Managing Public Costs in the Japanese Health and Nursing Care Sector*

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I. Introduction

This paper looks at some of the longer–term fiscal issues in Japan arising from likely developments in the health and nursing care sector. It first looks at recent OECD information on spending patterns. Likely future trends in spending are then discussed drawing on the results of recent expenditure projections of health and nursing care out to 2050. This is followed by a discussion of possible policy responses, focusing on areas where the efficiency of health care provision might be improved. Some tentative conclusions are drawn in a final section.

II. How Does the Japanese Health and Nursing Care System Perform?

The current health care system in Japan performs well when compared with most other OECD countries (Jeong and Hurst, 2001; Imai, 2002). The social insurance system provides for full coverage of the population for the cost of health care. A wide range of health risks is covered and the share of out–of–pocket spending in total health care spending remains below the OECD average (17 percent compared with 20 percent in 2004)[1]. Patients enjoy freedom in the choice of the provider and can get treatment at any time anywhere. On the supply side, medical professionals are limited in number when compared with other OECD countries. The number of doctors per capita is among the lowest in the OECD area, although it has been rising rapidly. This appears to be compensated by very high levels of activity, which often seem to have reached the physical capacity of doctors.

Quality of care and effectiveness of health care spending with respect to broader health care goals are difficult to measure due to the range of social and lifestyle factors that affect health. Nonetheless, the health care system does contribute positively to health outcomes to a degree and Japan scores very high on a wide range of health status measures.

Performance in terms of life expectancy and potential life years lost is among the best in the OECD

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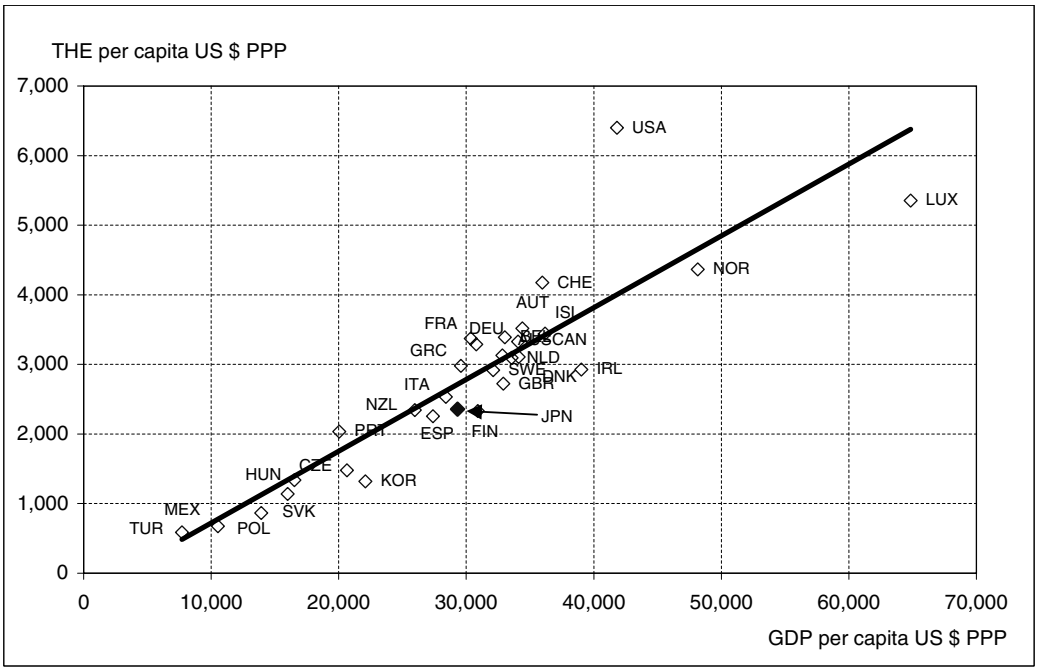
1 This may have risen subsequently as a result of increases in patient cost sharing introduced in 2003.

area. Seen from a fiscal point of view, Japan spends little on health care, relative to per capita income and as a share of GDP compared with other OECD countries (Figures 1 and 2). This is the case despite a slightly higher share of elderly in the total population than the OECD average and the fact that part of its nursing care spending is counted as health care expenditure.

Nonetheless, concerns have been raised about the quality of care (there tend to be long waiting times, short consultation periods, and variation in practice patterns across the country). The efficiency of the health care system is also an issue: the volume of consultations appears to be excessive and hospital stays tend to be long, reflecting large bed capacity. Moreover, the fragmented social insurance system has resulted in horizontal inequity in finance as well as the size of insurance funds that is insufficient to pool health risks effectively[2].

There are no obvious performance indicators for nursing care. But the situation prevailing in Japan prior to the introduction of the nursing care insurance in Apri1 2000 was inefficient beyond any

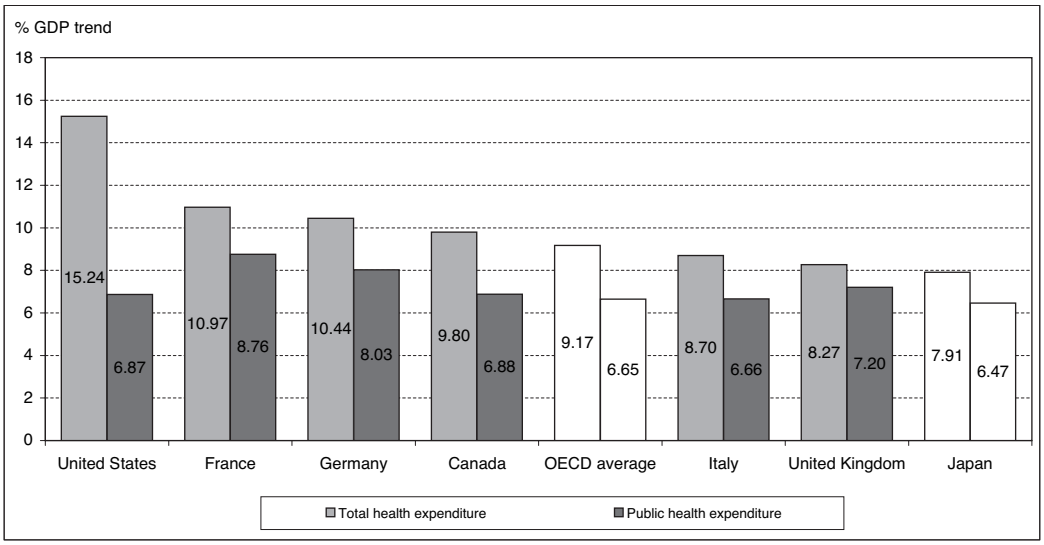
Figure 1 Total Health Expenditure (THE) Per Capita Versus GDP Per Capita, 2005



Notes: Data on total health expenditure (THE) for the following countries are estimated: Belgium, Denmark, Hungary, Japan, Luxembourg, the Netherlands, New Zealand, Poland, Portugal, Spain, and the United Kingdom. Data refer to 2005 except for Australia, Hungary, Japan, Luxembourg and the Netherlands.
Source: OECD HEALTH DATA 2007.

[2] For example, in fiscal year 1998 and for a comparable income level, the annual premium for National Insurance funds varied from a low of ¥138,300 in the 23 wards of Tokyo to a theoretical high of ¥1,070,720 (capped at ¥520,000) in Sapporo City (Matsutani, 2000). Ironically, administrative costs are not high as most of the health insurance funds limit the number of staff working to a base minimum because their tasks are limited (they do not process claims) as well as for financial reasons. The key insurance sector issues are that many of the funds are too small to pool risks effectively, and to play the role of an insurer. In other words, they tend to be a collector of funds and a payer.

Figure 2 Total and Public Health Expenditure as a Share of Trend GDP, 2005



Notes: Data refer to 2005 except for Australia, Hungary, Japan, Luxembourg and the Netherlands, which refer to 2004. Data on health expenditure (both total and public) for the following countries are estimated: Belgium, Denmark, Hungary, Japan, Luxembourg, the Netherlands, New Zealand, Poland, Portugal and Spain. OECD average excludes Mexico and Turkey.
Sources: OECD Health Data 2007; OECD, *Economic Outlook*, no. 81; and OECD, *Quavterly National Accounts,* 2007.

doubt[3]. The demand for nursing care was increasing steadily in the face of shrinking capacity to look alter the elderly at home and this combined with grossly insufficient public capacity to provide institutional care. This latter problem had been partially resolved by the expansion of geriatric hospital beds that was triggered by the policy change in the mid–1970s to make health care for the elderly free of charge. Thus, while estimates remain controversial, there were some 180,000 elderly who were effectively receiving nursing care but paid by health care insurance by 1999. After April 2000, this undesirable situation was significantly improved and the number of beds probably fell to some 60,000, as a large part of these were reclassified as nursing care beds that are financed by nursing care insurance[4]. With a rapid increase in service supply capacity for both institutional and home care that followed the introduction of nursing care insurance, the situation of excess demand has been largely corrected.

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[3] The nursing care insurance is social insurance with co–insurance of 10 percent. It is designed to minimize the risk of supplier–induced demand through an impartial assessment of care needs and to give the service recipient freedom of choice of care services and providers. Horizontal inequity in premiums is explicitly allowed and is reflected in benefit levels, although only to a limited degree, as only 18 percent of total benefit is financed by the premiums paid by the elderly.

[4] These figures come from <http://www.urban.ne.jp/home/haruki3/syakaiteki.html>. In a recent study, Hatano (2004) estimated the volume and cost of hospitalization of those aged 65 years and over for non–medical reasons. His estimates of the number of aged patients hospitalized for non–medical reasons are 221,000 in 1999 and 215,000 in 2002, which shows a much smaller reduction following the introduction of nursing care insurance compared with the figures cited in the text.

III. Health and Nursing Care Spending

Several factors contribute to the low level of total and public health care spending when compared to other OECD countries. On the supply side, the government has been able to maintain tight control over the prices paid for health care services through a single national pricing policy. First, the government has set an overall allowable increase in prices following the recommendation of a consultative council that comprises representatives from insurance funds, medical service providers, trade unions, and academics. Second, given the overall price increase, the pattern of relative prices (that is, the fee schedule) has been modified to discourage the services that the government considers to be the least cost–effective. But the modification of relative prices has also reflected the relative political power of the council representatives, notably the strong influence of doctors in private practice (Campbell and Ikegami, 1998; Ikegami and Campbell, 1999).

For example, the prices for hospital surgery are kept low relative to outpatient consultations, as are the prices for high–tech medicine such as imaging equipment. Assessing the influence of relative prices on relative service use is not straightforward as many services are complementary. Given a high level of beds *per capita* and the availability of imaging and other high–tech equipment, this pattern of relative prices has favoured ambulatory care consultations at hospitals, which then have become an important source of hospital admissions and demand for examinations by advanced imaging equipment (Imai, 2002). The impact of the likely distortions in relative prices on medical practice and quality of care remains an area of debate.

On the demand side, the significant cost sharing (30 percent up to a ceiling) may have limited the demand for health care services. But this cannot explain the low levels of spending when compared internationally[5]. Paradoxically, the share of out–of–pocket spending in total health care spending is below the OECD average, which is partly explained by the banning of balance billing by doctors[6]. Statistical factors also help explain the internationally low spending levels as measured. Until the advent of nursing care insurance in 2000, a significant amount of nursing care was provided by the small private hospital sector and was recorded as medical care, pushing up the health spending levels. This, however, has been changing rapidly as supply that is better adapted to nursing care and covered by nursing care insurance is increasingly becoming available (Mitchell et al., 2004). Hence, one reason why the spending levels in Japan have been lower since 2000 when compared internationally has been the change in statistical recording. As a counterpart, both public and total spending for nursing care has been boosted.

Nonetheless, health–care spending continues to rise with the steady increase in the share of the elderly in the population as a contributing factor. Over the period 1997–2002, total health care

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[5] Assuming the standard price elasticity of 0.1 to 0.2 and holding other things unchanged, spending levels could have been higher by 3–6 percent in the absence of the 30 percent co–insurance. But Japan has already had high levels of consultations per capita that may be constrained by physical limits of doctors, so that even this calculation may be overestimated.

[6] The share of out–of–pocket spending, as such, is not the relevant measure. One should also check whether such spending is insured or not.

spending has risen by 1 percentage point of GDP and public spending by 0.75 of a percentage point although it appears to have stabilised over the following two years. With weak growth in employment and wages and, as a consequence, social insurance contributions, there have been growing deficits within the social insurance system (Imai, 2002)[7].

OECD data for 2004 suggest that public spending on nursing care was around 1.2 of a percentage point of GDP, although this may be underestimated because all of the social beds may not have been included. (Total long–term care spending appears to be 1.7 percentage points of GDP in 2004). With the advent of nursing care insurance, public nursing care spending rose by 55 percent between 2001 and 2004, which can be decomposed into a rapid increase in the number of recipients (50 percent) and a rather moderate increase in costs per recipient (5 percent). The rapid increase in spending caused financial problems for insurers, even though premiums were raised in 2003.

IV. Future Developments in Spending on Care

While Japan has succeeded in containing health care costs more than other wealthy countries, a number of factors are likely to intensify upward pressure on both public and total health care costs over the coming decades (Dang et al., 2001; Bains and Oxley, 2004; Oliviera Martens and de la Maisonneuve, 2006). These factors include:

- Increasing household incomes and changing preferences and attitudes of the population and patients as regards the level and quality of care provided.
- Further technological change in medicine. While some of these developments can help reduce the cost of supply, the high levels of investment needed to produce, for example, new drugs, suggest that, overall, these increases are likely to be cost increasing as in the past. New medical equipment needs to be purchased and investment in human capital maintained. In addition, new treatments—such as keyhole surgery or better anaesthetics—can mean a wider share of the population can be treated.
- To the extent that the elderly consume more health care services than do the younger cohorts, the demand for both acute care services and long–term nursing care will increase with the projected rise in the share of the elderly in the population. This process is already underway in Japan: the share of the population aged 65 and over has increased from 10 percent of the total population in 1980 to 17.5 percent in 2000.
- The demand for nursing care services is also likely to increase as families are less and less able to provide informal care. Family size has fallen such that there are fewer children to care for the

[7] There is risk adjustment among social insurers covering the elderly (70 years old and above) and retired employees who are normally between the ages of 60 and 69. With the aging of the population, transfers from social insurers with relatively young membership to the Health Service System for the Elderly (HSSE) to cover the benefits for retired employees have been increasing. This has contributed to the deficits of the social insurance funds that are net contributors (typically the Society Managed Health Insurance funds and the Government Managed Health Insurance fund). National Health Insurance funds—which manage the HSSE and retired employees as well as covering the self–employed and others—receive transfers, but their premium revenues are insufficient to cover the rising benefit payment.

elderly than in the past and they often no longer live in close proximity to their parents. The labour force participation of women—who have been the main carers for the elderly in the past—continues to rise as well. Longer working lives, as retirement is delayed by pension reform, may also contribute to this trend.

- Finally, with health and nursing care becoming both labour– and human–capital–intensive, rising demand for care services may require higher relative wages and prices to attract more workers into the sector. Indeed, a major policy issue is whether the current policy of price controls by the Japanese authorities can be sustained.

V. Projections of Public Health and Nursing Care Spending

The OECD, in collaboration with the European Union and OECD member countries, has undertaken projection exercises to assess the possible impact of aging populations on public expenditure over the next half–century. The approach used is described in Box 1. The methodology has been progressively refined, most recently by Oliveira Martins and de la Maisonneuve (2006) at the OECD. Estimates of the increase in health and nursing care spending to 2050 on the basis of the methodology laid out in Box 1 suggest that public health and long–term care spending in Japan—starting from a base that was 6 percent of GDP in 2005—could rise to between 9 and 13 percent of GDP by 2050 depending on assumptions. Even the lower estimate has significant implications for fiscal policy, once combined with the expected growth in pension spending over the same period.

VI. Possible Policy Responses

Some of this increase in the public costs of health and nursing care may well be justified in terms of the marginal social benefits that ensue, and where this is the case, there is no reason why Japanese society should not benefit from the continuing flow of new technology that is likely to appear as a result of recent scientific advances (Aaron, 2003). However, the Japanese authorities will need to ensure that the health and nursing care systems provide care as efficiently as possible, and efforts in this direction could help moderate the fiscal impact of an increased allocation of resources to this domain. In this context, international comparisons suggest a number of areas where reforms could enhance the performance of the system.

First, in the ambulatory sector, the number of consultations per capita is roughly twice the OECD average (Figures 3 and 4). At the same time, the number of consultations per doctor is also very high —over double the OECD average. This is a likely reflection of the fact that doctors are in short supply, that consultation fees are low, and that doctors are paid on a fee–for–service basis. Some part of this high level of consultations may not be necessary or reflect regulatory factors[8]. The average length of consultations is consequently short, potentially raising problems of quality and patient

[8] For example, the recent extension of the time period of a prescription before renewal is required appears to have reduced the number of consultations (see Onda et al., 2004).

Box 1 Projecting Public Health and Long–Term Care Spending

The impact of aging on care costs

Initial attempts to project the impact of aging on public health care undertaken by the OECD and member countries took estimates of health care costs per capita by age group and multiplied these values by the number of individuals in the respective age group and then summed across age groups. This calculation was then undertaken for each five–year period from 2005 to 2050 using national projections of the population by age group. Estimates were then recalibrated to ensure that the estimates for 2000 equalled national accounts or budgetary estimates for that year. These estimates of health–care costs were then taken as a share of projected GDP. The price of health care supply was assumed to grow in line with economy–wide labour productivity. A similar approach was used to estimate nursing care needs and associated public spending.

Values for GDP were calculated on the basis of the growth in employment (allowing for increases in female participation rates and lower unemployment) and an annual increase in productivity of 1.75 percent per annum. With a rising share of elderly in the total population and higher per capita spending by the old, the share of spending in GDP increases in all OECD countries for which calculations have been made.

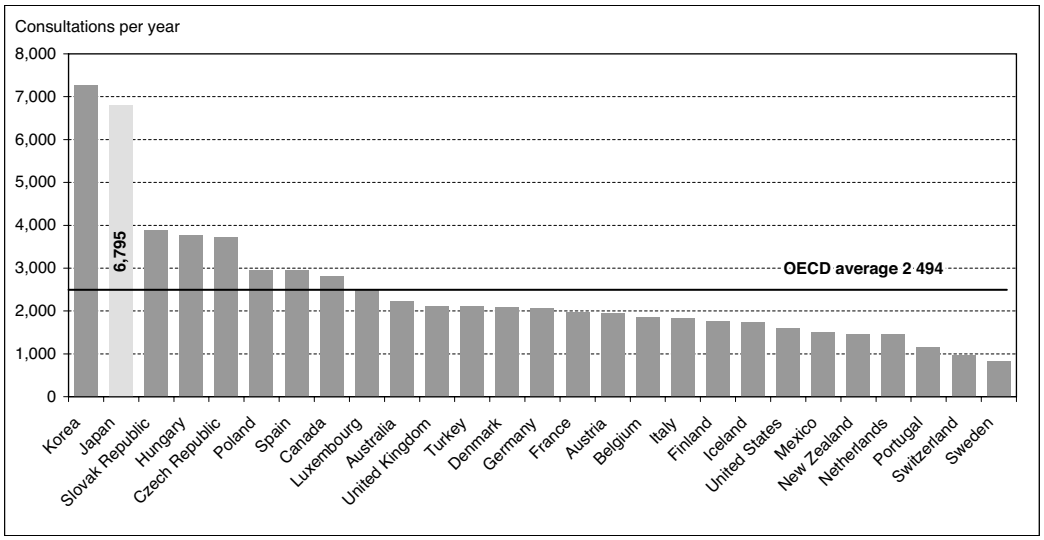
A number of authors have suggested that this approach may lead to overestimation of the increase in acute health care costs (Zweifel et al., 1999; Batljan and Lagergren, 2004). They argue that higher per capita spending on health care among the elderly reflects the fact that mortality rates increase with age and that a large share of lifetime health care spending occurs in the period just before death. With increases in average lifetimes, mortality in each age group will decline—particularly among the elderly—and the associated "death–related" costs would be put off into the future. Average lifetimes are expected to increase by approximately five years during the current half–century. This moderating effect will partly offset the impact of aging as the baby–boom generation moves into retirement where mortality rates are higher. The more recent calculations have attempted to take this effect into account. These estimates have also assumed that the increase in lifetimes will be in good health. These two assumptions combined with the projected lengthening of average lifetimes moderates the effect of the aging of the baby–boom generation on health care costs.

Non–aging–related spending increases

The changing population structure as a result of population aging can explain only a small part of the past increase in public health care spending in most OECD countries. The significant rise in spending as a share of GDP over the past three decades has been generally attributed to rising incomes and a range of unidentifiable forces grouped under the generic title of "technological change." The latter has been determined by a wide range of factors—including policies that affect both demand and supply for health care and its price. But there appears to be widespread agreement that technological change has played a large role in any past increase (Newhouse, 1992; Productivity Commission, 2005).

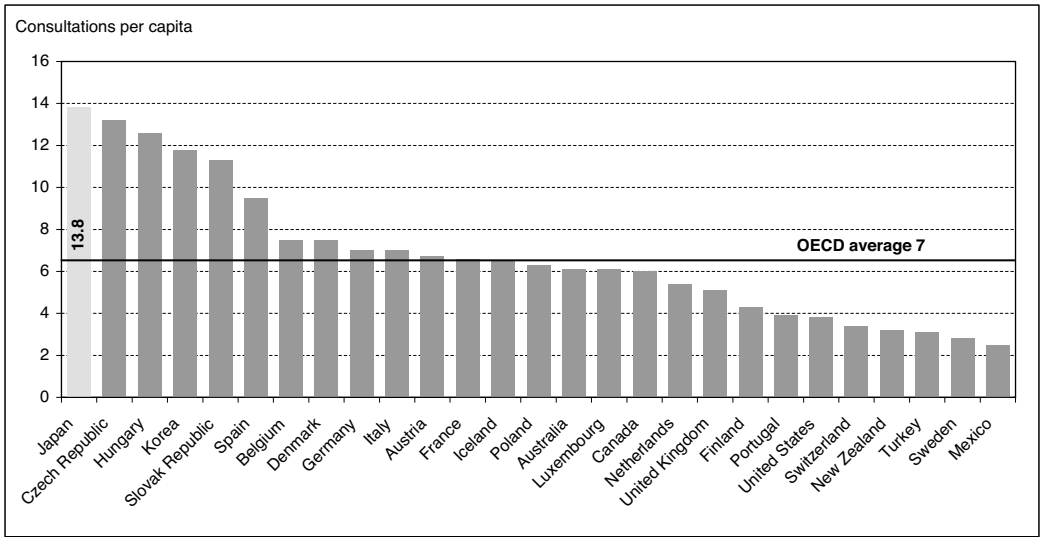
It has not been possible to identify the separate impact of income from that of technological factors with any precision. A very approximate separation has assumed that non–aging factors are affectedby: (a) income, assuming that the elasticity of health care spending with respect to income is one; and (b) a residual which is what is left over after aging and these income effects have been accounted for. Projections of the non–aging factors were calculated on the basis of projected trends in income using the same income elasticity and various assumptions concerning the path of the residual.

Figure 3 Consultations Per Doctor in OECD countries, 2005



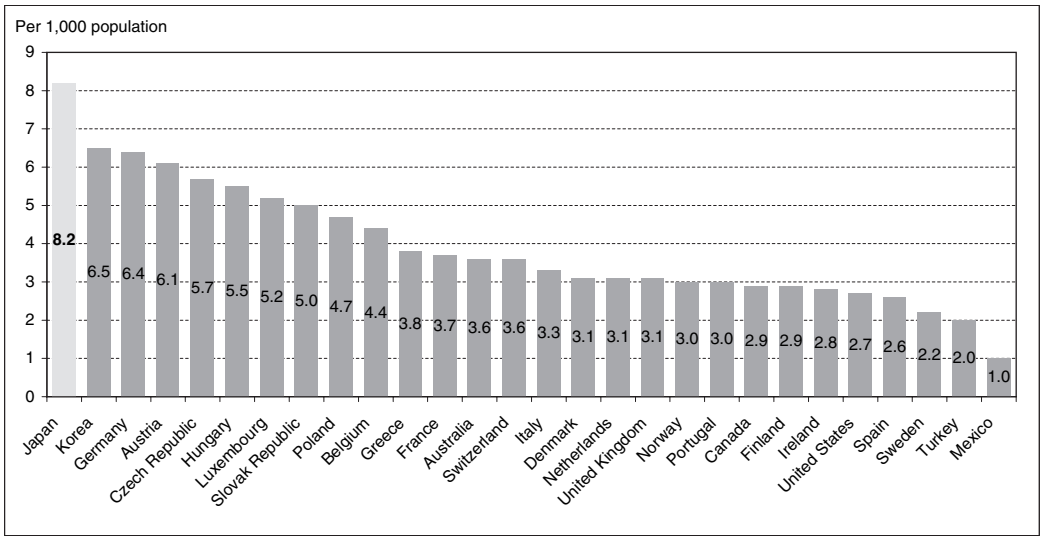
Notes: Data refer to 2005, except for Australia, Austria, Canada, Denmark, France, Germany, Hungary, Japan, Mexico, the Slovak Republic, Sweden, Turkey and the United States to 2004; New Zealand and Spain to 2003; and Switzerland to 2002. New Zealand presents a break in 2003 for the series on "Doctor's consultations per capita" and Poland presents a break in 2005 for the series "Practising physicians", OECD average excludes Greece, Ireland and Norway.
Source: OECD HEALTH DATA 2007.

Figure 4 Consultations Per Capita in OECD Countries, 2005



Notes: Data refer to 2005, except for Australia, Austria, Canada, Denmark, France, Germany, Hungary, Japan, Mexico, the Slovak Republic, Sweden, Turkey and the United States to 2004; New Zealand and Spain to 2003; and Switzerland to 2002. New Zealand presents a break in 2003. OECD average excludes Greece, Ireland and Norway.
Source: OECD HEALTH DATA 2007.

Figure 5 Acute Care Hospital Beds Per 1,000 Population, 2005



Notes: Data refer to 2005 except for Australia, Canada, Denmark, Greece and Spain. Turkey presents a break in 2005. OECD average excludes Iceland and New Zealand.
Source: OECD HEALTH DATA 2007.

dissatisfaction[9].

Second, and despite some overestimation, Japan also has the highest number of acute care hospital beds per capita in the OECD (Figure 5)[10]. While inpatient admissions are lower than the OECD average, occupancy rates are high, reflecting long average lengths of stay estimated to be in the range of 20 days (Figure 6)[11]. Once again, incentives are probably important in explaining this outcome: hospitals are largely paid on a bed–day basis.

Third, the level of per capita drug consumption remains slightly above the OECD average (Figure 7). This is thought to reflect, at least partly, the fact that doctors had an incentive to over–prescribe as they can sell as well as prescribe pharmaceutical drugs, and a significant portion of their income has come from this source. However, the growth in spending on pharmaceutical drugs has slowed sharply in recent years, reflecting the progressive narrowing of the profit margins on drug sales by doctors along with a substantial increase in the fee they can receive by issuing prescriptions. Around half of all drug prescriptions are now handled by pharmacies.

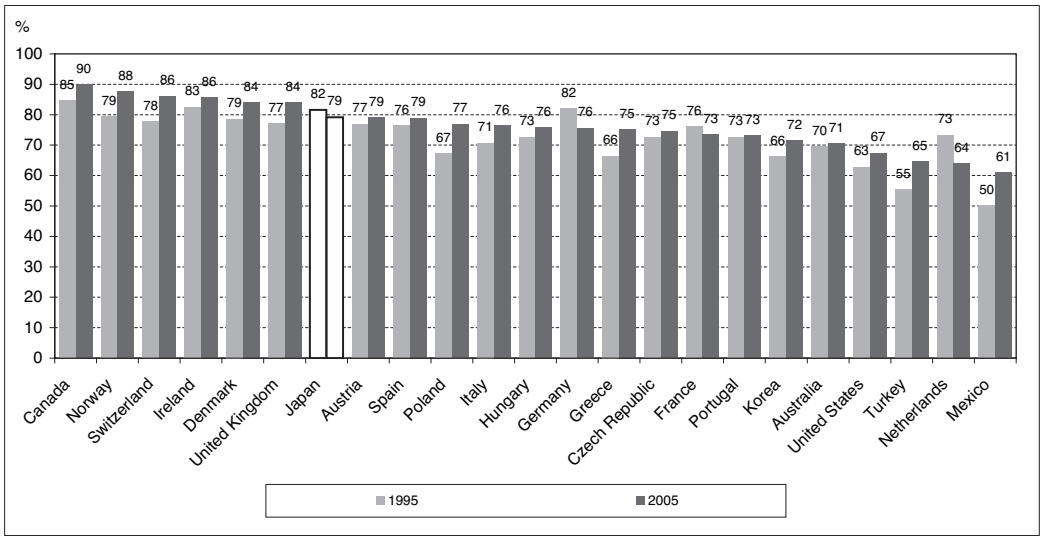
A final concern is the fragmentation of the insurance system as there are over 5,000 separate insurers. This leads to financial instability and also limits the capacity of the insurers to share risks and

[9] See Imai (2002) and Campbell and Ikegami (1998) for a description of measures of satisfaction of patients with treatment received and with the system overall.

[10] See note 5 above and the text to which it refers.

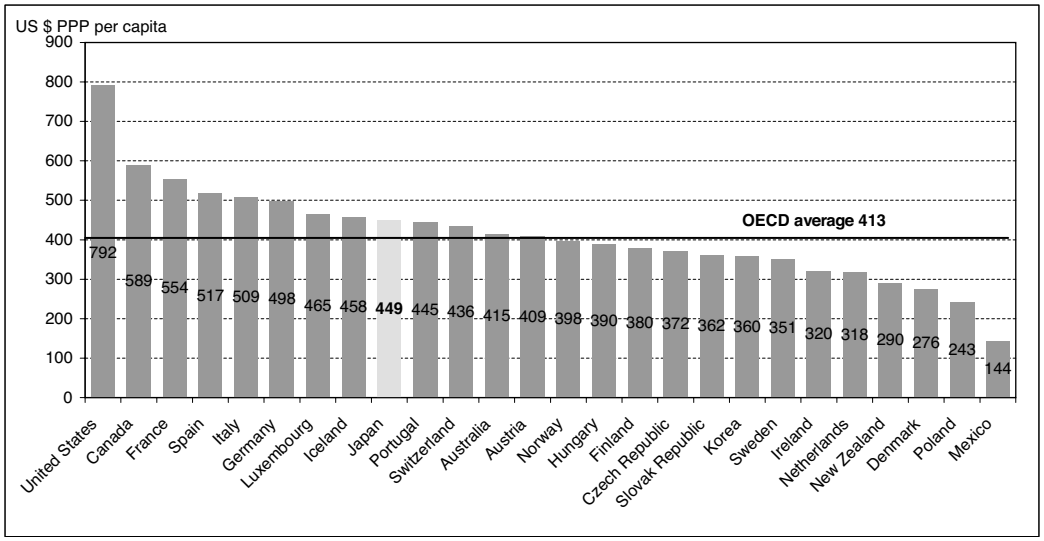
[11] Low admission rates may reflect a cultural dislike of invasive surgery. There is a problem of international comparability in the statistical information regarding hospitalization in Japan. The average length of stay reported in the OECD *Health Data* 2007 was 35.7 days in 2005. This number includes long–term (health) care beds. While there are no official statistics covering acute care beds alone, the figure compiled by the Japan Hospital Association for 2001 is quoted to be 18.4 days (Ishii, 2002).

Figure 6 Occupancy Rate of Acute Care Hospital Beds, 1995 and 2005



Notes: Canada presents a break in 1995. Data for Switzerland for 1995 refers to 1994. Data refer to 2005 except for the following countries Australia, Canada, Italy, Spain to 2004; Korea o 2003; Poland to 2002; and Denmark and Greece to 2001.
Source: OECD HEALTH DATA 2007.

Figure 7 Pharmaceutical Drug Spending Per Capita, 2005



Notes: Data refer to 2005 except for Australia, Hungary and Japan to 2004 and the Netherlands to 2002. Data for the following countries are estimated: Denmark, Hungary, Japan, Luxembourg, New Zealand, Poland, Portugal and Spain. OECD average excludes Belgium, Greece, Turkey and the United Kingdom.
Source: OECD HEALTH DATA 2007.

to oversee provider performance—either in terms of cost or quality. Limited risk sharing from large–scale pooling and inadequate adjustments to allow for differences in risks across insurers has led to wide differences in premiums across insurance funds, particularly (but not only) in the national health insurance system that covers the self–employed and farmers and the retired and is operated at the municipal level.

VII. Areas Where Efficiency Could be Improved

The area with the greatest scope for gains in efficiency is the hospital sector, where a major downsizing is called for. First, nursing care patients need to be shifted to more appropriate and less expensive long–stay nursing care facilities that are better adapted to the needs of the elderly. The nursing care insurance introduced in 2000 has been facilitating this shift. As noted, a major shift occurred in 2000 following the reclassification of some of acute beds as nursing care beds. Progress since has been slow, and it will require further expansion of supply. Even after this shift has been completed, the over–supply of acute beds is likely to remain as this partly reflects the incentives arising from the system of payment by bed–days. Shifting to a prospective pricing system such as a diagnosis–related group would encourage hospitals to reduce length of stay and place pressure on hospitals to downsize. The government has moved to introduce all inclusive payments per patient (the Diagnosis Procedure Combination) mainly to larger university hospitals. This has reportedly led to reductions in average length of stay. More widespread application began in 2003 but progress has been slow, particularly as there are wide differences in practice and cost patterns across hospitals. Such policies need to be consolidated and extended to the rest of the hospital system and combined with a wider policy of rationalization to ensure adequate supply in less–well–served areas.

Developments in the ambulatory sector concern quality issues as much as cost and efficiency. Physician training carried out by medical schools can vary and this is widely believed to have resulted in considerable variation differences in practice patterns and treatment[12]. This may also be the main reason why the Japanese ambulatory system suffers from the absence of doctors specialized as general practitioners (GPs). Policies in this area, however, have been evolving. The training of new doctors as generalists has begun and efforts are being made to adopt common clinical guidelines and the retraining of specialists.

With part of doctors' income coming from the sale of drugs, there can be conflicts of interest, potentially leading to higher prescribing than necessary. As noted, policy changes have reduced the incentives to sell pharmaceuticals over time, but there is scope for further limiting doctors' rights in this area. Over–prescribing may also be reduced by more widespread introduction of prescribing protocols, greater use of generic drugs and closer attention to the cost effectiveness and prices of new

[12] This phenomenon, known as small area variation (SAV), is observed elsewhere. In Japan, weak information dissemination has prevented the collection of data on SAV. But given the dominant influence of the professor running the Ikyoku—a highly specialized pyramidal unit within a medical school, where clinical training is offered—it can be reasonably expected that idiosyncratic treatment patterns prevail. This pattern of physician training is not suitable for the training of GPs either as they need knowledge in a wide range of specialized areas.

drugs appearing on the market.

Reforms that are being introduced in the insurance sector may improve efficiency and reduce financing inequity across funds. First, efforts are currently underway to consolidate the fiscal operations of the municipally–managed national health insurance (NHI) funds at the prefecture level, which should improve risk sharing and eliminate the horizontal inequity within a given prefecture, though inter–prefecture inequity would remain. Second, from October 2008, the government will split the management of the hitherto single government–managed health insurance (GMHI) into prefectural units, in order to reflect better the regional differences in income, age and other demographic factors in the pricing of premiums. These two developments may pave the way for eventual integration of NHI and GMHI at the prefectural level.

Rationalizing the scale of operation alone will not, however, be enough for these insurance funds to play a proper role as an insurer. Up to now, the Medical Fee Payment Fund has been entrusted with the screening of all bills presented by the providers for fraud and excessive medication, but this screening process has not been used as a utilization review mechanism to check the rapid growth in services. Progress in this area requires not only further improvements in data collection on provider activity but also empowering the insurance funds to sign contracts with service providers[13]. ICT technology will need to be expanded: less than 0.5 percent of the bills presented to the Payment Fund were in electronic form around the year 2001 (Imai, 2002) and this limits the scope for third–party oversight. The lack of a single social insurance number is a further obstacle in this process.

As another area of reform, effective April 2008, the government abolished the Health Service System for the Elderly, which had effectively existed only on the books (because it had no independent financial resources of its own), and replaced it with a separate social insurance fund for the elderly to which the elderly are now expected to pay premiums. This scheme, however, is confined to functioning as collector and payer, just like all other social insurance funds. Thus, it can be seen as a pretext for raising more revenues through more premiums. In fact, premiums are to be reassessed every two years, which means that, with the further aging of the population and the cap on the share of government contributions, premiums can only be expected to increase over time.

There has recently been an increase in the rate of co–insurance to 30 percent, but this has been combined with an extension of free care to a larger share of the poor population so that the net impact on the demand for health care is difficult to judge. Some further increase in the co–insurance ceiling for better–off households could help limit the growth in demand and the costs to the social health insurance system without prejudicing access to care. On the other hand, the progressive easing of restrictions on balance billing that is underway reduces cost sharing and boosts public health spending[14]. After five years of existence, the nursing care insurance system is being reviewed. As this system met the needs of the society, the benefit payment grew rapidly causing financial difficulties.

[13] This would mean a departure from the current policy of uniform fees. Increasingly, however, this principle has been violated as the government has attempted to cope with the complexity of reality. For example, in order to discourage outpatient consultations at large hospitals, the co–payment a patient makes at each new visit has been raised and the fees for consultations reduced for large hospitals (note that the concept of balance billing differs somewhat from that used in North America).

Premiums were raised in 2003 but the benefit payments have continued to increase. In an attempt to ensure financial sustainability, consideration is being given to widening the contribution base to include workers below the age of 40, which is politically difficult to implement without proposing some benefit to younger generations[15].

Rationalization of benefits should also be required. The current structure of benefits unduly favours institutional care, whereas the policy intention has been to promote home care[16]. But with diminishing availability of family members to look after the frail elderly, it would seem difficult to promote home care further without increased budgetary allocations to this activity.

As the nursing care industry has grown rapidly, the core employees have been overloaded by normal duties and training of new employees. This has created problems of low quality of services in some instances. Moreover, rapid growth in demand seems to have affected the work of care managers in playing the gatekeeper role in the system. As a result, the assessment of care needs has tended to err on the side of generosity. Concern has also been expressed that care managers are effectively captured by service providers. Ways of ensuring the neutrality of care managers are under consideration.

VIII. Conclusion

Part success in cost containment—when compared with other OECD countries—appears to have largely relied on price controls for health care provision and more recently on greater cost sharing. The scope for further gains from price restraint may now be limited and the authorities will now have to search for other policies to limit costs[17]. There appears to be considerable scope to increase the efficiency of the health care system in view of apparent excess supply of beds in the hospital sector, extremely high activity in the ambulatory sector and above–average spending on pharmaceutical drugs. These outcomes reflect, to a considerable extent, the incentives inherent in the fee–for–service payment arrangements and the passive role played by third–party payers.

Greater attention now needs to be focused on changing the incentives facing providers, restructuring the hospital sector and introducing more ICT technology to facilitate utilization reviews by insurers. Finally, continued efforts to restrain excess and inappropriate consumption of pharmaceutical drugs will be needed. As for the nursing care sector, the insurance system is much better–designed than in health care so that efforts should be focused on making the existing system work better—notably through rationalization of benefit structure and securing the neutrality of care managers—and ensuring financial sustainability by raising premium contributions rather than broadening the base to younger

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[14] The prohibition of balance billing has meant that a patient must bear the total cost of a treatment even if some part of it is normally covered by social insurance. For example, a patient having chemotherapy using drugs not covered by social insurance is denied the coverage of blood tests that are an integral part of chemotherapy. The positive list of exceptions to balance billing has been expanded and this process is likely to continue.

[15] One possibility is to extend the coverage to all cases requiring nursing care (for example, those below 65 who are handicapped by accidents). But the cost of such coverage extension would be enormous.

[16] The ratio of home versus institutional care did change from a ratio of 7:3 initially to 3:1 more recently.

[17] For example, fees for medical procedures were cut by the central authority by 1.3 percent in 2002 and by as much as 5–30 percent for some services such as CT scans and MRIs (Ikegami, 2003, cited in Mitchell et al., 2004).

generations.

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