Provider payment system in Japan – pursuing best match -

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Medical system in Japan

- System based on social health insurance
- Universal coverage of the population achieved in 1961
- Provider dominated by private
- Health professionals belongs to medical institution
- 10%-30% Patients’ co-payment

(Source: Medical Survey Facilities 2015)
Medical Expense system summary

(1) What is Medical Expense?
- A reward for the medical insurance service rendered by the Insurance medical Institutions and pharmacies.
- Flat rate for all insurance Institutions and pharmacies (nationally same rate)
- Minister of Health, Labour and Welfare decides upon the discussion by the Central Social Insurance Medical Council.(Announcement by the Minister of HLW)

(2) Functions of the Medical Expense (incl. those of the operating rules such as the point table)

① Fee setting for each Medical Care (characteristic as a fee table)
   ※ Technics and services as points and evaluated (10JPY /point)
② Range&detail setting for Medical Care (characteristic as an Item table)
   ※ Unless a Medical Care is set forth in the point table, it shall not be paid by insurance.
- Evaluation for the technics and services (Circa 5,000 items)
- Monetary evaluation for the goods
  (Pharmaceutical price shall be set forth by the NHI Phramaraceutical Price Standard. Circa 17,000 items)

(3) Main roles & effects of the Medical Expense
① Set forth the Medical Expense for each Medical Care.
   → Affects the Quantity and Quality of the medical service.
② Set forth for the medical income of the Medical Institutions.
   → Affects the Management of the Medical Institutions.
③ Allocation of the Medical Care cost (Medical Care resource) → Affects the Medical service structure.
④ Set forth the National Health Care cost together with the Service supply volume.
   → Affects the National budget (Finance).
“Basic Medical Care fee” mean a payment for the 1st consultation fee, follow-up consultation fee, consultation during hospitalization, and the basic medical cares as a lump sum amount. It includes simple examinations, Medical Care such as blood pressure measurement, etc., intradermal, subcutaneous, intramuscular, intravenous injections, and simple Medical Cares during hospitalization.

“Special Medical Care fee” means a payment for the special Medical Cares which are not appropriate to pay as a lump sum amount as a Basic Medical care fee.
(Ex.) ● Hospitalized due to the Acute appendicitis
   ● Performed appendectomy by opening the abdominal with Spinal anesthesia on the 1st day.
   Commence to eat meal from that night and hospitalized for 4 days.

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**Medical fee at a glance**

- **Basic hospitalization fee 7,128 points**
  (Breakdown) 10 to 1 Basic hospitalization fee  1,332 points x 4 Days
  Addition for the hospitalization not exceeding 14 days  450 points x 4 Days
- **Additions for the Basic hospitalization fee (4 Days) 870 points**
  Addition for the general hospitalization system 2 (per One Day)  120 points x 4 Days
  Addition for the clinical training hospital hospitalization consultation fee (1st Day)  20 points
  Addition for the clinical record management system 2 (1st Day)  30 points
  Addition for the medical safety measures (1st Day)  85 points
  Addition for the administration support system for MD (1st Day)  255 points
- **Appendectomy 6,210 points**
- **Anesthesia 950 points**
  (Breakdown) Spinal anesthesia  850 points
  Anesthesia administration fee (II)  100 points
  (Meals during hospitalization (I) @640 JPY x 8 5,120 JPY)

**Total: 15,158 points**

*Other examinations, X-ray analysis, dosages, injections.
(If the co-payment ratio is 30%, the amount deductible is 47,010 JPY)

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※Some hospitals implemented a lump sum payment system (DPC system) for the acute hospitalization and the consultation fee is based on the daily lump sum fee.
Inclusive payment vs. pay for service

Inclusive payment per day

- Easy to claim for hospitals
- Pursue efficiency
- Delayed discharge
- Tendency to select simple case
- Possibility to provide insufficient care

Pay for service

- Equity between patients who consume a lot and who consume less
- Visibility for provided care
- No incentive to avoid complicated case
- Induce exceeded care
- Complicated to claim
# Hospitalization fee for long term care

## Medical care necessity

<table>
<thead>
<tr>
<th>ADL</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>87.32</td>
<td>127.50</td>
<td>163.44</td>
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<tr>
<td>2</td>
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<tr>
<td>1</td>
<td>73.50</td>
<td>111.07</td>
<td>132.56</td>
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For units with:
- More than 1 nurse and 1 assistant nurse per 20 patients
- More than 80% of patients are medical care necessity level 2 or 3

## Necessity of medical care

<table>
<thead>
<tr>
<th>ADL</th>
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<th>3</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>81.45</td>
<td>121.63</td>
<td>157.57</td>
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<tr>
<td>2</td>
<td>77.12</td>
<td>119.20</td>
<td>152.70</td>
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<tr>
<td>1</td>
<td>67.73</td>
<td>105.20</td>
<td>126.69</td>
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</table>

For units with:
- More than 1 nurse and 1 assistant nurse per 25 patients
- More than 50% of patients are medical care necessity level 2 or 3

### Short history

- **2006** Fee depending on patients age and nurse/assistant nurse number (4 types)
- **2006** - Introduction of fee depending on patients medical/ADL status (5 types)
- **2010** - Introduction of elevated fee for units equipped with more nurse and have more critical patients (9 types)
- **2016** - Introduction of minimum requirement of critical patients

Fee for clinical examination, pharmaceuticals, injections, pathological examination, certain medical imaging and light surgery is included.
Medical fee revision is
① The revision rate decided by the cabinet through the budget planning process as a prerequisite,
② and base on the “fundamental policy” set forth by the WG for the medical insurance and by the WG for the medical affairs, Social Security Council,
③ and is implemented after the examination of the setting of the medical fee points in details at the Central Social Insurance Medical Council.

Flow of the medical fee revision:

- **Cabinet**
  - Decision on the revised ration through the budget planning process.
  - Decision on the total amount of the medical expense
  - Decision on the medical expense distribution

- **Social Security Council**
  - WG for the medical insurance /WG for the medical affairs
  - Examination of the basic medical policy.
  - Setting forth the “fundamental policy” for the medical fee revision.

- **Central Social Insurance Medical Council**
  - Examination according to the “fundamental policy” set forth by the Social Security Council.
  - Discussion about the point setting or calculation requirements for the individual medical fee item.
Central Social Insurance Medical Council

【Scope of work】
○ The Central Social Insurance Medical Council examines or replies upon the consultation by the Minister of HLW and may propose by itself.

【Trinity structure】
○ Trinity structure: committee at payee side and at Medical Care side consult each other as a party of the insurance contract and the Public Member adjusts between them. Term for service is 2 years (but not exceeding 3 periods of 6 years).
① Committee from payor side (Delegates of the insurer and the insured) 7psn
② Committee from Medical Care side (Delegates of the MDs, Dentists, and Pharmacists) 7psn
③ Public Member 6pns (approved by the Congress)

○ A chairman shall be elected from the Public Member by the vote among the committee.
○ Member of the committee for the public interest of the Central Social Insurance Medical Council shall discuss the meeting date, agendas, or other management issues hereof and both committee at payor

【Examination of the exclusive issue】
○ If the Minister of HLW thinks it is necessary to discuss the exclusive issue, he/she may appoint specialists respectively time to time but not exceeding 10 person.
## Researches relating the Medical Care Remuneration revision

<table>
<thead>
<tr>
<th>Organization in charge/ performance</th>
<th>Research name</th>
<th>Summary</th>
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<tbody>
<tr>
<td>Statistical Information Dept.</td>
<td>Survey of each social medical care</td>
<td>Survey of the QTY and points for the Medical Care.</td>
</tr>
<tr>
<td>Medical Care Div., Insurance Dept. at each Prefectural Welfare Dept.</td>
<td>Condition report for the medical institution standard report</td>
<td>Condition report for the medical institution standard regarding the Medical Care remuneration</td>
</tr>
<tr>
<td>Inspection WG/ Medical Care Div., Health Insurance Bureau</td>
<td>Inspection WG survey</td>
<td>Survey of the items to be inspected upon the Medical care remuneration by the Central Social Insurance Medical Council</td>
</tr>
<tr>
<td>Central Social Insurance Medical Council /Medical Care Div., Health Insurance Bureau</td>
<td>Survey of the Medical Economics fact</td>
<td>Survey of the Medical Institution’s management facts</td>
</tr>
<tr>
<td>Medical Care Div., Health Insurance Bureau</td>
<td>DPC Data</td>
<td>Medical Care data upon the use of the DPC</td>
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<tr>
<td>Medical Care Div., Health Insurance Bureau</td>
<td>National Data Base</td>
<td>Total Medical Care data by the e-Receipt</td>
</tr>
<tr>
<td>Economics Div., Medical Policy Dept.</td>
<td>Market price survey of the medicines and medical materials</td>
<td>Actual acquisition cost of the medicines and medical materials by the medical institution</td>
</tr>
<tr>
<td>Survey Div., Health Insurance Bureau</td>
<td>Medical Expense trend research</td>
<td>Total Medical Expense calculated by the receipt</td>
</tr>
</tbody>
</table>
Key questions

1. How we can simplify the payment list while assuring service quality?

2. How can we be sure not producing insufficient care while limiting overall expenditure growth, using inclusive payment?
Buck up slides
1. Brief overview of the provider payment system in Japan
   2. Combination of these payment system
   3. Continuous efforts to ensure best match
Flow of the Medical Care under the public health insurance scheme and the influence to the Medical Expense

① Payment of the Premium

② Medical service (Medical Care service is rendered)

③ Issuance of the Medical care invoice.

④ Sending the reviewed invoice.

⑤ Payment for the amount in the invoice.

⑥ Payment for the Medical care.

Medical Insurer

Medical care point table

Auditor for the payment
(Health Insurance Claims Review & Reimbursements Federation of National Health Insurance Associations)

Insured (Patient)

Medical care provision system

Insurance medical Institutions
(Hospitals, Clinics, Pharmacies, etc.)

Medical service provision system

Insurance MD

Review
Special Medical Care fee contains fee for techniques, devices and pharmaceuticals

Special medical care fee
- Special medical care
- Home care
- Clinical examination
- Medical Imaging
- Pharmaceuticals
- Injection
- Rehabilitation
- Psychiatry
- Surgery
- Radiation therapy
- Pathological examination

Examples

Care for diabetes
72 USD / month
Fee for other special medical care, medical examination, pharmaceuticals, injection and pathological examination is included
In case doctors prescribe medicine, not giving medicine in clinic

Blood sample examination
- ESR 0.81 USD
- Reticulocyte count 1.08 USD
- Erythrocyte count 1.53 USD etc.
- Fee for blood count analysis 11 USD

- 20 min. rehabilitation for patient having celebrovascular disease 9 – 22 USD
- Planning fee for rehabilitation 28 USD/month

1 USD = 0.00903 yen
Intensive care unit hospitalization fee

Type 1: 1,233 USD /day for first 7 days
1,095 USD/day for 8-14 days
Type 3: 845 USD/day for first 7 days
708 USD/day for 8-14 days

1 USD = 0.00903 yen

Below is included in hospitalization fee
- Basic hospitalization fee
- Certain addition for hospitalization fee
- Clinical examination
- Intravenous injection
- Central venous injection
- Oxygen
- Insertion of catheters
- Specimen making for pathological examination

• Require more qualified doctor
• 20 m² or more space per bed

• Engage one or more doctors inside the unit
• Always one or more nurses per two patients
• 15m² or more space per bed
• Clinical engineer always in hospital
• Equipped with materials (emergency kit, defibrillator, pacemaker, ECG, portable X ray, monitor etc.) and power generator
• 24h clinical examination including ion and blood gas
Palliative care unit hospitalization fee

- For the first 30 days: 445 USD/day
- From the 31st to 60th day: 397 USD/day
- From the 61st day onwards: 298 USD/day

1 USD = 0.00903 yen

Number of the nurse per day: enough to maintain one or more nurses per seven patients

- 8m² or more space per bed
- More than 30m²/person space
- More than one doctor/unit who finished a training on palliative care
- A room for family, kitchen for patients, meeting room, relaxing room
- Less than 50% of beds requiring additional out of pocket payment
- Doctors and nurses decide admission/discharge on a criteria
- Documents for explaining for patients/families are prepared, and explanation for patients/families are done based on these documents
- Center for cancer or qualified hospital
- Giving training for doctors/nurses of other hospitals

Fee for service is included except:
- Certain addition for hospitalization fee
- Pharmaceutical price
- Fee for goods/materials
- Central venous injection
- Radiation therapy
- Fee for education for going back home
What is DPC/PDPS?

"DPC(Diagnosis Procedure Combination/ per-diem payment system)” means

- Implemented to the designated function hospital in April,
- For the acute hospitalization Medical Care,
- And Based on the diagnosis group category, and
- Holistic evaluation system per diem.

* Originally used as an English proper noun to stand for the “Diagnosis group category idiosyncratic to Japan”.

Objectives for the implementation of DPC/PDPS (= to promote the standardization and clarification of the medical science)

Patients,
- are able to refer to the standard medical care by the unbiased data and to the fee/price information

Administrators at the medical institution,
- are able to understand pros and cons for each hospital, understand its position and prepare the future management strategy.
- are able to provide the medical practitioner the issues to improve based on the unbiased data.

Medical practitioners
- are able to understand the issues to improve for their medical care.
- are able to express his/her medical care results.
Comparison of DRG/PPS (Holistic evaluation per one hospitalization) and DPC/PDPS (Holistic evaluation per diem)

Payment is flat regardless of the hospitalization duration.

Strong incentive to shorten the hospitalization duration.

Currently hospitalization duration varies and huge gap incurs.

Shorter hospitalization means surplus.

Short hospitalization and unit price per day is high and surplus.