Comments on Dr. Jonathan Skinner's presentation

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Summary of Dr. Skinner's presentation

1. Little association between the age composition and healthcare spending
2. Regional variations arise largely because of uneven diffusion of medical technologies and treatment
3. Exnovation (de-diffusion) occurs when treatment is not useful or replaced by better one
4. Need for data monitoring, "shared decision making", price adjustments
5. Regional variation from uneven adoption

1. Aging and health spending

- Need to differentiate between cross-sectional comparisons and longitudinal comparisons
- For cross-sectional comparisons across countries, aging does not have effect: Total funds appropriated to healthcare is a societal decision
- But for longitudinal comparisons, aging does impact
  - Aging of population leads to higher health spending because older people consume more healthcare
  - If based on health spending, not on %GDP
  - If GDP↑, then even if health spending increases, no %↑

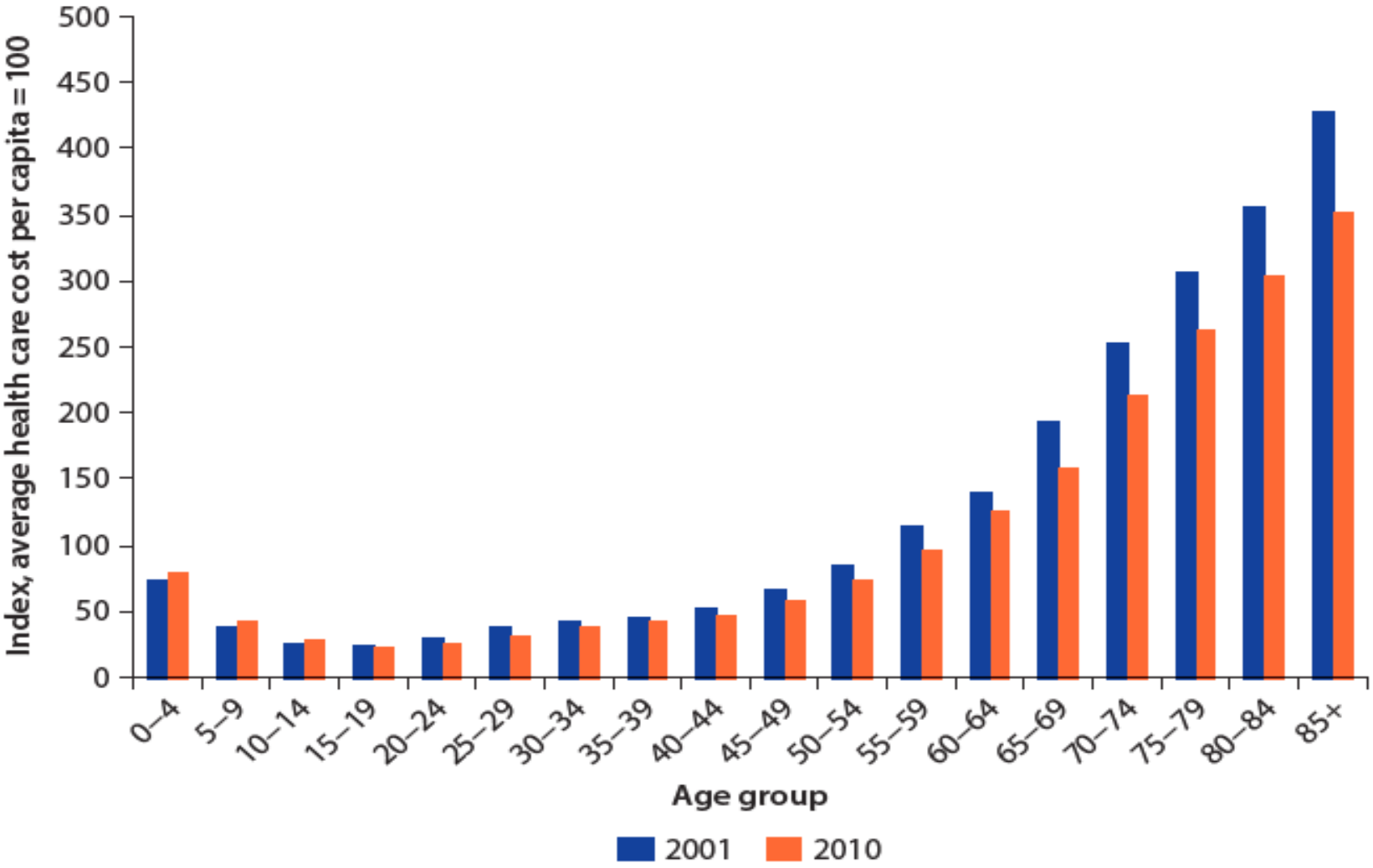
Impact of aging on costs in Japan

- One quarter of national health expenditures is financed from general revenues
- In order to set the budget to be allocated to healthcare, the next year's amount is estimated
- Next year's amount: Fee schedule revision + "Natural increase" (Shizenzou") (last 20 years)
  - Revisions: -3.16%~0.8%; Shizenzou: 1.2%~4.7%)
- Shizenzou = Aging + Others (technology advances)
  - Aging: 1.2%~1.8%; Others: -0.7%~2.8%
  - Aging: Assumes each 5 year age group spends the same

Can the effect of aging be blunted?

- Impossible to arbitrary set an age limit
  - Same protests against “death panels” in US & Japan
- Who wants to live to a hundred? Someone 99!
- However, as people age, they tend to prefer less aggressive (heroic) treatment
- Importance of shared decision making
- But will physicians encourage less aggressive treatment if it leads to their lower income?
- Hope? Per capita health spending has increased relatively less for older age groups in Japan

Healthcare spending by age in Japan, 2001 & 2010

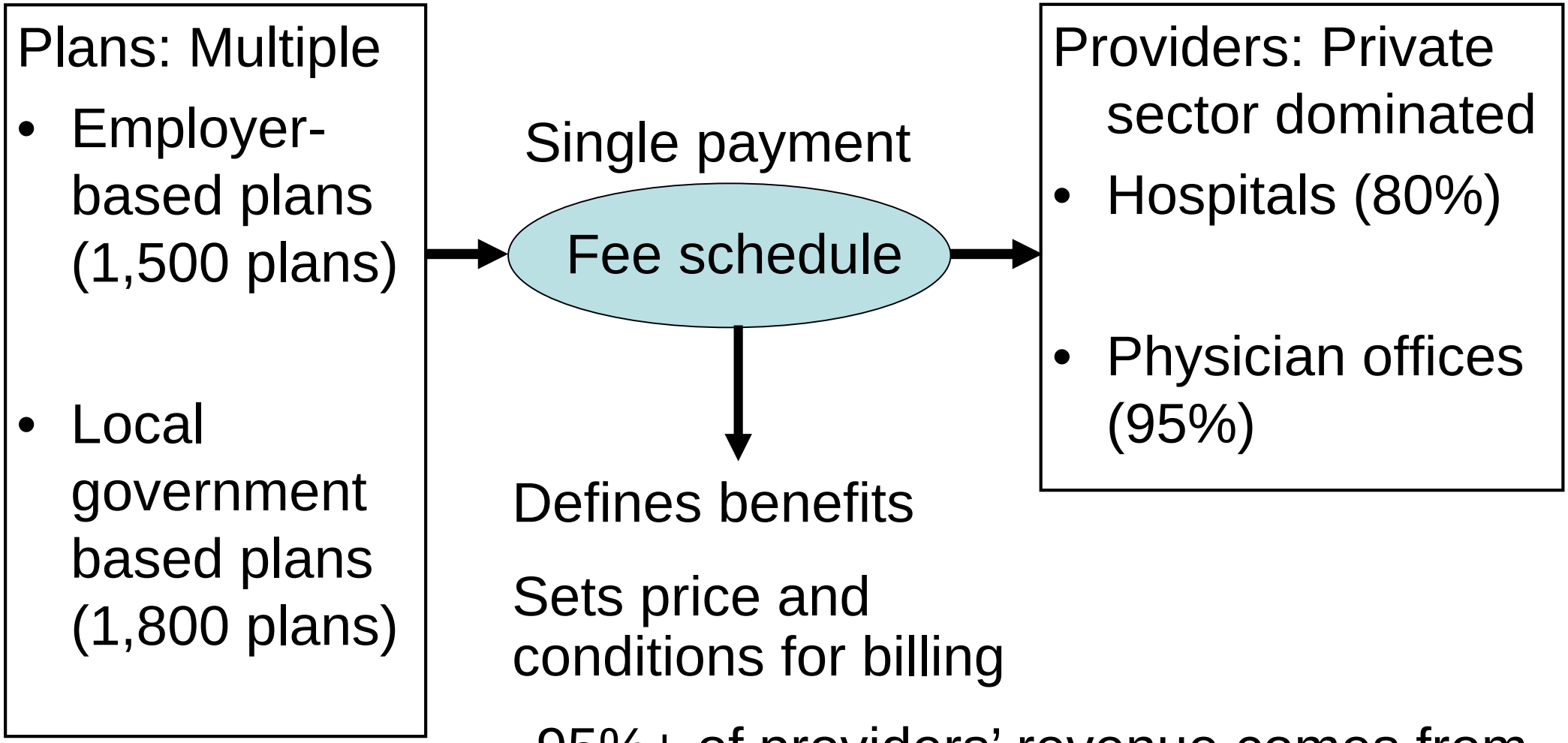


Oshio et al., in Ikegami, 2014

2. Focus of healthcare policy in Japan: National fee schedule

- Payment is fee-for-service: Providers can basically deliver any service and will be paid (reimbursed) for doing so
  - Incentive and pressure to deliver services
- But prices and conditions of payment are tightly regulated
  - Same price for all providers, whether public or private
  - Same price for plans enrolling those relatively rich and for those on public assistance
  - Balance billing prohibited, billing of services not covered restricted
- Regulations control non-price factors that increase costs
  - Non-price factors: Volume increases and shifts to high-tech
  - Conditions of payment (hospital facility standards, patient's clinical conditions) set by the fee schedule
  - Monitoring of adherence and penalties for not adhering

Controlling healthcare costs



95%+ of providers' revenue comes from services with prices set by fee schedule

Controlling volume by setting the conditions of billing

- To bill for rehab therapy, must meet following conditions:
  - Hospital employs 5+ PTs, rehab floor space > 160 m^2
  - Days after patient has had stroke or injury < 150 days
- On-site audits of medical records etc. made to check whether items billed had met the conditions
  - If not met, then hospital must pay back the amount billed in the past 6 to 12 months
  - If found to be systematic, stricter penalties imposed

Prohibiting balance billing, regulating extra billing

- Balance billing, charging more than the price set by the fee schedule, is strictly prohibited
  - If found, hospital must pay back the total amount billed under SHI
  - Hospitals must give patients detailed breakdown of the items delivered and the copayment for each
- Extra billing strictly restricted
  - Extra-charge beds (regulations on their standards) etc.
  - New procedures being tested for efficacy and safety
    - Hospital must submit data; once proved effective, then listed

Revisions of the Fee Schedule

Revised every two years: 3 Steps

- 1st Step: Setting the macro revision rate
  - Next year's expenditures = (Last year's expenditures) X (macro revision rate + increase due to "natural increase" α)
  - α: Shifts to more expensive services due to advances in technology (CT→MRI), + increases in volume due to aging etc.→ Rate for past 3 years (2-3%/year)
  - α is given so that by setting the macro revision rate, a global budget is imposed
- 2nd Step: Setting the micro revision rates for each item
  - Σ (price of each item adjusted↑↓) x (volume of each item) = Global budget (as set by the macro revision rate)
- 3rd Step: Revising the conditions of billing
  - Regulates the quality and volume of each item

How item-by item revisions are made equal to the global rate for medical services

- Volume of each item from national claims data
- Item-by-item revisions negotiated for 2010 revision
  - Repeat consultation fee in clinics: ¥710→¥690
    - Impact: Volume 63,478,641@▲¥20 = ▲¥126,957,282
  - Arthroplasty fee: ¥265,000→¥398,500
    - Impact: Volume 486@△¥135,500 = △¥64,881,000
- Cumulative effect is made equal to the global revision rate, as has been set by the prime minister
  - ∑Item by item revisions ↔ Global revision rate
  - Home care fees increased, MRI fees decreased

How to blunt cost increases

- Lower fees for taking MRI scans
- Price of purchasing a MRI goes down when new models are produced (far more so than cars!)
  - GE (USA) does not disclose even their list price
- Finance new types of MRI scans by lowering the fee for scans taken by old types
  - In the 2012 fee schedule revision, a new higher fee for MRI with 3.0 Tesla or more density
  - The costs for doing so were financed by lowering the fee for scans taken by MRI with less than 1.5 Tesla

Focus of geographical disparity in Japan: Hospital beds & Health spending

- Reasoning of policy-makers in Japan:
  - Nagano Prefecture has lowest health spending and lowest number of hospital beds (per capita)
  - Kochi Prefecture had highest health spending and highest number of hospital beds (per capita)
  - By containing beds, spending can be controlled
  - One step further: Set bed caps for each type of bed: High-tech acute 高度急性期, acute 急性期, rehab 回復期, chronic 慢性期)
- Prefectural governors can order or induce hospitals to comply with bed caps for each type

Better focus needed in health policy

- Policy-makers should not focus on costs or beds but on the factors contributing to these regional differences: What do they get for the money spent?
  - Does more PCI procedures lead to less AMI deaths?
- Using data to “name and shame” could be effective
- But, facts have no intrinsic value in Japan!
- Policy-makers do not want “evidence-based policy”, they want “policy-based evidence” to support the decisions they have already made