

Physicians' Conflicts of Interest in Japan and the United States: Lessons for the United States

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Abstract Japanese health policy shows that even with physician ownership and the absence of for-profit, investor-owned health care, physicians' conflicts of interest thrive. Physician dispensing of drugs and ownership of hospitals and clinics were justified in Japan as ways to avoid commercialization of medicine. Instead, they create physicians' conflicts and fuel patient overuse of services. Japan's Ministry of Health and Welfare (MHW) has responded by introducing per-diem payment, thereby creating incentives to decrease services in ways similar to those of American managed care organizations, but with none of their benefits, such as coordination of care, oversight of physicians practices, and quality assurance.

Although the United States and Japanese health care systems are organized and financed differently there is convergence in the source of their physicians' conflicts and the way they are addressed. The United States is starting to integrate institutional and physician payment and align their incentives, in a traditional Japanese way. In so doing, the United States creates new physicians' conflicts and reduces the role of countervailing incentives and power, an advantage of previous policy. Japan, in turn, has combined incentives to increase and decrease services, thus moving closer to the U.S. policy.

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In the 1980s, Arnold S. Relman (1980, 1984, 1986; Relman and Reinhardt 1986), editor of the *New England Journal of Medicine*, called attention to America's "new medical industrial complex," with its physicians' financial conflicts of interest ("physicians' conflicts"), commercialization of medicine, and corporate and for-profit medicine. Once viewed as healers loyal only to patients, now physicians are seen as businesspeople, insurers, and employees loyal to other parties as well (Stone 1998; Angell 1993). They now have financial incentives to work for parties other than patients, and this can compromise their clinical judgment, the patient-physician relationship, and medical ethics. Such conflicts can lead to over- or underuse of services or bias clinical choices and referrals, thereby lowering quality of care for patients.

The changes in physicians' roles that exacerbate their conflicts of interest are most striking in the United States. However, global markets and common health policy problems make the phenomenon worldwide. Yet we know very little about how physicians' conflicts vary among countries. With a few exceptions (Krause 1996; Hafferty and McKinlay 1993), American literature on medical physicians' conflicts, professionalism, and for-profit medicine focuses on the United States without comparison to other countries (Brint 1994; Friedson 1994; Gray 1986, 1991; Kimball 1992; Spece, Shin, and Buchanan 1996; Starr 1982; Stevens 1971). How might different relations between the physicians, markets, and the state affect physicians' conflicts? Might strategies used to address physicians' conflicts in one country be applicable in another and allow crossnational learning (Brown 1998)?

To shed light on these issues, this article compares physicians' conflicts in Japan and the United States. Three features of the Japanese health care system make for an interesting contrast to the United States. First, in Japan the hospital sector is traditionally a cottage industry, more than half of which is physician owned. The remainder is owned publicly or by not-for-profit institutions; only 1 percent is owned by for-profit, nonphysician investors. Some writers in the United States link for-profit medicine to physicians' conflicts (Relman and Reinhardt 1986) and the American Medical Association has explored physician ownership of managed care organizations (MCOs) as a way to address problems in managed care (Hirschfeld 1994). Because of this, it is interesting to examine the effect of physician ownership in Japan on conflicts of interest. Second, in Japan there are no MCOs, which in the United States are the most visible source of incentives to decrease patient services and are a source of physicians' conflicts with the opposite effect of fee-for-

service. Does the absence of MCOs in Japan result in no conflicts from incentives to decrease services? Third, Japan has a national health insurance program that controls spending by regulating prices while paying doctors fee-for-service. What effects do stringent price controls and fee-for-service have on physicians' conflicts?

This article draws four lessons. First, merging the roles of clinical care provider and entrepreneur (as when physicians dispense drugs and own hospitals) creates physician conflicts and commercializes medicine. The commercialization occurs even in the absence of for-profit nonphysician investors who receive dividends. Second, to control spending by regulating fees without addressing the underlying conflicts in fee-for-service payment will not reduce physicians' conflicts, inappropriate use of services, or related quality problems. Third, two promising ways to cope with physicians' conflicts are to create authority that counteracts the power of physicians and to balance incentives to increase services against incentives to decrease them. These approaches were more characteristic of the American than the Japanese health care system, but this is changing. Fourth, despite major differences in the way the Japanese and American health care systems are financed and organized, there is an emerging convergence in physicians' conflicts and how they are addressed in both countries. The United States is creating new conflicts similar to those that have characterized the Japanese health care system, and Japan is addressing some physicians' conflicts by reforms that make its health care system resemble more closely that of the United States. These points are elaborated below.

Japanese medical practice merges the doctors' role as advisor and agent for patients with one of a purveyor of medical services. For example, physicians dispense approximately 80 percent of drugs, and own over half of hospital beds and 90 percent of clinics. Physician dispensing and ownership of hospitals are justified as ways to exclude commercialism and profit-seeking activity by investor-owned firms. Yet these activities create effects that they were purportedly designed to avoid, if physicians became the main instruments of commercialism rather than investor-owned firms. When physicians dispense drugs and own hospitals, they function as businesspeople and engage in the same profit-seeking activity as investor-owned firms, despite traditional ethical obligations to act in the interest of patients.

Japan has eliminated one of the main problems in fee-for-service payment: high health care spending. However, it has not eliminated another significant problem: the tendency for physicians to overprescribe ser-

vices. By enforcing strict price controls and a highly regulated health insurance Japan spends about one-half per-capita what the United States does, despite using more medical services than in the United States (Campbell and Ikegami 1998; Ikegami 1991; Masuyama and Campbell 1996; Ikegami and Campbell 1999).¹ Indeed, price controls most likely contribute to Japan's high volume of services as doctors perform more services to generate their own and hospital income than if there were no price controls. Japanese cost-control regulations are not designed to and do not promote the most appropriate clinical choices or best quality of care, which remains a problem.

Japan has fewer checks on physicians' clinical choices than does the United States, and thus there is more risk that their conflicts will produce inappropriate decisions. The incentives of Japanese doctors are not countered by opposing hospital incentives. No equivalent of MCOs exists in Japan to counter fee-for-service incentives by administrative means, to promote standardized practices or to oversee physicians and coordinate care. There is less peer and utilization review and less information about decisions physicians make, all of which shields doctors from scrutiny. Japan also has less developed quality-assurance programs and weaker patients' rights and consumer health movements than does the United States (Rodwin 1994; Leflar 1996; Feldman 1997; Annas and Miller 1994), both of which counteract incentives for physicians to reduce services—an emerging conflict-of-interest problem in both countries.

Despite differences in financing and organization of the U.S. and Japanese health care systems, there is a partial convergence in American and Japanese physicians' conflicts and the ways in which providers and governments respond to them. Until recently, the United States had more diffuse incentives than did Japan. In the United States, hospital and physician payments were traditionally separate. This made it possible for doctors and institutions to be countervailing agents (Light 1991, 1993; Galbraith 1956). Doctors could advocate for increasing services for patients, and institutions could act for society to control spending (Schlesinger 1997). However, as MCOs share financial risk with doctors for hospital and ancillary services, American physicians' conflicts increasingly resemble those of physicians in Japan, where hospital and physician payment is integrated.

In turn, Japan has recently adopted payment reforms that combine incentives to increase some services and decrease others, thereby counter-

1. An exception is for surgery, which is very poorly reimbursed.

balancing them. For example, in geriatric and chronic care the state pays for rehabilitative and other services it wants in order to encourage using fee-for-service; and it uses bundled or per-diem fees for medications and other services that it wants to discourage (Takagi 1992b). These changes moderate the strong incentives that characterized the Japanese health care system in the recent past, bringing it closer to the traditional American approach, which balanced and counteracted incentives.

This article proceeds by defining conflicts of interest and showing that Japanese law and policy have used these concepts in ways similar to the United States. It then analyzes two broad areas of Japanese physicians' conflicts in comparison to U.S. physicians: (1) conflicts arising from dispensing drugs and from relations with the pharmaceutical industry; and (2) conflicts arising from physician ownership of hospitals and related hospital incentives. It concludes by summarizing implications for the United States.

Conflicts of Interest in Japanese Law and Policy

What Are Conflicts of Interest?

American legal principles that regulate conflicts have their origins in the law of trusts and agency and in the arrangements in which one party acts for the benefit of another. The party acting on behalf of the agent or trustee is the *fiduciary*. Fiduciaries typically control property of the party they serve or have special powers over their affairs. They often need discretion to perform their work (Rodwin 1993: 179–210). Fiduciaries have a duty to be loyal and they must account for their actions. Fiduciaries are held to high standards of conduct. There are remedies for breach of trust and rules for dealing with conflicts of interest. Courts and legislatures have extended fiduciary obligations to many professionals and have even used conflict-of-interest rules outside of fiduciary relationships.

Situations that compromise a fiduciary's loyalty or independent judgment are conflicts of interest: they increase the risk that fiduciaries may breach their obligations but are not acts of disloyalty or misconduct. We worry about such conflicts of interest because it is often hard to monitor fiduciaries' behavior, and the remedies for misconduct may not be adequate. Identifying conflicts makes it possible to take measures to prevent harm. Often as a precautionary measure, fiduciaries are barred from entering situations where conflicts of interest exist. There are procedures

too by which the party being served can permit a fiduciary to continue to work despite their having a conflict of interest.

Physicians have obligations to act in the interest of their patients. Sometimes they are considered fiduciaries, although their legal status is ambiguous (Rodwin 1995). There are two main types of physicians' conflicts of interest: (1) conflicts between a physician's personal interests (usually financial) and the interest of the patient; and (2) conflicts that divide a physician's loyalty between two or more patients or between a patient and a third party.

Japanese Law and Policy

There is ambiguity about both "interest" and "conflict" in Japan. American conceptions of conflict of interest may therefore resonate differently, especially in patient-doctor relationships where these ideas are challenging to apply even in the United States. The scope and form of conflicts of interest also depend, in part, on institutional context. Nevertheless, ideas about fiduciary relations are similar enough to make comparisons.

In Japan, as in the United States, fiduciary principles exist in the law of trusts, agency, and finance. The Japanese Trust Act and the Japanese Civil Code include special obligations for trustees, agents, and other fiduciaries, which scholars call *jutakusha* (trustee) and *juninsha* (fiduciary) or *shinnin kankei* (trust relationship). Agents and corporate directors are prohibited from entering into certain role conflicts or conflicts of interest (which the code calls *rieki-soban*) (Japanese Civil Code secs. 108, 57). The criminal code includes penalties for *hainin* (breaching fiduciary obligations) (Japanese Criminal Code sec. 247). Similar laws existed in Japan prior to reforms following World War II (personal communication with the authors by Professor Norio Higuchi, Tokyo University Law School, November 1998).

As in the United States, in Japan financial conflicts of interest have long been recognized for government employees, financial professionals, and lawyers (Itakura 1986). The criminal and civil codes prohibit breaches of fiduciary obligations and penalize bribes, kickbacks, and fraud by public employees in national and local government, public corporations, and any individual that a statute delegates to perform a public function.²

2. Japan's Mental Health and Welfare Act provides that psychiatrists, appointed by prefectural governors to determine whether patients should be involuntarily committed to hospitals to protect the public, perform these acts as civil servants. The newly enacted Long-Term Care Insurance Act has the same provision on care managers who perform need assessment of the disabled.

There are also laws that regulate the fiduciary obligations of corporate officers, directors, and lawyers, establish a duty of loyalty and prohibit the acceptance of bribes (Japanese Criminal Code secs. 197–198; Lawyers Act sec. 26; Commerce Act secs. 265, 486–493). To prevent harm of uninformed purchasers, Japan is now moving to address conflicts of interest of financial professionals by requiring increased disclosure of financial relationships, a process they call *tomeisei*, or transparency (Leflar 1996: note 274). Such disclosure rules were modeled on the U.S. Securities and Exchange Commission and corporation law but are less stringent than they are. The move to transparency is a more general phenomenon in Japan, as is seen in the recent enactment of the Freedom of Information Law (Efron 1999).

Like in the United States, Japanese fiduciary law is less developed in medical jurisprudence than in the law of public employment or corporations. Patient-physician relations are considered mandate contracts, which are confidential or fiduciary in nature. However, Japanese courts have not typically invoked fiduciary principles to decide cases involving informed consent, medical malpractice, kickbacks, or other health law issues. Japan shares with the United States the medical ideal that doctors should act in the interest of patients. But the Japan Medical Association (JMA) Code of Ethics and the more recent JMA report on social responsibility of doctors and professionalism do not explicitly address physicians' conflicts of interest (Physicians' Ethics Code 1951; Fourth Committee on Bioethics 1996). Nor is this a subject, with rare exceptions, developed in the Japanese bioethics literature (Kimura 1991). Even today, issues of physicians' conflicts of interest are rarely discussed in professional or popular publications.

The key Japanese statutes and regulations that oversee physicians and medical practice (the Physicians' Act, the Medical Service Act, the Health Insurance Act, and Fair Competition Rules of the Pharmaceutical Industry) include only a few narrowly drawn antikickback and bribe provisions. The Japanese Ministry of Health and Welfare (MHW) regulates medical practices without using a conflict-of-interest framework. It limits self-serving behavior that can increase costs, sometimes by prohibitions, other times by using its reimbursement system to create incentives to reduce spending. Physicians employed by public hospitals (which include the most prestigious medical centers, including top universities), however, are subject to much broader prohibitions on kickbacks, bribes, and gifts that apply to all public servants (Japanese Criminal Code secs.

197–198).³ Some conflicts, such as kickbacks, are illegal and many are on the border of accepted practice. Regulations and lawsuits document their existence, but not the frequency with which they occur. There is also a lack of data on undertreatment resulting from fixed per-diems or prospective payment.

Physician Dispensing and the Pharmaceutical Industry

Physician Dispensing

In traditional Chinese *Kampo* medicine, as routinely practiced in Japan earlier in the twentieth century, physicians were deemed to perform services altruistically (Ikegami 1989; Lock 1980; Norbeck and Lock 1987). They received no payment for their services. Payment for the cost of dispensed medicines was permitted on the grounds that patients merely reimbursed doctors for their supplies (Ikegami and Campbell 1995). In fact, dispensing medicine compromised the doctor's role as advisor. Dispensing allowed physicians to receive a secure income while maintaining the fiction they were not engaged in commerce. Data on the effect of dispensing in ancient medicine is unavailable. However, since the establishment of Japan's universal health insurance in 1961, physician dispensing led to overmedication of patients and a "cops and robbers" game as the MHW regulated the medical sector to address this problem (Fujii and Reich 1988).⁴

The pharmaceutical markup was as high as 25.7 percent of the reimbursement price in 1989 (*Asahi Newspaper* 1989), totaling to \$10 billion annually (statistics citing costs in U.S. dollars are based on the exchange

3. The prohibition on gifts includes gifts from patients to doctors. Although difficult to document, it is the custom for Japanese patients to give most surgeons cash gifts as a token of appreciation (Sato 1995). However, given the low fees of surgeons, this may be viewed as a form of copayment. Some scholars even propose that gifts should be allowed as a professional fee (Okamoto 1991). Unlike gifts from third parties, which can sway doctors' clinical decisions in ways that promote the gift giver's interests, patient gifts can help solidify the doctor's bond to them. Yet gift-giving may encourage unfair practices. Although doctors say that gifts do not affect whether they take a case or the quality of care patients receive, it might. Gifts can be used to secure access to surgeons or other specialists or to influence doctors' decisions, which affect common resources. Gifts can facilitate queue jumping when there is a backlog of surgical cases. Gifts might influence whether a doctor keeps a patient in a government hospital or discharges the patient to a private hospital that has less adequate nursing facilities.

4. For a Japanese language Web site relevant to excessive medication in Japan, see <http://www.ituc-rengo.or.jp/spa/hoken.html>.

rate of \$1 = 130 yen).⁵ The markup margin was later progressively reduced by the government by lowering the official reimbursement price and was about 5 percent in April 1998. Not surprisingly, Japanese physicians dispense frequently and choose expensive drugs. Practicing doctors who operate clinics without inpatient beds earned approximately 28.4 percent of their revenue as reimbursement for drugs in 1996.⁶

Over 29 percent of Japan's health care spending was for pharmaceutical products in 1993, while the United States spent only 11.3 percent (Central Social Insurance Medical Care Committee 1995). The incentive for doctors to dispense medications is exacerbated by reimbursement policy that pays very little for cognitive services and by the lack of independent information on the risks and benefits of drugs, such as a translation of the *Physicians' Desk Reference* or equivalent.

A national survey conducted by the MHW found that on average physicians prescribed at least three medications per patient visit, although because of items excluded the true number is about five (MHW Statistics and Information Bureau 1994: 14).⁷ Patients receive so many medicines that they apparently sometimes randomly choose which drugs to use. A study at Tokyo University, for example, suggested that it was unlikely that most patients took all their pills since there would be more reported illness from dangerous drug interactions (Documentary 1989).

Regulation of Physician Dispensing and the "Second Pharmacy"

The MHW developed three policies to cope with the conflict ensuing from physician dispensing: it reduced the reimbursement for dispensing drugs; it created financial incentives for doctors to prescribe but not dispense; and it encouraged the development of independent pharmacies (Fujii and Reich 1988: 21; Reich 1990).

In 1992, the MHW lowered the profit margin of drug prices from 25 percent to 15 percent and continued reductions until it reached 5 percent

5. 1.3 trillion yen.

6. The percentage of revenue of practicing doctors who own clinics without inpatient beds was calculated using data from the Social Insurance Claims Survey [*Shakai iryou shinryou kouji betsu chousa*] conducted in June 1996. The revenue reimbursed for drugs includes medication, IV, home care, laboratory, X ray, procedures, and surgery (MHW 1996).

7. The average was 3.25, but this underestimates the true number since claimants are permitted to omit listing drug names in insurance claims if they are priced less than \$1.70 (205 yen) per day. Approximately 36.5 percent of outpatient pharmaceutical costs are unaccounted for because of the omission.

in 1998. In addition, in 1997, additional patients' copayments were introduced to discourage multiple medication. The MHW also set a higher fee for prescribing when the doctor does not dispense the drug than when dispensing. For example, the 1998 prescription fee was approximately \$6.00,⁸ while the fee for prescribing when the doctor also dispenses was \$2.50.⁹ However, it was still in the physician's financial interest to dispense when the markup on drugs dispensed was approximately \$3.00,¹⁰ since this offset the lower prescribing fee.

In response, some doctors gamed the system by referring patients to a freestanding "second pharmacy" they owned rather than dispensing medicines in-house or merely prescribing. Such doctors advised patients to use the pharmacy (usually located nearby) and posted advertisements and directions to it in their waiting rooms. By so doing, doctors received the higher prescribing fee and through their second pharmacy, they earned an additional fee for dispensing medications plus income from selling drugs. Referring patients to a second pharmacy is similar to the American practice of "physician self-referral," where doctors refer patients to freestanding medical facilities in which they share ownership. Physician self-referral for ancillary services such as clinical laboratories, imaging centers, and radiology became major problems before Congress restricted the practice in the Medicare and Medicaid programs in 1992 and 1993 (Jost and Davies 1998).¹¹

There are no statistics on the number of Japanese physicians that referred patients to a second pharmacy. When the MHW discovered the practice, it treated it as double billing and required pharmacies to be independent of any health care facility (Head of Pharmaceutical Affairs 1982). The 1994 revision of the Physicians' Practicing Rules also prohibited physicians from directing patients to designated pharmacies and receiving kickbacks in exchange for referrals (Health Insurance Providers' Practicing Rules, secs. 19-3). As an added measure, the MHW modified its fee schedule to discourage financial ties between physicians and pharmacies. The 1996 fee schedule pays a lower rate for pharmacies with a close tie to the referring physician. Pharmacies that receive more than 70 percent of

8. 810 yen.

9. 370 yen.

10. 440 yen.

11. Several states also have laws that restrict physician self-referral (Rodwin 1993: 115–121).

their prescriptions from a single hospital or clinic receive only \$1.70¹² to dispense a drug, while other pharmacies receive \$3.80.¹³

Despite these policies, the fundamental conflict in physician dispensing persists, and in 1996, doctors dispensed approximately 80 percent of all medications (MHW Statistics and Information Bureau 1996b: 38). Japan spends more per capita on drugs than any other country does (Anderson and Poullier 1999: 186, exhibit 5).

Pharmaceutical Manufacturer Incentives and Voluntary Standards

The pharmaceutical industry also created incentives for physicians to dispense, since doing so promotes its income as well. The MHW has clamped down on these incentives when possible, but the tension between providers who want to sell and the MHW, which seeks to control spending, still persists. For example, wholesalers used to give physicians a set amount of free drugs based on the volume they purchased. By giving physicians who purchase drugs for resale free products, wholesalers maintained their rate of reimbursement, which is based on a market survey of wholesale prices. Doctors earned extra income by dispensing their “free” drugs while maintaining their reimbursement rate. The MHW viewed this practice as a rebate or kickback and banned it in 1970 (Textbook for Medical Representatives 1995).

More recently, to promote their products, pharmaceutical firms provided gifts to physicians of both money and services. For example, pharmaceutical firms used to freely assist medical school doctors with literature searches and photocopying. Representatives provided doctors with slides for presentations and research assistance. They sponsored medical school events and parties.

The Japanese Pharmaceutical Manufacturer's Association (PMA) established three voluntary guidelines for promotion in 1993. One was a revision of its 1976 guidelines, which had not significantly limited marketing. The other two were industry interpretations of the 1984 Japanese Federal Trade Commission (FTC) regulations on Pharmaceutical Manufacturers and Gift-Giving (PMA 1993a, 1993b, 1993c; FTC 1984). The

12. 200 yen.

13. 450 yen. Such incentive payment may backfire. Since patients pay a 10 percent to 30 percent copayment on the dispensing fee, it is less expensive for patients to use a pharmacy which receives most of its prescriptions from one hospital.

1993 guidelines were supposed to restrict inappropriate payments to doctors. They limit assistance that is unrelated to the pharmaceutical company's product (such as providing slides or photocopying of articles) to the monetary value of about \$700 a year per institution.¹⁴ But there are no limits on such assistance when it is related to the pharmaceutical firm's own products because this is deemed as legitimate promotion. Pharmaceutical firms can also contract with doctors to conduct research, write articles, give lectures, and perform other work. Firms are also permitted to reimburse transportation cost to doctors for attending conferences. These gray zones are loopholes.

It is hard to gauge the extent to which the PMA guidelines are followed since there are no reporting requirements. Some articles in the trade press say that medical schools changed as a result. Doctors complain about having to do their own literature searches and photocopying. However, some payments continue in different forms. One physician was quoted as saying that "year-end parties, group tours and golf-competitions can safely be continued by soliciting donations from 30 to 40 companies" (see *Monthly Detailman* 1993). The lack of restriction on pharmaceutical company assistance related to its own products facilitates financial ties that encourage physicians to dispense these products.

American Physicians' Dispensing and Relations with Pharmaceutical Firms

In the United States, dispensing and pharmacy ownership was looked at askance, but often tolerated, and never became a major source of physician income as in Japan. Dispensing patent medicine was long practiced by medical quacks. Perhaps this is why the American Medical Association (AMA)'s codes of ethics deemed dispensing medicine unethical from 1847 through the mid-1950s (Rodwin 1993: 35–37). In 1953, the AMA Judicial Council declared it unethical for doctors to have a financial interest in pharmacies or to profit from the sale of remedies they prescribed (AMA 1953). Still, by one estimate, nearly a quarter of doctors dispensed drugs in 1947 (U.S. House Subcommittee on Health and the Environment of the Committee on Energy and Commerce 1987).

In 1955, the AMA revised its code of ethics to allow dispensing of drugs "as long as there is no exploitation of the patient" (Rodwin 1993: 35–37; AMA 1955). Yet physician dispensing nearly disappeared in the

14. 100,000 yen.

late 1960s and has remained low since 1970, although only five states prohibited it (U.S. House Subcommittee on Health and the Environment of the Committee on Energy and Commerce 1987; OIG 1988). Why physician dispensing has remained low in the United States while it became a major source of revenue in Japan is uncertain. One possible explanation is that dispensing probably is not as profitable for U.S. physicians as are other ways to earn income, such as increasing office visits, performing medical procedures, owning outpatient treatment centers, or investing in and referring patients to diagnostic labs and other facilities. In the 1950s and 1960s, some American physicians also referred patients to pharmacies they owned, just as some Japanese doctors had. In response, several states restricted physician ownership of pharmacies (Rodwin 1993: 117–118). Physician ownership of pharmacies all but disappeared in 1993, when Congress passed legislation that prohibited doctors from referring Medicare patients to pharmacies and other facilities in which they invested (42 U.S.C. sec. 1395 nn.).

Early in this century, the AMA viewed receiving gifts from suppliers as unethical; however, in the 1950s it liberalized its ethics code to allow gifts, with certain restrictions. Gifts received by American doctors ranged from token items, such as pens, to paid trips to resorts that combine vacation and promotional seminars (Rodwin 1993: 19–151). A 1992 survey by the OIG of the Department of Health and Human Services found that pharmaceutical firms offered gifts or payments at least once in the past year to 82 percent of physicians, with the average annual cash value of gifts being \$727 per physician (Kusserow 1992). In 1990, in response to upcoming congressional hearings, the AMA adopted guidelines on gift-giving (U.S. Senate Subcommittee on Health of the Committee on Labor and Public Welfare 1974; U.S. Senate Committee on Labor and Human Resources 1990). These guidelines do not permit gifts of honoraria or travel expenses to attend educational meetings. However, they do allow gifts that are not sumptuous and primarily benefit patients or are educational (Council on Ethical and Judicial Affairs 1990). There is no limit on the number of this kind of gift that doctors can receive, according to the code. Moreover, the category creates confusion, as the permitted educational gifts of textbooks and other such materials subsidize physician practices, with no assurance that the financial benefits are passed on to patients. Furthermore, none of the restrictions of the guidelines are enforceable, except by expelling a doctor from the AMA. This is rarely done, and usually only for gross abuse involving conviction for violation of law.

Physician Ownership of Hospitals and Related Incentives Compared

As we shall see below, in Japan private hospitals and clinics are an extension of the doctor's practice. Although 99 percent of office-based physicians are in solo practice, over half of Japanese hospital beds are owned by doctors or medical corporations, which are in turn owned largely by doctors. Physician ownership creates conflicts of interest similar to physician dispensing. In response to conflicts arising from hospital ownership, the MHW created incentives to be frugal and in the process substituted new conflicts for old.

Hospital Ownership

Japan has a private and a public hospital sector. In the private sector, doctors own clinics and hospitals, while "for-profit corporations" that pay dividends are seldom permitted. The public sector employs doctors as civil servants and includes the top national university hospitals and teaching centers. Today most patients are treated in the private sector, but public sector hospitals are more prestigious. In 1996, ownership of hospital beds in Japan was divided as follows: 9 percent by the national government, 15 percent by state and local government, 20 percent by non-governmental, not-for-profit institutions, 1 percent by investor-owned institutions, and 54 percent by physicians as sole proprietors or medical corporations owned mostly by physicians (MHW Statistics and Information Bureau 1996a).¹⁵ In contrast, in 1996, U.S. ownership of hospital beds was 8 percent by the federal government, 16.5 percent by state and local governments, 64 percent by nongovernmental, not-for-profits, 11.5 percent by investor-owned firms, and physician ownership was almost nonexistent.

The private hospital sector in Japan is a cottage industry, unlike in the United States. Facilities with over twenty beds are considered hospitals even though they often perform functions equivalent to U.S. nursing homes. The average number of beds in privately owned Japanese hospitals (by physicians or medical corporations) is 131 beds, while in the United States it is 170 and over 29 percent of U.S. hospitals have over 200 beds (MHW Statistics and Information Bureau 1996a: 442, 448; Health Forum 1999). Moreover, in the United States over 44 percent of commu-

15. Japanese physicians or medical service corporations also own 80 percent of clinics without beds. The difference between clinics and hospitals is size. Clinics have on average nineteen beds or less.

nity hospitals are part of a multihospital system and another 29 percent are part of a multihospital network, neither of which have a counterpart in Japan (Health Forum 1999: 4, table 2; Health Care Info Source 1998).

The Japan Medical Association (JMA) championed restrictions on nonphysician ownership. Its 1951 ethical code prohibited doctors from being employed by nonphysicians or corporations ("Remuneration of Doctors," ch. 3, clause 3, Physicians' Ethics Code 1951). This position was followed in the Medical Service Act. In 1995, as part of proposed administrative reforms, industry supported allowing hospital ownership by "for-profits" (Subcommittee on Deregulation 1995, 1996). However, the JMA and the MHW, usually on opposing sides, came together to scuttle the plan (JMA 1996; MHW 1995).

Japanese restrictions on corporate ownership of medical facilities purport to limit commercialism. The policy assumes doctors don't seek profit and that corporations shouldn't earn "surplus value" from physician labor. Yet, like physician dispensing of medicine, hospital ownership allows doctors to increase their income by making clinical choices that are not in their patient's interest. Examples include, depending on how hospitals are paid, keeping patients in hospitals longer than desirable, not admitting expensive patients, discharging them too early, and prescribing or failing to prescribe medicines and tests.

Physician owners of hospitals earn profit when they hire doctors as employees. Physician-owned medical corporations can also form subsidiaries, nicknamed medical service (MS) corporations, and own for-profit subsidiaries or invest in for-profit corporations. Doctors can steer patients to clinical laboratories and other facilities that they or medical corporations own. There are no published data on the activities of MS corporations; however, a 1991 survey by *Nikkei Health Care* (1991: 35), a journal for health care administrators, reports 35 percent of the hospitals had established an MS corporation or pharmacy while another 18 percent planned to establish one.

Even some doctors in public hospitals seek profit, sometimes through illegal means. In the past decade several publicly employed doctors have been prosecuted for receiving kickbacks from medical suppliers in return for influencing the purchasing decisions of public hospitals. These doctors were civil servants, prohibited from receiving kickbacks, bribes, or gifts. Kickbacks were typically paid for the purchase of lab equipment, radiology machines, or anesthesia machines (*Asahi Newspaper* 1985; *Social Insurance Daily* 1994: 5, 1991: 7; *National Health Insurance Weekly* 1996: 14). Such practices were notorious in the pacemaker industry because

their prices were unregulated. Manufacturers could pass on the cost of kickbacks in higher prices. A kickback scandal of unprecedented magnitude came to light in September 1992. Seven doctors in public hospitals and twenty-four representatives of pacemaker manufacturers were prosecuted. Among those convicted were the head of cardiology at Tokyo Metropolitan Hospital and a professor at Tokyo University Medical School.¹⁶ In response, the MHW reduced reimbursement by 2 percent for the manufacturers involved.¹⁷

Japanese restrictions on corporate ownership of hospitals resemble the American legal doctrine prohibiting the corporate practice of medicine, but they are more restrictive.¹⁸ Early in the century, the AMA deemed corporate practice unethical. Doctors helped states to enact licensing laws, later used by courts to restrict corporate practice (Chase-Lubitz 1987: 468–469). The doctrine does not restrict ownership of hospital facilities. Yet its aim is similar to Japanese ownership restrictions: to keep doctors in control of medical practice. The doctrine blocked hospitals from hiring doctors as employees and integrating their finances, insurers from offering health services directly, and corporations from employing physicians to treat their employees. In the United States, most hospital-based physicians are still hired as independent contractors. They set medical standards and often have admitting privileges at several hospitals, a way to preserve their independence.

Over the past half-century, courts chipped away at the American anti-corporate practice doctrine by making exceptions and enforcing its rules laxly. At the same time, hospitals found other ways to influence doctors: through contracts and financial incentives, a trend that integrates the financial interests of hospitals and physicians, a traditional feature of

16. The pacemaker scandals were unprecedented in their impact and public attention. They are documented by the following sources: *Mainichi Newspaper*, 22 September 1992; *Yomiuri Newspaper*, 19 November 1992; *Kyodo News*, 28 January 1993; *Asahi Newspaper*, 23 February 1993; *Yomiuri Newspaper*, 8 March 1993; *Kyodo News*, 26 March 1993; *Jiji News*, 18 June 1993; *Kyodo News*, 26 July 1993; *Mainichi Newspaper*, 27 July 1993; *Social Insurance Daily*, 10 September 1993: 4693; *National Health Insurance Weekly*, 20 September 1993: 1859; *Kyodo News*, 28 February 1994; *National Health Insurance Weekly*, 28 March 1994: 1886; *Mainichi Newspaper*, 28 December 1994; *National Health Insurance Weekly*, 8 April 1996: 1992.

17. The MHW was aware of the risk of kickbacks and attempted to cap reimbursement; however, almost all pacemakers were imported from the United States and attempts to control prices led to trade conflicts. Seventeen thousand pacemakers were imported each year and the cost was \$100 million (13.3 billion yen) (MHW Medical Economics Division 1993). The Health Industry Manufacturers Association of the United States strongly opposed the price control. The U.S. trade representative threatened retaliatory measures and convinced the ministry to delay price controls until April 1992. By then kickbacks had become rampant (*Kyodo News* 1990).

18. The American legal doctrine is still on the books in many states, but it has not stopped the rise of the for-profit corporation (Starr 1982).

Japanese private hospitals. Today, the hospital sector in the United States is dominated by large not-for-profit and for-profit corporations, while Japan's private hospitals are still a cottage industry controlled by physicians in sole practice or small medical corporations owned by doctors and their families.

Aligning Hospital and Physician Incentives

In Japan, hospital, clinic, and physician payment is integrated and so are their conflicts of interest. The hospital or clinic bills for both institution and physician, and receives a per-diem flat hospital fee for room, board, and nursing as well as professional fees for surgery, medicines, and tests. Integrated billing aligns the interests of hospitals and doctors and intensifies the pressure for increased services, or the pressure for reduced services when paid a per-diem or fixed fee.

Aligning interests occurs most easily in hospitals in the private sector, particularly those owned by one or two doctors where hospital revenue is tantamount to the owner's income. It also occurs where private hospitals employ doctors. Hospital owners and managers use salaries and bonuses to reward employed physicians who help meet hospital financial goals. Although not yet widespread, a growing practice is for physicians to negotiate their salary to reflect the revenue they generate. A 1992 survey by *Nikkei Health Care* (1992: 59) indicated that nearly 8 percent of hospitals linked salary to utilization and 41 percent said they might do so. Hospital owners also decide whether they will continue to employ physicians, a powerful incentive for doctors to conform to norms. Mobility is high for Japanese physicians and the *Nikkei* survey found that 65 percent of doctors had an annual contract (*Nikkei Health Care* 1992). Doctors employed in the public sector are paid a monthly salary and receive no incentive bonuses.

Organizational norms and controls also encourage doctors to further the financial interests of the employer. Both private and public hospitals give doctors information on their financial performance in comparison to that of their colleagues. They note prescribing and utilization rates expecting that physicians will want to perform well. The impact of such information is probably greater in Japan than in the United States because more Japanese doctors are salaried employees of hospitals and clinics. Moreover, there is greater pressure in Japan to fit into groups and follow organizational norms (Nakane 1970).

In the United States, hospitals and attending physicians receive sepa-

rate payment and the incentives often differ. Since 1983, Medicare has paid hospitals a fixed amount per patient based on their diagnosis, creating incentives for hospitals to use services frugally. Doctors, on the other hand, are paid fee-for-service, which is an incentive to increase services. Division in roles, Mark Schlesinger (1997) suggests, creates the potential for countervailing “agency.” Doctors can be agents for patients, while hospitals, MCOs, or purchasers can be agents for society and limit spending. Countervailing incentives help cope with conflicts of interest arising from physician payment.

American providers in recent years have tried to overcome the divergence among physician, hospital, and MCOs. Many hospitals form joint ventures with physicians or allow doctors to become limited-partner investors in facilities that operate outpatient surgery, diagnostic testing, imaging, or other services. One private hospital chain in the United States, Columbia-HCA, grew rapidly when it sold limited partnerships in its hospitals to physicians. Some hospitals have created physician-hospital organizations that share financial risk. Many MCOs share financial risk with physician groups and hospitals. Such approaches link the incentives of doctors and institutions and integrate hospital and physician payment. In so doing, they create conflicts of interest similar to those in Japan.

Incentives to Increase and Decrease Services in Hospitals

In 1993, hospital stays in Japan were about three times longer than in the United States for similar diagnoses.¹⁹ The average length of stay was 29.6 days for general acute care admissions and even longer for geriatric and psychiatric care (MHW, Statistics and Information Bureau 1993: 727; Ikegami 1991).²⁰ To discourage prolonged hospital stays, the MHW uses a sliding pay scale. The per-diem hospital fee progressively decreases

19. For example, the average length of stay with the diagnosis of appendicitis in Japan is 9.8 days (MHW Statistics and Information Bureau 1993: 674), while the median length of stay in the United States with the same diagnosis (diagnosis related group code 167: Appendectomy without complicated principal diagnosis, age less than seventy without complication and/or comorbidity) is 3 days (U.S. Agency for Health Care Policy and Research 1990: 19).

20. The average length of stay of patients is longer in Japan for a variety of reasons. Hospitals include facilities with twenty or more beds, some of which perform functions similar to U.S. nursing homes. Still, length of stay is longer even for acute care hospitals. The average length of stay for different kinds of hospitals is as follows: overall hospital beds 43.4 days; acute care beds 29.2 days; psychiatric beds 436.2 days; geriatric hospital beds 217.9 days; long-term care hospital beds 199.8 days (Patient survey conducted by MHW Bureau of Statistics and Information, 1996).

from the initial \$47.30²¹ for the first two weeks to \$9.30²² for stays beyond six months (MHW 1998a).²³

To maximize revenue, some hospitals engage in a practice informally called "playing catch with patients." When the daily per diem is low, the hospital discharges the patient who is then admitted at the highest reimbursement rate to a cooperating hospital that will return the favor. Medically unjustifiable, the practice was publicized in a Japanese television documentary on how a distressed hospital became profitable (*How a Broken Hospital Is Revived* 1993). The new manager's first step was to negotiate agreements with nearby hospitals to swap geriatric patients. The MHW lacks authority to stop the practice; however, in 1998 it disallowed resetting the sliding-fee scale when patients are transferred between financially related hospitals (MHW 1998b).

Japanese policy makers have recognized that fee-for-service payment led to excessive use of services, especially overmedication. Fee-for-service payment is still the mainstay; however, in 1997 the MHW started a pilot program in ten hospitals to test prospective payment using a form of diagnosis related groups (DRGs) (Umeda 1998). Such incentives may result in undertreatment, and as Japan develops its more inclusive payment system, this may become a more serious problem than in the United States. The reasons are that Japan has an underdeveloped system for monitoring quality (Powel and Anesaki 1990; Ikegami 1988: 242; Leflar 1996: 9–10), that its consumer and patients' right movements are weaker, and that it is harder there to sue for medical malpractice (Leflar 1993: 744–751; Feldman 2000; Tejima 1993).

An inkling of potential problems is revealed by the payments for geriatric hospitals and dialysis patients. As of 1990, geriatric and chronic care hospitals can choose either fee-for-service payment or a per diem that covers most services, including nursing, laboratory, medicine, and injections. The per-diem fee increases with the number of nurses. Rehabilitation services are reimbursed using fee-for-service to encourage their use (Takagi 1992b). Medical management is billed separately. Hospitals with patients that did not need intensive resources quickly switched to per-diem payment. Later, other hospitals found that if they reduced the volume of ser-

21. 6,150 yen.

22. 1,210 yen.

23. The sliding scale applies to general acute care hospitals with average length of stay less than twenty-eight days. Different scales are applied to other kinds of hospitals. The scaled per-diem fee applies only to daily medical management provided by hospitals and the other hospital fee for room and board; nursing cost will continue to be paid the same amount all through the course of hospitalization.

vices, then per-diem payment was more profitable than fee-for-service. As of 1 July 1997, 89.2 percent of geriatric beds were paid by per diem (Nakano and Ohama 1998). Fee-for-service is being phased out this year with the implementation of the new long-term care insurance policy.

A survey conducted by MHW on eighty-six hospitals that switched from fee-for-service to per-diem payment revealed declines in expenditures for medication (34.2 percent), laboratory exams (42.7 percent), and injection of drugs (49.2 percent). Hospital profit increased by 62.4 percent. The survey also revealed increased personal services, such as nursing and body care, which were still reimbursed by fee-for-service (MHW 1991). Another study showed increased patient satisfaction and improved performance in activities of daily living (Takagi 1992a). Detecting under-treatment is hard because when paid by per diem, hospitals do not itemize the services they provide. Some observers believe that hospitals may not admit patients that require intensive use of services since per-diem payments are not adjusted for severity of illness (Ikegami 1999b).²⁴

Japan has 30 percent of the dialysis patients in all Organization for Economic Cooperation and Development (OECD) nations, 125 for every 100,000, compared with 100 for every 100,000 in the United States and more than twice the mean for OECD nations (Yamagami and Seoka 1995; OECD 1994). The large number is due in part to few kidney donors, which limits transplants as an alternative (Feldman 1994; Ohi et al. 1986). Dialysis is also very lucrative. Seiji Yamagami suggests that physicians induce demand for dialysis, and a study by Michio Kodaka found that in 1988 at least 10 percent of dialysis patients were started prematurely (Yamagami and Seoka 1995; *Asahi Newspaper* 1990). High income from dialysis encourages kickbacks for referrals. A recent prosecution revealed that a director of urology at a public hospital received about \$2,300 per referral.²⁵ The hospital administrator stated that the kickback could be paid off from the revenue a patient generated in one month (*Mainichi Newspaper* 1995).

Following a report by the Government Auditing Office (1993: 76) that found numerous cases of overbilling in FY1993, the MHW bundled drug payments and medical management fees for dialysis patients.²⁶ Bundled

24. This may change. Under the new long-term care insurance program that will start in 2000, per-diem payments for geriatric care will be based on five levels of severity of need.

25. 300,000 yen.

26. The audit revealed thirty-nine dialysis centers had improperly charged \$3 million (344 million yen) by inflating the amount or price of pharmaceuticals for dialysis or surcharging the meals provided to patients.

payments give dialysis centers an incentive to reduce their resource use. The incentive worked, perhaps too well. A survey revealed that 12.8 percent of patients noted that alcohol was substituted for iodine as a disinfectant and that the average amount of irrigation fluid used was 490 milliliters per minute, while clinical guidelines called for 600 (*Yomiuri Newspaper* 1994). Heparin (a less expensive brand) was substituted for Flagmin as an anticoagulant, and medical personnel also changed gloves less frequently (Kozeki 1995).

Bundled costs can reduce resources used without problems, but it can sometimes lead to poor quality. As in the United States, documenting underservice is more difficult than documenting overuse, and the problem is more recent. However, one example may illustrate the problem. In September 1994, five dialysis patients treated in a Tokyo clinic contracted hepatitis B and four died. An investigation concluded that contaminated needles were the most likely infection source (*Kyodo News* 1995). One cannot show a direct link between bundled payment and the infections; however, the cost cutting may have increased the risk. One American study suggests that such bundled payments for dialysis reduce quality of care (Barnett, Beard, and Kaserman 1993).

Summary

What is notable to American observers about Japanese physicians is that they merge roles and simultaneously recommend, provide, and own hospitals, clinics, kidney dialysis units, as well as dispense drugs. Performing these potentially conflicting roles creates tension between earning income from selling services or medicine and providing diagnoses, advice, and prescriptions. When clinicians are owners and entrepreneurs, they have financial incentives that compromise their independent clinical judgment and advice. Merging the role of clinician and owner is the main reason why Japan uses more pharmaceutical products, has longer hospital stays, and uses kidney dialysis more frequently than the United States. The MHW has addressed the cost aspect of this problem through strict price controls, but that does not address the inappropriate use of services; indeed, it probably exacerbates this aspect.

Physicians' conflicts of interest prove resistant to quick fixes in both Japan and the United States. Both countries initially substituted incentives to increase service with incentives to reduce them, creating new conflicts in the process. Like the proverbial balloon, which when squeezed on one side bulges at the opposite end, remedies to one kind of conflict

can often shift the problem elsewhere. Are old physicians' conflicts being jettisoned only to create new ones? The Japanese experience offers more positive lessons.

When incentives can't be calibrated to avoid creating physicians' conflicts, they can be made less of a problem by balancing them against contrary incentives. If one combines incentives to provide and to withhold services, together they form a more balanced incentive structure. When financial incentives are moderated in this way and combined with institutional checks, we are likely to cope better with the distortions caused by physicians' conflicts.

Financial incentives to provide or to reduce services can be countered with contrary incentives either for the same clinicians or by creating different incentives for health care institutions or other health care providers. Similarly, if physician incentives create a risk of inappropriate conduct, the power of physicians to make clinical decisions can be counterbalanced by other parties, or by clinical oversight by parties with different incentives. For example, independent pharmacies check physician incentives to dispense. Independent physicians counter hospitals that want to use or reduce services. Utilization review oversees physician behavior, and managed care counterbalances incentives to provide more services. Such administrative counterweights to financial conflicts do not work as well as they might, often because the counterweight is too small, but the merits of checks and balances are often overlooked: they constitute a way of coping with physicians' conflicts that can be strengthened.

Japan traditionally has much weaker countervailing incentives than the United States. Hospital and physician payment is merged and so are their financial interests. In addition, Japan has weaker controls on physician discretion than in the United States. There is very little peer review and utilization review has few teeth. Systems for monitoring quality are less developed in Japan than in the United States. There are no equivalents of the organizational and institutional controls that MCOs use to counter the incentives of physicians to increase services. The health care consumer movement is also weaker in Japan than in the United States.²⁷ Therefore, incentives for Japanese physicians to provide or reduce services probably have a greater impact than similar incentives in the United

27. Recent media attention to quality control and malpractice lawsuits might provide an informal check on doctors and hospitals (Leflar 1996: 8, 85–96). However, given the limitations of malpractice lawsuits as a means to promote quality it would be unwise to rely heavily on this (Weiler 1991; Weiler et al. 1993).

States. This contrast shows one of the strengths of the U.S. health care system that should be developed: countervailing power.

Though the United States and Japanese health care systems are organized and financed very differently, surprisingly there is an emerging convergence. Japan recently combined incentives to increase and decrease services and in so doing moved closer to the U.S. system with its stronger countervailing incentives. The United States is now integrating institutional and physician payment and aligned provider incentives, which is traditional in Japan. On the other hand, Japan, which traditionally aligned incentives of doctors and other providers, now moderates physicians' incentives for long-term care. In geriatric care, the MHW simultaneously utilizes a combination of fee-for-service for rehabilitative care to encourage their use and per-diem charges for medications to counter their overuse. This is a complex and sophisticated way of countering perverse incentives. It resembles a U.S. proposal to pay hospitals a combination of a prospective payment and a fee-for-service (Ellis and McGuire 1986) and experiments that a few MCOs have tried in combining incentives to decrease services with incentives to increase quality (Schlackman 1989; Beloff 1991).²⁸ Japan has also promoted the creation of independent pharmacies and attempted to separate prescribing from dispensing (with only limited success), a move that brings it closer to the traditional U.S. health model.

With increasing frequency, U.S. physicians play conflicting roles as advisors, providers, and owner-entrepreneurs. American physicians rarely own hospitals, clinics, and other freestanding facilities entirely on their own, as many Japanese physicians do. Yet in the past twenty-five years they have purchased ownership interests in medical facilities to which they can refer their patients, including hospitals, freestanding clinical laboratories, diagnostic and imaging centers, and lithotrophy and outpatient surgical centers. This change creates new conflicts arising from physician ownership that resemble long-standing Japanese physicians' conflicts.

The growth of American physician ownership has been partly limited by Medicare regulation, state legislation restricting referrals to such facilities, and by the spread of managed care (which reduces incentives to increase services). However, managed care, too, has spurred a new kind of physician entrepreneurialism. Physicians are now becoming financial partners with MCOs and assume much of the financial risk for provid-

28. In these two cases, however, the incentives for quality appear to be much weaker than incentives to decrease services.

ing services, receiving in turn a proportionate share of the earnings or losses. This change makes physicians insurers as well as cost-control agents with a stake in the profits—roles which conflict with being providers and advisors. It replicates the incentives of Japan, which has long integrated payment and incentives of physicians and hospitals.

Still, major differences in Japanese and American conflicts remain. Japan has fewer mixed incentives and countervailing powers than the United States does. The MHW has a mission of containing health care costs and regulatory powers that gives it significant controls over provider payments in both the public and private sector, powers much stronger than either the U.S. government or private payers exercise. Such governmental power was the Japanese equivalent of countervailing power to providers in an era when providers almost always benefited by offering more services. It succeeded in limiting per-capita health care spending.

However, as the Japanese health insurance program has sought to manage spending in geriatric care, it has introduced bundled payments, per-diem charges, and prospective payment using a variation of DRGs. The incentives of National Health Insurance (NHI) and providers became closely aligned, just as is the case with American MCOs and physicians. Now many providers as well as the government have incentives to cut costs. In this context, there is greater need for patients to have some independent party represent their interest in having more services, yet there is no party to perform this task.

U.S. pluralism encourages the approach of mixed incentives and powers. Compared with Japan, this is a strength of the U.S. health care system in addressing physicians' conflicts. For example, state legislatures have adopted some sort of legislation in every state to address at least the symptoms of incentives to decrease services (see Peterson 1999; Tapay, Feder, and Dallek 1998; Dallek, Jimenez, and Schwartz 1995; Pollitz, Dallek, and Tapay 1998). Both the Senate and House of Representatives have passed bills regulating managed care as well (Senate Bill S. 1344, passed 15 July 1999; House Bill H.R. 2723, passed 7 October 1999). Some managed care legislative provisions establish specific rules on what kind of medical care to provide. The more interesting ones, however, develop institutions of countervailing power. These include independent review of decisions not to treat, the right to appeal grievances to neutral parties outside MCOs, and the right to sue. Another step in this direction is to create ombuds programs, independent authorities to set standards for medical practice, and institutions to represent consumer

interests within and external to MCOs (Rodwin 1996, 1997, 1998, 1999, in press).²⁹

Concluding Observations

Americans are pro-business, pro-entrepreneur and favor minimal government regulation of the private sector—except when they want the opposite. Having rejected major health care reform during the first Clinton administration, public policy was *laissez-faire* and promoted the growth of for-profit health care and MCOs. The result: a public backlash and both state and federal regulation of managed care during Clinton's second term (Rodwin 1999). The conventional wisdom now is that for-profit health care providers, particularly MCOs, are the source of many of our problems, particularly physicians' conflicts of interest. There is a yearning for greater physician control over health care to address our problems.

Yet looking at Japan suggests that for-profit investor-owned firms are not the only source of physicians' conflicts, nor is physician ownership or control likely to be a solution. Physicians' conflicts exist in Japan in the absence of for-profit, investor-owned firms that pay dividends. Indeed, physicians' conflicts are present when physicians control the means of production directly, by owning a majority of hospitals. This should come as no surprise. American physicians had similar conflicts early in the twentieth century, when the corporate practice of medicine did not exist in the United States as it does today (Rodwin 1992; Robinson 1999). Likewise, Japanese health policy shows that MCOs are not the underlying source of incentives to reduce services; rather, it is the payer's wish to control spending. The Japanese MHW has created incentives to control health care spending for a simple reason: the MHW directs cost control for the national health insurance system. In the United States, however, cost control is largely delegated to MCOs.

We ought to be skeptical about promoting physician ownership or autonomy as a solution to the real conflicts now present in managed care. We need to recall that MCOs provide useful countervailing power to physician dominance and can promote physician accountability. Furthermore, if profits are merely shifted from for-profit organizations to physicians, we can expect that conflicts of interest may be displaced, rather

29. Japan's new long-term care insurance, which takes effect in 2000, will incorporate an official ombuds system. For an English language Web site on long-term care in Japan, see <http://caremanager.net>.

than eliminated. Having created MCOs to promote physician accountability, we now need federal health policy to promote MCO accountability (Rodwin 1999). Yet, we need to reflect carefully on what kinds of measures are likely to improve the situation.

There is irony in the changes under way in Japan and the United States. Japan, consciously adopting tools and emulating approaches from the United States, is now creating a significant innovation: targeting underprovided yet desirable services with fee-for-service payment while at the same time using per-capita and per-diem payment for services that are overused. The United States, in the meantime, while forging managed care innovations (physician risk-sharing with MCOs), has inadvertently come up with a long-standing Japanese approach: financial integration of institutional and physician payment. In the process the United States is reducing one of the main strengths it had in addressing physicians' conflicts: institutions of countervailing power and countervailing incentives.

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