International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Japan

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Extending Social Health Protection in Japan: Accelerating progress towards Universal Health Coverage

1. Introduction

A high-income country with the world's third largest economy and a predominantly urban population of over 126 million (UN 2019), Japan is renowned for its highly developed social health protection system (Ikegami 2019), which encompasses four compulsory, contributory social health insurance (SHI) schemes: an employment-based scheme called Employee's Health Insurance; a residence-based scheme called Citizens' Health Insurance for those not employed, self-employed, and retirees; a contributory Health Insurance for Advanced Elderly scheme that covers all adults who are 75 years and older; and an age-based long-term care insurance scheme. All schemes provide a similar comprehensive set of benefits, which is determined and approved by the National Government (The Commonwealth Fund 2020; Sakamoto et al. 2018; JHPN 2015).

Thanks to the country's strong social health protection system, with the right to lead a healthy and culturally fulfilling life enshrined in the Constitution of Japan (JHPN 2015), the country achieved the milestone of Universal Health Coverage (UHC) in 1961 (Ikegami 2019). There are nonetheless challenges in implementing effective social health protection. Today, the demands of a rapidly aging population are putting a strain on the health care system in Japan, with health expenditure rising from 7.2 per cent of GDP in 2000 to almost 11 per cent in 2017 (WHO n.d.). This increase has resulted in part from the lack of GDP growth in Japan for the past 30 years, which has been a hurdle for the mobilization of additional resources for health.

2. Context

The country's journey towards UHC began with the introduction of the Health Insurance Act in 1922, following which, Japan's first social health insurance scheme, Employee's Health Insurance (EHI) was implemented in 1927 (Ikegami 2019). The scheme initially only targeted manual labourers in factories and mines (who composed around 3 per cent of the total population). However, from the 1930s onwards the Government began to gradually expand its coverage to include formal employees in

other sectors and eventually certain categories of part-time workers (Ikegami 2019). In 1938, the coverage provided under the scheme was supplemented by Residence based Citizens' Health Insurance (CHI), following the adoption of the Citizens' Health Insurance Law, through which social health insurance plans for farmers and informal workers were introduced. The new law encouraged municipalities to establish CHI plans and enrol those living in their jurisdiction who were not covered by employment-based schemes. Although this led to a significant increase in coverage, some households remained uncovered and certain municipalities (such as Tokyo) did not establish health insurance schemes. Furthermore, even when such schemes were implemented, enrolment was not mandatory.

To address coverage gaps, several significant health insurance laws were passed in the second half of the 20th century, expanding the coverage of both the employment-based and the residence-based schemes. Among these is the Seamen's Insurance Act of 1940, which provided coverage to maritime workers. The most important legal advancement was the implementation of the new Community Health Insurance Law in 1958. Milestone amendments were made which mandated municipalities to establish CHI plans and made enrolment mandatory for all those not covered by the employment-based schemes, including foreigners. This led to a rapid growth in the number of enrollees, and the achievement of UHC by the early 1960s (Sakamoto et al. 2018). Decades later, in order to meet with the health and social needs of Japan's aging society, a new social insurance scheme was introduced in 2000 to cover long-term care (LTC) needs. To further reduce the financial burden on the CHI scheme, a separate insurance plan for the elderly population was introduced in 2006, known as health insurance for advanced elderly (AEHI).

3. Design of the social health protection system

- Financing

Until 2010, Japan's public health care spending as a share of GDP was below the OECD average; however, it is now one of the highest among OECD countries (Sakamoto et al. 2018), in part due to the inclusion of LTC expenditures. The health system is funded by contributions from the insured, as well as co-payments, which are made on varying rates based on the type of insurance and the socio-demographic characteristics of the insured. Public funding is mobilized to finance a proportion of health care expenses, and support schemes that have an inadequate financial basis, as well as to subsidize contributions for the elderly population. Government at all three administrative levels contribute to financing the system, but the major contribution comes from the National Government, while prefectural and municipal governments provide a smaller share.

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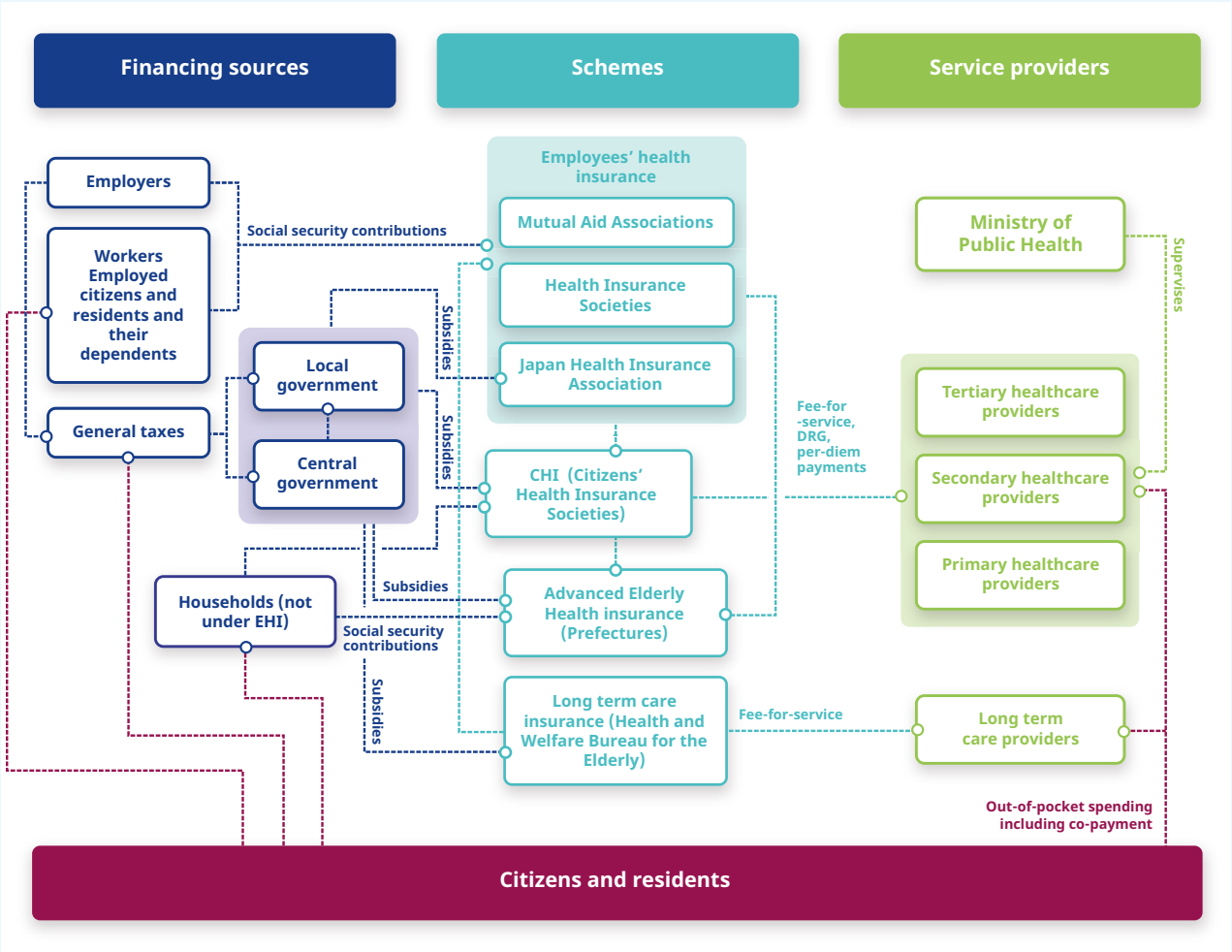
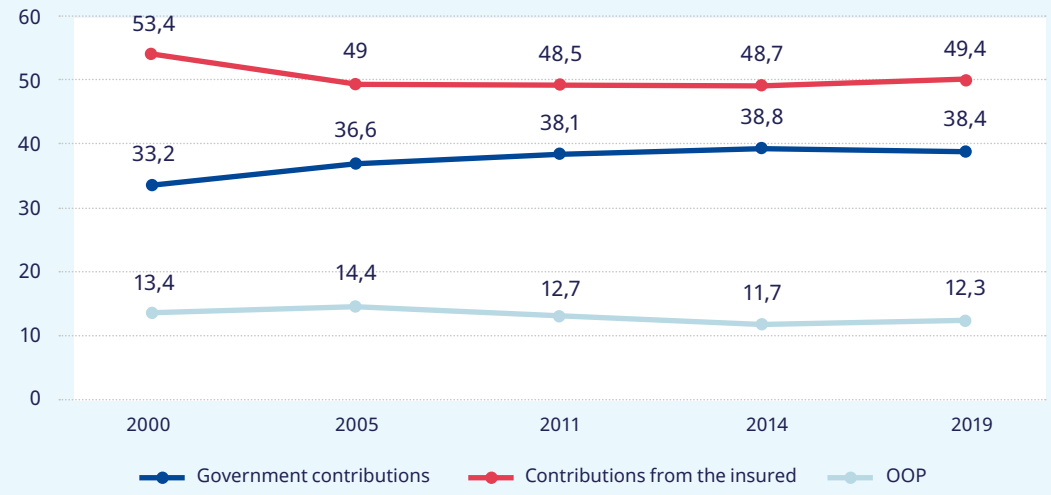
▶ **Figure 1. Overview of main financial flows of the social health protection system in Japan**



Source: Authors.

Currently, the largest share of funding comes from contributions, followed by government spending, and out-of-pocket (OOP) spending. However, the share of insurance contributions has been gradually decreasing over the years, due in part to the aging of the population and resulting decrease in the number of full-time workers contributing to the employee scheme. There have also been decreases in OOP spending, thanks to the gradual strengthening of financial protection policies, especially for the elderly. In parallel, the share of tax-funded resources has increased proportionally, resulting in a growing financial strain, which is currently at the centre of Japan's national social health protection concerns.

▶ **Figure 2. Health expenditure by Source (2000–2019)**



Source: Adapted from Sakamoto et al. (2018), based on from the Ministry of Labour, Health and Welfare.

Revenues for the country's four SHI schemes are sourced as follows:

Employee's Health Insurance (kenkô hoken)

EHI plans are financed by contributions from employers and employees, but the Japan Health Insurance Association (JHIA) receives government subsidies as a proportion of total expenditures; Mutual Aid Associations (MAAs) and Health Insurance Societies (HISs), on the other hand, are financed exclusively by contributions (Sakamoto et al. 2018). [1] Contributions, which are deducted from employee paychecks, reflect the health expenditures of their enrollees and the amount contributed to old age health care costs (Sakamoto et al. 2018; JPS n.d.). On average, the contribution rate for salaried workers is around 10 per cent of their total compensation, but this differs for each plan (Sakamoto et al. 2018; JPS n.d.). Employers must pay at least half of the insurance contribution, with the proportion differing for each plan. The ratio is decided by the employer and the employees, as defined by the governing board of the plan, in line with article 161 of the Health Insurance Act.

Citizens' Health Insurance (kokumin-kenkō-hoken)

CHI is financed through contributions and subsidies from general government revenues. Public subsidies are set at 50 per cent of the total CHI budget, and come from central and prefectural governments. CHI also receives some funds from the HIS, JHIA, and MAA to subsidize enrollees aged 65 to 74 covered under the CHI plans (JHPN 2015). Contribution rates are set by Citizens' Health Insurance Societies and municipal authorities, and vary considerably from municipality to municipality (Sakamoto et al. 2018). Contribution rates are calculated for each member based on personal income and the by-laws set in each municipality—such as income level of the enrolled household, the number of those enrolled in each household and predicted medical costs (Sakamoto et al. 2018). Calculated rates are then allocated on a per-household basis (SCH 2020). Overall, contribution rates range from around 7.3 to 15.9 per cent of total household income (Sakamoto et al. 2018) and are capped at amounts based on a beneficiary's age and income (The Commonwealth Fund 2020). Contributions to the CHI scheme are usually collected on a monthly basis and paid by the head of a household (JHI 2019), through banks or other financial institutions, post offices, convenience stores, at city or branch offices, or through automatic debits (SCH 2020). For

[1] For details on the JHIA, MAAs and HISs, see the "governance" section below.

individuals aged 70—74, contributions can be deducted directly from their pensions.

Pursuant to article 77 of the Citizens' Health Insurance Act, insurance payments can be reduced for persons in special circumstances. Accordingly, a person can apply for: (1) a contribution reduction programme, which allows for a reduction of the per-capita based charge if his/her household's income falls below a certain level or the person becomes involuntarily unemployed; or (2) a contribution exemption programme, which allows for exemption under extraordinary circumstances, such as natural disasters or serious illnesses (SCH 2020).

Advanced Elderly Health Insurance Scheme (Koki Koreisya)

The AEHI scheme is financed from the public budget (accounting for around 50 per cent of total funding), member contributions (accounting for around 10 per cent) and funds from the EHI and NHI schemes, which take the form of fiscal adjustment and total around 40 per cent of AEHI funding (Sakamoto et al. 2018; JHPN 2015). The National Government contributes around two thirds of all public funds, while prefectural and municipal governments contribute the remaining third (Sakamoto et al. 2018). The amount paid by the enrollee depends on their income. As is the case for CHI, lower-income members and members in special circumstances can apply for a reduction of contributions or an exemption. Contributions for AEHI are usually collected on a monthly basis through direct deductions from members' pension payments or through bank transfers or automated payment orders (Japan Ministry of Health, Labour and Welfare 2012).

Long-Term Care Insurance (Kaigo Hoken)

Around half of the LTCI budget is funded from tax revenues, and the remaining half is funded from contributions (Sakamoto et al. 2018). The contribution rate differs for each municipality and reflects its LTCI expenditures. Around two-fifths of contributions are funded by premiums levied from persons aged 65 and over who reside in the municipality, and around three-fifths is funded by the premiums from those aged 40—64, which is levied together with their health insurance by the same insurer. The premium level is revised every three years according to estimated expenditures, and the amount levied is allocated to the municipality's LTCI. Monthly LTCI contributions are usually deducted from pensions, or from wages for those employed and their dependents. For the self-employed and their dependents, contributions are levied together with other health insurance contributions (through account transfer, payment slip and so on).

Beneficiaries can benefit from a reduction of mandatory contribution amounts under specific circumstances —for example in cases whereby the insured has experienced a sharp decrease in income compared to previous year (City of Sapporo 2020). As for funding from taxes, 5 per cent of the total is allocated to municipalities that have a higher proportion of residents aged 75 and over and those that have a significant number of enrollees with low incomes. This allocation method is in place to ensure that factors that increase the contribution rate, such as age composition and income level, are adjusted, while at the same time placing fiscal responsibility on the municipality, as the as insurer.

- Governance

The administrative structure in Japan is de-centralized, with many important functions, including health protection, transferred to the country's local municipal authorities. For health insurance schemes, the Central Social Insurance Council under the Ministry of Health, Labour and Welfare (MHLW) sets and revises the fee schedule, which includes pharmaceuticals and devices. The Council has a multi-partite composition, comprised of payer representatives (employees and employers), provider representatives and relevant experts (The Commonwealth Fund 2020). The specific governance structures for each scheme are as follows:

Employee's Health Insurance (kenkô hoken)

EHI is comprised of three sub-schemes administered through different entities, all of which are governed by the Health Insurance Act No. 70 of 1922, the Seafarer's Insurance Law No. 73 of 1939, the Public Employees Mutual Aid Association Act No. 152 of 1962, and their subsequent amendments. The entities administering the three sub-schemes include Health Insurance Societies (HISs), which are established by large businesses to provide coverage for their employees; the Japan Health Insurance Association (JHIA), which enrols employees of small to medium sized companies;

and Mutual Aid Associations (MAAs) which provide coverage to public sector employees. There were 1409 HISs in Japan in 2016 (Sakamoto et al. 2018). The Health Insurance Act mandates that both employers and employees are represented in the governance bodies of the HIS and JHIA (Article 17 and article 21, respectively). MAAs are mandated by the Public Employees Mutual Aid Association Act and administered by Management Councils, which are monitored by the Federation of the National Public Service Personnel of MAAs. In 2016, there were 85 MAAs throughout Japan (Sakamoto et al. 2018).

Citizens' Health Insurance (kokumin-kenkō-hoken)

CHI was revised by the Citizens' Health Insurance Act No. 192 which was implemented in 1959. The scheme, for which the municipal government is the insurer, is administered by Citizens' Health Insurance Societies (CHISs) organized by the 1,716 municipal governments which are responsible for setting and collecting contributions and registering beneficiaries. However, high-level oversight of the scheme, including some limited pooling of funds and overseeing service delivery is undertaken by prefectural governments (The Commonwealth Fund 2020). In addition, there are 164 CHI societies that enrol the self-employed in the same occupation, such as barbers and construction workers. Each CHIS has a unique constitution and society council, with their own society directors and auditors. The CHI Council is composed of representatives of insured enrollees, providers and members.

Health Insurance for Advanced Elderly (Koki Koreisya)

The AEHI scheme is regulated by the Elderly Health Care Security Act and administered at prefectural level through regional alliances of municipalities for medical care of the advanced elderly established in each of the 47 prefectures (Sakamoto et al. 2018; Takeda Health Insurance Society 2015). The governing committee is similar to that of the CHI. Alliances are responsible for the provision of AEHI, including setting contribution rates (which are uniform within the prefecture) and monitoring payments made for medical costs (Japan Ministry of Health, Labour and Welfare 2012). Municipal governments assist alliances and prefectures with technical matters and collect contributions. These alliances were established because prefectural governments did not want the responsibility of running the programme.

Long-Term Care Insurance (Kaigo Hoken)

The LTCI system is governed by the Long-Term Care Insurance Act No.123 of 1997. LTCI is administered by municipalities, which set premiums, undertake contracting and coordinate service providers. The Health and Welfare Bureau for the Elderly under the MHLW oversees the implementation of the scheme by providing basic guidance and offering assistance related to planning, information collection and implementation (Sakamoto et al. 2018). The LTCI council has essentially the same composition as that of CHI at the municipal level, except for the fact that provider representatives are made up of LTC providers (both institutional and community level), and the nurse association also has a seat. "Public interest" is usually represented by academics.

- Legal coverage and Eligibility

Enrolment in an SHI scheme is mandatory for all Japanese nationals, as well as for foreigners officially residing in Japan. Specific eligibility requirements apply to each scheme, as follows:

Employee's Health Insurance (kenkô hoken)

To be eligible for affiliation with EHI, a person must be working full time at a company that has five or more regular employees. Some part-time employees are also included (JPS n.d.). Public-sector employees and maritime workers are separately covered. EHI also covers dependents residing in Japan if the dependent is financially supported by the insured and/or has an annual income below a certain level, earns less than the annual income of the insured or, in certain circumstances, less than the total financial support provided by the insured (JPS n.d.).

Citizens' Health Insurance (kokumin-kenkō-hoken)

Enrollees are comprised of the self-employed, unemployed, their dependents and retirees under 75 years of age. Any person, regardless of nationality, becomes eligible for the CHI scheme on the day that they obtain official residency status in Japan, and lose eligibility upon leaving the country or enrolling in another health insurance scheme.

Health insurance for advanced elderly (Koki Koreisya)

The AEHI scheme covers all persons, including foreign residents, aged 75 and over, regardless of their employment status and with no distinction made between the main contributor and dependents (Sakamoto et al. 2018; JHPN 2015). Individuals aged from 64 to 75 with certain disabilities are also covered by the scheme.

Long-Term Care Insurance (Kaigo Hoken)

All persons with formal resident status aged 40 and over are eligible for LTCI coverage and must pay contributions alongside contributions to one of the three SHI schemes (JHPN n.d.). Insured persons are divided into two categories: Category I is composed of those aged 65 and over who have unconditional rights to LTCI benefits, and category II is composed of those aged 40–64 experiencing age-related conditions such as stroke or Alzheimer's (Sakamoto et al. 2018; JHPN n.d.).

- Benefits

With the exception of LTCI, virtually all of the benefit services that are covered by the SHI plans and public assistance schemes are uniform in terms of service coverage and prices set. Over 5,000 medical and dental services and 17,000 drugs are listed in the MHLW fee schedule (Sakamoto et al. 2018). The fee schedule defines each item in detail and also sets the conditions of billing for each. For example, the fee for a first consultation may be billed only if the patient had not made a visit within the last 29 days or the doctor had not scheduled the next visit. The fee schedule is biennially revised by the MHLW following recommendations from the Central Social Insurance Medical Council [2]. Services listed include the following:

- hospital and clinic outpatient care services
- hospital and clinic inpatient care services
- primary and specialist services
- mental health care services
- therapy services provided by physiotherapists, occupational therapists and speech therapists
- most dental care services
- home care services provided by medical institutions such as visits made by physicians, nurses and therapists
- hospice care in all settings
- approved prescription drugs and materials such as artificial joints and stents

Treatments that are not included in the scope of the benefits include some forms of dietary treatments and medical treatment using advanced medical care techniques which have been approved for testing by the MHLW. These services may be delivered if the medical facility has obtained prior approval from the MHLW and the patient consents. When delivering the service, the medical facility must gather data on its efficacy and safety. Once the new technique is proven to be effective and safe, it is listed in the fee schedule. Health prevention and screening services are not listed in the fee schedule and their inclusion is determined by the health insurance plan, though the MHLW sets the basic requirements.

Long-Term Care Insurance (Kaigo Hoken)

The broad categories of benefits covered by LTCI are home care, day care, respite care, services at LTC facilities, equipment such as wheelchairs, assistive devices and home improvement such as ramps, and maintenance rehabilitation services (Sakamoto et al. 2018). Community-based preventative services are also included. The monetary amount of benefits provided to a beneficiary is determined according to the results of an assessment that evaluates a person's physical capacity and cognitive status, following which, the applicant is assigned one of seven levels of assistance, or declared as ineligible (Sakamoto et al. 2018; JHPN n.d.). The assessment is conducted using a standardized methodology that uses a questionnaire with 74 items to measure daily living activities and behaviours (Sakamoto et al. 2018) as well as further cognitive and behavioural questions. The results of the 74 assessment items are fed into a computer programme which sorts the applicant into one of the 7 levels of eligibility (or ineligibility). The results are reviewed by a Needs Assessment Review Committee established in each municipality, which reviews the statements made by the assessor and the opinion form completed by the attending doctor (Sakamoto et

[2] The Central Council deliberates and submits its conclusions to the Minister of HLW. The Minister then publishes the revised fee schedule in the official bulletin. The revision is then enforced from April 1, at the beginning of the fiscal year.

al. 2018). Those eligible then select a certified care manager, assigned by the insurer, who develops a care plan and coordinates service provision (Sakamoto et al. 2018; JHPN n.d.). Re-assessment is conducted every five years, or following a request due to a change in circumstances (JHPN n.d.).

There are ceilings on the amount of benefits that can be received from LTCI, determined by eligibility level (JHPN n.d.). If the beneficiary wishes to purchase more services, they can do so by paying out-of-pocket. Should the monthly co-payment exceed the amount set by their income level, the beneficiary may apply to have the amount exceeded reimbursed. In doing so, the co-payment for health insurance may also be taken into consideration. Low-income individuals may apply for additional exemptions (JHPN n.d.).

- Provision of benefits and services

Individuals enrolled in all of the statutory health insurance schemes can receive care from any medical provider (JHPN 2015). However, in exceptional circumstances, or for services listed in special programmes, services may have to be sought from designated providers (The Commonwealth Fund 2020). For example, patients with one of the 306 "difficult-to-treat" diseases must receive services from designated providers if they want to benefit from lower co-payment rates.

There were 8,442 hospitals, 101,529 clinics, and 68,940 dental clinics in the country in 2016, most of which were privately owned, with only about 15 per cent owned by the Government or government-affiliated entities (Sakamoto et al. 2018). LTC services are almost wholly delivered by the private sector, which has greatly expanded following the implementation of LTCI. For-profit providers are prohibited from participating in health care provision under the three main schemes, but are permitted to provide care under the LTCI scheme.

There is no strict referral system in Japan, and patients can access secondary and tertiary care facilities directly without a referral from a primary care specialist (Kato et al. 2019). Although guidelines require presentation of a referral letter upon a visit to a large hospital, patients can access services by paying an additional fee if they do not have a referral (Usui and Yamauchi 2019; JHI 2019; JHPN 2015). All patients enrolled in one of the SHI schemes (including LTCI) must pay co-payments when they receive health services (Sakamoto et al. 2018), with the exception of those on special programmes, such as those for victims of the atomic bomb. Those on public assistance are not enrolled in SHI and have all their costs covered.

The co-payment rate is generally set at 30 per cent of the service cost, while the remaining 70 per cent is covered by the insurance. For most enrollees of AEHI, the co-payment rate is 10 per cent, but for those with higher incomes, the rate is increased to 20 or 30 per cent (Sakamoto et al. 2018; Japan Ministry of Health, Labour and Welfare 2012). However, certain population groups have a lower co-payment rate. In particular, under school-age children and individuals between 70 and 74 years of age (unless they have an income at the same level as that of a working person) are charged a co-payment rate of 20 per cent or less (The Commonwealth Fund 2020; Sakamoto et al. 2018; JHPN 2015). For pre-school children aged below 7, the co-payment rate is 20 per cent. However, virtually all municipalities have expanded the age range and the co-payment rate.

There is no pre-determined waiting period for newly enrolled members before they can start benefiting from EHI coverage. Coverage for the eligible employee and his/her dependents begins on the first day of active work, as long as the enrolment procedure is completed within 30 days after being enrolled. For the community-based plans, they are enrolled in the CHI of their new residence. Both the EHI and CHI plans are legally required to start offering benefits immediately after enrolment.

Before accessing services, all patients must present a valid SHI card, which is accepted by over 99 per cent of health care facilities (JHI 2019). Persons aged from 70 to 74 also receive an Elderly Recipient Certificate (elderly benefits card) which may allow them to pay lower co-payments (SCH 2020). When accessing services from providers that do not accept SHI cards, or if a patient does not have a card when they receive the service, they must pay out-of-pocket for all medical expenses and then ask for reimbursement (JHI 2019). However, some providers may be willing to wait for the patient to show the SHI card. Patients must present their cards at the beginning of each calendar month. If a patient seeks care from a provider that does not accept SHI cards (which include services

from a health care provider outside of Japan), s/he has to pay the full cost of treatment and then seek reimbursement from his/her respective SHI insurer. In such cases, detailed documentation has to be provided, including an invoice and a doctor's certificate. The amount reimbursed in such cases is equivalent to that if the same services had been delivered in Japan.

There is a strict split of purchaser and provider functions in Japan. The service item and the price are uniformly defined by the fee schedule set by the MHLW, which applies for all SHI plans and public assistance programmes. The extra-billing and balance billing of services are strictly regulated. Most providers are paid on a fee-for-service basis but there are also some per-case and fixed monthly payments (The Commonwealth Fund 2020). Providers submit claims for reimbursement to the clearing houses at the beginning of every calendar month for the services delivered in the past month. The claims of patients enrolled in employment-based plans are submitted to Claims Review and Reimbursement Organizations (CRROs). For all other SHI plans, the claims are submitted to CHI organizations for review (Sakamoto et al. 2018). Before billing the plans, the claims undergo a review process by clinicians who are employed on a sessional basis (working about five days a month). Payment will be denied for any items which have been inappropriately billed. Compliance with billing conditions is inspected by the regional office of the MHLW. If medical records do not confirm compliance with the conditions of billing, then the provider is ordered to check the claims made in the past six or twelve months and return the amount that was inappropriately billed. The biennial revisions of fees and the conditions of billing of each item is fiercely contested when the MHLW negotiates with provider groups such as the Japan Medical Association (Ikegami 2019).

The fee schedule is established at national level and acts as a supply-side cost control measure (Sakamoto et al. 2018). In 2006, a diagnosis procedure combination per-diem payment system (DPC/PDPS) was established, in which a flat-rate per-diem fee based on the diagnostic and procedure group is made. The per-diem rate decreases as the length of stay increases. Each DPC sets three length-of-stay periods based on historical data. For example, the first period is set based on the number of days that the 25th percentile patient was discharged. These periods are individually revised for each DPC group based on performance (Ishii 2012). All of the claim data is recorded and stored in a national database, which aggregates information from all claims (Sakamoto et al. 2018).

▶ 4. Results

- Coverage

All those officially residing in Japan are covered by one of the statutory health insurance schemes. In terms of population coverage, EHI is the largest scheme, covering 55 per cent of the population in 2020, which is equal to 69 million people (Japan Ministry of Health, Labour and Welfare 2012). The CHI scheme covers 30 million people, or 24.2 per cent of the population — a figure which increased in the 1990s and the early 2000s due to increases in the number of unemployed persons (mainly attributed to the elderly after retirement), which put the scheme under a significant strain (Sakamoto et al. 2018). The introduction of AEHI led to the reduction of those covered by the CHI. In 2020, AEHI covered around 17.7 million individuals or 14.1 per cent of the population, with membership expected to increase as the number of the elderly persons in Japan continues to rise (Japan Ministry of Health, Labour and Welfare 2012). The number of elderly people requiring LTCI benefits is also on the rise, having increased from 2.2 million to nearly 5.7 million.

- Adequacy of benefits/financial protection

For all four schemes, the aforementioned range of exemptions or lower-co-payment rates helps to ensure better protection for vulnerable and disadvantaged categories of the population. Specifically, there are legal provisions for a postponement of and a partial or full exemption from co-payments for individuals who find themselves in difficult circumstances, and government subsidies for individuals with chronic diseases, disabilities or mental illnesses. Furthermore, those on public assistance programmes have the full costs of services covered. The fact that providers are paid at the same rate by the same fee schedule means that all are entitled to and receive the same quality and quantity of service.

There are thresholds on monthly and yearly OOP payment amounts, which vary based on the beneficiary's age and income; if the threshold is surpassed, the co-payment rate becomes 1 per cent for the amount surpassed (The Commonwealth Fund 2020; Sakamoto et al. 2018). This principle also applies if the annual combined health care and LTCI co-payments surpass the threshold (The Commonwealth Fund 2020). As a result, OOP private spending on health in Japan has remained relatively low compared with other OECD and high-income countries (WHO n.d.). This has resulted in Japan having the lowest risk of impoverishment from health care globally (Harvard Medical School 2020). However, the standard co-payment rate of 30 per cent for Japan's three main schemes is higher than rates in many other high-income countries (Shimazaki 2013).

However, a significant disparity has been observed between the EHI and CHI schemes, with CHI beneficiaries allocating a higher proportion of their annual income to OOP medical expenses than EHI beneficiaries. Furthermore, CHI contribution rates tend to be higher, despite the fact that the average annual income of CHI enrollees, many of whom are unemployed, partially employed or retired, is considerably lower than that of EHI members (Kido and Tsukamoto 2020). As such, CHI beneficiaries face greater financial risks, and are more likely to face difficulties in paying their health insurance contributions. Should they not pay, they will not be able to use their insurance until they have paid off all past premium contributions (Kido and Tsukamoto 2020). As a result of these challenges, it is believed that over 1 per cent of the Japanese nationals who are eligible for coverage are unprotected (Sakamoto et al. 2018). Another challenge in this regard is the exclusion of undocumented migrants from the coverage of the statutory schemes, which renders this group highly vulnerable to impoverishment from health expenditures.

Observers have also pointed to the possibility of greater financial risks for AEHIS beneficiaries compared to those covered by EHI, due to significantly higher average annual expenses among elderly members and higher premium rates (Kido and Tsukamoto 2020). Moreover, long-term care needs of the elderly tend to increase, while their incomes tend to decrease. While the LTCI scheme has shifted the financial burden of care-giving for the elderly from individual households to society, concerns have been raised about the capacity of the LTCI to compensate families for their opportunity costs (Sakamoto et al. 2018).

- Responsiveness to population needs
    - o Availability and accessibility

In general, services in Japan are available at affordable prices almost anywhere in the country (Sakamoto et al. 2018), which positively contributes to service utilization and equitable access to health care. However, as noted above, Japanese regulations have led to an exclusion of undocumented migrants (especially women and victims of trafficking) from social protection (SMJ 2010), which has contributed to an estimated 4 million people who live in Japan with limited or no access to health insurance (Kido and Tsukamoto 2020). On the other end of the spectrum, for those who are eligible for coverage, it has been observed that the high service availability and the comprehensive coverage offered by Japan's statutory health insurance schemes can lead to over-utilization in some cases, which has been partly linked to the absence of an effective gate-keeping system.

Some studies indicate that access to primary care remains an issue in Japan due to uneven geographical distribution (Kato et al. 2019). Certain prefectures were observed to have significantly fewer physicians than others, and the distribution of public hospitals was found to be uneven (Zhang and Oyama 2016). This is exacerbated as more workers and households move to larger cities in Japan, leaving many municipalities with a much smaller funding base (Sakamoto et al. 2018). Overall, according to latest estimates, Japan has 2.4 physicians per 1,000 people, which is higher than the global average (1.6), but lower than the average among high-income countries (3.1). On the other hand, the number of nurses and midwives (12.2) and the number of hospital beds (12.9) are both higher than the global average and the average among high-income countries (World Bank n.d.).

Regarding the availability of LTC, the introduction of LTCI has driven growth in this area, with the number of personnel engaged in LTC provision in Japan increasing more than threefold between 2000 and 2012 (OECD 2015). In 2011, there were over 2.5 million doctors, nurses, and other medical professionals engaged in the provision of LTC and over 2 million care workers (UNESCAP

2015), which is expected to increase to over 7.2 million by 2025. However, it has been noted that many LTC professionals face unfavourable employment conditions, which discourages certified care workers from pursuing LTC careers (Sakamoto et al. 2018). It has been projected that this could lead to a shortage of 300,000 LTC staff by 2025, and there is also evidence of a shortage of LTC facilities, especially in urban areas (JHPN n.d.).

- Acceptability and quality

Article 30-3 of The Medical Care Act No. 205 of 1948 obliges the MHLW to ensure a system that efficiently delivers good quality and appropriate medical care. As such, facilities in Japan are generally well-equipped and have advanced diagnostic tools and specialized facilities, although providers in some remote areas have been reported to face difficulties in this area (Sakamoto et al. 2018). To ensure quality remains high, prefectural governments carry out inspections of hospitals on an annual basis and the Government incentivizes voluntary reporting of quality-related indicators by hospitals on their websites (The Commonwealth Fund 2020). Furthermore Japan has a specialized, non-profit entity that provides accreditation to hospitals, though this is not mandatory and uptake is limited. The greatest driving force for improving quality is the payment system. For example, the fee schedule sets higher hospital fees if the hospital has higher nurse staffing ratios and the ratio of registered nurses to all nursing staff is 70 per cent or higher. Furthermore, physicians are paid an extra amount if they provide education in a systematic manner as defined by the fee schedule for patients with diabetes and other lifestyle diseases.

Evidence indicates that attention to the quality of health care has increased among the Japanese public in recent decades, and there has been greater demand for disclosure of information by health care providers (Matsuda 2019). A study based on data from Nationwide Patient Experience Surveys found that general patient satisfaction increased from 53.7 per cent to 64.7 per cent between 1996 and 2011 among inpatients, and from 48.1 per cent to 50.4 per cent among outpatients (Kawashima et al. 2015). A 2003 study concluded that waiting times in Japan were low compared to most other OECD countries (Siciliani and Hurst 2003). Waiting lists for services are not an issue in Japan, but the length of time that patients must wait after arriving at a health facility has been noted. A 2018 survey indicates that 47 per cent of respondents perceived waiting times at hospitals be too long (Statista 2021), and an earlier informal survey in one hospital estimated the average waiting time to see a doctor after arriving at the reception counter to be around 2 hours (Fujitsu Journal 2014). One reason for long waiting times can be attributed to the fact that Japanese patients prefer to go directly to hospitals, even when their health needs can be met by a primary health care provider (OECD 2015). This has been interpreted by some observers as a potential factor limiting the efficiency of the overall health care system (Kato et al. 2019).

Regarding LTC, the ability for users to choose and change their providers, along with the fee schedule requirements to maintain staffing levels in facilities and the qualifications of staff in community care have been major factors in maintaining quality. However, some studies have pointed to the lack of quality assurance mechanisms for LTC services (Yamamoto-Mitani et al. 2018). Furthermore, high staff turnover, inadequate skill development and inexperience among care workers has been noted as a set of challenges resulting from low wages, short-term contracts and unfavourable working conditions (Sakamoto et al. 2018). Aside from keeping the wages of workers low, other efforts of LTC providers to cut costs are likely to be affecting the quality of services.

▶ 5. Way forward

As evidenced by Japan's positive health outcomes, equitable population coverage, broad benefits package and high availability and quality of services, the health protection system in Japan is among the most developed in the world. Nonetheless, challenges remain. Moving forward, ensuring financial sustainability and efficiency in the context of diminishing revenue, without reducing the financial protection of the system, remains a priority for Japan. The development and institutionalization of new services tailored towards the needs of the rapidly ageing population may create opportunities for the optimization of care provision as well generating new income sources through employment creation (ILO 2017). However, it

is likely that structural changes to the existing health insurance system might also be needed. Between 2012 and 2018, there has been a trend towards consolidation, with the gradual transfer of fiscal management of residence-based schemes from municipalities to prefectures, although the premium contribution rate continues to be set by each municipality. Further consolidation could be envisaged to create a unified scheme with unified administration to improve risk pooling capacity and decrease operation costs.

To improve the system's functioning on the ground, the MHLW is currently leading a national initiative to strengthen medical education, increase the availability of primary care providers and to promote consultations with general physicians prior to visits to secondary and tertiary health care facilities (Usui and Yamauchi 2019). Furthermore, the Government is currently planning to establish a community-based integrated care system to ensure the provision of health care, nursing care, prevention, housing and livelihood support for those in need of LTC (Iwagami and Tamiya 2019). Notably, the MHLW has proposed the provision of incentives for LTC personnel, in addition to outsourcing some types of care to the community, promoting the development of the foreign workforce, and re-orientating LTC services to support the independence of the elderly (JHPN n.d.). However, for reforms to have effect, the fee schedules of the SHI and the LTCI schemes must be revised.

▶ 6. Main lessons learned

- Establishing effective health protection policy requires coherent and coordinated action to advance across population coverage, service coverage and cost coverage. In Japan, high population coverage is effectively combined with extensive financial protection measures to mitigate costs for patients, and a comprehensive health benefits package that is ensured through a uniform fee schedule. The fee schedule is the primary mechanism for promoting efficiency and equity.
- A fragmented health insurance system creates long-term financial vulnerabilities and weaknesses. In Japan, the large number of residence-based health insurance plans and the separation between employment-based and residence-based schemes results in financial imbalances, which has been further exacerbated by demographic and social changes. Japan has attempted to address this by introducing cross-subsidies and fiscal adjustment measures, increasing government financing of struggling schemes, and creating new schemes to re-adjust the distribution of financial burdens.
- Countries with aging populations need to plan early for health care cost reduction measures through the adoption of innovative health delivery and promotion mechanisms. Despite Japan's developed and well-financed health protection system, growing health care costs linked to aging pose a challenge. To contain rising health expenditures, preventive health care policies need to be developed and enacted (potentially with the use of new technologies) before the problem manifests itself.

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