Challenges against Japanese UHC system

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- Since the establishment of universal coverage in 1961, the Japanese health care policy could be summarized as the consistent pursuit of:

  "equal and smooth (no waiting in general) access" to "necessary high-quality services" with "affordable level of total expenditure (cost)".

- In which, controlling the level of health care expenditure to the extent manageable under the prevalent national economic conditions has been, and will be, a top priority for the continuation of such ideal health service for the public.

2

- To control health expenditure, revising the “fee schedule”, which refers to the price list of the covered services applied to all public health insurance schemes, has been quite an influential method in Japan under the open-ended health financing scheme.

- Conventionally, such revision takes place once every two years.

3

- Other factors that affect the level of health expenditure are:
  - ✓ Change of total population (↓, under current situation),
  - ✓ Aging (↑), and
  - ✓ "Others", including the increase of partial-copayment paid by the insureds (↓), and progress of medicine (new drugs, methods of treatment, etc., usually ↑ [but not necessarily so]).

(See next slide)

4

Factor Resolution of Growth Rate of Medical Expenditure

	(2010)	(2011)	(2012)	(2013)	(2014)	(2015)	(2016)	(2017)	(2018)	(2019)	(2020)	(2021)	(2022)
Growth rate of medical expenditure	3.9%	3.1%	1.6%	2.2%	1.9%	3.8%	-0.5%	2.2%	0.8%	2.3%	-3.2%	4.8%	*4.0%* (注1)
Influence of population change	0.0%	-0.2%	-0.2%	-0.2%	-0.2%	-0.1%	-0.1%	-0.2%	-0.2%	-0.2%	-0.3%	-0.5%	-0.4%
Influence of aging	1.6%	1.2%	1.4%	1.3%	1.2%	1.0%	1.0%	1.2%	1.1%	1.0%	1.0%	1.1%	0.9% (注2)
Revision of "fee schedule" (including revision of drug price)	0.19%		0.004%		0.1% -1.26% 消費税対応 (注3)		-1.33% (注4)		-1.19% (注5)	-0.07% (注6)	-0.46% (注7)	-0.9% (注8)	-0.94%
Other (Advancement of medical treatment, Raise of the patient's co-payment ratio etc.)	2.1%	2.1%	0.4%	1.1%	0.7%	2.9%	-0.1%	1.2%	1.1%	1.6%	-3.5%	5.1%	*4.5%*

Response for Consumption tax

(C-tax)

2020: Unusual decrease of demand due to COVID-19
2021: Reaction to such unusual decrease in 2020

Apr. 2014
Raise of copayment rate to 20% for 70 to 74 yrs old

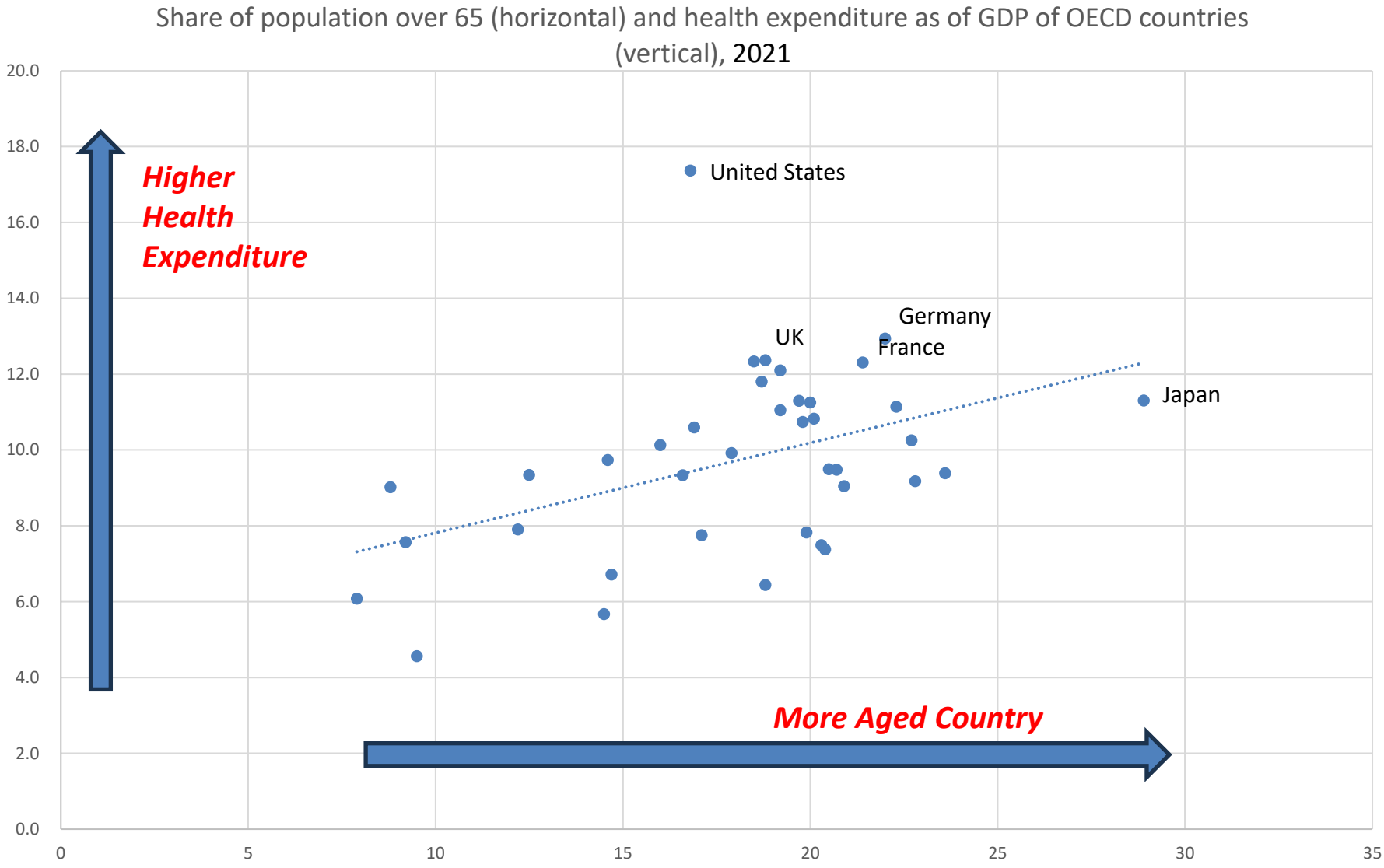
(Source : Health Insurance Bureau, MHLW (2023.12), modified and translated by the presenter)

- Historically, despites the degree of population aging, health care expenditure in Japan (as of GDP) could be considered as "not so high" compared to other countries.

(See next slide)

6

Compared to the degree of population aging, the health expenditure is not significantly high.



***Source*: OECD Health Data 2023**

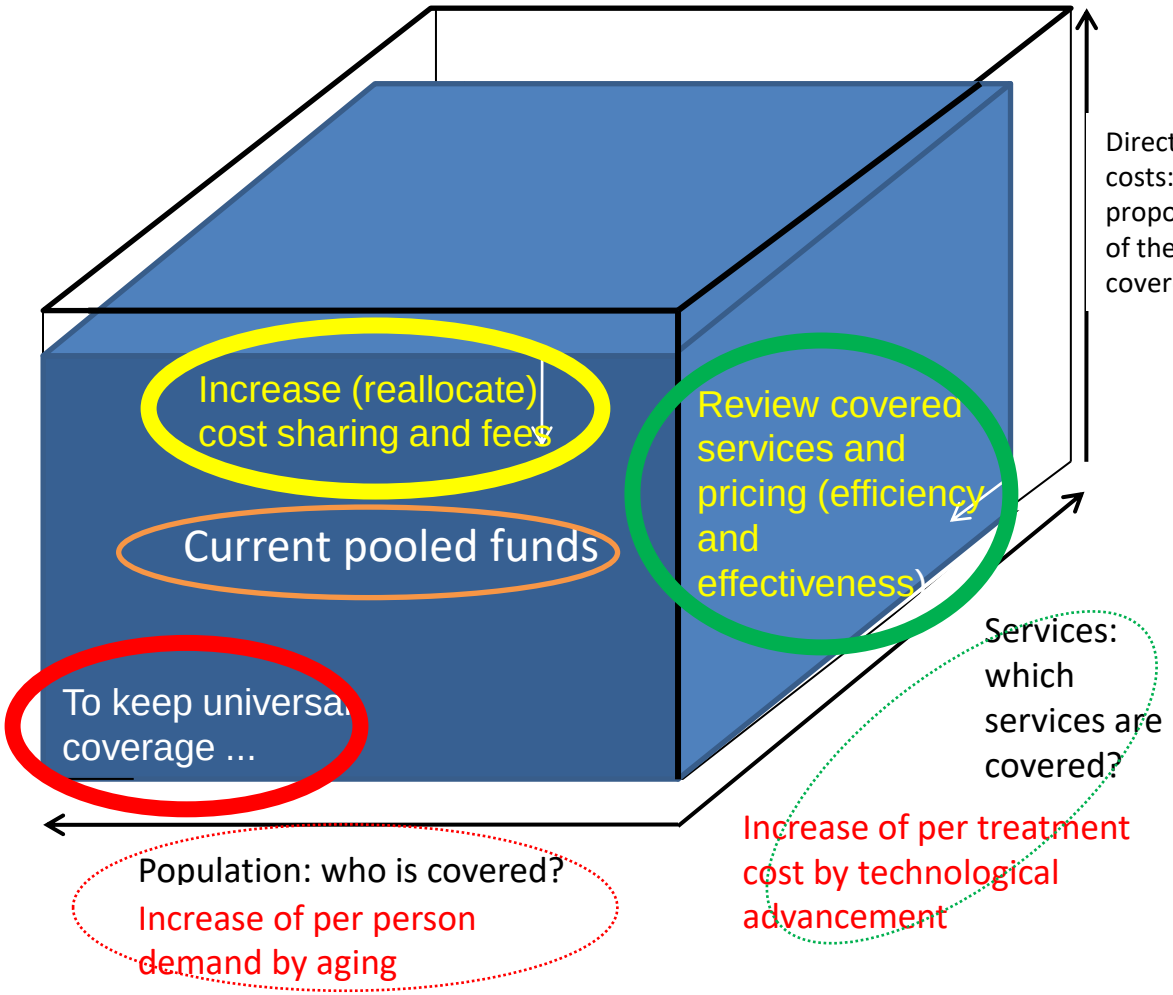
- While it has been relatively well-controlled, challenges continue to arise in maintaining the health care expenditure at a moderate level, as depicted in the "WHO's blue-box" model in the next slide.

- "Fee Schedule Revision" is effective, yet it is not the only measure to tackle with health expenditure, especially against structural issues.

8

We need to keep the level of public health care expenditure (=size of the “blue box”) at an “appropriate” level.

It is not right just to focus on “reducing” the size, as it might deteriorate the accessibility and quality of essential health care services for the entire population.



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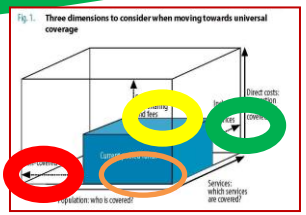
（Source: WHO, “Health Systems Financing – the path to universal coverage (World Health Report 2010) ”, modified By the presenter

However, keeping the level of public health care expenditure (=size of the "blue box") at an "appropriate" level does not mean doing nothing. Rather, policymakers are always struggling. The current direction for the general policy is as shown below:

Definitely need to maintain universal coverage for all to continue equal access to medical advancement.

Increasing cost sharing for the younger generation who already pay 30% copayment may lead to loss of confidence among the public regarding the scheme.

Therefore, prioritizing and achieving efficiency in service provision is necessary, if we want to continue to enjoy the progress of medicine equally.



Therefore, the following measures are pursued in recent reforms:

1) Promotion of measures against noncommunicable diseases

2) Efficient distribution of health care resources within the region
("Community Healthcare Vision")(Omitted)

3) Achievement of "Integrated Community Care"

4) Prioritizing medical care and long-term care benefits

1) Measures against noncommunicable diseases

“Specific Health Checkup” and “Specific Health Guidance”

Health insurers <u>are obliged to provide the specific health checkups</u> to their enrollees aged over 40 years old.

Those who meet the specific criteria

Healthcare insurers <u>are obliged to provide specific health guidance</u>

<u>Decrease in risk factors</u> related to life style-related diseases

“Specific Health Checkup” :

- Health screening for hypertension, dyslipidemia, diabetes and other lifestyle-related diseases resulting from visceral fat accumulation.
- Insurers of each public health insurance are mandated to provide checkups to the enrollees in the 40 - 74 years old age range.
- To those with unfavorable checkup results and whose measured abdominal girth (waist) is over 85cm (for male) and 90cm (for female).

“Specific Health Guidance”

- One to one consultation with the health nurse for motivating the person to improve the condition (exercise, diet, ---)

3) Achievement of “integrated community care”

- “Integrated Community Care” means ---

A regionally-organized system that provides various life-support services, including not only medical care and long-term care but also welfare services, within the daily living zone to secure elderly individual’s safety, peace of mind, and health in daily life, on the basis of the provision of residence that accommodates the needs of the elderly.

- Under such slogan, enhancement of home medicine and integration between medical care and long-term care services are aggressively promoted.

4) Prioritizing the medical care and long-term care benefits

Method 1: Changing the rate of partial copayment for the elderly

<Copayment Rate Schedule>

Children (under 6): 20%

Age 6 to 69: 30%

70 to 74: 20%, (30% for very high income)

75 and over: 10%, (30% for very high income)

⇒in October 2022, bracket for 20% copayment was introduced for the elderly (75 years and over) with equivalent level of income with working-age.

(Note: About 40% of "Health Insurance for the Elderly 75 and over" is financed by the transfer from health insurance schemes that cover younger generation. Introduction of the 20% copayment bracket is regarded as enhancing equity between the elderly and younger generation.)

Method 2: Introduction of extra surcharge to enhance efficient use of medical resources.

(Incentivize to use appropriate "level" of hospitals/clinics.)

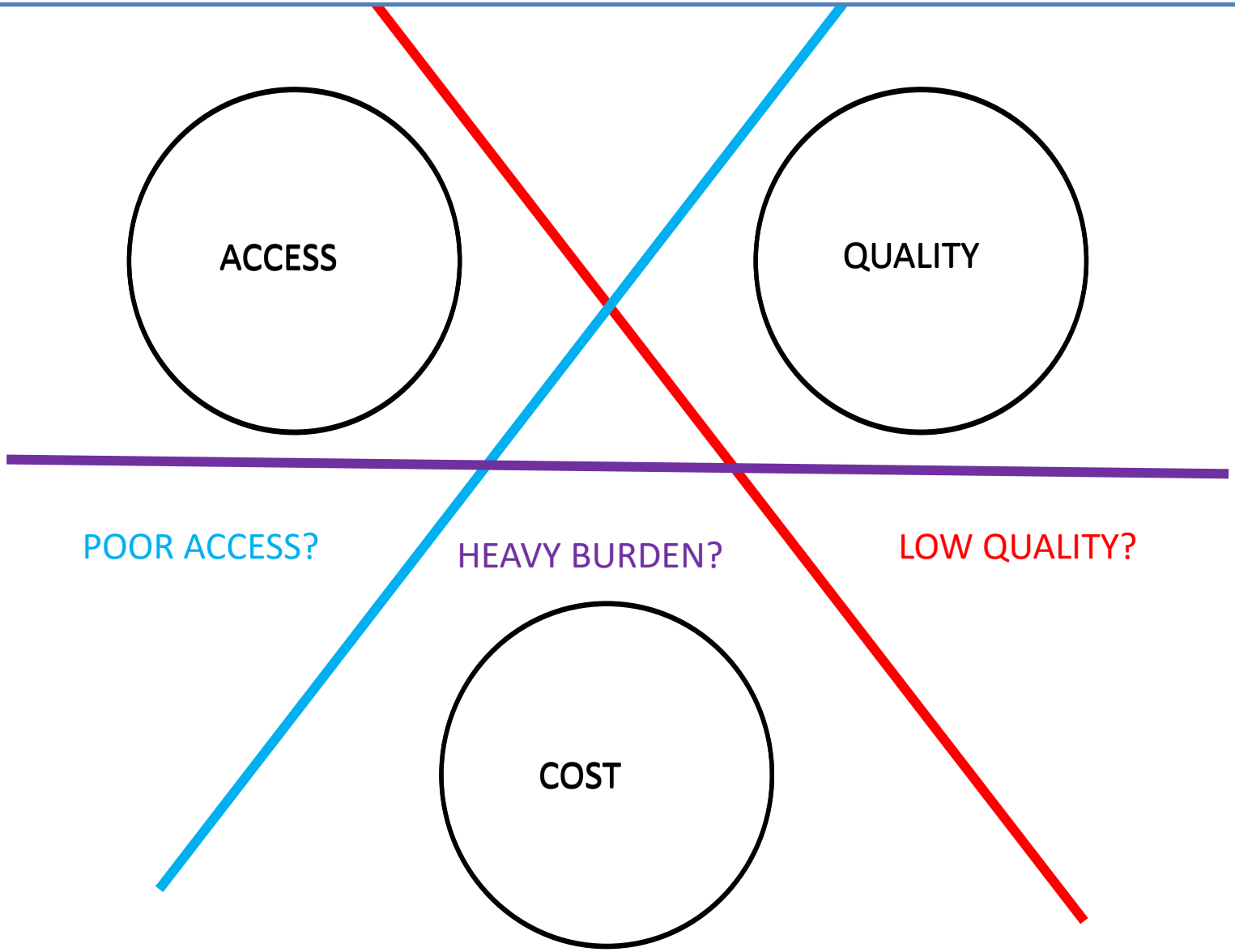
Under our "Free Access" scheme, in principle a patient can receive medical care at any institution by his/her own choice. (No gatekeeping, no pre-registration to certain institution.)

Starting October 2022, extra surcharge of 5,000 yen (or higher) is charged on top of 30% (10, 20%) copayment for visits to certain large hospitals without referral.

(Incentivize to use generic drugs.)

Starting October 2024, extra surcharge (amount depend on drug) will be imposed to purchase brand drug whose generic version is already on the market.

Healthcare policy: Not to “achieve the best at one time ”, but an ongoing endeavor to continue to pursue the “better”, with the “trilemma” in mind.

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