Women's Health Project

Expert Meeting

The Ideal System for Perinatal Medical Care in Japan in the Era of Declining Birth Rates

Discussion Points

July 17, 2024

Health and Global Policy Institute

HGPI Health and Global Policy Institute

Discussion point 1

Various factors will make it difficult to maintain Japan's system for providing safe and secure perinatal care with the existing perinatal care system. These factors include fewer births; shortages in and aging among physicians who are responsible for delivery, especially in rural areas; the rising cost of childbirth due to rising prices for goods and higher personnel expenses; and work style reform for physicians. We must consider every possible option, including increasing the existing lump-sum childbirth and child-rearing allowance and granting insurance coverage to childbirth.

Perinatal care in Japan is based on the division of functions and close coordination among primary, secondary, and tertiary health institutions. Primary health institutions are mainly obstetrics clinics, which are responsible for normal deliveries and other low-risk deliveries. Secondary institutions include regional perinatal medical centers or general hospitals, and handle intermediate-risk deliveries. General perinatal medical centers are tertiary health institutions and handle all high-risk pregnancies and deliveries. Looking at the nationwide distribution of deliveries among these facilities, we see that that deliveries in Japan are performed using a small-scale, decentralized healthcare provision system, with 47% of deliveries being performed at obstetrics clinics; 26% at general hospitals; 17% at regional perinatal medical centers; and 10% at general perinatal medical centers. While the number of OB-GYNs has been trending slightly upwards, a number of factors have led to a shortage in physicians providing perinatal care, which is a field where care must be available 24 hours per day. These factors include a shortage in physicians who can handle deliveries, the uneven geographical distribution of physicians, aging among physicians, and work style reform for physicians. On top of this, the perinatal care provision system faces severe financial circumstances due to factors like a decrease in the number of deliveries and rising childbirth costs due to soaring prices, and the number of clinics and hospitals handling deliveries is decreasing every year. This has pushed the perinatal care provision system to its limits, especially in rural areas.

While discussions are advancing on granting insurance coverage to childbirth, such talks tend to be limited to the pros and cons of doing so. (Strictly speaking, financial resources for the lump-sum allowance for childbirth and child-rearing are also provided by the health insurance system, but in the context of such discussions, "granting insurance coverage" refers to changing from cash benefits for childbirth to benefits in kind. For the sake of brevity, we will refer to this change to benefits in kind as "granting insurance coverage" or with similar terminology.) As such, in addition to innovation from a financial perspective, the existing perinatal care provision system also requires innovation to address the various difficulties it faces. The Basic Policy for Economic and Fiscal Management and Reform 2024 mentions "Secure perinatal care that enables safe deliveries in communities," and this topic will require broad consideration to ensure Japan can continue to have a world-class perinatal care system that is safe and secure.

Discussion point 2

Two goals related to financial resources for childbirth must be met: the financial burdens placed on expectant mothers and their families must be reduced; and health institutions providing perinatal care in communities must be able to operate in a sustainable manner. Achieving these two goals will require considering a broad financial support system that combines three financial resources: health insurance, public funds, and out-of-pocket payments.

Even if the annual number of births decreases, health institutions can count on births occurring at any time of day, around the clock. This means that health institutions that handle deliveries—even small-scale institutions—must establish systems that can ensure the necessary personnel are available 24 hours per day. On top of this, even for normal deliveries, there is a great degree of individual variance in labor times, from a few hours to several days. During that time, the mother and child must be monitored continuously by personnel like physicians, midwives, and nurses. For those who opt for painless delivery, a physician to handle anesthesia must also be present, so even more medical resources become necessary. This means it is important for health institutions to secure enough human resources and sufficient equipment to guarantee safe deliveries, which require financial resources. Granting insurance coverage to childbirth will, of course, help to prevent obstetric care institutions from facing further difficulties, but we must keep in mind that they already face financial difficulties under the current system. While a number of options are available, including maintaining or expanding the current system, or granting insurance coverage to childbirth, it will be necessary to seek methods of securing financial resources in a manner that is based on consensus among relevant parties who serve in real-world care settings.

After doing so, if efforts to see insurance coverage granted to childbirth gain momentum, we must strike a balance between reducing the financial burden on expectant mothers and their families and ensuring sustainability for perinatal care systems in communities. To do so, we should consider establishing a multilayered financial support system that takes into account safety-related costs in addition to healthcare-related costs; that combines health insurance, public funds, and out-of-pocket payments; and that allows people to choose treatments that are not covered by insurance or mixed treatments, which combine both insured and uninsured health services.

Specifically, in the first layer, basic medical services directly related to childbirth would be covered by health insurance and a legal revision would be introduced to establish a new framework in which expectant mothers would have no out-of-pocket expenses. This would significantly reduce the financial burden for expectant mothers. In the second layer, the features of each facility such as those with more substantial healthcare systems (e.g. with more personnel on staff) would, to a certain extent, be covered by health insurance. This coverage would be combined with subsidies from local governments to minimize the financial burden for expectant mothers who require additional services. Health institutions would have the flexibility to set prices within a certain range to help stabilize business and to support efforts to secure the necessary human resources. In the third layer, services that are not directly related to healthcare (e.g. aroma care, celebratory meals) would be treated as medical services not covered by insurance and could be provided as mixed health services limited to the area of obstetrics. This would meet patients' needs and help them feel encouraged to have more children. Using a multi-layered structure like this can help secure basic maternity care, ensure sustainability for health institutions, and create a flexible system that can meet the needs of individuals. However, to avoid sudden changes, it must be implemented in phases and while making adjustments. As mentioned above, for the first layer, it will also be necessary to reach a consensus among related parties as to what constitutes a "standard birth," as childbirth varies greatly among individuals. Expectations are also high for consideration to be given to the separation of benefits for prenatal and postnatal care (e.g. mental health care, preconception care, breast care) and education (e.g. parenting classes, maternity classes).

Discussion point 3

Nighttime deliveries account for about half of all deliveries. In the current system, the frequency of nighttime deliveries makes it extremely difficult to reduce the number of obstetricians on duty for deliveries while ensuring deliveries stay safe and secure. Given this unique characteristic of obstetrics, we must reconsider how to achieve the standards for overtime hours described in work style reforms for physicians.

Efforts to reform work styles for physicians began in April 2024. As mentioned in Discussion Point 2, securing human resources will be a vital part of ensuring safe perinatal care, and OB-GYNs at tertiary health institutions are no exception. Such personnel fall under Category A, which has an annual overtime cap of 960 hours, just like the general workforce. In response to this regulation, rigorous efforts made in real-world care settings have led to a reduction in annual hours worked from approximately 2,100 hours in 2019 to 1,750 hours in 2023. If hours worked continue to decrease at the current pace, it will be possible to meet the criteria for Category A by 2035. However, nighttime deliveries account for about half of all deliveries, and nighttime hours currently account for around 1,500 to 1,600 hours of the annual total. Given these circumstances, it will be difficult to strike a balance between maintaining the healthcare provision system and reforming work styles for physicians through efforts in health institutions alone. In the current system, health institutions must maintain the same capacity to perform deliveries during the night as during the day, making it difficult to reduce the number of shifts. In addition to duties at their own hospitals, physicians have many shifts at other hospitals in their regions, with many OB-GYNs at tertiary health institutions taking on an average of about eight shifts per month. In recent years, a system to permit physicians to work shifts requiring overnight stays has been introduced, under the conditions that they meet the general work standards for lightened or short-term duties during special circumstances, and that they are able to get enough sleep. Whether it is appropriate to treat shifts in obstetrics as overnight shifts, however, is questionable. Maintaining good personal physical and mental health for health professionals is an essential part of providing safe healthcare, and it goes without saying that their personal health must be ensured. Given the fact that there are currently no prospects for addressing the physician shortage, rather than advancing efforts to consolidate health institutions, to promote more active use of midwifery centers or midwives, or to examine systems for further collaboration from primary to tertiary health institutions, it will be more important to give thorough consideration to how to meet the criteria for overtime hours worked outlined in work style reform efforts for physicians without relying entirely on efforts in real-world care settings.

The root causes of this issue – namely, the uneven distribution of physicians geographically as well as among specialties, and the shortage of physicians, particularly in acute care institutions – is a major problem facing not only obstetrics and gynecology, but the entire medical community. While the national Government is currently advancing efforts to address the uneven geographic distribution of physicians and other measures, it will be essential to improve working conditions for physicians serving in acute care institutions, as their duties directly impact the lives of patients and expectant and nursing mothers, and place heavy burdens on physicians themselves.

Discussion point 4

As the birthrate declines, one measure being considered is the consolidation of obstetric care facilities over the medium to long term. However, consolidation places a greater burden on expectant mothers and their families the more rural the area is in which they live. As efforts to categorize health institutions by function continue to advance, careful consideration must be given to the question of how to consolidate obstetric care facilities while still maintaining the same level of care.

ETo respond to the impacts of physician shortages, work style reform for physicians, and the declining birthrate, discussions on consolidation in perinatal care are currently underway. However, any consolidation must be performed in phases and take place over the medium to long term. The eighth revision of the Medical Care Plan mentions promoting the flexible establishment of perinatal care areas and the consolidation and prioritization of health institutions and their functions, and discussions are also advancing at the national level. If multiple primary health institutions in an area close, it becomes impossible to perform deliveries in the region and causes expectant and nursing mothers to be concentrated in secondary and tertiary health institutions. This also increases working hours for physicians and forces health institutions to rush to secure more care beds and physicians. Consolidation may also make it impossible to provide sufficient care for high-risk expectant and nursing mothers. In rural areas where hospitals, clinics, and other facilities are unevenly distributed and scattered, or where there is little public transportation, consolidation may have a major impact on expectant and nursing mothers and their families by forcing them to travel long distances for care. The US is experiencing rapid consolidation of obstetric care facilities and maintains a high maternal mortality rate. From this, we can infer those efforts to consolidate do not always help create a safe system for childbirth. Discussions on consolidation should proceed with caution in order to protect Japan's safe delivery system. The basic premise of protecting this system is that childbirth is a fundamental human activity that has occurred throughout our entire history, and should be seen as an extension of everyday life. As such, when someone can no longer give birth in the familiar settings where they live, even if it is unavoidable for safety reasons, we must remain fully aware of the fact that childbirth is an extremely social and cultural act that is being separated from their everyday lives.

Discussion point 5

Pediatricians have major roles to play before and after childbirth, such as by attending deliveries or by providing perinatal visits before deliveries. Due to birthrate decline, the sustainability of the pediatric care provision system also faces the same challenges as the system for care during the perinatal period. These challenges include the difficulty of securing financial resources and a lack of aspiring entrants to the field. We must also consider how to establish systems providing seamless care from before birth to childhood.

Pediatric care has several important issues that it shares with or that overlap with obstetric care. The first issue is ensuring continuity in perinatal management. Mothers and children require consistent care starting from the prenatal period, and pediatricians work closely with obstetricians and fulfill various roles related to pregnancy and delivery, including detecting fetal anomalies and providing life-saving treatment for newborns. After 22 weeks, life-saving treatments for newborns are provided and managed by pediatricians in NICUs. Furthermore, unborn children with conditions like abnormal fetal morphology or growth restriction are not only handled by obstetricians; such cases also involve collaboration with pediatricians, pediatric surgeons, and

clinical geneticists. There are also times when pediatricians provide explanations to parents during perinatal visits. When health facilities like general clinics do not have pediatricians on staff, OB-GYNs are responsible for all care, but pediatricians play major roles before and after childbirth, such as by attending high-risk deliveries and births that require pediatric care. However, medical records before and after birth are not fully centralized, making it difficult to provide seamless healthcare. In addition, pediatricians sometimes attend deliveries or perform neonatal resuscitation and other such procedures, but such activities are currently not appropriately evaluated nor assigned sufficient medical service fee reimbursements.

Both pediatrics and obstetrics also face business-related challenges due to the declining birthrate. Just like in the field of obstetrics, it is becoming increasingly difficult to secure pediatricians, and it is questionable if the pediatric care system that supports community healthcare can be maintained. In particular, issues such as the reduction in medical examination duties for physicians in obstetrics clinics and a lack of appropriate standards for the staffing of nurses for newborns are resulting in serious problems in the pediatric care provision system, which supports perinatal care. As we can see, despite the fact that pediatric healthcare has a significant role to play throughout the perinatal period, a number of systemic issues or issues related to the declining birthrate mean that drastic initiatives must be implemented to reinforce the foundation for pediatric care, such as by strengthening collaboration with obstetrics or securing medical resources.

This Discussion Points have been prepared based on the opinions expressed at the expert meeting "The Ideal System for Perinatal Medical Care in Japan in the Era of Declining Birth Rates" held on July 17. The overview of the expert meeting is as follows:

In Japan, the number of births in 2023 was approximately 750,000, marking a continuation of record lows since data collection began. Addressing the urgent issue of halting the declining birth rate is critical. In response, the Japanese government has implemented various measures, such as increasing the "Childbirth and Childcare Lump-Sum Grant," establishing a system to transparently disclose childbirth expenses, and debates on the potential inclusion of childbirth costs in insurance coverage by 2026.
Moreover, while there are calls to reduce the burden of childbirth costs, the management environment surrounding obstetric medical institutions has become increasingly challenging due to the decline in births and rising costs. There is concern that sudden systemic changes could lead to the destabilization of the safe and secure perinatal medical care system.
At this meeting, we engaged in further enriched active discussions with experts on how to maintain a safe perinatal medical care system in the era of declining birth rates.

[Event Overview]
Date & Time: Wednesday, July 17, 2024, 16:30 – 18:10 JST
Format: In-person (on-site only)
This meeting was held under the Chatham House Rule and was not open to the public.
Venue: Otemachi Financial City Grand Cube 3rd Floor, Global Business Hub Tokyo Field
Language: Japanese
Host: Health and Global Policy Institute

[Program] (In no particular order; titles omitted. Please note that positions listed are current as of the day of the meeting.)

16:30-16:35 Opening Remarks and Explanation of Recommendations
Haruka Sakamoto (Senior Manager, Health and Global Policy Institute)

16:35-17:05 Presentations
Yoshimasa Kamei (Executive Director, Japan Society of Obstetrics and Gynecology)
Isamu Ishiwata (President, Japan Association of Obstetricians and Gynecologists)
Shigeharu Hosono (Director, Japan Society of Perinatal and Neonatal Medicine / Executive Director, Japan Pediatric Society)
Gaku Hashimoto (Member of the House of Representatives)

17:05-18:05 Roundtable Discussion
Isamu Ishiwata (President, Japan Association of Obstetricians and Gynecologists)
Yoshimasa Kamei (Executive Director, Japan Society of Obstetrics and Gynecology)
Yasuhiro Sato (Director of the Employees' Health Insurance Division, Health Insurance Bureau, Ministry of Health, Labour and Welfare)
Gaku Hashimoto (Member of the House of Representatives)
Kinya Hamaguchi (Executive Board Member, Japan Medical Association)
Shigeharu Hosono (Director, Japan Society of Perinatal and Neonatal Medicine / Executive Director, Japan Pediatric Society)
Ryuichi Ito (President, Japan Pediatric Association)
Megumu Mori (Head of the Emergency Healthcare Office, Regional Medical Care Planning Division, Health Policy Breau, Ministry of Health, Labour and Welfare)
Eri Yoshimura (Senior Manager, Health and Global Policy Institute)
Moderator:
Haruka Sakamoto (Senior Manager, Health and Global Policy Institute)

18:10 Closing

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Acknowledgement
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