Targeting "Elderly Market" for Growth Strategy via Regulatory Reform

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The Japanese economy has long been stagnant with just 1% GDP growth in real terms between 1990 and 2010. Due to the sluggish aggregated demand, the unemployed increased from 1.3 million to 3.4 million, and even among the employed, nonregular workers who do not have employment guarantees have increased to one-third of the total. The deterioration of employment is partly due to the shifting of production bases aboard by manufacturing industries, but mainly to an insufficient output increase in the service sector to provide qualified employment opportunities. The current government is eager to expand public expenditures for demand creation, though it is unlikely to be sustainable as the debt-to-GDP ratio, amounting to more than 200% in 2010 and the worst among OECD countries, is extremely high.

The policy target for sustainable growth lies in supply-side reform by stimulating private demand, in particular for health and nursing care services for the elderly, which are expected to grow strongly but are suppressed by heavy government regulations. There are, however, major obstacles preventing reform. The first is an ideology that these services should be in principle provided by the public sector or nonprofit organizations and not by for-profit firms; the second is the rule that beneficiaries have to be treated uniformly under the social insurance scheme with fewer options, unlike under market-based services; and the third is bureaucratic procedures covering details of the provision of services. Thus, regulatory reform to eliminate these impediments is a key to developing the elderly services market as an economic growth strategy.

Growing Elderly Market in Japan

Though the aging of the population is a common feature in many developed countries, Japan's aging process is marked by its high speed by international standards. The ratio of the elderly – defined as those aged 65 and above – to the total population had been stable at around 5% until the 1960s, but then sharply rose during the period of fast economic growth, reaching 20% in 2005. It is projected to rise to more than 30% in 2025 and close to 40% in 2050. It is attributable to a continuous decline in the total fertility ratio, which is now 1.3, well below the population replacement level of 2.1, and to the extension of longevity to the top level in the world. This aging process is associated with a decline in the population, which is likely to have peaked in 2006, and the declining trend is more prominent in recent projections, and will continue through the 21st century *(Chart 1)*. The declining population as well as increasing numbers of the elderly will exert strong pressure on the social security budget to increase, in particular for public pension and healthcare expenditures.

The aging issue is often considered a dismal phenomenon for the economy and society. As aging proceeds, either an increase in tax and social security contributions by the working generation or cutting benefits to elderly beneficiaries would be inevitable to maintain the budget balance. As both are politically difficult, the actual policy choice is to shift the burden to the later generation by leaving the existing commitment of too large benefits with too small burdens in the current generation, which is obviously not sustainable in future.

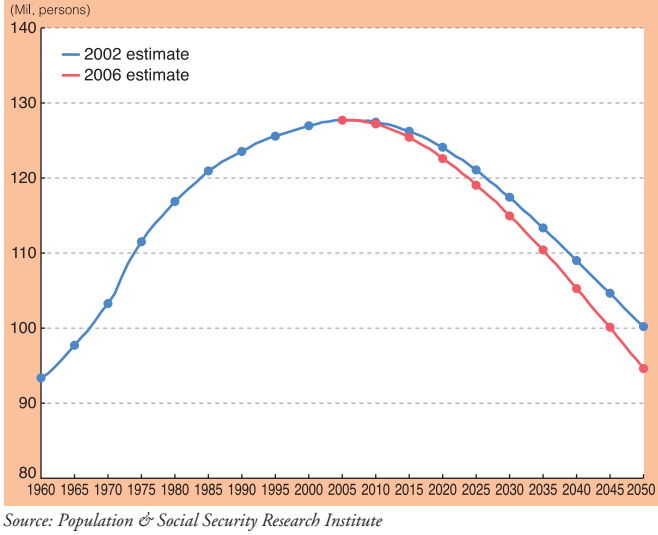
However, if we focus on the market demand side, the aging of the population means an expansion of demand for goods and services in the elderly market; the elderly population is projected to increase by 7.7 million between 2008 and 2020 despite a decline in the total population by 4.8 million. Besides, the current elderly households are not particularly poor – their per capita income was 1.92 million yen or 93% of the average in 2007. Also, 85% of the elderly households owned houses compared with 61% on the average of entire households, while the average financial assets of the elderly households were 20 million yen compared with the average 9.5 million yen. The elderly who receive full public pension benefits, which are in proportion to their past earnings, have gradually increased, accounting for 70% of total income. The after-tax average income of the elderly households, including social security benefits, was equivalent to that of those aged of 40-49 in 2008 *(Chart 2)*. Thus, the population aging in Japan would bring about an abundant consumer-oriented market.

Healthcare Services

The healthcare service sector is the most promising industry in the elderly market because of the following factors. First, demand for healthcare services is particularly strong among the elderly. Per capi-

CHART 1

Population estimates



Source: Population & Social Security Research Institute

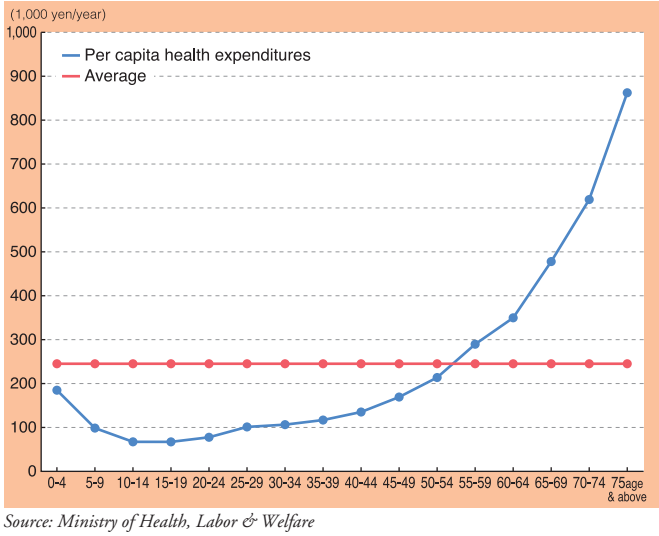
CHART 2

Income level by age group

Source: Ministry of Health, Labor & Welfare

CHART 3

Per capita health expenditure by age group (2007)



Source: Ministry of Health, Labor & Welfare

ta expenditures on healthcare services are closely related with one's age, and such spending of those aged 75 and above is about 3.5 times that of those of the average age *(Chart 3)*. Second, just as other professional services, the difference in the quality of services is particularly important, and people are willing to pay for higher value-added healthcare services. Third, as it is a highly technology-intensive industry with many spill-over effects in related areas like pharmaceutical products or medical treatment machinery, increasing demand for healthcare should have stimulating effects on manufacturing industries.

Nevertheless, the provision of healthcare services is highly regulated by two layers of regulations. One is the regulation on hospitals and clinics, and the qualification of doctors and other medical service staff. Another is on the way that public health insurance is applied to the respective healthcare services. These regulations were originally set for the benefit of patients but are often utilized for the protection of existing poor healthcare providers. Thus, they actually prevent an increase in the supply of qualified healthcare services meeting potential demand for better quality. If these regulations were removed, the healthcare service market could grow substantially.

Impediments to Financing Medical Institutions

The first major constraint on the development of the healthcare service market is the principle of "prohibition of profit seeking." This seems to be natural as healthcare meets basic human needs, but the definition of "profit-seeking behavior" is not clearly defined by the medical law. A poor substitute for the definition of "non-profitability" is the prohibition of dividends in financing the capital costs of hospitals and clinics. This odd definition of the law actually regards financing hospital buildings or equipment through bank lending as "non-profit," while that through new stock offerings in the capital market is seen as "for profit." However, according to the textbook of economics, interest and dividend payments are both defined as the "costs of financing capital" for a firm, even though interest payments are conventionally classified as "costs" while dividends are "the distribution of profits" in the company's balance sheet.

This prohibition of financing hospitals in the capital market de facto works for the protection of existing small hospitals and clinics. They effectively prevent new entrants by large hospitals of both domestic and foreign origin. If this regulation were removed, a huge capital market for mergers and acquisitions of private hospitals and clinics would be developed. Currently, there are not many first-class private hospitals in Japan – most of the nation's large-scale hospitals are publicly owned and not efficiently managed, running large deficits. Also, most private medical institutions are small clinics with only one doctor. This is partly because capital costs are not explicitly covered by public health insurance. Thus, without being financed by public funds as publicly owned ones are, many private hospitals have to finance their capital through bank lending even though that is limited by the collateral value of the hospitals themselves.

If capital costs for hospitals can be financed by issuing new stock, the financing of large-scale private hospitals would be easier. Also, the development of a franchise chain of small and medium-size hospitals under the same corporate brand would be stimulated. As a result, the existing hospitals and clinics would be able to enjoy more efficiently allocated funding, resulting in an improvement of dynamic efficiency in the hospital market. This is quite important for patients who seek better institutions under asymmetric information on their quality. But these reforms may be threatening to the existing clinics at the risk of losing customers, and the Japan Medical Association strongly objects to the move.

On the other hand, "non-profitability" in the healthcare service market could be better guaranteed by setting a form of "supply oblig-

ation," which means that they have to supply their services even in local areas with less profitability. This is similar to the regulation imposed on electricity or gas companies to secure public well-being. Setting the rule for mandatory healthcare service supply to a certain extent has to replace the current regulation on prohibiting corporate-managed hospitals. The regulatory reform of the healthcare service sector is a combination of liberalization of the means of financing and the introduction of effective means to provide healthcare services in a more equitable way.

Mixed billing in Health Insurance

In OECD countries, the share of healthcare expenditures in GDP varies, and Japan's share currently is not large by international standards, implying a good performance of its healthcare system, though the size of private health expenditures may well be underestimated. On the other hand, the ratio of public health expenditures to GDP is less varied, and the size of public healthcare expenditures financed by mandatory social security contributions or taxes would be more important.

A major constraint on the demand side of healthcare services is a ban on "mixed billing" or mixing public healthcare expenses with private expenses. This is the rule that two types of medical treatments, of which one is covered by the public insurance scheme and the other is not, cannot be combined into the same treatment. If combined, a patient must pay all medical expenses without depending on the public insurance system. For example, if a patient uses a new medicine or material that is not admitted by the public health insurance scheme, he or she has to pay not only the cost of this additional one, but the whole sum of treatment, i.e., public insurance cannot be used in this mixed treatment. This is in contrast with normal insurance contracts where the bulk of medical costs is covered by the insurance system regardless of the extra services voluntarily paid for by the insured.

This uncommon rule in Japan's health insurance system can be rationalized by the following logic. The first is an egalitarian nature of healthcare services, which is said to exclude the case that only the rich can use better healthcare services at additional cost. The second is that the public insurance system might be abused by combining it with treatments which are not necessarily effective. And the third is that doctors may well induce patients to choose unnecessary drugs or treatments by using their advantageous knowledge over patients. Regardless of the rationality of the above considerations, this rule on banning the mixing of public health insurance and private spending has brought about several problems.

The first concerns the egalitarian rule between different types of people; the rule does care for equality between those who can afford to pay extra costs other than covered by public health insurance and those who cannot, but simply ignores that between the rich who can afford to pay for costly quality healthcare services without using health insurance and those who can pay only for the extra costs in addition to regular services covered by public insurance. In this sense, too strict an egalitarian rule can be unfair to the majority of people.

The second point concerns an unclear issue – whether the current ban contributes to reducing public health insurance costs. The logic entirely depends on the assumption that patients give up using health insurance if combination with uncovered treatments is not allowed. However, there is a possibility that the costs covered by public insurance could be even larger because patients have to use less desirable treatments rather than being combined with the best practices not covered by public insurance. The conclusion depends on the results of empirical tests.

The third issue concerns the risk of providing unnecessary treatments. The ban can be relaxed only for those qualified hospitals and clinics for the prevention of abuse. On condition that the contents of mixed billing be fully reported to the insurers along with assessments on their adequacy, the qualification requirement could be removed if unnecessary treatments of what are covered by public health insurance are found.

If this ban is waived, there would be ample possibility for the expansion of the healthcare service market because of the following factors. First, qualified hospitals could have extra revenues to maintain their high level of medical treatments, which is not easy under the uniform billing rule of public health insurance. Second, competition for the better quality of healthcare services can be stimulated as compared with the current competition for quantity, i.e., for having more patients. Thirdly, patients would have wider choices in the costs and benefits of a variety of medical treatments, and may be willing to pay more for the better quality of services. After all, voluntary payments for purchasing healthcare services are less burdensome than the mandatory social security contributions or tax payments. As the costs of healthcare services grow with technical development and population aging, the share of the mandatory payments by taxpayers or patients will eventually have to be limited.

Thus, a key to realizing the scheme smoothly is deciding how to set a boundary for the healthcare services that have to be fully covered by public insurance. So far, the authorities have allowed hospitals to ask for extra charges on, for example, making a reservation for outpatients, amenities and certain highly specialized medical treatments. But they are on a list of exceptions to the regulations. It is necessary to set an exemption from the ban, either by the type of disease or by the quality of hospitals or clinics, as above, to help prop up the developing healthcare service industry.

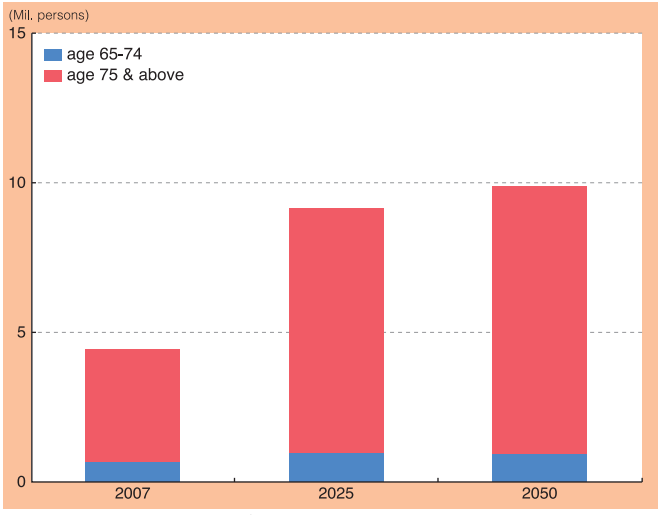
Nursing Care Services

The need for nursing care services should also grow in the aging society along with the increasing number of frail elderly. The possibility of being a frail elderly person would be 4.5% between ages 65 and 74, but rises to 29.8% at age 75 and above, according to 2007 data. Assuming that these ratios will be unchanged, the estimated number in 2025 and 2050 will double *(Chart 4)*. Nursing care services used to be provided in principle within a family, and public nursing care services were supplied as part of welfare services for those who do not have family support. On one hand, however, the number of families having frail elderly members has risen over time with aging and, on the other, the family's ability to take care of them has declined. This is because there is a trend of decline in the co-residence ratio between the elderly and their children's families as well as an increasing ratio of working women in the labor market.

Under such circumstances, a new social insurance scheme covering the costs of nursing care services for frail elderly people was established in 2000. This has several important characteristics for

CHART 4

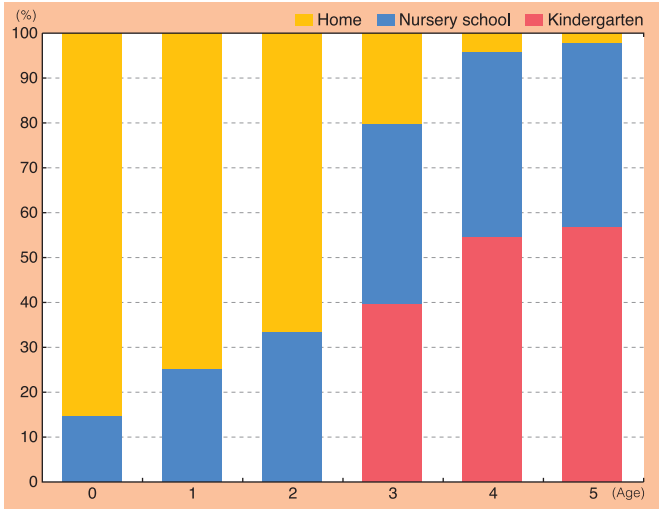
Estimated numbers of frail elderly by age group



Source: Ministry of Health, Labor & Welfare

CHART 5

Ratio of children at home by age group (2008)



Source: Prime Minister's Cabinet Office

the growth of the elderly market. The first is to allow private firms in addition to traditional nonprofit institutions to provide nursing care services, which is important in stimulating supply in the market to meet growing demand. The second is to share the costs of purchasing nursing care services through public insurance so that users of nursing care services are granted 90% of the costs. This is compared with the previous welfare system where only a limited group of beneficiaries is granted free nursing care services. However, the shift of costs from health insurance for the elderly to nursing insurance has turned out to be limited.

The nursing care insurance system has the following important implications for the growth of the elderly market. One: unlike in the case with healthcare insurance, entry to the market has been opened to private firms, which provide a variety of services and stimulate competition in the nursing care market. Two: public support through insurance benefits is directed to consumers rather than providers as in the case of welfare services so that consumers have a wider selection of services. Three: the range of options for consumers in combining extra nursing services with those originally covered by public insurance is broader than is the case with healthcare services.

Nevertheless, there is still room for regulatory reform. Nursing care providers sell a larger quantity of services with extra costs, but they cannot offer better-quality services at higher prices as in the case of most service industries. This "egalitarian rule" in providing nursing care services under social insurance has prevented the expansion of the elderly market, with a variety of services being provided at various prices. The clear division of role between the public and private sectors needs to be established so that the government assures the provision of basic services and that firms provide a variety of services to the market. The issue of asymmetric information on the quality of services between users and providers is less serious concerning nursing care services.

Nursery Services

Nursery services for preschool children are also expected to grow in the aging society as more women would work to support the growing elderly population. The increasing labor shortage due to aging of the population as well as the higher ratio of women's college enrollment should stimulate the labor force participation of married women. In that case, a major bottleneck is child-raising in a family, which needs to be substituted by market services. In fact, about 70% of married women leave their companies upon birth of their first baby despite various policy measures supposedly supporting child-rearing.

A major obstacle for married women not staying at work is a lack of childcare facilities, particularly for children aged 0-2. About three-fourths of the children in this age group are taken care of at home, implying large potential demand for nursery school services in future *(Chart 5)*. Nevertheless, nursery services have long been supplied by the public sector and nonprofit organizations as part of a welfare program for children who are not under good family care. Like other public services, the high cost of the provision of nursery services managed by public employees with seniority-based wages is a major factor for the lack of efficient service supply and a long queue on the waiting list in urban areas. As this is a similar situation to nursing care services before the public insurance scheme for frail elderly was introduced, the policy implication would be the same. If a new social insurance system for nursery services were implemented, the supply of such services should increase substantially. Also, combining childcare services with child education with extra expenses will widen consumer choices through market competition.

In summing up, with a substantial increase in Japan`s elderly population in the coming decades, the elderly market is expected to grow significantly. But most promising areas in the elderly market such as health and nursing services are under heavy regulation by the government. These services were originally provided by the public sector or de facto monopolized by nonprofit organizations as part of welfare policy. However, to expand supply to meet potential demand growing along with population aging, regulatory reform to expand the elderly market and help revitalize the economy has to be implemented. JS

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