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＜ Review ＞

Rehabilitation professionals for the aging society in Japan: Their scopes of work and related health policies and systems

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Abstract

Rehabilitation needs have been globally increased and how to involve rehabilitation in the health care systems is important. There is a large number of rehabilitation professionals in Japan, and rehabilitation services is delivered for people who require rehabilitation in any clinical phase. We overviewed history of rehabilitation in Japan, especially focused on an aspect of the aging society.

The official history of rehabilitation professionals has begun with the enactment of Physical Therapists and Occupational Therapists Act in 1965. In 2000, the law for medical fees was renewed and a new ward of recovery rehabilitation was approved to open. More and more rehabilitation professionals have been required there. In the same year, the long-term care insurance system was established based on the principle of "support for independence." Rehabilitation needs have grown under the system with further aging of the population.

Acute and recovery rehabilitation are mainly covered by medical insurance. There are payment systems of rehabilitation corresponding to certain major diseases such as cardiovascular, cerebrovascular, and musculoskeletal disease. Rehabilitation fee is applied for a fixed period differed by each disease ranging from 90 to 180 days. Provision of services is generally defined based on clinical evidence.

Long-term care insurance is covering rehabilitation for people in chronic conditions and long-term care needs. Therapist-led rehabilitation in this field is provided as three types of services: home visit, day care, and in-facility services. While Rehabilitation is mostly provided individually and directly under the medical systems, it varies under the long-term care systems. Functional training provided by non-rehabilitation professionals and collaborating with rehabilitation professionals are prescribed in addition to therapist-led rehabilitation. Although the systems have widely enabled older adults to receive the benefits of rehabilitation, there are still issues to be solved such as unclear applicable criteria and insufficient evidence of effective rehabilitation.

Rehabilitation is also delivered under the Community-based integrated care systems. Effective and efficient projects are created by municipalities following the regional characteristics under the systems, and rehabilitation professionals are involved in projects such as preventive population approach for healthy older adults. Rehabilitation professionals are starting to fulfill their responsibilities widely in the context of preventive care and support for independence in the community.

Through Japanese experiences and history to develop such rehabilitation services in the health care systems, we may learn lessons and get suggestions to apply to recent global initiatives on rehabilitation.

keywords: rehabilitation, policy and system, aging society, health insurance, long-term care insurance

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I. Global trends on rehabilitation

Among the Sustainable Development Goals (SDGs) by United Nations (UN), the Goal 3 directly relates to health. "To ensure healthy lives and promote well-being for all at all ages," it has 13 targets, and Universal Health Coverage (UHC) is one of them [1].

According to "Political declaration of the high-level meeting on UHC" by UN general assembly in 2019, rehabilitation counts among the essential health services, just the same as health promotion, prevention, medical treatment, and so on [2]. It means that rehabilitation is one of the keys for the global community to realize the value of the UHC and to make efforts toward achieving the SDGs.

At the same time, a recent research by WHO has shown that 2.41 billion individuals had conditions that can benefit from rehabilitation. The proportion is almost one third of the world's population in 2019. Furthermore, the research found out that the global needs for rehabilitation significantly increased in the past three decades [3]. It seems that now is the time to update the common view of rehabilitation. It is becoming one of the essential health services, rather than services required by a few people, such as persons with disability.

Thus, the global community began to recognize the importance and huge demands of rehabilitation. However, as of now, delivery and supply of rehabilitation services are not enough at all, especially in low- and middle-income countries. Most of those countries provide rehabilitation services only at tertiary level of their health system, few services at secondary level, and rare at primary level [4].

To solve the problems due to the gap of demand and supply in rehabilitation, since 2017, WHO is organizing a campaign that is named as "Rehabilitation 2030."

As a part of the campaign, WHO has made the following recommendations of A to G [4]:

A. Rehabilitation services should be integrated into health systems
B. Rehabilitation services should be integrated into and between primary, secondary, and tertiary levels of health system
C. A multi-disciplinary rehabilitation workforce should be available
D. Both community and hospital rehabilitation services should be available
E. Hospitals should include specialized rehabilitation units for inpatients with complex needs
F. Financial resources should be allocated to rehabilitation services to implement and sustain the recommendations on service delivery
G. Where health insurance exists or is to become available, it should cover rehabilitation services

Scope of the recommendations is broad. It includes health systems, service provision, workforce, finance, health insurance, and so on. It shows us that rehabilitation professionals have a vast area where they can present their expertise and that rehabilitation should spread globally so that we can realize the UHC and achieve the SDGs.

On the other hand, Japan is well known as a country that has realized the value of UHC. Moreover, Japanese health care system provides rehabilitation services at all levels from primary to tertiary. Through Japanese experiences and history to develop such rehabilitation services in the health care systems, we may learn lessons and get suggestions to apply to recent global initiatives on rehabilitation.

This paper aims to explore and describe history of rehabilitation in Japan, especially focused on an aspect of the aging society.

II. Transition in policies and rehabilitation with population aging in Japan

The aging rate in Japan has been increasing since the 1950s, and it reached 28.1% in 2018 [5]. Supply volume and the area of employment of rehabilitation professionals have been regulated by the policies and systems and considerably influenced by changes in policies and systems with population aging. Globally, there is the highest number of physical therapists, 192,327 [6], and the second-highest number of occupational therapists, 74,815 [7], in Japan. It could be said that the provisioning system of rehabilitation has been established, and the system in Japan has almost met to proposals of the World Health Organization [4,8] with a large number of therapists. We will explain the increasing needs of rehabilitation professionals focused on the following two aspects: proportion of disease and policies relevant to population aging.

1. Changes in proportion of disease post World War II

The proportion of infection decreased and that of non-communicable diseases such as stroke, cardiovascular disease, and cancer increased in the percentage of causes of death after World War II, around 1950. Stroke had been the highest in the percentage of causes of death for several decades since then [9]. It has decreased to 7.5% recently (fourth highest following cancer, cardiovascular disease, and senility) [10], while the number of stroke patients is still huge, more than one million and almost all of them are old (as of 2017) [11]. Stroke often leads to sequelae, and it causes a condition of long-term care need. It is the second highest reason for long-term care needs following dementia [12]. An increasing number of older adults who have se-

quelae of stroke is one of the main reasons for increasing the need for rehabilitation.

2. Transition of policies relevant to older adults

1) Health care insurance system

The health care insurance system in Japan began with the National Health Insurance Act of 1922 (Act No. 70 of 1922). The Medical Law of 1948 (Act No. 205 of 1948) regulated the standards of hospitals and clinics. The medical payment systems have been applied to the provision of medical (i.e., health) insurance services [13]. Registered physical therapists and occupational therapists (speech-language therapists were added in 1997) are allowed to provide rehabilitation as a treatment of medical payment systems. Historically, the importance of acute rehabilitation was recognized and emphasized in the system in the 1990s [14]. In 2000, the law for medical fees was renewed and a new ward in hospitals was approved to open [15], the "Kaifukuki Rehabilitation Ward" [16]. The English translation for this new ward varies among materials, and thus, in this article, we specifically define the medical rehabilitation service that is provided in this ward as "recovery rehabilitation," and a hospital that mainly offers the recovery rehabilitation services as "rehabilitation hospital." Recovery rehabilitation aims to improve the ability of activities of daily living and enable them to go back to their home for patients who discharge from acute hospitals. More and more rehabilitation professionals have been required in recovery rehabilitation hospitals.

2) Long-Term Care Insurance System

The Act on Social Welfare for the Elderly was enacted in 1963 (Act No. 133 of 1963) to deal with the declining caregiving capacity of families because of economic growth after World War II in Japan. Welfare facility for older adults was established under the act to care for them. As the aged population increased, the concept of policy had changed from caring for older adults in facilities to supporting them in their communities. Under the concept, projects such as functional training had started for preventing bedridden conditions for older adults [17]. With further aging of the population, the long-term care ("Kaigo" in Japanese) insurance system was established in 2000 based on the principle of "support for independence" (concurrent with the recovery rehabilitation in the medical insurance service) [18]. It could be said that rehabilitation needs have grown with the movement of "from institutions to the community" and "support for independence."

3) Community-based Integrated Care System

The Japanese government aims at establishing a structure of "the Community-based integrated care system" by 2025 when the estimation of the older adults population will reach its peak [19,20]. The system is defined as ensuring comprehensive services for preventive care and daily life support, such as medical services, nursing care, and welfare services, which are provided in one's living areas based on the long-term care insurance system [21]. One of the features of the integrated care system in Japan is emphasizing nursing care prevention; in other words, health promotion, and relevant project of community-based rehabilitation activities was newly established to facilitate nursing care prevention with the utilization of rehabilitation professionals. The establishment of the project has promoted the involvement of rehabilitation professionals in the field of care prevention. Roles of rehabilitation professionals have been enlarged with policy transition from "supporting independence for older adults who need long-term care" to "strengthening nursing care prevention for still healthy older adults."

III. Establishment of rehabilitation professionals in Japan

The official history of rehabilitation professionals (i.e., physical therapist and occupational therapist) in Japan has begun with the enactment of Physical Therapists and Occupational Therapists Act in 1965 (Act No. 137 of 1965). However, the demand for rehabilitation had been increasing since the World War II (1939–1945), which left many disabilities in survived but wounded soldiers. Before the World War II, the care for those who were mentally and/or physically disabled was thoroughly provided by their families and communities. The World War II triggered the need for medical rehabilitation offered by specifically trained personnel in the medical field to replace the family/community-based care, which had long been the main source of rehabilitation. Thus, the Japanese physical therapy and occupational therapy are rooted in the World War II and have developed as one of the professional medical fields since then [22].

After the World War II, three important laws were set: Child Welfare Act (Act No. 164 of 1947), Act on Welfare of Physically Disabled Persons (Act No. 283 of 1949), and Act on Social Welfare for the Elderly (Act No. 133 of 1963). Those laws played an important role in cultivating the base for rehabilitation needs in Japan after the War [23]. In addition, the World Health Organization (WHO) requested the Japanese government to organize an education system for physical therapists and occupational therapists. As a consequence of these series of movements, in 1963, the Japanese government approved a school for physical therapists and occupational therapists built in Kiyose city, Tokyo, which became the first official education facility for rehabilitation professionals [24]. After the enactment of Physical Thera-

pists and Occupational Therapists Act in 1965, a total of 203 graduates from this three-year program (183 from physical therapy department, 20 from occupational therapy department) passed the first national examination in 1966-, and became the very first physical therapists and occupational therapists in Japan [25]. The physical therapy association and occupational therapy association were also established in 1966. Physical therapy and occupational therapy further developed during the postwar years of spectacular economic growth.

1. Important milestones after the initial establishment of the rehabilitation professionals

Now that the officially trained specialists in rehabilitation were born in Japan, physical therapy and occupational therapy were run under the medical insurance system so that facilities that provided physical therapy and occupational therapy services could charge the medical fees. This means the care for those who were injured and ill, which used to be offered as family- and community-based service, evolved considerably and was qualified as "medical rehabilitation." With this significant step, the number of physical therapists and occupational therapists gradually increased up to 2000 [7,26].

During those postwar years until 2000, Japan experienced two major constructive changes in its society; the trend toward nuclear families and the aging [27], both of which significantly increased the demand for the medical rehabilitation, particularly for older adults. The number of illnesses that requires hospitalization increases with the number of older adults increasing, and more older adults need a longer period of care at a hospital due to factors such as the aging of caregivers at home and the lack of a younger generation to take care of older adults in families. After discharging, those older adults who have been hospitalized need to be able to do some activity of daily living to a certain extent, otherwise they would most likely become bedridden. Because of this background situation, in 2000, the recovery rehabilitation services started to be provided at a rehabilitation hospital.

Upon the onset of illness such as a stroke, the medical rehabilitation in acute phase begins along with the medical treatment to recover from the illness. During the recovery rehabilitation, immediately following after a few weeks of acute rehabilitation, patients are extensively trained to be able to perform applied skills in activity of daily living, in addition to the basic motor skills including movements on bed, sit to stand, and gait. Survivors after the stroke, for example, can stay in the recovery rehabilitation maximally for six months under the medical insurance, which tremendously contributes to gear patients for a return to home, community, and society. There are currently six standards to operate the recovery rehabilitation ward, and all require having a certain number of full-time physical therapists and occupational therapists. The number of beds in the recovery rehabilitation ward has been increasing rapidly since 2000 [28] (Figure 1), so as the number of physical therapists and occupational therapists (Figure 2).

Another contributor for the rapid increase of physical therapists and occupational therapists was the long-term care insurance system, which also became effective in 2000. The background behind the introduction of long-term care insurance was the fact that the welfare system and medical system for older adults in Japan before 2000 had limitations and could not handle the problems that arose with the increasing number of older adults who needed long-term care. Those problems included but not limited to the expensive cost to take care of older adults in the welfare system

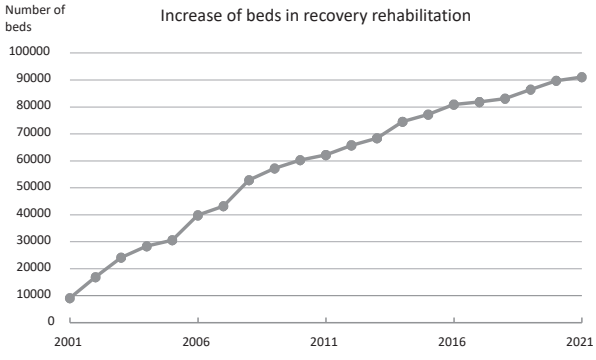

Figure 1 The number of beds in recovery rehabilitation since 2001 to 2021
The number continues to increase since the recovery rehabilitation ward started to operate in 2000 (the figure was made based on data in ref [28]).

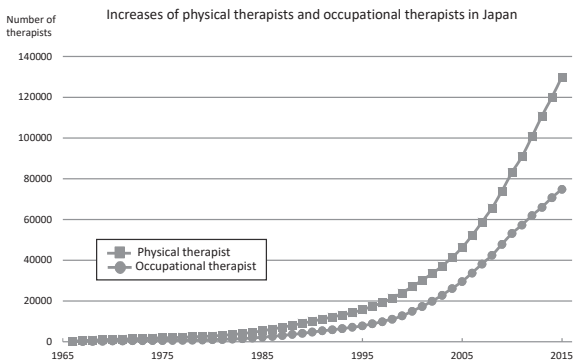

Figure 2 The number of physical therapist and occupational therapist in Japan since 1966 to 2015
The number shows a rapid increase after 2000 in both disciplines (the figure was made based on data in refs. [6] and [7]).

or the medical system, and the stereotypical services that may not fit all [27]. There were limited number of physical therapists and occupational therapists specialized in the initial welfare system started in 1963 because the main focus was to take care of bed-ridden older adults, which was mainly operated by nurses. Once the long-term care insurance system had begun, certain services, such as in-facility services and home-visit services, include rehabilitation that require to be done exclusively by physical therapists and occupational therapists, not by nurses or any other medical professionals. This requirement is based on the primary aim of the long-term care insurance system, which is to avoid bed-ridden and to promote independence of older adults in their own homes and communities. The introduction of the long-term care insurance system significantly expanded the field for physical therapists and occupational therapists to utilize their specialty from hospital to community, and thus, as in Figure 2, the number of physical therapists and occupational therapists showed a rapid increase after 2000.

2. Current statistics of physical therapists and occupational therapists in Japan

Currently, the official education for physical therapy and occupational therapy is offered as three- or four-year program at a college (undergraduate level) or a vocational school. The total number of graduates from those physical therapy and occupational therapy schools who passed the national exams was 192,327 (for physical therapists in 2021 [6]) and 74,815 (for occupational therapists in 2015 [7]). The places for physical therapists and occupational therapists to be employed are categorized into various types including facilities under medical insurance (such as hospitals and clinics) and the long-term care insurance system (such as care homes for older adults and home-visit rehabilitation services). The number of members for the physical therapy association was 129,875 in 2021 [6] and 62,294 for the occupational therapy association in 2019 [30], of which 65.2% of physical therapists and 56.3% of occupational therapists work at medical facilities [6,29].

IV. Rehabilitation under the Medical and Long-Term Care Insurance Systems

Rehabilitation has been provided to older adults in any phase: from the preventive phase for healthy older adults to the chronic phase for older adults in long-term care need along with the system development in Japan (Figure3). We would introduce rehabilitation for older adults and its system in this chapter.

1. Rehabilitation under the Medical Insurance Systems

Payment systems corresponding to disease have been applied, and standards for providing rehabilitation such as the number of professionals, area of rehabilitation room, and so on have also been prescribed based on the disease. The minimum unit of payment is 20 minutes of rehabilitation, and the unit fee is defined by the disease [30]. Rehabilitation under the medical insurance system is generally provided based on guidelines, which are created using evidences. One of the current issues in this field is insufficient cooperation between medical facilities and related institutions of long-term care services in communities when patients discharging back home.

1) Acute and recovery rehabilitation

Acute and recovery rehabilitation aim to improve physical/ mental functions and performance of Activities of Daily Living (ADL). Acute rehabilitation is attempted mainly for the prevention of disuse syndrome through early intervention, while recovery rehabilitation is mainly for improving functions and abilities of ADL with intensive rehabilitation. There are payment systems of rehabilitation in those phases corresponding to major five diseases; cardiovascular disease, cerebrovascular disease, musculoskeletal disease, disuse syndrome, and pulmonary disease [30]. Rehabilitation fee is applied for fixed period differed by these diseases. The periods of rehabilitation are prescribed for 150 days, 180 days, 150 days, 120 days, and 90 days, respectively. One patient can receive rehabilitation that combines physical, occupational, and speech-language therapies of 6 to 9 units

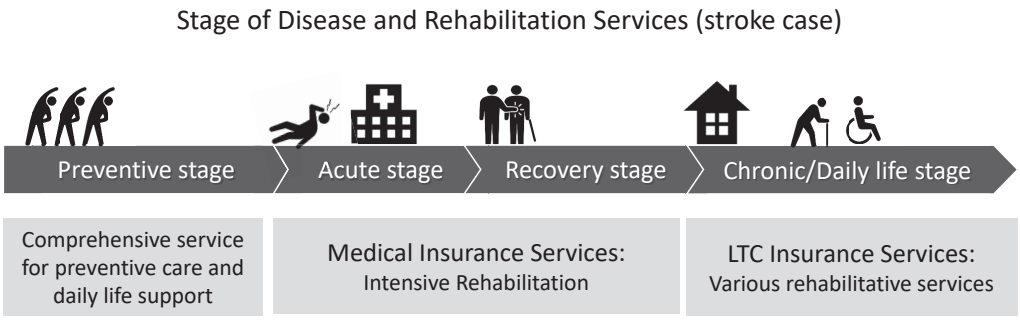

Figure 3 Rehabilitation services in Japan are provided through all stages of disease
The figure shows the correspondence of rehabilitation services and each stage of a disease (stroke case in this figure)

(for 2 to 3 hours) a day. The amount of payment of rehabilitation services for those 5 diseases is slightly increasing. The total number of counted payments was more than 35,000,000 at more than 25,000 medical facilities, and the payments for cerebrovascular disease and musculoskeletal disease accounted for 87% of the total [31,32]. Other rehabilitation services fees are prescribed for intractable diseases, children or persons with disabilities, cancer, and dementia. Considering the acute rehabilitation, other treatments such as the very early phase rehabilitation for patients in the intensive care unit and rehabilitation of swallowing have been added. One of the characteristics of recovery rehabilitation is that the results of rehabilitation are evaluated, and profit is added if there are good outcomes. Outcome measurements are the proportion of patients discharging to their home, functional change assessed by Functional Independence Measure, and so on. Especially, profit is added when rehabilitation is provided on both weekdays and weekends so that many rehabilitation hospitals have provided rehabilitation 365 days a year [33].

2) Rehabilitation in other phases

Rehabilitation as medical services is also provided for patients in the chronic phase at chronic ward and community-based integrated care ward. Rehabilitation at community-based integrated care ward has a role to make patients go back to their home based on a concept of the community-based integrated care system in Japan. Two units (40 minutes) of rehabilitation per patient are provided a day at those wards [30].

2. Rehabilitation under the Long-Term Care Insurance Systems

There are mainly three types of services: home visit, day care, and in-facility services under the long-term care insurance systems in Japan. Rehabilitation by professionals under the systems is also provided as those types. While rehabilitation under the medical insurance system is mostly provided individually and directly, it varies under the long-term care insurance systems [33]. Service of functional training provided by non-rehabilitation professionals and service collaborating with rehabilitation professionals are prescribed in addition to therapist-led rehabilitation [33]. The latter can be considered as indirect involvement of rehabilitation professionals. Although the systems have widely enabled older adults to receive the benefits of rehabilitation, there are still issues to be solved such as unclear applicable criteria and insufficient evidence of effective rehabilitation.

1) Directly provided rehabilitation by professionals

Rehabilitation services by the professionals (i.e., therapy-led rehabilitation) under the long-term care systems occur at patients' homes, day care centers for rehabilitation, and long-term care health facilities. The long-term care health facilities are intermediate facilities for patients to go back home through rehabilitation. Additional payments of short-term intensive rehabilitation for patients after discharge from hospital and for dementia are prescribed among this kind of rehabilitation in the facilities [33]. Any type of short-term intensive rehabilitation can be applied for 3 months, and more than two sessions of 20 to 40 minutes per patient are provided a week as short-term intensive rehabilitation [33].

2) Other rehabilitative services

Functional training service is provided by functional trainers who are not only rehabilitation professionals but also care workers, acupuncturists and practitioners of moxibustion, nurse, and so on. They make functional training plans for long-term care insurance users individually and conduct training based on the plan. The plan should be made for each user individually, but training is not necessarily provided individually.

Currently, the service of cooperation for functional improvement of older adults users is newly established [30]. It can be applied when long-term care service providers cooperate with rehabilitation professionals who are belonging to other institutions and obtain advice from professionals about making plans, assessments, and how to care for older adults. In this case, rehabilitation professionals are indirectly involved in older adults' long-term care services [30].

Various rehabilitation services have been promoted under the long-term care systems to facilitate support independence.

3. Comprehensive Service for Preventive Care and Daily Life Support

Comprehensive service for preventive care and daily life support is a framework to promote community-based integrated care. The project enables municipalities to create effective and efficient support following the regional characteristics. It has consisted of various kinds of supports provided by local resources of NPO, citizens, etc. [34]. It includes rehabilitation-specific projects to promote effective preventive care. Rehabilitation professionals are involved in a project of preventive care for frail older adults through day care or home-visit support and a preventive population approach for healthy older adults. Moreover, professionals attend conferences for individuals who need support living in the community depending on municipalities. Rehabilitation professionals are starting to fulfill their responsibilities widely in the context of preventive care and support for independence in the community.

V. Conclusion

The number of rehabilitation professionals gradually increased and their field expanded from medical treatment for patients in acute or recovery phase to long-term care for older adults in chronic status, and to the care prevention for healthy older adults according to changes in policies and systems with the advancing aging society. In addition, it can be said that the involvement type of rehabilitation professionals had been no longer only direct and to an individual but also indirect and to a population to cope with the further aging society. Systems of rehabilitation in Japan have shifted and met domestic needs to some extent, and thus, experiences and results in Japan might be beneficial when we design the system of rehabilitation in other countries. The current issue in this field in Japan is developing evidence of rehabilitation and reflecting it on policy especially in long-term care systems. Recently, the Japanese government has newly developed a national information system named "Long-Term Care information system for evidence (LIFE)." Information on interventions and conditions of the service users have been included in this novel system. It is essential to develop robust evidence of rehabilitation with analysis of such large-scale data [35]. Our efforts to solve the issue and its results might be beneficial in building effective and efficient rehabilitation service delivery systems especially in low- and middle-income countries where resources relevant to rehabilitation have been limited.

Conflict of Interest: COI

There is no conflicts of interest.

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＜総説＞

日本における高齢化とリハビリテーションの変遷
―医療・介護保険制度下における展開―

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抄録

リハビリテーションは健康増進・疾病予防・治療等とともに，ユニバーサルヘルスカバレッジの必須項目に含まれている．近年，社会の高齢化が国際的な課題となっており，リハビリテーションのニーズも高まっているが，特に低・中所得国においてリハビリテーションは十分に提供されておらず，その需要は満たされていない．一方，本邦においては，世界的にもリハビリテーション専門職の数が多く，多様な対象者に対し，全ての段階におけるリハビリテーションの提供を概ね達成している．リハビリテーション提供体制の構築に関しては，国の政策・制度に依るところが大きいことから，本著では高齢者に対するリハビリテーションに焦点をあてて，高齢化先進国である本邦のリハビリテーションの普及の過程について，疾病構造の変化や政策・制度の変遷から論じるとともに，現在の医療・介護保険制度下におけるリハビリテーションの提供体制について整理した．

リハビリテーションの普及に大きな影響を与えた事象として，非感染性疾患－特に脳卒中患者の増加，施設入所高齢者の地域生活移行の促進，自立支援を基盤とした介護保険制度の施行と自立支援強化のための回復期リハビリテーション病棟の創設が挙げられる．これらは医療・介護保険制度に組み込まれ，リハビリテーションも制度内に位置づけられることとなった．これによりリハビリテーション専門職が増加し，広くリハビリテーションサービスを提供できるようになった．近年では，地域包括ケアの理念に基づき，重度化防止・介護予防のさらなる促進のため，より広く多様なリハビリテーション専門職の活用が進められている．今後の課題としては，大規模データの分析等によるエビデンスの確立と，エビデンスに基づく政策立案・制度設計が挙げられる．

本邦における医療・介護保険制度下でのリハビリテーション提供体制は，リハビリテーションの提供が十分でない他国におけるリハビリテーションの制度化・体制整備を考える上で参考になると考える．

キーワード：リハビリテーション，政策・制度，高齢化，医療保険，介護保険