Preface

> 'Like all great travellers, I have seen more than I remember and remember more than I have seen'. Benjamin Disraeli. Prime Minister of the United Kingdom, 1868 and 1874–80.

Over the past six years I have had the privilege of working in 60 countries on nearly 200 occasions. I have travelled the circumference of the world 70 times over and worked with hundreds of public and private sector organisations and governments of varying political persuasions. Quite literally, I have engaged with thousands of clinicians, executives and patients from every walk of life. It is an honour to have met so many inspiring people across the world who want to provide outstanding care to the patients and populations they serve.

Three years ago two friends and colleagues – Lord Nigel Crisp, Chair of the All-Party Parliamentary Group on Global Health, and Sir Robert Naylor, Chief Executive of University College London Hospitals – suggested that I capture, in a series of essays, my reflections on the countries I have worked in (but not clients because of confidentiality). This short book, written in a personal capacity, is the result and I am grateful for their encouragement. In between running a global health practice, visiting countries and client engagements, I have scribbled notes and ideas on planes, trains and automobiles at crazy times of the day and night (the only benefit of jet lag) and turned them into a series of observations.

As we all have busy jobs, each chapter can be read in the time it takes to drink a cup of coffee. This is not an academic treatise and has been written for practitioners that have an interest in policy, and policy-makers who want to support better practice. I also hope that patient groups and politicians dip in and out of this book, as well as students in global health.

The 25 country chapters selected for this book cover 80 per cent of the world's economic wealth, 60 per cent of its population and 50 per cent of its land mass. I have chosen these countries because they are both striking and familiar to me. The themes have been selected because of their global importance and the

extent they represent common concerns across health systems, countries and continents.

As KPMG's Global Chairman for Health, I prepare for each country I visit through detailed briefings which come in five parts: the political, social and economic context of the country; its healthcare policies and practices; the declared strategy of the system or organisation in question; the characters involved; and the possible solutions required. The job can be pulsating and the time zones punishing but the learning is unique. I have tried to be even-handed with the facts but these inevitably change as the world turns and health services move on. That said, the underlying foundations of most countries' health systems are sturdy and do not shift quickly; it is highly unusual for a country to dramatically change its health status, health service, funding or strategic thrust.

I would like to thank the clients and countries I have visited, the partners and staff in KPMG member firms and the 12-strong International Review Panel that commented on the first draft, which was underpinned by painstaking research from Tanvi Arora and her team in Delhi. I am grateful to Jonty Roland and Richard Vize for drafting and editing advice and could never have entertained the possibility of writing a book without my publishers, Palgrave Macmillan.

As St Augustine says above: 'The world is a book and he who does not travel reads only one page.' If you have got this far, I hope you are encouraged to go further.

Mark Britnell
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Asia and Australia

2 Japan
Live long and prosper

There is an apocryphal Japanese story which tells of five old men sitting in their hospital beds talking about their well-being. They had been in hospital for the past 20 days and were wondering what had happened to their friend, the sixth patient on the ward, who wasn't in his bed that morning. 'Where is Keiichi?' one of the men asked, only for another to reply: 'He is feeling very unwell so he decided to go home.'

This Japanese joke has a grain of truth in it. The demographic forces at play in Japan are monumental. Standing at 83.3 years,[1] Japan has among the highest life expectancies on the planet, and the combination of longevity and a declining birth rate means the country is ageing rapidly. Over a quarter of Japanese people are over 65 and this group already accounts for more than half of Japan's health spending.[2]

Japan's total healthcare spending reached US$479bn in 2013, making it the third-largest spender in the world after the US and China.[3] But healthcare only cost 10.3 per cent of GDP in 2013, around the middle of the Organisation for Economic Co-operation and Development (OECD) countries,[4] making it a cost-effective system.

Demography is placing great pressure on the country's creaking finances, as healthcare costs are forecast to outstrip GDP growth for the foreseeable future. This is compounded by a massive decline in population; it is estimated that Japan will shrink by 32 million people (26 per cent) from 127 million in 2015 to 92 million by 2055, by which time 40 per cent of the population will be aged 65 or over.[5] A smaller, older population producing less tax revenue in a sluggish economy is a dangerous combination for healthcare. Japan's ability to confront these challenges will offer important lessons for other developed countries.

Kaihoken

Established in 1961, Japan's universal health insurance system, known as *kaihoken*, has contributed to sustained and dramatic improvements in life expectancy. The rapid increase, which began in the 1950s, has been attributed to a strong and growing economy, assertive public health policies which tackled communicable diseases, high literacy rates and educational levels, traditional diet and

exercise, and a stable political environment. Universal healthcare is a treasured principle among Japanese people.

Kaihoken has a number of distinctive features which have slowly percolated through the cultural, social, economic and political seams of Japan. The goal of universal healthcare was part of a wider drive to create a welfare state in the 1950s and 1960s, as the country moved decisively away from the militarised economy of the 1930s and 1940s. Every Japanese citizen can receive medical care from any hospital or clinic – public or private – with a uniform fee schedule for reimbursement applied nationwide through a system of universal medical insurance. The creation of universal insurance reflected the political desire for social solidarity rather than an ideology of competition and choice.

Fragmentation

Fragmentation is a dominant feature of Japan's healthcare system, with myriad insurers and providers and weak clinical collaboration. There are around 3,500 health insurers,[6] divided into municipally run 'Citizens Health Insurance' schemes for the retired, self-employed and unemployed, and employer–employee schemes. All plans provide the same national benefits package, which covers hospital and ambulatory care, mental health care, drugs, home care, physiotherapy and most dental care. Individuals have no choice of health plan and there is little competition as the government sets the prices. It is widely recognised that there are too many health insurance schemes and many are too small to drive the changes which the healthcare system needs.

There is an element of cost sharing, with everyone having to make co-payments of around 10–30 per cent, with some exceptions for young children and poorer people. A safety net caps personal payments by limiting annual household health and long-term care costs.

The government's ability to control prices has been highly effective, reducing costs or marginally increasing them when rates are set every two years. Effectively, the Cabinet decides the total healthcare expenditure and the Ministry of Finance and Ministry of Health, Labour and Welfare deliberate over the details.

There are over 8,500 hospitals and 100,000 clinics (defined as having fewer than 20 beds),[7] which provide around 13 beds per 1,000 people, triple the OECD average.[8] These facilities are overwhelmingly too small, uneconomic and lacking in critical clinical mass. These extraordinary numbers arose because, historically, facilities developed out of physicians' practices. This is reflected in the current ownership structure: around 80 per cent of hospitals are privately owned, and about half of those are in the hands of doctors.[9] All hospitals are not-for-profit. While private corporations and large employers, such as Hitachi, do own hospitals they are not run to provide a return to their shareholders. Almost three-quarters of hospitals operate at a loss.

With so many institutions and beds, staffing per bed is very low while Japan has four times the number of magnetic resonance imaging (MRI) scanners and six times the number of computed tomography (CT) scanners compared with a similar European population.[10]

Doctors work long hours and there are serious shortages in rural areas, a problem the government is trying to tackle. Collaboration between doctors and specialists is often poor, with multi-speciality teams and clinics uncommon. In an effort to change this, financial incentives were introduced in 2008 to improve care coordination, particularly in cancer, stroke, cardiac and palliative care.

The system is undermanaged, with too little attention paid to organising patient access and developing efficient care pathways. There is no clear boundary between primary and secondary care, and no one acts as a gatekeeper between them, leaving patients free to consult any care provider – primary or specialist – at any time, with full insurance coverage.

This unrestricted approach to access is straining the insurance system and encouraging heavy use of healthcare. The average Japanese makes 13 visits to the doctor every year, more than double the OECD average, while the average length of hospital stay is nearly triple the OECD average.[11] Many patients are in the wrong place; people are using hospitals for routine care that could be provided elsewhere, while elderly patients are in acute hospital beds because they cannot get residential care.

The government has now embarked on a radical reform of facilities and pathways. The proposed changes are enormous: a drastic reduction in acute beds and a big increase in sub-acute beds; nursing care beds; long-term care facilities; and domiciliary care services. All these changes are to be implemented by 2025, along with a rationalisation of hospital sites to improve quality and efficiency.

Bold Reforms in Long-term Care

A big step towards providing older people with the right sort of long-term care was taken in the year 2000, when the government initiated a mandatory long-term care insurance scheme (Kaigo Hoken) to help older people lead more independent lives. The scheme is effectively another pillar of social security alongside healthcare and pensions. It marked a recognition that the traditional approach of leaving families – overwhelmingly women – to provide care was inadequate, and that there was an important role for socialised care. Traditionally, public residential care has been stigmatised, commonly associated with Ubasuteyama (a legendary mountain where old women were abandoned) and implications of family neglect.

The scheme is run by the municipal governments, whose task of predicting demand for care funding is considerably simplified by the government setting the prices. The financing system includes money from central government and

contributions of about 1–2 per cent of income paid by anyone over 40. The total cost is around 2 per cent of GDP and it is widely admired, providing a comprehensive range of in-home, community and institutional care. However, cost increases of around 5 per cent a year between 2007 and 2011 have led to reforms to improve efficiency and place greater emphasis on prevention.

Mental health services have lagged behind other countries on issues such as patient rights and public understanding, and there has been a powerful stigma attached to mental illness. But this is now abating and increasing numbers of patients are seeking treatment. Japan has the largest number of psychiatric beds per head in the world – to some extent reflecting the degree of stigma – but in the past decade care has been moving into the community as acceptability has grown.

Healthcare quality is overseen by the 47 local government prefectures, which are responsible for drawing up 'visions' covering everything from prenatal care to disaster medicine. One could argue that this means decisions are made closer to community-level, but the small scale means that quality monitoring is underdeveloped, with an over-reliance on simplistic measures such as staff numbers. There is no systematic national collection of treatment or outcome data, and limited oversight of physician training. Prefectures also oversee annual hospital inspections, but rarely do these get to the heart of the patient experience.

Hospital accreditation is voluntary and undertaken largely as an improvement exercise; roughly a quarter of hospitals are accredited by the Japan Council for Quality Health Care. It does not reveal which hospitals fail.

Tackling health inequalities is undermined by a lack of clear leadership on population health. Since 2000, the government has championed a strategy badged as the National Health Promotion Movement in the 21st Century (Health Japan 21), which aims to prolong healthy life and reduce inequalities. It includes targets for healthy behaviours, diseases and suicides.

The Japanese diet seems to be a key factor in high life expectancy, with Japan having the lowest heart disease rate in the OECD and an obesity rate of around 3.3 per cent, roughly a tenth of that in the US.[12] However, obesity rates are creeping up as the traditional diet is influenced by Western habits, and the rates of some cancers are also climbing. Despite its ageing population, Japan has one of the lowest levels of dementia – and of Alzheimer's disease in particular – in the developed world.

The economic importance of healthcare is underscored by its inclusion in Prime Minister Shinzo Abe's plan to generate growth. Deregulation in healthcare is part of the 'Third Arrow' of the economic turnaround plan – structural reform – alongside fiscal stimulus and monetary expansion. The strategy aims to promote exports of medical technology and accelerate approval of drugs and devices. It is seen as a test of Abe's commitment to deregulation. Just like in the UK, the role of the private sector in healthcare has proved controversial among doctors, with the Japan Medical Association warning that nothing must be done which undermines universal health insurance.

Conclusion

Japan has made huge progress over the past 60 years. It recognised the value of universal healthcare to economic growth and social cohesion early on, and its system has contributed to dramatic improvements in life expectancy. It has been radical in developing a new social policy for its ageing population but its demographic pressures and slow economic growth present substantial challenges for the future. Like many other healthcare systems there is a broad consensus on the reforms that are needed but no clear path for making them happen. There is a crowded bureaucracy with numerous hospitals, insurers and prefectures involved but little clear leadership to drive through the reforms.

While the single-price-setting system has many advantages, the lack of innovation between fragmented payers and providers, coupled with the decentralisation of political power, make change difficult. Japan is a remarkable country with great resilience and ingenuity. The innovation and entrepreneurial flair that made it a global powerhouse will need to be applied fully to healthcare.

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