



In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

In Japan, All-Payer Rate Setting Under Tight Government Control Has Proved to Be an Effective Approach to Containing Costs

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Synopsis

Japan's health insurance system, which provides universal coverage through a mix of social health insurance, has been able to contain health care spending, as a share of gross domestic product, to about half the level seen in the United States. According to Commonwealth Fund-supported research, Japan has been able to maintain access to care and avoid rationing while also taking advantage of the latest medical technology by applying a standardized fee schedule for nearly all health care goods and services and combining hospital and physician fees.

"In the United States, the existence of multiple payment systems has seriously hindered efforts to contain overall hospital spending because providers have been able to negotiate rates with private payers that are higher than those they receive from Medicare and Medicaid."

Background

International comparisons highlight two important differences between the U.S. and many other industrialized countries when it comes to health care spending. First, the level of spending is much higher in the U.S., primarily because prices are higher. Second, other developed countries are able to have multiple health insurers without the large payment variations across insurers that exist in the U.S.

Japan, which achieved universal coverage in 1961 after expanding its social insurance system, has been successful at standardizing and containing costs—even in a sluggish economy and with a significant over-65 population. The percentage of GDP that Japan spent on health rose from 7.7 percent in 2000 to 8.5 percent in 2008, compared with an increase from 13.7 percent to 16.4 percent in the U.S. during that same period.

How the Japanese System Works

- **Mandatory coverage.** All employees must join the health insurance plan offered by their employer. People who are unemployed, self-employed, or retired must join the plan managed by their local government. Although all insurers are ostensibly independent entities, they are de facto either extensions of the personnel department of a large company, public sector organizations, or parts of local governments.
- **Access to care.** Spending is contained without any form of explicit rationing. Virtually every patient is seen on the same day that he or she decides to visit the doctor. In fact, Japan has more annual per capita physician visits, hospital admissions, and magnetic resonance imaging units than the U.S.
- **Standardized fee schedule.** The government determines the statutory benefit package and sets the price of all services, drugs, and devices as part of a nationwide fee schedule. The schedule, reviewed and adjusted every two years, uses a single price, without any regional adjustments. Elements factored into the rates include actual market prices for drugs and devices, volume changes in specific services, historical profit margins, the rate of economic growth, new technologies, and utilization data by age groups.
- **Case-mix–based payment for inpatient care.** The payment system for inpatient care is based on case mix, similar to the diagnosis-related groups (DRGs) used in the U.S. Medicare program. Payment is made on a per-day rather than a per-stay basis, with the daily rate declining as length-of-stay increases. The system does not adjust for regional cost differences, which helps hospitals in lower-cost, often medically underserved areas to attract physicians by paying them higher salaries.
- **Expanding use of case-mix payments.** Japan’s case-mix–based payment was initially applied to only 82 hospitals in 2003, but has since been extended to nearly 1,400 hospitals—about half of all acute hospital beds in the country.

Lessons for the United States and Japan

Japan’s single payment system contains spending while retaining the advantages of multiple health insurance plans. Combining hospital and physician fees—not typically done in the U.S.—also helps achieve these objectives. Applying a single rate to U.S. providers, a growing number of whom are employed by hospitals, would simplify billing, provide incentives for physicians to practice more efficiently, and possibly encourage more physicians to locate in medically underserved areas. “[A] single payment system would . . . ensure that all patients were treated similarly because providers would be paid the same amount for delivering the same service,” write the authors. At the same time, they note that such a payment system “would not by itself be a panacea for containing costs in the United States.”

Citation

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