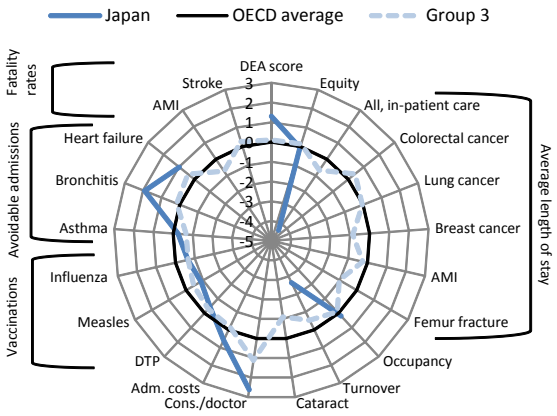
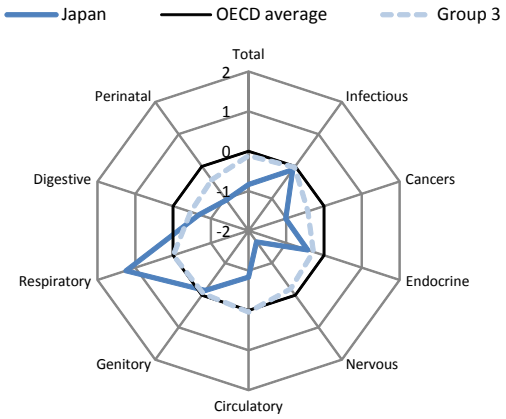
Japan: health care indicators

Group 3: Austria, Czech Republic, Greece, Japan, Korea, Luxembourg

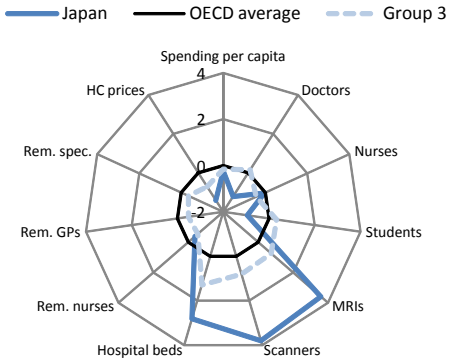
A. Efficiency and quality



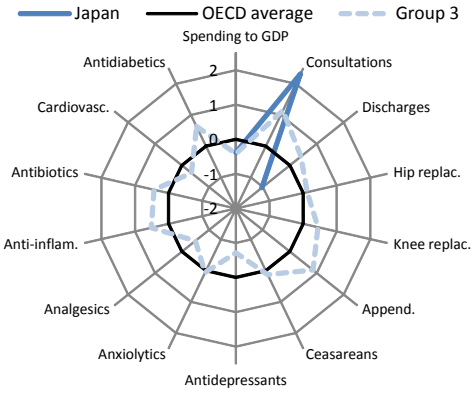
B. Amenable mortality by group of causes



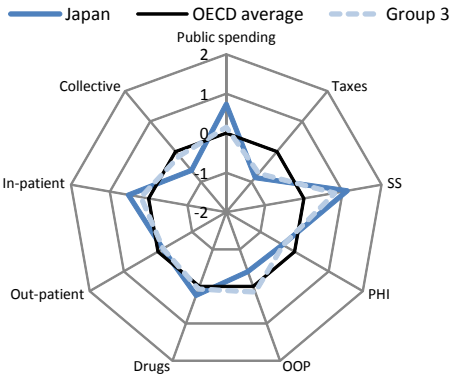
C. Prices and physical resources



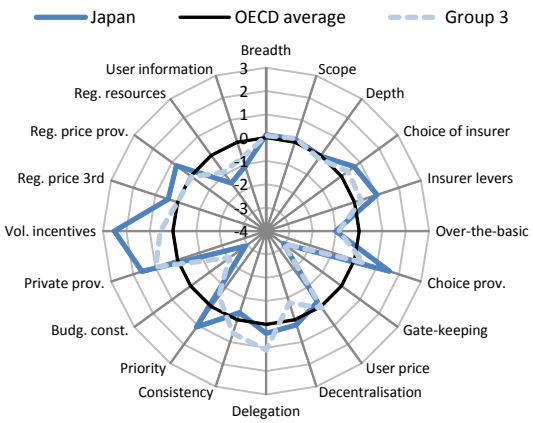
D. Activity and consumption



E. Financing and spending mix



F. Policy and institutions



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.

Source : OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

JAPAN

GROUP 3: Public basic insurance coverage with little private insurance beyond the basic coverage. Extensive private provision of care, with wide patient choice among providers and fairly large incentives to produce high volumes of services. No gate-keeping and soft budget constraint. Limited information on quality and prices to stimulate competition.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
High DEA score and low amenable mortality rate			Large public funding share and small share for out-of-pocket payments		Overall (DEA) efficiency is high. Two main features are however striking: the large reliance on hospitals for long-term care and the very large number of consultations *per capita* and per doctor
Rather low output/hospital efficiency, with very low turnover rate for acute care beds	More acute care beds and high-tech equipment *per capita*	Less hospital discharges *per capita*		More private provision, higher volume incentives for providers coupled with strict regulation on provider prices	Consider options to reduce the use of hospitals for long-term stays. Reforming the hospital payment system (by extending the case-mix element) should be examined
About average quality of out-patient care and very high number of consultations per doctor	Less doctors and medical students *per capita*	Much more doctor consultations *per capita*		More choice among providers but less information on quality and price of services. No gate-keeping	Consider introducing gate-keeping and/or a reform of the payment system (*e.g.* combining some capitation with the existing fee-for-services) to reduce the number of consultations. Increase information on quality and prices of services to reinforce pressures on providers to provide high quality services
Low administrative costs				More decentralisation; less consistency; more priority setting; softer budget constraint	