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Comparing different Models of the Public/Private Sector Mix in the Delivery of Healthcare Services

Hierarchy, market or network?

Analysing governance of the Japanese mixed health care delivery

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Hierarchy, market or network? Analysing governance of the Japanese mixed health care delivery

(a very preliminary draft)

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Abstract:

Governing healthcare delivery is one of critical challenges in the health care sector for many countries. With different mixes of public and private delivery in different regions, as in Japan, it would be difficult to make a simple regulatory framework on providers to achieve policy goals regions because different kinds of provides have different organizational principles and motivations for their activities under different general regulations correspondent to their legal status. This qualitative study aims to gain insights from an in-depth case study on the governance of the Japanese mixed health care delivery, which has historically developed differences in public/private mix of delivery. The paper starts with a brief overall description of the healthcare system. Then it describe the system from perspectives of the three models of governance: hierarchy, market and network. The government has strong influence on the healthcare "market", consisting of public and private providers, but limited hierarchical power to directly control providers, particularly private providers. When market failures arise, different models can be used in different regions with different public/private mixes. Third, the paper describes historical changes of government regulations and interprets as changes in ways of governance. The government tried to expand the healthcare "market" until the middle 1980s, when overall restrictions on number of hospital beds were introduced. Since the 2000, the government has been increasingly engaged in transforming

healthcare delivery with slightly enhanced regulatory power. Yet the governance of the system seemingly is shifting from the market model to the network model, not to the hierarchical mode. The paper concludes with general remarks on the governance of mixed healthcare delivery from comparative perspectives.

Introduction

Governing healthcare delivery is one of critical challenges in the health care sector for many countries. With different mixes of public and private delivery in different regions, as in Japan, it would be difficult to make a simple regulatory framework on providers to achieve policy goals regions because different kinds of provides have different organizational principles and motivations for their activities under different general regulations correspondent to their legal status.

This qualitative study aims to gain insights from an in-depth case study on the governance of the Japanese mixed health care delivery, which has historically developed differences in public/private mix of delivery. The paper starts with a brief overall description of the healthcare system. Then it describes the system from perspectives of the three models of governance: hierarchy, market and network. Third, the paper describes changes of government regulations since the 1990s and interprets as changes in models of governance. The paper concludes with general remarks on the governance of mixed healthcare delivery from comparative perspectives.

The Health Care System in Japan

The Japanese health care system, established in the 1960s as with the current structure, is based on the Statutory Health Insurance System, on which a variety of providers

deliver health care to people. The majority of health care funding goes thought the statutory health insurance system; in 2014 FY, taxes, premiums, and cost-sharing accounted for about 39 %, 49%, and 12% percent of the current health expenditure, respectively[1]. Citizens are automatically enrolled in an employment- or residence-based insurance plan according to his or her employment status, i.e. citizens have no choice of plans. For example, if you are a retired person with no more jobs and living in Kyoto, you are automatically enrolled in Kyoto City Health Insurance Plan, a plan based on the Citizen Health Insurance Act[2,3]. If you are employed by Toyota for a full time job, you are automatically enrolled in Toyota Health Insurance Society, which is a self-managed society operating under the regulations set by the government. Finally, if you are an employee at a small- or medium-sized company, you are enrolled in a plan of the Japan Health Insurance Association, which is a publicly managed insurance organization for those working at small- and medium-sized companies and the largest insurance plan among all statutory insurers.

Although the system comprising more than 3,400 mutually exclusive plans that have slightly different ways of calculating premiums, especially between employment- and residence-based plans, they have similar benefit packages stipulated by the Payment Rules set by government. Also, since the mid-2000s, all insurance plans have the same 30% co-insurance rate for ordinary citizens, except for children and the old citizens, whose rates are lower. The rate is applied to all covered services, including primary care,

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[1] Ministry of Health, Welfare and Labour (2016) Summary of the National Health Expenditure, FY 2014 (http://www.mhlw.go.jp/toukei/saikin/hw/k-iryohi/14/index.html).
[2] Although the official translation of the act is "National Health Insurance", this paper follows the translation by Naoki Ikegami to make it clear that the Citizen Health Insurance plan covers only a part of the total population.
[3] Since 2008, citizens aged 75 and older are covered by plans operated by 47 regional bodies, under the Healthcare for the Old-Old Citizens Act.

hospital inpatient and outpatient care, mental care, palliative care, and prescribed pharmaceuticals.

With the mixed provision, healthcare delivery is organized accidental or historical combination with the market mechanism and the public intervention. Private institutions have a major share of the total provision. Because of limited regulations on healthcare provision, private institutions, either individual or legal entities, are able to enter the healthcare market provided that they followed quality standards. Meanwhile, there has been a rule that the chief operating officer of a medical institution shall be a certificated medical doctor.

The following three points are critical to understand the healthcare delivery in Japan. First, in the late 20 century, when the health care sector expanded massively, the government did not develop health care delivery by direct public provision; rather it fostered private not-for-profit institutions by making loans with low interest rates available for them. The government has not allowed private for-profit organizations to enter the market except the case that companies proposedly establish medical institutions for their employees and employers.

Second, public provision of healthcare also has been developed partly as a part of the market and partly as supplements to the market. Local governments, either municipalities or regions, established a significant number of public hospitals and occasionally primary care centres. Those hospitals are not only for people living in remote areas and with low income, but also for ordinary citizens. There are many local government hospitals in urban areas as Metropolitan Tokyo. In contrary, primary care centres are usually established in geographical areas and services that the market fails to delivery in their jurisdictions. Those local public providers have been regulated, and

occasionally supported, by the national government with conditioned subsidies and guidelines The national government itself, however, limited its role in expanding healthcare: it maintained educational hospitals at prestigious national (public) universities and newly established publicly medical schools, and hospitals previously for military people before 1945, and later in the 1970s, national centres with highly specialised focus of care.

Finally, in the mixed market, private and public providers compete each other, facing the same payment rules from the SHIS, to survive and develop. After the establishment of the current system in the 1960s, the majority of the health service market has been regulated by the government with financial incentives brought by the Statutory Health Insurance System. Between the 1960s and the 2010s, the share of the private sector in hospital services increased gradually. In 2014, the private sector shared 57 % in the hospital sector, and 83 % in outpatient clinics.

Mixed models for governing delivery of health care

As describe in the previous section, the Japanese health care system can be regarded as a market with public and private providers and supplementary provision by public providers under the Statutory Health Insurance System having a unique payment system. I will skip descriptive explanations on different types of providers here. Rather, I would like to explain how the state[4] overall govern the system with providers having different motivations and institutional duties using an analytical lens: the three models of governance: hierarchy, market and network. In this section, I will describe how the

[4] Japan has a parliamentary democracy with two representative houses. I has two-tier local government with 47 regions and more than 1500 municipalities. Inter-governmental funding transactions have been developed with complex procedures.

three models work in governing the health care delivery in Japan.

The predominant model of governance in health care delivery has been the market. In this model, providers respond to the situation of the market in which prices of health services and pharmaceuticals are controlled by the state with the Social Health Insurance System working as a single payer in term of payment. In the market primary care has not been well differentiated from secondary care because most hospitals provide out-patient services including primary care, there are many small-sized hospitals, and patients can choose providers by themselves. In other words, hospitals can rival practicing physicians who operate clinics whether without beds or with a small number of beds. The undifferentiated market was represented by the payment system: the same fee-for-service payment schedule was adapted to hospitals as well as practicing clinics[5]. The market has been open to both private not-for-profit and public providers. New health care providers were able to enter the market if they meet quality standards given by the government and other institutional rules[6]. Meanwhile, the government restricted the entry of local government hospitals and other public-interest medical institutions in the early 1960s. It is not surprising, therefore, that private providers increased their share when the health care market expanded between 1950 and 1990.

The health care market does not always work well. In such cases, local governments, either municipal or regional governments, try to do solve the problem as they, together with the national government, are responsible for ensuring a system that efficiently provides good-quality and well-suited medical care to residents. The network and

[5] In the last decade, a new per-diem payment using the Diagnosis Procedure Combination (DPC) system, a case-mix classification similar to diagnosis-related groups, has been prevailing.

[6] Other institutional rules includes a rule that the head of a hospital must be a medical doctor.

hierarchical model emerges to deal with this market failure. But because the market predominantly constitutes health care delivery, the government interventions were often reactive rather than proactive and varied in response to problems raised within the existing mixes of providers. Also, we can assume that network-based solutions are sought among local stakeholders. For example, in the rural areas where no private agencies did not practice but a powerful agricultural co-operative exist, municipalities can establish their out-patient clinics, often with financial supports of the national government; but, the agricultural cooperative, which is designated to manage "public-interest" medical institutions, also can establish its out-patient clinic with financial supports from the municipality. What solution, therefore, is finally chosen is dependent on the decision of local stakeholders. Here we cannot assume that local governments decide a policy direction by themselves because they do not have responsibility of directly delivering health care, but have general responsibility of ensuring a good delivery. They need to collaborate with other stakeholders to establish a feasible solution.

The network-based governance also are used to organize collaborative actions of providers that may compete each other in general terms. For example, after several emergent cases that were not timely treated, local governments set up emergency information and delivery systems for make emergent care accessible every time in any medical fields. Both private and public providers with emergency department to participate in those system.

The hierarchical model of governing that a top-level body on the top level make rules and forces lower-level bodies subordinate to them. This model, also referred to as the command-and-control model, is not prevalent but were used in the relationship between the national government and the national hospitals, where physicians, nurses, managers

and other staff were employed as public servant. The daily management of national hospitals were conducted within their discretion but investments for health care were decided by the Ministry of Health and Welfare[7].

The free entry to the market made it possible to swiftly increase the supply to meet increasing the demand for health care. As money follows activities at the point of services in the Japanese Statutory Health Insurance System, agencies expanded their activities or established new providers, which resulted in the growth of the market, though the government was busy negotiating with paying stakeholders, as the Association of Health Insurance Societies, the National Association of Citizen Health Insurers (*Kokuho-Rengokai*), and others[8]. Besides the market, the national government established hospitals for specified reasons, such as medical education and expansion of research capabilities. Local governments rather were supposed to do something to develop, or at least, maintain health services at their jurisdictions and established local hospitals and out-patient medical centres. Once such providers are established as a part of public services, they are controlled with the hierarchical model. However, local governments and other stakeholder have possibilities to collaborate for delivering health care in various ways. In summary, the predominant market model of governance, supplemented by the network and hierarchical models, were used in the era of health care expansion.

Transforming the delivery of health care with shifting to the network model

As the health expenditure increased and the increase rate of population slowed down,

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[7] The management of most national hospitals were transferred to the National Hospital Organization, an independent administrative agency.

[8] Within the government, the Ministry in charge needs to negotiate with the Ministry of Financing in the process of drafting the annual general budget because around one-fourth of the National Health Expenditure comes from the budget.

policy makers had the idea that something should be done to control the expansion of the health care market. The idea resulted in the introduction of regulations on the total number of hospital beds in regions in the 1980s, followed by more detailed planning on health services and functional differentiation of hospital beds. In the market under the pressure to increase efficiency, the network governance mode has been more emphasized in regional health policy making, though the market model

In the mid-1980s, the government introduced a regulation that regional governors have power to restrict the number of total hospital beds in their jurisdictions. According to the method provided by the national government, regional governments calculate the necessary number of hospital beds. If the number of existing hospital beds exceeds the necessary one, governors can reject can reject applications either from private agencies or from public or public-interest agencies. After that, the health care market has been gradually shrinking with the payment rules favouring larger scale of hospitals. Also, because the entry to the market has been restricted in terms of scale, competitions between providers has been supposed to be changed: they don't need to be worry about new comers but look at each other's activities.

Meanwhile, differences between regions in health care expenditure per capita has emerged and those evidences showing the differences were occasionally interpreted as showing inefficiency in some regions, possibly caused by "physician-induced demand". The interpretation has not been confirmed due to theoretical and empirical limitations and the government did not move toward explicit need-based resource allocation; rather, an idea that regions should be more responsible for regional health care came to policy makers.

The idea maintains the existing structure of the health care system, i.e., the combination

of the Statutory Health Insurance and the mixed provision, but it emphasizes that health care services should be efficiently coordinated to meet regional needs by organizing collaboration and gathering information of regional providers. It also emphasizes that statutory health insurers should be engaged in the collaborating process at the regional level as representatives of payers.

The government legislated to concrete the idea. First, regional governments gain power to collect information on functions of hospital beds, with this power, they make tentative estimation of demand for hospital beds by their functions. Then hospital service providers are requested to submit their own plans on beds and to decide "Regional Health Care Delivery Visions" at the Regional Health Care Council[9].

Second, statutory health insures has been re-organized so that they are engaged in regional health policy making. The management of Citizen Health insurance will be transferred from municipalities to regions from FY2018. The Health Insurance for Old-Old Citizens are organized at the regional level, though involving municipalities, since its inception. The National Health Insurance Association, covering workers at small- and middle-sized companies, established 47 regional operation branch that are supposed to account for financing in each region. With this structural change, statutory insurers in a region organizes a "Regional Insurance Council"[10] to participate in regional policy making.

Third, by the amendment of Medical Care Act in 2014, governors of regions have more, but still limited, power to influence behaviour of providers. Previously they had no power to direct private providers to implement plans. They only can reject applications of

[9] The council is a part of regional governments and are do not have direct relationship to the Statutory Health Insurance System.

[10] Health insurance associations for large-scale companies, located in that region, participate in the Council as well.

hospital plans increasing number of beds and generously ask them to collaborate to achieve objectives in the plans. After the legislation, governors have authorities to order private providers to be involved in discuss health care visions, and to request, recommend or direct providers to develop services to achieve health care visions. But their power are still limited: they can only publicize the name of providers if they ignore orders of regions.

Finally, the new emerging structure of regional governance does not exclude the market model, particularly in out-patient care, but is changing the governance of in-patient services. With the negotiation process, it is assumed that the network model of governance deal with complex modification of regional health delivery to increase efficiency and to achieve social goals. It should be noted, however, that the model is not voluntarily emerged[11], rather the national government forces regional stakeholders to achieve goals that it decides. Meanwhile, the government employs a new regional fund to develop health care delivery, which is granted in response to applications of regional governments with concrete plans.

Conclusion

This paper shows a case study of a health system where the market model of governance are predominant with supplements of networking and hierarchical models of governance. The market model worked in general in the era of expansion of health care provision. In the era of increasing inefficiency and higher financial pressure, the government has been setting up a new regional governing structure based on the network model, which has

[11] A variety of voluntary collaboration has been observed in the delivery of health care. How the new structure affect the existing collaboration is to be studied elsewhere.

not replace the market model but may modify it significantly. Meanwhile, to implement the new structural arrangement, the national government use the hierarchical model and orders regional stakeholders to collaborate to achieve set the national goals.

This paper shows the framework of the three models of governance useful to describe governance of a health system with a mixed delivery. It shows changes in governance can take place even if the main funding mechanism, the Statutory Health Insurance, is maintained. It also shows that different models of governance works at different levels, i.e. national and regional levels in the health care sector, though whether the network model of regional governance in Japan works well is not clear so far. The models of governance is useful to understand and describe complex governance of the delivery of healthcare.

References

[to be added... with my apology]