Research Report

No. 215 January 2005

The Implications of Establishing Accredited Healthcare Corporations

Yukihiro Matsuyama

The Fujitsu Research Institute
Economic Research Center
Tokyo, Japan

ABSTRACT

American medical schools and hospitals have entered an age in which they are now accepting patients and researchers from abroad and even exporting their services. Cornell University, for instance, has been hired by the government of Quatar to administer a medical school, which opened in October 2002, in the capital city of Doha. In another example, the UAE has hired Harvard University as the consultant for its project to construct the Dubai Healthcare City, a world-class healthcare village. The management of Japanese medical schools and hospitals, by contrast, is far below the global standard, and many management resources are currently being wasted.

The following two steps should be followed in order to make Japanese healthcare competitive at the forefront of the global industry: first, the formation of hospital groups (IHNs) within each wide area healthcare market and, second, a business alliance between such a group and the medical schools in the area. Such an alliance would create the business infrastructure needed to eliminate redundant investments and generate the operational mass needed to attract patients, human resources, and funds from around the world. A concrete example of this model can be seen in the US state of Missouri, where a business alliance is developing between the Washington University School of Medicine (St. Louis) and BJC Healthcare, a large community based non-profit IHN.

In order to attain international competitiveness while still guarding the non-profit ethos, Japan's healthcare industry must create IHNs, centered upon public hospitals (e.g. municipal hospitals) and based on wide area healthcare markets. Depending on the region, there are some privately run hospitals that could be said to be even more non-profit oriented and geared toward public utility than the public hospitals themselves. If these forward thinking hospitals are also included in the structure of Japanese IHNs, the nation's system for healthcare provision will undergo vast improvement.

The establishment of the accredited healthcare corporations (AHCs) by the Ministry of Health, Labor and Welfare in December of last year can be seen as a concrete policy meant to carry forward this type of reform. In the first stage, AHCs can be given a holding company function, which would allow hospitals within the group to take advantage of cooperative activities such as group purchases, IT investments on the level of wide area healthcare market, and human resource pooling. This will ease the transition into the second stage in which the management of the hospitals are

completely integrated. The region that takes the leadership in creating such integrated hospital groups will have the potential to move to the top of the national industry, capable then of exchanging technologies and personnel with the top rated IHNs in the US.

CONTENTS

1. Introduction

1.1 The Export of Medical Schools and Hospitals

In November of 2004, when I visited BJC Healthcare and the Washington University School of Medicine (St. Louis, MO), I found that American medical schools and hospitals had entered a new age in which they were actively forming business relationships, and utilizing superior management configurations to increase their power and efficiency.

Established in 1891, the Washington University School of Medicine, boasting several Nobel laureates amongst its graduates, is famous for its medical education. Its Healthcare Management Business School, established in 1946, was the pioneer program for the cultivation of healthcare management personnel in the US. Recently, the Washington University Medical Department has formed a business affiliation with the large-scale non-profit Integrated Healthcare Network (IHN), BJC Healthcare. Together, they plan to establish a flagship hospital devoted to the field of clinical research and clinical education, and to jointly invest in the construction of state-of-the-art treatment facilities. The University of Washington Medical School will match BJC Healthcare's $2.5 billion in annual contribution with $1.0 billion of its own to form a total capital base of $3.5 billion. The effort to streamline the management operation is a main part of this project.

The superior management of hospitals in the US has not only made US healthcare the best in the world, setting the global standard, but it also draws patients, personnel, funds, and now even procurements from abroad. In 2002, Cornell was hired by the government of Qatar to build and administer a Cornell Medical School campus in the capital city of Doha. Afterwards, the UAE hired Harvard University as consultants in its construction of a 1,700 sq. km. healthcare village in Dubai. Saudi Arabia is also in the process of constructing a hospital with the cooperation of the first rate US healthcare company Cleveland Clinic. But the construction of healthcare centers does not stop with the Middle Eastern countries. According to Dr. Muler, Director of the International Division of the Washington University School of Medicine, the university is now involved in hospital construction projects in Beijing and Shanghai. "What we are seeing amongst the American universities who are in competition for the global the standard in the healthcare field," explains Dr. Muler, "is a boom in overseas operations."

The level of the Japanese healthcare industry, in contrast, is far below the global standard. Asked why the competitiveness of the healthcare industry in Japan, a country who leads the world in the fields of electronics and automobiles, was so low, I could only reply that though the hospital facilities and medical equipment in Japan are not inferior to that of the US, a serious lack of proper management plagues the hospitals and medical schools alike.

1.2 Policies for Hospital Group Formation

In comparison to the US, the quality of management in Japan's medical schools and hospitals is alarming. Large amounts of operational resources are simply being wasted. If hospitals hope to compete on the global level as the speed of technological advancement in the healthcare field quickens, they must being to procure needed finances through their own initiatives and cease to rely on government handouts. In search of the proper model, I have surveyed the structure of the healthcare industry in America, where medical institutions are competing at the forefront of the field, and have come to the conclusion that hospital group formations based on wide-area healthcare markets is the most powerful business model for encouraging the self-generation of financial resources. The formation of regional affiliations between hospitals and medical schools would eliminate overlapping investments, and would create the critical mass necessary to attract patients, human resources, and finances from around the world. The new business coalition formed by the Washington University School of Medicine and BJC healthcare is a prime example of this model.

I often hear the protestation that: "This system is an American system." "Out of the total US population of approximately 280 million," many point out," 45 million people do not have health insurance. On the other hand, the Japanese healthcare system has 100% health insurance enrollment, and this makes it superior in comparison." But such critics belie their own ignorance. First of all, the number of insured or uninsured people is an issue of the health insurance system, and shouldn't be used to defend the management deficiencies of Japanese hospitals. Secondly, 10,000,000 people in Japan are delinquent in their health insurance payments, and the number of people that are not covered has reached 600,000. In short, 100% enrollment has long since fallen apart. Thirdly, management methods such as Balance Score Cards and Six Sigma, which have recently become very popular amongst Japanese hospital managers, were both "US systems" conceived in the US. Finally, the formation of business relationships between medical schools and hospital groups that

comprise wide-area healthcare markets is a business model that is not only successful in the US but is also producing significant results in Canada, Australia, and even China.

There are also critics who claim that "the formation of hospital groups by wide-area healthcare market is impossible in Japan." But hospital groups such as the Ibaraki Prefecture Kōseiren Hospital Group and the Itabashi Central Hospital Group, groups that resemble the IHN's in the US, already exist in Japan. Moreover, these regionally based hospital groups have shown positive performance despite cuts in medical service fees.

The management deficiencies of public hospitals – municipal hospitals as well as hospitals affiliated to national universities – are rooted in a long history of reckless management policies, many of which have been cultivated through a dependence on government grants. Thus, the most effective way to reform the management of these hospitals is to simply eliminate the grant money, which they use to compensate debts deriving from non-medical costs. Bringing the figure for this debt compensation grant to zero will be difficult considering the culture of tax dependency that pervades public hospital management. But in light of the financial crisis that the hospital owners – i.e. the national government and the local government – now find themselves in, this type of step may be inevitable. For this reason, the initiative to streamline management by bringing together public hospitals in the same wide-area healthcare market is beginning to gain momentum.

The ideal way to establish these hospital groups would be to break down all bureaucratic divisions (avoiding stovepipe management) and integrate the management of the various hospitals all at once. But given the different degrees of financial crisis faced by the various hospitals – the factors include the system of salary, the status of revenues, and the total figure of debt – there will only be a few healthcare markets that could undergo comprehensive one-time integration. A more realistic approach would be to initiate cooperative practices such as group purchasing, personnel pooling, and joint developments for new hospital facilities as preparation for the full unification of management. But this requires the existence of a healthcare corporation with a holding company function. Though it is, of course, formally possible to establish a holding company function within the current public hospitals, the regulations that govern the salary system for public employees stand in the way of gathering and efficiently managing a diverse group of professional personnel. For this reason, it is necessary that hospital employees be freed from the regulations applicable to government employees, i.e. become private employees, and this requires incorporation.

The AHC, whose creation was announced by the Health and Welfare Ministry in December of last year, will provide the solution. As both an independent (incorporated) legal entity and one that will have a holding company function, AHCs will enable the most efficient formation of large-scale hospital groups.

2. An Overview of the Arguments Concerning the Accredited Healthcare Corporation

2.1 Problems with the Current System for Healthcare Corporations

2004 has been the year in which the management structure of Japan's medical institutions has been seriously put to question. The most important manifestation of this inquiry has been the vigorous and continuing debates between the Regulation Reform and Privatization Convention (*Kisei kaikaku minkan kaihō suishin kaigi;* RRPC), which advocates the privatization of hospital management, and the Japan Medical Association, which opposes it. At the heart of the issue is a structural problem in the system of healthcare provision. The public hospitals, which serve the important function of healthcare safety net for regional society, have been too slow in their efforts to improve management and, moreover, continue to maintain "for profit" practices despite their "non-profit" claims. Thus, RRPC promotes privatization as a remedy to these problems. But the Medical Association, meanwhile, argues against the stock company management of hospitals, citing article 7 of the Healthcare Law, which states the legal grounds for the non-profitability of healthcare:

> "Article 7 (Permission to Establish): When establishing a hospital, or when a person who wants to establish a medical office is not a medical doctor or a dentist, or when a person who wants to establish a birth center is not a maternity nurse, permission must be received from the governor of the prefecture in which the building will be located. (For medical offices and birth centers being established within a city or a special ward with a public healthcare center, permission can be received from the mayor of that city, or the ward head of that special ward…)
>
> (Items 2 and 3 omitted)
>
> Item 4: The governor of the prefecture, the mayor of the city, or the ward head

of the special ward, when requested for the permission described in items 1 through 3, must grant permission if the building and facilities of the establishment in question and the person who owns them are in agreement with the conditions set forth in the Ministry of Health, Labor and Welfare decree, which is based on regulations in article 21 and article 23 of this law.

Item 5: It is possible to refuse the permission described in item 1 to those who are establishing the hospital, medical office, or birth center for the purpose of making a profit, regardless of the regulations set forth in the previous items." (author's underline)

In Article 7, Item 5, the provision, "It is possible," is very important. Under a common sense interpretation of the legal text, the fact that the provision reads "possible" means that the article, so long as the other fixed conditions are met, acknowledges the case of allowing a profit oriented corporation to establish a hospital (or other medical institution).

[sort public/private/healthcare corporation]

The Japan Medical Association also uses Article 54 of the Healthcare Law, which prohibits healthcare corporations from distributing profits as dividends, as further grounds for the non-profit essence of healthcare corporations. However, in reality, not only is it possible for managers of these healthcare corporations to actually gain a portion of the profits through manager compensations instead of through a dividend, but those company employees who contributed seed money to the healthcare corporations have a claim to the retained profits at the time they retire. At the end of March 2004, of the 38,754 healthcare corporations in Japan, 37,977 (98%) of them were associated healthcare corporations, hospitals in other words that had members with rights to the retained profits. Thus, most people can see that the Medical Association's claim for the "non-profit" principle in Japan's healthcare system has lost its basis in reality.

Nonetheless, the Medical Association's assertion that "the operation of healthcare must be based on the non-profit ethos" has strong support. The truly non-profit ethos, it is believed, is indispensable to a system of healthcare provision that forms the bottom line safety net for the livelihood of the people. In non-healthcare industries, e.g. automobiles or home electronics, as each company becomes more selective and focused in terms of its product strategy and management resource distribution, consumer utility as whole increases and so do the company profits. In the

healthcare industry, however, if the healthcare institutions of any given healthcare market were to become selective and focused, it would lead to over-investment in high cost medical equipment and a visible shortage of medical doctors in the low-revenue medical fields. There are clear investment overlaps amongst neighboring hospitals and shortages of pediatricians and anesthesiologists in Japan. Even in the US, primary care (low return basic medic treatment) or treatment in obstetrics and gynecology (targets for free medical care for low income earners) are rarely offered by private hospitals because of the low profit margins. Consequently, it is up to the networks of non-profit medical institutions to fill the gaps.

From the standpoint of assuring a basic healthcare safety net for societies, the bankruptcy of individual hospitals is not that significant. The network of non-profit healthcare institutions, however, is a last resort resource that must not be diminished. The role played by the network of non-profit healthcare institutions as a safety net for regional society is comparable to the settlement function of the central bank with respect to the entire financial market. Certainly, the current public hospitals satisfy the conditions for truly non-profit healthcare institutions. However, because of their dependency on taxes to cover their debts, they lack the ability to be a secure safety net. Thus, the question of how to generate a network of healthcare institutions that can truly carry out the bottom line role has become an important policy issue.

There is one misconception that is held by both the RRPConvention in their call for hospital incorporation and the Medical Association in their defense of the non-profit principle. This is the belief that "non-profit American IHN's are able to exist while providing 5% of their medical service revenue as charitable medical care, thereby fulfilling the safety net function, only because they are able to compensate for it through the donations they receive; which is to say that these services are, in reality, rendering debts." But this is misguided. First of all, donations are accepted by a foundation that is a different legal entity from the non-profit IHN. In other words, the accounts of the foundation and the accounts of the non-profit IHN are managed separately. The system setup is such that donation funds cannot be used as operation capital for the non-profit IHN. Second, the average amount of donations that non-profit IHN's receive is less than 1% of their yearly revenue and would thus be too small to be used as a resource for their charitable services or debt compensation. Though BJC Healthcare for instance had an annual intake of $2.5 billion, its foundation did not acquire more than $10 million in donations (2003 performance). Medical schools like Harvard and the Mayo Clinic that are able to solicit donations in excess of $100 million a year are extreme exceptions to the rule.

2.2 The Framework for Accredited Healthcare Corporations

The Ministry of Health, Labor and Welfare has laid down the following five points as the basic principles guiding the reform of the 50 year old system for healthcare corporations: 1) implement a thoroughly non-profit system, 2) establish a public utility function, 3) improve efficiency, 4) assure transparency, and 5) achieve sound healthcare management. The ministry also announced its intention to include the establishment of the AHC, as an entity designed to fulfill these principles, in the upcoming 2006 (fiscal year) revision of the Healthcare Law. If ten or more AHCs emerge in each healthcare market and are able to successfully divide the functions required by the market among them, the result will be a network of truly non-profit healthcare institutions that can securely and properly serve the safety net function.

After submitting an article on the implications of establishing AHCs to the *Ronten* section of the Asahi Shinbun, I received some valuable questions from readers that include some members of the RRPC. The following are some of the questions and my replies:

Question 1: Despite the fact that healthcare corporations have the ability to become special healthcare corporations or designated healthcare corporations, both of which are entitled to tax benefits, 98% of them have not made this change. What makes you think that they will change when it's an accredited healthcare corporation? If there was more confidence in the system of management, then private healthcare corporations might be attracted to the tax benefits attached to becoming a special, designated, or accredited healthcare corporation. But the majority of them simply do not have faith in the management system. Moreover, giving up the rights to retained profits is too big of a sacrifice. At most, you would probably get about 20-30% of the current healthcare corporations to changeover to accredited healthcare corporations. Even if that should be the case, the rest of them would go on as before, continuing their for-profit practices while using the non-profit pretences to justify barriers to entry into their market.

Answer 1: Currently, the tax rate that is applied to healthcare corporations with capital contributors is 30% (the same as private corporations) while the rate for designated healthcare corporations is 22%. Even if the accredited healthcare corporations were, in contrast, to be given the extra low tax rate of 10%, or even say the

complete exemption given to public hospitals, the number of current healthcare corporations – which are mostly family owned profit pursuing businesses – that would make the changeover to an accredited healthcare corporation may still be small. But even if few in number, hospitals managers who, with the highest of aspirations, want to re-invest all their profits into medical treatment instead of pocketing it and who are willing to part with their rights to retained profits, do exist.

Furthermore, the legal configurations for healthcare institutions are convoluted and require simplification. What is most in need of clarification is the actual degree of non-profitability and public utility that each hospital maintains. Discovering which of the private healthcare institutions are actually non-profit and contributing to public utility, and then being able to garner support for the private hospital with the best performance in this respect, is one of the primary purposes in establishing AHCs. The second purpose has to do with using the AHC as a mechanism for reforming public hospitals. From the perspective of constructing a Japanese model IHN, this reason is clearly the most important.

Any policy aimed at improving and maintaining the overall health of the people would have to deal with three main medical services: health management (starting with eating habits), acute phase care, and non-acute phase care (such as disease management and nursing). Out of the three, health management is better in Japan than it is in the US and only a small gap separates it from the US in non-acute phase care.

The inefficient management of acute phase care, however, along with inadequate personnel cultivation, is the primary reason for Japan's delay in industrializing its healthcare industry. In Japan, acute phase care is mainly provided by the public hospitals. If we could bring the level of management efficiency in public hospitals up to the level of some of our excellently managed private hospitals, the Japanese healthcare industry would take a great leap forward. Changing the public hospitals into stock market companies would be one way of doing this. But this would only result in a rush toward selection and focusing, increasing the divergence between healthcare needs and resource distribution. What we need instead is a hospital group with high non-profitability and public utility that would fill this gap and take on the function of the social safety net. This is why the non-profit IHNs are such major players in American healthcare, the most advanced healthcare industry in the world.

In conclusion, the advancement of Japan's healthcare industry will not necessarily require many hospitals to changeover to AHCs. As long as certain key healthcare corporations, i.e. those that play a core role in the regional healthcare

market, make the change and are then able to make business affiliations with the public hospitals that have turned AHC (affiliations made possible by designating all hospital employees private employees), substantial progress is assured. If the management practices of private hospitals that changeover to accredited healthcare corporations are, in fact, found to be superior to the others, then a good idea would be to place the surrounding hospitals under their charge. Finally, it is important to recognize that various sources of business will surround the AHC network and that establishing this network will not preclude the entry of private businesses.

Question 2: The problem is essentially about competition. Like the US, you're trying to maintain the efficiency of public non-profit hospitals by having them compete with corporate hospitals. AHCs are all right. But what about increasing competition by liberalizing investment toward the currently existing regional healthcare corporations?

Answer 2: I am not opposed to permitting the entry of stock companies into hospital management. I am merely asserting that those who believe stock companies are more efficient than the current healthcare corporations are mistaken. When speaking in 2004 to both Mr. David L. Bernd, then Chairman of the American Hospital Association, and Dr. James O. Hepner, reputedly one of the inventors of hospital management studies, they said that "in terms of the efficiency of hospital management, there is no significant difference between stock company hospitals and non-profit hospitals. What determines the efficiency of management is not the company's configuration but its management abilities. The strategy of both hospitals is the same. The only difference is the destination of the profits: whether it goes into the hands of stock holders or is recycled back into local society." After having extensively researched "ways to improve the efficiency of the Japanese healthcare provision system as a whole," I can't say that the question of whether or not to permit the entry of stock companies is very important.

It goes without saying that "encouraging competition" will be very important in improving the efficiency of Japan's healthcare provision system as a whole. However, when thinking in terms of industrializing the entire nation's healthcare and bringing it to the level of global competitiveness, more effective than competition amongst stock company hospitals and non-profit hospitals within the same healthcare market would be competition between the healthcare markets themselves, i.e. the IHNs. In terms of a policy plan, this type of brand name competition is clearly more important. In the

US, we find that competition within the healthcare markets is not very strong. The stock company hospitals, interested primarily in maximizing their profits by specializing in fields with high-profit ratios, have no desire to compete with non-profit IHNs on the level of comprehensive healthcare services. Moreover, the stock company hospital chains have merely become aggregate bodies of scattered stand-alone hospital sites. The fierce competition that we see in US healthcare industry is a brand name competition that occurs between the non-profit IHNs themselves. In this type of competition, regionally scattered non-profit IHNs – the Mayo Clinic in Minnesota, the Cleveland Clinic in Ohio, BJC Healthcare in Missouri, Intermountain Healthcare in Utah, Sentara Healthcare in Virginia to name a few – are vying for research funds and patients from abroad. This type of competition is the driving force behind the development of US healthcare.

Originally, academics who supported the RRPC claimed that if one was going to propose a concrete method for "encouraging competition," it would be necessary to analyze the behavioral patterns at work in Japanese healthcare and to delve into research that would clarify 'what kind of incentive given in what type of way' would be most effective in changing this behavior. Without such research, the AHC movement may lose the support of these researchers who have thus far put themselves at some distance from the Japan Medical Association and have entered the debate on healthcare policy from a neutral standpoint. Without such research, there is also the danger of squandering funds by repeating a mistake made in the past: using electronic charts without a supporting system of analog human relationships to convey medical information during clinical treatment; without such a support system, an electronic chart is just a metal box.

Question 3

Question 3 appeared in the *Ronten* column of the *Yomiuri Shinbun* in reference to the following paragraph written by the author and published in the same newspaper column.

> "…The government's RRPC is putting the main emphasis on privatizing the public market. However, when it comes to bottom line healthcare, customer satisfaction will not increase through mere privatization. This is because, while public health insurance uses 97% of the funds that it collects toward medical care services, private health insurance does use more than 70%; the other 30% disappears into stock owner dividends, employee

salaries, and advertisement costs…"

Question: How is it that public health insurance can use 97% percent of the insurance costs that it gathers for medical care while private health insurance doesn't use more than 70%? Isn't it necessary for public healthcare insurance to distribute employee salaries just like the private insurance systems?

Answer 3

When we say that "97% of public health insurance revenue is used for medical care," this is after subtracting costs such as personnel expenses. Because private health insurance societies in reality shoulder most of the personnel expenses, this number should really be thought of as more like 94-95%. Even in the case of American HMOs (a type of private regional health insurance), the average proportion of insurance revenue that is used for medical care by both for-profit and non-profit HMOs is 88% (2000 performance; Matsuyama *Jinkō hangen* (Population Halved)). Therefore, it must be said that the 70% figure for Japanese private health insurance is an abnormal value. The reason why the gross margin rate of Japanese private health insurance is as high as 30% is because, on top of installing a safety buffer in the insurance fees, the benefits are distributed on a fixed amount basis, not necessarily until the patient is cured. In other words, the product design is such that the insurance organizations are not taking on any real risks in medical expenses. It is thus only natural that the representatives of companies that run these profiteering private health insurance systems, the same people who head the associations that seek public sector reform, would from the beginning be opposed to fair competition.

Question 4

There are many types of healthcare institutions, whether public or private, in Japan. Of these, which healthcare institutions and how many of them do you think will make the changeover to AHCs?

Answer 4

1) The case of private hospitals changing over to AHCs

AHCs will be firmly rooted in the principles of non-profitability and public utility, where all profits are recycled back into the regional community and none devolve to a specific individual. The absorption of profits by founding owners and families through subsidiary companies should also become prohibited. Therefore, the private

hospitals that are likely to become AHCs are those that have become practically independent from their founding owners, families, and companies. The other case would be those private hospitals whose present owners or families are willing to completely dispose of their controlling rights to the profit distributions of their hospital group.

2) The case of current public hospitals changing over to AHCs

Currently public hospitals, beginning with municipal hospitals, will likely changeover to an AHC once their employees become non-public servants and they begin the process of privatization.

3) The case of newly established public hospitals choosing to become AHCs from the start

I believe that the majority of AHCs will consist of newly established hospitals that opt to become AHCs from the outset.

It is inevitable that, in order to reform the management of public hospitals (municipal hospitals in particular), hospitals within the same healthcare market will form hospital groups. In the process of forming these hospital groups and unifying the management and decision-making process, it would be ideal if the current public hospitals could make investments in kind and management could be integrated in one step. In reality, however, differences in current performance levels, as well as personnel predictions for losses and gains in salary, pose a barrier to the integration of management. Thus, the second best solution is to give the holding company function to the new hospitals that are soon to be built within the same healthcare market, and, as a primer for actual integration, to first let hospitals enjoy the benefits of collaborative business practices such as group purchasing and personnel pooling.

Because of the problems in local government finances, municipal hospitals should ideally procure funds for their fixed assets investments on their own through the capital markets instead of receiving local government bonds. For this to happen, all employees must become non-public servants and the hospital must form a management body capable of displaying the type of detailed budget plans that would satisfy private investors.

In what was a very significant step in the development process, the following established understanding of the AHC appeared in the "Initial Report on the Promotion of Regulation Reform and Privatization," published on December 24th, 2004:

"As one part of its 2006 healthcare reform bill, the Ministry of Health,

> Labor and Welfare intends to revise the healthcare corporation system according to the fundamental guidelines of management transparency and comprehensive non-profitability. More specifically, it intends to establish a new type of healthcare corporation that will have a level of managerial transparency and disclosure that is on par with private stock companies. Moreover, given that such things as the use of surplus capital can be clarified, these new healthcare corporations will be given preferential tax treatments as well as the right to contribute capital to other healthcare corporations. Streamlining the configuration of and networking the healthcare corporations along the lines of current private corporations will lead to much more efficient hospital management. Thus, this new type of healthcare corporation can function as a legal agent for the privatization movement in public hospitals. However, in order for these newly configured healthcare corporations to be evaluated as providers of high quality healthcare services, there needs to be more than just a reform of group structure. Beginning with the disclosure of charts, it is necessary to install a system that can accurately respond to the needs of patients…."

Furthermore, in my opinion, it would be much better if the level of managerial disclosure in the AHC were not just "on par with" but higher than that of private stock companies.

2.3 The Financial Administration and Preferential Tax Treatment of Accredited Healthcare Corporations

The number of hospitals that changeover to AHCs will vary greatly depending on the level of preferential tax treatment. While healthcare corporations receive the same 30% tax rate as other private corporations, designated healthcare corporations pay 22% under a preferential tax benefit. Therefore, if we want to provide ample incentive for private healthcare corporations to changeover to AHCs, we must at the very least bring the tax rate for AHCs down to 10%. But moreover, logically speaking, if AHCs are going to take on the same function as public hospitals, they should by all accounts receive the same complete tax break that public hospitals receive. But the Finance Ministry will naturally guard their revenue and will fight against granting any sort of tax benefit. Looking closely at the two possible cases of a 0% tax and a 10% tax, the following points can be made:

1) The case for a 0% tax (the same as public hospitals)

So long as AHCs are obligated to have the same type of non-profitability and public utility as public hospitals, it would seem obvious that in terms of taxes, they should receive the same tax-free treatment. Furthermore, if they were not given this full tax break, a contradiction would arise with the Koseiren Hospital Group and the Saiseikai Hospital Group, which are not taxed despite the fact that they are privately run businesses because it is understood that they are otherwise public.

If the currently untaxed public hospitals could receive the same no tax treatment upon changing over to an AHC, the effect upon the finances of the national and local government would be neutral. In comparison to this, tax revenue would be negatively affected in the cases of private hospitals changing over to an AHC. But in considering the AHC, it is important to get beyond the narrow view of increases and decreases in tax revenue to look toward the larger potential benefits inherent in establishing the system. Our judgments should be made from the perspective of the combined national and local government finances as a whole. If, for instance, the utilization of AHCs improve the efficiency of public hospital management and enables reductions in the cash subsidies from the national government – e.g. the deficit compensations – the overall financial budget may very well become positive despite the reduction in revenue.

2) The case for a 10% tax

As mentioned above, the large majority of AHCs will most likely be made up of the to-be-completed public hospitals that choose to take on AHC status from inception. Therefore, if the tax rate for AHCs is set at 10%, it is highly likely that the rise in tax revenue resulting from public hospitals becoming AHCs, and thus paying more than they would have, will exceed the loss in revenue resulting from private hospitals becoming AHCs, an thus paying less.

However, because municipal hospitals, by becoming an AHC, will begin paying its taxes to the national instead of the local government, those funds will no longer be recycled back into the regional community. This will be a very strong disincentive for municipal hospitals to make the change, and will cause the number to fall drastically. This is especially so as it is already possible to create a holding company function under the current configuration of jointly managed public hospitals. Therefore, it would be essential to, at the very least, give a special tax exemption to just those AHCs established under the initiative of the local government, or perhaps earmark and redirect the taxes imposed upon them back to the local government.

But it can also be argued that the tax revenue from private hospitals turned

AHCs, and not just municipal hospitals, should go to the local government and not into the national coffers. Private hospitals that become AHCs, for example, will work together with the current public hospitals and contribute to regional healthcare projects. Furthermore, they will be a leading force in forming the management body that will be integrated with the up and coming regionally based insurance system.

One simple solution would be to cut the cash subsidies (20.2 billion yen in 2002) that national governments distribute to municipal hospitals in exchange for redirecting the tax revenue that the AHC's will pay to the national government back into the local government. Either way, the taxation right and the taxation amount with respect to the AHCs is a problem closely tide up with Prime Minister Koizumi's Three-In-One Reform plan, a reform initiative aimed at decreasing national expenditure and decentralizing power by shifting tax revenues to the local level and reviewing the national budget allocations to local governments.

3. Accredited Healthcare Corporations To Carry Out the Holding Company Function

3.1 The Ministry of Internal Affairs and Communications Aims To Create a Japanese Version of the US IHN with Municipal Hospitals at its Center

On November 30, just before the Ministry of Health, Labor and Welfare presented its plan for the creation of the AHC, the Ministry of Internal Affairs and Communications (MIC), which governs the municipal hospitals, publicized a report submitted by its Committee to Consider the Approaches to Regional Healthcare and Municipal Hospitals. The following ideas, which were put forth under the heading, "Effects of Restructuring and Networking Municipal Hospitals," are important in relation to the AHC:

> "…One effective way to solve the problems pervading the system of municipal hospitals is to restructure the roles and functions that they take on, entrusting the core healthcare functions to the flagship hospital and leaving the routine healthcare services to the other hospitals and clinics within the region. This would create closer affiliations amongst the hospitals and clinics and bring about a system wide network of healthcare institutions. If pursued comprehensively, this initiative will lead to the integration of healthcare operations. However, depending on the strengths and weaknesses of the

affiliations and the larger network, this initiative may take on a variety of forms.

The reformation and the networking of the municipal hospitals should have the following effects:

1) By reviewing and reforming the current functions of hospitals, it will be possible to provide healthcare services that respond to new healthcare needs.
2) Through the specialization enabled by the division of functions, it will be possible to provide more efficient healthcare.
3) Through the concentration of specialized doctors in the flagship hospitals, the quality of high-level medical care will be assured. Through this type of focusing, those hospital will have plenty of experience with high-level treatment and will also be able to easily recruit the necessary doctors.

There are many hospitals that, despite the apparent benefits, will not be able to manage this change right away. However, competition between hospitals of different regions will nonetheless emerge as more and more people recognize the benefits, and as more and more actual examples become visible. This is why flagship hospitals will be so important, and also why it is hoped that this initiative will be taken up by geographically wide regions, i.e. second tier healthcare markets and wider…"

From this text, it is clear that the MIC is looking to build Japanese version IHNs with municipal hospitals at the center. Incidentally, just as in Japan, there are over 1000 municipal hospitals in the US. Because most of the American municipal hospitals have already achieved the above standards, and are serving the function of the medical safety net for regional society, they are an extremely useful reference in considering the reform of our own municipal hospitals.

The Sarasota Memorial Healthcare System (Sarasota County, Florida), which I visited in March of 2003 can be used as a model for the municipal hospital centered IHN in the US:

- The system has 9 board members who are elected from various districts. The duties of the board member are to referee the job performance of the managing and executive officers, and to give their advice to the local government on how much of the annual regional tax revenue should be used toward medical care. The executives, the managers, and all the

personnel working under them are private workers. That is to say that, just like a private corporation, the governing body is separate from the managing body. It is a structure in which "governance is left to the government and the work is left to the people."

- The financial resources for low cost healthcare policies such as those to aid low-income patients are drawn from the fixed assets tax revenue of the local government, and 1/3 of the investment costs that go into building new hospitals is drawn from the regional sales tax revenue.
- The board meetings are made public to regional citizens through live television broadcast.
- The annual medical service revenue of the Sarasota Memorial Healthcare System is $420 million. Compared to other IHN's in the US, the scale is small. Notwithstanding, it has achieved the global standard in cardiovascular treatment and, while independently developing electronic medical charts, it sustains high quality in its healthcare and management.
- The yearly donation revenue that it receives from foundations is between $2.0 and 2.5 million, less than 1% of its annual medical service revenue. Roughly half of the donations it receives are saved in preparation for the building of new hospital buildings.

Of the methods detailed above, that which is most important for Japanese healthcare to adopt is the structure in which "governance is left to the government, and work left to the people." This is because the personnel costs of private municipal hospitals, high compared to private hospitals, are the structural source of their debt. Thus, no matter what kind of reform proposal the municipal hospitals gives to the regional people in the future, the condition of adopting private workers, i.e. non-public servants, will be essential.

3.2 Fifty Billion Yen As the Minimum for IHN Medical Service Revenue

In the report published by the MIC, it is important to pay particular attention to the section that reads, "second tier healthcare markets, or wider…" Up until now, the healthcare plans in Japan have been compiled prefecture by prefecture. In this process, labels such as first tier, second tier, and third tier were applied to healthcare markets in accordance with the level of medical care that the area could and would be expected to supply. Among these, second tier healthcare markets have been the subject of

attention as the standard area "which could ensure general healthcare services and which would require, in principle, just one core flagship public healthcare center, a government run medical institution that would enforce the healthcare policy. However, the working group report published in September of 2004 by the Committee for Considering a Review of Healthcare Planning, pointed out the following problems with respect to second tier healthcare markets:

- The average scope of population for the second tier healthcare markets is 350,000. However, a closer analysis of these second tier healthcare markets shows that there are actually wide discrepancies between them in terms of both population and area. The Nagoya healthcare market, which has the highest population, is 122 times as big as the Oki healthcare market, which has the smallest. 2/3 of the second tier healthcare markets have populations below the average. The healthcare market in Tokachi, the one with the largest area, has 273 times more land space than the healthcare market in Minami Kawa-uchi, the one with the smallest area. Moreover, there are some second tier markets in which half the population is concentrated in 1/7 of the market area.
- Because second tier healthcare markets are established by prefectural unit, they do not reflect the medical care needs of citizens that live outside of the prefecture in the border regions.
- Due to the high concentration of people, big cities have an abundance of healthcare institutions. Moreover, because of the developments in the transportation networks in these cities, the health service procurements of urban dwellers cannot be confined to a specific area. For this reason, it has been suggested that such big cities be regarded as their own second tier healthcare market. But the attempt to include such exceptions has complicated the process of adopting the system in general.
- Too much emphasis has been placed on existing administrative districts, such as cities, towns, and villages, in defining the second tier healthcare markets. As a result, several of them are not in sync with the daily activities of the market or the healthcare reception habits of the citizens.
- Because there are wide area service networks (such as those for organ transplants) that surpass the third tier healthcare market, and because there are healthcare services (such as emergency medical centers and general perinatal health centers) that lie between second tier and third

tier healthcare markets, it is difficult to divide healthcare functions cleanly amongst first tier, second tier, and third tier markets.

Thus, in constructing the Japanese version IHN with municipal hospitals as the base, using the second tier healthcare market as a standard area would be unsuitable. Another standard must be sought. What will serve as a hint in determining a better standard is the point that what citizens want from their healthcare providers is nothing less than the "global standard." In order for healthcare institutions to sustain the global standard, they must be able to invest at the pace of technological advancement, a pace that is accelerating as we move into the 21st century. In order for one hospital group to independently acquire the financial resources for such investments, they will need, in addition to management abilities, a medical service revenue above a certain standard amount. In my opinion, 50 billion yen is a reasonable amount for the minimum medical service revenue needed to invest at this pace, and thus establish a successful Japanese IHN. If municipal hospital groups with earnings of 50 billion yen were to streamline their management, within 3 to 4 years, they would be able to develop the financial resources necessary to continuously build leading edge healthcare facilities and keep up with the most advanced technologies.

3.3 The Municipal Hospitals of the Eastern General Healthcare Market as Viable Candidates

With a combined annual revenue surpassing the 50 billion yen mark, the municipal hospitals of the Chiba Prefecture Eastern General Healthcare Market, with the Asahi Central Hospital at their center, would be viable candidates for a Japan-model municipal hospital based IHN. The Asahi Central Hospital is a municipal hospital that was jointly established by Asahi City and the three towns of Iioka, Unakami, and Hikata in 1953. Because of its excellence in the quality of its service and management, it serves as a model for municipal hospitals nationwide. As shown in Figure 1, the hospital derives 1.0 billion yen in annual profits from an annual revenue of 25.1 billion yen, and has no cumulative deficits. By contrast, the ten hospitals that surround the Asahi Central Hospital, though they bring in 29.8 billion yen in aggregate revenue, have collectively announced a 1.3 billion yen deficit, and that on top of 12.1 billion yen that they share in cumulative deficit. These municipal hospitals, moreover, are struggling to secure personnel, particularly medical doctors. If these 10 hospitals were to form a Japanese-model IHN with the Asahi Central Hospital, they would be able to solve their financial and personnel problems. The Asahi Central Hospital will also stand to benefit from such a configuration.

Figure 1　Basic Data for the Municipal Hospitals in the Eastern General Healthcare Market

～Fiscal Year 2002, Unit: 100 Million Yen～

	All 11 Municipal Hospitals	Asahi Central Hospital	The Other 10 Hospitals
Gross Earnings	549	251	298
Hospitalization & Outpatient Care	460	225	235
National Subsidy	14	1	0.4
City/Prefect. Subsidy	14	1	0.5
Other Subsidy/Grants	63	14	49
Total Costs	550	241	309
Employee Wages	270	103	167
Cost of Materials	130	74	56
Ordinary Profit & Loss	▲ 3	10	▲ 13
Cumulative Deficit	▲121	—	▲121
No. of Employees	3,243 people	1,591	1,832

Source: Compiled from data in the Regional Public Sector Yearbook

Because these 11 hospitals, each established by different people, would become the core of a new IHN, it would be best if the management could be integrated all at once: all hospitals would use their assets as investments in kind and the management of revenue as well as the decision making process would be completely consolidated. However, as mentioned before, it would be difficult in reality to convince the various hospital owners about the value of consolidating management, at least before they actually experience the benefits that the IHN offers.　Thus, the next best plan would be a gradual shift in which just group business practices are initiated once the IHN framework has been established.　After 5 to 6 years, once hospitals have begun to appreciate the benefits of the IHN configuration, it will be much easier to move forward toward complete business integration.　The creation of the AHC will play an important role in this respect for it will provide the holding company function under which group business practices can take place prior to the full integration.

3.4 The Concrete Ways to Derive the Benefits of Integration

The first concrete step that can be taken toward deriving the benefits of integration under the AHC system is cutting costs through group purchases. The Asahi Central Hospital has, through its own efforts alone, been able to lower the purchasing costs of its drugs and healthcare materials to the level of private hospitals. The purchasing costs of the other ten hospitals, in comparison, are an average of over 20% higher than that of private hospitals. With an aggregate yearly purchasing total for these hospitals reaching 5.6 billion yen, the margin of costs that they have to pay due to their lack of management is nearly equal to their total annual deficit. If, for example, the 11 hospitals came together to purchase as a group, and the purchasing costs for the ten hospitals could be lowered to at least to the same level as Asahi Central, this would be enough for the ten hospitals together to make their way back toward the black.

On the other hand, it might be said that from Asahi Central's perspective, even if the purchasing costs of the other ten hospitals go down, so long as its own purchasing costs do not decrease, there is no incentive to participate in the purchasing group. But, as seen in purchasing groups in the US, the benefits can be adjusted so that the total profit achieved by the group purchase is distributed according to the purchasing contribution of each member. In other words, the total money saved by all 11 hospitals would be distributed according to the purchase volumes of each hospital. Of course, once management becomes more fully integrated under the IHN, and the decision-making and revenue management are consolidated, this type of savings distribution will no longer be necessary.

The second concrete step that can be taken toward deriving the benefits of integration under the AHC system is joint IT investment. Governments in the US, Canada, Australia, and the UK are forcibly advancing the standardization of healthcare information. The aim is to construct a system, within the near future, that would enable doctors and patients to access necessary healthcare information from anywhere at anytime. In the US, in a project anticipating the government initiative, one IHN has begun investing in healthcare IT as a private business group. What is unique is that the IT investment and the IT utilization designs are being made not hospital by hospital but by the wide area healthcare market. Self-propelled development on the healthcare market level is now underway. In Japan's, case though a similar concept was developed years ago, the country is dragging its feet in standardizing healthcare information and has failed to develop ways of utilizing this information. Investment in

healthcare IT has been, as always, planned and executed only by individual hospitals, and its effects have been diluted as a result. If, on the other hand, the municipal hospitals that participate in an IHN as well as the various surrounding healthcare institutions used a common system, investment costs would go down as the amount required per hospital decreases, and investment effectiveness will go up as hospitals begin to share information.

The third concrete step that can be taken toward deriving the benefits of integration under the AHC system is personnel pooling. As mentioned before, changing the status of hospital employees from public servants to private employees is a pre-requisite for reforming the municipal hospitals. However, municipal hospitals, even if they are within the same healthcare market, will have different management configurations if they have been established by different local governments. This will inevitably be a cause for time delays in the changeover from public servants to private employees among the hospitals. Moreover, aside from hospitals like the Asahi Central, which carries brand name power, the majority of municipal hospitals have shortages in doctors, nurses, and management personnel. One reason for the unpopularity of municipal hospitals is that their training courses are ill-equipped and have earned a reputation of forcing heavy workloads upon trainees. Within the steady initiative to shift employee status to that of private employee, all personnel that are newly acquired by the hospital will become affiliated with the AHC and can be cultivated by the IHN as a whole. This will be an effective way to secure necessary personnel.

3.5 Achieving the Global Standard

Using AHCs as catalysts for the creation of municipal hospital centered IHN's will be easier in the regional areas than in big cities like Tokyo and Osaka. Because these cities contain many different types of hospitals, which serve as rivals to the municipal hospitals, the IHN, even if it could be formed, would have trouble forging the regional affiliations necessary to acquire patients on its own. Indeed, the local citizens of these areas would not be unduly troubled if all municipal hospitals were taken away. By contrast, in the Eastern General Healthcare Market, for example, a region where no major private hospitals exist next the municipal hospitals, a primary care network amongst practicing physicians could be easily formed. Especially, if agreement can be reached between the heads of the local governments, the IHN could be initiated from the top down. Similar types of wide area healthcare markets exist in each region of the country. Aomori Prefecture is a good example. The healthcare market, which

supports a population of 1.48 million people, contains as many as 33 municipal hospitals. The total earnings of these hospitals are about 100 billion yen, covering about 1/4 of the prefectures total medical expenses of 400 billion yen. Up until now, the municipal hospitals have made no effort to divide functions amongst close proximity hospitals, and continue to waste funds through redundant investments. As a result, they have accrued a cumulative deficit of 70 billion yen. Yet, for as much waste as the present system creates, that much can be gained from the construction of an IHN.

From one perspective, the fact that healthcare markets with the potential to become IHNs exist all around the country means that we are now facing a new challenge. This is because if IHNs emerge across the country and competition becomes strong, so long as all of them follow the same strategy, there is no guarantee that personnel, patients, or research funds will come to the IHN from outside the healthcare market. It is important then is to recall the foundation for our standards: Whether it be patients, personnel, or corporations and government organizations that distribute research funds, they are all seeking the "global standard" and the management abilities necessary to achieve it. In other words, as the pace of technological advancement increases, only IHNs that have established a brand name and have setup a framework capable of continuously providing healthcare and management at the global standard will be able to stand at the top.

As mentioned before, hospital groups such as the Kōseiren Hospital Group and the Itabashi Central Hospital Group, groups that have modeled themselves after US IHNs, already exist in Japan. But compared to the US IHNs, it is hard to say that they have attained the global standard in terms of healthcare and management. Thus, municipal hospital based IHNs have the potential to become the first IHNs in the country to achieve this standard of healthcare.

In attaining such goal, Japanese model-IHNs, once they are established, should form business affiliations – e.g. personnel and technology exchanges – with the most highly evaluated IHNs in the US, such as BJC Healthcare and Sentara Healthcare. From the point of view of the US IHNs, this will be an opportunity to acquire Japanese patients in search of healthcare technologies that have not yet been approved in Japan. Moreover, they will be able to acquire more research funds by setting up joint research programs between US and Japanese IHNS, such as those for healthcare materials development. The executives of US IHNs have already expressed strong interest in doing this, saying: "If serious IHNs develop in Japan, we want to collaborate."

4. In Closing

2004 has been the year in which the all the various issues that will determine the future direction of Japanese healthcare have been debated. I would like to close this report by touching on the relationship between these themes and the AHC.

First of all is the relationship of AHCs with the debate over the legalization of dual medical service. Dual medical service is the simultaneous provision of insurance covered medical care together with free or uncovered medical care. In Japan, because the health insurance system's strict adherence to the principle of on-site payment deductions, dual medical service has been prohibited. As a result, patients who seek dual medical service have had to foot the entire bill (including the portion for services normally covered by insurance). However, through the establishment of the special care payment system, dual medical service was permitted if it was setup in advance. However, the rise in the bankruptcy risk of the public healthcare system has driven up the costs of healthcare for patients, and this has fueled, among other things, a growing demand for more full legalization of dual medical care. After heated debate, a compromise was reached to expand the scope of the special care payment system, resulting in near complete legalization of dual medical care.

However, the promoters for legalizing dual medical services are missing something very important. What needs to be prevented with respect to dual medical treatment is the dishonest act of recommending uncovered medical treatment. This is when doctors, for the purpose of personal profit, tell the patient that uncovered treatment has more curative effects than the covered one. In order to prevent this type of dishonesty, dual medical services involving advanced medical technology must be carried out under a system where profits are circulated back into society, and not to a certain individual. In this regard, it would be worth it to consider a stricter qualification requirement for using advanced medical technology: not just should private hospitals be able to demonstrate healthcare provision capability, but they should also be an AHC.

Another important issue is the encouragement of administrative collaboration between national university affiliated hospitals and the regional IHN. As the pace of technological advancement accelerates, in order for hospitals and medical schools to keep at the forefront of the global industry, they will have to gain the ability to procure funds on their own, and not rely on subsidies for required funds. Forming hospital groups based on wide area healthcare markets, and then forging administrative affiliations between these groups and the university hospitals would further eliminate

redundant investment and help create more pull for patients, personnel, and funds from abroad. In a related matter, Japan's national universities have become incorporated as of April 2004. Along with their new legal status has come more self-responsibility for their education, research, and management. The modernization of the hospitals associated with their medical schools is one of the most pressing issues. If the revenue of these university hospitals continues to fall below their expenses, the universities may be forced to fill the gap with cuts from other departments.

Moreover, in order for university hospitals to achieve and sustain the global standard in clinical research and clinical education, their primary field of responsibility, they must be able to make advanced technology equipment investments. Up until now, the equipment investments of university hospitals have been funded by loans from fiscal investment programs. It seems, judging from the direction of financial administration reform, that loans from these funds will soon be closed off, and it is possible that the hospitals will be faced with having to procure capital from the market. But even if these university hospitals were to be able to continue borrowing from the funds, it would be impossible for them pursue the global standard with this dependence.

An effective solution for national university affiliated hospitals would be to actually separate their management from the medical schools and integrate themselves with a municipal hospital based IHN. This would eliminate overlapping investment, and entrust the fields of clinical research and clinical education to the IHN. There is really nothing more wasteful than the way university hospitals, prefectural hospitals, and prefectural city hospitals within the same narrow healthcare market all compete in their equipment investments. Because university hospital employees will become non-public servants as a result of the incorporation of national universities, these hospitals, after separating themselves completely from the universities, should changeover to AHC's and become holding companies within the municipal hospital IHNs.

A final topic of importance is the future creation of decentralized health insurance system. The AHC has many merits with respect to the type of healthcare planning that this new system will require. The Ministry of Health, Labor and Welfare has announced its intentions to change national health insurance into a system that is based on the units of prefecture and major city. This system will correct the distortions that have come about through the blanket application of national compensation standards to regions with varying healthcare prices, and will thus lead to fairer evaluations and policies.

Furthermore, because the structures of population and disease differ from

region to region, the measures required to improve people's health also differ from region to region; and what's more these needs continue to change over time. Therefore, once healthcare becomes integrated by region, each prefecture and city will have authority over a fixed region in determining the healthcare compensation level. Giving prefectural and city governments such discretion, while it is currently a political problem, is important in that it will have a very positive influence on medical reform

But once this has happened, each prefectural and major city government will need to collect healthcare information as a basis for their judgments in formulating healthcare plans. In other countries, the national government collects this type of healthcare information. In Japan, however, such a system scarcely exists, due in part to the delays in healthcare IT investment. The AHC will be effective in remedying this delay. Using AHCs as a functional agent, we must encourage the formation of Japanese model IHNs and begin to put even coercive pressure upon the hospital groups to gather and store healthcare information.

Under this system, the functions (medical services) carried out by AHCs in the regional healthcare market will be reflected in the healthcare plans. So long as the non-profit, public utility AHC is sufficiently fulfilling its function, it will become unlikely that new healthcare institutions, with the potential of becoming rivals, would be approved. Being recognized in, and having influence over, the healthcare planning will be an important incentive for private hospital managers to dispose of their claims to retained profits and allow their hospitals to become AHCs.

REFERENCE

Institute of Local Finance, 2004, "Fiscal Year 2002: Regional Public Sector Yearbook."

Ministry of Health, Labor and Welfare, December 10, 2004, "*Dai yonkai: igyōkeiei no hi-eirisei nado nikansuru kentōkei shiryō* (Fourth Meeting: Materials from the Review Committee for the Non-Profitability of Healthcare Management)."

Ministry of Health, Labor and Welfare, September, 2004, "*Iryō keikaku no minaoshi nado nikansuru kentōkai: waakingu gurūpu hōkokusyo* (Review Committee for the Examination of Healthcare Planning: Working Group Report)."

Ministry of Health, Labor and Welfare, December, 2002, "*Kokuritsu daigaku hōjinka-go no kokuritsu daigaku huzoku byōin no un-ei ni tsuite* (On the Administration of National University Hospitals After the Incorporation of National Universities."

Ministry of Internal Affairs and Communications, November 30, 2004, "*Chi-iki iryō no kakuho to jichitai byōin no arikata nado nikansuru kentōkai hōkokusho* (Report from the Review Committee for the Status of Municipal Hospitals and the Securing of Regional Healthcare)."

Regulation Reform and Privatization Convention, December 24,2004, "*Kisei kaikaku minkankaihō no suishin ni kansuru dai-ichijitōshin* (Initial Report on the Promotion of Regulation Reform and Privatization)."