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Short Curriculum Vitae: Akio Onishi

Specializes in systems and policies of innovations, technology assessment and regulation, and insurance in the healthcare field. Graduated from the University of Tokyo School of Engineering and The Wharton School of the University of Pennsylvania (MBA). After working at the Ministry of International Trade and Industry, McKinsey & Company, the Organisation for Economic Co-operation and Development (OECD), and in communications/IT venture company management, he became Vice-President of Medtronic, Inc. in 2003, a role which he served in until 2012. Since 2011, he has served as a University of Tokyo Graduate School of Public Policy Specially Appointed Professor, his present post. From 2012 to 2013 he was Deputy Director General of the Medical Innovation Promotion Office, Cabinet Secretary. He has also served for various official committee positions including as a member of the Ministry of Health Labour and Welfare for Commission on Policy Evaluation and Evaluation of Incorporated Administrative Agencies, a National Institute of Advanced Industrial Science and Technology Research Unit Assessment Committee member, a Japan Science and Technology Agency Centre of Innovation Visionary Team Member, and a trustee of the Pharmaceutical and Medical Device Regulatory Science Society of Japan (general incorporated foundation).

Developments Related to Healthcare Systems

In the United States, there is much coverage in the mass media about the question of whether or not the Patient Protection and Affordable Care Act (Obamacare), which became law in March 2010, is going to be revised or repealed under President Donald

Trump, and if so, how. The United States did not have a universal health insurance system, and the rate of citizens who did not have any health insurance (mainly unemployed and impoverished) had increased to one out of every six before the introduction of Obamacare. The program of health insurance subsidized by the government with mandatory subscription by all citizens was introduced beginning in 2013. The number of people covered by healthcare insurance increased as a result, but it is also a fact that the introduction increased the burden on the national finances. The Trump administration is affiliated with the Republican Party, which was opposed to Obamacare at the time of its passage, and is calling for its repeal or revision, partly in connection with Trump's advocacy of policy for lower taxes. The debate on this subject will presumably proceed in Congress from now on. The companies providing insurance and the people receiving the related medical services are reportedly worried about what sort of change, if any, will come in fiscal 2018. The insurance providers are undoubtedly very concerned about whether or not government subsidies will be available, and the people, about what will become of insurance that they can afford.

Putting the situation in the United States aside, in Japan, the national healthcare insurance system is reviewed once every two years. In a very recent development, there was a revision that made reimbursement for acts of diagnosis and treatment in effect negative in 2016. More specifically, by "negative," I mean that the reimbursement paid to hospitals and clinics in the year before was reduced beginning in April 2016. This reduction was made because of a partial revision of the costs of hospitalization and of some acts of diagnosis and treatment. In addition, reviews were made of calculation rules and standards for beds for patients with conditions in the acute stage, for which reimbursement levels are higher. The next revision is going to be made in April next year, which is, fiscal 2018. This time, the review of the long-term (nursing-type) care insurance program, which is revised once every three years, will be made at the same time. The discussion has already begun, and will come to ahead from autumn to winter.

The Japanese and US systems have mutually different makeups, and each has its own strengths and weaknesses. For example, in Japan, the fee-for-service scheme is at the backbone of the system. In essence, determinations are made of points that serve as the basis for calculation of reimbursement for acts of diagnosis and treatment (examination,

diagnosis, treatment, and rehabilitation), the technologies and procedures applied for the drugs and medical equipment used in these acts, and the drugs and equipment themselves. Hospitals and clinics calculate the cost of care for each patient by adding up the points for execution or use of each of the items awarded points. They then bill the patient for the portion of this cost that is to be borne by the patient, and the insurer for the remainder.

In the United States, billing is done in the same way as in this scheme in cases such as diagnosis and treatment on an out-patient basis. In the case of hospitalization, however, the system of diagnosis-related groups (DRG) is generally applied. This system stipulates a blanket amount of compensation for each type of disease and injury diagnosed. [1]

While space would not permit me to describe these systems here, I would like to mention one point common to both. It is that the people, medical institutions, and companies supplying drugs and medical equipment would find it difficult to foresee how the system will change and what the influence of the change will be.

Under the prevailing circumstances in the United States, as noted above, it is hard to predict whether there will be an insurance system available for subscription next year, and if one will, about how much more expensive subscription will be as compared to the arrangement so far. This holds true also for the companies designing and selling insurance, manufacturers of medical equipment, and other principals. Manufacturers are apprehensive about imposition of an additional tax, and also worried about the amount and the kind of impact it will have on their earnings and stock prices.

In Japan, there was even a case in which a reduction in prices for high-cost drugs was suddenly sought right in the midst of revision of the system. Some have even voiced concerns about an increase in such cases beginning next year. There are likewise apprehensions that the drug price revision, which has been made once every two years so far, is going to be made every year.

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[1]Properly speaking, the acronym is DRG/PPS, which stands for “diagnosis-related groups / prospective payment system.” The system links DRGs, which are international classification codes for disease names and treatment details, to PPS, a scheme of blanket payment.

A bill is under discussion in the United States, but revisions in reimbursement for acts of diagnosis and treatment are in many cases not accompanied by legal amendments in Japan. In some cases, parties are suddenly faced with a new situation in the following spring. The last revision of the reimbursement system triggered a commotion that involved the National Diet. This is because, at some clinics, there was a steep decrease to a few tens of percent of the previous level in reimbursement for residential care treatment immediately after the revision. Similarly, the last revision of reimbursement for long-term care incorporated a reduction in unit reimbursement prices, and there were cases in which certain nursing businesses found that their income had dropped by almost 10 percent all at once when the results were in.

The situation surrounding medical service financing is basically harsh in all countries. Developed countries are being confronted by the trends of population aging, advances in medical technology, and an increase in the financial burden. Authorities are anguishing over the question of how to maintain the quality of medical care. Many developing countries are shifting to policy for introduction of universal healthcare insurance, but are having trouble figuring out at what speed they should augment the system while maintaining the balance of payments. Even Japan, whose system was considered a model from the 1980s to the 2000s, now ranks at the top among developed countries in terms of the severity of the financial burden it entails.

Although there is optimism about the future of the market for medical services and health, in fact, the outlook also contains very substantial uncertainty. As is well-known, it is not clear what positioning will be accorded in the context of the system to newly approved or registered technologies and services, either. It is also becoming harder to foresee how the system will change once the technologies and services are introduced to the market. In the belief that the matter should not be left to the free market mechanism, adjustments have been made through policy-oriented discussion on systemic revision. This approach has nevertheless had the drawback of making it impossible to expect the system to remain stable over the medium and long terms. The question of how to handle the increase in the impact of systemic changes on businesses and service suppliers as the market grows is becoming a critical issue. It nevertheless should be noted that it would take quite a long time to make changes in the allocation of

resources and patterns of action where things do not rely on the forces in the market. This observation is by no means confined to the field of medical services. I can only continue hoping for the emergence of another type of human wisdom for systemic reform, on a par with that which has led the research and development of medical technologies.