Session 5: Public or private financing for UHC?:
Consequences for health policy

Regulating payment in Japan

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Three objectives in health care policy

- 1st : Not bankrupt the patient
  - Healthcare costs are the leading cause of poverty
  - Quality should be guaranteed to all patients
- 2nd: Not bankrupt the government: Health care costs must be controlled by the budget
  - Costs must be contained to within the amount that the rich (who must pay a large share) will agree to pay
- 3rd: Manage expectations of patients, physicians
  - Set “appropriate” quality level
  - Set “appropriate” income level of physicians

1st : Not bankrupt the patient

- How to prevent the patient from becoming bankrupt as a result of healthcare costs?
- Cannot be left to the patient: In a life or death situation, prepared to pay any price, go into debt
  - Patients are not prudent consumers
- Cannot rely on physicians: Will advice patients to choose the best, especially if they get paid
- Must be publicly financed, not privately: Restrict out-of-pocket payment and private insurance

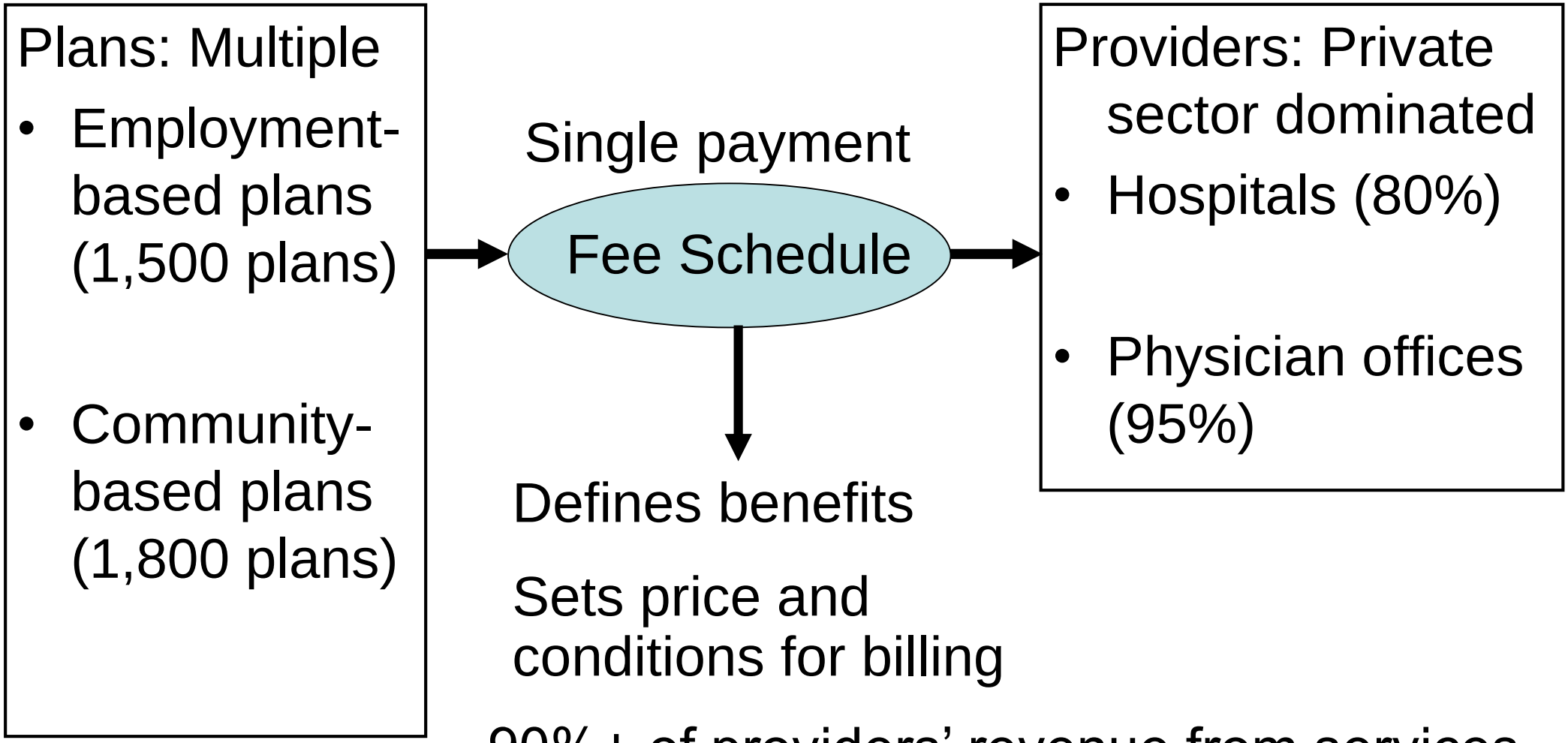
Out-of-pocket payment

- Copayment for publicly financed services
  - A fixed amount per visit, or per day while hospitalized
  - A percentage of the service fee and the price of drugs
  - Object lies in containing patient's demand
  - Ceilings placed on the amount the patient must pay
- "Topping-up": Extra-bill for services and drugs not publicly available or balance-bill the surcharge
  - Difficult to control individual transactions
  - What to allow: New drugs still being tested, Private rooms, Treatment by renowned physicians?

Role of private health insurance

- Best insurance plan: Low premiums, generous benefits
  - How to achieve above: Enroll those who are healthy and are at low risk, exclude chronically ill
  - High risk, chronically ill will be thrust on public system
- For equity reasons, private health insurance must be regulated and restricted
  - Not supplement public insurance, but complement
  - Benefits could cover private rooms, treatment by renowned physicians

How Japan does it



90%+ of providers' revenue from services delivered at prices set by Fee Schedule

1st : Not bankrupt patients

- Patients pay 30% of the total as a general rule
  - However, elders and children have reduced rates
  - If copayments exceed the ceiling, patients pay only 1%
- Strict restrictions on “topping-up”
  - Extra-billing generally limited to new technology being developed in approved hospitals (<0.001% of total)
  - Balance-billing generally limited to extra charge beds
  - Other than the above, “topping-up” is strictly prohibited

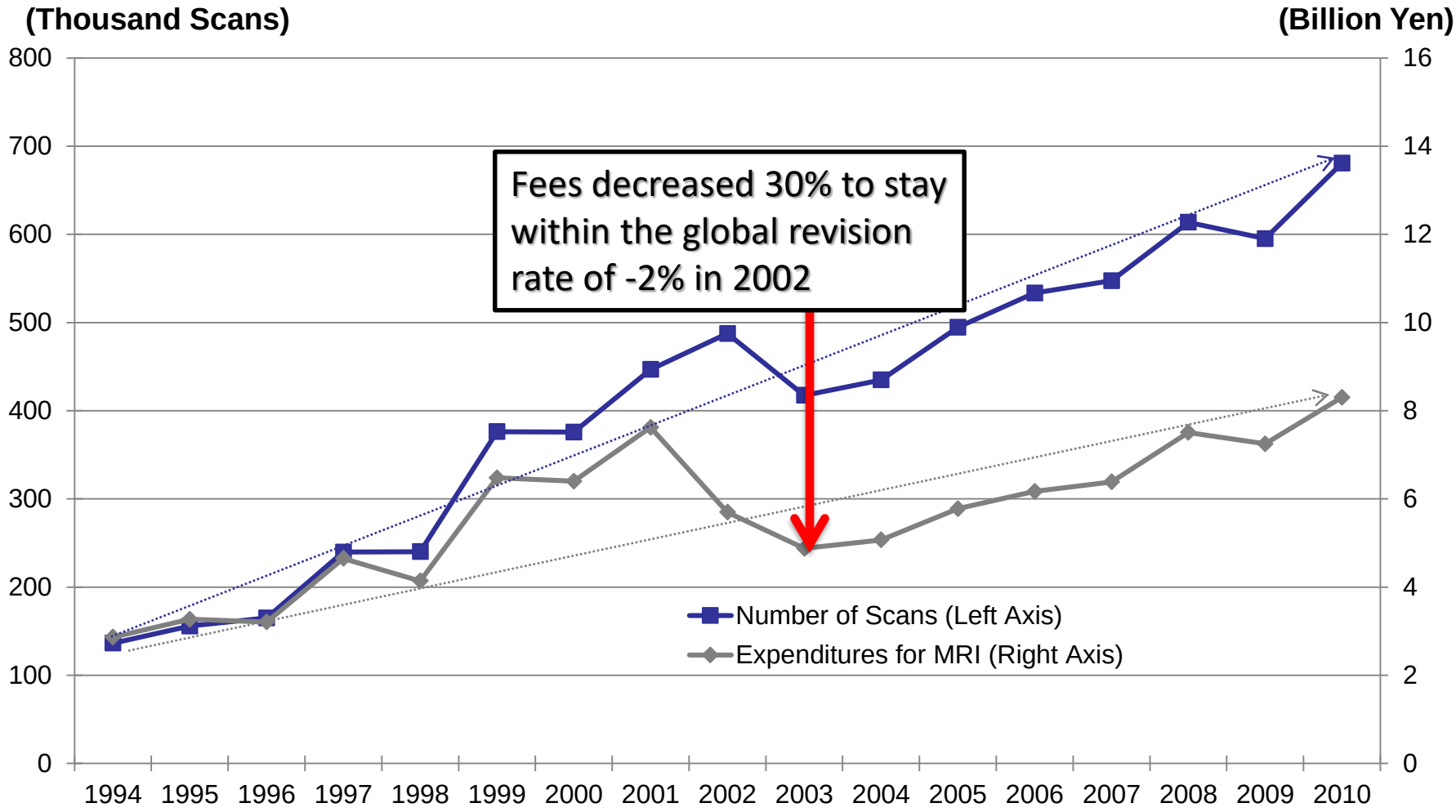
2nd: Not bankrupt the government

- Control total healthcare costs by the budget
- Achieved in Japan despite private sector dominated providers and fee for service payment
  - 80% of hospitals in private sector
  - Providers bill for each item delivered to patients
- Health expenditures = $\sum$ Fee $*$ Volume
- Fee Schedule not only sets the fee but also the volume of each item by the conditions of billing
  - Example: First consultation fee can only be billed if the patient had not made a visit in past 29 days etc.

Revising the Fee Schedule

- Fees & drug prices are revised every two years
- Process starts by setting the global budget
  - Global budget set by the global revision rate: the volume-weighted revision rate of all items
- Once the global budget is set, then the fees and conditions of billing are revised item-by-item
  - Not across-the board: Some fees go up, others go down; some conditions tightened, others loosened
  - Government has data on the volume of all services delivered→ Revisions must be made within the budget

Reducing MRI scan fees



Source: Ministry of Health, Labour and Welfare (MHLW) " Survey of Medical Care Activities in Public Health Insurance"

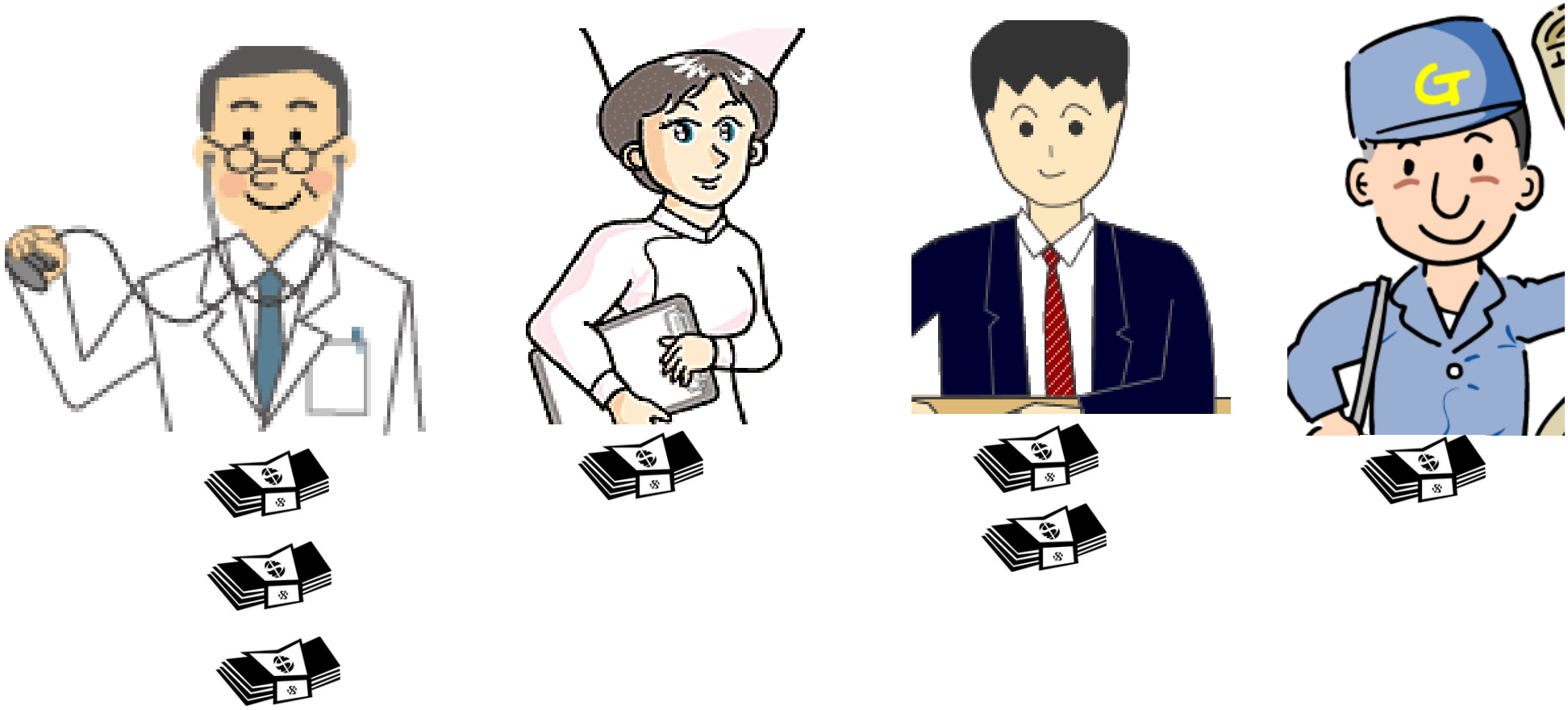
Enforcing regulations on providers

- Claims (bill from providers) review
  - Claims reviewed for adherence to conditions of billing
  - Reviewers: Senior physicians who are employed 5 afternoons per week and paid $2,000 per month
  - Claims denied compose 1.4%, amount denied 0.3%
- On site audits: Match claims with medical records
  - If not documented in the patient's records, the facility must self-audit the claims submitted in the past 6-12 months and pay back the amount inappropriately billed
  - If purposeful, physician & facility may loose license

3. Managing expectations

- Health service delivery is relatively stable
  - Physicians deliver services based on their experience
  - Patients' expectations are based on their experiences
  - CT scan for persistent headache can become the norm
- Half of all healthcare expenditures is labor
  - Healthcare expenditures = Physicians' & nurses' income
  - When providers say "costs", they mean "income"
  - How much does it cost? → How much should I be paid?
  - Relative costs (income) is critical

How much income should physicians earn? Compared to nurses? To other workers?



Which physicians earn more? Balancing non-monetary rewards with monetary rewards

Japan

Rest of world

Institutionalized negotiations

- Government cannot unilaterally dictate terms to physicians and hospitals
  - Decisions on resource allocations are made by physicians who have professional autonomy
- A formal process of negotiations is needed
  - Physicians and hospitals must organize themselves
  - Government must establish an organized structure
- The media, political parties and civil societies must represent the public

To summarize

- The goal of UHC is not just about population coverage, but also financial protection of the patient
- To achieve this goal:
  - Public financing is essential
  - “Topping-up” must be strictly regulated
  - Physicians and healthcare workers must focus on providing services in the publicly financed sector
  - Payment system must be well designed and revised
  - Expectations of physicians and patients must be managed