Factors limiting home infusion therapy in Japan

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Home parenteral nutrition was recognized as a reimbursable item in Japan's health care insurance system in 1985. Since that important change in insurance reimbursement, home enteral nutrition, pain management, and cancer chemotherapy have also been declared reimbursable. About 4000 patients in Japan are currently receiving home infusion therapy services. This small number reflects the steep barriers that have continued to limit Japan's home infusion therapy market.1

Attitude of physicians. One reason for the slow development of home infusion therapy services in Japan appears to be the medical community's attitude toward home care services. Unlike their U.S. counterparts, Japanese physicians have continued to own hospitals and clinics, which has given them total control over all aspects of patient care. There is very little incentive for them to discharge patients to home care settings.

Lack of processes, prohibitive costs. Processes provided by hospitals and medical service suppliers to support home care patients adequately and safely are incomplete or absent in Japan. It is practically impossible for a hospital to provide home care services because personnel expenses, equipment costs, and facility maintenance fees for home care are extremely high. Home care would also put a considerable financial burden on patients and families.

Insufficient participation by industry. Until recently, there were very few industry participants in Japan's home care market. This resulted in a lack of momentum in home care market growth. However, since Japan's first home infusion therapy conference, held in 1992, manufacturers and service providers have been encouraged to participate in the home care industry by many medical communities and by officials of the Ministry of Health and Welfare, and there have been many home care-oriented conferences supported by manufacturers, distributors, and service providers.

Lack of knowledge. Japanese clinicians, such as nurses and pharmacists, often lack the education, training, and experience necessary to properly execute their roles in the home care setting. There are no continuing-education requirements for the maintenance of a nurse's license, so nurses have little incentive to invest in further educational programs, such as those relating to home care nursing. On the other hand, programs in home infusion are being evaluated and slowly implemented at various pharmacy colleges.

Hospitals are still not familiar with the services that can be provided in the home care setting. This reality is coupled with a shortage of nurses and social workers who are knowledgeable about discharge planning for home care and a shortage of providers who are willing and able to serve home infusion patients.

Legal barriers. Japan's medical laws have been another obstacle to the growth of home infusion therapy. By law, it is illegal for nurses to initiate and access i.v. lines outside hos-
hospital or clinic facilities. Therefore, all home infusion therapy patients currently receive central lines. Japanese law also prohibits nurses from administering drugs intravenously, except to patients in medical facilities. In the early 1980s, however, the potentially harmful effects of long-term hospitalization were publicized in Japan, and people began to show interest in home care as a route to higher-quality medical services. The Japanese Management Association has proposed expanding the services nurses may provide without a physician’s supervision under the new Care Insurance System, which is scheduled to begin in April 2000.2

A physician may prescribe antineoplastic drugs for home use but not antiemetics and diuretics, which are needed to suppress adverse effects of the antineoplastic drugs.3

Poor reimbursement. Another reason for the lack of progress in Japan’s home infusion market has been the reimbursement restrictions imposed by the Ministry of Health and Welfare. Although the reimbursement schedule was revised in 1996 to increase the fees for home infusion therapy services, many home care providers remained dissatisfied with the amounts. For example, monthly reimbursement was set at $291 for home parenteral nutrition, $242 for home enteral nutrition, $136 for chemotherapy, $126 for pain management, and $97 for an infusion pump (for total parenteral nutrition or enteral nutrition). Reimbursement for a nursing visit was pegged at $51. Analgesics that are covered by health insurance have been limited to nonsteroidal anti-inflammatory drugs.5 Recently, however, the Ministry of Health and Welfare approved insurance reimbursement for both oral and intravenous morphine used in home care. In reality, when a physician indicates that it is medically necessary, home use of i.v. morphine may be reimbursed on a case-by-case basis. Reimbursement for home parenteral nutrition is provided only if the patient has an approved, diagnosed chronic disease.

Cultural factors. A variety of cultural factors contribute to the home care picture in Japan. First, patients hardly ever question physicians about their treatment and care. Patients are grateful to be seen by a physician. Second, it is widely believed that a private company should not profit from patient care, especially the care of the terminally ill. Third, home care is not necessarily considered “quality of life” when a patient can enjoy a hospital’s air conditioning in summer and central heating in winter. Fourth, for elderly patients who are unable to prepare meals, hospital food is welcome. There are no Meals on Wheels services in Japan. Fifth, family dynamics in Japan have changed since the beginning of the 1990s; both parents are now in the work force, and extended families are becoming rare in cities. Therefore, home care imposes a burden that family members are increasingly unwilling to assume. Sixth, a hospital stay is more cost-effective than home care for Japanese patients because all medical expenses except copayments are reimbursed by the government under the current system. Seventh, Japanese homes are very small and cannot easily accommodate the demands of home care on space. The noise generated by equipment, such as an infusion pump, may also pose a problem because of the limited living space. (Medical device manufacturers in Japan must meet higher standards for noise abatement than U.S. manufacturers.) Finally, male patients are in most cases reluctant to learn self-care, since they expect to be taken care of by women. This increases the need for caregivers to be present in the home.

Care Insurance System. A new government health care program, the Care Insurance System, is planned to go into effect in April 2000. Provisions of this program will make home care more feasible as a business in Japan. There will be an increase in reimbursement for home parenteral nutrition to $970 per month. Reimbursement for home enteral nutrition and pain management therapy will also increase. A goal has been set to reduce the average hospital stay from the current 36 days to 28 days. Since there currently is no interim care, such as subacute care and long-term nursing care, in Japan, a majority of hospitalized, chronically ill patients will be referred directly to home care services upon discharge.

Going forward. Japan’s home care enterprise will continue to evolve and refine itself within the health care system. The U.S. home care industry has much to offer Japan in terms of business knowledge, clinical education and training, and exchange experiences. In return, there is much to be learned from Japan’s experience in terms of its establishment and fine-tuning of this service-oriented business.

References


References