The Japanese Healthcare System

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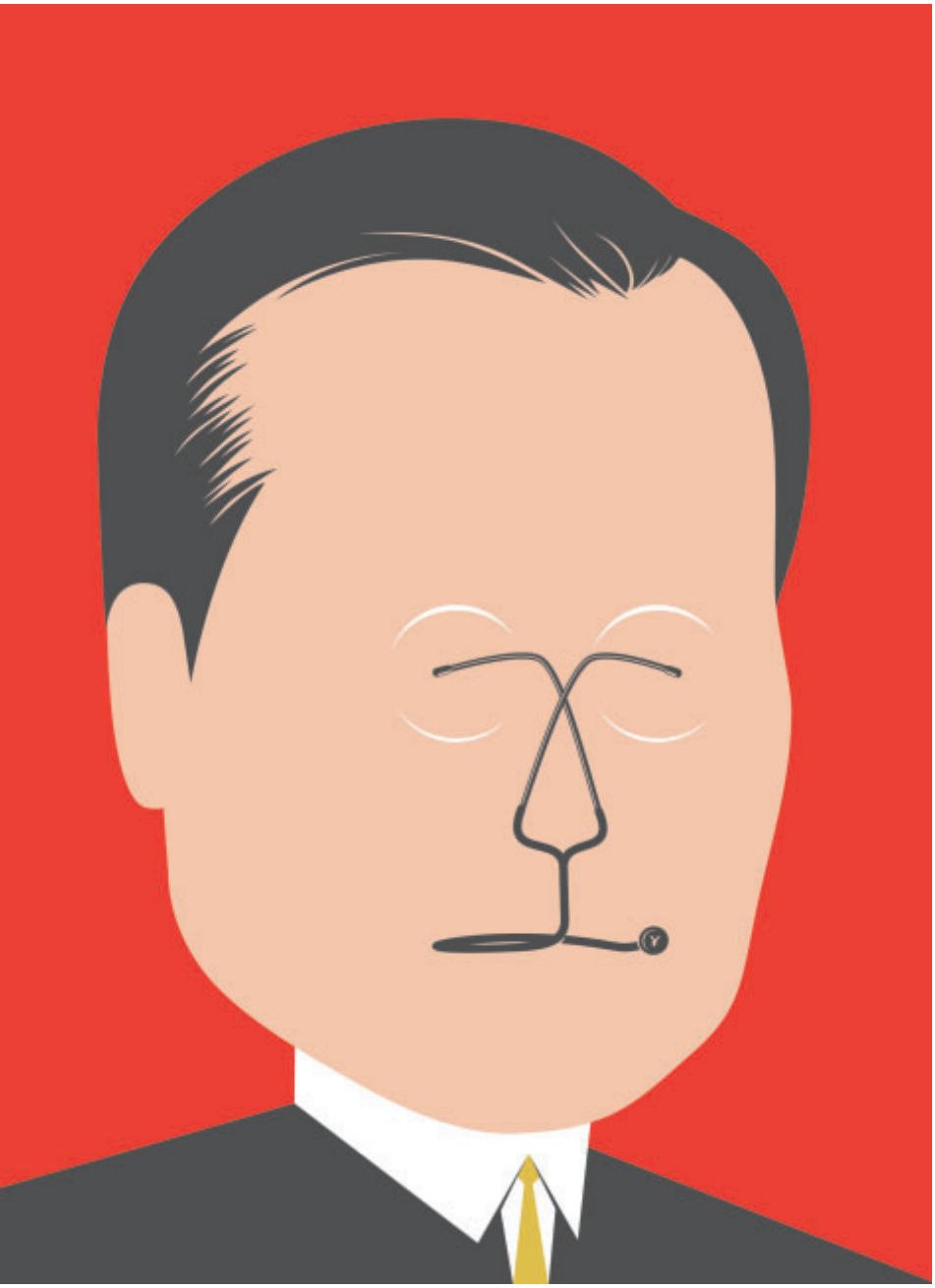

Japanese healthcare is in a crisis. Unlike past crises, this one is a very quiet one, as it is coming from disappearing essential services. On weekends, we find emergency rooms (ER) of any major hospitals practically deserted, as patients are turned down before – and after – their arrivals. The hospitals don't have enough staff to operate the ERs, and, even if they did, they couldn't afford to take care of the patient volume. In rural communities, local governments are closing their public hospitals in large numbers due to lack of funds. We have serious shortages of physicians, nurses, emergency facilities, pediatric hospitals, obstetric facilities, etc.
We have observed a series of bad decisions by the Ministry of Health, Labor and Welfare (MHLW) during the past decade that should have contributed to this crisis, but they are more results than causes.
We have a shortage of funds because we have not infused enough money into our health insurance system to care for the growing population of the elderly. In the past few years, no one wanted to talk about tax increases for fear of losing the next election. The government has been piling up a huge national debt for almost two decades, which has reached almost twice the size of the GDP. The implicit debt in our public pension program is almost the same size too. The Ministry of Finance wants to restore primary balance by year 2011 and wants the MHLW to keep the lid on healthcare expenditures, allowing only a ¥1.1 trillion increase in the costs of all social security programs during the five-year period prior to 2011.
In response to these pressures, MHLW produced a reform package in 2006 con-

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sisting of medical insurance programs for people over 75, and a new reinsurance scheme for people from 65 to 74. They put them into effect in April 2008, but so far, they have turned out to be extremely unpopular. In what follows, I will explain the outlines of this financial reform package and the reasons why it has met with strong public opposition.

For historical reasons, the Japanese public health insurance system consists of two basic types of insurance programs: employees' programs and municipal programs. The two types of programs have very different comparative health risks and financial bases. In short, employee programs have smaller healthcare needs and a larger revenue base, while municipal programs have much larger healthcare needs and a smaller revenue base. In spite of these gaps, up to the 1970s, the government was able to provide sufficient subsidies for the municipal programs to keep them running. As retired workers started to concentrate in the municipal programs, however, these gaps started to widen even further. By the early 1980s, the government, facing its own huge deficits, could no longer keep up with paying subsidies to meet the bulging demands of the municipal programs.

In 1982, the government introduced reinsurance of the healthcare costs of those at age 70 or older in our health insurance. In the scheme, the government contributed half of the costs, and asked all the programs to pay for the other half, according to a formula using several factors, including the number of individuals in their programs. Over the years, the contribution formulas have been modified several times, and in the meantime, the minimum age for reinsurance has been moved up to age 75. Finally, starting in April 2008, the government renamed the reinsurance scheme as 'medical insurance programs for the old-old,' reorganized it into regional insurance programs, and started to collect ten percent of the costs mostly through their own poll taxes. Furthermore, it has come up with its own benefit package, adopting comprehensive payment for most outpatient care, instead of the former fee-for-service system.

This scheme has generated an enormous public outcry. Some have even compared the insurance to a legendary 'granny dumping mountain,' blaming the government for attempting to deny anyone above the age of 75 their normal healthcare services. As soon as the details of this package became public, most physicians expressed their strong opposition to its comprehensive payment scheme, claiming that it will prevent them from performing necessary procedures, using necessary drugs, and ordering necessary tests. Furthermore, because of the regressive poll taxes, this old-old insurance has been very unpopular, particularly among the poor. It may very well cost the present ruling parties the next election.

In the past, there was another reinsurance program involving those under the age 75, in which employee programs reimbursed municipal programs for the cost of those who had switched from employee pensions. Starting in April 2008, the government replaced this program with a comprehensive reinsurance of healthcare costs of all the individuals between the ages of 65 and 74. Their healthcare costs are paid by all insurance programs in proportion to the shares in insured individuals between birth and age 74. The government makes no independent contribution to this scheme, but it provides subsidies to municipal programs for half of their contributions and to small companies' programs for 17 percent of their contributions.

This new scheme has met another strong protest, this time from large companies. Let me explain why. Suppose we have someone who had his 65th birthday on the 31st of December last year. Let us also suppose that he used to spend one unit of healthcare a year until his 65th birthday, but now he spends four units a year. We want to find out how the extra three units will be paid in our new re-

Facts & Figures

An Aging Population: Japan has the highest life expectancy, the lowest infant mortality, and the most aged population in the world today. It will age even further in the first half of this century. By the year 2055, life expectancy for men is expected to reach 83.7 years, compared with 79.2 years in 2007, while women's life expectancy is expected to reach 90.3 years, compared with 86 years in 2007. Reflecting the improved longevity and low fertility, the percentage of the population at age 65 or older increased dramatically, from 4.9 percent in 1955 to 20.1 percent in 2005. It is expected to reach 40.5 percent in 2055.[1]

Medical Care System: Japan has a national health insurance system. The insurance covers the entire population either through employee programs, municipal programs, or special programs. All programs offer the same benefits. Employers pay 50 percent of the insurance premium. Patients currently contribute either 10 percent (age 70 or older) or 30 percent (all others and affluent elderly) to the cost of inpatient or outpatient care, or prescription drugs. Children also have a 20 percent co-payment, but many municipalities and cities are now bearing some or all of these costs to attract and keep citizens. For people between age 70 and 74, the co-payment rate was scheduled to move up to 20 percent, but the move is temporarily suspended. There is a maximum subsidy of ¥350,000 (about US$3,200) to the cost of delivery for childbirth. Routine checks during pregnancy are not covered by health insurance.

Within the Organization for Economic Co-operation and Development (OECD) countries, Japan ranks slightly below the average in terms of health spending per capita, but the contribution of its public sector to health spending is – at 83 percent – well above the OECD average of 73 percent. Japan has fewer physicians per capita, about two thirds of the OECD average, which is at least partly due to government policies fixing limits on the number of new entrants to medical schools. Japan has the highest number of hospital beds, more than twice the OECD average, and the highest number of magnetic resonance scanners, about four times the OECD level.

Long-term Care System: Public long-term care insurance was introduced in the year 2000 to provide various home care and institutional care services for the elderly. Insurance premiums are collected in two ways: namely, through a surcharge to health insurance taxes for individuals between age 40 and 64, and through community poll taxes for residents age 65 or older. The co-payment for benefits is set at ten percent of the costs. The total cost of the benefits has already doubled since the start of the system and reached ¥5,571 billion in 2006.[2] Half of the costs are paid by general tax revenues.

Morbidity and Mortality: Circulatory system diseases are the most prevalent major diseases among the elderly, affecting 30.1 percent of this population segment. They accounted for ¥5,379 billion, or 21.5 percent of the medical expenditures, in 2005. Cancer was the leading cause of death, accounting for 30.1 percent of all deaths, followed by heart disease for 16 percent, and by cerebrovascular diseases for 12.3 percent.[3]

Lifestyle Risk Factors: Smoking is by far the most important single health risk factor in Japan. Smoking among Japanese men is, with 39.9 percent, still the fourth-highest among developed countries, whereas cigarette prices are at one of the lowest levels. An average pack cost ¥304.6 in 2007.[4] There are few smoke-free public areas.[5] Recently, the government has been emphasizing obesity as a major health risk. Although only 3.9 percent of all Japanese in 2005 were obese (compared to 34.3 percent in the U.S. in 2006), it has launched a compulsory national program to check for metabolic syndromes for employees at age 40 or older.

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[1] 2008 Annual Report on the Aging Society, Cabinet Office, Government of Japan
[2] www.mhlw.go.jp. Last accessed Sept. 16th, 2008
[3] www.mhlw.go.jp. Last accessed Sept. 16th, 2008
[4] www.mof.go.jp. Last accessed Sept. 16th, 2008
[5] www.who.org. Last accessed Sept. 16th, 2008

Women: 85.99 years (2007)

Men: 79.19 years (2007)

Dentists
Number per 1,000 Resident Population
0.761 (2006)

Hospital Beds
Number per 1,000 Resident Population
8.2 (2006)

Physicians
Number per 1,000 Resident Population
2.1 (2006)

Nurses
Number per 1,000 Resident Population
9.3 (2006)

Life Expectancy at Birth

Total Expenditure on Healthcare as Percentage of GDP: 8.2% (2005)

Share of the Age Group 65+ of the Health Expenditure: 35% (2005)

Contribution of the Public Sector to Health Funding: 82.7% (2005)

Total Expenditure on Healthcare per Capita (adjusted for purchasing power parity): US$2,474 (2005)

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insurance scheme. First we must consider co-payment, then this reinsurance, and lastly, government subsidies. By a simple back-of-the-envelope calculation, we find out that co-payment pays only three percent, government pays 25 percent, premiums of employee programs pay 52 percent, and premiums of municipal programs pay less than 20 percent. In 2005, the insurance premiums paid 49 percent, and the government paid 36 percent, of national healthcare costs. The new reinsurance package will increase the marginal share of premiums to 72 percent and reduce the marginal share of the government to 25 percent. The government is simply shifting its burden to employee programs.

Employees are already paying almost the same amount as their own healthcare costs in their payments for the elderly. As the elderly population increases, so will the employees' payments. This process will eventually stop when a sufficient number of those in employee programs get angry. I would hate to see more rounds of cuts in our healthcare services and their tragic consequences. Besides, we should worry about the deadweight losses from such very high payroll tax rates: They will reduce employment and the companies' profit. Payroll taxes may be far better than poll taxes, but they are not as equitable as consumption taxes to finance the healthcare of the growing elderly population. After the next election, I hope politicians will summon enough courage to raise the consumption tax rate to solve our current crisis in healthcare.

Another interesting implication of this reform package is its impact on weaker company-specific employees programs. We still have more than 1,200 company-specific programs, many of which may decide to dissolve and join the new regional programs for employees of small companies, rather than paying higher tax rates. In the long run, we may come closer to having more integrated health insurance programs, at least among the employees' programs.

The opinions expressed in this article do not necessarily reflect those of Siemens Healthcare.

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