# L E T T E R S

## Optimal Health Care System

**Re:** Akaho E, Coffin G, Kusano T, et al. A proposed optimal health care system based on a comparative study conducted between Canada and Japan. *Can J Public Health* 1998;89(5):301-7.

The article by Akaho et al. provides an interesting descriptive comparison. It is one of the first such articles I have come across. It is succinct, and it offers several insightful comments on health care structures in Japan and Canada. For this, I commend the authors. The points I raise in this letter are offered in the spirit of dialogue and clarification. My principal concern is that several of its claims and some of its conclusions on an "optimal health care system" (Table IV) are unsupported by the text.

For one, comparing health care spending as a % of GDP, which the authors claim indicates Japan has been more successful at cost containment, is misleading since the GDPs of the two countries are so different. (The larger the GDP, the lower the health care %, regardless of how effective or efficient that system might be.) The per capita costs in US dollars, which the authors also provide, are a more accurate comparative measure. This comparison still shows Japan with lower per capita expenditures. However, unless we are provided more information on comparative costs of physician and hospital services and pharmaceuticals, we cannot know why the per capita costs are lower. This comparison alone does not provide sufficient data on which to conclude, as the authors do, that these lower costs are due principally to Japan's co-payment (user fee) scheme.

Evidence is cited that hospital and physician visits have gone down since the Japanese co-payment scheme was introduced, but the amount of the decrease is not provided. Moreover, in the absence of detailed studies of characteristics of persons and complaints no longer being seen by physicians and hospitals, we cannot know if this decline is at the expense of the poor. How able are they to afford Japan's co-payment scheme of between 10% to 30% of physician and hospital services? The authors reference studies to defend that co-payments are unlikely to deter people from seeking services in "more serious cases." These studies, however, appear to be American and may not necessarily apply to the cultural or organizational contexts of the two systems actually being compared by the authors (Japan's and Canada's). The authors also acknowledge that the American studies still show a "constraining effect on...semi-serious illness." To my mind, this cries out for a further equity analysis of co-payments within, at least, Japan: What semi-serious illnesses are not being attended to, in what population group (i.e., lower income persons?), and with what short- or long-term consequences? I would be more cautious than the authors in concluding that co-payments help constrain only unnecessary health care costs.

Several other conclusions of their "proposed system" are also moot. The claim that a private delivery system of hospital services is an effective way to reduce health care costs is based on one citation. There is no actual discussion in the paper of how or why a private delivery system plays this cost reduction role, nor any comparative analysis of it for the two countries in question. Nor is there any discussion of whether this reduces "unnecessary" costs, or just overall costs with no discrimination of whether they are good or bad. The authors' conclusion, then, may or may not be valid, but it is impossible for the reader to judge which is the case on the basis of the evidence cited in the article itself. The same applies to the discussion of better-controlled computer records of individual service use and treatment, something with which I happen to agree. But where is the evidence, comparison and discussion that leads to this conclusion? Finally, one of their recommendations, that physicians counsel patients on lifestyles, seems to be contradicted by another, that physicians should be limited to "true medical works." Of course, the authors could be inferring that education constitutes a true medical work, but once again, the article doesn't discuss this issue or offer any comparative analysis.

In summary, the article offers an interesting descriptive comparison of Japanese and Canadian health care funding schemes. It forms a nice base upon which to build an *analytical comparison*, but, at least as presented, begs more questions than it answers. My concern particularly is that much of what the authors conclude to be "a proposed optimal health care system" needs to be considered with caution by readers, until such an analytical comparison is forthcoming.

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**Authors' reply:**

Ronald Labonte's comments were welcomed, especially since they have helped us realize one of our primary objectives, namely, to develop dialogue on how best to enhance health for Canadians. We hope that our responses to Dr. Labonte's comments will further this process.

While we recognize that it is difficult to make comparisons of the amount of resources countries allocate to health care, we have had to rely on reasonably well-accepted measures (% of GDP, per capita health care costs in US dollars) developed by international bodies such as the OECD. They are not perfect but they are considered acceptable points of comparison.

In addition to suggesting that lower health care costs may be due principally to Japan's co-payment system, we also implied that other factors likely are involved as well. Perhaps we could have been more explicit.

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With respect to the deterrent effect of co-payments, it appears that the literature provides mixed opinions. Indeed, there are studies that indicate that such user fees not only deter unnecessary care, but also that which is necessary. There are also studies, as we noted, which suggest that such fees are not significant deterrents to necessary care.

Regarding the suggestion for private delivery of hospital services, we were attempting to raise for discussion the points raised by Deber[1] as ways to potentially reduce the costs of providing such services. Again, we have no firm answers but only serious questions.

Finally, we agree that lifestyle counselling should not be the strict purview of physicians. As we noted in Table IV, No.7, a number of different and appropriate health professionals can "provide patient education guidelines regarding the appropriate control of the disease, and provide health professionals guidelines to ensure cost-effective and high quality medical services."

In conclusion, we are encouraged by the response and discussion that our article generated. We all share the same fundamental goal: to improve health care for our countries' citizens.

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## REFERENCE

1. Deber R. Canadian Medicare: Can it work in the United States? Will it survive in Canada? *Am J Law and Medicine* 1993;XIX, Nos. 1&2:75-93.