

# Reform of the health care system in Japan

## - The aims of the June 2006 Partial Amendments to the Health Insurance Act

**The Partial Amendments to the Health Insurance Act that were passed by the Diet on June 14, 2006, decided the direction of subsequent health care system reforms in Japan. The amendments were made within a context of steeply rising medical expenditure for the elderly, and consisted mainly of measures to curve the medical expenditure by increasing the size of co-payments by the elderly, and by preventing lifestyle-related diseases.**

The main measures decided upon included the following:

- (1) the promotion of medical check-ups and health guidance, setting of numerical targets for reducing the incidence of lifestyle-related diseases, and reduction of the time needed for treatment and enhancement of the quality of regional health care, in order to improve patients' quality of life;
- (2) the raising of the medical payments of elderly patients by, for example, increasing the co-payment rate of patients aged 70-74 from 10% to 20%, and the partial reduction of the coverage of public insurance benefits; the increase of support for those giving birth to and raising children, as a countermeasure to Japan's declining fertility rate;
- (3) the establishment of a medical system for the elderly aged 75 and over, and the collection of new insurance premiums. The Ministry of Health, Labour and Welfare (MHLW) believe that these reforms will lead to an 8 trillion yen saving in the potential amount of medical expenditure made in the year 2025.

### **Background to the 2006 reforms - following on from the reform of public pension schemes (2004) and the long-term care insurance system (2005)**

It is expected that the percentage of elderly people aged 65+ will continue to rise sharply over the coming years, rising from the 2005 rate of 21% to 27.8% in 2025, and reaching 35.7% in 2050. The percentage of the population accounted for by elderly people aged 75+ is a particular cause for concern. The 2005 rate of 9.5% is expected to rise to 16.7% in 2025, and reach 21.5% in 2050. (The data for 2005 is taken from the Ministry of Internal Affairs and Communications' *Population Census of Japan 2005*, and the data for subsequent years from the National Institute of Population and Social Security Research's *Population Projections for Japan*, published in January 2002.)

In order to cope with this change to the population structure, systematic reforms of the pension, healthcare insurance and long-term care insurance programs have gathered pace in recent years, in an effort to ensure their sustainability.

#### **■2004 reform of the pension schemes**

The Japan's pension system that provides livelihood support for the elderly is a two-tiered system that consists of the national pension with universal coverage and the employee's pension. The 2004 reforms of the pension system provided that: (1) In order to avoid limitless future

increases in insurance premiums, the premiums are to be increased gradually until 2017 (employees' pension premium rate based on standard monthly wage is to be raised from the pre-reform rate of 13.58% to a fixed rate of 18.3% in 2017, and national pension monthly premiums from the pre-reform level of 13,300 yen to 16,900 yen), after which an insurance premium standard is to be fixed. (2)The amount of pension benefits that people receive is to be adjusted on the basis of average wages and the consumer price, while the pension benefit level of standard pensioner households is to be set at over 50% (it was 60% prior to the reforms) of the average income of working households. In other words, the policy is intended to limit growth in the amount of pensions paid while gradually increasing insurance premiums to a level at which they will be fixed in the future. The Ministry of Health, Labour and Welfare (MHLW) expects that the total benefit costs, projected to reach 73 trillion yen in 2025, could be reduced to around 62 trillion yen as a result of these reforms. (This would ultimately make it possible to maintain the pension system.)

### ■2005 revision of the long-term care insurance system

The Long-term Care Insurance System for the elderly (people aged 65 or over) was initiated in 2000, and was substantially revised five years later, in 2005. The revisions included:

(1) instituting support services focused on prevention that will improve physical exercise, nutrition, and oral functions, for elderly people who are expected to require long-term care or whose condition is likely to be sustained or improved even if they do require long-term care; (2) the adopting charge partial cost of accommodation and meal service for facility users, that had hitherto been covered by Long-term Care Insurance benefits; and (3) creating a flexible, community-based, small-scale in-home and facility-based care system. MHLW expects these reforms to help reduce the total cost of Long-term Care Insurance from 19 trillion yen in 2025 to approximately 16 trillion yen.

### **Background to the reforms to the health care system - the debate over the sustainability of the 'basic pension for every Japanese citizen' system**

Under the Japanese health care system, the universal coverage for every Japanese citizen has continued through a combination of tax and the national insurance system since 1961. The wide recognition of free access to medical institutions is one of its special characteristics.

According to the World Health Organization (WHO), Japan's healthy life expectancy of 74.5 years is the highest in the world. WHO's World Health Report 2000 also placed Japan first in its survey of health system attainment and performance in all member states. On the other hand, according to the OECD's Health Data 2005, Japan's expenditure on health as a percentage of GDP (7.8%), is lower than that of the USA (13.9%), Germany (10.8%) and France (9.4%), making it one of the lowest health spenders among the advanced nations. Japan's health care system has made an efficient and significant contribution to improving the quality of life of its citizens.

However, despite reductions in medical service fees, national medical care expenditure is increasing much more rapidly than national income. National medical expenditure as a percentage of the national income rose from 6.1% (16 trillion yen) in 1985 to 8.6% (31.5 trillion yen) in 2003, and is expected to rise further to 12.2% in 2025. At the same time, medical expenditure for the elderly as a percentage of the total amount of national medical care

expenditure has been growing steadily (from 25.4% in 1985 to 36.9% in 2003). This has resulted in mounting concern that the burden on the public will increase.

'Healthy Japan 21', a 10-year project to improve the nation's health, was launched in 2000. The project's biggest target is to prevent people from contracting the lifestyle-related diseases that kill around 60% of Japanese people — including malignant neoplasm, cerebrovascular and heart disease - and extend the length of time that they can lead healthy lives. The Health Promotion Law was passed in 2002, in an attempt to further promote the nation's health and prevent disease. The law supports scientific research, measures to combat passive smoking in public places, and the widespread promotion of educational activities concerning lifestyle issues such as eating habits, exercise, nutrition, smoking, alcohol, and dental care.

These measures have further increased the momentum of moves to make wide-sweeping reforms to the health insurance system centered on medical care for the elderly, vastly improve the nation's health and achieve fiscal soundness throughout Japan. This is what led to the reforms made to the health care system in June 2006. The reforms were more than just the revision of a single law - simultaneous revisions were made to several laws including the Health Insurance Act, the National Health Insurance, the Act of Health Service for the Elderly, the Long-term Care Insurance and the Medical Service Act; the 'reform of the health care system' is a blanket term for these comprehensive amendments. They include the maintenance of the universal coverage for every citizen, efforts to improve the nation's health in order to enhance quality of life, a review of patients' co-payment and range of benefit covered by the insurance, and the reorganization and integration of existing insurers. There are a variety of interim measures for each of these, and they will be conducted on a tiered basis.

## **Contents of the reform of the health care system: the containment of medical expenditure increases, the creation of a new health care system for the elderly, and other measures**

### **1. The improvement of health and the promotion of the containment of medical expenditure increases**

#### **1) Formulating a plan for a system designed to control medical expenditures: policies for reducing the incidence of lifestyle-related diseases and the extended hospital stays**

In Japan today, the number of patients with diabetes and other lifestyle-related diseases is continuing to increase. Cases in which these diseases lead to cerebral infarction and myocardial infarction as aging progresses are on the rise. In addition, as pointed out previously, the average hospital stay in Japan is extraordinarily long compared with the length of hospitalization in many other countries, and there is also a sizeable regional disparity in this regard within Japan. In order to improve this situation, each prefecture now has to prepare a plan for a system designed to control medical expenditures. Intended as medium- and long-term measures, these prefectural initiatives will take the form of five-year plans that will commence in 2008. The plans are to incorporate, for example, targets for reducing the number of people suffering from or at a risk of lifestyle-related diseases and targets for reducing the average length of hospital stays, and steps that the national and prefectural governments are to take for the purpose of achieving those targets.

As a result of the revision of the Medical Care Law, systems for regional cooperation in the sphere of health care services are to be created for each major program, such as disease-specific programs to fight cerebrovascular diseases, diabetes, and cancer. It was further decided that numerical targets are to be set for the total number of days of hospitalization each year, the annual frequency of outpatient treatment, and the rates of in-home terminal care and of post-discharge home care. The reform process also encompasses other action for the purpose of providing quality medical care services. For instance, each prefecture is to set up a system for collecting information on medical institutions and making it available to the public. Patients are to be provided with clear explanations concerning treatment plans in medical institutions and services needed for care after their discharge from the hospital. Additional steps include the implementation of measures by each prefecture to secure physicians and the promotion of regional cooperation in the area of health care services.

Through the above efforts, the government aims to achieve specific policy goals on a nationwide scale by the year 2015. Namely, the objectives are to reduce the number of people suffering from or at risk of lifestyle-related diseases by 25% and to shrink by half the gap between the national average for hospital stays, which is 36 days, and the shortest prefectural average for the length of hospitalization, which is 27 days.

## **2) The revision of public health insurance benefits: increasing the costs borne by patients, raising hospitalized elderly people's room and meal costs, and other modifications**

The following are some of the key elements of Japan's revision of public health insurance benefits.

- The co-payment (portion of medical charges borne by patients) has been changed. Prior to the revision, the share of medical charges paid by patients was 30% for individuals under the age of 70 and 10% for those aged 70 and over (but 20% for individuals aged 70 and over with the same level of income as that of the younger generation, that is, the working population). The post-revision patient costs are as follows.
  - 30% for individuals aged 70 and over with the same level of income as that of the younger generation (an annual income of approximately 5.2 million yen or more per couple) (effective as of October 2006)
  - 20% for individuals aged 70 - 74 (effective in April 2008)
  - The costs for those aged 75 and over remain unchanged at 10%.
- The amount that an elderly patient in a long-term care bed (there are 250,000 such beds for long-term care covered under medical insurance) must pay for meal and room costs was raised. Until now the patient's burden for the cost of ingredients was 24,000 yen.
  - The standard payment amounts have been set at 42,000 yen for the cost of meals and 10,000 yen for the room cost (effective in October 2006).
- An overhaul of cash benefits
  - The amount of the lump-sum childbirth allowance was changed from 300,000 yen to 350,000 yen (effective in October 2006).
- Expansion of the age range covered by the reduced co-payment rate for infants
  - The age group covered by Japan's reduced co-payment rate for infants (20% of medical charges) was expanded from children under the age of 3 to those who have not yet started elementary school (effective in April 2008).

Overall, the elderly are being required to bear a more appropriate share of their medical fees, and the amount of support for childbirth and bringing up children has been increased in an effort to reverse the country's declining birth rate. Income-based caps have been set for the amount of medical costs for which patients are responsible so as to ensure that the cost burden borne by them does not escalate without limit.

### **3) The reduction of beds for long-term care: shifting beds for patients with a lower need for medical care to nursing care facilities and their own homes**

With regard to beds for long-term care, the number of beds being used for long-term care in hospitals rather than nursing care facilities totaled approximately 380,000. It has been previously pointed out that there are many hospitalized patients who have a lower need for medical care. For that reason, by the end of fiscal 2011 (March 31, 2012), the number of beds for long-term care in hospitals is to be reduced to 150,000, and those beds are to be specifically designated for cases in which the need for medical care is high. Hospitalized individuals whose need for medical care is lower are to be shifted to facilities that chiefly offer nursing care or to their own homes, with nursing care then carried out in those settings.

## **2. The creation of a new health care system for the elderly**

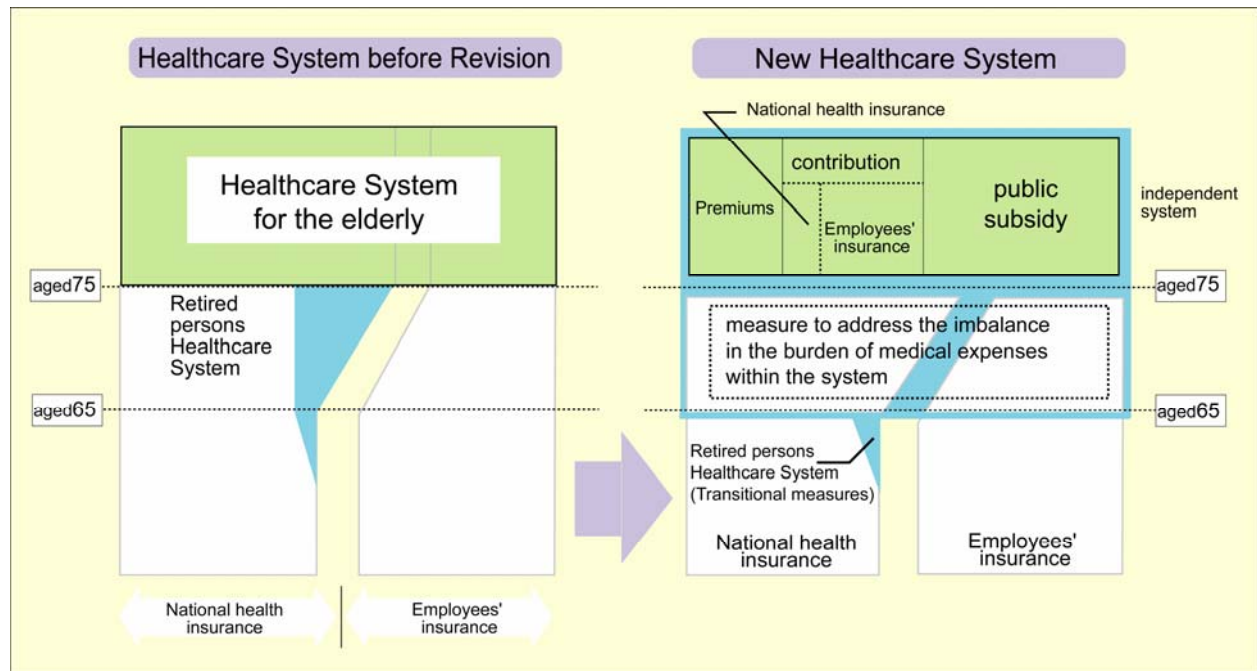
Several types of public health insurance are available in Japan. Until now the options have consisted of insurance that can be divided into two major groups as depicted in the figure below. One is employees' insurance, which is for employees of private companies and public service employees. Approximately 76 million people are covered by employees' insurance. The other is national health insurance, which is for self-employed persons, retirees, and so forth. It covers approximately 51 million people. (Both figures are as of 2005).

- There are various kinds of employees' insurance, with the type depending on factors that include the size of a business establishment and a person's occupation. Insurers include the national government – in the case of government-managed health insurance, which is primarily for the employees of small and medium-sized companies – and an array of health insurance societies. These health insurance societies include, for instance, societies operated by major business corporations as well as societies established for specific industries. The payment of premiums is in principle shared equally by employees and their employers, and the amount of an insured person's premium is determined by multiplying the sum of that individual's standard monthly remuneration and bonus(es) (up to a maximum) by a contribution rate. Contribution rates differ depending on the type of insurance. To give an example, the rate for government-managed health insurance is 8.2%. State subsidization of this insurance program is extremely small compared with the national treasury's contribution to national health insurance.
- In most cases municipalities are the insurers for national health insurance. When national health insurance and employees' insurance premiums are compared on the same basis, those for national health insurance are relatively high. Japan's national treasury serves as the source of approximately half of the funds for this program.

The handling of the elderly in the health care system thus far  
Most retirees up to the age of 74 enroll in national health insurance. In the case of retirees whose period of employment in private companies was 20 years or longer, employees' insurance has

been providing support for their medical expenditures by making contributions to national health insurance.

Furthermore, funding for the health care system for people aged 75 and over is provided by two sources. Half of it comes from public subsidies and the other half from employees' insurance and national health insurance contributions. Premiums have not been collected thus far.



**1) The creation of an Advanced Elderly Health Care System for elderly people aged 75 and over: instituting the collection of premiums from the advanced elderly, too**

Individuals who are covered by medical insurance for the elderly and are aged 75 and over (15.18 million people) account for 11.9% of Japan's total population. The annual cost of medical care for the elderly adds up to 11.7 trillion yen, an amount that accounts for 37.7% of the nation's total health care spending of 31.1 trillion yen (these figures are taken from the 2005 *Annual Report on Health and Welfare*), and it is projected that this amount will rise further. Moreover, the process in the case of the present health care system for the elderly has been for the elderly to continue to be enrolled in national health insurance and employees' insurance and for municipalities to manage their medical benefits and so forth. The financial resources for this have come from contributions provided by the national health insurance and employees' insurance systems and from public funds. This has meant that the entities determining and collecting premiums and the entities dispensing benefits were separate organizations, and that accountability in terms of fiscal management was ambiguous. For this reason, a stable independent system is to be established so that each wide area union that all municipalities in that prefecture will join and that will manage medical insurance for the elderly aged 75 and over starting in April 2008. At the same time, the collection of premiums from these advanced elderly people is to be newly instituted. Their premium amounts will vary depending upon their income. The breakdown of the financial resources for this advanced elderly health care system, excluding co-payments, will be as follows: 10% will

come from premiums paid by the elderly; approximately 40% from financial support derived from national health insurance and employees' insurance premiums paid by insured persons up to the age of 74; and approximately 50% from public subsidies. Also, a system is to be established to adjust the proportions of the health care cost burden borne by the advanced elderly and the younger generation in line with the population ratios of these two groups. As a result of the introduction of this system, the share of the burden shouldered by the advanced elderly will rise in the future.

## **2) Fiscal equalization of the medical care expenditures of the early elderly aged 65 to 74: A broader public base to support the early elderly**

With most elderly persons aged 65 to 74 enrolled in the national health insurance system, the financial condition of this system has become extremely serious as the burden on it has mounted. For this reason, starting in 2008 the financial burden for early elderly person's medical expenditures is to be split between national health insurance and employees' insurance in accordance with the number of people enrolled in each of these insurance systems. This arrangement will create broad-based financial support for early elderly persons' medical care expenditures through nationwide public solidarity. Given that most elderly persons aged 65 to 74 enroll in national health insurance, this will mean that support will be provided to national health insurance by employees' insurance.

## **3. Other matters**

Insurer restructuring will also be carried out in response to the present reform of the health care system. There has been criticism about the lack of a mechanism to ensure that medical expenses incurred in individual regions are reflected in government-managed health insurance premiums. Namely, under uniform nationwide management of this insurance by the insurer, the Social Insurance Agency, such disparities have not been factored into premiums. Consequently, as of April 2008 a public corporation independent of the national government is to be established as the insurer on a nationwide basis. Fiscal management on a prefecture-by-prefecture basis, including the setting by prefectural unit of contribution rates that reflect regional medical expenses, will then become standard operating procedure.

## **Medical care benefit savings produced by health care system reform**

The amount for medical care benefits in Japan's fiscal 2006 budget was 28.5 trillion yen. According to Ministry of Health, Labor and Welfare projections, the amount for these benefits will climb to 56.0 trillion yen in fiscal 2025 if reform is not implemented. A provisional estimate indicates that this number can be squeezed to 48.0 trillion yen through measures under the present reforms, such as increasing the share of costs borne by the elderly.

## Appendix Table 1: Outline of the Health Insurance System and the Contents of Reform

(Underlined portions are part of the current revision.)

	Persons covered	Insurers	Premiums	Share borne by patients (co-payment)	Financial resources
<b>Employees' insurance</b> <ul style="list-style-type: none"> <li>Ratio of the elderly: 2.6% for health insurance societies 5.4% for government-managed health insurance (as of the end of March 2003)</li> </ul>	Current (and retired) employees of private companies and public institutions <i>approx. 76 million people</i>	Various kinds of health insurance societies, chiefly in large companies, and government-managed health insurance, mainly in the case of small and medium-sized companies <u>From Oct. 2008 on, a public corporation will be the insurer for government-managed health insurance and will manage this program on a prefecture-by-prefecture basis.</u>	Standard monthly remuneration + bonus(es) (up to a maximum) × contribution rate <ul style="list-style-type: none"> <li>in principle shared equally by employees and employers</li> <li>includes dependent(s) benefits portion</li> <li>e.g., 8.2% contribution rate for government-managed health insurance</li> <li>e.g., with 3 million yen annual income, premiums (per year) of 60,000 yen to 130,000 yen in the case of health insurance societies and 82,000 yen in the case of government-managed health insurance</li> </ul>	<i>Through March 2008</i> <ul style="list-style-type: none"> <li>Under age 3: 20%</li> <li>Aged 3 to 69: 30%</li> <li>Aged 70 and older: 10% (but 20% for patients with the same level of income as that of the younger generation, <u>then rising to 30% for these patients starting in Oct. 2006</u>)</li> </ul>	Premiums + state contribution (state contribution: 13% of benefit expenses for government-managed health insurance and fixed amounts otherwise)
<b>National health insurance</b> <ul style="list-style-type: none"> <li>Ratio of the elderly: 26.0% (as of the end of March 2003)</li> </ul>	Current (and retired) farmers and self-employed persons <i>approx. 51 million people</i>	Municipalities in most cases	Determined on a household basis by municipalities in accordance with income and the number of insurance enrollees; there is an upper limit <ul style="list-style-type: none"> <li>e.g., with an annual income of 3 million yen, a premium (per year) of 190,000 yen to 240,000 yen for a 2-member household and 210,000 yen to 290,000 yen for a 4-member household</li> </ul>	(Same as above)	Premiums + state contribution (state contribution: approx. 50% of benefit expenses and so forth)
<b>Retiree health care system</b> <ul style="list-style-type: none"> <li>Not an independent system</li> </ul>	Retired persons up to age 74 who are covered by employees' insurance, with most enrolled in national health insurance	Municipalities	Essentially the same as for national health insurance	(Same as above)	Premiums + contributions from employees' insurance Burden borne by municipal national health insurance organizations: 84%
<b>Fiscal equalization of early elderly medical care expenditures</b> <ul style="list-style-type: none"> <li>Not an independent system</li> </ul>	<u>Early elderly (persons aged 65 to 74)</u> <i>approx. 14 million people</i>		Essentially the same as for national health insurance	<u>From April 2008 on</u> <ul style="list-style-type: none"> <li>Under age 6: 20%</li> <li>Aged 6 to 69: 30%</li> <li>Aged 70 to 74: 20%</li> <li>Aged 75 and older: 10%</li> </ul>	<u>Eventual burden borne by municipal national health insurance organizations: 42%</u> <u>(accomplished by increasing the burden borne by employees' insurance)</u>
<b>Elderly health care system</b> Not an independent system	Advanced elderly (persons aged 75 and older), with most enrolled in national health insurance	Municipalities serve as the administrative organizations.	No premium	(Same as above)	Contributions from employees' insurance and national health insurance (approx. 50%) + public funds (approx. 50%, with a 4:1:1 split among national, prefectural, and municipal governments)
<b>Advanced elderly health care system</b>	Advanced elderly (persons aged 75 and older) <u>who enroll in the new system</u> <i>approx. 13 million people</i>	<u>Fiscal management by prefecture-by-prefecture basis wide area union</u>	<u>Premium contribution rates set on a prefecture-by-prefecture basis</u> <ul style="list-style-type: none"> <li>e.g., an annual total of 74,400 yen for an average beneficiary of employee pension (2.08 million yen per year) and 10,800 yen for an average beneficiary of basic pension (790,000 yen per year)</li> </ul>	(Same as above)	<u>Premiums (10%) + financial support for the advanced elderly</u> (contributions from employees' insurance and national health insurance) (approx. 40%) + public funds (approx. 50%)

### Sources:

Ministry of Health, Labour and Welfare, *Annual Report on Health, Labour and Welfare*, 2005

All-Japan Federation of National Health Insurance Organizations, *Kokumin Kenko Hoken no Antei o Motomete* (In pursuit of the stabilization of National Health Insurance), 2004



**Appendix Table 2: Schedule of Revision of Health Care System**

Date of enforcement	Main scope of reform
Oct. 2006	<ul style="list-style-type: none"><li>▪ Raising the ratio of co-payment for the elderly with the same level of income as the younger generation (20%→30%)</li><li>▪ Revision of the payment of meal and accommodation expenses for the elderly in beds for long-term care</li><li>▪ Creation of Regional Health Insurance Society</li></ul>
Mar. 2007	<ul style="list-style-type: none"><li>▪ Revision of the membership structure of the Central Social Insurance Council</li></ul>
Apr. 2008	<ul style="list-style-type: none"><li>▪ Raising the ratio of co-payment for the elderly aged 70 to 74 (10%→20%)</li><li>▪ Reducing the ratio of co-payment for infants (expansion of age eligible for a burden-relief policy for infants &amp; babies (20%) (up to 3 year-old →until the entry into primary school)</li><li>▪ Introduction of a planning system designed for controlling medical expenditure</li><li>▪ Introduction of such countermeasures against life-style related diseases as imposing the obligation of frequent medical checkups and appropriate counseling on insurers</li><li>▪ Establishment of Medical System for the Elderly Aged 75 and Over</li><li>▪ Establishment of fiscal adjustment system regarding medical expenditure for 65 to 74 year-old</li></ul>
Oct. 2008	<ul style="list-style-type: none"><li>▪ Change of the insurer of Government-managed Health Insurance into a Public Corporation</li></ul>
Apr. 2012	<ul style="list-style-type: none"><li>▪ Abolition of beds for long-term care covered by Long-term Care Insurance System</li></ul>

Source:

Ministry of Health, Labour and Welfare “Partial Amendments to Health Insurance Act” (2006)