THE SYSTEM OF MEDICAL CARE INSURANCE IN JAPAN AND ITS DISTINGUISHED CHARACTERISTICS

*ANONG ROJVANIT**

Medical care insurance is not a new thing in Japan, the first law of medical care insurance for general workers was promulgated in 1922 and the law of medical care insurance for the self-employed workers other than the general employees was established in 1938. However, it is with the rapid high economic growth achieved in Japan after the end of the Second World War that these laws were expanded substantially. The expansion of the medical care insurance for the whole nation was completed in 1959 when the law of medical care insurance for general residents not cover under any other insurance plans was amended and enforced in 1961. Since then, the whole population has been covered by either one of the medical care insurance plan in the country.

* Lecturer, Faculty of Economics, Thammasat University.

The present medical care insurance system may roughly be classified into two categories : one is employees' medical care insurance (the employee himself is the insured person and his family dependents are also covered), and the other is community medical care insurance which is to cover self-employed persons and other general publics. As for employees' insurance, there is first of all, the extensive medical care insurance system for employed persons in general, called Health Insurance (HI). HI is further devided into two parts--namely, Government-managed health (insurance GHI) mainly for employees of small-and-medium-sized enterprises with the National Government serving as insurer, and Society-managed health insurance (SHI), for which the Health Insurance Society jointly organized by management and employees of a big enterprise or of a group of enterprises in the same trade serves as insurer. Secondly, there are medical care insurance plan for employees in particular fields of work--that is, Seamen's Insurance (SI), Day-Laborers' Health Insurance (DLHI), and four Mutual Aid Associations for national public service, local public service, public corporation employees, and private school teachers and employees.

The community medical care insurance is called National Health Insurance (NHI), and it is for those persons who are not covered by any of the above-mentioned insurance plans for employees. It is managed by either local authorities (cities, towns or villages) or National Health Insurance Associations, each formed by a group of people engaged in the same occupation, such as farmers and doctors. The details of classificatian of medical insurance plans are presented in Table III-1, and the number of insured persons under these various plans are also shown too. It can be observed that, in general, the system of medical care insurance in Japan has been largely formed and developed on a group-by group basis centering on places of work. Coverage, benefits--with emphasized on medical benifit--and financial resources, of each insurance plan shall be discussed in the following section.

(I) Employees' medical care insurance

1. Health Insurance (HI). Estabished by Basic Act No.70, of April 1922, HI is the insurance plan for employed persons in general. HI is devided into two parts, GHI for employees in small-and medium-sized enterprises and SHI for employees in big enterprises.

GHI is mainly for working places where five or more persons are employed with the National Government serving as insurer. The plan covered approximately 31 million insured persons and their family dependents in 1982.

SHI has the Health Insurance Society serving as insurer. The Health Insurance Society may be established by an employer or bu employers jointly, that employ normally more than 300 employees, with the consent of more than half of the employees, upon approval of the Minister of Health and Welfare. However, the Minister of Health and Welfare may order any employer who normally and consistently employers 500 or more employees on the payroll in one, two, or more places of work to establish a Health Insurance Society. SHI covered 28 million insured persons and their dependents in 1982.

The original HI Act has been amended 57 times up to March 1981 since its enactment in 1922, resulting in a broad expansion of coverage and improvement in insurance benefits.

Coverage

All persons employed in places of work such as places where the manufacture of goods, mining or the sale of commodities is carried on or in the offices of the Government or corporations, where in all cases five or more persons are normally employed, are compulsorily insured, regardless of their earnings and properties. Almost every kind of work is covered. There are several exceptions, namely, persons employed in agriculture, forestly, fishery, restaurants, and hotels.

Benefits

(1) Benefits in kind or medical care benefits. For the insured persons, in the event of sickness or injury due to non-occupational causes, the insured is entitled to medical care benefits in kind from any of the medical care organization under contract with the insurer. The medical care fee is in the charge of the insurer except for a small amount of partial cost-sharing born by the insured person at the time of the first consultation and of hospitalization and clinical service. Partial cost-sharing was adopted in 1943, and is 800 yen in case of the first consultation, and 500 yen per day for the period of one month in case of hospitalization and clinical service thereafter there is no partial cost-sharing. There is no limit of medical care benefit duration since 1963.

Medical care benefits includes

(a) medical consultation fee,
(b) supply of medicines and other therapeutical materials,
(c) medical treatment, operations and other therapentical care,
(d) hospitalization and clinical service,
(e) nursing, and
(f) transportation.

Medical care benefits for the same sickness or injury or from a disease resulting therefore shall be given until recovery.

Medical care benefits for their family dependents are granted in kind as with the insured persons. However, the beneficiary must pay 20% of the cost for in-patient care and 30% of the cost for out-patient care. Partial payment for in-patient care was 30% until March 1981. It was decreased to 20% by the amendment of the Basic Act in 1980.

The word "family dependents" under HI, and also other insurance plans in Japan, has a very broad meaning. It includes lineal ascendents, spouse (including unregistered marriage cases), children, grandchildren, younger brothers and sisters of the insured person mainly supported by him, and any relative of the insured person to the third degree living under the same household and mainly supported by him.

(2) Cash benefits include sickness and injury allowance, delivery expense, maternity allowance, child care allowance and funeral expense. Cash benefits are granted to both the insured person and his dependents

(3) High cost medical care benefits. This system was introduced in 1973, when the partial cost-sharing of the insured person or the partial payment of the dependent for medical care is very high, the difference between that amount and the partial cost-sharing required shall be reimbursed to the insured. The high cost medical care cost was set at 39,000 yen in 1974 and it was changed to 51,000 yen in 1981. However, this is applied for one illness per a month only. This standard amount is reduced to 15,000 yen for the low-income insured and his dependents, (A low-income insured person

is one who is not levied the municipal tax or who receives the daily life security benefits.)

Finances

HI is financed from contributions paid by the insured person and employer, and national subsidy.

(1) Contribution

The contribution is calculated by multiplying the monthly standard remuneration of the insured persons by a certain contribution rate. The amount of the monthly standard remuneration under HI is classified into 42 grades at present, form the lowest amount of 30,000 yen to the highest amount of 470,000 yen. The contribution amount is in principal shared by the employer and the insured person. In the case of GHI, the contribution rate is 8.5% as of October 1981, and the amount is shared by the employer and the insured person in equal proportion. The Minister or Health and Welfare may change the contribution rate under GHI within the range of 6.6% to 9.1% after consultation with Social Insurance Council.

In the case of SHI, the contribution rate is determined under the provision of the Articles within a range from 3% to 9.5% upon the approval of the Minister of Health and Welfare. The average contribution rate was 7.947% as of March 1981, of this an average of 4.556% is shared by the employer and an average of 3.392% is shared by the insured person. However, the rate for the insured person may not exceed 4.5%.

In 1978, the imposition of a special contribution from the so-called 'bonus' was newly introduced. Under the GHI, its contribution rate is 1% and the amount of contribution shall be in principal shared by the employer and the insured person in equal proportion, but the National Government subsidizes two-fifth of the amount of contribution shared by the insured person. Under the SHI each society can determine whether to impose a special contribution or not, and it rate is determined in accordance with the Societies' Articles within 1%.

The employer is responsible for payment of contributions of both the employer and insured person, and is authorized to deduct the amount equal to the contribution of the insured person from wages paid to him.

(2) National subsidy

All the medical insurance plans are in financial difficulties. As a result of amendment of the law in 1973, financial operation of HI was turned to a favorable condition by the strengthening of its financial base with national subsidies and increases in contributions by the insurers. But as medical care expenditure is still increasing, the stability of its finances has not yet been secured.

The administrative expense of the plan is to be borne by the National Government, and since 1978, the national treasury has born 16.4% of the expenses for the medical care benefits, sickness injury allowance, maternity allowance, and benefits for high-cost medical care under GHI. For SHI, a fixed amount for aid to medical care benefit is also subsidized by the Government, and it was 1.5 billion yen in 1981.

2. Day-Laborers' Health Insurance (DLHI). Established by Basic Act No. 207, of August 1953, DLHI is one of the three medical care insurance plans for employee in particular fields of work.

Coverage

The insured persons are day-laborers defined in the Basic Act :

(a) Persons employed on a temporary basis, by the day or for less than two months;

(b) Seasonal laborers employed for less than four months;

(c) Persons employed at work of a provisional nature for less than six months.

The above-mentioned laborers shall be compulsorily insured if they are employed in places of work which is under the application of the DLHI Act, or employed in the working places for public enterprise or for under-employment policy enterprise.

Benefits

Medical care benefits are almost the same as those of the HI plan, the insured person need only to share a small partial cost-sharing to the medical care organization at the first visit which is 100 yen at present, and this amount is decided by the Minister of Health and Welfare within the limit of 200 yen. Medical care benefits include all types of medical care, dental care, hospitalization, nursing and transportation which are granted for five years from the first day of treatment. In addition to these benefits, sickness and injury allowance, maternity allowance, delivery expense and funeral expense are granted as cash benefits. To be eligible for insurance benefits, the insured person has to pay the contribution for more than 28 days within 2 months or for more than 78 days within 6 months immediately proceding the application for the benefit.

The insured person's family dependents shall pay 30% of total medical care cost as the partial cost-sharing.

If the amount of medical care cost of the insured person or his dependent exceeds 39,000 yen in a month, i.e. a high-cost medical care case, the difference shall be reimbursed to the insured person afterwards.

Finances

DLHI is financed by contributions paid by the insured persons, employers, and national subsidy.

(1) Contribution

The contribution is calculated on the basis of daily earnings. The contribution is fixed according to the daily wage devided into eight classes, which shall be shared by the employer and the insured persons. The contribution rate ranges from 60 yen to 660 yen.

(2) National subsidy

The national treasury bears the managing expense within the limit of the budget and 35% of the benefits expense.

3. Seamen's Insurance (SI). Established by Basic Act No. 73, of April 1939, the plan is a comprehensive insurance plan for seamen, covering occupational as well as non-occupational risks of sickness and injury, unemployment, invalidity, old-age and death.

Coverage

A person employed by a shipowner as 'seamen' as defined in the Mariners' Act shall be insured compulsorily. The seamen prescribed in this Act are captains, seamen, and reserve seamen on board the vessels of Japanese nationality or other vessels designed by Cabinet Order. However, the crews on board the following vessels are excluded : vessels under five gross tons; vessels sailing on lakes, rivers or only within a harbor; and fishing boats under 10 gross tons, excluding boats prescribed by Cabinet Order.

Benefits

Medical care benefits are granted in the event of sickness and injury, regardless of

causes, to the insured person and his family dependents, and the persons formerly insured if the sickness or injury originated before his disqualification as an insured person.

Medical care benefits under SI are almost the same as those under HI. However, hospitalization or supply of food and necessary lodging for medical care at the Seamen's Home designated by the Commission of the Social Insurance Anency are included as medical care benefit. The insured person shall pay :

(1) 800 yen at the first consultation to the medical care organization,
(2) 200 yen in case of a commuting accident,
(3) 500 yen per day for the duration of one month in case of hospitalization as partial cost-sharing. No such liability is needed in case of occupational disease or injury.

There is no limit to the duration of the medical care benefit. However, in the case of non-occupational sickness or injury, the duration is limited to 5 years from the day treatment commences if the person is disqualified as an insured person.

Benefits for high-cost medical care of the insured person and for the medical care fees of dependents is the same as for HI.

Cash benefits include sickness and injury allowance, delivery expense. maternity allowance, and funery expense are also granted to the insured person and his dependents.

Finances

SI is financed from contribution shared by the insured person and the shipowner, and national subsidy.

(1) Contribution

The amount of contribution is calculated by multiplying the contribution rate to the monthly standard remuneration of the insured person. As to the occupational accident comp compensation, the shipowner must contribute the whole rate, insurance other than the occupational accident compensation the rate is shared by the shipowner and the insured person in equal proportion. The amount of the monthly standard remuneration under SI is classified into 36 grades at present, from the lowest 45,000 yen to the highest 440,000 yen. And the average contribution rate is 7.2% in 1981.

(2) National subsidy

The national treasury bears the administrative expenses of the SI plan within the limit of the budget. Since 1957 the national treasury has also subsidibed a part of the expenses for the medical care benefits within the limit of the annual budget, and it was two billions in 1981. However, there is no national subsidy to the expenses for the occupational accident compensation.

4. Mutual Aid Associations (MAA). There are four MAA; National Service MAA (NSMAA, under the jurisdiction of the Ministry of Finance) established by the basic Act No. 69 in 1948, Local Public Service MAA (LOPSMAA, under the jurisdiction of the Ministry of Autonomy) established by the basic Act No. 152 in 1962, Public Corporation Employees' MAA (PCEMAA, under the jurisdiction of the Ministry of Transportation, Finance and Postal Service) established by the basic Act No. 134 in 1956, and Private School Teachers' and Employees' MAA (PSTEMAA, under the jurisdiction of the Ministry of Education) established by the basic Act No. 245 in 1953. The aims, functions and the benefits of these associations are almost the same, and the benefits are similar to those under the HI plan. Each plan covers the members and their dependents

for sickness, injury, invalidity, death, delivery, retirement and disaster, in order to compensate economic loss resulting from non-occopational causes and furnishes the welfare facilities for them. Here the NPSMAA plan shall be used as the representive of all the MAA plans and described in detail.

Coverage

Persons employed to be in charge of Government business and paid wages from the national treasury shall become compulsory members at the time of taking their posts.

Benefits

Medical care benefits are the same as those provided under HI for the insured person and their dependents. Cash benefits are also granted.

Finances

Each MAA plan is financed by contribution and national subsidy.

(1) Contribution

The rates of contribution are determined by each MAA in its articles, at present they range from 6.05% to 11.85%. The contribution is borne by the members and the Government in equal proportion.

(2) National subsidy

The national subsidy within the limit of the budget shall be granted to the MAA for the administrative expenses of the association. No national subsidy is disbursed for medical care benefits.

(II) Community medical care insurance

National Health Insurance (NHI). Established by basic Act No. 60 in 1938, it is for those persons who are not covered by any of the above-mentioned insurance plans for employees. This Act has been wholly amended by the Act No. 192 in 1958, according to which every city, town and village took responsibility to enforce the NHI. This amendment has brought about the completion of the medical care for the entire population program in 1961.

Coverage

(1) All of the householders and their family members resident who are not covered under the medical care insurance plans for employees in the areas for which the city, town or village are competent, shall be insured under NHI managed by that city, town or village.

(2) Where a National Health Insurance Association, which formed by a group of persons engaged in the same occupation, has been established, members of the association are to be insured under the NHI Association.

Those persons insured under other plans are excluded from coverage under NHI.

Benefits

Medical care benefits and cash benefits are granted to the insured persons and their family by each respective insurer. Medical care benefits include all types of medical care, hospitalizatibn, dental care and pharmaceutical medicine. Under the NHI plan, the amount of partial cost-sharing has become 30% of the cost of medical care since 1968, as a result of the amendment of the NHI Act in 1966. Before that the amount of dependents' partial cost-sharing had been 50% of medical care, whereas that of householders 8 was 30%. Beginning from 1974, if the 30% of medical care expense payable by the insured exceeds 39,000 yen a month, the amount over 39,000 yen was to be reimbursed to the insured by the respective insurer. This anount has changed to 51,000 yen now, for low income insured it is reduced to 39,000 yen.

Cash benefits such as sickness and injury allowance, confinement allowance, nursing allowance, condolence money and so on shall be provided by the insurer one by one. Each insurer prescribes the content of each benefit by the order of the city, town or village, or

by the article of the NHI Association. In this point, NHI is different from other medical care insurance plans.

Finances

NHI is financed by contributions paid by the insured persons and national subsidy

(1) Contribution

Contributions or National Health Insurance Tax shall be paid by the householders under whose roof the insured persons live. The amount of the contribution and the method of collection are prescribed in the laws, regulations or articles of the insurer concerned.

The rate of contribution is set to meet individual financial ability in consideration of income, property, capitation and flat sum. The average contribution amount per household was 86,066 yen in 1981. The standard equation for calculating contribution can be written as :

$$\text{Contribution} = \left(\frac{40}{100}\right)(\text{income}) + \left(\frac{10}{100}\right)(\text{property}) + \left(\frac{35}{100}\right)(\text{capitation}) + \left(\frac{15}{100}\right)(\text{flat sum})$$

(2) National subsidy

a. The amount granted to insurers from the national treasury is 40% of the medical care expense.

b. A grant to adjust finances of local public body, which equals to 5% of the medical care expense, is given to needy city, town, or village.

c. Management expense subsidy within the national budget

d. Subsidies are also granted to insurers concerning midwife benefit, construction of hospitals and clinics.

Distinguished Characteristics

Upon reviewing the Japanese medical care insurance plans we may notice several distinguished characteristics.

1) Group spirit. The present medical care insurance plans have been formed and developed on a group-by-group basis centering on places of work.

2) Compulsory. Under the Japanese medical care insurance system, any person shall be insured compulsorily under one of the insurance plans. And to cover the cost necessary for the operation of the insurance plan, contribution (or tax) shall be paid by the insured persons

3) No choices. The insured person cannot choose his own insurance plan. He must be insured under the plan that he is assigned; and this is according to where he works if he is an employee, or where he lives if he is self-employed.

4) Public provision and administration. Through the contribution-expenditure process, medical care insurance in Japan has been publicly provided. And all the insurance plans are administered by National Government, or Local Government, or Public Organizations. However, medical care is still supplied through the private practioner system, i.e. there is no public production of medical care.

5) Copayment. In all the insurance plans, there are partial cost-sharing payment, though some are very low.

6) Same subsidy insurance. Same kind of benefit and same amount of content shall be granted to every people covers under the same plan regardless of his income level.

7) Reimbursement. The fee for medical care is prescribed by the Government in the form of an Index, and it is paid to the

providers of medical care service by two particular organizations, Social Insurance Medical Care Fee Payment Fund and Prefectural Federation of National Health Insurance Association, on behalf of the Government. And the insurers shall pay, under contract, the commision based on the bills to these two organizations. One problem with this arrangement is that, if insurance covers the full cost or the large portion of cost of care regardless of what the cost is, neither the demander nor the supplier of care has any incentive to be concerned about cost. Thus there is an inducement for inefficiency on the supply side as well as on the demand side. The subject of the behavior of supplier under insurance lies outside the scope of this study and should be discussed seperately.

Note : A special plan was adopted in 1972 for people aged 70 or over to be covered under an old-aged medical care insurance arrangement. The medical care fee was in cherge of the relevant insurer for 70%, the National and Local Government subsidized the remaining 30%. But in 1982, Partial cost-sharing payment was introduced into the plan.

A Summation of Benefits and Financial sources of all Medical Care Insurance Plans in Japan (1981)

Name of Plans			Responsible body	Coverage		Benefits			Cash benefits	Financial Sources	
				Total Insured Dependents	Ratio to total population**	Medical Care benefits				Contributions	National Subdidy
						Insured	Dependents	High-cost medical benefits			
				(thousand)	(%)						
I. Insurance plans for employees	1. General fields of works	GHI	National Government	31289 14562 16727	26.7	100%*	80% for Inp. 70% ,, Out.	Amount exceeds y 51,000 (y 15,000 for low income-persons)	Sickness and injury allowance, delivery expense, maternity allowance, child care allowance and funeral expense.	8.5% Insured-4.25, Emplo.-4.25.	16.4% of medical & cash benefits
		SHI	1670 Medical Insurance Societies	27507 11431 16071	23.5	100%*					A fixed amount for aid to medical care benefits.
	2. Particular fields of works	SMHI	National Government	672 212 460	0.6	100%*					
		DLHI	National Government	518 318 200	0.4	100%*	70% for both Inp. & Out.	Amount exceeds y 39,000			35% of med. benefit & a fixed amount.
		NSMAA LOPSMAA PCEMMAA PSTEMAA	25 MAA 3 MAA 54 MAA 1 MAA	3042 6808 2072 603	2.6 5.8 1.8 0.5	100%*	80% for Inp. 70% for Out.	(Same as HI)			None.
Insurance or self-employed		NHI	Municipalities & NHI Societies	44536	38.1	70%	70% for both Inp. & Out.	Amount exceeds y 51.000 (y 39,000)	As prescribed by each authority concerned.	Annual average y 86,066 per year.	40%-45% of med. benefits

Source : Health Insurance, Bureau, Ministry of Health and Welfare, "Statistical Mannual on Medical Care Insurance".

Note : 1. Administrative expenses are granted to all the plans.
2. * Some partial cost-sharing payments.
3. ** Total population = 117,071,000

References

1. Emi, K. 1978 *Essays on The Services Industry And Social Securitry In Japan Economic Research Seminars* No. 17. The Iustitute of Economic Research, Hitotsubashi University Tokyo : Kinokuniya Book–Store Co. LTD.
2. Emi, K. 1983. "Increasing Medical Expenses And The Social Insurance System." *Hitotsubashi Journal of Economics* 24 (June) : 1–10.
3. Health and Welfare Statistics Association, *Hoken – To – Nenkin – No – Doko* (Trend of Social Security).
4. Ministry of Health and Welfare *The White Book On Health And Welfare.*