



OECD Economics Department Working Papers No. 321

Health Care Reform in Japan

Yutaka Imai

<https://dx.doi.org/10.1787/105381128500>

Unclassified

ECO/WKP(2002)7



Organisation de Coopération et de Développement Economiques
Organisation for Economic Co-operation and Development

12-Feb-2002

English text only

ECONOMICS DEPARTMENT

ECO/WKP(2002)7
Unclassified

HEALTH CARE REFORM IN JAPAN

ECONOMICS DEPARTMENT WORKING PAPERS NO. 321

by
Yutaka Imai

All Economics Department Working Papers are now available through OECD's Internet Web site at
<http://www.oecd.org/eco>

JT00120719

Document complet disponible sur OLIS dans son format d'origine
Complete document available on OLIS in its original format

English text only

ABSTRACT/RÉSUMÉ

Health Care Reform in Japan

The health status of the Japanese is one of the best in the world. The healthcare system has no doubt contributed to this, though the current state of research in health economics does not permit the determination of the extent of such contribution. The Japanese system, based on social insurance, has provided both basic care and free choice of doctors to every citizen at affordable costs. It has, however, become increasingly clear that the Japanese system has failed to allocate resources properly, ensure financial equity and adapt to changing patterns of demand. This paper first explains how a system that once seemed to function well has become inappropriate, then how policies have tried to overcome some of the problems. The paper concludes with key considerations shaping future reform.

JEL Classification: 110, 118

Key words: Healthcare system, Japan

Réforme du système de santé au Japon

L'état de santé de la population japonaise est un des meilleurs du monde. Le système de santé a sans aucun doute contribué, même s'il est difficile de déterminer le rôle respectif du fonctionnement du système de santé par rapport aux autres facteurs. Le système de santé japonais, basé sur l'assurance sociale, assure la l'offre universelle des soins de base ainsi que le libre choix du docteur à un coût raisonnable. Il est néanmoins devenu de plus en plus évident que le système de santé japonais a échoué dans la répartition efficace des ressources nécessaires, ainsi que dans l'équité du financement, et est mal adapté à la mutation de la demande de soins. La première partie de ce document de travail explique comment un système qui, auparavant, fonctionnait bien est devenu inapproprié, puis comment les politiques ont essayé de résoudre certains problèmes. La dernière section traite des éléments dont il faudra nécessairement tenir compte pour l'élaboration des mesures futures de réforme.

Classification JEL: 110, 118

Mots-clés: Le système de santé, Japon

Copyright OECD, 2002

Applications for permissions to reproduce or translate all, or part of, this material should be made to: Head of Publications Service, OECD, 2 rue André Pascal, 75775 Paris Cedex 16, France.

TABLE OF CONTENTS

HEALTHCARE REFORM IN JAPAN	4
Introduction	4
Salient features of the system	5
The evolving system: recent and on-going reforms	10
Shaping a future reform	13
Conclusion	17
BIBLIOGRAPHY	19

Tables

1. Estimates of the volume of health care, 1998
2. Health expenditure share by type of service, 1998
3. Summary of recommendations concerning the healthcare system Recent labour market indicators

Figures

1. Health expenditure and GDP per capita, 1998

HEALTHCARE REFORM IN JAPAN

Yutaka Imai¹

Introduction

1. The Japanese healthcare system has provided necessary care services to the whole population at a relatively low cost, while offering a free choice of service providers by patients as well as an equitable access. The Japanese people enjoy excellent health status,² though it is difficult to establish analytically the extent to which this is due to the functioning of the healthcare system or other factors such as life style. The Japanese system is perhaps a model to follow for developing countries where the priority is to ensure a universal provision of basic care at an affordable cost, but it is a system poorly adapted to a high-income country where the demand for quality care is rising.

2. Japan's healthcare system is faced with several challenges. It has to deal with a serious financing problem stemming from a combination of low growth of revenues and a strong upward pressure on spending in part due to a rapid ageing of population. As well, people are becoming more sensitive to the quality of care provided, particularly with the frequent reporting of medical errors, not to speak of a well-known phenomenon of a long waiting time at the outpatient service in large hospitals and an extremely short consultation time.

3. Various reform proposals have been put forward, and the new government has expressed its determination to pursue a bold reform of the system. This paper begins with a brief review of the salient features of the Japanese healthcare system as a way of identifying the weaknesses that need to be tackled. It then discusses the recent and on-going reform efforts to deal with perceived problems. The paper concludes with considerations that are crucial in shaping a future reform.

1. The author is Head of Division in the Economics Department of OECD. An earlier version of this paper served as input into the 2001 OECD Economic Survey of Japan which was published in December 2001 under the authority of the Economic and Development Review Committee. The author would like to thank Jorgen Elmeskov, Michael Feiner, Jeremy Hurst, Hideyuki Ibaragi, Junichi Izumi, Hyoung-Sun Jeong, Grant Kirkpatrick and Peter Scherer for helpful comments. Thanks also go to Brooke Malkin who contributed invaluable technical assistance with tables and graphs, and Nadine Dufour and Charlotte Todd who provided expert word processing. Remaining errors are the author's responsibility.

2. The life expectancy at birth, 84.0 for females and 77.2 for males in 1998, is the highest, and the potential years of life lost under age 70 is the lowest (except for males in Sweden) in the OECD area.

Salient features of the system³

4. Japan's healthcare system, which is highly regulated by the government, combines a mainly private provision of services with mandatory health insurance. Service providers are paid directly by insurers (the third payer system). Payments for outpatient care are predominantly on a fee for service basis, and inpatient care is paid through a mixture of per diem and fee for service. Fees for different medical services are set out in the Fee Schedule announced by the government and revised every two years. Between 20 and 30 per cent of the fees are born by patients as co-payments. But with a ceiling (see below) the effective co-payment rate is about 14 per cent. Health insurance is a complex arrangement born of its history and has a fragmented structure. Employees of large companies are covered by an insurance society at each company (about 1800 such societies), those of SMEs by one big subsidised central government insurance scheme and most others by schemes run by municipalities (about 3250 of them). There is a special medical scheme for the elderly run by municipalities but financed through transfers from all insurers and the government. In addition, a separate old-age nursing care insurance was introduced in April 2000. The health insurers have little control over the volume of medical services provided. They entrust the screening of the bills submitted by the providers along with the record of corresponding medical services to the Payment Fund.⁴ While obvious overmedication and dishonest claims are sanctioned, this screening process has not been used as an utilisation review mechanism to check the rapid increase in the volume of medical services.

5. The Japanese system is relatively inexpensive. Total medical spending as a share of GDP was 7.6 per cent in 1998, below the OECD average of 8.3 per cent. In per capita terms Japan spends less than might be expected of a country with a similar standard of living, by some \$232 PPPs (or 11.4 per cent) in 1998⁵ (Figure 1). Aggregate health expenditure has been controlled through three mechanisms. First and most important, the government has adjusted the Fee Schedule so as to constrain the overall rate of price increases as well as encourage what they think to be the most cost-effective services. Second, co-payments have contributed to dampening demand, though this effect seems limited because of a capping at a relatively low level.⁶ Third, supply-side control, through regulation of the number of medical students and hospital bed numbers, played some role.

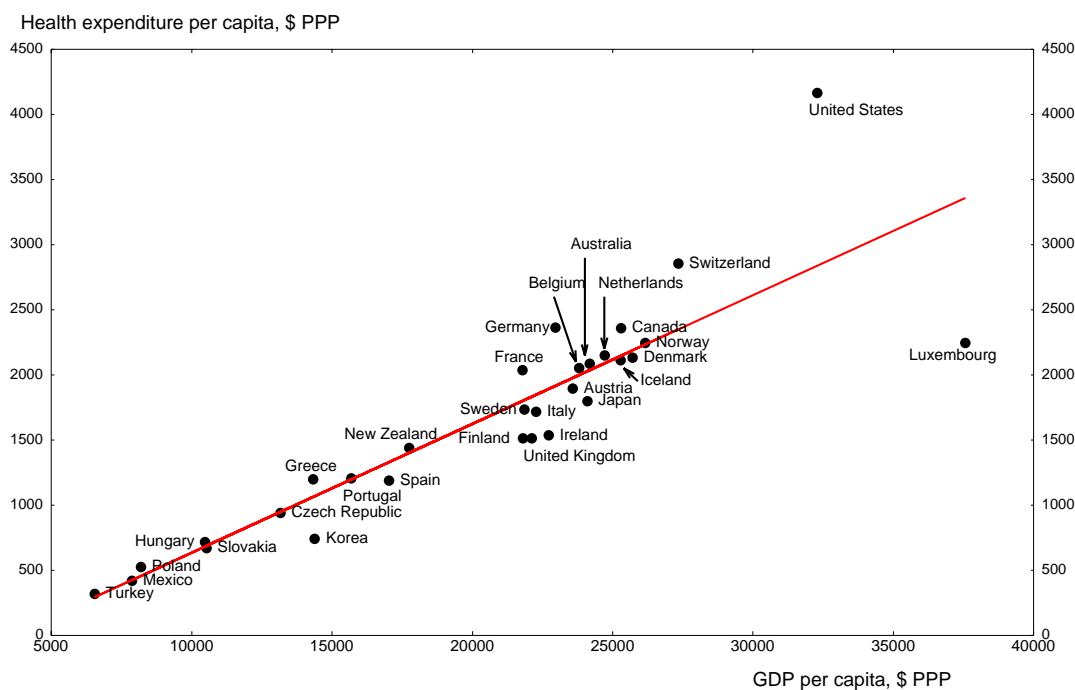
3. This section draws heavily on an OECD working paper, Jeoung and Hurst (2001).

4. The long name for this fund is the Social Insurance Medical Fee Payment Fund, which is a public enterprise set up to provide the screening service for insurers.

5. This is based on by now a standard regression line linking per capita health spending and per capita income across OECD countries. Results excluding two outliers, the United States and Luxembourg, are not much different from those reported here.

6. The cap is 63 600 yen per month, compared with the average monthly disposable income per household of 561 000 yen. The cap for low income families is 35 400 yen.

Figure 1. Health expenditure and GDP per capita, 1998



Note: The regression line is:
 Health expenditure per capita = $-353 + 0.0988 * \text{GDP per capita}$
 (-1.7) (10.1)

R squared = .786

Source: OECD.

6. Another characteristic of the Japanese system is a conspicuous lack of differentiation and standardisation. First, the fee for a given service is identical across service providers and does not recognise the difference in quality. Second, general practice medicine is not clearly established as a separate discipline, so that specialist doctors are not differentiated from general practitioners.⁷ Virtually all doctors in private clinics try to deal with all the problems of their patients. Third, there is no legally imposed separation between prescribing and dispensing of drugs, even though separation has been increased through incentive mechanisms. The weak functional specialisation coexists with underdeveloped standardisation in medical practice. Evidence-based clinical practice guidelines remain to be developed largely because medical education is apprenticeship-oriented and idiosyncratic to each medical school.⁸

7. Professional division of labour is not very clear for other health personnel either. Nurses cannot earn recognised credits for specialisation, nor is there any formal process of accreditation for medical social workers or medical record librarians. There are no professional schools for hospital administration.

8. Moreover, the medical school remains a big factor for the career of individual doctors. Hospitals do not advertise a position but simply call on a medical school. As a result, doctors from a given medical school tend to dominate a hospital.

7. A result of the fee-for-service payment is a high volume of services. In outpatient care, the absence of restrictions on frequency and duration of consultation appears to be responsible for the high number of visits and the short consultation time per visit (Table 1). The number of consultations per capita per year is more than twice the OECD average. As for in-patient care, the admission rate to general beds is well below the OECD average, due partly to people's aversion to invasive surgery. But the average length of stay is about four times more than the OECD average reflecting the fact that many acute care beds have taken on the long-term care function for the elderly, the phenomenon known as "social hospitalisation". Finally, Japan has the third highest drug consumption per capita among the 25 OECD countries for which data are available. While comparison of volumes is difficult, the rapid increase in drug spending over the last 15 years or so is largely due to volume expansion stimulated by the fact that doctors' incomes depended heavily on dispensing drugs until recently. Largely reflecting these features of service volumes the share of inpatient care spending in total health expenditure is among the lowest of the OECD countries for which comparable data are available. Correspondingly, the share of outpatient care and that of drugs are among the highest (Table 2)⁹.

Table 1. **Estimates of the volume of health care, 1998¹**

	Japan	OECD average	Highest	Lowest
Number of doctor consultations per capita, per year	16	6.6	19.7	2.1
Admissions to acute care beds ² per 1000 population	95.7	161	258	68.9
Average length of stay in acute care beds ²	31.5	8.2	31.5	4.7
Drug expenditures, per capita US\$ in PPP's	301	259	447	102

1. For several countries data are for either 1996 or 1997.

2. The Japanese data are proxied by general beds (Ippan Byosho).

Source: OECD Health Data 2001.

Table 2. **Health expenditure share by type of service, 1998**
Per cent of total health expenditure

Country	Inpatient care	Outpatient care	Drugs
Japan	37.6	32.8	16.8
Average	43.8	29.4	13.2
Highest	55.1	49.9	21.9
Lowest	30.7	20.2	7.6

Note: Data for the nearest year to 1998 were used for some countries.

Source: OECD Health Data 2001.

8. Quality may be sacrificed as Japanese doctors pursue quantity to maintain their incomes. In this sense, certain failures in responding to the desire of the patients can be seen as the side-effects of the effective spending control mechanism that operates through price fixing by the government. Such failures may also represent a relative lack of policy emphasis on promoting patients' right (Cambell and Ikegami, 1998). Specific points of dissatisfaction often voiced by patients include long waiting time, short consultation time, insufficient explanation by doctors, lack of medical information for the patient, poor

9. The data is for 1998, the first year when the change in estimation method made figures for Japan roughly in line with OECD Health Data standards.

quality of both “hotel” care and high technology care in hospitals. The phenomenon of long waiting time is more marked in large hospitals, which are thought to have higher quality. A survey shows that in 1999 the share of outpatients who waited less than 30 minutes was 47 per cent in small hospitals and 30 per cent in large hospitals, whereas those who waited for more than one hour was 15 and 29 per cent, respectively.¹⁰ On the other hand, consultation time seems to be short across different hospitals. Two thirds of those surveyed experienced less than 10 minutes of consultation, of which 18 per cent less than 3 minutes. Even so, 42 per cent are satisfied with their consultation times and only ten per cent dissatisfied. This may be explained by the low expectation of patients regarding the consultation time and also to some extent by the fact that a non-negligible proportion of consultations is only for renewing drug prescriptions. Nevertheless, consultation time does appear to be too short for doctors to treat patients on the basis of informed consent. Though international comparisons of patient satisfaction are sparse and need to be interpreted with caution, what available information there is shows that the percentage of patients who are satisfied with their healthcare system is low in Japan relative to that in North America or Western Europe.¹¹

9. In the Japanese system neither the consumer’s choice of health insurers nor the insurer’s choice of service providers is possible. People are assigned an insurer according to their employment situation or residence. Service providers are now designated by the central government as eligible for treating patients under the social health insurance.¹² Competitive forces operate only in the market for services, with no guarantee that this results in efficient resource allocation, in the absence of basic attributes of a well-functioning market. For example, high demand for the outpatient services in large hospitals is largely due to the fee structure and the absence of objective information concerning the quality of service providers. Hospitals find the outpatient service an attractive revenue source not only because of the relatively generous payments by insurers but also because it represents an important source of admission to beds. About 60 per cent of admissions resulted from consultation in the outpatient department of hospitals. On their part, the patients view large hospitals as offering superior services compared with smaller ones and private clinics, which is not necessarily true. But they can rely on no objective assessment of the quality of medical service providers, and information dissemination in this regard has been heavily regulated. The increased outpatient services offered by hospitals have been seen by doctors in private practice as a competitive threat. As a result, many private clinics have developed a small inpatient capacity and evolved into small hospitals. Such a development, *i.e.* everybody trying to do everything, is unlikely to be efficient.

10. The Japanese healthcare system provides a high degree of equity of access by geographical areas despite the apparent unevenness in the distribution of medical personnel and facilities across regions. If the crude mortality rate of each prefecture is taken as a proxy for the need for healthcare, there are good correlations between the need and access rates variously measured, *i.e.* doctors and beds per capita, consultations and admissions per capita and health expenditure per capita. Thus, the uneven geographical distribution of resources and treatments largely reflects different needs in different prefectures. This is a result mainly of universal health insurance but has been reinforced by the regional medical plans drawn up by prefecture governors to rectify geographical imbalances. It is not possible to carry out a similar analysis of equity of access across income groups in the absence of relevant mortality and morbidity information. Nonetheless, there is a weak negative correlation between healthcare utilisation (as measured by health

10. See Ministry of Health, Labour and Welfare (1999).

11. Surveys indicate that those who responded as satisfied were 51 per cent for ambulatory care and 55 per cent for inpatient care in 1999. International comparisons are difficult in this area, but these figures appear to be low compared with 65 per cent in France and Germany, and 85 to 90 per cent in Finland and Denmark (see Mossialos (1997)). A separate survey conducted by Louis Harris and Associates for the Harvard Community Health Plan shows overall satisfaction rate for Japan to be 67 per cent, compared with 87 for the United Kingdom, 88 for the United States, 92 for Germany and 94 for Canada (see McKinsey Global Institute (2000)).

12. Until the end of March 2000 this was the authority of prefecture governors.

insurance benefits) and income level, which indicates that the health insurance scheme is re-distributive. As for equity of finance, evidence suggests that payment for healthcare from all sources of finance combined is regressive, more so for insurance contributions and co-payments.¹³ Regressive finance, however, is normal across OECD countries.

11. Apart from the vertical equity of finance, questions about horizontal equity remain both across and within the main health insurance schemes. For dependent employees insurance premiums are a fixed percentage of wage incomes. For self-employed and others, *i.e.* those covered by schemes run by municipalities, premiums are calculated on the basis of incomes, assets and benefit payments of the preceding year. For the scheme covering employees of large companies, the difference in contribution rates can be as much as 1.5 times between those that are prosperous and those that are in decline. The gap in employee contribution rates can be even greater as employers' share varies from 50 to 80 per cent. The difference in premiums is more marked among the schemes run by municipalities. To the extent that premium payments are related to incomes it is normal to expect average premiums to differ across these insurers. For example, in FY 1999 the maximum gap in average premium was 6.7 times in the schemes run by municipalities. But even for a given income level there are large discrepancies. Comparison of premiums calculated on a common basis shows that in FY 1998 the maximum gap was 3.7 times for some 650 municipalities included in the calculations.¹⁴ The main reason for this wide gap is that a large variation in health risks is not offset by the current risk equalisation mechanism. Moreover, the formula for computing premiums allows a degree of risk rating at the level of municipality since it includes actual benefit payments per capita and/or per household as one component

12. The financial position of insurers has deteriorated to a point where many cannot meet payment obligations if the current financing arrangements remain unchanged. The deterioration in the financial position is due to both low revenue growth and a relatively rapid spending growth. The growth rate of health insurance contributions deflated by the GDP deflator fell from 4.3 per cent over the 1980s to 3.5 per cent in the 1990s, reflecting quasi-stagnant economic conditions of the 1990s.¹⁵ The decline in revenue growth is a structural phenomenon inasmuch as economic stagnation is. Spending growth increased over the same period, largely because of rapid population ageing.¹⁶ The share of the elderly (65 or over) in total population increased from 9.1 per cent in 1980 to 12.0 per cent in 1990 and to 17.5 per cent in 2000. Since spending per capita by the elderly (70 and over) is five times that by non-elderly (this ratio is high internationally), the rising share of elderly population has pushed up medical spending. This has in turn led to an increase in transfers from insurers to the special scheme for the elderly run by municipalities, since the benefit payment by this scheme is financed 70 per cent by transfers from insurers and 30 per cent by the government. For the government-managed insurance for employees of SMEs the reserve fund is likely to be exhausted in FY 2002, *i.e.* they will become unable to meet payment obligations. The situation is not much better for society-managed insurers for the employees of large companies. Nearly two thirds of them were in the red in FY 2000, and this proportion is expected to reach 90 per cent in FY 2001.

13. Insurance contributions accounted for 52.9 per cent, government transfers 32.2. per cent and co-payments 14.8 per cent of total medical spending covered by social health insurance in 1998.

14. See H. Matsutani (2001). The reported figures are for a single person with local residence tax payment of 60 000 yen, which forms an income base for premium calculation. The lowest was just below 140 000 yen for the 23 wards in Tokyo and the theoretical highest 1 070 000 yen for Sapporo City in Hokkaido. The actual highest, however, is capped at 520 000 yen.

15. This deceleration in real premiums is less marked than that of economic activity since wages growth remained relatively robust.

16. The average annual growth rate of real health expenditure per capita increased from 2.7 per cent in the 1980s to 4.0 per cent in the 1990s.

13. The brief review of the healthcare system above revealed a number of weaknesses. First, the particular combination of the predominantly fee-for-service payment, a degree of competition in the market for service provision and an ineffective third payer control of service provision is likely to have resulted in the expansion of service volumes well beyond what might be necessary on clinical grounds. The longest average length of stay in hospitals and the third largest drug consumption per capita in the OECD area corroborate this judgement as does the virtual absence of evidence-based clinical guidelines and standard drug prescriptions. Hence, there does appear to be an important scope for efficiency gains in the current system. Second, as a result both of excessive volume expansion and the relative neglect of patients' right, the quality of care has suffered, while their demand for quality services has been rising. Third, the system is faced with financing difficulties with a sharply reduced revenue growth and a rising spending in part due to population ageing. In a way, economic stagnation and population ageing have brought to the fore the existing inefficiencies in the system just as dissatisfaction with quality of services is making an increase in contributions difficult. Fourth, horizontal inequity of finance should be addressed. Finally, while government intervention is necessary in the healthcare system to correct well known "market failures", the current regulation leaves much scope for change.

The evolving system: recent and on-going reforms

14. The government has attempted to address the problems just discussed. The measures adopted to date, however, have tended to be directed to altering certain parameters of the system, rather than implementing a systemic reform. This is largely because the decision making process has relied heavily on consensus between the service providers (mainly the Japan Medical Association representing doctors in private practice), insurers and the government. One big exception was the introduction of the long-term care insurance system that partly covers certain types of medical care such as rehabilitation.

The long-term care insurance is expected to reduce the length of hospital stay

15. The long-term care insurance, which started in April 2000 and is run by municipalities, provides nursing care for the aged both at home and in specialised institutions. It was introduced primarily as a mechanism to ease the burden of families looking after their frail elderly. The need for such a mechanism has intensified as the population ageing advanced and the female labour market participation increased. Not only the number of elderly requiring assistance but also the age of the family members providing the support has increased.¹⁷ Eighty five per cent of family members providing support are women. The introduction of this system was also expected to bring with it a welcome easing of the financial burden on the health insurance by shifting many inpatient elderly away from hospital beds towards nursing beds and by covering certain services that were subject to reimbursement by the health insurance.

16. Half of the revenues of the nursing care insurance come from premiums that are paid by those 40 years of age or older, and the other half from the government.¹⁸ Premiums for persons aged 65 over are set by each municipality according to their income level¹⁹ but the gap among the municipalities (and hence horizontal inequity) is much smaller than that of health insurance because of a greater role of risk equalisation mechanism. A distinct feature of the long-term care insurance scheme is that it has a

17. Over a half of the family members providing support was 60 years of age or above and 25 per cent 70 years and above in 1998. See Ministry of Labour, Health and Welfare (2000).

18. The central government pays 25 per cent, and the prefecture and the municipality concerned 12.5 per cent each.

19. Premiums for those aged 40 to 64 are calculated in the same way as those of health insurance run by municipalities.

gatekeeper function. The needs of the elderly who ask for benefits must be assessed and the status of the elderly classed into one of six categories, each with a ceiling for maximum spending per month. The assessment, which is formally a decision of a specialised committee, is carried out by a newly created *Care Manager* in consultation with family members and, where necessary, doctors. Care managers then help the elderly to prepare a specific plan of service use that would best meet their needs within a ceiling of maximum allowable spending. A co-payment of 10 per cent applies.

17. Despite some initial teething problems the new insurance system has contributed to the expansion of care services. While it is too early to draw firm conclusions, the wide acceptance for the introduction of the scheme suggests that it is possible to raise social charges if accompanied by a corresponding increase in the services for which latent demand is strong. Utilisation of care services has increased significantly, and so has their supply capacity with new service providers entering the market. There has also been a reduction in social hospitalisation with a significant, albeit less than anticipated, decrease in the number of geriatric beds covered by health insurance. Surveys by municipalities also show that 40 to 50 per cent of the families who received care services reported that their physical burden had been reduced compared with the situation prior to the introduction of the long-term care insurance.

18. Nevertheless, the experience so far has also revealed certain issues to be dealt with. First, there are issues related to financing of this system. Co-payments have been criticised as discouraging the elderly poor unduly from using the services available, even though a cap applies for these people. As of the end of 2000, out of some 2.5 million elderly whose needs had been assessed, about 600 thousand were not using the services. Insurance premiums are also slightly regressive. The collection of premiums that started on October 2000 has encountered some compliance problems despite the fact that only half the premium applies until October 2001. Indeed, municipalities have adopted ad hoc measures to alleviate the financial burden for the elderly poor. Second, relative prices of various services need to be adjusted, particularly as between home care and institutional care. For FY 2000 actual utilisation of home-care services (including the use of day care centres) was about 80 per cent of the approved budget, while waiting lists have continued to expand for special care institutions. This suggests that the relative prices should be changed to shift demand from institutional care to home care. Among the various home care services too there seems to be a scope for changing relative prices. In particular, demand has expanded most for assistance for household work, which is the least expensive. But this service does not appear to be profitable for the service providers. Official price revisions are planned for 2003, but the desirable relative price changes should be implemented as soon as conditions permit. Effective relative price changes for users of services can also be brought about through variable co-payment rates across services as well as net of transfer payments. One possible way of making home care more attractive may be to introduce cash payments to family members providing support. Even though this might raise the possibilities for abuse, the presence of care managers could keep them in check.

19. Finally, there are issues concerning the linkages between the long-term care insurance and the medical scheme for the elderly. As noted above, the reduction in geriatric beds covered by the health insurance (and hence the corresponding increase in those covered by the long-term care insurance) was less than anticipated, by about 40 per cent. This entailed a greater benefit payment by the health insurance than otherwise, and vice versa by the long-term care insurance. The less-than-hoped-for shift of beds from one insurance scheme to the other was primarily due to initial uncertainty about the benefit levels under the long-term care insurance. Certain municipalities also hesitated to encourage such a shift because it meant higher spending from their own budget.²⁰

20. The statutory burden of municipalities is 5.0 per cent of benefit payment for the medical scheme of the elderly, whereas it is 12.5 per cent for the long-term care insurance.

Reform of drug pricing and separation of prescription and dispensing are progressing

20. Conscious of the likely over-prescription of drugs the government has tried to make drugs less attractive as a source of income for doctors and hospitals as well as promote the separation of prescription and dispensing of drugs. Until the early 1990s, reimbursement prices were determined by the “90 per cent bulk line” method, that is, at the price at or below which 90 per cent of the supply of a given drug could be bought in the market. In 1992 a new pricing method was introduced, based on the average of wholesale prices weighted by transaction volumes plus a reasonable margin (the so-called R-zone). The R-zone was reduced substantially in successive steps, from 15 per cent initially down to 5 per cent in 1998. Doctors apparently countered the price declines by volume expansion. Between 1984 and 1997 the reimbursement prices of drugs rose only by 0.1 per cent per year relative to the GDP deflator, whereas drug consumption volumes per capita grew by 3.8 per cent per year. The R-zone was cut further in 2000 to 2 per cent as a transition to a new pricing system to be adopted in 2002 and are renamed “the adjusting zone”. Consensus was reached to abolish the R-zone method as it gave incentives to use higher price drugs, but an alternative rule is yet to be announced. Considerations are also being given to eliminate the difference in reimbursement price between the new and old drugs with broadly similar clinical values as well as to raise the prices of innovative drugs so as to provide greater incentives than hitherto to their introduction.

21. The government has been promoting the separation of prescription and dispensation as a way of improving the management of drug use by patients. The concept of a “family pharmacy” has been advocated as the key agent helping patients to avoid side effects from multiple prescription and to observe better compliance with the recommended dose. The diminishing pecuniary attractiveness of doctors dispensing drugs, combined with an additional fee income from issuing prescription for pharmacies, worked to increase the number of separate prescriptions. The ratio of separate prescriptions to the total rose from below 10 per cent in the mid-1980s to a little over 30 per cent in 1998 and seems likely to have continued to increase.

Other changes are also taking place, albeit slowly

22. There have also been some noteworthy changes in other areas, which are potentially significant in improving the functioning of the healthcare system. First, efforts have been made to introduce methods of payment other than fee for service. An inclusive per diem payment that bundles hospitalisation, drugs and laboratory tests was introduced as an option for chronic inpatient care in 1993. This had a dramatic effect. A frequently cited study of one geriatric hospital shows that after the adoption of the inclusive per diem the spending on drugs was cut by two thirds and that on laboratory tests by 90 per cent (Takagi, 1996). A fee scheme based on Diagnostically Related Group (DRG) has been tested for acute inpatient care since 1998 as a pilot study.²¹ This involves 183 DRGs at 10, mainly national, hospitals, and the results will be evaluated in 2003. DRGs are difficult to develop in Japan given the wide variation in clinical practices, but this pilot study prepares grounds for future applications of DRG-based payment. Second, there have been attempts to improve the availability of information concerning the quality of hospitals and clinics. Restrictions on advertising by medical service providers have been eased partially. Moreover, third party assessment of hospitals has started in 1997. As of March 2000, there were 318 hospitals that went through such a voluntary assessment. So far, however, only the names of the hospitals that were assessed to be satisfactory have been published.

21. This is a form of inclusive payment but applies to a group of diagnosed medical conditions and is based on standardised treatment costs. Under this payment system hospitals have incentives to treat patients in a most cost-effective way as possible. Development of DRGs contributes to standardisation of medical treatment, which is underdeveloped in Japan.

Shaping a future reform

23. Heightened concerns about the financial sustainability of the health insurance system and rising demand for quality care have intensified the domestic debate about appropriate reforms. Various proposals have been put forward, and the basic directions of desirable reforms have been summarised in official documents of the Ministry of Labour, Health and Welfare. Some ideas have also been aired by the Council on Economic and Fiscal Policy. Rather than commenting on each and every such proposal, the following paragraphs discuss key considerations while making a selective reference to the proposals that have been advanced.

Spending control through expenditure targeting could be useful in reconciling health policy and cost containment objectives

24. It has been suggested in some quarters to introduce an explicit cap on aggregate spending to control its future growth. This suggestion is often made in reference to “successful” cases in France and Germany. However, the experience abroad is much more complicated and should not be characterised simply as a success. In France it has worked to stabilise the spending by hospitals. For public hospitals that are subject to strict budgetary constraints, the quality of services has suffered because of rigid wage and employment practices. Private sector spending has been difficult to control as it has been driven by fee-for-service payment, and certain aspects of the mechanism of ex-post adjustment for doctor fees has been ruled as anti constitutional.²² In Germany, where such a mechanism was accepted, spending growth did slow for several years but started to reaccelerate, exceeding the cap. This illustrates how difficult it is to enforce a spending cap.

25. On the other hand, spending control through a combination of a socially-agreed spending growth target and the successive adjustment of fee levels could be an effective approach to reconcile health policy and cost containment objectives. This comes close to the one followed in the U.S. Medicare system where a target for sustainable overall spending growth is set for payments for doctors, which are adjusted symmetrically in the following year taking into account the deviation (both positive and negative) of actual spending growth from the target.²³ The traditional Japanese approach to spending control through the adjustment of fee schedule can be seen as a variant of this same approach, except that it relied more on the adjustment of relative fee levels and that the spending growth target has been implicit. Making the expenditure growth target explicit merits consideration as this could be a way to attain social consensus on sustainable spending growth. Nonetheless, if the spending control approach of a U.S. Medicare type is seen as a model to be followed in Japan, allowance has to be made for the fact that, unlike the United State, Japan lacks a DRG-based payment system as well as rigorous utilisation reviews by the insurer. Spending control should therefore rely on an improved use of regulated reimbursement mechanisms, the introduction of new forms of payments and a strengthened utilisation review by insurers.

Current reform proposals for elderly medical scheme raise a key issue of institutional design

26. As discussed above, the financing needs of the elderly medical scheme have been rising rapidly, and the associated increase in transfers from health insurers has led to significant deterioration of their financial positions. Broad consensus has been formed that a fundamental reform of the elderly medical

22. See the *OECD Economic Survey: France*, July 2000, for detail. It was the proportionality of refunding by doctors in case of spending overshoot that was judged anti constitutional.

23. This applies to Part B of the U.S. Medicare system. As for Part A that concerns hospitals a DRG-based payment system is used.

scheme is inevitable. There are currently four different proposals for organising the health insurance coverage for the elderly:

- (A) Set up a new separate insurance regime covering the elderly (the threshold age being either 65 or 75) financed mainly by transfers from the government but small portions paid by contributions by the elderly and co-payments to retain desirable attributes of the insurance system;
- (B) Set up an additional regime covering only the elderly who contributed to various schemes for employees while active, financed by contributions from the elderly, transfers from the employee insurance schemes (*i.e.* younger employees) and transfers from the government at least as much as the amount currently paid under the present regime;
- (C) Keep the present arrangement but introduce a more extensive risk adjustment transfer mechanism based on age than currently (*i.e.* based only on those aged 70 or above); and
- (D) Set up an integrated system embracing all.

27. Even though there is an aspect of horse trading among the proponents of these proposals,²⁴ they do raise an important question of an institutional design that affects the operation of the current insurance-based system. Should the elderly be treated separately (Options A, B and C) or not (Option D)? The main argument in favour of separation of the elderly is that a priori it should make risk and income adjustment easier across the remaining populations.²⁵ But proponents of a separate system implicitly or explicitly envisage an eventual integration of the health and nursing care insurance schemes for the elderly.²⁶ Having a separate health scheme for the elderly may facilitate the adoption of payment and other arrangements that are more suitable for the predominantly chronic nature of the elderly care. Should this happen, the integration of the two schemes might be feasible. On the other hand, Option D reasserts the principle of social insurance to cover the health risk by the society as a whole without making distinctions by age or occupation.²⁷ It offers a basis for an alternative evolution of the system over a long term as it facilitates the reduction of horizontal inequity in finance as well as the very need for risk and income adjustments.

Horizontal inequity in premiums should be reduced

28. It is necessary to reduce the horizontal inequity of finance that the current arrangements entail through integration of fragmented insurers. The large gap in premiums that still remain after adjustment for income levels cannot be justified as people have guaranteed access to the same medical benefits throughout

24. For options A, B and C it is not difficult to see who the main supporters are. Option A means more money from the government so that both service providers and insurers would support it, though it ultimately depends on how increased government transfers will be financed. With Option B current employee-based insurers will probably gain. Option C gives financial advantage to the schemes run by municipalities at the expense of employee-based insurers.

25. While risk and income adjustment across insurers are not relevant in the United States, the presence of the separate scheme for the elderly financed by payroll tax (Medicare) must have reduced private insurance premiums than otherwise.

26. It is difficult to integrate the two schemes that are so much different in their design. At a minimum, the current payment methods in the health scheme for the elderly must be changed significantly before contemplating such a possibility.

27. Company-based insurance societies could then offer supplementary plans, as in France. But if these plans are allowed to cover co-payments, the resulting reduction of incentives to minimise excessive consumption of medical services will have to be dealt with.

the country. These gaps can be reduced if insurers become larger, allowing a more effective risk pooling. Certain municipalities are simply too small a unit to cover health risks effectively, and so are certain companies even though they may be classified as large companies.

The payer role should be strengthened

29. Insurers have long been accustomed to playing a passive role of financial agent receiving contributions and pay as they received the bills. Introducing competition among (social) health insurers could be one way of making them to play an active role. This, however, is an option for which opinions can differ greatly and which in any case is premature. It is well known that competitive pricing of health risks leads to social exclusion of those who need the healthcare the most, and that the prohibition of risk-rated premiums leads to cream-skimming behaviour on the part of insurers. To avoid such behaviour a mechanism of transfer payment known as risk equalisation is necessary, but risk equalisation can only be imperfect in practice. The experience in Germany clearly illustrates these difficulties, and it is too early to conclude that competitive social insurance may be a good model for Japan to follow. In these circumstances, ways should be sought to strengthen the role of insurers as an active agent for consumers.

30. Integration of insurers would facilitate them to play this role. Insurers' ability to overcome the problem of information asymmetry is crucial in ensuring that competition in the market for service provision and delivery leads to efficient resource allocation. To be able to interact with service providers effectively, insurers must have a relatively stable financial base that allows them to have a sufficient number of administrative and professional staff. The experience of insurers for employees of large companies confirms that both financial stability and the number of support staff increase with the size of insurers.²⁸

31. The review of bills and treatment records, one concrete way in which insurers interact with service providers has been centralised at the Payment Fund, a special status public corporation, under administrative guidance of MLHW. This review service should be opened up to private agents, as recently recommended by the Regulatory Reform Commission. Moreover, even though it seems legally possible for insurers to negotiate special terms with service providers, insurers apparently have not pursued such possibilities. While it is not clear to what extent the performance of those managing insurance schemes has been subject to objective assessment, it is clear that a sound governance framework is necessary. As with the case of good corporate governance practices, management of health insurance must be accountable to its members for its performance, financial or otherwise. There must also be a mechanism that ensures transparency of appointment at senior levels as well as remuneration.

Payment system needs a further change away from fee for service

32. It is by now well recognised that biases in the fee schedule that favoured outpatient consultations and discouraged hospitalisation and high technology medicine resulted in an undesirable pattern of medical resource use. In future revisions the pay schedule should correct these biases, while moving away from fee for service payment. Fee for service will remain a suitable payment for cases that have a low degree of predictability of required clinical acts and hence cannot be standardised in a meaningful manner. For others, however, inclusive payment of various kinds (per visit, per day, or per case like DRG) would provide more appropriate incentives to service providers. Even though it is not straightforward to determine the right levels of pay, inclusive payment should be introduced where possible, initially at a rate

28. Association of Health Insurance Societies (1998).

guaranteeing current revenue. It should subsequently move to a rate based on crude performance measures that may be refined as and when more data and evaluative studies permit.²⁹

Strengthening competition in service provision requires regulatory reform and better information

33. While a stronger role for the payer and improved relative price signals would both strengthen competition in the market for service provision and promote better allocation of medical resources, there are measures that would further contribute to this end. First, entry restrictions to the market for service provision should be eased substantially so as to promote the restructuring of supply. These comprise direct control of supply, notably the number of hospital beds in each region and the number of medical students; and indirect restraints, notably the prohibition of for-profit companies to run hospitals and the requirement that the owner of hospitals must be a medical doctor. Direct control of supply may be justified under the current payment arrangements but would have to be eased progressively in tandem with the change in the system that would make such a planning approach ill-adapted to reality.³⁰ As for the indirect restrictions, there is no justification for their existence. Administration of a modern hospital requires managerial capability that medical doctors do not necessarily possess, and many private hospitals are effectively run like profit-making entities without the possibility of issuing equity. Second, the government should promote information dissemination by healthcare service providers. Restrictions on advertisement by doctors and hospitals should be eased further so that the patients can learn more easily about the different characteristics and capacity of service providers. Moreover, evaluation of hospitals by an independent agency should be made a requirement for them to be designated as eligible for providing services under social insurance. Results of evaluation should also be made public, rather than the current practice of making only the names of successfully reviewed hospitals available on the web site of MLHW. Improved information about the quality of services offered gives a better basis for the choice of service providers by patients and, it is hoped, insurers.

The issue of “balance billing” requires careful evaluation

34. One of the hotly debated issues in the context of deregulation is that of easing the current restrictions on “balance billing”, which refers to the practice of mixing the medical acts covered by social insurance with the ones that are not. This practice is allowed for 9 specific cases including extra payment for beds with better amenities and certain high-technology treatment. It has been argued that deregulation in this regard is necessary for the supply side to meet the increasingly diverse demand by patients. It has also been pointed out that the resulting increase in private payments is the only way to meet the rising health spending needs, if people disagree with increases in contribution rates and taxes. These are valid arguments. It would appear, however, premature to be done with this restriction all together given that a consensus is not reached as to what constitutes a minimum package of care that need to be financed socially. The underdeveloped patient’s rights and the absence of mechanisms to deal with the problem of information asymmetry between doctors and patients would also favour a cautious approach. An expansion of the list of allowable services in tandem with advances in the practice of informed consent and the development of private health insurance would seem to be the desirable approach.

29. Ikegami and Campbell (1999) make a concrete proposal along these lines as an option for those hospitals that are striving to upgrade their services so as to promote functional specialisation of hospitals.

30. The limit on the number of medical student is based on projections of future demand for doctors, carried out by a working group consisting primarily of doctors. When the parameters of the system are changing significantly, the usefulness of such an exercise is greatly diminished.

ICT technology has a strategic importance

35. ICT technology has a strategic role to play in promoting the many desirable changes in the system, and its use is rising where there are competitive pressures. Several private insurance companies have started to offer health insurance funds services to transform medical treatment records in an electronic form so as to save costs through improved utilisation review. Only 0.4 per cent of the 750 million bills with treatment record are currently sent to the Payment Fund in electronic form. The ICT technology is also used aggressively by certain medical service suppliers to disseminate information to consumers. As noted, there are restrictions on advertisement by hospitals and doctors. But they can put any information they wish on their web site, and a number of hospitals actually do so. Increased communication through e-mails among specialist doctors also contributes to melting the idiosyncrasies in medical education and thereby reducing the variation in clinical practices and promoting evidence-based medicine.

36. One obstacle to the development of an efficient information system is the absence of a common social security number. Currently each and every insurance fund has its own system of health insurance identification number that is not portable across the system. The lack of number portability not only makes it difficult to set up a record of medical history for each citizen but also encouraging a fraudulent behaviour by some to evade contribution payments. The CEFP's proposal to introduce a national social security number merits serious consideration.

Conclusion

37. The gist of recommendations emerging from the analysis presented in this paper is to strengthen the consumer as well as insurer choice of service providers (Table 3). The strengthening of the consumer choice should be facilitated by better information flows concerning the quality of services provided by doctors and hospitals. The strengthening of the insurer choice requires bigger and determined insurers, which in turn necessitate integration of insurers as well as mechanisms to ensure their accountability to the insured population. Insurer integration is in any case necessary to reduce horizontal inequity in finance. In fostering both the consumer and insurer choice, improved third-party accreditation of service providers is a must and so is the wider application of ICT technology. To instil incentives for quality improvement and cost saving, more innovative methods of remunerating service providers should be introduced. Once these mechanisms are in place, there would be a greater assurance that an increase in healthcare spending is genuinely needed to meet the population's needs and that corresponding increases in contributions and taxes would meet least resistance.

Table 3. **Summary of recommendations concerning the healthcare system**

Health insurance funds should be integrated to form a larger unit	This would not only reduce the horizontal inequity of finance through a more effective risk pooling, but also help strengthen their role as agents for patients
The payer role of health insurance funds should be strengthened	This requires tighter review of bills and treatment records submitted by doctors for reimbursement. The review service, which is currently monopolised by a public corporation, should be opened to private agents. The governance mechanisms of health insurance funds should also be strengthened to make management accountable for its performance
Payment system needs to move further away from fee for service	The official fee schedule should correct the existing biases against hospitalisation and high technology medicine, while moving towards inclusive payments of various kind.
Regulatory reform of health service provision is necessary	Entry restrictions should be eased to promote the restructuring of supply, and so should be restrictions on information dissemination by health service providers. The third-party evaluation of hospitals should be made compulsory.
Balance-billing restriction should be eased with prudence	A gradual expansion of the list of allowable services should be envisaged in tandem with the formation of consensus on the minimum package of socially-financed services, advances in the practice of informed consent and the development of private health insurance.

Source: OECD.

BIBLIOGRAPHY

- Association of Health Insurance Societies (Kenko Hoken Kumiai Rengo Kai) (1998),
Report on Appropriate Size of Health Insurance Union, March, (in Japanese).
- Campbell, J.C. and N. Ikegami (1998),
The Art of Balance in Health Policy: Maintaining Japan's Low-Cost Egalitarian System, Cambridge University Press.
- Ikegami, N. and J.C. Campbell (1999),
"Health Care Reform in Japan: The Virtues of Muddling Through", *Health Affairs*, 18 (3), May/June.
- Jeong, H.S. and J. Hurst, (2001),
An Assessment of the Performance of the Japanese Health Care System, Labour Market and Social Policy Occasional Papers, No. 56, Paris, OECD.
- Matsutani, H. (2000),
National Health Insurance Is Grossly Unfair to Honest Contributors, Takarajima Publishing Co., Tokyo, December, (in Japanese).
- McKinsey Global Institute (2000),
Why the Japanese economy is not growing: micro barriers to productivity growth, Washington.
- Ministry of Health, Labour and Welfare (1999),
Survey on Patients Behaviour and Satisfaction (Juryo Kodo Chosa) 1999, Tokyo (in Japanese).
- Ibid (2000),
A brochure on Long-term Care Insurance, Tokyo (in Japanese).
- Mossialos, E. (1997),
"Citizen's Views on Health Care Systems in the 15 Member States of the European Union", *Health Economics*, 6 (2), March/April.
- Takagi, Y. (1996),
"The Impact of Financing Reform: Inclusive Per Diem Reimbursement in Geriatric Care," in *Containing Health Care Costs in Japan*, pp 172-176.

ECONOMICS DEPARTMENT

WORKING PAPERS

320. *Enhancing Expenditure Control with a Decentralised Public Sector in Denmark*
(February 2002) Steen Daugaard
319. *Options for Reforming the Finnish Tax System*
(February 2002) Isabelle Joumard and Wim Suyker
318. *Product Market Regulation and Wage Premia in Europe and North America: An Empirical Investigation*
(January 2002) Sébastien Jean and Giuseppe Nicoletti
317. *Competition, Innovation and Productivity Growth: A Review of Theory and Evidence*
(January 2002) Sanghoon Ahn
316. *Labour Market Institutions, Product Market Regulation, and Innovation : Cross Country Evidence*
(January 2002) Andrea Bassanini and Ekkehard Ernst
315. *Ongoing Changes in the Business Cycle - Evidence and Causes*
(January 2002) Thomas Dalsgaard, Jorgen Elmeskov and Cyn-Young Park
314. *Comment encourager une croissance écologiquement durable en France?*
(December 2001) Ann Vourc'h et Patrick Lenain
313. *Increasing Efficiency and Reducing Complexity in the Tax System in the United States*
(December 2001) Richard Herd and Chiara Bronchi
312. *Product and Labour Markets Interactions in OECD Countries*
(December 2001) Giuseppe Nicoletti, Andrea Bassanini, Ekkehard Ernst, Sébastien Jean, Paulo Santiago and Paul Swaim
311. *Modelling Import Responsiveness for OECD Manufactures Trade*
(October 2001) Mara Meacci and David Turner
310. *Trade Linkages and the Trade Matrices in the OECD Interlink Model*
(October 2001) Laurence Le Foulher, Wim Suyker and Dave Turner
309. *Encouraging Environmentally Sustainable Growth in Australia*
(October 2001) Ann Vourc'h and Robert Price
308. *Financial Market Liberalisation, Wealth and Consumption*
(September 2001) Laurence Boone, Nathalie Girouard and Isabelle Wanner
307. *The Economic Integration of Germany's New Länder*
(September 2001) Eckhard Wurzel
306. *Standard Shocks in the OECD Interlink Model*
(September 2001) Thomas Dalsgaard, Christophe André and Pete Richardson
305. *Fiscal Implications of Ageing: Projections of Age-related Spending*
(September 2001) Thai Thanh Dang, Pablo Antolin and Howard Oxley
304. *The Width of the Intra-European Economic Borders*
(August 2001) Alain de Serres, Peter Hoeller and Christine de la Maisonnette

303. *Surveillance of Tax Policies: A Synthesis of Findings in Economic Surveys*
(July 2001) Paul van den Noord and Christopher Heady
302. *Reforming the Tax System in Portugal*
(July 2001) Chiara Bronchi, José C. Gomes-Santos
301. *Tax Systems in European Union Countries*
(June 2001) Isabelle Joumard
300. *Encouraging Environmentally Sustainable Growth in Belgium*
(June 2001) Paul O'Brien, David Carey, Jens Høj, Andreas Woergoetter
299. *Encouraging Environmentally Sustainable Growth in Poland*
(June 2001) Grzegorz Peszko, Patrick Lenain
298. *Tracking the Euro*
(June 2001) Vincent Koen, Laurence Boone, Alain de Serres, Nicola Fuchs
297. *Firm Dynamics and Productivity Growth: A Review of Micro-evidence from OECD Countries*
(June 2001) Sanghoon Ahn
296. *How should Norway Respond to Ageing?*
(May 2001) Pablo Antolín and Wim Suyker
295. *How will Ageing Affect Finland?*
(May 2001) Pablo Antolín, Howard Oxley and Wim Suyker
294. *Sectoral Regulatory Reforms in Italy: Framework and Implications*
(May 2001) Alessandro Goglio
293. *Encouraging Environmentally Sustainable Growth: Experience in OECD Countries*
(May 2001) Paul O'Brien and Ann Vourc'h
292. *Increasing Simplicity, Neutrality and Sustainability: A Basis for Tax Reform in Iceland*
(May 2001) Richard Herd and Thorsteinn Thorgeirsson
291. *Options for Reforming the Tax System in Greece*
(April 2001) Chiara Bronchi
290. *Encouraging Environmentally Sustainable Growth in Canada*
(March 2001) Ann Vourc'h
289. *Encouraging Environmentally Sustainable Growth in Sweden*
(March 2001) Deborah Roseveare
288. *Public Spending in Mexico: How to Enhance its Effectiveness*
(March 2001) Bénédicte Larre and Marcos Bonturi
287. *Regulation in Services: OECD Patterns and Economic Implications*
(February 2001) Giuseppe Nicoletti
286. *A Small Global Forecasting Model*
(February 2001) David Rae and David Turner