International Seminar on Population Aging and Health Policy in Asia

Financing healthcare in rapidly aging Japan

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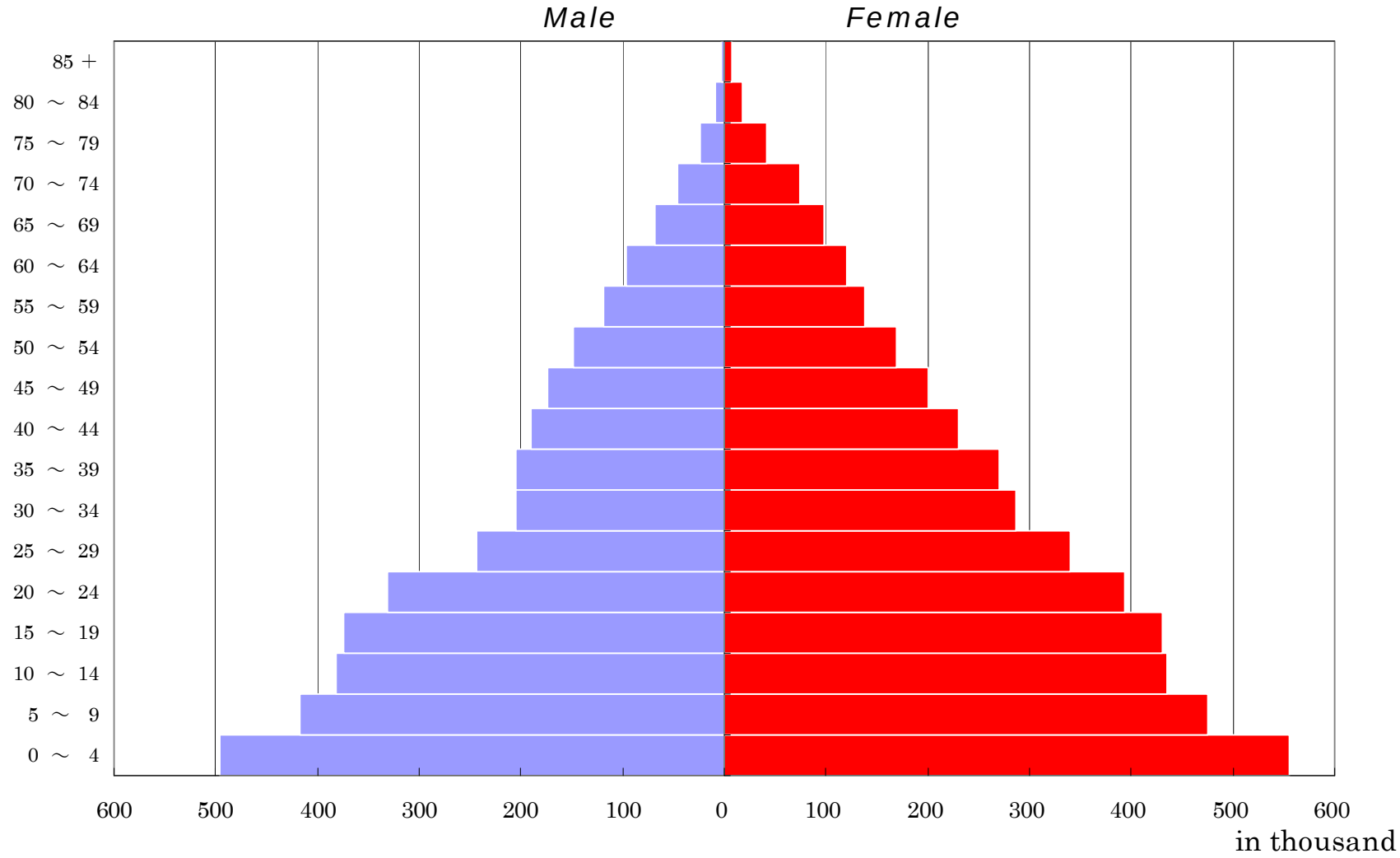
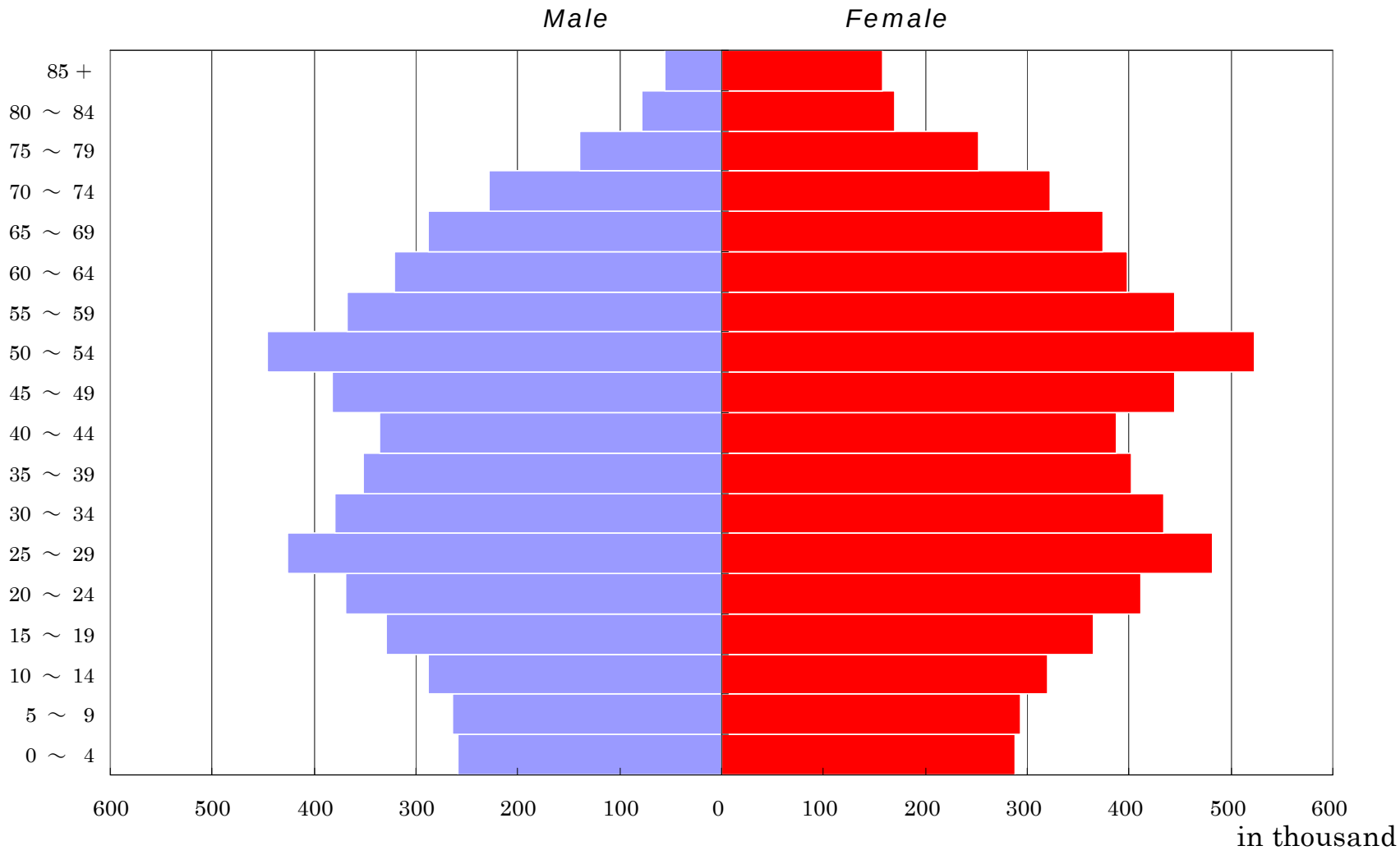
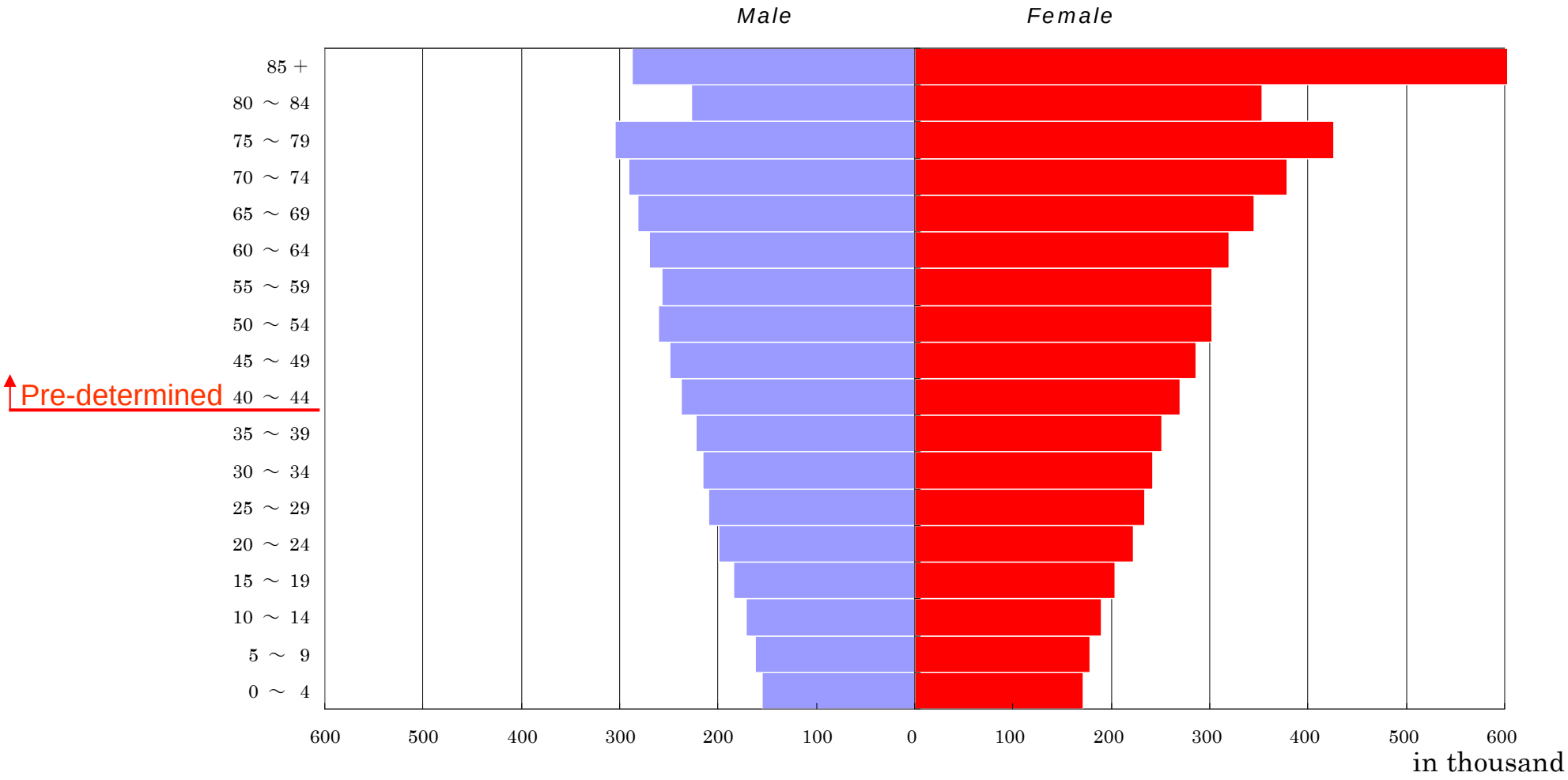
Population of Japan by Age and Sex, 1950



Population of Japan by Age and Sex, 2000



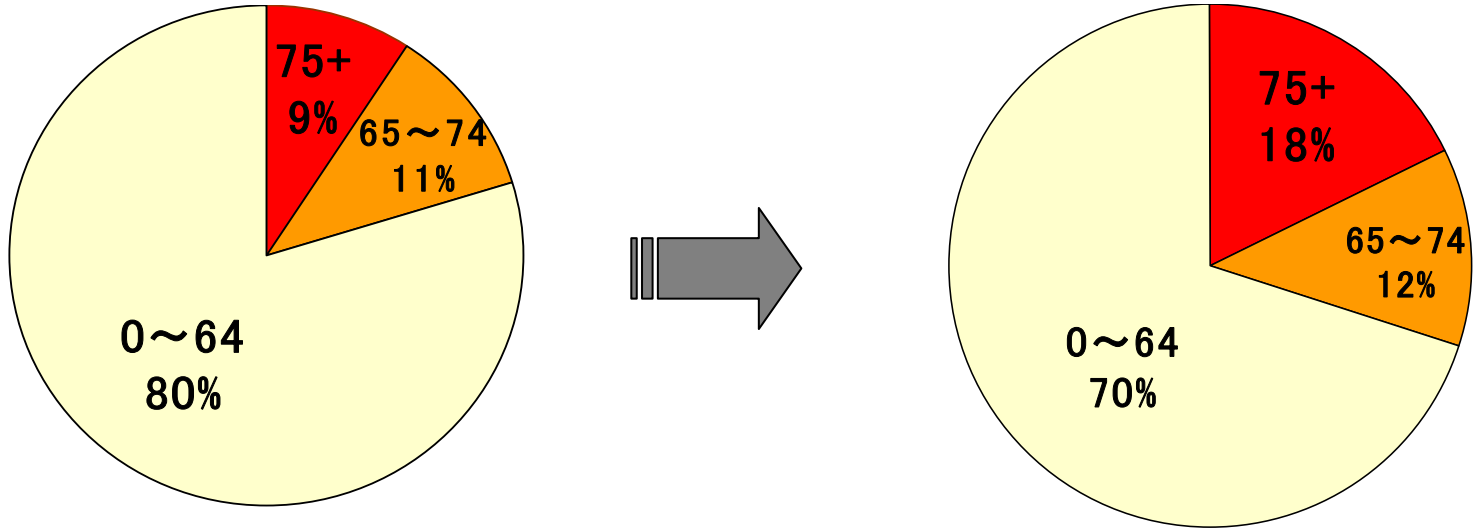
Population of Japan by Age and Sex, 2050



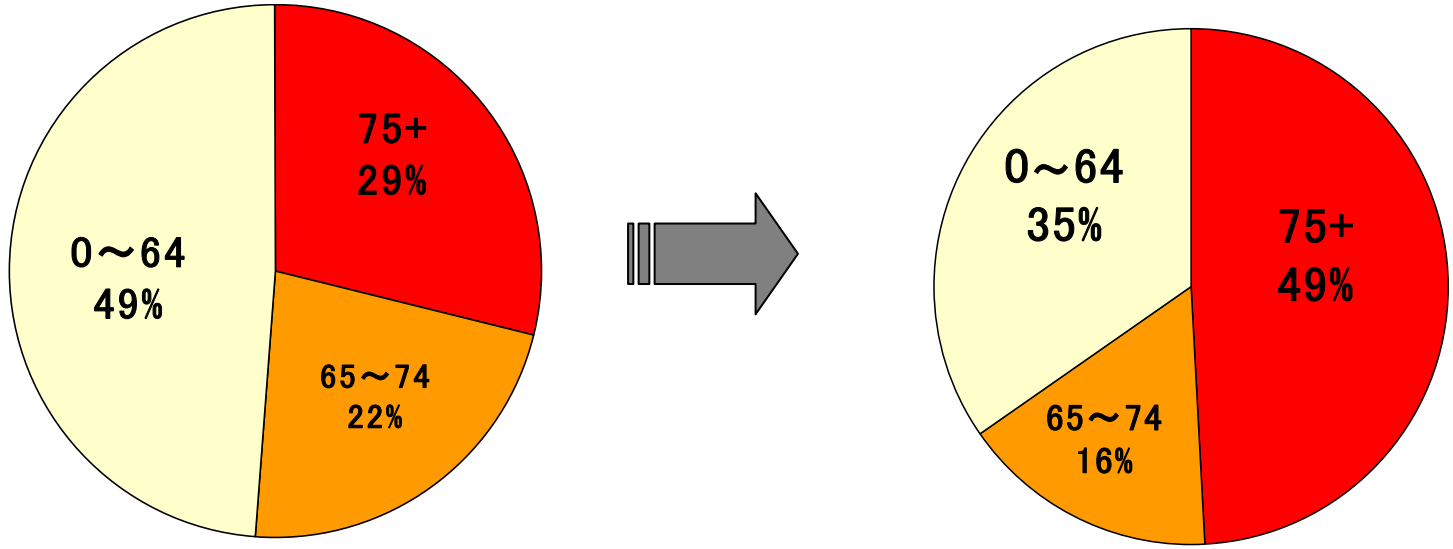
Composition of 65～74 and 75+ in Japan

2005 *2025*

In population



In health expenditures



Need to change the focus of healthcare

- In twenty years, two-thirds of all patients in Japan will be 65+
  - If patients seen by obstetricians and pediatricians are excluded, then close to three-quarters will be 65+
  - My advice to medical students: You should not become a doctor unless you like talking to old people
- Typical hospitalization for frail, elder patient: Admitted on a stretcher, discharged on a wheelchair
- Disease management programs won't work when the patient has multiple diseases as is often the case with elders

⇒How can the financing be changed?

Financing healthcare in an aging society

- Issues I would be raising:

(1) Can the younger generation's burden be mitigated?

(2) Can total health expenditures be contained?

(3) Can health insurance for elders be reformed?

(4) Can end-of-life care expenditures be contained?

(5) Is long-term-care affordable?

(1) Can the younger generation's burden be mitigated?

- Elders are no longer all vulnerable
  - Elders own 70%+ of all assets
  - 80% of elders own their home (60% for all adults)
- Elder's co-payment rate and premium contributions have increased
  - Co-payment: 10%, but for those with incomes more than average worker: 30% (same as rest of population)
    - Note that when co-payment amount exceeds $400 per month, the rate becomes 1% (catastrophic cap)
  - Premium contributions: Tax exemption for income from pensions decreased (= more premiums must be paid)
- Containing total health expenditures
  - If denominator (total) is contained, then numerator (elders' costs) can also be contained

(2) Can health expenditures be contained?

- Yes! Japan ranks 22nd among the OECD countries in the percentage of healthcare expenditures to GDP: 8.0%
- Despite rapid aging of society, wide diffusion of technology and no waiting lists
  - Highest per capita number of CAT scans, MRI in the world
- The mechanism: Fee schedule (tariff) controlling the price, conditions of reimbursement
  - Money flows through a single pipe from all payers to all providers
  - Global control over both hospital and physician fees
  - Fees reduced individually on targeted items
  - Has compressed increases in costs due to advances in technology

Revisions of the fee schedule

- Made every two years
  - Implemented in April 1, when the new fiscal year starts
- Revision consists of three steps
  - 1st Step: Global revision rate
  - 2nd Step: Drug and device price revision
    - Mostly based on survey of market price
  - 3rd Step: Revision of individual procedures
    - Each procedure fee is individually revised
- 1st Step: Political decision made by prime-minister
- 2nd and 3rd Step: Made by Council within the Ministry (Ministry of Health, Labor & Welfare)

Example of revisions in fees for diagnostic imaging：MRI (Yen)

Year	Head	Body	Limbs
2000	16,600	17,800	16,900
2002	11,400	12,200	11,600
2006	10,800 if <1.5 Tesla, 12,300 if >1.5 Tesla*		
2008	10,800 if <1.5 Tesla, 13,000 if >1.5 Tesla**		
2010	10,000 if <1.5 Tesla, 13,300 if >1.5 Tesla**		

30% ↓ , despite only 2.2% macro ↓

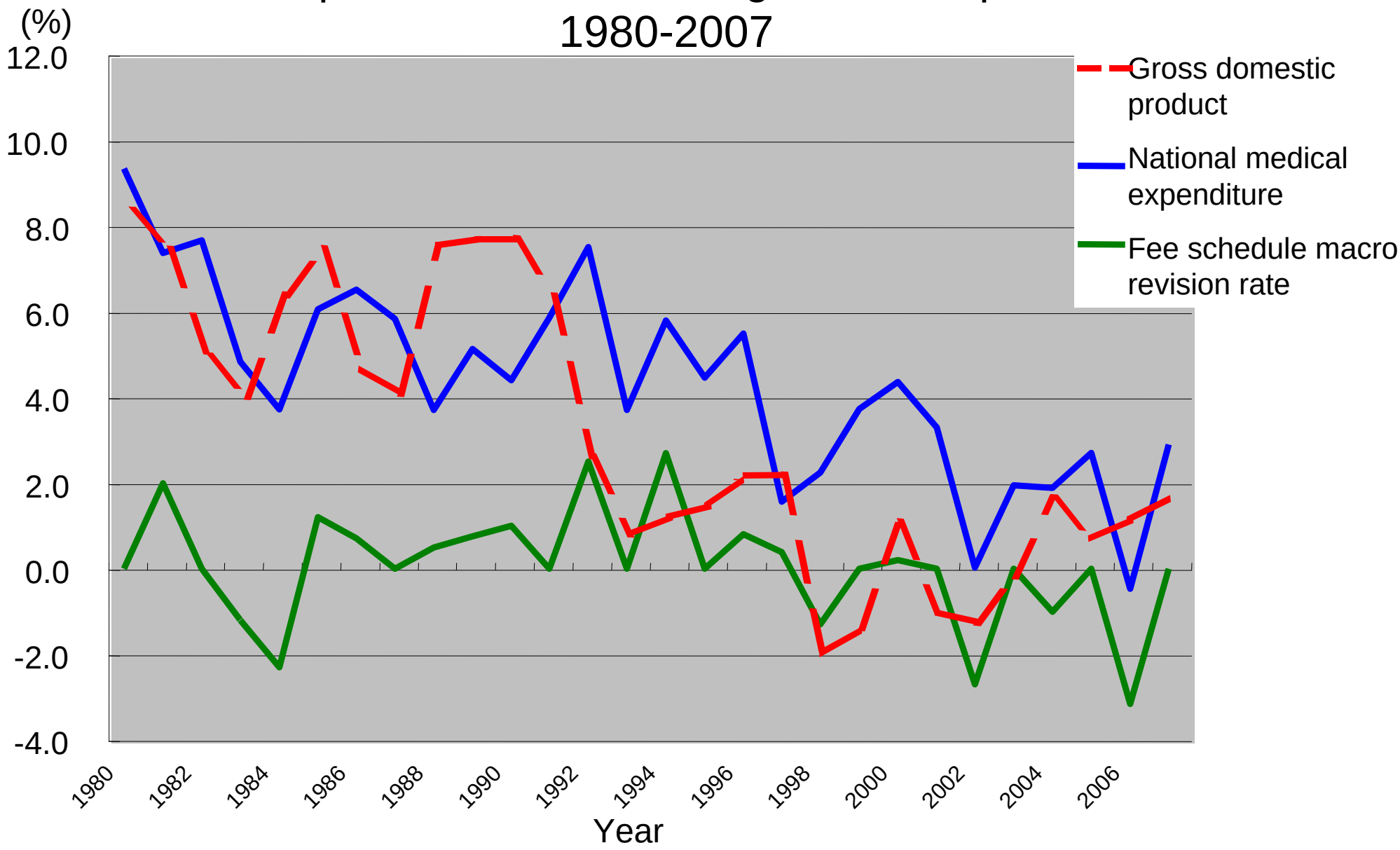
* Differential fees according to equipment type introduced for the first time

**Successful lobbying by radiologists?

Extra-billing and balance billing prohibited

- Providers can only bill for the amount and conditions set by fee schedule
- If providers wish to do so, then the entire amount must be paid out-of-pocket
- Has prevented impoverishment from health expenditures, over-selling of services by providers
- Main exceptions for extra-billing: private room charges, new technology still under development
  - Weak power of specialist organizations (until now)
  - De facto relaxation for compassionate use: Patient buys the drug independently, based on “comments” from doctor
- Giving gifts to physicians: Only in premier medical centers and for inpatients in private rooms

Annual Changes in Gross Domestic Product, National Medical Expenditures and Average Fees, Japan, 1980-2007



(3) Can health insurance for elders be reformed? The case of the new insurance for elders 75+

- New insurance for all elders 75+: Implemented April, 2008
  - On 75th birthday, all had to leave their former plan and join this plan
- Political fiasco for government
  - One reason for the LDP defeat in the August, 2009, election
- Three main reasons for its unpopularity
  - Official name “Health Insurance for Later Period of Old”
    - Resentment against the unfamiliar term → Next stage after “later”, death
    - Came to be referred to as “hurry up and die insurance”
  - Forcing low-income elders to pay premiums
    - Those who had been covered as dependents of their child had to start paying
  - Slightly different benefits for the 75+
    - Over 99% the same, but some slight differences such as consultation for end-of-life care only for 75+→ All abolished in 2010 fee schedule revision
- 75+ plan to be “abolished” in 2013: Pledge by government

(4) Can end-of-life care expenditures be contained?

- Whether at end-of-life or not is revealed only ex post (after death)
- Patient's wish when in critical condition
  - To be aggressively treated and cured if at all possible
    - Difficult to deny this wish, even if the chances of recovery are slight
    - More likely if young and the onset is sudden
  - Not to receive aggressive treatment that will prolong suffering
    - Option should be made available
    - More likely if old and the onset is gradual
- Growing trend: Most deaths now occur after 75 in Japan
  - Proportion of all deaths occurring after 75: only 1/3 in 1968, but 2/3 in 2008
  - Few people die when young or middle-aged
  - The proportion of those opting for aggressive treatment should decline
  - Although the absolute number of deaths will increase, from I million deaths (2002) to 1.7 million deaths (2038), the proportion of deaths occurring after 75 would also increase

Caveats in containing end-of-life care costs

- Public opinion against explicit discrimination of healthcare provision according to age
- End-of-life care costs may not be so high
  - On an individual basis, end-of-life care costs may constitute one fifth of total life time expenditures
  - But for society, on a cross-sectional basis, the Ministry has estimated that healthcare costs for the last month of life would be only 3% of total expenditures

(5) Is long-term care affordable?

- In past 10 years, healthcare costs have increased 15%
- LTCI costs have doubled
- But LTCI expenditures were planned to increase
  - Service benefits only: Time is required for people to get used to purchasing care services
  - Service providers have to be developed
- Too successful!→ Why?
  - Eligibility criteria set too low, and benefits too generous
  - 98% of applicants were certified as being eligible
  - Why?→ Government were afraid that those receiving services before LTCI would lose their benefits
    - Services have been targeted to low income (not so frail) elders

What are long-term care services?

- Personal care: ADL (Activities of Daily Living) assistance in dressing, eating etc.
- Domestic care: IADL (Instrumental ADL) assistance in meal preparation, cleaning, shopping, medication management
- Home modifications (ramps, hand rails), emergency alert systems
- Transportation to & from adult day care centers, healthcare facilities
- Services by physicians generally not included, except when the physician is employed by the institution
- Vocational training would be included for non-elders having physical, learning and mental disabilities
  - Introducing LTC just for elders would be more feasible, and would have more popular support

In theory: Public LTC Insurance is not only needed, but should also be less expensive

Healthcare system

- Services become medicalized
- Public expectations: Best care available
- Expensive professional staff has dominant role
- Patients find it difficult to exercise choice

LTC system

- Services are a combination of health and social care
- Public expectations: Decent level of care
- Low-wage staff has dominant role
- Clients find it easier to exercise choice

LTC may be the best way of containing healthcare costs

Calculating LTC expenditures

- Expenditures=No. of eligible in each eligibility level multiplied by the benefit amount ($) of each level
- Number eligible: Based on eligibility criteria
  - Number and severity of ADL deficits etc.= Extent of support needed for walking, eating etc.
  - Of the 65+, could cover from 10% (Germany) to 16% (Japan)
    - Japan extends coverage to those who need only light care
- Amount of benefits: From parsimonious to generous
  - The balance can be left to be paid by the user
  - Public responsibility is to cover a “decent level” of services
- Both the eligibility criteria and the benefit amount are set by policy-makers, not physicians
- Much less pressure to provide the best available service for all
- Mistake in Japan: Too wide in coverage, too generous in benefits
  - Partially or totally (for poor) including hotel costs for institutional care

The future

- Where Japan is now, the Korea will be 20 years later
- Plan according to what has been, or has not been, shown to be possible in Japan, NOT on beliefs or wishes

  (1) Younger generation’s burden can be mitigated

  (2) Total health expenditures can be contained

  (3) Public opposes targeting cost containment on elders

  (4) End-of-life care expenditures may not increase

  (5) Long-term care is affordable (if designed correctly)