HEALTHCARE DELIVERY IN CRISIS?

The potential for mutual learning between Japan and the UK

Conference Report

FRIDAY & SATURDAY, 28 FEB – 1 MAR

Nissan Institute of Japanese Studies
University of Oxford

REPORT OVERVIEW

This symposium was held on Friday 28 February and Saturday 1 March 2025 at the Nissan Institute of Japanese Studies and St Antony's College, University of Oxford, UK

Convenors: Professor Roger Goodman, Nissan Professor of Modern Japanese Studies and Warden of St Antony's College, University of Oxford; Professor Naoki Ikegami, Professor Emeritus of Health Policy and Management, Keio University; Professor Catherine Pope, Professor of Medical Sociology, Department of Primary Health Care Sciences, University of Oxford.

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SYMPOSIUM OUTLINE

'"Japan is a global leader when it comes to affordable health care — yet with a declining and aging population, the country has been dealing with a train wreck in slow motion' (Japan Times, August 2024)

'The NHS is in "serious trouble" with declining productivity, "ballooning" waits and "awful" emergency services that put patients at risk' (BBC September 2024).

The Aims of the Symposium

This two-day symposium aimed to bring together leading healthcare experts (academics, practitioners, policymakers) from Japan and the UK to interrogate existing assumptions behind the delivery of healthcare in the light of the huge changes – political, economic, demographic – which have been taking place in their respective countries; to understand how they see their systems responding to the challenges of the coming decades; and to discuss what they can learn from each other's experience.

Context

The Japanese and the UK healthcare systems have developed their own distinctive histories and characteristics:

When the NHS was established in 1948, it was based on three core principles:

1. That it would be available to all and financed entirely from taxation.
2. That it would provide a comprehensive range of healthcare services.
3. That it would be free at the point of use.

The NHS was established as a nationalised system that was centrally managed by the government to provide universal healthcare services and funded from general taxation. It is today the world's fifth largest employer (after the US Department of Defence, the Chinese People's Liberation Army, Walmart and McDonalds). It was a radical departure from the previous system, which was based on a patchwork of private and charitable healthcare providers and was widely celebrated as a landmark achievement in social welfare provision. It is characterised by primary care services (GPs) who act as a gateway to secondary care services (hospitals). The NHS has enjoyed high esteem around the world.

Japan has had a universal health insurance system since the 1960s designed to cover costs through pooled insurance contributions (supported by employers and local governments) and patient co-payments. The system is characterised by its egalitarian nature and direct access to health providers and treatments.

SYMPOSIUM OUTLINE

‘Unlike the UK, though, in the immediate postwar period, the private medical sector was encouraged (through generous tax incentives) to expand in order to reduce the need for state expenditure. Today, 70% of Japan’s 8000+ hospitals and 90% of its 100,000+ clinics are private of which combined around 80% might be defined as ‘family businesses’.

The effectiveness and efficiency of the Japanese healthcare system is well documented. Japan has among the world’s highest rates of life expectancy and lowest rates of infant mortality and workdays lost through ill health. Patients can visit any clinic or hospital without referral and without being placed on a waiting list. Compared to the OECD average, Japanese patients see doctors twice as often; doctors undertake three times as many consultations; there are five times as many MRI and CT tests; inpatient stays are three times as long. It has developed a strong system of long-term care insurance (LTCI) which enables the care of the elderly in the community. The rate of Covid-related deaths in Japan was roughly one-fifth of that of the UK. At the same time, if one controls for the age of the population, Japan spends a lower proportion of its GDP on health care than the OECD average (2022: 81% of UK spend).

The ‘crisis’ in healthcare

Japan’s population is already the world’s oldest - with around 30% aged 65 or over and one in ten people aged over 80 – and is continuing to age rapidly as its fertility rate remains well below replacement level. Older people need more healthcare and pay fewer taxes. Contributions to insurance plans and patient co-payments currently cover only 62% of total healthcare costs; the remaining 38% of the total healthcare costs are now met by government subsidies, and this is rising rapidly. The NHS has struggled hugely to respond to demand in the post-pandemic period. As of mid-2024, 7.5 million people are on NHS waiting lists for treatment; more than 300,000 have waited for over a year, and 1.75 million have been waiting for between 6 and 12 months; the UK has appreciably higher cancer mortality rates than other countries; more than 100,000 infants waited more than 6 hours in Emergency Departments (Accident and Emergency) in 2023 and nearly 10 per cent of all patients are now waiting for 12 hours or more, causing an additional 14,000 more deaths a year; there were 345,000 referrals where people are waiting more than a year for first contact with mental health services. As a result of these trends, there has been a major shift towards private healthcare: while only around 6.4 million people (12% of UK adults) had private health insurance at the end of the pandemic in 2021, an estimated 11.7 million people (22%) had taken out private health insurance policies by the end of 2022, an 83% increase in a single year. As well as people paying directly for private healthcare, almost one in five planned NHS operations in England where a patient is admitted to hospital are being carried out in private facilities.

SYMPOSIUM OUTLINE

Potential for mutual learning

In a 2024 interview in the Japan Times, Health Minister Keizo Takemi identified the following as key area for healthcare reform and development which in his opinion Japan needed to explore:

- Digitalising the system (Medical DX) to be able to collect large health data at speed and to be able to share health data between institutions (domestically and internationally).
- Strengthening of drug discovery infrastructure from basic research and the creation of start-ups to clinical trials to mass production through to regulatory approval and the delivery of drugs to those who need them; the development of venture capital to support drug discovery.
- Introduction of cutting-edge technology and better governance structures for crisis management.
- Development of greater use of wearable AI for those with dementia and of robots in nursing care.
- Introduction and retention of high-quality labour from overseas to work in the health sector, mainly supporting the long-term care system.

The area of the NHS, however, which has seen the most interest in Japan is the principle of registering with a GP who acts as an entry point to health care as a way to coordinate services and prevent unnecessary visits to hospitals.

A 2024 review by respected surgeon Lord Darzi found widespread issues across the health service. The new Labour Government has responded by promising a ten-year reform programme around shifting more care to communities (and primary care) and moving from a focus on dealing with sickness to one of working on prevention alongside moving from analogue to digital forms of working.

It was concluded that there has never been a more important time for mutual learning between Japanese and UK healthcare specialists, researchers and educators.

SUMMARY OF ATTENDANCE

Symposium Attendance

This symposium was an opportunity to introduce key elements of the Japanese and UK systems of healthcare delivery and establish the foundations for future collaborative research projects and programmes.

It was completely booked out with **150 registered participants.** These included practitioners, policy-makers, faculty as well as a large number of graduate students from (but not limited to) the following University of Oxford programmes:

- MSc/MPhil in Japanese Studies;
- MSc in Applied Digital Health;
- MSc in Global Healthcare Leadership;
- MSc in Translational Health Sciences; Master of Public Policy;
- plus, DPhil students of medical sciences, health policy, Japanese studies and allied subjects

and the following programmes at the London School of Hygiene and Tropical Medicine (LSHTM):

- MSc Public Health;
- MSc Public Health for Global Practice;
- MSc Health Policy, Planning and Financing (joint with LSE).

Participants were from both the UK and Japan, as well as various other countries, and thus there were excellent opportunities for mutual learning on diverse healthcare systems. During the Q&A sessions, the workshops, and the final round table at the end of the symposium, participants engaged in lively discussion and exchange of perspectives with each other and with the invited speakers. There was strong positive feedback from the participants on the value of the symposium.

Itinerary of Invited Japanese Speakers

In addition to their presentations during the symposium itself (see programme), the invited speakers from Japan (Professor Naoki Ikegami, Professor Haruko Akatsu, Dr Taroh Kogure, and Mr Ryoji Noritake) were all invited to visit a local GP Practice (Donnington Medical Partnership) in Oxfordshire, hosted by a fellow speaker, Dr Sharon Dixon and her colleagues on Thursday, 27th February.

The guests were able to observe the day-to-day work of their Britsih colleagues and reported that this was a valuable learning experience that deepened their understanding of the UK healthcare system. Similarly, the British GPs reported that they were very eager to learn from the Japanese guests' observations of their practice.

PROGRAMME

PROGRAMME OF EVENTS

DAY 1

Friday, 28th February

8:30 Registration

Nissan Institute of Japanese Studies Foyer

9:15 Introduction and Overview of the Aims of the Workshop

Nissan Institute Lecture Theatre

Roger Goodman
Nissan Professor of Modern Japanese Studies, Oxford

9:45 Session 1 — Scene setting: The ideology and development of contemporary healthcare in Japan and the UK

Nissan Institute Lecture Theatre

Naoki Ikegami
Professor Emeritus of Health Policy and Management, Keio University
Nicholas Mays
Professor of Health Policy, London School of Hygiene and Tropical Medicine

11:15 Coffee break

The Buttery, Hilda Besse Building

11:40 Session 2 — Tales from the front line (1): The theory and practice of primary care in Japan (clinics) and the UK (General practice)

Nissan Institute Lecture Theatre

Taroh Kogure
Owner and Director of Kogure Clinic, Saitama Prefecture
Sharon Dixon
NIHR Doctoral Research Fellow and General Practitioner, Oxford

PROGRAMME OF EVENTS

DAY 1

Friday, 28th February

13:10 Lunch

St Antony's Dining Hall (for all registered workshop participants)

14:10 Session 3 — Tales from the front line (2): The theory and practice of secondary care services in Japan (hospital chains) and the UK (hospital trusts)

Nissan Institute Lecture Theatre

Haruko Akatsu
Professor and Vice President, International University of Health and Welfare

Meghana Pandit
Professor and CEO, Oxford University Hospitals NHS Foundation Trust

15:40 Tea Break

The Buttery, Hilda Besse Building

16:00 Session 4 — Current debates in healthcare reform in Japan and the UK

Nissan Institute Lecture Theatre

Ryoji Noritake
Chair of the Health and Global Policy Institute, Tokyo

Richard Hobbs
Mercian Professor of Primary Care and Director of Oxford Institute of Digital Health

18:00 Reception & Greetings from H.E. Hiroshi Suzuki, Ambassador of Japan to the UK

Combined Common Room, Hilda Besse Building

PROGRAMME OF EVENTS

DAY 2

Saturday, 1st March

9:00 Session 5 — Small groups working on how different systems respond to different symptom presentations

Various breakout rooms

10:00 Session 6 — Small groups working on responses to: hospital to home OR analogue to digital OR treatment to prevention

Various breakout rooms

11:00 Coffee break

The Buttery, Hilda Besse Building

11:15 Session 7 — Reconvene for feedback from sessions 5 & 6

Nissan Institute Lecture Theatre

11:40 Session 8 — Roundtable discussion among Day 1 speakers on the potential for mutual healthcare learning between Japan and the UK

Nissan Institute Lecture Theatre

Chair: **Catherine Pope**
Professor of Medical Sociology, Oxford

12:30 Session 9 — Group reflection

Nissan Institute Lecture Theatre

13:00 Farewell lunch

St Antony's Dining Hall (for all registered workshop participants)

DAY 1 (28TH FEBRUARY) OUTLINE OF TALKS

Introduction and Overview of the Aims of the Workshop

Speaker: Roger GOODMAN (Nissan Professor of Modern Japanese Studies, Oxford)
Presentation Title: What lessons, if any, could/should the NHS take from the Japanese healthcare system?

Bio:

Professor Roger Goodman is the Nissan Professor of Modern Japanese Studies at the University of Oxford and the current Warden of St Antony's College. Professor Goodman's research is mainly on Japanese education and social policy. In 2004, he was appointed as the inaugural Head of the new School of Interdisciplinary Area Studies (SIAS). For the academic year 2006-7, he was Acting Warden at St Antony's following the retirement of Sir Marrack Goulding. In 2008, he was appointed Head of the Social Sciences Division within the University of Oxford, a position which he held until becoming Warden at St Antony's. He was elected a Fellow of the UK Academy of Social Sciences in 2013, was Chair of Academy's Council between 2015-19 and has been President of the Academy since 2020. In 2024, he was appointed Commander of the Order of the British Empire (CBE) for services to Social Science.

Abstract

Roger Goodman's talk set out some of the key aims of the workshop. It started by differentiating between health and healthcare. While Japan, for example, clear has excellent statistics in terms of health (life expectancy, infant mortality, workdays lost through ill health as well as the lowest probability of dying between ages of 30 and 70 from any of cardiovascular disease, cancer, diabetes or chronic respiratory disease (Hasegawa et al, Health Care Policy in East Asia, 2020: 72), this is not necessarily connected to its healthcare system.

The presenter gave two examples of the process of treatment for two common conditions in Japan (trapped sciatic nerve and Benign Paroxysmal Positional Vertigo) and how this differed from treatment in the UK. He also described the system for annual health checks provided by local authorities in Japan through their insurance programmes. The picture that emerged from this account is of a highly competitive system of private healthcare providers in Japan operating in a free-market of practice with very egalitarian access. This helped explain they Japanese pay twice the OECD average number of visits to physicians each year, has the highest use of medical equipment (five times the OECD average of MRI machines) as well as the highest provision of hospital beds and the longest hospital stays. At the same time, there are such strong cost controls over the fees-for-service payment system which 'nudges' doctors towards lower-cost interventions (more therapy/less tests) that the net result is that total health costs in Japan are 81% of UK age-adjusted spend per capita OECD 2022 figures

Session 1 — Scene setting: the ideology and development of contemporary healthcare in Japan and the UK

Speaker (Japan): Naoki IKEGAMI (Professor Emeritus of Health Policy and Management, Keio University)
Presentation Title: Healthcare in Japan

Bio:

Naoki Ikegami is Professor Emeritus at Keio University, Tokyo, and Adjunct Professor, Kurume University, Kurume. He was Chair of the Department of Health Policy and Management at the Keio School of Medicine, from which he received his MD and PhD, and Professor at St Luke's International University School of Public Health (2016~21). He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School and has continued to be a Senior Fellow at Wharton. He is a founding member of interRAI (a non-profit international consortium of researchers and clinicians focused on care planning instruments), and served as a consultant to the WHO and the World Bank. He has been President of the Japan Society of Healthcare Administration and of the Japan Health Economics Association. He has sat on various national and state government committees. His research areas are health policy, long-term care and pharmacoeconomics.

Abstract

Naoki Ikegami's talk situated the current Japanese healthcare system in its historical context. Before Japan was opened to the west in 1854, private practitioners were well established, but there were virtually no welfare institutions or hospitals. After the opening of the country. in 1884, medical licenses given to existing practitioners and to their sons if they were 25 or older. Public hospitals established to serve military, teach medical students, isolate patients with communicable diseases. Most hospitals were built by doctors as part of their clinics.

Today, of all hospitals, 80% are in the private sector, 70% have less than 200 beds. Most have expanded from clinics, of which some have come to be owned by non-profit chains. Around half have long-term care beds. In the case of doctors, 63% work in hospitals, 37% in clinics. Almost all clinics are solo-practices. Specialist qualifications were only legally defined in 2020; today 62% of the doctors have qualifications as a specialist. Only 2% of doctors who have finished their mandatory two-year postgraduate training have chosen primary case (known as 'comprehensive medicine) which is one of the 18 basic specialities as their speciality. Most clinic doctors instead have relied on on-the-job training.

The government works hard to contain costs through the fees-for-service system where the conditions of billing are strictly enforced to control volume and the fees themselves are regularly reviewed to prevent ‘game-playing’ by providers and list new services. It tries to minimise the subsidises to the social health insurance schemes which enrol those with low income and/or have higher ratios of the elderly. In total, the national budget funds around 25% of health expenditures and these allocations to health care compose around 10% of the total national budget.

The fact that specialist services are readily available is one of the reasons that waiting lists are not an issue in Japan as is the fact that chronic conditions (and care of the elderly) is normally treated in small and medium size private hospitals leaving the complex cases to the larger, public-sector institutions. The main reason for the absence of waiting lists may be the flexibility of doctors who quickly adjust their practices to the capacity of the hospital to which they are dispatched or to that of their own practices. Doctors also quickly respond to the revisions of the fee schedule.

Session 1 — Scene setting: the ideology and development of contemporary healthcare in Japan and the UK

Speaker (UK): Nicholas MAYS (Professor of Health Policy, London School of Hygiene & Tropical Medicine)
Presentation Title: Principles, Performance and Current issues in English NHS

Bio:

Professor Mays has diverse experience in the field of health policy. Before coming to the London School of Hygiene & Tropical Medicine he worked in the National Health Service in England (with spells in public health and in representing consumers' interests), in academic health services research (at the Universities of Leicester and London (St Thomas' Hospital Medical School), and the Queen's University of Belfast), in the independent sector (with a think-tank, the King's Fund, where he was director of health services research) and as a civil servant (as a policy adviser with the New Zealand Treasury). He joined the School in May 2003 after almost five years in New Zealand. He maintains a direct involvement in health and wider social policy-making by continuing to provide periodic advice to the New Zealand Ministry of Health and the Treasury.

He directs the National Institute for Health Research (NIHR) Policy Research Programme-funded Policy Innovation and Evaluation Research Unit (PIRU) which is a collaboration between LSHTM, the Care Policy and Evaluation Centre (CPEC) at the London School of Economics and Imperial College Business School.

Abstract

Nicholas Mays outlined the key principles of the NHS: universal, comprehensive (in theory), free at the point of use (largely), collectively funded out of general taxation, goal of equitable access to services. 85% of total UK health spending is public from taxation. Cash-limited budget set by Government based on its priorities compared with other demands. NHS spending is rising as a share of national income and public spending Largest public sector employer in the UK with a workforce of 1.7 million. But not all NHS services are provided by public bodies (e.g. GP practices, dentists, others). In 1985, both defence and health constituted about 4% of GDP expenditure; today defence is only about 2% while health is around 9%.

NHS is not unitary but has separate organization across England and the three devolved nations of Scotland, Wales and Northern Ireland. Care is delivered via specialist services, mostly hospital-based, tertiary and secondary in public hospitals (NHS Trusts) and in community health services and, primary care services through general practices. In this system, GPs act as ‘gatekeepers’ referring patients to most specialty services. The English NHS is currently organised around 42 area-based integrated care systems (ICSs).

It has gone back to a system of cooperation and economies of scale in contrast to the reforms made by the Conservative government which emphasized competition between service provider and more local commissioning of services.

There are approximately 7500 GP practices in England for 55 million patients. Practices are privately owned and work on contract to the NHS, typically as small businesses. Average list size approximately 7500 patients on enrolled lists. 25% of GP consultations currently virtual (phone or online). Blended payment through: capitation (Global Sum), P4P (QOF), fee for service (Enhanced Services), premises. (Capitation payments based on: patient age and sex, patients from nursing and residential homes, additional needs of patients, adjustment for list turnover, a 'Staff Market Forces Factor', an assessment of the rurality of the practice.)
GPs have progressed from single-handed small businesses through larger group practices to some extensive networks of practices.

Major current policy challenges for the NHS include: Tackling an inadequate social (long-term) care system in terms of both finance and provision; Recruitment and especially retention of (experienced) staff in NHS and social care; Improving timely access to care of all types; Improving population health and reducing widening health inequalities. Labour Government solution to these challenges is through three shifts: From treatment to prevention; From hospitals to primary and community care; From analogue to digital, with a focus on innovation. Whether these will work or not is questionable as England is a society with a 'Scandinavian appetite for public services and an American taste for taxation'.

Session 2 — Tales from the front line (1): The theory and practice of primary care in Japan (clinics) and the UK (General practice)

Speaker (JAPAN): Taroh KOGURE (Owner and Director of Kogure Clinic, Saitama Prefecture)
Presentation Title: A country doctor in Japan: The theory and practice of primary care

Bio:

Dr Kogure is the owner and director of Kogure Clinic located in Saitama Prefecture. A graduate of Jikei University School of Medicine, he took over as Director in 2020 after working in various hospitals in Japan, including Tokiwadai Surgical Hospital and Aoto Hospital. He is a certified neurosurgeon and the fifth generation of his family to run a clinic in this rural area.

Abstract

Taroh Kogure introduced the clinic in Saitama of which he is the owner and director. He is a certified neurosurgeon and the fifth generation of his family to run a clinic in this rural area. Four generations share the Kogure name; three generations share the same blood line. He outlined the history of the family and the clinic. He took over as Director in 2020. The community that he serves is mainly agricultural with an elderly population and is very traditional; the system of neighbourhood watch and being responsible as a group (tonarigumi) may be one of the reasons that young people do not want to relocate there. Visits to the doctor are often based on convenience rather than necessity; many who visit doctors in the area are often accompanied by relatives who are usually available only on holidays and weekends - hence Dr Kogure's clinic is open 6 days a week, including Sundays and most holidays (it used to be open 7 days a week). The clinic is very well equipped, including MRI machine, X-ray machine, ECG, EEG, Echo sonography, DEXA scan. Medical records, however, are still paper-based and handwritten.

The clinic has one radiographer, 1 full-time and 2 part-time laboratory technicians, 2 full time and 2 part time nurses and 2 full time and 2 part time medical clerks. There is no practice manager. Part time doctors see 30-40 patients a day; Dr Kogure sees 70-90 (his record is 103). Appointments are not scheduled; anyone can check in during consultation hours. Most tests are performed and explained on the same day as the consultation. Patients consult on non-medical as well as medical matters.

The fees for service system incentivises less talking with patients, more examinations, more revisits, more prescriptions, and more referrals. Income can be secured via the National Health Insurance system on the points basis and also via private expenses and medical insurance, which are used for occupational/sports injuries; health examinations; vaccinations.

Fukaya City has 9 hospitals and 72 private clinics for a population of 140,000 (average age 47). Nakase Town however where the Kogure clinic is situated only has 3 clinics demonstrating the very unequal distribution of medical facilities due to the freedom to establish one anywhere and the lack of zoning. Being a fifth-generation clinic makes local acceptance easier; trust is already established, and patients accept doctor's opinion; there is no need to advertise as most patients are either members of local families who have used the clinic for generations or are introduced by word-of-mouth by such patients (often coming from long distances).

The greater costs involved in running a rural clinic are not recognised in the fees for service system which awards the same number of points for every procedure wherever it is undertaken. The increasing problem for aged members of rural communities to travel to see doctors is also not catered for. These both need to be acknowledged if the high quality of rural medical provision is to survive.

Session 2 — Tales from the front line (1): The theory and practice of primary care in Japan (clinics) and the UK (General practice)

Speaker (UK): Sharon DIXON (NIHR Doctoral Research Fellow and General Practitioner, Oxford)
Presentation Title: Delivering primary care in Oxford

Bio:

Sharon Dixon is a GP partner and a practice safeguarding lead. She has represented the RCGP as a college representative at national safeguarding and FGM meetings. She has co-developed a resource for primary care to support GPs when caring for people from communities potentially affected by FGM. She has contributed to RCGP safeguarding resource development. She is a researcher, including exploring primary care perspectives on supporting patients with experience of FGM, domestic violence and abuse, of delivering safeguarding care during the pandemic, experiences of uro-gynaecology, possible endometriosis and women's health. She has undertaken work exploring equity in research and on partnership priority setting in Femtech. She is currently an NIHR Doctoral Research Fellow at the University of Oxford working to develop knowledge to improve care for adolescents with dysmenorrhoea, focussed in primary care.

Abstract

Sharon Dixon introduced the Donnington Medical Partnership in Oxford, where she is a GP partner. It has around 13,500 patients of whom approximately 20% are over 60 years old and 14% have a QOF chronic disease which is managed by the clinic. (QOF refers to the Quality and Outcomes Framework which is an annual reward and incentive programme for GP practices in England, Wales and Northern Ireland, designed to improve the quality of care provided to patients.) The practice has 12 GPs (4 partners, 7 salaried GPs, 1 GP trainee). It also has PCN (Primary Care Network) staff: including pharmacist, social prescribers, mental health practitioners, care home navigators, a first contact physiotherapist as well as 2 advanced nurse practitioners, 4 specialist practice nurses and 2 health care assistants.

Oxford has significant health inequalities. While it is on the whole an affluent city, there are significant areas and pockets of deprivation. Life expectancy for children born today in deprived areas are on average 13 years lower (men) and 9 years lower (women) than those born in affluent areas. Oxford is identified as an area notable for inequalities related to 'pockets' of relative deprivation. Donnington Health Centre and its related PCN care for people living in these areas of relative disadvantage. This has impacts on workload, with higher levels of morbidity and multi-morbidity, and can contribute to challenges in recruiting and retaining staff. There is a well-documented inverse care law for GP provision in England.

The landscape for accessing GP services in the NHS has become increasingly complicated. When a contact comes to the GP practice, there are now options for service provision, including being offered an appointment at the GP practice (immediately or in the next few weeks), a phone or online appointment, a minor illness appointment in a shared PCN hub, or at an urgent GP clinic which is located in the grounds of the local hospital. However, the ultimate responsibility and onward care and work arising from these options falls to the named GP; there is work in balancing delivering appropriate care, ideally prioritising continuity of care between acute and ongoing or long-term care needs.

Patients in the NHS are registered with (only) one GP practice, and within this structure, in the Donnington practice, each patient has a named GP. Within the NHS, their secondary care and specialist contacts are coordinated through the GP practice which holds and maintains a holistic cradle-to-grave health record for that patient. GPs are responsible for almost all prescribing, including medications advised or initiated by specialist consultants. At the Donnington practice, each GP holds a named patient list, aiming for a list of about 500 patients per clinical day worked (though for partners it is significantly more than this). All letters and contacts for that named list are directed towards that clinician, aspiring to offer informational continuity of care alongside relational continuity. This record is a huge strength of general practice, for care and increasingly research, and enables audit, transparency and accountability. The work and support that GPs offer includes looking after their own lists and patients with shared health records; managing immunisations, screening and shared care; managing long-term conditions; blood tests, ECG, urine dip on site; able to refer for X-ray and very limited MRI tests; some minor procedures (ring pessaries, joint injections); referral to specialist care.

A large part of the work of GPs can be described as ‘invisible work’. This includes acting as triage in the booking of appointments, urgent care, responses to emails and calls, home visits; supervising, teaching, supporting other staff members who are delivering routine and urgent care; checking all prescriptions and medication management; dealing with devolved tasks from secondary and specialist care; responding to letters and onward tasks; engaging in safeguarding and statutory responsibilities; management (at level of both practice and PCN), quality improvement work; community engagement, meeting with colleagues; preparing insurance reports, letters for court, advocacy letters, housing reports, welfare benefit reports.

The burden of this ‘invisible work’ contributes to the burnout of GPs and the significant reduction in GPs and GP practices in many parts of the UK. This has been impacted by adverse media reporting about GPs and general practice.

The presentation concluded that although there are difficulties and changes to navigate, the joy of long-term relationships, with both patients and staff, nurtured and developed over years in practice, and the stories that underpin these, continue to sustain the GP and their enduring love of general practice’s core values of continuity, care and advocacy.

Session 3 — Tales from the front line (2): The theory and practice of secondary care in Japan (hospital chains) and the UK (hospital trusts)

Speaker (Japan): Haruko AKATSU (Professor and Vice President, International University of Health and Welfare)

Presentation Title: Hospitals in Japan

Bio:

Professor Akatsu is the current Vice President of the International University of Health and Welfare (IUHW). As a Fulbright Scholar from Japan, Dr. Akatsu studied Medicine in the US at Harvard University and Brown University School of Medicine and obtained her medical license there. After internal medicine and endocrine training at Stanford University, she taught and practiced endocrinology at both the University of Pittsburgh and Stanford University. She has been honored as a Top Doctor in America and a Best Doctor in America. After 25 years of experience in the U.S., Professor Akatsu returned to Japan to join the IUHW as its Dean of Medical Education from April 2017.

Abstract

Haruko Akatsu based her talk on Japanese hospitals around three main questions: Q1: Why does Japan have minimal wait times for healthcare access? Q2: How do hospitals and physicians in Japan handle such a high volume of patients without being overwhelmed? Q3: Why are Japanese hospitals generally so efficient?

In response to Q1, she argued that the answer lies in the fact that Japan has an extensive network of healthcare facilities, from general practitioners to specialists and that people have essentially free access to these facilities at an affordable cost regardless of their insurance type. Walk-ins are generally allowed not only for urgent care, but for regular clinics. In support of her argument, she shared detailed information on the overall supply of medical care in Japan: Total number of medical facilities (including dental) as of 2021 was 182,800 of which the following were the key providers: 8,205 hospitals of which 320 were national, 1,194 public, and the rest were private. Of the 104,292 clinics, 545 were national, 3,997 were pubic and the rest were private. Japan also has 67,899 dental clinics.

The talk introduced three of the largest hospital chains in Japan: Itabashi Medical System (IMS), International University of Health and Welfare (IUHW) and Tokushukai Group. In particular, she introduced IMS, which is not only family-owned but also invests considerable resources into developing a family-like internal culture. According to the head of its flagship hospital, Dr Ryotaro Kato, 'The spirit of community is reflected in cherished annual events, including overnight trip to the countryside, the Bon festival, a large (over 6000 employees participate) athletic competition, and a Christmas service. Each day at IMS Hospital begins with enthusiastic greetings and ends with a heartfelt "thank you'. Our collegial culture strengthens communication, enhances teamwork, and ultimately leads to better patient care.'

The talk also covered the challenges that IMS faces, according to Dr. Kato: these come from rising costs, recruitment costs, closure of wards due to staff shortages, prolonged stay for the elderly of whom 30% admitted through ER cannot return to their previous residence and pressure to take on more emergency cases and perform more surgeries in order to retain status of an acute hospital for reimbursement purposes. According to Dr. Kato, the governance of IMS (which may because of its scale differ from family-run institutions elsewhere, sees very clear separation between clinical practice and financial management; hospital directors (who, by law, must be physicians) have limited authority to make financial, personnel, or contractual decisions without approval from the administration, unlike in many other hospitals. The owner (president) is the only person overseeing both domains. The rigid separation between clinical and financial decision-making may result in slower response, less transparency, reduced flexibility and a tendency to prioritize stability over innovation.

The disaggregated nature of healthcare delivery in Japan means that there are more than seven times more facilities per capita than in the UK: approximately one for every 1,000 people as opposed to one for every 7500. There is also huge disparity in pay; doctors in large national hospitals earn less than owners of clinics, even if they have the same experience and training. There are also major disparities in tuition fees among Japan's 82 medical schools; on average private school fees are nine time higher than those at any of the national or public medical schools with the most expensive private school being almost 14 times higher.

In response to Q.2 above, Japan's bedside healthcare delivery is highly test-oriented, driven by financial incentives of the medical institutions and patient preference. This approach helps reduce face-to-face physician patient time. Among OECD countries, Japan has the highest number of CT and MRI scanners per million people. In fact, Japan has 9 times more MRI scanners and 13 times more CT scanners per million people than the UK (2013).The widespread implementation of routine health check-ups and frequent doctor visits, even for minor illnesses, may also help prevent severe cases from accumulating and overwhelming the healthcare system.

In response to Q.3 above, the talk suggested that Japanese culture is often described as a culture of hospitality, as reflected in the expression 'the customer is God'. Providing services that ensure the other party - especially customers (or, in the case of hospitals and clinics, patients) -feels as comfortable as possible is crucial for competition among medical institutions. Efficiency is highly valued as part of this customer service, and this is not unique to Japanese hospitals but rather embedded in Japanese culture.

Session 3 — Tales from the front line (2): The theory and practice of secondary care in Japan (hospital chains) and the UK (hospital trusts)

Speaker (UK): Meghana PANDIT (Professor and Chief Executive Officer, Oxford University Hospitals NHS Foundation Trust)

Presentation Title: Leading in the current NHS

Bio:

Professor Pandit was appointed Chief Executive Officer at Oxford University Hospitals NHS Foundation Trust (OUH) in July 2022 (fixed term until substantive appointment in February 2023). OUH is one of the largest acute University teaching hospitals in the country with 14,000 staff, who deliver care on four sites and across forty-five community locations. As CEO, she made 'People', 'Patient care', 'Performance' and 'Partnerships' her four key strategic pillars and has focused on the OUH People Plan, productivity and delivery of compassionate and excellent patient care underpinned by the highest levels of research and innovation, and through embedding Quality Improvement across the organisation.

Professor Pandit was a Consultant Obstetrician and Gynaecologist, Clinical Director and Divisional Director at Milton Keynes University Hospital before joining University Hospitals Coventry and Warwickshire (UHCW) where she was Chief Medical Officer from May 2012 to December 2018 and Deputy Chief Executive from 2015. Professor Pandit was awarded the Founding Senior Fellowship of the Faculty of Medical Leadership and Management in 2015, is Honorary Professor at Warwick University and Fellow at Exeter College, University of Oxford. She is a Non-Executive Director at the Medical Protection Society, a Trustee at NHS Providers and at Medical Detection Dogs (registered charity).

Abstract

Meghana Pandit introduced the basic structure of the NHS in England and described the 10 years of reform from 2012 to 2022 during which it moved from an organisation focus to a systems focus. The 44 Integrated Care Systems (ICSs) are partnerships of health and care organisations who come together to plan and deliver joined up services and to improve the health of their populations. Their role is to develop a system plan for population & allocate resources to deliver the plan. ICS leaders, trusts and system partners, are expected to work to identify shared goals, appropriate membership and governance, and ensure activities are well aligned with ICS priorities.

According to the 2024 Darzi report, health inequalities in the UK are getting much worse: A&E attendances nearly twice and emergency admissions 68% higher for the most deprived; undiagnosed diabetes rate double in the bottom deprived quintile compared to the top; in the poorest communities, people are four times more likely sectioned under the Mental Health Act; the average age of death among homeless men is 45 and for homeless women 43 years; people under 75 in most deprived areas are twice as likely to die of heart diseases. These inequalities are particularly acute in Oxford.

Services have also declined dramatically in recent years: 35% of patients with long term condition do not have a care plan; since 2010, the number of Learning Disability nurses has declined 44%; long waits in ED contribute 14,000 more deaths in a year; 13% of beds occupied by people waiting for social care support; health visitor numbers fell by nearly 20% between 2019-2023;7.6 million people nationally are waiting for planned acute care.

The talk explored how Oxford University Hospitals is set to deal with these challenges. It has £1.6bn turnover with over14,000 staff; 4 hospital sites, 60 wards, 49 operating theatres, more than 1m annual patient contacts; Major Trauma Centre, Vascular, Transplant Centre, 7000 births/year; Medical School (OU)/ Nursing School (OBU); undertakes world-leading research, innovation and improvement. Its plan is based around four pillars: people, patient care, partnerships and performance. It starts with the basis that all of these are in need of dramatic improvement. For example, its staff are suffering from being exhausted, demotivated and demoralized; long pay disputes, industrial action; high sickness rates and non-existent discretionary effort; recruitment and retention challenges. Responses to these challenges include measures from reducing recruitment timelines, cost of living solutions, affordable housing, outdoor gyms to refurbished changing rooms. In all areas, the management is introducing a culture of continuous improvement, for example empowering those closest to the challenges to make meaningful and measurable change and working to support patients accessing care as close to home as possible, leading to an increase in referrals to Hospital at Home Service, saving equivalent of 60 bed days in the first three months of this year and an increase in number of patients discharged home before lunch. Importantly, OUH Staff Survey has demonstrated an increase over the past three years of staff members of staff feeling able to both suggest and make improvements within their team and department.

Session 4 — Current debates in healthcare reform in Japan and the UK

Speaker (JAPAN): Ryoji NORITAKE (Chair of the Health and Global Policy Institute, Tokyo)

Presentation Title: Current debates in healthcare reform in Japan: Lessons from aging Japan

Bio:

Ryoji Noritake is the Chair of Health and Global Policy Institute (HGPI), a Tokyo-based independent and non-profit health policy think tank established in 2004. He also served as Asia-Pacific Lead for Project HOPE, a US-based medical humanitarian aid organization. Through HOPE and HGPI, he has led health system strengthening projects in the Asia-Pacific region and engaged in the US Navy's medical humanitarian projects. His focus is a multi-sectoral approach to health issues such as public-private partnerships and civil-military coordination. He was a member of the Tokyo Metropolitan Government's Policy Discussion Roundtable for Super Ageing Society (2018) and served as a Visiting Scholar at the National Graduate Institute for Policy Studies (2016-2020). He is currently serving as a member of World Dementia Council (WDC), the Salzburg Global Seminar's Advisory Council, Advisory Board Member of Elsevier Atlas, and the Dementia Innovation Alliance hosted by the Ministry of Economy, Trade and Industry (METI), Japan. He was awarded the 32nd Takemi Incentive Award in 2022. He is a graduate of Keio University's Faculty of Policy Management and holds a MSc in Medical Anthropology from the University of Amsterdam, the Netherlands.

Abstract

Ryoji Noritake introduced five of the major debates which are currently engaging the healthcare delivery world in Japan. Behind all of these debates is Japan's changing demography. According to a World Economic Forum report from 2019.: 'As many as 12 million Japanese people may disappear from the country's workforce by 2040, according to official estimates. That's a fall of around 20%. Compared with the 65.3 million working-age people in 2017, the Health, Labor and Welfare Ministry expects there to be just 60.82 million in 2025 and only 52.45 million in 2040'. In short, Japan is on the brink of being a 'super-aged society'.

The first debate is around work style reform for medical staff. Approximately 40% of full-time hospitalists work more than 960 hours of overtime per year. Of these, approximately 10% work overtime more than 1,860 hours per year. Emergency, obstetrics and gynaecology, surgery and younger physicians in particular tend to work longer hours. Of those responding to the 2024 MHLW survey, 300 health care facilities experienced a physician withdrawal; 82 facilities experienced a reduction in practice due to the withdrawal of physicians. Medical Service Act for the Purpose of Promoting the Efficient Provision of High-Quality and Appropriate Medical Care" came into effect on April 1, 2024.

The second debate is around the consolidation of medical institutions. Japan is an outlier among OECD countries in terms of the number of medical facilities it has per head of population. In December 2024, a major government committee released a vision for 'comprehensive medical care delivery system reform' by 2040 that includes outpatient care, home care, and medical and nursing care coordination. In addition to reporting on the function of hospital beds, it also requires new reporting on the function of medical institutions.

The third debate relates to the uneven distribution of doctors across Japan. In May 2024, the Fiscal System Council, an advisory body to the Ministry of Finance, proposed reducing medical fees in areas with an excess of clinics and regulating new practices in areas with an excess of physicians. In September 2024, the Minister of Health, Labour and Welfare, Keizo Takemi, announced a comprehensive package of measures by the end of this year that combines economic incentives, physician training programs, and regulatory measures to further correct the uneven distribution of physicians.

The fourth debate relates to raising the cap on the copayment that patients must pay. It was proposed that from August 2025, that for those with annual incomes between 7.7 million yen and 11.6 million yen, the maximum amount will be raised by more than 20,000 yen to 188,400 yen. For those with annual incomes of 11.6 million yen or more, the maximum will be raised by nearly 40,000 yen to approximately 290,400 yen.

The fifth debate is aimed at strengthening insurer functions. The advocacy functions of the Federation of Health Insurance Associations and the Japan Health Insurance Association have been strengthened, and insurers have been reminded that they are the contracting parties in insured medical care and should enhance their functions as the payers of medical fees. At the moment, most of the 1.3 billion bills (FY2023) are reviewed automatically by artificial intelligence (AI) and other means. Only 10% of the bills that meet certain conditions are visually reviewed by staff at the Medical Fee Payment Fund.

In general, patients in Japan are satisfied with the level and quality of healthcare. They are most satisfied with the public health insurance coverage and ease of access; they are least satisfied with their understanding the healthcare system and the increasing cost of insurance premiums.

Finally, the paper explored three major paradigm shifts in Japanese healthcare delivery:
Independence support: To go beyond simply providing necessary long-term care to also support the independence of elderly people.
User-oriented system: To provide integrated access to health and welfare services from diverse entities to be mobilised at the user's own discretion.
Social insurance system: To develop a social insurance scheme with a clear relationship between benefits and burdens.

Session 4 — Current debates in healthcare reform in Japan and the UK

Speaker (UK): Richard HOBBS (Mercian Professor of Primary Care and Director of Oxford Institute of Digital Health)

Presentation Title: Challenges for UK healthcare and options for primary care

Bio:

Richard Hobbs is Mercian Professor of Primary Care in the Nuffield Department of Primary Care Health Sciences and is a Pro-Vice-Chancellor without portfolio at the University of Oxford. He has served a decade as National Director of the National Institute for Health Research's School for Primary Care Research and was Director of the NHS Quality and Outcomes Framework (QOF) Review panel from 2005-09. He has served many national and international scientific and research funding boards in UK, Ireland, Canada, and WHO, including the BHF Council, British Primary Care Cardiovascular Society, and the ESC Council for Cardiovascular Primary Care. He currently chairs the European Primary Care Cardiovascular Society, a WONCA Special Interest Group. He is one of the world's most referenced academic leaders in primary care, and has developed at Oxford one of the largest and most highly ranked centres for academic primary care globally. He has also made major contributions to growing primary care academic capacity, in terms of people development and research networks.

Abstract

Richard Hobbs started his talk by listing the current challenges for hospital care in the UK. These include: waiting lists for access to services (such as, elective procedures & diagnostic services); loss of generalists in hospitals (leading to A&E demand/waiting times & a dependency on GP triaging); variations in patient care; patient complexity increasing; health of the nation declining; and a desire to transfer care to the community. Primary care is key to dealing with all of these.

Why is primary care important to patients and to health systems? Its importance to patients includes: access, especially daytime; the fact that it is local; continuity of care and long-term relationships; and prompt referrals for specialist care when needed. For health systems it is important because of its volume of care - most illness presents and is managed in primary care, with over 90% of NHS consultations; the importance of prevention (most disease prevention and health promotion in primary care, though under 5% of research funding is on disease prevention; its public health function; its gate-keeper role; its integrated care providing holistic care for multi-morbidity; and the fact that it enables generalist function in primary care and super-specialism in hospital. These are some of the reasons that most health systems globally are rapidly investing in primary care.

What are the current challenges for primary care in the UK? Workload/GP numbers have worsened access and made continuity of care the exception; variations in clinical and social care; patient complexity increasing means more generalist but also more special interest GPs are needed; general health of the nation declining; GP practice issues, including the ability to recruit 'full service' primary care teams; the lack of direct access to diagnostics; limited digital enhancement; and the funding basis and requirement for better investment in primary care, contrasting with the complexity of independent contractor status and partnerships.
The workload of GPs has increased by 1-1.5% per year for the past decade, due to both the increased UK population (2010, 62,760m; 2024, 67,961m) but also because the largest population growth is in those over 75 and under 10, the heaviest users of services.

What have been the primary care responses to these trends and issues? These have included the development of larger primary care organisations and federations which allow more efficient administration, provide a wider range of services, better opportunities for staff development and training, more effective working with specialists, hospitals, social services and patient groups. The reduction in the number of GP practices in England from 7484 in December 2016 to 6514 in January 2022 reflects these trends.

More innovation has occurred but needs to be intensified. Primary care has been largely paperless for 20 years with the huge opportunity that digitised continuous health records provides only latterly becoming exploited. A unified record, based upon the GP record from birth, with investment in training for better coding and research access to the unstructured record (10 times the data than in the coded databases) could offer a more efficient and safer delivery of service and improve prevention and earlier diagnosis strategies. Examples of such innovation in cardio-metabolic disease risk screening was discussed and the potential for greater patient self-management of their long-term conditions, exemplified by our data on digitally enabled self-management of hypertension, the commonest chronic disorder globally and major cause of stroke, heart disease, and dementia.

In summary, UK NHS is under major demand pressures and offers too much variation in care. NHS needs investment in prevention and community based primary care, led by generalist physicians with public health training with the expansion of practice team numbers and skills with a focus on population health as well as personal care via a digital transformation.

Some tentative conclusions from symposium participants

There is a level of similarity around how decisions about health delivery priorities are made in the two nations.

In Japan, decision-making is taken at the level of the centralised Ministry of Health, and then relayed to/enforced at the periphery (healthcare providers) through the highly structured (book of) approved tests, procedures, etc.

In the UK, National Institute for Health and Care Excellence (NICE) guidelines are used extensively to determine which drugs and devices are used within the NHS on grounds of cost-effectiveness, and likewise, the Quality and Outcomes Framework (QOF) is a national framework of incentives for general practices to undertake particular tasks such as blood pressure monitoring, identifying people with dementia, etc. In both cases, these sorts of policies shape local work by clinicians.

An important difference between the two countries though appears to be the level of general patient satisfaction with various levels of the health delivery system, e.g. primary care, A&E, secondary specialist care; and that at least for the first two, patient satisfaction in Japan is substantially greater.

A century ago, Japan and England had much more in common in terms of healthcare delivery: solo-practice GPs and big public hospitals. Since then, England has tried to restructure the system by 'rationalizing', Japan has not. Yet, Japan seems to be in a better position today as money follows the services much more directly than in the UK.

It is also a much more demand-led system which is made affordable by the very low unit costs of many health care services. This has put Japan in a better position to meet the challenges of a rapidly aging society, especially with the implementation of the Long-Term Care Insurance (LTCI) system.

Solutions

There was a general feeling that greater transparency would be helpful in both countries. Japanese participants recommended greater facility to share medical records across small/ medium hospitals, and reference was made to the different levels of IT support in the two countries.

In the UK, it was felt that patients waiting for treatment or diagnosis deserved to know precisely where they had reached in the process which would also require investment in better IT systems.

In conclusion, it could be said that healthcare on the provider side is a small business in Japan and a 'bureaucracy' (made up of a series of statutory public bodies linked together hierarchically plus a wide range of contractual relationships with private and third sector providers) in England. This may be why the situation seems so disordered in Japan and so ordered in England. For a variety of reasons, the NHS today had long waiting lists, while there is timely service in Japan. Maybe healthcare needs have been well served in Japan by it having basically remained a personalized business in Japan.

The biggest lessons that were taken from the conference was the value of mutual learning from other healthcare system and the constant need to review the assumptions on which one's own system is based.

APPENDICES:
DAY 2 (1ST MARCH)
WORKSHOP MATERIALS

APPENDICES: DAY 2: SATURDAY 1st MARCH: WORKSHOP 1 OUTLINE

Review these scenarios and work through how the healthcare system you are most familiar with would respond to them, making use of the **slide handout** to record your initial thoughts for each scenario.

Then, pick **one** scenario from **Scenarios 1–4** and explore it in greater depth, using the **grid**. Think about whether the response changes with how long these patients have had the symptom(s), or if they were of a different age, as well as any other factors that might be relevant.

Finally, use the other side of the grid for each of the cases listed in **Scenario 5**.

Scenarios

Scenario 1:

A 62-year-old patient needs advice about a cough.

How (would) this be different if they were 6 years old?

Please consider what services or clinicians would be involved, whether/where they would be seen, what tests or follow up might be considered (with whom and where) – in Japan (column A), and England (column B).

Please make a note in column C of any other considerations involved when making these decisions.

Scenario 2:

A 48-year-old patient needs advice about back pain.

How (would) this be different if they were 76 years old?

Please list what services or clinicians you would utilise, whether/where they would be seen, what tests or follow up might be considered (with whom and where) – in Japan (column A), and England (column B).

Please make a note in column C of any other considerations involved when making these decisions.

Scenario 3:

A 28-year-old patient wants some advice about managing insomnia and stress.

How (would) this be different if they were 14?

Please list what services or clinicians you would utilise, whether/where they would be seen, what tests or follow up might be considered (with whom and where) – in Japan (column A), and England (column B).

Please make a note in column C of any other considerations involved when making these decisions.

Scenario 4:

A 34-year-old patient needs some advice about pelvic pain and want a screen for sexually transmitted infections.

How (would) this be different if they were 16 years old?

Please list what services or clinicians you would utilise, whether/where they would be seen, what tests or follow up might be considered (with whom and where) – in Japan (column A), and England (column B).

Please make a note in column C of any other considerations involved when making these decisions.

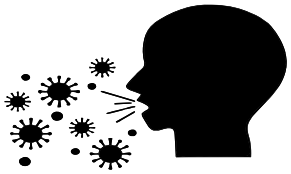
Scenario 5:

Where might the following people interact with the system to seek care? List all possible places:

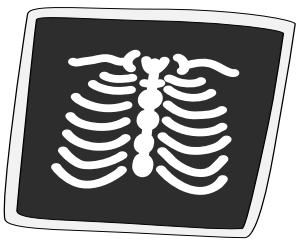
- A person needs a letter providing evidence for housing or social benefits or an asylum claim.
- A 63-year-old patient has found a breast lump or has cancer.
- A 76-year-old patient needs support with a long-term heart condition.
- A 27-year-old patient has just found out they are pregnant.
- A 22-year-old patient with asthma.

Scenario 1

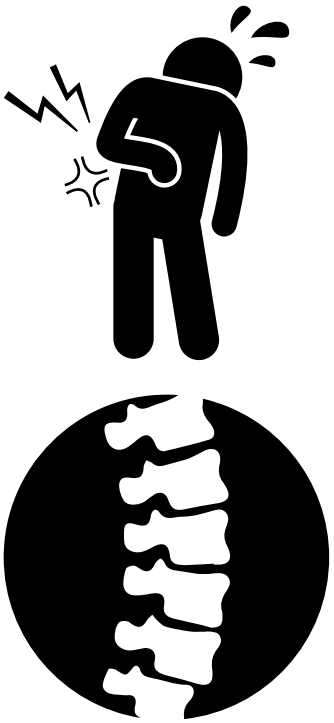
A 62 year old patient needs advice about a cough



How (would) this be different if they were 6 years old?



Scenario 2:



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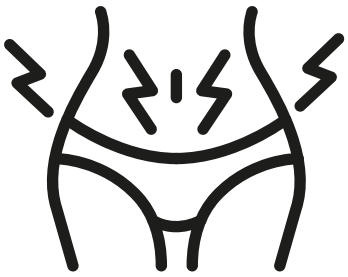

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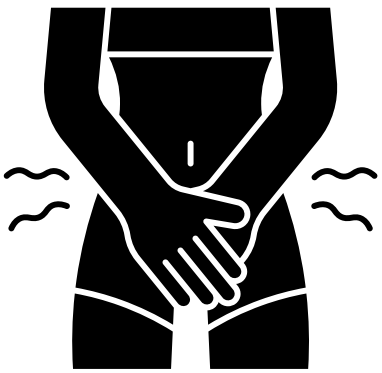

Where might these people go to seek care?

A person needs a letter providing evidence for housing or social benefits or an asylum claim.
Someone who has found a breast lump or has cancer
Someone who needs support with a long-term heart condition
Someone who has just found out they are pregnant
Someone with asthma

Choose one scenario from scenarios 1-4:

	Japanese primary care	English primary care	Other considerations/points of discussion?
Where 'should' they be seen? **What influences this for example, policy, protocol, cost, access?**			
Where 'might' they be seen in reality? **What influences this for example, policy, protocol, cost, access?**			
Where might next steps in treatment or tests happen?			
Where might subsequent or follow up care happen?			
Cost or other considerations?			

Where might these people go to seek care?

	Japan	England	Any comments or notes.
A person needs a letter providing evidence for housing or social benefits or an asylum claim.			
Someone who has found a breast lump or has cancer			
Someone who needs support with a long-term heart condition			
Someone who has just found out they are pregnant			
Someone with asthma			

WORKSHOP 2 OUTLINE

When the 2024 Darzi Review identified widespread issues across the NHS, the new Labour Government responded by promising a ten-year reform programme around how to achieve three "shifts" in services: **more community-based care, prevention, and use of digital technology**.

At the same time, the Japanese Health Minister Keizo Takemi identified **digitalising the system (Medical DX)** to be able to collect large health data at speed and to be able to share health data between institutions (domestically and internationally) as a top priority of healthcare reform in Japan as well as continuing to develop Japan's system of community-based and preventative care.

Behind the reforms in both societies is the desire to reduce healthcare costs while improving healthcare delivery.

This Workshop is designed to explore whether there are lessons that the Japanese and UK systems can learn from each other in securing the above aims.

The groups, which have been formed for this exercise, are asked to focus on **one** of the proposed shifts in services - hospital to home care; treatment to prevention; analogue to digital - using the material from the talks in Day 1 which are available on the drive along with other supporting materials.

All of the groups have a mixture of expertise on Japan and the UK and a facilitator who is asked to lead the discussion. Each group is asked to complete a poster setting out some of the thinking and potential 'findings' of their group. To allow comparison across groups, they are invited to follow the format below:

Issue: Examine *one* of….	**Challenges**	**Lessons from Japan/UK**	**Applications/Solutions**
Hospital to Home Treatment to Prevention Analogue to Digital	What are the economic, political, sociological, cultural challenges in introducing reforms in this area in Japan/UK?	What are the possible positive and negative lessons that can be learnt from the experience in this area in Japan/UK?	What are the potential applications and solutions that could be applied from these lessons to enable these reforms in each country?