

Aging Asia: Social insurance sustainability, chronic diseases and long term care

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Financing healthcare in rapidly aging Japan

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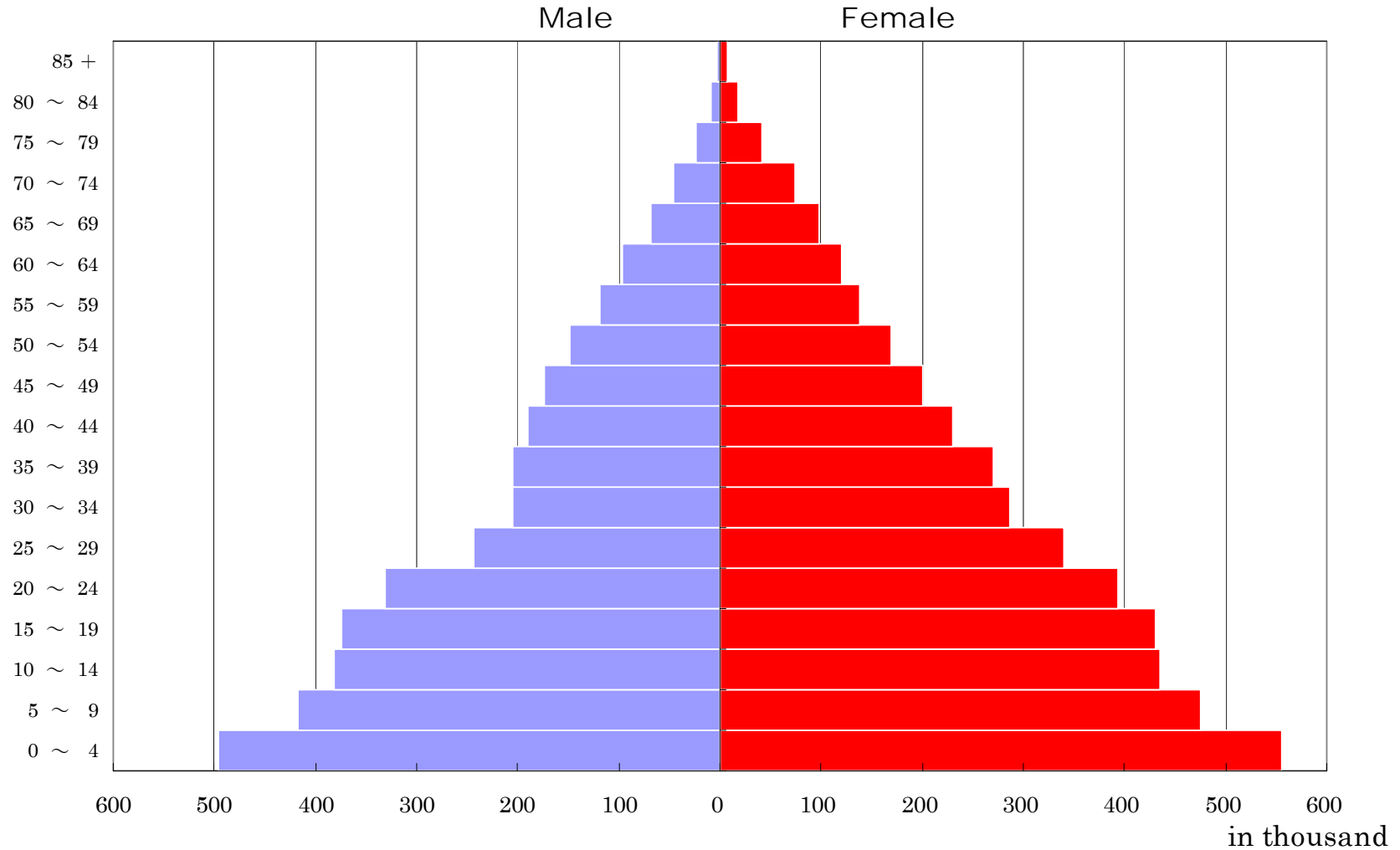
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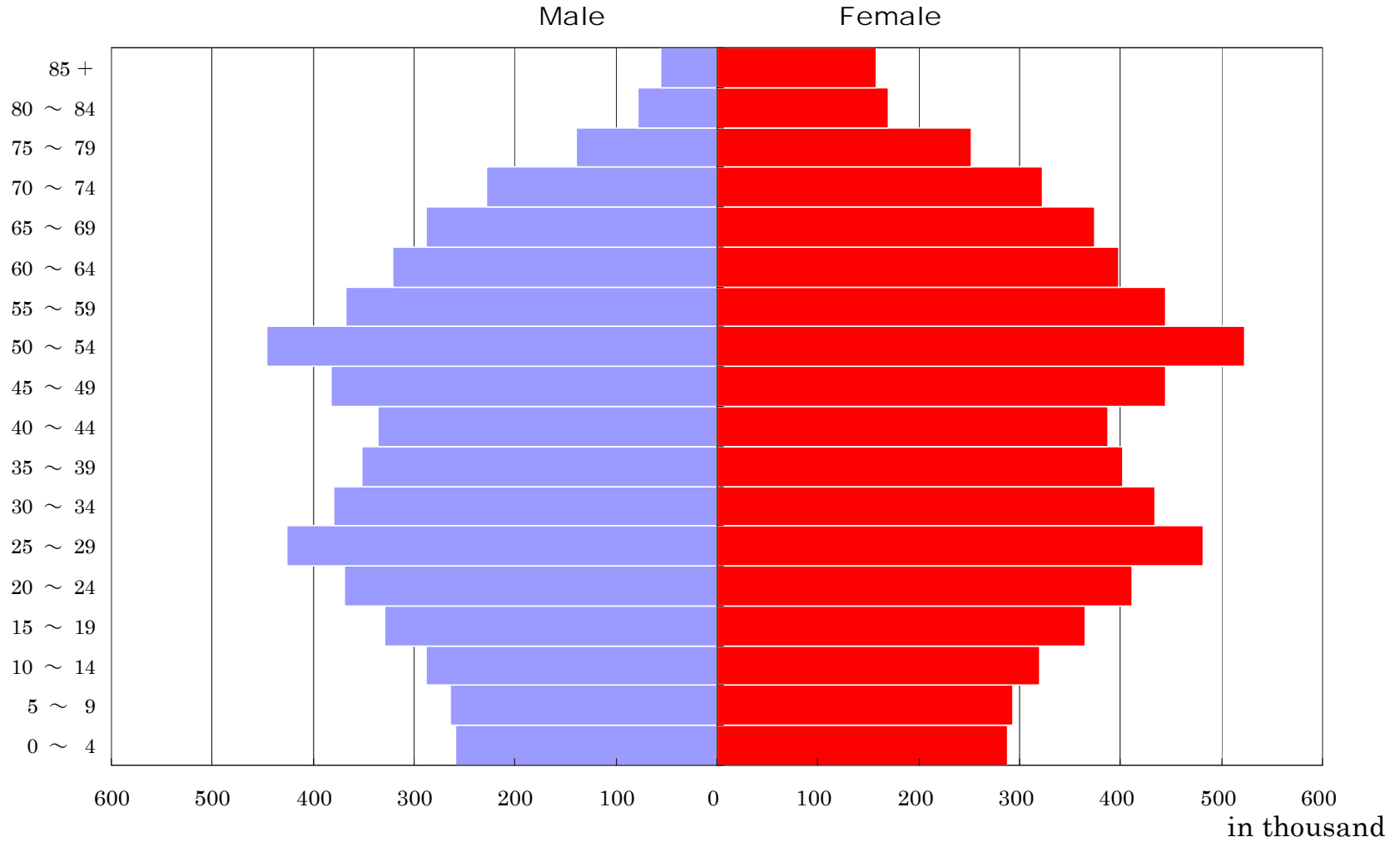
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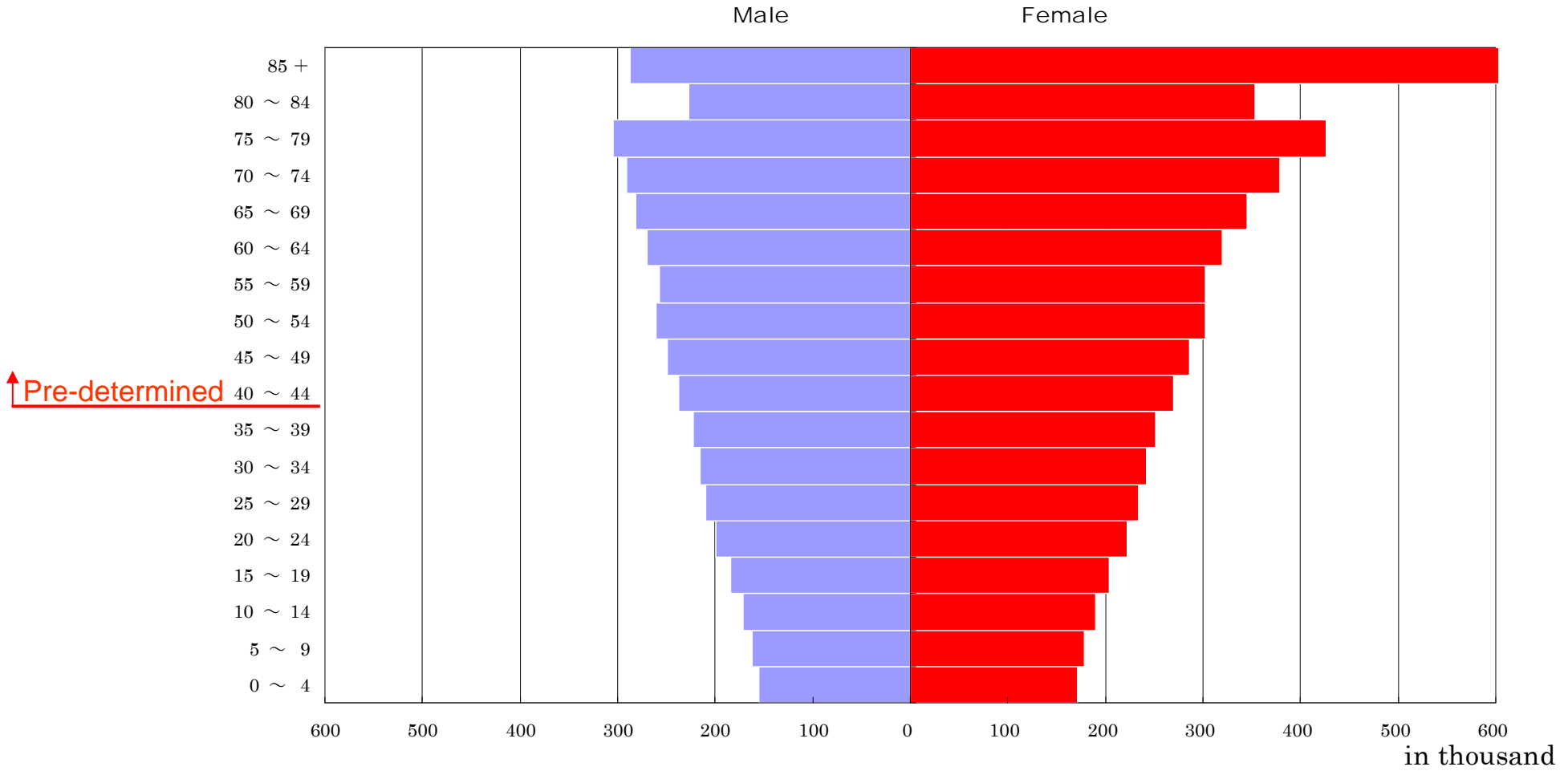
Population of Japan by Age and Sex, 1950



Population of Japan by Age and Sex, 2000



Population of Japan by Age and Sex, 2050

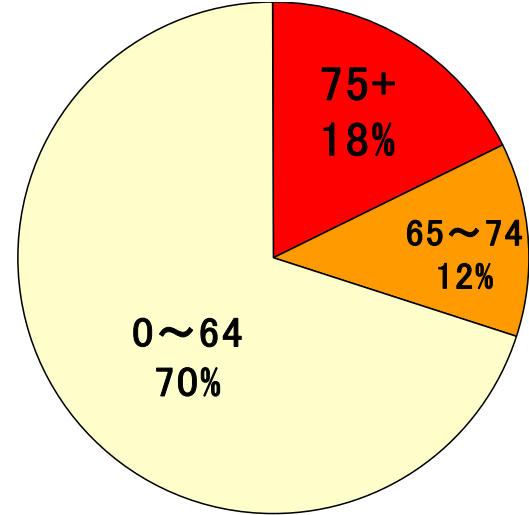
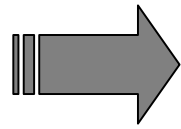
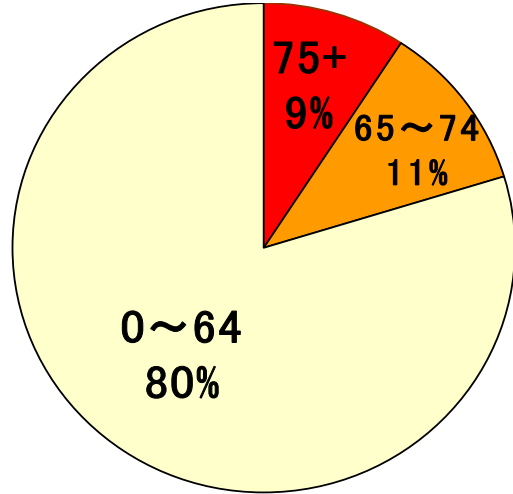


Composition of 65~74 and 75+ in Japan

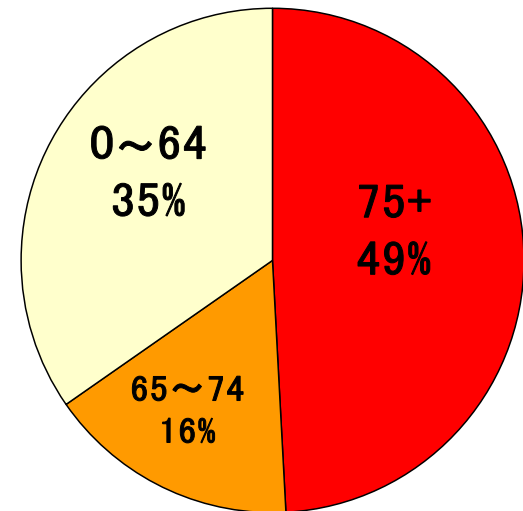
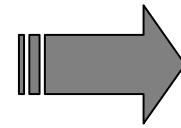
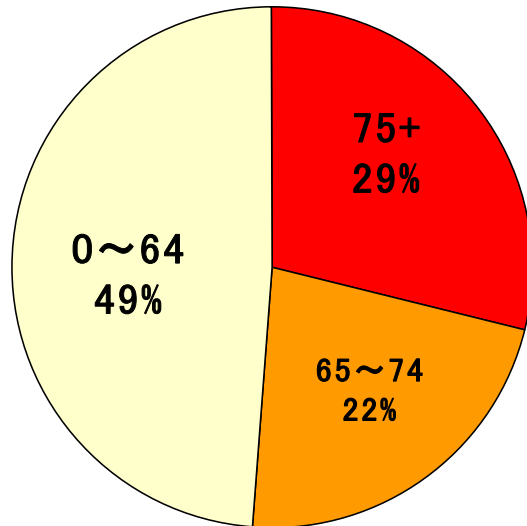
2005

2025

In population



In health expenditures



Need to change the focus of healthcare

- In twenty years, two-thirds of all patients in Japan will be 65+
 - If patients seen by obstetricians and pediatricians are excluded, then close to three-quarters will be 65+
 - My advice to medical students: You should not become a doctor unless you like talking to old people
 - Typical hospitalization for frail, elder patient: Admitted on a stretcher, discharged on a wheelchair
 - Disease management programs won't work when the patient has multiple diseases as is often the case with elders
- ⇒ How can the financing be changed?

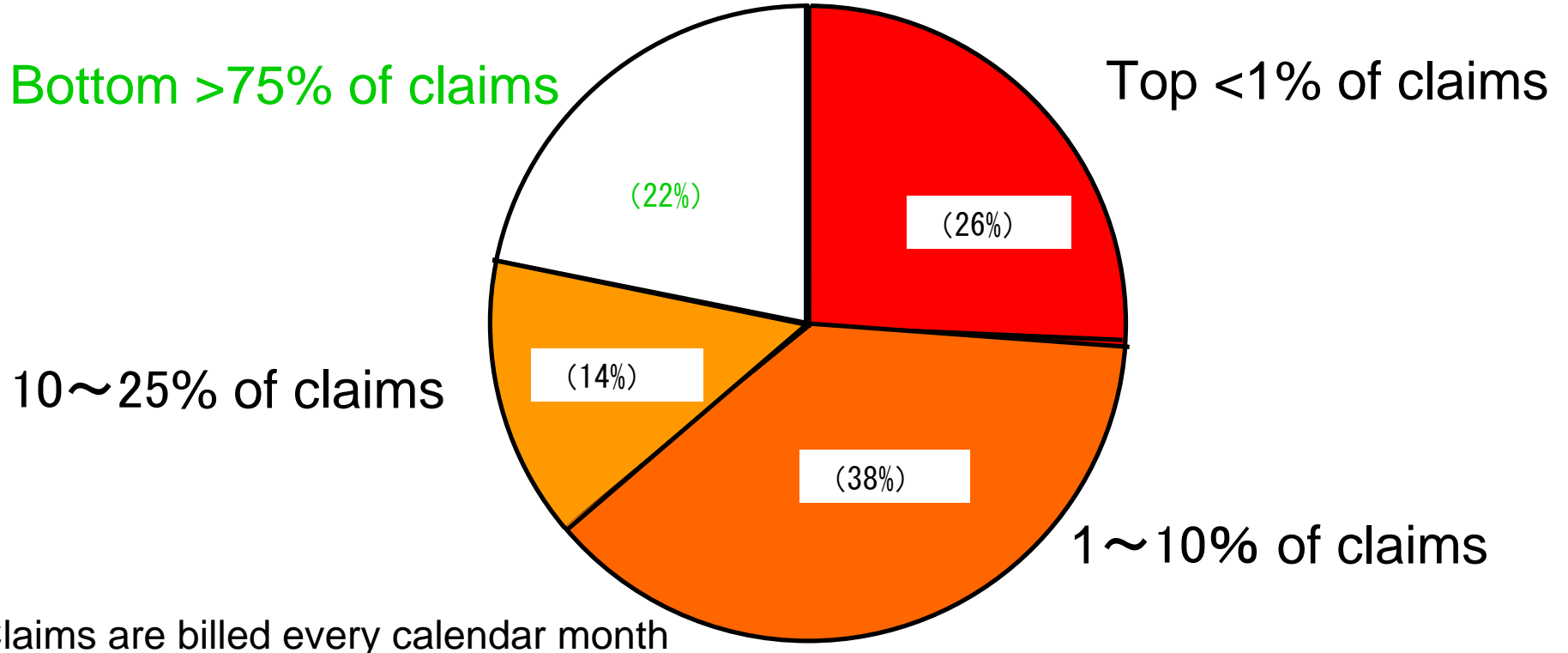
Financing healthcare in an aging society

- Issues I would be raising:
 - (1) Can the younger generation's burden be mitigated?
 - (2) Can total health expenditures be contained?
 - (3) Can health insurance for elders be reformed?
 - (4) Can end-of-life care expenditures be contained?
 - (5) Is long-term-care affordable?

(1) Can the younger generation's burden be mitigated?

- Increasing the elder's co-payment rate and premium contributions
 - Co-payment: Most now pay 10%, those with high income 30%
 - When co-payment exceeds \$400 per month, the rate becomes 1%
 - Premium contributions: Decreasing tax exemption for income from pensions
- Containing total health expenditures (explained later)
- Policy not adopted: Societal savings approach
 - Premiums deposited in savings pool for each generation
 - Younger generation will have to pay not only for their current and future expenditures, but also for elders until the program matures
 - Difficult to estimate future healthcare costs (cf. US Medicare)
- Policy not adopted: Health savings account (HSA)
 - HSA is only for minor events, major events covered by catastrophic insurance
 - The 80:20 rule in health expenditures
 - 80% of expenditures incurred by 20% of the patients

Percentage of total healthcare expenditures billed in descending order of the claim amount Japan Social Health Insurance, 1993



National Claims Survey, 1993, Japan, Ministry of Health & Welfare

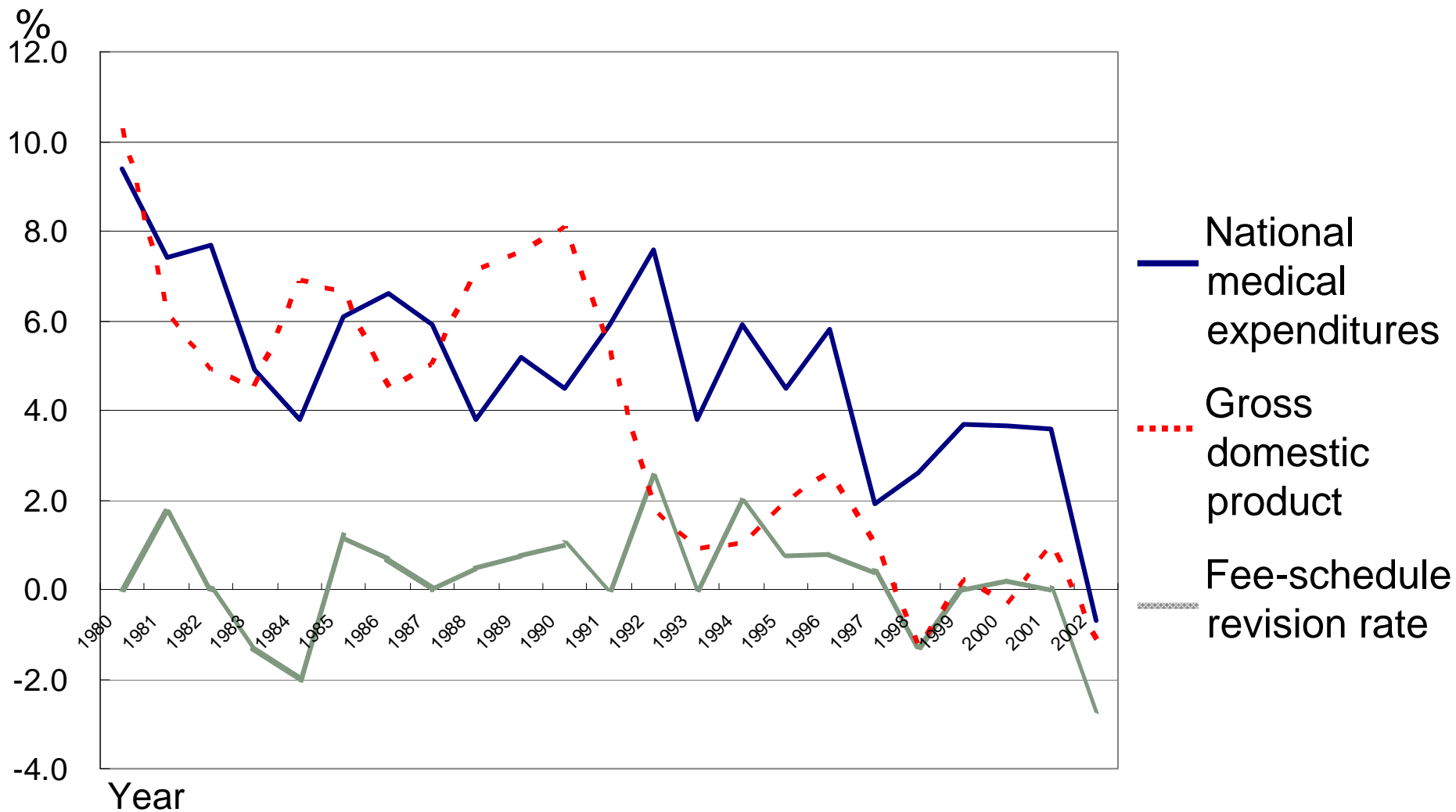
(2) Can health expenditures be contained?

- Yes! Japan ranks 22nd among the OECD countries in the percentage of healthcare expenditures to GDP: 8.0%
- Despite rapid aging of society, wide diffusion of technology and no waiting lists
 - Highest per capita number of CAT scans, MRI in the world
- The mechanism: Fee schedule (tariff) controlling the price, conditions of reimbursement
 - Money flows through a single pipe from all payers to all providers
 - Global control over both hospital and physician fees
 - Extra-billing and balance billing prohibited
 - Fees reduced individually on targeted items
 - Example: CAT scans and MRI fees were cut by 30% in 2002, when the global volume-weighted revision rate was reduced by only 2.7%
 - Has compressed increases in costs due to advances in technology

Trends in Japanese medical expenditures: 1980-2002

- National Medical Expenditures (NME) is the government compiled data used for budgeting
 - NME is 80% of OECD estimates because OTC drugs, preventive health etc. not included
 - Nominal NME and GDP are used for the analysis
- NME and GDP
 - In the 1980s, increased at same rate so that the ratio of NME to GDP remained constant at 5%
 - After 1990, with the decline in the GDP growth rate, NME increased more than GDP: Ratio of NME to GDP increased to 6.0%
- NME and the fee schedule revision rate
 - Revision rate: Volume weighted rate for all services, drugs etc.
 - Strong correlation: 0.78
 - Price regulations have been effective
 - In 2002, revision rate was -2.7% which led to 0.7% reduction in NME

Annual Changes in Gross Domestic Product, National Medical Expenditures (NME) and revision rate, Japan, 1980-2002



Decomposing increases in NME: 1980-2002

Annual rate of change decomposed to the following:

1. Due to demographic factors
 - Population growth: 0.8% decreasing to 0.1%
 - Population aging: 1.0% increasing to 1.7%
 - Assumption: Per capita expenditures remain the same for each age group
 - Cumulative effect of both constant at 1.8% during this period
2. Fee schedule revision rate: 0.46%
 - 1% less than the CPI which was 1.46%
3. The residual not explained by 1+2: Changes in volume (No. of visits and admissions) and technology: 2.8%
 - Less than the annual growth rate of the GDP which was 4.0%
 - Cf. For Medicare, the growth rate due to technology was 1% in excess of the GDP

(3) Can health insurance for elders be reformed?

The case of the new insurance for elders 75+

- New insurance for all elders 75+: Implemented April, 2008
 - On 75th birthday, all had to exit their former plan and join this plan
- Political fiasco for government
 - One reason for Prime-minister Fukuda's resignation
- Three main reasons for its unpopularity
 - Official name “Health Insurance for Later Period of Old”
 - Resentment against the unfamiliar term → Next stage after “later”, death
 - Came to be referred to as “hurry up and die insurance”
 - Forcing low-income elders to pay premiums
 - Those who had been covered as dependents of their child had to start paying
 - Slightly different benefits for the 75+
 - Over 99% the same, but still some differences

The new item just for the 75+

- One item introduced just for 75+ that led to uproar:
Consultation fee for end-of-life care
 - \$20 fee to discuss for one hour end-of-life issues
- Criticized as not being consultation, but persuasion to end life quickly in order to contain costs
- Uproar led to freezing its implementation
- Should have been introduced for all, not just 75+
- Indicates difficulty of establishing different rules just for elders → Must maintain intergenerational equality

(4) Can end-of-life care expenditures be contained?

- Whether at end-of-life or not is revealed only ex post (after death)
- Patient's wish when in critical condition
 - To be aggressively treated and cured if at all possible
 - Difficult to deny this wish, even if the chances of recovery are slight
 - More likely if young and the onset is sudden
 - Not to receive aggressive treatment that will prolong suffering
 - Option should be made available
 - More likely if old and the onset is gradual
- Growing trend: Most deaths now occur after 75 in Japan
 - Proportion of all deaths occurring after 75: only 1/3 in 1968, but 2/3 in 2008
 - Few people die when young or middle-aged
 - The proportion of those opting for aggressive treatment should decline
 - Although the absolute number of deaths will increase, from 1 million deaths (2002) to 1.7 million deaths (2038), the proportion of deaths occurring after 75 would also increase

Caveats in containing end-of-life care costs

- Public opinion against explicit discrimination of healthcare provision according to age
- End-of-life care costs may not be so high
 - On an individual basis, end-of-life care costs may constitute one fifth of total life time expenditures
 - But for society, on a cross-sectional basis, the Ministry has estimated that healthcare costs for the last month of life would be only 3% of total expenditures

(5) Is long-term-care affordable?

- Typical reaction in US: Too expensive. Universal healthcare is our first priority.
- Yet, Germany and Japan have implemented public long-term care
 - Affordable, controllable and manageable
 - Both countries spend LESS money than the US Medicaid and Medicare on LTC
 - Explained in detail in Professor Campbell's presentation

What are long-term care services?

- Personal care: ADL (Activities of Daily Living) assistance in dressing, eating etc.
- Domestic care: IADL (Instrumental ADL) assistance in meal preparation, cleaning, shopping, medication management
- Home modifications (ramps, hand rails), emergency alert systems
- Transportation to & from adult day care centers, healthcare facilities
- Services by physicians generally not included, except when the physician is employed by the institution
- Occupational training would be included for non-elders having physical, learning and mental disabilities
 - Introducing LTC just for elders would be more feasible, and would have more popular support

Copernican shift: Public LTC Insurance is not only needed, but could also be less expensive

Healthcare system

- Services become medicalized
- Public expectations: Best care available
- Expensive professional staff has dominant role
- Patients find it difficult to exercise choice

LTC system

- Services are a combination of health and social care
- Public expectations: Decent level of care
- Low-wage staff has dominant role
- Clients find it easier to exercise choice

LTC may be the best way of containing healthcare costs

Calculating LTC expenditures

- Expenditures=No. of eligible in each eligibility level multiplied by the benefit amount (\$) of each level
- Number eligible: Based on eligibility criteria
 - Number and severity of ADL deficits etc.= Extent of support needed for walking, eating etc.
 - Of the 65+, could cover 10% (Germany) to 16% (Japan)
 - Japan extends coverage to those who need only light care
- Amount of benefits: From parsimonious to generous
 - The balance can be left to be paid by the user
 - Public responsibility is to cover a “decent level” of services
- Both the eligibility criteria and the benefit amount are set by policy-makers, not physicians
- Much less pressure to provide the best available service for all

The future

- Where Japan is now, the US will be 30 years later
- Plan according to what has been, or has not been, shown to be possible in Japan, NOT on beliefs or wishes
 - (1) Younger generation's burden can be mitigated
 - (2) Total health expenditures can be contained
 - (3) Public opposes targeting cost containment on elders
 - (4) End-of-life care expenditures may not be significant
 - (5) Long-term care is affordable