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Cost Control: What the United States Can Learn from Japan's Fee Schedule

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I. INTRODUCTION

Healthcare reform is a continuous process. Even when it looks like a nation has found an acceptable healthcare delivery system, factors such as a changing economy, changing demographics, or changes in the weather could influence people to become more satisfied, or more dissatisfied with the healthcare delivery system of their nation. The United States is no different.

In an attempt to effectively balance the needs of the people it serves, the needs of the special interest groups who support it financially and politically, and the needs of an economy in distress, the United States has taken on the task of significantly reforming its national healthcare system. While trying to find a system on which everyone can agree, it is important that standards such as quality of care are neither forgotten nor overlooked. During this process, legislators and pundits must examine what has worked and what has failed in other countries.

This article will explore the functionality of Japan's universal healthcare system, and expose some of the issues it now faces. Japan provides an excellent case study, as it has found success through its universal healthcare system. Pursuant to the Organisation for Economic Co-operation and Development (OECD) Health Data sheet, Japan spent less than half the amount of its Gross Domestic Product (GDP) on health care that the United

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States spent of its GDP on health care in 2008, but it also had the lowest infant mortality rate and the highest life expectancy of nearly all of the thirty-two OECD member countries.[1] With such a low percentage of GDP spent on healthcare, and such a healthy patient base, Japan makes the perfect place for this examination to start.

This article will first provide a background of Japan's universal healthcare system and what reforms have led to the current plan. Next, it will discuss the issues that Japan faces in maintaining that system. Finally, this article will analyze what can be gleaned from Japan's fee schedule to help the United States grow an effective and sustainable healthcare system.

II. HEALTHCARE IN JAPAN

In the aftermath of World War II, Japan was forced to undergo economic and social reconstruction.[2] In 1947, the Japanese Constitution was amended to guarantee "wholesome and cultured living" to every Japanese citizen.[3] By 1961, Japan launched *kaihoken*,[4] a universal healthcare system designed to meet that guarantee.[5] Since then, the system has undergone several changes.[6]

To meet Japan's goal of providing necessary and adequate medical care to all citizens at a low cost,[7] the government developed a system of healthcare that allows its citizens to choose any primary care physician or

1. OECD Health Data 2011, How Does Japan Compare, *available at* www.oecd.org/dataoecd/45/51/38979974.pdf.

2. *See* Naoya Ono, *Medical Insurance in Japan*, 1 THE J. OF KAMPO, ACUPUNCTURE & INTEGRATIVE MED. (SPECIAL EDITION) 105 (2010).

3. Comments, *U.S. Health Care Reform: Some Lessons from Japanese Health Care Law and Practice*, 9 TEMP. INT'L & COMP. L. J. 365, 374 (1995).

4. *Health Care in Japan: Not all Smiles*, THE ECONOMIST, Sep. 10, 2011, www.economist.com/node/21528660.

5. Ono, *supra* note 2, at 5.

6. *See, e.g.* Ono, *supra* note 2, at 106-07.

7. Randall S. Jones, *Health-Care Reform in Japan: Controlling Costs, Improving Quality and Ensuring Equity* 7 (OECD Econ. Department, Working Paper No. 739, 2009).

specialist from any hospital or clinic.[8] Essentially, both quality of treatment and scope of care are consistent, hospital-to-hospital and clinic-to-clinic.[9]

Participation in the healthcare system is both universal and mandatory.[10] All Japanese citizens have some form of medical insurance through one of 3,500 plans that are determined by factors such as age, employment, and location.[11] Those 3,500 plans come from one of the following four insurance programs endorsed by the government: Society-Managed Health Insurance (SMHI), Japan Health Insurance Association-Managed Health Insurance (JHIAHI), National Health Insurance (NHI), and Mutual Aid Associations (MAA).[12]

Funding for medical care comes from three sources: insurance premiums, government subsidies, and co-payments by patients.[13] Payment for outpatient services comes predominantly from a fee-for-service system, whereas payment for inpatient care comes from a combination of fee-for-service and *per diem* payments.[14] Each medical procedure or service is assigned a price by the government.[15] The fee schedule is then evaluated and updated every two years.[16] Similarly, insurance companies are heavily regulated by the government and are forbidden from earning a profit.[17]

Another characteristic of the Japanese healthcare system is the frequency

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8. Tadahiko Tokita, *The Prospects for Reform of the Japanese Healthcare System*, PHARMACOECONOMICS 2002, 20 Suppl. 3, 58 (2002).

9. Jones, *supra* note 7, at 7.

10. Blaine Harden, *Health Care in Japan: Low-Cost, for Now*, WASH. POST, Sept. 7, 2009, www.washingtonpost.com/wp-dyn/content/article/2009/09/06/AR2009090601630.html.

11. Kenji Shibuya et al., *Future of Japan's System of Good Health at low Cost With Equity: Beyond Universal Coverage*, THE LANCET 68, 69 (September 1, 2011); *see also* Ono, *supra* note 2, at 105.

12. Jones, *supra* note 7, at 8.

13. Harden, *supra* note 10.

14. Yutaka Imai, *Health Care Reform in Japan* 5 (OECD Economics Department, Working Paper No. 321, 2002).

15. *Id.*

16. *Id.*

17. Jones, *supra* note 7, at 9.

with which Japanese citizens visit the doctor, and their length of stay in hospitals and inpatient clinics. A typical Japanese patient visits the doctor fourteen times per year, which is more than four times the amount of visits a typical American patient makes.[18] Similarly, the average hospital stay in Japan is nearly four times as long as the average hospital stay in the United States.[19] Whether the difference in length of stay is beneficial or detrimental to Japan's healthcare system is a topic of debate in the medical community.[20]

III. ISSUES CREATED BY THE JAPANESE SYSTEM OF UNIVERSAL HEALTHCARE

Japan's universal healthcare system is often lauded for its ability to maintain a high level of collective health without draining money from the people who use the system. The problems that the *kaihoken* model poses, however, are beginning to rear their collective head. There are two broad issues that need to be addressed to maintain the level of satisfaction with *kaihoken* that is seen today: a) rising healthcare costs; and, b) substandard quality of care.

A. Rising Healthcare Costs

The cost of healthcare in Japan is rising due mostly to low economic growth rates and an unstable political climate, combined with structural inefficiencies and population aging.[21] As is true with most of the global

18. Harden, *supra* note 10.

19. *Id.*; Imai, *supra* note 14, at 7; Jones, *supra* note 7, at 12.

20. *Compare* Jones, *supra* note 7, at 12 ("One exceptional feature of the Japanese health care system is the number of hospital beds and the length of the average stay, which are both about four times longer than the OECD average.") *with* Imai, *supra* note 14, at 7 ("But the average length of stay is about four times more than the OECD average reflecting the fact that many acute care beds have taken on the long-term care function for the elderly, the phenomenon known as 'social hospitalization.'")

21. Shibuya, *supra* note 11, at 69.

economy, the Japanese economy is struggling.[22] It has been suggested that the biggest challenge to solving the nation's fiscal situation is the financing of healthcare.[23] Many of the issues that are created by the universal healthcare system were overlooked during periods of economic success, but can no longer be tolerated in the current economic climate.[24] In fact, without a commitment to structural reform, it is predicted that costs could double within the next decade.[25]

The rise in health spending is due in large part to the following four factors: population aging, population growth, changes in the fee schedule, and other factors such as changes in technology.[26] Japan, as a nation, is aging more rapidly than any other country.[27] The aging of the Japanese society continues to drive up healthcare spending.[28] Spending on citizens ages seventy and over is five times the level of spending on the remaining citizens, which is high as compared to other nations.[29] Much of the blame falls on a combination of the fee-for-service model of payment and the insurance policies that pay for care of the elderly.[30] As the nation continues to age, the fee-for-service model and the insurance structure continue to place a heavy burden on younger generations, and more specifically, the working population.[31] Under the current Japanese insurance structure, inequities amongst the various insurance plans are addressed by imposing "cross-subsidies" between the different insurance plans to account for the

22. CIA World Factbook – Japan (Feb. 24, 2012 10:32 AM), www.cia.gov/library/publications/the-world-factbook/geos/ja.html.
23. Shibuya, *supra* note 11, at 70.
24. *Supra* note 4, at 2.
25. Harden, *supra* note 10.
26. Jones, *supra* note 7, at 6.
27. Tokita, *supra* note 8, at 58.
28. Imai, *supra* note 14, at 9.
29. *Id.*; Ono, *supra* note 2, at 106.
30. *See, e.g.* Hideki Nomura & Takeo Nakayama, *The Japanese healthcare* system, 331 BRIT. MED. J. 648, 648 (Sept. 24, 2005).
31. *Id.*

number of elderly people enrolled in the various plans.[32]

In 1973, the government passed legislation that abolished the co-pay for the nation's elderly,[33] which had the unintended consequence of growing the rate of long-term care patients in hospital beds, "turning hospitals into *de facto* nursing homes."[34] This trend – known as "social hospitalisation" – reflects a number of factors.[35] Those factors include: 1) a shortage of formal long-term care facilities, such as nursing homes; 2) the trend among the Japanese population of going to large medical centers as opposed to small hospitals, giving small hospitals an incentive to fill their beds with long-term care patients; 3) healthcare costs for the nation's elderly, including long-term care costs, which are not capped by the budget like other social welfare programs; and 4) the aging population.[36]

B. Substandard Quality of Care

The second major problem that needs to be addressed with regard to Japan's healthcare system is the issue of quality of care. As the global community has become interconnected, Japanese expectations regarding the quality of healthcare have risen.[37] The healthcare system, vis-a-vis the government, however, has been too slow in its response.[38] Specific complaints include: long wait times coupled with short consultation time with a doctor; insufficient explanation of procedures and maladies, including a lack of availability of medical information; and an overall poor level of care in hospitals.[39] The "blame" for the lack of quality of care in

32. Shibuya, *supra* note 11, at 69.
33. Ono, *supra* note 2, at 106; Tokita, *supra* note 8, at 56.
34. Jones, *supra* note 7, at 13.
35. Imai, *supra* note 14, at 7; Jones, *supra* note 7, at 14.
36. Jones, *supra* note 7, at 14.
37. Shibuya, *supra* note 11, at 71; Imai, *supra* note 14, at 10.
38. Shibuya, *supra* note 11, at 71.
39. Imai, *supra* note 14, at 7-8.

Japan can be attributed to three different aspects of the healthcare system: doctors, pharmaceuticals, and equality.

1. Doctors

In an increasingly globalized world, patients in Japan are becoming increasingly aware of quality standards and physician standards.[40] The current healthcare system has not allowed doctors to keep up with those changes.[41] The barriers stem from a) the fee-for-service model, and the effects it has on physician incentives; and, b) the lack of differentiation between general care and specialty care.[42]

a. Fee-for-service model

As previously stated, one of the main objectives of the Japanese government is to provide "necessary and adequate" healthcare to its citizens.[43] An unintended consequence of the fee-for-service payment method with regard to providing "necessary and adequate" care is that the definition of "necessary" changes over time.[44] In other words, the fee-for-service model creates a culture where treatment that is considered "necessary" is determined less by its medical effectiveness and more by the price point of that treatment, which leads to a higher volume of prescription of higher-priced services.[45] A higher volume of services leads to higher reimbursement for providers, thus it creates a system that values quantity over quality.[46]

Most Japanese doctors earn significantly less than doctors in the United

40. Hideki Hashimoto et al., *Cost Containment and Quality of Care in Japan: Is there a Trade-off?*, 378 THE LANCET 1174, 1179-80 (2011).
41. Shibuya, *supra* note 11, at 71.
42. Imai, *supra* note 14, at 6.
43. Jones, *supra* note 7.
44. *Id*. at 19.
45. Imai, *supra* note 14, at 7.
46. *Id.*

States.[47] The government keeps strict control over the amount of doctors in the market, and the average Japanese patient visits the doctor fourteen times per year.[48] This combination of fewer doctors and more frequent patient visits leads to very long working hours for the already underpaid physicians, severely diminishing the quality of care.[49] As a result, the most skilled doctors in Japan tend to leave the long hours and low wages of hospitals for the predicable schedule and higher income of private clinics.[50] Indeed, most doctors in Japan who make the switch from hospital to private clinic double their income.[51] When the more skilled doctors leave the hospitals for private clinics, the quality of care at the hospitals suffers. In fact, one of the most common complaints among Japanese patients is that they spend as long as three hours waiting for three minutes of face time with a doctor, and quality and depth of service suffers as a result.[52]

b. Accreditation

The flight of doctors from hospitals to clinics has led to a disparity of trust between clinic doctors and hospital doctors, which reflects the lack of accreditation standards in Japan.[53] Physicians in Japan are allowed to represent themselves as specialists without extra training in the area in which they claim to specialize.[54] Specifically, roughly two-thirds of doctors in Japan claim a specialty, although as few as half have undergone formal training in that specialty.[55]

In addition to the distrust in doctors that spreads as a result of the lack of

47. Harden, *supra* note 10.
48. *See generally*, Imai, *supra* note 14; s*ee also*, Harden, *supra* note 10.
49. Jones, *supra* note 7, at 11.
50. Harden, *supra* note 10.
51. *Id.*
52. Jones, *supra* note 7, at 11.
53. *Id.* at 24.
54. *Id.* at 24.
55. *Id.* at 25.

accreditation, there is a shortage of doctors to fulfill certain specialties.[56] These shortages are most prevalent in the areas of obstetrics, emergency care, pediatrics, and surgery.[57]

2. Pharmaceuticals

The pharmaceutical industry also weighs heavily against the quality of healthcare in Japan. Unlike in the United States, there are no laws in Japan mandating the separation of prescribing drugs and dispensing drugs.[58] Consequently, physicians are selling pharmaceutical drugs to supplement their incomes.[59] Under the current fee schedule, physicians are compensated for each prescription they write and each test they perform, not the amount of time or the quality of care given to a patient.[60] This system has resulted in an increase in the number of drugs and tests prescribed and consumed, with little regard for quality,[61] making Japan the highest among OECD nations in prescription and consumption of drugs and administration of tests.[62]

IV. HEALTHCARE IN THE UNITED STATES COMPARED TO HEALTHCARE IN JAPAN

As detailed above, Japan has very good reason to be proud of its healthcare system. The Japanese government has been able to find a delicate balance between keeping consumer costs down, while maintaining impressive health outcomes. To that end, the aspect of *kaihoken* that is most helpful for the United States is the strict fee schedule set by the

56. *Id.* at 7; Shibuya, *supra* note 11, at 71.
57. Jones, *supra* note 7, at 7; Shibuya, *supra* note 11, at 71.
58. Imai, *supra* note 14, at 6.
59. Jones, *supra* note 7, at 11-12.
60. Nomura, *supra* note 30, at 648.
61. *See* Jones, *supra* note 7, at 12; *see also* Nomura, *supra* note 30, at 648; *see also* Tokita, *supra* note 8, at 62.
62. Jones, *supra* note 7, at 20.

Japanese government.[63] The tight control of healthcare in Japan is a double-edged sword, however; while it allows the government to keep costs at a minimum, it also limits the quality of care in the country.[64]

The Japanese government keeps tight control over the cost of medical goods and services by setting a fee schedule.[65] This fee schedule has been integral for Japan in limiting the cost of care for its patient population.[66] The process of setting the fee schedule begins every two years, when members of the Japanese government decide on a global revision rate, which is the rate by which the entire budget for healthcare spending is increased or decreased.[67] After the global revision rate is set, the Central Social Insurance Medical Council[68] works within that guideline to revise the price for each drug, device, and service on an item-by-item basis.[69] Those numbers are, then, negotiated between provider groups and the Ministry of Health, Labour and Welfare.[70] When they come to an agreement on the price of each drug, device, and service offered, those are the numbers that are used for the following two years, until the entire process begins again.[71]

Like the system in the United States, *Kaihoken* is a multi-payor system that charges for medical care on a fee-for-service basis; but, unlike the

63. *See, e.g.* Hashimoto, *supra* note 40, at 1181.

64. *See generally* Jones, *supra* note 7 (explaining that the Japanese government has struggled to balance quality and cost throughout its fifty year history of providing universal healthcare).

65. *See* Harden, *supra* note 10.

66. Naoki Ikegami & John Creighton Campbell, *Japan's Health Care System: Containing Costs and Attempting Reform*, 23 HEALTH AFF. 26, 26 (2004).

67. Hashimoto, *supra* note 40, at 1175.

68. Committee consisting of payers, providers, and public interest appointed by the Minister of Health, Labour and Welfare.

69. Hashimoto, *supra* note 40, at 1175-76.

70. *Id.* at 1176.

71. Mark J. Ramseyer, *The Mortality Effects of Cost Containment Under Universal Health Insurance: The Japanese Experience*, HARVARD L. SCH. JOHN M. OLIN CENTER FOR L., ECON. & BUS. DISCUSSION PAPER SERIES, Paper 619, 4 (2008), *available at* http://lsr.nellco.org/harvard_olin/619.

United States, it uses the fee schedule to maintain one single payment system.[72] The effect of this single payment system is equality of care across the entire nation because every insurance plan is essentially the same in what is covered, and all procedures cost the same throughout the country.[73] Furthermore, the strict regulation of costs allows the Japanese government to promote specific technologies and procedures by lowering their costs, while deterring other technologies and procedures by raising their costs.[74]

As discussed in depth above, the strict regulation of the fee schedule does not achieve low-cost healthcare without consequences, which come mostly in the form of diminished quality of care. Because of the fee schedule and its highly regulated costs, most Japanese doctors make less money than their American counterparts.[75] In an effort to subsidize their income, Japanese doctors maximize the number of patients they see each day, which limits the amount of time spent with each patient.[76] The result is "assembly line medicine."[77]

Additionally, while strict adherence to the fee schedule keeps costs at a low, standard level for the consumer, it simultaneously dissuades doctors from specializing.[78] In other words, because doctors are being paid a set amount for each procedure, regardless of their level of expertise in that procedure, there is no incentive to gain extra training in a particular field of medicine.[79]

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72. Hashimoto, *supra* note 40, at 1175; Karen Davis, *Slowing the Growth of Health Care Costs – Learning from International Experience*, 359 NEW ENG. J. MED. 1751, 1753 (2008).
73. Hashimoto, *supra* note 40, at 1175.
74. Davis, *supra* note 72, at 1753.
75. Harden, *supra* note 10.
76. Ramseyer, *supra* note 71, at 5.
77. Michael Tanner, *The Grass is Not Always Greener: A Look at National Health Care Systems Around the World*¸ POLICY ANALYSIS NO. 613 (CATO Inst.) 17 (2008).
78. Ramseyer, *supra* note 71, at 6.
79. *Id.*

Similarly, the heavy regulation of the health insurance firms enhances the equality of care, but limits incentives to increase quality and efficiency or to develop innovative techniques and procedures.[80] It achieves this goal by completely banning insurance companies from turning a profit, which arguably would never be permissible in the United States.[81]

The fee schedule may not be the sole reason for the diminished quality of care in Japan, however, which comes as good news to those responsible for restructuring the American healthcare system.[82] The seemingly poor quality of care in Japan is likely rooted more in the physician and hospital culture in Japan, than in the fee schedule component of Japanese healthcare.[83] To that end, studies show that levels such as the postsurgical mortality rate are consistently on the low end as compared to other developed countries.[84] Additionally, as noted at the outset of this article, the overall health outcomes of Japanese people are excellent according to the global indices of health.[85]

The fact that the quality issues that Japan faces as a result of their fee schedule seem to be more systematic and cultural than resultant of the government's tight grip on medical costs is encouraging for the United States. It would logically follow that a country such as the United States, which already has a culture of high-quality medical care, would be less vulnerable to many of the quality concerns that Japan faces. Thus, experimentation with greater government regulation of healthcare in America could prove to be the answer to the crisis of rising healthcare costs.

Finally, based on the lessons that can be learned from Japan's struggle to maintain a high-quality, low-cost universal healthcare system, it may be

80. Jones, *supra* note 7, at 9.
81. Harden, *supra* note 10.
82. Hashimoto, *supra* note 40, at 1174, 1177.
83. *Id.*
84. *Id.* at 1178.
85. *Id.* at 1180.

wise for the United States to place a priority on delivering care to everyone before it perfects the quality and efficiency aspects of its healthcare delivery system.[86]

V. CONCLUSION

Japan serves as a great model for the United States because it has a system of universal healthcare that has been in place for over a half-century. The factors that frustrate healthcare spending and quality in the United States are many of the same factors that frustrate Japan's healthcare spending and quality. In the end, it is very difficult to balance the need for equality with the need for quality, and one is sure to suffer at the behest of another.[87]

However, we can learn a lot from Japan's artful balance of low-cost healthcare and effective healthcare outcomes. Specifically, Japan's use of strict government control over healthcare costs has provided a useful example of a system that has curbed spending without affecting the bottom line of health care quality. While the day-to-day aspects of quality to which we have become accustomed in America are not always present in Japan, the Japanese people enjoy longer lives and lower infant mortality rates than most of the developed world.[88] Combining some of the high quality of care aspects that the United States already has in place with aspects of the Japanese fee schedule could prove to be the answer the United States has been looking for all along.

86. Hashimoto, *supra* note 40, at 1180-81.

87. Jones, *supra* note 7, at 7 ("According to the landmark study by Campbell and Ikegami (1998), 'The underlying principle of the Japanese healthcare system is equality, among patients and providers, and equality and quality tend to conflict.'").

88. OECD Health Data, *supra* note 1, at 1.