"Healthcare Reform and Economic Growth"

Date: July 13, 2010

Location: International Lecture Hall,
Tsukiji Campus, National Cancer Center

The Canon Institute for Global Studies (CIGS)

<Panel Discussion>

Nobuhiro Nishizawa

Deputy CEO, Saku Central Hospital, Nagano Kouseiren

Masahiro Kanno

CEO, Social Medical Corporation Foundation Tousenkai

Howard P. Kern

President & Chief Operating Officer, Sentara Healthcare, Virginia, U.S.A.

Jeffrey Braithwaite

Professor & Foundation Director, Australian Institute of Health Innovation, Faculty of Medicine, University of New South Wales, Australia

Yukihiro Matsuyama

Chief Research Fellow, the Canon Institute for Global Studies

(honorifics omitted)

Matsuyama: As the first subject of the panel discussion, I would like to bring up policies on competition in healthcare services. For example, what is the relationship between anti-monopoly laws and a healthcare provider such as Sentara that has an overwhelming position in the local healthcare region?

Kern: In the US, regulations based on anti-monopoly laws are carried out by the federal government and state governments. These frameworks apply to all businesses, not just to healthcare. In the case of healthcare, the number of beds is used as the criterion for judging whether a hospital has too much power in a given region. At the federal level, federal courts and the Federal Trade Commission are involved with these regulations. As IHNs have grown in scale, the Federal Trade Commission's interest in healthcare has increased. Participation by hospitals and doctors in joint ventures is also regulated.

Matsuyama: Is there competition among public medical corporations in Australia?

Braithwaite: Even though the public sector accounts for two-thirds and the private sector for one-third of the Australian healthcare delivery system, there is a belief that healthy competition among general practitioners and hospitals is necessary. Patients are allowed to receive treatment wherever they like. There is some competition among the hospitals in a state. For example, there are special funds provided, and a mechanism called a case mix, which depends on what kind of care they provide, how many patients they see, whether they use PET and CT, and whether they have adopted new information technology, and they compete for funds in that way. Public and private hospitals all have to meet the same standards. There are incentives to do so, and penalties for failing to do so.

Matsuyama: With Nagano Kouseiren creating a regional Integrated Healthcare Network by building an advanced medical center, have any issues arisen with other public or private hospitals?

Nishizawa: There is a public hospital 4 kilometers away. We have a competitive relationship with it. We provide tertiary emergency care, while it provides secondary care. Our role is to support the community and refer treatment. Even so, we are quite competitive.

Kanno: First, regarding competition with public hospitals, we have a fully cooperative relationship with a public hospital in northern Noto. In concrete terms, we send physicians when the public hospital performs surgery. On the other hand, we could be considered rivals with a public hospital that is about a 15-minute drive away. Regional healthcare rebuilding funds are distributed to two selected medical regions, 2.5 billion yen each for a total of 5 billion yen. Most prefectures have created endowed chairs at universities, and in return the universities dispatch physicians. The result has actually been that doctors are dispatched preferentially to public hospitals.

Matsuyama: A number of the audience members suggest, "IHNs have not disseminated in Japan." However, Nagano Kouseiren is moving to build a regional vertically integrated system, and Dr. Kanno's Keiju Healthcare System, while small in scale, is already a form of IHN.

Kanno: If I may say so, it's a matter of power. When there's a powerful medical institution like Saku Central Hospital in a given medical region, it will absorb some other hospitals. Therefore, in Japan's case, prefectures could exercise leadership to advance the elimination and consolidation of municipal hospitals as a means to shift to IHNs.

Nishizawa: It's just as Dr. Kanno says. Because there are doctor shortages in various areas, hospitals that once were rivals develop cooperative relationships through the dispatch of physicians. Once personal relationships develop, collaboration on division of roles in patient care can also develop.

Kern: In the US, integration proceeded because of two driving forces that invited the collapse of healthcare. One was a reduction in the amount of dollars being paid for health care. The other was health-care powerhouses like Kaiser Permanente becoming drivers.

Matsuyama: In Japan, there are serious physician mismatches in terms of geography and specialties. Are there any policies in Australia to address uneven distribution of physicians?

Braithwaite: That's a very interesting question. Healthcare delivery in Australia is uneven. There are some hospitals that are large and have many functions, while hospitals in lightly-populated areas have very few functions. Those of us at medical schools therefore work to bring in students from such areas.

Matsuyama: Do state governments control the distribution of physicians in Australia, or do the Area Health Services do that?

Braithwaite: Generally, the Commonwealth government and state governments control medical personnel. Distribution of personnel is not handled locally by public medical corporations or Area Health Services.

Matsuyama: How are local residents involved in the placement of medical facilities and capital investment? In Japan, local residents want large hospitals to be built. Local assemblies make building hospitals into political issues. Sentara has over 100 satellite facilities. How is their distribution decided?

Kern: In the US, various methods are used to get input from local residents. For example, there are state regulations regarding capital investment above five million dollars and investment in high-tech medical equipment. The state government decides whether we can increase the number of beds, build a new wing, or purchase advanced equipment. Community and media representatives attend the board meetings of healthcare providers.

Matsuyama: Who decides the placement of facilities in Australia? Is it the state governments?

Braithwaite: If public funds are used for construction, then it's the state government. In the case of private funds, however, they use market research to decide where a good location is and what ROE they can expect and then decide on their own.

Matsuyama: We will now take questions from the audience.

Audience: I agree that it is necessary for medical institutions to cooperate on regional vertical integration in Japan as well. However, the tragedy in Japan is that medical institutions are operated by so many different parent organizations, most of which are in the public sector. As Mr. Kern described, in the US, economic incentives were the driving force. In Japan's case, there is no way that integration will take place through economic incentives. So isn't this talk just so much pie in the sky? I want to know what you think about this problem. Also, Dr. Kanno mentioned "prefectures showing leadership," but I'm against that as well. Give money to bureaucrats, and they tend to use it for the sake of the bureaucracy. Regional healthcare rebuilding funds are a case in point.

Matsuyama: I agree 100 percent with your points. However, an era in which the mechanisms of economic incentives function in Japan is coming. This is because Japan's finances are in a far riskier state than Greece's were. In the near future, the public funds flowing to public hospitals can be stopped. Japan will therefore have to vertically integrate for different reasons. Also, there are political issues. It's odd to debate whether Social Insurance hospitals should be kept or gotten rid of. If there were debate from the perspective of optimal use of their medical resources, various things would become apparent. Waiting until the country is in financial crisis and there is real collapse is a terrible thing.

Kanno: I think only the prefectures can convince mayors of municipalities to eliminate and consolidate town, city, and prefectural hospitals. I think it would be possible for prefectures to appoint administrators for eliminated and consolidated hospitals. It's true, however, that if the public sector is given this responsibility, private-sector hospitals will suffer.

Matsuyama: Moving on, I would like to ask you for some additional comments on investment in EMR.

Kern: At Sentara, we call our EMR project "eCare." It allows patients to access medical information from their own computers. Patients' physicians and medical staff can share medical information. On the hardware side, the project will cost 160 million dollars over 10 years. Including training costs and so on, the total investment will be about 280 million dollars. We calculate that our economic benefit will equal about 30 percent of the capital investment and operating costs.

Braithwaite: In Australian EMR investment, they're considering a tie-up with Microsoft's HealthVault or its rival Google. They're trying to build a system in which patients can manage their own records and health providers can be provided with the information as well. May I ask a question? Japan has achieved many things through cooperation. Japan has done so well in fields outside health; why is it unable to cooperate on health reforms?

Audience: If the transformation can be carried out with flexibility, in light of its history, I think Japan can succeed. However, transformation requires throwing out the benefits of the previous system. In that case, most stakeholders would rather keep the current system. They don't try to respond flexibly to new systems.

Matsuyama: I don't think there is any other industry in Japan where reform is lagging as much as it is in healthcare. The cause is medical management, not medical technology. In order to reform that, it will be necessary to bring some sort economic pressure. It all comes back to the biggest problem with Japan's healthcare delivery system being bad management of the national and public hospitals that are subsidized with large amounts of taxes.

Audience: In Japan, public hospitals include the National Hospital Organization, the Japanese Red Cross, Saiseikai, and Social Insurance hospitals. All of them are horizontally integrated from Hokkaido to Kyushu. In addition, there are private hospitals that account for 60 or 70 percent of beds. So the problem is how medical institutions in each region with their various functions can provide seamless healthcare. Meanwhile, it's apparent that the financial crisis means that it will be impossible for some prefectural and municipal hospitals to continue. So I'd like to suggest as a first step that Social Insurance hospitals and Employees Pension Insurance hospitals be retained and turned into an independent administrative agency called the Organization for Regional Healthcare Promotion. In short, the first step is to create a mechanism to consider healthcare management in each region.

Matsuyama: Next, I would like to exchange some opinions on cancer treatment networks. For example, Nagano Kouseiren is creating an advanced medical center. Please describe what cancer treatment is like at this point and what it will be like in the future.

Nishizawa: Japan has a system of cancer treatment center hospitals. Saku Central Hospital, which I described previously, is the only cancer treatment center for the Toshin region, which covers an area as large as Kanagawa Prefecture. Our hospital has the only specialists in the main cancers of lung cancer, liver cancer, breast cancer, and blood cancers, so those patients all come to our

hospital. The idea of clinical liaison pathways has come out, but the problem is that there are no medical institutions that we can realistically link with.

Matsuyama: Dr. Kanno, how about Ishikawa Prefecture?

Kanno: Ishikawa Prefecture is long from north to south, covering almost 300 kilometers. It's divided into four medical regions. There are four cancer treatment center hospitals in the Ishikawa Central region, where Kanazawa is located. There are no treatment center hospitals in the regions above and below. Moreover, the Noto region is 100 kilometers from Kanazawa. Its farthest point is 200 kilometers away. The problems are how to get to a cancer treatment center from there, and how to follow up afterward.

Braithwaite: In Australia, we take integration of cancer care very seriously. Cancer is also a psychological and social problem. It's an important problem for patient mental health and for their families and friends. So in Australia, we react holistically. When people are diagnosed with cancer, they are treated by their general practitioner or family doctor. They are also treated by radiologists and chemotherapy specialists and receive mental health counseling. In addition, NPOs provide various kinds of support to cancer patients as well. In other words, the treatment is not only medical.

Matsuyama: Since our theme today is economic growth, next I would like to discuss the development of healthcare personnel. In the audience, we have someone involved with developing Japanese medical management human resources at the university level, so I'd like to ask for comments on the current situation and any issues.

Audience: Regional management integration at one fell swoop would indeed be difficult. However, at a preparatory stage, aren't there projects that can be carried out cooperatively on the regional level? I think human resources development would be one. Training in the region could be done together. Medical information could also be shared. Regional alliances could be added. Shared regional purchasing is also conceivable. Integration of regional insurers is beginning. I think that is an opportunity for significant regional integration.

Kern: Sentara has a college for training nurses and medical personnel. It's efficient for Sentara to develop human resources internally, but other colleges and educational institutions provide us with personnel as well.

Matsuyama: How does Nagano Kouseiren develop staff other than doctors and nurses?

Nishizawa: Our lack of such development is our biggest issue. Currently, we have almost no HR development for medical management personnel.

Kanno: We still have some surviving textbooks that have been prepared before by the Ministry of Economy, Trade and Industry. Some people from hospital groups also make HR development programs for medical management personnel. Utilizing them is about all we do. Currently we just send employees to big hospitals to study.

Braithwaite: In Australia, we carry out training of doctors and nurses, other medical staff, and management personnel. Policy is created by the Commonwealth government.

Audience: I have a question for Mr. Braithwaite. In Australia, is where to work and what to specialize in 100 percent the doctor's decision, or does the government exercise some degree of compulsion regarding those decisions?

Braithwaite: The government attempts to exercise influence over where doctors go, but it has no power to force them, so doctors decide for themselves. At universities, we try to enroll some students from lightly-populated areas. For example, we might try to enroll a certain percentage of Aborigines, our indigenous people. Some of these people have taken up posts in lightly-populated areas after they became doctors.

Kern: There are no regulations in the US. There are lightly-populated areas and areas with doctor shortages in the US. Students from such areas can receive free tuition. In return, they are asked to work there. Academic societies also decide how many physicians they will train.

Audience: Please tell us about the salary standards for a physician's secretary or a medical secretary in the US and Australia.

Kern: Medical secretary salaries are about half what a nurse earns. On an annual basis, they earn about 25,000 to 30,000 dollars. It can't be called a high salary.

Braithwaite: In Australia, the standard wage for a medical secretary is about 70 percent of a nurse's. In the future, as electronic records spread, medical staff will handle them directly, so the people working now will no longer be needed.

Audience: Dr. Matsuyama says that public hospitals are the problem with Japan's healthcare delivery system, but in terms of numbers, there are overwhelmingly more private hospitals. Isn't arguing that public hospitals are the whole problem taking it to extremes? Also, Australia's population is about one-fifth that of Japan, but it seems to have more hospitals per capita. My impression is that that's probably because Australia is so spread-out geographically that it has many small hospitals.

Braithwaite: That's right. There are also large hospitals. They're the same size as American and European hospitals. However, there are very small hospitals in lightly-populated areas.

Matsuyama: The reason that public hospital reform is so important in Japan is that private hospitals are operated by owners. Government cannot compel for-profit hospitals with owner fundamental funds. That would infringe on their property rights. I think that in order to build soundly-managed safety net healthcare providers, we should invest more money in public hospitals. With the current system, however, much of the money would be wasted. That's why I said that we should begin by supporting places that can create Japanese-version IHN systems.

End