Health & Medicine | Mikiya Sato

Japanese government incentive scheme relieves strain on health services providing end-of-life care

Humans currently have the longest life expectancy of any time in our history. This is due to a complex array of factors including the introduction of childhood immunisations, improved sanitation, advancements in medical knowledge and improved social and healthcare practices. By 2030, one in six people in the world will be over 60 years of age. Following this trajectory, by 2050 the number of people aged 80 years or over is expected to triple, reaching around 426 million. When a person reaches the age of 65, statistics indicate they can expect to spend an average of 50% of their remaining life in good health. However, the likelihood of experiencing multiple chronic health problems or becoming disabled increases with age. In the UK, The Health Survey shows that in 2016, almost 50% of people aged 75 years and over had two or more chronic health conditions, which often require complex treatment from health services. Therefore, countries with an ageing population are experiencing increased demand on their health services.

PALLIATIVE CARE: HOW IS IT DELIVERED?

Japan is home to the largest population of elderly people in the world, with approximately 30% of its citizens aged 60 or over. By 2030, nearly a third of the Japanese population will be aged 65 or over. The fact that Japan’s ageing population harbours an increased number of chronic health problems inevitably causes increased demand on palliative care.

Palliative care refers to health and social care provided for a person who is nearing the end of their life due to a terminal or advanced stage of an illness. Amongst other aspects, this could include pain management, distressing symptom management, assistance with washing or dressing, and providing the patient and their family with support in making medical decisions. In most developed countries, end-of-life care will include a holistic and multi-disciplinary approach from a number of different specialists such as palliative medical consultants, palliative care nurses, specialist occupational therapists and physiotherapists. Depending on the patient’s wishes and other factors such as medical needs and familial support, palliative care may take place at home, in a care home, a hospice or a hospital.

A shift away from staying at home

In recent years, the most common place of death for elderly people in Japan has shifted away from their home and moved instead towards hospitals. In 1960, only 21.9% of people died in hospitals, with 70.7% dying at home, whereas, in 2000, 81% of people died in hospitals, with only 13.9% of people dying at home.

Research has shown this is likely due to a complex mix of factors such as the patient’s belief that better medical care is delivered in a hospital, mixed with the desire to not place the burden of caring for them on loved ones and relatives. This being said, hospital-delivered palliative care is putting a significant strain on Japanese health services, with hospital beds for end-of-life patients in increasingly high demand.

To remedy this, in 2006 the Japanese government started to allocate more resources and financial reimbursement into end-of-life care taking place in nursing homes (or Residential Aged Care [RAC] facilities) and within patients’ homes through the national long-term care insurance (LTCI) programme and the national health insurance programme, in an effort to encourage more people to receive end-of-life care outside of hospitals.

DIFFICULTIES DELIVERING END-OF-LIFE CARE AT HOME

In a 2018 study, data showed that informal care given to elderly patients (65 years and over) by a primary caregiver such as a family member required significantly more minutes of care per day than formal care from long-term care insurance, regardless of gender. This shows that living in the community until the end of life needs much more informal care than in RAC facilities or hospital, and the physical and psychological burden on caregivers is likely higher.

People may want to live at home until the end of life, but caregivers cannot always provide sufficient informal care.

In recent years, there has been a shift away from end-of-life care at home, and a dramatic increase in people who are dying in hospital, which puts a significant strain on health services. Dr Mikiya Sato of the University of Tsukuba, Japan, assesses the effectiveness of a government incentivised long-term care insurance programme (LTCI) in shifting end-of-life care away from hospitals.

The Japanese government started to allocate more resources and financial reimbursement into end-of-life care taking place in nursing homes (or Residential Aged Care [RAC] facilities) and within patients’ homes through the national long-term care insurance (LTCI) programme and the national health insurance programme, in an effort to encourage more people to receive end-of-life care outside of hospitals. In a study published in 2021, Sato and colleagues examined the effect of the governmental incentivisation scheme on the place of death of elderly people receiving long-term care between 2007 and 2013.

EFFECTS OF THE LTCI PROGRAMME ON DEATHS AT HOME

In hospital deaths decreased immediately after the scheme began, with 83.5% of the 923,666 decedents dying in hospital...
in 2007, 4% dying in RAC facilities and 12.5% dying at home. However, by 2013, six years after the incentivisation programme was initiated, hospital deaths had fallen to 7.8%, risen to 8.2% in RAC facilities and home deaths had increased to 13.2%.

In hospital deaths were negatively associated with age, and were found to occur more frequently among men (78.6%) than women (71.3%) and were more frequent in people living in the community (76.6%) than those being cared for in RAC (71.2%) groups.

The decrease in the percentage of in-hospital deaths was higher in the RAC group than in the community group. This could be because when RAC facilities are better financially supported and better equipped to care dying people than caregivers at home, transitions to hospital are less frequently needed around the end of life care at home, in an effort to decrease unnecessary emergency room visits and hospital admissions. However, this has proved to be less successful than the changes made to support end-of-life care at RAC facilities, possibly because the preference of people and informal caregivers for treatment and location of dying remains influential, regardless of how much formal care home-visiting doctors and nurses are able to provide. It remains true that staff in RAC facilities are likely to be better equipped to deliver end-of-life care needs.

The LTCI scheme was seen to be effective in decreasing in-hospital deaths in people aged 65 or over. This was due in part to an improvement in care quality and abundance of RAC facilities, leading to higher levels of effective end-of-life care being delivered by these facilities. The scheme did not have the expected result of significantly increasing deaths at home, possibly due to peoples’ and caregivers’ preference for location of dying. Furthermore, end-of-life care delivered at home was found to be more time-consuming and labour-intensive, which is likely to contribute to the consistently low percentage of people receiving end-of-life care at home.