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I would like to provide some context for the article "Patients Adrift: The Elderly and Japan's Life-Threatening Health Reforms" by Hiratate Hideaki, recently translated from Shukan Kinyobi for publication in Japan Focus. Japan has a long and honorable tradition of muckraking reporting on its medical care system. To illustrate that point with a personal anecdote: My colleague Naoki Ikegami and I published a book about a decade ago called Japan's Medical Care (*Nihon no Iryou, Chuuou Kouron* Shinsho) itself a translation of a book we published in English called *The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System* (Cambridge University Press). Although it pointed out quite a few problems, the overall tone of our book was as positive as the English title indicates. Many Japanese readers told us it was the first time they had ever read anything good about their own medical care system. They were used to reading magazine articles and books full of pitiful anecdotes and unrelenting criticism.

Hiratate is well within this tradition. He certainly points to some real problems, and I share his concern that the upcoming reform of medical care for people 75 and over has some worrisome aspects, that planned attempts to cut long-term care in hospitals down to levels more like other countries will be quite difficult that there is a real shortage of doctors and specialized hospital facilities in rural areas, and more generally that cost-cutting in health care has recently gone too far. But the unremittingly bleak picture Hiratate presents might lead even Americans to feel better off than Japanese when it comes to health care, which would be ridiculous. Some context is needed particularly for international readers.

First, without necessarily claiming that Japan has the best health care system in the world, it is demonstrably true that the Japanese population is very healthy and that access to medical care is widespread and quite egalitarian (i.e. usage of the system is not related much to income). The system is also extremely efficient as indicated by the fact that spending per capita and as a percentage of GDP is very low compared with OECD countries. Not only is life expectancy the highest the world, a recent WHO report points out that healthy (or disability-adjusted) life expectancy is highest, and so is life expectancy at age 65 and age 80, indicating that Japanese older people are especially healthy. [1]

Second, older people have been favorably treated by the Japanese health-care system since the highly political "no-fee old-age medical care" (*roujin iryouhi muryouka*—meaning no co-payments) policy of the early 1970s. That proved so expensive that enormous cross-subsidization from employee health insurance was provided in the early 1980s. Added at that time was a tiny patient burden, which has increased since—for a few elderly households, those with incomes equivalent to that of average workers (around ¥5 million or $50,000): co-pays for this group have been increased to equal to those of employees (30 percent). For the great majority of older people, however, the co-pay is still only 10 percent. As Hiratate himself indicated, usage is high and burdens low for the elderly.

It is a tribute to the efficacy of the Japanese government's cost-control system, based mainly on manipulations of the universal fee schedule, that from the early 1980s until the mid-90s growth in medical spending was kept parallel to the growth rate of GDP. Even since then, health-spending growth has continued to be quite low, but because GDP growth flattened out, health care's share of the economy started to increase slightly. In an atmosphere of extreme fiscal stringency, conservatives found that an attractive target and called for new measures to constrain health care spending.

The old-age health care program drew particular attention from the government for three reasons. First, as everywhere, older people consume a disproportionate share of health care. Second, the population was aging rapidly and would continue to do so. Third, awareness grew that the very advantageous treatment of older people—low co-pays, and also that older people listed as dependents by an employee child paid no health insurance premiums at all—might not be justified. That is, the economic position of older people was, on average, much stronger than had been assumed in the old days, and indeed many were better off than younger people. That was due to the maturation of the pension system, as well as earlier high savings.

These perceptions led to the new scheme for people aged 75 and over that started on April 1. Its introduction brought on a small firestorm of consternation and opposition. Partly it was due to another botch by the Ministry of Health and Welfare, on the top of the pension records debacle. Everyone 75+ had to show their new insurance card to get service but a sizable number of people did not get their cards in time.

One provision was to collect premiums from those who had been waived because they were dependents of their children (though implementation was postponed due to LDP worries about a backlash). Most older people are not newly paying premiums, they are just switching from paying into municipal health insurance programs to paying into the new system organized at the national level—some will pay a bit more, some a bit less, but the difference will not be dramatic at least for the present. However, deducting the premium from people's pensions, on top of the recently increased premium for Long-Term Health Insurance (*Kaigo Hoken*) , seemed to be a jolt for many. Whether for real or psychological reasons, people preferred to pay the contributions to the municipality.

A second provision of the new system is an attempt to increase the role of the family doctor as a "gate keeper" in coordinating health care. However, this new designation of "home-care physician" (*zaitakui*) is voluntary on both sides, and the monthly fee of ¥6,000 is to cover only some routine care. If expensive procedures are needed, they are paid fee-for-service, and patients are not restricted from seeing another physician, so there is no reason to expect big changes in practice patterns in the near future.

The new plan has substantial measures to protect low income people, but there are worrisome aspects. One is the impact on people who are above the poverty threshold but still in a marginal economic situation, since the change in premium collection could affect muncipal-level subidy programs. Another is that with people ages 75+ in a separate system, future cutbacks in care or increases in burdens could be carried out more easily because younger and presumably more powerful people would not be affected.

Such problems are more prospective than current. Still, such discrimination (*sabetsu*) of older people was widely criticized and people started calling the new system *hayoshine hoken* or "hurry up and die insurance." What would seem to be an overreaction in rational terms may reflect widespread public distrust in government, especially the MHLW.

Incidentally, Hiratate presents two sad real-life illustrations about old-age health care. I would point out that his 85-year old lady living on a tiny income would clearly qualify for public assistance if she wanted it, and that Mr. and Mrs. A would be receiving double the amount of pension benefits mentioned if they had paid their legally obligated premiums. As for their costs, it was said that they pay ¥20,000 out of pocket twice a month for visits to the hospital, including transportation; such a high cost is certainly unusual and in most cases would be more like ¥2-3000. Moreover, the services this couple are presumably getting from Long-Term Care Insurance are not mentioned. It is hard to argue about anecdotes, but they certainly should be taken with a grain of salt.

The two other topics that Hiratate takes up at some length are, in my view, more worrisome than the new old-age health care plan, though not quite as dire as pictured. First, it is true that the government is planning a drastic reduction in the number of hospital (not nursing home) beds devoted to long-term care (*ryouyoubyoushou*). Japan has far more older people in actual hospitals getting long term care—for six months or longer—than does any western nation. It has tried to reduce this number through incremental moves for decades and is finally planning fairly drastic action by cutting back on the number of such beds.

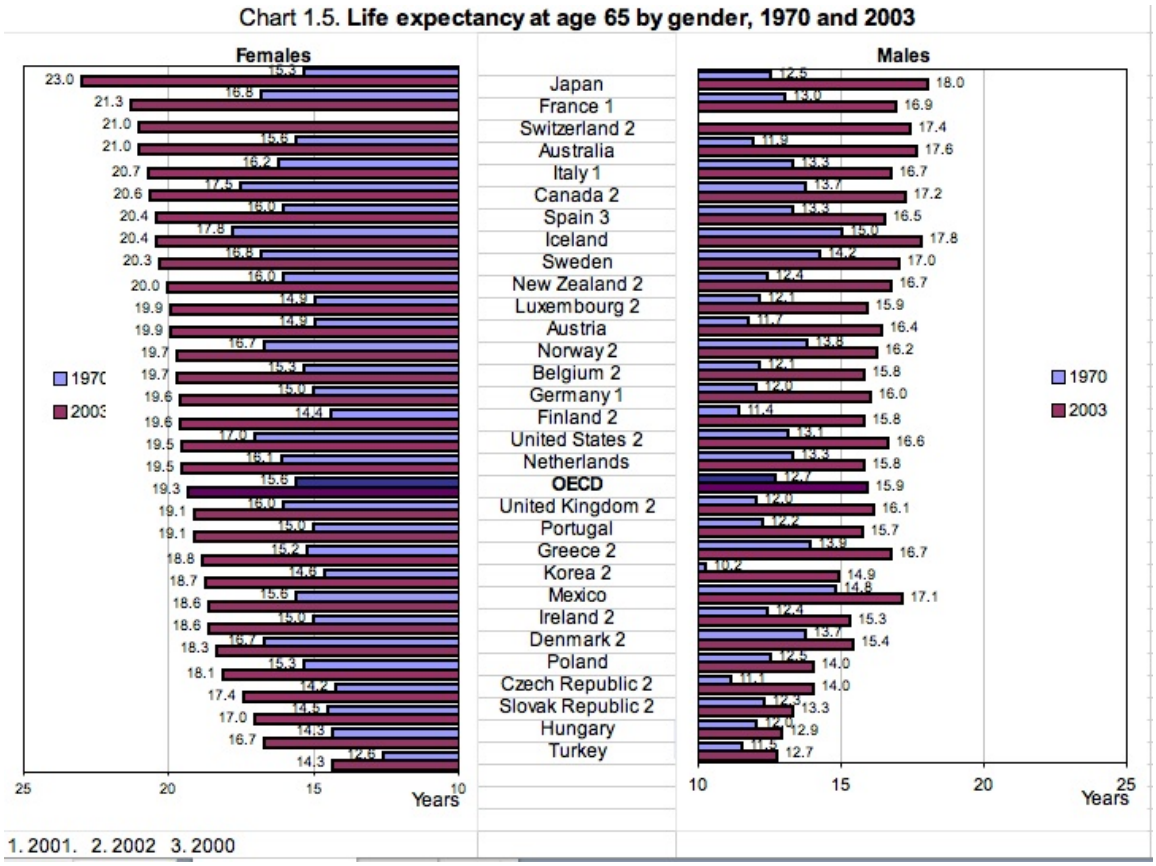
This decree has already been softened in response to widespread concern, and that may happen again, but here Japanese policy is very much part of a worldwide trend away from institutionalization (including traditional nursing homes) and toward home-and-community-based care. Japan is already ahead of the rest of the world except Scandinavia in that area, including, for example, almost nine million people attending adult day care, thanks to the 2000 Long-Term-Care Insurance System. The biggest challenge is in developing more residential facilities (like American assisted-living, though that is almost entirely paid for out of pocket) where people can live an affordable life with adequate services short of complete institutionalization.

For his third topic, Hiratate gives many vivid examples of regions losing specialized doctors and hospital facilities, to the extent that residents lose access to decent care. This trend is the result of changes in residency requirements for graduate physicians (aimed at improving quality) that had the unanticipated effect of bringing young doctors back into more urban areas, plus cutbacks in subsidies to local governments that reduced their support for local public hospitals (indeed, not a few have been merged or closed).

Again, some context is needed. The main impact has been in quite rural areas, and while these account for a high proportion of Japanese territory, the number of residents is low (perhaps 10 or 15 percent of the Japanese population). And the problem is often limited to particular illnesses and conditions, though the lack of quick access to an emergency room potentially affects nearly all residents of these provincial areas.

All nations have difficulty in providing medical care in sparsely populated areas. Concentrating some services makes sense—in Japan too many high-tech procedures, particularly difficult surgery, has been carried out in hospitals with low volumes (and therefore low competence). More centralization would be a plus if the problems of access could be managed better. In fact, technological fixes (helicopter ambulances, telemedicine) may be more available in health care than in the other policy sectors affected as rural areas decline both in population and in national budget allocations.

More generally, Hiratate raises the question of whether the Japanese medical care system is underfunded. Japanese do spend less per capita than citizens of the other highly advanced OECD nations—the United Kingdom used to be lower but the Blair government decided to increase its investment (mainly in response to complaints about long wait times for operations, a problem Japan doesn't face). My personal opinion is that more should be spent in some areas, but in the main the Japanese should take pride in how quality and egalitarian access has been maintained despite rapid population aging, at a remarkably low growth rate of expenditures.



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Unfortunately, conservatives are still pointing with alarm at health spending and proposing more radical changes. Amazingly enough, thanks to the prestige of neoliberal economic theories, many want to learn from America and introduce more market mechanisms. I'm sure Hiratate and I agree that this course would be a disaster, and happily so far the medical establishment has and the public have been successful in resisting such demands.

In short, recent developments in Japanese health policy are worthy of continued journalistic scrutiny. As an aging consumer of Japanese health care myself, I plan to pay attention as the effects of these and other policy changes play out. Foreign observers should pay attention too, of course, but they would be misled if they conclude that medical care in Japan has fallen apart, and they would miss out on some interesting lessons for their own countries if they do not examine what Japan has been doing well.

Note

[1] The former see this. For the latter see OECD Health at a Glance 2005. OECD Social Issues/Migration/Health, Volume 2005, Number 18, November 2005 , pp. i-175.

John Campbell is the author (with Naoki Ikegami) of The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System. New York: Cambridge University Press, 1998. Japanese edition, 1997. He wrote this commentary for Japan Focus. Posted on April 26, 2008.

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