Reflections on Japan’s Complex Medical Culture
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had the recent privilege of carrying the “flags” of our school and of American Health & Drug Benefits to the enchanting island of Japan as a plenary speaker at the 113th Annual Congress of the Japanese Surgical Society. I would like to share some of my reflections on this incredibly complicated, and sometimes even paradoxical, medical culture during my 1-week whirlwind visit.

The theme of the 113th Annual Congress was designated as “soushi” and “keiji,” which mean “the creation and succession of will.” Each major medical conference in Japan has a theme, and this conference was no exception. Hence, my first observation is of the great respect Japanese have for their ancestors, juxtaposed with a modern, vibrant, and futuristic society. Soushi and keiji, as articulated by Yoshihiko Maehara, MD, PhD, the Congress president, mean that by developing various revolutionary diagnostic techniques, creative surgical methods, and robust perioperative management methods, the subsequent achievements accompanied by the strong will that made them possible have been continuously passed down to us as keiji. In the past 25 years I have never attended a medical meeting in the United States that had a theme explicitly recognizing the contribution of our elders and the notion of a collective will to succeed.

In Tokyo, the hyperkinetic movement of one of the world’s mega cities is in stark contrast to the ancient city center with the Emperor’s palace, reflecting the longest-lived dynasty in the world. The palace is surrounded by unbelievable traffic and skyscrapers, including the world’s tallest observation tower.

While in Tokyo, I had the opportunity to meet Takashi Fukuda, PhD, and Shunya Ikeda, MD, MS, DrMedSci, who are members of the Japanese National Committee that is charged with establishing individual drug pricing. Let me put this into context. Japanese universal healthcare insurance is composed of essentially 3 categories: employee health insurance, district health insurance, and elderly health insurance. Employers are mandated to provide health insurance coverage to employees and their dependents, although premiums are shared by both the employer and employees. This is a hybrid model: the government pays 25% of the healthcare costs, and the remainder is paid by employers and workers. In a nutshell, it is a single-payer system that is used by multiple payers.

In my meeting with Dr Fukuda and Dr Ikeda, it became clear that Japan’s cost-containment strategy is primarily attributed to its payment system; that is, through supply-side cost control provided by the nationally uniform fee schedule, the central government annually revisits all reimbursement decisions. In other words, a multidisciplinary team of experts, including my dinner guests, thoroughly review every single drug sold in Japan and establish a uniform price for its use. In addition to drug price review, all procedures in Japan are similarly assessed. This means that throughout the nation there is an almost completely uniform reimbursement rate.

The multidisciplinary groups make a recommendation to the central government, and the cabinet then decides on the global revised rate of all services and drug prices based on the prime minister’s evaluation of the nation’s political and economic situation.

In a way, one can draw a straight line from Japan’s overall economic condition to the cabinet to these multidisciplinary assessment committees to the price of an individual pharmaceutical agent.

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As a result of this national drug review process, the science of health economics and outcomes research (HEOR) becomes paramount. Japanese pharmaceutical companies have continued to invest resources in skilled
scientific teams that are capable of conducting advanced HEOR. These teams then promote their work, both in Japan and globally, in the peer-reviewed literature in an attempt to influence the decision-making of the multispecialty review boards that are charged with individual drug assessments.

During my visit, I had the opportunity to meet with a team of HEOR experts from Bayer Pharmaceuticals. The team, led by Edward C.Y. Wang, PharmD, MBA, Head of Health Economics and Outcomes Research at Bayer Yakuhin, Ltd, was truly representative of a global company in that most of the individuals were multicultural and multilingual. They had been trained in various leading academic organizations in the United States and abroad. They were an impressive lot, and they helped me to further understand how important HEOR data have become in Japan. If a nation is going to build a national formulary, it is best to have the most current available information about the cost-benefit and cost-effectiveness of each product.

Although the price of every drug and service is revised on an item-by-item basis, it is fascinating to note that these decisions are supported by a national claims data survey. With a centralized system, the Japanese government is able to collect claims data on virtually every rendered service. Once this level of data is collected, it can be adjusted for severity. The Japanese severity (or case mix classification) system is called the diagnosis procedure combination (DPC). This is a methodology used to level the playing field across Japan, and it enables the government to more accurately predict next year's utilization level. The DPC is made up of 3 core elements: the diagnosis, the procedures, and a combination of the comorbidities and the complications. Hospitals have a mandatory reporting system, whereby they submit clinical information from medical records and claims data. Then, by linking information about severity, resource use, and outcome, the Minister of Health, Labour, and Welfare can apply these data to their per-diem and per-drug pricing schemes.

Japan's centralized delivery system helps to promote greater uniformity in pricing. Because 80% of major surgeries and cancer treatments are conducted in only 200 hospitals nationwide, the central government has a tight rein on overall costs. During my trip, I had an opportunity to briefly visit one of these 200 major hospitals, namely, Kyushu University Hospital in Fukuoka. Kyushu University Hospital has nearly 1300 beds and would rival any major academic medical center with which I am familiar in our country. Three blocks from Kyushu University Hospital is a Shinto shrine, Hakozakigu, that dates back more than 9 centuries and was rebuilt after a fire in 1594. The juxtaposition of a 1200-bed, ultramodern, 5-year-old major academic medical center within walking distance from a historically important shrine built in the 16th century was truly a unique sight.

My trip culminated with my plenary presentation at the Japanese Surgical Society meeting in Fukuoka. I had the opportunity to describe the “volume-to-value” movement in the United States, with a special emphasis on the Affordable Care Act. The 8 presentations that followed my opening address were also quite fascinating. Although I cannot describe each in detail here, 2 are worth noting.

I was particularly impressed by Ken Shimada, MD, the Director of Medical Information in the Department of General Surgery at St Luke's International Hospital, Tokyo. Dr Shimada reviewed St Luke’s experience with the American-based National Surgical Quality Improvement Program (NSQIP) and related national measures. It was clear to me that St Luke's was making very enviable progress in keeping pace with most major American medical centers regarding their excellent NSQIP scores.

The other presentation that I found memorable was by Kenji Takenaka, MD, PhD, Director of Fukuoka City Hospital. Dr Takenaka described his journey in creating surgeon-specific measures of quality and outcomes. Although some aspects were clearly lost in translation, the gist of his presentation was how difficult it is to implement cultural change, especially in a society that has such deep respect for hierarchy, and a comparable level of respect for experience and age.

With business meetings in Tokyo, Kyoto, and the Surgical Congress in Fukuoka, it made for a whirlwind week of travel on the Shinkansen, better known as the “Bullet Train.” After my Fukuoka-based plenary presentation at the surgical society, I was fortunate to be able to travel by Shinkansen to Hiroshima with my physician wife for one deeply moving afternoon. My heartfelt wish is that every physician would have an opportunity to visit Hiroshima and thereby rededicate ourselves to a world focused on peace and on friendship.

Soushi and keiji—creation and the will to succeed. We have much to learn from our Japanese colleagues about drug pricing, utilization of resources, establishing a national budget for healthcare, and related concepts. I hope to return to Japan in the near future, and I look forward to providing you with additional reflections at that time.