



## Japan's search for a seamless care package: Is the micro-multifunctional community facility providing total care for older people the answer? And would it meet the needs of an ageing population in the UK?

At a time when, post Dilnot, the focus in England is on the Care Act and delivering more integrated and holistic care and support services for older people, this case study takes a detailed look at the very serious challenge of meeting the unprecedented demand for long-term healthcare and social care for Japan's ageing population. It offers some fresh insights into recent and current measures taken, particularly the micro-multifunctional community facility for a *total* care package with some appreciation of both the impact and remaining challenges in this field.

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## Introduction

Leading the global race for sustainable solutions, Japan faces the very serious challenge of meeting the unprecedented demand for long-term healthcare and social care for its ageing population – together with increasing dementia care needs. Already, a quarter of Japan's 127 million population are aged 65 or over – which means that questions of sustainability are being raised in policy circles on both the financial and infrastructure systems of existing healthcare and social care provision. The rising demand for such provision coincides with a decreasing active workforce, leading to decreasing tax and social insurance revenues and a consequential increasing national debt. The viability of the care provision infrastructure is now threatened due to the long-term ethos of the medicalisation of provision reflected in the highest hospital bed occupancy *per capita* and the longest measured hospital stay among developed nations. This promoted and continues to provide a basis for the primacy of longevity as an objective within care provision rather than an approach which seeks to secure 'quality of life'. Furthermore, there is an increasing acute shortage of long-term residential care provision – attributed in some measure to social stigma attached to this provision as well as unrealistic 'capacity-capping' measures through government controls. Similarly, there has been and continues to be a chronic shortage of community based resources – particularly the lack of sheltered housing-with-care designated to support care in the community.

In response to these differentiated – and growing – care provision pressures, the government introduced, in 2000, the radical, mandatory and universal Long-Term Care Insurance (LTCI) system. This was highly popular and led to a planned and purposeful expansion in care provision (through new financial remodelling) but due to the surge in uptake, sustainability remained an unresolved problem.

An overarching if ambitious policy aspiration was to establish and embed a system which allowed all older people with any disability or illness to remain at home, and in their own community setting, to live out their lifespan with dignity and respect in a familiar and natural environment – and enjoying a continuity of their life-style for as long as feasible. This policy reflected radical rethinking and echoed the wider precepts of the Japanese government's stated '2025 Vision' – to provide a localised, comprehensive *total* care system with 2025 being the predicted date for the ratio of the over-65 age group within the total population to strengthen from 1:4 to 1:3. Effectively, this anticipated the delivery of an inclusive and integrated package of healthcare, social care, preventative initiatives, housing and supported living programmes – together with ancillary welfare services.

In the wake of this drive towards localised *total* care, there was a shift from the total hospital experience to a medical in-reach community based model, and from a 'medical' model of care to a 'social' model of care. A financial platform to support these policy shifts and actual changes in the patterns and methods of the provision of care was provided through the enactment in 2011 of the comprehensive measures for social security and tax – for example, the doubling of VAT. In terms of strengthening the infrastructure of the care delivery system, there were further reforms visited upon the LTCI and healthcare systems, reforms which emphasised the need for integration, cost efficiencies and increased productivity – all of which aimed to boost the impact of the community based model. One model, the micro-multifunctional local community facility for a *total* care package, was introduced and became a key example of these measures.

## Overview: The ‘new’ model

The micro-multifunctional local community facility for a *total* care package was introduced in the LTCI reforms of 2005 and was provided by a range of organisations. It was, in several respects, a radical initiative – and indeed originated and was piloted in charity-funded drop-in and respite facilities available to the entire local older community – with affordable costs. After being recognised, evaluated and approved, the LTCI-supported micro-multifunctional facility was replicated and universalised across Japan. The model was intended to provide holistic, seamless care services:

- 365 / 7 / 24 all round open access
- core day care provision
- planned and emergency day / overnight respite care
- regular and on-demand health care (oral hygiene / visiting nurses)
  - personal care (hygiene; assistance in toileting)
  - domestic support (shopping, cooking & cleaning).

In addition, the day care provision included personalised services and support such as assisted bathing, health screening, nutritiously planned meals and discreet monitoring – as well as having the benefits of group interaction and socialisation. All of the above was planned and provided in conjunction with local GP services and their medical resources.

Each micro-multifunctional facility had a designated Care Coordinator who held the responsibility for the design, delivery and monitoring of every service-user’s ICP (Individual Care Plan) – as well as supporting any individual carers or families. Each facility catered for a maximum of 25 registered, eligible older people from any of the seven established care-need levels (to be discussed later) still living at home in the local community. This ensured that the model remained localised, personalised and responsive in its flexibility to meet needs – and the size, scale and scope *initially* secured a high quality level of service delivery. Staffing levels were maintained at a high ratio; staff were mainly qualified and formed effective multi-disciplinary teams (the MDT model). Managers were obliged to have achieved specific levels of training and experience in dementia care – reflecting the increasing rise in dementia-diagnosed users. Furthermore, and in keeping with the ethos of localisation, each facility was required to organise and host bi-monthly, local care conferences: involving local people; care providers; local council staff; along with service-users and their families – with the stated objectives of raising issues and concerns, networking and seeking to expand further collaboration and optimisation of local resources.

Another innovation brought in by the micro-multifunctional facilities was the shift towards monthly fixed fees – away from the previous pay-as-you-go model. This was introduced to promote flexibility and a degree of independence for users – and ensure some gatekeeper mechanism to filter demand and so prevent overuse. The universal, government approved, fixed fee formula was based on the seven levels of care needs (see Table 1 below) with users paying a standard 10% part-payment charge – with the 90% balance being met by LTCI funding. This led to a secure financial basis for the providers and their cost-management – bearing in mind a system of ‘top-up’ payments for first-time users; dementia cases and high staffing levels.

**Table 1: Basic monthly fixed fee for service-users based on the seven levels of assessed needs criteria**

<i>Assessed needs level</i>	<i>Monthly fixed fee (10% of total cost)</i>	<i>Needs descriptor</i>
Care Level 1	£26.20	Mostly independent; may need some assistance to sustain independence and postpone deterioration
Care Level 2	£46.80	Needing partial support with activities of daily living (ADLs)
Care Level 3	£66.90	Requiring support with ADLs and intervention care
Care Level 4	£99.50	Requiring care at Level 3 and support with additional ADLs
Care Level 5	£136.30	Needing extensive support with ADLs and significant comprehensive care
Care Level 6	£149.80	Unable to live without comprehensive care – regarded as practically bed-bound
Care Level 7	£164.60	Deemed to be bed-bound and so needing total comprehensive care

*KEY: £1 sterling currently = 172 Yen (¥172) – at May / June 2014 exchange rate*

### **Challenges and opportunities – the case for reforms**

Despite the initial apparent successful introduction of the micro-multifunctional facilities sponsored by the LTCI through government promotion, the actual expansion of the model by providers was less rapid than expected leading to an overall ‘slow development’ and as a consequence a ‘slow uptake’ by service-users. For example, currently across Japan, some 4,000 facilities support the needs of 76,000 service-users – a mere 2% of eligible community based care service-users.

Possible reasons for this slow uptake by potential providers could be located in the range of negative responses voiced by current managers of these micro-multifunctional facilities interviewed by the author of this article – evidence which was strengthened by the findings of a national survey and subsequent reports. Turnover, profit margins and financial rewards were becoming squeezed with 50% of the 605 facility provider managers surveyed reporting *losses* in their most recent financial year. Reasons for this cited were: difficulties in engaging the target of 25 per facility service-users (on average, only 18 registered users joined each facility) and in addition, many of these service-users were in the lower assessed needs category – thus bringing in a minimum revenue stream.

In terms of sustaining the promise to respond to the stated preferences of both service-users and their carers and families, it is inevitable that difficulties arose in the process of managing and modelling their aspirations and requests during the negotiation stage of the ICP (care plans) – as an unscheduled, open-ended and on-demand service response was essentially financially unfeasible: for example, direct workforce costs average out at 70% of annual turnover and so any modulation in their increase has a significant financial impact in a fixed-fee context. Inevitably, provider managers reported that there was a pragmatic shift on a costs basis from flexibility and user-led provision to a resources-led model. Some providers withdrew from the broad front of service level provision and offered a more simplified and cost-effective ‘day care service’ (reduced) model. However, apart from these financially constraint-led reductions and adjustments to the driving vision, service-users and their wider circle of carers and families rated the provision highly. There is evidence that the provision was sustained by the efforts of highly motivated and committed staff who – along with energetic and creative managers – maintained high quality levels of service.

### **The modifications: Government responses and developing aspirations**

Through the administration of the LTCIs, the government sought to tackle the emerging challenges of the low numbers of facility providers participating in the scheme. These reform responses ranged from restructuring and a redefining of the service models (i.e. staffing levels) to providing start-up cost subsidies and increasing levels of flexibility. For example, to increase the flexibility within the facilities, it was permitted for managers to deploy staff as required between the core facility and, at most, two other satellite facilities still based in the local community catchment area. To offset the disappointing profit on turnover returns which deterred some potential scheme providers, the government started to inject capital subsidies for start-up costs – as grants not loans – on a scale from £87,000 to £174,000 per facility. These start-up subsidies were in effect capital grants and were mainly spent on new builds however the rules were flexible enough to allow for renovation of existing facilities to raise standards. It is important to note that at this juncture, these start-up capital grants were not designated to be used for staff recruitment, retention or training costs – nor was the money allowed to be spent on medical resources or services.

Taking the opportunity to introduce improvements through the reforms, the government also tried to address two significant issues: firstly, the emerging threat of these facilities becoming unintentional ‘warehouses’ for those on the waiting lists for residential care, as some facilities were perceived to be developing into temporary alternatives to such provision; secondly, there was an awareness of the growing needs for more generic medical interventions together with, specifically, ‘end-of-life care’ required by a growing proportion of service-users, which increased the requirement for (more expensive) medical services.

Driving these reforms – and embodying implicit strategic aspirations for localised *total* care provision – the government was increasingly coming to regard these micro-multifunctional facilities as the core community hub for *total* care not just for the ‘registered eligible’ but for the entire local older population. This was a step closer to the realisation of the previously acknowledged ‘2025 Vision’ – the aspiration for a localised, comprehensive *total* care system to be in place to meet the needs of predicted 1:3 older population within Japan’s total population.

Innovations brought in with these reforms included the attachment of many facilities to community centres – providing the opportunity for education and training in dementia awareness and dementia-care strategies. Healthy living and ‘wellbeing’ programmes – often within an array of preventative education modules – were available to the wider community and promoted the benefits of exercise and the provision of lunch clubs for the active older population. In some instances, the care provision proposed was even more ambitious – with children’s nurseries as well as after-school activity clubs being attached to and incorporated into the micro-multifunctional facilities – which were now evolving into intergenerational foci for wellbeing. The next step was to develop an integrated model which combined micro-multifunctional facilities with ‘safe housing’ provision.

### **Safe housing – a step towards ‘care added supported living’ facilities**

In 2011, a fresh government initiative made it feasible for providers to physically combine micro-multifunctional facilities with highly subsidised ‘safe housing’ (sheltered housing) schemes in purpose built units. Prior to this, such schemes were not present in the government’s range of strategies and so this combination of safe housing with micro-multifunctional facilities brought the ultimate goal expressed in the 2025 Vision a step closer. The ‘care added supported living’ facilities model provided users with affordable renting opportunities, together with a barrier free, protected environment which allowed residents to live their lives with dignity and independence.

Unfortunately, certain issues emerged which raised concerns – for example, standardisation in the design and cost-efficiently built units led to impersonal environments. Similarly, the need to maximise the profit margins from the micro-multifunctional facilities within the units led to instances of the managers over-directing safe housing residents to use these facilities – instead of accessing the wider range of LTCI care services in the wider community.

### **In conclusion: the way forward ... and some signposts perhaps for the UK**

Despite all the challenges – and partial solutions – outlined above – the Japanese government continues to regard this micro-multifunctional facility model as the way forward to deliver localised, comprehensive *total* care for a wider older population: as expressed in their target to increase (by 2025) the number of registered service-users of micro-multifunctional facilities to 400,000. This represents a predicted and anticipated increase of user uptake from 2% to 9% of those entitled to access this provision. In order to achieve this goal, it becomes crucial for both the providers and the service-users to function within a feasible financial framework. For those proposing to become providers of service delivery – new and existing organisations – it has been determined to continue the grant aided capital subsidisation of start-up costs in addition to the current proposal to increase the fixed monthly service fees – especially for the low-needs assessed groups. With these twin proposals for financial underpinning and sustainability, the government hopes that their plans for expansion will be realised. For current and potential service-users, sensitive to any proposed increase in fixed fee charges, the introduction of a means tested assessment (together with further subsidies for the less affluent) will secure a continuing increase in the levels of access to and uptake of this provision.

The dearth of up-to-date research, evaluation and literature prevents any definite and definitive verdict on the impact and success of both actual and proposed reforms to the delivery, feasibility and sustainability of the micro-multifunctional facility system for localised, comprehensive *total* care: but the government is clearly committed to further develop and possibly expand the role of these facilities within its grander aspiration to achieve the ‘2025 Vision’.

## **And for the UK?**

It is clear that the prime requirement for those proposing to investigate or even implement similar models for *total* care packages in the UK is more evaluative evidence from the Japanese experience. Objective analysis based on evidence is in short supply due to two factors – the literature has been written by scheme proponents to a great extent and other evidence secured through limited research and inquiry has been more quantitative than qualitative.

Furthermore, the implementation of such provision of *total* care in the community in the UK context – within the matrix of political and institutional legacies – is potentially frustrated by the current binary divide between the forces and resources of the NHS and local authority controlled adult social care. For example, the Better Care Fund issue regarding the pressure on hospitals to free up beds remains partially unresolved despite radical proposals for the Treasury to give the NHS the go-ahead to divert funds to local authority social services to provide accommodation resources for those deemed to be ‘bed blocking’.

The *total* care model delivered in Japan, it must be noted, was successfully delivered through one system by one unified conglomerate care provider rather than attempting to weld together the disparate sections and functions of healthcare and social care systems. The UK might benefit from considering this signpost from the Japanese experience which points towards a seamless care pathway provision rather than the fragmented ICP (care planning) and care provision from the current multi-agency approach.

In the UK, Day Care Services are no longer ‘flavour of the month’ facilities – indeed this provision has been dubbed a ‘dinosaur service’ by some pro-reforming thinkers. The emphasis is being radically shifted towards a person-centred approach to care within a ‘personalisation agenda’. In this personalisation model, day-care service-users are supposed to experience an all-in-one package. Against this emerging concept stands the voice of many service-users as well as care coordinators and other professionals who now increasingly prefer to receive care and support at home rather than currently more institutionalised, day-care services provision. Listening to these views, perhaps this could be a new form of ‘extra care’ provision in the future?

## **About the author**

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## **Note**

This paper is based on two features that first appeared in the Health Service Journal. The views expressed in this paper are those of the author and not necessarily those of the Housing Learning and Improvement Network.

## **About the Housing LIN**

Previously responsible for managing the Department of Health's Extra Care Housing Fund, the Housing Learning and Improvement Network (LIN) is the leading 'learning lab' for a growing network of housing, health and social care professionals in England involved in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults with long term conditions.

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