Second Session (Medicare)
Prof. Yasuo Uchida (Emeritus Professor, Kobe University; Dean of the Graduate School, Ritsumeikan Asia Pacific University) opened the second session with a presentation on 'shared growth' in Asia.

There were positive correlations between economic growth and the percentages of the population over the age of 65 in East Asian countries. In Europe, Scandinavian and Mediterranean countries had also had high aging ratios, but Scandinavian countries with better social supporting systems have gradually improved birth rates.

Although East Asian economies were growing, the high aging ratios indicated the need for strengthening social security. The main characteristic of social security systems in Asia was the way public and private schemes were combined to provide services. Japan, Taiwan, and Korea used schemes based on the social insurance systems of Germany, while the system of Hong Kong was tax-based, a British model. Singapore was based on the medical savings account, tax and voluntary insurance schemes.

Apart from the structure of each countries scheme, there were epidemiological transitions throughout East Asia away from communicable diseases to non-communicable / lifestyle diseases. Prof. Uchida hoped that the second session would see an interesting discussion on how Asian social security and medical care systems could deal with changing disease structure and aging populations.

Speaker 1: Prof. Masako Ii (School of International Public Policy, Hitotsubashi University)
Japan had implemented universal health care since 1961. The country had the world's highest average lifespan and a high standard of health care. In Japan, hospitalization was very common. Japan had the highest number of hospital beds of OECD countries and a low number of practitioners –12.8 practitioners per bed in Japan, as opposed to 41.1 in other OECD countries.

Medical costs in Japan were rising, especially for the elderly. One reason for this was the changes that took place in the 1970s that allowed the aged to receive free medical treatment in hospitals. Since that time, the number of elderly inpatient and outpatient consultations at hospitals had jumped. Other factors that had caused health expenses to rise were the aging of the population, the spread of the health-care insurance system, rising personal incomes, supplier-induced demand, and prices in the health sector.

There were three major solutions to rising health care expenses: 1) efforts to control health care costs through cost-cutting measures and a medical supervision system for insurers; 2) streamlining a multi-faceted health insurance system; 3) the use of consumption tax funds for medical services.

Speaker 2: Dr. Etsuji Okamoto (Physician and Chief of Management Science, National Institute of Public Health)
One of the problems Japan was facing was that many people in Japan did not pay for health insurance. This problem stemmed in part from the fact that, because Japan had universal coverage, at one time insurers would give insurance cards to everyone whether they paid or not. This practice had changed in recent years.

Japan's health insurance programs were divided between those administrated by local governments and those administrated by employers. The National Health Insurance Program of municipal governments was financed half from government subsidies and half from premiums charged on those enrolled in the program. Those enrolled in municipal government systems were charged a basic household premium, a basic premium per enrollee, and income related premium, and a real-estate related premium. Statistics showed that those with lower incomes tended to spend more on health care. Likewise, residents of wealthier areas tended to spend less on health-care. The latter relationship remained constant when looking at any region in Japan.

Dr. Okamoto concluded that given the trends he had discovered, policy makers may want to pay greater attention to the relationship between health and wealth when creating policy.

Speaker 3: Dr. Rouselle Lavado (Research Fellow, Philippine Institute for Development Studies)
The health sector in the Philippines was complex. Consumers paid taxes to the government, premiums to health insurance, and user fees to their health care providers. The government finances public hospitals and public health programs as well as pay for premiums of indigent population to the national health insurance program (called Philhealth). Philhealth reimbursed health care facilities and workers who in turn provide health care to consumers.

The national health insurance program was established in the Philippines to help offset medical costs. It was divided into five programs: the employed sector program, the individually paying program, the overseas workers program, the sponsored program, and the non-paying program/lifetime program for those who had reached 60 and above.

Based on the latest health accounts data, 57% of all health care costs were paid out-of-pocket. Heavy dependence on out-of-pocket spending suggested that health insurance provided inadequate benefits. One issue was that health insurance spending showed a bias toward hospital-based care, and unlike Japan, Filipinos rarely visited hospitals for treatment. In relation to the previous presentation, the data suggested that in the Philippines it was actually the richest part of the population that spent the most on medical expenses. Households unable to afford medical care were forced to spend less on food and education, but this only freed up a small amount of money.

In order to analyze the effectiveness of health insurance in the Philippines, Dr. Lavado had researched into whether membership led to a higher rate of using hospitals for births instead of more traditional methods. She had found that insurance did not have an effect on the likelihood of going to a hospital for a birth, rather wealth and one's educational background seemed to be the dominant factors.

Commentator: Dr. Tan Khee Giap (Chair, Singapore National Committee for Pacific Economic Cooperation (SINCPEC))
Dr. Tan stated that he felt that Dr. Lavado's presentation had revealed the severe market failure of health care in the Philippines. He highlighted a number of points from her presentation which he found to be worrying.

The problem of health care in Japan was the problem of success. Increasing life expectancies had caused health care expenditures to increase. This was worrying. If Japan could not deal with increased costs along with economic success, how could smaller economies hope to deal with costs in the future? Dr. Giap asked about what other factors there were for rising costs in Japan, and the extent that supplier-induced demand had reduced costs.

As a fundamental model for APEC, every researcher should think about models in which the state was not overburdened by the costs of healthcare. Countries like the Philippines, they should seriously look into reexamining co-payment systems.

Dr. Lavado responded that decentralization had been a problem in the Philippines and had led to a loss of economies of scale. She agreed that there should be work regarding co-payment schemes. She suggested that a system like the 30 baht program in Thailand may work in the Philippines.

Dr. Ii explained what the other factors were in creating rising health care costs in the Japanese system. In particular, advances in medical technology had led to greater demand for surgery and rehabilitation and increased costs. As for supplier-induced demand, studies had shown both evidence that they had reduced costs and increased costs.

Q & A

Dr. Gloria Pasadilla suggested to Dr. Lavado that perhaps one reason why women did not go to hospitals was that, especially in poorer areas, the nearest hospital may be very far away.

Dr. Lavado answered that although it had not been included on the slide, she had looked into travel distances from hospitals, and found that this was unrelated to whether or not a woman decided to go to a hospital for a birth. Rather, women tended to respond that they did not go to a hospital because they did not like going to hospitals. They stated that the medical workers at hospitals were not friendly, they could not ask the worker to do housework for them after the birth, and they could not pay hospitals in installments.