



East Asia – A look at selected health policy developments and health care assessments in universal health coverage systems



In this issue of *Health Policy*, we feature a number of articles on East Asian countries, namely Japan, Taiwan, Korea and Singapore. While the countries share some of the characteristics of other high-income countries (e.g. the demographic change with population ageing, increasing burden of non-communicable diseases and long-term care needs), they also have their specific features, which deserve more attention – and *Health Policy* provides a forum for this. Among the issues receiving attention abroad is the determination of these countries to achieve universal health coverage (UHC) – first in Japan, then South Korea, Taiwan and Thailand – while maintaining high efficiency and thus relatively low health expenditure, a feature long attached to the Japanese and Korean health systems. As recently as 2007, health expenditure as a percentage of GDP was 7.9% and 5.4% respectively (when it was 9.2% in the Netherlands, 10.3% in France and 14.9% in the US). Ten years later, it had increased by more than a third in Japan (to 10.7%), almost half in Korea (to 7.6%), while the increase was only one tenth in the Netherlands (to 10.1%) and in France (to 11.3%) and one sixth in the US (to 17.9%) [1].

While quite a number of articles published in *Health Policy* have described and analysed health financing, health care and health policies in South Korea (see our Editorial in 2016 [2]), much less is reported on Japan – not only in *Health Policy* but also for example in OECD's "Health at a Glance".

The paper by Li and Niu in this issue [3] examined the extent and determinants of satisfaction toward Japan's health care system and services, and compared the results with those of eleven other high-income countries. Based on the 2014 survey, which was designed to be comparable to the 2010 Commonwealth Fund International Health Policy Survey, this study showed that Japanese population's overall satisfaction with the health care system is lower than other high-income countries. For example, perceived need for a fundamental change in the health system in Japan is higher than that in other OECD countries. But older respondents evaluated the system more than twice as favorably as younger respondents. And the respondents' overall satisfaction with the health care system was also related to their experience of health services actually received. In addition to improved health care quality governance, policy to inform younger people of health care utilization can help increase their satisfaction on health system in Japan.

Facing demographic change, investment in health of children is very important. Japan has medical subsidy for children (MSC), which consists of monthly stop-loss policy, i.e., caps on out-of-

pocket payments, for health services and a free prescription policy. In the study by Miyawaki and Kobayashi [4], the expansion of the MSC in 2013–2017 was used as a natural experiment in a Japanese prefecture. The study found no significant effect of the stop-loss policy on outpatient/inpatient expenditures, regardless of the children's baseline health status. The stop-loss policy for children is potentially efficient because it selectively reduced out-of-pocket payments in high-volume users and did not increase overall expenditure. In contrast, the free prescription policy significantly increased prescription drug expenditure to 116% in the total sample and 121% among children with good health status, but not among children with poor health status. Increased health expenditure among healthy, low-volume users was found to cause increased overall expenditure, implying that no copayment for prescription was potentially an inefficient policy.

The paper by Noguchi and Shen [5] examined key determinants of the health checkup decisions, taking into account time preference. In addition to relevant personal attributes, the model includes hyperbolic discounters, who use higher discount rates for short horizons and lower discount rate for longer horizons, leading to time-consistent decisions. The study shows that some sociodemographic variables such as gender, age, income, household size, occupational status, educational level are significant and hyperbolic discounters are more likely to seek health checkups. The result of the study that the effect of time preference on health checkup behavior differs significantly among the different types of time discount structures can be applied to other types of health or risk-taking behavior.

On the other end of the spectrum, several authors studied health care for high-cost patients with high utilization and thus costs, groups not only of concern for policy-makers due to the costs but also the quality of care. Maeda and others compared the treatment costs of home-based care and hospital-based care for enteral nutrition patients in Japan, using claims data from September 2013 to August 2014 [6]. Costs were compared for all patients, as well as for specific diseases, such as pneumonia, sequelae of cerebrovascular disease, and dementia. The panel data analysis found that the cost estimates for hospital-based care were consistently higher than those for home-based care. Compared with hospital-based care, home-based care was still less expensive even when long-term care services were included in the cost estimates. Therefore, home-based care is a preferred option for older patients, considering low treatment cost as well as their preference for staying home.

Taiwan implemented a community pharmacist home visit project for high utilizers of health care, selected in terms of the number of chronic diseases, drug expenditure, and the number of medical institutions that they visited. For voluntarily participating patients, community pharmacists provide home visit services, including medication review, medication consultation, and health education. They can also accompany patients to their physician offices and discuss medication prescriptions with the physician. Huang and Cheng applied the difference-in-difference method to the propensity score-matched sample of patients who are enrolled in the project (about 80% of them are over 55 years of age) and those who are not [7], and found that the project reduced physician visits, number of medication items used per day, annual expenditure, probability of hospital admissions. This paper sheds a light on the importance of disease management and the role of community pharmacist in health care utilization and expenditure of older people in the community.

Traditional medicine is popular in Asia. In Taiwan, for example, Traditional Chinese Medicine (TCM) Clinics accounts for about 18% of total number of (non-hospital) clinics. The paper by Chang and others [8] examined the factors related to the performance of Taiwanese TCM Clinics with data for 4905 TCM clinics [8]. Claim value made by TCM clinics for reimbursement from national health insurance is used for performance measure. It showed that consumer characteristics such as the frequency of disabling injuries had positive impacts on the volume of medical services provided by TCM clinics but aging of population did not. Although the overall impact of global budgeting is controversial, this study showed that it contributed to suppressing the revenue of TCM clinics through the peer review mechanism.

Since the special section on South Korea published in Health Policy in June 2016, newer articles have evaluated the provision of “integrated care” combining Western and Korean medicine for stroke patients [9], looked at Korea’s way to introduce DRGs (and compared it to hospital financing reforms in Japan and Thailand) [10] and assessed the quality of primary care for diabetes patients compared to Taiwan [11].

Since 2012, the Korean government has introduced 46.5% price cut for off-patent medicines in order to contain drug expenditure. Using an interrupted time series analysis with segmented regression for 2007–2016, Kwon and others examined the impact of the price cut measure on pharmaceutical expenditure [12]. It showed medicines spending significantly dropped with the price cut initially but bounced back to the original level. Although it reduced unit price, the effect did not last long. The impact of price regulation in the pharmaceutical sector has limited impact as in the case of the health services in Korea because price regulation does not affect the quantity of medicines prescribed or health services provided in the long run.

The health system in Singapore, still a country with low health expenditure, have only recently been featured in Health Policy. For a long time, Singapore’s health system and its financing mechanisms (Medical Savings Accounts, MediShield and Medifund) were considered to provide inequitable financial protection and to be inadequate for their focus on acute care. Yin and He compared its MediShield Life reform of 2015 to achieve UHC with the planned introduction of the Voluntary Health Insurance Scheme in Hong

Kong [13]. The latter omission has received policy-makers’ attention and led to the introduction of care coordination through Regional Health System (RHS) in 2008 to increase health outcomes and reduce costs. In 2018, Ong and colleagues analysed the plans to reduce the number of RHS from six to three [14]. In this issue, the qualitative study by Ow Yong and Cameron [15] examined how the policy idea is transferred and translated in the policy process of the development of integrated care in Singapore. The policy process was characterized by interacting forces of structures and various stakeholders, including government agency and non-government stakeholders in health and social care, as well as negotiations and debates especially because of multiple and pluralistic interpretations of integrated care.

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