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Naoki Ikegami

The Health Care System in Japan



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THE HEALTH CARE SYSTEM IN JAPAN

Naoki Ikegami*

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1. COUNTRY OVERVIEW



- » Sub-Region: Eastern Asia
- » Capital: Tokyo
- » Official Language: Japanese
- » Population size: 126,5 million (in 2020) (UN 2018)
- » Share of rural population: 8.2 % (in 2020) (UN 2018)
- » GDP: 5,082 billion US-\$ (in 2019) (World Bank 2021)
- » Income group: High income
- » Gini Index: 32.9 (in 2013) (World Bank 2021)
- » Colonial period and Independence: N/A

Source: D-maps.com (<https://d-maps.com/m/asia/japan/japonryukyu/japonryukyu29.gif> accessed September 2021). Ryukyu islands included at the bottom right. Northern Territories claimed by Japan and occupied by Russia are only partly depicted.

2. SELECTED HEALTH INDICATORS

Indicator (2019 or latest year available)	Japan	Global Average
Male life expectancy at birth (World Bank 2021)	81.4	70.4
Female life expectancy at birth (World Bank 2021)	87.5	74.9
Infant mortality rate per 1,000 live births (World Bank 2021)	1.8	28.2
Maternal mortality rate, modelled estimate for 100,000 live births (World Bank 2021)	5.0	211
HIV prevalence among adults aged 15-49 (UNAIDS 2019)	<0.1%	0.7%
Tuberculosis incidence per 100,000 population (World Bank 2021)	13	130

Source: The World Bank 2021; UNAIDS 2019

3. LEGAL INTRODUCTION OF THE SYSTEM

Name and type of legal act	Health Insurance Act (Health Insurance Law No. 70), 1922
Date the law was passed	April 22, 1922
Date of <i>de jure</i> implementation	January 1, 1927
Brief summary of content	The law mandates health insurance for employees earning less than 1,200 Yen in companies of specified sectors with ten or more employees. Originally, the law referred only to formally employed manual workers, and coverage was only subsequently expanded to include all formally employed workers and their dependents. For small enterprises, government-managed funds were established as health insurance carriers. In larger enterprises, insurance societies were responsible for health insurance (Ikegami et al. 2011; Tataru & Okamoto 2009).

4. CHARACTERISTICS OF THE SYSTEM AT TIME OF INTRODUCTION

a. Organizational structure

The Health Insurance Act of 1922 defined two types of insurers. Government-managed health insurance (GMHI), organized by the Social Affairs Bureau, Ministry of Interior, was responsible for workers in enterprises with less than 300 permanent employees. In enterprises with 300 and more employees, health insurance societies, managed jointly by employers and employees, served as insurance carriers. In 1927, the government-managed insurance covered 1.14 million workers, while about 0.8 million workers were insured by the society-managed insurance branch. In total, the health insurance system covered 3.2 % of the population (Tatara & Okamoto 2009: 30-31). The benefit package comprised free medical attention, hospital treatment, medical appliances, and operations over 20 Yen for the insured, though medical care for family members was not included. Moreover, a sickness benefit of 60 % of the basic wage was paid after four waiting days (Waggaman 1935).

b. Provision

Under the Health Insurance Act, medical care was mainly provided through solo primary care practitioners. When the Act was implemented in 1926, 32,155 physicians, or 70 % of all licensed physicians, contracted with a government or society-managed insurance plan to offer services for insured workers (Tatara & Okamoto 2009: 31). Hospital services only had a minor role at the inception of the insurance scheme (Ikegami 2011: 2). In 1930, hospital statistics listed 3,716 hospitals with 121,945 beds, owned by government, charitable organizations, health insurance societies and physicians (Sakai 2011).

c. Financing

According to Sugita (2012: 43) and Waggaman (1935: 662), employees and employers shared insurance contributions equally, while employee contributions may not exceed three percent of their base salary. About ten percent of the expenses were financed by the government to cover administrative costs. Moreover, society-managed insurance deficits had to be balanced by the employers (Sugita 2012: 40; 43).

d. Regulation

While the Social Affairs Bureau established government-managed health insurance (GMHI), each enterprise with 300 or more employees established its own society-managed health insurance plan. In annual negotiations, the government and the Japan Medical Association (JMA) determined the budget payable by the government to the JMA for remunerating physician services for the GMHI. The JMA defined a fee schedule used to distribute the budget to contracted physicians according to the services provided (Sugita 2013: 115). Remuneration methods in the society-managed insurance were dependent on the individual sickness funds, which used their own respective fee schedules. In 1943, however, the remuneration schemes were merged into one fee schedule for the employment-based schemes. (Tatara & Okamoto 2009: 31).

5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE

a. Major reform I

Name and type of legal act	Citizen's Health Insurance (National Health Insurance Law No. 60), 1938
Date the law was passed	April 1, 1938
Date of <i>de jure</i> implementation	July 1, 1938
Brief summary of content	The law established the Citizen's Health Insurance (CHI) in order to extend coverage to farmers and the self-employed, including their dependents, and subsequently all those not covered by the Health Insurance Act of 1922. The municipalities were responsible for establishing CHI funds. However, the implementation of health insurance co-operatives was only encouraged by the law and not made mandatory (Ikegami 2017: 348). Moreover, the enrolment of eligible individuals was not compulsory until two thirds of the eligible population were enrolled in the insurance (Sugita 2011: 118).
Socio-political context of introduction	The main motives for the expansion of health insurance were concerns over the health status of draftees from rural areas as the war with China escalated.

b. Major reform II

Name and type of legal act	(New) Citizens' Health Insurance Act (National Health Insurance Law No. 192), 1958
Date the law was passed	December 27, 1958
Date of <i>de jure</i> implementation	January 1, 1959
Brief summary of content	The law mandated all municipalities to establish a residence-based health insurance scheme (CHI). All those not covered by employment-based plans were compelled to enrol. The law also stipulated that all CHI plans adopt the fee schedule of the employee-based health insurance fund. By 1961, all municipalities had established a citizens' health insurance scheme, and Japan achieved nearly full health insurance coverage. Nevertheless, there were disparities, as co-insurance rates differed substantially (Ikegami et al. 2011).
Socio-political context of introduction	The major political parties competed over the establishment of a welfare state, including a health insurance for all. The motive for the introduction of the new CHI was to achieve universal health care coverage.

Further important reforms which shaped the health insurance system in Japan were incremental rather than radical as they did not challenge the established system. These reforms included the

- » Revision of Health Insurance Act, 1972, introducing coverage for catastrophic health expenditure for the family dependents enrolled in employment-based plans; introduced for CHI in 1975;
- » Revision of the Welfare Act for Elders, 1973, stipulating free medical care for all elders aged 70+ as well as a monthly and annual cap on co-insurance for non-elders;
- » Elders' Health Act, 1982, regulating more equitable cost-sharing mechanisms among all social health insurance (SHI) plans for costs of elders, and re-introducing co-insurance for elders;
- » Revision of Health Insurance Act, 1984, which explicitly defined the services that could be billed extra, such as extra charges for rooms and new technologies under development (if not listed as such, then the patient must pay for all services and pharmaceuticals, including those covered by the Act);
- » Act to Ensure Health Care for Elders, 2006, revising cost-sharing among SHI plans to improve equitable sharing of costs of elders 65+, while those aged 75+ became covered by the new Late Elders' Health Insurance system

The driving force behind the above reforms had been disparities in the co-insurance rates among the different SHI plans. Originally, employees did not have to pay any co-insurance, while all others had to pay 50%. Under the CHI, the rate was reduced to 30% for household heads in 1963 and for other family members in 1968. However, financial barriers continued to exist because there was no catastrophic coverage at that time. Free medical care was introduced by the socialist governor of Tokyo in 1969. The national government was forced to follow suit. The elders' co-insurance was financed by general revenues. The fiscal burden led to the reforms of 1982 and 2006.

6. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM

a. Organizational structure

Every resident of Japan must legally enrol in a social health insurance (SHI) plan. The only exceptions are those on public assistance, but they have the same benefits as payment to providers is based on the same fee schedule. Opting for private health insurance is not allowed. Private health insurance is complementary to SHI and mainly limited to cash benefits if hospitalized or if diagnosed with cancer. In 2013, the proportion of the population covered by private insurance was 62%, based on the percentage of the population who have life insurance plans with supplemental coverage for health care (Kwon, Ikegami, Lee, 2020).

Because the fee schedule is set at the national level, the role of the 47 prefectural governments is limited mainly to health planning. However, since the amount available for investing in new development is limited, the main purpose of planning has been to set ceilings on the number of hospital beds. The 1,700 municipal governments are not involved in health care, but they are responsible for providing and financing long-term care (LTC) (Ikegami, 2019b).

b. Provision

In 2018, there were 315,406 physicians practising in Japan, corresponding to a physician density of 2.5 per 1,000 inhabitants. More than 1.5 million nurses and midwives worked in health care, i.e., 12 per 1,000 inhabitants (OECD 2021). The density of physicians is below the OECD average, while that of the nurses is higher compared with other high-income countries. The OECD counts more than 1.6 million hospital beds in Japan. The hospital beds density of 13 per 1,000 inhabitants is the highest among OECD nations. However, over a third of the hospital beds are either LTC beds (over one sixth) or psychiatric care beds (under one sixth) (MHLW, 2020). Moreover, post-acute care is also delivered by hospitals.

Indicator (2018)	Number	Per 1,000 inhabitants
Practising physicians	315,406	2.5
Practising nurses and midwives	1,519,810	12.0
Hospital beds in total	1,641,407	13.0
Hospital curative care beds	983,700	7.8

Source: OECD 2021

Concerning ownership, about 90% of the hospitals are in the private sector. However, in acute care, especially at the high-tech level, the public sector is dominant. Public sector hospitals in Japan are not limited to those that are government-owned, but also include facilities owned by the Red Cross, Farmers' Cooperative Association and so forth. The private sector is mainly composed of physician-owned or controlled organizations. Investor-owned hospitals are not permitted, with the exception of those that were established before 1950 when the decree was issued. Parenthetically, investor-owned hospitals were, and have continued to focus on delivering care to their employees and the local community. It is also noteworthy that over 90% of the clinics are solo practices owned by physicians.

Historically, with the exception of hospitals established by the government for the military, for educating medical students and for quarantining those with communicable diseases, most hospitals were established by physicians as an extension of their private clinics. Consequently, almost all hospitals, including large medical centres,

have large outpatient departments. Although the government has encouraged referrals to the larger hospitals (over 200 beds), many patients visit the hospital directly. After discharge, many hospital physicians continue to see patients at least until they are stable. In small hospitals, the revenue from outpatient department may be greater than that of the inpatient sector. The exceptions to this general rule are the chronic care hospitals which function as de facto nursing homes.

c. Financing

SHI plans are broadly divided into employment-based and community-based plans. For all those who are formally employed, employers must provide SHI coverage and pay more than half of the premiums. Large companies have their own plans through the Health Insurance Societies (HIS), which number about 1,400; as do government workers through about 80 Mutual Aid Associations (MAA). Small company employees are enrolled in the National Health Insurance Association (NHIA, a quasi-government association). Those who are self-employed, informally employed or not working must enrol in the Citizens' Health Insurance (CHI) if less than 75 in age. All those aged 75 and over must enrol in the Late Elders' Health Insurance (LEHI). CHI plans are jointly run by the prefectural and municipal governments. The LEHI plans are managed by a coalition of municipalities established at the prefectural level. In total, SHI plans number more than 3,000.

In general, SHI plans that have a risk pool with higher average income levels and lower average age tend to have a lower premium rate. In order to mitigate these differences, the central government subsidizes the NHIA, the CHI and the LEHI. In addition, half of the funding for elders aged 65 and over comes from contributions from the other SHI plans. These contributions amount to about half of the premium revenue for the employment-based plans, about which the plans have expressed deep resentment. The contribution rate for the NHIA is 10% of wages, bonus and other compensations, and is contributed equally by employers and employees.

Indicator	Value
Total expenditure for health in % of GDP	11.0 %
Domestic general government health expenditure in % of current health expenditure	84 %
Domestic private health expenditure in % of current health expenditure)	16 %
Out-of-pocket expenditure in % of current health expenditure	13 %
External health expenditure in % of current health expenditure	0 %

Source: WHO 2021

In 2018 total health expenditure as a percentage of GDP amounted to 11 %. Note that this percentage includes almost all expenditures for long-term care (LTC) and composes about a fifth of the total. Of the expenditure covered by SHI, 48.9% is covered by SHI premiums, 38.9% by taxes, and 32.9% by patient payment (2015 data) (Kenporen, 2018). Although the coinsurance rate is set at 30%, except for elders and children whose rate is generally 10%, there is catastrophic coverage for all if the monthly co-insurance exceeds that amount. The maximum amount paid as co-insurance rate varies according to the enrollee's income level and the duration of co-insurance payment. Above this threshold, the co-insurance rate is one percent.

Providers are not allowed to balance bills (demand more than the SHI rate) or charge extra (i.e. bill for services not listed in the Fee Schedule) with a few exceptions such as extra-charge beds or new services tested. During the test phase of a medical service or product, the provider must gather data on its efficacy and safety. Once approved and established, the new technology is listed in the Fee Schedule.

d. Regulation

The licensing of physicians and other health professions is carried out by the national government. Among providers, about four-fifths of the hospitals and virtually all clinics are in the private sector (MHLW, 2020). Payers are divided into more than three thousand social health insurance (SHI) plans based on employment or residence. However, the benefits are essentially the same for all SHI plans and precisely listed in the Fee Schedule that sets the fees and conditions of billing (facility standards and patient characteristics) for all physician and hospital services and the prices of all pharmaceuticals. All pharmaceuticals and services that have efficacy been approved

are listed in the fee schedule. Pharmaco-economic evaluations are used to set prices, and not to deny listing. Balance-billing and extra-billing are very restricted and monitored by the MHLW (Ikegami, 2006, 2019a).

The fee schedule effectively sets a global budget and allocates resources. Moreover, it directly controls prices and indirectly controls the volume of services by the conditions of billing of each item (Ikegami, 2011, 2014, 2019b). First, the Cabinet biennially sets the global revision rate, which is the volume weighted revision rate of all service items and pharmaceuticals listed in the fee schedule. Next, the price and conditions of billing of each item are revised by the Ministry of Health, Labour and Welfare (MHLW). Pharmaceutical prices are generally reduced by about 4% on average every year, while service fees are increased by about 0.5% every two years.

Pharmaceutical prices are reduced in a two-step process. The prices of established products are revised individually every year, based on the results of a government survey of the price paid by the provider. The price is set at 2% higher than its volume-weighted average market price to cover administrative costs. The market price is usually driven down because of competition among wholesalers to sell products to pharmacies and hospitals. Independent of this process, the price of new products is reduced if the volume sold is greater than the amount predicted by the pharmaceutical company, since the company will be able to recover its R&D costs from the increased sales volume.

Service fees and the conditions of billing for each item are set by the MHLW. Based on the financial condition of each type of provider (hospital size, clinic specialty etc.), and national claims database, some fees are increased and their conditions of billing relaxed, while other fees are reduced and their conditions tightened. The cumulative effect of these revisions must be made equal to the budgeted amount set by the global revision rate. While the volume of each item billed after the revision is not likely to be one hundred per cent accurate, the net effect of all the item revisions should be more or less accurate. Any unpredicted changes are remedied in the next revision.

Aside from containing costs, revisions have been made to meet policy goals. For example, to nudge primary care services, if physicians in clinics provide advice on improving a patient's lifestyle, they can bill an additional payment. If hospitals staff nurses at higher levels, they are paid higher per diem rates. The precise terms of the revisions are deliberated by the Central Social Health Insurance Council at the MHLW, with members representing payers, providers and public interest. However, the detailed negotiations are made between the physicians in charge of each section within the MHLW Medical Affairs Division and the provider groups.

Adherence to the conditions of billing is inspected through a three-stage process. First, there is a peer review of claims. Inappropriately billed items are denied payment. Second, claims are verified by an on-site inspection of medical records and so forth by the regional office of the MHLW. If non-compliance is established, the provider is ordered to retrospectively check and pay back the amount inappropriately billed in the past six or twelve months. Third, if a blatant fraud is identified, the inspection becomes an audit, following which the facility may be ordered to close.

e. Co-existing systems

There is no co-existing health care system. Private insurance is only supplementary.

f. Role of global actors

Global actors are of minor relevance.

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