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Future Challenges for Medical Care

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Challenges facing the Japanese Healthcare System: A Comparative Perspective

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The Japanese healthcare system is known for its universal access, relatively high performance (e.g., cost containment), and successful outcomes (e.g., longevity). Despite this, it has faced many challenges in recent years. The sources of these challenges are both exogenous (e.g., demographic patterns) and endogenous (e.g., demands for more open and transparent decision-making processes). This summary report will touch on some of these challenges, primarily by comparing and contrasting maternity care services in Japan and Ireland. Maternity care sits at the intersection of family, society, and state and illustrates the point that healthcare needs to be examined from a broader 'societal' perspective in the future.

Japan and Ireland are both high-income island countries, but they seem to be in very different societal phases: Japan is in an unprecedented era characterized by a rapidly aging and declining population, while Ireland is currently enjoying a baby boom and simultaneously achieving higher status and more active participation for women in society. Table 1 provides comparative data.

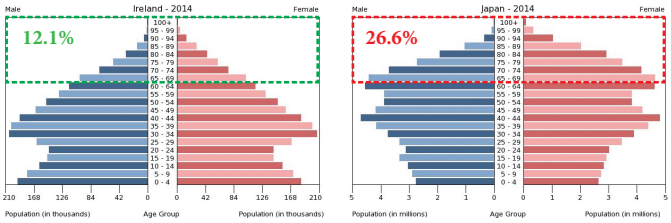
Ireland's land area is roughly that of Hokkaido, and its population is roughly one-thirtieth of Japan's. Ireland has 32 counties across two countries—26 counties in the Republic of Ireland, and 6 in Northern Ireland, which is part of the United Kingdom. Hereafter, the term Ireland refers to the Republic.

Despite Japan's high GDP, its GDP per capita is lower than that of Ireland. Economic inequality has increased in both countries in recent years, but the issue is particularly prominent in Japan, where it is causing social problems such as poverty among the old and the young, including among single parents.

The most remarkable difference between the two countries is that the Irish population is much younger than Japan's (Figure 1). When looking at the longitudinal trends, Ireland's total fertility rate (TFR) has remained almost stable or increased since the mid-1990s, while Japan's has steadily decreased. Ireland's birth rate dropped between 1980 and 1995, around the time that the government approved oral

	Japan	(Hokkaido)	Ireland
Population (thousands)	125,047	(5,417)	4,592
Population density (per km^2)	338	(64.9)	65
Area (1,000 km^2)	376	(83)	70
GDP (billion USD)	$4,302		$178
GDP per capita (USD)	$33,772		$39,778
Foreign population (percent)	1.6		11.2
Ethnic composition	Japanese 98.3% Chinese 0.5% Korean 0.4% Filipino 0.2% Brazilian 0.2% Other 0.4%		Irish 86.8% British 2.5% Other EU 6.1% Other European 0.4% Asian 1.4% African 0.9% American 0.5% Other 1.4%

Table 1. Japan and Ireland in comparison



Ireland		Japan
35.7	Median age (2013)	46.1
80.9 (F:83.2/M:78.7)	Life expectancy (2013)	84.2 (F:87.7/M:80.9)
15.18	Birth rate (2014 est., births/1,000 population)	8.07
2.01	Total fertility rate (2013, children born/woman)	1.39

Figure 1. Ireland and Japan, demographics

	Japan	Ireland
Physicians per 1,000 pop.	2.2 (2010)	2.7 (2010)
Nurses per1,000 pop.	10 (2010)	12.2 (2010)
Total hospital beds per 1,000 pop.	13.4 (2011)	3 (2011)
Curative (acute) care beds per 1,000 pop.	8 (2011)	2.2 (2011)
OB/GYN (number of persons)	12,708 (2012)	387 (2012)
OB/GYN per 1,000 pop.	0.1 (2012)	0.08 (2012)
Midwives (professionally active)	31,835 (2011)	2,085 (2011)
Midwives per 1,000 pop.	0.25 (2011)	0.46 (2011)
MRI units per million pop.	45.9 (2013)	2.0 (2013)
CT scanners per million pop.	101.2 (2013)	4.5 (2010)
Institutions providing intrapartum care	2,868 (2014)	20 (2012)
Deliveries per institution per year	44.1 in hospitals (>20 beds) 30.4 in clinics (<20 beds) (2011)	Huge variations—1,179 in South Tipperary Gen. Hospital to 9,109 in the National Maternity Hospital, Dublin (2012)

Table 2. Healthcare resources in Japan and Ireland

contraceptives. However, it has completely recovered since then, increasing by over 33 percent. As a result, the TFR in Japan is 1.39, while that of Ireland is 2.01—one of the highest among the world's advanced industrial economies.

The comparative statistical data further suggest that people's attitudes towards marriage differ distinctly in the two countries. First, there are very few children born to single parents in Japan. In 2011, the proportion of Japanese children born outside of marriage was only 2.2 percent. In contrast, the proportion of children born outside of marriage is 36.5 percent in Ireland (this has been emerging as a global trend over the last three decades). Second, marriage and childbirth occur in reverse order in Japan and Ireland. Japanese women tend to get married first (at an average age of 29.2) and have their first child later (at an average age of 30.2). Irish women tend to have children first (at an average age of 30.0 for the birth of their first child) and to marry later (at an average age of 32). Although both Irish and Japanese women become mothers at a later stage relative to other OECD countries, which seems to accelerate a general trend toward medicalizing pregnancy, Japan has maintained strong traditional cultural norms about marriage and childbearing.

Table 2 compares Japan and Ireland's healthcare resources. In terms of head counts, both countries appear to have a similar number of physicians and nurses. The number of nurses per 1,000 people in Ireland (12.2) is significantly higher than the OECD average (8.7), while in Japan the number (10.0) is slightly higher than the average. The number of physicians in both Japan and Ireland is below the average (3.2). However, Japan has a much greater number of hospital beds for both acute and chronic patients, as well as more medical equipment such as MRI and CT scanners, which could explain Japan's long hospitalization rates and the high availability of medical technology services in Japan. Similarly, Japan's maternity care units have ultrasound (vaginal and abdominal) and cardiotocography (fetal heart monitoring) devices readily available, even in small clinics.

The data seem to suggest that similar levels of obstetric care are available in the two countries. However, these figures require very careful interpretation. First, not all obstetricians/gynecologists necessarily work for maternity care units; they also work for patients with gynecological diseases, and conduct infertility treatments, research, and education. In Japan, compared to Ireland, numerous institutions deal with a much smaller number of deliveries (44.1 per month per hospital and 30.4 per month per clinic in 2011); therefore, a much higher number of obstetricians is required to meet the needs across Japan. In addition, Japanese midwives are required to have nursing as well as midwife licenses while Irish midwives are not. Among 31,835 practicing nurse-midwives in Japan in 2012, 65 percent of them worked in hospitals, 21 percent in clinics, 6 percent in midwifery centres, 5 percent in educational/research institutions, and 3 percent in local government offices. When Japanese nurse-midwives work in hospitals, they usually rotate across various clinical units as nursing staff. Therefore, many of the practicing 'midwives' included in the totals may actually be working as nurses outside obstetrics.

In 2013, almost 99 percent of women in Japan gave birth in medical institutions: 52 percent in hospitals and 47 percent in clinics. Approximately 1 percent of women gave birth in midwifery centres, and only 0.2 per cent did so at home or in other non-institutional settings. This means that almost all pregnant women's primary healthcare providers are obstetricians, as the family doctor system is not well established. Obstetricians provide prenatal check-ups along with ultrasound examinations, attend deliveries, and provide postpartum check-ups. They prescribe medicine, order laboratory tests, and intervene medically—e.g. with an episiotomy or caesarean section—when necessary. They work with nurse-midwives and nurses, and their collaborative styles vary. Interestingly, unlike in many other countries, including Ireland, Japanese women automatically receive midwifery services in many hospitals and clinics while receiving maternity care from obstetricians (who serve as their primary healthcare providers) even if they do not have midwives during

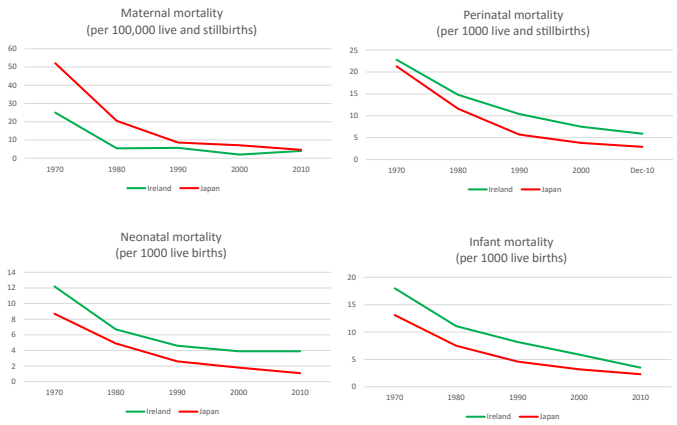


Figure 2. Birth outcomes in Ireland and Japan, 1970–2010

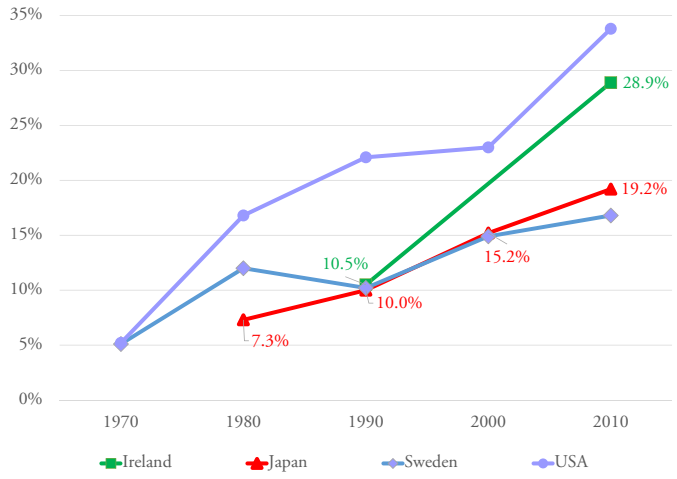


Figure 3. Caesarian section trends

their perinatal period.

Similarly, in Ireland, birthplaces have shifted from homes to large maternity units or hospitals, which has meant further medicalization. For example, women in Ireland are more likely to undergo caesarean sections than they were previously (see Figure 3). However, the difference between the two countries is that in Ireland a family doctor provides an initial examination once a pregnancy is confirmed. After that, a further five examinations are provided both by the family doctor and at a maternity unit or hospital. Therefore, for the majority of women, shared care between the family doctor and the maternity unit/hospital is the norm. The Irish recognition of midwifery as a separate and distinct profession from nursing also sets the country apart from Japan. From the late 1990s, there have been some moves to develop midwifery-led services in some areas of the country. An example is the DOMINO (DOMiciliary care In aNd Out of hospital) midwives scheme. In Ireland's healthcare system, the amount of resources and the professional boundaries (midwives versus consultants) play a great role in shaping services.

Having achieved the world's best level of perinatal mortality statistics (Figure 2), practitioners and the general public in Japan may take these outcomes for granted. However, lawsuits are more frequent in obstetrics than in other medical fields. Risk management has become a major issue, influencing maternity healthcare providers' practices and attitudes. In December 2004, for example, a patient who had undergone a caesarean section at Ōno Fukushima Prefectural Hospital died. The gynaecologist who had performed the operation was subsequently arrested in May 2006 on the basis of Article 21 of the Medical Practitioner Law, although a reconciliation process with the victim and her family was already underway. In Japan, the article stipulates that upon discovering an 'unnatural death,' medical doctors are obliged to report it to the police. Although what constitutes an 'unnatural death' is contested in every country, direct police involvement in such cases in Japan caused great anxiety among the medical professions. This concept of 'unnatural deaths'—and arrests based on them—became a focal point of ensuing discussions and criticisms. However, a growing shortage of obstetricians and nurse-midwives led to closures of obstetric wards and clinics both in urban and rural areas across Japan, and around 2006 the term 'childbirth refugees' (Osan Nanmin/Shussan Nanmin) was coined to refer to pregnant women who could not find a place to give birth attended by trained professionals. The lack of gynaecologists in Japan and the worsening working environment for doctors caused public apprehension and led to an outcry in favour of the professionals. In July 2006, the Japanese Medical Association set up a working group to discuss the possibility of establishing an Alternative Dispute Resolution mechanism to deal with 'unnatural deaths.'

In August 2008, the Fukushima District Court acquitted the gynaecologist accused of manslaughter. This sentence underlined the importance of clinical judgment in the prosecution process. The case became a watershed, subsequently resulting in a new policy stipulating that medical incidents be investigated first by an independent committee set up internally in every hospital. Responding to the concerns about the availability and safety of maternity care, in 2009 the government introduced the Japan Obstetric Compensation System for Cerebral Palsy, aiming to compensate families for any financial burden in cases of severe cerebral palsy related to childbirth while assisting in the prevention of recurrences by analysing the causes of accidents.

Similarly, in Ireland, malpractice by a consultant obstetrician who performed an excessive number of peripartum hysterectomies came to light in 2006. In 2007, a statutory, government-funded agency, the Health Information and Quality Authority (HIQA), was established to monitor the safety and quality of healthcare and social care in Ireland. There have also been scandals in recent years that have called into question the country's long-held reputation of safety and quality in the maternity care system.

The 1990s took Japan and Ireland in different directions. Particularly during the most recent economic boom referred to as the 'Celtic Tiger,' Ireland has since undergone a radi-

cal social and economic transformation. In Japan, skepticism towards the Japanese-style high economic growth model emerged when the bubble economy burst and the Liberal Democratic Party's dominance collapsed. Almost at the same time, the concept of 'gender equality' was placed firmly on the Japanese agenda. The Basic Law for a Gender-Equal Society (Danjyo Kyōdō Sankaku Kihonhō) came into force toward the end of the 1990s, encouraging women to be active players both at home and in the labour market.

Japan introduced a universal long-term care insurance scheme in 2000 with the original intention of reducing pressure on families (primarily women, and traditionally, a daughter or the eldest son's wife). The scheme was also meant to reduce the fiscal burden on the health insurance system caused by long stays in hospitals ('social admissions'). However, the process of changing labour market laws and practices took a long time. In addition, gender disparities persisted in wages and tax structures, discouraging housewives from participating in the labour market. Since then, the family unit has become smaller. For example, the proportion of families living in three-generation households in Japan has decreased from 15 percent in 1986 to 6.9 percent in 2014. Accordingly, an informal but key support mechanism for the Japanese maternity care system had to be adjusted. Known as Satogaeri, pregnant women used to return to their parents' home late in their pregnancy, give birth near their home town, and stay with their parents for a few months after birth so that they could receive daily support from their mother rather than from their husband. As it has become harder to obtain such support, particularly in urban areas, the outsourcing of postpartum care by paying non-family members has increased. Examples of such support include respite care services for postpartum women and their babies, home visiting services for housekeeping and infant care, various consultation and comforting services for new mothers, and babysitting services for older children. Although some local governments make efforts to support these services, most service fees are paid by the mothers directly, putting them out of reach of many less-affluent families. Both in maternal and long-term care, the changing shape of families in Japan, and the recent labour market policy have great implications for the structure and effectiveness of the overall healthcare and social care system.

Shedding light on maternity care services in Ireland and Japan helps us understand some of the key challenges for the Japanese healthcare system. Although demographic changes and population aging might be expected to relieve pressures on Japanese maternity care services, the combination of delayed pregnancies and high expectations for safe deliveries has put the system under strain. The shortage of maternity professionals has led to some reforms of the country's safety and quality regulation. However, urban-rural divides and socio-economic disparities have become more prominent, and cost containment measures, amid societal aging, dominate the policy domain. More attention needs to be paid to issues such as the effects of professional boundaries on care delivery, public and patient involvement, professional training and organizational support, and informal aspects of care that have traditionally contributed to the resilience of the country's cost-effective, equitable, and well-performing system. Similarly, other domains, including mental health and end-of-life care, would merit further inter-disciplinary and comparative research in the future.

Following the presentation, the first commenter drew on his expertise as a demographer to problematize the idea that societal aging is necessarily a 'demographic time bomb' to the degree that it is commonly assumed to be. The notion, he suggested, is that 65=old; old=sick; and old/sick=dependent. However, this is an artificial construction that does not necessarily correspond to what is happening and can lead to policy paralysis. The norm of treating 65 as the threshold of old age is based on century-old rates of sickness and death. Put another way, we are using old notions of old age to forecast our future. We should be taking into account changes in life expectancy and quality of life. If we hold remaining life expectancy constant, 70 is now the new 65. Comparing 1950 to 2050, 80 would be the new 65. If we shift the boundary of 'old age' to the point at which people have a remaining life expectancy of 15 years, the prospective old-age-dependency ratio is much lower. Things suddenly do not look quite so bad. Of course, there are other issues to consider, in particular whether morbidity will compress or expand. Diseases such as Alzheimer's carry a particularly heavy burden. Thus, although the notion of an 'aging time bomb' may be overstated, action does need to be taken along the lines that Dr. Kodate suggested. Improved early diagnosis and treatment, innovation, greater investment in social care, ongoing pension and social insurance reform, and economic growth are all keys to success for Japan's healthcare system.

A question then arose about Dr. Kodate's research scheme: namely, why focus on maternal care, elder care, and patient safety? Dr. Kodate responded that maternity services and elder care capture how people receive health care services at the beginning and the end of life, respectively. Since we tend to focus on longevity and costs in the Japanese context, maternal services sit at an interesting intersection between health care and other social policies, especially as the government encourages maternity. With regard to patient safety, it is interesting to look at the democratization of the health care system in terms of the advocacy, perceptions around transparency, and so on. Looking at maternal care, elder care, and patient safety together helps to highlight the different effects that formal and informal institutions can have on the overall

system.

A second question addressed the relative importance of socio-cultural factors in shaping healthcare expectations and outcomes. The commenter pointed out that he happily complies with his university's annual check-up requirement, whereas in other countries this might be perceived as an infringement of freedom. Dr. Kodate agreed that such factors can be important. On the one hand, society is changing, and this needs to be looked at in terms of policymaking and the role government; on the other, change can be slow. For example, while doctors, midwives, and nurses talk about collaboration, there is still an evident hierarchy, and conservatism remains at play, especially at the organizational level. Informal routines, lifestyles, family structures, and attitudes are enormously important in sustaining the health care system and the country's health, but there are big gaps in terms of what is seen as 'health policy' in the Japanese context. Much of this is outside of the government's remit; it is not something that it can produce, but something that it can certainly leverage.

A third commenter asked for some clarification on a few 'blunt layman's questions.' How can we evaluate if the system is working? In simple terms—is Japan doing well, or is it not? Dr. Kodate responded that it is hard to say—in part owing to a lack of data, and in part because people have a subjective experience of well-being and service quality.

The next question was about how medicalization is shaping maternal care in Japan. Dr. Kodate responded that while he is unsure about how conversations are taking place between mothers and their doctors, there does seem to be a bigger focus on home births today in the areas where midwives have historically played a larger role. However, midwives are generally fighting a losing battle, and consultants are having a larger and larger influence.

Another participant asked whether specific funding models do a better job than others at balancing efficiency and delivery, in particular with regard to co-payment schemes. Dr. Kodate responded that the Japanese government is trying to save long-term insurance, which is modeled on a German scheme, but soaring costs have led to eligibility restrictions. The government is willing to privatize, but there are of course challenges around access to care and the distribution of services across the country. Japan has sought to achieve balance by allowing a choice of service providers while the central government contains costs. This has been largely effective, but many doctors are not happy with the payments they receive. In that sense, under Japan's current system, doctors share the burden. Ultimately there is no perfect balance. Co-payment is good in principle, but it is not a panacea; the details of prices and the marketplace will always affect incentives and outcomes.

A commenter then pointed out that we can and should have individualized forecasts and insurance based on particular employment and lifestyle profiles, rather than averages. In addition, although the labour market has changed, expectations around retirement have changed, and the nature of illness has changed, we are still using the same tools to think about and solve issues as we were 70-100 years ago. When we talk about people working until 70, for example, we are no longer talking about assembly lines and coal mines. We need a more nuanced understanding of the transitions and relationships between work and post-work periods of life.

The next participant asked about the relative political alignment of doctors, and the implications of their positionality for potential healthcare reform. Would it be possible to put the political autonomy of doctors and service providers at the centre of the healthcare system? In Japan, for example, doctors are strongly aligned with the LDP and make large contributions to the party and its members. However, it is not clear whether they are getting enough in return, especially in this age of austerity. In the United States, MDs are largely happy with Obamacare even though they are tend to identify with the Republican Party, which opposed it. Another participant added that, 20 years ago, the group that was most active and most effective at pushing patients' rights in Japan was a group affiliated with the Communist Party. Doctors working with communist-affiliated hospitals were pushing the issues as well. These professionals may not have been as significant in terms of their numbers as the LDP-affiliated professionals, but they may have been much more effective. It was these groups that really pushed things forward in terms of patient consent, access to records, and informing patients about diagnoses. The LDP resisted these changes until the mid-1990s. But these issues go to the heart of the patient-doctor relationship and the nature of care.

Dr. Kodate responded that in Ireland, when doctors run for office, they do so as independents rather than as members of a party. In Japan, we do not see doctors running for office and talking about these issues. There have been questions about the extent to which doctors should maintain close links with the LDP, but the return to stable LDP rule brought about by Prime Minister Abe has also brought about a return to the status quo. As for the doctor-patient relationship, doctor training (particularly around non-technical skills) varies by hospital. Thus organizational culture is very important in determining how these issues are dealt with. The incentive structure is also hugely important in affecting how relationships are built and shaped. In short, the way the whole system is constructed and its different parts work together really matters.

Lost in (Knowledge) Translation? Mutual Learning and Japanese Health and Long-term Care Practices

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The 2003 movie Lost in Translation, which is about Americans encountering Japan, includes a scene in a Japanese hospital. Though there is no apparent translation the main character, played by Scarlett Johansson, manages to get her sore foot x-rayed. Her new friend, a washed-up actor (Bill Murray) making Suntory Whisky commercials, somehow arranges, speaking English to a staff member who only responds in Japanese, to get a consultation. The doctor does not communicate in English; Johansson's character, though, understands the x-ray image he shows. This scene roughly characterizes the nature and application of comparative healthcare services research that includes Japan. While the broader elements of the system are difficult to understand, the clinical aspects of medical practice appear to be translated well. Also, the main characters are American.

Lost in translation describes how aspects and/or nuances of meaning are missed when texts or speech are translated from one language to another. Throughout the film much of the cross-cultural interactions are 'lost' as the Japanese and Americans seem to operate in almost parallel worlds. One reason is that the attempts at translation, when made, are only perfunctory. Second, it seems that no one on either side of the language barrier is particularly interested in truly communicating. This could be because they are either uninterested or because they view the exercise as largely futile.

Knowledge translation (using research to inform decisions) and its complements (evidence-based medicine, management and policy) have emerged as key principles for health and long-term care scholars and practitioners. Multi-country studies contribute to this orientation by providing benchmarks and examples of what does and does not work in various contexts. What does the comparative healthcare research that includes Japan look like?

Studies focusing on or including Japan should provide useful evidence informing how organizations and governments can address common challenges. After all, healthcare access has been universal in Japan for nearly 60 years, and the country is now at the forefront of rich countries facing aging populations. Further it has long been apparent, in terms of macro indicators, that Japanese healthcare is relatively accessible but inexpensive, as research discussed below shows. As Evans and Stoddart wrote in a seminal paper on the determinants of health more than 25 years ago, 'Whatever the explanation, it is clear that something very significant is happening (or has happened) in Japan—something reflected in trends of life expectancy that are remarkable relative to any other world experience.'

This recognition notwithstanding, ideas and evidence from Japan tend to figure less prominently than those from many other countries in discourses on healthcare policy and practices. A current Google Scholar search, for example, using the terms 'Japan,' 'health care policy' and 'comparative,' produced about 4,270 results; substituting 'United States,' 'United Kingdom,' 'Canada' or 'Germany' for 'Japan,' delivered about 21,600, 12,700, 11,800 and 6,700 results, respectively. Though an imperfect measure, these data suggest a situation that differs from that in the 1980s and 1990s when the international competitiveness of Japanese firms gave rise to a vast and influential literature on the 'secrets' of Japanese management and industrial policy.

A review of widely-used research journal databases suggests that comparative work is limited. In the 1990s, only about four such articles were published yearly, though this has increased to about ten a year since 2000 (see Figure 4). These studies tended to have a small number of comparators. Just over one third of the articles compared Japan to only one other country, and another quarter considered two to four others. A third of the studies had 6 to 19 comparators. Many at the higher end of this range used OECD data. About 7 percent of the papers had data from 20 or more countries other than Japan. The largest country samples were summa-

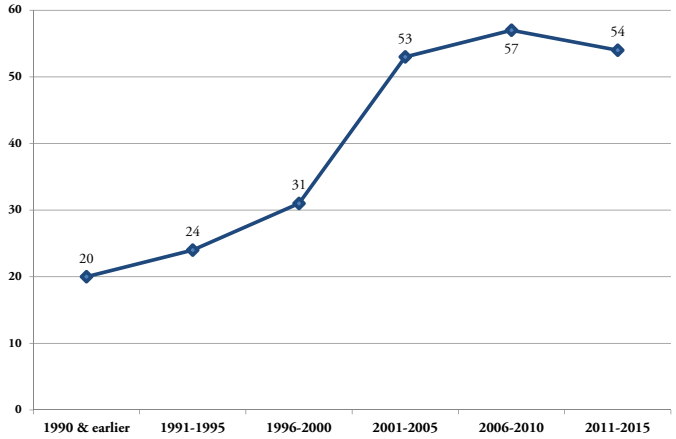

Figure 4. Published comparative health services articles that include Japan

ries of WHO studies that included up to 181 countries.

The country comparators were used for different levels of analysis. Many studies used the country as the unit, for policy or national spending comparisons, for example. In more cases, the country was a categorical variable when comparing individuals (e.g. patients or doctors) or organizations between countries.

Anglophone countries were the most common partner. The United States particularly was a popular match, included in more than 60 percent of the studies. The UK (mostly England) was next, as it was part of more than one-third of the studies, followed by Canada and the Netherlands, both at nearly 30 percent. Germany and France were next, in about a quarter of the studies, followed by Australia.

It is interesting that fully 20 percent of the work included South Korea. The inclusion of Korea and Taiwan is relatively recent, likely because they did not introduce their universal healthcare systems until the 1990s.

When selecting cases for comparative research researchers justify their choices based on contextual similarity or differences. The prevalence of studies that compare Japan with the United States, the UK and Canada suggests that they are interested primarily in differences. These Anglophone countries do not have health care systems based on social security;

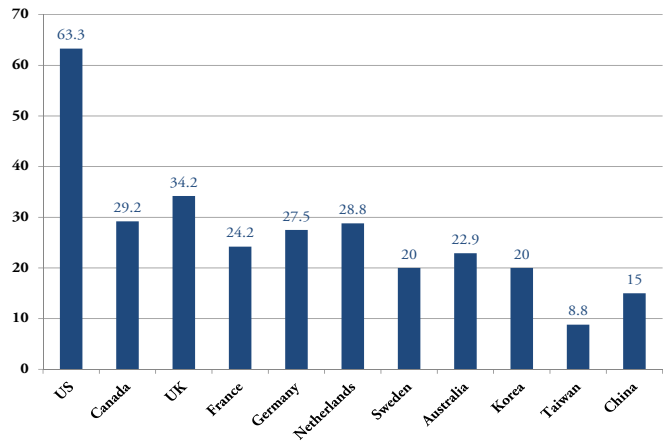

Figure 5. Total share of articles (%) including country with Japan

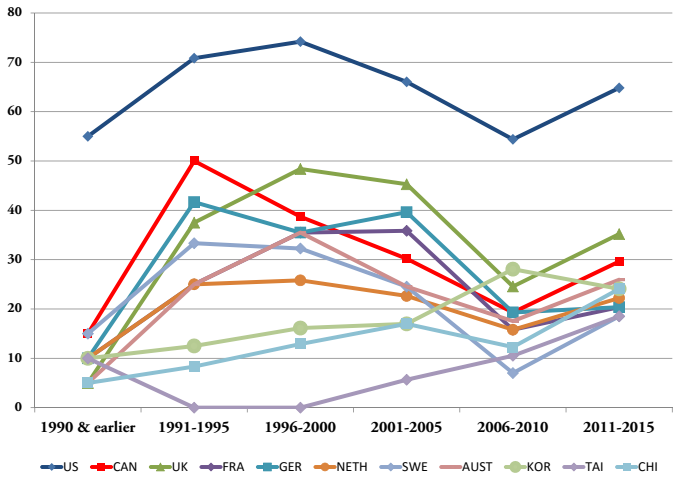

Figure 6. Share of articles (%) including country with Japan by period

	Current health expenditure (percent of GDP)	Doctor visits per year (average per person)	Average hospital length of stay (all causes)	MRI machines (per million population)
Japan	10.2	12.9	17.2	46.9
United Kingdom	8.5	5.0	7.0	6.2
United States	16.4	4.0	7.0	38.1
Canada	10.2	7.7	7.6	8.8
France	10.9	10.9	5.6	10.9
Germany	11.1	9.9	9.1	11.6

Table 3. Comparative health system data (2014 or closest year)

countries such as Germany and France are closer to Japan in this respect. However, it could be that researchers select these comparators because of the international linkages fostered by the United States and the UK, and the prominence of the use of English, typically the lingua franca of international scholarly research.

Studies in the 1990s using OECD data concluded that Japan has a fiscally-efficient health care system, and this is still the case. Moreover, the system delivers a lot of care. The average duration of hospital stays in Japan, while declining, is long; people access doctors frequently; and there is a surfeit of imaging technology, as indicated by the relative number of MRI machines. The main reason Japan is relatively inexpensive, despite offering generally good access, is that prices paid through insurance programs to providers are fairly inexpensive. This is accomplished by tight, central control of prices, which are set regularly with government oversight.

Japan's long life expectancy can be attributed to impressive early progress on lowering infant mortality, controlling infectious diseases (including tuberculosis), and improving treatment for cardiac failure. These are the outcomes of strong public health programs, especially those related to prenatal care and early health screening for children. Japan has also performed very well in terms of the determinants of health. Japanese are less likely to be obese than Americans, tend to eat healthful diets and, in urban centres, live in places conducive to daily walking, all which of contribute to longer lives.

Studies examining relative tendencies to perform surgeries or prescribe medical treatments for physical ailments indicate that Japanese choices tend to be less aggressive than elsewhere. For example, Japan's rates of spinal surgery are 25-40 percent of the rates of those in the United States and Korea. Japanese tend to use older, less effective chemotherapies than are used in Europe and the United States, but outcomes are not significantly different, possibly because surgeons rather than oncologists tend to take the lead.

Though often less aggressive, Japanese clinical interventions are nonetheless effective. Treatment for heart attacks and strokes tends to be as good or better than in other countries, for example, and Japanese outcomes for end-stage renal disease compare favourably to the United States, Canada, and other European countries. An exception is dental care, which in Japan tends to be curative rather than prevention oriented.

Figure 7. Life expectancy and perceived health

In general, research confirms that Japanese providers tend to be slow to introduce new medical technologies. In the case of drugs, regulation matters. For example, academic (as opposed to industry-driven) investigators in Japan have traditionally been relatively constrained compared to their counterparts in the United States, Korea, and the UK in their ability to conduct off-label trials—although the Ministry of Health, Labour and Welfare has recently moved to change this.

There is a stream of studies that investigates the degree to which Japanese healthcare providers and regulators have been adopting practices that differ from traditional approaches. These practices primarily aim to place patients at the centre of care. A key aspect is greater transparency, which in turn tends to improve patient safety. This admittedly expansive category includes steps taken to change approaches to some stigmatized clinical conditions, including mental health and terminal care. These changes all reflect a transition from more paternalistic provider-patient relations to those that offer more patient autonomy. The studies in this review suggest that changes are occurring, but practices may retain Japanese elements.

A general study comparing healthcare worker perceptions of patient safety culture in Taiwan, Japan, and America showed that Taiwan and Japan had similar, but lower assessments of this than their American counterparts. Another survey, comparing approaches to safety reporting at a Japanese and American academic hospital, found that one Japanese hospital (Kyoto University) took on average three days to report an event, compared with only one day for the American one (Brigham Young).

The potential for a better safety culture may grow, according to a related study comparing resident physicians' relationships with their superiors in U.S. and Japanese teaching hospitals. The results showed, somewhat surprisingly, that there was no significant difference in the tendencies of residents to challenge their seniors if the latter were about to do something potentially unsafe. The expected deference of Japanese to their senpai (superior) was not found, at least based on the scenarios presented in the study.

It is somewhat surprising that doctor-patient communication of bad news, at least in some contexts, has yet to change. It is well known that in Japan it has been common for providers to leave patient family members with the choice of whether to disclose bad prognoses to their loved ones. A study comparing American and Japanese nurses, for example, found that the Japanese nurses communicated more indirectly with patients than their American counterparts, particularly when faced with terminal diagnoses. While the Americans preferred straight up truth-telling, the Japanese indicated they preferred to keep news from the patient, if the family desired, so the patient could retain dignity. However, nurse in both countries placed patient comfort at the centre of their work, especially for end of life care.

Mental health is difficult for most societies and their health professionals to address. An important shift has been to consider its manifestations as illness, like other physical ailments, thus removing the stigma it had traditionally been associated with. Several studies comparing approaches to mental disorders tend to conclude that Japan's approaches were less modern than those of comparators, but they are evolving. A 1990 paper found that in Japan the number of hospital mental inpatients had grown since the 1950s, while they had declined in England. A Japan-Germany comparison of schizophrenia patients found that in Japan patients are kept in hospitals longer (as in all clinical areas), are given more drugs, and are more likely to have restraints applied. Compared with Australians, Japanese were found less likely to use clinical terms when describing depression and discussing it beyond their families. They were though more positive about the prospects for recovery, and showed more confidence in counselors than doctors.

There are two important gaps in the pool of comparative studies. First, there are few studies of policies and practices associated with integrating primary, acute and long term care. Second, and relatedly, the introduction of health information management technologies such as electronic health records (EHRs), which can facilitate integration, did not figure in the work. These are more recent emerging issues as more people live longer with often multiple chronic conditions, and the capabilities and use of telecommunication technologies increase.

What has been 'lost in translation,' and what can be found? This snapshot of the literature indicates that potential mutual learning about healthcare policy and practice learning may indeed be somewhat lost in translation. Though the number of studies has increased, it is only from only about four or five articles a year to about ten. Also, as in the movie, the main players are American, though the research literature features other Anglophone countries also, such as the UK and Canada. Finally, the number of comparator countries tends to be relatively small, as about 60 percent of the studies include only three or four.

The reasons for the relative lack of communication between researchers in Japan and elsewhere can only be the subject of conjecture. It may be that there is limited international familiarity with Japanese healthcare. Also, healthcare delivery, unlike the industries that Japan was known for during the 'miracle,' is not typically subject to direct international competition, so providers are not compelled to look outside for ideas. Alternatively, researchers may perceive that the cultural and political contexts in Japan may prevent ideas from being translated and adopted effectively.

That said, the flow of knowledge seems to be towards Japan rather than the other direction. This is because the most notable aspects of Japan's healthcare tend to be hard to translate. The generally positive characteristics of the determinants of health in Japan, such as a healthful diet and low obesity, broad education, and reasonably equitable income distribution, can be hard to adopt in other contexts. These factors reach well beyond healthcare services and require broader political initiatives and behavioural changes. Similarly, financial efficiency at the macro level is linked to not only the ability, but also to the willingness of authorities to try to control expenditures.

In contrast, Japan's technical effectiveness in surgical procedures is likely the result of more easily codified and shared international technical practices. The professional orientation of physicians and the global nature of the advanced health technology industry and academy foster this type of translation. Japan has also learned from other jurisdictions in terms of increasing micro-level efficiencies, such as lowering lengths of stay, and is making progress on adopting more modern medical service policies, fostering transparency, and promoting patient-centredness. These are more readily translated because they are situated firmly in the health care sector.

Two steps are required to identify best practices that can be translated successfully: first, researchers should acknowledge that important and interesting things are going on in Japan; second, they should not assume that efforts at translation will be futile, because stresses on their systems may force countries to adopt practices they historically would not consider. However, it does mean that efforts should be made to understand the context—what is similar and what is different—so that identifying ideas for translation and transplanting can be examined thoughtfully. There is no reason for good ideas to be 'lost in translation.'

Following Dr. Tiessen's presentation, the first discussant focused on the issues of comparative analysis and mutual learning. She was particularly struck by the relative absence of Japan in the literature, and wondered whether the Euro-centric or Anglo-centric focus of the research might be due to the perception that Western analytic tool kits are inappropriate for studying Japan. Is it possible that existing typologies cannot encompass the Japanese case? Are new frameworks required to encompass Japan's low-expenditure conservative corporatist model of healthcare?

On the question of doing more comparative Asian research, the discussant suggested that while more research on Asian healthcare in general is certainly welcome, the purpose of the research should determine which comparator countries are most appropriate. When it comes to policy learning, it is important to remember that there are large differences between systems in terms of the norms and values that underpin them. This means that healthcare challenges are embedded in particular contexts that may limit cross-jurisdictional learning and translation.

The second discussant suggested that comparative healthcare research is interesting precisely because it allows us to become aware of and test our assumptions about healthcare. Healthcare in Japan is particularly interesting because of the longevity issue. If you look at Japanese populations in other countries and control for other factors, they do not live any longer than the other sub-populations. This raises the question: what is going on in Japan? Japan's longevity increased faster than in other countries that were developing during the same period, yet the relative cost of the healthcare system has not increased proportionately. One potential explanation is 'compressed morbidity,' which suggests that however long people live, the healthcare cost does not really change, because such an overwhelming proportion of healthcare needs accrue in the last 6 months of life. Another interesting puzzle is that Japan has some of the most informed consumers of healthcare, but some of the least informed patients. 'Informed consumers' means that people are making choices all the time about where they get their healthcare from. Without a general practitioner system, patients have to self-diagnose and then actively decide which doctor in the area is most qualified to deal with the particular health issue. On the other hand, doctors will do something or tell patients to do something, but will not give much feedback. This may have something to do with the role that one plays as a patient in Japan: going to see a doctor is a highly ritualized experience, and one that people enjoy participating in.

In his response, Dr. Tiessen first sought to address the question about the relative lack of research on Japan, and agreed that Euro/Anglo-centrism is a compelling explanation. It may also be that researchers think that they can easily find the requisite knowledge for a given comparative study among familiar Western countries.

Addressing another question about why Japan's healthcare is relatively cheap, Dr. Tiessen pointed out that doctors—even specialist experts—are paid significantly less than their counterparts in the United States, for example. The United States remains a compelling comparator for Japan, in particular with regard to operational efficiency and innovation around healthcare payment and financing.

Next, a participant asked about the Trans-Pacific Partner-

ship (TPP), in light of popular concerns that it could result in a deterioration of medical services in Japan. In particular, there is a fear that increased trade with American pharmaceutical companies will come at the expense of Japanese interests. Dr. Tiessen responded that assessing the potential advantages and disadvantages of TPP depends on one's interests. The Japanese pharmaceutical industry, for example, is rich with talent, and could stand to benefit from greater intellectual property protection and trade. The country could be commercializing more discoveries and become a real global player.

The next question was about doctor remuneration and its relation to overall healthcare costs. What is the relative share of self-employed business-owner doctors vs. those working in hospitals? Has the number of doctors working in hospitals increased relative to those working elsewhere? If so, has this increased overall costs? Dr. Tiessen responded that this was a great question, but that he had not encountered the answer in his research. Another commenter then pointed out that doctors seem able to find the best remuneration when they are able to open their own clinics, and are thus incentivized to go into business for themselves. Additionally, the relative cost of private vs. public medical schools, as well as the relative difficulty of being accepted, can also shape doctors' incentives and remuneration, and thus overall healthcare costs.

Another commenter asked about gender-related issues. What are some of the trends around medicalization or non-medicalization of gendered health issues, such as menopause? Dr. Tiessen responded that while he did not encounter this directly, he suspects that the slow increase in the number of female doctors in Japan may help with medicalization and access to services, depending on the links between professional communities and policy communities.

Next, a participant sought to problematize the concept of 'compressed morbidity'—an optimistic way of looking at the world, but one that only works if there is an artificial divide between healthcare and social care. The long-term chronic management of Alzheimer's, for example, is not compressed into the final years of life, and also imposes significant social costs that are not captured by a narrow accounting of end-of-life medical expenses. As the nature of aging changes, this may become more of an issue than some have made out. The commenter then asked whether Dr. Tiessen had been able to review any studies in Japanese. Dr. Tiessen responded that his search turned up some Japanese studies, but that he only had time to review the abstracts. It would be interesting to explicitly include Japanese studies in more detail, because this would reveal Japanese attitudes and perspectives on other countries' healthcare systems.

A final question asked about evidence-based policy, especially in social policy, where there is some concern that it can create stigma. Dr. Tiessen responded that this is an important question, and one that he had hoped his research might shed some light on. It is not clear how committed Japanese policymakers are to evidence-based policymaking relative their counterparts in other countries, but it is worth remembering that while evidence-based policy always seems like a good idea, it can be difficult for policymakers to implement.

Reexamining Japan in Global Context

Future Challenges for Medical Care

Friday, March 18, 2016, St. Antony's College, University of Oxford, Oxford, UK

Keynote Speakers

- Dr. Naonori KODATE, *University College Dublin*
- Dr. James TIESSEN, *Ryerson University*

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- Professor Richard GIBBONS, *Weatherall Institute of Molecular Medicine, John Radcliffe Hospital*
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