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Review article

Differential development strategies of aged care support and continuity services in China, Japan, and Australia

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ABSTRACT

Facing the unprecedented ever-increasing healthcare demands of its aging population, Beijing municipal government has been endeavoring to improve the continuity of medical services for the elderly in the People's Republic of China. In this article, a comparison of the healthcare services for the aged in China with those in Japan and Australia was performed, indicating the feasibility in China of the Japanese health insurance policy and Australian geriatric evaluation and management model of care. The problems associated with the current healthcare system for the elderly in Beijing were discovered and analyzed. Possible strategies and specific measures that need to be improved are proposed by analysis and utilization of the personal experiences of Japan and Australia.

1. Introduction

The aged continuity service is a new care model and the core concept of general/family medical service, which is characterized by the humanization and individuation of care for patients, forming elderly services distinctive for their continuity, comprehensiveness, coordination, and practicability. During the operation of continuity service, several other features of general medical service can be easily reflected and put into effect. Continuity service emphasizes the fixed doctor–patient relationship, and is divided into two operation periods:[1] the period of the disease, covering the preclinical stage, clinical stage, rehabilitation stage, return to society, and recurrence prevention stages; and the life period, referring specifically to the life-long health services experienced from birth to death. The objective of this service is to create a sound human living environment, involving: (1) healthy birth and infant growth, to ensure that aristogenesis is obtained; (2) healthy physical development, involving preschool-to-adolescent healthcare, such as the maintenance of mental health and physical exercise; (3) healthy aging, involving middle-aged and aged chronic disease management (such as control of some degenerative diseases) and healthy longevity promotion. In China, the aged continuity service and general medical service are both still at the initial stage of development, and are confronted with many new problems caused by poor laboratory facilities and supplemental examinations. In order to promote the establishment of the aged continuity service in Beijing city, Beijing Geriatric Hospital undertook a research program in 2011 concerning "Strategies for aged medical continuity service and its application in Beijing", in which the differential service systems were compared between China, Australia, and Japan.

To obtain the goals of this program, we performed a data analysis on the basic situations of continuity services in three countries by visiting Tokyo Metropolitan Geriatric Hospital, Japan, and the University of New South Wales and Melbourne Monash University, Australia, to acquaint ourselves with their operation algorithms for general medical service at different levels of geriatric institutions. Meanwhile, by comparison with the Beijing elderly healthcare system, we tried to find the flaws and advantages of our aged continuity service, and to establish basic strategies for the promotion of municipal aged medical continuity services in order to enact feasible measures to enhance the health levels of the aged population.

2. The status of aged healthcare services in Japan

2.1. The features of Japan's population aging

Japan entered the aging society in 1970, as indicated in the 2010 population statistics in Table 1.[2,3] Owing to the aging of the

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Table 1
Comparison of aged populations of China, Japan, and Australia.[2,3]

Year 2010		Japan	Australia	China	Beijing[a]
Population (million)		126.536	22.268	1339.72	12.580
Area (×10,000 km^2)		37.7	768.2	960.0	1.68
Population density (per km^2)		336	3	140	749
Increase rate per year (%)		−0.07	1.33	0.57	0.0
Population aged >65 y (%)		22.7	13.4	8.87	8.7
Life expectancy (1995–2000)	Male (y)	80.1	79.9	72.1	79.1
	Female (y)	87.1	84.3	75.6	80.6

[a] The figures for the household population number in Beijing.

population, medical costs in Japan displayed a high-speed increase. According to statistical data from the Japanese Ministry of Health, the annual medical cost of 2008 was 34.8 trillion yuan, with an increase of 2% over the previous year, among which the healthcare fee for the elderly was 11.4 trillion yuan, accounting for one-third of the national medical expenses. Entering the 21st century, Japan faced a continuous economic downturn and population aging along with a lower birth rate, which has become a very serious social problem that needs to be solved by the Japanese government.[4,5]

2.2. Healthcare policies and regulations for the elderly in Japan

The Medical Affairs Bureau is a constituent of the Ministry of Health, Labor, and Welfare, and has jurisdiction over the Medical Affairs Departments located in the Health and Welfare Bureaus of all provinces, which administer the respective medical healthcare departments located in the Healthcare Divisions of the Health and Welfare Bureaus in each city. The medical institutions serving the elderly include geriatric hospitals, general hospitals, clinics (19 beds or fewer), dental clinics, aged care institutions, special nursing homes for the elderly, nursing homes, and other medical facilities.[6]

In the 1950s, the Japanese government revised a famous law called the "six codes of social welfare", which has become the basic law for social and medical welfare, including the Livelihood Protection Act, Child Welfare Law, Disabled Persons Welfare Law, Act for the Welfare of Persons with Intellectual Disabilities, Act for the Welfare of the Elderly, and Act for the Welfare of Single-parent Families.

Japan's medical insurance system is a mandatory insurance for all Japanese nationals, which is divided into three types. The first is Labor Union Health Insurance, held by about one-third of the population and covering the majority of enterprise and government staff and their dependents. The second is Government-managed Health Insurance, covering the staff in small- and medium-scale enterprises and their dependents or immediate family members. The third is National Health Insurance, covering the self-employed and pensioners. The regulations related to the elderly are mainly composed of the National Health Insurance Act, Major Medical Expense Financing System, Healthcare Insurance Act, and Healthcare for the Elderly System, all of which can ensure medical treatment and healthcare for the elderly, give preferential support for medical insurance, and provide a life nursing guarantee at different stages from hospital to home by means of effective healthcare linkages, in order to relieve family concerns about retirement and pension issues.[6]

2.3. The healthcare system for the elderly in Japan

In order to significantly improve emergency medical care, emergency medical institutions and systems and information systems are to be established, all of which consist of three large units: emergency medical delivery, medical treatment, and information exchange. Delivery (from home to hospital) is to be done by fire agencies, and treatment is performed locally or in large- and medium-sized hospitals. There are mid- and long-term care services for the elderly.[7]

The mid-term care service is an intermediate service agency, which falls in between the hospital and the nursing home or family service, and belongs to general medical institutions. Aged patients who find it difficult to take care of themselves and cannot immediately return home after their discharge from acute care hospitals, may follow the related regulations to be recruited to the elderly healthcare institutions for rehabilitation and convalescence and acquire their possible medical care. Since the implementation of the 2000 Healthcare Insurance Act, the elderly healthcare institutions have been divided into two parts, namely healthcare institutions for elderly nursing and restorative medical institutions, to meet the needs of the elderly prior to returning home.[7]

Long-term care can be supported by nursing insurance, and is generally divided into two parts: a lighter coverage, called subsidiary insurance (graded 1 and 2), and a heavier coverage, called nursing insurance (graded 1–5). With the exception of personal living expenses (such as for residence and meals), various forms of care can be covered by these insurances. Care receivers need pay for only one-tenth of the nursing expense, and amounts in excess of one's individual affordability can be subsidized by subsidiary insurance.[5,8] This service is normally performed in various levels of nursing institutions such as nursing homes.[7]

3. The healthcare service models for the elderly in Australia

3.1. Features of the elderly care service

Population aging is also becoming a prominent issue for the Australian government, with increasing medical expenses that even affect the government's long-term financial situation. After many years of exploration, Australia has formed a set of relatively complete elderly healthcare management models, featuring effective discharge planning, comprehensive geriatric assessment and multi-disciplinary integration management for the elderly, all of which provide the preconditions for the continuity of elderly healthcare services.[9]

3.2. The geriatric evaluation and management model of care

The concept of the geriatric evaluation and management (GEM) model[9,10] was first developed in Great Britain in the 1930s mainly based on the work of Dr Marjory Warren, who thought that general hospitals should establish geriatric wards, and that a multidisciplinary and integrated assessment model could be used to improve healthcare levels, shorten the duration of hospitalization, and avoid unnecessary hospital stays. In the 1960s, the geriatric assessment unit was first established in Australia, followed by the establishment of the long-term care department and geriatric department. In the 1980s, the multi-disciplinary elderly care assessment team was first established and continually developed. The first inpatient GEM unit was established in 2002 in Royal Perth Hospital, Western Australia, as part of the National Demonstrations Hospital Pilot Phase 4 program, which examined the use of multidisciplinary teams to manage and serve aged patients.[11–13]

In Australia, hospitals rated level 6 and level 5 that are equipped with emergency rooms are required to establish an inpatient GEM unit in order to early identify and minimize functional decline in the elderly and reduce hospital costs by keeping lengths of stays to a minimum. In rural areas, inpatient GEM units are established at