

# Clinics With Beds in the Healthcare Delivery System

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## Japan's Healthcare Delivery System

For over 50 years since it adopted a universal healthcare system in 1961, Japan has maintained a system in which the entire population is covered by health insurance and has access to healthcare. It has created “free access” in which anyone can receive healthcare at any medical institution and has achieved the world's longest life expectancy. Meanwhile, Japan's society is aging and deaths are expected to over 1.5 million in 2025, or 1.3 times the current level, and it is anticipated that there will be a shortage of facilities to provide terminal care (**Fig. 1**).<sup>1</sup> The number of one-person households with a senior citizen (aged 65 or older) living alone has already climbed close to five million and is forecast to exceed seven million in 2030 (**Fig. 2**).<sup>2</sup> The highest priority issue in healthcare as seen by the public is “inpatient facilities for long-term hospitalization of the elderly.” There is high anxiety regarding early hospital discharge and the decrease in hospital beds.<sup>3</sup> Challenges facing community healthcare include the shortage of places to accept patients discharged early, anxiety over places that provide terminal care, the shortage and uneven distribution of physicians, exhaustion of hospital-based physicians, the shortage of facilities covered by long-term care insurance and shortage of services, elder-to-elder care, and senior citizens living alone. It is an important mission of the Japan Medical Association (JMA) to propose ways of providing community health-

care and nursing care services that are reassuring to the public.

## What Are Clinics With Beds?

The healthcare system is made up of the delivery system and the healthcare financing pays for it. Broadly speaking, there are two types of medical institutions in Japan: hospitals and clinics. The Medical Care Act enacted in 1948 defines institutions with 20 or more beds as hospitals and those with 19 or fewer beds as clinics. Hospitals accept outpatients but mainly provide inpatient treatment and have standards such as having at least three physicians. There are approximately 8,000 hospitals nationwide. Clinics mainly offer familiar medical care provided by a primary care physician and have one or more physicians. Clinics without beds are facilities that only accept outpatients; there are approximately 90,000 nationwide. Clinics with beds are facilities that have 19 or fewer beds; there are approximately 10,000 nationwide.

Among clinics with beds, 40% are internal medicine clinics while surgery and orthopedics each account for 10% and obstetrics and gynecology accounts for a quarter. While childbirth is mainly handled at hospitals and clinics with beds, 504,257 deliveries out of the nationwide total are conducted at clinics with beds. This accounts for 47.1% of deliveries overall.<sup>4</sup>

Clinics with beds have an auxiliary bed function in that they accept inpatients discharged early

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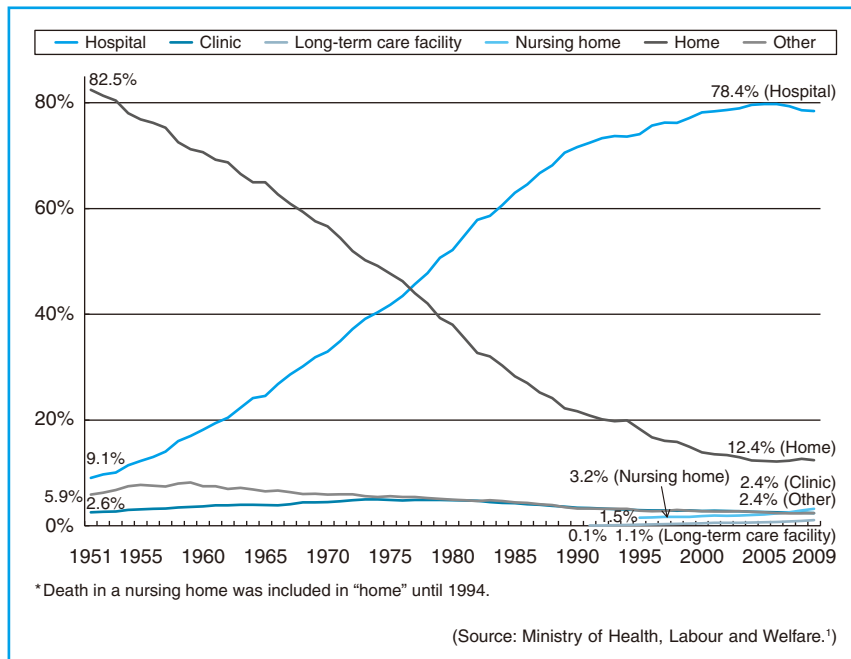


Fig. 1 Number of deaths by place of death

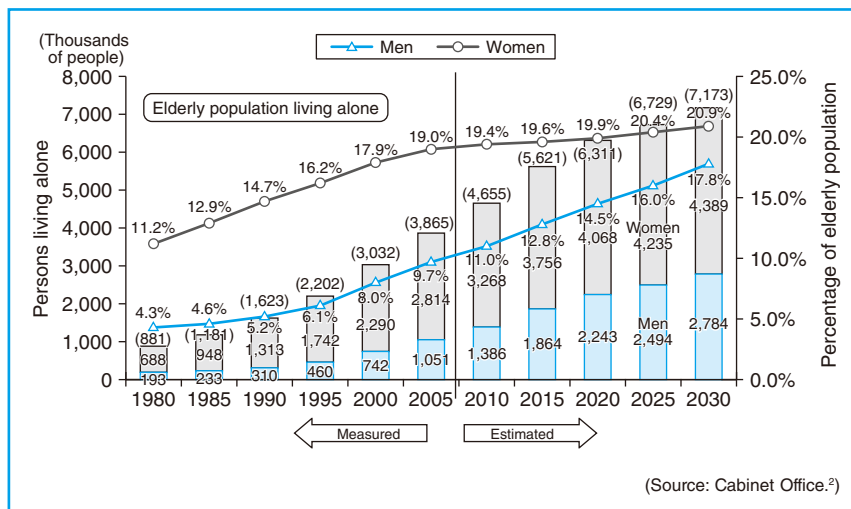
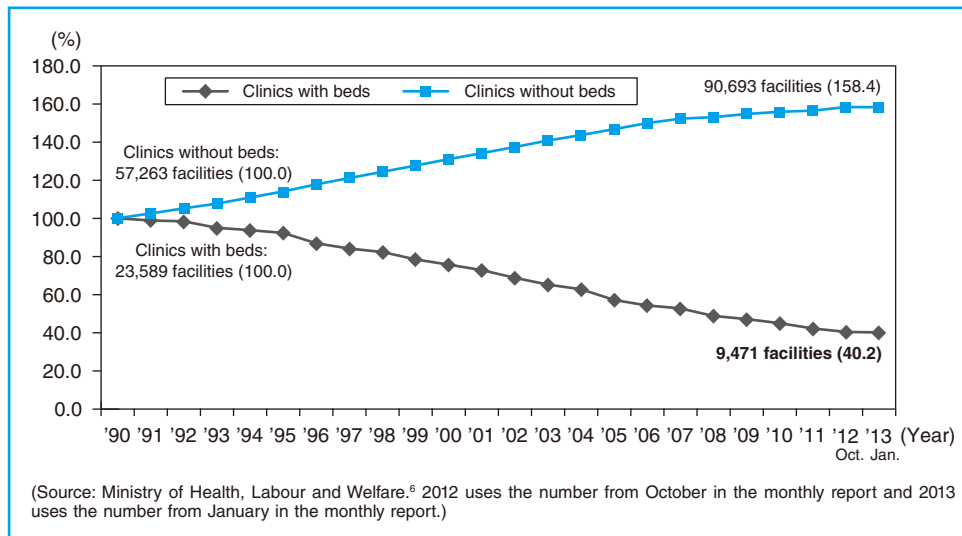


Fig. 2 Increase in the number of senior citizens (65 and older) living alone

from hospitals and they also provide ongoing medical care, including visiting care after discharge. They accept emergency admissions when patients experience acute exacerbation. Sixty percent of clinics with beds accept emergency admissions of one kind or another at an average rate of 3.6 cases per month.

“Home care support clinics” that provide 24-hour home healthcare are more common in rural areas, where they provide home healthcare according to community needs. A quarter of facilities conduct 20 or more home examinations per month. Of clinics with beds overall, 53.6% provide end-of-life care (terminal care), and this



**Fig. 3 Number of clinics with beds and clinics without beds over time (1990 = 100)**

While clinics without beds have continued to increase, clinics with beds have decreased to about 40% of their number in 1990.

percentage rises to 86.5% for internal medicine clinics with beds.<sup>5</sup> At clinics with beds, terminal care can be tailored to the wishes of patients and their families in communities where they are used to living.

### Challenges Facing Clinics With Beds

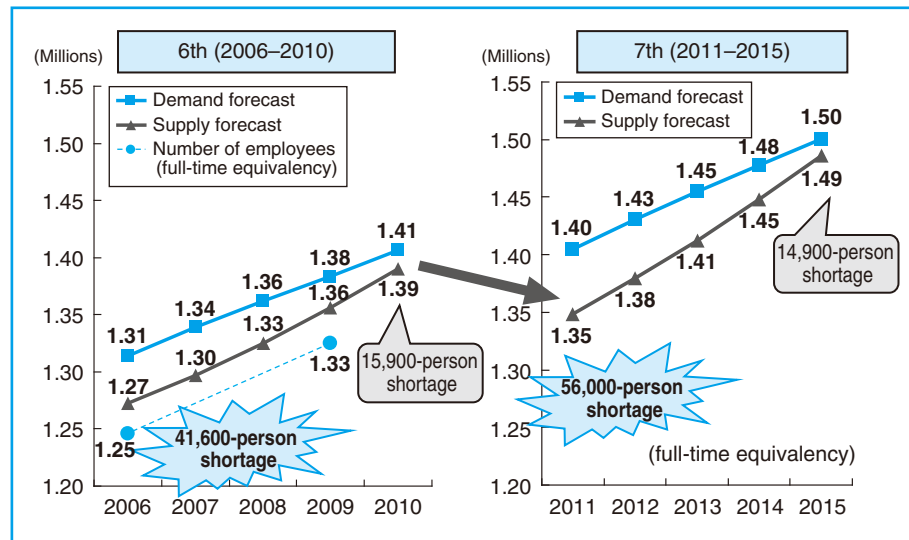
The number of facilities has declined from 23,589 about 20 years ago to 9,471 today (as of January 2013). The number of beds has decreased from 272,000 to 124,000 (**Fig. 3**).<sup>6</sup> Reasons for the decline include difficulty securing nursing personnel, changes in patient demographics, and the work burden on physicians, but the biggest factor is the financial difficulty caused by the remarkably low evaluation in the medical fee schedule. While they are a facility in which physicians and nursing personnel can provide medical care, the basic inpatient fee at clinics with beds is set lower than at nursing homes. Hence, the current situation is one in which it is not possible to adequately improve the compensation packages of nursing personnel, deal with aging facilities, and lessen the burden on physicians by staffing facilities with multiple doctors.

It is clear that the breakdown of community healthcare will proceed further unless a stop is put to the conversion of community-based

clinics with beds, which underpin community healthcare through a variety of functions, into clinics without beds. That is why the position of clinics with beds needs to be clarified in the Medical Care Act and the medical fee schedule needs to be made such that the functions of clinics with beds, which differ from those of hospitals, are valued and enable even small clinics to operate.

Further, it is difficult to see how the securing of nursing personnel can improve only with the salaries based on the medical fee schedule, since there is an absolute shortage of nursing personnel. Although the Forecast for Supply and Demand of Nursing Personnel, which the Ministry of Health, Labour and Welfare (MHLW) develops every five years, estimates that an improvement will be made five years later even though there is a shortage of about 50,000 people in the first year of the plan, the fact of the matter is that there is no feeling whatsoever in medical settings that the shortage problem has gotten any better (**Fig. 4**).<sup>7</sup>

On top of an absolute shortage, there is uneven distribution in favor of urban areas and also in favor of large hospitals, due to the effects of the medical fee schedule. This makes it much more difficult for clinics with beds and small- and medium-sized hospitals to secure nursing



**Fig. 4 Forecast for supply and demand of nursing personnel**

The 6th forecast gave a supply of 1.39 million nurses in 2010, but in the 7th forecast the supply in 2011 was revised down to 1.35 million nurses. The forecast is not met in the end.

personnel. Local medical associations run their own training schools for nurses in an effort to secure more personnel. But, unless the MHLW makes a serious effort to secure the nursing personnel needed to protect the health and lives of the public, it will be difficult to ensure the country has the 1.9 to 2 million nurses that are thought will be needed in 2025, making it impossible to support a healthcare delivery system for a super-aged society.

### The Future of Clinics With Beds

Clinics with beds have a major role to play in the integrated community care system that aims to provide seamless medical and nursing care. There is a wide patient demographic that beds with clinics can accommodate. Patients admitted to clinics with beds cite the facts that it is where their primary care physician is and that it is nearby as the major reasons they choose to be admitted at a clinic with beds.<sup>8</sup> If beds are used differently according to patients' conditions, clinics with beds will be able to provide medical and nursing care services that are closer to community residents as small-scale multi-functional inpatient facilities. When clinics that provide community healthcare have beds, it broadens the scope of medical care and leads to increased

motivation and skills among young doctors. It is important to use small-scale clinics with beds flexibly.

Below are the three principles of clinics with beds taken from the interim report<sup>9</sup> put out in June 2011 by the JMA Investigative Committee on Clinics with Beds on the question of clinics with beds for the next generation, or how to further enhance the stable administration of and reliable medical care at clinics with beds in anticipation of the next simultaneous revision of medical fee schedules for medical and nursing care services.

#### Three principles of clinics with beds

1. A medical institution in which a primary care physician provides medical care to inpatients as a link between outpatient and at-home care: A facility that truly practices the principle of primary care, where a primary care physician that is familiar with the lifestyle and health condition of a patient can admit the patient if necessary. At a time when the birth rate is falling while the population is aging and the number of senior citizens living alone is forecast to increase, being able to provide inpatient medical care on one's own as a primary care physician will be extremely effective within future healthcare.

2. A community-based, patient-oriented inpatient facility that underpins community medicine and community healthcare:

An inpatient facility that provides community-based medicine, being the closest to the patient's and his/her family's home(s). At a time when hospitals are consolidating due to the shortage of doctors and the importance of home medical care is increasing, clinics with beds play an important role in providing integrated medicine together with hospitals, moving fluidly from outpatient to inpatient, home and end-of-life care.

3. A small inpatient facility to provide specialized medical care:

Clinics with beds provide a diverse range of specialized medical care, including everything from minor surgery to relatively advanced surgery. Obstetrics clinics with beds, for example, handle approximately 47% of all deliveries in Japan. They also underpin the community healthcare delivery system and help ease crowding in hospitals and the overwork of hospital-based physicians.

The function of the primary care physician is to respond accordingly to medical, health, nursing care, and welfare needs from a position close to patients and to continuously provide each patient with the best solution along with adequate explanation. The principles of clinics with beds should be clearly indicated in the Medical Care Act so that clinics with beds can continue to exercise their full potential within communities and perpetually fulfill their roles.

There is also a need to clarify the following five functions of clinics with beds and to repeatedly disseminate information to make them well known and see to it that they are fulfilled.<sup>10</sup>

### Five roles of clinics with beds

1. Function as a bridge for patients discharged early from a hospital before receiving home care or going to a nursing care facilities (auxiliary bed function):

At a time when medical functions are being divided and shared within the community more and more, there is an important function to fulfill as a midway point in the process of returning patients who have gotten over the acute phase to home care or a nursing care facility. While some patients get over the sub-acute phase smoothly and can go home early,

other patients require ongoing treatment over a long term. Therefore, the mechanical reduction of the standard hospitalization fee in the medical fee schedule, which is intended to shorten the inpatient period, needs to be reconsidered cautiously.

2. Function of providing specialized medical care that compliments the role of hospitals:

In recent years, nearly half of Japan's child-births have been conducted in clinics with beds, which also carry out a considerable number of ophthalmologic, gastroenterological, obstetric and gynecologic, and orthopedic operations. Clinics with beds fulfill the role of hospitals in communities where there are no hospitals within the daily living area, and it is not uncommon for them to be the only inpatient facility in remote areas and on outlying islands. In such regions, the inability to keep running clinics with beds means the inability to ensure community medicine itself, which, it must be said, is a grave situation.

3. Medical function for responding to emergencies:

The percentage of clinics with beds that respond every day as needed, including at night and on days off, under difficult conditions has reached 30%. There is a strong demand for emergency services especially in remote areas and on outlying islands. Responding to these kinds of requests can create a loss-making situation, and so something needs to be done as soon as possible with the medical fee schedule. Another important role is accepting emergency admissions when there has been a sudden change during recuperation at home, and if one knows as the family doctor a patient's everyday life, it is possible to provide rapid and accurate medical care.

4. Function as a base for home care:

Being close to patients receiving treatment or recuperating at home and accepting them on an as-needed basis as inpatients when a condition requiring admission appears is a most effective form of medical care for continuing home care. Clinics that support home care can play a more effective role if they have beds. Transferring a patient to a hospital is quite possible if necessary after accepting an emergency admission, and the base function of these kinds of clinics with beds is an essential role in spreading and establishing home treatment and home care.

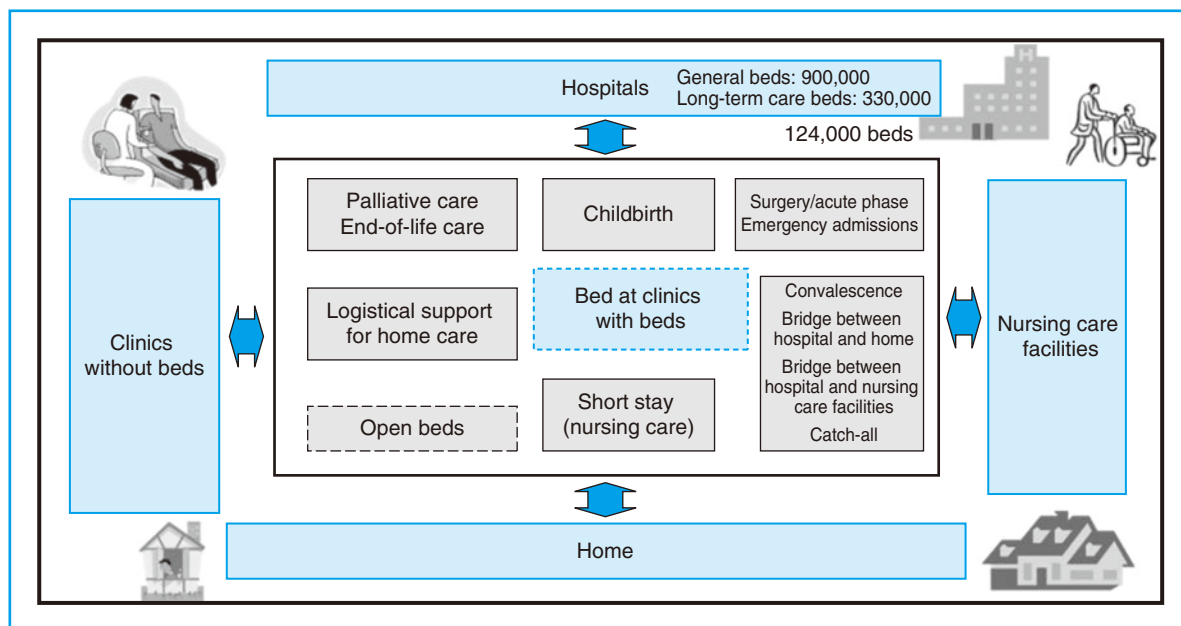


Fig. 5 Use of beds in the healthcare delivery system

#### 5. Function in providing end-of-life care:

A system in which people spend their last days in the home they are used to living in and from which they can receive needed medical care until the end at a familiar clinic with beds is going to be a form of community medicine in the future. The role of small inpatient facilities is going to be important not only in end-of-life treatment for cancer, which is currently the top cause of death, but also in future medical

care within a super-aged society.

Many clinics with beds combine a number of these roles and functions and operate flexibly according to local circumstances (Fig. 5). Clarifying the position of clinics with beds in the healthcare delivery system and making effective use of their 124,000 beds will enable the provision of patient-oriented healthcare that meets the needs of patients in the community and should help alleviate the burden on acute hospitals.

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