Public Interest vs. Individual Rights
- Lessons from Experiences of the Swine Flu Panic in Japan -

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Overview of
All Japan Hospital Association

Hirotoshi Nishizawa
Our Mission and Our Members

- Our Mission: The All Japan Hospital Association (AJHA) is dedicated to improve the quality of hospital management and the health and welfare of the society by offering high quality, effective and valuable healthcare service.
- The number of member hospitals: 2,290 (26% of all hospitals in Japan)
- 99% of member hospitals: private hospitals (The largest private hospitals association)
- Decreasing of total number of hospitals, increasing of member hospitals of AJHA

Although the total number of hospitals has been decreasing, our members are increasing steadily.
List of Committees

• General Affairs
• Finance
• Regulations
• Future Planning
• Public Relations
• Future of Hospitals
• Healthcare Providing System and Taxation
• Health Insurance and Reimbursement
• Healthcare Improvement
• Long-term Care
• Human Resources
• Patient Safety
• Hospital Accreditation
• Art and Science
• International Exchange
• Physical Checkup
• Personal Information Protection
• Emergency Medicine and Disaster Damage Prevention
• Examination and Accreditation of Medical Administrators

Major Activities
1) Emphasizing on survey and research
2) Offering education programs
3) Proposing health policy
4) Receiving several research grants
5) Joining several committees hosted by Ministry of health, Labour and Welfare
6) Publishing “AJHA News”
7) Publishing reports on the activities and study results
Public Interest vs. Individual Rights
- Lessons from Experiences of the Swine Flu Panic in Japan –

Tomonori Hasegawa
Road Map

• 1. Swine Flu Panic
  – Swine Flu H1N1
  – Declaration of pandemic by WHO
  – Governmental Reactions
  – Experience of Swine Flu panic

• 2. Japanese Healthcare System
  – Low Mortality
  – Good access to Healthcare Facilities
  – Efficient Use of Healthcare Resources

• 3. Challenges
  – Sustainability
  – Lessons
Swine Flu Panic
Swine flu H1N1

- FAQs of Influenza A H1N1 from Ministry of Health, Labor and Welfare (MHLW)
  - Different antigen from seasonal influenza
  - No immunity among general public
  - Possibility of pandemic
  - Symptom; cough, running nose, a sudden high fever, fatigue, headache, muscle ache, etc
  - Main treatment; Tamiflu, Relenza.
  - High risk group; underlying diseases, infants, pregnant, elderly people
# Pandemic Phase by WHO

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>No influenza virus circulating among animals have been reported to cause infection in humans</td>
</tr>
<tr>
<td>Phase 2</td>
<td>An animal virus circulating in domesticated or wild animals is known to have caused infections in humans and is therefore considered a specific potential pandemic threat</td>
</tr>
<tr>
<td>Phase 3</td>
<td>An animal or human–animal influenza reassortant virus has caused sporadic causes or small cluster of disease in people, but has not resulted in human–to–human transmission sufficient to sustain community–revel outbreaks</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Human–to–human transmission of an animal or human–animal influenza reassortant virus able to sustain community–revel outbreaks has been verified</td>
</tr>
<tr>
<td>Phase 5</td>
<td>The same identified virus has caused sustained community–revel outbreaks in two or more countries in one WHO region</td>
</tr>
<tr>
<td>Phase 6</td>
<td>In addition to the criteria defined in Phase 5, the same virus has caused sustained community–revel outbreaks in at least one other country in another WHO region</td>
</tr>
<tr>
<td>Post Peak Period</td>
<td>Levels of pandemic influenza in most countries with adequate surveillance have dropped below peak levels</td>
</tr>
<tr>
<td>Post Pandemic Period</td>
<td>Levels of influenza activity have returned to the levels seen for seasonal influenza in most countries with adequate surveillance</td>
</tr>
</tbody>
</table>
Declaration of pandemic by WHO

Swine Influenza
- Appropriateness of the current phase 3-
  Statement to the press, 25 April 2009

In response to cases of swine influenza A(H1N1), reported in Mexico and the USA,

World now at the start of 2009 influenza pandemic
- Raising the level of influenza pandemic alert from phase 5 to 6-
  Statement to the press, 11 June 2009

“Worldwide, the number of deaths is small.”

“Globally, we have good reason to believe that this pandemic, at least in its early days, will be of moderate severity.”

“We know that the novel H1N1 virus preferentially infects younger people. • • • • the majority of cases have occurred in people under the age of 25 years.”

“Countries with no or only a few cases should remain vigilant.”

Margaret Chan,
WHO Director-General
Infectious Diseases Law of Japan

• **Purpose**
  – Preventing outbreak and prevalence of infectious diseases to improve and promote public health

• **Categorization based on Severity and Public Threat**

• **Revision of the law (May, 2008)**
  – New Category for Novel type Influenza similar to Category 1 (very dangerous)
  – Report to Prefectural Governor
  – Hospitalization (mandatory)

• **Again, novel Influenza was assumed to be highly toxic**

Having supposed coming of Influenza A(H5N1), the government revised the law as above.
Guidelines for Swine Flu

• Estimation
  – 25% of population will be infected
  – Fatality rate from 0.53 (Asian flu) to 2.0% (Spain flu)
  – Death Toll from 170 thousand to 640 thousand

• Phase of outbreak
  – Antiviral drugs for precaution
  – Closedown of schools and self-restraint of assemblies

• Phase of pandemic
  – Distribution of stockpiled antiviral drugs
  – Maintaining social infrastructures
  – Vaccination
Responses by the Government and Mass Media

- Frequent appearance of minister of MHLW on mass media to mention “Never be in panic!”
- No stable policies
- Broadcasting pictures of “coastal operations” at the airport almost everyday
- Dramatic increase of articles of swine flu among 5 major newspapers after the first patient detected on May 9th
- Bashing on the patients with swine flu and treating as criminals
Citizens in Panic

• Rushing into drug stores to purchase flu masks whose scientific evidence of preventing flu has not been clarified
• Surging crowd to clinics and hospitals to demand not only check-up but vaccine and antivirals
• Condemning a school by many citizens over the telephone whose students caught in swine flu and setting press conference of apology by the principal
The Situation of Swine Flu

- Seasonal flu from January to February
- Remarkable prevalence of swine flu from August to December

Pandemic influenza A (H1N1) situation report of Japan (December 25, 2009)

Infectious Disease Surveillance Centers
Responses by Healthcare Facilities

- Setting up “outpatients department for patients with fever” to isolate influenza like illness (ILI)
- Counseling over telephone
- Stockpiling plenty of surgical masks and spirit
- Vaccination according to priority specified by MHLW
- Prescribing Tamiflu or Relenza
Request from Hospital Associations

• Compensation for loss of beds without inpatients by preparing for infectious disease beds only for swine flu patients
• Subsidies to prepare for PPE, easy check kits, tents, tamiflu, respirators and so on
• Compensation to revise hospital structures in order to accommodate swine flu patients
Patient Distribution and Use of Antiviral Drugs

MHLW, Changes in Number of Estimated Patients and Antiviral Drugs, Inpatients Surveillance of Swine Flu, March 21st 2010

Tamiflu (capsule)  Tamiflu (dry syrup)  Rilenza  # of patients (estimated)

MHLW, Changes in Number of Estimated Patients and Antiviral Drugs, Inpatients Surveillance of Swine Flu, March 21st 2010
Do Japanese people love Tamiflu?

- 77% of Tamiflu in the world was used in Japan in 2005
- Stockpile of Tamiflu adequate to treat about 34 million people (25% of total population) in 2010, according to MHLW

Hoffmann-La Roche INC, Pediatric Advisory Committee Executive Summary for Tamiflu, Nov 11 2005
### Extremely Low Mortality in Japan

Table 1: Selected severity characteristics of pandemic influenza A (H1N1) 2009 virus infections, data as of 6 November 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>% of hospitalized cases with no co-morbidity</th>
<th>% of hospitalized cases who are pregnant</th>
<th>% of hospitalized cases who are female or female hospitalised</th>
<th>Cumulative number of hospitalisations</th>
<th>Incidence of hospitalisation (per 100 000 population)</th>
<th>Incidente de l’hospitalisation (pour 100 000 habitants)</th>
<th>Median age of hospitalized cases (years)</th>
<th>Rate of ICU admission or hospitalization</th>
<th>Number of deaths - Number of deaths (deaths per million population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>38</td>
<td>5</td>
<td>1 999</td>
<td>5.8</td>
<td>24</td>
<td>0.20</td>
<td>95</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Japan</td>
<td>63</td>
<td>0.3</td>
<td>3 746</td>
<td>2.9</td>
<td>8</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>43</td>
<td>7.5</td>
<td>–</td>
<td>–</td>
<td>15-24</td>
<td>–</td>
<td>135</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Mexico</td>
<td>–</td>
<td>–</td>
<td>10 337</td>
<td>9.3</td>
<td>–</td>
<td>–</td>
<td>328</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>27</td>
<td>7</td>
<td>9 079</td>
<td>3.0</td>
<td>21</td>
<td>0.25</td>
<td>1 004</td>
<td>3.3</td>
<td></td>
</tr>
</tbody>
</table>


**Lowest Mortality Rate**

WHO, Weekly Epidemiological Record, 13 November 2009
What Can We Learn from Our Experience of Swine Flu Panic?

• No leadership
  – No leader is a good news?

• Panic
  – Easy to heat-up and easy to cool-down

• Good access

• Dependence on Tamiflu
  – Healthy patients with uncomplicated illness need not be treated with antivirals (WHO guideline)

• Low mortality
  – 200 deaths / 20 million patients
Healthcare System in Japan

• Access
  – Universal coverage
  – Low co-payment rate (30%) and ceiling of out of pocket money
  – No gate-keeping system

• Efficiency
  – Lack of differentiation of healthcare organization
  – Too many HCOs with low patient volume

• Empowerment
  – Patient participation has just began

• Integration
  – Low, small sized/ owner-driven hospitals

• Quality
  – Seemingly high, but lack of data to demonstrate high quality

• Low Cost
  – Although the society is ageing rapidly
Coverage of Health Insurance 1897–1985

- 1897 Plan for Worker’s Insurance
- 1907 Government Worker’s Insurance
- 1927 Worker’s Insurance
- 1938 Community Insurance
- 1943 Worker’s Insurance
- 1943 Family Coverage
- 1961 Universal Coverage
- 1983 Elderly Insurance
- 2000 LTC
Japanese Healthcare System

Universal Insurance (1961-)
  - community insurance
  - workers’ insurance
  - elderly insurance (1985-)
  - LTC insurance (2000-)
  - reorganization and health plan for the elderly (2008-)

High Educational Level
  - illiterate 2-3%
  - 40% enter university

High Standard of Living
  - US$34,312 per capita GDP (2007)

Ageing population
Government Bankruptcy?

Change!!

Long Hospital Stay
Lack of Differentiation
Lack of Standardization
% of Elderly People (65y or more)

OECD, OECD Health Data 2009, 2009
# of Beneficiaries of LTC insurance (2000-)

x1000
Health Expenditure (% of GDP)

OECD, OECD Health Data 2009, 2009
Health Expenditure (% of GDP)
Who Pays Money?

Increase of co-payment in worker’s insurance and elderly insurance
Japan Government: Close to Bankruptcy?
Average Length of Stay (2006)

Data are of 2006
As for Japan, data are those of hospitals participating DPC in 2006
## Features of Hospital Beds

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>2.7</td>
<td>NA</td>
<td>NA</td>
<td>4.2</td>
<td>7.3</td>
</tr>
<tr>
<td>France</td>
<td>3.7</td>
<td>5.7</td>
<td>0.65</td>
<td>1.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Germany</td>
<td>5.7</td>
<td>9.2</td>
<td>0.62</td>
<td>2.0</td>
<td>7.9</td>
</tr>
<tr>
<td>Italy</td>
<td>3.3</td>
<td>3.2</td>
<td>1.0</td>
<td>3.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Japan</td>
<td>8.2</td>
<td>2.3</td>
<td>3.6</td>
<td>1.0</td>
<td>19.2</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>2.8</td>
<td>2.9</td>
<td>0.96</td>
<td>6.5</td>
<td>7.5</td>
</tr>
<tr>
<td>United States</td>
<td>2.7</td>
<td>5.3</td>
<td>0.51</td>
<td>5.0</td>
<td>5.6</td>
</tr>
</tbody>
</table>
Health Sector Reform (2001-)

• Direction
  – Accountability and Transparency
  – Quality and Safety issues
  – Deregulation and a market-oriented approach

• Payment schedule
• Reorganization of Insurance Bodies
• Privatization of National Hospitals and National Universities
• Decrease of Hospital Beds
• New Regional Health Plan
• IT introduction
Conclusions

• Success story
  – Good efficiency and equity (WHR2000)
  – Universal coverage (1961-)
• Health sector reform
  – Market-oriented mechanism
  – Competition
  – IT
• Long lead time and political instability
• Challenges
  – Consensus on cost and service level leading to financial problems
  – Decreased function as safety net
  – Threat to Solidarity
Thank you for your attention