What is Japan Health Policy NOW?
Created in 2015 by Health and Global Policy Institute (HGPI), Japan Health Policy NOW (JHPN) is the only centralized platform in the world on Japanese health policy available in both Japanese and English.

As the world’s attention turns to Japan, one of the world’s fastest ageing countries, there is increasing interest in Japanese health policy and a growing need to share information on Japan’s health policy with the world. JHPN is committed to addressing this need by delivering factual information about the Japanese health system, Japanese health policy stories of interest, recent Japanese health policy news, and a resource list for those who want to learn more about Japanese health policy. For more information, please see www.Japanhpn.org.
4.1 Financing | Health Expenditures

Health spending in Japan is generally considered low when compared to other advanced economies, yet costs exceed OECD averages in terms of public expenditures on health and pharmaceutical expenditures. In Japan, where public sources fund 83% of health spending, health expenditures have great implications for health care sustainability.\(^1\)

**Expenditure overview**

In recent years, total health expenditures (all money spent on medical goods and services) as a part of GDP has been on the rise in Japan. Between 2008 and 2013, health spending rose from 8.5% to 10.2% of GDP surpassing the 2013 OECD average of 8.9%.\(^2\) And while the OECD reports that health spending is expected to slowdown, Japan remains one of the few OECD countries where health spending to GDP has increased since 2009.\(^3\) Part of this increase is in part due slow economic growth. However, while public and private spending per capita continues to hover close to the OECD average, the annual average per capita health expenditure growth rate between 2009 and 2013 was well above the OECD average growth rate for the same years.\(^4\)

**Growth in expenditures**

Similar to other advanced economies, growth in health expenditures can be attributed to increasing healthcare costs associated with population ageing as well as increasingly specialized and advanced medicine. For example, in 2011 64% of hospital expenditures were used to care for the 65 and older population, which comprised 23% of the total population in 2012.\(^5\) By 2020, the share of the 65 and older population is expected to reach 30% and health expenditures for this population is projected to increase to 66% of national health expenditures.\(^6\) Enrollment in health insurance for the oldest of the old increased by 3% between 2011 and 2012 and the number of long-term care benefit recipients increased by 5.5%, or 2.85 million people, between 2011 and 2012.

**Pharmaceutical and medical devices sector**

Japan is one of the world’s largest medical device markets estimated in 2012 at $32 billion, an increase of 8.7 percent from 2011. The market size is expected to continue to grow given the ageing population.

Japan continues to see increased growth in pharmaceutical spending while other countries have seen a slowdown in recent years. Public spending on pharmaceuticals increased by 5% annually between 2009 and 2013 and, in 2013, per capita spending on pharmaceutical was second highest within the OECD.

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2. Data extracted on 12 November 2015 02:36 UTC (GMT) from OECD Stat.

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One reason often attributed to high spending on pharmaceuticals is the low penetration of generics in the market. In 2013, generics comprised 11% of pharmaceutical market value compared to the OECD average of 24%. Japan also ranks low in terms of market volume of generics at 28% compared to the OECD average of 48%. In contrast, generics comprise over 80% of the pharmaceutical market in terms of volume in Germany, the UK, and the US.\(^7\)

The Japanese government has been working for years to accelerate the use of generic drugs in Japan. In 2002, there were a few changes made to the fee schedule and prescription methods intended to increase use of generics drugs. However, the government’s intentions were unclear until the goal to increase pharmaceutical market volume share of generics to 30% was declared as a part of the Cabinet-led 2007 economic and fiscal reform legislation. The MHLW followed up later that year with the “Action Plan to Promote the Safe Use of Generics,” which set policies related to patient understanding of generics, generic drug quality, and dispensing of generic drugs. Between 2008 and 2012, various adjustments were made to the fee schedule and to prescription regulations to further encourage the use of generic drugs. In 2013, the MHLW released its new goal of increasing the share of generic in the market (where generic replacement is possible) from the 2010 figure of 40% to 60% by 2018 in its “Roadmap for Further Promotion of Generic Medicine Use” released that year. In addition to setting a new goal, this “roadmap” set policy to strengthen the system to monitor progress toward this goal and clearly identified actions to be taken by the government, industry, and health care providers in order to achieve this goal.\(^8\) In 2015, the government announced a new goal to bring generic drug use to over 80% (where generic replacement is possible).

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\(^8\) Japan Generic Medicines Association, [http://www.jga.gr.jp/medical/about/generic07/](http://www.jga.gr.jp/medical/about/generic07/)
Medical service fees are defined as the fees received by a medical facility or pharmacy in exchange for insured medical services or products provided to an insured person. These fees are overseen by the Ministry of Health, Labour and Welfare (MHLW), which sets the fee schedule and determines the billing conditions for medical services, medical devices, and pharmaceuticals all providers must adhere to. There are prohibitions against setting fees higher than those in the fee schedule and providers are restricted from combining non-listed services and products with listed ones, with very few exceptions. Mixed medical care series (MMS or kongo shinryo) is currently being introduced and further exceptions to these restrictions are expected in 2016.

**Fee for service**

Since the system was established in its current form in 1961, healthcare fees have been administered on a fee-for-service (FFS) basis. When a service, pharmaceutical product or medical device is provided through the insurance system, the provider calculates reimbursements based on the number of points allocated for each item. The provider is then reimbursed for the service or product based upon the number of points.

**Diagnosis Procedure Combination**

Diagnosis procedure combination (DPC) is a uniquely Japanese payment system that first emerged in the early 2000s amidst growing concerns over healthcare costs, length of hospital stays, and the healthcare needs associated with the growing aging population. The goal of DPC is to support improvement in health care standards and transparency. Through the collection of objective treatment information made accessible through a database, this system strives to not only help hospital administrators and providers better understand the outcomes related to the care they are delivering, but also to improve quality of care and address disparities between hospitals. Patients also have access to data-based care standards as well as pricing information. DPC was also designed to shorten the average hospital stay length. As of 2012, this payment system was estimated to cover nearly 53% of general hospital beds in Japan (Ishii 2012). Similar to the diagnosis related groups (DRG) prospective payment system (PPS) found in the U.S., DPC is prospective and uses codes based on diagnosis categories and diagnosis groups. As of April 2012, there were 2,927 DPC codes. The unique part of this payment system, however, is that it is per-diem and integrates standard FFS payments. Providers are paid a flat-rate prospective fee per day of inpatient hospital stay for certain DPC services and paid FFS for non-DPC services.

More specifically, **DPC payments**:
- Are dispersed for hospital stays, diagnostics, injections, pharmaceuticals, and medical treatments valued at less than 1,000 points. Payments are calculated on a per-day basis depending on the DPC code and medical institution’s coefficient, which was previously unique to each institution. This coefficient is currently being revised to reflect hospital type giving hospitals of similar type across Japan the same coefficient.10
- Do not cover surgery, radiation therapy, anesthesia, and

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medical treatments valued at more than 1,000 points. These instead are paid FFS.

- Differ according to hospitalization period within the specified period of hospital stay.* Per-day payments for the first period of hospital stay are higher than the latter two periods. Per-day payments within the second period, which lasts until the average length of stay, are set lower effectively neutralizing the higher payment provided in the first period. Per-day payments within the third period are lower than the payment rates of the second period. If length of stay becomes exceptionally extended, all payments become FFS.

Various analyses have been conducted to determine whether DPC is succeeding in achieving its intended purposes. While it has largely been shown that DPC has not resulted in lower costs due to its unique mix of PPS with FFS, there is strong opposition against further integration of PPS.11,12,13

**What is the specified period of hospital stay?**
The specified period of hospital stay divides a hospital stay into three periods. Period 1 refers to the length of time equal to the 25th percentile of the average length of stay (ALS) for the specific episode. Period 2 extends from the 25th percentile to the ALS. Period 3 begins after the patient remains in the hospital after the ALS and lasts until a period equal to the ALS plus 2 standard deviations. Under the DPC system, after a patient exits period 3 and leaves the specified period of hospital stay, medical expenses are reimbursed fee-for-service. See figure below.

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4.3 Financing | Cost control

Bi-annual fee schedule review
Fees for medical services, products, and pharmaceuticals delivered by almost all providers are dictated by a national fee schedule. Every two years, the fee schedule along with conditions for billing are reviewed and revised by the MHLW. This process, which begins in the spring of odd-numbered years and finishes in April of the following year, sets fees and policies that dictate the healthcare benefit package as well as nearly all provider and medical facility income. This policy tool acts as the government’s cost control lever as both overall costs and line-item costs can be adjusted affecting provider behavior. With clear objectives and ongoing oversight, this mechanism acts as a strong rein on the healthcare system’s associated costs, supply, and service provision. Interestingly, it also extends to ensure the financial health of providers.

Revision to the fee schedule
Revision to the fee schedule takes place first at a global level before moving on to the item level. The global level process signals the government’s health spending intentions over the next two years. Specifically, the Ministry of Finance’s Budget Bureau and the Health Insurance Bureau (HIB) of the MHLW decide on the global revision rate, which is the combination of volume-weighted adjustments to prices of services and pharmaceuticals. These figures are based on discussions between various stakeholders, including the ruling party and the JMA, and estimates based on the Empirical Survey of Medical Care Economics (Iryou Keizai Jittai Chousa) and the Pharmaceutical Price Survey (Yakka Chousa). Economic, social, and political considerations are also taken into consideration. Because these rate changes only reflect adjustments in pricing, it may be more helpful to think of these figures as signals rather than a reasonable estimates because changes in volume and product availability ultimately affect overall costs over the next two years.

Central Social Insurance Medical Council (Chuikyou)
After global rate reductions are finalized in December, line item revisions are made to the fee schedule and pharmaceutical prices by the Central Social Insurance Medical Council (Chuikyou), an advisory group to the MHLW Minister that is staffed by the HIB and includes members who represent payers, providers, and the public. This group is one of the most critical groups within Japanese health policy. These price adjustments are made in order to achieve specific outcomes. For example, medical service rate increases are used as provider incentives and decreases are used to contain high-volume services. These rates are also adjusted to ensure income and costs are relatively equitable across the various health specialties. Because these revisions directly affect provider income, this process includes the reflected interests of the ruling party and finance ministers as well as extensive negotiations between interest groups and MHLW bureaucrats.

When are the fee schedule revision “winners and losers” decided?
In the lead up to the fee schedule revision held once every two years, most health policy stakeholders are holding their breath (See: “Lining up from early morning to see Chuikyo”). In fact, the anticipation of which fees will be cut and which areas will see increases amidst limited resources brings forth a “slash or be slashed” mentality reminiscent of a Japanese historical drama. So, when are the winners and losers officially decided? The global revision rate that outlines the foundation of the fee schedule revision is released in December of the year before the revision. Consequently, the scramble for pieces of the “fee schedule and pharmaceutical pricing pie” takes place between October and December.

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15 Maeda, p.103-104
16 Maeda, p.103
17 Maeda, p.111

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Pharmaceutical rate revisions are a unique and important part of the cost control process. Once the volume-weighted average price is set, the new price is decided by adding a certain percentage onto the average price. Because the difference between these rates and provider purchase price is equivalent to provider income, purchase prices have been pushed down by provider negotiations leading the MHLW to further push down the payment rates to control costs.\textsuperscript{18}

**Revision of conditions for billing**

Unlike the fee schedule, revisions to the conditions for billing are not limited to once every two years, but can be revised by the MHLW at any time. Through these conditions, the provision of products and services can be controlled enabling an additional method of cost control. These conditions also serve as the main source of quality control on healthcare services. By setting certain standards that must be met before a service can be billed, the MHLW is able to ensure that, for example, the proper equipment is used for a specific service or the appropriate number of staff is available to each inpatient receiving treatment.\textsuperscript{19}

\textsuperscript{18} Maeda, p. 77
\textsuperscript{19} Maeda, p. 73