“Healthcare Reform and Economic Growth”

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<Keynote Speech>

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"Health Reform and Economic Growth -How to pursue both healthcare cost increase and fiscal reconstruction at the same time-"

I am [Yukihiro] Matsuyama of the Canon Institute for Global Studies. I will report on the same theme as the symposium's title, "Health Reform and Economic Growth." I will raise five issues: "Under a rigid public system amidst a fiscal crisis, is there a way to get additional funds for healthcare?"; "How can Japan create new jobs in the healthcare industry and stimulate economic growth?"; "Healthcare is mainly for the domestic market; can Japan’s healthcare industry obtain foreign currency in the future?"; "How can Japan establish a world-class healthcare business cluster like those in the USA and the EU?"; and "Can we absolve government and municipalities from the management risk of national hospitals and public hospitals?" There are two keys for solution: "Options in the public health insurance program" and "Vertical Integration."

I would like to list nine failures of common knowledge regarding healthcare reform in Japan. Failure of common knowledge 1 is "Healthcare reimbursement rates in Japan are not too low." In fiscal 2008, when medical treatment fees were reportedly lowest, Nagano Kouseiren posted operating revenue of 78.1 billion yen and current profit of 950 million yen. This indicates that it is possible to operate in the black if all services from preventative and home care to acute and emergency care are provided.

Failure of common knowledge 2 is "The healthcare delivery system in Japan has the highest commerciality in advanced nations." The global standard for judging the commerciality of a medical institution is "Whether a particular individual can take part of the profit or not." Of Japan's approximately 8,700 hospitals, about 5,300 are medical corporations with owner fundamental funds. Judged by the standard of commerciality, these hospitals that are medical corporations with owner fundamental funds are for-profit. Thus, Japan has the highest percentage of for-profit hospitals.

Failure of common knowledge 3 is "Integration instead of affiliation." When regional medical networks are discussed in Japan, the term "affiliation" is often emphasized. However, it is difficult to form a regional medical network through affiliation. According to Harvard University's Professor Michael Porter, forming regional medical networks by creating Integrated Practice Units by medical condition is effective. This is the model used by Sentara Healthcare run by Mr. Kern. In the UK, France, Australia, and other developed countries other than the US, the similar concept "Clinical Governance" is emphasized, and top-down regional medical networks have been created. In contrast, affiliation is often emphasized in Japan, and progress on regional medical networks is lagging.

In order to understand the reasons for this, we must look to a distinctive contradiction in the healthcare market: "Medical institutions that attempt to raise healthcare quality and cut costs will not receive 100 percent of the benefits." An effective way to overcome this is to integrate with medical institutions that have different functions and become a single organization. In other words, the competitive strategy for healthcare should not be thought of in terms of market-based competition among individual healthcare facilities, but in terms of the idea of promoting competition among regional healthcare entities. Thus, failure of common knowledge 4 is "Neither advocates nor opponents of free market economics are correct about the healthcare market."

Failure of common knowledge 5 is "It is wrong to reinforce the insurer's function versus MDs and nurses." Failure of common knowledge 6 is "EMR expenses cannot be recovered through cost savings alone." Because EMR investment costs are very high, it is impossible to recover them solely through medical cost-savings effects such as elimination of redundant examinations and prevention of medical errors. In addition to medical cost-savings effects, increased revenue through patient retention, clinical cohesion through improved quality, and brand enhancement must also be achieved. Failure of common knowledge 7 is "The existing private health insurance in Japan should not be allowed to substitute for public health insurance."

Failure of common knowledge 8 is "A healthcare cluster is not simply building many facilities in one site." Japan has areas it calls healthcare industry clusters, but these are simply places where several healthcare-related facilities and companies are located. They do not draw doctors, researchers, and patients from around the world. Obtaining additional healthcare revenues through medical tourism is a centerpiece of the Japanese government's strategy for new growth. However, the world has already moved from medical tourism to direct export of hospitals and medical schools. This is failure of common knowledge 9.

Next, I will discuss the latest trends in reform of healthcare delivery systems in Europe and North America. Canada operates its medical system on a province-by-province basis. Ontario drew attention with its passage of a Local Health System Integration Act in 2006. France passed a new law on regional healthcare governance in July 2009. The key concept of the new law is "one-stop shopping," which is the same as the vertical integration I mentioned. In the state of New South Wales, Australia, there are eight public medical corporations. The mechanisms, scale, and facilities distribution of these public medical corporations are similar to those of American IHNs.

Next, I will discuss defects in the Japanese healthcare delivery system. In part because of ongoing efforts at management reform, I think that overall the bottom lines of national hospitals have shown significant improvement. Looking at the 145 national hospitals on a case-by-case basis, however, most of them are small or medium sized, with revenue from medical services of 8 billion yen or less. They are managed separately, with 40 hospitals operating at a loss. As you know, Social Insurance hospitals have become a political football. Debate in the Diet went awry because it failed to focus on the idea of optimal use of medical resources in medical regions rather than on rescuing individual

hospitals. There are about 1,000 hospitals run by local governments in Japan. Despite receiving annual subsidies of 750 billion yen, they lose around 180 billion yen every year. They carry an unappropriated cumulative deficit of more than 2 trillion yen. With the financial crisis, in the near future it may become impossible for national universities to have affiliated hospitals. This, however, potentially represents a breakthrough for reform.

I would like to discuss potential breakthroughs linking healthcare reform to economic growth based on the conditions in Japan that I have described. The first breakthrough is an existing policy, early implementation of insurer integration by each prefecture. The second breakthrough would be to revise public health insurance into two-tier structure to obtain additional funds. The reason for this is that the low birthrate, aging society, and slow economic growth are worsening conflicts between generations and income brackets. This will make it increasingly difficult to reach consensus on healthcare reform with a uniform national program. The third breakthrough would be to establish healthcare public benefit corporations that are financially independent from the government. Their governance could be set up through existing systems, as independent administrative agencies or social medical organizations. A political stance that politically supports only ambitious regions rather than uniformly scattering public funds around the country is essential for healthcare delivery system reform.