

Why Did the Policy to Convert Hospitals Into Facilities Not Work in Japan?

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Abstract

The government of Japan formulated measures to significantly reduce the number of hospital beds for long-term care in 2006. In particular, long-term care hospital beds covered by long-term care insurance (sanatorium medical facilities) were to be abolished in 2012, and existing sanatorium medical facilities were to be converted into long-term care insurance services such as geriatric health services facilities. However, the conversion did not progress in spite of various support measures, and the deadline for abolishment was extended. In order to clarify the reason for this, we selected 28 hospitals with 402 or more long-term care beds and 28 health services facilities with 158 or more beds and examined their management philosophies and analyzed the keywords included. The most popular keyword was “community” in both hospitals and facilities. Hospitals had a significantly higher rate of 60.7% ($P < 0.05$) of including “trust” or “feeling of relief” in their management philosophies. Facilities had higher rates of including any of the terms “return” or “independence” or “home” (32.1%, $P = 0.051$), and also of including either “service” or “care” (46.1%, $P < 0.05$). In conclusion, it is suggested that hospitals with long-term care beds differentiate themselves from neighboring facilities in that they are able to simply accept the situation and be responsible for terminal care whenever inpatients may have difficulty returning home. In addition, it seemed difficult for hospitals to convert into health service facilities, the aim of which is to enable residents to return home.

Keywords: facility, geriatric medicine, hospital, Japan, long-term care, terminal care

1. Introduction

Long-term care beds in Japan were designated as beds for hospitalization of patients requiring long-term care, and after the first enforcement of the Long-Term Care Insurance Act in 2000, the beds were operated separately as beds covered by medical insurance and as beds covered by long-term care insurance (hereinafter referred to as “sanatorium medical facilities for the elderly,” “kaigo-ryoyo” in Japanese) (Ministry of Health, Labour and Welfare [MHLW], 2018b; MHLW, 2002).

Meanwhile, problems regarding the healthcare delivery system in Japan had been pointed out; compared to other countries, the number of beds per population was larger and the average length of hospital stay was longer (OECD, 2005).

With rapid population aging, long-term care beds with a particularly long average hospital stay became a target for further reduction in the 2006 Medical Expenditure Optimization Project.

In this project, it was stipulated that long-term care beds should be operated only in wards that accept patients with high medical needs and covered only by medical insurance, and that sanatorium medical facilities for the elderly would be abolished in 2012. Sanatorium medical facilities existing at that time were obliged to convert into one of the long-term care insurance services by 2012 (MHLW, 2008c; MHLW, 2008a).

Among the various types of insurance services for the elderly requiring long-term care, a facility service called “geriatric health services facility” (called “roken” in Japanese) was most similar to existing sanatorium medical facilities in terms of medical staffing standards and facility standards. Therefore, the Japanese government established various support measures on personnel and facility standards so that existing sanatorium medical facilities could be smoothly converted into geriatric health services facilities (MHLW, 2008d).

However, this policy of converting sanatorium medical facilities into health services facilities was not accepted by owners of the sanatorium medical facilities and did not move forward. This was due to the fact that sanatoriums in Japan are operated exclusively by private sectors, most of which are controlled by medical doctors, and conversions cannot take place without their willingness and accompanying effort (MHLW, 2008c; 2664 hospitals in 2006 → 1766 hospitals in 2012, the deadline for initial abolition (MHLW, 2017)).

The actual operating deadline for sanatorium medical facilities was extended for 6 more years from 2012, but the transition to geriatric health services facilities has not progressed. The Long-term Care Insurance Act of 2018 established a new type of long-term care insurance service called “integrated facility for medical and long-term care” (called “kaigo-iryoin” in Japanese) and the transition from sanatorium medical facilities to integrated facilities for medical and long-term care has started step-by-step since that time. The integrated facility for medical and long-term care is designated as a long-term care insurance facility for elderly people who have both long-term medical and nursing care needs, and it combines medical functions such as “daily healthcare administration” and “end-of-life care” with “residential space” functions (MHLW, 2018; MHLW, 2019, April 26).

In 2010, the Ministry of Health, Labour and Welfare conducted a multiple choice questionnaire survey for all owners of hospitals with long-term care beds in relation to the reasons why they were not willing to make a conversion into health services facilities. With a response rate of 91%, the survey result became the direct basis for politically determining the extension of the deadline for the elimination of sanatorium medical facilities for the elderly.

As of October 2005, just before the policy to abolish long-term care beds became known to the public, the number of hospital beds covered by long-term care insurance was 129 942 in 3400 hospitals (MHLW, 2006). Over the course of 4 years after April 2006, only 1112 beds in 26 hospitals were converted into health service facilities (MHLW, 2010). According to the government survey, during these 4 years, the largest number of beds were converted into medical care beds which are covered by medical insurance: 17 765 beds in 575 hospitals. However, beds covered by medical insurance are more expensive to operate compared to those covered by long-term care insurance, which contradicts the government's goal for financial soundness.

Although the questionnaire was completed only 2 years before the deadline for abolishment, when asked which service their facilities would be converted into, 1190 owners of sanatorium medical facilities replied that it was “undecided.” The most popular reason for this was, “we want to make the decision after obtaining information about the direction of the next reimbursement revision” (58%). Certainly, the survey was conducted in April 2010, which was just 2 years before official prices for basic reimbursement of medical and long-term care insurance were revised. However, if a sanatorium medical facility converted into a health service facility, it was no longer necessary to meet the personnel required by the Medical Care Act. The difference in reimbursement amount was not so much compared to the difference in labor cost at that time (MHLW, 2011). Therefore, reimbursement alone cannot explain why conversion did not progress during the 4 years after 2006.

The second popular reason why the conversion was “undecided” was because “there are concerns” (52%) and 620 owners checked this item. Details of these concerns include “difficulty to convert due to the need for long-term care hospital beds in the community” (72%), followed by “difficulty in finding where existing inpatients can be transferred and accepted” (55%).

This questionnaire was followed by a study that compared population attributes, such as medical needs, among inpatients of sanatorium medical facilities and residents of health service facilities. This study revealed that a large proportion of inpatients require enteral feeding and sputum aspiration (Institute for Health Economics and Policy, 2011). However, according to the survey, the median length of stay in sanatorium medical facilities was 17.7 months in clinics and 18.8 months in hospitals. The majority of patients surveyed in 2010 were hospitalized after it became known that sanatorium medical facilities would be abolished. Since admission to sanatorium medical facilities is based on a contract with patients, depending on the local characteristics, it might have been possible for hospitals to some extent change the type of patients they admitted, from 2006 onward, as a long-term strategy with conversion into facilities in view. Furthermore, the standards of reimbursement, facility and personnel for health services facilities were not extremely unfavorable to the owners of hospitals, compared to those for existing sanatorium medical facilities, because they were established taking into account these survey results (that many users need daily medical care).

The government questionnaire survey revealed that only 19% of hospitals had chosen “resistance to stopping or converting hospitals” as the reason why conversion was “undecided.” This might not have been regarded as a major problem to be addressed immediately at the time of survey result reporting in 2010.

On the other hand, at a review meeting on “how long-term care beds should be operated” held by the Ministry of Health, Labour and Welfare in October 2015, Dr. Orimo, a member of the association and an owner of health service facility, stated that conversions did not take place sufficiently because the government promoted the conversion of hospitals into facilities (MHLW, 2015). This statement is closest to the choice “resistance to stopping or converting hospitals” in the 2010 questionnaire, but it is also likely to be related to “difficulty to convert due to the need for long-term care hospital beds in the community.”

On the basis of the above, we considered that there might be a fundamental factor behind the reason why conversions did not progress sufficiently that cannot be solved solely by the government’s guidance measures such as the adjustment of reimbursement amounts, facilities standards and personnel.

We did not see any academic report whose main purpose was to identify the reason why the hospital-to-facility conversion did not progress. For more information, in 2008, many prefectures set larger target number, as of March 2013 of long-term care beds than government's estimation, as a result of using different methods from that government-sponsored. Yokosawa & Niki noted this may indicate a prefectural concern that medical and long-term care refugees may arise in some cases (Yokokawa & Niki, 2010).

In this study, we evaluated the management philosophy expressed by hospitals with long-term care beds and health care facilities on their own website as a surrogate indicator. We would like to supplement our explanation of phrases that medical and long-term care service providers in Japan disclose on their own websites as management philosophy. First, there is no system in Japan for the administration to evaluate individual contents of management philosophy itself. Noting of related system, all providers of long-term care insurance services in Japan obliged to start disclosing information on their service contents and operating status on an aggregated content website (<http://www.kaigokensaku.mhlw.go.jp/>) in 2006, with the aim of users' comparison and appropriate selection; operating policy was lined up as one of the items that each provider discloses. We can describe the contents of their operating policy on the aggregated content website as their “corporate identity” or “corporate image”, rather than specific goals for their business management, perhaps because of this background. In cases of at least large-scale hospitals and facilities such as our survey targets in this study, the phrases on their own websites as “management philosophy” and those of “operating policy” on the aggregated content website were different; the meanings sound similar, but phrases of management philosophies were often more abstract and conceptual than operating policies. Because conversions from hospitals to facilities cannot take place without managers’ willingness, we wanted to evaluate what managers in charge emphasized as corporate images in this study. This management philosophy was considered to be an appropriate index for measuring what the service providers are voluntarily trying to appeal, because it clearly reflects what role each hospital and facility is trying to fulfill in their environment.

We also discussed whether the difference in management philosophy could be one of the factors for making many sanatorium medical facilities difficult to convert into health service facilities.

2. Methods

No management philosophy is available as a database. However, hospitals with a certain size of long-term care beds or health care facilities of a certain size voluntarily disclose their own management philosophy or that of their corporation on their websites.

In this study, the top 28 hospitals with the largest number of long-term care beds and the top 28 health service facilities with the largest number of beds were selected.

We referred to the list of sanatoriums in Japan and the number of long-term care beds owned by each institution as of April 2011, which were published on the website in 2011 by each regional bureau of health and welfare (Regional Bureau of Health and Welfare, 2011). For the number of beds in health care facilities for the elderly requiring long-term care as of April 2011, we consulted information published by Welfare and Medical Service Network System in 2011 (Welfare and Medical Service Network System, 2011). We selected the year 2011 because that was the year when the Japanese government decided to extend the deadline to abolish sanatorium medical facilities for another 6 years.

On 14 May 2019, we accessed and surveyed the websites of a total of 56 of these hospitals and facilities, and we extracted statements that included the word “philosophy.” If a hospital or facility had its own individual philosophy, this was extracted. In cases where a hospital or facility did not disclose its individual philosophy, we extracted the philosophy of the entire corporation.

Twenty-eight hospitals and 28 health service facilities were divided into each group, and the numbers of hospitals and facilities that included specific keywords in their management philosophy were tabulated. Then we grouped 2

or 3 keywords that were similar, and we tabulated the number of hospitals and facilities that included any of the keywords in these keyword groups. In addition, we compared the proportion of hospitals to the proportion of facilities that included any of the keywords in the keyword groups using the chi-square test. A p-value of 0.05 or less was considered significant. IBM SPSS Statistics 25 was used for this assay.

In addition, we performed an interval estimation of the proportion of relevant hospitals and facilities by using formula (1) with a confidence interval of 95% ($k=1.96$) and with a confidence interval of 90% ($k = 1.65$).

$$\hat{p} - k \sqrt{\frac{\hat{p}(1 - \hat{p})}{n}} < P < \hat{p} + \sqrt{\frac{\hat{p}(1 - \hat{p})}{n}} \tag{1}$$

Since this study analyzed data that are voluntarily published by institutions on their websites without linking them to any institutional-specific information, we did not go through the process of obtaining individual consent from these organizations or the process to obtain ethics committee approval.

3. Results

3.1 Basic Attributes of Surveyed Hospitals and Facilities

The number of long-term care beds in the top 28 hospitals with long-term care beds were 402 to 1024, and the total number of beds in these 28 hospitals was 15 388, with an average of 549.6 ± 164.2 . The number of beds in the top 28 health service facilities were 158 to 300, and the total number of beds in these 28 facilities was 5340, with an average of 189.7 ± 36.1 .

All 28 hospitals and 28 health facilities disclosed their philosophy related to the operation or management on their websites in Japanese. In 5 of the 28 hospitals surveyed, we could not identify any trace of having beds covered by long-term care insurance at any time, and all beds were covered by medical insurance. Another 5 hospitals used to have beds covered by long-term care insurance, but as a result of conversion, they had no beds covered by long-term care insurance at all at the time of the survey. However, all 5 of these hospitals had long-term care beds covered by medical insurance at the time of the survey. On the other hand, all 28 health service facilities continued to operate health service facilities for the elderly requiring long-term care as of the survey date.

3.2 Percentage of Including Individual Keywords

Table 1 shows the percentage of 28 hospitals and 28 facilities surveyed that had specific individual keywords included in their management philosophy.

Table 1. Percentage of hospitals and facilities that include specific keywords in their management philosophy

Keyword	Hospitals with long-term care beds	Health services facilities
care	4%	18%
return	7%	21%
community	36%	54%
environment	25%	14%
family	21%	11%
home	0%	21%
living	14%	36%
recuperation	21%	14%
feeling of relief	32%	21%
safety	18%	11%
satisfaction	11%	18%
independence	7%	14%
self-worth	11%	25%
service	14%	43%
support	7%	25%
trust	36%	18%

Among hospitals with long-term care beds, the most common keywords were “trust” and “community” used in 10 hospitals (36%), followed by “feeling of relief” in 9 hospitals (32%). In health service facilities, “community” was the most common keyword included in 15 facilities (54%), followed by “service” in 12 facilities (43%) and “living” in 10 facilities (36%).

Keywords with higher percentages in hospitals were “trust” (18% difference), “feeling of relief” (11% difference), “environment” (11% difference), “family” (11% difference), etc. Keywords with higher percentages in facilities were “service” (32% difference), “living” (22% difference), “community” (18% difference), “support” (18% difference), and “self-worth” (14% difference), etc.

3.3 Percentage of Including any Keyword in the Keyword Groups

The percentage of including either “trust” or “feeling of relief” was 17 hospitals (60.7%) and 8 facilities (28.6%), and was significantly higher in hospitals ($P < 0.05$). The percentage of including “return” or “independence” or “home” was 3 hospitals (10.7%) and 9 facilities (32.1%), and was somewhat higher in facilities ($P = 0.051$). The percentage of including “service” or “care” was 5 hospitals (17.9%) and 13 facilities (46.4%), and was significantly higher in facilities ($P < 0.05$).

The 90% confidence intervals and 95% confidence intervals are shown in Table 2.

Table 2. Percentage of including some of the keywords in the management philosophy

Keywords		M	90% CI		95% CI	
			LL	UL	LL	UL
“Trust” or “Feeling of relief”	Hospitals	0.61	0.45	0.76	0.43	0.79
	Facilities	0.29	0.15	0.43	0.12	0.45
“Return” or “Independence” or “Home”	Hospitals	0.11	0.01	0.20	-0.01	0.22
	Facilities	0.32	0.18	0.47	0.15	0.49
“Service or Care”	Hospitals	0.18	0.06	0.30	0.04	0.32
	Facilities	0.46	0.31	0.62	0.28	0.65

Note. Hospitals = hospitals with long-term care beds, Facilities = health services facilities; CI = confidence interval; LL = lower limit, UL = upper limit.

4. Discussion

First, for both hospitals with long-term care beds and health service facilities, the most popular word was “community,” and both groups seemed to be trying to meet the needs of local residents in some way.

A high percentage of hospitals with long-term care beds included “trust” or “independence.” Neither sanatorium medical facilities nor health service facilities have rules that directly prohibit long-term stays. For both sanatorium medical facilities and health service facilities, the income primarily comes from the comprehensive basic reimbursement provided by public insurance for each day of treating an elderly requiring long-term care. This reimbursement is an official price, but the longer the stay, the lower the reimbursement. Therefore, this system provides a financial incentive to accept more new residents and, indirectly, to encourage long-term residents to leave. Especially, the amount of reduction in reimbursement associated with long-term stay is larger in health service facilities. Therefore, it is virtually considered a taboo for a resident or his/her family members to explicitly request a long-term stay, even when there is difficulty to return home for any reasons. On the other hand, in sanatorium medical facilities, the amount of reduction in reimbursement associated with long-term hospitalization is relatively small; therefore, it is more advantageous to keep a high percentage of operating beds than to recommend patients’ discharge from the hospital in order to stabilize management. Accordingly, inpatients and their family are usually not encouraged to leave the hospital. What is more, sanatorium medical facilities are the only long-term care insurance facility services staffed by night-shift nurses and duty physicians. We found that hospitals with long-term care beds are trying to differentiate themselves from their neighboring health service facilities by stressing “trust” and “feeling of relief.”

A high percentage of health service facilities included “return” or “independence” or “home.” The former Long-term Care Insurance Act stipulated the role of sanatorium medical facilities as “providing medical care

management, nursing, long-term care and other care under medical management, functional training, and other necessary medical care.” On the other hand, the act stipulated the role of health service facilities as “providing nursing, care and functional training under control of medical management, and other necessary care for medical treatment and daily activities” (Japanese Law Translation Database System, 2009). In addition, while there was no substantial change, the 2018 revision of the act specified the target users of health service facilities as “persons requiring assistance primarily to maintain and restore their mental and physical functions and to enable them to live in the home.” In other words, while health service facilities provide “functional training” for those who aim to return home, sanatorium medical facilities put “care” ahead of functional training by definition. The results of this study may be a direct reflection of this difference.

A high percentage of health service facilities included “service” or “care.” There may be a variety of opinions on this point. In accordance with the definition of health service facilities as above, we believe that health service facilities, compared to hospitals with long-term care beds, have a tendency to be more conscious of obtaining some type of outcome, such as functional recovery, from a direct contact with residents. It should also be noted that the percentage of including “environment,” which is a symbolic target for comparison with these keywords, were slightly higher in hospitals with long-term care beds than in health service facilities.

It is also interesting that more hospitals with long-term care beds included “family” and more health service facilities included “home,” although significant differences were not shown in this study. Hospitals that provide planned terminal care must be attractive to “families” with inadequate home care settings. This result may suggest the present situation in Japan that there are substantial needs for services that are different from health service

In Japanese medical and long-term care field, no method of assessing true management philosophy has systematize, so we cannot ensure the phrasing of the philosophy itself really reflects their real philosophies.

We did not have a process in this study to show actively whether management philosophy can be taken as an appropriate index for measuring what the service providers are voluntarily trying to appeal; we checked that there is no academic report we should doubt this in Japanese medical and long-term care field.

The number of facilities extracted was too small. For convenience, only large-scale facilities were selected. It may be controversial whether this method could ensure representativeness of all sanatorium medical facilities and health services facilities nationwide. However, the conversion of hospitals with a large number of beds is a high-priority issue considering its financial effects. In addition, in big hospitals and facilities, the group attributes of patients and residents are somewhat stable, and the management philosophy of such facilities may also be linked directly to their management strategies. Therefore, the results of this study are meaningful, though the reasons why small clinics cannot be converted need to be considered separately.

For long-term care beds, single data on the number of beds of sanatorium medical facilities (beds covered by long-term care insurance) were not available on a per-hospital basis. However, the definition of long-term care beds is the same in the Medical Care Act, whether they are covered by medical insurance or long-term care insurance. Therefore, we consider that the presence or absence of beds covered by long-term care insurance and their proportion do not significantly affect the content of the management philosophies of hospitals and corporations.

Furthermore, although hospitals and facilities to be surveyed were extracted from the 2011 database, information on the management philosophy could be obtained only as of 2019. During this time, there were some hospitals that converted their long-term care beds, so we cannot deny the possibility that the management philosophy was also revised at the same time. However, according to a survey conducted by the Ministry of Health, Labour and Welfare in integrated facilities for medical and long-term care in November 2018, only 7.5% of the facilities created a new management philosophy when they converted their hospitals into new integrated facilities. When asked the reason for not re-creating the management philosophy, the most common answer (91.4%) was “it is the same as our original management philosophy” (MHLW 2019, April 10).

As stated above, integrated facilities for medical and long-term care were established in April 2018. These facilities offer medical functions, such as “daily healthcare administration” and “end-of-life care” and functions as a “residential space” to elderly people who have long-term medical and nursing care needs. Taking into account that more than 70% of the predecessors of integrated facilities are hospitals with long-term care beds, sanatorium medical facilities and integrated facilities seem to have an affinity in that they can accept the existence of residents who require routine medical management and who are practically difficult to return home.

Finally, in this survey, there were no keywords with extremely different ratios in hospitals with long-term care beds or in health service facilities. As a survey method, if we could not find the individual management philosophy of a

hospital or a facility, we extracted the philosophy of the entire corporation, but we must note that corporations with long-term care hospital beds also often owned health service facilities, and vice versa.

5. Conclusion

This study compared the management philosophies of hospitals with a large number of long-term care beds to those of health service facilities with a large number of beds. Many hospitals were found to have a management philosophy to meet the needs of local residents to provide a well-planned terminal care environment. On the other hand, many health service facilities stated that their management philosophy is to meet the needs of the elderly in the community by providing direct care in order to enable them to return home.

From the start of the long-term care insurance system in 2000 until the establishment of integrated facilities for medical and long-term care in 2018, sanatorium medical facilities and health service facilities were the only long-term care insurance facility services staffed by full-time physicians and night-shift nurses. Even after the announcement of the policy to eliminate sanatorium medical facilities in 2006, there must have existed needs for a long-term care insurance service as a “final home” for elderly people who do not require hospitalization by medical insurance but still have certain medical needs. Actually, those without high medical needs can choose “geriatric social welfare facilities” (called “tokuyo” in Japanese), which is one of the long-term care insurance services, as their “final home.”

In sanatorium medical facilities (hospitals with long-term care hospital beds) and health service facilities, the staffing standards for medical personnel are similar numerically, but the purpose of investing medical resources differs qualitatively, in terms of both legal definitions and actual management philosophies. Because sanatorium medical facilities are based on the philosophy of accepting the actual condition of elderly people who practically cannot return home and treating them until their final stage, it seemed difficult for them to convert into health service facilities, which aim to enable residents to return home.

As stated at the beginning, elimination of long-term care beds in hospitals and conversion into long-term care insurance facilities were politically decided with the goal of restoring financial health. Our study suggests that hospitals with long-term care beds may have indicated opposition to the government which encouraged their conversion into a facility with a very different management philosophy.

In establishing integrated facilities for medical and long-term care, a new long-term care insurance facility service in 2018, discussions were repeated with people with different viewpoints on topics such as the roles that long-term care beds are currently playing in the local community, the roles that are difficult for existing health service facilities to fulfill, and the roles that would be demanded more in the future in Japan. Therefore, the issue of definition and philosophy may have improved compared to the previous policy of converting hospitals into health service facilities.

From now, it is necessary to observe whether conversions into integrated facilities for medical and long-term care will take place, and if they do not, to clarify the cause.

Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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