Transition toward community-based integrated care in Japan: Lessons from “BUURTZORG” as a sustainable community care model

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Changes in Living Arrangements (proportion of 65+)

History of Health and Welfare Policies for the Elderly

<table>
<thead>
<tr>
<th>Time</th>
<th>Rate of the elderly population (%)</th>
<th>Major policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960s</td>
<td></td>
<td>1963 Enactment of the Welfare Law for the Aged</td>
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<td></td>
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<td>Setting up of special nursing homes for the elderly</td>
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<td></td>
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<td>Legislation of home helper system</td>
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<td>1970s</td>
<td>7.1% (1970)</td>
<td>1973 Free medical care for the elderly</td>
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<tr>
<td>1980s</td>
<td>9.1% (1980)</td>
<td>1982 Enactment of the Health and Medical Service Law for the Elderly</td>
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<td></td>
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<td>Introduction of partial payment of medical expenses for the elderly</td>
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<td>1989 Formulation of the Gold Plan (The Ten-Year Strategy to Promote Health Care and Welfare for the Elderly)</td>
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<td></td>
<td></td>
<td>Urgent development of facilities and promotion of in-home welfare</td>
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<td></td>
<td></td>
<td>Improvement of in-home welfare</td>
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<tr>
<td></td>
<td></td>
<td>1996 Policy agreement of three ruling coalition parties</td>
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<tr>
<td></td>
<td></td>
<td>Ruling Parties Agreement as to the establishment of the Long-Term Care Insurance System</td>
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<tr>
<td></td>
<td></td>
<td>1997 Enactment of the Long-Term Care Insurance Act</td>
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<tr>
<td>2000s</td>
<td>17.3% (2000)</td>
<td>2000 Enforcement of the Long-Term Care Insurance Act</td>
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<td></td>
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<td>Partial revision of the same Act</td>
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</table>
Introduction of the LTCIS

- increasing number of the elderly who need long-term care
- prolonged periods of nursing care
- increase in the number of nuclear family
- aging of family members who care for the elderly
- vertically-divided system of health, medical and welfare services

Introduction of the Long-Term Care Insurance System (2000)
Care by FAMILY ⇒ Care by SOCIETY

- Social insurance system (insurer = municipalities)
- Independence support
- Client-oriented
  - Client can receive health care and social care services comprehensively
  - Clients decide which services, how much (up to ceiling), which provider
  - Advice and coordination by care managers (not municipal caseworkers)
Growing Cost of LTCIS

(1) Growth of total cost: Total cost of long-term care insurance increases annually (2.3 times as high in 10 years)

(2) Changes in insurance premiums of primary insured persons (weighted average)

Many older people hope to live/die at home

Future Situation of Long Term Care

- The ratio of elderly persons aged 75 or older will increase; it is expected to exceed 25% in 2055.

- The number of elderly persons with dementia whose “daily life independence level” is rated 0 or higher will grow among people aged 65 or older. (The higher the rating, the less independent they are.)

- The number of elderly persons who live in households with “daily life independence level” is rated 3 or higher (as a percentage of the population aged 65 or older)

- The number of single-member and husband-and-wife households will grow among households with households aged 65 or older

Aging in Place (toward Community-based Integrated Care System)

- Many people requiring long term care want to remain at home as long as possible
- Lack of support for elderly-only households or persons with high care need
- Shortage of professional care workers

Community-based integrated care system

Expectations to enhance QOL in the community with the limited resources

Choice and preparation Of the elderly and their family
Reform of LTCI (2006) ⇒ Care by COMMUNITY

- **Active Aging**
  - Substantial increase in those in a slight care-need condition
  - The services for those in a slight condition fail to improve conditions of such users

- **Sustainability of LTCI**
  - An increase in the elderly who live alone or suffer from dementia
  - Enhanced in-home care support
  - Coordination between nursing care and medical care

- **Comprehensive social security**
  - Review of benefits for facilities
  - Review of burden sharing and system management
  - Securing and improvement of the quality of service

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**Overview of Prevention-Oriented System**

1. **The elderly**
   - Screening for long-term care prevention
   - Those who seem to require support or long-term care
   - Investigation of how much labor is required for long-term care
   - Investigation of possibility of keeping or improving the life functions

2. **Care needs certification**
   - Non-certified persons
   - Those who might be in need of support or long-term care

3. **Persons requiring support or long-term care**
   - Community general support center (Care management for preventive long-term care)
   - Persons requiring support
   - Persons requiring long-term care

4. **Community support projects**
   - Long-term care prevention measures for specified elderly individuals
   - Prevention benefits
   - Care management for Long-term care

5. **Care by COMMUNITY**
   - Creation of new prevention benefits
   - Creation of community support projects
   - Creation of community-based services
   - Establishment of a new service system
   - Creation of a community comprehensive support center
   - Improvement of residential services

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**Community Support projects on LTC prevention and daily life support**

- Created based on the judgments of municipalities

- Provision of comprehensive, seamless services to elderly persons who move between nursing support and non-nursing support
- Smooth introduction of services for elderly persons who are frail, shielded, or otherwise non-competent to use all forms of medical care
- Provision of opportunities for participation in society and other activities for people with a high desire for independence and participation

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**Image of the Reform by 2025**

- Comprehensive management
  - Medical care
  - Home medical care
  - Community medical care
  - Long-term care
  - Nursing care

- Life support/preventive long-term care
  - Support, preventive care, medical care, etc.

- Establishment of a new service system
  - Securing and improvement of the quality of service
  - Review of burden sharing and system management
  - Securing and improvement of the quality of service

- Shift to a prevention-oriented system
  - Creation of new prevention benefits
  - Creation of community support projects
  - Creation of community-based services
  - Establishment of a new service system
  - Creation of a community comprehensive support center
  - Improvement of residential services
**Who cares for the elderly in Japan?**

- **Phase 1:** Care by Family (-1999)
- **Phase 2:** Care by Society (2000-2005)
- **Phase 3:** Care by Community (2006-)

<table>
<thead>
<tr>
<th>Phase</th>
<th>Care Provider</th>
<th>Management</th>
<th>Professional</th>
<th>Financial resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care by Family</td>
<td>Family member (mainly daughter, daughter-in-law)</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Care by Society</td>
<td>Private Sector</td>
<td>Government municipality</td>
<td>Certified care worker</td>
<td>90% are covered by LTCI benefit</td>
</tr>
<tr>
<td>Care by Community</td>
<td>Informal Network</td>
<td>Municipality, Local Community</td>
<td>Managed by staff in community care center</td>
<td>Part of care are covered by LTCI and Tax injection</td>
</tr>
</tbody>
</table>

**History of Home Nursing**

1982 The Law of Health and Medical Services for the Elderly was enacted, providing the legal ground for home-based nursing for the first time. The law was revised in 1991, establishing a home-visit nursing system for the elderly.

1994 The Health Insurance Act was partially revised. In response to nursing needs of从 children to older people, nursing activities were promoted in collaboration with medical care and welfare at home.

1997 Home-based nursing was incorporated into the basic nursing education curriculum.

2000 Gold Plan 21 was set, in prospect of establishment of 9,900 visiting nursing stations in 2006.

2006 Medical fees and long-term care fees were revised. The scope of home-visit nursing was expanded to special nursing home for the elderly, group shared residence, etc.

**Funding for Home Nursing**

Variety of professionals support care at home.
Introduction of combined service (1)
24 hours round the clock home-visit nursing&care

Introduction of combined service (2)
day care/short stay/home-visit nursing&care

Place of Employment of Nursing Staff and Graduates of Schools/Training Schools

Percentage of nurses work for LTC to the population aged 65+(2009)
Transition needed!

- Demographic change (Ageing, declining birth rate)
- Disease structure change (Multimorbidity, Continuous → Chronic care, long term “care-cycle”)
- Change in definition of “Health”
- Change in concept of “Support”: Medical model to Ecological model, ICF

Quality of Life (context, narrative × individual, family, community), sustainability

- Fragmentation of care and support, lack of continuity
- Emerging (total and useless) cost
- ...and shortage of Care workforce

Community-based integrated care: 2 concepts bringing together

Community-based care

Community-based care features a health system that is based upon and driven by community health needs. Moreover, it is tailored to the health beliefs, preferences, and societal values of that community and assures a certain level of community participation (Plochg and Klazinga(2002)).

Integrated care

a discrete set of techniques and organizational models designed to create connectivity, alignment and collaboration within and between the cure and care sectors at the funding, administrative and/or provider levels(Kodner and Kyriacou(2000)).
**Chronic Care Model (Wagner et al.)**

- Community Resources and Policies
- Health System Health Care Organization
- Self-Management Support
- Decision Support
- Clinical Information Systems
- Trustful relationship
- Improved Outcomes

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**core competencies for caring for patients with chronic conditions** [WHO (2005)]

1. Patient-centred care
   - Interviewing and communicating effectively
   - Assisting changes in health-related behaviours
   - Supporting self-management
   - Using a proactive approach

2. Partnering
   - Partnering with patients
   - Partnering with other providers
   - Partnering with communities

3. Quality improvement
   - Measuring care delivery and outcomes
   - Learning and adapting to change
   - Translating evidence into practice

4. Information and communication technology
   - Designing and using patient registries
   - Using computer technologies
   - Communicating with partners

5. Public health perspective
   - Providing population-based care
   - Systems thinking
   - Working across the care continuum
   - Working in primary health care-led systems

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**Buurtzorg – Quick Scan**

- New organization and care delivery model
- Delivering community based integrated care
- Started in 2007 with 1 team of 4 nurses
- 2014: 9000 nurses in 800 independent teams
- 45 staff at the back office and 15 coaches; no management: self-organization!
- Supporting 70,000 patients a year
- Turnover: € 280,000,000,- in 2014

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**(Self)-Organisation, Team Spirit!**

- Max of 12 nurses a team, taking care of all types of 40 - 50 clients: Generalists as a team!
- 50% Bachelor educated nurses
- Working in a neighborhood of 10,000 inhabitants.
- who organize and are responsible for the complete process:
  - clients, nurses, planning, education and finance (own education budget);
  - and all kind off coordination activities!!!!
- Optimal autonomy and no hierarchy: TRUST
- Complexity reduction (also with the use of ICT)
- Informal networks are much more important than formal organizational structures
ICT makes it possible: Buurtzorgweb

- Shared values
- Knowledge management
- View on quality of care, Transparency (OMAHA SYSTEM)
- Position in the care-chain, relationship with other caregivers.

TEAM COMPASS
- Grip on the business

Community
Instruments
Communication in the care chain
Production
Relationship professional and client

Onion Model in Buurtzorg

1. Selfmanagement client
2. Informal networks
3. Buurtzorgteam
4. Formal networks

CLINICS

Results: Better care, Better work, lower cost

- Higher quality/lower cost (up till 30%)
- Satisfied clients (9.1): supporting participation!
- Satisfied nurses: best employer NL: 2014
- Supporting the needed transition
- More knowledge on outcome
- Influenced the Dutch policy on community care
- Influenced the ideas on organizing principles
- Started in Sweden, USA, Belgium and Japan, China, and Korea!

Our Journey for Transition

Buurtzorg → Community nursing, GP, Multidisciplinary Primary care
→ self management team, Team Spirit
→ Accountability → Transition

Public, Open, TV, Radio, Papers.. continuous dialogue
Professionals closed discussion, (health/social), professional org.
Policy people, academics, Patient, nursing school, study visit, exchange knowledge various gatherings, field visit for discussion in the community
**Primary-care oriented care delivery system (NL)**

[Image of a diagram showing the primary-care oriented care delivery system with labels in Japanese and Dutch, indicating various medical professionals and care providers, such as doctors, nurses, therapists, and Community nurses.]

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**Open innovation platform for Japanese version Buurtzorg model (Co-Evolution)**

[Image showing the Orange Cross Foundation with labeled boxes for Social Community Nursing research project, Family Medicine research project, People Centered Integrated Case Management case study research project, and Community-based Integrated Care Team Experiment Project (2015-2016, 1 year) (Facilitator: Ms.Akiyama, Prof.Nishimura and Hotta).]

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**Community-based Integrated Care Team Experiment Project : Mission**

Sustainable community care to promote “Aging in Place” through facilitating/organizing community-based ONION, people-centered integrated care


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**Community-based Integrated Care Team Experiment Project : Vision**

- Knowledge sharing between Buurtzorg, successful community-based integrated care model and pilot teams from all over Japan
- All the pilot teams draw their own TRANSITION PLAN toward community-based integrated care team
- With continuous dialogue, discussion and evaluations between professionals, academics, stakeholders and government
- Promoting transition toward community-based integrated care team, Inter-Professional (multi providers) Working team expected to realize
  - Better Care
  - Better Work
  - Lower Cost

[Image with a list of points and a triangle divided into 4 sections: Client (Citizen), Formal networks, Community-based integrated care team, Informal networks.]
Community-based Integrated Care Team: Image of the Pilot teams

- **Flat team** (no hierarchy)
- Supporting **whole community**
  (working **in** the community **with** the community)
- Depend on **ONION model**
- **Integrating** (at least) “Nursing”, “Personal Care”, “Prevention”, “Rehabilitation”, “Case Management” and “Medical Care”

Shared Vision, Mission and Transition Process among 38 teams

<table>
<thead>
<tr>
<th>date</th>
<th>event</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2014</td>
<td>Start recruiting teams</td>
</tr>
<tr>
<td>March 2015</td>
<td>○ Kick-off meeting</td>
</tr>
<tr>
<td>April 2015</td>
<td>○ Workshop1 (inviting 2 BZ nurses)</td>
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<tr>
<td>May 2015</td>
<td>2 nurses (OCF) to the Netherlands, BZ (2 weeks)</td>
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<tr>
<td>June 2015</td>
<td>○ Workshop2 (inviting Mr. Jos de Blok, CEO BZ)</td>
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<tr>
<td>September 2015</td>
<td>Study tour (participating teams) to BZ (1 week)</td>
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<tr>
<td>October 2015</td>
<td>BZ nurses and GP visited several teams</td>
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<tr>
<td>October 2015</td>
<td>○ Workshop3 (inviting 2 BZ nurses and a GP)</td>
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<tr>
<td>November 2015</td>
<td>○ Workshop4 (guest speaker from local municipality)</td>
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<tr>
<td>February 2016</td>
<td>○ Workshop5 (guest speaker from community general support center)</td>
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<tr>
<td>May 2016</td>
<td>Open seminar</td>
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</table>

Conceptual framework for integrated care based on the integrative functions of primary care
What is a transition? ... no single answer

- Outcome of developments unfolding at multiple levels: larger dynamics, the status quo, and small-scale innovation interact with one another leading to structural changes (socio-technical systems)

- Structural societal change that is the result of economic, cultural, technological, institutional as well as environmental developments, with both influence and strengthen each other (Rotmans 2005)

- Processes of structural change in major societal subsystem. They involve a shift in the dominant ‘rules of the game’, a transformation of established technologies and societal practices, movement from one dynamic equilibrium to another—typically stretching over several generations (25-50 years) (Meadowcroft 2009)

The multi-level perspective (Geels and Schot 2007)

- Macro level: formed by the socio-technical landscape, which refers to aspects of the wider exogenous environment, which affect socio-technical development (globalizations, environmental problems, cultural changes) (Geels 2005)

- Meso level: formed by socio-technical regimes

- Micro level: formed by technological niches, the locus for radical innovations (‘variation’)...Niches are important because they provide locations for learning processes and space to build the social networks which support innovations

Increasing structuration of activities in local practices (Geels and Schot 2007)

- System insight
- Long-term thinking
- Flexible objectives
- Timing is crucial
- (Dis)equilibrium are both useful
- Creating niches
- There is ‘no outside the system’
- Focus on learning
- Participation

Tenets of Transition Management: basic elements for steering societal transitions

- System insight
- Long-term thinking
- Flexible objectives
- Timing is crucial
- (Dis)equilibrium are both useful
- Creating niches
- There is ‘no outside the system’
- Focus on learning
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