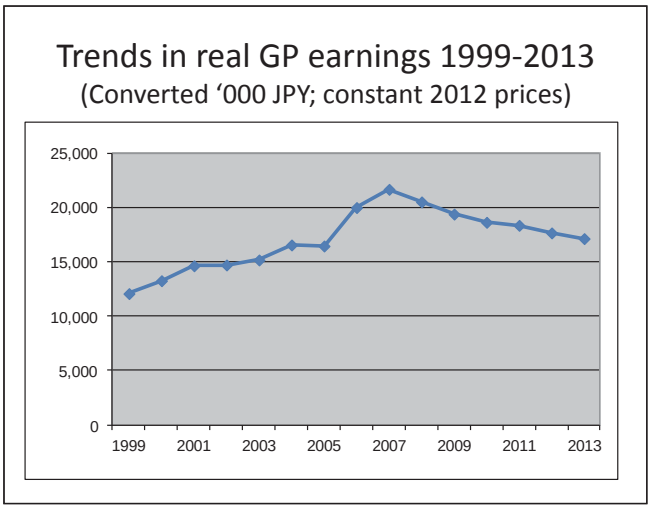
Trends in six QOF indicators 2001-2006



CHD	Coronary heart disease
STROKE	Stroke
HBP	Hypertension

[slide 035]

General Practitioner earnings took a big jump in the year QOF was implemented, in 2004. This was my attempt to make this chart in yen. I am not sure whether this income seems high or not – is 20 million yen high by Japanese standards. I may have got the conversion wrong! At any rate, it is 100 000 pounds, or 120 000 Euros. That salary rate has not risen since QOF – in fact, they have declined. In fact all wages in our health system have either held level or declined in recent years.



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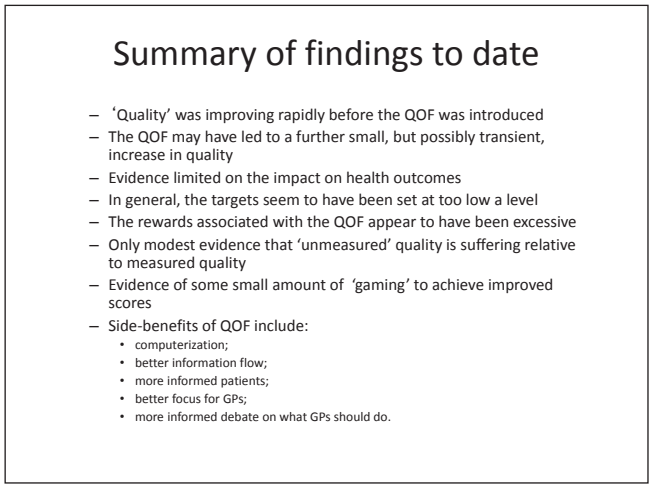
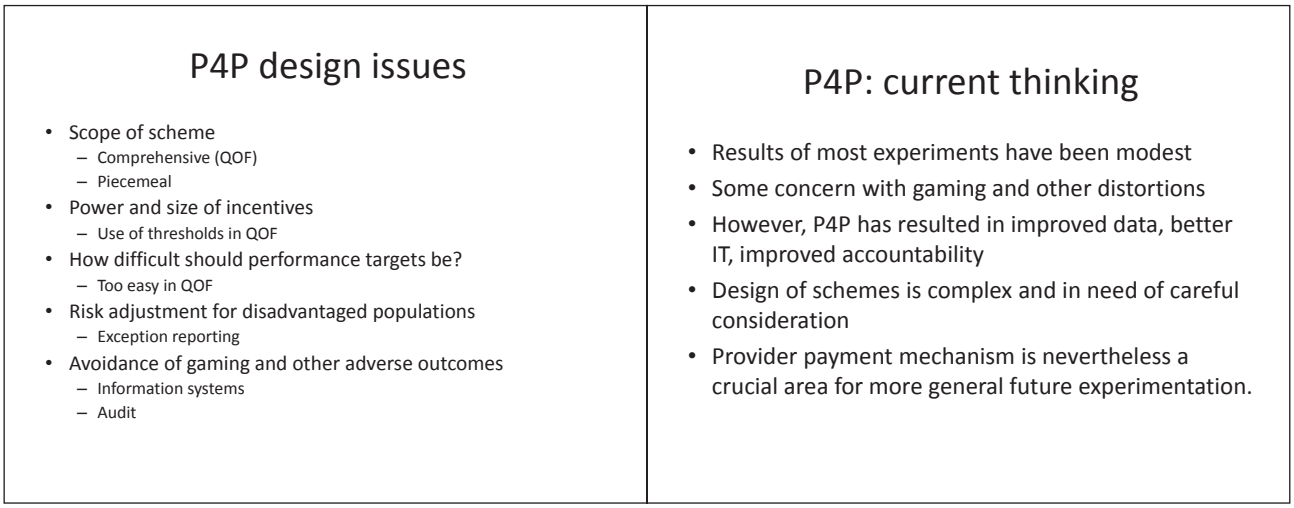


This has been an interesting experiment. Quality was improving before QOF was introduced. It may, however, have led to further improvements. These improvements have probably been quite small. What I would emphasize, again, and in the interest of time I am moving on to the last part, there have been some important side-benefits. Amongst these, the computerization of general practice, better information flow in terms of what the 150 indicators give us. In addition, patients are better informed about the quality of their primary care physicians. It has been a very interesting experiment to involve general practitioners in asking them what they are trying to do, and what is important in their respective practices. The involvement of general practitioners has been very important. We now have a more informed debate on what we think primary care should be doing. My own personal feeling is that this has been quite an important and interesting experiment, but we didn't need to spend 20% of general practitioner earnings on achieving these things.

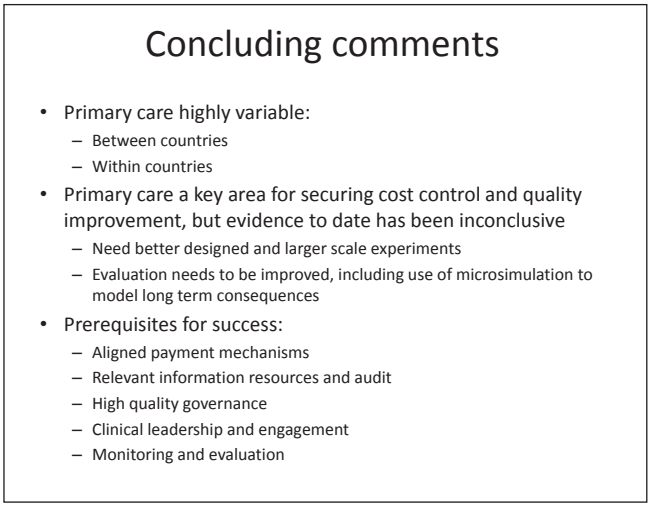
[slide 037 & 038]

In the interest of time I have to skip over some of the slides. I think that pay-for-performance will become more important in health systems. We have not seen too many successful schemes yet, but I think that is because policy makers are still experimenting, and still feeling their way. In fact, in contrast to the UK scheme, most schemes internationally are being underpowered. General practitioners have not been given enough reward to have a significant impact. I think we must be patient, but I think this is the way health systems will pay in the future.



[slide 039]

In conclusion, I just wanted to say that I think primary care is a very important part of all health systems, or should be. However, primary care is highly variable. Of course it is variable between countries, and we know that there are countries where there is virtually no primary care practice, and countries where it is patchy. The other thing to note, however, is that even when primary care is in place in a system, it is highly variable. I would say for example that in the UK, the best primary care is fantastic. It is very high quality. However, there is also some very terrible primary care in our system. For example, I used to live in Westminster, near the Parliament Building, and every morning I would go past a primary care practice there, where people queued outside the door in the morning to wait to get an appointment – not even to see the doctor, simply to get an appointment. That is completely unacceptable, but you see that kind of thing happening. Of course, the best practitioners have computerized systems, and you see you doctor when you want to see them.



I think primary care does offer big scope for securing cost control and quality improvement. However, probably because of the big variability between practices, the evidence has been inconclusive. We need better experiments. My own personal view is that policy makers should be much better at introducing experiments so they can be evaluated properly. We waste a huge amount of effort and time in our country because we have big reforms in our health system, and then afterwards academics are asked to evaluate the reforms. And then we say, "Actually, you have implemented these reforms so it is almost impossible to evaluate them properly." I would really like the design of reforms to be such that we can evaluate

them better in the future. It is interesting that one of our strongest evaluations was when that fundholding was abolished. That is not the best time to evaluate something.

Nevertheless, for success in the primary care area, I think the following things are essential. First, payment mechanisms must be aligned with what you are trying to achieve. Too often, we see the payment mechanisms are misaligned. We have got to have the information resources available, on performance and many other factors. We also must have good audit. What we found is that in the past there has been mistrust of evidence, of information that was provided, and that can be very damaging for both the professionals in the system and the patients as well. We do need good quality information. We need high-quality governance of the system to ensure that what is required is carried out properly. I think our experience has definitely been that we need good clinical leaders. Without the clinical leaders – particularly the doctors – we cannot make this work. This needed general practitioners to lead these experiments. Finally, we must monitor and evaluate the system so we know what is working and what is not working. Then we can make reviews and adjustments in the future.

In conclusion, I would like to wish all of those involved with Japanese healthcare the very best in the challenging years ahead, and to say that I think certainly the development of primary care is a policy area well-worth considering, but it has to be done carefully and there are pitfalls that can arise in this area. However, there are many experts, in Japan and internationally who can help refine policy and make sure you escape the worst traps that some other countries have fallen into.

Thank you very much indeed.

Session 1, Discussion:

Comments on Professor Smith's presentation on "the role of primary health care in controlling the cost of specialist health care.

School of International Public Policy,
Hitotsubashi University

Professor Masako Ii

[slide001]

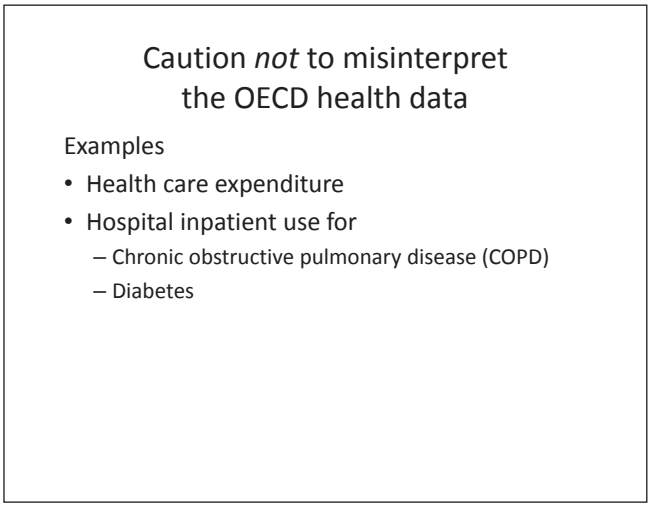
Professor Smith, thank you very much for your presentation. It was a comprehensive overview of the UK healthcare reforms in the last 15-20 years, and the research done to evaluate such reform.

[slide 002]

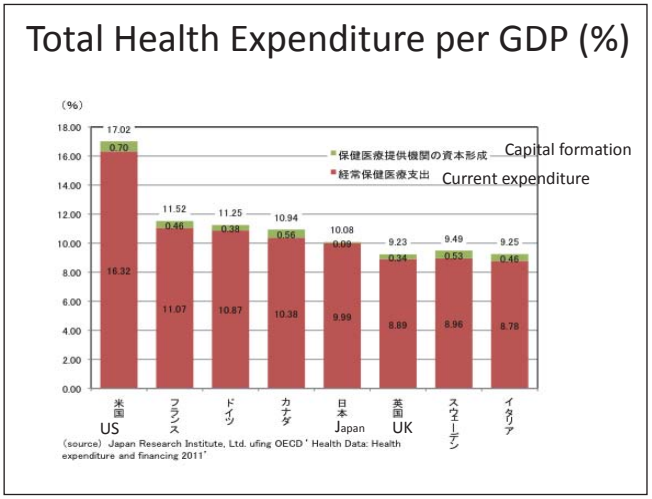
I would like to make a comment on the following points. First, some comments on OECD health data. Second, some comments about the data availability in the UK. I think one of the strengths of the UK system is that the comprehensive and essential data are available. Some people that in Japan rich data sets such as DPC or Administrative Claim Data, but we have seen that the richness of the UK data, particularly on outcome indicators on the common diseases, which are no comparison with Japanese data. I would like to discuss this. Then, Professor Smith evaluated two policies – fundholding and QOF. These are major innovations in the history of primary care in the UK, so I would like to discuss their implications. Finally, I would like to draw some lessons from UK healthcare reform.

[slide 003]

We often use OECD health data to make international comparisons, however we have to be very careful in interpreting the data. In this respect, first, I would like to discuss about healthcare expenditure, and then some hospital impatient use, that Professor Smith mentioned.



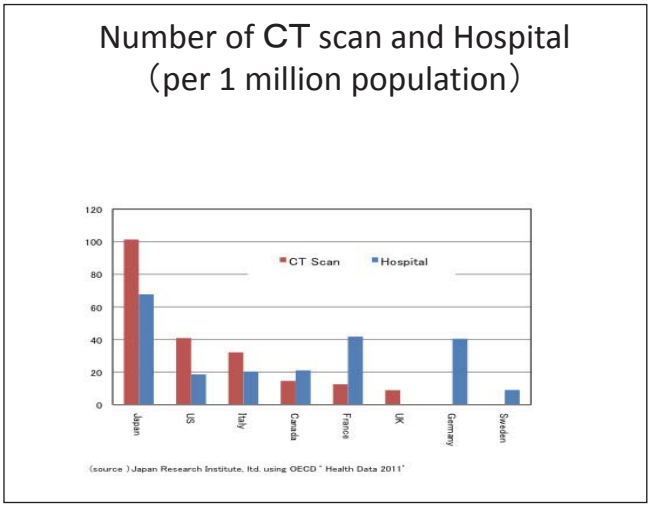
[slide 004]



This is very famous data. It is the percentage of total health expenditure per GDP. As is well known, the US spend about 17% of their GDP on healthcare expenditure, whereas in Japan it is about 10%, and in the UK it is 9%. It is relatively lower among the OECD countries. However, if one looks at the data very carefully, we find many discrepancies among the data. For example, this green part shows the capital formation. In Japan, only 0.09% of GDP is spent on capital formation, and the UK it is 0.34%, or about four times larger than in Japan. In the US it is 0.7% - so about eight times larger than in Japan.

[slide 005]

However, here is some more data from OECD. It is also well known that the endowment of CT scans and MRI, and the number of hospitals and hospital beds are exceptionally large in Japan among the OECD countries, so I suspect that this healthcare expenditure on capital formation may be underestimated. So there are some discrepancies.



[slide 006]

Then, on slide 10 of Professor Smith's presentation is about the COPD. The number of Japanese COPD patients must be underestimated because the COPD is rarely diagnosed at the primary care level in Japan. The number introduced in slide 10 is OECD health data – about 0.22 million – is the number of patients, mostly at the tertiary level consulting with pulmonologists. It was estimated that in 2001, there were already 5.3 million patients suffering from COPD without being consulted professionally. So we miss many patients at the primary care level, and that seems to be reflected in the OECD data.

Slide10: **(COPD)** All hospital admissions with a principal diagnosis code of COPD

- The number of Japanese patients for COPD (0.22 million) must be very underestimated as COPD is rarely diagnosed at primary care level in Japan. This number, 0.22 million, in the OECD data is the number of patients mostly at tertiary level consulted by pulmonologists. It was estimated in 2001 that in Japan nearly 5.3 million are suffering from COPD without being consulted professionally.

[slide 007]

Slide11: **(Diabetes)** All admissions with principal diagnosis code of uncontrolled diabetes, without mention of a short-term or long-term complication

"Educational Hospitalization"

Patients stay in hospital only for the purpose of education of diabetes.

On slide 11 of Professor Smith's presentation, about diabetes, we find that there are many inpatients in Japan. This is because of what we call "Educational Hospitalization." Patients stay in the hospital only for the purpose of education about diabetes. I think this is a peculiar phenomenon in Japan.

Therefore, when we do an international comparison using OECD health data, it is quite important to be cautious about the background of the healthcare system. Of course OECD Health Data are very useful.

I would like to go on the policy evaluations. Professor Smith has evaluated two policies which aim at improving health system efficiency: Fundholding and QOF. Both research results are published in the Journal of Health Economics, one of the top journals in the field.

[slide 008]

The first policy is about fundholding. The research estimated the effect of fundholding using a Difference in Difference (DID) methodology on a 4-yeal panel of English general practice, before and after the abolition of fundholding. For the Japanese audience, I would like to explain what general practice is, because some of them might not know what it is. Family medicine and general practice mean the same thing. They are terms that describe care by doctors specializing in primary care.

Policy 1: Fundholdings

Estimate the effect of fundholding using a DID methodology on 4-year panel of English general practice(=family medicine) before and after the abolition of fundholding.

Consider the various effects of budgetary regimes such as transitional effects:

1. After the end of fundholing in April 1999 ex-fundholding practices were allowed to keep their accumulated fundholding surpluses to be spent over the following 4 years. Thus even in the last 2 years of fundholding fundholders still had an incentive to reduce elective admissions to accumulate surplus.
2. The anticipated end of fundholding gave fundholders an incentive to delay referrals so that the patient would be admitted in the post-fundhodling period at the much lower post-fundholding price.

Dusheiko, M., Gravelle, H., Jacobs, R., Smith, P. (2006), "The effect of budgets on doctor behaviour: evidence from a natural experiment", *Journal of Health Economics,* 25, 449-478.

From an economists' point of view, what I find particularly interesting in this research is that this estimate on the effect of fundholding, considers the dynamic aspect, the dynamic effect, of fundholding. For example, after the end of fundholding in April 1999, ex-fundholding clinics were allowed to keep their accumulated surpluses to be spent over the following four years. Therefore, even the last two years of fundholding, fundholders still have an incentive to reduce elective-admissions to accumulated surpluses. Also, fundholders were able to anticipate the end of fundholding, so they might delay the referrals to the hospital so that the patient would be admitted after the fundholding ended. Such dynamic effects are considered in this research. The result is that the fundholdings were cost-effective.

[slide 009]

Result:

Fundholders made 4.9% less use of the relevant non-emergency hospital treatments than their non-fundholding counterparts, a difference that quickly disappeared after abolition.

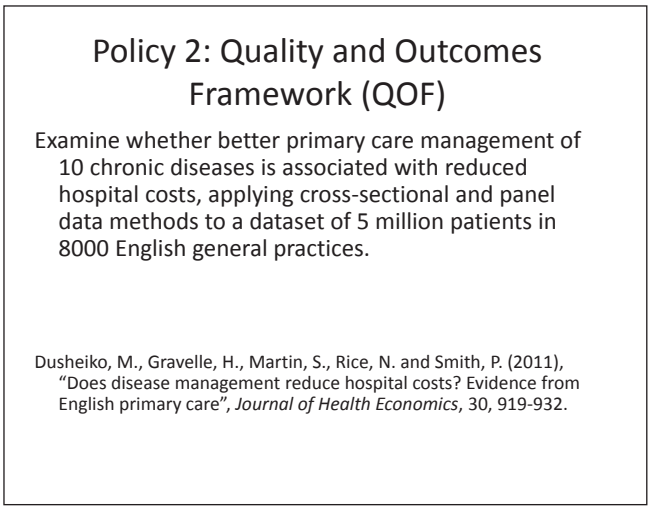
Fundholding: Participation of GPs is voluntary

Primary Care Trust: Participation of GPs is mandatory

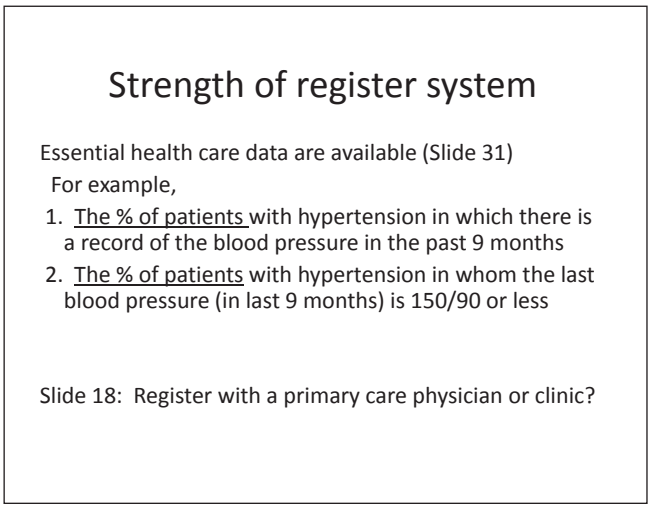
After the fundholding ended, Primary Care Trust started. What I understand is that there seems to have a similar role, despite a different name. This change was made, as Professor Smith explained, because of a change in administration from the Conservative Party to the Labour Party. The one noticeable difference between fundholding and primary care trust is that for the fundholdings, general practitioner participation is voluntary. However, for Primary Care Trust, general practitioner participation is mandatory. So I would like to know why the participation has become mandatory. Is it because your research found the effectiveness of fundholding? Or is that another reason?

[slide 010]

The next policy that was evaluated was QOF. This examined whether better primary care management of ten chronic diseases is associated with reduced hospital costs, applying cross-sectional and panel data methods to a data set of about 5 million patients in 8000 English general practices. Here, "general practice" means the unit of care. It means the general practitioner's (GP's) clinics.



[slide 011]



In studying about QOF, what I found impressive was the richness of the data. It was an indicator of outcomes which were shown in slides 31-32. These GP contract indicators and clinical indicators had an example of hypertension indicators. So, because any UK resident has to register with a primary care physician, essential health data is available in all the communities. My one question is about slide 18, where you showed the figures from OECD. I am not sure if this is the register for the primary care physician, or the register for the clinics. That is a minor question.

Anyways, because of the registrations, essential healthcare data is available. For example, in any community in the UK, you can obtain the percentage of patients with hypertension in which there is a record of blood pressure in the past nine months, or the percentage of percentage of patients with hypertension with whom the last blood pressure is 150/90 or less. So, it is quite impressive that in any community in the UK, you can have such rich indicators.

[slide 012]

According to Professor Smith's slide 30, there were ten domains. However, I looked at the recent National Health Service (NHS), which is easily available on the Internet, and it said at latest count, they have 30 domains. When I wrote the handouts, I thought it was 18, but I noticed when I counted yesterday that there were actually 30 domains. I tried to count how many indicators there were, but there was so many I gave up! How many indicators did you say there was? You said it was about 150 before, but of course, domains have now increased to 30, maybe even more. Anyways, there are many outcome indicators on common diseases available.

Slide 30: 10 domains -> 2013/14: 30 domains with more than 100 indicators

examples of newly added domains are:

- depression
- learning disability
- osteoporosis

(secondary prevention of fragility fractures)

[slide 013]

Examples of indicators

Depression: The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis

Learning disability: The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities

Osteoporosis: Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan

Some examples of newly added domains are depression, learning disability, and osteoporosis. Professor Smith mentioned that GPs spend one-third of their time on these cases, and there is a lot of money spent as well. I suppose there are more domains included in the mental health area. An example of an indicator is something like for depression, the percentage of patients aged 18 or over, and patients with learning disabilities and so forth. As I said before, this data is available in any community all over the UK.

[slide 014]

One of the conclusions in Professor Smith's research is that the primary care, a key area for securing cost control and quality improvement, but evidence today has been inconclusive.

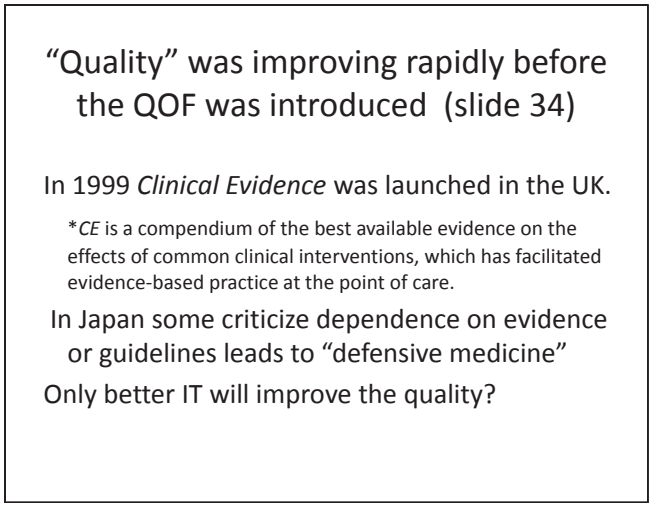
One of the conclusions: Primary care a key area for securing cost control and quality improvement, but evidence to date has been inconclusive.

However,

- "Quality" had been improving rapidly even before the QOF was introduced (slide 34)

[slide 015]

I think we have to be careful about the implications of this. I think the most important implication, or purpose of QOF is not cost-control. Rather, it offers the best available evidence for the treatment of common diseases. What I found interesting is that the quality has been improving rapidly, even before the QOF was introduced as was explained in slide 34. One of the reasons Professor Smith mentioned, was computerization and introducing IT. But did only introducing IT really improve the quality? It is probably necessary, or at least important, but perhaps not the best reason. I think the most important reason of the quality improvement in the UK was that the UK introduced Clinical Evidence in 1999. So, that is why before introducing QOF, the quality was increasing rapidly.



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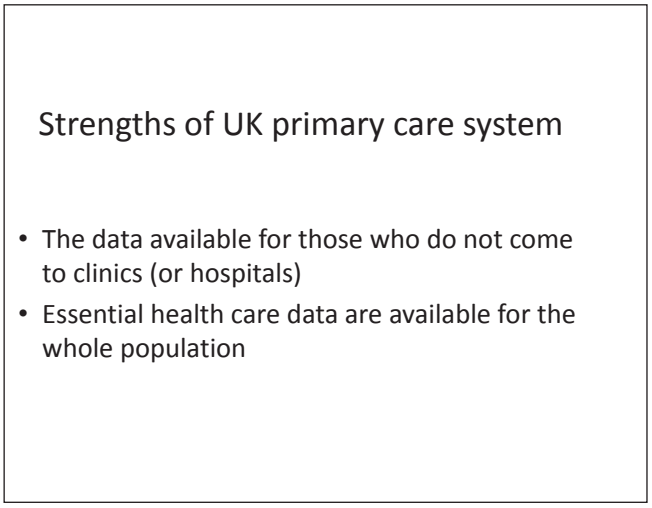
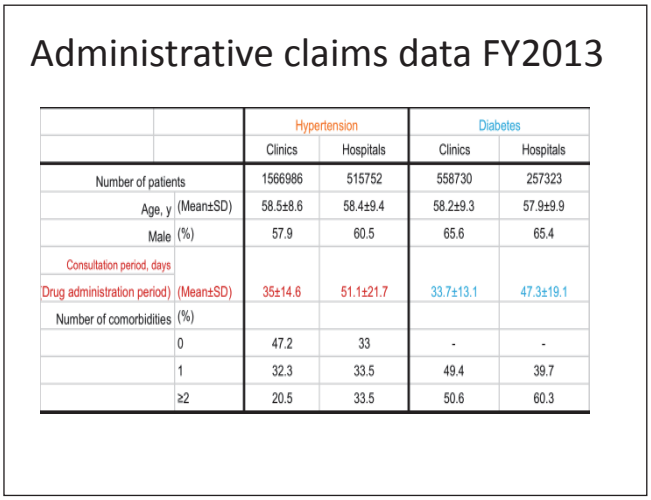


We are quite envious of the UK's system because of the register system, and the data that is available even for those who don't go to clinics or hospitals. This essential health care data is available for the whole population.

[slide 017]

Finally, I would like to share some of the findings from the two research I am conducting. For hypertension and diabetes, we were comparing the consultation period for clinics and hospitals. For the consultation period for patients with hypertension, they see a doctor on average every 35 days at clinics, and every 51 days at the hospital. Because standard deviation is 14.6, that means that some patients see a doctor every 20-21 days for hypertension. For patients with diabetes, it is a similar frequency. This frequency is quite amazing – how often patients see their doctors. By global standards it is quite frequent. It may be



		Hypertension		Diabetes	
		Clinics	Hospitals	Clinics	Hospitals
Number of patients		1566986	515752	558730	257323
Age, y	(Mean±SD)	58.5±8.6	58.4±9.4	58.2±9.3	57.9±9.9
Male	(%)	57.9	60.5	65.6	65.4
Consultation period, days (Drug administration period)	(Mean±SD)	35±14.6	51.1±21.7	33.7±13.1	47.3±19.1
Number of comorbidities	(%)				
	0	47.2	33	-	-
	1	32.3	33.5	49.4	39.7
	≥2	20.5	33.5	50.6	60.3

effective, but we don't have the outcome indicators like the UK so we don't know. We cannot evaluate.

[slide 018 & 019]

The second research I am conducting is motivated by Professor Smith's research published in Health Affairs last year. Professor Smith and his research group conducted a survey – the Commonwealth fund conducted the survey and prof. Smith wrote the paper based on the survey data from 11 countries. The survey looked at people's perception of the overall health system performance and affordability and effectiveness of care. One of the questions is about overall opinion. The questionnaire asks "How do you evaluate your country's healthcare system?" And one must choose one of four answers: "On the whole the system works pretty well. Only minor changes are necessary to make it work better;" "There are some good things in our healthcare system, but fundamental changes are needed to make it work better;" "Our healthcare system has so much wrong with it that we need to completely rebuild it;" and then the final option is "Not sure." So this is the result from Australia, Canada, France, Germany, and the UK. In the UK, 61% is the highest number – the highest percentage of people are satisfied with their healthcare system. Only 3% of people believe that complete reform is needed.

So, with the help of Professor Smith, I was able to obtain the questionnaire from the Commonwealth Fund, and we conducted it for Japan. What do you think the results for Japan were like? Of course taking into account the translations and backgrounds, it cannot be a complete comparison, so maybe I should ask someone how you think most Japanese will choose. Any volunteers? I am a teacher, so I can go up to someone and ask! Professor Kawaguchi has so much responsibility, and I hesitate to ask you, but what do you think?

Papancolcas, Sylus, and Smith(2013) "An analysis of survey data from eleven countries finds that 'satisfaction with health system performance means many things", *Health Affairs*

Survey respondents' perception of overall health system performance, Affordability of care, effectiveness of care,

Overall opinion

Overall opinions	Aus	Can	Fra	Ger	UK	US
On the whole, the system works pretty well, and only minor changes are necessary to make it work better	23.2%	34.3	43.2	36.8	61.3	28.9
There are some good things in our health care system, but fundamental changes are needed to make it work better	54.5%	54.5	48.2	51.6	35.1	42.7
Our health care system has so much wrong with it that we need to completely rebuild it	21.4%	10.3	8.1	11.4	3	25.4
Not sure	1.0%	0.8	0.4	0.3	0.7	2.4

[slide 020 & 021]

We asked about 2,000 people – 1,000 in a big city, and 2000 in rural areas. Age distribution is quite equal.

This is the result. It is quite amazing that only 4.4% of people said that they thought only minor changes were necessary. But what I was especially amazed by was the fact that 16.7% or people said they were "Not sure." I think this is the problem of the Japanese healthcare system. Although healthcare is an important part of life, many people do not know what the problem is. Finally, starting in 2017, the national accreditation system for 19 medical and surgical training programs will start, including general practice.

Overall opinion

Overall opinions	Aus	Can	Fra	Ger	UK	US	JPN
On the whole, the system works pretty well, and only minor changes are necessary to make it work better	23.2%	34.3	43.2	36.8	61.3	28.9	4.4
There are some good things in our health care system, but fundamental changes are needed to make it work better	54.5%	54.5	48.2	51.6	35.1	42.7	67.9
Our health care system has so much wrong with it that we need to completely rebuild it	21.4%	10.3	8.1	11.4	3	25.4	11
Not sure	1.0%	0.8	0.4	0.3	0.7	2.4	16.7

Lessons from the UK experiences

- Promote standardized managements of chronic diseases (such as hypertension and diabetes) at primary care level.
- Construct a database to show the profile of primary care.
- Evaluate quality and efficiency based on treatment outcome of chronic diseases.
- Finally in Japan, staring in 2017, the national accreditation system for 19 medical and surgical speciality training programs, including family medicine/general practice, will start.

[slide 022]

I think one of the reasons that the UK has small numbers of "Not sure," is because the UK has a very strong community-based primary care system. Many people grow up and live with primary care doctors and general practitioners. People are aware of its importance.

So, what should we do in Japan? That is what I would like to discuss with all of you.

Thank you.

Primary care

- Fundamental pillar of the UK National Health Service. The UK has a strong system for training GPs (general practitioners/family doctors) as key players to provide continuous, comprehensive, person-centered care in the community.
- In Japan, there still exists a strong voice that no formal training in primary care is necessary and primary care should be provided by each specialist. Many Japanese believe that quality of patient care is much better if patients see several specialists rather than one primary care doctor.

Session 2

Session 2, Presentation:

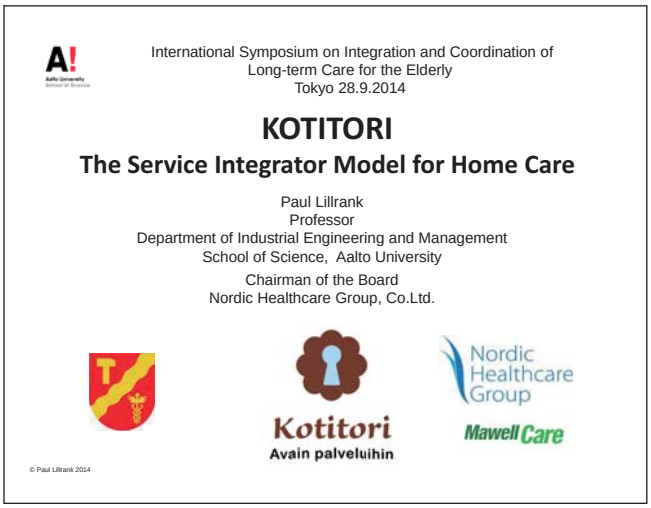
Kotitori: The Service Integrator Model for Home Care

Department of Industrial Engineering and Management, School of Science,
Aalto University; Chairman of the Board, Nordic Healthcare Group, Co. Ltd.

Professor Paul Lillrank

[slide 001]

Ladies and gentlemen and organizing universities, thank you very much for inviting me here. I am honored. I appreciate this chance to share our experiences. A few words first about the approach I am going to take. I am working at an engineering school. I am not an engineer myself – my academic background is in social sciences – but I spent several years in Japan in the 1980s, as a foreign student, and I did my PhD on quality management in Japanese industry. That took me to a career in industrial management.

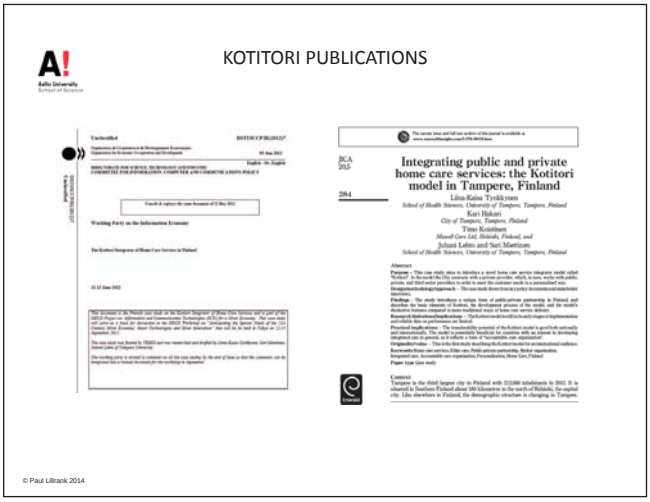


The academic field which I now represent is healthcare operations management. It is a rather new, small field, but it is rapidly growing. You could think of it as management people looking at healthcare as if it were any industrial service, and trying to apply what is applicable from what we have learned from other industries in this world. So, it is not exactly the same as when doctors at medical school start to study management. In Europe, that is called Management in Medicine, which is another discipline. Management in Medicine is more concerned about clinical leadership and decision-making, while Healthcare Operations Management leaves the clinical side to the medical profession. We are only interested in service production systems, and how to design systems, and how to improve them. That is what we do.

The presentation here, the Kotitori example, can be thought of as an example of service engineering. Use capital for names of scientific disciplines: Healthcare Operations Management, we cannot build hospitals in a laboratory. Engineering schools typically do not have their own experimental hospitals. We need to work with existing organizations – hospitals that are there or municipalities or whoever. In that sense, every service design is a collaborative effort with somebody else. We try to add some perspective, and some expertise in these kind of exercises.

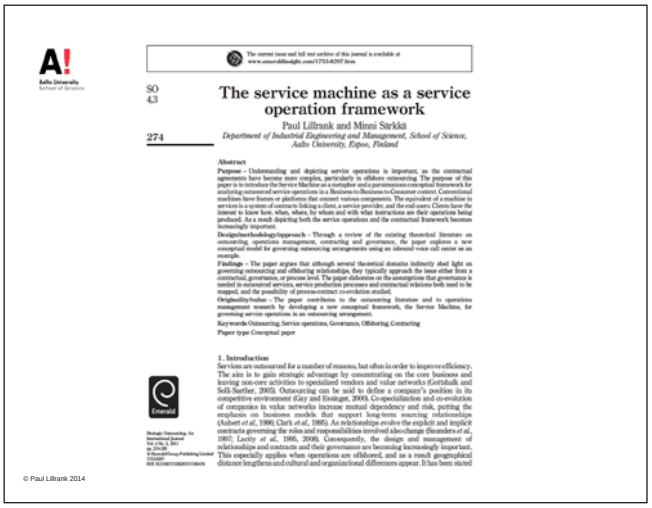
[slide 002]

Kotitori is a service design. The word “kotitori” means home – koti means home, and tori means marketplace or market square. Basically, Kotitori is a marketplace where one goes to shop for health or welfare related services which are used at home. There has been some articles about the Kotitori experience already. I assume some of you have read, in particular the OECD paper. I am not going to repeat what has been said in those. Instead, I will take a little bit of a different perspective that comes from another article which is also management related. Let me explain this a bit.



For some time, I have been interested what is known as frugal innovations. This means innovations that dramatically reduce the production cost of something. For that purpose, developing countries are extremely interesting. In my case, I have frequently been to India because they do not have the resources but they have the needs, and they are increasingly aware of the availabilities that modern technology and medicine can bring. So they have a situation where they try to achieve as much as possible with very little funding. The background is very different from the rich countries. That is why there is an incentive and a pressure in developing countries to develop frugal solutions.

[slide 003]



Several years ago, my students did some research about outsourcing business services in India, in particular, the famous call center business. We did research on outsourcing – in particular cross-border, long-distance outsourcing – which highlights many of the problems that we have in the public/private partnership situations, there are a lot of players that do different things in which they specialize, but somehow you need to integrate them into a whole.

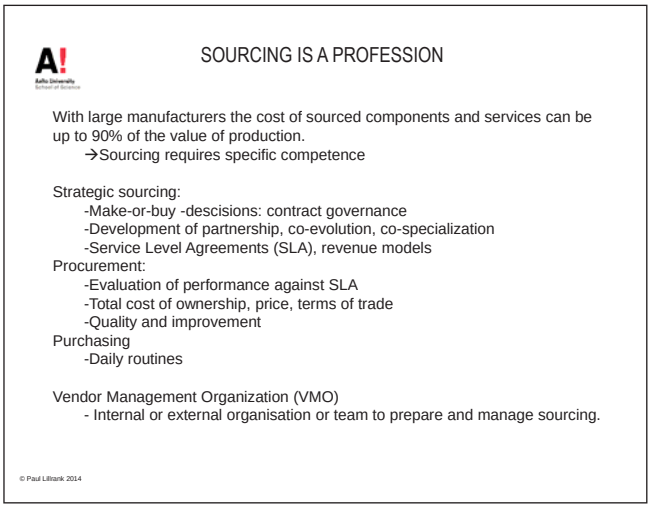
Now, think of this from an engineering perspective. It is exactly the same as machine design. That is how we came to this concept of the service machine. The services are like machines.

An example of a machine is a laptop computer. It has a number of different specific functionalities and technologies. For example, a display, a keyboard, a processor, memory, electric systems and so on. All these are necessary to have the integrated thing called a laptop computer. The various functions and modules have to be integrated into a frame. They have to be integrated in a frame. In the same way, a service machine can be seen as a frame, where various service providers, financiers, regulators, and customers have to be integrated into. With physical products, you put the frame together by using metals and fasteners and wires. In service machines, you put the things together with contracts.

You keep them running by incentives. Of course, it is obvious that contracts are not as solid as a metal connector. Contracts can be broken, and there can be various moral hazards. Contracts can deteriorate. Also, in that sense, systems can be misaligned or mis-constructed. So in that sense, a service machine is not hard or solid. Nevertheless, you can think of it as a machine.

[slide 004]

Coming from this kind of thinking, we looked into the sourcing as an attempt to put together a service machine. Sourcing is an increasingly sophisticated area of management. Big manufacturing companies, for example Toyota, buy 90% of all components that go into their cars. That means that the person who sits on 90% of the cash flow is a the big boss. He requires a high level of professional knowledge. The same is also true for services.



What we then discovered was a Vendor Management Organization (VMO). That means that the company, or the government, or any of the principals can also outsource the outsourcing. They can leave the management of the outsourcing to a professional organization, a VMO that can get deep professional understanding about how to manage the service machines as networks or many different suppliers.

While we were playing around at the university with these kinds of thoughts, and explored how it might be turned into a business, people at the city of Tampere were wrestlig with similar problems. They were exploring how they could manage their network of service suppliers that they use for long-term home care for the elderly. It was a sort of lucky break that two lines of thoughts came together and reinforced each other.

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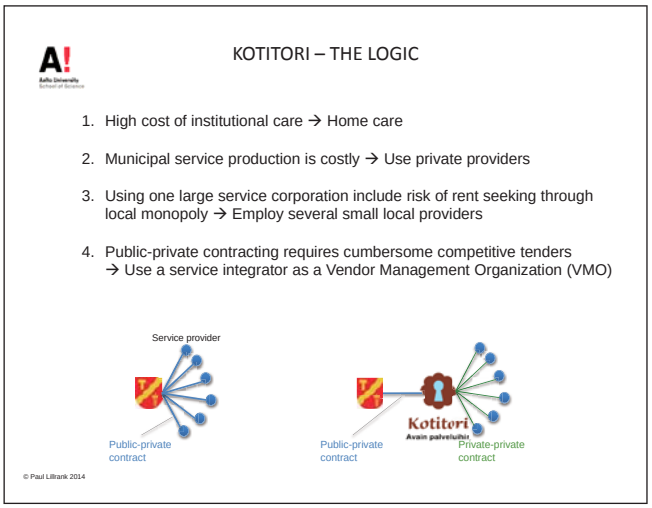

In this respect, the Kotitori logic is pretty simple. Finland has had a problem with a very high level of institutionalized care for the elderly. We have about 28 000 beds now, while Sweden which has double the population of Finland, has about 3 000. There are a lot of historical reasons why this is so, but institutional care, keeping patients lying in a bed the last one or two years of their life, is extremely costly, and it means that they have a very poor quality of life. So the government wants to get rid of this. But, it takes a while to dismantle a large capacity of beds. So, the most important policy measure is to go from institutionalized care to home care.

But then comes the next question. Home care, if operated or managed by the city, tends to be expensive because you have to deal with civil servants. Solution to that is to outsource, and use private providers. However, from that follows the problem of who these private providers will be. There are a number of big, international stock-listed providers in the Nordic countries, mostly from Sweden, but they are frequently perceived as dangerous. For example, if a city makes a contract with one big service provider, then the provider may use its local monopoly position to ask for increase in prices. These kinds of things have happened in smaller cities in Sweden, and the municipal managers were not amused. So, the thinking is that there should be a lot of small, local service providers. The politically correct service provider would be a very small company, established by an experienced old nurse, with a couple of colleagues, who would take over a block or flats or a part of the city, and they would run the business there and take good care of their clients.

In Finland there is a law about public procurement which says that if a government or a city wants to buy a service or product from a private provider, they have to go through an open tendering process, so that every potential provider can participate in the bidding. It follows that if the City of Tampere wants to use a small nurse-led company, they would have to do 150 tendering processes that are bureaucratic and complicated. Many of them are challenged in court and delayed, so it is a bureaucratic nightmare. Then simply, use a VMO. The City makes one contract with one private company – the integrator – and there is no law regulating private-private contracts. If you use your own money, you can buy whatever you like from whoever you like, and it is none of the government's business. It is this private-private contract that makes the whole thing possible. It is an administrative solution to an administrative problem.

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Tampere is one of the three major cities in Finland. Kotitori activity started there in 2009. This is their advertisement sheet, this is what they promised to do.

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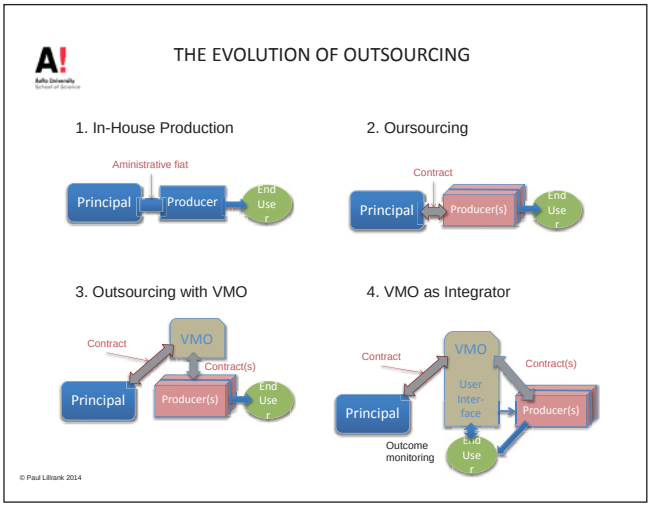

If you look now at the administrative structure from an evolutionary point of view, we can say that the first starting position is an in-house production, meaning that the city is producing services using its own organization, with its own employees. Here the city manages the producing organization through administrative power. However, it is not very strong power because the people who work for public administration are civil servants, they are strongly unionized, so you cannot boss them around. Simply, in Finland many outsourcings happen because the administrative power of the principal over the producer is not working. It is easier to manage a contract than part of the city administration.

Contracts can be written in different ways. If a contract is broken, then you can just throw it out, and bring in somebody else. However, if a civil servant is not working hard enough, there is no way you can fire them. These are the governance-based outsourcing cases.

Then, if the number of your producers gets very large, there is a case for having a VMO, either as an external specialist or an internal special unit which is managing the producers. Here we have examples of contractual relationships. And then, production is here.

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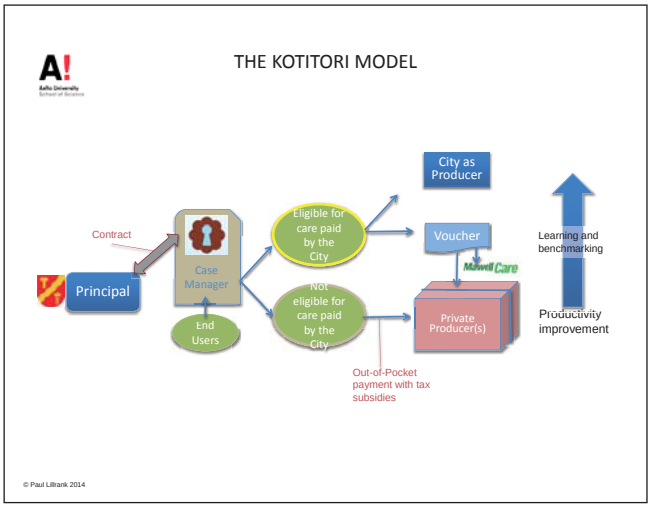


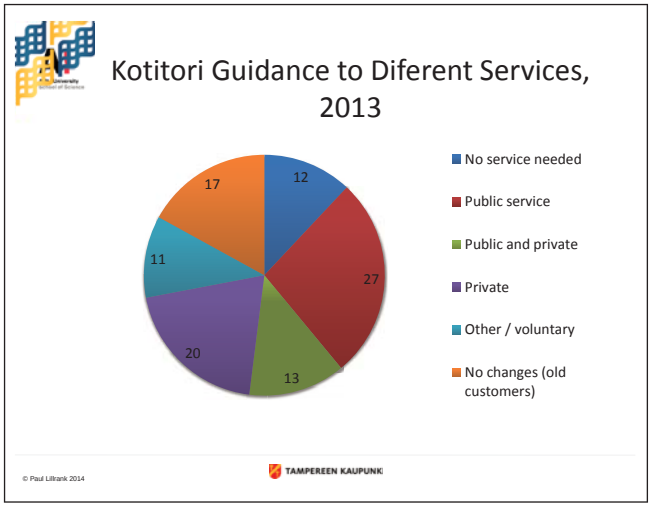
Now, the fourth step, Kotitori, means that the VMO also takes over the job of integrating the end user interface. Kotitori has an office, webpage and phone number where people who think they need these services can go and get advice, the City of Tampere has its own policies about which elderly people can get services, paid wholly by the City. There are a number of criteria based on medical condition and income. So if you are poor and very sick, the city will take care of you – if you are rich and a little bit weak in your legs then you are asked to pay for yourself. So, there are two groups of end users that come to Kotitori.

Those who are under the care of the City can be moved to the City production, or they can be given a voucher that they can use to buy the service from Kotitori, or the producing organization, which I will explain in a moment. Those who are not eligible for direct support from the City can go to Kotitori in order to find a private service provider who suits their needs best. Kotitori manages these producers. Kotitori has an added function in the contract that says that the City of Tampere wants Kotitori and its producers to serve as a

benchmark, as a leverage to improve productivity in the City's own production. It is interesting that the City of Tampere explicitly wanted this function in the Kotitori model. The wanted to kick their own staff in the behinds.

[slide 010]

A few numbers from last year. 12% of those who approached Kotitori were advised that they needed no services, 27% went for a public service, 13% for public and private, 20% for private, 11% for voluntary services, and then 17% of all customers were advised to continue the way they had been up till now.



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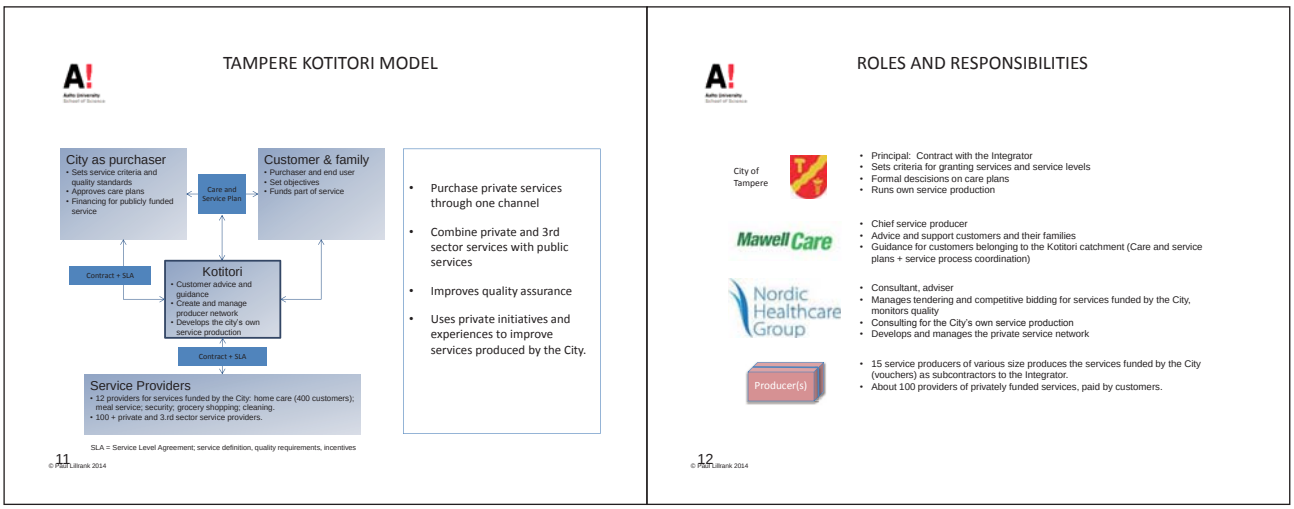
Kotitori is managed by a joint venture between two companies on an assignment. The set-up is that the City of Tampere has the overall responsibility according to law about providing care to elderly people. The City also sets the criteria of who gets paid for what kind of service. The City has the final say in the care plans that then determines the service level that it is given. The City also has its own production, there is a company called Mawell Care, which produces some services and the IT system. It is the lead contractor in this consortium. It has its own boots on the ground, so to speak, and experiments to develop new more effective methods. It gives advice and support to patients and their families. Then, there is the Nordic Healthcare Group – where I am the chairman – a consulting company that provides administrative and improvement support NHG provides only analysis, administration and advisory services, the company does not touch patients. We manage the whole tendering and bidding, and contracting process within Kotitori and subcontractors. We monitor quality, and then do consulting services for the City of Tampere's own production. There are 15 service producers of various size that are sub-contractors to Kotitori joint venture. They are the core group of service providers. They typically get paid through the voucher system. Then, there are about 100 providers of other services that are fully private and paid out of the pocket. This network is managed so that the customers can approach it through one channel. In other words, these are rather small companies that do, for example, catering service, or hairdressing for old ladies. Kotitori is there as a sales and marketing channel for them.

Now the question is whether this is a good idea or not? Should anybody else pick up this model and develop it? This takes us to the question of performance measurement. Performance measurement in healthcare gives us problems, as we have already heard today. In healthcare operations management, we want to design services, and how do we know which are better if we do not have good measures of performance. Performance measurement is a "known unknown" kind of problem that needs to be solved. By and large, we can say that performance measurement should start from health policies,

from which follows goals – for example, the goal to reduce institutional care of the elderly and allow people to spend the last days of their lives in their own homes. From that follows certain finance arrangements to which resources are required. Then, you have the services that produce outputs.



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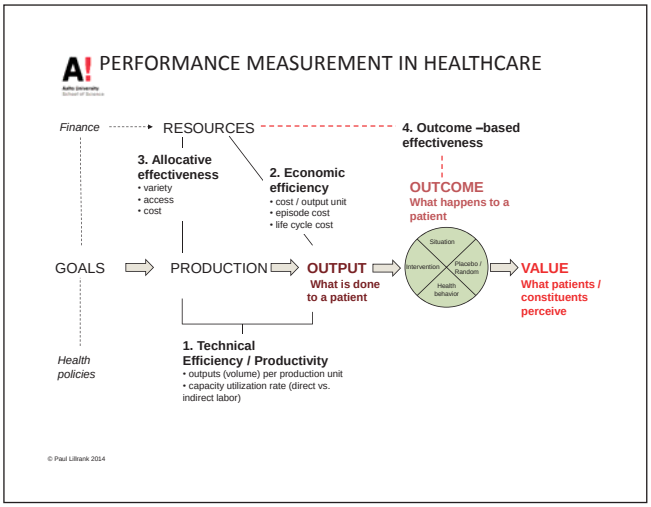

Here are a number of relations that can be used as performance measures. The first and fundamental one is technical efficiency, which we can also call productivity. So, how much work is done with regard to a team or individual. What is the pace they can achieve per day. This can be formalized as the capacity utilization rate – how much of their available capacity is used productively to serve the patients. This is reasonably easily calculated. It is a rigorous measure, but it is not necessarily relevant. Then, we have economic efficiency. If you know the amount of time spent on service production, and the cost of labor, then you can calculate the economic efficiency. What is the cost per one visit or one output? If you want to be more sophisticated you can look at the costs over a persons life-cycle. The third is the question of allocative efficiency. Where are the resources located? From this follows the question: What kind of varieties of services can you give? What is the access, or travel distance? This is the easy part. It follows the measures that can be used in manufacturing.

The weak part, however, is the measurement of outputs. Output means simply what is done to a patient. For example, a nurse visits an old person. An old person spends a day in the hospital. There is a surgical operation. There is something concrete that is done – one unit of service activity. In a car plant you can think that the more cars produced the better – the more cars we can sell the better. In healthcare this is not true. You cannot say that maximizing the volume of output will be a health policy objective. The health policy objective is health. If the output contributes to health then it is good, but if it has no contribution it is muda, as you say in Japanese. But in the worst case, it can be harmful. In healthcare, unfortunately, there are a lot of outputs that are directly harmful to the patient, to a negative value. So that is why the output cannot be the real anchor of the performance measurement in healthcare. It needs to be measured, but it cannot be the only thing.

The other thing is what is called outcomes. We can define outcomes as what happens to a patient – what is the patient's medical condition or quality of life after some treatment has been done. The problem with outcomes is that you can measure the health status of any person at any point of time, but the question is how do you assign the possible causes of this? Was it because there was some output or intervention? Was it a coincidence? Or was it because the patient fell in love and got invigorated? From the perspective of the medical sciences, is the logical flow from the output to the outcome is sometimes very random. There can be a number of non-medical, non-clinical things. There is not a one-to-one relationship here.

Finally, we have what are called subjective value – the perceived value of the whole thing. From a health policy perspective the fundamental thing is to create health value.

The performance measurement issue is complicated. We are working very hard on it, but I have not yet seen anything that would be the silver-bullet solution.

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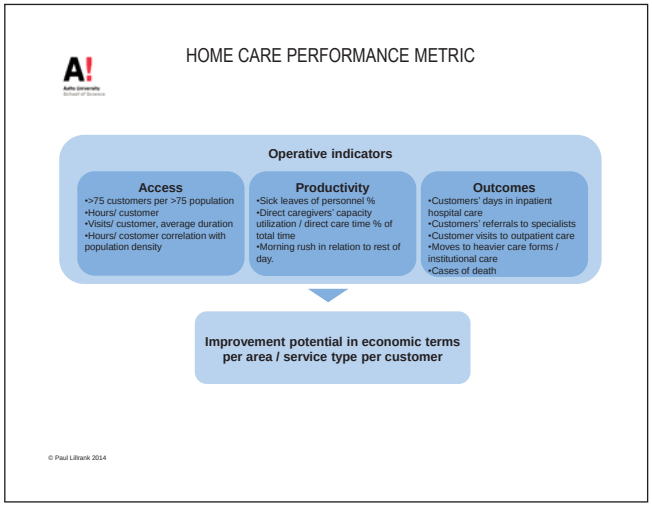

In Kotitori, we have been playing around with a number of possible indicators. Accessibility is one factor. How easy is it to access a service? Then, there are the productivity issues. As funny as it sounds, personnel sick leaves are an important indicator. In typical home care operation in Finland, about 20% of the staff are absent on any one day – one in five. That is not only related to the health situation of the social workers, it has to do with the work environment. Perhaps, the most important productivity measure is the direct caregiver's capacity utilization: the direct care time as a percent of the total labor time. We call that capacity utilization rate. Typically, that tends to be rather low. In most big cities in Finland, it is something like 40-45%, and private providers have about 70%. There are very few service production instances where you can get 100% capacity utilization, because people need to go to the toilet, and take breaks. Even in high intensity places like call centers, they say the best utilization rate is 75-85%.

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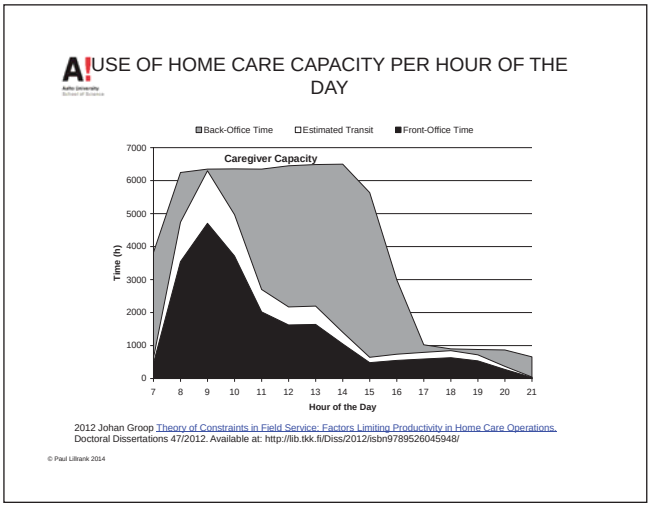

Then there is a funny little detail – the question of the morning rush in relation to the rest of the day. Here is an interesting picture that was very astonishing. This was done by one of our doctoral students, Johan Groop. It started the home care the homecare production in a city near Helsinki. The starting problem was that this city was complaining that they didn't have enough resources, and their nurses are extremely busy – they are burning out. They had problems in managing the labor, and there was continuous political pressure for more resources, more people, Johan Groop went to collect data about the caregiver capacity utilization by the hour of the day, during an ordinary weekday. This is coming directly from the City's statistics – it is not an approximation, it is hard data. The black area in the figure is the time that the caregiver spends with the patient. The white are means transportation time. The gray area is back-office or administrative time used for record keeping and meetings, but with wireless devices this could as well be done at the patient's home. But, isn't this funny? When the caregivers say that they are extremely busy and they are running from one patient to another, from home to home, and no time to take it easy, they are talking about the hours between 8:00AM and 11:00AM. That is when they are busy. Then, in the afternoon, they sit in the office and drink tea and chat. Anybody who has worked for the government knows that this is what frequently happens.

Now, why is this happening? Johan Groop, and this is a very good doctoral dissertation – you can download it if you want – found that there is a fault in logic. You are working as a home helper. First of all, you go to the office every morning, and see the list of patients you must visit. So, you pick the patients that live in the same building, or very close to each other first, to reduce the travel time – the distances in Finland are much greater than in Japan, because of low population density. But every patient has the same needs. You have elderly people who absolutely need somebody to come in the morning, because they cannot get out of bed by themselves. Then there are people who need somebody to come once a week to look after their medication. So if you try to minimize the travel time, you end up having critical and non-critical clients served during the morning rush time. Of course, this is crazy. It takes a doctor from an engineering school with a lot of data to show this to the people, because they were not aware of this situation. This is the power of data.

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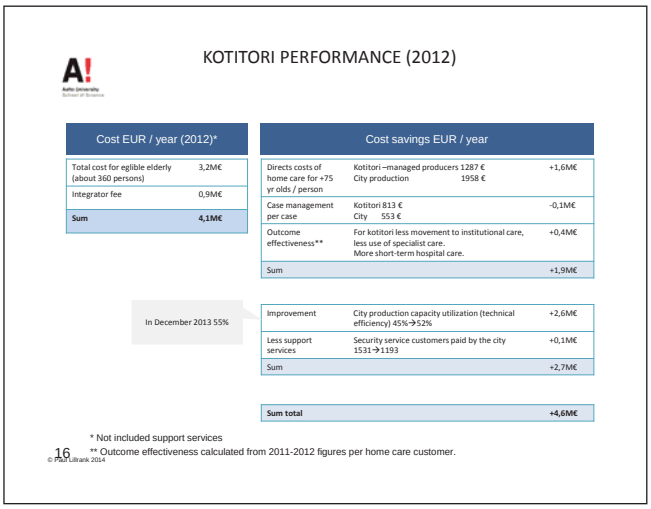


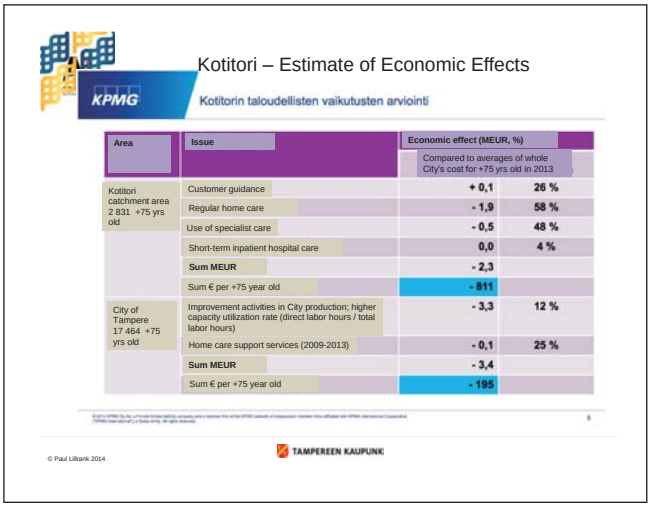
The performance measurement for Kotitori is not a good as it could be. It is still under construction. Here are some numbers that we know so far. Within the Kotitori catchment in 2012, there were 360 patients. The total cost was 3.2 million Euros, and the integrator took a fee of 0.9 million Euros. What we start to see here is when we compare the cost per patient over 75 years old, the Kotitori average cost was 1287 Euros, while the City production was significantly higher. In this data, we do not see the normalization of the severity of the patients, but we know from other sources that Kotitori patients tend to be slightly more severe than the average. They are not the easy ones. Then, interestingly and quite obviously, the case management is a lot higher for the Kotitori customers than for the City customers. But that stands to reason. The whole idea of Kotitori is to spend sufficient amount of time in the case management, and getting the right patients on the right track, and getting the right service set up for them.

The outcome effectiveness measures that we have been discussing are proxy measures, such as how many of the Kotitori patients are moved to institutional care. If a patient needs to be moved to hospital or institutional care, it means that somehow the home care has failed, unless there are obvious medical reasons. On average the more you have movements to institutional care, the more you can see that the home care system is not succeeding in its objective to keep people healthy at home until the end of their life. Kotitori is performing there better than the City. Kotitori patients also have shorter hospital care.

If you look at the effects on the City side, the City production capacity utilization has improved quite significantly as an impact of Kotitori, and of the consultants who introduce data about the morning rush and other issues. Then there are the auxiliary services, for example emergency response to accidents, the cost of which has gone down. So, overall, this is the first performance measurement of Kotitori, and it looks good.

[slide 017]

These are some figures put together by our auditor, KPMG. I just received the figures last week, so I am not quite sure I understand them all. But as you can see this is from the year 2013, and in the Kotitori catchment area the number of patients have been increasing dramatically. It was 360 last year, and now it is 2831. Again, the cost of customer guidance is higher. Regular home care compared to the city of Tampere is still cheaper than Kotitori. Use of specialist care is slightly less, and so on. So there is general improvement.



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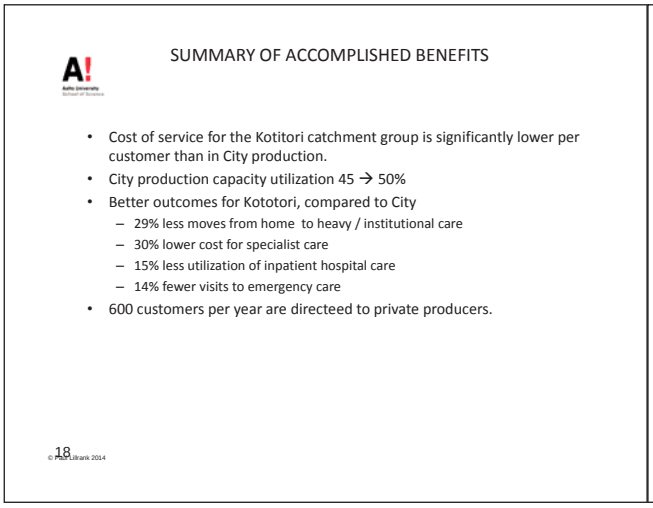
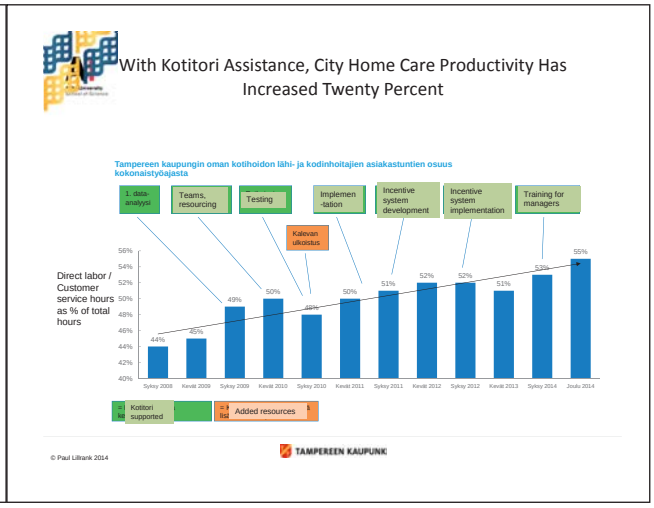
On the City of Tampere's side, there is continuous improvement of the productivity of work. By and large while all of these exercises are not complete or comprehensive, we have reason to believe that there are positive results. If you want to sum it up, the Kotitori catchment group, the people who manage through the Kotitori system the cost per patients are significantly lower than for the comparative group for the City of Tampere. It is clear that the City's production has been steadily improving, and the outcome-related proxy measures, less movements to institutional care, lower cost of specialist care, meaning typically accidents and emergency transport. It looks reasonably good so far. This shows the path of performance by the City of Tampere production.





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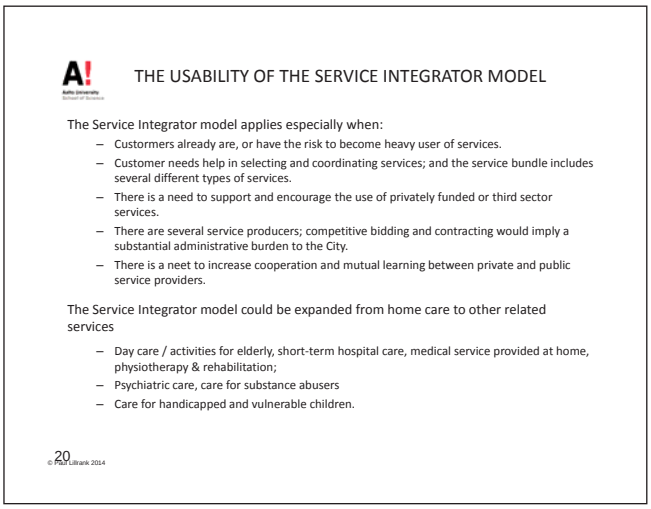
To conclude, Kotitori is about service design, and service engineering. It is a prototype that still needs to be developed and kicked around, but I think we can say that the sort of service integrator model is useful, not as a universal solution to everything, but in specific situations, particularly for customers who are already heavy users of services of run the risk of becoming heavy users.



Another line of research we are pursuing is to identify the heavy users among the health and welfare customers. We found that 10% of the population consumes about 80% of the health and welfare costs. I do not know if anybody is astonished. It is quite similar all over the world. This finding has not got the proper policy response in Finland yet. We have been working on that. If you have a very small group of people in a city – for example a couple of hundred people – who consume 80% of your health and welfare budget, then isn't that a problem? It certainly is a problem. There should be some kind of system to manage this group of people. We also studied what the particular profile of this type of person is. In most cases you have mental problems, drug abuse problems, three to six other somatic problems, all in one bundle. The cost comes because these individuals are thrown from one health service provider to another, so they keep rotating in the system without anybody taking a control over them. For this reason, the costs keep accumulating.

Now, if there are people like this, or people who run the risk of falling into this category, then some sort of integrated system that catches them and manages their care is important. It is also good for anybody who need two or more types of services, because it is easier to shop around for services from different channels. In the case that there is a reason for the government or the city to encourage people to use private services and pay with their own money. Many people can afford that and willingly pay. So there is a business case for making it easier. Also, if there is a situation where municipal service providers feel that their productivity is lacking compared to the private side, this is an easy way to induce a benchmarking exercise with continuous improvement. Then, this could be applied to other services too, not only long-term care for the elderly. There are some experiments in the psychiatry care on substance abusers, and that could use a similar thing.

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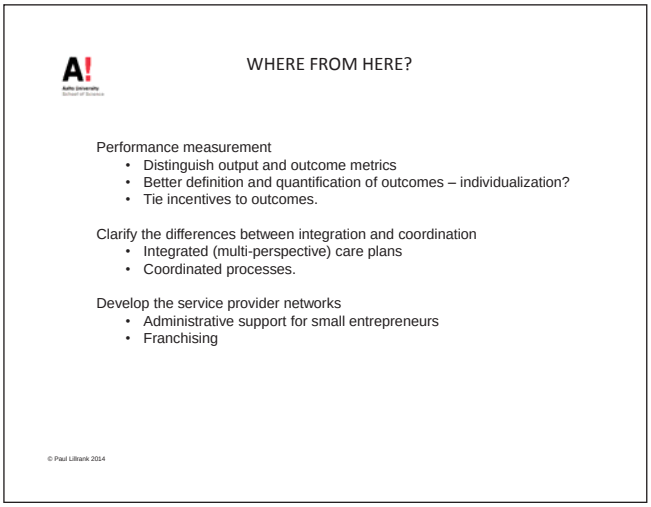

This is where we stand today, and think of what needs to be done next. The performance measurement system is still one of the weak points. It is an area where the basic scientific research would be needed to provide better understanding of how the performance system should be set up, and how incentives and financial flaws should be aligned to the performance. Also, I think there needs to be clarification between integration and coordination. Integration is making the care plan, so that an individual gets a care plan where various aspects – mental, economic, social – are integrated in a core plan for that individual. Then, it is coordination of production – to see that the scheduled services happen at the right time.

Finally, I believe there is a lot potential in developing the service provider networks. Many of these companies are small. They are driven by people who are very motivated by their job but have very poor or non-existent management skills to run their company. For Kotitori, a possible development venue would be a franchising system – to provide the basic accounting and tax and personnel management, and things for anybody who would like to do these kinds of services so they could concentrate on treating their customers well and leave the business management to somebody else.

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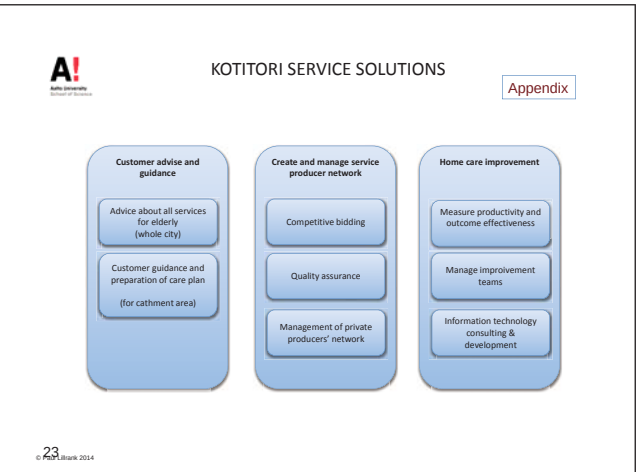
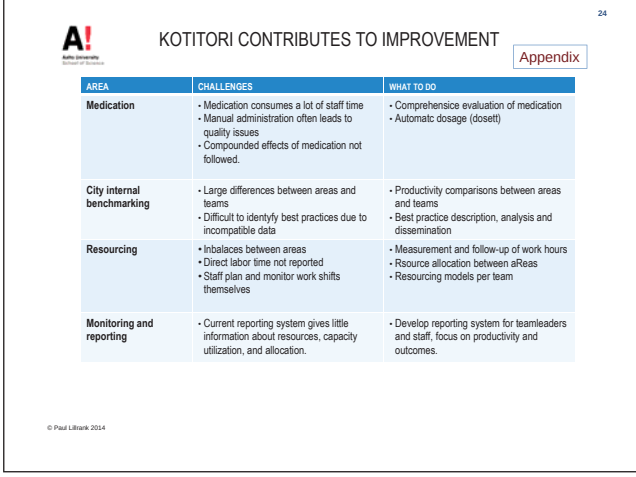
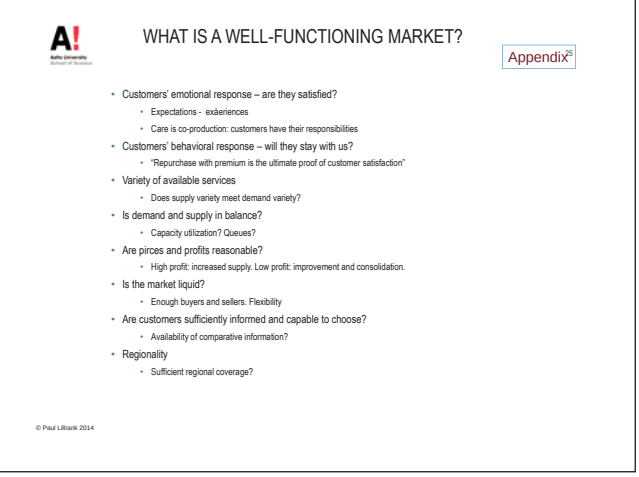
“Kotitori ohjaa palvelun luokse.” In Finnish, that means that Kotitori leads you to the right service.

Thank you.







Session 2, Discussion:

Kotitori: Discussion of Prof. Lillrank's presentation & Relevance to the Japanese system

Hiroshima University
Professor Michiko Moriyama

Seijo University
Professor Hiroyuki Kawaguchi

[slide 001]

Prof. Hiroyuki Kawaguchi: Last year, I visited the Aalto University, and had a chat with Professor Lillrank. I was very surprised because the concept of Kotitori is quite interesting for Japan. For this discussion, I will just do the introduction part, and then Professor Moriyama will take the important part.

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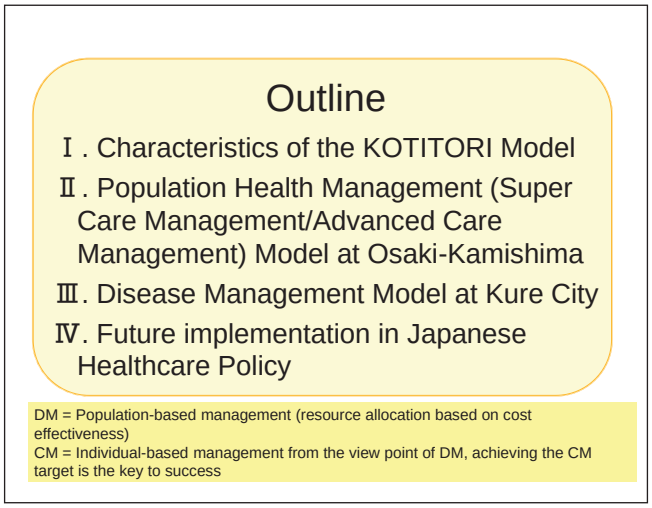
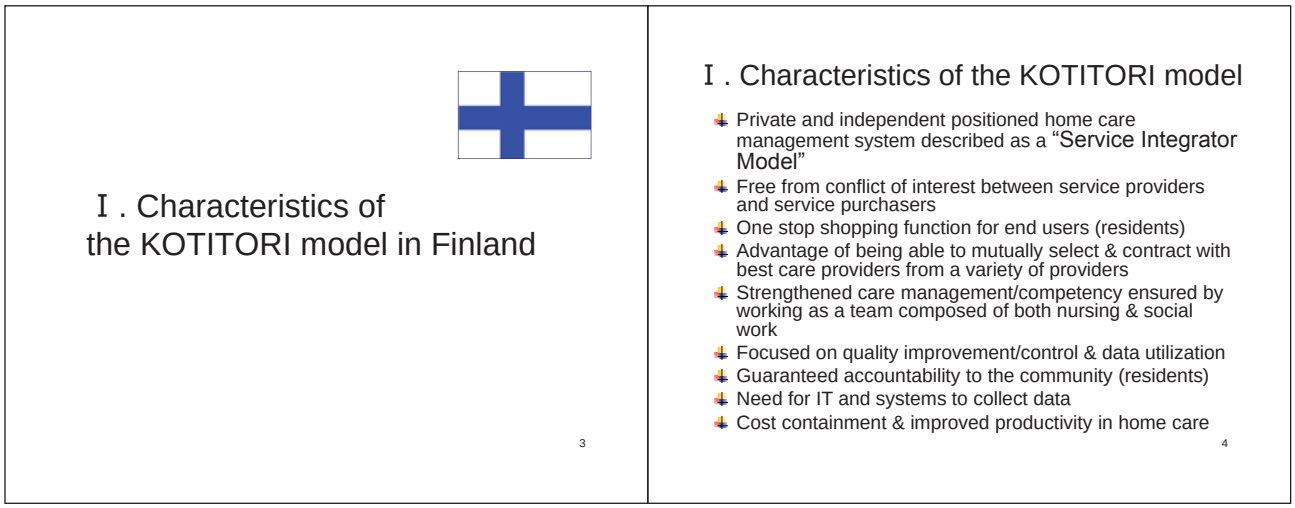


From the Professor Lillrank's presentation, we would like to discuss in four parts. The first part is our interpretation of the Kotitori model – if you have a different perspective, the consequence from the presentation would be different. In the second and third parts, Professor Moriyama will present very detailed information about the two new care models in Japan. After that, in the last part, I would like to sum up several implications for the Japanese healthcare policy.

[slide 003 & 004]

We are very impressed in the Kotitori model as "service integrator model". Professor Lillrank said they are "outsourcing the outsourcers." There would be two outstanding points. The first point is that it is free from the conflict of interest between service providers and argent of service purchasers. The second point is that they have very strong care management as a team. The teams include practicing nurses and social workers. In addition, there is observation data about both cost containment and improved productivity.



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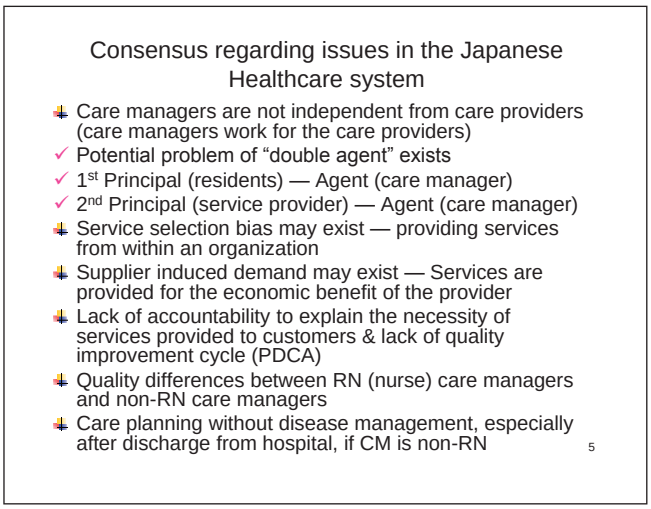
As first point, when we see the Japanese Healthcare system in the context of the Kotitori model, we may find the "double agents problem" in case of Japan. This is because we have care managers and they are supposed to be an agent of the long term care users. Simultaneously, they may be an agent of the service provider because they tend to belong to the service provider. So, there would be some conflict of interest between an argent for user and an argent for service provider as the same care manager.



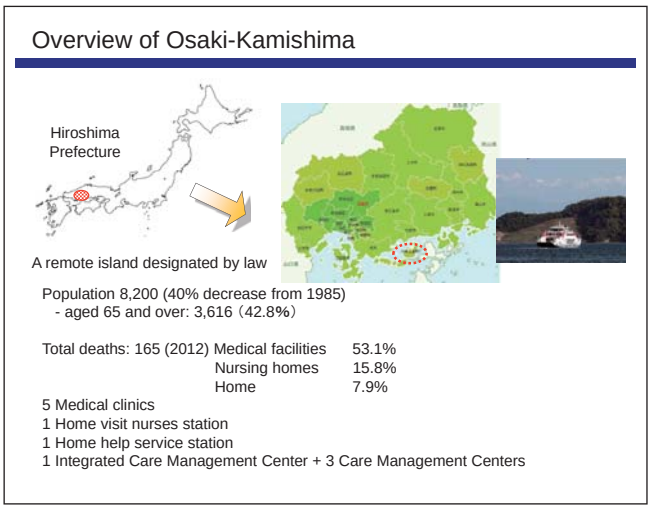
As the second part, there are actually two kinds of care managers who specialty is nurse and is social worker in Japan. There is a little evidence that there is difference of assessment or difference of care plans in terms of their specialties. Before we talk about policy implication from the Kotitori model, let's check two Japanese cases that have innovative aspects.

[slide 006]

Prof. Michiko Moriyama: Hello, this is Michiko Moriyama. I am a nurse. First, I believe that primary care system is important, and is needed to be introduced in Japan. Advanced case management, which I am going to talk, is effective if it is practiced in primary care system. However, we don't have primary care system. That is why, I, as a nurse, started a disease management/care management company by myself to compensate service deficit, as a venture business. Our clients are insurance organizations under the national healthcare insurance system. Right now, we provide our services to more than fifty insurance organizations, from Hokkaido to Okinawa. This is one of the models – we call it the Super Care Manager Model.

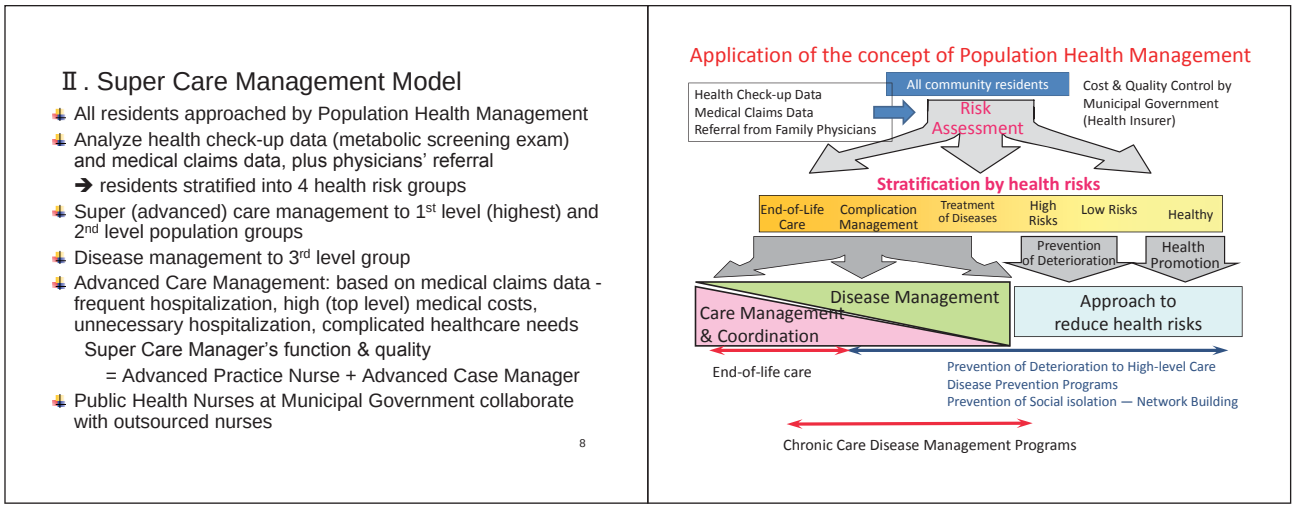
[slide 007]

This is a remote island designated by law. The population is 8,200. The elderly population is over 40%. Total number of deaths is 165 in 2012. Then, these figures are the characteristics of Japan. Even on this small island, there are five medical clinics. The biggest strength of this island is that there are no hospitals. Therefore, we had a chance to develop a new model based on the concepts of primary health care and population health management.



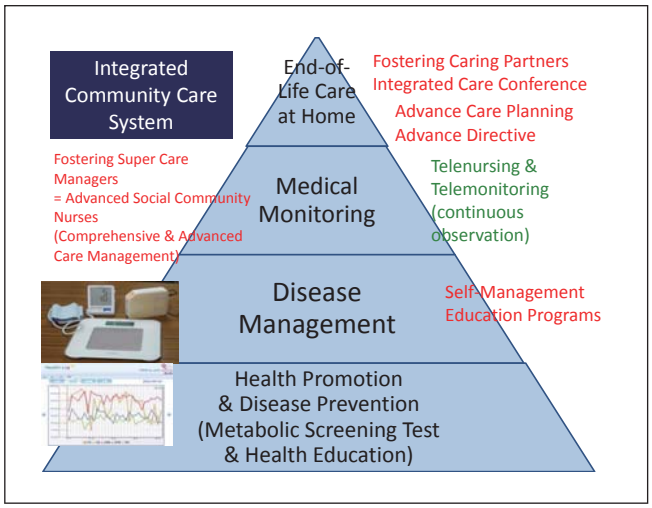
[slide 008 & 009]

I am going to introduce this model. This Super Care Management Model is based on this concept of population health management. This is the one. First, we analyze all health data – for example health checkup data. In Japan, annual health checkup is mandated, however, only 20% of residents take this. We also use and analyze medical claim data, and referral from family physicians of this island. So, we can analyze all kinds of health data, and based on this analysis, we stratify and categorize all residents into these categories. Then, in terms of cost effectiveness, we provide integrated care from end-of-life care to health promotion.



[slide 010]

This is the Osaki Kamishima Island care system we are developing and providing services right now. The top part is the high-risk residents – who need end of life care. Majority of elderly people here live alone and their children left to big cities such as Tokyo and Osaka. Under the national long-term care insurance system in Japan, all kinds of long-term care services are prepared and provided; however, aging population living alone is bigger than the amount of those healthcare services. Therefore, we decided to foster informal service providers called a care partner under the municipality government's leadership, especially we needed to prepare informal services for dying people who stay with them and support them at home if we want to promote death at home. To promote death-at-home, we started the integrated care conferences for dying patients periodically with all healthcare providers in the island--physicians, home health nurses, home helpers, care managers, and so forth. Advanced care planning including advanced directives is also needed to promote death at home. Advanced directive is not legislated by law in Japan; therefore, we need to educate community people to understand and prepare, write advanced directives. So we provide educational classes in the community, and then help them to write advanced directives.



This is the ending notebook we designed. This workbook includes a life history part, living wills and advanced directives.

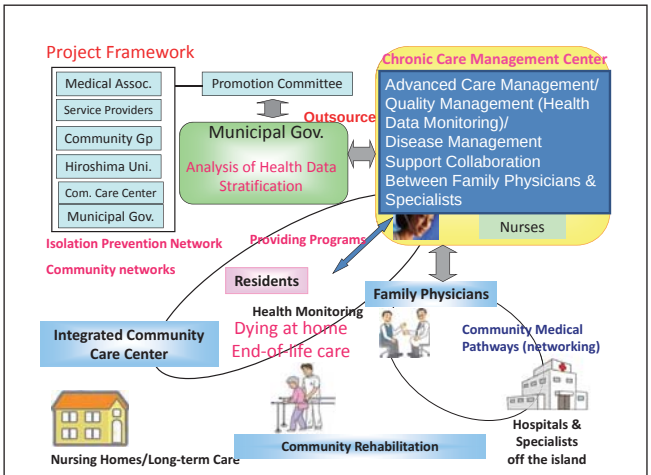
This is the second level of health risks who requires medical, vital-signs monitoring such as blood pressure, pulse, weight. Nurses monitor and provide telenursing disease management services from outside of this island. This includes advanced case management services by advanced practice nurses. Because of fee-for-service and free access in. Japan, people stay longer in a hospital, repeat hospitalization, are provided over amount of medical services, but patients receive less disease education of a disease management and not high level care management. That is why we analyze claim data from hospitals, and then we find and select target population who spend high amount of medical services and medical cost. After finding the person, we visit the patient and provide health and resource assessments and provide advanced case management plus telenursing, since we think disease management is the center of case management of the care-needy elderly people. An elderly who needs care usually have a complicated health care needs and many complications. So, we believe disease management is the core of case management. Therefore, we foster so-called "super care managers" – which means advanced social community nurses or advanced case manager.

The third level of health risk is categorized as disease management. To this target population, we provide many kinds of chronic care disease management, such as diabetes, CKD, stroke, hypertension, hyperlipidemia, CHF, ischemic heart diseases, and so on. Now we are developing disease management program for depression as well since occurrence of depression in the elderly population is high, and it is the one of the causes of elderly death.

The bottom level is health promotion and disease prevention. This part is provided by the municipal public health nurses.

[slide 011 , 012 & 013]

To develop this community integrated care system, collaborating with the public long-term care system, we organized this committee with municipal government and stakeholders in this community. Then described this future framework of this community.



Ⅱ. Super Care Management Model

Common Points in the KOTITORI model and the Super Care Management Model

- #1 Independent CM Organization
  - ⇒Real advocate for clients (address double agent risk)*
  - ⇒Eliminate care plan bias (curbing induced demand)
- #2 Advanced Quality (specialized quality: medical professionals + knowledge of social resources)
  - ⇒not only referral but also coordination and management of allocated services
  - ⇒plus advanced assessment(especially DM)
- Strength in Japan: Public Health Nurse system
  :well-prepared Municipal level long-term care infrastructure

*Blomqvist (1991) "The doctors as double argent" J of HE

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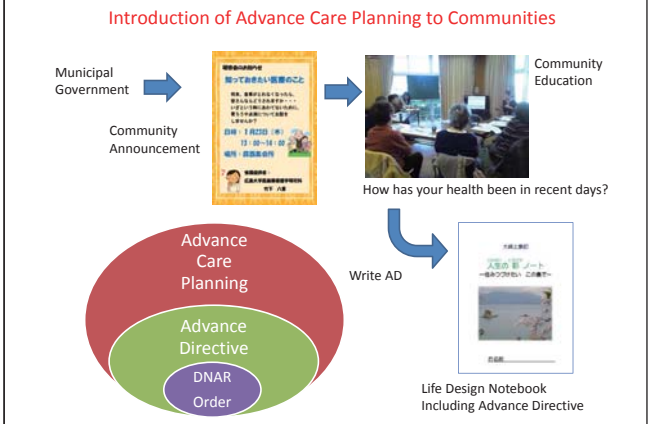
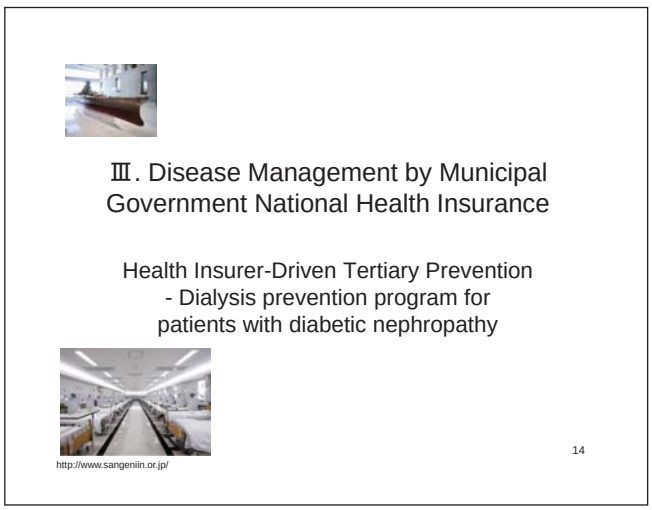


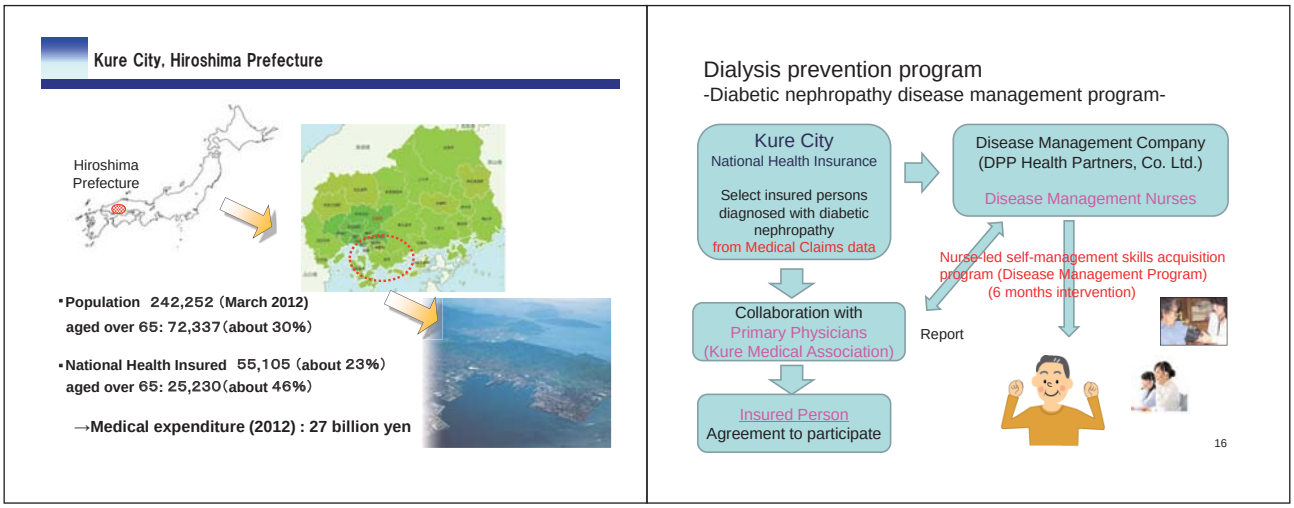
[slide 014]

This is the third part – disease management by municipal government under the national health insurance system. Since we don't have GP system, means no gate keeping system, even though patients, such as diabetes patients, visit many clinics and hospitals, still their data are not controlled well, and increasing number of diabetes patients go to reno-dialysis since chronic disease management and patient education are poor at clinic and hospital sites. Before, health insurance organizations, a payer, were not able to control medical cost. Because of this project, first done in Kure-city, Japanese government has decided that health insurance organizations in all nation needed to control medical costs on chronic diseases such as diabetes, by providing disease management programs. This is the tertiary prevention program provided by health insurance organization. Outsourcing to disease management companies is recommended. This, called Kure city-model, in which Kure city municipal government and Hiroshima university collaborated and developed the disease management program on pre-dialysis patients of diabetic nephropathy in order to prevent them going to dialysis.



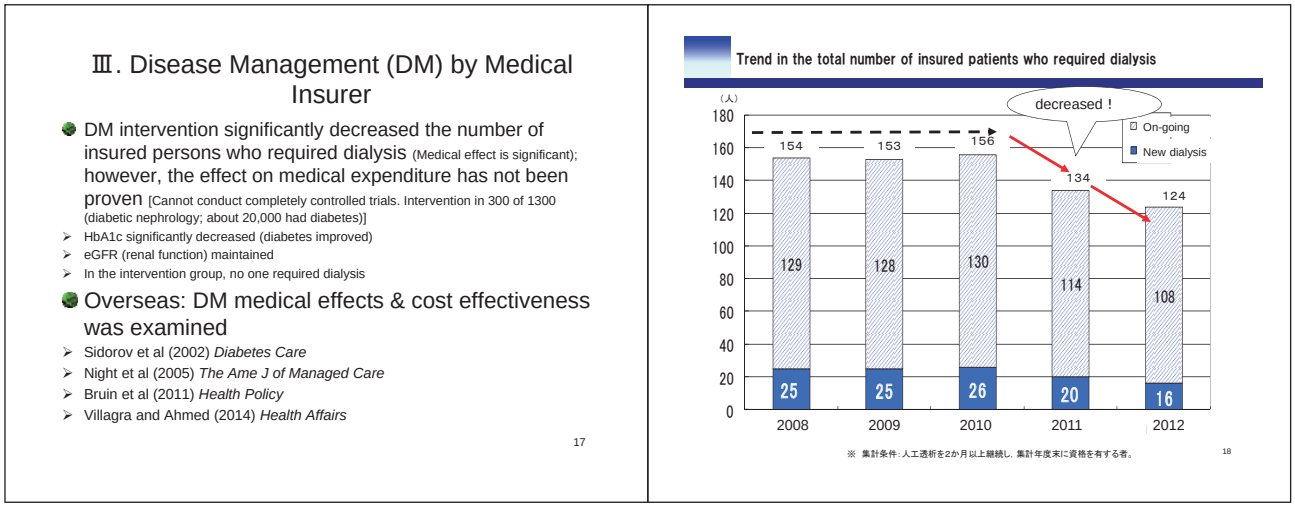
[slide 015 & 016]

This is the dialysis prevention program for patients with diabetic nephropathy. This is a health insurer-provided-disease management program. This type of disease management has started in US. This is the first one in Japan. In Kure city about 30% of the population is age over 65. The insured of this National Health Insurance is about 55 000. Out of that number, 46% are elderly people. In implementing this program, we analyzed their health claim data, selected the target population who have been diagnosed as diabetic nephrology. Then, we called the patients and received consent to attend on this program, because in Japanese health insurance system, it is not an opt-out system. It is an opt-in system. This is why we needed to call all patients to get consent, to all targeted populations, and we say,“ Hello, good morning – will you please participate in this program?” We called every targeted patient. Then, when they said yes, we provided disease management programs.



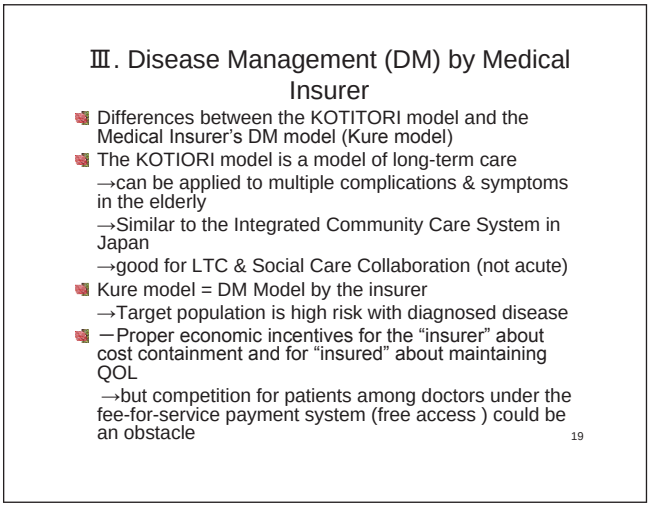
[slide 017 & 018]

We got good outcomes. It means that obviously the patients who went to dialysis have decreased. The outcome showed effectiveness of this program from medical view point. However, because every year we can provide this program only to 100-300 patients out of 1000, the number of those who diagnosed as diabetic nephropathy. Therefore, even though we calculate medical expenditures, we cannot obtain a significant level of medical cost reduction. If we have a primary care system and if we have a gate keeping system, this program works better and may effectively reduce medical costs.



[slide 019]

Prof. Hiroyuki Kawaguchi: Now, we showed two case studies. The first one is the "super care manager model". The second one is the "disease management model" by insurer. Then, we would like to discuss about the Kotitori model – is there any similarity between the two countries models?



In terms of advanced care manager models, there are two similarities. One is the independent care manager organizations. The KOTITORI model has exclusive care management team and the team independent from service providers. The super care manager model have an independent organization from service providers and it is specialized organization for care management. So, we would have a cue to start thinking about "double agent problem". In the case of the independent care manager organization, we may eliminate the care plan bias, which means the care managers tend to put more services in the care plans from their belonging providers than from other providers.

The second similarity is the enhanced quality of both care coordination and care integration. The KOTITORI model has exclusive care management team including both nurses and social workers. The super care manager model has a kind of practice community care nurse who is very good at assessment for disease management.

When we discussed about these two Japanese models in our research group, we find that there is one advantage in Japanese system because we have a broad public health nurse system – Hokenshi-san in Japanese – who knows where there are aging populations, or who has disabilities. That is a good infrastructure we can use in terms of improvement of long term care system in Japan. The super care manager model made good use of this strong point.

We would like to recommend to introduce disease management by public health insurer. The similarity to the Kotitori model is that enhanced coordination of the care plans as outsourcing from main body to independent third party organization. However, there are some other aspects as well. The Kotitori model is mainly for the chronic disease models, so they are integrated with the care service plans. So, it is very similar to the integrated community care system, in Japanese "Chiki Houkatu Care system". In Japan, there are now huge discussions about that system.

In the case of the disease management model by health insurer, it is focused on the target population, for example, the third degree risk residence. The disease management model tries to improve relatively high risk condition. However, one drawback of the Japanese system is that there is "patient attracting competition" among service providers due to the "free access" (no limitation to access to care) to the providers. Therefore, providers need to attract these patients for keeping their operating income to maintain their organizations. Especially, medical institutions have an incentive to interfere from keeping the relatively high risk residents from medical institution by introducing disease management model by public health insurer.

[slide 020 & 021]

We would like to conclude our presentation to point out two policy implications for Japanese long term care system. The first point is "two layer care management system". We propose the idea of the combination of care manager and advanced care managers. The regular care manager would be concentrated on making care plans and coordination of services. The "Advanced care managers" will do the needs assessment and check the suitability of the care plans made by the regular care managers. The municipal government may outsource the task of advanced care managers to the independent organizations. Professor Moriyama already established one of independent organization to concentrate on care management and disease management. So, the two layer care manager system would be very effective to increase the quality of assessment and care management.

Ⅳ. Future implementation to Healthcare Policies in Japan

Toward Integration of Care in the Settings of Chronic Stage Medical Care/Long-Term Care of the Elderly

20

Need to Strengthen Functions of the Integrated Care System in Japan

- ✓ Combination of Super Care Management (Advanced CM) ＋ regular CM
- ✓ Need to discuss preparing Independent (free from conflict of interest) Advanced CM Organizations

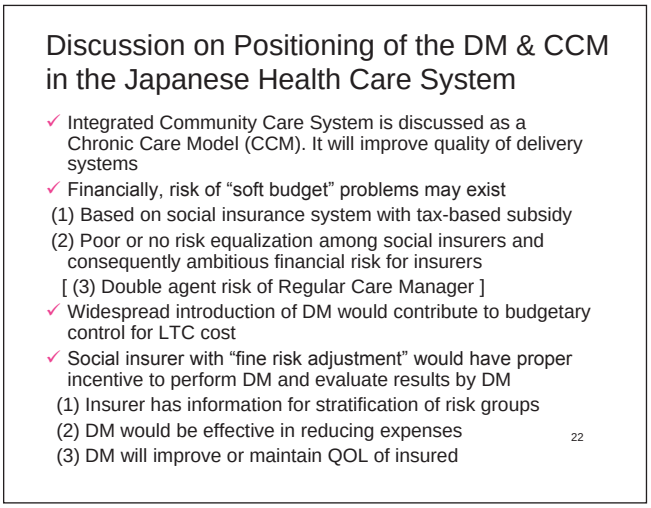
(1) Municipal Governments outsource Advanced CM to Independent Organizations

(2) Require Advanced Specialists [have to be in the medical (nursing) profession with knowledge of social resources]

- ✓ Regular CM may focus on coordination, referral among care providers, and care management of low risk clients
- ✓ Municipal Governments need to activate & collaborate with social resources in the community
- ✓ Municipalities outsource assessment of needs to Super CM and outsource Quality Management/QI to Independent Integrators

21

[slide 022]



The second point is that we may need to decide clear positioning of disease management model in the Japanese long term care system. The Kotitori model in Finland and the integrated community care system in Japan could belong to the chronic care model. The Finish health care system has strict budget constraint because the system is financed mainly by tax. On the contrary, Japanese long term care system has weak budget constraint because the system supported by mixed financing system both tax and public insurance. Therefore, we need pay more attention to enhance budget constraint in the long term care system in Japan. The public health insurer with fine risk adjustment would have proper incentive to perform the disease management and evaluate their results. Because the insurer has both medical claim data and health check-up data, the insurer has information for estimation of risk degree for individuals and for evaluation of the outcome of disease management. Secondly, introduction of disease management could be effective in reducing some expenses. It is not so clear, but maybe there is some effect. Third, the disease management will improve or maintain the quality of life of the insured. It is made the insurer possible to provide a good service to the insured. These reasons are why we think the insurer should do some disease management.

Prof. Michiko Moriyama: I learned that Kotitori model is very interesting, and I want to learn more. I want to collaborate! Thank you very much.

Session 3

Session 3, Presentation:

Long-term care in the Netherlands: Towards managed competition?

Erasmus University Rotterdam Professor Richard van Kleef

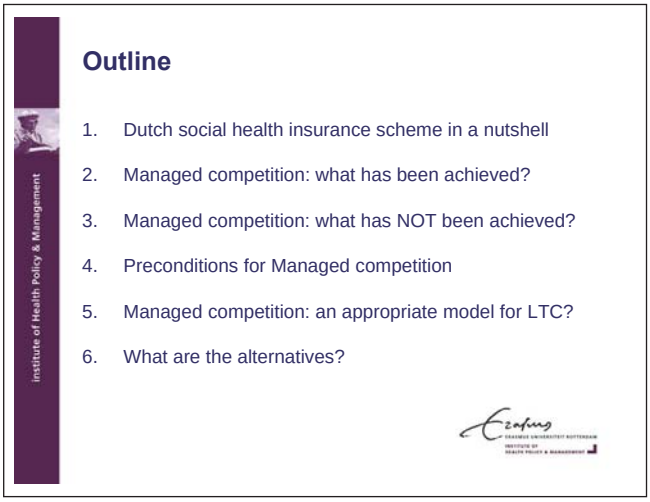
[slide 001]

Thank you so much Prof. Kawaguchi for inviting me to this great conference. We also had a great conference two years ago on the interaction between public insurance and private insurance. Now it is on long-term care. You asked me to share with you the experiences that we have with long-term care in the Netherlands. What I would like to do is not only to give you an overview of how the long-term care in the Netherlands is organized, but also to give you an idea of the debate on long-term care in the Netherlands. So, what should we do with our long-term care systems in the future? I think there are many similarities with the problems you are having in your countries.

At the moment, the main question we are having in the Netherlands is should we have managed competition for long-term care? As you will see in my presentation, the government already decided it on this issue two weeks ago. A part of the long-term care in the Netherlands is transferred to the scheme of managed competition that we already have. I will argue in my presentation that I have serious doubts whether this was a good decision, at least at this moment.

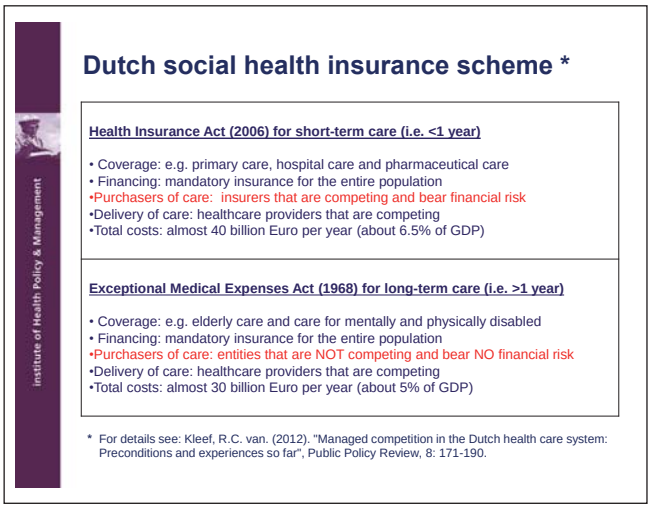
[slide 002]

This is what I will do in my presentation. I will first give you a very brief overview of the system of health insurance that we have in the Netherlands. Then I will give a very short summary of the meaning of managed competition, and the way we implemented managed competition in 2006 in our healthcare system. Then, I will come to the question: Given the experiences that we have had with managed competition in the last 8 years, since 2006, should we also apply managed competition to long-term care? If the answer is no, then what are the alternatives? Are they better or worse than this idea of managed competition?



Of course, you cannot explain a healthcare system in one week or month or year, so you have to make choices. I have made the choice to present some key points of our healthcare system on one slide. The major key point is that we in fact have two schemes for our social health insurance. One is the health insurance you can say for long-term care, and the other one is for non-long-term care. I define non-long-term care as short-term care in this presentation. I do not think it is the right terminology, but I hope it is fine for now.

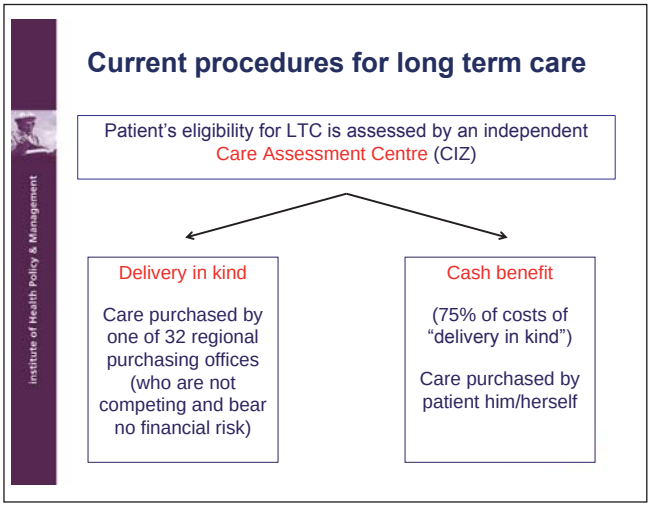
[slide 003]



There is one major difference between the scheme that we have for long-term care and the one that we have for short-term care. For the short-term care, we have a model of managed competition. This means that private health insurers purchase the care for all people who have the basic health insurance. These health insurers are competing with each other, and they bear some financial risk. These are two key points of the managed competition model. So purchasers of care bear financial risk and are competing. This is totally different in the scheme for long-term care at the moment, where we have purchasers of care who have no financial risk and are not competing. Now, the question or the idea of the government is to transfer this long-term care, or parts of the long-term care to the system of the regulated or managed competition. If you are interested in the other details of our healthcare system, you can go to the paper that is at the bottom of this slide. It is in English and Japanese. So, that was my first paper in Japanese. Thank you for editing, Professor Tajika and Professor Kawaguchi! However, a lot has changed since then, but I would like to refer to that to save some time for the really interesting things.

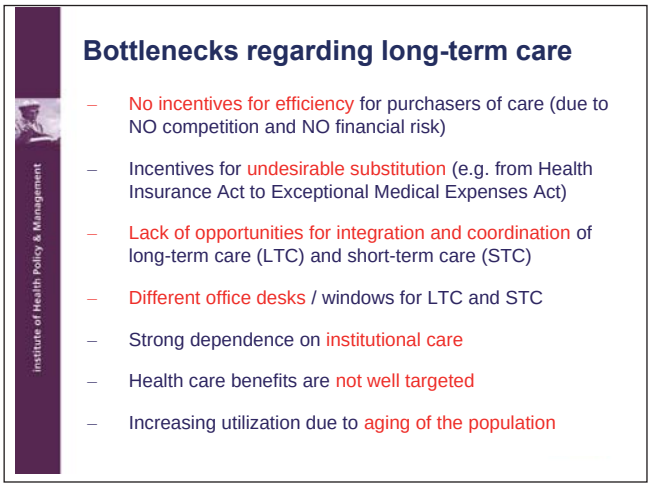
[slide 004]

Just one slide on the long-term care to give you an idea on how our current long-term care system is working. Assume that I am a patient or a consumer who is in need of long-term care. Then, I go to what is called the Care Assessment Center (CIZ). It is an independent organization that assess whether I am, or am not in need of long term care. I think you also have something this in Japan – maybe there is one in Germany and the Nordic countries as well.



Once the care assessment center decides that I am in need of long-term care, then there are two options. I can get the care in kind, so the care is delivered in kind to me. Or, I can receive a cash benefit and go to the organization that I want to go to. I think that about 10% of our current long-term care budget is spend on cash benefits, and 90% is spent on delivery in kind. What happens with the delivery in kind? We have these administration officers, 32 in total, who are not competing. They have no financial risk. What they do is purchase the care for me, and I can get the care from the providers directly.

[slide 005]

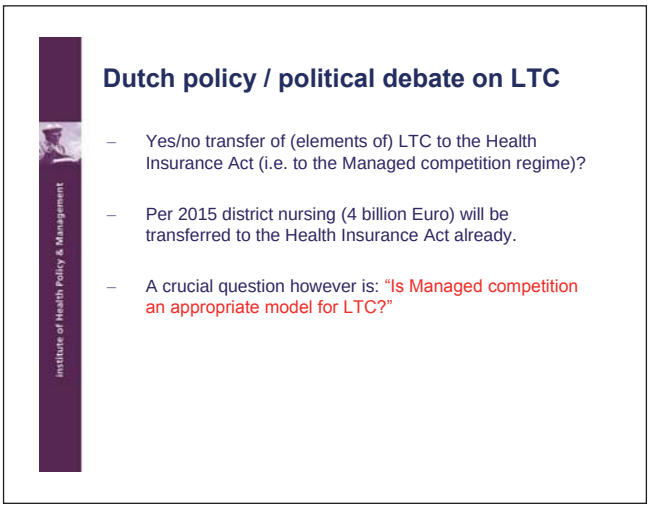


What are the bottlenecks with this scheme for long term care? This is a list of the bottlenecks that have been discussed in our debates during the past years. So, I did not make them up. I just got them from the discussion that we are having in the Netherlands. The first is that there are no financial incentives for efficiency for the purchasers of care. Because these purchasers of care are just administrative offices, no competition, no financial risk, there is no financial incentive to look at cost containment. A second point is that we have serious incentives for undesirable substitution. For instance, with the two schemes, one for the short term care with competing insurers, and one for the long term care, the insurers have a financial incentive to transfer healthcare benefits or costs from the short-term to the long-term care scheme, because it will reduce their cost. This is not possible for all types of short-term care, but of course there is a great area in between – which can be short-term or long-term care – for which this undesirable substitution is possible. The third point is that there is a lack of opportunities for integration and coordination of short-term care and long-term care. Also, because of the two very different schemes, and between the schemes there is a very wide hole, it is difficult to integrate and coordinate the two. And because of that, there are different windows and offices, and this is not so good for the patients who are in need of short-term and long-term care. Another point is that in the Netherlands, there is a strong dependence on institutional care, so if you look at the OECD data, then what we see is that relatively much of the long-term care is provided in the institutions, which is quite expensive. It has been studied that a lot of this long-term care, which is provided in the institutions, can be provided outside of the institutions by home care. Then, the healthcare benefits are not well targeted, so

there is evidence that healthcare benefits are also provided to people who are in fact not really in need of long-term care. The last point is that the population is aging. That is a common problem that we of course have in all countries. So, these are some bottlenecks that we have in our country's long-term care system. And these are the reasons why the Dutch government is thinking about changing the system.

[slide 006]

What is the political debate about in Holland? I think the main question is should we, or should we not, transfer the long-term care, or parts of the long-term care, from the current scheme, the public scheme, to the scheme of managed competition, which is now for short-term care? As I said, it has been decided that in 2015, the district nursing (I am not sure if this is the right term – maybe it is home care? It is care delivered at homes by nurse practitioners.) will be transferred to the national Health Insurance Act already. Later, I will argue that at this time, that may not be a very good decision. A crucial question, however, before you can decide whether or not you should go this direction, is whether the managed competition model is appropriate in theory with regard to long-term care. It may be an appropriate model for short-term care, but that does not necessarily mean it is also appropriate for long-term care.



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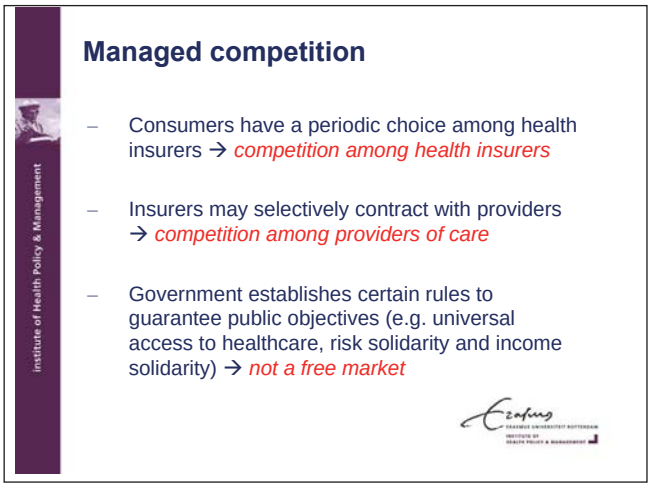
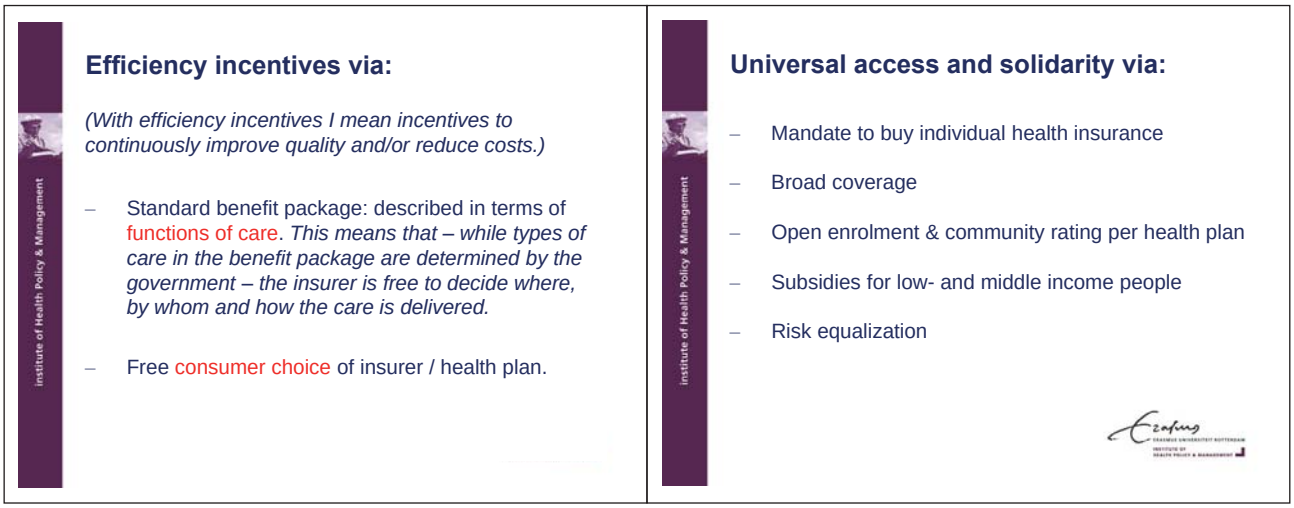


This is a very brief summary on one slide about what managed competition is. It was also described in the 2012 paper, and many other papers. It means that the consumers have a periodic choice of insurer, which leads to competition among the insures because they need to do what is best for their client in order to attract new clients. Then, the insurers may selectively contract with providers, which gives providers an incentive to do what is best for the patients, in order to get a contract from the insurance company. So, this is the game of competition. It is not a free market. The government has established certain rules in order to guarantee some public objectives to guarantee access to affordable care, and solidarity in the financial contributions to healthcare.

[slide 008 & 009]

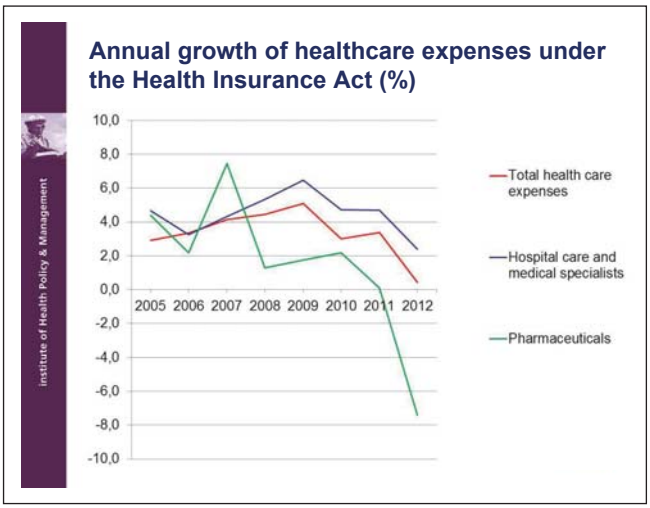
I will skip these two points, because I think you have the point about managed competition.



[slide 010]

I would like to go to some very recent research that I have done together with my colleagues Professor Erik Schut and Professor Wynand Van de Ven. It was earlier this year that we evaluated the Dutch healthcare system. The main question was whether the managed competition model is working? Does it lead to the outcomes that we expected, that are desirable? One of our main conclusions is that the purchases of healthcare, with the insurers that are competing and have financial risk, are increasingly successful in maintaining the cost of the healthcare scheme. This is a little different than what I presented two years ago. At that time, I showed that an effect of the managed competition model was that we had a reduction in the prices for pharmaceutical care and hospital care. This is something you already knew. However, since 2012, we also see a reduction in the growth of hospital care due to a new type of budget contract between the insurer and the hospital.

[slide 011]



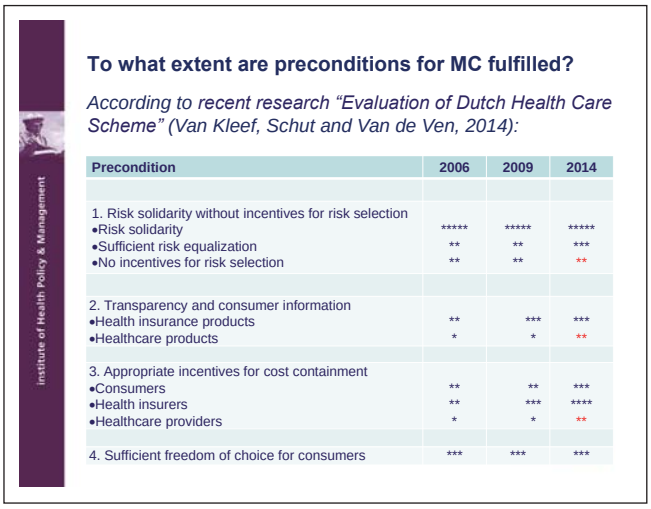
So, what is this new type of contract? In 2012, the insurers, not only one, but almost all insurers started to negotiate general budgets per hospital. The idea was that the insurers said to the hospitals, for example, "I calculated that, given your population of patients, you can make it with this budget for next year, so you should adhere to this budget, with maybe some adjustments because of negation. But, if you exceed the budget, then you have a problem." Many hospitals succeed in maintaining their costs within the budget. I think this was a very important step in the evolution of the model of managed competition, which has led to a reduction, not only of prices, but also of volumes. We see that in this picture. This is only about short-term care, not long-term care. Here, we see the expenses on pharmaceuticals, which has went down sharply since 2010. Not only the growth in expenses went down, but also the expenses themselves went down for pharmaceuticals. For the hospital care and the medical specialists, we also see that the growth in expenditures is substantially reduced. So, the growth in 2012 was only 0.5%. That is much lower than the growth that we have had in the years before. So, the total expenses in the Netherlands for our short-term care are not decreasing, but they are also not increasing as fast as they used to do years ago.

[slide 012]

I think that this is the main reason why the government is thinking about having managed competition for the long-term care. When you see this picture, and you work at the ministry of finance, you think that the managed competition works because it reduces costs. If you are interested only in reducing costs, then this can be a nice way to go. However, then we come to our second conclusion of the evaluation that we did earlier this year. That is that purchasers of healthcare are not yet successful in improving and stimulating the quality of care. There are two important reasons for this. The first is that there are insufficient incentives to improve the quality of care for insurers. The second reason is that they have insufficient tools or instruments to stimulate the quality of care. These two shortcomings have to do with the fact that some of the crucial pre-conditions for managed competition have not yet been fulfilled. Two years ago, I presented this long list of preconditions for managed competitions to you. We looked very carefully and concluded that some of these preconditions were not fulfilled. That is still the situation today. Managed competition in theory is very simple, but in practice a lot of preconditions need to be fulfilled to make the system work.

[slide 013]

Here are four of the ten preconditions. The others are one the next slide. I will not describe them in detail, but I would like to highlight some of the preconditions that are a problem. The first is that we still have incentives for risk selection in the system. This is because the insurers have to charge community-rated premiums while they know that the chronically ill are more expensive than the young and healthy. We have a risk equalization system, which is the cornerstone of our managed competition model. This should reduce these predictable profits and losses to zero. That is not happening at the moment. Here we see, for some groups in the population in relatively poor health, the predictable loss for the insurer per person per year. It shows, for instance, that for people who have at least one chronic condition, about one third of the population, the insurer has a predictable loss of more than 300 Euros per year.



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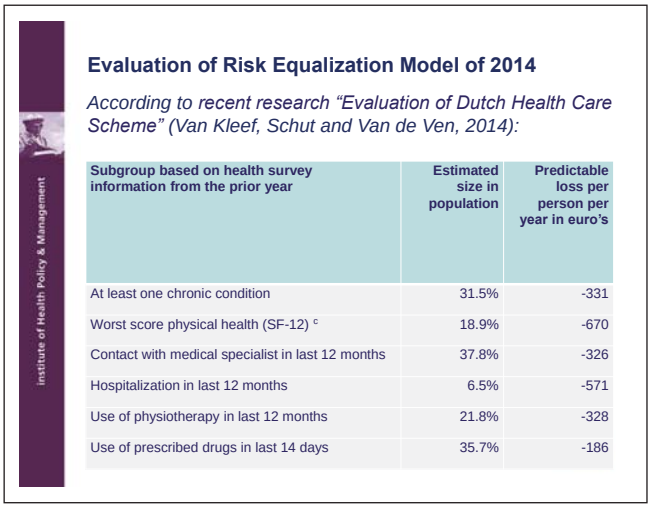
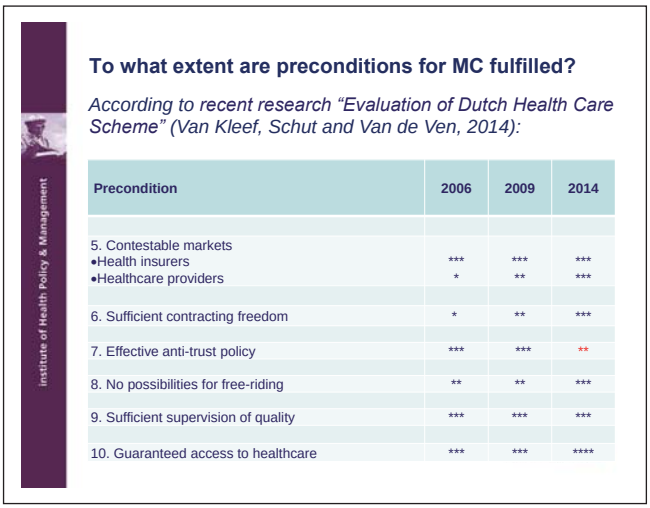


Our main conclusion was that all groups of people in relatively poor health bring a predictable loss to the insurer. And all the groups in good health bring a predictable profit. If you see this table, you can question whether the insurer has an incentive to do what is best for these patients, whether they have an incentive to improve the quality of care for people with chronic diseases. If an insurer is quite naïve, and chooses to improve the quality of care for people with chronic conditions, then the expectation is that he will attract many of these people and will be confronted with large predictable losses. This is what we mean by the incentives for improving the quality for people with chronic diseases are not sufficient at this moment. That is a problem. We need to further improve or risk equalization system.

[slide 015]

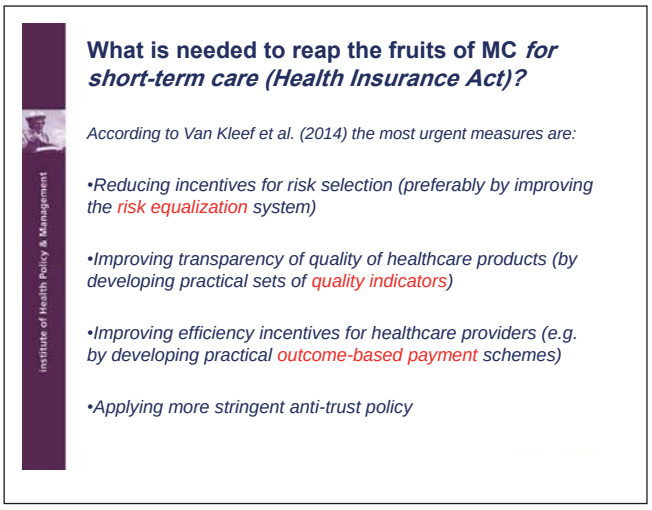
The other problem that we have is that, and we are very jealous of our colleagues in the UK, we have no transparency at all in the quality of healthcare products. At least at this moment we have a classification of health care products, so all health care products are more or less defined at this moment, but for these health care products, we have no idea what the quality is. We cannot compare the quality across providers, for instance. So, if, as an insurer, you have no idea about the quality, how can you involve quality in the negotiations you do with the hospitals. This is a real problem, and this is what we mean when we say that insurers do not have the tools at this moment to include quality as a very important aspect in the negotiations, when purchasing the care.



For instance, maybe our ideal world is where the insurers pay the providers by some sort of pay-for-performance, but in order to do that you need the information on the quality, and that is not possible at this moment.

You can see the ten preconditions here. I will not discuss them in detail today, but if you are interested, please send an email, and I will send you a couple of interesting papers.

[slide 016]

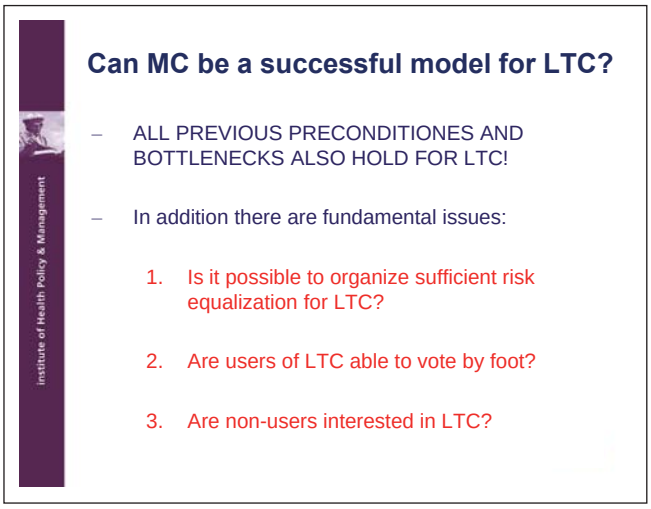


The report, unfortunately, is only in Dutch, so we have to work on an English paper. I hope that we will succeed next year.

The report's conclusion for short term care was that what is needed to reap the fruits of managed competition is to improve the risk equalization system and to develop a nice practical set of quality indicators. For instance, the QOF model that is used in the UK. Once you have the quality indicators, the insurers can use them in negotiation with healthcare providers, or even for some sort of outcome based payment like pay-for-performance.

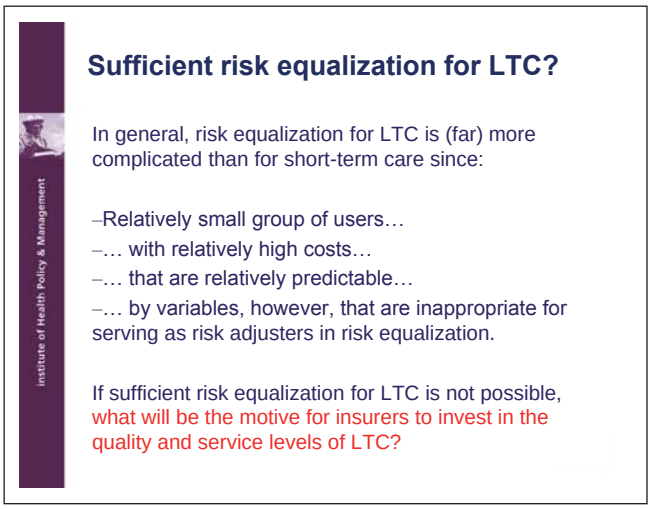
[slide 017]

Then, the most important question for this conference is can the managed competition be successful for long-term care? An important remark, of course, is that all the ten preconditions that were on the previous slides for short-term care also apply for long-term care. All the bottlenecks that we still have with these preconditions for the short-term care also apply for long-term care. So, maybe it would be a good idea to wait with managed competition for long-term care until we fulfilled these preconditions for short-term care.



I think the discussion is even more serious. There are fundamental issues about whether or not managed completion is appropriate for long-term care. There are three important questions, I think. Fundamental questions. One: Is it possible to organize sufficient risk equalization for long-term care? Two: Are users of long-term care able to vote by foot – to choose their own insurance product and health care provider? Three: Are non-users interested in long-term care?

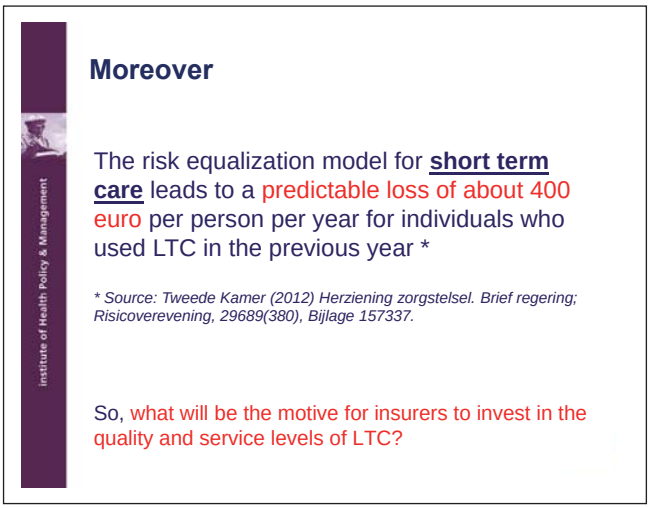
[slide 018]



Let me explain these fundamental issues in more detail. With regard to risk equalization, I showed you that risk equalization is the cornerstone in our managed competition model. If it is not working good enough, then insurers have no incentive to invest in quality of care for people with a chronic disease. For short-term care, this is not working good enough. For long term care, it will be even more difficult to organize a good risk equalization system. The explanation is very simple. When we compare to the short-term care, the group of users of long-term care is relatively small. These people have relatively high, or very high costs. These costs are very predictable for the insurers. So, for instance, when a patient uses long-term care, when a patient is in an institution this year, it is very likely that the patient will be in the institution next year. The insurer can look at the data and know this. The insurers can estimate these relatively high expenses quite well. They can predict them. However, the variables you can use to predict these expenses are not so appropriate for risk equalization. When you include such risk adjusters in risk equalization – this means if somebody in an institution this year, the payment will be higher next year, and if not, the payment will be lower. If you include a risk adjuster like this, then there is an incentive for the insurers to have more people in the institutions. That will increase their payment for later years. This incentive you do not want to introduce in a risk equalization system.

[slide 019]

If we cannot manage to organize sufficient risk equalization for long term care, then what will be the motive for insurers to invest in the quality and service for long term care? This is one of the fundamental issues that we have to deal with. Moreover, this may be related to the decision that the Dutch government made two weeks ago. In our evaluation we calculated that people who use long-term care this year are under-compensated for short-term care next year.



What will be the motive for insurers to invest in the quality and service level of long-term care?

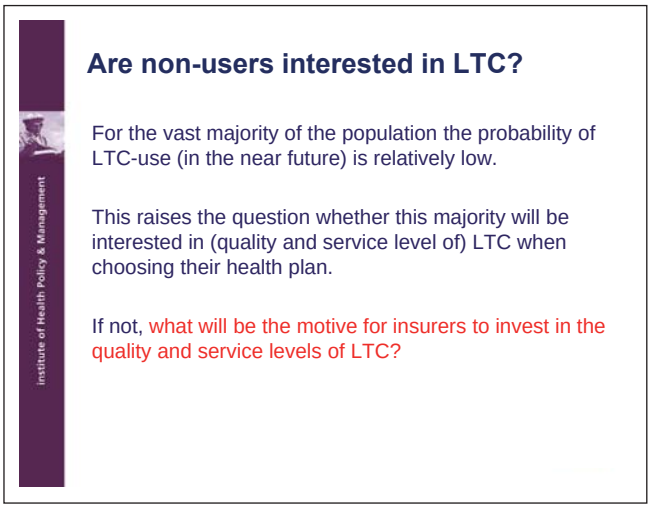
I think there aren't very many politicians or policy makers who really understood this point. If they did, I doubt they would have decided to have home care transferred to the short-term care, managed competition scheme by 2015.

[slide 020]

Another fundamental question is whether the users of long term care can vote by feet? This is an important precondition for managed completion. If insurers do not do what is best for their clients, then the clients should be able to switch insurer. If your insurer is not doing well, then you go to another insurer. That provides the insurer with incentives to do what is best for the patients. However, when we look at the patients that use long-term care, you can ask the question whether these people are able to make choices between insurance contracts and health care providers. For instance, how about patients suffering from dementia or drug addiction? Or psychiatric disease? I think these people are not so likely to make well-considered choices when it comes to health care products and health insurance products. So, if they cannot make choices, at least themselves, then what will be the motive of the insurer to invest in the quality of the service? This is another fundamental issue I think.

[slide 021]

The third issue is that the majority of the population does not use long-term care. It is a relatively small part of the population who uses it. The people who do not use long term care, like young people, also expect not to use it in the near future. If the majority of the population is not interested in long-term care, what will be the motive for the insurers to invest in the quality and service for long-term care? As an insurer, it is most likely that you will invest in the things that your potential clients are interested in. These are three fundamental issues that I do not have the answer to. I think it is very doubtful that all these questions will be answered with a "yes."



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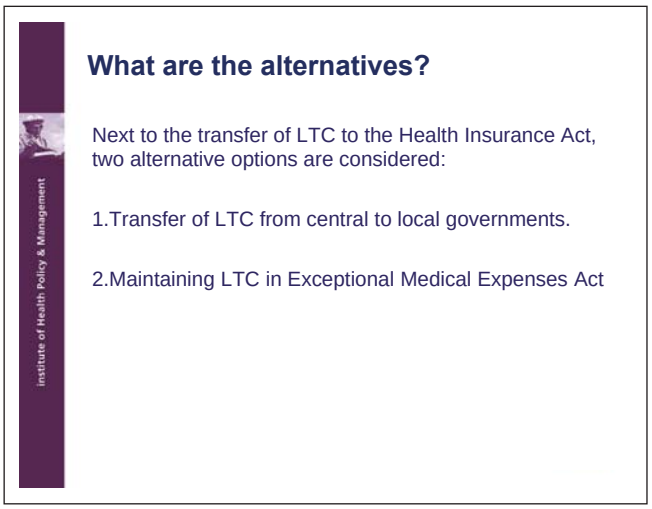


So, what are the alternatives? If we conclude one day in the Netherlands that managed competition is not a good model for long-term care, than what should we do? I think there are two options under consideration? The first is to transfer long-term care, or parts of long-term care from the central to local government. The second is to maintain the long-term care like it is now – in this Exceptional Medical Expenses Act, in this public scheme that we already have.

[slide 023]

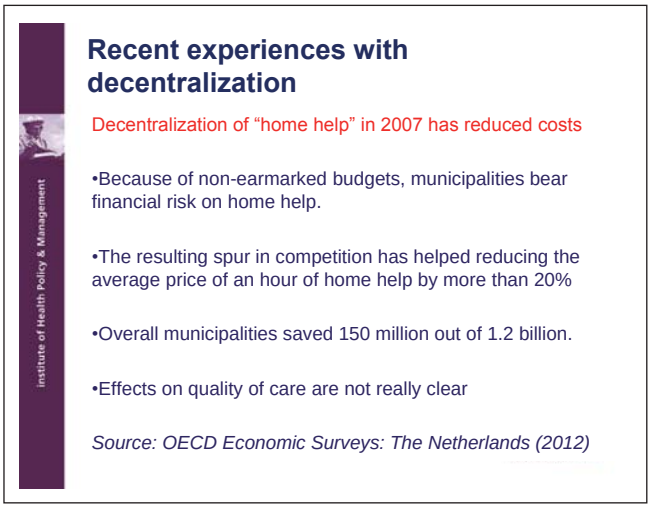
What does it mean to transfer long-term care to the local government? It means that the local government becomes responsible for organizing long-term care. It has some advantages compared to, for instance, the managed competition option, which are that the integration with other local services will be easier. There will be no risk selection problems, which is a very important advantage. In addition, voting by foot will not be necessary for long-term care patients – instead there will be a democratic process, which will put some pressure on the local government to have good quality of long-term care. Also, I am only

presenting a couple of advantages, and a couple of disadvantages, but I am sure that you will come up with more.

The disadvantages are that integration with short-term care will be more difficult. So, for instance, if we put together the insurance for the short term care and long term care, there are great possibilities for integration and coordination. But when we keep the two separate schemes, short-term care for insurers and long-term care for local governments, then you will still keep these problems with integration and coordination. Another risk is that there can be potential differences in quality and service between regions – between the municipalities. And there will be less freedom of choice for patients. So, if the long term care in your municipality is very poor then you can move to another area. But we all know that life is often not as flexible as that. Another factor is that you still need risk equalization, albeit for another purpose – to divide the budget for long-term care across the municipalities. And the municipalities, of course, must be equipped for this new task. It is very different from things that they are doing now. They have to specialize in long-term care – maybe they can use the model from Finland! That would be nice. But at least they have to make investments in order to execute the system.

[slide 024]

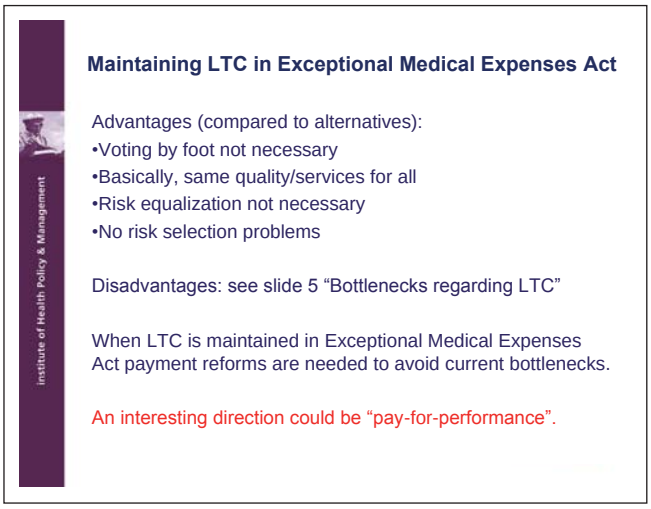
It is a very realistic option, I think, that the entire long-term care will not be transferred to local government, but parts will be transferred. In fact, in 2007, a part of the long-term care was already transferred to local governments. It was home help. So not home care, but home help – assistance that people receive within their home. For example, with making coffee or showering. The results were very appealing. This is how it works. The municipality receives a non-earmark budget for the long-term care, which means that if they succeed in not using the entire budget, then they can spend the remaining part on other things. So, in fact, they have financial risk. If they exceed the budget, then they have a problem.



This resulted in competition. Within the municipalities, the pressure to look at the cost, and purchase the care efficiently were taken into account. What we saw was that the average price for an hour of home help decreased by more than 20%, compared to the system that we had before. So, this option can really lead to cost reduction. Overall, the municipalities saved 150 million out of 1.2 billion. However, the effects on quality were not so clear. Also, this option can lead to cost reduction at least. The other option, maintaining the situation as it is, also has some advantages. Voting by foot is not necessary. We have the same quality and service for all. Risk equalization is not necessary, and there are no risk selection problems. So we will avoid all the problems that we will have with the managed competition. However, we will have the disadvantages that I presented already, on slide 5. It is obvious that we have to make serious tradeoffs when we talk about long-term care.

[slide 025]

What we should do at least, if we keep the situation as it is, is to implement supplementary measures to tackle these bottlenecks. One concept that is also part of the debate in the Netherlands is that maybe we should have some form of pay-for-performance. We all know, after the presentation by Professor Smith, that pay-for-performance cannot be realized from one day to another. You must invest, and then maybe it will work in five to ten years – or even longer.



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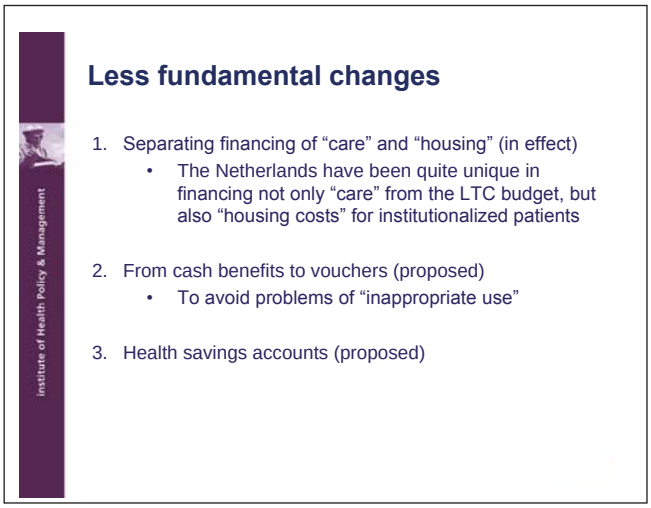


This is the fundamental question: Who should be the purchaser of care? At the same, we have some less fundamental changes which are important for this discussion. They are that we now try to separate the accommodation cost and the cost for healthcare in our system. I think the reason that there is a relatively large share of people in institutions is that the cost used to be financed from the long-term care budget, which gives incentives to go into the institution. But now, we are trying to turn this by separating the two. Another point is that it has been proposed to move from cash benefits to vouchers because there are serious problems with inappropriate use of cash benefits. Many people receive cash benefits, who are in fact really in need for long-term care. And health savings accounts are also proposed. Let's skip this point for the discussion, and let's go to the conclusion.

[slide 027]

Here are some lessons from the debate we are having in the Netherlands. All questions are still open. They also have to be answered in the Netherlands. We are in the middle of this debate, so I cannot give you answers to the questions they have raised. I can only give you the questions. For short term care, managed competition has reduced the growth in health care costs. That is an observation that we can make. But it is not yet effective in proving the quality of care. So, our public objective with the managed competition is to do both – to reduce cost as much as possible, and to improve quality as much as possible. It is working on one aspect, but not on the other, which is quite serious I think. In 10 years, if nothing changes, we may end up in a system that, from an international perspective, has very low costs but also low quality. And that is not what we want. This is because there are crucial preconditions for managed competition that have not been fulfilled yet, so we have to do some work on risk equalization and quality indicators. We think that fulfillment of these preconditions are much more complex for the long term care. Therefore, the question is whether we should go in this direction. My personal opinion is that it is a great risk if we do this – at least at this time. We should wait a couple of years, and see how managed competition evolves with regard to the short-term care system.

However, the alternatives are also not without disadvantages. When I made the presentation, I thought that the key question we are having now in the Netherlands is that "Who should be the purchaser of care, and under what conditions?"

Let me be clear when I talk about managed competition. In the Dutch model, we have the insurer who is the purchaser of care – who has the financial risk and is competing. These points, these conclusions apply to all schemes in which the purchaser of care is competing and bears financial risk, so not necessarily just the insurer, but it could also be another party.

I think that is my presentation. I hope I have finished in time.

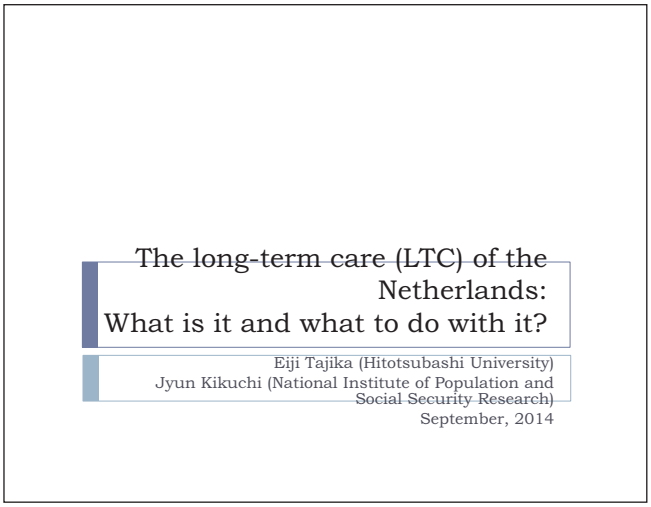
Session 3, Discussion:

The long-term care (LTC) of the Netherlands: What is it and what to do with it?

Hitotsubashi University Professor Eiji Tajika

[slide 001]

Thank you chairman for introducing me. Thank you Professor van Kleef for a comprehensive discussion for both managed competition and long-term care. In fact, a couple of years ago, we invited Professor van Kleef to a seminar where we discussed the proper mix of private and public insurance. But discussion there was mostly on short-term healthcare insurance. So, we are very pleased to discuss long-term care. Moreover, his reference to the recent developments, namely the reduction of health care costs, is very interesting too.



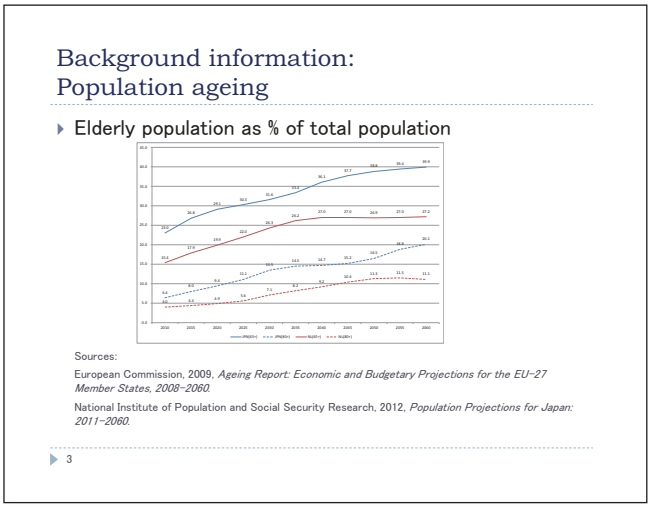
[slide 002]

The purpose of my comment is to know better about the Dutch long-term care insurance, about which we know very little. I think we already have had three presentations and two comments, and people are very frustrated with being silent, the second object of my purpose is to make my presentation as short as possible!

As I said, my intention is to know better about long-term healthcare insurance. And I would like to draw some ideas of reform of Japanese long-term care insurance. Let me go this way. What is the long-term care of the Netherlands – what are the problems, and what to do with long-term care. The Netherlands is starting their long-term care reforms in 2015, so I think this topic is very hot.

[slide 003]

As I said, my goal is to squeeze time for people here, so let me go very swiftly. Just for some background information about ageing. This tells you what share of the population is aged 65 or above. This is Japan, and this is the Netherlands. This is 80 or above in Japan and the Netherlands. I don't have much to say about it other than in Netherlands it something like 1 in every 13, 14 people on the street will be above this 65 years old, whereas in Japan it is 1 in every 4 people. The Netherlands is a much younger nation, and according to this the population of people over age 65 is about 18% of the total.



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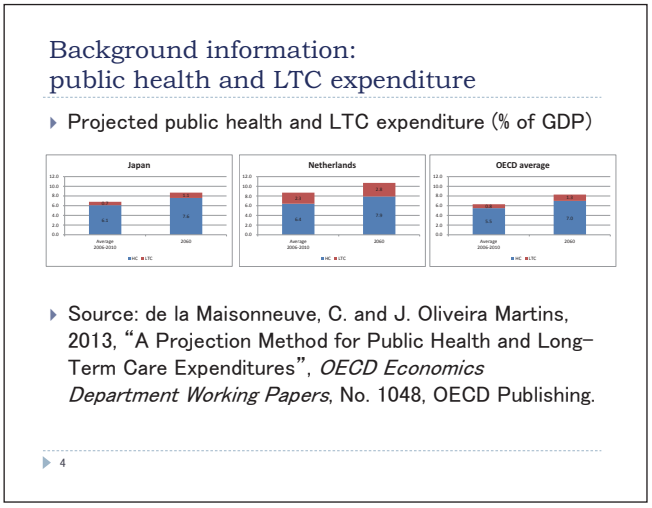
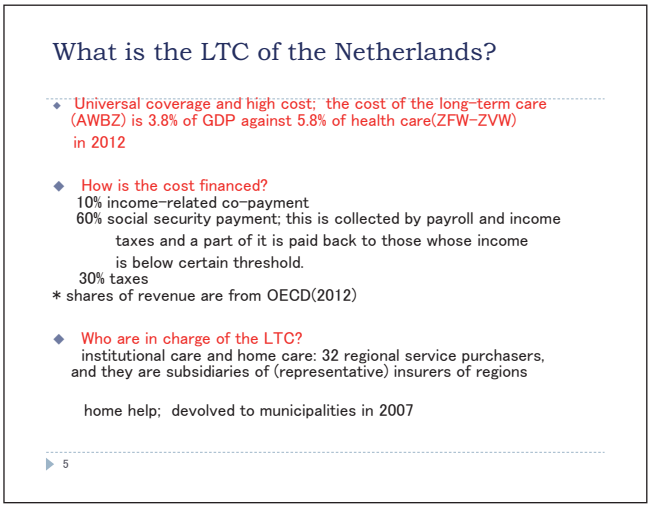


This is another background point to mention, public health and long-term care expenditures. Japanese spendings are small, and Professor Ii discussed it in her presentation, so I shouldn't say much about it. But my understanding is that Japanese health and long-term care expenditures is about 8%-10% of GDP. Whereas, in the Netherlands, it is much higher. I will talk about it later, but one point to mention is that the portion of long-term care in the Netherlands' total healthcare cost is very high. We have been wondering why this is the case.

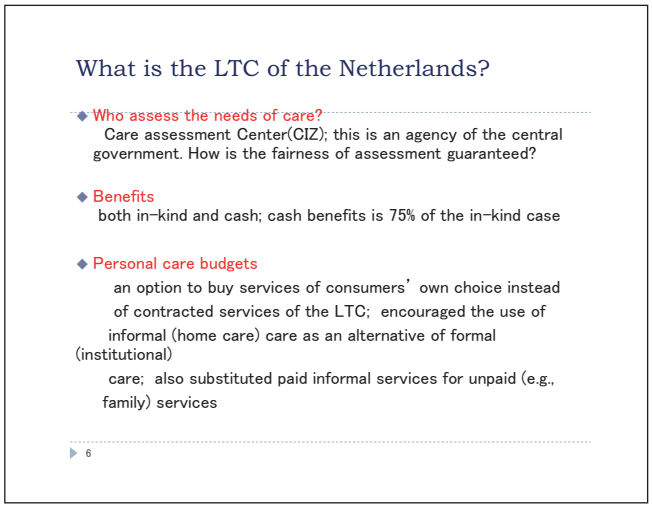
[slide 005]

We have received Professor van Kleef's description of the system in the Netherlands, but now I will give my interpretation or understanding of the things going on there. The long-term care of the Netherlands is universal, and this is different from Japan. Japanese long-term care is primarily for the care of people over age 65. The cost of long-term care – they call it exceptional care in the Netherlands, is that according to my data, the percentage with regards to GDP is 3.8%, but Professor van Kleef told us this is 5%, and the short-term care is 6.5%. Also, how is the cost financed? 10% of it is an income-related co-payment. 60% is social security payment. And remaining 30% is collected through taxes. These numbers were taken from the references.



[slide 006]

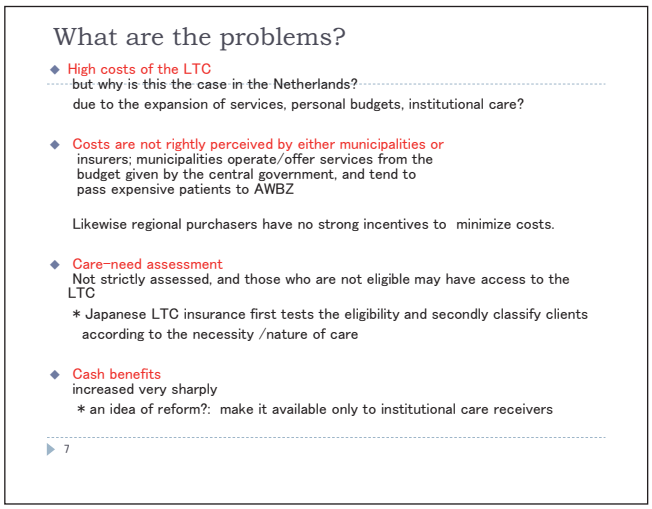
As was mentioned in a previous speech, home help is an issue as well. Who assesses the need for care? Has an agency been set up – an agency of the central government – and how is the fairness of assessment guaranteed?



In terms of benefits, when comparing both in-kind and cash benefits, cash benefits account for 75% of the in-kind case. We would like to know a bit more about this. Professor van Kleef said "minor changes," but I have some doubts about that, especially as a fiscal economist.

In terms of personal care budgets – consumers have an option to buy services of their own choice, instead of contracted service of the LTC. The idea is that let's consume with more individual freedom. This personal care budget should encourage the use of informal care.

[slide 007]

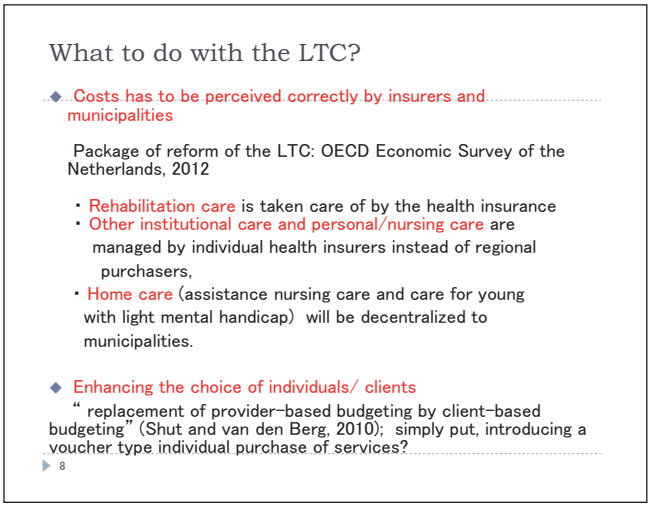


If I have money, and I can spend it on my own long-term care use, that would mean that instead of asking my wife or relatives to take care of me, I will ask a professional care worker to work for me. So, this personal care budget will substitute paid services for unpaid services. I would like to know about personal care budget. Professor van Kleef enumerated a lot of the problems already. I asked this question already, why is this the case in the Netherlands? Professor van Kleef said that costs are likely not perceived by either municipalities or insurers. This is interesting. The municipalities operate – or offer services from the budget given them by the government, so what they tend to do is to pass expensive patients to AWBZ.

In terms of care-need assessment, we need to know more about it. It is not strictly assessed, which means that those who are not eligible may have access to long-term care. Most of the audience here is Japanese, so I don't have to say it, but the Japanese long-term care insurance first tests eligibility, and secondly necessity. In a sense, as far as I know, Japanese care assessment is not really the point of discussion today. I would like to know better about the system in the Netherlands.

In Japan, we do not have cash benefits. It increased very sharply in the Netherlands. This is also an element that we don't have in Japan, and what sort of implication will this have on the way it we follow the long-term care of the Netherlands.

[slide 008]



Now, I will get into the major question – what to do with the long-term care. We have discussed something that seems to me to come from two parts. The first part is that cost has to be perceived correctly by insurers and municipalities. And, in another example, it must enhance the choice of the individual and the client. This is a major part of the reform. I do not know much about the reform package, and frankly neither about the ongoing reform. However, the OECD survey says that rehabilitation is taken out of the AWBZ, and taken care of by health insurance. Other institutional care and personal nursing care are managed by individual health insurers instead of regional purchasers. What does this mean? Are these are taken out of AWBZ, and put into the short-term care insurance? Is that what is going on there?

Professor Richard van Kleef: This is about the home care.

Mr. Eiji Tajika: So you want to introduce risk adjustment there?

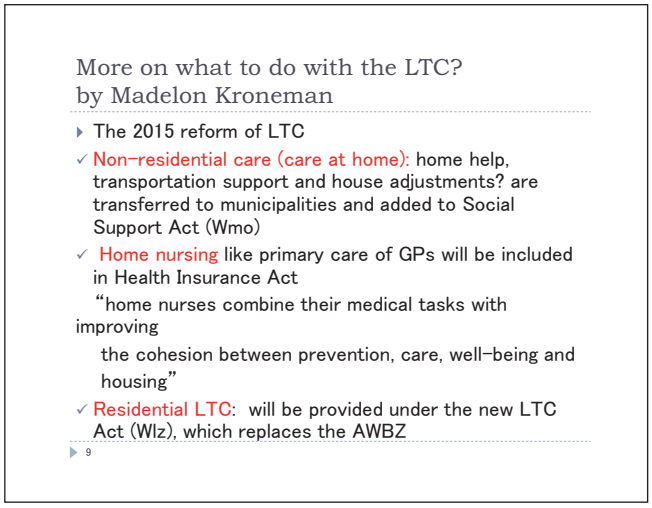
Professor Richard van Kleef: Yes.

Mr. Eiji Tajika: This part is taken out of the AWBZ. Is it being discussed whether and how to introduce risk adjustment to this part of the long-term care?

Professor Richard van Kleef: What is important to know is that this publication is from 2012, and a lot has changed in the last two years.

[slide 009]

According to the 2015 reform, residential care – care homes, home help, transportation support and house adjustment – are transferred to the municipalities, and added to social supporters. As we said a moment ago, home nursing, like primary care, general practitioners, will be included in the health care act. Here is the important statement: Home nurses combine their medical tasks with improving the correlation between prevention, care, well-being, and housing. So, home nurses play the principal role.



Residential long-term care will be provided under the new long-term care, which replaces AWBZ.

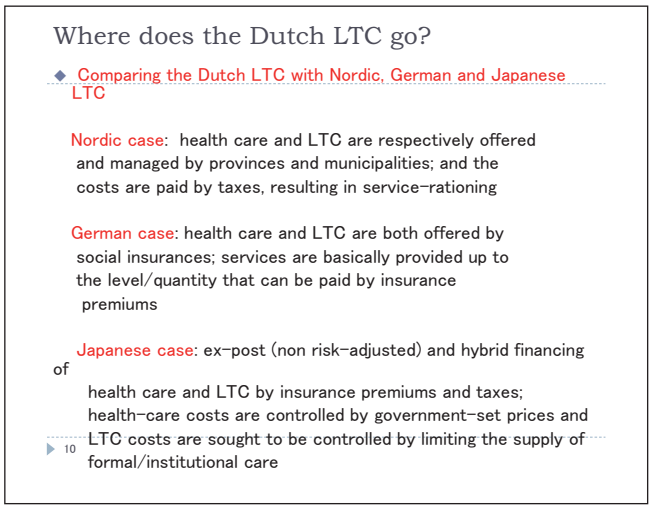
Professor Richard van Kleef: Yes. I did not mentioned the change of the name of the AWBZ. Basically, all things that remain in the AWBZ will remain in the new long-term care.

Mr. Eiji Tajika: But they have already given us a fancy name!

Prof. Richard van Kleef: That's right.

Mr. Eiji Tajika: The second one, and I want to know more about, is the enhancement of the choice of individuals and clients. And, re-placement of provider base to client-based budgeting. It is something we are discussing, and I would like to know more about it. This is our reading of the reform. I have a question. Where does the Dutch long-term care go from here?

[slide 010]



After all the discussions – where do you want to go from here? The Nordic case seems to be something like this. Health care, long-term care is respectively offered and managed by provinces and municipalities. And the cost is paid by taxes. That is why Professor Lillrank came to us and offered us management organization that is somewhere between the government and the consumers.

In the German case, health-care and long-term care are both funded by social insurances. Services are basically provided by insurance premiums. In German long-term care insurance, it is not fully compensated. From the beginning, it is partial compensation. Long-term care is 100% managed by the premium, which dictates the service patients receive.

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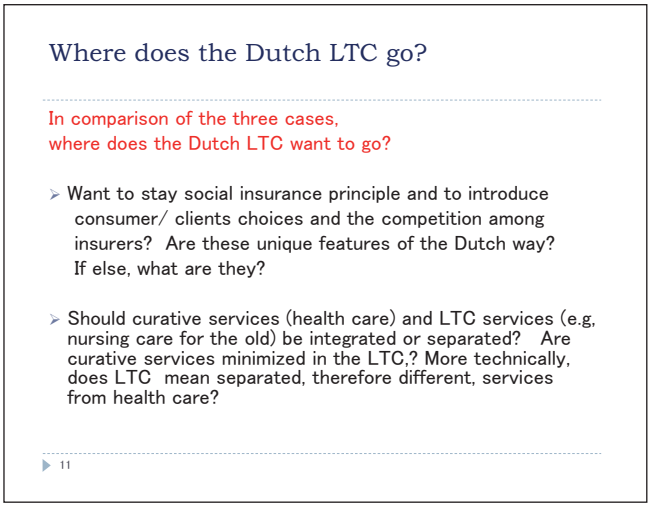
service patients receive.

In the Japanese case, premium and taxes are mixed, and costs are paid retrospectively. And the long-term care costs are sought to be controlled by limiting the supply of formal institutional care.

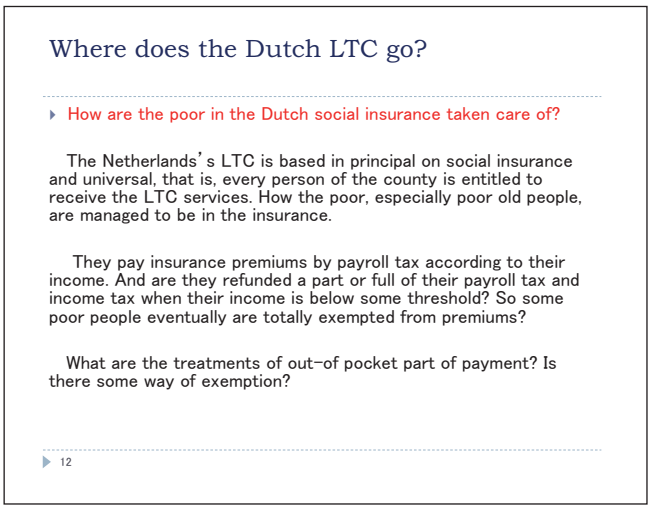
[slide 011]

In a comparison of the three cases, where does the Dutch LTC go? Do you want to stay with the social insurance principle, and to introduce consumer/client choices and competition among insurers? Is this the unique feature of the Dutch method? Or, if it is something else, what is it?



Should curative services, like health care, and long-term care services, like nursing care for the elderly, be integrated or separated? Are curative services minimized with the long-term care? Or, more technically, does long-term care mean separate, therefore different, services from health care? It may sound off-point to you, we would be very happy if you said something about this.

[slide 012]



Finally, how are the poor in the Dutch social insurance taken care of? In the Netherlands, long-term care is based in principle on social insurance, and that means that every person in the country is entitled to receive long-term care services. Then, what about the poor? Especially, how are they managed within the insurance system? We have lots of discussions, and maybe half of our long-term care discussions is what to do about poor elderly people. In Japan, people over 65 years old pay their premiums for long-term care insurance. However, nowadays there are brackets. The difference between the bottom bracket and the highest bracket is maybe three times or more. This is the way we take care of the old in Japan. How is it in the Netherlands? Are the premiums paid by payroll taxes refunded to the poor old people?

What is the treatment of out-of-pocket payment? This again is an issue we Japanese are discussing very much. Is there any financial support to this portion of payment?

Thank you very much.

Open Discussion

Prof. Hiroyuki Kawaguchi: It is time to move to the open discussion. So, there are some members who have attended this conference but have not presented. Mr. Ogata, if you have any questions or comments about the presentation please do so.

Prof. Hiroya Ogata: Thank you. So I corrected the questionnaire paper before, so could you answer the question. First, Professor Smith, I think there is the paper. Can I?

Prof. Peter Smith: So the question, which is anonymous, is, "Is there any data on variations of quality and outcome among GP doctors?" And the fact is that the data are there. They do exist. Certainly on all of those 150 indicators they are made available and in principle a concerned patient could look on the website to see how a doctor is doing. The issue that I think needs more attention is that most of these indicators are easier to achieve if you have a young, healthy, wealthy population. And there is no adjustment made for that. So doctors who are working in difficult environments will appear to be worse. So I think that's the area that needs some attention. There is an adjustment made in the payment for that because the doctors can exclude certain patients from their calculations if they are difficult patients and will not comply. But in the data that ordinary citizens can see that adjustment is not made. So I think there is an issue about making these data more transparent and more comparable between practices, but they are certainly there. They are not easy to find, but if you are really determined you can look for all of those data publicly.

Prof. Hiroyuki Kawaguchi: Thank you very much. Do you have any additional questions?

Prof. Paul Lillrank: Is more professional integration needed? "Yhteyshenkilö sairaanhoitaja" in Finnish means "contact nurse" or the person who interacts directly with the patient. The discussion in Finland among professionals and policy makers has been focused on the integration of the care plan level and that's exactly what the Kotitori model seek to help out with. The problem in general is that elderly people who have two or more medical problems are treated by two or more different service providers and there is no formal mechanisms for how the different perspectives like somatic, mental, economic, housing etc. issues should be put together in a comprehensive and integrated care plan. I think that's perhaps the

biggest problem that needs to be addressed. When that has been done, then we have the coordination problems. If you have a different specialized service provider, for example, three or four different people who comes to an old person's home, then there obviously needs to be scheduling and some consideration of what is the proper order in which these people come, and in which days and in what times of the day. That is the daily management of the service system.

Prof. Hiroyuki Kawaguchi: Thank you. Any answers or an additional question?

Prof. Michiko Moriyama: But also to him too. You can start.

Prof. Paul Lillrank: The question is "in integrated community care system, which factors did contribute to less moves from home to institutional care?" I don't have exact case-based data on that, but this idea comes from Sweden. There's a municipal called Nacka south of Stockholm that started an incentive system for home care based on the number of incidents. If an old person who lives at home and gets home care slips on the floor and breaks a bone or gets some other emergency situation that requires then a trip to the emergency clinic with an ambulance, that is recorded as an incident. The assumption is that if the home care service is well managed, the number of incidents will go down. The idea is that the home service person should take an overall look at the housing and where there are risks, such as slippery mats, they should use common sense and try to eliminate those risk factors. This provides an incentive to the home care person to do preventive risk management. How it's down at the detail level, I don't know. Perhaps they get some instructions of what are the typical risks that happen in the home. But this creates an incentive to look at the whole picture.

Prof. Michiko Moriyama: I think to add on this, in Japan people do not believe they can stay at home until the end of their life.They believe they have to go to a hospital and be taken care of. So we need to educate people first, and then increase the advanced directive levels. Also we have to reduce the medical care level at end of life stage, onto home health nurses. In Japan, because our service is segmented, home help service providers provide food and bathing stuff, and then home health nurses just provide medical care. Then they just believe that they need to provide very high level of medical care until the end. It is not that way. So we have to make in-between-professions, between a nurse and a home helpers like Holland, Germany and other countries. They have that level of nurses. So we have to provide the combined care. They can provide nursing care-in the morning and night time. In this way older people can stay at home.

Prof. Hiroyuki Kawaguchi: Professor van Kleef, would you like to answer your questionnaire?

Prof. Richard van Kleef: Yes, thank you. First of all I would like to thank Professor Tajika and Kikuchi for all the questions. So I have a lot of homework. The first question is, "Are there any needs from family who care for elderly persons for a long time?" If LTC is not, the young generation has to quit their job to care for their families. I agree. This is also in the Netherlands, like in Japan, a very serious issue where we have to think about the human resources. In fact, the main idea or purpose of our cash benefit was to give the people the opportunity to reward the informal caregiver. So if you receive the cash benefit you have the information to just keep your informal caregiver and to pay him for that. So that was the motivation but in practice it worked not very well. Well maybe it did, but there was a very serious disadvantage and that was fraud. It was targeted in a wrong way. Like there are examples where people took their mother to a jazz festival from the money of the cash benefit, so that was of course not the purpose. So that was again the reason why we abolished it.

But I think we should reintroduce it in order to stimulate the informal care, but to have better screening of the use of this cash benefit and maybe we should even go further.

Like in Germany, there is also some sort of cash benefit. But next to the cash benefit the long term care budget also pays for the informal caregiver's social security, premiums, and so on. So that's one step further in order to stimulate the informal caregiving and I think that's a very interesting option also for the Netherlands and also for other countries. So maybe we should look at Germany.

Then another question was, "Explain about the financing of housing costs for the institutionalized patients." I think this strongly relates to one of the many questions by the professor next to me. How does it work? I think the Netherlands was the first country in the world that introduced a social insurance for long term care. It was 1968, and it was really generous. It also included the housing and accommodation cost and once you include accommodation cost in a social insurance scheme it's very hard to put it out because people are familiar to the situation. So in fact the situation was, until a couple of years ago, that the housing cost, accommodation cost, were fully financed by the long-term care budget and that's also the reason like I told you that we have relatively many patients in an institution compared to the patients that receive home care. But since a couple of years we tried to separate these two by increasing the copayments for the accommodation costs. I think the goal of the current government is to fully separate the two, but to have compensations for the poor people who cannot afford the accommodation cost. So we come from full reimbursement and we go to no reimbursement with subsidies for the low income people. I hope that's an adequate answer to the question.

Prof. Hiroyuki Kawaguchi: Is there any other questions from the floor? OK, we have another time. Then, we'd like to go back to the presentations. Prof. Smith, could you reflect your question?

Prof. Peter Smith: Well I've certainly noted down the questions. Whether they are the ones you intended me to answer, I'm not sure. But thank you very much Professor Ii, for your very insightful summary and comment on the paper.

So the first question was about the registration of patients and who they are registered with. Whether it's with the physician or a clinic. In fact in the UK, you register with a practice and practices are getting increasingly large, but they will typically be about five family practitioners operating together. You will be attached to one of the doctors there, but the doctors are only the partners and the practice will often have a lot of part-time people working for them or what are called "locums." So it's really the practice which is the key center and that is really like a clinic I guess. It's getting closer and closer to being a clinic. One factor I just wanted to make clear, which Prof. Ii mentioned is that things have changed since my slides. I'm afraid the changes are too great for me to fully understand, but the principles have remained unchanged. One thing that has changed though, is that the responsibility for doing the QOF has been given to our health technology organization. It's called NICE – the National Institute for Health and Care Excellence.

NICE was originally responsible for doing health technology assessments for recommending whether treatments and pharmaceuticals should be included in the benefits package. But they are now responsible for almost all aspects of guidelines and good practice, and also creating the QOF. And so they've made some major changes. The structure of the QOF hasn't changed but they are trying to make it increasingly evidence based, so they do huge reviews of the literature.

Their guidance is freely available on the web and actually I think it's a global, public good that other countries could benefit from, but also contribute to.

There was some mention by Professor Ii of defensive medicine and the risk of evidence or guidelines leading to defensive medicine over treatment. Actually I think the role of NICE in the UK is to reduce the practice of defensive medicine because they try to reduce the ambiguity. The challenge to doctors as I understand it, particularly in the United States, is that they may be concerned about what constiutes "best practice". What NICE tries to do in the standard guidelines is make it less of a concern for doctors as long as they follow the NICE guidelines they should avoid legal challenge. So I think in fact the standardization of guidelines is actually helpful in reducing the risk of defensive medicine. OK, so those are the only points I picked up.

Prof. Masako Ii: For the fund holdings, participation of GP was voluntary, but later it became mandatory.

Prof. Peter Smith: Although fundholding was abolished as I said in 1998, it was reintroduced in a different form in the early 2000, partially because our evidence showed that it had been successful in constraining costs, one of the few examples of knowing that our work has any impact whatsoever. But, like so frequently, the policy makers decided they thought it was so good they should make it compulsory and that actually I think was a catastrophic mistake because doctors are very entrepreneurial and enthusiastic but only if it's something they want to do, not if they're being told what to do. So I think that apparently small change made a really big difference to its effectiveness and it had very feeble effectiveness when it was reintroduced. That for me is a real lesson for policy makers everywhere, which is to look very carefully at evidence and not just to say pay for the performance works or pay for performance doesn't work, and so adopt policies on those principles. It is to adapt evidence from elsewhere and really carefully make. This is why the Dutch experience with preconditions is so useful because it tells us the conditions under which that policy would be successful.

Prof. Hiroyuki Kawaguchi: What do you think, Professor Moriyama?

Prof. Michiko Moriyama: Yes. Again the same question to you. In Japan the government sets the price, so there are no incentives for the cost. So how does it work in your country?

Prof. Paul Lillrank: We don't have price regulation. Services are funded from national and local taxes with some out-of-pocket payments. All tax final systems have the problem of overutilization of a free or subsidized service. Therefore there must be a gate-keeping-mechanism to reduce excess consumption. At times some people do not get the care they think they need, which leads to public anger against the gatekeepers who are perceived to restrict the right to service. Since there are no insurance companies involved, the gate-keeping task falls to the medical professions.

Prof. Michiko Moriyama: OK so the municipalities are outsourced the case management – ask case management to private organizations, and then they set the price, means competition exists?

Prof Paul Lillrank: The service providers have contracts with the city, that determine both the price and the service level agreements. In theory, providers can't cheat on quality, but if they can improve efficiency in other ways they of course can keep the difference, so they have a profit motive to improve. The city production doesn't have that element. Consequently the productivity and capacity utilization of the city production is lower than of private producers.

Prof. Hiroyuki Kawaguchi: About the long-term care cost, there is so many questions from the floor. Could you please pick up one or two questions?

Prof. Eiji Tajika: He knows it.

Prof. Richard van Kleef: No, please let's not do that. I think that the most important question was on the taxes. Is that right? OK let me answer two questions. The first is about the taxes. Well I have to admit that I do not know the complete details. But in general the system works like this. We have an income related contribution for the long-term care. So the contribution of the people depends on their income. Nobody in the Netherlands has no income. So if you have no work there are all kinds of security allowances and even if you have a security allowance, the government says, OK, that is your income and you should pay 9% or 10% of your income on healthcare. What happens with the very poor people? So they have this income related contribution also, but they are compensated in a separate scheme for out-of-pocket expenses, for instance due to accommodation. That is a very short and quick answer. But I am sure you want to know the details, and when I am back in the Netherlands I will look this up for you and send them to you.

The other question – which direction do we want to go? It's a very interesting question but I cannot give an answer. But I can give an advice to the Dutch government, which is if there are three ways to go, to have the long-term care, going to the insurers, to the municipalities, or do nothing and just keep up with the current situation, I think the best way to go is to use this list of preconditions that I presented for the competition model and to make also a list of preconditions for the model with the local governments and maybe also for the current situation, and then you know what the preconditions are that need to be fulfilled to make these three models work. Then you can test for the long-term care that is still in the long-term care package, whether or to what extent these preconditions are fulfilled, and if you have to make a choice maybe choose the model for which the preconditions are fulfilled to the largest extent.

That's one thing. My second advice would be not to do this exercise for long-term care in total, because we always discuss what to do with long-term care, but when we look into the package of long-term care there is much variation. There are so many differences between different types of long-term care. So a lot of variation. This also means that if different types of long-term care have different characteristics then you should also do this exercise "to what extent are the preconditions fulfilled" not for long-term care in general, but separately for all different types of long-term care that are in the package. So that would be my advice. Just do this exercise and then decide what to do. OK.

Prof. Hiroyuki Kawaguchi: Are there any other questions? We have some time to answer the questions.

Prof. Hideki Hashimoto: Very quick question. The outcome evaluation – because in terms of the healthcare systems the outcome evaluations are tricky but still possible by the risk adjustment and other kind of stuff. But for the long term adjustment systems, it's kind of much more tricky and complicated because even though you have the best quality of care, but still it's only just slow the decline of the functions. So we need to know what is the projected counterfactual change in the function and compared to that, to make the evaluation of the systems. So this is really technically and academically challenging, so what is the use of the outcome evaluation in the long-term care?

Prof. Peter Smith: We've had some experiments in England with patient reported outcome measures, which asked patients very simple questions about their well-being. So there are five questions about their level of mobility, their anxiety, their pain and so on. But in aggregate these measures are quite reasonable indicators of first of all the quality of life before any intervention and then tracking what happens after an intervention. So these have been tried in the acute sector with before and after knee replacement, hip replacement, and hernia repair.

Prof. Hideki Hashimoto: I think that is quite reasonable for the acute care, but for the long-term?

Prof. Peter Smith: There are now experiments going on with applying that to chronic care. So this would track over time, what happens to citizens with long-term conditions. Now this was expected to be introduced two years ago and so I don't know why it hasn't been and there may be some technical issues, because of what you say, because it's more difficult than we think. But my feeling is that is really the only way in the long-term we can go to have some good measurement instruments routinely applied to actually try and track changes, so that will help us track the quality of certain providers, it will help us also track different institutional arrangements to see whether for certain types of patients different types of care are better than other types. So I think there's a lot of promise there, but its early days.

Prof. Hideki Hashimoto: Yes, and Prof. Lillrank?

Prof. Paul Lillrank: Outcome based incentive systems are problematic. The medical status of a person can be measured at any point of time. New technologies make that easier and cheaper. My colleagues in medical device research believe that within ten years we will have a universal diagnostics machine: you can just walk through a scanner and it says exactly what your situation is. The technicalities are solvable. The problem is that if you measure outputs and you give incentives from performing procedures, then service providers have the incentive to maximize production volumes rather than health outcomes. This is a problem particularly in long-term care where there are rather complex life situations.

Output-based systems require a theory that would make it possible to predict what each person in each situation really needs. We don't have that theory and I don't believe it can ever be made because people are different and situations vary. That's why the logic of outcome based system is that the preferred outcomes are given on a general level, but not the exact procedures that are required to achieve those outcomes. In the example of reducing ambulance traffic for the elderly, the idea is that caregivers are rewarded for keeping their customers in good shape and see that nothing bad happens. What needs to be done in particular situations is left for the caregivers to decide. Outcome based incentive systems need to include a decentralization of decision making to lowest possible level.

Prof. Hiroyuki Kawaguchi: Any other comments?

Prof. Richard van Kleef: Also an important issue for the Netherlands I think is that there is a major risk if you have good information on cost and hardly any information on quality. We are discussing very important questions now for our future. Real system changes. And if you change a system, and you will only learn about the cost, and the outcome will be that the cost will be lower or the growth in cost will be lower, and you have no information on quality, then you may be too positive on the outcome. So my advice would be not only to the Netherlands but to any country in the world – start reporting quality in a good way. Even if you do not want to have pay for performance or outcome based payments, but also for future changes of the healthcare system you need that information in order to judge whether you should change your system and what the outcome of the system change will be. You can not only focus on the cost. That is too risky.

Prof. Hideki Hashimoto: Thank you.

Prof. Hiroyuki Kawaguchi: Thank you very much for the very interesting discussion, but unfortunately we are running out of time. So I would like to finish all the schedule of this symposium by thanking all the participants and I also thank the people who worked for this symposium from the JTB and the Kawaguchi-Seminar. I hope this symposium will be helpful for everyone who contributes to policy making. Thank you very much.

[END]

Managing Integration of Long Term Care for Elderly and Policy Implication

高齢者医療・介護統合モデルの構築と政策への適用

発行日　2015年3月31日
発　行　学校法人成城学園
〒157-8511 世田谷区成城6-1-20
TEL：03-3482-1092
FAX：03-3482-1489
http://www.seijogakuen.ed.jp/