短 評

Expanding the role of health service providers and the health care profession in the delivery of long-term care

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The forecasted rapid growth in the aged population has made the development of long-term care (LTC) services a priority in both social and medical care systems. In January 2004, the Department of Health invited seven internationally renowned researchers and policy planners to participate in a dialogue to outline the future LTC policy in Taiwan. Recommendations have emerged from the four-day conference and were presented to the Department of Health[1]. Their critical evaluation of the LTC system in Taiwan identified four issues that may have important implications to health service providers and the health care profession.

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1. Establishing a needs-based, as opposed to means-based, LTC program to meet the care needs of adults with disabilities.

Rather than treating it as a program for the poor, all who need it should have equal access to it. At present, only the low-income, which made up about 0.76% of the general population, may receive public funding for LTC care services [2]. The general public still face significant financial barriers in using LTC services. As a result, unmet needs for care are prevalent among the disabled elderly residing in the community. In a recent survey of community-dwelling elderly, as high as 33% of the disabled did not receive the needed care in activity of daily living[3].

It was recommended that eligibility for service reimbursement by public funding should be based on needs, not means. An innovative scheme of combining needs-based reimbursement with co-payments would help to ensure access for all who needs services, increase financial viability through cost sharing, and yet, reduce the moral hazards of inappropriate use. The level of disability should determine the amount of services reimbursed, and the ability to pay should determine the amount of required co-payment. However, co-payment should be set at a level that would not discourage low-income persons from receiving services. The change to needs-based program would likely lead to an increase in funding for medical care services, such as home nursing care and physical therapy. Health service providers would likely to have a more im-

portant role as a LTC service provider.

2. LTC efforts should be directed toward enabling home- and community-based care services for older and disabled people.

Home and community-based service has been the mainstream of LTC in many developed countries. It is also one of the WHO recommendations in the development of a LTC system. Reforms in LTC systems have involved shifting the balance between community and institutional care by making considerable greater resources available to community services[4]. Despite of its importance, the development of community-based care resource is only a recent phenomenon in Taiwan. Its past emphasis in developing institutional care has led to an overabundance of institutional beds. Based on data from the Department of Health and the Ministry of Interior Affairs, currently there are more than 50,000 institutional beds. After including beds in uncertified institutions and the long-term care beds in hospitals, it averages to about 3 institutional beds per one hundred elderly, higher than the beds to elderly ratio in England[5].

Despite some government efforts to increase community-based care resources, its growth has been stagnant. The general public has a low awareness of services, receives only limited service reimbursement, and are unwilling to pay for the services. Furthermore, the lack of coordination among various services has presented a picture of fragmentation among the services. These problems led to low service utilization, and consequently, the lack of interest in private sectors to invest in resource development. Before community-based care can become the mainstream of services, these issues need to be properly addressed. The involvement of health service providers in providing community-based services will instantly increase resources and bring credibility to the services.

3. Post-acute care (PAC) should be handled separately and covered under National Health Insurance.

PAC is a crucial element in the LTC system. It includes a set of services that seem to continue the work of hospital after discharge, such as rehabilitative and nursing care. With hospitals pressured to discharge patients quicker and to reduce length of stay, many of the PAC will need to be provided at home, rather than in hospitals. Without expanding coverage for PAC, many patients will be left without care. Increased hospital re-admissions and medical expenditure could result due to insufficient post-acute care. A study found that 24.4% of the hospital discharge patients with disability and at least a diagnosis of progressive chronic disease or chronic impairment following an acute episode had unplanned readmissions within 2 months after discharge. The percentage increased to 40.9% for those with progressive chronic diseases[6].

Whether to implement a DRG-based reimbursement for hospitals is still being debated fervently within the Bureau of National Health Insurance. Its implementation will likely have a negative effect on access to PAC services. Hospitals will have financial incentives to discharge patients quicker and withhold PAC services. Resources should be allocated specifically for the provision of PAC services to ameliorate the negative consequences. While the topic is still being discussed, the pressure for hospitals to reduce length of stay still remains. Thus, appropriate coordinating and assessment mechanisms, such as hospital discharge planning, comprehensive geriatric assessment, and care management should be implemented to bring cohesiveness and continuity of PAC and LTC services.

4. Investment in education and training for the development of human resources is an immediate concern.

Human resources should included physicians, nurses, therapists, social workers,

and homemakers. Projections of needs for human resources should be made based on national data and should be included in the manpower development plan within the Ministry of Education. Training should be provided to increase their effectiveness in working with LTC, particularly with community-based services. Geriatric training for physicians ought to be established. Additional incentives are probably needed to encourage physicians to work with LTC. Long-term care curriculum should be included in their educational development. Rosters of qualified workers providing LTC should be maintained by participating providers and municipal government. To compete with foreign laborers, local workers should increase the quality of care through continual on-job training. The use of foreign workers for publicly funded programs should be actively discouraged in order to reduce reliance on foreign labor, and to increase job opportunities for local workers. With increased job security, it will be easier to attract better, qualified workers and reduce turnover.

Health care providers and health care professionals are becoming increasingly important in the delivery of LTC services. The establishment of needs-based reimbursement, the emphasis on community-based services, the expansion of post-acute care, and the development of additional human resources are the likely changes that will take place in the process of establishing a LTC system in Taiwan. These changes in LTC policy will expand the role of health service providers and the health care profession, and the effects of these changes should be evaluated extensively.

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