Protecting Our Lives through Healthcare Reform

The Health Economics Perspective

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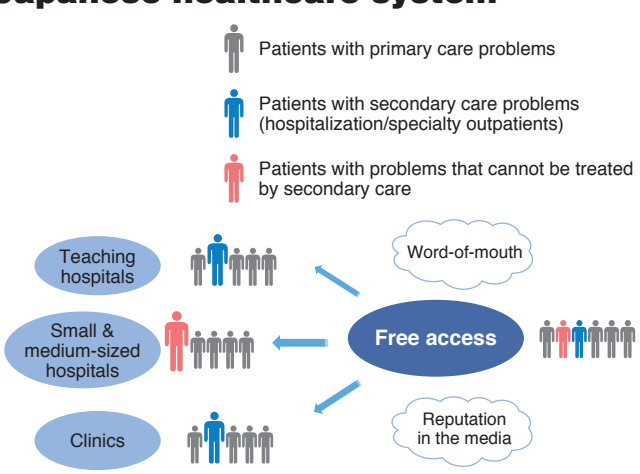
Is the Japanese Healthcare System Really Superior?

The Japanese healthcare system has been called one of the best in the world. One of the reasons for this is that Japan has become the country with the longest life expectancy in the world, with low medical expenses, and low child mortality as well. On the other hand, we are being told that health care is collapsing because there are too few doctors and nurses, leading to overworked doctors abandoning hospitals in droves. So, is there really a lack of doctors and are healthcare expenditures really low? In fiscal year 2013, social security took up 45% of the Japanese government's general expenditures. Medical expenses accounted for nearly one-third of social expenditures and are expected to continue to grow, putting an even greater burden on the national treasury.

There are statistics that are useful when discussing this issue: the number of medical practitioners per 1,000 people in the OECD Health Data database. The number of doctors per 1,000 people in Japan was 2.2, according to Health Data 2011 *(Chart 1)*. This figure is well below the OECD average of 3.1 — 28th out of the 34 OECD member countries. We are increasingly seeing the media and political parties using this OECD data to call for increasing the number of placements available at medical schools, claiming that Japan has significantly fewer doctors relative to its economic power from an international perspective.

CHART 1

Japanese healthcare system



Source: Noriaki Sawa, Korekara no Nihon no Iryouseido to Katei Iryo ("The Future of the Japanese Healthcare System and Family Healthcare"), Shakaihoken Junpou (Japanese Journal of Social Insurance), April 1, 2012

However, the statistics indicate only a small facet of reality. Among OECD countries, Greece has the most doctors, at 6.2, much higher than second-place Austria (4.8) and Norway (4.0). Fourth-place Portugal (3.9) and fifth-place Spain (3.8), like Greece, face serious fiscal challenges. On the other hand, the United States, which is supposed to have the highest medical costs in the world, at 2.43 is not so different from Japan, while Canada at 2.0 has fewer than Japan. South Korea, with a rapidly growing economy in recent years, is at 1.86, but we hear very little talk of medical care collapsing there.

Come to think of it, shouldn't countries such as Canada and the US, which are vast and have low population densities on the one hand, and Japan, South Korea and the like, which have small territories and high population densities on the other, have different requirements for the number of doctors? Japan has the fourth-highest population density among OECD countries. When the number of doctors per square kilometer is calculated, Japan comes in sixth among the 34 members behind Mexico, the Netherlands, Israel, Belgium, and Germany. In other words, it is not unreasonable to assume that access to doctors for the Japanese public is not so bad after all from a geographical, physical movement perspective.

It is often given as a characteristic of Japanese medical care that the ratio of medical expenses to GDP, at 8.3% in 2010, is low. Indeed it is true that inpatient treatment costs as a proportion of Japanese medical expenses are small; however, outpatient treatment costs are some of the highest in the world. Hypertension, diabetes, depression, back pain and other lifestyle diseases top the list of medical expenses covered by local governments. Many items in the estimates of Japanese medical expenses are not included in estimates using the Systems of Health Accounts (SHA), the international standard for national health accounting, leading to underestimation. Taking the Systems of National Accounts (SNA), useful in making international comparisons, to calculate the economic scale of the health sector (with the caveat that there are constraints such as a lack of information on hospital-related investments and a market-based accounting system being used, which does not include government subsidies), it came to 47.1 trillion yen in 2007, which is significantly larger than the 41.8 trillion yen for Japanese medical expenses published by the OECD. The former is the equivalent of one-tenth of GDP, which is roughly on the same level as the other countries except the US.

The number of doctors and the amount of medical expenses are important indices in making international comparisons, but one must

take care to interpret them properly. For example, the Japanese case rate for heart disease, on a par with South Korea's, is one of the lowest in the OECD, while the mortality rate due to heart disease per 100,000 people is a quarter of the US figure and one-third of the Australian and Canada figures. The reason for the low Japanese mortality rate is clearly the low case rate, not superior medical technology. When the diseases are different, the number of doctors and medical expenses should be different as well.

What Are the Challenges of the Japanese Healthcare System?

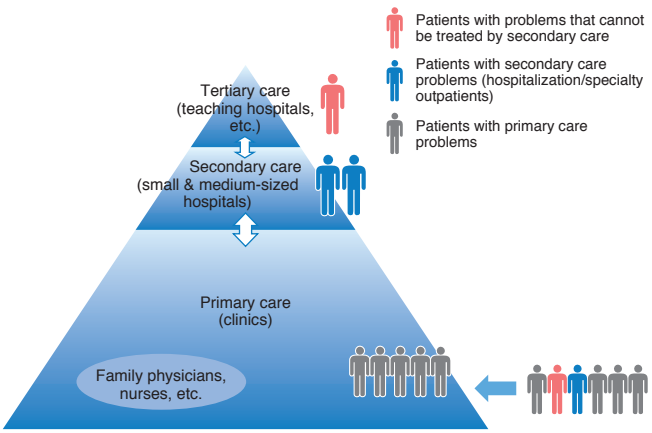
One feature of the Japanese healthcare system is that it has pursued "equal access", "equal benefits" and "equal burden on the patient" under an egalitarian principle. "Equal access" is in practice free access; in Japan, even a slight headache entitles you to a visit as an outpatient at a teaching hospital *(Chart 1)*. This is an aspect of the Japanese healthcare system that astonishes foreigners, since it means that the general public, who have no medical expertise, must select outpatient treatment at a significantly high level of specialization such as cardiovascular medicine, gastrointestinal surgery, orthopedics, urology, obstetrics and gynecology, brain surgery, and psychosomatic medicine.

Outside of Japan, provision of medical services is in principle divided into three layers, as *Chart 2* shows: primary medical care, which covers daily health issues such as colds and headaches; secondary medical care, which covers appendicitis surgery and other medical care that requires hospitalization and specialized outpatient treatment that requires high levels of expertise; and tertiary medical care, which covers serious high-emergency diseases such as acute myocardial infarction as well as some special diseases. It is customary overseas to have a system that distinguishes between the roles of medical institutions depending on the nature of the patient's health issues and the seriousness of the illness. This way, the efficiency of medical services and the level of medical treatment are enhanced through role-sharing between medical institutions depending on the health issues. Generally speaking, in most cases, primary, secondary, and tertiary medical care are conducted by clinics, small and medium-sized hospitals, and large teaching hospitals respectively.

Primary health care, or "primary care" for short, is the foundation on which medical services rest, and consists of the medical services that support our daily lives. It responds to common but acute problems such as colds, stomach aches, shallow cuts, and sprains as well as chronic diseases such as hypertension, diabetes, and depression. It covers most (80%-90%) of our healthcare and medical needs. It covers all people from babies to the elderly regardless of age. It is gender-free, but also deals with issues unique to women such as menstrual pain, menopausal disorders, pregnancy, and childbirth. It deals with all areas of medicine from depression and other mental health issues to dermatological problems such as itching and rashes. One important feature of

CHART 2

Framework for healthcare services worldwide



Family physician introduces patient to the most appropriate department.

Source: Edited by the author from Noriaki Sawa, Korekara no Nihon no Iryouseido to Katei Iryo ("The Future of the Japanese Healthcare System and Family Healthcare"), Shakaihoken Junpou (Japanese Journal of Social Insurance), April 1, 2012

primary care is preventive medicine, which protects us by minimizing the risk of disease through preventive measures such as flu vaccination.

"Primary" also means "first or highest in rank, quality, or importance; principal." Primary care is care of the "highest…in importance" covering most of our medical needs.

Doctors who specialize in primary care are called general practitioners/family physicians. It is usually the case that there is an asymmetry of information between the patient and the doctor. Since the patient does not have sufficient information to make the appropriate decisions, the wise thing to do is to leave the decision-making to the better-informed doctor. Acting as agent to the patient as principal, the doctor provides medical information as the person responsible for the health and medical care that supports the daily life of the patient.

However, the family physician is not established as a distinctive discipline in Japan. Thus, Japan is the only country where the space for family physicians is left blank in *Table 1* where the number of physicians per 1,000 people is indicated. In Japan, specialized training and continuing education as family physicians is not considered important. It is seen as something that will be learned by receiving training in internal medicine at a hospital or spending a few years in the community providing health care. Neglecting the establishment of an appropriate system for primary care, which is the most frequently used form of medical care, has resulted in an unnecessary burden on hospital medical care, inefficient consumption of medical resources, and the inefficiency of the overall healthcare system.

Japanese doctors are mainly advocates at the secondary and tertiary medical care levels. Medical students are not taught to be advocates in primary care, while primary care has not been established within the healthcare system. Thus, there are cases

TABLE 1

Providing health care: international comparison
(OECD health data 2008)

	Physicians per 1,000 people (ratio of general practitioners/family physicians)	Nurses per 1,000 people	Hospital beds per 1,000 people	Days hospitalized	Percentage of treatment (number of outpatient visits per year)	CAT scans per 1 million people	MRIs per 1 million people
US	2.43 (12%)	10.75[2)]	3.1	5.5	4	34.3	25.9
Japan	2.15 (—)	9.54	13.8	18.8	13.4	97.3	43.1
Germany	3.56 (18%)	10.68	8.2	7.6	7.8		
UK	2.61 (29%)	9.52	3.4	7.1	5.9	7.4	5.6
France	3.34[1)] (49%)	7.93[2)]	6.9	5.2	6.9		
Canada	2.27[1)] (48%)	9.2	3.5	7.5	5.7	13.9	8
South Korea	1.86 (37%)	4.36	7.8	10.6[3)]	13	37.1	19
Netherlands	2.88 (25%)	11.24[2)]	4.3	5.9	5.9	10.3	10.4
Australia	2.97 (51%)	10.08	3.9	5.9	6.4	38.8	5.9

Note: The definition of "family physician" differs from country to country. It appears that pediatricians and obstetricians are included in the US figure.
1) Professionally active physicians
2) Professionally active nurses
3) 2003 data
Sources: OECD Health Data 2010; WHO

TABLE 2

Diseases which have high expenditure (Outpatient)

Order	Name of disease	Number of persons	Expenditure in yen	(accumulated %)
1	hypertension	2,832	186,611,804	11.4%
2	chronic renal failure	114	108,637,579	18.0%
3	diabetes mellitus	2,704	103,360,656	24.4%
4	dyslipidemia	3,482	84,860,333	29.5%
5			58,790,200	33.9%
6	gastric ulcer chronic gastritis	2,592	39,685,233	36.3%
7	integration disorder syndrome	279	32,841,039	38.3%
8	rheumatoid arthritis	228	27,418,750	40.0%
9			24,661,710	41.5%
10	osteoporosis	774	21,675,398	42.8%
11	carcinoma of the prostate	415	19,113,030	44.0%
12	depression	362	18,752,295	45.1%
13	osteoarthritis of the knee	700	18,208,182	46.2%
14	multiple myeloma	22	16,457,004	47.2%
15	allergic rhinitis	1,235	16,154,971	48.2%
16	bronchial asthma	697	15,826,290	49.2%
17	lumbago	1,448	14,177,158	50.1%

Note: population 31,000 people, population aging rate 35%, insureds 7,862 people
The 5th and 9th diseases are very unusual and only a small of number patients suffer from them. To avoid these patients being identified, the columns for these diseases are left unfilled.
Source: Complied by the author

where a patient has a simple illness but makes the rounds of several departments and clinics, receiving tests and medication at each stop. While the number of patients rises, the unit value for medical care remuneration is low, so a physician must treat many patients very quickly in order to make it profitable. Thus, there is insufficient time to explain to the patients and chronic diseases take a turn for the worse. Many people who have jobs avoid medical institutions because of the long waiting times. Hospitalization due to kidney failure, respiratory failure, pneumonia and other illnesses because of chronic diseases made worse by not receiving proper medical treatment is also increasing medical expenditures in Japan. This is a particularly serious problem for the elderly with multiple chronic illnesses. The high proportion of the elderly is not the only reason why medical expenditures for the elderly is higher than in other countries.

Table 2 gives data on the National Health Insurance in a regional city. It shows large outlays in medical expenditures for lifestyle diseases. Many local governments in Japan follow a similar trend, appropriating 30%-40% of outpatient expenditures under the National Health Insurance system for lifestyle diseases.

The importance of specialized education for doctors responsible for primary care is finally becoming recognized in Japan. One characteristic of the Japanese healthcare system has been that doctors are free to claim specialties. However, this system has been reviewed. A new medical specialist system will be introduced in 2017, and specialists in general practice/family medicine (general practitioner (GP), family physician) will be recognized and trained as the 19th category of medical experts. To foster and maintain the quality of the care by this 19th category of specialists will be the key to constructing a highly cost-effective healthcare system. There is a proposal on the table to charge people who come to a major hospital without a referral letter a fixed 10,000 yen fee in order to limit free access. However, it is first necessary to secure the quality of care at the primary level.

Controlling the flow of patients so that they will not converge on major hospitals from the beginning is called gatekeeping, but this is just a small part of the functions of the family physician. The family physician also continuously serves the families in the area of his/her responsibility as the true agent of the members of the local community, facilitating health maintenance and nursing consultations, terminal care, and tending to the needs of the families of the patients by understanding the physical characteristics and medical histories, and even the lifestyles and values of the families. The doctors responsible for primary care are the doctors of first and last report: the doctors whom people meet at the very beginning and engage with to the very end.

What Is a Healthcare System that Enhances Patient Satisfaction & Also Limits Healthcare Expenditure?

The OCED countries that we have looked at vary when it comes to

primary care. Countries such as the United Kingdom, the Netherlands, Australia and Canada, which are making national efforts to attain highly cost-effective healthcare systems that emphasize primary care, see major benefits in high patient satisfaction and limitation of healthcare expenditure. There are many overseas studies showing that when family physicians are deployed appropriately within the healthcare system, health indices such as specific premature mortality rates due to circulatory, respiratory and other diseases see major improvements, and patient satisfaction is enhanced at low cost in terms of healthcare expenditure, contributing to the reduction of disparities in health.

In countries with progressive primary care, each resident is usually registered at one primary care clinic, where one family physician is responsible for approximately 2,000 people. Since only a fraction of the 2,000 actually visit the clinic, reimbursement for healthcare is designed to make clinics financially viable whether or not patients come by forging a careful balance between a fixed fee per head and pay-for-performance fees. This means that there is no need to secure reimbursement by resorting to excessive tests and medication; this serves as a restraint on medical expenses. Needless to say, robust treatment guidelines and healthcare-quality oversight are in place to avoid healthcare deficiencies. Since each resident is required to register with one family physician, data concerning the local residents accumulates with the family physician. This is another major benefit of this arrangement.

In Japan, by contrast, reimbursement under the medical insurance system takes the form of a fee for service, which means that there is an incentive for the medical institutions to receive more reimbursements by conducting more tests and prescribing more medicine than necessary. What surprises all overseas medical professionals is the fact that children in Japan routinely undergo CT scans of their heads even though there is a risk of radiation exposure. Another quirk of the Japanese healthcare system is the frequent resort to thoroughgoing medical checkups including CT scans, MRIs, and PET scans even though there is no evidence of their effectiveness. As you can see from *Table 1*, Japan has the highest rate of CT scans in the world, almost three times as often as the US and 10 times as many as the UK and the Netherlands.

In countries where primary care is properly provided for, high-quality healthcare means medical interviews and physical examinations are conducted thoroughly while it is explained to the patient that tests, such as CT scans, that impose burdens on the human body will be avoided unless they are necessary. It is the opposite in Japan. Patients are so accustomed to receiving excessive tests and medication that many feel let down without them. The presence of a family physician as a primary care medical expert with high communication skills more than makes up for this sense of letdown; indeed, this will actually enhance trust between the patient and the physician. It is also important to train family physicians in order to avoid useless doctor shopping.

What Can We Do to Protect Community Health Care?

There have been several occasions in Japan when the argument was put forward that primary care should be established together with a correspondingly appropriate reimbursement system, but it was always defeated by opposition from vested interests who would lose out as a result. There is growing public awareness of excessive medical treatment today. However, the debate over the reform of the healthcare system has centered mainly on making the fiscal ends meet, with the result that policies such as increasing copayments and raising insurance premiums have received priority and fundamental reform has kept being pushed back. It is difficult to receive the public's understanding and support in this situation. We the people, not to mention politicians and the media, should take an interest in reforming health care as it is actually practiced, which is of paramount importance in our daily lives, through such means as primary care.

Particularly in health care and welfare, it is crucial that members of the local community participate in the policy-making process, where it is important not to rail at the lack of healthcare funds or doctors but to examine the available policy choices and choose between them.

For example, should the consumption tax and insurance premiums be raised so that public insurance can extend full coverage to members of the local community who obtain antibiotics for a cold or receive a CT scan just because of a slight knock on the head, or should efforts be made to avoid raising taxes by establishing primary care and avoiding unnecessary medication and tests as much as possible?

When deciding whether to build a new hospital in one's municipality, the construction costs will be borne by raising taxes and any deficits that the hospital incurs will have to be defrayed by the tax money of the locals. However, it now takes 30 minutes to go to the hospital in the next town but it will take only 10 minutes when the hospital is in place.

Members of the local community and the local assembly must make these choices. "Benefits according to the burden" is at the heart of governance. It is crucial that members of the local community choose the medical services that they require in accordance with the residence taxes, fixed asset taxes, and other taxes and charges that they pay. The individual can easily be isolated from society at large, but can be trained to think about the public interest by participating in local government at the most granular level and acquiring an interest in public affairs such as community health care. By engaging in community health care, we the people can study democracy in depth and may be able to overcome growing disparities and other challenges of globalization. JS

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