

* This English manuscript is a translation of a paper originally published in the *Psychiatria et Neurologia Japonica*, Vol.125, No.9 p. 771-778 which was translated by the Japanese Society of Psychiatry and Neurology and published with the author's confirmation and permission. If you wish to cite this paper, please use the original paper as the reference.

Special Feature Article

Trends in Psychiatric Service Use in Japan Using a Nationwide Claims Database (fiscal years 2013-2019)

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Psychiatria et Neurologia Japonica 125: 771-778, 2023

Abstract

We aimed (1) to review the trends in medical care plans for mental illness and their clinical indicators, and (2) to investigate trends in psychiatric service use in fiscal year 2013 through 2019 in Japan using a nationwide claims database (NDB). Results from the NDB suggest that: (1) because medical care needs for comorbid physical illness in psychiatric inpatients increase with aging, medical care for physical illness in inpatient psychiatric care and their evaluation are important; (2) because the management of dementia in general inpatient care has been provided largely by nursing staff and most medical institutions do not have consultation-liaison psychiatry services, there may be a room for care by psychiatrists; and (3) there is a marked increase in the number of outpatients in psychiatric health services; thus, attention should be given to this trend.

Keywords: medical care plan, health policy, clinical indicators, key performance indicators, plan-do-check-act cycle

Introduction

On July 6, 2011, the Medical Care Subcommittee of the Social Security

Council agreed to add mental disorders to the list of diseases to be included in medical care plans.³⁾ This paper describes the evolution of medical care plans and indicators concerning mental disorders. It also presents longitudinal changes in psychiatric health services from fiscal years 2013 to 2019 using the National Database of Health Insurance Claims and Specific Health Checkups of Japan (NDB). NDB is a database including all electronic claims for insurance-covered medical treatment in Japan.

I. Medical care plans and indicators

1. Purpose of medical care plans

Starting with the Sixth Medical Care Plan (FY2013–2017), mental disorders were added to the four diseases (cancer, stroke, acute myocardial infarction, and diabetes) that must be included in medical care plans.⁴⁾ Consequently, prefectures are now required to “establish medical service systems for these five diseases: cancer, stroke, acute myocardial infarction, diabetes, and mental disorders, to improve quality of life, while also considering the situation of increasing patient numbers.”⁴⁾

2. Utilization of indicators

Starting with the Sixth Medical Care Plan, to support prefectures in effectively implementing their PDCA cycles (plan-do-check-act cycle), the

Ministry of Health, Labour and Welfare provides example indicators for each disease and initiative.⁴⁾⁶⁾ For example, in the Sixth Medical Care Plan's “Example Indicators for Assessing the Current Status of Mental Disorders Care Delivery Systems,” structure indicators such as “Number of Psychiatric Emergency Care Facilities,” process indicators such as “Number of Night-time/Holiday Visits and Hospitalizations at Psychiatric Emergency Care Facilities,” and outcome indicators such as “Average Length of Stay for Discharged Patients” were set as “mandatory indicators” available for all prefectures.⁴⁾⁶⁾ Prefectures are required to document the numerical data obtained through essential indicators and other means in their medical care plans to assess the current state of their regional healthcare delivery systems.⁴⁾ Furthermore, prefectures must identify issues based on the results of this assessment, set numerical targets for resolving any issues, formulate measures to achieve these targets, and verify the progress of these measures to realize the numerical targets.⁴⁾ Following the mid-term review of Seventh Medical Care Plan, numerical targets were revised to focus primarily on outcome indicators, such as the “discharge rate from psychiatric beds within 3 months of admission.”⁹⁾¹¹⁾

3. Evolution of indicator examples

Between Sixth and Seventh Medical Care Plans, the Ministry of Health, Labour and Welfare published examples of indicators at three time-points.⁶⁾⁷⁾¹⁰⁾ As shown in Table 1, Seventh Medical Care Plan changed all outcome indicators from Sixth Medical Care Plan except for the “readmission rate within 3 months.”⁶⁾⁷⁾ After the mid-term review of Seventh Medical Care Plan, the only outcome indicator retained from Sixth Medical Care Plan, “readmission rate,” was changed to “average number of days living in the community.”¹⁰⁾ Considering other minor points as well, the evolution of indicators was significant, making it difficult to conclude that the indicators were capable of fully performing their original function of facilitating fixed-point observation of policy effects.

4. Examples of numerical targets

For example, Saitama Prefecture's Sixth Medical Care Plan set targets, such as: (i) increasing the average discharge rate of patients hospitalized for less than one year from 68.1% in fiscal year 2009 to 76.0% in fiscal year 2017, and (ii) increasing the discharge rate within two months for new dementia inpatients from 24.0% in fiscal year 2008 to 50.0% in fiscal year 2017.¹³⁾ The Seventh Medical Care Plan

omitted descriptions of these two targets and instead established numerical targets for: (i) the number of chronic-phase inpatients (hospitalized for one year or longer) in psychiatric beds, (ii) the discharge rate at three months after admission in psychiatric beds, and (iii) the number of physicians who completed training to improve primary care physicians' dementia care skills.¹⁴⁾ Furthermore, following the mid-term review of the Seventh Medical Care Plan, it also added to these existing targets.¹⁵⁾

II. Longitudinal changes in medical care provision

Sources of information for the indicators used to assess the current state of the medical care system for mental disorders in Sixth Medical Care Plan were primarily mental health welfare data and patient surveys.⁶⁾ In Seventh Medical Care Plan, the primary source of information shifted to the nationwide claims database (NDB).²⁾ A research project, entitled: “Research on Ensuring Sustainable, High-Quality, and Appropriate Psychiatric Care and Monitoring Systems” (Principal Investigator: Masashi Takeshima), was conducted. As part of this project, the authors had the opportunity to utilize NDB data covering the 2013 to 2019 fiscal years. This allowed them to compile statistics

from diverse perspectives to assess the current state of psychiatric health services provision, supplementing previous indicator examples. This paper presents some of the results from these analyses from three perspectives: (i) psychiatric inpatient care, (ii) general inpatient care, and (iii) psychiatric outpatient care.¹⁶⁾¹⁷⁾ (Table 2). Please note that interpretations of the research findings in this paper represent the authors' personal views and do not reflect those of the research team.

1. Psychiatric inpatient care

The average daily number of patients admitted to psychiatric beds decreased from 239,198 in fiscal year 2013 to 228,744 in fiscal year 2019 (Figure 1). Notably, the number of patients aged 0–64 decreased from 104,254 to 82,567, respectively. Conversely, the number of patients aged 85 or over increased from 28,340 to 37,008, respectively. This indicates a declining trend in psychiatric inpatient care, with the primary users being the elderly, and a significant annual increase in the very elderly population. Note that NDB at the time of analysis excluded recipients of public assistance, so the reported figures are approximately 20% lower than actual numbers.

The risk of coexisting chronic physical illnesses increases with age. However, patients for whom medical fees for

physical illness management in psychiatric beds (Psychiatric Emergency/Complication Hospitalization Fee or Psychiatric Physical Complication Management Surcharge) were billed numbered only 38,725 in fiscal year 2019, showing minimal changes over time, which is inconsistent with the trend of rapidly increasing very elderly patients in psychiatric inpatient care. This indicates that providing and evaluating medical care for physical complications in psychiatric inpatient care remains an urgent issue.

2. Medical care in general hospital beds

The number of patients diagnosed with dementia in general hospital beds increased from 642,156 in fiscal year 2013 to 975,999 in fiscal year 2019 (Figure 2). One factor contributing to this sharp rise in dementia cases in general hospital beds, alongside the overall aging population, was likely the introduction of the Dementia Care Add-on Fee in the 2016 medical fee revision. This fee is based on dementia care provided by nurses and other staff for patients achieving Rank III or higher on the “Assessment Criteria for the Level of Independence in Daily Living for Elderly Persons with Dementia.” Between fiscal years 2016 and 2019, the number of patients for whom this add-on fee was billed increased from 281,964

to 869,997, while the number of medical institutions billing it rose from 2,241 to 3,792, respectively.

Next, we present the billing status for psychiatric consultation-liaison services in general hospital beds. Between fiscal years 2013 and 2019, the number of patients billed for inpatient psychotherapy in general hospital beds increased from 105,044 to 137,888, and the number of medical institutions providing this service increased from 1,354 to 1,365, respectively. Furthermore, the number of patients for whom psychiatric liaison team fees were billed increased from 6,378 to 32,324, respectively, and the number of medical institutions providing this service increased from 46 to 208, respectively. These figures are markedly smaller compared with those for dementia care fees.

According to the Medical Institution Survey, the number of medical institutions with general hospital beds in fiscal year 2019 was 5,786.¹²⁾ Furthermore, survey results from 529 facilities affiliated with the Japan Hospital Association indicate that the most significant role expected of psychiatrists in general hospital beds is “addressing dementia and delirium.”¹⁾ Thus, while care systems involving nurses are being established to address dementia and delirium associated with the aging population in general hospital

beds, the majority of these medical institutions lack the capacity to provide psychiatric consultation-liaison services. This suggests there is scope for involvement by psychiatrists.

Furthermore, the number of patients for whom the Initial Diagnosis and Treatment of Mental Disorders Fee, a key indicator of suicide prevention, was billed was only 4,276 in fiscal year 2019. The number for the Emergency Patient Psychiatric Continuation Support Fee was even lower, at just 189 patients. Although these are designated as key indicators, they reflect only one aspect of psychiatrists' suicide prevention efforts involving patients in general hospital beds.

3. Medical care provision in psychiatric outpatient settings

The number of patients billed for outpatient/home-based psychotherapy increased 1.24-fold from 5,022,277 to 6,223,517 between fiscal years 2013 and 2019. The number of medical institutions providing this service increased 1.14-fold from 6,886 to 7,872, respectively (Figure 3). Among those under 20 years old, the number of patients increased by 1.58 times, from 327,212 to 517,795, respectively, while the number of medical institutions increased by 1.12 times, from 5,706 to 6,415, respectively. Furthermore, the number of patients under 10 years old

increased by 1.63 times, from 82,847 to 135,366, respectively, while the number of medical institutions increased by 1.23 times, from 1,689 to 2,081, respectively.

Because the increase in patient numbers exceeded that of medical institutions, it should be interpreted that the number of outpatients per facility has increased. This significant rise in outpatient numbers warrants close attention, as it raises concerns about potential consequences, such as extended treatment waiting periods and a decline in the quality of care.

Furthermore, the number of patients receiving cognitive and cognitive behavioral therapies, key indicators of psychiatric outpatient care, was only 8,926 in fiscal year 2019, while those receiving group therapy for addiction treatment numbered just 174. Although these are designated as key indicators, they also reflect only one aspect of psychiatric outpatient care.

Conclusion

Based on the analysis of NDB data from fiscal years 2013 to 2019, this study concludes that: (i) In psychiatric inpatient care, there is a need for medical provision and evaluation that address physical comorbidities associated with the super-aging of society; (ii) In inpatient medical care involving general beds, although care delivery systems for dementia provided

by nurses are gradually being established, most medical institutions do not have systems in place to provide consultation-liaison psychiatry, indicating that there remains room for involvement by psychiatrists; (iii) In psychiatric outpatient care, close attention is needed to adapt to the accompanying marked increase in the number of outpatients. While the primary focus of the medical care plan is for prefectures to take the lead in building healthcare delivery systems to improve residents' quality of life, taking into account the increasing number of patients with mental disorders, it was pointed out that the indicators used to assess the current situation do not necessarily capture the full picture of mental health care delivery systems.

Editor's Note: This special feature article is based on the symposium held at the 118th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with Tadashi Takeshima (Kawasaki City Inclusive Rehabilitation Center/Taisho University) as the representative.

Conflict of Interest

Taisho University, the research institution for the project: "Research on Ensuring Sustainable, High-Quality, and Appropriate Psychiatric Care and Monitoring Systems" (Principal

Investigator: Tadashi Takeshima), funded by the Ministry of Health, Labour and Welfare's Administrative Promotion Survey Project Subsidy (Comprehensive Research Project on Disability Policy), had a business contract with the General Incorporated Association for the Promotion of Clinical Epidemiology Research (Representative Director: Yasuyuki Okumura) concerning NDB analysis.

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表 1 精神疾患の医療体制構築に係る指針の変遷

特徴	改定時点		
	第 6 次医療計画 (2013~2017 年度) ^{5,6)}	第 7 次医療計画 (2018~2023 年度) ^{7,8)}	第 7 次医療計画中間見直し後 (2021~2023 年度) ^{10,11)}
めざすべき方向	(1) 保健サービスやかかりつけ医等との連携により、精神科医を受診できる機能 (2) 患者の状態に応じて、外来医療や訪問医療、入院医療等の必要な医療を提供し、保健・福祉等と連携して地域生活や社会生活を支える機能 (3) 精神科救急患者（身体疾患を合併した患者を含む）、身体疾患を合併した患者や専門医療が必要な患者等の状態に応じて、速やかに救急医療や専門医療等を提供できる機能 (4) うつ病の診断および患者の状態に応じた医療を提供できる機能 (5) 認知症に対して進行予防から地域生活の維持まで必要な医療を提供できる機能	(1) 精神障害にも対応した地域包括ケアシステムの構築 (2) 多様な精神疾患等に対応できる医療連携体制の構築	同左
医療機能の区分	・ 予防・アクセス ・ 治療・回復・社会復帰 ・ 精神科救急・身体合併症・専門医療	・ 統合失調症 ・ うつ・躁うつ病 ・ 認知症 ・ 児童・思春期精神疾患 ・ 発達障害 ・ アルコール依存症 ・ 薬物依存症 ・ ギャンブル等依存症 ・ PTSD ・ 高次脳機能障害 ・ 摂食障害 ・ てんかん ・ 精神科救急 ・ 身体合併症 ・ 自殺対策 ・ 災害精神医療 ・ 医療観察法	同左
必須指標/重点指標の数* (うちアウトカム指標の数)	26 (3)	35 (3)	44 (3)
アウトカム指標	・ ところの状態 ・ 1 年未満入院者の平均退院率 ・ 在院期間 5 年以上かつ 65 歳以上の退院患者数 ・ 3 ヶ月以内再入院率 ・ 退院患者平均在院日数 ・ 自殺死亡率	・ 精神病床における入院後 3, 6, 12 ヶ月時点の退院率 ・ 精神病床における新規入院患者の平均在院日数 ・ 精神病床における退院後 3, 6, 12 ヶ月時点の再入院率 (1 年未満入院患者・1 年以上入院患者別) ・ 精神病床における急性期・回復期・慢性期入院患者数 (65 歳以上・65 歳未満別)	・ 精神病床における入院後 3, 6, 12 ヶ月時点の退院率 ・ 精神病床における新規入院患者の平均在院日数 ・ 地域平均生活日数 ・ 精神病床における急性期・回復期・慢性期入院患者数 (65 歳以上・65 歳未満別)

*第 6 次医療計画では全都道府県で入手可能な指標「必須指標」として設定されていた項目は、第 7 次医療計画から「重点指標」と表現が変更されている。重点指標は、「地域住民の健康状態やその改善に寄与すると考えられるサービスに関する指標」と異なる定義とされているものの、類似の用法となっている。
(文献 5~8, 10, 11 より著者が作成)

Table 1: Evolution of guidelines for establishing mental disorder care systems

Characteristics

Revision Timing

6th Medical care plan (FY2013–2017)^{5),6)}

7th Medical care plan (FY2018–2023)^{7),8)}

Post-midterm Review of 7th Medical care plan (FY2021–2023)^{10),11)}

Desired Direction

- (1) Function enabling access to psychiatrists through coordination with health services and primary care physicians.
 - (2) Function providing necessary care (outpatient, home-visit, inpatient) according to patient condition, supporting community and social life through coordination with health and welfare services.
 - (3) Function to promptly provide emergency care and specialized medical care, etc., according to the condition of psychiatric emergency patients (including those with comorbid physical illnesses), patients with comorbid physical illnesses, and patients requiring specialized medical care.
 - (4) Function to diagnose depression and provide medical care according to the patient's condition.
 - (5) Function to provide necessary medical care for dementia, ranging from progression prevention to maintaining community living.
-
- (1) Establishment of a community-based integrated care system that also addresses mental disorders.
 - (2) Establishing a medical collaboration system capable of addressing diverse mental disorders and related conditions.

Same as above

Classification of Medical Functions

- Prevention/Access
- Treatment/Recovery/Social Reintegration
- Psychiatric Emergency Care/Physical Comorbidities/Specialized Medical Care

- Schizophrenia
- Depression/Bipolar Disorder
- Dementia

- Childhood/Adolescent Psychiatric Disorders
- Developmental Disorders
- Alcohol Dependence
- Substance Dependence
- Gambling and Other Addictions
- PTSD
- Cognitive Impairment
- Eating Disorders
- Epilepsy
- Psychiatric Emergency Care
- Physical Comorbidities
- Suicide Prevention
- Disaster Mental Health
- Medical Observation Law

Same as above

Number of Essential/Key Indicators (including number of outcome indicators) *

26 (3)

35 (3)

44 (3)

Outcome Indicators

- Mental State
- Average Discharge Rate for Patients Hospitalized Less Than 1 Year
- Number of Discharged Patients Aged 65 or Older with a Hospital Stay of 5 Years or More
- Readmission Rate Within 3 Months
- Average Length of Stay for Discharged Patients
- Suicide Mortality Rate

- Discharge rate at 3, 6, and 12 months after admission in psychiatric beds
- Average length of stay for new admissions in psychiatric beds
- Readmission rate at 3, 6, and 12 months after discharge in psychiatric beds (separated by patients hospitalized less than 1 year and those hospitalized 1 year or longer)

- Number of acute, recovery, and chronic phase inpatients in psychiatric beds (separated by those aged 65 and over and those under 65)
- Discharge rate at 3, 6, and 12 months after admission to psychiatric beds
- Average length of stay for new admissions to psychiatric beds
- Regional average length of stay
- Number of acute, recovery, and chronic phase inpatients in psychiatric beds (separated by age: 65 or over, under 65)

*In Sixth Medical Care Plan, items designated as “mandatory indicators” (available in all prefectures) were reclassified as “priority indicators” starting with Seventh Medical Care Plan. Although priority indicators are defined differently as “indicators related to services considered to contribute to the health status of local residents and its improvement,” their usage is similar.

(Compiled by the author from References 5-8, 10, 11)

表2 精神疾患の医療提供体制に係る現状把握のための集計抜粋

指標	年度							医療計画における指標の区分
	2013	2014	2015	2016	2017	2018	2019	
精神病床の医療提供								
1日平均在院患者数*								
全体	239,198	235,915	234,009	232,809	231,687	230,974	228,744	なし
0～64歳	104,254	99,372	95,721	92,377	88,925	85,751	82,567	なし
65～74歳	57,434	58,516	58,849	58,462	58,190	57,498	56,889	なし
75～84歳	49,169	49,012	49,399	50,479	51,142	52,184	52,280	なし
85歳以上	28,340	29,014	30,040	31,491	33,429	35,541	37,008	なし
精神科救急・合併症入院料あるいは精神科身体合併症管理加算が算定された患者数	38,557	38,091	37,571	38,928	39,196	39,296	38,725	重点指標
一般病床の医療提供								
統合失調症診断を有する患者数**	331,159	344,945	362,381	362,151	381,159	388,376	400,106	なし
うつ・躁うつ病診断を有する患者数**	408,211	411,676	419,494	410,584	417,934	415,678	421,670	なし
認知症診断を有する患者数**	642,156	697,283	729,063	809,028	907,924	959,759	975,999	なし
認知症ケア加算が算定された患者数	—	—	—	281,964	642,677	805,154	869,997	なし
認知症ケア加算を算定した医療機関数	—	—	—	2,241	3,131	3,578	3,792	なし
入院精神療法が算定された患者数	105,044	105,283	109,220	119,036	126,758	131,595	137,888	なし
入院精神療法を算定した医療機関数	1,354	1,354	1,349	1,383	1,390	1,371	1,365	なし
精神科リエゾンチーム加算が算定された患者数	6,378	9,228	13,276	21,181	25,814	28,789	32,324	重点指標
精神科リエゾンチーム加算を算定した医療機関数	46	56	74	142	172	190	208	重点指標
精神疾患診断治療初回加算が算定された患者数	4,180	3,832	3,754	4,007	4,066	3,879	4,276	重点指標
救急患者精神科継続支援料が算定された患者数	—	—	—	97	226	173	189	重点指標
精神科外来の医療提供								
通院・在宅精神療法が算定された患者数								
全体	5,022,277	5,217,336	5,448,743	5,576,841	5,756,977	6,028,855	6,223,517	なし
20歳未満	327,212	347,655	383,735	414,500	447,784	483,655	517,795	参考指標
10歳未満	82,847	91,646	101,984	111,643	121,269	128,326	135,366	なし
通院・在宅精神療法を算定した医療機関数								
全体	6,886	7,150	7,299	7,469	7,577	7,712	7,872	なし
20歳未満	5,706	5,836	5,972	6,106	6,153	6,256	6,415	参考指標
10歳未満	1,689	1,733	1,804	1,887	1,911	2,027	2,081	なし
認知療法・認知行動療法が算定された患者数	8,856	10,390	10,254	10,618	10,336	9,110	8,926	重点指標
依存症集団療法が算定された患者数	—	—	—	68	155	159	174	重点指標

*1日平均在院患者数の年齢区分別の合計は、丸め誤差のため全体と一致しない。

**レセプトにおける診断名は、レセプト請求が受理されるよう記録されるため、実際の診断名と一致するとは限らない。
(文献16より著者が作成)

Table 2: Excerpted aggregate data for assessing the current state of psychiatric service use

Indicator

Fiscal Year 2013 2014 2015 2016 2017 2018 2019

Indicator category in medical care plan

Psychiatric bed medical care provision

Average daily inpatient count*

Total

239,198 / 235,915 / 234,009 / 232,809 / 231,687 / 230,974 / 228,744 / None

0–64 years old

104,254 / 99,372 / 95,721 / 92,377 / 88,925 / 85,751 / 82,567 / None

65–74 years old

57,434 / 58,516 / 58,849 / 58,462 / 58,190 / 57,498 / 56,889 / None

75–84 years old

49,169 / 49,012 / 49,399 / 50,479 / 51,142 / 52,184 / 52,280 / None

85 years old or older

28,340 / 29,014 / 30,040 / 31,491 / 33,429 / 35,541 / 37,008 / None

Number of patients for whom psychiatric emergency/complication hospitalization fees or psychiatric physical complication management surcharges were calculated

38,557 / 38,091 / 37,571 / 38,928 / 39,196 / 39,296 / 38,725 / Key Indicator

Medical care provided in general beds

Number of patients diagnosed with schizophrenia**

331,159 / 344,945 / 362,381 / 362,151 / 381,159 / 388,376 / 400,106 / None

Number of patients diagnosed with depression/bipolar disorder**

408,211 / 411,676 / 419,494 / 410,584 / 417,934 / 415,678 / 421,670 / None

Number of patients diagnosed with dementia**

642,156 / 697,283 / 729,063 / 809,028 / 907,924 / 959,759 / 975,999 / None

Number of patients for whom dementia care add-on fees were calculated

– / – / – / 281,964 / 642,677 / 805,154 / 869,997 / None

Number of medical institutions that calculated dementia care add-on fees

– / – / – / 2,241 / 3,131 / 3,578 / 3,792 / None

Number of patients for whom inpatient psychotherapy was billed

105,044 / 105,283 / 109,220 / 119,036 / 126,758 / 131,595 / 137,888 / None

Number of medical institutions billing for inpatient psychotherapy

1,354 / 1,354 / 1,349 / 1,383 / 1,390 / 1,371 / 1,365 / None

Number of patients for whom psychiatric liaison team add-on fees were billed

6,378 / 9,228 / 13,276 / 21,181 / 25,814 / 28,789 / 32,324 / Key Indicator

Number of medical institutions that billed for psychiatric liaison team add-on

46 / 56 / 74 / 142 / 172 / 190 / 208 / Key Indicator

Number of patients for whom the initial diagnosis and treatment fee for mental disorders was calculated

4,180 / 3,832 / 3,754 / 4,007 / 4,066 / 3,879 / 4,276 / Key Indicator

Number of patients for whom Emergency Psychiatric Continuation Support Fee was billed

— / — / — / 97 / 226 / 173 / 189 / Key Indicator

Outpatient Psychiatric Care Provision

Number of patients for whom outpatient psychiatric care/home-based psychotherapy was billed

Total

5,022,277 / 5,217,336 / 5,448,743 / 5,576,841 / 5,756,977 / 6,028,855 / 6,223,517 / None

Under 20 years old

327,212 / 347,655 / 383,735 / 414,500 / 447,784 / 483,655 / 517,795 / Reference

Indicator

Under 10 years old

— / — / — / 82,847 / 91,646 / 101,984 / 111,643 / 121,269 / 128,326 / 135,366 /

None

Number of medical institutions billing for outpatient/home-based psychotherapy

Total

6,886 / 7,150 / 7,299 / 7,469 / 7,577 / 7,712 / 7,872 / None

Under 20

5,706 / 5,836 / 5,972 / 6,106 / 6,153 / 6,256 / 6,415 / Reference Indicator

Under 10 years old

1,689 / 1,733 / 1,804 / 1,887 / 1,911 / 2,027 / 2,081 / None

Number of patients for whom cognitive therapy/cognitive behavioral therapy was billed

8,856 / 10,390 / 10,254 / 10,618 / 10,336 / 9,110 / 8,926 / Key Indicator

Number of patients billed for addiction group therapy

— / — / — / 68 / 155 / 159 / 174 / Key Indicator

* The total daily average inpatients by age group may not match the overall total due to rounding errors.

** Diagnoses on claims are recorded to ensure claim acceptance and may not correspond to actual diagnoses.

(Created by the author based on Reference 16)

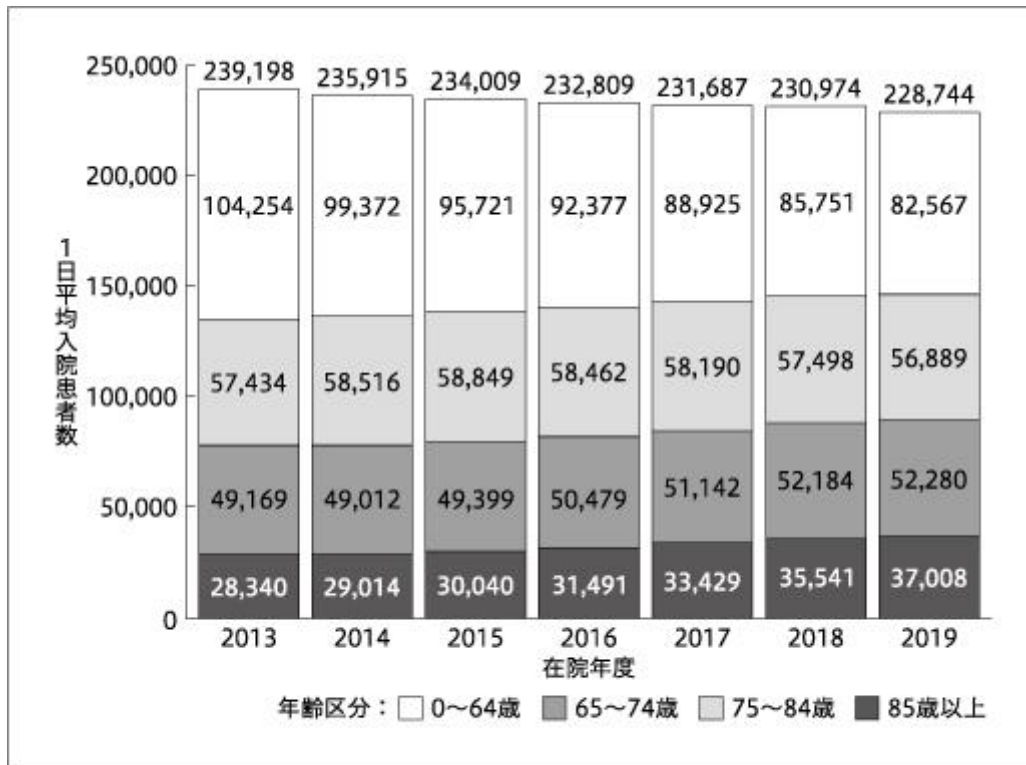


図1 精神病床における1日平均在院患者数のトレンド
(文献16, 17より著者が作成)

Figure 1: Trend in daily average inpatients in psychiatric beds
(Created by the author based on References 16, 17)

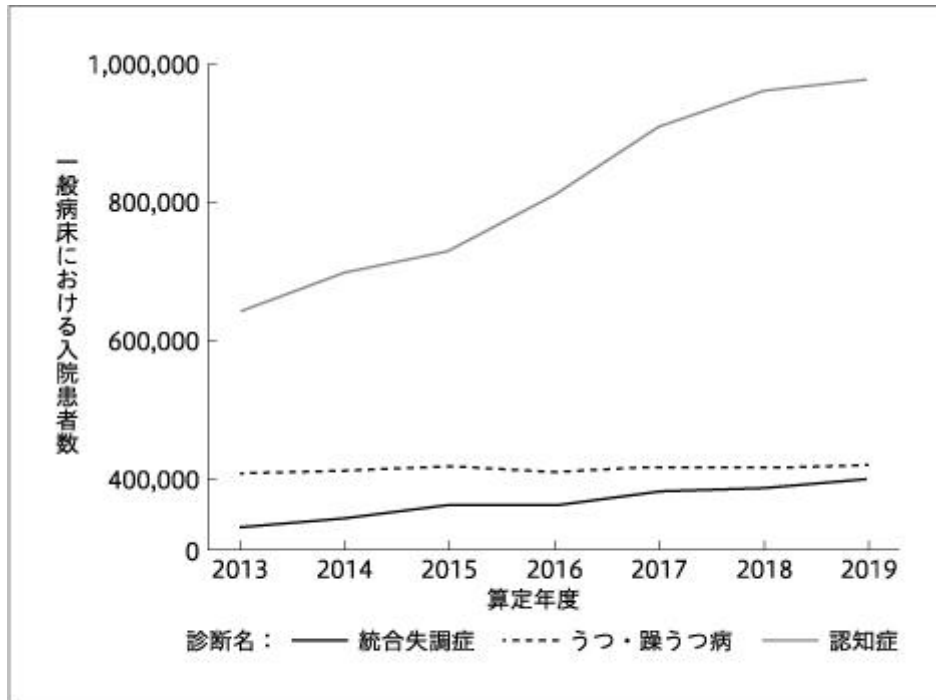


図2 一般病床において認知症診断などを有する患者数のトレンド
(文献16より著者が作成)

Figure 2: Trend in the number of patients with dementia diagnoses in general beds
(Created by the author based on Reference 16)

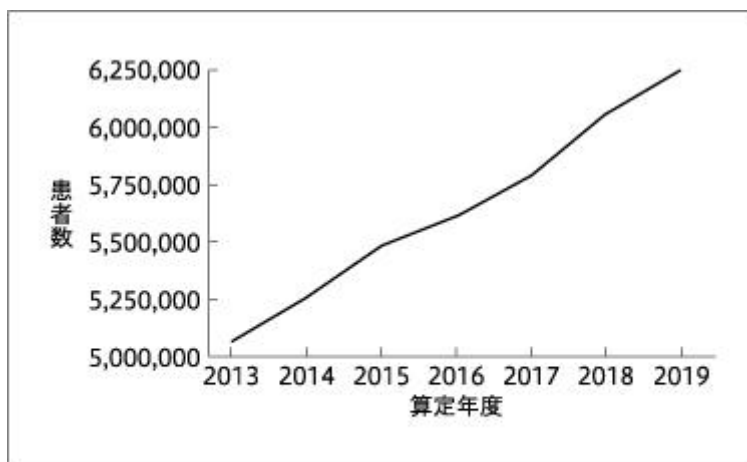


図3 通院・在宅精神療法が算定された患者数のトレンド
(文献16より著者が作成)

Figure 3: Trend in the number of patients for whom outpatient/home-based psychotherapy was billed