Impediments to International Service Transactions in the Health-related and Social Services Sector

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5.1 Impediments to International Service Transactions in the Health-related and Social Services Sector -- Market Access and National Treatment

It is not easy to classify all health and social services sectors into the four groups in the WTO classification, since they are sometimes cross-related. Hospitals and clinics, for instance, are supposed to be included in group "A. Hospital," but in principle in Japan the administrator of a hospital or clinic must hold a doctor's license. Thus, the problems of market access and national treatment in the category of hospital involves the problem of the nationality clause for doctors. Service by certified doctors, however, is classified into the code 1ah, "Professional Services, Medical and Dental." Another example is that social insurance and pension services are very close to the category code 7A, "All Insurance and Insurance-related Services."

If we consider the nine basic fields of social security to be included in "Social Services," it becomes difficult to distinguish the two categories, i.e., "Social Services" and "Other Social Services." Social services cover a wide variety of subjects, as well as

competent authorities. This is why we distinguish between social securities in a narrow sense, as "Social Services," and in the broad sense, in "Other Social Services."

Before entering the main theme of this paper, we would like to point out that governments have enormous roles in the health and social service sector. This is not peculiar to Japan, but the fact that Japan introduced universal health insurance and pension systems in 1961 shows that its government has a strong influence in this sector. Because this sector has long been supervised by the government, liberalization in the two major categories of impediments, i.e., market access and national treatment, has not advanced smoothly so far.

5.1.1 Hospitals

There are many types of hospitals, such as general hospitals, specialized hospitals, mental hospitals, contagious disease hospitals and geriatric hospitals. They also have a variety of forms of ownership. The government, various local self-governing bodies, nonprofit organizations, social insurance societies, medical foundations[1], educational (medical) foundations[2], individual physicians[3], among others, can own hospitals. In 1994, there were 9,731 hospitals in Japan, among which 4,624 were operated by medical foundations and 2,349 by individuals. Government-owned (392), local self-governing body-owned (1,375), and social insurance society-owned (135) hospitals are all public, meaning that the private sector cannot participate in their ownership. On the other hand, private individuals can invest in the establishment of hospitals owned by medical foundations, individuals, educational foundations, or nonprofit organizations.

[1] A medical foundation is a corporate body as defined in Article 39 of the Medical Law.

[2] Medical schools must have attached hospitals with at least 600 beds. These attached hospitals make up 1.9% of the total number of hospitals and 6.5% of the total number of beds.

[3] Individual physicians can establish hospitals as personal assets. These hospitals are divided into two types: clinics, which have less than 20 beds; and private hospitals, which have at least 20 beds. For the

In 1994, just 856, or 10% of these four types were owned by either medical schools or nonprofit organizations. Thus, we will mainly focus on medical foundation-owned and individual-owned hospitals in this section. Article 43, Paragraph 3 of the Medical Law provides that the administrator of medical foundation must be a person who has a medical or dental license. Article 10 of the same law prescribes that the founder of an individual-owned hospital must hold a medical or dental license. Based on this requirement, the establishment of hospitals or clinics is approved by the prefectural governor.

The problem of market access and national treatment in this sector can be translated into the problem of acquiring a medical license[4]. We will now list problems in that foreign firms or individuals may face as they seek to enter this sector in Japan.

1. When foreign companies or foreign individuals establish hospitals or clinics in Japan, they are required to obtain the permission of the local prefectural governor, and there is no legal restrictions on nationality for getting this permission.
2. The administrator or founder must have a medical or dental license.
3. Non-Japanese nationals who want to practice medicine in Japan are required to pass the National Examination for Medical Practitioners. In order to be eligible for the exam, they must finish six years of medical school in Japan. However, if they already have a medical license outside Japan and are residents of Japan, they may obtain a waiver from the eligibility requirements for the exam from the Minister of Health and Welfare (Article 11, Paragraph 3 of the Medical Practitioner's law).

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latter, but not the former, there are provisions on the number and the type of staff.

[4] Investor into medical foundations and clinics do not necessarily have to hold a medical or dental license. There are no legal regulations on the capacity of a investor, so they do not have to hold Japanese

4. The National Examination for Medical Practitioners is conducted in Japanese language.

5.1.2 Other Human Health Facilities

This section covers health facilities other than hospitals, which include for instance public health centers and quarantine stations. These facilities are basically founded by public organizations. The following are the features of these organizations.

1. Public health centers are set up, as means to promote the public health, by local public organizations, ordinance-designated cities, or special wards, in accordance with Chapter 2, Article 5 of the Local Public Health Law. As of 1996, there were a total of 847 such facilities, of which 625 were founded by prefectures, 169 by ordinance-designated cities and 53 by special wards. Chapter 4, Article 18 of the Local Public Health Law prescribes that municipalities can establish health centers, and Article 19 of the same law prescribes that the Government will grant a subsidy for such facilities. Thus, there are no private public health centers. Employees of health centers are in principle local government employees.
2. The 17 existing quarantine stations are all governed by the Ministry of Health and Welfare, and there are no private quarantine stations. A total of 263 superintendents supervise food hygiene at these quarantine stations. They are local government employees.

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nationality.

Foreign corporations or foreign individuals will face the following problem if they seek access to these markets: because public health centers, municipal health centers and quarantine stations are public facilities governed by the Ministry of Health and Welfare, foreign corporations or individuals cannot operate them. Natural persons can, however, be employed by them.

1. There are a various types of jobs in the health centers[5]. More than half of them are for public health nurses, midwives, and nurses. These jobs require passing a national exam to receive a license. (For practical nurses, the exam is conducted by each local government.)
2. Although there are no regulations on nationality for employment in public health centers or municipal health centers[6], these organizations tend to use employment examinations and guidelines as barriers against the hiring of foreigners.
3. Two proposals have emerged as means to deregulate this actually regulated situation[7]. One is referred as the "Kochi proposal," and the other as the "Kawasaki proposal."
4. The bill from the "Kochi proposal" failed to pass through the Kochi Prefecture Assembly in 1996, and is now in limbo. It aims to eliminate all provisions regarding nationality, with a few exceptions, for local government employees and to give an equal opportunity for foreigners to be promoted to administrative

[5] The types of jobs are: doctors, dentists, pharmacists, veterinary surgeons, radio-therapists, clinical examiners, dieticians, physio-therapists, public health nurses, hygienists, midwives, nurses, etc.
[6] The National Personnel Authority has no rules regarding nationality for local government employees, though it does for the governmental (state) officials, .
[7] K. Okazaki(1996).

posts.

5. On the other hand, the Kawasaki proposal, which is now in effect, partially deregulates the nationality provisions. Kawasaki is trying to make it possible for foreigners to be promoted to administrative positions within 20 years.

5.1.3 Social Services

Japan's social security consists of nine sectors: social insurance, public assistance, social welfare, public health and medical services, health services for the aged, pensions, assistance for war victims, housing, and employment. The first five sectors are social security in the narrow sense, while the total is social security in the broad sense. In this section, we define the social sector in the narrow sense as "Social Services," and the other four sectors as "Other Social Services."

Table 5-1 Japan's Social Security

1	Social Insurance	Health (Medical) Insurance, Defined Benefit Pension Plan, Worker's Accident Compensation Insurance, Unemployment Insurance, Seamen's Insurance, Other Society Managed Insurance, etc. (Ministry of Health and Welfare, Ministry of Labor, Ministry of Forestry, Agriculture and Fisheries)
2	Public Assistance	Livelihood Protection(Ministry of Health and Welfare)
3	Social Welfare	Social Services for Mentally and Physically Handicapped, Aged, Mother and Child, etc.
4	Public Health, Medical Services	Tuberculosis, Mental Illness, Narcotics, Contagious Diseases, Water and Sewage, Waste Disposal, etc. (Ministries of Health and Welfare, Ministry of Construction)
5	Health Services for the Aged	Medical Care, Health Care Facilities, and Nursing for the Aged (Ministry of Health and Welfare)
6	Pension	Pensions for Civil Servants, Military Pension for Bereaved Families, etc. (Ministry of Health and Welfare)
7	Assistance for War Victims	Pension for Bereaved Families of War Dead, etc. (Ministry of Health and Welfare)
8	Housing	Public Housing (Ministry of Construction)
9	Employment	Unemployment Measures (Ministry of Labor)

Sources: National Federation of Health Insurance Societies (1996).

Note: Social Security in a narrow sense covers numbers from 1 to 5, while in a broad sense from 1 to 9.

Because social insurance is the core of social security, and because health (medical) insurance, pensions, and unemployment insurance (including worker's accident compensation insurance) are the main points of this section, we focus on these in the following section.

Health (Medical) Insurance

The universal health insurance and pension systems, which are two salient features of Japan's social security, were established in 1961. Enrollment in medical insurance is compulsory, through either state, health insurance societies, or municipalities, depending on the place and type of work. There are over 5,000 insurance providers. The Government-managed Health Insurance (Seifu-kansho-kenko-hoken) played a central part in the process of establishing the universal health insurance system. In this case, the government became the largest insurance provider for small- and medium-scale industries which found it difficult to establish their own insurance societies or associations. The government/ Ministry of Health and Welfare has had an increasingly powerful voice on medical policies since then (Ikegami and Campbell, 1996, p.106).

Japan's medical insurance is basically composed of two types: National Health Insurance (Kokumin-kenko-hoken) and Employee's Health Insurance (Hiyosha-hoken). National Health Insurance covers 34% of the total population. The insurers are municipalities and associations, while the insured people are composed of self-employed workers, farmers, pensioners, and workers in cottage industries (firms with 5 or fewer employees) workers. On the other, Employee's Health Insurance is composed of Mutual Aid Associations (Kyosai-Kumiai, which covers 10% of total population, with 82 bodies), Society-managed Health Insurance (Kumiai-Kansho-Kenko-Hoken, 26%, with 1,817 public corporations), and Government-managed Health Insurance (30%, with one body)[8]. The Mutual Aid Association insures public employees, Society-managed Insurance is for workers in big corporations, and Government-managed Health Insurance is for workers in small and medium size corporations.

[8] There are exactly other two types of insurance, i.e., Seamen's Insurance (which covers 0.2% of the total

Since all insurance outside of Society-managed Health Insurance is insured by the government or municipalities, private individuals cannot become insurers in any case, regardless of nationality. The only way a foreigner can be an insurer is to establish a public corporation to insure a Society-managed Health Insurance. There are no restrictions on nationality in this case. It is not uncommon for foreign corporations to group together and establish a common public corporation for Society-managed Health Insurance.

Defined Benefit Pension Scheme

Japan's pension system was reformed in 1985, with the introduction of a basic old-age pension, and it now has the following structure:

a. Pensions for workers in private corporations are made up of the following parts: insurance for health and welfare pension, which is in proportion to the employee's remuneration, and already includes a basic old-age pension, and the welfare annuity fund. The insurance for health and welfare pension is compulsory, while that for the welfare annuity fund is optional.
b. Pensions for public employees are composed of a mutual aid pension that has the same properties as the insurance for health and welfare pension. It is compulsory for public employees.
c. Pensions for self-employed persons are composed of a national pension that is compulsory, and a national pension fund system that is option.

Every person who lives in Japan and is over 20 and less than 60 years old must be a member of some pension system, according to place and type of work, and must pay a basic

population) and Day Laborers' Insurance (0.1%).

old-age pension fee. Since all of these pensions are under the jurisdiction of the Japanese government (or the Ministry of Health and Welfare), private corporations cannot become pension providers regardless of their nationalities.

Unemployment Insurance and Workers' Accident Compensation Insurance

Unemployment insurance, which was established in 1975, has manifold goals such as stability of employment, promotion of employment, improvement of workers' abilities and the prevention of unemployment. Since unemployment insurance is intended for all industries, all workers must be members.

Workers' accident compensation insurance is intended for all business that employ workers[9]. Objects of compensation are injury, disease, physical disability, and death that are caused ether at the work place or on the commutation. The provider is the government (Ministry of Labor) and the Ministry of Labor, and the related office work is performed by the different prefectures.

Since unemployment insurance and workers' accident compensation insurance are under the jurisdiction of the government, private corporations cannot become insurance providers.

5.1.4 Other Social Services

The category of "Other Social Services" covers the following:

a. Pensions for civil servants and military pensions for bereaved families (Ministry of Health and Welfare).
b. Assistance for war victims -- pensions for bereaved families of war dead (Ministry of

[9] Except for seamen, government officials, local government employees (Health and Welfare Statistics

Health and Welfare).

c. Housing -- public housing (Ministry of Construction).

d. Unemployment measures (Ministry of Labor).

These social services, which are related to pensions, housing and unemployment, are placed under government control. Because of their nature, these services include discriminatory treatment against people who do not have Japanese nationality[10].

5.2 Impediments to International Service Transactions in the Health-related and Social Services Sector -- Evaluations

The following table shows evaluations of impediments to service transactions in the health-related and social services sector. Evaluations by PECC report are also given in the table for the purpose of comparison with the results of this study.

Association, 1996).

[10] Pension for bereaved families of war dead are not provided for those who do not have Japanese nationality. According to the code 9-1-3 of the pension law, pensions for civil servant or military pension cannot be drawn if the recipient loses Japanese nationality.

Table 5-2 Evaluations

			Market Access				National Treatment			
			1	2	3	4	1	2	3	4
8 A	Hospital	PECC	0.0	1.0	0.5	0.0	0.0	1.0	0.5	0.0
		This Survey	0.0	1.0	0.5	***0.5***	0.0	1.0	***1.0***	***1.0***
8 B	Other Human Health	PECC	0.0	1.0	0.5	0.0	0.0	1.0	0.5	0.0
		This Survey	0.0	1.0	***0.0***	***0.5***	0.0	1.0	***0.0***	***0.5***
8 C	Social Services	PECC	0.0	1.0	0.5	0.0	0.0	1.0	0.5	0.0
		This Survey	0.0	1.0	0.5	0.0	0.0	1.0	0.5	0.0
8 D	Other Social Services	PECC	NA	NA	NA	NA	NA	NA	NA	NA
		This Survey	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Notes：PECC means the values calculated in PECC (1995). Italics indicate evaluations of this survey which are different from those of the PECC (1995) report.

Market access impediments are those which regulate the entry of foreign service providers into the host economy. National treatment impediments determine whether or not the regulatory treatment received by foreign service providers is consistent with the treatment received by domestic service providers.

Mode 1＝Cross-border Supply, Mode 2＝Consumption Abroad, Mode 3＝Commercial Presence, Mode 4＝Presence of Natural Persons.

Calculated frequency according to the same method as PECC report is shown in Table 5-3.

Table 5-3 Frequency

Frequency		PECC Report	This Survey
Counting 0.5 out	Counting NA as 0.0	81.3	75.0
	Excluding NA from a denominator	75.0	
Counting 0.5	Counting NA as 0.0	71.9	65.6
	Excluding NA from a denominator	62.5	

The Japanese government only addresses category 8A, "Hospitals," in the "Schedule of Specific Commitments" of the WTO's "General Agreements on Trade in Services (GATS)." According to this "Commitments," while there are no provisions in mode 2 and for the entry of foreign capital in mode 3, the government makes no commitments regarding mode 4[11].

Next, we will briefly explain the reasons for the several differences between PECC and this study's evaluations. There are discrepancies of evaluation in market access for mode 4 and national treatment for modes 3 and 4 in the category "Hospital," and in market access and national treatment for modes 3 and 4 in the category "Other Human Health." In the category "Hospital," foreign natural persons can provide medical treatment in Japan if as long as they hold a medical license in Japan, regardless of nationality. After entering the market, they can receive national treatment. They can also receive national treatment in the management of hospitals once they enter the market.

In the case of non-hospital facilities, on the other hand, it is difficult for private individuals irrespective of nationality to enter the market because nearly all such facilities are

[11] Because service trade in this sector is technically impossible, the Japanese government has not made any commitment for mode 1.

governed by the Japanese government or by local governments. Thus, market access for mode 3 is rated 0.0 in this study. Also, even though there are no legal provisions on local government employees, in practice there are, through the use of, for instance, examinations. Thus, market access for mode 4 should be 0.5. National treatment for mode 4 should be 0.5, if we consider the current situation where even in Kawasaki City the promotion of foreigners to administrative positions is restricted.

5.3 Price Differentials

Japan's medical treatment system is characterized by a uniform fee system in which the same medical treatment costs the same throughout Japan. This fee system takes into consideration neither the type of hospital nor the quality of the practitioner, including experience and reputation. It means that the fee for examination or treatment does not necessarily reflect the actual cost of the procedure.

The medical treatment fee schedule gives the prices, calculated on a system where one point is worth 10 yen, and is revised every two years. The Central Social Insurance Medical Council (Chuikyo), which revises the uniform fee schedule, is composed of 20 members[12].

The liberalization of this sector in Japan was not the central issue in WTO debates, as can be seen by the fact that the Japanese government has not committed any liberalization in the sector, except for the in mode 2 and a part of mode 3. The arguments on liberalization

[12] 20 members are composed of 8 representing providers (5 physicians, 2 dentists, and 2 employers), 8 representing payers (4 insurers, 2 employees, and 2 employers), and 4 representing public interest groups (ususally, economists and journalists). (Ikegami and Campbell, 1996, p.21, and Yoshikawa, 1996, p.11).

that are going on between Japan and the US mainly involve tradable goods, namely prescription drugs and medical instruments. At the Structural Impediments Initiative (1989-90), the two governments discussed improvements in price differentials in prescription drugs. Following this, the Japan-US framework talks was initiated in 1993 and there has been a follow-up meeting every year. At this meeting, the two sides discussed certification criteria for drugs and government procurements of medical instruments. Also, in APEC the Japanese government does not refer to the liberalization of the health and health-related sectors in its individual action plan (IAP).

Japan's annual per capita medical expenditure is about 270,000 yen, which is lower than the US and Switzerland but higher than Germany, France and Canada. Since the definition of national medical expenditure varies across countries[13], it cannot be deduced from this ranking alone that Japan's medical services are cheaper than those of the US and Switzerland. Unfortunately, however, there has been little research so far on price differentials in these services.

Table 5-4 National Medical Care Expenditure (1993)

Country	Annual Per Capita Medical Care Expenditures		Annual Medical Care Expenditures to GDP	
	Rank	Value (Yen)	Rank	To GDP (%)
USA	1	366,879	1	14.12
Switzerland	2	365,495	3	9.91
Japan	3	273,896	18	7.28

[13] Japan's data excludes, in particular, the following four items. (1) various costs associated with government hospitals, including construction costs and financial subsidies; (2) research and development funding for medical research; (3) welfare-related expenses, such as nursing home costs; and (4) medical expenses not covered by the universal health insurance system, such as fees for amenities, care givers, over-the-counter drugs, and so forth. (Yoshikawa, 1996, p. 15.)

Germany	4	257,074	8	8.57
Luxembourg	5	254,020	20	6.94
France	6	236,815	4	9.78
Austria	7	235,414	5	9.29
Norway	8	218,238	13	8.18
Canada	9	216,072	2	10.23
Iceland	10	211,490	11	8.26

Source：Ministry of Health and Welfare (1996).

Note：Ranks are among OECD member countries.

The “Price Report” published by Japan’s Economic Planing Agency (EPA) is a rarely-seen comparison between Tokyo and other cities abroad. The results are shown in Table 5-5.

Table 5-5 Price Differentials in Health and Medical Services

(Tokyo=1.00)

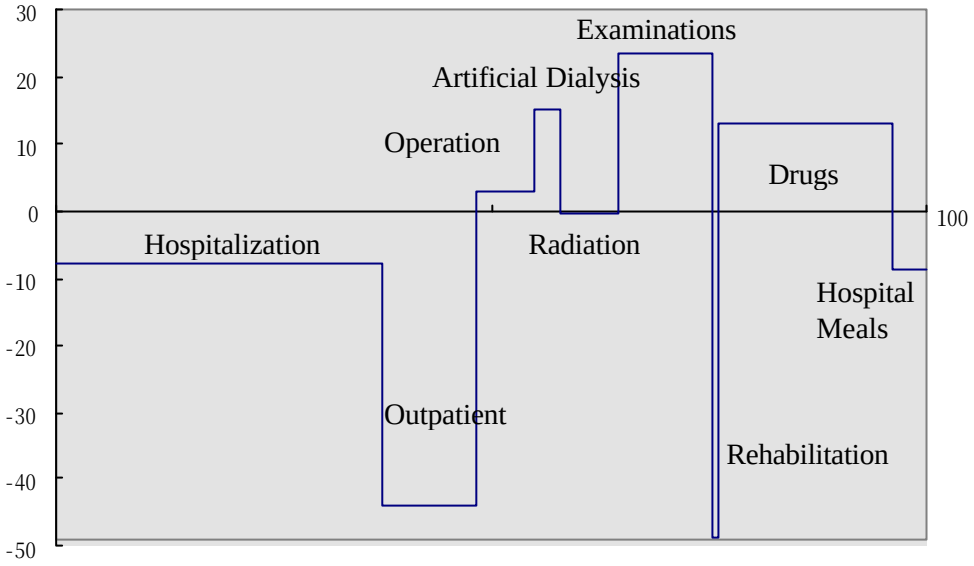
Date of Survey	New York	London	Paris	Berlin	Geneva
Nov. 1993	0.80	1.83	1.69	3.55	—
Nov. 1994	0.86	2.19	1.81	3.72	—
Nov. 1995	0.90	2.20	1.60	3.40	0.31

Source：Economic Planning Agency (1994, 1995, 1996) .

From Table 5-5, we can see that the prices of health and medical services in Tokyo are higher than those in New York but lower than those in London, Paris, and Berlin. Table 5 shows for example that the average price of health and medical services in Tokyo is 2.20 times as much as in London, 1.60 times as much as in Paris, 3.40 times as much as in Geneva in 1995. Note, however, that this price differential combines medical and hygiene services into one category, and is thus a very rough classification. Since health insurance systems and medical care systems vary across countries, it is not easy to calculate such price differentials.

We, thus, should create two sub-categories, i.e., prescription drugs and medical examinations, since in Japan they are great sources of profits for hospitals. Outpatient and hospital treatments are generally loss-generating, while prescription drugs, examinations and artificial dialysis create profits. Examinations have the highest profit rate, while drugs hold the largest share of profits. Although artificial dialysis so far has not affected total profits significantly, national medical expenditure on dialysis amounts to 1 trillion yen and are still increasing.

Figure 5-1 Composition of Profits and Losses



Composition of Profits (%)

Source: National Hospital Federation of Japan (1993).

The share of drug expenditures in national medical expenditure in Japan is extremely high (29.5%) compared with other countries such as the US (11.3%), Germany (17.1%), France (19.9%) and the UK (16.6%). Annual per capita expenditures on drugs in Japan amounted to 57,589 yen in 1993, whereas other countries had figures below 50,000 yen. Next we should see if there are price differentials for prescription drugs across countries.

According to a survey conducted in 1995 by the Osaka Insurance Doctors' Council (Osaka-Fuken-I-Kyokai), the prices of all prescription drugs in Japan are higher than in other countries, except that the average price of WHO indispensable 37 items was lower than in the US. Table 5-6 shows for example that the average price of Top 62 sales drugs is 1.49 times in Tokyo as much as in the US, 1.65 times as much as in Germany, 3.22 times as much as in France, etc. It shows also that average price of drugs approved in 1994 that compose of 16

items is much higher than those of other countries, i.e., US, Germany, France, and UK.

Table 5-6 Prices of Prescription Drugs (Japan=1.00)

	USA	Germany	France	UK
Top 62 sales	1.49	1.65	3.22	3.25
Cheap drugs 37 items	2.04	1.24	2.96	4.69
WHO indispensable 37 items	0.99	1.08	3.14	3.70
Approved in 1994, 16 items	2.95	2.93	5.85	4.73

Source: Osaka-fu-Hoken-I-Kyokai 1995 survey and R. Hama (1996).

Notes: "Top 62 sales" are, among the assumed top-selling 106 drugs in the Japanese market, those which are approved and sold at least in one other country. "Cheap drugs 37 items" are drugs that are old enough that they have a solid reputation and their prices have been reduced. "WHO indispensable 37 items" are a random sampling of 37 items from the indispensable drugs chosen by WHO for developing countries. Drugs "Approved in 1994" are 16 new drugs that were approved in 1994 which are comparable among the four countries.

One reason for these price differentials in drugs can be attributed to the opaqueness of the "comparison procedure for the similar efficacy of drugs[14]" under which the prices for new drugs are set higher than those of old ones if a new drug is even marginally improved. Since drug prices are revised downward every two years, old drugs with a stable reputation become relatively cheap, while new drugs that have not undergone such a revision are in general extremely expensive. Thus, there are strong incentives for both drug makers and practitioners to develop, produce and use drugs in search of a "doctor's margin"

[14] The "comparison procedure for the similar efficacy of drugs" is a pricing system for new drugs. Clinical tests are conducted on a new drug in comparison with other old drugs that have similar efficacy, chemical formulas, and medical action. If the new drug has advantages, no matter how slight, over the old ones, it is priced higher than the old ones (Osaka Association of Doctors authorized by Health Insurance Plans, 1994).

(yakka-saeki)[15]. As a result, expenditures for drugs are increasing[16], although the average standard prices of drugs have been reduced since the 1970s.

Information on production costs are not public in spite of the constant efforts of the Japan-US framework talks. The best way to eliminate the price differentials would be to bring transparency to this comparison procedure. The Japanese government recently revised the plans for promotion of liberalization. In this revised plans, the government will make some proposals to bring transparency to the drug pricing systems within FY1997.

Next, we will focus on the issue of examinations, since they hold a large share of total medical expenses. According to Fukuhara and Norton (1994) who estimated prices of medical services using samples from one Japanese hospital with 606 patients and two US hospitals with a total of 2,307 patients, CT scans cost US$88 in Japan and US$442 in the US, and magnetic resonance imaging (MRI) tests for cerebral apoplexy cost US$162 in Japan and US$925 in the US.

Table 5-7 Estimated Prices of Medical Services (US$)

	Name of Disease	Japan	USA
Marginal hospital charges per day (including room and board fees and consultation)	Myocardial Infarction	85	610
	Cerebral Apoplexy	78	570
CT Scan	Cerebral Apoplexy	88	442
MRI	Cerebral Apoplexy	162	925

Source：S. Fukuhara and E. C. Norton (1993)

Note: 1 dollar = 130 yen.

[15] The doctor's margin is the difference between the reimbursement rates for pharmaceuticals and the prices the pharmaceutical companies charge physicians. (Yoshikawa, 1996, p.12).

[16] Economic Planing Agency (1996), p.151.

Although the prices of examinations are much lower in Japan than in the US, examinations account for a large portion of Japanese hospitals' profits, as mentioned earlier. Two main reasons can be pointed out to explain this phenomenon. The first is that the prices of instruments used for medical examinations are much more expensive in Japan than in other countries. Second, Japanese hospitals tend to have many expensive instruments. For example, the price of a pacemaker in Japan is 1.6-1.7 million yen, while it is 0.6-0.7 in the US and 0.4-0.5 in Germany. In Japan, the price of an MRI machine is 25-43 million yen, while it is less than 20 million yen in both the US and Germany[17].

Table 5-8 Number of Hospitals Possessing Expensive Medical Equipment

	USA			Japan		
	Number of Equipment Holders (Hospitals)	Rate of Installation	Number of Equipment Holders per 100,000 people	Number of Equipment Holders (Hospitals)	Rate of Installation	Number of Equipment Holders per 100,000 people
CT Scanner	3,544	70.1%	14.2	5,001	49.5%	40.5
MRI	919	18.2%	3.7	733	7.3%	5.9
ECHO	4,262	84.3%	17.0	8,034	79.6%	65.0
Stone Crusher	319	6.3%	1.3	286	2.8%	2.3

Source: Kawamura and Ohishi(1993).

Table 5-8 shows that there are 2.9 times as many CT scanners per 100,000 people in

Japan as in the US, 1.6 as many MRI, and 3.8 as many echographer or ultrasonographer (ECHO). It may be inferred from these two facts that since hospitals and clinics who possess these expensive instruments have an incentive to make the greatest possible use of them in order to recover costs, their frequency of use is very high.

In addition to the price differentials of drugs and examinations, Fukuhara and Norton (1994) estimate that additional expenses per day for room and board and consultations in hospitals come to US$85 in Japan compared to US$610 in the US in the case of myocardial infarction, and US$78 versus US$570 for the case of cerebral apoplexy.

Fukuhara and Norton (1994) attribute the lower prices of medical treatment in Japan than in the US to the low unit prices on services set by Japanese government. However, since the comparable data controlled under the same conditions (i.e. sex, age, anamnesis, types of disease, existence of complications, and so forth) is not available, it is very difficult to identify whether the true cause for the price differentials is the uniform fee schedule or the quality of services or both.

5.4 Conclusion

Japan's medical and health related service sectors are strongly regulated compared to other service sectors. Although strong regulations in the health-related and social services sectors can be seen in other developed countries, Japan has two salient systems, namely universal medical insurance and universal pension systems. Through the uniform fee schedule, the Japanese government generally keeps medical service prices very low.

[17] Japan External Trade Organization (JETRO) (1996).

Compared to the US, medical service prices in Japan are low for both examinations (MRI and CT scans) and hospitalization (room and board, and consultation), though not for prescription drugs. Due to the government's price control through the uniform fee schedule and to the government's efforts to seek equality rather than efficiency, medical service prices in Japan have been set relatively low.

This controlled pricing system, however, has brought with it the peculiar phenomenon of "drug dependence and excessive examinations." In regard to price differential of prescription drugs, we have seen that free access to information on the process of setting prices, that is, the "comparison procedure for the similar efficacy of drugs," is needed in order to lessen the price differentials.

As Japan becomes an aged society, animated arguments have taken place on the need to reform social security. Some people are calling for reforms in the health insurance system that may lead to heavier burdens on insured people, as well as a radical reform of the process of setting prices for prescription drugs. At the same time, internationally, there were discussions from 1989 to 1990 at the Japan-US Structural Impediments Initiative regarding the price differentials of drugs and the government procurements of medical instruments, and the Japan-US framework talks have taken over these debates since 1993. Efforts toward free access to information and deregulation have just begun.

Because of the nature of this sector, deregulation is not necessarily the best policy. Cutting the quality level of medical care and social services has a more serious influence than in does in other areas. It is also still unclear whether liberalization leads to competition and raises the quality of the services. However, free access to information on the process of determining prices will certainly bring benefits to consumers. In addition to helping reduce the price differentials, it will also narrow the information gap between practitioners and patients,

cutting the asymmetric information pattern of medical care services, and may improve safety in this sector.

We must note in closing that because of data limitations we were not able to scrutinize the price differentials in social security and health services for aged people. This will surely soon become a crucial issue in all developed countries.