APRU Public Health Workshop
Panel Discussion V

Engagement of Universities with Government, Business and NGO stakeholders

Developing payment systems in healthcare

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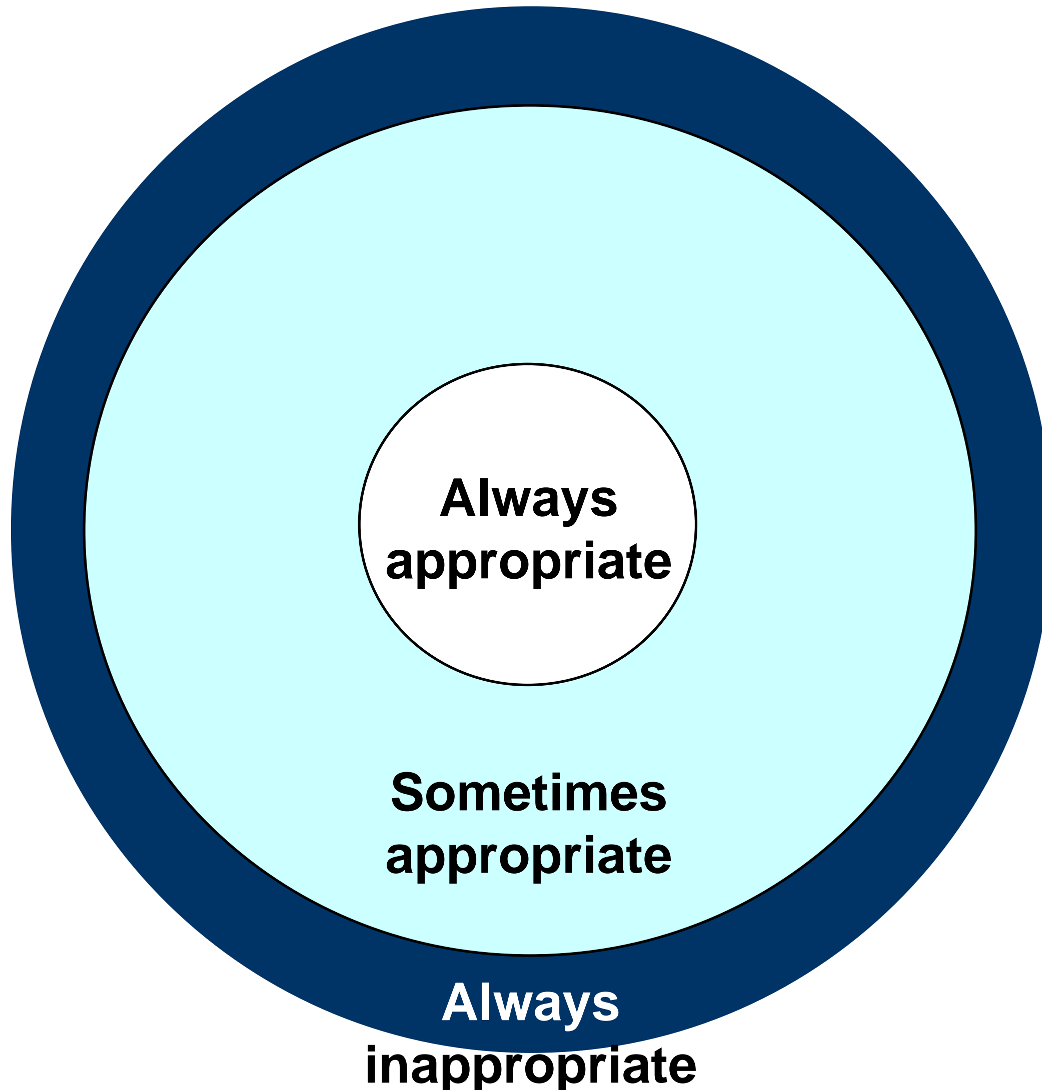
♪Money makes the world go around♪

- How physicians and hospitals are paid is the key to how services are provided
- Solid financial basis is the prerequisite for high quality services and research opportunities
  - Proverb: Becoming poor means becoming slow-witted
- The shifting criteria of “medical need”
  - Large grey area of what is “need”
  - Expands in fee-for-service, contracts in inclusive payment

What is appropriate treatment?



“Appropriate" depends on:

1) Each physician’s experience: training encounters with patients etc.

2) Where the physician practices

3) How the physician is paid: fee for service or inclusive

Conflict of interests

- University hospitals: Maximize revenue under current payment system
- Government: Minimize total expenditures under current payment system
- Business: Open and expand market for products
- NGO stakeholders
  - Provider side: Lobby for more favorable payment system, minimize conflict among members
  - Payment side: Lobby for cost containment, but also for expanding the market for their products
  - Patient groups: Lobbying for better care exclusively targeted to their members

Japanese payment system

- Designing a payment system is a complicated process: Formerly left entirely to insiders→ Government bureaucrats and JMA (Japan Medical Association)
  - Fee-for-service but fees revised individually by negotiations
  - Has contained costs and maintained harmony (façade?)
- But increasing pressure for more accountability→ Evidence-based health policy
- But the reality is evidence-selected health policy
  - Setting health policy is a political process
  - Priorities are decided by politicians representing (?) the interests of the general public
  - Assisted (manipulated?) by bureaucrats

Examples of targeted cuts in fees for MRI diagnostic imaging (Yen)

	Head	Body	Limbs
2000	16,600	17,800	16,900
2002	11,400	12,200	11,600
2006	10,800 if <1.5 Tesla, 12,300 if >1.5 Tesla		
2008	Increased to 13,000 if >1.5 Tesla		
	Extra fee for special imaging eliminated		

Where do healthcare academics stand?

- Need for more evidence, even if selective, has expanded their role
- Delicate balancing
  - To have principles, but not to be too rigid→ When to compromise, when not to compromise
  - To remain on good terms with powerful constituents, but not to appear too close
  - Appropriate mix of medical science and social science
- Being based in medical school
  - Plus: Participant observer of university hospital management
  - Minus: Will not be regarded as being impartial when revising payment system for university hospitals

Personal experience in policy making: Sequel to my presentation in Beijing

- Since 2003, Chair of a Sub-Committee that conducts research for designing and revising a case-mix grouping system for chronic care hospitals
  - Case-mix grouping system: Classify patients based on their clinical characteristics for payment purposes (counterpart of acute care DRG in US and DPC in Japan)
  - Conduct studies of patient characteristics and the costs generated by patients
  - Prior to the introduction of the new system in July, 2006, chronic care hospitals were paid a flat rate, irrespective of severity
  - Original goal: Hospitals treating more severe patients would be paid more, those treating less severe patients paid less on a budget neutral basis

New payment introduced in July, 06

- Algorithm for grouping patients into case-mix groups basically as designed by sub-committee
- But payment amount for the majority of groups was set well below costs as a result of a political decision to contain costs and to force chronic care hospitals to close their beds
- Sub-committee members protested that there was no point in doing the study if their results were disregarded
- Ministry responded that fees are not their mandate
- A new study was made in 2007 to validate the results but the 2008 payment revisions were minimal

Costs per patient per day (07 study) (Yen)

	Medical 1	Medical 2	Medical 3	Total
ADL level 3	16,875	17,788	21,443	18,517
ADL level 2	15,620	17,358	20,760	16,855
ADL level 1	13,469 (D)	14,824 (D)	16,494	13,966
	13,133	14,797		
Total	15,117	17,176	20,999	17,351

(D) : Those with dementia

Fees set by government (08) (Yen)

<table>
<tr><th></th><th>Medical 1</th><th>Medical 2</th><th>Medical 3</th></tr>
<tr><td>ADL level 3</td><td>8,850（～）</td><td rowspan="2">13,200
（240↓）</td><td rowspan="3">17,090
（310↓）</td></tr>
<tr><td>ADL level 2</td><td rowspan="2">7,500
（140↓）</td></tr>
<tr><td>ADL level 1</td><td>11,980
（220↓）</td></tr>
</table>

Does not include extra payment for meals, rehab etc.
↓ and ～ show changes from the 06 fees

Summary

- The case-mix based system may not reflect costs but its introduction has made the extent of policy intervention more transparent
- Greater role of health services research
  - More legitimacy by sharing the same conceptual approach and by using the standardized methodology
  - Once one side in the health policy arena becomes more sophisticated, the other side must reciprocate
  - Health services research arms race in United States
- More engagement of university-based health service academics by university hospitals, governments, businesses, and NGO provider, payer and patient organizations
- Development of university-based health services research units and training programs needed in Japan