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Yudhoyono and Kalla: Two Distinctive Styles of Policymaking in the Case of Fuel Subsidy Reduction in Indonesia

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Abstract
In response to ballooning oil prices immediately after the 2004 inauguration of Susilo Bambang Yudhoyono and Jusuf Kalla as President and Vice-President respectively of Indonesia, there was an unprecedented crisis sparked by the rapid rise in global oil prices which eventually led to a divisive debate about whether the government's fuel subsidy should be reduced or not. There was also public controversy involving a significant number of interest groups, politician and intellectual alike. This article will describe the differences in style reflected in the differing attitudes of the President Yudhoyono and Vice-President Kalla in responding to the issue. It will argue that Yudhoyono inclined to use an incremental adjustment process, whereas Kalla displayed a more radical and rational style. Results of this study suggest that this difference was more or less triggered by the differing background and personalities of Yudhoyono and Kalla. Besides, the tendency of the multiparty system—adopted by Indonesia's post-Suharto regimes since 1999—to bring instability and executive and legislative deadlock, pushed Yudhoyono to use partisan mutual adjustment in launching the policy.

Keywords: Indonesia, fuel subsidy, governance, welfare.

It is common that styles of policy may "differ from one area of policy to another and from one point in time to another" (Richardson, 1979: 341). Consequently, a model which accurately depicts one area of policy may not be compatible with describing another. Nevertheless, "one area of policy might be found to exhibit more than one policy style" (Richardson 1979: 341), as happened during the formulation of the 1973 Water Act in the United Kingdom in which both incremental and rational policy styles can be detected.

The two policy styles also occurred in response to ballooning oil prices immediately after the late 2004 inauguration of Susilo Bambang Yudhoyono and Jusuf Kalla as President and Vice-President respectively of Indonesia. There was an unprecedented crisis sparked by the rapid rise in global oil prices which eventually led to a divisive debate about whether the government's fuel subsidy

should be reduced or not. This article focuses on the subsidy reduction that occurred in March 2005.

Specifically, the following questions will guide the trajectory of this article: How would a rationalist approach the reduction of the fuel subsidy in response to the rapid rise in global oil price? On the contrary, how would an incrementalist approach it? In the Indonesian case, how would you describe the differences in style reflected in the differing attitudes of the President and Vice President in responding to the issue? This article is mainly designed to answer this kind of questions. The extent to which incremental policymaking had been approached by Yudhoyono on the one hand, and the rational style which had been used by Kalla on the other, will be delineated comprehensively.

To begin with, this article will briefly explain the background, that is, the relationship between Yudhoyono and Kalla in the ruling duumvirate and the rapid increase in global oil prices as the most significant challenge for the new government. It analyses the relationship between Yudhoyono and Kalla through the lens of competition. It subsequently describes a strong tendency of Yudhoyono's approaches to deal with the problem of oil prices through incremental adjustment process. By comparison, Kalla's rational style will also be explored. As well as exploring the incremental and rational policymaking, the article will be completed with the inclusion of discussion of key concepts and theories, such as interest groups, the policy cycle model, and the relationship between executive and parliament and so on.

Finally, it concludes that the Indonesian President had decided the reduction policy after months of speculation; therefore, a more incremental style was most likely to appear in the issue concerning the fact that the cutback in subsidy is a controversial issue in Indonesia. Further, the multiparty presidential system requires such a political consensus to prevent executive-legislative deadlock, regardless of whether or not the style is viewed as being inefficient in practice.

Background

Briefly speaking, Yudhoyono and Kalla won decisively at the 2004 direct presidential elections The background of Yudhoyono is military, more nationalist in outlook, and less knowledgeable about economic issues. He is well-known as a cautious consensus builder, by which "he calculates what he can do politically and what he thinks would be too disruptive to attempt" (Woolcott, 2005: 3). In addition, his political vehicle, the Democrat Party, has less than half as many seats as Kalla's Party (Golkar for the Functional Group). Instead of his lack of parliamentary support, Yudhoyono's strength is derived from the size of the popular mandate (Liddle and Mujani, 2005: 121-22).

Meanwhile, Kalla is one of the most prominent indigenous (*pribumi*) business persons, "long-time Golkar stalwart and major financial contributor to the Yudhoyono-Kalla ticket" (Liddle and Mujani, 2006: 138). He obviously accepts the values of globalization. Accordingly, he is often described as a proponent of market

forces and an internationalist. It is strongly suspected that Yudhoyono and Kalla together began the run up to the 2004 presidential elections with such bargaining power. If they were to chosen by the people, Kalla wanted to be an active Vice-President, not a *ban serep* (spare tire). Accordingly, he was granted a wider mandate to cope with economic matters. This is why the president was deferential to Kalla in choosing Yudhoyono's economic ministers (Liddle and Mujani, 2006: 138). Meanwhile, because of his military background, Yudhoyono is more responsible for dealing with the problems of security (terrorism), gambling, drugs, the eradication of corruption, and the like.

In practice, however, Kalla was also more active in taking the initiative for the peace settlement in Aceh with GAM (The Free Movement of Aceh). According to the respected International Crisis Group (ICG) report, the success of the peace agreement between the GAM and the Indonesian government was made possible by Kalla's skillful diplomacy (ICG, 2005). Kalla also played a prominent role in responding to the horrible tsunami attacks on Aceh. He was also seen by the press as a key actor behind the scenes, who contributed in extinguishing the religio-social-nuanced conflicts in Poso, Central Sulawesi. The latter, as well as the negotiated peace settlement in Aceh, relates to the issues of security with which Yudhoyono should initially cope.

After being sworn in by the People's Consultative Assembly (MPR) on 20 October 2004, Yudhoyono and Kalla faced unexpected economic crises. Since the end of 2003, global oil prices have shown a significant increase, with the April 2006 price being more than double that in January 2004 (WB, 2006). It has undermined Indonesia, which set petroleum prices by giving subsidies to its people. The increasing global oil prices have made a financial burden on the budget, and the government had been spending a third of its budget on fuel subsidies, more than double the average price of fuel in November 2005 (UNESCAP, 2005). It would worsen the government's capacity to enhance other sectors, such as education, health services, and so forth.

As a pair of candidates who were elected at the first presidential elections in Indonesian history, a large increase in oil prices became the most significant challenge for Yudhoyono-Kalla. The policy proposal to reduce the subsidy was not only a matter of economic issue, but it was also a political matter. Despite some economists strongly urging him to cut the subsidies through raising domestic fuel prices it was, something that the President appeared to be reluctant to do, stemming from his worries of a popular backlash.

Yudhoyono: Incremental Process

The pros and cons in the subsidy reduction were seen by political analysts through the lens of a political race between Yudhoyono and Kalla. Despite Kalla being given a broader authority to face economic issues, the top decision-making is still in the hands of Yudhoyono. Kalla and Aburizal Bakrie (Coordinating Minister for Economy) were unable to convince Yudhoyono to increase domestic oil prices until

March 2005. In response, Yudhoyono inclined to use the incremental adjustment concept to overcome the problem.

In order to give a broader sense of Yudhoyono's inclination to the incremental approach, I will first of all describe decision making and problem solving based on the incremental adjustment concept, which is generally explained as follows: (1) The definition of problems and incremental goals; (2) The appraisal of current situation and estimation of incremental adjustment needed to cope with the problems; and (3) The consequences of incremental adjustment should be quantified and determined, whether satisfactory or not. The repercussions of implementting incremental adjustments should be evaluated and return to step 1.

In the incremental approach of policymaking, firstly, problems and incremental goals must be defined. The problems are found to lay in the amount of fuel subsidy which the government covered. In general, a subsidy is "a price in which part of the cost of a commodity or service or production input is paid for by someone other than the recipient, usually the state" (Harik, 1992: 482). In theory, the subsidy in less developed countries is initiated to help the poor.

Despite Indonesia being one of the oil exporting countries, it became a net importer in late 2003 (Woolcott, 2005: 2). The subsidy has kept the fuel price low, even at the height of the rapid increase in world oil prices. Yudhoyono realized that any cutback in the subsidy would affect the people, such as increasing the price of transportation and kerosene, which is largely used by the poor for cooking.

This is why the reduction of the fuel subsidy has become such a sensitive issue in Indonesia. Previously, Megawati's administration cut the subsidy in March 2004. As a result of extensive demonstrations in virtually all major cities, the government was forced to promise that there would be no further rises that year. It created a dilemma, because the subsidies had accounted for $7 billion of government spending at the end of 2004 (WSJ, 2005).

Secondly, as a proof of Yudhoyono's tendency to use the incremental style of policymaking in this case, he defined the incremental goals. Concerning Yudhoyono's cautious attitude and high sensitivity in perpetuating his self-image, it therefore came as no surprise that the president did not immediately reduce the subsidy. He knew that partisan mutual adjustment was needed before the subsidy would eventually be cut. The underlying reason for partisan mutual adjustment was the fact that policy takes place in a crowded arena, in which numerous political, economic, and social groups are trying to influence the policy and each will undertake partisan analysis (Lindblom, 1979: 135). The policy of subsidy reduction would not only require inter-party support in parliament, but it would also provoke widespread anger among society, students, and non-governmental organizations. The partisan mutual adjustment had been used as a means of compromising various interests and promoting political and economical stabilities.

Shortly afterwards, Yudhoyono appraised the current estimation and estimated incremental adjustment to be made to achieve the goals. He was aware that Indonesian politics in the post-Suharto period has been marked by the combination of a multiparty and presidential system. This institutional configuration is rather

problematic, even a "difficult combination," as surveyed by Mainwaring (1993: 198). None of the world's 31 stable democratic countries (defined as those that have existed for at least 25 consecutive years) apply the multiparty presidential system.

Three main reasons are upheld (Mainwaring, 1993). First, the absence of a majority party in parliament that leads to executive-legislative deadlock as shown by the emergence of *Koalisi Kerakyatan* versus *Koalisi Kebangsaan* in the case of the Indonesian legislature (*ABC,* 2004). The former refers to an inter-party coalition which supports government policy, including the reduction of the subsidy. The latter corresponds to an inter-party coalition led by the PDI-P which strongly opposes the government. Second, compared to bipartism, the multiparty system tends to produce ideological polarization. Third, permanent inter-party coalitions are more difficult to create in presidentialism than in parliamentarianism. *Koalisi Kerakyatan* versus *Koalisi Kebangsaan*, for example, was no longer relevant after Kalla was elected as the chairman of Golkar party.

In response, incremental adjustment as a method of achieving partisan mutual adjustment had been started by lobbying members of parliament. In attempting to ease ideological polarization which was more or less supported by the emergence of pros and cons against the proposed policy, lobbying played a prominent role in reaching a consensus. In addition, in presidentialism, each law, including the proposed policy of subsidy reduction, must be "approved by" or at least made after consultation with the legislature, before it takes effect.

Furthermore, Yudhoyono ordered the Ministry of Information and Communication Sofyan Jalil to design such public opinion. Between October and February, in cooperation with the respected pollster, the Indonesian Research Institute (Lembaga Survei Indonesia/LSI), several nation-wide surveys were conducted to trace the will of people concerning the proposal of the subsidy reduction (Amir, 2005: 6). Parts of the survey results were publicized through announcements, broadcast by television and radio stations, as well as via advertisements in national and local newspapers. The ministry succeeded in asking key figures of political parties, film stars, and influential *ulama* (traditional Islamic scholars) for implementing the plan within society with less likelihood of public protest being aroused.

In the incremental decision-making process, an identification of all possible alternatives is not required. Instead, an appraisal of the recent situation is the most necessary and policy makers should identify satisfactory incremental adjustments. Those aforementioned adjustments would subsequently be followed by the identification of satisfactory incremental adjustments. In theory, if not satisfactory for the policy makers, return to step 2, that is, appraise the recent situations (Wu, 1981). Otherwise, take action to implement incremental adjustment. It is noteworthy that "incremental adjustments are chosen not because they will necessarily lead to immediate achievement of goals but because they can improve the current situation and be consistent with the decisionmakers' current aspirations" (Wu, 1981: 136).

The last stage of incremental process was the evaluation of the repercussions of implementing incremental adjustments. Although the postponement of the reduce-

tion of subsidy implementation produced wider support, it resulted in an increased financial burden on the budget. Further, Yudhoyono's approaches appeared to implement the policy cycle model, in terms of consultation and coordination. In this context, policy consultation included discussions with parliament, profess-sionals and non-government interests. Through consultation, the policy proposal can be "improved, ideas tested and, when appropriate, support gathered" (Bridg-man and Davis, 2004: 27). Meanwhile, coordination requires discussions with treasury about the availability of the state's budget to survive from deficit until the policy of subsidy reduction could eventually be applied.

Kalla: Rational Style

On the contrary, in response to world oil prices that grew continuously, Kalla displayed a more rational outlook. Together with economic ministries, notably Aburizal and Sri Mulyani (State Minister of the National Development Planning Agency), it was agreed to view the rising oil prices as a big problem. After being inaugurated as Vice-President, 15 percent of total government expenditure was spent on the subsidy, which was regarded as regressive, distortionary and ironic, because as stated by Kalla, "the subsidies go to the users of oil who drive luxurious cars or factories that should compete" (Reuters, 2004). Also, the subsidy clearly ignores the scarcity of resources "leading to wasteful over-consumption of oil, to massive smuggling, and to local shortages of fuel products" (Sen and Steer, 2005).

The next step to a rational approach by Kalla was the determination of the values, goals, and objectives of the decision-maker. In fact, there was such a con-sensus among policy makers that the government should reduce the fuel subsidy in line with global oil prices. However, each of them proposed various ways to reach these goals. Unlike Yudhoyono, who inclined to wait for a more conducive politi-cal climate, Kalla repeatedly stated that Indonesia would have to cut energy subsi-dies as soon as possible, at least by the beginning of 2005. Kalla revealed that the subsidy reduction was inevitable, because the proposed policy was a more rational way to save the state's budget despite probable demonstrations. Aside from that option, in order to achieve the goals, Kalla and the economic ministries not only simply cut the subsidies, but also tried to identify other possible options. As recognized by Kalla, however, rising global oil prices meant that the government had no choice but to increase domestic energy prices (Reuters, 2004).

As a politician and businessman as well, Kalla was really aware of the cost and benefits of each option. Accordingly, a comparison of costs and benefits as the following rational step was needed. Although the option of subsidy reduction could lessen the state's financial burden, the plan might provoke widespread grievances. To anticipate the impact of the plan, Kalla initiated a modified subsidy scheme as a means of appeasement of the public. This scheme was aimed at replacing the previous scheme, which was seen as benefiting the rich more than the poor (JP, 2006). The price subsidy can be changed into the implementation of programs that were planned to help poor communities directly. By comparison of costs and

benefits, Kalla predicted that the government could avoid a budget deficit and pay more attention to building up other sectors (TI, 2005).

Furthermore, the role of interest groups in pushing the government's immediate response to increase domestic oil prices should also be acknowledged. Given that Yudhoyono appeared to be reluctant to do so, because of his high sensitivity to public pressure, the Freedom Institute bought a full color page of advertisements (Kompas, 2005). The article was aimed at pushing the government to reduce the fuel subsidy immediately by convincing society that the subsidies were in fact benefiting the wealthy and were thus obviously regressive. There were 36 people, of whom many prominent economists, philosophers, journalists, political scientists, and so on, signed the advertisement on their own behalf.

Theoretically, interest groups can be understood as a form of organized group (in spite of political parties) with shared interests to influence the government's policy. Yet, interest groups are involved in institutional politics and operate within the formal mechanism of policymaking (Marsh, 2002). Relating to the type of political activity in which scholars often distinguish pressure groups by measuring the degree of closeness to government, the Freedom Institute can be included as an "insider" rather than an "outsider." Indeed, the term "insider" is at odds in contrast with the popular image of a group that usually exerts pressure from outside of the system (Davis *et al.*, 1993). The reason why the Institute is categorized as an "insider," is supported financially by the coordinating minister of economical affairs, Aburizal Bakrie. Further, Rizal Mallarangeng, the executive director of the Freedom Institute, is currently a political advisor of Bakrie.

Based on the explanation above, clearly while Yudhoyono appeared to use political considerations to gather broader support, Kalla seemed to use the logic of economics. Budiono (2005: 315) reminds that "the dynamics of politics and those of economics are not naturally in harmony with each other and, [when] they are not, setbacks in both politics and economics eventually result." Fortunately, the difference in style between the President and Vice-President did not lead to a more fractured and straitened relationship between the two top leading figures. Kalla acknowledged that thereby the decision would be in the hands of Yudhoyono. Yudhoyono himself accelerated the incremental decision process to ease the government's fiscal burden through Presidential Regulation No. 25/2005 on the hikes in domestic oil prices on 1 March 2005.

Both Yudhoyono and Kalla also agreed to launch a spectacular breakthrough, that is, an oil subsidy compensation program, which was aimed at helping the needy directly, such as in the improvement of health, educational services and the like. Besides, the program seems to be more rational rather than an oil price subsidy; it has widely been accepted as a means of anticipating the negative impacts of policy and can be of direct benefit to the poor. The compensation program consists of four divisions: education, health, provision of subsidized rice, and suburban infrastructure. Aside from this compensation program, the government also allocated a budget for direct grants to the lower income classes in which its distribution is the same with the oil compensation program.

However, the difference of incremental and rational styles in the case of the subsidy reduction was not entirely clear cut. It is argued by scholars that a rational approach is more impractical, too narrow, utopian, and so on (Smith and May, 1980; Hill, 1997). Kalla, who represented a more rational view, appeared to be "more practical" and efficient rather than Yudhoyono, who demanded to follow all incremental adjustments with such requirements as consultation and coordination with parliament, interest groups, and the public. As regards theory, Lindblom (1979: 127) reworked Simon's work of "bounded rationality" to provide a well-practiced guide to policymaking. In the case of the fuel subsidies, the complexity of the problem, Yudhoyono's personality, and the need of parliamentary support, contributed to it being less practical and efficient.

Conclusion

Straitened fiscal conditions caused by rising global oil prices were not the sole argument for reducing the subsidies. In other words, the primary target of the subsidies was misguided, and the rich should not be subsidized. In addition, due to the subsidies, oil prices in Indonesia became cheaper than international prices and conducive of fuel oil smuggling. These causal factors lead Yudhoyono and Kalla to decide upon the policy of the fuel subsidy reduction.

Nonetheless, the two top policymakers had differences in style, reflected by the differing attitudes of Yudhoyono and Kalla in approaching the issue. This article has endeavored to show that Yudhoyono inclined to use an incremental adjustment process, whereas Kalla displayed a more radical and rational style. To some extent, this difference was more or less triggered by the differing background and personalities of Yudhoyono and Kalla. As President, however, it is Yudhoyono alone, who eventually decided upon the policy, despite Kalla and the Ministry of Economical Affairs Aburizal Bakrie convincing him to issue the policy far sooner than March 1, 2005.

In the case of oil subsidy reduction, the incremental style of policymaking was more likely to be approached by Yudhoyono concerning an immediate cutback in the subsidy would lead to destabilizing current political conditions. An incremental style would therefore be more effective. Furthermore, the tendency of the multi-party system—adopted by Indonesia's post-Suharto regimes since 1999—to bring instability and executive and legislative deadlock, pushed Yudhoyono to use partisan mutual adjustment in launching the policy. Those causal factors led to the appearance of the less practical incremental style, which was inefficient in the sense of the financial burden on the state budget.

References

ABC, ABC Radio Australia (2004), SBY Reforms Hampered by Factional Parliament, *www.abc.net.au/ra/asiapac/programs/s1237349.htm.*

Amir, S. (2005), Jusuf Kalla dan Validitas Survei LSI, *Kompas*, October 27.

Bridgman, P. and Davis, G. (2004), *The Australian Policy Handbook,* Allen and Unwin, Sydney.

Budiono (2005), Managing the Indonesian Economy: Some Lesson from the Past, *Bulletin of Indonesian Economic Studies,* Vol. 41, No. 3.

Davis, G.; Wanna, J.; Warhurst, J., and Weller, P. (1993), *Public Policy in Australia*, Allen and Unwin: Sydney, Australia.

FI, Freedom Institute (2005), Mengapa Kami Mendukung Pengurangan Subsidi BBM?, *Kompas,* February 26.

Harik, I. (1992), Subsidization Policies in Egypt: Neither Economic Growth nor Distribution, *International Journal of Middle East Studies*, Vol. 24, No. 3, pp. 481-99.

Hill, M. (1997), *The Policy Process in the Modern State*, Prentice Hall: London.

ICG, International Crisis Group (2005), Aceh: A New Chance for Peace, *Asia Briefing No. 40*, International Crisis Group, Jakarta/Brussels, August 15.

JP, Jakarta Post (2006), Government Confirms Fuel Price Hike in 2005, *www.thejakartapost.com*.

Kompas (2005), February 26.

Liddle, R.W. and Mujani, S. (2005), Indonesia in 2004: The Rise of Susilo Bambang Yudhoyono, *Asian Survey*, Vol. 45, No. 1, pp. 119-26.

Liddle, R.W. and Mujani, S. (2006), Indonesia in 2005: A New Multiparty Presidential System, *Asian Survey*, Vol. 46, No. 1, pp. 132-39.

Liddle, R.W. and Mujani, S. (2008), Leadership, Party and Religion: Explaining Voting Behavior in Indonesia, *Comparative Political Studies*, forthcoming.

Lindblom, C.E. (1979), Still Muddling, Not Yet Through, *Public Administration Review,* Vol. 39, pp. 517-26.

Mainwaring, S. (1993), Presidentialism, Multipartism, and Democracy: The Difficult Combination, *Comparative Political Studies,* Vol. 26, No. 2, pp. 198-228.

Marsh, I. (2002), Interest Group Analysis, in J. Summers *et al.* (eds.), *Government, Politics, Power and Policy in Australia*, Longman Cheshire, Melbourne, Australia.

MF, Ministry of Finance (2005), Oil Subsidy Compensation Program FY 2005, *www.djapk.depkeu.go.id*.

Reuters (2004), Jakarta Has to Cut Energy Subsidies Next Year, *www.reuters.com*.

Richardson, J.J. (1979), Policy Making and Rationality in Sweden: The Case of Transport, *British Journal of Political Science*, Vol. 9, No. 3, pp. 341-53.

Richardson, J.J.; Jordan, A.G., and Kimber, R.H. (1978), Lobbying, Administrative Reform and Policy Styles: The Case of Land Drainage, *Political Studies*, Vol. 26, pp. 47-64.

Sen, K. and Steer, L. (2005), Survey of Recent Developments, *Bulletin of Indonesian Economic Studies,* Vol. 41, No. 3.

Smith, G.D. and May, D. (1980), The Artificial Debate Between Rationalism and Incrementalist Models of Decision-Making, *Policy and Politics,* Vol. 8, No. 2, pp. 147-161.

TI, Tempo Interaktif (2005), Tambahan 4.2 Trilyun untuk Sektor Pendidikan,

Tempo Interaktif, *www.tempointeraktif.com*.

UNESCAP (2005), *Socio-Economic Policy Brief,* November.

WB, World Bank (2006), Knowledge Exchange Series, report, *www.esmap.org*.

Woolcott, R. (2005), Remarks at the Asian Bankers Association Conference in Melbourne, November 17-19, *unpublished document*.

WSJ, Wall Street Journal (2005), website, *online.wsj.com.*

Wu, F.H. (1981), Incrementalism in Financial Strategic Planning, *The Academy of Management Review*, Vol. 6, No. 1, pp. 133-43.

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An Asian Comparative Study on Child Unwantedness and Neglect and Protective Measures

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Abstract
This article is based on a comparative study of child protective measures that was carried out in a progressive state of India, namely Goa, and Singapore. The two were found to be comparable as they are similar with reference to the Asian cultural context and comparable political, economic and demographic profiles. The sources of information for the project are literature review and visits to institutions and meetings with the key personnel. The study makes a comparison between the two places with reference to the need for child protection with reference to child unwantedness and neglect, the child protection measures against child unwantedness and neglect in terms of strengths and gaps, and similarities and differences, and draws recommendations for child protection measures for both.

Keywords: Comparative Study, Protective Measures, Child Unwantedness, Neglect, Asia, Goa, Singapore.

The discourse on child rights should begin with whether children are wanted or not wanted. Child unwantedness is a phenomenon that takes place due to out of wedlock conception/ birth, preference for male child and poverty. Child bearing is institutionalized in marriage for perpetuation of the patrilineal lineage. Babies born out of wedlock are, therefore, considered "illegitimate" and vulnerable to unwantedness. Female babies are particularly unwanted in patriarchal families where sons are preferred to daughters. Unwanted babies face the possibility of the ghastly fate of being killed, before or after birth, abandoned, and in poor families, surrendered for adoption. These children's right to life, survival and parental care are at stake.

If the child is wanted, the child's right to life and survival can still be at stake if his/her basic needs are neglected. According to the Department of Health in Britain and the US Department of Health and Human Services, child neglect is considered one of the core categories of child abuse. Such conceptualization has blurred the distinction between what is unintentional and what is intentional and child neglect needs a separate focus than child abuse, especially in developing countries. Since providing for child's basic needs is primarily the parents' responsibility, child neg-

lect generally takes place due to one or both parents' incapacity, unavailability or unwillingness to care for the child. Children are vulnerable to neglect when parents are incapacitated due to imprisonment, substance abuse, terminal illness such as HIV/AIDS, or disability; when parents are unavailable due to death, desertion, separation, or divorce and/or living with step-parents; when parents are unwilling due to out of wedlock relationship or unwanted children; or when family relationships are seriously disrupted. Extreme manifestation of child neglect are abandonment or surrendering of babies, institutionalized children, street children, children in conflict with the law and child-headed households. Thus child neglect cannot be considered a form of child abuse, however, neglect by parents can lead to abuse and commercial exploitation by others (Desai, 2008).

Table 1: General Comparison of Goa and Singapore

	Goa	Singapore
Political Profile	• Colonized by the Portuguese whereas India was colonized by the British • Liberated in 1961 • State of a nation	• Colonized by the British and the Japanese • Liberated in 1965 • City-state
Income growth rate	9.4 per cent in 2007	7.9 percent in 2007
Literacy	Total: 82.3 per cent; male literacy: 88.8 per cent; female literacy: 75.5 per cent in 2001 (fourth highest in India)	Among aged 15 years and above: 94.6% in 2004
Median Age at First Marriage	Men: 30.2; women: 24.8 in 1999	Men: 29.7; women: 27 in 2006
Life Expectancy at Birth	Men: 61.1 years (54.1 in India); women: 66.6 years (54.7 in India)	Total: 79.6 years; men: 77.7 years; women: 81.5 years in 2005
Fertility Rate	1.77	1.26 in 2006
Infant Mortality Rate	12.40 in 2001 (Lowest in India)	2.6 in 2006 (Lowest in the world)
Population of 0-14 Years	24.6% in 2001	19.3% in 2006

Sources: GDHS (2007), IIPS (2000), GDE (2001), STS (2007), WK (2007), and USDS (2007).

The purpose of this article is to identify the protection measures to ensure child rights to life, survival and care in the context of unwantedness and neglect through a comparative study in the Asian context. The literature that uses the term "comparative studies" for child related policies, comprised of two types. The first type of

such "comparative studies" is found to be compilations of standalone articles and not comparative studies as defined above (e.g., Franklin, 2002; Grootaert and Patrinos, 1999). The second set of comparative studies found in the literature on child related policies was limited to studies comparing the developed countries (e.g., Bradshaw *et al.*, 1993; Kamerman and Kahn, 1981; Wazir and Van Oudenhoven, 1998). The Western construction of childhood and adolescence has led to the scientific construction of "normal" childhood (White, 2003), that does not adequately reflect the Asia scenario. There is a need for comparative studies in the Asian region for understanding the children's situation and policies in the region better.

This article is based on a comparative study of child protective measures that was carried out in a progressive state of India, namely Goa, and Singapore. The two were found to be comparable as they are similar with reference to the Asian cultural context and comparable political, economic and demographic profiles discussed later in the article as shown below.

Situation of Child Unwantedness

Goa

Compared to the sex ratio for the entire population in 2001 which was 960, and the sex ratio for the population in the age group zero to six years in 1991 which was 964, the sex ratio for the population in the age group zero to six years in 2001 was only 938. It was higher in rural areas (952) than in urban areas (924) (IMHFW, 2005). Small family norms practiced Goa has resulted in couples not having the second child if the first child is a male, whereas if the first child is a female, then they do opt for having the second child hoping it to be a male. In such situations, medical technologies are used in urban areas to detect the sex of the child and terminate unwanted female fetuses. A declining sex ratio in this age group is clearly indicative of gender discrimination (Haladi and D'Souza, 2006).

The National Family Health Survey has reported a strong male child preference in Goa, where 3.9 percent of all pregnancies result in induced abortions, which is more than twice the all India average (IIPS, 2001). A study conducted by Salgaokar (NCW, 2004) on the sex preference prevalent in the Goan society showed that the son preference exists even among doctors in Goa though it was much more forcefully expressed by the factory workers and more prevalent among the Hindu community.

Babies born out of wedlock, before or after marriage, who are considered "illegitimate," are often abandoned in Goa. Surrendering babies is catching on as another dangerous phenomenon in the field of adoption. Poor parents are often encouraged to give away their children in adoption to give them a better life (Furtado, 2006).

Singapore

The sex ratio for Singapore for the 0-4 years old is 1,019 females per 1,000 males. Chuan (1995) noted that Singapore does not appear to exhibit a strong sex preference for children. The results of the Fifth National Family Planning and Population Survey in 1992 show that 31 per cent of currently married women aged 15-44 years have no preference for either sons or daughters. The mean number preferred is 1.5 for both boys and girls. The majority of women would not have more children even if their desired number of children is of the same sex. The rate of teenage pregnancy in Singapore is also among the lowest in the world, six per 1000 girls who are 15 to 19 years old (UNFPA, 2003).

Measures to Prevent Unwantedness

Goa

Section 20 of the Hindu Adoption and Maintenance Act of 1956 states that "a Hindu is bound, during his or her life-time, to maintain his or her legitimate or illegitimate children. ... A legitimate or illegitimate child may claim maintenance from his or her father or mother so long as the child is a minor."

The Indian Penal Code of 1860 (and regularly amended), criminalizes foeticide, infanticide and abandonment of babies. Sections 312-318 of the Indian Penal Code criminalizes whoever voluntarily causes a woman with child to miscarry, including the woman who causes herself to miscarry; whoever before the birth of any child does any act with the intention of thereby preventing that child from being born alive or causing it to die after its birth, if such acts be not caused in good faith for the purpose of saving the life of the mother; whoever being the father or mother of a child under the age of twelve years, or having the care of such child, shall expose or leave such child in any place with the intention of wholly abandoning such child; and whoever, by secretly burying or otherwise disposing of the dead body of a child whether such child die before or after or during its birth, intentionally conceals or endeavors to conceal the birth of such child.

The Indian Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT Act) of 1994, as amended up to 2003, brings within its ambit the techniques of pre-conception sex selection to pre-empt the misuse of such technologies. It has explicit provisions for the use, regulation and monitoring of ultrasound machines to curb their misuse for detection of the sex of the fetus. The Act prohibits determination and disclosure of the sex of fetus, as well as any form of advertising about facilities of pre-natal determination of sex (IMHFW, 2005). In Goa, the Department of Health Services has formed an Advisory Committee on the implementation of the PCPNDT Act that includes representatives of voluntary organizations. The Committee has been conducting advocacy programs for private practitioners and other specific target groups. However, the voluntary organization representatives feel that a proper policy needs

to be worked out in order to effectively carry out awareness programs and for monitoring violations of the Act (Haladi, 2005).

A Balika Samriddhi Yojana is a national scheme implemented in Goa, which aims at changing negative family and community attitudes towards birth of the girl child at birth and towards her mother, improve enrolment and retention of girl children in schools, raise the age at marriage of girls and assist the girl to undertake income generating activities. For girls in families below the poverty line, born after August 15, 1997, the type/quantum of assistance includes a post-delivery grant amount of Rs. 500 to the mother and an Annual Scholarship of Rs. 300 for each class from class I-X (IMWCD, 2002).

In spite of the Indian Penal Code criminalizing foeticide, the PCPNDT Act regulating the prenatal diagnosis of the sex of the foetus and the Balika Samriddhi Yojana supporting the girl child's education, female foeticide continues in India and in Goa, because of prevalence of discrimination against girls.

Singapore

According to Part VIII of the Women's Charter, "it shall be the duty of a parent to maintain or contribute to the maintenance of his or her children, whether they are in his or her custody or the custody of any other person, and whether they are legitimate or illegitimate, either by providing them with such accommodation, clothing, food and education as may be reasonable having regard to his or her means and station in life or by paying the cost thereof."

The Singapore's Penal Code of 1872 (practically a re-enactment of the Indian Penal Code, and regularly amended) also criminalizes foeticide, infanticide and abandonment of babies. Sections 310-318 of the Penal Code consider any woman who by any willful act or omission causes the death of her child being a child under the age of 12 months, guilty of the offence of infanticide. It also criminalizes whoever voluntarily causes a woman with child to miscarry and whoever, being the father or mother of a child under the age of 12 years, or having the care of such child, exposes or leaves such child in any place with the intention of wholly abandoning such child.

Babes is a program of a voluntary organization called Beyond Social Services, dedicated to helping teenage pregnant girls in providing them with the support they need. The emphasis is on nurturing responsible decision making based on the options open to them. To provide a comprehensive service, Beyond is operating the program in partnership with other agencies similarly concerned with this issue, namely, Alife, Pregnancy Crisis Service both of which provide counseling; Project Cherub which provides case management services; Rose Villa and Andrew and Grace Home which provide shelter for pregnant teenagers; and KK Women's and Children's Hospital; Association of Muslim Professionals and Mendaki (BY, 2007).

Comparison of Situation and Protective Measures Against Child Neglect

Child Right to Care

Article 18 of the UNCRC states the following: For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Situation of Child Neglect

Goa. The vast majority of children, who belong to the local Goans, seem to be cared for in their own homes for most of the day (De Souza and Desai, 2006), due to low labor force participation by women (22.3%). However, children of the migrants who are employed mainly as low skilled workers and comprise 30.8 percent of Goa's population are vulnerable to neglect. They assist their parents in work or are unattended, and spend a major part of their time on the street or the beach, working or begging (INSAF Goa, 1996; Morais, 2004). It is these children who are exploited for labor (Talpankar, 2006) and are vulnerable to child sex tourism and pedophilia in Goa (Desai, 2006).

Singapore. The female labor force participation among women was 56.6 percent in 2005 leading to a need for child day care. In 2006, divorce rate was 7.9 males per 1000 married resident males and 8 females per 1,000 married resident females (SMCDS, 2006, 2007). In 1990, the single-parent families comprised 10.5 percent of the total households (SDS, 1993). Interestingly, the latest data on single-parent families was not available for Singapore. With a high rate of working women, increasing divorce rate, and increasing single-parent families, the need for day care of children is increasing. A large proportion of children in conflict with the law in Singapore come from single-parent/ reconstituted step families.

Protective Measures Against Child Neglect

Goa. India's Integrated Child Development Services (ICDS) program was launched in 1975 with an integrated approach to extend a package of six basic services, namely, health check-ups, immunization, referral services, supplementary feeding, pre-school education and health and nutrition education for children up to six years and expectant and nursing mothers through a single-window delivery, at village level. As of 2005, Goa has 11 ICDS projects and 1,012 Anganwadi centers, under the ICDS scheme, covering 36, 248 children in rural and urban areas. In order to start an Anganwadi there must be at least 10 children in the age group of 2 ½ to 6

years attending these centers. However, due to smaller families and higher utilization of birth control, there are fewer children in Goa. Since this figure is not attained in many areas, the number of functioning Anganwadis is less than those sanctioned, which is 1,216 (SVHAI, 2001).

India's Central Social Welfare Board runs a Scheme of Creches for Children of Working and Ailing Mothers since 1975 that provides for day care services to children in the age group of zero to five years. The facilities are provided to the children of working women belonging to economically backward sections of casual, agricultural and construction labor in remote, rural and urban slum areas. Children of sick women also get the benefit of this program. Under this scheme, the Goa State Social Welfare Advisory Board provides grants to 20 creches in Goa, mainly for children coming from mining areas, tribal areas, those coming from backward classes, children from red light areas and children of construction laborers (De Souza and Desai, 2006).

The Goa Labor Welfare Board implements a Crèche scheme for workers' children. Under this scheme two crèches were set up at industrial estates. However, despite the large number of mothers who work at both these sites, there was a very poor response to the initiation of these crèches.

In addition, the Goa Labor Welfare Board has facilities for the payment of a lump sum grant of Rs. 1,000 to women industrial workers on the birth of a child, under a Child Care Benefit Scheme. This money is payable only on the birth of the first two children (De Souza and Desai, 2006).

With regard to legislation, the GCA states that creches and day care centers for infants and children of working mothers in all sectors of employment may be set up at the work site or close to the same, in cities and villages, to the maximum extent of available resources. The GCA also states that "The State shall lay down guidelines for early childhood care and education and for all pre-school educational institutions for children, including registration and regulation of standards." However, such guidelines for registration and regulation are not yet formulated.

Singapore. Child Care Centers (CCCs) provide full day and half-day care programs to children below the age of seven years. Most centers admit children from 18 months onwards. Some centers provide infant care services to children who are two to 18 months old. In addition to providing working parents with reliable care services, CCCs have programs aimed at educating and developing pre-school age children through effective early childhood education programs in a safe and conducive environment. The government provides subsidy to low income parents to use the services of these centers for their children. The MCYS also promotes and facilitates the implementation of family day care at the community level through selected child care centers. These centers coordinate training for the caregivers and match them with parents who need their services.

Student Care Centers (SCCs) provide care and supervision to school-going children aged seven (Primary 1) to 14 years (Secondary 2). It aims to supervise homework, play, enrichment and recreational activities for school-age children

before or after school to enhance their wholesome development—physical, intel-lecttual, emotional, social and moral development. SCCs reassure working parents that their school-going children are well cared for while they are at work.

Moreover, the Family and Juvenile Justice Center (FJJC) runs projects with reference to children of divorcing couples, namely, counseling to reach agreement on children's issues, KIDSLine for explaining the effects of divorce to children, Project Contact that deals with supervised access between child and the non-custodial parent, and Project Impact, that organizes parenting workshops for the divorced couples.

Also, the Baby Bonus Scheme was introduced in 2001 and enhanced in 2004, in order to support parents' decision to have more children by helping to lighten the financial costs of raising children. The Scheme now benefits the first and the fourth child with a cash gift of $3,000 for the first and second child and $6,000 each for the third and fourth child. The second to fourth children also enjoy government contributions in the form of a dollar-for-dollar matching for the amount of savings the parents contribute to the child's Children Development Account (CDA). The savings in the CDA may be used to pay fees for all the children who are attending child care centers, kindergartens, early intervention programs and special education schools registered with the government. The CDA savings can also be used to purchase MediShield or Medisave-approved private integrated plans for all the children. As Sherraden (2001) noted, the Baby Bonus Scheme is bold and note-worthy because it is quite likely the most substantial Children's Development Account policy worldwide. However, the differential treatment of children based on birth order could be avoided.

On top, the Home Ownership Plus Education (HOPE) scheme is a program to help young, low-income families move out of the poverty trap by providing them with comprehensive forms of assistance. Launched in 2004, the Scheme aims to encourage low-income couples to have fewer children so that they can concentrate their limited resources on the children and give them a headstart. Each HOPE family receives the following benefits, if the couples do their part to upgrade their skills and keep their families small: educational bursaries per annum per child, housing grant, one-off grant, mentoring support and cash incentive. While the Baby Bonus Scheme encourages the rich to have more children, the HOPE Scheme discourages the poor to have more children. However, both aim at comprehensive investment for children.

Single-parent families in Singapore (Ting, 2007) are not accorded the same social status as dual-parent families. For example, public housing applicants in Singapore must be a proper "family nucleus"—comprised of a married couple—in order to be eligible for a government-subsidized apartment. Another example she sites is the pro-natal Baby Bonus, a government cash grant for newborns of married couples, where one of the eligibility criteria is that the mother of the child is lawfully married to the child's father. The Home Ownership Plus Education (HOPE) is also only available to married-couples or widowed families and thus exclude divorced and unwed families.

Thus, instead of being helped, single-parent families are often discriminated or disadvantaged by government policies. Most notably, single-parent families living in relative poverty are not specifically targeted by any state assistance program in Singapore. Divorcees and unwed mothers are viewed as blemishes in achieving the ideal of the family as the foundation of the nation (Ting, 2007). However, the Family Service Centers run Single-Parent Support Group, Education Programs for Single Parents, Group Work for Children from Single-Parent Families and Support Recovery Program to single-parent families, based on the needs of the local community.

Conclusions

The study shows that patriarchy exists in both the places with reference to babies born out of wedlock being considered "illegitimate" and vulnerable to unwantedness. Goa and Singapore both need to do away with use of the term "illegitimate" with reference to children as it gives them a life-time label based on their parents' behavior. However, patriarchy with reference to unwantedness of female babies exists in Goa but not in Singapore. Besides preference for a male child, poverty is another reason for unwantedness in Goa. Thus, the basic child right to life and survival are at stake in a progressive state such as Goa. Low labor force participation among women leads to less need for child care of a majority of children in Goa. However, children of migrants are vulnerable to neglect due to poverty. On the other hand, with a high rate of working women, increasing divorce rate, and increasing single-parent families, the need for day care of children in Singapore is increasing. Neglected children in Goa are vulnerable to exploitation for labor and commercial sex, whereas neglected children in Singapore are vulnerable to conflict with the law.

In both the places the Penal Codes criminalize foeticide, infanticide and abandonment of babies, and several childcare programs are provided to ensure child right to life, survival and care. However, in Goa, the legislation is enforced with less effectiveness, and the child care programs are either inadequate or inappropriate and do not seem to have successfully reached out to the migrants' children who remain vulnerable to neglect and commercial exploitation. Goa urgently needs to undertake awareness programs for non-discrimination of girls and sex education, guidance and support programs for mothers with unwanted pregnancies, income maintenance programs for poor families and investment and child care programs for the migrants' children.

Although Singapore has a comprehensive approach to prevent child neglect through child care and financial assistance programs, it excludes single-parent families from provision of social services although their children are found to be vulnerable to neglect. Singapore needs to focus on providing support systems to single-parent families. Singapore is noteworthy in its comprehensive investment programs for children through the Baby Bonus Scheme and the HOPE Scheme. However, while children from single-parent families are more vulnerable to neglect

these schemes are available only for dual-parent families. Moreover, while the former encourages the rich to have more children, the latter discourages the poor to have more children, amounting to an anti-poor population policy.

References

Bradshaw, J.; Ditch, J.; Holmes, H., and Vilhiteford, P. (1993), A Comparative Study of Child Support in Fifteen Countries, *Journal of European Social Policy*, Vol. 3, No. 4, pp. 255-71.

BY (2007), website, *www.beyond.org.sg*.

Chuan, K.E. (1995), Sex Selection at Birth, Statistics Singapore Newsletter, Vol. 17, No. 3, *www.singstat.gov.sg/ssn*.

De Souza, N. and Desai, M. (2006), Early Childhood Development, paper submitted for the *Status of Children in Goa: An Assessment Report 2007*, Goa Initiative for Mainstreaming Child Rights: Panjim, India.

Desai, M. (2008), Towards a Comprehensive Cross-National Conceptual, *forthcoming*.

Desai, N. (2006), Sexual Offences Against Children, *Social Development Issues*, Vol. 29, No. 3.

Franklin, B. (ed.) (2002), *The New Handbook of Children's Rights: Comparative Policy and Practice,* Routledge: London.

Furtado, S.P. (2006), Review of Child Adoption, paper submitted for the *Status of Children in Goa: An Assessment Report 2007*, Goa Initiative for Mainstreaming Child Rights: Panjim, India.

GDE, Goa Department of Edcuation (2007), *various documents*.

GDHS, Goa Department of Health Services (2007), *various documents*.

Grootaert, C. and Patrinos, H.A. (eds.) (1999), *The Policy Analysis of Child Labor: A Comparative Study,* Palgrave Macmillan: London.

Haladi, A. (2005), Health Reforms in Goa: A Perspective on Public-Private, *unpublished document*.

Haladi, A. and D'Souza, S. (2006), Development of the Girl Child, paper submitted for the *Status of Children in Goa: An Assessment Report 2007*, Goa Initiative for Mainstreaming Child Rights: Panjim, India.

IIPS, International Institute for Population Sciences (2001), *National Family Health Survey-2, 1998-99: India*, IIPS: Mumbai, India.

IMHFW, India, Ministry of Health and Family Welfare (2005), Annual Report on Implementation of the Pre-Conception and Pre-Natal Diagnostic Techniques Act, *mohfw.nic.in*.

IMWCD, India, Ministry of Women and Child Development (2002), Balika Samriddhi Yojana, *wcd.nic.in*.

INSAF Goa (1996), Excerpts of Goa Profile, presented at the Workshop on Child Prostitution in Western India.

Kamerman, S.B. and Kahn, A.J. (1981), *Child Care, Family Benefits, and Working Parents: A Study in Comparative Policy*, Columbia University Press: New York.

Morais, P. (2004), Situation of Street Children in Goa—Need for a Citizens Response, *Friday Balcao,* Vol. 6, No. 8, *goadesc.org/balcao/synopses*.

NCW, National Commission for Women (2004), *A Situational Analysis of Women and Girls in Goa*, NCW: New Delhi.

SDS, Singapore, Department of Statistics (2007), Life-Cycle Analysis of Singapore Households, *www.singstat.gov.sg/pubn/papers*.

Sherraden, M. (2007), Singapore Announces "Baby Bonus" and Children's Development Accounts, *gwbweb.wustl.edu*.

SMCDS, Singapore, Ministry of Community Development and Sports (2006), Social Statistics in Brief, *www.mcys.gov.sg*.

SMCDS, Singapore, Ministry of Community Development and Sports (2007), Key Indicators on Marriages and Divorces, *www.singstat.gov.sg/stats*.

STS, Statistics Singapore (2007), *various documents*.

SVHAI, Sangath and Voluntary Health Association of India (2001), *The State of Goa's Health,* SVHAI: Panjim, India.

Talpankar, P. (2006), Vulnerability of Children from the Migrant Community, in Goa Initiative for Mainstreaming Child Rights (ed.), *Status of Children in Goa: An Assessment Report 2007,* Goa Initiative for Mainstreaming Child Rights: Panjim, India.

Ting, W.M. (2007), Social Security for Single-Parent Families in Singapore, *Asian Journal of Public Affairs*, Vol. 1, No. 1.

UNFPA (2003), State of World Population, *globalis.gvu.unu.edu*.

USDS, United States Department of State (2007), website, *www.state.gov/r/pa/ei/bgn*.

Wazir, R. and Van Oudenhoven, N. (1998), *Child Sexual Abuse: What Can Governments Do? A Comparative Investigation Into Policy Instruments Used in Belgium, Britain, Germany, the Netherlands and Norway*, Martinus Nijhoff: The Hague.

White, B. (2003), A World Fit for Children?, paper delivered at the *51st Anniversary of the Institute of Social Studies*, The Hague.

WK (2007), website, *wikepedia.org*.

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Health Care in Singapore

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Abstract
Singapore today has one of the most effective and efficient health care systems in the world. It features strong public intervention, high quality of health care services and relatively low price levels of services provided. High quality in health care delivery in international perspective is hard to come by, that is why this study sheds a greater light on the inner workings and the overall performance of the Singaporean health care system. The article looks at operational structures, the finances, the program level, hospital services, and the provision of pharmaceuticals. The final part of the study gives a brief overview of the developmental aspect of the Singaporean health care system.

Keywords**:** Singapore, health policy, health care system, social policy.

Singapore's health system was ranked sixth in the world in the World Health Organization (WHO) report of 2000, *Health Systems: Improving Performance* (WHO, 2000). The WHO ranking implied that Singaporeans have access to a system that is highly effective in terms of contributing to low morbidity and mortality rates and high life expectancy; that the system is responsive in that it delivers on principles of choice, user-friendliness, and timely access to high quality care and support services; and that funding is progressive with the existence of redistributive policies aimed at delivering equitable access to health services.

Certainly, there is evidence that provides strong support for the WHO ranking. Infant mortality in 2005, at 2.1 per thousand live births, in Singapore was low compared with other parts of the developed world and developed East Asia (the OECD average in 2005, for instance, was 6.1/1,000; Japan's rate was 3/1,000; South Korea's was 6.2/1,000). Singaporeans also have long life expectancy. In 2006, male life expectancy at birth was 78 years and for females it was 81.8, both of which were around the OECD average. Childhood immunization rates for major diseases are also high at around 95 percent.

These figures are achieved against a background of one of the most interesting factors about the Singaporean health system. This is the comparatively low expenditure on health care. In 2005, total expenditure was S$7.6 billion or around 3.8 percent of GPD which was well below the OECD average of 8.7 percent. Government health expenditure was a mere S$1.8 billion or 0.9 percent of total GDP. This low level remains a constant source of interest among countries looking

for lessons around how to provide high quality care, with good access and at reasonable cost. In addition, and in stark contrast with most European countries, the public portion of health spending in Singapore is only 25 percent, considerably lower than the United States (45 percent) or the average for OECD member countries (72.5 percent in 2005).

Singapore, of course, has some advantages over other countries, particularly that it is a city-state with the entire population of just over 4.5 million living in close proximity to one another. This means it benefits from economies of scale with services concentrated in a small number of highly advanced hospital and other health care facilities. Other countries, with people spread across wide geographic areas, require more hospitals and service delivery locations and therefore more infrastructure. Another advantage is Singapore's status as a "tiger" economy, with a history of very strong economic growth driven by direct foreign investment, trade and one of the world's busiest ports (Holliday and Wilding, 2003).

Singapore also has the advantage of having a strong paternalistic government that has closely managed the development of the health system and done a relatively good job of this. Underpinning the government's health policies and the health system is the philosophy of "shared responsibility," that "government will subsidize health care to make it affordable, but Singaporeans able to do so must fork out their fair share too" (Lim, 2004a). Coupled with this is the notion that people should know what their health care is costing and how much they are personally spending on this, and that there should be incentives to focus people on staying well. Naturally, the health system, especially the arrangements for funding, is designed to reflect these principles (Gauld, 2005). Finally, the Singapore government has long sent a message to the public that they need to practice parsimony in their use of health care resources. The government has also been consistent in promoting the idea that is the responsibility of every Singaporean to stay fit and be healthy.

In keeping with the above, the Singapore government is deeply involved in regulating all aspects of the health system and plays a key role in "balancing" it with a mix of policies that control overall expenditure as well as the actual costs that patients pay for service delivery (one of the principles underpinning Singapore health policy is that patients should personally pay a portion of service costs) (Gauld *et al.*, 2006). Furthermore, the government is proactive in that it pays close attention to current and future pressures facing the health system. As such, in recent years there have been various incremental adjustments to different parts of the system.

The present arrangements for funding were established in 1984. The backbone and most widely-discussed part of the funding system are Medical Savings Accounts (MSAs). These are individualized insurance accounts, with minimal risk pooling, which are used by patients to co-fund services. As discussed, the idea behind these is that patients should pay at least some of their health care costs and that there should be an incentive for individuals to focus on being healthy. However, often overlooked is the fact that MSAs and related arrangements fund

only around 10 percent of Singapore's total health care costs. The remainder comes from employer benefits (35 percent), government subsidies (25 percent), patient co-payments at point of service (25 percent) and private insurance (5 percent). As discussed below, the scope of MSAs has evolved over the years in keeping with service demand and the capacity for providing an adequate funding mechanism, with new schemes and rules for use periodically created. Presently, there is debate around whether risk pooling of MSA money would be a more effective way of funding future health care needs (Asher and Nandy, 2006). If risk pooling were increased this would alter one of the fundaments of the Singaporean model: the focus on individual responsibility.

Service provision in Singapore is a public-private mix. Around 72 percent of hospital admissions are in public hospitals which are organized into two "clusters" that are required to compete but also to collaborate with one another. In contrast, public clinics provide only 20 percent of primary care general practice consultations. Singapore's hospitals provide services that are among the most advanced in the world. It has not been uncommon for Singaporean surgeons, largely working in private institutions, to perform world-first operations such as the attempt, in 2003, involving a team of 30 surgeons, to separate adult Siamese twins conjoined at the head (Nathan, 2003). A central tenet of present Singapore government policy is promoting and investing heavily in biotechnology and life sciences research to establish this as a core industry and future driver of the economy. Over the longer term, this can only be of benefit to the Singaporean population and health system.

The Operation of the Health Care System

The Singapore health system, in common with most health systems, is regulated and monitored by the government's Ministry of Health which is, in turn, answerable to the Minister of Health. Thus, the government of Singapore and Health Minister set directions for health policy, which the Ministry implements, although, as with most developed countries, the Ministry does a considerable amount of analytical and advisory work that informs government policy making (Blank and Burau, 2004). The Ministry itself is a large centralized agency, reflecting its widespread involvement in the health system. It is organized into three groups. The Policy and Corporate Group has divisions which are responsible for strategic planning, finance (including issues around MSAs), corporate communications and so forth. The Professional Group contains divisions dedicated to epidemiology and disease control, health regulation, workforce standards and development, clinical quality improvement, health services integration, and health information management. The Operations Group houses divisions of communicable disease, resource management, operations strategy and readiness, and a legal branch.

In 2006, there were around 11,545 beds in 29 hospitals and specialty centers across Singapore, with a ratio of 2.6 beds per thousand population. Thirteen of these institutions were public, and these tend to be larger ranging in size from 185 to 2,064 beds. The 16 private hospitals have from 20 to 505 beds. Public hospitals

accounted for around 72 percent of all hospital admissions. Average occupancy was 75 percent and average length of stay was approximately 4.7 days. The health workforce in 2006 included 6,931 registered doctors at a doctor to patient ratio of 1:650, or 1.5 doctors per thousand people. 3,505 doctors were employed in the public sector, 2,966 were in private practice and 460 were not in active practice. There was a total of 20,927 registered nurses with 11,574 in the public sector and 6,109 in the private (3,244 were inactive). The nursing ratio was 1:210, or 4.7 per thousand population.

Public hospitals are run as though they are private corporations. They are under government control yet set up as state companies which gives them managerial flexibility and an incentive to focus on providing high-quality patient care. They receive state subsidies but patients are also charged for all services received. In this way the government, as the dominant hospital provider, plays a key role in influencing the supply of hospital beds, the availability and introduction of new and high technology services, and the levels at which costs to patients are set. It also provides something of a standard against which private hospitals establish their prices. Notably, the government has put considerable effort over the years into controlling cost growth. Key strategies include limiting the purchase of expensive technology and rationing access to this, as well as restricting the number of doctors allowed to practice in Singapore on the assumption that more doctors will drive up over all costs (Asher and Nandy, 2006; Barr, 2005).

Among the public institutions are five advanced general tertiary and emergency service hospitals, a women's and children's hospital and a psychiatric hospital. There are also six specialty centers that provide specific services for cancers, heart disease, eyes, dermatological conditions, neuroscience and dentistry. The public hospitals are organized into two service delivery clusters: the National Healthcare Group which is host of the National University Hospital; and Singapore Health Services (SingHealth) which contains the Singapore General Hospital. The two clusters were developed in part to eradicate duplication that had occurred as a result of hospital corporatization in the early-1980s. The clusters are designed to be vertically integrated service networks that provide the full range of services from primary through to tertiary (Holliday, 2003). Within each cluster collaboration among providers is expected with the aim of delivering high quality, comprehensive and cost effective services. However, the clusters are also expected to engage in "friendly" competition with one another around issues such as quality of care and facilities, financial performance and service pricing, innovation, and so forth. Each cluster also features common electronic patient records, accessible across cluster service delivery sites but also transferable between the clusters. This is one example of where the clusters are expected to collaborate. Allied with each cluster are other "community" hospitals that provide less advanced services as well as primary care "polyclinics." Each cluster is also host to a selection of the six national specialty centers.

Public hospitals feature different classes of beds that receive differing government subsidy levels, although all patients receive the same quality of medical care

and range of interventions for comparable conditions. Public hospitals routinely charge patients for their services and the costs to patients will vary depending on the choice of bed class. A standard Class C bed will be in an open hospital ward. Class B beds will be in a shared room. Those who choose Class A beds will usually have their own room with various hotel features such as their own bathroom, television, and food menu.

There have been various reforms to public hospitals over the years aimed at improving efficiency and effectiveness, as discussed below. More recent initiatives include the introduction, in 2005, of global budgeting where hospitals receive a fixed annual sum of money adjusted in accordance with the historical case-mix per patient treated. Another initiative is the move to "step" patients down from tertiary hospitals, once treatment such as major surgery is complete, for recovery in less expensive community hospitals by adjusting pricing structures (the fees patients pay) to reflect the different institutional settings.

There have also been initiatives aimed at better coordinating services for the populations of specific geographic areas. An example is a pilot community-based initiative launched in 2004 in Jurong, a satellite town of 300,000 people. Called HealthConnect, the aims include coordinating multiple public and private providers from primary care through to hospitals and making care patient-centered and reorganizing services around them. HealthConnect has a particular focus on building public-private partnerships around care of the elderly and people with chronic disease and moving various diagnostic and treatment services from hospital to more accessible community settings. Another aim is to provide the population with the tools to better manage their personal health so as to avoid hospitalization. Specific initiatives include regular screening for chronic disease of all residents, with targeted follow-ups for those deemed to be of high risk, as well as a health information center, telephone helpline and comprehensive web-based information. Information technology is one of the key drivers of HealthConnect with all clinics and hospitals in the area linked electronically and using common electronic patient records (JHC, 2007).

Publicly funded primary care is provided via 18 polyclinics which are divided evenly between the two service delivery clusters. Polyclinic patients pay a highly-subsidized rate of around S$8.00 on average for a consultation. Fees are subsidized up to 75 percent for those over 65 and under 18 years of age. All other Singaporean citizens receive a 50 percent subsidy. The polyclinics are intended to provide comprehensive primary care including medical consultations, follow-ups for patients following hospital discharge, pharmacy services, and various public health services such as immunization, screening for disease, and health education. There are incentives for those who can afford it to seek primary medical care in the private sector as there tend to be lengthy queues at polyclinics, with patients sometimes waiting several hours for a consultation. However, anyone regardless of income can seek treatment at a polyclinic. Polyclinic consultation times are also shorter on average, with polyclinic doctors seeing around 50 to 60 or more patients in a day; private sector counterparts average around 40 patients (MOH, 2007).

The 80 percent of Singaporeans who patronize private general practitioners are served by around 2,000 separate clinics. These receive no government subsidy, but practitioners are required under government regulation to advertise their charges. In early-2007, the Singapore Medical Association abolished a process of providing fee guidelines that had been in place for two decades so as to satisfy new competition law. Practitioners were not complied to follow the Association's recommended price range, but their fees tended to be reflective of this.

As a multi-ethnic but predominantly Chinese society, there are many practitioners of complementary and traditional medicines. Most work outside of any regulatory system. Research indicates that 76 percent of the Singaporean population use complementary and alternative medicines (Lim *et al.*, 2005). Of these, 88 percent favor Traditional Chinese Medicine (TCM) which is the predominant alternative to modern Western medicine and perhaps natural in a population which is 77 percent Chinese. Reflecting developments elsewhere, such as in Hong Kong, the government passed the TCM Practitioners' Act in 2000. This initially required the registration of all practicing acupuncturists and subsequently of all TCM practitioners. TCM practitioners must therefore be registered with the TCM Practitioners' Board and hold a valid practicing license. The Board, in turn, oversees practice standards, including adherence to its code of ethics. Since 2005, graduates from recognized courses in Chinese herbal medicine dispensing have also been able to voluntarily list with the TCM Board.

Health care quality is today a core theme across the Singaporean health system, with the government proud of the fact that several hospitals have received accreditation by the Joint Commission Initiative from the United States. Quality efforts commenced in the early 1980s and, following corporate ideals and the restructuring of public hospitals into corporate entities, were largely focused on service quality, as opposed to the quality of clinical care. As such, there was an emphasis on certification of service delivery standards (ISO 9000 and so forth), on producing well-trained doctors, and every hospital was required by the government to have a quality committee and to promote quality circle arrangements that allow staff to share ideas about how to improve service quality. The assumption was that excellent facilities and health professionals would result in good care and outcomes (Lim, 2004b).

Since around 2000, and largely inspired by the report into medical error of the United States Institute of Medicine (Institute of Medicine, 2000), there has been an emphasis on clinical quality improvement with the government taking a leading role. For instance, in 2000, the government required that all hospitals – public and private – participate in the Maryland Quality Indicator Project. This has meant comparative data is routinely collected across a series of hospital quality indicators including mortality rates, unscheduled post-care readmissions, and infection rates. Patient satisfaction surveys are also routinely conducted with feedback used to plan improvements. In 2002, a new branch was created within the Ministry of Health charged with driving quality improvement across both the public and private sectors. The Ministry has since been involved in collecting data on adverse events.

Data has not been made public, but a system for reporting sentinel events and studying the root causes of these has been put in place. The Ministry has begun to publish reports comparing clinical outcomes for procedures across different hospitals (e.g., Ganesan, 2006), and has been encouraging hospitals themselves to publicize outcome data. The Ministry has also developed a Healthcare Quality Improvement Fund which grants money to support innovative quality and safety initiatives.

In 2003, continuing medical education (CME) was made compulsory for all practitioners registered with the Medical Council. There has been an increasing emphasis on service integration which was partly behind the clustering of public institutions. CME programs have focused on forging strong working relationships between private general practitioners and public hospitals, particularly around developing shared care programs for specific conditions such as cancer treatment which requires both hospitalization and various primary care interventions. Shared care arrangements have also become common among general practitioners and private hospitals. In keeping with shared and integrated care notions, there has also been a strong emphasis on development of evidence-based clinical guidelines and protocols for the management of common diseases, such as heart disease, strokes, diabetes and asthma, which have been made available to all public and private health professionals. As with CME, such approaches have meant that all professsionals involved in the care process have been required to discuss and refine these processes (Lim, 2004b).

In 2006, the Minister of Health announced that Singapore would be committing to the World Health Organization Global Patient Safety Initiative aimed at reorienting health systems toward safety and sharing lessons among participants about quality improvement.

Financing of the Health System, Hospitals and Medical Goods

MSAs are at the heart of Singapore's financing model although, as noted, they fund only a small portion of total health care expenditure and are not really a "public" financing mechanism for the fact that MSA finance is considered to be private. This said, MSAs are a government invention, are closely monitored and regulated by government, and much of the money that comes from MSAs goes toward services provided in public institutions.

MSAs have been the subject of considerable international debate and also the attention of foreign policy makers, particularly from the United States for their potential as a private funding source and fact that they are designed to focus individuals on taking responsibility for their personal health expenditure (Robinson, 2005). Singapore's MSAs are a component of the government's Central Provident Fund that workers compulsorily pay into to also fund retirement and housing. MSAs are designed to help fund hospital and some associated services, but increasingly specific primary care and outpatient services are being added to the schedule of services that account holders are permitted to pay for. Furthermore, the

scope of MSAs continues to expand in response to growing service costs, questions about the amount of money in accounts to pay for these, and demographic change. MSA use is subject to several restrictions, such as the range of services allowed to be paid for and the total amount payable for any one health encounter, to ensure that individuals do not exhaust their funds. There are also different types of account aimed at different groups of people, in addition to a safety net arrangement for those without sufficient MSA funding.

Medisave

The original Medisave scheme was established in 1984. Today, Medisave accounts pay for only around eight percent of total health care costs in Singapore (an additional two percent comes from the MediShield and Medifund schemes discussed below). It is compulsory for every person in the paid workforce to have a Medisave account which is a personalized account, but managed by the government. Depending on their age, employees contribute between 6.5 and 8.5 percent of their income to Medisave. Contributions must continue until an individual's account reaches the Medisave Contribution Ceiling. This is adjusted each year to ensure adequate funding levels and, in 2007, was S$33,500. Once this limit is reached, funds are diverted into a special fund for those aged under 55, or a retirement fund for those over 55 years. Medisave accounts are tax free, interest bearing and a part of one's estate on death. Risk pooling is limited to within families, meaning that only dependents can be paid for from an individual's account. Indeed, under Medisave regulations, this is how a dependent has their health care funded and there are many such people. As Reisman notes:

> Such transfers are believed to be in keeping with filial piety and "Asian values." Sharing will be of particular value to an aged parent who has used up his own Medisave or to an unemployable schizophrenic who has no contributions history. The labor force participation rate of the over-15 resident population is only 64.8 percent: 46.1 percent of women, 24.2 percent of men have no paid employment. Earning nothing, they are putting nothing into their Medisave nest-egg (Reisman, 2006).

Medisave accounts are primarily used to pay for hospitalization in an "approved" list of hospitals including both public and private. Account withdrawals may be made for doctor fees and allied services and equipment, daily ward charges, and surgical procedures, and are determined by a strict schedule of service fees that are set by the government. The scheme also allows payment, albeit with various limitations, for approved day surgery, psychiatric treatment, and maternity services. Reforms in 2006 were designed to allow payment for proactive community care of patients with chronic disease.

Patients in Class C hospital beds are required to pay 20 percent of costs, with the remainder subsidized by government. Medisave generally pays a significant

portion of the 20 percent, meaning a personal co-payment is always required. Hence, the idea of "shared responsibility" for funding. If a patient's account is exhausted, other family members are allowed to settle bills from their accounts or arrangements can be made for future payments once new money is available in an account. Patients who choose B1 Class (20 percent government subsidy), B2 Class (65 percent subsidy) or A Class beds (no subsidy) face substantially higher co-payments. Medisave also pays for some outpatient services, such as vaccinations, renal dialysis, cancer treatments and invitro-fertilization. From 2007, in recognition of the growing burden of chronic disease, payments of up to S$300 per year have been allowed for the treatment of diabetes, hypertension and strokes.

In December 2006, there was just over S$37.2 billion in Medisave accounts (roughly five times Singapore's total annual health expenditure). Withdrawals from Medisave accounts for 2006 were S$444.6 million or less than 8.5 percent of the total invested. Whether this considerable sum of money in Medisave accounts provides an adequate funding mechanism is an important question. As noted below, few Singaporeans are in a position where they do not have sufficient Medisave funds to help pay for their care. Yet around 17 percent of account holders have less than S$1,000 in their accounts meaning that they are at high risk of exhausting their funds in the event of hospitalization (Lim, 2004c).

In response, in 2004, the government considered increasing the level of risk-pooling but, instead, adjusted contribution and benefit levels. More recently, Asher and Nandy have suggested that Medisave itself is a flawed scheme and that there ought to be greater risk pooling to improve benefit coverage. The approach of periodically adjusting the existing system, they assert, will not provide for the needs of a rapidly ageing population which, over time, will place increasing demands on Medisave (in 2000, 6.8 percent were over 65 years; in 2030, projections are that 14.8 percent will be over 65). Finally, Medisave benefits are skewed in favor of wealthier people and are, therefore, inequitable (Asher and Nandy, 2006).

MediShield

An optional addition to the compulsory Medisave is the "opt out" MediShield scheme. This was introduced in 1990 in recognition of the need for a low-cost scheme that would provide additional coverage for hospital costs resulting from catastrophic illness. Presently, around 54 percent of Medisave members have MediShield accounts, meaning that a considerable proportion of the population lack catastrophic coverage (Asher and Nandy, 2006). MediShield premiums are paid for from Medisave accounts and premiums are dependent upon age with a basic plan ranging from around S$30 to $510 (prior to a 2005 reform aimed at increasing MediShield funds they were considerably cheaper). There is a claim limit per individual covered of S$50,000 per annum or $200,000 over a lifetime. Other limits on payouts include that patients pay a deductable, meaning that they personally pay the costs of any services provided that come in below the financial threshold for

MediShield payments to commence. Patients also personally pay the costs over and above daily MediShield reimbursement rates, providing strong incentives to patronize lower class heavily subsidized public hospital beds. The limits on the scheme mean that MediShield pays, on average, around 60 percent of the costs that hospitals bill patients. MediShield is also limited to people under 80 years of age, although the government has been considering raising this to 85 years. The 2005 reforms opened MediShield to private insurers who are now offering additional benefits to people who opt to take their insurance with them. These cover private hospital stays, although there are higher deductable fees.

Those who want more comprehensive coverage and access to higher quality surroundings can opt to pay the higher premiums for MediShield Plus. This is designed specifically for people on higher incomes and provides coverage for private hospitals and for the top two classes of beds in public hospitals. The 2005 MediShield reforms saw NTUC Income, a private insurer with links to the trade union movement, awarded the contract to manage MediShield Plus, meaning that the scheme is effectively separated from the government's Central Provident Fund.

Eldershield

The third type of MSA falls under the banner of Eldershield, a scheme introduced in 2002 to help pay for the care of people in older age once they are unable to care for themselves. Again, this is an opt-out scheme available to people aged 40 to 65 years. As of 2005, around 33 percent of those eligible had chosen not to enroll with the scheme. Eldershield payments can be made from Medisave accounts. As with other MSAs, there are restrictions on the monthly payments that can come from Eldershield accounts.

Eldershield reforms of 2007 had three aims: to increase Eldershield affordability for the general population; increase benefit coverage; and offer extended coverage for those who could afford this. Thus, where Eldershield accounts were initially offered by two private agencies, the 2007 reforms aimed to increase competition with the addition of a third insurer. This resulted in a general lowering of premiums. The reforms provided an increase on the cap on payouts to S$400 per month for up to six years (previously it was $300 for five years) therefore extending benefits. The reforms also saw the introduction of a second tier supplementary Eldershield scheme, also fundable from Medisave accounts. The supplementary scheme allows for payouts of up to S$1,000 per month for up to ten years.

Medifund

It needs to be stated that Singapore is not a welfare state per se. However, in common with most developed countries, Singapore does have a safety net, known as Medifund, for those unable to subsidize their costs via any of the above three schemes. Indeed, it is not uncommon for patients to have difficulty financing co-payments and deductables, or not to have accrued enough Medisave funds to finance their treatment. Medifund is, therefore, there to serve the approximately 12.6 percent of the Singaporean population who live below the poverty line as well as the considerable number who do not earn much more and who are most likely to require assistance (Reisman, 2006). This said, it has been calculated that only around two percent of C Class bed patients experience difficulty in paying their bills (Lim, 2004a).

Established in 1993 with a government injection of S$200 million, Medifund is an endowment fund which offers charity-style assistance paid for out of the interest that the fund generates. With subsequent funding injections, Medifund presently stands at around S$1 billion, but the government's target for the fund is S$2 billion. The interest from Medifund is distributed to public hospitals and a small number of voluntary organizations. Patients must then apply to the organization that they are receiving treatment from for Medifund assistance and they are means-tested in the process; they must also be admitted to lower class beds. Virtually all applications are accepted, with rejections generally as applicants are found to have other means available such as a family member able to help out (Reisman, 2006).

Other Mechanisms for Funding Health Care

Much of the government's expenditure on health care goes toward subsidizing public hospitals so that the funds drawn from MSAs are minimized. Indeed, 75 percent of public beds are heavily subsidized. As such, the charges for most patients are a fraction of the actual cost. Patients in Class C beds pay only 20 percent of costs from their MSAs. Class B patients pay up to 80 percent of costs, while Class A patients pay full cost. Even then, full cost beds continue to be cheaper than their private sector counterparts leading Barr to suggest that such prices are subsidized in order to create downward pressure on private sector pricing structures (Barr, 2005). As noted above, public hospitals are all corporate entities, required to run as private businesses and are free to set their own pricing structures. There is naturally some variation these. In 2005, the Ministry of Health decided to publish comparative data on public hospital charges on its website in the endeavor to drive prices towards the lowest, and to give patients the tools to minimize their MSA costs. The exercise resulted in some price reductions (Lim, 2005). The two hospital clusters have also worked together to keep prices down. An example of this is the creation of the centralized Group Procurement Office which manages the negotiation of bulk purchase prices on behalf of all public hospitals, including for pharmaceuticals (see below), and medical supplies.

In keeping with the fact that the Singapore government continues to extend services for underprivileged groups, a Primary Care Partnership Scheme was created in 2000 initially on a pilot basis and later extended to all eligible residents. The scheme was designed to provide subsidies for elderly people with disabilities, who are below a certain income, for services at participating private general practices and dental clinics near their homes. The scheme means such people no longer need to travel to one of the government's polyclinics, and pay only the polyclinic rate. Similar sorts of schemes have been developed by the hospital clusters. An example is the SingHealth General Practitioner Empowerment Program designed to forge closer working relationships with private general practitioners, which offers, among other things, rights to admit patients directly into SingHealth hospitals, quicker access to specialists, and better access to information about patients receiving hospital treatment.

Benefits of the Public Health Care System

Singapore contrasts with developed European countries in that it is not a welfare state and makes no apologies about this. In this regard, there is no "public" health care system to speak of with patients required to pay for all services. That said, features of the funding model ensure that all Singaporeans have access to basic health care via a polyclinic or C Class hospital bed. The extent to which access is equitable has been debated. Despite receiving a high overall ranking by the World Health Organization in its health systems report of 2000, in terms of fairness of financing, the Singapore system was given the rather low ranking of 101 out of 191 countries, implying that it favours wealthier people. This led Lim to suggest that the Singaporean system was founded on a different model (Lim, 2004a). This is that poorer people should not necessarily expect the same services as wealthier people (hence, the existence of different bed classes), and that the wealthier are expected to use available funds, including from MSAs, to pay for better class beds and private treatment, reducing the burden on more heavily subsidized services. Moreover, wealthier people were prohibited from applying to the Medifund scheme for aid, which was designed to ensure access to care for poorer people.

There have also been debates around the extent to which the Singaporean population have access to a full complement of services. MediShield, for instance, excludes claims on any disease that a patient acquired more than 12 months prior to joining the scheme, and there is no coverage for a list of conditions such as mental illness, congenital abnormalities or AIDS related illnesses (cf CPF, 2007). This contrasts with the situation in a number of developed world tax-funded health systems where access to such services is universal. Moreover, as Asher and Nandy note, MediShield "was structured in such a way that effectively no insurance cover was provided for the first seven days of hospitalization. The 2005 reforms have increased this period even further" (Asher and Nandy, 2006).

Financing of Hospitals, Medical Facilities/Goods and Remuneration of Doctors

While public hospitals receive some funding from patient charges and MSAs, the largest portion of their funding comes from the 25 percent of Singapore's total health expenditure that the government provides. The government does not make information readily available on how it allocates funding to public hospitals. Like many countries, hospital funding in Singapore is partly based on historical patterns of service utilization and this is how the "global budget" allocated to each of the two hospital clusters is established. The global budgeting approach, of course, provides incentives for the clusters to work within certain service provision parameters and to look closely at how much they are spending on medical devices, facilities, human resources and so forth. Hence, the existence of a centralized Group Procurement Office that works on behalf of the two clusters to bulk purchase medical supplies and pharmaceuticals for all public hospitals. Global budgeting also provides incentives to search for more efficient ways of working, especially in terms of developing initiatives such as the recent focus on primary care management of chronic disease that should serve to reduce the demand for hospitalization. Such initiatives are part of a coordinated strategy that also includes new allowances, as discussed above, for funding chronic disease management from MSAs. Public hospitals are also funded in part on the basis of a diagnostic related group mechanism.

Doctors working in public hospitals and clinics are salaried in accordance with civil service pay scales, with a loading to recognize their medical expertise. As is common practice across many industries in Singapore, most also receive an annual bonus which can be substantial. Public doctors with particularly heavy workloads, who bring additional money into the hospital as a consequence, are often paid extra in recognition. In contrast, a private sector doctor will build their income entirely from the number of patients and types of conditions they treat.

Pharmaceutical Products

In primary care general practice settings and in common with many of its neighbors, such as, Hong Kong, Singaporean doctors both prescribe and dispense drugs. Dispensing their own drugs means that they stand to make a profit and, in many cases, this also helps to subsidize consultation costs. Most private general practitioners have their receptionists or clinical assistants dispense prescription drugs for their patients. This means that professional pharmacists mostly provide over-the-counter medicines and pharmaceutical advice (Coleman, 2007). Patients, however, can also choose to have their prescription filled by an independent pharmacist, although this is rare, and the government has been looking at regulatory changes to ensure that private general practitioners clearly itemize the costs of both their consultation time and of the pharmaceuticals dispensed. By contrast with the

private sector, the government's polyclinics do employ pharmacists to do their dispensing.

All public hospitals have their own pharmacy departments. Many commonly-used prescribed drugs that are listed on the government's Standard Drugs List are subsidized for both inpatients and outpatients, although MSA funds are not generally allowed to be used to pay outpatient prescription charges. This said, the recent changes to Medisave to fund chronic and long-term illness have included allowances for prescription medicines. Prices are kept down by the fact that the Standard Drugs List tends to include mostly generics; newer or branded drugs are not generally included and so patients will pay full cost for these. In addition, the Group Procurement Office calls for tenders to supply drugs, negotiates purchase prices and undertakes bulk purchasing on behalf of all public hospitals. A key aim here is to drive prices down through use of monopsony power, while providing access to the best possible range of medicines.

All pharmacists must be registered with the Singapore Pharmaceutical Board which oversees professional practices and standards, including requiring evidence of continuing education as mandatory for continued registration. Membership of the Pharmaceutical Society of Singapore, which aims to promote the profession of pharmacy and provides various services such as an annual conference and continuing education services, is voluntary (Coleman, 2007).

Health Promotion

Statistics suggest that health risks among Singaporeans are comparatively low. At around 14 percent, Singapore has one of the lowest smoking rates in the world, with considerably more men than women being regular smokers. However, there is concern at the increasing incidence of youth smokers. Obesity levels, at only around six percent of the population, are also low when compared with rates of well over 20 percent in many developed Western countries.

Health promotion and public health activities are centralized and under the firm control of government. Behind the above statistics is a strong emphasis on health promotion across the spectrum of Singapore health and public policy. Visitors to Singapore will note signs displayed in food markets that warn against unhealthy choices, while anti-tobacco campaigns and advertisements are ever-present. There are also national fitness campaigns and workplace based fitness programs.

The Health Promotion Board, established in 2001 as an independent government-funded body, is the key agency responsible for promoting health and disease prevention with a vision to "build a nation of healthy and fit Singaporeans." It has a wide-ranging program that spans promotion of screening services, injury prevention programs, child and elderly health, physical activity and nutrition, smoking cessation, and AIDS education. The Board also provides extensive information services via its website, offices and a telephone helpline (cf HPB, 2007).

Responsibility for population-based public health is shared between the Epidemiology and Disease Control Division and the Communicable Disease Division

of the Ministry of Health, along with the National Environmental Agency. The Ministry Divisions collect data and monitor the causes and incidence of disease and provide related policy advice to the government. The Environmental Agency is charged with control of vector-borne and food and hygiene related diseases. For example, in 2007, it had around 300 officers working on controlling the environmental factors (eradicating mosquitoes and their breeding grounds) contributing to the incidence of dengue fever. Recently, the government has undertaken a review of its infectious disease control legislation and was planning to introduce a series of new measures. These are designed to improve control in the event of an outbreak such as SARS which Singapore was seriously threatened by. The new measures include increased capacity to carry out public health surveillance, to close premises found to be responsible for an outbreak, to obtain information from patients, and to restrict public gatherings in times of emergency. There is also increased scope for penalizing those found to have been responsible for transmitting the HIV virus.

Development of the Singaporean Health Care System

Singapore has a history as a former British colony that achieved self-governance in 1959 and then complete independence in 1965. The present system for health care delivery in Singapore was preceded by a substantially different set of arrangements that reflect its history as a colony and then a developmental state. Thus, the focus in the early years was on establishing basic services. By the mid-1970s, Singapore boasted a range of hospitals and outpatient clinics and its doctor-patient ratio was improving (in 1960 it was 1:2,573 people; by 1985 it was 1:972). However, despite the government's best attempts, increases in hospital beds were failing to keep pace with the growth of the population (in 1960 the bed ratio was 1:229 people; by 1985 it was 1:259) (Lim, 1989).

By around 1981, the government commenced a process of limiting the number of hospital beds as a measure to keep costs down. In 1965, government expenditure on health care was around 50 percent of total health expenditure. By 1980, this had reduced to around 40 percent, but there was evidence that the public proportion of expenditure was on the increase, with corresponding reductions in the private proportion. Furthermore, the public health care system was closer in design to the universally-accessible "national health system" model of Britain and other former British colonies such as New Zealand.

In 1983, in keeping with its determination to avoid the promotion of a "welfare culture" and associated "entitlement creep," the government introduced its National Health Plan which outlined future directions for the health system and the place of MSAs within this. Central to the new philosophy of "shared responsibility" and fiscal responsibility that underpinned the National Health Plan was the corporatization of all public hospitals. These were to be run as government-own businesses, under government control, but with a new responsibility for budget control and for improving the cost-effectiveness and quality of services delivery. Financial responsibility was similarly shifted to patients via the requirement to pay for at least some

of the costs of hospital care. The public share of health expenditure progressively dropped to around its current level of 25 percent (Lim, 2004a).

Since the reforms of the 1980s, the basic structures for health care have remained relatively consistent. As discussed in this study, developments since have tended to be incremental adjustments to the rules around the various funding schemes.

As expected, the government has also introduced new schemes to deal with emergent areas such as the increasing elderly population that Eldershield is aimed to cater for. It has also adjusted the focus of its policies and the health system, in reflection of international trends. Service integration is at the centre of the creation of the two public hospital clusters formed in 2000, service quality and safety have come to the fore, as has the proactive management and treatment of chronic disease in primary care settings.

References

Asher, M.G. and Nandy, A. (2006), Health Financing in Singapore: A Case for Systemic Reforms, *International Social Security Journal*, Vol. 59, No. 1, pp. 75-92.

Barr, M.D. (2005), Singapore, in R. Gauld (ed.), *Comparative Health Policy in the Asia-Pacific*, Open University Press: Maidenhead, UK.

Blank, R.H. and Burau, V. (2004), *Comparative Health Policy*, Palgrave Macmillan: London.

Central Provident Fund Board (2006), *Saving for Retirement. Annual Report 2006*, Central Provident Fund Board: Singapore.

CPF (2007), website, *www.cpf.gov.sg*.

Coleman, V. (2007), Pharmacy in Singpore: Comparing Experiences in the UK and Asia, *Hospital Pharmacist*, Vol. 14, pp. 96-98.

Ganesan, G. (2006), *Lasik Surgery: Outcomes, Volume and Resources. MOH Information Paper: 2006/17*, Ministry of Health, Government of Singapore: Singapore.

Gauld, R. (2005), *Comparative Health Policy in the Asia-Pacific,* Open University Press: Maidenhead, UK.

Gauld, R.; Ikegami, N.; Barr, M.D.; Chiang, T.L.; Gould, D., and Kwon, S. (2006), Advanced Asia's Health Systems in Comparison, *Health Policy*, Vol. 79, pp. 325-36.

Holliday, I. (2003), Health Care, in I. Holliday and P. Wilding (eds.), *Welfare Capitalism in East Asia: Social Policy in the Tiger Economies*, Palgrave Macmillan: London.

Holliday, I. and Wilding, P. (eds.) (2003), *Welfare Capitalism in East Asia: Social Policy in the Tiger Economies*, Palgrave Macmillan: London.

HPB (2007), website, *www.hpb.gov.sg*.

Institute of Medicine (2000), *To Err Is Human: Building a Safer Health System*, National Academy: Washington D.C.

JHC (2007), website, *www.juronghealth connect.com.sg*.

Lim, L.Y.C. (1989), Social Welfare, in K.S. Sandhu and P. Wheatley (eds.), *Management of Success: The Moulding of Modern Singapore,* Institute of Southeast Asian Studies: Singapore.

Lim, M.K. (2004a), Shifting the Burden of Health Care Finance: A Case Study of Public-Private Partnership in Singapore, *Health Policy*, Vol. 69, pp. 83-92.

Lim, M.K. (2004b), Quest for Quality Care and Patient Safety: The Case of Singapore, *Quality and Safety in Health Care*, Vol. 13, pp. 71-75.

Lim, M.K. (2004c), National Health Insurance, *Health Policy Monitor*, Vol. 4, No. 4.

Lim, M.K. (2005), Transparency of Hospital Bills, *Health Policy Monitor*, Vol. 5, No. 5.

Lim, M.K.; Sadarangani, P.; Chan, H.L., and Heng, J.Y. (2005), Complementary and Alternative Medicine Use in Multiracial Singapore, *Complementary Therapies in Medicine*, Vol. 13, pp. 16-24.

MOH, Ministry of Health (2007), website, *www.moh.gov.sg/mohcorp*.

Nathan, D. (2003), In the End, It Was Not to Be: Laleh and Ladan Die After Landmark Surgery, *The Straits Times*, July 9.

Reisman, D. (2006), Payment for Health in Singapore, *International Journal of Social Economics*, Vol. 33, No. 2, pp. 132-59.

Robinson, J.C. (2005), Health Savings Accounts: The Ownership Society in Health Care, *New England Journal of Medicine*, Vol. 353, No. 12, pp. 1199-202.

WHO, World Health Organization (2000), *The World Health Report 2000: Health Systems: Improving Performance*, World Health Organization: Geneva, Switzerland.

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The Japanese Health Care System Revisted

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Abstract
The long history and the current system characteristics of the Japanese health care system deserves a more detailed appraisal. In this study the author has examined the status quo of the Japanese health care system as is has come to face the mounting crisis of the soon to be super-aged society. Health care insurance and long-term care insurance are facing new huge pressures stemming from the seemingly irreversible demographic changes of our times, the onset of super-aged societies. The article comes to the conclusion that the Japanese health care system can look at a very successful history, but as it is the changed conditions of a super-aged society, it now stands on shaky grounds, financially speaking.

Keywords: Japan, social policy, health care system, health insurance, long-term care insurance, aging society.

The Japanese health care system is characterized by two opposing elements, its remarkable achievements for these five decades and its increasing difficulties in sustaining the system because of population aging and large government deficits. The achievements are produced by with a relatively low ratio of expenditures to gross domestic product (7.6%) compared other OECD member countries (Table 1). This ratio is considerably lower than that of USA (13.9%). The health indexes of both infant mortality (less than 3 per 1,000 live births) and life expectancy at birth (78.4 years for males and 85.3 for females) are among the best in the world. The health system is well equipped for adaptation of newly developed medical technology to actual treatment, which is well comparable with that used in the United States. CT scanners and MRI have come into far wider use in Japan (Getzen, 2004; OECD, 2001, 2002, 2004) (cf Table 2).

The combination of low costs of health care and universal insurance coverage has created egalitarian system, which functioned well. However, reflecting the aging of population, the epidemiological patterns have been shifted into chronic and non-communicable diseases. This causes Japan's health system to be more costly than before. The effect of the aging population is well reflected in the increasing health expenditure and growing deficits in health insurance funds. Grown older patients, who absorb a large share of health resources, affect the insurance

funds. Furthermore, the health sector faces heavy pressure from the financial authority to uphold macro-economic adjustments due to huge government deficits. However, improving of the quality of medical care is a pressing issue, although it is not a central policy issue (cf Nishimura, 1997).

Since the universal health insurance was fully established in 1961 (Before the universal coverage established, there had been mandatory employment-based enrollment schemes and limited sized community schemes.) Presently, the health system in Japan needs major reforms due to financial constraints, geographical unbalances and shortages of physicians in some specialties, such as obstetricians/ gynecologists and pediatricians.

The efficiency in the health sector needs to be certainly enhanced, however, macro-economic arguments for the needs to reduce government debts (accounting for about 150 percent of GDP, the worst position of all OECD member countries) and the cost containment of medical care (one of the lowest expenditure ratio of GDP among all OECD member countries) should not be muddled up (cf OECD, 2002, 2004). It is not reasonable to force the welfare sector such as the health sector to bear burdens through the stringent budgetary policy, in order to reduce the government debts as a whole, which are largely created for nearly five decades by enormous amounts of (i) unfeasible public investment projects in mainly other sectors, such as industrial infrastructure and (ii) unaccountable subsidies to varied public- or semi-public organizations. Consequently, the government debts have piled up into the unmanageable magnitude.

Thus, the health sector also faces increasing pressure to contain public sector expenditures and improve efficiency. However, quality issues of health care have not received adequate attention from the government, on the other hand, increased and increasing co-payments have turned patients to be more quality-conscious of the health care or active consumers to purchase better services (cf e.g. Sawano, 2000; Wise and Yoshiro, 2006).

Table 1: Comparison of Health Expenditure, as Percentage of GDP (2001)

USA	13.9
Germany	10.7
Canada	9.7
France	9.5
Sweden	8.7
OECD average	8.3
Japan	7.6
UK	7.6
Luxemburg	5.6

Source: OECD Health Data (2003).

Table 2: International Comparison of Health Resources

	Hospital beds per 1,000 population	No. of doctors per 100 beds	No. of nurses per 100 beds	Average length of hospital stay	No. of CT scanners per 1 mill. population (1998)	No. of MRIs per 1 mill. population
Japan	13.1	12.5	43.5	31.8	63	28
Germany	9.3	37.6	99.8	12.0	7	7
France	8.5	35.2	69.7	10.8	7	8
UK	4.2	40.7	120.0	9.8	4	5
USA	3.7	71.6	221.0	7.5	41	19

Sources: OECD Health Data (2003) and MHW (1997).

Aging Society

Japan has first seen that the ratio of those 65 and older has finally gone beyond the 20 percent of the total population (Figure 1). The ratio of those to Japan's total population reached the world's highest, 21 percent, in 2005 and is projected to hit 30 percent in the latter half of the 2030s. Consequently, they will constitute one third of the total population in 2050.

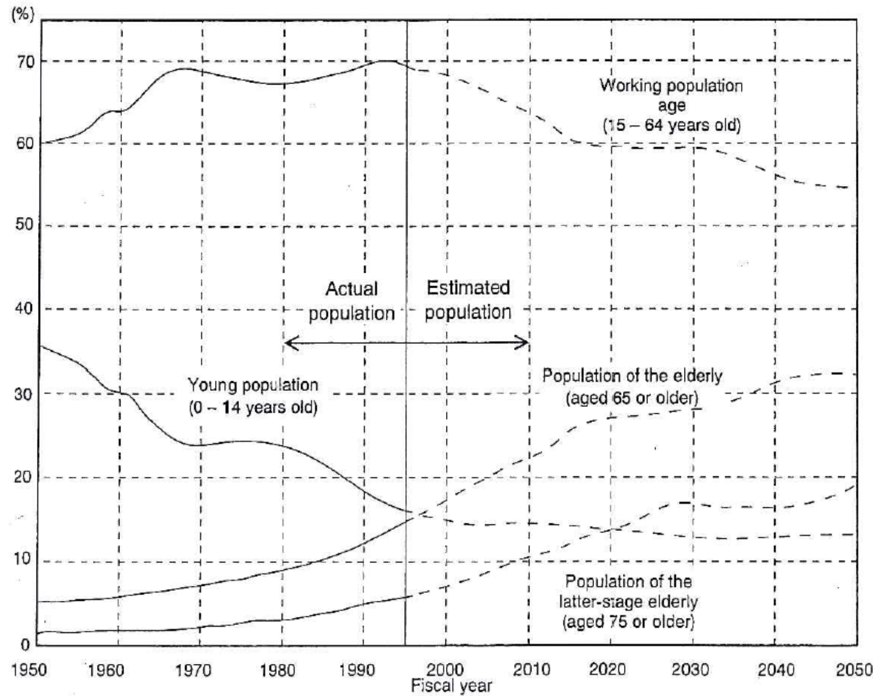
On the contrary, the ratio of people under 15 has dropped to the world's lowest level, 13 percent in 2008. The proportion of unmarried people went up among those between the ages of 20 and 64. This will lower the fertility rates further. Japan's fertility rate has been on the decline to be 1.33 in 2001 since falling below 2.0 in 1975. This low fertility rate of below 2.0 indicates a gradual decline in the population. More importantly, those working population is shrinking on absolute and relative terms, which are main contributors of the welfare system that is based on income transfers among generations.

Social Health Insurance

Most Japanese health professionals tend to agree that the prominent health status is realized by the Japanese egalitarian health system. This is designed to allow extensive cross-subsidization among insurance schemes to nearly equalize purchasing power for health care across the population. This system also ensures both comprehensive benefit package of the insurance, and free access to medical institutions (free choice of any institutions for any kind of treatment without GP's reference requirement). Under the insurance system, beneficiaries can access medical services at any medical institutions, private or public (as to be discussed later, this has made the cost structure of health services highly complex and unaccountable). For the providers' side, the medical fees are remunerated on the basis of "fee-for-service." The total of these price of the medical service provided is remunerated as the service fee (Conversely, gate keeping mechanism can hardly exist). There is no

opportunity for people to opt out by buying private insurance except for some special complimentary/ additional insurance to be handled by private insurance firms.

Figure 1



Source: "Population Projections for Japan" (Provisional data of January 2002) by the National Institute of Population and Social Security Research

The history of the Japanese social health insurance can date back to around the early 1900s (Table 3). In the late 1890s, the establishing of health insurance already became a policy agenda within the Meiji government and started being studied and discussed, stimulated by the Bismarck model enacted in late 19th-century Prussia. The author presumes that the insurance for the government sector aimed to nurture and cement the public employees' state spirit and loyalty to firm up the newly born modern nation-state.

In the beginning of the twentieth century, a workers' insurance started, which was narrowly defined to employees of government and state-owned enterprises. This original mode was gradually developed into mandatory workers' insurance. In 1922, the Health Insurance Law was enacted into covering not only the government sector, but employees of private sectors as well. After the interruption of the World

War II, the community insurance was re-created and thereafter integrated with the workplace insurance, which led to the universal social health insurance in 1961.

Table 3: Developments in the Japanese Health Insurance

1922	Health Insurance Law enacted
1938	National Health Insurance Law implemented
1961	Universal health insurance coverage achieved
1982	Law for the Health and Medical Services for the Elderly enacted
1984	Introduction of co-payments of 10% in employee health insurance
1997	Co-payments lifted to 20% in employee health insurance
2000	Long-Term Care Insurance Law implemented

Universal Health Insurance

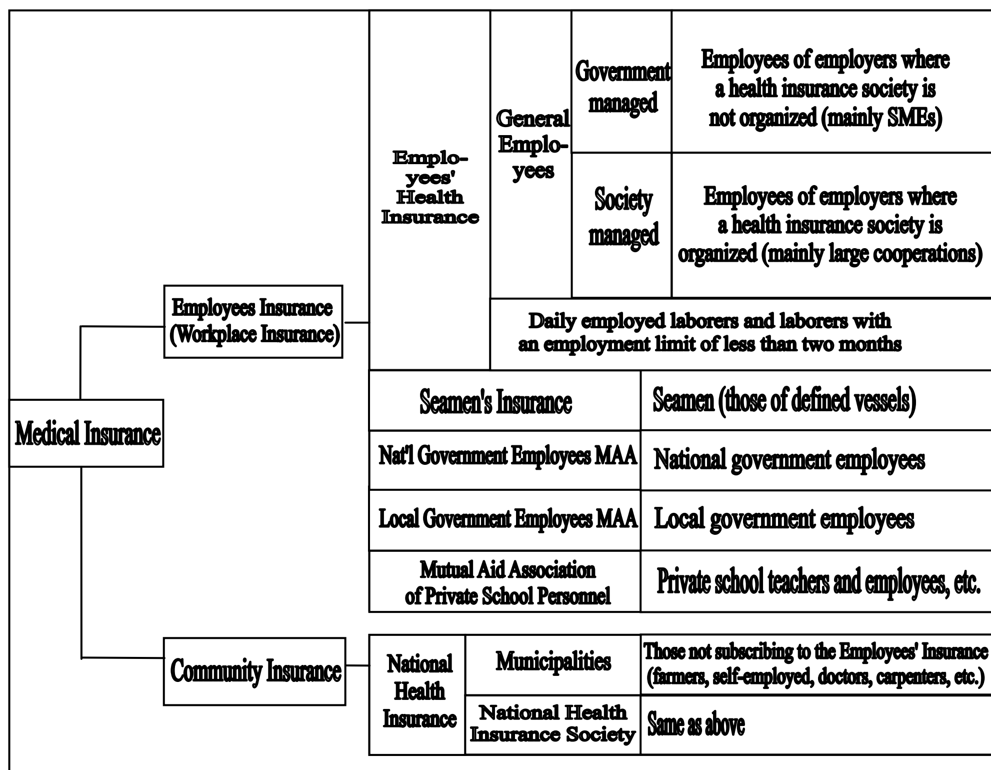
The system is mainly composed by employment based schemes (workplace insurance) and local community-based schemes (community insurance) (Figure 2). In addition to the health insurance plans, a long-term care insurance system was introduced in 2000 to meet the needs of the aging population (cf MoH, 2005; MoHW, 1997).

The employees' schemes comprise the health insurance system is largely composed by (a) *society-managed insurance* (covers the employees of major corporations) and (b) *government managed schemes* (small- and medium enterprises, and government employees are covered). The first one covers the employees of major corporations. About 1,800 health insurance societies exist, and the premiums are 6 to 9 percent of salaries, split equally between the employer and employee. Employees of the major corporations generally earn better and are in good health; therefore, the health associations are financially viable without subsidy. The second one, whose premium is about 9 percent, is not able to cover total costs, but the government finances their deficits.

However, the community insurance plans cover the self-employed, the unemployed, retirees, and all others. Accordingly, the community schemes are affected by aging population and increasing low-income population, Not only the average age of the enrollees on the community-based schemes are highest among all three kinds of insurance plans, but also the retired population under the plans are increasing in number and growing older year after year.

The enrollment in the schemes and payments of premiums is compulsory for all people who are out of the employment category, but those, who arbitrarily opt out of the insurance, account for 4.8 millions households (19 percent of the total households). They are mostly part timers and jobless. Default rates on payment to the community scheme are also growing to be more than 10 percent of the enrollees. Downward pressure on wage are getting heavier, reflecting the globalize economy.

Figure 2: The Japanese Health Insurance System



Note: People aged 75 and older and the bed-ridden aged people between 65 and 75 among the subjects of respective systems are eligible for medical care benefits under Health and Medical Service Law for the Elderly.

Health Insurance for the Elderly

Reflecting rapidly growing medical expenditure largely caused by the health service to the elderly, how to finance medical costs on the elderly is a crucial issue for health insurance system as a whole.

As seen above, two types of insurance schemes, community insurance and workplace insurance largely compose the social health insurance as a whole. However, financial constraints were particularly serious for the community schemes, because the enrollment for most of the retired is transferred from the workplace schemes into community ones. The number of insurers in deficits has been growing to be 73 percent of the total community-managed insurers in 2003 (Table 4).

A separate fund, "Health Insurance for the Elderly" was established in 1983. Eligible age was designed to be over 75 years old or at least 65years old if in bedridden status. This is a separate fund from the main social insurance plans, but contributions to the elderly scheme is currently financed from contributions from

each insurance schemes (about 50%) and tax revenue (about 50%). Contributions from the social insurance schemes used to be 60 percent, but it has been lowered subsequently. Contributions to the elderly scheme took a heavy burden on insurers, both community-based and employment-based. Community schemes normally suffer financially, holding many retirees of their enrollees. Furthermore, employment schemes cannot find much reason for health promotion to the employed, because the incremental surplus to be generated as a result of the better health of the employees has to be contributed to the elderly scheme, and the premium amounts the employers and the employees are obliged to pay regularly are not allowed to be lowered. In another word, primary incentives for promoting health and thus reducing insurance contributions, which must be the principle of health insurance, are unable to function at all under the system.

The government contribution towards the medical expenses of elderly persons has increased to 50 percent. Currently, a fixed rate co-payment for outpatients, uniform 10 percent is currently in effect.

Long-Term Care Insurance

Japan's mandatory long-term care insurance (LTCI) started in 2000. LTCI is administered by municipal authorities. Everyone age 65 and older, plus anyone ages 40 to 64 with an aging-related disability (e.g., Alzheimer's disease or stroke, etc.) is eligible for LTCI. This insurance covers nursing care services in the home, elderly people's homes, and other recognized forms of nursing care and support. The LTCI benefits are funded 50 percent by the government and another 50 percent by insurance premiums payable by the insured. The user contribution is set 10 percent (cf Campbell and Ikegami, 2003a,b; Aspalter and Lai, 2003).

Table 4: National Health Insurance (for regular insured persons in municipalities)

	Revenue (trillion yen)	Expenditure (trillion yen)	Contributions to the Health Service System for the Elderly (trillion yen)	Balance of Income and Expenditure (billion yen)	No. of Insurers in Deficit	Ratio of Insurers in Deficit (%)
1994	5.527	5.664	1.674	-137	2,157	66.3
1995	5.770	5.879	1.773	-109	2,157	66.4
1996	6.048	6.164	1.926	-115	2,117	65.2
1997	6.217	6.245	1.995	-29	1,543	47.5
1998	6.294	6.397	2.105	-103	1,817	55.9
1999	6.692	9.813	2.368	-120	1,967	60.6
2000	6.647	6.726	2.193	-108	1,722	53.1
2001	7.012	7.160	2.506	-148	2,012	62.2
2002	7.016	7.121	2.793	-105	2,051	63.6
2003	7.444	7.678	2.526	-233	2,289	72.8

It was originally designed not only to meet the growing needs of nursing care services, but also to separate long-term care costs from other medical care expenditure, which is financed by health insurance funds. Thus, it is possible to say that the establishing of the long-term care insurance system included the implicit agenda to make the health insurance fund sustainable, which is in a creeping crisis. This program operated within its budget for the first few years and now faces some financial constraints. However, LTCI is well accepted in the country as an appropriate and effective social program. As the focus of care has gradually shifted from hospital care to long-term care, the emphasis within the LTCI system is expanded from institutions to housing.

In 2003, three yeas after the implementation start, the LTCI system was revised, which reflected government policy to contain costs, promote home- and community-based services to prevent institutionalization, and emphasize services to prevent disability and encourage independence of disable seniors. Accordingly, the LTCI fee-schedule was adjusted to be lower for institutional services, but higher for care management, home-helper services, and in-home and facility-based rehabilitation services.

Complementary Insurance Scheme

The importance of complementary (or supplementary) insurance to the social health insurance is hardly discussed in the context of the Japanese health system. However, complementary effects to the funds of the social health insurance are worthwhile being referred to. Complementary insurance, which is run by private insurance companies, has been increasing its subscribers. It seems to be in more demand than before. Most of the policy includes travel costs to the hospital, income guarantees during hospitalization, the costs of private beds, and the costs of medical devices, which are not covered by public health insurance.

As being discussed below, both private financing (except co-payment) and social insurance are not allowed to be used jointly for one episode cycle. Therefore, patients are given two choices, First, if a patient chooses payment though the social health insurance (albeit being of comprehensive package), they have to accept medical services which are covered by the social insurance, thus the patient cannot receive any special medical services which are not covered by the social plan. Or, second, if a patient pays for private health service, one has to pay the entire amount on its own without receiving any support from the social plan.

Reflecting this regulatory constraint, some private schemes, which cover most of cost for a single disease episode, are getting popular in recent years. Moreover, some private schemes include services of consultation through telephone and/or e-mail, obtaining a second opinion from another doctor, a regular through medical checkup, etc. This indicates that there is an increase in those who seek for more special medical care, which is not covered by the social insurance

Automobile Liability Insurance

Social health insurance does not finance in principle the costs of medical service costs caused by traffic accidents, because these costs are to be covered by automobile liability insurance, which belongs to a perpetrator. All car owners are obliged to buy car insurance, which provides coverage for the health care of victims for injuries suffered. In addition, most Japanese car owners also subscribe to voluntary automobile liability insurance, because of the limitations of the required minimum insurance.

Health Care Costs and Population Aging

Japan's national medical spending increased to 33.1 trillion yen for fiscal 2005, a record for the third straight year (Figure 3). This figure represents the total paid to medical institutions by the government, health insurance schemes and patients' co-payment for treatment of illness and injuries.

Japan's annual medical spending per capita has been climbing continuously since financial records started being kept in 1954. The increase of health expenditure has continued to exceed that of national income since 1990. While national income has been barely growing at 1 to 2 percent or so for the corresponding period, the national health expenditure continues to rise by an average of about 3 to 4 percent. Total spending per annum has already reached over 33 trillion yen.

The rising costs are attributed on the clinical dimension to advances in medical technologies and higher numbers of patients with lifestyle-related illnesses. This includes diabetes, which often requires long-term treatment. However, the increase in the overall figure is also attributed to higher per-person expenses in the aging population. 38 percent of the annual expenditure of national medical costs is spent by the care to the elderly patients (over 75 years), representing about 18 percent of the total population.

The aging of the population is a major factor in the increase in the health expenditure. Medical spending by those aged 65 years and older accounts for over 50 percent of the total health expenditure. Medical expenses for those 75 and older account for more than one-third of total health costs, as already mentioned, 90 percent of the annual increase in national health costs is contributed by the care to the elderly patients. For this age group population, the medical cost is on average 727,000 yen per person, 4.7 times that young people. Likewise, 6.8 times for hospitalization, and 4.2 times for outpatients. The causal relationships between medical spending and elderly care can be discussed as follows:

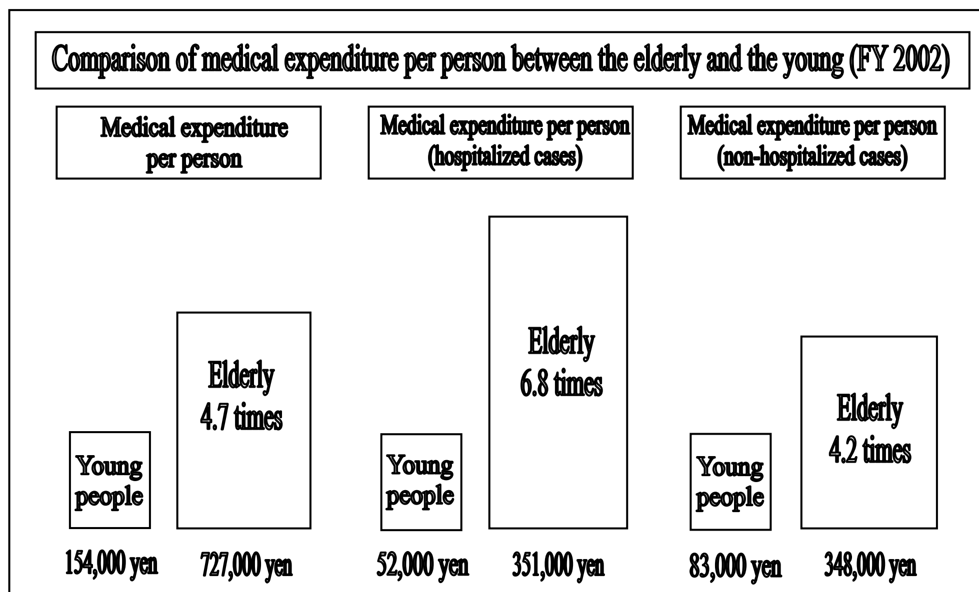
1. The elderly show a higher frequency of visiting medical institutions with higher examination rates, because they tend to have compound illnesses. Their hospital length of stay is on average longer, which lead to higher health costs.

2. Terminal care to elderly patients involves heavy expenditure because of employing the methods of acute care. The care given for a last few weeks before patients' death tend to increase the expenditure sharply.

As to be discussed in the next section, the Ministry of Health, Labor, and Welfare (MHLW) is seriously concerned that total medical spending will increase by 1 trillion yen each year unless the system is revised to keep medical expenses under control. The government has begun working on medical insurance system reform, which aims to curb medical expenses. These reforms include restructuring the medical insurance program, setting up a new insurance program for the elderly, and reducing lifestyle-related illnesses by requiring health check-ups for all people aged 40 years and up.

The problems are not only the health insurance funds, but also hospital sector suffers from financial difficulties, because the fee schedules in the insurance have had increased dissociation from actual costs.

Figure 3



In reality, the number of hospitals operated by municipalities has declined about 300 between the year of 2000 and 2006. Prefectures, cities, towns and villages have pulled out of chronicle loss making operations to improve their finances. A growing number of municipalities are selling their hospitals to the private sector or merging them neighboring institutions. Municipal hospitals in rural areas have seen their financial conditions deteriorate as population have aged and shrunk. In large

cities, private hospitals have been attracting more patients. More than 60 percent of municipal hospitals are in the red.

Medical Institutions

The main medical facilities are hospitals, clinics, midwifery home, and health care facilities for the elderly. Hospitals and clinics, whether private or public, are run within the framework of the social health insurance. Hospitals are split into two groups. Large public and university hospitals contain medical schools and research facilities. Small facilities owned by private practitioners provide less sophisticated treatment and simple therapeutics. In Japan, for-profit investor-owned hospitals are prohibited. All reimbursement is regulated by the uniform fee schedule for both non-profit private and public hospitals/clinics. Medical fees are standardized for all services, including diagnosis, medications, treatments, operations, admissions, nursing and dietary treatments. However, the capital asset position is different between public and private facilities. The former is heavily subsidized. Reflecting this difference, the fee schedule in the health insurance has been adjusted to alleviate the disadvantage of the private

In most OECD countries, the number of hospital beds has declined steadily in the past three decades. This reflects the rapid development of new medical technologies and growing pressure for cost containment. Nevertheless, total inpatient beds per 1,000 population in Japan are still as high as 13.1, which is one of the highest of the member countries, e.g. 4.2 for the United Kingdom, 3.7 for the United States, etc. (OECD, 2002, 2004) (cf Table 2).

An intractable problem in the medical delivery system in the Japanese aging society is so called “social hospitalization.” This refers to the situation where elderly people are hospitalized mainly in order to receive long-term care. This raises issues concerning both the treatment of the elderly, effective use of medical resources and how to alleviate social costs. This sort of issue constitutes the rationale for establishing the long-term care insurance.

On the hand, waiting rooms in hospitals look to be used for the elderly as their informal community centers. They visit there to come across their friends, not only for receiving medical treatments. In the increased aged society, social roles of hospitals may not only be highly functional institutions to provide solely medical services any more.

Health Sector Reforms

Health sector reforms in Japan have been carried out slowly through a series of modifications for the health insurance and incremental changes of the subsidy structure, instead of a comprehensive reform of the health system. Quite a few reform proposals had been issued between early 1980 and the beginning of 2001, but the realizing of the proposals often faced considerable social and political difficulties with conflict of interests among various stakeholders (cf Nakamura,

1998). However, the last Koizumi administration (April, 2001 to September, 2006) changed policy environments noticeably across several major sectors, which facilitated those policy proposals to be effective (although still being piecemeal changes). This policy reform (mainly various modifications of the regulatory measures) seems to continue even after the Prime Minister had already stepped out.

Contrary to the expectation of the policy makers, a variety of new measures for expenditure control have not necessarily led to projected results. In some cases, a cost reduction measure has induced provider or patients to increase health expenditure. The complex nature of health sector reform is getting more recognizable in Japan.

But, the total medical expenditure was more or less leveled off between 1998 and 2002, however, although not officially published yet, the expenditure seems to start growing again after 2003 to be 33 trillion yen from 31 trillion. Japanese are now learning through the reforms, which have been made up to the present, how the health sector is complex and that simple theory-induced reform plans can be detrimental to the health sector as a whole. As mentioned before, there are constant concerns among medical professionals and others that government has not adequately addressed quality issues of health care (cf Wise and Yoshiro, 2006).

Development of Policy Proposals

First of all, 1983 saw the clear start of some reform, in which totally free medical care for the elderly, which had been available since 1972, was modified into some co-payment. In the late 1990, a more systematic reform plan was prepared, which were composed by two reform policy proposals; "Health Insurance and Provision of Health Care Directions for Comprehensive Changes in Health Insurance and Provision of Health Care" was proposed by the MoH and "National Healthcare Guidelines for Securing Quality health Care and Health Insurance for All" by the Health Insurance System Reform Council of the then majority, the Liberal Democratic Party. Since then, these policy proposals have been playing a central role in designing reforms in the health system. The main issues of the policy proposals include further modification of fee schedule, revisions of drug tariffs, separations of a health care insurance system for elderly and so forth. Thereafter, basic reform steps were taken to bring about the clarification and prioritization of the use of hospital beds, the promotion of evidence-based medicine, the introduction of a new training system for physicians, the promotion of effective use of information technology in the medical care and so forth.

However, financial constraints in the health sector remain to be serious. In fact the newly introduced Long –term Care Insurance System failed to give impact to reduce financial burden by health care services to the elderly patients.

A New Insurance Program for the Elderly

In 2006, the government prepared a new health insurance system reform to contain medical expenses and make the system sustainable. This was to separate a community-based plan from the health insurance for the elderly (over 75 years) and establish an independent health care insurance system for the elderly. This proposal was passed in the Diet and is in operation in 2008.

The plan is mainly composed by restructuring the medical insurance program, setting up a new insurance program for the elderly, and reducing lifestyle-related illnesses by requiring health check-ups for all people aged 40 years and up. Under this new health insurance program for those aged 75 years and older, the introduction of fixed rates for outpatient services aims to reduce excessive testing and treatment. Fixed rates are only used in some parts of inpatient service; thereby co-payment amounts for patients will be lowered. This is because medical fees are generally determined under the fee-for-service by adding up unit prices set for each treatment step.

Nevertheless, there are strong concerns among the Japan Medical Association and other specialists groups that fixed rates should be applied only in a limited manner, otherwise these measures will restrain patients from getting the necessary health care.

Restrictive Free Access

Free access to medical institutions (free choice of any institutions for any kind of treatment) has been one of the major elements for the Japanese equitable health system. However, the Japanese government is examining the feasibility to limit the extent of access, as long as patients' choices are not too narrowly restricted. In fact, it is still practically difficult to limit the access effectively and efficiently, since Japan has never established a geographically well–designed referral system. Thus, the MHLW has introduced a system in which patients must pay higher charges (bypass charges) in a secondary and/or tertiary hospitals, visiting without a referral form from a primary care clinic. A primary care clinic is now encouraged to refer a patient to a higher layer institution. It is not very clear how well this incentives work under the combination of fee-for service and social health insurance. It was believed among providers that holding patients for an episode cycle was financially beneficial under the fee-for service.

Inclusive Payment System

The fee-for service system is one of the major causes to the excessive supply of medical services. The government introduced an inclusive payment system in order to contain the growing health expenditure. In the payment system, a fixed price is determined for a series of medical examination. Namely, a series of medical examination is taken for one standard package.

Nevertheless, some scientific researches have clarified that the inclusive payment system failed to reduce medical costs (Campbell and Ikegami, 2003a,b). Medical institutions tend to choose either the inclusive payment or the fee-for-service to gain better revenues within the regulations of the social health insurance. For example, providers choose relatively high inclusive payment, in case the average fee for a patient is low. However, when they provide patients serious and costly care, they choose the fee-for-service. But MHLW has not published the aggregate effects by the inclusive payment.

Case payment like DRG is now being implemented in an experimental manner in Japan. This is called DPC (diagnosis procedure combination). Most of academic hospitals, which provide highly advanced care, are now obliged to employ this case payment method. DPC is expected to contribute to improving hospital management, strengthening the accountability of health care, and rationalizing the health system. For improving of hospital management, DPC can develop several indicators useful to management, cost analysis and benchmarking. The accountability of health care can be strengthened by information of clinical outcomes created through DPC and more rational financial management. Therefore, better database for regional health planning can be created for rationalizing the health system.

But there are some concerns about the introduction of DPC; too much cost containment is to be induced under the rationalizing the health system, for example suboptimal quality care, immature discharge can take place, on the other hand, unnecessary treatment may be motivated within the package of medical care inputs.

It is the most fundamental problem of the health financial mechanism in Japan that the fee schedule linked with disbursement amounts does not reflect the "real costs" of medical services. The all reimbursement is regulated by the uniform fee schedule for both private and public services.

However, the financial basis of capital asset between the private and public sectors has been keeping some disparities, thus, to adjust financial positions between these two sectors, the fees are negotiated among the MoH, the Japan Medical Association and insurance plans (carried out almost every two years) The half-a-century long highly artificial adjustments of the fee schedule system have been divorced from the real costs of services.

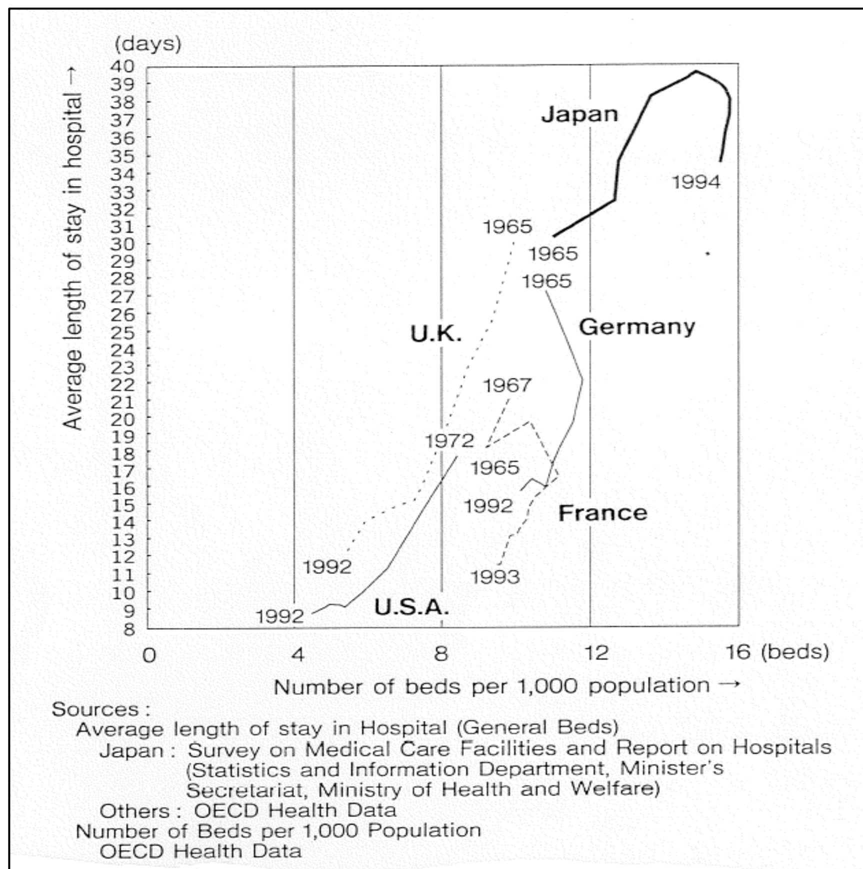
Mixed Treatment

Mixed treatment (or mixed payment) is currently a most controversial health system issue. Mixed treatment (integrating insured and discretionary treatments) under the social health insurance is allowed to make only for dental care. In another word, both private financing (except co-payment) and social insurance is not allowed to be used jointly for one episode cycle. The government makes it to rule public insurance coverage even for insurance-eligible diagnosis, drugs, and surgeries, other procedures and hospital costs when a patient opts for an uninsured treatment that is often expensive.

However, this government rule on the insurance will be rectified in the near future. Cancer patients took to the Tokyo District Court the ban on mixed treatment as being unjust, aiming to obtain insurance coverage in the case of mixed treatment. This was because their financial burdens would be enormous if they opt for anti-cancer drugs not eligible for insurance coverage. In November 2007, the District Court ruled it illegal for the government to wholly deny a cancer patient insurance coverage because the treatments he received included a medical procedure uninsured by the public healthcare insurance policy.

Furthermore, the Court concluded that the state interpreted the health insurance law incorrectly. The MHLW's regulation to ban the mixed treatment may have lost its legal basis or legitimacy. Although MHLW is reported to be considering an appeal of the case to a higher court, the judgments will gradually give significant impacts to the regulatory framework of the health care payment methods.

Figure 4: Average Length of Stay in Hospital



Sources :
Average length of stay in Hospital (General Beds)
Japan : Survey on Medical Care Facilities and Report on Hospitals (Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare)
Others : OECD Health Data
Number of Beds per 1,000 Population
OECD Health Data

Hospital Fee

Average length of hospital stays in Japan (approximately 32 days) is much longer than the average of other OECD member countries, such as about 10 days in the UK (cf Table 2 and Figure 4). In 2000, the two reform policy proposals issued in the late 1990 were realized into an actual measure. The hospital fee system was totally reformed and a new basic fee for hospitalization was established. The basic fee is set higher for hospitals where the average length of patients' stay is short. These measurers provide hospitals strong incentives to decrease the length of hospital stays.

Moreover, the MHLW has started revising medical treatment fees paid to a hospital from the national health insurance system so that they are based on the actual nursing-care needs of patients, not simply on the number of nurses at that hospital as used to be applied to (cf Tsutui and Murmatsu, 2005).

Excess Capacity of Health Sector Resources

To help reduce excessive testing and treatment, MHLW plans to introduce fixed outpatient medical fees for those aged 75 years and older, in which costs would depend on the disease, not the number of tests and drugs administered.

In the addition of several control measures, the MHLW limits the numbers of doctors and beds, because there was strong relationship among the numbers of doctors and beds, length of hospital stays and health expenditures. In the middle of 1980s, the Ministry conducted an in-depth survey to clarify the required beds in several hundred areas. As a result, in areas where the number of existing beds exceeds the standard requirement, an application to open new hospitals or increase hospital beds is hardly accepted in a local government.

On the education front as well, the government is reducing the number of doctors to be produced. Student enrollment in university faculties of medicine has been restricted. However, doctors are not only geographically unevenly located, but also unbalanced in terms of specialty, such as a serious shortage of obstetricians and pediatricians. On the other hand, strains of overwork of medical professionals are now one of notable social problems in Japan. The MHLW revealed in 2006 that a rise in the number of women doctors is welcome in terms of gender issue, but quite a few female physicians leave their positions every year probably due to overworking environments and few hospital nurseries available for them to make an easy use of. While 95 percent of female physicians in their 20s are engage in practice, the ratio fall to around 85 percent among those in their 30s. This adduces one of the reasons for the shortage of obstetricians/ gynecologists and pediatricians. Moreover, there is no good incentive structure to retain and/or increase these specialists, male or female, which is closely related with the present design of the social insurance system (MHLW, 2007).

In relation of discussions on the excess capacity of health resources, government does not seem to adequately address quality issues of health care. Physician

density (practicing physicians per 1000 population) in Japan is 1.9, which is classified into the lowest group of OECD member countries. The OECD average is 2.8, and 3.3 per 1,000 population is the figure of Germany, whose social health insurance gave a fundamental influence to that of Japan.

Rationalizing Pharmaceutical Prices

Adjustment of pharmaceutical prices is crucial to reform in the health insurance schemes. The costs of pharmaceuticals are estimated to account for nearly 30 percent of the national expenditure for health care. This can be well compared with the United States, the world's heaviest spender for health care, with the expenditure of about 11 percent for pharmaceuticals. As discussed below, a few major policy measures are preceded, such as revision of prescription drug prices, separation of pharmacy from medical care, and promoting generic drugs.

Pharmaceuticals

Revision of Prescription Drug Prices

Prescription drug prices in Japan generally can remain above market prices at which drugs are sold to pharmacies and hospitals. Medical institutions may pocket the difference between government-set and actual purchase prices. Therefore, regular revision of prescription drug prices is a most regular intervention for the MoH. Prices for prescription drugs covered by public health insurance plans are reviewed using market-price surveys as part of biannual assessments of government-mandated medical treatment fees. Drug costs account for 20 percent of overall medical spending, thus, narrowing the price gap is always one of the policy measure for health expenditure control. Those regulated drug prices have been decreasing by 4-10 percent over the past decade. The government seeks to revise the policy measure to review drug prices once a year to bring them down to levels comparable to those paid by hospitals and clinics as early as possible. The MoH estimates that annual price changes would slash the government's drug spending by about 100 billion yen.

Separation of Pharmacy From Medical Care

Pharmacy services have been separated for the purpose of preventing hospitals from prescribing excess drugs under the fee-for-service system. Consecutive cuts of reduction in prescription drug prices as well as the spread of the inclusive payment system made it less attractive for hospitals to have their own pharmacies, and the separation has been gradually spreading. The proportion of prescriptions filled outside hospital is currently estimated to be above 50 percent.

There remain a number of problems with effecting separation of prescribing and dispensing. For example, the prevalence of "gate-front pharmacies "located

adjacent or close to hospitals or clinics, which are engaged in filling prescriptions from those institutions (JICA, 2005).

The separation looks to be more or less on a cosmetic stage. However, some indicate that the separation has allowed local pharmacy to prescribe prescriptions from multiple hospitals and clinics, maintain patient medication profiles, and give detailed advice about taking medication. This policy is called as the "focused pharmacy system," which is promoted by the MoH. This policy also includes the upgrading of the professional capacity of pharmacists. The university degree program for pharmacy has been extended from a 4-year to 6-year program. This length is the same as the medical degree program.

Patients are able to have significant benefits by receiving better advice from about taking medicine from the pharmacist, since Japanese patients have long faced problems of excessive prescriptions/dispensing and duplication and drug interactions, partly thank to free choice/access to medical institutions.

Promoting Generic Drugs

The use of generic drugs in Japan is significantly low, being still in about 17 percent of the total sales on a volume basis, while the corresponding ratios in some other OECD member countries accounts for about 60 percent. The government is now encouraging medical institutions to use more generic drugs, whose prices are 30 to 70 percent less than those of their brand-name counterparts. The MoH is promoting the use of generics will contain the rise in medical expenses. It aims to increase the Japanese share to at least 30 percent by 2012. It discloses that 17.4 percent of prescriptions were marked with a notation stating that they can be filled with generic version, however, the generics were actually dispensed 8.2 percent of the time. In another word, generics accounted for only 1.4 percent of all prescriptions filled.

Needless to say, hospitals and pharmacies hold the key to the success of the plan to modify prescription forms to encourage the dispensing of generics. However, they seem to be reluctant to offer more generic drugs. While medical professionals often cite concerns quality and their ability to procure steady supplies, the real reason can be presumed that generics are not as profitable as brand-name products. As mentioned above, the margins that hospitals and pharmacies can generate between government-set process and wholesale prices are bigger for brand-name drugs, which carry high prices.

The use of generic drugs is only slowly increasing, even though the MoH adopts the new prescription form. The MoH is examining the feasibility of a system where patients opting for previously patented medications will have to shoulder a large financial burden if an equally effective generic version is available. But, some medical doctors claims that the MoH should review a good system of quality assurance for generic drugs.

There is seen the development of new medical treatments in the fields of reproductive medicine and nanotechnology, cutting-edge medical pharmaceuticals based

on genetic information. However, the Japanese pharmaceutical industry is not internationally competitive enough. In fact, representatives in the is industry and the government collaborated to draw up "Pharmaceutical Industry Vision" in 2002, with the aims of improving the international competitiveness of the Japanese pharmaceutical industry (MoH, 2002). However, looking at this development from the angle of generic drugs, the capacity problems in the Japanese pharmaceutical industry seem to lead indirectly to unenthusiastic policy environments for promoting generic drugs.

Preventive Care and Health Promotion

Health Promotion

Preventive services can be an effective measure to contain or reduce medical costs as a whole. Facing the new century, the MoH prepared a health promotion policy for Japan, called "Healthy Japan 21." The idea of this initiative is the health actualization with various types of people through providing support to individuals' efforts to stay healthy. The initiative is designed to make it possible for individuals to fulfill good lives by setting specific health related goals against death from diseases, illness and risk factors in lifestyles. It also expects the providing of sufficient information, the building of an environment for people to individuals to improve their life-styles and improve health through informed choices.

The MoH will in 2008 raise the ceiling for company workers' health insurance premiums to 10 percent of annual pay. Medical care reforms taking effect in 2008 will require all workers 40 and older to under go annual physical examinations. Although this move may cost several thousand yen each, the 10 percent cap will help cover the additional spending. As a result, the total medical costs would be contained. These interventions are expected to make the Japanese aging society sustainable.

Passed in 2002, the Health Promotion Law sets goals and basic policy for the entire nation, directs, local governments to formulate health promotion plan in response to the local circumstances, and sets newly common guidelines for occupational, community-based and school-based health checks, which have been already well expended national-wide for some decades.

The preventive care is emphasized in the "Healthy Japan 21." The strategic objective in the plan is to (a) reduce untimely death under the age of 65 and (b) prevent and reduce disability of the elderly. The interval death score for those under 65 already record about 15 percent. For the disability of the elderly. the number of bedridden and/or senile people is to reach two million by 2010. In particular, municipalities conduct the program of disease prevention and health promotion for community residents who are over 40 years. Regular preventive checks programs

Nevertheless, the health promotion policies conducted so far in Japan looks to have lots of loopholes or defects in its practice. Firstly, working population who are

major supporters of the health insurance funds must have an enormous opportunity cost to go to hospital, because of a long waiting time in a hospital caused by lack of collaboration among medical institutions and old-fashioned management style. To receive even a preventive care is not necessarily a simple task, although municipalities and workplaces provide regular health check-ups. Secondly, as seen below, smoking control in Japan has been in a halfhearted way.

Tobacco Control

The typical example is that smoking control policies have been noticeably few and ineffective in Japan. Smoking rates among adults in Japan are still among the highest in the world (49% for men and 14% for women). This makes a sharp contrast with less than an average 25 percent in Scandinavian countries.

A series of measures, especially the Health Promotion Law of 2003, are only recent efforts by government agencies in response to determined movements driven by changing attitudes in a large segment of the population.

The Framework Convention on Tobacco Control (FCTC), initiated by the World Health Organization, took effect in February 2005. In the face of many objections to the implementation of this global treaty on public health, the Japanese government looks unenthusiastic in taking its leadership as one of the 49 parties to the treaty. The Health Promotion Law merely *advises* public facilities (e.g., schools, hospitals, offices, restaurants) to take measures to protect their users from environmental tobacco smoke. The law has, thus, limited effectiveness, and imposes no penalties. As discussed below, there are several institutional factors working against the promotion of tobacco control in addition to the Health Promotion Law.

Firstly, in many service industries in Japan, countermeasures to indoor air pollution are non-existent. This contrasts noticeably with several other countries that have enacted truly effective antismoking laws. In most restaurants, cafés and bars, non-smoking and smoking areas share the same space. Incomplete separation with partitions of human height has been shown to be surprisingly ineffective in protecting nonsmokers from secondhand smoke. Reflecting the large smoking population, most proprietors have been reluctant to introduce control measures for fear of losing customers. Self-regulation in this business sector simply will not occur without a stronger policy in place.

Secondly, vending machines are the major retail channel for tobacco in Japan. About 50 percent of total cigarette sales are made through approximately 630,000 such machines. There are no regulations governing numbers of machines, their location or operation except for a few municipalities' ordinances controlling sites. Accordingly, machines are found everywhere: on the street, in restaurant lobbies, at gas stations, in supermarkets, etc. Minors can easily purchase cigarettes without being monitored.

Thirdly, cigarettes are significantly cheaper in Japan. The average pack of 20 is about one-third the retail price in many other industrialized countries (although prices vary by brand). While Japanese prices range between ¥280 to 300, the

British, for example, pay ¥900 to 1,000. Prices are controlled by the Ministry of Finance and maintained at a low level. The Ministry has been averse to raising prices, fearing a decrease in tax revenue resulting from sagging sales.

Lastly, the mass media and many people in public life have been less than cooperative in fighting this form of indoor air pollution. The media still favors the euphemistic term *aienka* (smoking aficionado) for smokers, and several prominent professionals including doctors have gone so far as to publish books and articles mocking concerns about the effects of secondhand smoke on nonsmokers.

Pro-tobacco interests have virtually muzzled the Diet, and while some local governments have adopted measures on smoking, they often focus on etiquette, with ordinances regulating inconsiderate behavior such as discarding cigarette butts and smoking on the street. It is time for the Japanese government to take firm action and enact a complete ban on smoking in such public places as hospitals, restaurants, bars, and taxis.

Quality of Care

The egalitarian and relatively low-cost health system has succeeded in creating the prominent health status and the good welfare society. However, the quality seems not to be highly prioritized in the Japan's health services. The quality issues have yet to receive adequate attention from the government. Under the cost containment measures being carried out, the quality problems are by far most important and pressing issues. Japanese nationals are compelled to wait for a long time in a hospital. This is commonly called "five minutes with a doctor, after a five-hour wait." Working population who are major contributors to the health insurance funds bear such enormous opportunity costs to go to hospital. A survey commissioned by the MoH reveals that most of the respondents sought more communication with medical staff than physical amenities. For example, the primary condition outpatients feel necessary in choosing a hospital is "communication" (Kawabuchi, 1998; Ie and Ookusa, 2002).

Systemic Problems

These are often pointed outs; a lack of explanations or informed consent procedures, sub-optimal physical facilities and insufficient collaboration among medical institutions. More fundamental concern is weaknesses in professional standards, (degree of arbitrariness and inconsistency in medical decisions), inadequate continuing medical education and lack of quality control. A high rate of medical errors during the delivery of medical services is increasing the awareness of quality problems among the public beyond medical professionals.

Health care quality problems are believed to be systemic in nature, with only a minority of quality problems resulting from malfeasance or negligence on the part of individuals, organizations, or institutions. The health care system is not organized in ways to promote best quality. That is to say, service delivery is largely un-

coordinated, slowing down care and decreasing rather than improve safety (cf OECD, 2004). Doctors' professional levels are hardly assessed before making employment contract, and all most all hospitals in Japan hire any number of doctors on a part time basis. Thus, it can be said that there is not well-established professional labor market for medical doctors. Doctors are not only geographically unevenly located, but also unbalanced in terms of specialty, such as a lack of obstetricians, etc. as seen below.

Fallings of the Emergency System for Child Delivery

The Government Fire and Disaster Management Agency announced that a total of 667 pregnant women transported by ambulances were refused admission by three and more hospitals in 2006 across Japan. This reflects a lack of obstetricians and poor coordination among medical institutions. The MoH separately showed that in the year 2005 70 percent of medical centers, which were specially designed to accept pregnant women and newborns, who were considered at high risk, refused to admit those pregnant women, and 60 percent refused to admit newborns. In fact, a pregnant woman in Nara Prefecture suffered a miscarriage while the ambulance was on its way to try to visit the tenth hospital after she was already refused by nine hospitals.

Enhanced Activism for Health Care in Patients and Consumers

Surveys conducted between 1998 and 2006 by the Tokyo Metropolitan Government reflect a notable increase in the number of patients who want to choose their own treatment rather than leave it up to the doctors. It also showed the number of those who has seen multiple doctors for the same illness or symptom had double from 2001 and 2006 (NW, 2007). Japanese patients look to be becoming less passive and more self-responsible in regards to their health care.

With continued scandals at medical institutions have aroused a generalized fear among Japanese people. Patients must have a heightened awareness of various defects of the current health system. Already increased and increasing co-payments have turned patients to be more quality-conscious of the health care or active consumers to purchase better services.

In addition, thanks to increased information via the Internet and so, patients and/or consumers are now able to gain access to more information, share information with other people who have similar diseases and even to ask for second opinions.

Conclusion

The health system in Japan was successful, but the system is financially shaky, under the aging of the population and increasing pressure to contain pressure to

contain health expenditures. Compare internationally, it is difficult to argue that health sector resources in Japan are excessive in almost all respects.

The combination of free access to health care and fee-for-service is to be reconsidered. Raising the co-payment rate under the present system and the redistributing costs among various insurance schemes must have almost reached to the limit as a policy instrument. Long-term care insurance is already on a financially uncomfortable position, and has had little detectable effect to the expenditure of the social health insurance, principally because of free access to health care and fee-for-service being maintained.

The problems are not only the health insurance funds, but also hospital sector suffers from financial difficulties, because the fee schedules in the insurance have had increased dissociation from actual costs. Overwork problems of medical professionals remain to be chronic. On the other hand, the quality of care is a far more serious issue than before among the people.

Younger working population will not support more intensified income transfer among the generations any longer. Toward the end of 2007, the government's tax commission called for raising the consumption tax to ensure a stable revenue source to cover growing social security costs in its tax reform proposal, which is one of the most controversial political agenda.

Many health professionals in the health sector understand that a more comprehensive reform of the health system is absolutely needed, but they also know the drastic and far-reaching reform made in the health sector of other countries (e.g., the UK, New Zealand, etc.) has not produced a satisfactory effect. It is widely believed in Japan that a well-designed incremental approach should be promoted with the stable political will.

References

Aspalter, C. and Lai, O.K. (2003), Welfare Capitalism in Japan, in C. Aspalter (ed.), *Welfare Capitalism Around the World*, Casa Verde: Hong Kong.

Campbell, J.C. and Ikegami, N. (2003a), Japan's Radical Reform of Long-term Care, *Social Policy & Administration*, Vol. 37, No. 1, pp. 21-34.

Campbell, J.C. and N. Ikegami, N. (2003b), Long-Term Care Insurance Comes to Japan, *Health Affairs*, Vol. 19, No. 3, pp. 26-39.

Getzen, E. (2004), *Health Economics*, Wiley: New York.

Ii, M. and Ookusa, Y. (2002), Economic Analysis of Demand for Health Services, Nihhon Keizai Shinnbun-sha: Tokyo (in Japanese).

JICA (2005), *Japan's Experiences in Public Health and Medical Systems,* Institute for International Cooperation, Japan's International Cooperation Agency: Tokyo.

Kawabuchi, K. (1998), *Introduction to Health Care Economics*: *Understanding Japanese Health Care Reform,* Yakuji Nippon: Tokyo.

MoHW, Ministry of Health and Welfare (1997), *Annual Report on Health and Welfare, 1996-1997*, Ministry of Health and Welfare, Government of Japan: Tokyo.

MoH, Ministry of Health (2005), *Labor and Welfare: Annual Report on Health, Labor and Welfare*, *2004-2005*, Ministry of Health, Government of Japan: Tokyo.

MoHW, Ministry of Health, Labor, and Welfare (2007), website, *www.mhlw.go.jp*.

Nakamura, Y. (1998), Government Administration of Medical Affairs, Gyosei: Tokyo (in Japanese).

Nishimura, S. (1997), Economic Analysis of Health Care, Toyokeizai Shimpoh Sha: Tokyo (in Japanese).

NIPSSR, National Institute of Population and Social Security Research (2002), *Population Projections for Japan*, NIPSSR: Tokyo.

NW, *The Nikkey Weekly* (2007), October 8.

OECD (2001), *Health at a Glance*, OECD: Paris.

OECD (2002), *Measuring Up: Improving Health System Performance in OECD Countries*, OECD: Paris.

OECD (2003), *OECD Health Data*, OECD: Paris.

OECD (2004), *Towards High-Performing Health Systems*, OECD: Paris.

Sawano, K. (2000), Co-Payment, Coinsurance Range and the Elderly Care in Japan, *Journal of Health Care and Society*, Vol. 10, No. 2, pp. 115-37 (in Japanese).

Tsutsui, T. and Muramatsu, N. (2005), Care-Needs Certification in the Long-Term Care Insurance System of Japan, *Journal of American Geriatrics Society*, Vol. 53, pp. 522-27.

Wise, A.D. and Yoshiro, N. (2006), *Health Care Issues in the United States and Japan*, The University of Chicago Press: Chicago, IL.