Reforming healthcare
- Experience and lessons from Japan –
2. Physicians and hospitals
Suggestions for China

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4. Physicians and hospitals in Japan

• Laissez-faire
  – 80% of hospitals and 94% of clinics in private sector
  – Physicians are allowed to open clinics anywhere and proclaim any specialty without authorization
  – Authorization needed to open hospitals or expand beds (restrictions imposed after 1985, until then no limitations)
  – Even now, hospitals can purchase any equipment, open any specialty dept without authorization

• Strict regulations
  – Almost all revenue controlled by the fee schedule
  – Physicians legally obligated to provide service to patients
  – Entry of investor-owned hospitals legally prohibited
    • Profits cannot be distributed as dividends, must be reinvested in capital
Hierarchical structure of physicians

- Well-developed system of private practitioners, mainly in Chinese medicine, existed before westernization began in 1868
- System remained intact because they, and their sons, were provided with licenses
  - Allowed relatively good access to continue
- But new entry restricted to those trained in western medicine
  - Parallel schools of traditional medicine that exist in China, prohibited
- Hierarchical structure of medical education
  - Limited funds invested in University of Tokyo: German professors invited
  - Graduates of Tokyo University sent as faculty to other medical schools
  - Private, non-university level education for private schools except Keio
  - Remained intact until the post-World War II reforms
  - Allowed for affordable expansion of healthcare
  - But, absolute lack of well-trained physicians until recently

Development of hospitals

- Hospitals did not exist before westernization
  - Reliance on extended family for social support
- Hospitals created for four purposes
  - University hospitals for medical education
  - Military hospitals for enlisted men
  - Public hospitals for infectious diseases
  - Private hospitals by physicians (largest ratio)
- Public hospitals built by taxes, private hospitals built by private capital from revenue regulated by fee schedule
  - Prestigious hospitals in public sector
  - Private sector hospitals do not have enough resources to invest because of tight control on reimbursement
  - Waiting lists for some departments in some prestigious hospitals → Patients can be referred if they do not or can not wait
Appointment of physicians in Japanese hospitals

Mutual interests: medical schools wanted high quality hospitals, hospitals wanted high quality young doctors ⇒ Development of closed network between university clinical departments and affiliated hospitals

Basic structure of physicians and hospitals

Among physicians: Vertical relationship stronger than horizontal relationship
Doctors identify more with their university clinical departments than with their professional societies

Among hospitals: Antagonism between high-prestige, subsidized public hospitals and generally low-prestige, unsubsidized private hospitals

⇒ Concentration of power to the Japan Medical Association: Professional societies and hospital associations have less power
⇒ Private practitioners focusing on primary care have higher incomes than specialists in hospitals
**Lack of professional quality control**

- Training and accreditation of specialists under-developed → Lack of standardization
  - Appointment to major hospital positions: Under control of university clinical departments, credentials as specialists less important
  - Each university department sets its own standards
  - Has made it impossible to control the number of residency training positions in each specialty
- Lack of standardization in hospital quality
  - Hospital accreditation started 12 years ago, but still only ¼ accredited
  - All hospitals inspected by local government but this is focused mainly on staffing (number of physicians, nurses to patients) and floor space per bed
  - Has made it impossible to control the installing of expensive equipment
    - Whether the hospital has the human resources to use the equipment or not considered, nor whether there will be sufficient volume to maintain quality
- Main pressure to maintain quality → Competitive environment
  - Compete for patients (by grape-vine), and for physicians, nurses etc.
  - If unsuccessful, then goes out of business
    - Number of hospitals: 9,490 (96) → 8,943 (06)

**Emphasis on outpatient care**

- Of total medical expenditures, less than half (48.5%) is inpatient care and the majority (51.5%) is outpatient
- Free access to virtually all hospitals
  - Even in university hospitals more than one third come without any referrals
- Patients are admitted from outpatient dept or ER
  - Most hospitals operate large outpatient dept
    - 1,000 bed hospital may have 4,000 outpatients per day
    - Even tertiary hospitals have many primary care patients
    - Physicians are kept busy providing outpatient care
- Of the outpatient expenditures, clinics compose 60% and hospitals compose 40%
- Evaluating quality more difficult in outpatient settings
Major concerns of hospital CEO

• Hospital CEO must legally be a physician in Japan
  – Historical reasons: hospitals were built mainly by physicians

• Keep the hospital in business, expand if possible: How?
  – Anticipate where government policy is heading by evaluating the general direction of fee schedule revisions
  – Adjust quickly to the fee schedule revisions

• Recruit and retain physicians and nurses
  – Physicians: Income + high-tech facilities, equipment
    • Maintain good relations with university clinical departments
  – Nurses: Daily inpatient hospitalization fees based on staffing
    • More nurses per patient, higher daily rate, more income for hospital

• Private sector hospitals (80%): Retain family control → Make sure child succeeds as CEO

• Public sector hospitals (20%): Protect and enhance status of those who are currently employed

Public-sector hospitals

• Public sector: 20% of hospitals (8,943), 40% of beds (1,626,589)
  – Ostensive dual mission: high tech care (2/3) + serve isolated rural areas (1/3)
  – High-tech care: Together with university hospitals, provide 75% of surgical operations requiring general anesthesia

• Composition of public-sector hospitals
  – 5 National centers: Cancer, Cardiovascular etc.
  – 1 National hospital corporation with 146 hospitals
  – 294 Prefectural government hospitals
  – 753 Municipal government hospitals
  – 349 Quasi public: Red Cross, Farmer’s Co-op etc.
  – Plus University medical schools: 43 national gov, 8 local gov, 29 private

• Government subsidies: 0-20% of hospital revenue
  – In addition: Exemption from all taxes (corporate tax, property tax etc.)

• CEO, physicians, nurses etc. are all civil servants
  – Accepting gifts from patients is a criminal offense
Management of public hospitals

• In theory, revenue from SHI should equal expenditures as they do in private hospitals
• Why most public hospitals have deficits
  – Can rely on government subsidies to cover deficits
    • Cf. If private hospitals continue to have deficits, they go out of business
  – Lack of managements skills
    • CEO appointed from among the hospital’s senior physicians
    • Administration staffed by local gov officials, rotated from other sections
  – Strong unions and seniority-based wages
    • Income of a nurse about to retire is more than three times that of a new graduate
  – Pressure from politicians
    • Admit certain patients, expand or retain certain services etc.
  – Equity reasons: Ensuring access to those with low income
    • Percentage of extra-charge rooms must be 10% or less (national mean: 17%)
    • Minor role of indigent care because of universal coverage and low-coinsurance
    • But quasi-public hospitals under similar constraints do not have deficits

Mounting pressure to reform

• National government’s policy
  – Decrease subsidies to local governments
  – Decrease direct subsidies to public hospitals and shift towards global allocation to local governments
• Local government’s fiscal condition has worsened
  – Local government must include hospital’s deficit in financial statement
• Attempts being made to preserve public hospitals
  – Transfer to a public corporation: Not much difference
  – Merge with other public hospitals: But, different cultures
  – Sell to private sector: Need to pay off the staff
• Difficult to define the “public services” which can’t be delivered as a result of the low fees in the fee schedule
  – If definable, then project-specific subsidies could be given on tender basis
  – Example: Providing 24 hour comprehensive emergency services
Minor role of regional health planning

• Introduced in 1985 at the prefectural level
  – 47 prefectures have population from 0.6 to 13 million
  – Prefectural governors mandated to draw health plans
• Has been restricted to a cap on hospital beds
  – If number of beds per population is more than the national mean in each
    health planning area, then expansions would be prohibited
  – But many hospitals increased beds before implementation of the plan
• Health planning strengthened in 2007
  – Mandating coordination among hospitals and between hospitals and clinics for
    the 4 diseases of cancer, acute heart diseases, strokes and diabetes
    • Acute hospitals must publicize where patients are transferred for rehabilitation etc.
  – Can coordination be mandated?
• Still no regulations for purchasing high-tech equipment, or opening
  new clinical departments etc.

4. Reforming healthcare in China

• How to achieve the five reform programs?
• How to ensure that the increases in funding would lead to achieving the desired outcomes?
• How to decrease the disparity between regions, and within regions?
Flow of money in the Chinese healthcare system

- **Government**
  - National taxes: 15%
  - Local taxes: 3%
  - Subsidies: 7%

- **People**
  - Directly by patient: 50%

- **Public-sector facilities**
  - Fee schedule: 93%

- **Private-sector facilities**
  - Premiums: 32%

Priority objectives

- **Establish nationally uniform fee schedule and drug formulary**
  - Need to establish central agency having power over all three insurance systems
  - Set basic services and their relative price, and essential drugs which must be included in the benefit of all plans
  - Each plan or region allowed to expand the above, but not change relative price
  - Each plan or region allowed to set its own conversion rate to RMB
  - Any benefits outside of basic package must be entirely financed by premiums raised at the local level, and not subsidized by national government

- **Increase funding to the New Rural Cooperative Medical Insurance (NRCMI)**
  - National government’s subsidies should be linked to the estimated income level of the community

- **Future goal:** All plans cover all services and drugs listed
Caveats in introducing DRG-PPS

• Positive aspects
  – Removes incentive to provide more: drugs, lab tests
  – Standardized payment → Standardized medical care
    • Deviant behavior by physicians would increase costs

• Negative aspects
  – Can the quality of data be assured?
    • Fraud: Group patients into highest paying DRG group
    • Up-coding: Group inpatients in gray areas to the highest paying DRG group
  – Can the quality of care be assured?
    • Economic incentives: Under-treat or refuse to admit patients who are likely to incur heavy costs such as having major co-morbidity
    • Just admit, diagnose into groups, not treat and discharge → Profits ↑
  – Will it contain costs?
    • Just shift costs to outpatient care without any savings in inpatient care

Reforming reimbursement for drugs

• Goal is nationally uniform formulary and the same price set for all drugs
  – Variations to be allowed in the co-insurance rate
  – In rural NRCMI, only a minority of drugs would initially be covered, but these essential drugs should have no co-insurance
  – Future goal is to have an uniform co-insurance rate for all China
• Conduct survey of the market price paid by the hospitals and reduce prices for each drug based on the results
• Improving GMP (Good Manufacturing Practice) is pre-condition for generics use
  – Unless quality is guaranteed, physicians have valid reason not to prescribe
• Give physicians incentives to prescribe generics
  – Increase prescription fees if all drugs are generic
• Give hospitals incentive to prescribe generics
  – Amount paid for generics exceeds X% of total drugs purchased, then hospital receives an extra Y% of the total amount reimbursed for drugs
• Give pharmacists incentives to dispense generics
  – Increase dispensing fee if all drugs are switched to generics
Reforming public hospitals: Basic policy

- Reform of current fee schedule and drug prices is a pre-condition for the reform of public hospitals
  - Currently, use of high-tech care and expensive drugs leads to more revenue, profits for hospital; more income for specialists
- Gradually revise fee schedule so that primary care generates more profit than high-tech care
  - In Japan, rural hospital doctors earn twice the income of large urban hospital doctors because rural hospitals are reimbursed at the same rate as urban hospitals
    - Labor costs lower for non-physicians in rural area
    - Same payment allows rural hospitals to pay doctors more
    - Doctors prefer practicing in urban medical centers: Why pay more?

Reforming public hospitals

- Use subsidies as an incentive for hospitals to comply with policy goals
- Link government subsidies to the achievement of policy goals, and not just reflect the previous year’s budget
- Set policy goal targets for each hospital based on previous year’s actual figures
  - The percentage of patients treated who were NOT enrolled in the UEBMI in emergency dept, outpatient care, inpatient care
  - The percentage of revenue derived from services, NOT drugs
- Make accepting gifts from patients a criminal offense
- Make purchasing of high-tech equipment subject to approval of the regional government
Investment in management

- Recruiting and training managers the key to success
  - Managers for the government, insurance plans and hospitals
  - Understand the nature of supply and demand in health care
  - Senior physicians: Short training courses in the art and science of management
    - Those recruited would command esteem from their peers
    - But hospitals would lose clinical expertise
  - Well-trained managers may be good revenue maximizers!

- Developing data basis
  - Data needed to fine-tune fee schedule revisions
  - Reliability and validity of data are prerequisites
  - Select representative hospitals as beacon points for data

- Restructuring existing organizations
  - Hire consultants who will take the blame and the responsibility
  - Public image of the consultants is a crucial factor when hiring