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Health Care Reform In Japan: The Virtues Of Muddling Through

Tops in equality of access, among the lowest in health spending, Japan nevertheless has important problems to solve—gradually.

by Naoki Ikegami and John Creighton Campbell

PROLOGUE: Japan’s universal health care system, built on the German social insurance model and remarkably inexpensive by American standards, has nevertheless entered an era of economic stress and government calls for more radical reforms. The reasons why Japan has been able to constrain its health care spending are multiple, but some of the explanation lies in its record of much lower levels of expensive social phenomena compared with most other industrialized nations. Its rates of crime, divorce, teenage births, drug use, high-speed motor vehicle accidents, and incidence of human immunodeficiency virus (HIV) are all appreciably lower than comparative numbers in the United States. However, from a policy perspective, authors Naoki Ikegami and John Campbell believe that one of the system’s most significant achievements is its record of effective cost control without first restructuring its traditional system of health care delivery. Nevertheless, as Ikegami and Campbell discuss, Japan’s health insurance system faces tough challenges in three major areas: growing consumer consciousness, a rapidly aging population, and rising costs.

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ABSTRACT: Japan’s universal and egalitarian health care system helps to keep its population healthy at an exceptionally low cost. Its financing and delivery systems have been adapted over the years in a gradual way that preserves balance. In particular, its mandatory fee schedule has proved to be effective in controlling spending by manipulating prices. Today, with severe fiscal problems, pressures are mounting for more radical reforms. However, these proposals attack the wrong problems and are impractical. Real problems include inequitable health insurance financing and insufficient regard for quality of hospital care. We suggest incremental reforms that would improve these situations.

Japan’s health care system, perhaps least well known among those of the large industrialized nations, helps to keep Japan’s population exceptionally healthy at a cost that is about half that in the United States. Everyone in Japan is covered equally for medical care. Japanese can go to any physician or hospital, with no difference in cost, and physicians are in principle free to treat or prescribe as they see fit. To a great extent, the Japanese system is a variant of the “international standard,” in that its main characteristics are generally similar to those found across all of the industrialized nations except the United States. Interestingly, Japan greatly expanded health care and then imposed effective systemwide cost controls without major structural reform. Its strategy was to “muddle through” by preserving balance among the system’s main components. The success of this general approach led Naoki Ikegami to predict that Japan would remain largely untouched by the global trend toward more competition and accountability in health care. Such has been the case so far, but today, with Japan facing economic crisis, the government is proposing more radical reforms. Here we describe and critique these proposals and offer some alternatives; first, however, we explain how Japan’s health care system is now structured.

Japan’s Health Care System

Insurance plan financing. The Japanese government began providing health insurance in 1927, and in 1961 universal coverage was achieved. In the years since then the government has reduced differences among insurance plans and made the system more egalitarian. However, these changes have been incremental rather than sweeping, and the relationships among plans and among types of enrollees have been essentially maintained. Japan’s health insurance system is still a social insurance system in which nearly everyone is assigned to a specific plan via employment or place of residence. The nation’s more than 5,000 independent insurance plans fall into three major groups, each enrolling about a third of the total population. (1) Large-firm employees and their dependents are cov...
ered by Society-Managed Health Insurance (SMHI); public-sector employees, by Mutual Aid Associations (MAAs). There are nearly 2,000 of these independent plans, jointly managed by representatives of the employer and employees. Premiums vary from about 6 to 9.5 percent of monthly wages up to a ceiling, at least half of which is paid by employers. (2) Small-firm employees are covered by Government-Managed Health Insurance (GMHI), in a single national pool operated by the Ministry of Health and Welfare. The employer pays half of the premium, which is now 8.6 percent of wages up to a ceiling. (3) Self-employed persons and pensioners are covered by Citizens’ Health Insurance (CHI). These insurers are the more than 3,000 cities, towns, and villages in Japan. The full premium—based on income, assets, and number of people in a given household—is collected directly by the municipal government; premiums vary widely, but the maximum is about $430 per household per month.

Achieving equality of benefits. Benefits are essentially the same for all plans and include all approved curative medical and surgical procedures, pharmaceuticals, long-term care, dental care, and some preventive care. Given that these three groups enroll persons with very different income and risk levels, how has it been possible to provide essentially the same benefits across groups? The answer lies mainly in two mechanisms for equalization: differential subsidies from tax revenues, and a pooling fund for the elderly.

First, under CHI (for the self-employed and pensioners) an average of 50 percent of total benefits comes from tax revenues; under GMHI (for employees in small firms) 14 percent of benefits comes from tax revenues. Coverage for enrollees under SMHI and MAAs receive no subsidy because these enrollees tend to have higher incomes and lower use of health services. Second, persons age seventy and older may be enrolled in any insurance plan (as a principal or a dependent), but the great majority have always been in CHI, where their high use of services has far outstripped their premium payments and required increasingly higher government subsidies. The advent of free medical care for the elderly (elimination of copayments) in 1973 greatly aggravated these problems. The government responded in 1982 by restoring a tiny copayment and, more importantly, by requiring other insurers to bear a fair share of these high costs rather than making up the shortages from general revenues. All insurance plans contribute the sum that they would have paid in benefits if their elderly enrollment was at the national average. These contributions from insurers account for 70 percent of spending in the program for the elderly, with the rest coming from the national government (20 percent) and municipal and prefectural governments (5 percent each).
These two mechanisms have turned Japan’s financing system into a hybrid of social insurance and tax-based models. Almost one-quarter of total health care expenditures comes from national-level tax revenues, and another 7 percent from local government revenues. Moreover, the employment-related insurance plans (SMHI, MAAs, and GMHI) are forced to transfer between a quarter and a third of their premium revenue to the pooling fund for the elderly. Counting this transfer, close to half of total health care spending in Japan is provided outside the traditional social-insurance principle—that a defined social group should cover its own costs. Whether these two mechanisms are sustainable in Japan’s rapidly aging society, especially in light of current financial pressures, is considered below.

An undifferentiated delivery system. Patients in Japan can freely choose between going to a physician’s office or a hospital. Virtually all physicians’ offices (called clinics) are solo practices, professing some specialty but providing primary care. About a third of these practices have a few outpatient beds. The majority of hospitals are similar to these practices: They are owned and operated by individual physicians, and nearly all got started as expansions of private practices. These hospitals rely on outpatient primary care for a large proportion of their revenues. Most of the larger high-tech hospitals are in the public sector.11 These, too, have large outpatient departments from which to draw patients. Office-based physicians do not have access to hospitals and do not often refer patients to them.

On the one hand, the Japanese system does not clearly differentiate between large and small or public and private hospitals, nor for that matter between hospitals and private practices. On the other hand, the division between small and private hospitals versus large and public-sector hospitals has greatly weakened all of these hospitals’ collective voice in the health policy arena.

The payment mechanism reflects and reinforces the undifferentiated delivery system. Physicians and hospitals are covered by the same fee schedule, which sets fees in essentially the same way for both. For example, fees for hospital services such as bed and board are listed together with physicians’ consultation fees. From the fees they receive for each itemized service, hospitals pay both their physicians’ salaries and their capital and administrative costs. This puts hospitals at a financial disadvantage compared with physicians’ offices. Moreover, the fee schedule is structured so that routine outpatient care (including drug dispensing) is covered by more gener-
ous fees than those for high-tech inpatient care. As a consequence, public-sector hospitals rely on direct subsidies from the national and local government.

However, the large medical centers also tend to maintain large outpatient departments. These hospitals have become more popular with patients, partly for reasons of prestige but also because they are perceived to offer higher-quality care, particularly for difficult surgery and other sophisticated treatments. In response, many small hospitals and even physicians’ offices have purchased expensive machines, to the extent that Japan’s diffusion rate of computed tomography (CT) scanning and magnetic resonance imaging (MRI) equipment is the highest in the world. They are able to do so because the government does not control capital expenditures and medical practice. The result is easy access to high-tech diagnostics but also too many hospitals doing too few procedures to build up the experience needed for high-quality work at reasonable cost.

Finally, the growth of long-term care has followed a similar pattern of weak differentiation. Although care at home by a daughter-in-law has long been regarded as normal in Japan, today the rate of institutionalization of the elderly (about 6 percent) is similar to that of other industrialized nations. However, uniquely, most institutional care is provided in hospitals rather than in nursing homes. This pattern began with free medical care for the elderly in 1973, which made hospital care affordable for this population at the same time that many small private hospitals were losing acute care patients to larger and better-equipped facilities. Despite many attempts at reform, even now, elderly long-term patients often can be found on the same floor as acute care patients from the emergency ward. Financing institutional long-term care remains a severe burden in Japan, and major reforms are planned.

**Incremental adjustments.** As in the financing system, Japan’s health care delivery system has experienced a series of incremental adjustments. Tremendous expansions of both inpatient and outpatient hospital care, of long-term care for the elderly, and of high-tech medicine (at least in the diagnostic area) have occurred without radical changes in the organization of the delivery system or in the payment mechanism. Health care delivery’s basic structure is still weighted toward outpatient care, so that Japan has the highest rate of physician visits and the lowest rate of hospital admissions among advanced industrialized nations.

**Why The Relatively Low Costs?**

As Organization for Economic Cooperation and Development (OECD) data indicate, total health spending in Japan is quite low in
international terms (Exhibit 1). Some of the explanation lies in a number of social factors that are difficult to quantify. Particularly compared with the United States, Japan has much lower levels of expensive social phenomena such as crime, divorce, teenage births, drug use, high-speed motor vehicle accidents, and incidence of human immunodeficiency virus (HIV). Nutrition and living habits in Japan also may contribute to better health. Japan’s egalitarian income distribution is also important, because poverty (and perhaps inequality itself) may be a cause of poor health. If we look more directly at patterns of medical care, a major cost difference is that only about one-third as much surgery is done in Japan as in the United States. One factor is a cultural antipathy for invasive procedures and a preference for more conservative treatments. Another is that the fees paid for surgery in Japan are very low—an indication of the importance of government policy in controlling costs.

In short, the comprehensive and mandatory fee schedule is a major factor in Japan’s low health spending. A key point is that inexpensive services such as ordinary consultations and pharmaceutical dispensing are profitable, whereas expensive procedures such as surgery and other high-tech treatments are often priced below actual cost. An obvious question is, Why should hospitals provide surgery and other unprofitable services at all? One answer is that physicians find that these services are professionally rewarding and feel a responsibility to provide the best care. Another is that a reputation for good surgery and high-tech medicine is an advantage in competing for patients. Finally, most surgery is carried out in

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**EXHIBIT 1.**


<table>
<thead>
<tr>
<th>Year</th>
<th>United States</th>
<th>Canada</th>
<th>Germany</th>
<th>France</th>
<th>Japan</th>
<th>United Kingdom</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>14.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1975</td>
<td>12.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>10.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td>8.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>6.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>4.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

public-sector hospitals, where financial constraints are weaker because costs are subsidized by government. 

Social factors and the fee-schedule structure help to explain why health spending in Japan is low relative to other nations, but not why the spending growth rate has been so low. Actually, in the 1970s Japanese health spending was rising even more rapidly than U.S. spending was. The government succeeded in leveling off spending by controlling prices. In 1979–1993 the annual medical inflation rate (unit price increase) was only 0.38 percent per year. Even leaving out drug prices, which sharply decreased, medical inflation was just 2.81 percent, higher than the Consumer Price Index (2.33 percent) but below the average increase in wages (3.34 percent).^17^  

Why did price controls not lead providers to maintain their income by increasing volume? To some extent they did, particularly in dispensing pharmaceuticals, where the quantity of drugs per patient has increased.\(^18\) For the most part, however, an unusual characteristic of the Japanese fee schedule has made effective counter-attacks impossible. In Japan's regular (usually biennial) fee revisions, rather than adjusting for inflation with an across-the-board conversion factor, as is common elsewhere, the prices of most of the roughly 3,000 items are altered individually, allowing manipulation of relative prices without attracting too much attention. In particular, fees for procedures that show inappropriately large increases in volume will actually be reduced, while other fees are raised.

For example, fees for laboratory tests and diagnostic imaging have been continuously lowered, either directly, through bundling (per unit fees are lowered as the number of tests increases), or through restrictions on the number of times these services can be billed within a calendar month. As a result, despite major advances in technology for diagnostic tests between 1979 and 1993, their average unit price has remained the same. Similarly, to encourage hospitals to shorten their average lengths-of-stay, basic hospitalization fees are progressively lowered so that after ninety days the per diem rate is less than half that of the first fourteen days. Geriatric hospitals have been encouraged to opt for an inclusive per diem rate that bundles drugs, laboratory tests, and so forth.

Many of these individual fee revisions have been effective in holding down spending. Average hospital length-of-stay decreased by 13 percent between 1987 and 1995 (although it is still the highest in the world at thirty-four days, mainly because of elderly long-term care admissions). The inclusive per diem rate had the most dramatic results: A study of one geriatric hospital showed that after introduction of the per diem reimbursement, bills for medications decreased to one-third and bills for laboratory tests to one-tenth their former
levels. The policy of selectively reducing fees for procedures that show “inappropriate” volume expansion, along with underpricing for high-tech care and keeping a tight control on fee increases, has helped to keep health spending at a moderate rate of growth since the early 1980s.

Successful policies often have a downside, however, and we note the example of pharmaceuticals, for which cost containment through the fee schedule has had unfortunate effects. Japanese physicians and hospitals dispense drugs directly and profit by buying from wholesalers at a discount and selling at the fee-schedule price; this has led to the highest per capita consumption of drugs in the world. From the early 1980s the government radically cut drug prices and succeeded in constraining spending: pharmaceutical costs’ share of total medical costs fell from 38.7 percent in 1981 to 25.9 percent in 1997. The problem was that the price cuts applied only to existing drugs; manufacturers responded by marketing marginally improved “new” drugs, which have high launch prices. The unfortunate side effect has been to push most pharmaceutical research and development (R&D) into these profitable “me-too” products. Research in Japan on truly innovative drugs has been discouraged because their prices probably will be cut before the investment made in them can be recovered.

The politics of fee-schedule revision. Officially, fees in Japan are revised by order of the minister of health and welfare, after hearing the views of the Central Social Insurance Medical Care Council, whose twenty members include eight representatives each of providers and payers plus four from public-interest groups. In practice, fees are negotiated between the Japan Medical Association (JMA), which nominates all five physicians who sit on the council, and the Ministry’s Health Insurance Bureau (HIB), which acts as the secretariat of the council and is an insurance carrier itself (as manager of GMHI). Hospitals, pharmaceutical companies, and other important actors are not directly represented on the council. In effect, those on the provider side must work through the JMA, while the HIB takes the lead for insurance carriers and business and labor interests on the payer side.

The major external institutions affecting health care are the governing Liberal Democratic Party, which backs the JMA in exchange for support in elections, and the Ministry of Finance, which has authority over the quarter of health spending that comes directly from the general budget and which is naturally on the side of austerity. From the 1960s to the 1970s the JMA, led by the powerful Taro Takemi, had overwhelmed the normal decision-making process to win big fee increases by threatening to make physicians go on
“strike” and to withdraw JMA members from government committees. However, in the 1980s the JMA was inhibited by the government’s general austerity policy, which appeared to have popular backing. The 1990s saw something of a backlash among physicians against the continued stringency in setting fees, but the increases that were granted remained modest.

■ **Fee-revision process.** The fee-revision process essentially proceeds through three stages. The first stage involves deciding how much to reduce drug prices, based on the current market-price survey. The government researches the current wholesale price of each medication through a survey of providers and on-site inspections at distributors; it normally finds that these prices have been lowered since the previous survey because of competition to sell to providers. The fee-schedule price then is lowered to a fixed percentage above the average “market” price; this percentage (called the reasonable or “R” zone) allows a small profit. This approach relies on true market mechanisms to hold down costs, albeit indirectly. The savings made from reducing drug prices are available to finance increases in medical service fees.

The second stage involves determining the net increase in the fee schedule. Technically, this is the volume-weighted average increase for all procedures and products. The government analyzes data from several sources, including volume by item as surveyed annually from health insurance claims, and increases in production costs calculated through regular government studies of the financial condition of hospitals and physicians’ offices. In practice, this decision also is influenced by current economic growth, budget worries, and the strength of the JMA’s demands.

Here the GMHI system for small-business employees plays a pivotal role, because it is so large and because its finances are the direct responsibility of the HIB officials who also manage the overall process. The fact that the general revenue subsidy portion of the GMHI system is a fixed proportion of benefits gives the Ministry of Finance a strong interest as well. If the GMHI revenues do not cover benefit spending (including the contribution to the old-age system), the HIB must seek a hike in premium rates or get tough on the fee schedule. If a good economy brings rising wages, revenues may be comfortable enough to allow more generosity on benefits.

In the third stage the government allocates whatever increase was decided among the more than 3,000 items listed in the fee schedule. As explained above, differential increases and decreases are used primarily to control costs and secondarily to influence providers’ behavior in other favored directions. Beyond such policy goals, close attention is paid to changes in the relative economic
standing among categories of providers: hospitals versus office-based physicians, inpatient versus outpatient care, internists versus pediatricians versus surgeons, and so forth. If a technological or social trend has disproportionally affected one category for better or worse, various fees can be adjusted to bring them back into balance. For example, the fee for pediatric consultations was raised when low birthrates meant fewer young patients.

This balancing principle inhibits rapid change. Initial fees for new high-tech procedures, for instance, usually are set at a low level, reflecting the general policy of stringency. This would have a greater impact on large medical centers and contain increases in their share of health care costs. These procedures get listed in the fee schedule promptly, however, which means that the medical centers must provide them anyway (government subsidies make that possible). More fundamentally, the balancing principle benefits those who were the most powerful in the 1960s and 1970s: the office-based physicians who, not coincidentally, are the mainstay of the JMA. That fact in itself has been a major element in controlling costs, since the typical procedures used by office-based physicians are relatively profitable but not very expensive.

In general, the “balance” approach to revising the fee schedule aims at minimizing conflict. It keeps important constituents from becoming too dissatisfied and, if they are dissatisfied, allows them to hope to do better in the subsequent fee-revision process two years down the line. Ad hoc and unscientific as this process may appear, the Japanese experience shows how costs can be contained by muddling through, without resorting to radical reforms.  

What Went Wrong?
The neatly balanced Japanese health care system maintained itself into the early 1990s with relatively minor changes, such as tinkering with cross-subsidization rates and adjusting copayments. In recent years, however, the system has faced increasingly tough challenges in three main areas: growing consumer consciousness, aging population, and sharply rising costs.

First, the growth of ethical and consumer consciousness regarding physician accountability, information sharing, adequate explanations to patients, patient consent, and end-of-life decision making has effected gradual changes in both the legal framework and actual practice in these areas.

Second, in addition to the already cited policies aimed at constraining the costs of health care for the elderly, major policy expansions have been implemented to deal with Japan’s rapidly aging population. These include a new type of long-term care institution...
in 1986, the “Gold Plan” of 1989 (aimed at doubling or tripling the quantity of long-term care) and public, mandatory long-term care insurance, passed in 1997 for implementation in 2000. This last is similar to the recent German long-term care insurance program, although it primarily covers only those age sixty-five and older. However, the benefit level in Japan is much higher than Germany’s for both institutional and community-based long-term care, and the eligibility threshold is lower.26

The third and most serious challenge to Japan’s health care system is, once again, costs. As Exhibit 2 indicates, although health care spending has been growing at a stable rate, Japan’s economic downturn that started in the early 1990s (and that has become an official recession) means that health care spending’s share of stagnant gross national product (GNP) has edged upward, arousing much concern.27 Neither premiums, which are a fixed percentage of wages, nor tax revenue, which finances government subsidies, have kept pace with even the gradual rate of increase in medical costs.

The problem was felt most acutely as a deficit in the pivotal GMHI system for small-business employees, where in 1998 the HIB was forced to raise the premium rate from 8.2 percent to 8.6 percent of wages. Many SMHI and CHI carriers also have raised premiums. On the spending side, the copayment rate for employees in all plans was raised from 10 percent to 20 percent in September 1997, and a surcharge on certain multiple medications was introduced for all patients. No one thought that these stop-gap measures would be enough, and sentiment grew for a radical reform (happon kaikaku) of the entire health insurance system.
The Government’s Plan For Reform

In the past Ministry of Health and Welfare officials and experts often talked about radical reform, but their ideas failed to be enacted or turned out not to be so radical. Today the Japanese government is discussing many health care system changes. We concentrate here on the official proposals, drawn from a Ministry working paper of July 1997 and a September 1997 revision by the Health Care Insurance Reform Deliberating Council of the Government Coalition Parties. The reforms are slated for April 2000, although none has been enacted so far. Four ideas have received the most attention.

■ Increasing patients’ share of costs. Conservative politicians from time to time observe that if the public rejects increases in taxes or premiums, having patients pay more is the only viable alternative. The Ministry’s proposal to hike employee copayments another 10 to 30 percent was dropped by the Party Council in July 1998, but recommendations to permit balance billing for physician consultations and to give hospitals more freedom to charge extra for amenities in inpatient care remain in the plan.

■ Creating an independent insurance plan for the elderly. Insurers complain that it is their ever-rising contributions to the old-age pooling fund, not benefits for their own members, that have forced them to raise premiums. They have called for an independent insurance plan, to be primarily financed from taxes but with a large proportion covered by premiums collected from the elderly themselves.

■ Introducing inclusive payments for acute inpatient care. A demonstration project has been launched with ten hospitals (mostly nationally owned) to develop, test, and begin using diagnosis-related groups (DRGs) for acute inpatient care.

■ Setting reference prices for drugs. Despite price reductions that have been made in each fee-schedule revision, there is widespread belief that drug costs are still too high and cannot be reduced further as long as providers profit from dispensing. Under the new proposal, a reference price would be set for a group of drugs with similar pharmacological characteristics. If the provider buys at a lower price, the reimbursement would be at the actual purchase price; if the provider buys the drug at a higher price, the patient would have to pay the difference. The first provision would eliminate all profits from drugs for hospitals and physicians, while the second is expected to force drug companies to lower prices because physicians would defer from prescribing high-priced drugs.

■ Problems with government proposals. These reform proposals are meeting political resistance to enactment. They also are difficult to implement, and it is doubtful that they will work as intended.
First, the financial impact of most measures to increase the patient’s share of costs is limited as long as Japan keeps its low catastrophic cap (all patient costs above ¥63,600 or $530 per month are fully covered). As Exhibit 3 shows, 10 percent of health insurance claims account for two-thirds of medical spending in any given month, and these patients’ shares would barely be increased by higher copayments. Indeed, those with low incomes or chronic conditions are capped at much lower levels, and any increase in copayment would bring calls to extend the lower cap to cover more conditions. An attempt to introduce balance billing would similarly ignite public sentiment against a two-tier system. Such an attempt also would run up against the practical problem that most of the large medical centers that perform most of the expensive procedures are in the public sector. Big medical centers would have trouble demanding extra payments from patients because these hospitals rely on subsidies financed by local taxation.

Second, an independent insurance plan for the elderly would not solve the main problems. Older people as a group are unable to pay most of their health care costs. Indeed, under the government’s original proposal, the other insurance carriers still would have to bear about half the burden of health care for the elderly, and taxes would cover another 30–40 percent—not much different from the status quo. Moreover, local governments are cool to the idea of a new insurance plan because they would be the insurers and deficits would be inevitable.

Third, developing the necessary databases for setting DRG rates would be very difficult. Few hospitals have cost data (because they are paid by fee schedule) or accurate records of diagnoses (only 40 percent of hospitals write discharge summaries). Also, per diem fees

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**EXHIBIT 3**

Composition Of Medical Costs, By Amount Of Claim, 1983

![Diagram showing medical costs distribution](source)

SOURCE: Calculated by the authors from data collected in the 1983 National Claims Survey, which is conducted annually by the Ministry of Health and Welfare.

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“Today’s financial problems are caused not by how the health care system has been operating, but by the recession.”

for bed and board are now based on a hospital’s nursing staff ratios, not on a patient’s severity of illness, and the highest per diem rate is more than double the lowest. If paid by DRGs, the better hospitals with many nurses would run large deficits. Proponents of DRGs admit that even if the demonstration project succeeds, national implementation would take at least five years.28

Fourth, reference pricing also faces high hurdles. These include grouping drugs with similar pharmacological action, setting the appropriate price for each group, and obtaining accurate information on actual prices paid by providers. This approach has no mechanism for lowering prices, an attractive aspect of today’s system. Ironically, the rationale for this proposal has been largely obviated by lowered launch prices, in response to criticism that they had been set too high. Moreover, the pace of new drug introductions has slowed markedly since the adoption of more rigorous standards for clinical trials in 1997.29 Finally, the profit that providers can make from drugs is down substantially because the “R zone” or margin has been progressively reduced, from 15 percent in 1992 to 5 percent in 1998.

What should be done? In our judgment, these proposed reforms are difficult to enact and implement, may have undesirable effects, and would have no major impact on health spending—the problem everyone wants to solve. What course should be taken?

Today’s financial problems are caused not by how the health care system has been operating, but by the recession. It is now popular to condemn all institutions in Japan (the health care system among them) claiming that only thorough reform can get the nation back on its feet. In fact, as observed earlier, health spending has been growing at the same moderate, steady rate for twenty years, with no diminution in quality or access. We contend, therefore, that the existing system is not broken and does not need to be fixed.

We anticipate two objections to this contention. First, if the Japanese economy does not recover, the fiscal crisis will get progressively worse, and many cutbacks will be required, including in health care. However, given that Japan’s key macroeconomic problem is oversaving, not overspending, cutting back on health care and other social provisions does not seem to be a good solution. (Doing so might induce people to save more against uncertainty.) Second, many observers point to population aging as the true crisis for Japanese health care because older persons incur greater costs than younger persons do. They argue that cutbacks are needed
now to prepare for the future. However, although population aging is projected to be rapid—the number of Japanese age sixty-five and older is projected to rise by some 60 percent from 2000 to 2025—Japan has already been aging rapidly for quite some time. Its population is now much older than the U.S. population; the fact that Japan’s health spending is still so low should be celebrated.

Moreover, the fastest-growing component of health care costs for the elderly is inpatient long-term care, and the new long-term care insurance system will remove some of that burden. This insurance will be expensive in itself, but, given population aging, higher health and service spending is inevitable. With its focus on real assessment of need and provision of community-based care when possible, the new system offers a much more rational approach to dealing with the problem of frail senior citizens than does the present system or the Japanese government’s proposed health care reforms.

Real Problems, Possible Reforms

Despite our advice to relax somewhat about the fiscal status of Japan’s health care system, we do see two specific areas where reform is urgently needed: the inequality of burden among consumers, and quality of care.

Inequality of burden. In most respects, Japan has one of the most egalitarian health care systems in the world. An anomaly is the rather wide variation in health insurance premiums (as a proportion of income). This occurs because, with the exception of the national GMHI system for small-business employees, each carrier determines its own premiums. In SMHI (for employees and their dependents in large companies), the difference in rates between firms (and especially between whole industries) that are prosperous and growing versus firms in decline can be as much as twofold. The differences in CHI rates (for self-employed persons and pensioners) among municipalities, depending on the age and income levels of their nonemployed residents, can be still higher.

The variation in premiums is not as extreme as in the United States, and, perhaps because actual premium costs are usually not very high, the issue has not attracted much political attention in Japan. However, because of corporate restructuring, population aging, and continued migration to urban areas, the gaps may widen. More important, this problem is symptomatic of a deeper structural predicament: the great differences in the financial health of insurers, particularly those insurers within the CHI system. Quite a few small rural municipalities manage only with large subsidies of up to 80 percent of their benefit payments, but they may not be viable for long, even with such support from the central government.
To increase equity of burdens among health insurers in Japan, we propose a gradual reform of health insurance, beginning with the introduction of risk adjustment to determine subsidies for CHI insurers. Initial indicators could include age, sex, and the difference between premium revenue and benefit expenditure; more sophisticated indicators could be used later on to calculate risk adjustment. Following that, it may be desirable to amalgamate CHI up to the prefectural level, with cross-subsidization among these forty-seven insurers, as well as continued support from the employee systems and general revenues. One also can imagine a parallel process for SMHI and perhaps eventually a comprehensive framework of several competing plans managed at the prefectural level.

### Quality of care

Quality problems are mentioned in government proposals, but specific recommendations about how to address issues of quality are not. Many of the public’s commonly voiced complaints about quality miss the more important points, such as the lack of external evaluation of physicians and the absence of cross-institutional professional protocols. The movement for more specialty boards has developed slowly because physicians’ hospital appointments are usually controlled by the clinical department of the university with which the hospital is affiliated and are usually lifelong. This arrangement seems to obviate the need for external evaluation and has made the establishment of professional protocols that transcend university departments difficult. It also has provided little incentive for hospitals to try to get formal accreditation, since physicians would be appointed to hospitals by university departments irrespective of their accreditation. (A new hospital accrediting organization created in 1997 had half the number of applicants expected in its first year.)

High-tech care and hospital facilities are especially plagued by quality problems, for several interrelated reasons. One is the systematic underpayment for much high-tech medicine, as mentioned earlier. A more subtle reason is that payment by a one-price-for-all fee schedule offers few financial incentives to improve quality and tends to discourage entrepreneurship and innovation. Finally, the fact that health spending is low and is biased toward office-based physicians also has an impact on quality, particularly on hospital infrastructure that is not directly reimbursed (such as medical records, often in terrible shape), quality assurance programs, and hospital amenities. As a result, even well-regarded private hospitals in Tokyo and other big cities are marked by run-down buildings, small crowded rooms, and few support staff.

We believe that issues of quality in hospitals and high-tech care deserve much more attention than they have gotten so far. One
potential reform is to change the payment system for hospitals that aspire to provide sophisticated, high-tech care. Instead of fee-for-service, they could be paid by per diem rates for inpatient care and per visit rates for outpatients. The rates would be negotiated by each hospital with the prefectural government, starting out with the criterion of maintaining current revenues but then moving to a performance formula including such indicators as average lengths-of-stay, number of major surgical operations, and referral rate for outpatients. Once proven to work, quality and productivity measures would be introduced. DRGs could be used as one productivity measure (the purpose for which they were originally designed). These hospitals would explicitly be allowed to receive discounts on pharmaceutical and medical device purchases.

The majority of private hospitals would not opt to go this route: Many would continue on their present journey toward becoming nursing homes; others would operate as convenient community hospitals under the old fee schedule. For the larger, more ambitious private hospitals as well as those in the public sector, the new payment system would provide incentives to increase revenues by improving performance rather than by ordering more tests and dispensing more drugs. New revenues could be used to improve infrastructure and facilities. Also, local governments could tie their subsidies for capital investment into these indicators and make them available on a competitive basis to qualifying private and public hospitals. This would enhance accountability and strengthen the regional medical planning system, which, so far, has been used only to limit beds. Because this reform could be designed to be budget-neutral, does not encroach on private practitioners, and focuses on the highly visible defects of the present system, it has had the active support of the JMA.31

We have argued that the crisis in Japanese health care has been overblown, that many popular criticisms are off-target, and that most of the reform proposals now under discussion are misguided. We rate the Japanese system as excellent in cost control and access and very good in equality. Although the health care system is weak in some aspects of quality, it must be remembered that, by any measure, the Japanese population is quite healthy. Japan’s system has some lessons for Americans; many are the same as those offered by Germany and other countries.
with highly regulated, multiple-payer financing, but some, such as large, publicly managed insurance pools for small-business employees, are unique to Japan.

Our suggestions for health care reform in Japan aim to draw on many of the approaches associated with the managed care revolution in the United States, such as risk adjustment, evidence-based medicine, and various ways to insert market mechanisms. In the future, more transparency and foresight in setting objectives are needed to gain the support of Japan’s general public and to make the system sustainable in the long run.

However, our proposals do not aim to transform the basic structure of Japan’s health care system and would essentially preserve balance among the major actors in the system. We believe that “muddling through” is the approach best suited to Japanese health policy, because in the realm of power, Japan’s health care system will always be dominated by interest-group politics, and in the realm of knowledge, real-world experience is considerably more valuable than theories and models. Despite current calls for sweeping and radical change, we see a continuation of this evolutionary approach to reform as both likely and beneficial.

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NOTES
4. Most of the points in this paper are described more fully in our book, The Art of Balance in Health Policy: Maintaining Japan’s Low-Cost, Egalitarian System (New York: Cambridge University Press, 1998), but we do not cite it further.
5. For example, in the 1970s copayment rates were reduced (and abolished for the elderly), a catastrophic “cap” was introduced for all systems, and the burdens on low-income people were eased. Copayments were marginally increased again in the 1980s.
6. Non-Japanese must enroll in health insurance after a year in residence. Medical care for the 900,000 people on public assistance (many because of mental disability) is covered from tax revenues, although the payment mechanism is the same as that of health insurance.
7. There is also Seamen’s Insurance, similar to SMHI, and Citizens’ Insurance Associations within CHI. The latter institution is the only exception to mandatory assignment to an insurance plan, since certain self-employed tradespeople and professionals such as carpenters, barbers, and private-
practice physicians can choose between it and the CHI plan where they live or work. Note that CHI is often officially but misleadingly translated as “national health insurance.”

8. All conversions are at $1=¥120. The income ceiling for CHI is lower by about half compared with employee-based insurance, making it more regressive.

9. The copayment rate is now 20 or 30 percent, depending on the plan, but nominal for the elderly. The cash benefit for normal childbirth also differs among plans, and not a few SMHI plans provide nonstatutory benefits such as partial reimbursement of copayments and preventive services.

10. For example, if a certain plan has 3 percent elderly enrollment and pays them benefits totaling ¥X billion, it must pay ¥3X billion into the pooling fund because the national ratio of those age seventy and older is 9 percent.

11. Prior to westernization, Japan lacked the public or religious institutions that became nuclei for hospitals in the West. Public-sector hospitals developed from the few institutions established for teaching, serving the military, or controlling infectious diseases in the late 1800s and early 1900s.


14. The number of nursing homes was limited on the supply side, because their capital and operating costs had to be covered by government budgets, and perhaps on the demand side, because as “welfare” institutions they were somewhat stigmatized, particularly in rural areas.

15. We use proportion of GDP as the best single comparative indicator, but other measures, such as per capita spending at purchasing power parity, lead to similar conclusions. Note that a study of expenditures that often are left out of the Japanese accounts, such as under-the-table payments to doctors, revealed that these added very little to the totals and that the OECD figures are generally valid. See Y. Katsumata, “Comparison of Health Expenditure Estimates between Japan and the United States,” in Containing Health Care Costs in Japan, 19–32; and OECD Health Data 98.

16. In a rough calculation using 1990 figures, William Hsiao estimates that about 25 percent of the difference in per capita health spending between Japan and the United States was attributable to a lower incidence of disease (partially a matter of the social environment), 15 percent to less aggressive practice styles, 15 percent to lower hospital staffing levels, 10 percent to smaller administrative burdens, 15 percent to the lower income of the majority of Japanese doctors who are on salary, and 20 percent other. W.C. Hsiao, “Afterword: Costs—The Macro Perspective,” in Containing Health Care Costs in Japan, 45–52.


20. Japan’s drug spending per capita for 1996 was $349, the highest among OECD countries, followed by the United States ($344) and France ($337).


22. Because hospitals have remained relatively weak, the JMA is virtually the only
voice for organized medicine. A member from the Japan Hospital Association used to sit on the Central Council, but he was forced to resign in 1963. Since then, all physician members have been nominated by the JMA.

23. For example, a differential in initial consultation fees between office-based physicians and hospitals to encourage referrals and raises in fees for home doctor visits. These have generally had modest results.

24. Appropriately reimbursing costs to providers is a difficult task because (1) the gold standard for quality is not easily defined, (2) costs are dependent on the operating rate, and (3) there is no consensus on how much physicians and other health care workers should be paid. The Japanese government made a massive cost study in the 1950s but could not use the results because of the wide difference among hospitals and because payers thought that physicians should be paid only 20 percent more than the average worker, while the JMA maintained that they should be paid at least three times as much.


27. The Ministry of Health and Welfare produces its own estimate of health spending, based on payments made under social insurance. It includes the copayment but leaves out public subsidies, preventive health, extra-charge rooms, over-the-counter drugs, and so forth. Our independent analysis shows that this is about a quarter less than the OECD’s total health spending figure. However, the government’s fiscal concerns are based on its own estimates, referred to here as “medical costs” to distinguish them from the OECD figures. This term is used because they are, in fact, the cost to payers and government.


29. Physicians must now obtain written informed consent for clinical trials, which presents a major hurdle because neither they nor their patients are used to doing so. Any explicit mention of side effects has frequently led to patients’ refusing to participate. However, perhaps the more profound problem is that trials must now be conducted with strict standardized protocols, which is proving to be difficult because of the variations in practice patterns.

30. From 1975 to 2000 the increase in the population age sixty-five and older is projected to be 140 percent. The pattern is similar for the group age seventy-five and older: 210 percent growth before and 113 percent growth after 2000, over twenty-five years. Based on the January 1997 “medium” estimate of the National Institute of Population and Social Security Research.

31. The full extent of the variation is not visible in the premium rates because societies with high costs generally collect an additional amount from bonuses (some one-third of annual income), which are not included in the usual figures.

32. The top complaint in public opinion surveys is long waiting times for appointments. Queues are inevitable, given free choice of providers and equal cost, and a significant annoyance only in the outpatient clinics of high-status hospitals. In any case, nearly everyone is seen on the same day. Waits for surgery are sometimes fairly long for some procedures in high-status hospitals but have not become a social issue in Japan.

33. Japan Council for Quality Health Care, Letter to Surveyors from the Chair, Ryuichiro Tate, 29 January 1999.

34. This reform is included in the JMA Health Policy Committee’s fiscal year 1992 and 1994 reports.