Health insurance coverage for conservative lymphoedema treatment in Japan

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Abstract

Petitioning for the necessity of complex physical therapy started in the early 2000s and led to the provision of one-time prophylactic guidance for the management of lymphoedema for cancer patients and a partial reimbursement for compression garments in 2008. In 2016, complex physical therapy itself became part of the national health insurance system. This change was a major step in the right direction, but a number of tasks remain, such as inclusion of all kinds of lymphoedema regardless of the underlying cause.

As in many other countries of the world, complex physical therapy (CPT, also known as complex or complete decongestive therapy or decongestive lymphatic therapy) is current medical practice for the treatment of lymphoedema in Japan. Several further options are available and microsurgery (Koshima, 2011; Mihara et al, 2014) especially has gained a lot of attention, with promising results in recent years. However, conservative treatment is still the unchanged mainstay for lymphoedema patients.

In Japan, CPT, the professional medical conservative treatment for lymphoedema as specified by the International Society of Lymphology (2013) and others (Yamamoto and Yamamoto, 2007), has been available since 1999. The first Japanese person to obtain a Földi manual lymphatic drainage/CPT instructor license from Germany was a massage therapist who started treatment at the Goto College of Medical Arts and Sciences. Soon after, the first professional training course for healthcare professionals was conducted, and today there are >2,000 certified lymphoedema therapists working in >200 medical facilities throughout Japan.

In April 2016, the Ministry of Health, Labour and Welfare (MHLW) specified that only medical doctors, registered nurses, physiotherapists, occupational therapists and massage therapists with extra training in lymphoedema care be allowed to treat lymphoedema patients under national health insurance (MHLW, 2016a). A major milestone in the history of petitioning for insurance coverage for lymphoedema was thus reached. While far from being perfect, this long-awaited goal marks the beginning of a new era and took >10 years to achieve.

Petitioning for lymphoedema therapy

In the early 2000s, various stakeholders teamed up to raise awareness of lymphoedema on a large scale. From the beginning, these activities centred around petitioning the MHLW about the necessity of insurance coverage for CPT. One major event was a 2-week signature campaign for CPT in 2007 that gained support from almost 240,000 people, whose signatures then were presented to the MHLW and to the Japanese Medical Association (*Figure 1*).

Several years of awareness-raising activities and the impact of the signature campaign then resulted in Japan's first national health insurance service for patients with or at risk of lymphoedema in 2008. One-time prophylactic guidance for the management of lymphoedema (*Table 1*) was provided as an individual information session for cancer patients either in the month of hospitalisation or in the month prior to or post surgery. In addition to this, partial reimbursement for compression garments for patients who had already developed lymphoedema was introduced.

Health cover, however, was and remains limited to patients with uterine or uterine adnexa cancer, prostate cancer or breast cancer with axillary lymph node dissection. Reimbursement for compression garments is limited to patients with extremity lymphoedema caused by lymph node dissection from one of the aforementioned kinds of cancer, from malignant melanoma or urological cancer. The MHLW set the medical treatment fee for the prophylactic guidance at JPY1,000 (~USD9); reimbursement for arm sleeves was limited to JPY16,000 (~USD140) and for stockings was JPY28,000 (~USD245) (MHLW 2008a, 2008b).

Revision of medical fees

In Japan, medical treatment fees are revised every 2 years. There is therefore a chance


Figure 1. Presenting the result of the signature campaign for complex physical therapy to the Ministry of Health, Labour and Welfare (above left) and the Japanese Medical Association (above right).

to have new services included in the national health system every 2 years if, after thorough scrutiny, they are found to be medically necessary. After the inclusion of the first lymphoedema service in 2008, continuous petitioning led to the addition of a second prophylactic guidance session in 2010. Further changes in 2012 made it possible to receive such guidance in a medical facility other than that in which the patient underwent cancer surgery – which had been a restriction until then – but only if this facility was part of the regional health cooperation plan. Changes are summarised in *Table 2*.

Insurance coverage for complex therapy of lymphoedema

Revisions in 2016 finally covered the conservative treatment of lymphoedema. The MHLW decided to name the treatment 'complex therapy for lymphoedema' (CTL). This comprised all the well-known elements of CPT, namely skin care, manual lymph drainage, compression therapy, exercises under compression and guidance on self-management. The numbers and lengths of sessions are divided by lymphoedema severity (*Table 3*).

Any patient seeking to receive treatment under national health insurance must have been diagnosed with lymphoedema after the treatment of uterine cancer, uterine adnexa cancer, prostate cancer or breast cancer with lymph node dissection (MHLW, 2016a). In other words, the MHLW applied the same patient restrictions as the prophylactic guidance to CTL. Payment for CTL is based on points: 200 points for a treatment session lasting at least 40 minutes and 100 points for a treatment session of at least 20 minutes. These points are multiplied by a factor of 10 JPY to make a total of 2,000 JPY (~18 USD) for 40 minutes or 1,000 JPY (~9 USD) for 20 minutes of treatment that will be paid to the unit performing CTL.

Lymphoedema therapists must have an appropriate license and prove completion of at least 100 hours of special lymphoedema care training. Doctors who do not plan to treat patients with CTL themselves but need to supervise their lymphoedema staff must have completed one special training course of at least 33 hours.

Medical facilities seeking to offer CTL under health insurance must prove that they have at least one full-time lymphoedema specialist doctor and another full-time healthcare professional trained in lymphoedema management on staff. The facility must also show proof that it provides prophylactic guidance >50 times per year, or that one of its cooperative partners registered as an institution authorised to treat patients under national health insurance and involved in lymphoedema treatment does so. The facility must also be able to offer inpatient treatment and treatment for lymphoedema complications, such as cellulitis, or have a cooperative partner that can take over this task (MHLW, 2016b).

Table 1. Overview of prophylactic guidance for the management of lymphoedema.

Information is to be provided to the patient about:

- The cause and pathology of lymphoedema
- An overview of therapy methods
- The importance of self-management, with specific guidance on how to avoid and ameliorate regional lymph fluid stagnation:
    1. manual lymph drainage
    2. compression with compression garments or bandages
    3. exercises wearing compression garments or bandages
    4. skin care
- Precautions in everyday life – prevention of infections and obesity
- Coping strategies for infections – the necessity for clinical examination and medication against infections

Ministry of Health, Labour and Welfare requirements

The MHLW demanded that several requirements be met before CPT could be considered part of the health insurance system. The three main requirements were:

- The examination of practitioners after completion of a lymphoedema training course by an independent third-party organisation to ensure a nationwide treatment standard
- A Japanese guideline for the diagnosis and treatment of lymphoedema
- A multi-centre study showing that CPT is effective on Japanese patients.

In 2012, the Japanese Certification Board for Lymphedema Therapists was established with the aim of independently conducting examination and certification of trained therapists. In 2013 the *Guideline for the Diagnosis and Therapy of Lymphedema* was published by the Japanese Certification Board, followed by the results of a study about the effectiveness of CPT in 11 Japanese medical facilities in 2014 (Ashino et al, 2014), which paved the way to the MHLW 2016 revision to national health insurance.

Issues to be addressed

In summary, prophylactic guidance for the management of lymphoedema, compression garments and complex therapy for lymphoedema are currently offered via national health insurance in Japan. These services enable the patient to identify risk factors, interpret early signs of lymphoedema and take care of themselves (prophylactic guidance), allow for continuous management of their condition (compression garments) and to receive professional medical treatment

(CTL). Several revisions of medical treatment fees between 2008 and 2016 have created a system that supports early diagnosis and treatment of lymphoedema, and also clearly shows that the importance of and necessity for this kind of treatment has been officially recognised. Unfortunately, the current system falls short in several areas that make it difficult to offer treatment to patients under national health insurance.

One of the foremost problems is that cover is limited to secondary lymphoedema occurring after the treatment of certain types of cancer. This excludes patients who develop secondary lymphoedema due to other kinds of cancer or through other causes, including primary lymphoedema patients. Furthermore, the number of treatment sessions and the treatment times are limited to a degree that in most cases make appropriate treatment impossible, e.g. 20 minutes twice a year for an International Society of Lymphology early stage 2 patient.

Therapists are required to prove they have undergone >100 hours of special training in lymphoedema care. There is, however, no clearly defined consensus on training between the different training schools.

Another issue is that although third-party examination to ensure the same level of treatment in every part of the country has been conducted for >4 years, it is no prerequisite for offering treatment. Facilities are not only required to have at least a full-time specialist doctor and another full-time healthcare professional for lymphoedema on staff, but also need to provide prophylactic guidance for the management of lymphoedema >50 times every year, offer inpatient treatment and treatment for cellulitis, etc. in their own or a facility within the cooperative. All of these are themselves strict conditions that few facilities can fulfil.

Even if institutions can overcome these hurdles, they receive an extremely low payment for CTL. As treatment is not cost-effective, lymphoedema treatment units in hospitals or other medical facilities are left with negative earnings. In many cases, this forces management to offer CTL on an out-of-pocket-payment basis or to close the unit, which is counterproductive.

Table 2. National health insurance coverage of conservative lymphoedema treatment.

Year	Revision introduced
2008	• Prophylactic guidance for the management of lymphoedema (one time during hospitalisation) • Partial reimbursement of compression garments
2010	Prophylactic guidance for the management of lymphoedema (a second time for the same patient in the same hospital after discharge)
2012	Prophylactic guidance for the management of lymphoedema (free choice of facility for the second guidance session, provided it is part of the regional health cooperation plan)
2016	Complex therapy for lymphoedema

Table 3. Ministry of Health, Labour and Welfare 2016 revision of treatment frequency and session length according to the severity of lymphoedema.

Severity	Frequency and time
Severe cases (International Society of Lymphology late stage 2 or higher)	• Minimum of 40 minutes per session • 11 sessions in the first 2 months • 1 session a month from month 3
Non-severe cases (International Society of Lymphology stage 1 or higher)	• Minimum of 20 minutes per session • 1 session every 6 months

Future actions

The right to equal medical treatment for all lymphoedema patients regardless of the underlying cause, access to an appropriate number of treatment sessions of sufficient length, mandatory third-party examination and the revision of medical fees to an economically appropriate level together with less strict conditions for medical facilities that would like to offer CTL on national health insurance remain the main aims for the future.

To achieve this and to meet the needs of all patients and healthcare providers, it is necessary to focus future petitioning on providing cover for lymphoedema patients who are currently ineligible, appropriate treatment times, a cost-effective treatment plan, appropriate treatment level and accessibility. A large-scale academic study about the degree to which medical facilities are affected by the 2016 revision and a survey addressing patients' economic burden before and after the 2016 revision is necessary to demonstrate problems in the current system. Research results could then be used to urge the MHLW to revise health insurance so that all lymphoedema patients have access to appropriate healthcare services.

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