The Current State of Health Care System Reforms and Future Issues


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Proposal by the Japan Medical Association (JMA)

1. Focus of the proposed reforms

Several years have passed since the public outcry for reforms of the health care system was first heard. As one of the forerunners who saw the need for such reforms much earlier, JMA first announced “A Proposal for Health Care Reforms” in July 1997.

Since then JMA has submitted specific proposals for structural reforms such as creating a medical care system for the elderly, reforms of the medical fee payment system, and structural reforms of the pharmaceutical related system. These reforms were compiled in an Interim Report in July 1999. Additionally, JMA’s “Grand Design for Health Care in 2015” was publicly announced in August 2000, wherein JMA’s medium-term vision of the health care system and the direction in which the reforms should ideally progress were presented.

In the pursuit of structural health care reforms, the JMA has advocated the policy dynamics approach to address the foremost issue of creating a medical care system for the elderly. This approach promulgates the pursuit of focal and dynamic policies to realize overall policies and reforms.

The Japan Federation of Economic Organizations (Keidanren), the National Federation of Health Insurance Societies (Kemporen), and the Japanese Trade Union Confederation (Rengo) have generally agreed with the crux of the reforms, the creation of a medical care system for the elderly or radical reforms of the medical system for the elderly as advocated by the JMA. In truth, there was heated debate about this issue between these organizations until last year, which subsequently produced the general consensus to unite and dismiss minor differences.

However, in the face of unstable political circumstances, critical economic depression, and other negative factors, the administrative and legislative branches of the government have been unable to adopt concrete policies on this issue, and it has continued to be shelved.

2. Cause of the confusion behind the reform debate

Based on these circumstances, the course of
the reform debate was clearly beginning to deviate in 2001, and the cause is due to the intervention of the Ministry of Finance (MOF).

The Basic Policy on structural reforms announced by the Council on Economic and Fiscal Policy (CEFP) in June 2001 and the Medium-Term Strategy of the Council for Regulatory Reform announced in July 2001 are reports that were compiled essentially under the control of the MOF, despite being touted as having been prepared under the supervision of the Prime Minister’s Office.

It is common knowledge that the MOF is the ringleader that created the economic bubble, was directly involved in the frolic, and failed to soften the landing when it burst. It is an undeniable truth that their failure is one of the underlying causes for the deterioration in Japan’s national finances. The series of proposed measures from the CEFP aim to shuffle off the bill of debts to health insurance finances and decrease the burden of the national treasury for health costs by shifting the financial obligation elsewhere and thereby, evade national responsibility.

The content of the draft plan of the Ministry of Health, Labor and Welfare (MHLW) that was announced in September 2001 reflected the inability of the MHLW to resist the overwhelming pressure of the MOF. Subsequently, the plan has been unable to escape the ruling precept that prioritizes financial concerns.

Furthermore, the Accounting Agency of the MOF announced its paper on “The Issues Debated in Structural Reforms of the Health Care System” one month later in October, as if in rebuke to the lukewarm stance of the draft plan submitted by the MHLW, which clearly outlined further health cost controls and an increased share of health costs to be borne by the patient. Such public intervention by the MOF authorities in the jurisdiction of other ministries and agencies is unprecedented.

The MHLW is in charge of improving the health and welfare of the nation. As one of the major ministries of the country, it should strongly protest and oppose the MOF’s act of overstepping its jurisdiction. The MOF’s public intervention is just one in a series of acts aimed at controlling structural reforms.

The cabinet led by Prime Minister Koizumi has pursued structural reforms by utilizing its phenomenal public support, but in the area of health system reforms, the voice and interests of health and medical professionals and patients have been completely excluded — this is the crux of the problem.

If the government had taken a more firm and systematic approach when a medical care system for the elderly was being seriously debated, the MHLW would never have presented such a proposal on health reforms. It can be clearly stated that the government is seriously responsible for the consequences of having shelved these reforms for too long.

**Problems in the Draft Plan Proposed by the Ministry of Health, Labor, and Welfare**

I would like to comment on specific items in the bill on structural reforms of the health system proposed by the MHLW, as well as to touch upon the future steps to be taken for these reforms.

1. **The implementation of a system to control the growth rate in health costs for the elderly**

   Measures to forcibly contain health costs for the elderly by implementing a system to control the growth rate of these costs have been proposed. Specifically, the elderly health cost amount for the following fiscal year is estimated and fixed by multiplying the elderly population and the per capita GDP growth rates. If the actual cost exceeds this fixed amount, the surplus amount is adjusted in the medical fee payment system in the following second fiscal year. Regional disparities in the elderly population or the individual characteristics of health and medical institutions have
been completely ignored, and health costs are controlled through penalization and legal authority.

The foremost controversy is that this system may be unconstitutional and in violation of Article 13 of the Constitution of Japan, which stipulates that all citizens are to be respected as individuals, and first paragraph of Article 14, which stipulates equal legal rights for all Japanese citizens.

A case in point, the bill for the social security finances act submitted to the French Parliament in 1998 to be enacted for the following fiscal year advocated a similar system. It was concluded to be unconstitutional and was discarded. Under this bill, physicians participating in the health insurance agreement were repaid the medical costs that exceeded the allocated fixed amount. It was this aspect of penalizing groups that was determined to be in violation of the principles of equality and respect for the individual under the Constitution of France.

The system to control the growth rate of health costs for the elderly suggested in the proposed reform bill in Japan contains several other major shortcomings. Firstly, the estimated GDP growth rate, that is used as the index to fix the standard amount of health costs for the elderly, is inaccurate. According to the data from January to March 2001 of the Economic and Social Research Institute, the primary preliminary value showed a 0.2 percent reduction in the annual growth rate of the previous fiscal year, in contrast to the GDP of the same period. But the secondary preliminary value showed a 0.1 percent increase — a disparity of 0.3 percent.

In view of the inaccuracy of past estimated GDP values, it would not be erroneous to state that accurate estimations for the following fiscal year can not be made. In addition, increased health costs due to unavoidable factors such as the onset of influenza have not been considered. Under the Medical Practitioners Law, physicians should not deny request for providing medical care, and health and medical institutions are required to provide medical treatment under the health insurance program to all health insurance cardholders. If there is an influenza epidemic, this extremely irrational system greatly penalizes all medical institutions for providing reliable treatment that they are legally required to administer.

When health care is seen as an industry, objective data from the Input-Output Table show that it is a sector with an extremely high ripple effect in terms of employment and income.

2. What are the appropriate health cost controls for the elderly?

Forced health cost controls will unquestionably lower the quality of health care, and the public will be forced to bear the brunt of this consequence. Government officers should realize that this is a significant issue that is directly related to Article 24 of the Japanese Constitution, which stipulates that the government is entrusted with the social mission to protect the right to life of all its citizens.

With the marked aging of the population, increased health costs for the elderly will definitely rise. However, forced controls will only have a negative impact. Measures to moderate that growth should be based on a medium to long-term perspective, and should be approached systematically.

Specifically, these include such measures as introducing a reasonable medical fee payment system and a flat rate system based on the budgets of national and university hospitals. To moderate the growth in a short term, trials should be also made to set up an appropriate drug price table where the prices have been maintained high due to diminished efforts to lower the purchase price in a market, and an appropriate medical material/device price table where both the domestic and foreign price differences are given as a topic of discussion.

3. Reduced benefit ratio and the increased financial burden of the patient

One other important shortcoming of the proposed bill by the MHLW is the reduction in
the benefit ratio and the increased co-payment of the patient. It proposes to establish a fixed co-payment rate of 10 percent, to remove the existing ceiling, and with the exception of a designated segment of the population, the younger generation will be responsible for paying 30 percent of the cost. Additionally, it proposes to raise the minimum amount that will be paid by the patient for high health costs.

As can be corroborated by past case examples, the increased financial burden of the patient has simply been shifted to public expenses and family finances. What must be reviewed is the burden that family finances must bear as a financial source for health costs, i.e., the combined total health cost paid by the insured and the patient presently exceeds 45 percent.

The financial burden on the family finances of the elderly over the age of 70 is equivalent to 10 percent of the total health cost paid by family finances; this is equivalent to the population growth rate. The stance of the government council regarding the financial contribution of the elderly population should realize that the elderly are already contributing their fair share.

Basically, health costs should be covered by health insurance premiums. The government’s role in terms of social security is to supplement the amount that is lacking from public expenditures to maintain stability and sustainability.

The bill of the MHLW has also proposed expanding the special health cost system. But such a move will produce disparities in the health services that are dispensed according to the economic condition of the patients. This is not only a denial of the element of equality in public insurance, but an increased burden on the patient’s finances, i.e., their family finances.

It is imperative that we escape the unchanging government scheme to reduce health cost expenditures by increasing the patient’s financial burden.

4. Proposed radical reforms of the system

One other problematic issue is that the ministry’s bill is a distortion of JMA’s proposal to establish a medical care system for the elderly. Thus, the proposed bill may end up being merely superficial reforms of the medical system for the elderly.

The medical system for the elderly according to this bill targets citizens over the age of 75 years, advocates increasing the investment ratio of public expenditures, and other components that at first glance appear to be similar to JMA’s proposal; and this is what is problematic. However, the JMA proposal advocates creating a health insurance system that is designed for subscribers who are at high risk for disease, which in turn will strengthen the element of guarantee, invest 90 percent of public expenditures, and raise the participation awareness of subscribers through insurance premiums, which will also give them the opportunity to voice their opinions.

The JMA has also proposed eliminating payment from the general health insurance fund for the elderly, which will be managed according to financial sources comprised of an 80 percent health insurance coverage and a patient co-payment fee of 20 percent of the health cost. This system is also designed to help mobilize the general health insurance system to adequately reflect the costs of new medical technology and preventive medicine.

This will require establishing a strong system of financial adjustments between insurance companies, beginning with adjustments between the national health insurance and employees health insurance companies in each prefecture. The next step is to carry out financial adjustments between the national insurance and employees health insurance plans, and lastly, it is necessary to integrate the national insurance and employees health insurance as a regional insurance plan in each prefecture. The MHLW has also advocated reorganizing and integrating the insurance companies, but this is a task that can not be accomplished overnight and must be pursued in stages over the medium term.
Although an increase in the absolute number of subscribers in the medical system for the elderly is unavoidable, the JMA proposes fixing the unit growth of health costs of each patient per day at a low figure to control the burden as much as possible, on the premise that preventive medicine for the younger generation will become substantial, life-long health program will become systematized, an appropriate medical fee payment system will be developed and introduced, and the area covered by the newly developed technology will be relatively minimal in comparison to the younger generation because of differences in disease structure.

In contrast to this, the draft bill of the MHLW suggests simply to curtail the number of subscribers according to age (75 years and above) and to address the problem strictly from a financial standpoint only. In this sense, it is totally different from JMA's proposed plan.

5. Verifying the financial source for health insurance

Hence the ministry’s proposed bill simply shifts the financial source for medical expenses from the national treasury to family finances. But the government has not taken any measure to corroborate and publicly circulate the facts about whether there is a real need for stringency in health insurance finances. There is a need to study Japan’s health insurance finances from a broader perspective to conduct well-grounded and direct debate using objective data.

The following facts became clearly delineated when the settled account reports for FY1999 of each insurance company and their amount payables, as well as those of the All-Japan Federation of National Health Insurance Organizations were linked.

According to the profit and loss statement, overall health insurance generated a net profit of 196.6 billion yen (US$ 1.49 billion) and net assets of 5.6 trillion yen (US$ 42.42 billion). When seen separately, the Association-managed Health Insurance had a separate reserve fund of 2.2 trillion yen (US$ 16.67 billion), the National Health Insurance had uncollected insurance premiums of 800 billion yen, and the Government-managed Health Insurance had unsettled liquidation problems with the government’s general accounting. As long as these are issues that concern public health insurance, it is the government’s responsibility to actively resolve these problems, and the path to rebuilding health insurance finances begin by each insurance company executing their management responsibilities.

Assessing Japan’s Health Care and Health Care Costs

Lastly, I would like to discuss the reforms of the health care system and what needs to be done in order to achieve these reforms.

Firstly, Japan’s health care system should be evaluated by the third party organization. The public and the mass media have been influenced unknowingly by the government’s propaganda that health care cost is the behemoth that will destroy Japan’s finances. If Japan’s health care costs are compared with international standards and objective data, we will find that they are not exorbitantly high as they are purported to be.

To the contrary, Japan’s health care system has been given top objective ratings for its equality and impartiality, its health index, and the cost of its services, according to OECD data and WHO rankings. In other words, our health system is a success from a macro perspective.

The key to this success was the implementation of a universal national health insurance system, the design of a health insurance system that was focused on benefit in kind, the stance of nonprofit health care, and the provision of fair and equal access to health care for all citizens.

From a micro perspective, the aging of the population continues to progress rapidly as we enter the 21st century, and there are many issues under the present system that must be
reviewed. For example, there must be undeniably more active work in the area of information disclosure and improving the quality of health care.

Those elements that are outstanding in Japan’s health system should be safeguarded, and those elements that need to be changed and kept must be reviewed impartially by relevant parties who are able to put their respective interests aside. Those elements that have a negative impact should be changed and replaced with elements that will produce positive benefits.

The nucleus of health care is a respect for life, and it is a humanitarian activity that is carried out by health professionals who utilize their knowledge and their technical expertise to relieve the primary pain and fear of patients suffering from a disease that has disrupted their health or threatened their life.

The health services that are rendered to the patient from the physician should not be transacted according to monetary values that represent health and life, but rather compensation for health services should be based on the principals of medical or bioethics. This concept is immutable and timeless, and the relationship between the health provider and receiver should be based on trust, specialized scientific knowledge, and ethical autonomy.

At the front line of health care, the patient will always want the best health services possible and the physician should constantly strive to provide such quality services. This may be called “optimum guiding principle”.

Health care that truly represents the patient’s best interests is achieved when this principle is implemented naturally.

Therefore, I strongly believe that reforms should not violate this principle. We must not overlook the fact that the crux of all health reforms is concerned with how institutional, environmental, and legal foundations can be concretely improved to develop and maintain the optimum guiding principle at a high standard.