Health Insurance Scheme for the Aged in Japan—Its Outline and Challenges—

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Abstract

In order to respond the expanding needs of health and ADL care for the aged, the Japanese government has implemented a series of health and social programs for the aged. The author thinks that the political populism is the most important cause of current difficulty of re-organizing the Japanese health system. For example, the introduction of free medical program for the aged in 1972 was decided as a result of political rivalry between the Ruling party and the left-wing Opposition parties. This program made our system too much medicalized and caused a rapid expansion of medical expenditures. The Long-term care insurance scheme (LTCI) was introduced in 2000 in order to de-medicalize the system by expanding home care capacity, but has not reduced medical expenditures as estimated before. In order to re-organize the system for the aged, the new scheme of health insurance for the aged has been introduced in 2008. However, just before the introduction of the new health insurance scheme, there started very strong opposition against the introduction of new scheme. Mass media launched a tremendous volume of negative campaigns and the Opposition parties has been criticizing the responsibility of government and Ruling parties. The two main points of critics are ageism and heavy financial burden for the aged, especially for those of lower economic status. According to the author’s perspective, the most important cause of mistake for the introduction of new scheme is insufficient consideration for QOL and clinical outcomes. The debate has too much focused on cost sharing and financial burden. The philosophy of social security policy must be QOL issue, not financial control. The well organized health insurance scheme for the aged must be one of basic infrastructures in order to construct an active aged society. More creative debate is necessary.

Key words: health insurance scheme for the aged, long-term care insurance, ageing society, Japan

Introduction

The very rapid graying of society is ongoing in Japan. It is estimated that the percentage of population over 65 years old will be over 30% in 2025\textsuperscript{1). Besides this very rapid ageing, the number of births has been decreasing. TFR (Total Fertility Rate) has become 1.34 in 2007\textsuperscript{2). This demographic change means the increase in users of social and health services and the decrease of tax payers, which requires the Japanese government to re-organize its social security system. In terms of social services for the aged, with fewer children, more women working, and changing attitude toward family responsibilities, the traditional system of informal care-giving is widely perceived as inadequate to take care of the increasing number of the frail elderly. In fact, about 40% of the households with elderly people are now so called “aged households”, that is, single old person’s household or old couple’s household. This situation naturally requires the socialization of care. In 2000 the Japanese government introduced the Long-term Care Insurance as a new scheme for the
frail elderly\(^3\). In terms of medical services, the increase of aged population means the increase of patients who need medical care. Along with the ageing of the society, the number of patients with cancer, cardio-vascular diseases and other life-style related diseases has been increasing. The recent advance in medical technology has made it possible to save the lives of acute patients, such as ischemic heart disease and stroke patients. As a result, such patients require acute medical care services and then following chronic care services. This situation naturally expands medical expenditures. As our previous study showed, the combination of ageing and advance of medical technology is the main cause of rapid increase of the medical expenditures\(^3\).

The basis of current health insurance scheme was established in 1961 when the Japanese population was young and average life expectancy was around 66 for male and 70 for female. The situation has changed dramatically. The Japanese government has launched a series of health care reform targeting the aged population. In this article the author will explain the history of Japanese health insurance scheme for the aged, actual debates and future perspectives.

**Japanese Health Insurance Scheme**

Japan’s universal health insurance system, which covers the country’s 127 million population, is segmented according to working status and age. The type of company one works for determines the insurance society to which one belongs and the financial contributions one must make. The health insurance scheme is categorized into two basic groups according to age and employment status; Employee’s Medical Insurance scheme (EMI) for employers and their dependants, and National Health Insurance scheme (NHI) for self-employed, farmers, retired and their dependant. Because the Japanese system allows free access, Japanese residents can receive medical services at any medical facilities with a modest co-payment.

Figure 1 shows the EMI scheme. The Health Insurance Law requires each enterprise to organize its health insurance fund. The contribution rate is about 8–9% of the salary and generally one half comes from the employee and the rest from the employer. In the case of a small company, the health insurance fund is substituted by the mutual organization with governmental subsidy (the Japan Health Insurance Association). When an insured person receives medical services at a medical facility, he has to pay 30% of the total cost as co-payment. The ceiling of co-payment is set in order to prevent too much economic burden of patients. The ceiling level differs according to income level. Each medical facility demands the reimbursement of the rest for the fund. In order to prevent an unfair demand for reimbursement and to realize an efficient administration, a reviewer organization in each prefecture can intervene between the medical facilities and funds.

Figure 2 shows the NHI scheme. The NHI is a scheme for the self-employed and the retired. The
NHI Law requires for each municipality (or their association) to organize its NHI fund and gathers a premium from the insured. The formula of calculation of the premium is different among the funds to some extent, but basically based on the income, the number of family members, and the amounts of other prosperities of each household. The average premium in 2006 was ¥78,671 per person per year. The relationship among patients, medical facilities, and the fund is the same as that of EMI. The ceiling system of co-payment is also same as in EMI.

The first health insurance scheme was organized by the Kurabo textile company in 1882 as a fringe benefit for the workers. This voluntary scheme had been adapted by other large companies. On the contrary the original NHI was created by the government in 1940. In those days the Japanese government was very worried about the health problem of males who would support the local economy as farmers and become soldiers. The main purpose of NHI was to improve the general health situation of the working population who did not covered by EMI. However, because of economic difficulty, the NHI did not function well.

After the Second World War, the government organized the universal coverage using the above mentioned framework. At first, the government established the Law of Health Insurance in 1946 that required for the companies to organize their own health insurance scheme for their workers and dependent families. Finally the government issued the Law of National Health Insurance in 1960 that required for each local municipality to create the NHI for their inhabitant.

As explained later, this difference of origin between EHI and NHI is one of the reasons for current confusion concerning the health care reform in Japan.

❖ Origin of Health Insurance Scheme for the Aged

Along with the economic development in 1960s, the living condition of general population was dramatically ameliorated. On the contrary, various social problems emerged, such as environmental problem caused by rapid industrialization, occupational accidents and diseases due to bad working conditions, ageing of local community due to large internal immigration from local to urban areas, and poverty problems of aged population who did not have any family and pension. In order to respond these situations, the national government established the Law of Welfare for the Aged in 1963. According to this law each local government organized various welfare services for the aged, i.e., home help services, nursing home. However, this law was too powerless to solve the above mentioned problems. The pressure for institutional services increased in rural areas because of rapid ageing due to the large scale internal emigration to urban areas.

In those days, there were the two important social movements influencing the health policy; communism and welfare government movement. Influenced
by the communism movement around the world, the left wing parties obtained large support from general population and become the ruling parties in some local governments. Some left-wing local governments such as Tokyo and Kyoto introduced the free-of-charge medical services for the aged. With the rapid economic growth in 1960s, it was not so difficult to maintain this very generous program. Furthermore, with a rapid economic growth of the Japanese company, the trade union asked to return more profit to the workers and to realize a welfare government.

The national ruling party of those days, the Liberal Democratic Party (LDP), considered that the popularity of left-wing local government and trade union was risky for their governance and finally decided to promote the welfare services. As one of these programs the government generalized the free medical services for the aged in 1973. As it was not necessary to receive a means test for hospitalization, this program was enthusiastically welcomed by the aged and their family. As a result, many frail aged peoples have been hospitalized in medical facilities not in social facilities, such as nursing homes and assisted living nor receiving the home care services at their residence, even though they do not require in-hospital medical services.

The Ministry of Health and Welfare (MHW) already recognized the difficulty to maintain this scheme. They tried to introduce the independent health insurance scheme for the aged with the separate fee schedule. However, the Japan Medical Association was strongly against such a scheme and finally this scheme was not introduced. It is quite natural that the elderly need more medical services although their income becomes less than before. Under the economic recession, most of the NHI funds faced severe financial difficulty. As a result, both local and central governments were obliged to financially support the NHI to an enormous extent, resulting in an immense deficit.

Finally the government decided to abandon the free medical services for the aged in 1983. There were tough debates among the related groups for the new scheme. For example, the MHW tried again to introduce an independent scheme for the aged with bundle type payment. This plan was strongly criticized by Japan Medical Association and finally abandoned. The All-Japan Federation of National Health Insurance Organization proposed a unification of public insurance schemes but this proposal was denied by EMI that was strongly against the increase of their contribution. Finally the cabinet of Prime Minister Hashimoto created a new scheme that was a mixture of various proposals. This was the medical care scheme under the Health Service Law for the Aged.

❖ Health Service Law for the Aged in 1983

In 1982, the government promulgated the Health Service Law for the Aged in which a special medical insurance scheme for the aged was created. Figure 3 shows the scheme for the elderly. The most important point was that the cost sharing between EMI and NHI was introduced under the principle of national solidarity in order to stabilize the financial basis of the fund. The fund created in each municipality receives 70% of the cost from EMI and NHI according to the established calculation formula, 20% from the national government, 5% from the prefecture and the rest from the local municipality. Different from the former free medical service scheme, an elderly patient was required to pay 10% of total cost (originally it was 500 yen for out-patient services and 400 yen per day for in-patient services). For the remuneration, the bundle type of payment scheme was introduced.

Another important point of this scheme was the introduction of health promotion program. The law required for each municipality to organize the health screening program and health education program for the inhabitant more than 40 years old. The cost of
these health promotion programs were equally shared by central government, prefecture and municipality.

The introduction of new law ameliorated the financial situation of NHI. But this effect lasted only temporally. The hospitalization of the aged was too much spread out around entire Japan to rationalize it. The health and social services for the frail aged have become too much medicalized and institutionalized. It is considered that this is the most important cause of today’s difficulty of reorganizing health and social facilities for the aged.

❖ Ten Year Strategy for Promotion of Health and Welfare for the Aged (Gold plan for the aged)

The Japanese industries overcame the economic difficulties caused by the two oil crises during 1970s by development of energy-saving technology, efficient production system by automation and computerization, change of industrial structure for high-value-added one, cost cutting and etc. Because of these efforts, the Japanese economy regained its vitality during 1980s. After the Plaza Accord, an agreement aimed at devaluing the US dollars, the Japanese government moved forward monetary relaxation and deregulation policy. This policy stimulated the internal demand and then caused the bubble economy.

This economic situation increased the tax income. Based on this favorable condition, the government tried to promote the welfare services for the aged. They established the Ten Year Strategy for Promotion of Health and Welfare for the Aged (Gold plan for the aged) for 1989 to 1999. This plan set the volume targets for welfare services, i.e., 100,000 of home helpers, 240,000 beds for nursing home, 10,000 institutions for day service, and 50,000 beds of short-stay. Total amount of budget was 6 trillion yen. In 1988, the 3% consumption tax was introduced in order to finance the welfare policy.

However, the situation changed drastically in the debut of 1990s. The government switched to a tight money policy in order to control the bubble economy. This policy was so much influential that the Japanese economy went into the recession mode. The land price and stock price decreased very rapidly. Because of this economic recession, it became very difficult for government to realize the target written in the Gold Plan.

In those days, the traditional system of informal care-giving was widely perceived as inadequate to take care of the increasing number of the frail elderly. There were many scandals concerning care for the aged, i.e., abuse and neglect targeting the frail aged by care-givers who were usually exhausted daughter-in-law and spouses. This situation naturally required the
socialization of care and the general population asked for the government to organize more feasible programs.

In order to solve this difficult situation, the Cabinet of Prime Minister Morihito Hosokawa proposed the increase of consumption tax from 3 to 5%. It was too sudden to be accepted by the general population. Finally the government was forced to promote the welfare services for the aged by other financing methods. In 1995, the German government introduced the Long-term Care Insurance. After the considerable researches, the Japanese government decided to create the Long-term Care Insurance as an alternative of tax based welfare services for the aged.

❖ Long-term Care Insurance in 2000

Figure 4 describes the LTCI scheme (Modified in 2006). The budget of the insurance is based on fifty percent from the general tax and another fifty percent from the premium of the insured. There are two types of insured; the first category of insured who are 65+, and the second category of insured that is between the age of 40 and 64. The first category of insured is asked to pay a premium deducted from pension or direct payment for insurer according to their pension status. In the case of the second category of insured, his or her premium is withheld from the medical insurance premium.

The benefit includes social welfare services such as home help and bathing service, stay in nursing home, as well as the use of medical services such as visiting nurses and institutional care in long term care hospitals. The eligibility process begins with the individual or his/her family applying to the insurer (usually municipal government). A two-step assessment process follows and determines the limit of benefit. The first step is on-site assessment using the standardized questionnaire. The result of questionnaire is analyzed by an official computer program to classify the applicant into one of 6 levels of dependency or to reject eligibility. The lightest level is “assistance required” which is subject to preventive services; the other five levels are called “care required”. The second step is the assessment conference by health care professionals. The conference reviews the classification made by a computer program by taking into account the descriptive statement plus a report from

Note 1: According to the modification of the law in 2006, the number of the eligibility levels has become seven. The former care required level 1 is divided into two levels; assistance required level 2 and care required level 1.
the applicant’s home doctor.

Each eligibility level entitles the applicant to an explicitly defined monetary amount of services. The recipient has to pay 10% of the cost as co-payment. Theoretically, users are free to choose services, but in reality, the care-manager who constitutes a care plan and a weekly time schedule of services, intervenes in this process and co-ordinates the services for the applicant.

Main objectives of LTCI are de-medicalization and de-institutionalization of care for the frail aged. In 2000, 600,000 aged were institutionalized, and 1,240,000 aged received home-based Activities of Daily Living (ADL) care services on monthly basis4). On monetary base, these figures correspond to 194.0 billion yen (1.94 billion USD; 100 yen=1 USD) to institutional care and 99.6 billion yen (1.00 billion USD) to home-based care in each month. Six years later, in 2006, the monthly average number of aged persons who received institutional care and home-based care increased up to 810,000 and 2,570,000, respectively. On monetary base, these figures correspond to 206.3 billion yen (2.06 billion USD; 100 yen=1 USD) to institutional care and 228.9 billion yen (2.29 billion USD) to home-based care. Even though the home care has been much advanced, the government considers there is still a room for promotion of home care.

❖ New law for the aged in 2008

Although the system constructed by Health Service Law for the Aged was evaluated “very sophisticated design under the solidarity concept”, insurers had been criticizing this scheme. The NHI complained that they could not afford to cover the large number of aged insured because of increasing low income insured persons. On the other hand, the EMI complained that they were suffering from a large amount of deficit because of solidarity contribution to the medical service scheme under the Health Service Law for the Aged. The large amount of contribution means the increasing labor cost for the employer. So Nippon Keidanren (Japan Business Federation) requested the health care reform to create a new health insurance scheme for the aged. There was no objection among the key players for the necessity of new scheme for the aged. In order to create a new scheme, a lively debate was sprung up since 1997. In 2000, the Japan Medical Association, the National Federation of Health Insurance Societies (EMI), All-Japan Federation of National Health Insurance Organizations (NHI) and academics made their proposal as follows5):

a) Independent insurance approach (Japan Medical Association): the establishment of a medical care insurance system independent from the various existing schemes to cover all aged. The 90% of cost is covered by tax and another 10% by contribution from the insured aged.

b) All-in approach (National Federation of Health Insurance Societies): Creation of a new insurer to cover former employees. Employees continue to join the scheme to which they belong before retirement. Cost to be covered by the employees’ insurance group as a whole.

c) Age risk adjustment approach (proposal from academics): Assuming the current insurers, the discrepancies in expenditures due to differences in age composition would be estimated by a specific formula and then the imbalance in liabilities between the insurers would be adjusted accordingly.

d) Unified approach (All-Japan Federation of National Health Insurance Organization): The creation of a single medical care insurance system by unifying the current individual scheme (EMI and HNI) to cover entire population.

The National Federation of Health Insurance Societies has been strongly against the age risk adjustment approach and the unified approach because of difference in income liability for contribution and high possibility to pay more contribution. For the independent insurance approach proposed by Japan Medical Association, it became a point of issue in dispute; the government and insurers questioned about feasibility of source of finance under the severe economic situation and future sustainability.

Finally they agreed to create the independent model referring the LTCI scheme as a compromised plan. A bill was passed in the Diet in 2006 and the scheme has been introduced in April, 2008. Figure 5 shows the scheme for the aged more than 75 years old.

❖ Debate on the new scheme and future perspective

Just before the introduction of the new health
insurance scheme on April 2008, there started very strong opposition against the introduction of new scheme. Mass media launched a tremendous volume of negative campaigns and the Opposition parties such as the Democratic Party of Japan and the Japanese Communist Party have been criticizing the responsibility of Liberal Democratic Party. The two main points that these parties have been criticizing are ageism and heavy financial burden for the aged, especially for those of lower economic status. Some politicians have criticized that there is no such a health insurance scheme that separates the population according to the age category. Apparently this criticism is misleading. The US Medicare scheme is the public health insurance for the aged. As Figure 5 shows, the new scheme employs the cost sharing of medical expenditures between the aged and working population under the principle of national solidarity. In this meaning, the scheme does not seem to be a product of ageism. The point must be the financing method; that is tax based or insurance based.

In terms of services covered by the scheme, the chronic disease management type of services is introduced. It seems that the government has tried to introduce the British type of primary care scheme in order to balance the cost and outcome. As this scheme limits the reimbursement for the physicians, the Japan Medical Association is strongly against it. Some academics point out that such scheme has a possibility to cause the under-treatment. Considering these critics, the government has made it possible for doctors and patients to choose the same tariff schedule as that for younger generation. It is very important to recognize that the Japanese government seems to have an intention to introduce the primary care model for caring the aged.

It is no doubt that the Opposition parties used the new scheme for the aged as a tool for attacking the ruling party LDP. Under the aged society, the aged generation is stakeholder for the election. However, the author thinks that this kind of populism among the politicians is very problematic and harmful for the future of Japanese society. If the government introduces a more generous scheme for the aged, i.e., free medical services for the aged, the future working population will not be able to support the system. With fewer working population because of decreasing Total Fertility Rate (TFR; 1.3 in 2007) and increasing unemployment rate among the young generation, such a generous scheme will be a too heavy burden for them to support. In this point, the government and politicians have to explain the reality with a concrete data. Apparently they have not been doing sufficient effort of communication with general population. With a rational explanation, most of the aged will be able to realize the situation. We absolutely need a powerful and capable politician with strong leadership who can
show us a clear future vision with concrete strategy and plan that will be better than today.

Some researchers point out the similarity of new scheme with LTCI. According to their explanation, LTCI is accepted by the aged very well and so the aged will accept the new scheme if they understand the similarity of financial mechanism of two schemes. The author does not accept this perspective. The most important problem of new medical insurance scheme for the aged is that the scheme has been explained only from the financial point of view not from the point of quality of life or clinical outcome. In the case of LTCI, the aged can expect a newly introduced ADL services that would ameliorate their QOL, because the ADL care was a really big concern for them in those days. With new medical insurance scheme, what kinds of new services can they expect in order to ameliorate their QOL and clinical outcome? Maybe no answer is prepared by politicians and the government. I think this is the real problem behind the current opposition by the aged. As Prof. Montague suggested, the health reform must make the situation better. If not, any reform cannot be accepted by the population.

❖ Conclusion

As explained above, the author thinks that the most important cause of mistake for the introduction of new scheme is insufficient consideration for QOL and clinical outcomes. The debate has too much focused on cost sharing and financial burden. The actual principle for cost sharing does not seem fatally problematic. In order to support the aged, some kind of cost sharing between the generations must be necessary. However, the government posed too much importance on explanation for the cost containment. It is thought that the origin of current strategy of MHLW has been the famous paper of Mr. Yoshimura, a former director of MHLW, so called Rupture of national finance due to expanding medical expenditures. In this article, he explained the necessity of program that limits the increase rate of medical expenditures within that of Gross Domestic Product. With rapid ageing and emerging concern about quality of care, this financial limitation cannot be maintained.

As Prof. Montague suggested, a new scheme must be the situation better than today. This requires a better health management system for the aged. The aged are suffering from multi-morbidity and ADL problems. This situation requires a well organized primary care services that cover both medical and ADL needs. In this meaning, the traditional solo practice of physicians seems to face to difficulty to respond this requirement. Furthermore, the services must be seamless between institution and community, and between medical and social. In United Kingdom, medical services have become to be delivered under the concept of primary care (Primary Care Trust) and integrated care (Social Care Trust). The new scheme for the aged must be such a system that will promote primary care and integrated care. The provider group is also required to construct some proposals in order to realize this vision.

Considering the actual socio-economic situation, it is an urgent task to re-construct the system. The year 2012 when both of medical insurance scheme and LTCI scheme will be revised, must be a big year for the Japanese social security system.

❖ References