

Medical Expenditure: “Saving Account” Recommended for an Aging Society— Ministry Plan Not Effective in Curbing Medical Expenditure

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On October 19, the Ministry of Health, Labor and Welfare released a plan for the reform of the medical system. This was in response to another plan, recently worked out by the Council on Economic and Fiscal Policy, whose centerpiece was the macro-level control of total medical costs. The Ministry plan aims to curb medical expenditure through the accumulated effects of various measures, including 1) medium and long-term measures, such as the prevention of life-style related diseases; and 2) a short-term measure, centering on a review of out-of-pocket outlay by elderly patients.

The plan also includes a number of measures designed to stabilize the finance of the health insurance system. These measures have long been debated by the government panel on social insurance. The proposed measures include the following: 3) transferring to each prefecture the management of the “seikan-kenpo,” an insurance system for the employees of small and medium enterprises, for which the government is the insurer; 4) the creation of a separate insurance system for the 75-and-over age group (the older elderly); and 5) for those between 65 and 74 years of age (the younger elderly), who will remain in the national health insurance system, the correction of the imbalance between the burdens of the national health insurance system and the employee health insurance system, by distributing the burden of benefit payments according to the number of the insured under each system.

The Ministry states that these reforms will reduce benefit payments in 2025 from the 56 trillion yen envisioned under the present system to 49 trillion yen, and curb the rate of increase in medical expenditure. With respect to the finances of the insurance systems, the proposed plan is expected to reduce by fiscal 2008 the finance of the “seikan-kenpo” by 230 billion yen, and that of the national health insurance managed by municipalities by 220 billion yen, while increasing the burden of health insurance societies (an insurance system for the employees of big companies) by 220 billion yen.

No Incentive to Prevent Life-style Related Diseases

The most important measure for the prevention of life-style related diseases is to provide incentives to the insured and the insurers, who control and manage the insurance systems, rather than to prefectural governments. The effect of the Ministry plan is doubtful because it provides hardly any incentives to the insured or the insurers to take measures to prevent life-style related diseases. The financial effect of the proposed reforms is calculated under the assumption that the measures will be effective. That is, the Ministry's assumption is equivalent to its conclusion. Whether the programs will be really effective is another matter.

It is thought that life-style related diseases manifest themselves as chronic diseases as a person ages. However, since both the proposed new independent insurance system for the 75-and-over age group, and the national health insurance system, which covers those between 65 and 74 years of age, will be able to receive assistance to cover their deficits, the insurers will suffer no financial difficulties even if they do not work hard to prevent life-style related diseases. Moreover, since, under the proposed plan, out-of-pocket expenditure by the elderly will not be increased significantly (rather, the percentage of the cost borne by patients themselves will be reduced for those between 65 and 74), there will be no incentive for the insured to make an effort to prevent disease. There is also the more fundamental question of what the prefectures, which are not the insurers, will be able to do with respect to the national health insurance system and the proposed new independent health insurance system for the 75-and-over age group.

There are also problems with the short-term measures. The effect of increasing out-of-pocket payments by patients will be merely a one-time change in the level of payments. It will not curb the rate of increase in medical expenditure. Basically, the same is true for the proposed increase in the patient's share of hospital accommodation costs (meals and lodging).

Stabilization of the Finance of Insurance Systems Still Doubtful

It is quite uncertain whether or not stability will be maintained in the finances of national health insurance systems run by individual municipalities, which will have to manage the new insurance system for the 75-and-over age group. Even within the 75-and-over age group, medical expenditure varies greatly with age. Therefore, it will be necessary to make certain adjustments for age composition (adjustments of risk structure) through, for example, transfers of funds from municipalities, in which the average age of the older elderly is low, to those in which the average age of the older elderly is high. Generally, risk adjustments in public health insurance systems take the form of financial assistance to the systems with large shares of elderly people and low income-earners, from other systems. In the proposed Ministry plan, adjustments in the national health insurance systems run by municipalities will be made only for age, and in "seikan-kenpo" for age and income, but there will be no adjustment whatsoever in the proposed new independent insurance for the 75-and-over age group. The Ministry is contradicting itself by proposing different approaches in different systems. In terms of

finance, health insurance societies will be the sole loser. This is largely attributed to the fact that the share of the 75-and-over age group is very small in those systems. If this is the case, why does the finance of the health insurance system of mutual aid societies (for government employees, etc.) not deteriorate? Thus, the Ministry's method of calculation is being questioned.

As yet another means of curbing medical expenditure, both the Council on Economic and Fiscal Policy and the Ministry of Health, Labor and Welfare's plan discuss a reduction in doctors' fees. However, the effectiveness of this is also doubtful, because a reduction in doctors' fees may increase "doctor-induced demand" for more medication and examinations, so that doctors will be able to secure certain levels of income.

"Saving Account" Formula Will Motivate Individuals to Save

As in the case of pension finance, a partial introduction of a "saving account" formula appears to be an effective means of easing the impact of the aging population. This could be done in the same way as Medicare (public health insurance for the elderly) in the United States, namely, by building a reserve through the charging of slightly higher premiums to workers, or through the introduction of a "medical saving account (MSA)" for individuals. The MSA is an individual saving account for medical expenditure. The funds therein may be used exclusively for medical care, and there are tax incentives for the account holders. The system is in use in Singapore and elsewhere, and if the funds are not used for medical purposes, they can be reimbursed as pensions. This gives individuals an incentive to save medical costs, which is an important benefit to be considered.

Needless to say, it is imperative to make medical care slim and lean. At present, a great deal of medical expenditure is being wasted. To correct this situation, the system must provide both the insurers and the insured with incentives to reduce costs, rather than take such ineffective measures as reducing doctors' fees or motivating prefectures. The prerequisites for such saving are to introduce an electronic means of medical record keeping and to standardize medical care (or set a standard so that medical costs for the same disease are roughly the same). This will change the system of payment to medical institutions from reimbursement for whatever care they have given to patients, to the diagnosis procedure combination (DPC) formula. Also, the function and power of insurers should be strengthened, so that medical institutions, which give excessive treatment, may be excluded from insurance systems.

Moreover, since there are inevitably limits to medical care that can be provided under public insurance, it will be important to reduce the scope of public insurance, as in the case of the National Health System (NHS—a public medical system run with tax money) in the United Kingdom, or expand so-called "mixed care," under which part of the treatment can be provided outside of public insurance. Also, it seems that there is room for further increases to the share of medical costs shouldered by elderly patients. An increase in out-of-pocket outlay by elderly patients will be an important incentive for improving people's life-styles.