The Transition and Characteristics of Japan's Healthcare System

Introduction

In Japan, there were many changes from 1940 in the areas of tax, the economy and other social systems. The Public health insurance and healthcare system in Japan is strikingly different from that of many countries. Japan's development experience in the health sector has shown-four aspects to be crucial to improving health, no matter where in the world. The purpose of this review is to enable emerging economies to better understand Japanese health insurance reform since 1961 so that it can be utilized as an example for the revision of other health systems. This first part of the case study summarizes the history and development trends of the administration of healthcare in Japan since the mid-1980s.

Overview of Japan's health system and its development

Japan has a healthcare system which is publicly funded and privately delivered. History has shown how Japan successfully managed to fully transfer public health insurance benefits within the country from the beginning, and later to extend it outside the country (JICA RI, 2005). Over time, Japan has experienced the common healthcare problems of rapid growth in healthcare costs, changes in disease structure from acute to chronic diseases, increasing demands for better-quality healthcare and greater choice and empowerment of patients. This transition can be divided into 5 phases which are explained

briefly below.

Phase 1

Healthcare reform has consistently been a heated political issue in Japanese politics. The first period runs from 1868 – 1919 where acute infectious disease control led to the establishment of a centrally directed epidemic prevention system and the collation of health statistics.

Phase 2

Phase 2 is the 1920 – 1945 period characterized by chronic infectious disease control and formation of maternal and child health services. The first Health Insurance Law was legislated in 1922, adding health benefits to some additional benefits which labor qualified citizens for and this formulation was based on the Japanese custom of 'managerial paternalism'. (World Health Organization, 2000, p. 12) Here, the country began taking gradual steps in expanding the insurance system and by 1958, the foundation of the current legal structure of Universal Health Insurance was adopted. Notable initiatives taken to improve the Japanese health system at that time included the initiation of a community-based approach to public health centred around public nurses.

Phase 3

After the Meiji restoration came a third phase characterized by a restructuring of the entire health administration from 1946 – 1960. This phase especially featured measures addressing post-war acute infectious diseases, chronic infectious diseases, maternal and child health, and sanitation. Trends in live birth numbers and fertility rates show that initially the total number of live births increased steadily on the whole, except during the Second World War. As seen in figure 3 (2017), the end of the Japan-China war marked the first baby boom period 1947- 1949, with the number of live births reaching a high of 2.6 million and meaning the overall fertility rate exceeded 4. However, from 1950 both rates fell rapidly. Vital statistics of Japan (2017) shows the crude death-rate history and highlights all the main causes of death in the Meiji, Taisho and early Showa eras as being highly infectious

diseases, but this changed markedly from about 1958.

The Japanese life expectancy at birth increased rapidly in the 1950s and early 1960s as a result of decreased mortality rates for contagious diseases in children and young adults, which was largely attributable to the government's strong stewardship in investing in key interventions for public health. Thus, it was at this time that a restructuring of how healthcare was administered emerged as necessary, and led to a community-based health approach to public healthcare services being established.

Phase 4

From 1961 – 1979, this period is famous for medical services expansion. Japan achieved universal health coverage of its population in 1961, just 34 years after the introduction of social health insurance.

During this time, lifestyle related diseases, traffic accidents, environmental pollution and occupational health issues dislodged contagious diseases as the main constraints being faced, and for which the universal health insurance coverage came into effect to better address.

Shifting trends are best picked out in the vital statistics, most especially in changes in the data for live birth rates and crude death rates. For example, the "Hinoeuma" (1966) superstition manifests as a marked low point in live births, notwithstanding its occurrence amid the gradually rising wave that characterized the second baby boom and had the fertility rate remaining above 2.0. This trend reversed in 1975 and has continued a downward trajectory ever since. Other discernible trend reversals include that for deaths caused by heart disease. This appears as a drop in 1994, but the fact that the rate rises in subsequent years indicates healthcare advances playing out as a 'lag factor.'

Deaths due to cerebrovascular diseases showed a similar pattern of decline after reaching an all-time high in 1970. However, pneumonia continuously occupied the fourth leading cause from 1975, and death rates for suicides have also been another main cause. (Director General for Statistics, Information Policy and Policy Evaluation, 2017)

On the other hand, history has also shown that the quality of life for an average Japanese has

significantly improved since the 1960s, due to development in medical technology and good health policies. (Kusago) Medical services were expanded and this marked the beginning of the national movement for better public health and medical services. Central Government led the way in promoting good practices, expanding on the early establishment of a solid social insurance system before World War 2, and then universal health insurance coverage, achieved in 1961, enabling the promotion of equitable health provision. Thus, Japan consolidated its health insurance system.

Phase 5

The last phase, covers 1980 until the present and is known as the challenging era of an ageing society (JICA RI, 2005). This phase is also known for rising inequity since the 1990s and the rapidly ageing population have had a big impact on the healthcare system and broader population health outcomes. It is during this time that policies now aim to reduce inequality in health coverage outcomes, strengthen primary healthcare, and improve coordination between hospitals and long-term care facilities to meet the needs of the aged population. These are the challenges facing the governing of healthcare provision.

The vital statistics of this phase show that malignant neoplasm, heart diseases and cerebrovascular diseases became the leading causes of death from 1958-2011. Cases of malignant neoplasm have constantly increased reaching an all-time high in 2017 and the number of deaths have been rising since1980. The median life expectancy increased such that even the declining rate of birth managed to remain above the rate of abnormal deaths over time. In addition, infant mortality rates are slowly decreasing. Consequently, the population increased for a while despite decreasing fertility, which is threatening to change the structure of the Japanese family.

The ageing population has become a regional burden as this comes with increased medical costs. By age group, the number of deaths of elderly people aged 75 years and older has since increased from 1980 and has been more than 70% of total deaths from 2012 (see figures 1 and 2 (2017), Heart diseases persist as the second highest cause since 1985, but cerebrovascular diseases values have

remained constant since 1991. Fertility rates have been decreasing year-on-year except for a slight increase in 2006, after the downward trend is re-established. All these point out the biggest challenge today reflecting the consequences of an ageing population.

The Public Health Insurance Scheme

The notion behind universal health coverage (UHC) is that every citizen should be able to access quality health services. Japan adopted this idea in 1961 and serves as a good example of a country with rapid economic expansion that has managed to achieve UHC. Noting that Japan was a relatively poor country in 1960 with low growth (see figure 4), adopting UHC meant that the country had to up its game, for domestic human health relied on commensurate economic health.

This public health insurance system stands on two legs which are:

- Free access
- The universal compulsory public health insurance

The scheme provides universal access, allowing everyone to receive consultations, medical treatments and medical procedures at any medical institution in Japan, with or without referral subject to a small co-payment fee. (Sakamoto, et al., 2018)

Everyone is obliged to contribute to a body (representative insurer) of the public health insurance according to the persons type of work. This has contributed to the outstanding health status of the Japanese, which ranks at the top of OECD countries in many categories. The scheme is relatively efficient, as Japan's favorable health status has been achieved with total healthcare spending that is below the OECD average as a share of GDP despite factors that tend to boost spending, notably Japan's relatively high income and large proportion of elderly. (World Health Organization, 2000)

Financing of the system

Initially, the healthcare expenditures in Japan increased much more rapidly than did the GDP during

the 1960s and 70s. This relative growth rate of healthcare expenditures was higher than the OECD average. But it was not far from the general OECD trends during the 1960s and 70s. Through the relatively high economic growth periods of the 1960s and 70s, healthcare expenditures also grew very rapidly in Japan. Later though, such trends changed considerably in the 1980s and 90s. Those decades saw healthcare expenditures in Japan grow more slowly than did GDP, and so its percentage of GDP decreased in the 1980s. This contrasts with the OECD average trends in healthcare expenditures, which still continued to grow faster than GDP in the same period, although the pace of growth substantially slowed down.

However, this situation reversed again in the 1990s as healthcare expenditures in Japan again began to grow faster than did GDP, meaning its percentage of GDP rapidly increased (7). This again contrasts with the OECD trends as a whole, which followed almost the same tendency in the 1980s. Such changes in trends of healthcare expenditures in Japan during the 1980s and 90s constitute the essential background to the deterioration of public health insurance finance and the resulting discussion about healthcare reform these days.

As a result, the percentage of healthcare expenditures in GDP in Japan increased from 3.0% in 1960 to 7.4% in 1997, almost a two-and-half-fold increase. The same figure in the OECD as a whole grew from 3.8% to 7.6% (twofold) during the same period. Japan experienced a little higher growth in healthcare relative to economy than the OECD average.

Healthcare is financed through Public Health Insurance covering the entire population. Economic development and universal health coverage through public health insurance has led to a rapid improvement in health outcomes in Japan. Now as a leading country with the highest life expectancy and the third-largest economy in the world, the overall health status of the Japanese population is markedly better than that of most other Asian countries.

The OECD data (2000) indicates that the total health expenditure increased substantially and accounted for 10.9% of the GDP in Japan in 2015 (ranked 3 among 34 countries), about two

percentage points above the OECD average. Direct out-of-pocket payments contributed only 11.7% of total health financing. The health insurance coverage rate was nearly 100% while the share of household consumption spent on out-of-pocket payments was only 2.2%, 0.6% less than the OECD average of 2.8%.

Currently, all the medical services are financed through the public health system and prescribed drugs are partly covered by the health insurance together with co-payments by the patients. (Kato, 2009) Figure 5 illustrates how the medical security system mixes social insurance, tax subsidies and some amount of out-of-pocket payment. Social insurance premiums account for less than 60% of Japan's total healthcare expenditures, and subsidies from both central and local governments account for more than 30%.

Japanese patients have freedom of choice

The World Health Organization (WHO) (2000) applauded Japan for ranking 7th in having one of the best healthcare systems worldwide. Patients with Japanese health insurance can go to any hospital, including doctors or hospitals. The transportation planning process is divided into two. Patients can go to any clinic for treatment other than clinical expertise. If the patient wants to go to secondary healthcare, he or she must bring a doctor's certificate. There are other options: in the case of free baby, emergency medical care, dental treatment, rehabilitation, family medicine and hemophilia, patients can go to any hospital without being referred.

Challenges and Constraints in the Health Sector

Despite the relatively low out-of-pocket payments, the key challenges in Japan are population ageing, rapid increases in chronic illness, escalating medical expenditure, contracting fiscal space, and pressures on the healthcare workforce. Reforms of the financing system and greater efficiencies in health systems will be necessary to sustain good health at low cost with equity in the future.

The two major challenges are:

(1) financial sustainability of and fiscal pressures on the healthcare system; and

(2) a rapidly ageing population.

In response, two major reforms carried out have been the merger of insurance societies into a single insurer system, and the separation of medicine prescribing from medicine dispensing.

The survey conducted by the Japan Nurse Association (1991) confirms that the utilization and healthcare expenditure by the individual are not affected by an individual's income level. Out-of-pocket expenses for copayments amount to only 12 percent of the total healthcare expenditure provided under the public health insurance system. Since rapid economic expansion (see figure 4), the costs of healthcare have remained low in comparison to other countries. A rise in public medical expenses was seen in 2014 and

Healthcare delivery in Japan relies heavily on private providers, who encourage demand for new, but sometimes not cost-effective, services and technologies not yet included in the public health insurance benefit package because they are not subject to fee regulation. As in other private sector dominated delivery systems, the referral system in the country does not function well, and patients prefer tertiary care hospitals. Tension between private providers and the Government (and the public health insurance system) has been substantial, and healthcare providers have been a stumbling block to healthcare reforms such as the prospective payment system. (Shibuya, et al., 2011)

However, population ageing and the increasing price of pharmaceuticals and medical devices has led to a consistent increase in health-related expenditures, while the decades-long economic stagnation has decreased the premium and tax revenue intended for use in the public health insurance scheme, resulting in an ever-increasing rate of health expenditure per GDP.

Increase in the elderly population

Major concerns over why the system needs to be reformed come from the unsustainability of the previous scheme when applied to the demands of the ageing populace. As shown in Figures 6 and 7,

the economic growth rate in the country has been substantially lower than the budgeted national medical expenditures. Increases in medical expenditure for chronic degenerative diseases, have become a large social burden.[(Matsuda, 2019), (Shibuya, et al., 2011)] Also the people aged 65 and above account for more than half of the total money spent thus the financial sustainability of Japan's universal coverage is under threat from demographic, economic, and political factors.

Regardless of the universal coverage of the population, financial protection and high out-of-pocket costs remain important policy challenges. Out-of-pocket costs still required for social insurance include co-payment for eligible services and full payment for services not included in the benefits package. Patients pay 20% of the cost of inpatient care insurance services and, depending on the level of the healthcare provider, an out-of-pocket care is applied to the difference. Public health insurance exempts the poor from copayments, reduces copayments for catastrophic illnesses such as cancer, limits the cumulative copayments based on income, and pocket payments are important policy matters. Therefore, high out-of-pocket payments have remained a key policy issue.

The traditional cost containment measures such as raising co-insurance rates have not been enough for the long-term stability and sustainability of the schemes. In Japan, comprehensive healthcare reforms have been discussed since 1997, when co-insurance of salaried persons in public health schemes was increased to 20% of total healthcare costs since the growth of healthcare expenditures exceeded the GDP growth in the 1990s. In 2001, the Ministry of Health, Labor and Welfare (source 11) made public that new reforms will be focused on the healthcare system for the elderly (source 10). Initially, though a lot of money had been spent on healthcare, it represented a relatively smaller portion of the country’s GDP in comparison with other OECD countries (Table.5). But, the ministry has increased this spending for the technology age and ageing population

Reforms in the public health insurance scheme

Reforms since the mid-80s which were proposed and implemented were focused on co-payments by the patients and social insurance contributions paid by the insured persons.

General tax, social insurance contributions and coinsurance and co-payments are the three main sources of funding for healthcare expenditures in Japan. Reforms since the mid-80s which were proposed and implemented were focused on co-payments by the patients and social insurance contributions paid by the insured persons.

Due to the continued upward pressure on expenditure, in part due to rapid population ageing, a drastic reform in the public health scheme was carried out in 2006. The most prominent feature being an increase in the co-payment rate to stimulate growth without which, the government say, would have squeezed the medical expenditures when a new system for the elderly started in 2008.

Furthermore, a debate in 2008 on the sustainability of healthcare and long-term care led to the passing of the "Comprehensive Reform of Social Security and Tax". This is a joint reform of the social security and taxation system that should improve fiscal sustainability for the Japanese social security system. The priority areas of the social security system are indicated to include measures for the support of children and child raising, increasing the employment rate of Japanese youth, reform of medical and long-term care services, pension reform, measures against poverty and income inequalities and measures for low-income earners as cross-system issues. The Comprehensive Reform of Social Security and Tax has remained a key principle for healthcare and long-term care policy in Japan. Since 2010, several related laws have been made under this reform to address current healthcare inefficiencies and inequalities.

Conclusion

An understanding of the system of administration for healthcare services in Japan can serve as an important model for developing countries that are still struggling in providing adequate healthcare for their citizens. It also offers insight into how Japan has historically managed to operate in addressing the needs of a growing population with later developments involving reductions of total fertility rates, long life expectancy at birth, reductions in tuberculosis and other infectious disease deaths, and the sustaining of relatively low out-of-pocket health expenditure. This review presents a

brief description of the transition and characteristics of Japan's healthcare system and its dramatic shift into the National Healthcare Insurance system in 1961. Investigating the practice casts light on how to come up with sound reform policies that might be emulated elsewhere and that are better able to help Japan deal with the now ageing society, low birth rates, new technologies, new immigration policies and other demographic changes.

References

Director General for Statistics, Information Policy and Policy Evaluation. (2017). *Vital Statistics of Japan.* Japan: Ministry of Health, Labour and Welfare. Retrieved from https://www.mhlw.go.jp/english/database/db-hw/dl/81-1a2en.pdf

Ikegami, N. (1991). JAPANESE HEALTHCARE: LOW COST THROUGH REGULATED FEES. *Health affairs, 10*(3), 87-109.

JICA RI. (2005). Japan's Experiences in Public Health and Medical Systems. *Japan System Reviews: Health Systems in Transition , 8*(1).

Kato, R. R. (28 May, 2009). *The Public Health Insurance Scheme and Its Reform in an Ageing Japan.* International University of Japan.

Kusago, T. (n.d.). *Japan's Development: what economic growth, human development and subjective well-being measures tell us about?* Osaka: Osaka University . Retrieved from http://www.happysociety.org/ppdoconference/session_papers/session12/session12_takayoshi.pdf

Matsuda, S. (2019). Health Policy in Japan – Current Situation and Future Challenges. *JMA Journal, 2*(1), 1-10.

Musgrove, P. (2011). *Financial and other rewards for good performance or results: a guided tour of concepts and terms and a short glossary.* Washington DC: World Bank.

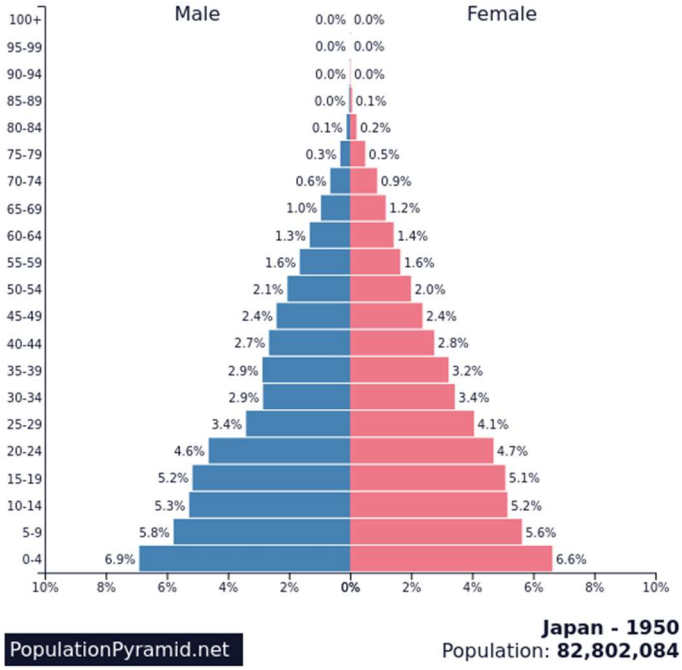
Sakamoto, H., Mizanur, M. R., Nomura, S., Okamoto, E., Koike, S., Yasunaga, H., . . . Ghaznavi, C. (2018). Japan Health Ayetem Review. *Health Systems in Transition, 8*(1).

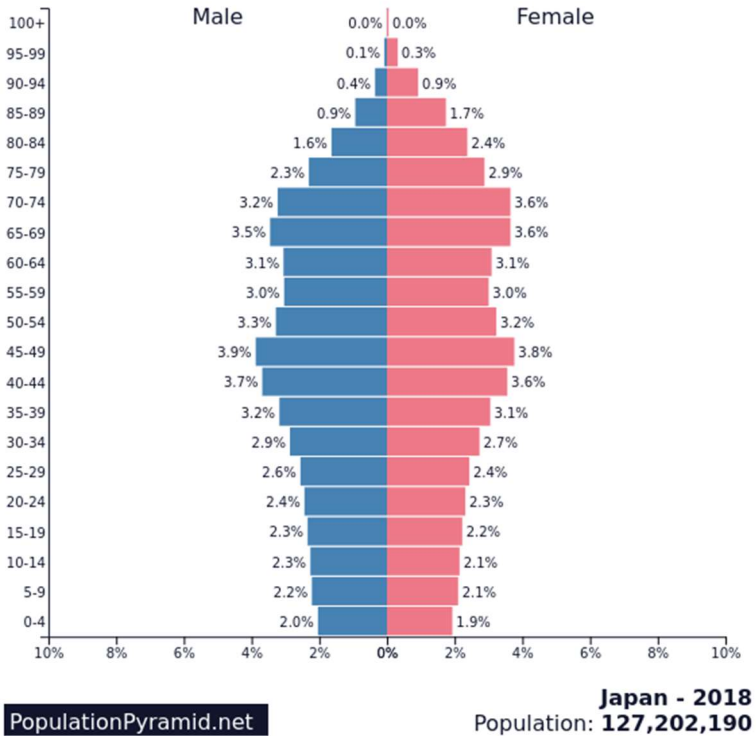
Shibuya, K. H., Ikegami, N., Nishi, A., Tanimoto, T., Miyata, H., Takemi, K., & Reich, M. R. (2011). Japan: Universal healthcare at 50 years 6: Future of japan's system of good health at low cost with equity: Beyond universal coverage. *The Lancet, 378*(9798), 1265-73.

World Health Organization. (2000). *Health Systems Improving Perfomance.* Geneva: World Health Organization.

Appendix

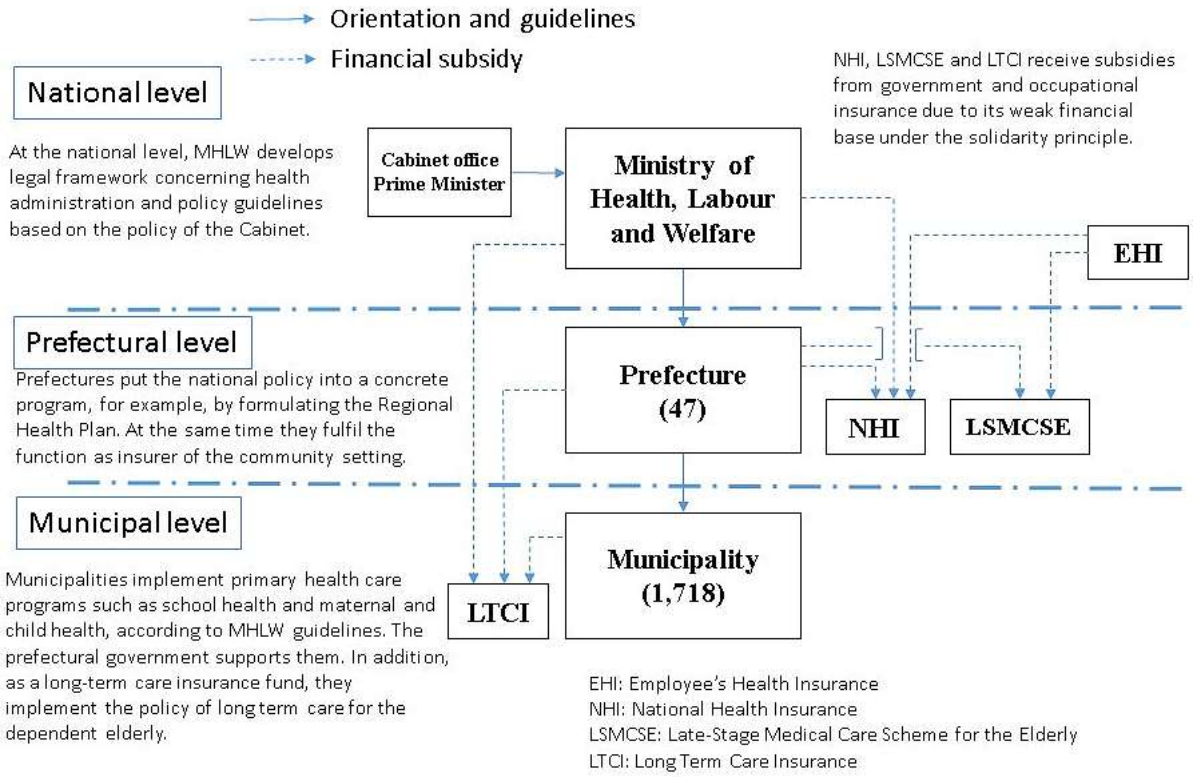
Figure 1: Comparison of Japan's 1950 and 2018 Population





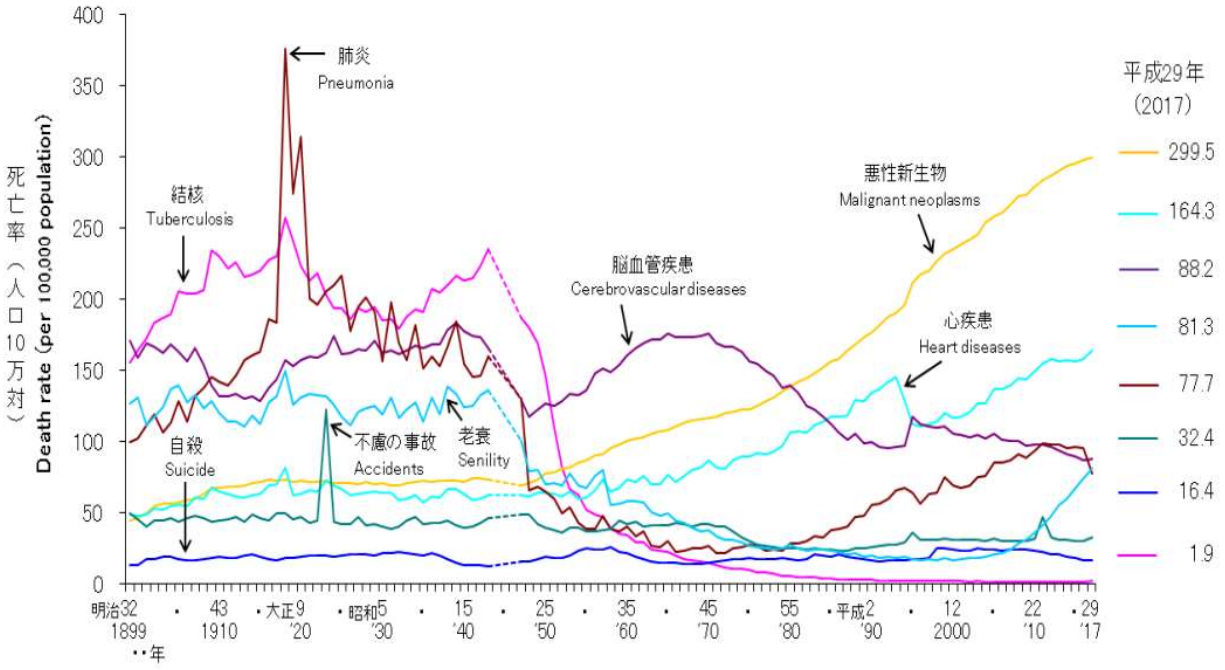
Source: (Population Pyramid, 2019)

Figure 2: Framework of public health insurance in Japan



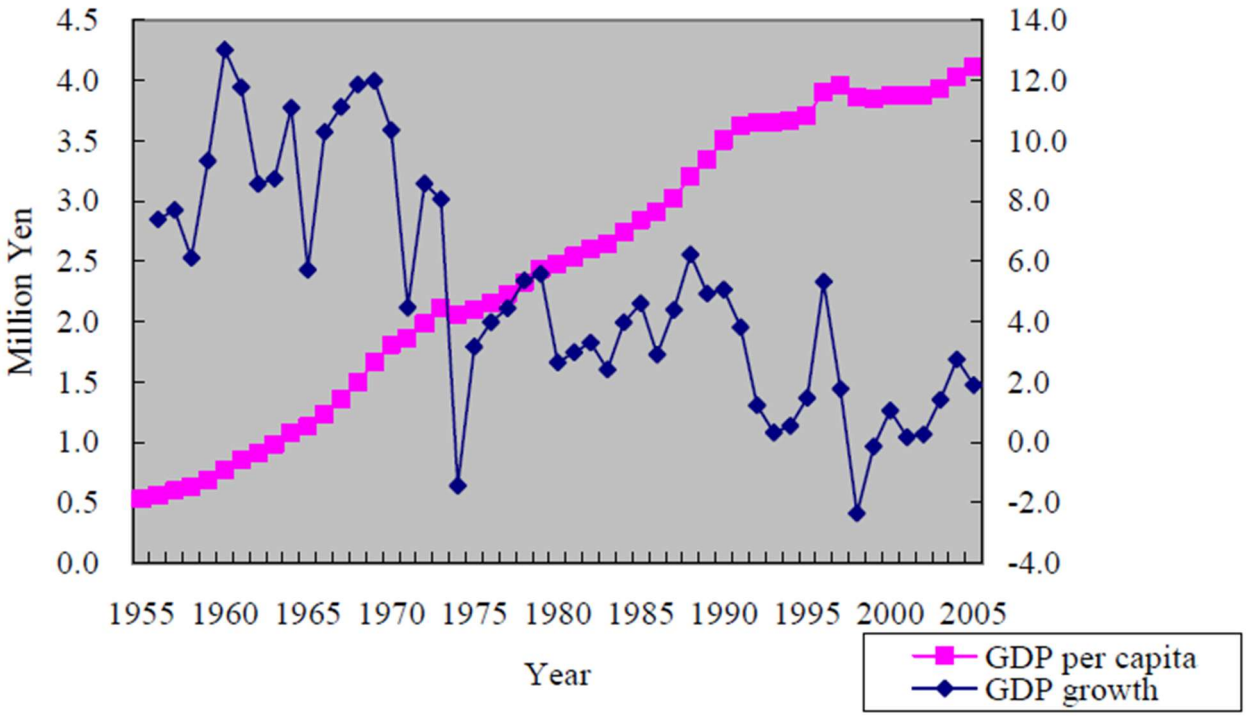
Source :(Matsuda, 2019)

Figure 3: Trends in death rates from leading causes of death, 1899-2017



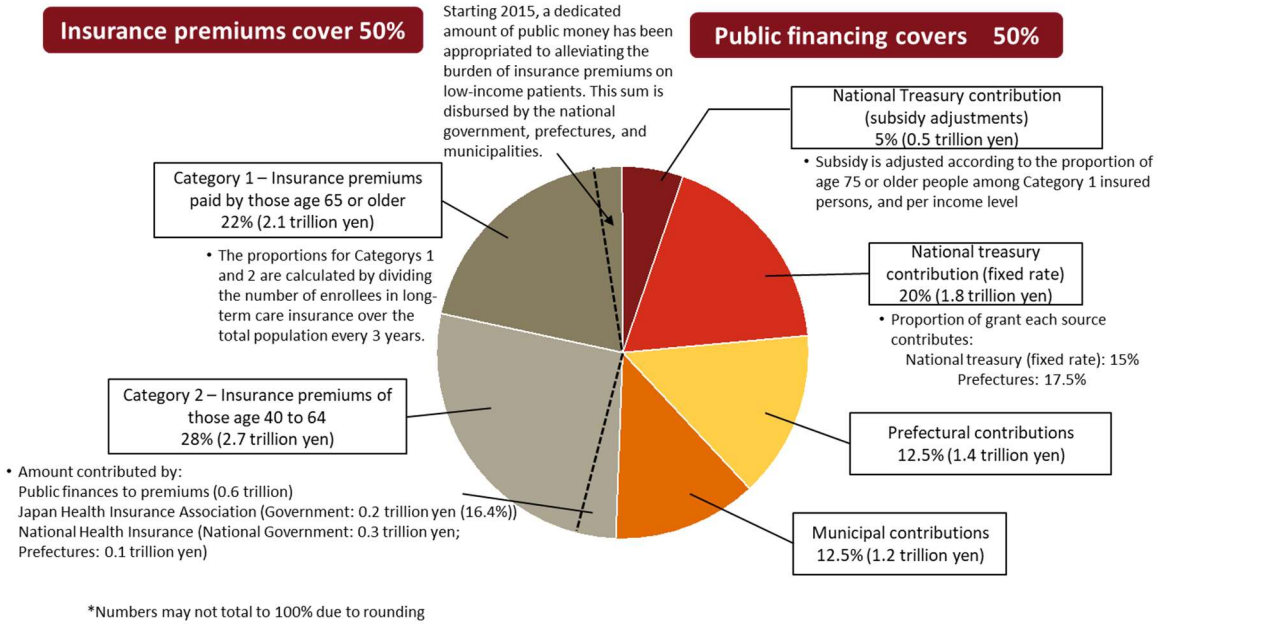
Source: (Director General for Statistics, Information Policy and Policy Evaluation, 2017)

Figure 4: Japan's economic growth pattern



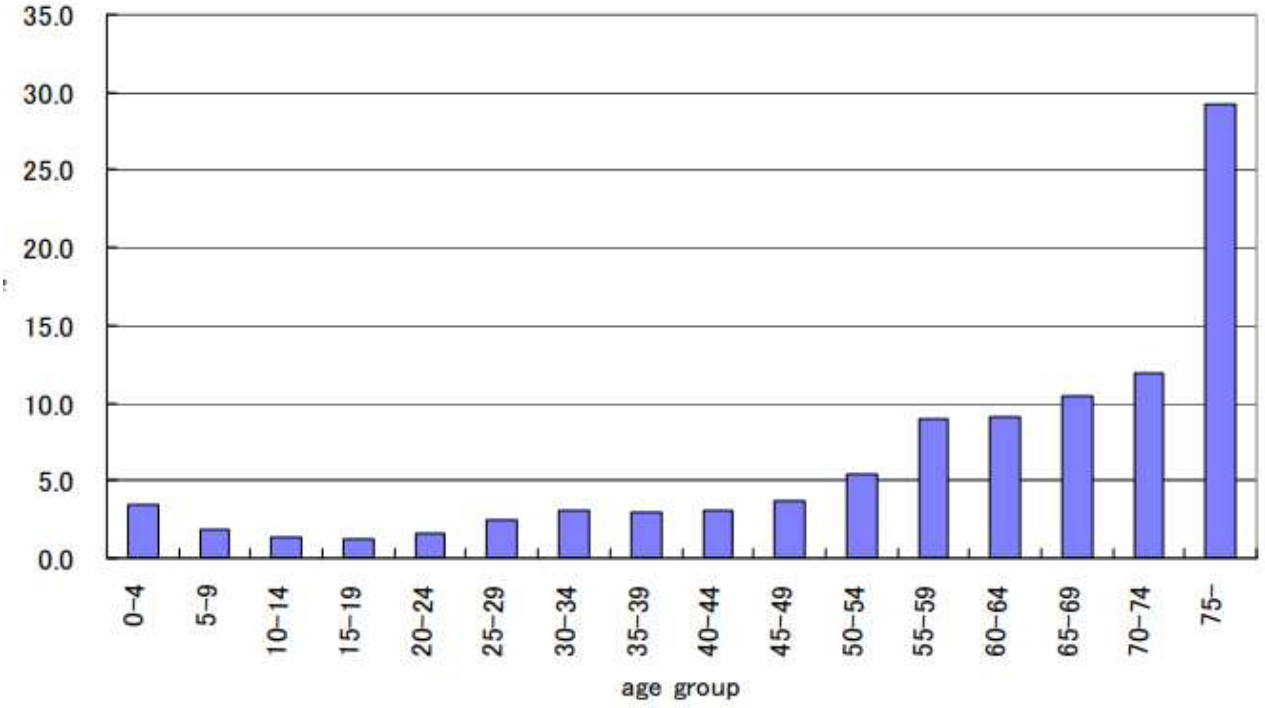
Source: (Kusago)

Figure 5: Long-term care insurance framework



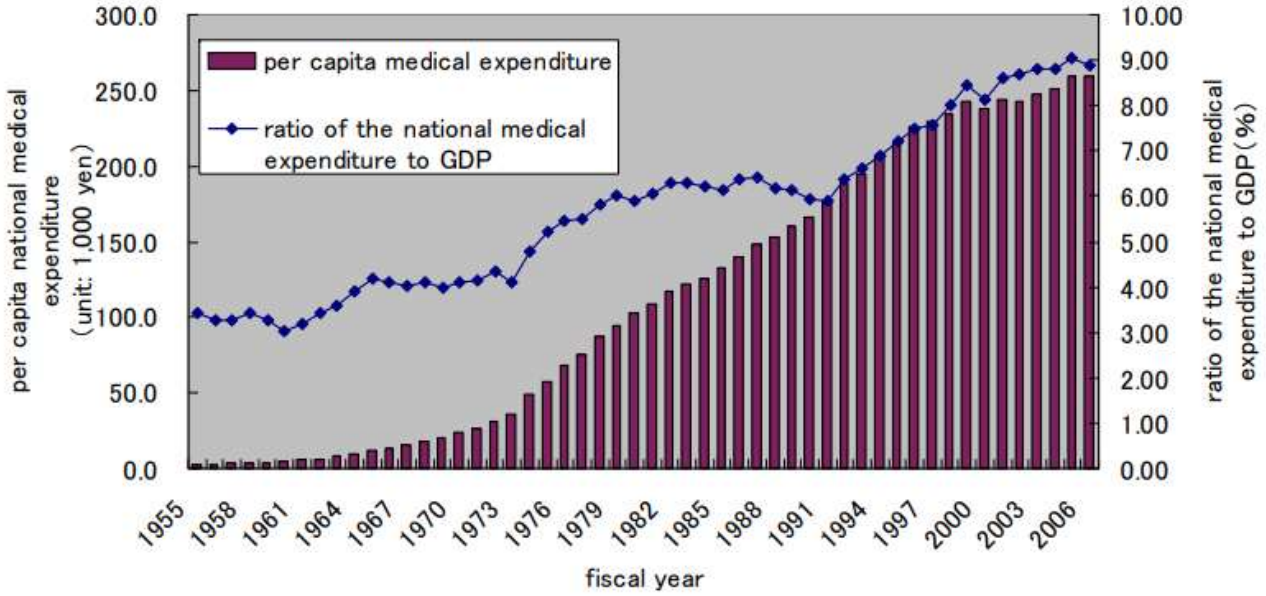
Source: Created by Specified nonprofit corporation Health and Global Policy Institute and PwC Consulting LLC, Strategy& based on data from the "Current state of nursing-care insurance system and its future role" report by the Ministry of Health, Labour and Welfare

Figure 6: Ratio of age groups to GDP in Japan



Source: (Kato, 2009)

Figure 7: Ratio of national medical expenditure to GDP in Japan



Source: (Kato, 2009)