DEALING WITH JAPAN'S AGING SOCIETY: LESSONS FROM CONSUMERISM IN AMERICAN HEALTH CARE

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LIST OF ABBREVIATIONS

GM	General Motors Corp.
GMHI	Government-managed health insurance
HMO	Health maintenance organization
HRA	Health reimbursement account
HSA	Health savings account
JHQHC	Japan Council for Quality Health Care
JMA	Japan Medical Association
NLG	National Leisure Group
PCA	Personal care account
PPO	Preferred provider organization
SMHI	Society-managed health insurance *(kenpo)*
WBF	Wise Business Forum

ABSTRACT

The purpose of this paper is to examine the American health care system in an effort to determine how to deal with problems in its Japanese counterpart, especially with respect to a rapidly aging society.

Japan's population is aging faster than that of any other industrialized country. Citizens aged 65 or older accounted for 19 percent of the Japanese population in 2003; this figure will jump to 26 percent in 2015 (Figure 1). Medical expenditures are continuing to soar due to this phenomenon. The question of improving the medical service and health care business is of such import in Japan that it is the subject of an ongoing national debate. The medical service and health care business involves important issues that have a profound influence on the nation's economy and corporate competitiveness.

The United States is also experiencing problems with its health insurance system; in particular, there are many Americans who are uninsured. In addition, the nation's per capita health care spending is the highest in the world. But it cannot be said that the quality of American health care reflects the costs. In general, the American health care system is believed to be an example of failure. For the purposes of comparison, Figure 2 shows the health expenditures and the healthy life expectancies of some countries. ("Healthy life expectancy" is different from "life expectancy." "Healthy life expectancy" refers to the age to which a person can expect to live a healthy and relatively active life.)

At first blush, the Japanese health care system looks very different from that of the United States. On the whole, however, because of its egalitarianism, the Japanese health care system seems to be somewhat better than that of the United States. All Japanese people are insured under the public system. In addition, the health care costs are low compared with other industrialized countries.

I believe, though, that careful study of the current status and the future of the medical service and health care business in the United States, including health insurance, may prove extremely useful in creating a system and business structure that can help resolve problems in Japan. The reason for this is because Japan and the United States have a common problem, i.e., a lack of consumerism in health care. As health care consumers, most people are not very conscious of costs or quality. In the health care field, it is very difficult for patients, namely consumers, to check and control costs and quality, mainly because there is third-party insurance between the consumers and the health care providers.

In the United States, many ongoing efforts are aimed at encouraging consumers to check and control health care costs and quality. This movement is often described as "consumer-driven health care." The medical service and health care business that is related to consumer-driven strategies has been expanding more rapidly in the United States than in Japan. Thus, the American experience in this matter has a good deal to teach Japan and deserves attention.

This paper first examines the characteristics of the American health care system with a focus on problems related to health care delivery and increasing national health care costs.

This will be followed by an outline of Japanese health care.

Third, the paper will explore the fact that, although there are certain differences between American and Japanese health care, there is also a common problem, i.e., the lack of consumerism. In short, people in both countries tend to be unconscious of cost and quality, mainly because of the health insurance system, which divides people into health care consumers and health care suppliers. Thus, in this area, the usual market mechanism is not seen. As a result, people need to be persuaded to be conscious consumers of health care in order to control costs and quality.

Finally, this paper describes various attempts to encourage consumerism in American health care. These efforts are not perfect yet, but their dynamism would be useful in finding clues to solving Japan’s problems in this regard. Some similar Japanese attempts are also mentioned.

INTRODUCTION

"They [health systems] have contributed enormously to better health, but their contribution could be greater still.… Failure to achieve that potential is due more to systemic failings than to technical limitations. It is therefore urgent to assess current performance and to judge how health systems can reach potential."[1]

Assuming that universal coverage, freedom of choice, a simple system, lower costs, and a healthy population are the goals for a national health care system, it is difficult to say that the United States has achieved them.

General Motors Corp. (GM), the world largest automaker, is suffering from a heavy "illness," namely rising health care costs. The company says that it spent $4.8 billion or almost $4,000 per employee for health care benefits in 2003. GM has set out to achieve a $10-a-share profit by mid-decade, but this looks impossible due to surging health care as well as pension costs.[2]

There is more obvious evidence that American companies are worrying about the burden of heavy health care spending. Some companies are trying to not to hire "non-healthy" people. Union Pacific Corp., for example, has started a pilot program in seven states not to hire smokers. They consider smokers to be potentially high-health-care-cost employees. General Mills Inc. imposes a smokers' surcharge of $20 per month on their health premiums. According to Mercer Human Resource Consulting, employers consider smoking to be one of the main causes of high health care fees, along with obesity and chronic conditions like diabetes, heart disease, cancer, and so on. Recently, many companies have attempted to get employees to improve their health

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[1] *World Health Report* 2000.

[2] "GM Retreats From $10-a-Share Earnings Goal," *Wall Street Journal* 16 November 2004.

by encouraging them to change their lifestyle or to exercise. But now, some companies are implementing more drastic measures.[3]

Health insurance premiums paid by U.S. employers are continuing to rise rapidly. According to a survey by the Kaiser Family Foundation, the increase was almost 14 percent in 2003. Before 1996, the rate was declining because of the spread of managed care. Managed care type health plans restricted employees' freedom of choice as to their medical providers and could reduce health care costs. But these plans were not accepted by many doctors, and employers had to loosen their restrictions on choice. Therefore, health insurance spending by employers has returned to double-digit growth again.[4] In another Mercer survey of more than 3,000 employers, total health care costs per employee, which included all medical, dental, and other health benefits, rose to $6,679 in 2004 from $6,215 in the previous year, an increase of 7.5 percent.[5] *OECD Health Data 2004* shows that American health expenditures accounted for 14.6 percent of the GDP in 2002 and that, during the same year, the per capita expenditure was $5,267 at that time. Both figures were the highest in the world by an overwhelming margin.[6]

Although Japanese health care spending was about 7.8 percent of the GDP in 2001 and is relatively low compared to most other industrialized countries, the cost is increasing at a brisk pace. According to the Ministry of Health, Labor and Welfare, the cost of Japanese health care rose 3.2 percent to more than ¥31 trillion (about $300 billion) in fiscal 2001 (Figure 3).[7] A 2002

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[3]Bernard Wysocki Jr., "Companies Get Tough With Smokers, Obese, to Trim Costs," *Wall Street Journal* 12 October 2004.

[4]Survey by Kaiser Family Foundation.

[5]Survey by Mercer Human Resource Consulting.

[6]OECD Health Data 2004.

[7]The Ministry of Health, Labor and Welfare, Japan.

survey by Nippon Keidanren, one of the three major business organizations in Japan, showed that the per-employee expenditure has risen 0.9 percent to ¥96,755 (about $920) per month on average. This includes not only health care, but also pension costs.[8] Many companies insist that the burden of social security is becoming increasingly heavier and that this has an adverse effect on the competitiveness of Japanese enterprises. The case of GM should not be overlooked, and such circumstances should not be put off as of no concern to Japan.

Nor should the quality of health care be underestimated. Poor-quality health care is not valuable for anyone, even if it is cheap. Thus, both the cost and quality of health care must be taken into account.

In Japan, the health care system has been a major target of deregulation and social reform. It is said that doctors prescribe too many medications, patients' rights are underdeveloped, and that there are insufficient incentives for providing top-quality health care. In Japanese health care, paternalism has penetrated into people's minds; they tend to be willing to go along with what their doctors say without sufficient explanation. We cannot afford to ignore the problems in this area and must consider how to create an improved health care system. We have to seek a system as well a new type of health care business that best meets the country's needs. Consumerism in health care is needed in Japan too.

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[8]2002 Survey by Nippon Keidanren.

CHAPTER 1

CHARACTERISTICS OF THE AMERICAN SYSTEM

First, the characteristics of American health care system should be described.

Cost

American health care spending rose 9.2 percent annually between 1980 and 2001. It is said that, by 2011, the expenditures will reach $2.8 trillion, or 17 percent of the GDP. The main reason for this is the aging of the American population. In 2011, the baby-boomers will begin to reach age 65. This will bring the number of Americans over age 65 to an estimated 40.4 million, or 13 percent of the nation's population.[9]

In 2002, total American medical spending on health care was $1.6 trillion, or 14.9 percent of the GDP (Figure 4). John Creighton Campbell, a Professor of Political Science at the University of Michigan, and Naoki Ikegami, Professor and Chair of the Department of Health Policy and Management at Keio University School of Medicine, point out that American hospitals are well organized for making money and that this is one reason why health care costs are very high in the United States. According to the two authors: "Entrepreneurial coalitions of highly trained managers and savvy physicians alertly searched out every opportunity to maximize the revenues that brought them more money or power."[10]

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[9]The Ministry of Health, Labor and Welfare, Japan.

[10]John Creighton Campbell and Naoki Ikegami, *The Art of Balance in Health Policy: Maintaining Japan's Low-Cost, Egalitarian System* (Cambridge, U.K.: Cambridge University Press, 1998) 53.

Providers

In 2000, there were 5,810 hospitals in the United States. Of these, 52 percent were non-profit, 20 percent state and local government owned, 13 percent for profit, and 4 percent federal. In 2002, there were 2.4 practicing physicians per 1,000 population, while that of practicing nurses was 7.9.[11]

As for the quality of health care, American hospitals have considerable room for improvement. The Leapfrog Group, a coalition of large employers looking to contain health care costs by reducing medical errors, released the results of its first Hospital Quality and Safety Survey in November 2004. It showed that only 21 percent of American hospitals are fully compliant with the 27 safety practices developed by the National Quality Forum.[12]

Payers

In general, American health care expenses are paid by one or some combination of individuals, employers, indemnity insurers, managed care organizations, and the government. The costs for around 45 million people who are not insured are paid through some combination of charitable care and out-of-pocket payments.

Employers provided about 177 million employees with medical coverage in 2001. As for private insurers, managed care organizations should be noted. Their enrollees agree to limit their care to specific doctors and hospitals in exchange for reduced costs. In 2001, 93 percent of insured Americans were enrolled in managed care plans, up from 54 percent in 1993.[13]

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[11]OECD Health Data 2004.

[12]Laura Landro, "Hospitals Make Fewer Errors, But Fall Short on Safety Goals," *Wall Street Journal* 17 November 2004.

[13]Survey by Kaiser Family Foundation.

CHAPTER 2

CHARACTERISTICS OF THE JAPANESE SYSTEM

The characteristics of the Japanese health care system will be considered next.

Cost

Japanese health care spending reached ¥31.3 trillion, or 7.8 percent of the GDP, in fiscal 2001. Just over 49 percent of the spending is used for people aged 65 and older. Health care costs are expected to rise continuously along with the aging of the Japanese society. Health care spending per person rose to ¥246,100 in fiscal 2001 from ¥239,200 in fiscal 2000. It can be said, however, that Japanese health care costs are relatively low by world standards.[14]

It is very difficult to provide a simple explanation of why this is the case. This is because there are so many interrelated factors. One major reason, though, may be the national fee schedule, which lists all the procedures and products of health care. It is mandatory for all goods and services. This single standard applies to all patients and providers. It is revised every two years after negotiations between payers and providers. The fee schedule is used to control prices and influence providers' behavior. In general, the fee schedule has been making inexpensive outpatient primary care relatively profitable, and, in order to hold down health care costs, makes expensive high-tech medical care unprofitable. Administrative costs are also low because all negotiations are done at the national level in advance, and a common format is used for billing purposes.

That the Japanese people are "health-conscious" might be another explanation. Japanese tend to be willing to take medication at the first sign of illness, and they visit doctors much more

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[14]Survey by the Ministry of Health, Labor and Welfare, Japan.

frequently than Americans do. In addition, mass health screening is very popular. It is provided at school, work, and so on. It is useful to detect an illness before it becomes serious. As a result, costs for treatments and drugs can be kept lower.

Providers

According to a survey by the Ministry of Health, Labor and Welfare, in 2002, there were 9,187 hospitals in Japan. Private non-profit corporations called *iryo-hojin* operated more than half of them. Doctors and the public sector managed most of the rest. For-profit organizations are not allowed to operate hospitals because of regulations. A study by the Japan Hospital Association shows that 66.1 percent of about 1,200 hospitals it surveyed were in the red. There are also about 90,000 small clinics in Japan. In 2002, the number of practicing physicians per 1,000 population was 2.0 and that of practicing nurses was 8.2.[15]

Private-sector hospitals are owned by doctors as their personal property or a non-profit corporation. In many cases, private-sector hospitals are operated as family businesses. Doctors who have not received any managerial training usually manage Japanese hospitals. Although the hospitals are taxed in the same way as for-profit companies, their capital investment has to be financed by debt or from accumulated revenues.

For-profit hospitals are legally prohibited. In addition, hospitals cannot advertise anything but their clinical specialties, location, office hours, and similar information. Although it is permissible to advertise some items and services, many restrictions preventing the commercialization of health care remain. The Japan Medical Association (JMA), dominated by private practice physicians, has opposed deregulation. The JMA insists that if for-profit

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[15]OECD Health Data 2004.

companies entered the field of health care services, they would focus only on profitable treatments and patients and that the quality of health care would be hurt. On the other hand, it is widely believed that the JMA tries to protect its members' interests by minimizing competition.

Payers

Japan has a universal health insurance system, founded in 1961, under which all Japanese people are insured. Public insurers pay health care providers for their services. The prices are based on the national fee schedule that has been described above. Japanese people can go to any hospital or doctor they like without any differences in cost. Wherever they go, the price is the same, if the treatments and drugs they receive are the same. Co-payments, which patients have to pay for treatments including prescription drugs, are charged for everything. The co-payment rate is usually 30 percent of the total cost. The rest is covered by health insurance. This is one reason why the Japanese health care system is regarded as egalitarian.

Public health insurance is non-profit and classified roughly into two large groups, that is, national health insurance and health insurance for salaried workers. There are two kinds of health insurance for salaried workers. One is health insurance managed by societies (society-managed health insurance, or SMHI, often called *kenpo*), and the other is government-managed health insurance (GMHI, often called *seikan kenpo*). An SMHI is founded by a large company for employees and their families' health benefits. There are now about 1,600 SMHIs in Japan, and some 31 million people are covered by this type of insurance. In general, employers and employees go halves on the premiums. SMHIs also bear the costs of health care for the elderly.

The burden is becoming heavier: 43.2 percent of about 1,600 SMHIs were in the red in fiscal 2003.[16]

GMHIs cover about 36 million people, namely, employees of small companies and their families. It is a single pool administered at the national level. Premiums are shared equally between employers and employees. It is predicted that, in 2007, this will go into the red as well because of the cost burden of health care for the elderly.[17]

National health insurance (often called *kokuho*) covers non-employees, such as self-employed individuals and retirees. It consists of around 3,200 insurance pools at the city, town, and village level.[18]

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[16]Survey by the Federation of Health Insurance Societies (Kenporen).

[17]"Restructuring GMHIs," *The Nihon Keizai Shinbun* 24 January 2005.

[18]"Restructuring."

CHAPTER 3

COMMON PROBLEMS BETWEEN THE UNITED STATES AND JAPAN

As this paper has indicated, there are many differences between the American and Japanese health care systems.

It seems that the Japanese system is excellent. It keeps the national health care costs lower than in other industrialized countries. Although these costs are increasing as the society ages, the percentage of the GDP is still relatively low on a worldwide scale. Besides, it has produced a population that is number one in the world in terms of high life expectancy and low infant mortality.

On the other hand, the cost of American health care is very high as compared to other industrialized countries. In 2002, the cost reached $1.6 trillion. In addition, it is believed that about 45 million Americans do not have health insurance.[19] Besides, although the United States spends quite a bit of money on health, it ranks behind many developed countries in bottom-line measures such as life expectancy. Because of these and other problems, health care reform was one of the most important issues in the past presidential election.

So, can anything be learned from the United States about health care? I believe the answer to this question is yes.

There is a common problem between Japanese and American health care, i.e., the need for efficiency. In health care, efficiency means not only keeping costs low, but also keeping quality high. Even if the service is cheap, poor quality can never satisfy the people who pay for it. The lack of consumerism is also a major problem shared by the United States and Japan. As health care consumer, people in both countries tend to forget to check the cost and quality of

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[19]Lucette Lagnado "Forgoing Insurance, Mr. Selby Bargains For His Health Care," *Wall Street Journal* 24 November 2004.

health care, so the mechanism of consumerism does not work efficiently in the health care industry.

In Japan, thanks to the health insurance system, people have the freedom to choose and go to hospitals and clinics as they like, even when they have a slight cold. They have easy access to medical services. It is very convenient and valuable, but there are also "side effects" of this system. Japanese people tend to forget cost and quality. Of course, they pay premiums for their insurance. But it is doubtful that many people know the exact amount of money they pay in premiums every month. Further, Japanese hospitals are not clearly differentiated from one other, and people tend to rush to larger hospitals, believing that they can provide more sophisticated services than their smaller counterparts. But actually, patients have to wait in a crowded waiting room for a very long time to see a doctor. "Wait for three hours, be seen for three minutes" is a common expression. The tendency of people to flock to large hospitals may not only lower quality, but also raise costs; this is because large hospitals tend to order more diagnostic tests and other procedures than small hospitals and private practitioners.

Regina E. Herzlinger, a Professor at Harvard Business School, points out: "There is no consumer in most of the health care system. Instead, a third party, a government, or an insurance company, pays for the services. As a result, the users do not know the costs of the services they use, and the payers do not know how the users feel about them. Little wonder that the costs of the system are a mess!"[20] The lack of consumerism, which would monitor the efficiency of health care, is a common problem in both Japan and the United States.

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[20]Regina E. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, MA: Perseus Books, 1997) 250.

It is also said that health care is the only sector in the economy where there is almost no price transparency or consumer price competition. Patients usually do not know how much medical tests, doctor visits, and prescription drugs actually cost. In most cases, individuals covered by employer plans are only responsible for only a small co-payment; thus, they have little incentive to reduce the costs. Needless to say, insurance is one of the most important mechanisms by which we can prevent exposing ourselves to the risk of high out-of-pocket payments. So we have to use insurance more carefully. Patients generally have to depend on providers to determine how much care they need and, to date, have no reliable way to measure quality. We must have adequate information about health care in order to behave as smart consumers.

The most important development to date is charging people with the responsibility for their own health care services. In the United States, the idea of "consumer-driven health care" is becoming a key to try to solve these problems. In a normal economy, people buy only good cars, PCs, clothes, services, and so on. Providers that cannot supply good prices and quality products will lose out and ultimately vanish in the market. The same mechanism is needed in health care.

According to studies by Campbell and Ikegemi, Japanese health care has done far better with respect to cost and access than the United States, while Americans can buy higher-quality services such as more comfortable hospitals, modern equipment, and well-trained physicians.[21] It is very difficult to maintain both low costs and high quality, but encouraging consumers to be in charge of their own health care might help solve this problem. The reason for this is because consumers essentially call for lower-cost and higher-quality services.

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[21] Campbell and Ikegami 215.

CHAPTER 4

CONSUMER-DRIVEN MOVEMENTS IN THE UNITED STATES

In the United States, there have been many efforts aimed at helping people to check and raise the efficiency of health care services. I think this is because health care problems there are very serious. In this regard, the most noteworthy concept is that of consumer-driven health care.

The core of consumer-driven health care is making people aware of the cost of the health care they actually use by showing them and making them take more responsibility. Once they are conscious of the spending, they will tend to choose the less expensive options. Besides, people can take better care of themselves if they know that bad habits mean more money. A wise consumer of health care will be able to be smarter.

According to President George W. Bush "… there's a systemic problem. Health care costs are on the rise because the consumers are not involved in the decision-making process. Most health costs are covered by third parties. And therefore, the actual user of health care is not the purchaser of health care. And there's no market forces involved with health care…"[22]

The federal government is trying to encourage this new trend to consumer-driven health care. President Bush is promoting health savings accounts (HSAs). The basic idea here is to turn medical care into a service that consumers buy like any other. By scaling back the third-party payment system and giving people a stake in controlling health care costs, he aims at restraining the increase of health care spending. HSAs were created in December 2003 as part of federal legislation that restructured Medicare. They became effective in January 2004. President Bush insists that HSAs place people in charge of their own health care and that people own the plan.[23]

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[22]Third Presidential Debate, 2004.

[23]David Gratzer, "HSA Man vs. Healthzilla," *Wall Street Journal* 12 October 2004.

HSAs are personal savings accounts that are used in conjunction with high-deductible health insurance policies. They allow the individuals purchasing coverage with a high-deductible – a minimum of $1,000 for an individual or $2,000 for a family – to make tax-free contributions into a savings account for future medical expenses. The annual tax-free contributions can be no more than the deductible, up to a maximum of $2,600 for an individual and $5,150 for a family. The contributions are not taxed; nor are withdrawals for health care expenses. For example, in the case of a plan with a $1,500 deductible, you must pay the first $1,500 of your health care costs. Once you do so, regular insurance kicks in. Insurance typically covers 80 percent of health expenditures, while the policyholder pays 20 percent. Finally, when an annual out-of-pocket maximum is reached, the insurance policy will cover all costs. HSA plans are needed to have maximum out-of-pocket spending limits. The limits are $5,000 for an individual and $10,000 for a family. Furthermore, HSAs can be invested in stocks, bonds, or mutual funds. The unused money rolls over each year and is owned by the individual. Most HSA plans allow people to obtain certain preventive care, such as annual checkups, for free.

Employers can offer HSA plans to their employees, or individuals can purchase them on their own. HSAs are portable from one job to another.

It is said that, under HSA plans, people have incentives to keep their health care expenses as low as possible because they can save the money they do not spend. They will shop around for a less expensive pharmacy, look for generic or cheaper brand-name drugs, ask if medical tests are necessary, and avoid costly emergency room visits for minor ailments. People will demand to know how much things cost, insist on the best value, and avoid unnecessary expenses.

According to America's Health Insurance Plans, an insurance industry trade association, as of September 2004, around 438,000 Americans were covered by insurance accompanied by HSAs. About 91,500 individuals with HSA-eligible policies got them through their employers.

Mercer Human Resource Consulting says that 73 percent of U.S. employers are likely to offer HSAs by 2006. And Bush has made sure that HSAs will be an option for federal employees this year.[24]

One of the nation's largest health care providers, Aetna, which offers a consumer-driven health plan called HealthFund with incentives similar to HSAs, says that, in 2003, costs in the consumer-driven plan went up 3.7 percent compared to a 16.2 percent increase for a similar patient population in traditional insurance plans. The individuals in HealthFund used the emergency room less, switched more quickly to generic drugs, and took greater ownership of their own health care by checking prices and medical information through the company's Web-based resources.[25]

When we look back at history, however, American health care has traditionally headed in the opposite direction from a consumer-driven strategy.

In the United States, the real growth in total health care spending slowed down to 2.4 percent a year between 1993 and 1999. It is said that health maintenance organizations (HMOs) worked well as a health insurance system that could control health care spending. Many Americans joined the system. Between 1988 and 2000, membership in managed care plans rose from 27 percent to 92 percent of workers with health coverage through their employers (Figure 5). But a number of problems gradually began to appear. Physicians claimed that there were too many restrictions on treatment options. Patients complained too. They insisted that they had no choice of physicians and were sometimes denied care. By the 1990s, preferred provider

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[24] Andy Laperriere "HSAs Are A-OK" *Wall Street Journal* 24 January 2005.

[25] Laperriere.

organizations (PPOs), which had fewer restrictions than HMOs, started to be more popular. Managed care was going in the opposite direction from consumer-driven health care.[26]

Definity Health, based in Minneapolis, is one of the most aggressive companies leading the new consumer-driven impetus in health care in the United States. It was founded in 1998 and insists that it has left the managed care principles of restrictions and embraced the power of freedom. They explain that the concept is that health care consumers are given direct access to their money and the freedom to choose services that suit their needs.

Definity has three main consumer-driven solutions: health reimbursement accounts (HRAs), HSAs, and PPOs. They all focus on consumerism in health care. Definity's plans are quite different from traditional managed-care-type health plans. The HRA program offers members the opportunity to use money provided by the employer as if it is their own. The plan consists of four components. First, a personal care account (PCA) is funded by employers at a set amount each year, on a pre-tax basis. Employees can access this account first and use the money to pay for medical and pharmacy services. Money remaining in the account at the end of the year is rolled over to the next year and can be used to cover medical costs in the future. This is an incentive for employees to save the money in the PCA.

Member responsibility is the second component. If all the money in the PCA is used, employees have to pay some out-of-pocket costs. The cost is called member responsibility. PCA rollovers can offset this cost, so it provides another incentive to save PCA money.

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[26]"Treating the Symptoms," *The Economist* 15 July 2004.

The third component is health coverage. Once employees meet the provision of member responsibility, the program pays all remaining costs. That is, if an employee's annual health care costs exceed the PCA benefit dollars, health coverage is provided once a deductible is met.

Finally, preventive care is also an important component of the program. Preventive care is typically completely covered; the cost is never deducted from the PCA. Employees can get information about providers, pricing, and so on.

In order to support and engage employees as they become more involved with their health care decision-making, Definity also provides extensive tools and information by phone and on the Web. The information includes medical and drug pricing, a consumer medical library, hospital quality ratings, and so on, which help employees exercise greater choice and be more involved with their health care decisions. Health coaches are available around the clock on the phone and online.

Definity is pushing to improve the performance of the health care system by permitting and stimulating employees to be more conscious of how they use it. It offers employees comprehensive choices and encourages them to be responsible when they make decisions on the health care service they get.

Definity's customers are many national, self-insured employers, including BellSouth, CVS Pharmacy, Amazon.com, Coors, Medtronic, BASF, Siemens, and Wells Fargo. On January 1, 2005, Definity had about 500,000 members in all 50 states. The company says that more than 95 percent of its members re-enrolled for 2003 and 2004.[27]

According to *Business Insurance,* a publication of Crain Communications Inc., National Leisure Group (NLG), a Boston-based travel agency, faced a rate increase of around 35 percent

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[27]Definity, Website.

for its PPO plan in 2003 and decided to switch to a consumer-driven health plan offered by Definity. Eighty percent of the company's 1,250 employees joined, and NLG is succeeding in reducing health care spending.

NLG contributes $1,000 to the employee's PCA in the case of single coverage. The employee has a $500 deductible once all the funds in the PCA are used. For family coverage, NLG pays $2,000 to the PCA, and the deductible is $1,000. Under the plan, the rate of increase in health care costs was only 8 percent in 2004. The company said that it is "very pleased with the results." For instance, 60 percent of the employees stayed within the limitation of their accounts and, therefore, did not have any out-of pocket expenses.[28]

According to Definity, the approximately 50 large clients that also used Definity's plans are expected to see average increases in health care costs of only about 3.6 percent in 2004. If this were compared to an average industry trend of about 14 percent, total savings for 2004 would amount to more than $18 million.[29]

An article in *Employee Benefit News* on April 1, 2004 presented another interesting example. Wise Business Forms (WBF), a manufacturer of traditional business forms and digital print-related products and services for resale, had a self-funded co-pay PPO plan. When the 2001 renewal contract included a proposed 35 percent increase, the company decided to switch to Definity and a consumer-driven health plan. With the previous PPO plan, the total average annual claim paid per employee was $4,346. In the consumer-driven plans in 2002, on the other hand, the costs decreased 13.3 percent to $3,772. In 2003, the costs were reduced by another 8

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[28]"Consumerism Brings Savings, Member Satisfaction," *Business Insurance* 28 June 2004.

[29]Definity.

percent to $3,475. The company, employing approximately 500 associates, has experienced a total decrease of 21.2 percent in health care costs since it adopted the consumer-driven plan.[30]

Some employees, however, are dissatisfied with such plans. Those with long-term conditions like diabetes and asthma, in particular, are concerned because they feel that more of the costs are being shifted onto them by their employers. Critics insist that only the healthy and the wealthy can take advantage of consumer-driven health plans. Low-income families using a great deal of health care could run into high out-of-pocket costs, especially if their employers set the deductible bar high. If more of the wealthy and the healthy go to consumer-driven plans, the poorer in wealth and health will have to pay more than now, critics point out.

A January 2005 report by the Washington-based consulting firm Watson Wyatt Worldwide found that more than 50 percent of about 1,000 individuals who were surveyed felt that the high deductibles associated with HSAs were extremely undesirable, and around two-thirds said the same about full payment for prescription drugs before meeting the deductible.[31] It is undeniable, then, that there are some complaints from both employers and employees. But eHealthInsurance, a web-based company that helps individuals and small businesses to select, purchase, and manage their health care benefits, found that a third of HSA policies sold through its website have been to the previously uninsured.[32] Thus, it is equally undeniable that consumer-driven plans can help the uninsured to have health care options.

There are also consumer-driven efforts as well as effects in various other areas. Today, most patients accept their doctor's treatment suggestions, drug recommendations, and specialist

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[30]Tony Cannata, "Georgia Printer's CDH Plan Reduces Claims Costs by 21 Percent." *Employee Benefit News* 1 April 2004.

[31]2005 survey by Watson Wyatt Worldwide.

[32]Gratzer.

referrals without question. Consumer-driven health care will inevitably shift decision-making away from employers and insurance companies to patients. So, needless to say, information about the cost and quality of health care is becoming more and more important for people if they are to make wise decisions. They cannot be wise consumers if they do not know a good deal about the price and quality of the medical services they use.

In the United States, hospitals maintain that their voluminous fee schedules, called chargemasters, are tantamount to trade secrets and have tried to hide them from the public eye. But California has begun to publish this data.

A new law in California, which went into effect in 2004, gives hospitals there a mandate to open up their chargemasters, which list prices for medical goods and services, from drugs and rooms to bandages, X-rays, and CT scans. Under the law, anyone can go to a hospital and ask to see its price list. It is also possible to see some of these lists online.

According to a survey of seven hospitals by *The Wall Street Journal*, one of the most dramatic price differences is seen in blood tests, which usually consist of 14 analyses that look for abnormalities in the liver and kidneys, as well as checking blood sugar and other measures of health. The "comprehensive metabolic panel" test is $97 at a public hospital in San Francisco, but at a hospital in Modesto, which is owned by a for-profit chain, the price is $1,732.95 or more than 17 times greater. As for a 325-milligram tablet of Tylenol, or its generic version, acetaminophen, the public hospital in San Francisco charges $5.50, while another in Los Angeles hospital charges 12 cents. At some hospitals, the drug is free. By way of comparison, the retail price of Tylenol is eight to nine cents per pill.[33]

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[33]"California Hospitals Open Books, Showing Huge Price Differences," *Wall Street Journal* 27 December 2004

Every hospital uses a different set of formulas to decide how much it will charge patients. This is the main reason why there are surprising price differences among hospitals. For example, at one non-profit hospital in Sacramento, medicines bought for under $40 are sold at a list price that is 13.5 times the wholesale cost. For medicines that cost the hospital more than $40 but less than $100 wholesale, the formula is 7.5 times cost. The mark-ups are lower for outpatients because the fees do not include overhead costs related to overnight stays. Regional factors like labor costs and real estate seems to affect price differences among hospitals too.

In the past, hospitals were honest about pricing because whether or not they got paid could depend on both the government and the insurers paying what they were billed. Although they had mark-up formulas, they only added a small profit on top of costs. Since the 1980's, however, this situation has changed. The federal Medicare program announced that, in most cases, it would pay hospitals only a flat rate for specific treatments. Besides, with HMOs gaining power in the 1990's, hospitals had to give steep discounts off retail prices. Hospitals began to mark up the prices of various goods and services in order to survive. Hospitals did not know how much their rivals charged because of antitrust restrictions. Eventually, great price differences arose. Even so, the California law does not ask the hospitals to explain how they arrived at a given price.

For a long time, patients did not know how much they were racking up in medical costs until they received a bill. California's new law is designed to make it easy for patients to know how much certain services cost. Those who supported the law insist that the price information can help people compare prices and shop around for the best services before they decide which to "buy." Others also say that the information will be useful to ascertain why health care costs are rising so rapidly. Some critics insist that the chargemasters will not help consumers. Actually, there seem to be few patients, except the uninsured, who pay the list prices. Hospitals negotiate

various lower prices with many insurers and do not have to inform the public about the prices they actually charge them. But the new law could be a key to forcing hospitals to disclose more detailed information and to make more rational price lists. So it is possible to regard this law as a first step on the road to consumerism in health care.

Medicare's website has also started to provide price information. People can compare prices of similar drugs for five common conditions: high cholesterol, high blood pressure, allergies, arthritis, and stomach ailments. Although the prices are only applicable to seniors using Medicare drug-discount cards, officials say people not in Medicare or the drug-card program can also look up prices so they can consider switching to cheaper alternatives to save money. The expectation is that encouraging people to be better consumers will cause price competition among drug makers.

Needless to say, information on health care – quality as well as price information – is very important for patients. Such information helps consumers choose good providers and pushes providers to raise the quality of health care.

The state of Minnesota recently issued a report card in order both to provide patients with information about medical errors at individual hospitals in the state and to encourage those hospitals to prevent such mistakes in the future. The first report described the mistakes, including 21 preventable patient deaths, reported by 139 hospitals in the state. According to the report, there were also three preventable patient disabilities, 13 operations on the wrong body part, and one operation on the wrong patient. Minnesota is the first state to disclose such detailed data about individual hospitals. The Minnesota reports are available to the public through the Internet.[34]

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[34]"First State Hospital Report Card Is Issued," *Wall Street Journal* 20 January 2005.

Although most hospitals are reluctant to disclose this kind of data because they fear that lawsuits will increase and they will lose public confidence, some hospitals are taking a positive slant on the matter and have started disclosing such information in an effort to improve services.

In order to keep patients from falling, for example, Fairview Health Services, a non-profit network of seven hospitals, puts yellow bands on the wrists of patients who have had surgery or are on medications that might cause them to fall. One executive of a Minneapolis-based hospital says: "If you report, you can learn and then you can fix."[35] Thus, disclosure of medical mistakes could be an effective trigger for winning public confidence.

The Leapfrog Group evaluates hospitals on safety measures, such as using procedures that prevent medical mistakes. Leapfrog rates hospitals according to three safety standards: computerizing drug prescriptions, putting intensive care under specialist management, and concentrating high-risk procedures in hospitals with a sufficient volume of work to develop the necessary expertise. People can sign up at the website of The Institute for Safe Medication Practice for its safe-medicine newsletter, which urges people to become active partners with their doctors in preventing medication errors.

Pay-for-performance programs, bonus plans that reward primary-care doctors for following "best practices," are typical of efforts that try to provide higher-quality services at a lower cost. In California, six health plans participate in the largest program, which analyzes data from patient encounters with 45,000 doctors. They pay bonuses to doctors who push preventive care and follow-up on patients. They hope it could save a great deal of money and prevent unnecessary hospitalizations. The Centers for Medicare and Medicaid Services have also launched some pilot programs to reward doctors for providing quality care and investing in new

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[35] "First State Hospital Report Card."

technology to better track patients. It predicts that, in the next five to 10 years, pay-for-performance compensation could account for 20 to 30 percent of what the federal program pays health care providers.[36]

Some doctors say that pay-for-performance programs do not take into account specific risks of individual patients. Most ratings depend primarily on claims data or the coded invoices doctors submit for reimbursement, but it is said that the data do not always reflect an individual patient's risks. Early evidence shows, however, that financial incentives can work to raise the quality of care. The Hawaii Medical Service Association, the largest health plan in the state, found that, in 1997, ACE inhibitors, which heart-failure patients should use, were being prescribed in only 40.8 percent of cases. After a bonus program was introduced, this figure rose to 64.2 percent. At the same time, the important test for diabetics known as glycosylated hemoglobin was being given to only 51.5 percent of patients. After the incentive plan was started, this number rose to 79.6 percent by 2000.[37] PacifiCare Health Systems Inc, a health plan in California, started its own quality report in 1998. The report showed how its doctors scored on 16 measures. After three years, doctors showed improvements of about 5 percent without any bonuses being offered. But after the plan started to give bonuses, the improvement in 12 of 16 measures averaged 34 percent.[38]

The case of Quad/Graphics, one of America's largest printing companies, is an example of health care for consumers. Quad, headquartered in Sussex, WI, and established in 1971, has its own medical facilities and staff to care for its 12,000 employees and their families. About 80

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[36]"To Get Doctors to Do Better, Health Plans Try Cash Bonuses," *The Wall Street Journal* 17 September 2004.

[37]"To Get Doctors to Do Better."

[38]Vanessa Fuhrmans, "One Cure for High Health Costs: In-House Clinics at Companies," *The Wall Street Journal* 11 February 2005.

percent of them use the company's clinics as their main source of primary care and other common services like prenatal and skin care. In 2004, 60,500 patients visits were made to these facilities.

Quad opened its first clinic in 1990 because their employees were constantly complaining about medical claims and doctors' appointments. In addition, the health care costs of the company were rising. Therefore, Quad decided to provide most of the necessary care on its own. Since then, it has expanded the scope of its care. It employs its own internists, pediatricians, and family doctors. It also operates its own laboratory, pharmacy, and rehabilitation center, and contracts directly with local hospitals and specialists for advanced care. There are 26 doctors in all at the clinic, and their bonuses are tied to patient evaluations and health outcomes. Employees pay $5 per visit.

The company spent about $6,000 per employee on medical costs in 2004. That was 30 percent less than the average company in Wisconsin. Quad's health care costs have risen less than 5 percent annually over the past five years.

There seem to be several reasons why Quad can hold down its health care costs. One might be that Quad spends more on primary care. In 2003, it spent 13 percent of its total health care costs on primary care, while average employers spent only 5 percent. Quad's approach helped employees and their families avoid having to obtain services from high-priced specialists and hospitals. In 2003, Quad spent an average of $1,540 per employee on hospital costs, compared with a local average of $2,250.[39]

The consumer-driven health care movement also provides opportunities to start new businesses. MinuteClinic Inc, based in Minneapolis, is providing a new type of service with

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[39]Fuhrmans.

direct-to-consumer marketing that promises not only care, but also convenience and relatively low prices.

MinuteClinic's convenient "mini-medical offices" are designed to treat a limited set of common family ailments such as ear, bladder and sinus infections, as well as strep throat. MinuteClinic now has 13 such offices. They are cropping up in Target and Cub Foods stores in the Minneapolis-St. Paul area. The offices have nurse practitioners and physician assistants who hold master's degrees. Such medical professionals can diagnose and treat common illnesses and minor injuries, prescribe medication when necessary, perform physical assessment and examinations, counsel and teach health and nutrition, screen and refer patients to specialists and other health care providers, and offer education to allow patients to make decisions about their health care. All of these locations have a doctor available by phone during business hours. Patients do not have to make an appointment. If a nurse practitioner is busy, a patient can get a beeper and do errands until paged. Affordable treatments range from $25 to $78. Steve Pontius, a founder of MinuteClinic, says: "We thought, if we could find a way to deliver the service quickly and conveniently, that people would be willing to pay for that." Since its inception, the company has treated 165,000 patients.

Some physicians insist that patients often go to the emergency room complaining of a minor illness that turns out to be more serious. But some nursing experts say that nurse practitioners are certainly qualified to deal with conditions presented at a quick clinic. MinuteClinic has a computer system, which takes note of patients who come back repeatedly with the same complaint. Based on this information, nurse practitioners can recommend that patients to go to their regular doctors. MinuteClinic also has clearly defined rules that nurse practitioners have to follow. It invested $15 million in software for nurse practitioners to use in diagnosing and treating patients. At the conclusion of each visit, the software generates

educational material, an invoice, and a prescription for the patient, as well as a diagnostic record that is automatically faxed to the patient's primary care physician.[40]

The clinic's services are popular because they are fast and relatively cheap. According to the Centers for Disease Control and Prevention, in 2002, the average time spent in an emergency room was 3.2 hours. At MinuteClinic, usually it takes about 15 minutes to care for one patient, and most services cost $44. This compares to an average of $109 at most primary care physician offices, $125 at urgent care centers, and $329 at emergency rooms. Most health insurance plans cover MinuteClinic's services. They typically require small co-payments of $15 or $20, and, in the case of some self-insured companies, the co-payment is as little as $5.[41]

Minneapolis-based Vivius Inc., founded in 1999, provides a software platform that allows consumers to design their own health care benefit package. The consumers can check the prices charged by local doctors, clinics, and hospitals and they can also choose the level of their co-payment. The lower the charges employees incur, the lower their payroll deduction.[42]

As this report has described, the Japanese health care system seems to work more efficiently than that of United States. National health care expenditure is relatively low compared to most industrial countries, and the average life expectancy is the highest in the world. We may even count it as a "successful example" of health care systems.

But the aging of society is a major problem in Japan. In general, the older people become, the more health care they need. Japanese health care spending already is growing rapidly. The government is trying to control and reduce costs by changing some rules, including the rate of

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[40]Michelle Andrews, "Next to the Express Checkout, Express Medical Care," *The New York Times* 18 July 2004.

[41]Andrews.

[42]Vivius, Website.

patients' co-payments, but this seems to be less successful than anticipated. If Japan cannot find any way to control health care spending on an ongoing basis, the public health insurance system may well collapse.

In Japan, the traditional way of reducing costs has been to try to cut the prices of treatments and drugs, which are decided in advance on the national fee schedule. The national fee schedule is usually revised every two years by negotiations between payers and providers through the Central Social Insurance Medical Care Council, an advisory committee to the Minister of Health, Labor and Welfare. But the JMA has strong political power as an interest group supporting the ruling Liberal Democratic Party. So it has been difficult to cut these prices dramatically. Besides, health care needs have been growing. After all, health care spending continues to increase year by year. In such a supply-side approach, people tend to forget about checking the efficiency and quality of health care on their own.

Other approaches may be necessary. The important issue, though, is to empower people to check the cost and quality of health care. Actually, there are examples of consumerism not only in the United States, but also in Japanese health care. Most of them have just begun and are still at the trial-and-error stage. And, compared with American consumer-driven movements, the incentive for Japanese patients is weak and not clear. But the direction in which both countries are heading in order to control costs and quality seems to be the same. That is the reason why this report underscores the importance of learning from American experiences.

As for SMHIs, they focus on encouraging their members to prevent diseases and to be conscious of health care costs.

Matsushita Electric Industrial Corporation's health insurance society, for example, is trying to improve employees' health in cooperation with the employer and the labor union. The society was founded in 1937 and now covers about 360,000 people working at its 156 group

companies. The society has a plan for disease prevention called “Kenko Matsushita 21.” The plan was formulated in response to the aging of Japanese society and the increase of chronic diseases that force the society to put forth more money, in order to reduce health care spending and prevent the electronics company from losing its vigor and competitiveness. The goal is to encourage the employees to be healthier, not only by having regular medical checkups, but also by modifying their ordinary life and habits. The plan contains many kinds of activities.

For example, the company appeals to its employees to try to quit smoking. The rate of male employees who smoke dropped from 55 percent in fiscal 1997 to 47 percent five years later. The organization also recommends that employees keep their weight normal because obesity can cause serious health risks. In addition, it encourages them to find ways to relieve mental stress. It warns employees not to worry in solitude, but to consult someone appropriate if they need to.[43]

Mitsubishi Electric Corporation says that it is becoming more and more important for companies to keep their employees healthy. Thus, Mitsubishi’s health insurance society also has its own plan for disease prevention.

The plan called “Health Plan 21” consists of two stages, namely the first, from March 16, 2002 to March 15, 2007, and the second, from March 16, 2007 to March 15, 2012. Mitsubishi has set several targets to be achieved through the plan. For instance, it aims to lower the rate of smokers to 30 percent or less in the first stage and to 20 percent or less in the second stage. The rate was 40 percent when the plan began.

In addition to these targets that are common throughout the company, there are goals that the members try to achieve in each office unit. Moreover, every member has to set his or her own personal target. Those who meet their target are eligible to receive special treatment at the end of

[43]Matsushita Electric Industrial Corporation’s, health insurance society, Website.

the fiscal year. To support the members, the health insurance society provides services such as health education programs, campaigns against smoking, and making and putting up posters for Health Plan 21.

The most popular way to encourage individuals to become conscious of health care costs is sending them notices about their own health care spending. Mitsubishi's health insurance society sends such notices to each employee on a quarterly basis, i.e., in February, May, August, and November. The reports contain information such as the dates when an employee consulted a doctor or went to the hospital, the names of the doctors and hospitals, the total sum of money the employee and the society paid for the medical services and providers, and so on. The society insists that employees usually do not care about the total cost of health care, except for their own co-payments or out-of-pocket costs, even though they are paying the society a premium every month. It aims at raising the employees' consciousness and preventing medical care costs from continuing to rise. It asks employees to check the notices in order to ensure that there are no mistakes in the totals or excess treatments or drugs listed on them. At Matsushita Electric Industry Corporation, the health insurance society sends these notices monthly and issues an annual report every April.[44]

Such activities are very popular among the health insurance societies. But there is little incentive for employees compared with the mechanism of American consumer-driven health plans that offer financial benefits to the members to save their own money like HSAs or the Definity programs. As this report has pointed out, although health insurance societies are founded by large companies, they have to be operated and managed according to the common rules set forth by the government. It has so far been very difficult for each health insurance

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[44]Mitsubishi Electric Corporation's health insurance society, Website.

society to do something noteworthy or radical to give employees strong incentives. Many societies encourage individuals to be conscious of health care costs. The actual condition at the moment, however, is that they are depending on the employees' vague attitudes towards keeping themselves healthy and reducing costs.

The Ministry of Health, Labor and Welfare, which is responsible for health services, is trying to make people cost-conscious in health care. For example, the ministry is considering the restructuring of the GMHI system, which mainly covers employees of small companies. This type of insurance is operated by the Social Insurance Agency under the ministry. According to its plan, the structure of the provision of insurance will be divided into 47 units and, after around fiscal 2008, every prefecture will operate one such unit. Currently, the insurance premium is the same for all members nationally. But the ministry thinks that the structure is too vast for a member to feel any relationship between his own medical spending and his premium. Under the new setup, if a prefecture makes an attempt to reduce health care costs and succeeds, it will be able to lower its premiums. On the other hand, a prefecture whose health care costs rise will have to increase premiums in order to survive. The ministry predicts that this system will incorporate financial incentives and will make people more cost-conscious.[45]

In Japan, there have been some efforts aimed at forcing health care providers to change. Typical of these are attempts to provide information about hospitals and doctors to patients. The Federation of Health Insurance Societies, or Kenporen, has started to disseminate hospital information through its website. It covers 2,696 hospitals out of more than 9,000 in Japan. The information, based on the hospitals' answers to questionnaires, includes not only special fields of expertise and office hours, but also data on medical examinations, surgeries, and procedures for

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[45]"The Ministry of Health, Labor and Welfare Considers Restructuring the GMHI System," *The Nihon Keizai Shinbun* 24 January 2005.

informed consent. Patients can browse the site by the names of disorders or specialties to seek and select the best hospital to go to.[46]

The Japan Council for Quality Health Care (JCQHC) is the nationally authorized organization for accrediting hospitals. The not-for-profit organization was established in 1995, mainly sponsored by the Ministry of Health, Labor and Welfare and the JMA. JCQHC evaluates each hospital with regard to its policies, organizational fundamentals, response to community needs, medical care and support system, patient satisfaction, administration, and so on. The evaluation consists of documents and an on-site assessment. Several hundred items are checked by the survey team, whose members include physicians, nurses, and administrators. If a hospital can meet the evaluation standard, it can get a certification from JCQHC. As of January 25, 2005, 1,503 hospitals had obtained such a certification. This is about 16 percent of all the hospitals in Japan. The certification is valid for five years. Hospitals can choose whether to get evaluated or not, and they pay JCQHC for the evaluation if they ask for the survey. The aim of the JCQHC evaluation is to assure trustworthy quality health care and continuously improve it.[47]

According to a survey of 87 hospitals that were evaluated in fiscal 1999, 76 of them expected the morale of the staff to be boosted by the evaluation, 66 anticipated improvement of hospital functions, and 59 looked to improved quality of services for patients (Figure 6). On the other hand, 50 hospitals said that it took more than six months to reach consensus among the staff about being evaluated. Patients can see the detailed information on the evaluations of

[46]The Federation of Health Insurance Societies (Kenporen), Website.

[47]JCQHC, Website.

individual hospitals' through the Internet. But the information is only provided about hospitals that allow JCQHC to do so.[48]

[48]JCQHC, 1999 survey.

CONCLUSION

Medical services and health care are directly related to human lives. Needless to say, life is very precious to everybody. Therefore, we tend to consider medical services and health care independently of cost. In some cases, we have to separate medical services and health care from economic rationality. Sometimes, it might be necessary to explore life-saving medical technology without compromising in order to lower costs.

But we have to supply medical and health care services to people efficiently. This is becoming more and more important as societies age rapidly and, thus, demand an increasing number of medical and health care services. Inefficiency attacks national and corporate finances through a heavy burden of largely unnecessary costs.

Although the health care system in the United States is far from ideal, many experiments in the American health care market can give useful suggestions to help solve Japanese problems in this connection. A consumer-driven viewpoint is also needed for Japan in order to create dynamism in the health care industry.

The issue of improving the medical service and health care business in Japan is partly due to the tight government regulation of medical services. For-profit corporations, for example, cannot operate hospitals and clinics in Japan. This, in turn, reduces the rewards for entrepreneurship and discourages functional differentiation of health care providers. Such over-regulation has prevented Japan from preparing for how to deal with the country's aging society.

In Japan, competition has not been the main principle for cost control and raising quality in health care. The main principle has been based on regulations. Private-sector hospitals do not have enough surplus revenue to allow much investment in expansion or new services, and for-profit companies cannot provide efficient services even if they have excellent ideas. Public

insurers are not allowed to create their own groundbreaking systems to control health care costs and quality. Therefore, as Campbell and Ikegami say: "The Japanese health-care system thus does not appear as dynamic and interesting as that of the United States."[49]

As some American examples indicate, consumer-driven health care has the potential to reduce costs and raise the quality of health care. It is not farfetched to promote consumer-driven health care in Japan because Japanese health care seems to be heading in the direction of consumerism.

Traditionally, it has been said that health care is too important to leave to the market. But it is now time to say that it is too important not to leave to the market. One way to control costs while maintaining quality is for consumers to choose among competing providers.

Japan should improve its health care system from the point of view of consumers. The system has to allow people to behave as smart consumers. Public insurers should use their own discretion to encourage members to check health care efficiency. They should have options to give members clear incentives to choose better health care. On the other hand, there needs to be a market where various health care providers can compete, by allowing for-profit organizations to participate. In order to encourage consumers to make appropriate decisions, information on health care is very important. Thus, insurers have to play a role in providing information about health care costs and quality and support their members in making intelligent decisions. Health care providers also have to be willing to disclose information about themselves.

Each country's health care system reflects its society, culture, and history. So it is difficult to change health care systems over a short period. The Japanese system, in particular, has succeeded so far in terms of controlling costs. Needless to say, the advantages of the Japanese

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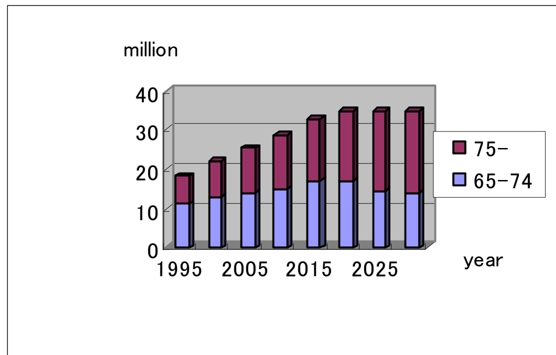
[49]Campbell and Ikegami 19.

system should be retained. But, at the same time, it is important to use the power of the consumers to improve the system as soon as possible.

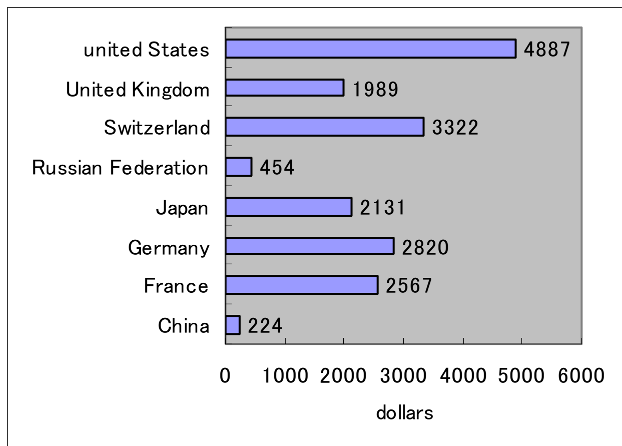
Figure 1. Citizens Aged 65 and Older in Japan



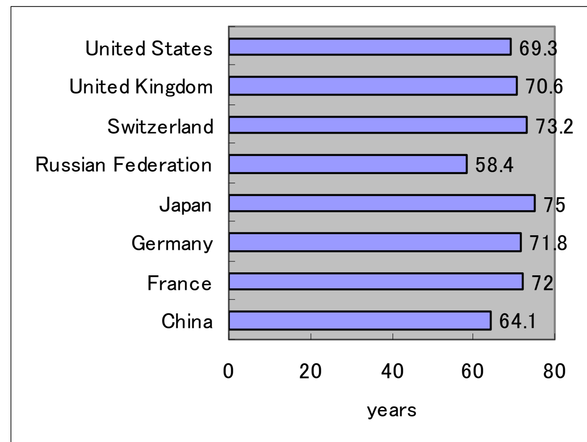
Source: The 2002 White Paper on Aging Society

Figure 2. Health Expenditures and Life Expectancy

Per Capita Expenditure on Health (2001)

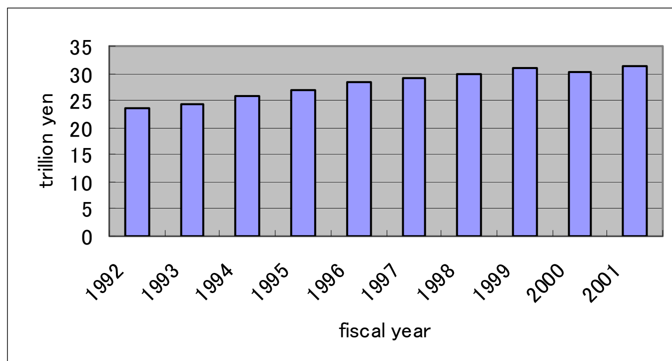


Healthy Life Expectancy (2002)



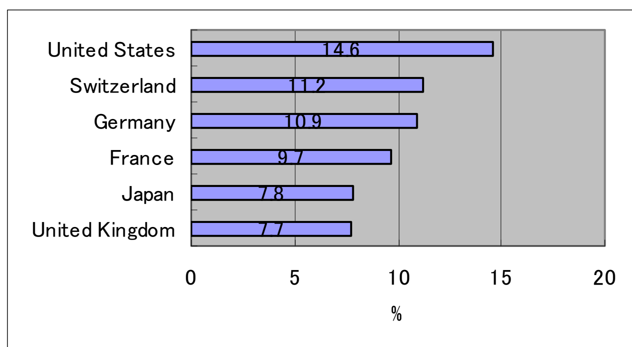
Source: The World Health Report 2004

Figure 3. Japanese Health Care Spending



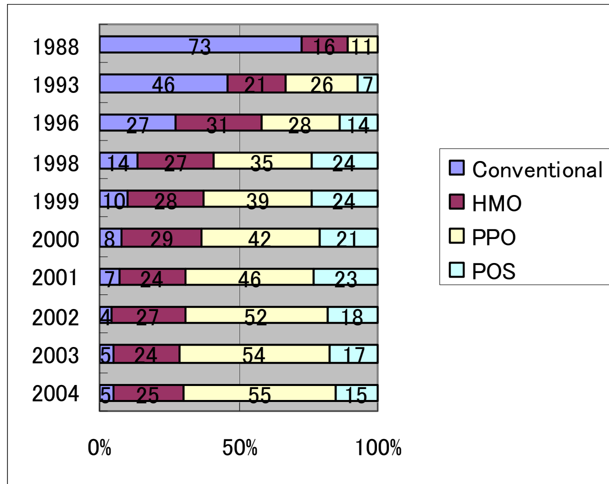
Source: Ministry of Health, Labor and Welfare

Figure 4. Health Expenditures as a Percentage of the GDP (2002)



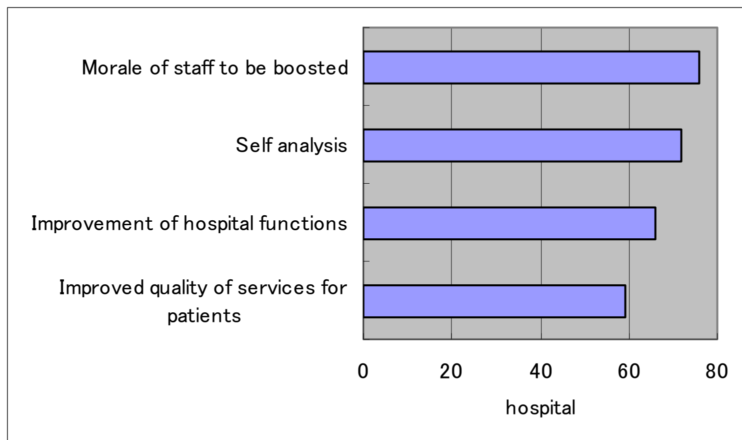
Source: OECD Health Data 2004
Note: Data for Japan are for 2001

Figure 5. Health Plan Enrollment for Covered Workers (by Type of Plan)



Source: Kaiser Family Foundation

Figure 6. The Aim of JCQHC Evaluation



Source: JCQHC

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