

Papers on the Local Governance System and its Implementation
in Selected Fields in Japan No.13

**The Development of a Health Insurance System
for the Elderly and Associated Problem Areas**

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Foreword

The Council of Local Authorities for International Relations (CLAIR) and the National Graduate Institute for Policy Studies (GRIPS) have been working since FY 2005 on a “Project on the overseas dissemination of information on the local governance system of Japan and its operation”. On the basis of the recognition that the dissemination to overseas countries of information on the Japanese local governance system and its operation was insufficient, the objective of this project was defined as the pursuit of comparative studies on local governance by means of compiling in foreign languages materials on the Japanese local governance system and its implementation as well as by accumulating literature and reference materials on local governance in Japan and foreign countries.

In FY 2008, as a project which were begun in FY 2005, we continued to compile “Statistics on Local Governance (Japanese/English)” and to conduct a search for literature and reference materials concerned with local governance in Japan and overseas to be stored in the Institute for Comparative Studies in Local Governance (COSLOG). We have also started a new research to compile a new series on “Historic Development of Japanese Local Governance”.

In addition, continuing from the previous year, we will continue to compile “Up-to-date Documents on Local Autonomy in Japan” and will make up 4 themes in FY 2008 on “Papers on the Local Governance System and its Implementation in Selected Fields in Japan”, for which we have taken up 10 themes already in the past years.

This project is to be continued in FY 2009, and we aim to improve the materials so that they will be of real use and benefit to those who are working in the field of local governance.

If you have any comments, suggestions or inquiries regarding our project, please feel free to contact the Council of Local Authorities for International Relations (CLAIR) or the Institute for Comparative Studies in Local Governance (COSLOG) of the National Graduate Institute for Policy Studies (GRIPS).

March 2009

Michihiro Kayama
Chairman of the Board of Directors
Council of Local Authorities for International Relations (CLAIR)
Tatsuo Hatta
President
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Preface

This booklet is one of the results of research activities conducted by the Institute for Comparative Studies in Local Governance (COSLOG) as one part of a project that started in FY 2005 entitled “Project on the overseas dissemination of information on the local governance system of Japan and its operation”, in cooperation with the Council of Local Authorities for International Relations (CLAIR). For the purpose of implementing this project, a “Research committee for the project on the overseas dissemination of information on the local governance system of Japan and its operation” has been set up, and a chief and deputy chiefs with responsibility for the project have been designated from among the members concerned with each research subject.

“Papers on the Local Governance System and its Implementation in Selected Fields in Japan” (FY2008, Volumes 11-14) were written under the responsibility of the following five members. (Title of members as of March 2009)

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This booklet, the thirteenth volume in the series, is about The Development of a Health Insurance System for the Elderly and Associated Problem Areas, and was written by Professor Shimazaki.

The population in Japan is aging at a speed unparalleled in the rest of the world, and against this background, a new health insurance system for elderly persons was established in April 2008. The system has many unique features in the world as a whole, and this booklet sets out not only to explain the mechanism of the system itself, but also to give a broad overview of the background context, within which the system was generated, and future issues.

We will continue to take up new topics, and add to the series.

Finally, I would like to express my appreciation to Professor Shimazaki, and also to other members of the research committee for their expert opinions and advice.

March 2009

Hiroshi Ikawa

Chairperson

Research committee for the project on the overseas dissemination of information
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The Development of a Health Insurance System for the Elderly and Associated Problem Areas

Kenji SHIMAZAKI

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1. Introduction

In June 2006, several laws concerning reform of the medical system were enacted, and from April 2008, a reformed Health Insurance System for the Elderly started to be implemented as one pillar of that reform. The system consists of 2 parts, ① the introduction of a fiscal adjustment system among insured parties in respect of “younger” elderly persons between the ages of 65 and 74, and ② the creation of an independent health care system for advanced elderly persons aged 75 and over. The system described here under ② is an entirely new device; in this system, when persons reach the age of 75, they leave the system with which they have been registered (e.g. National Health Insurance, Health Insurance Society, etc) and join an independent health insurance system providing insurance only to people aged 75 and over. However, this system has been the target of criticism by the Japanese people from the moment of its inception. Part of this criticism was directed against the inadequate explanation of the system, but there was a significant amount of criticism directed against the design of the system itself. For example, representative criticisms are that treating elderly people as belonging to a separate class of insured persons constitutes ageism, and that it is linked to practices of “discarding the elderly” and weakening the basis of social solidarity. Furthermore, with reference to the “younger” elderly listed under ① above, voices citing demands and dissatisfaction have been raised, saying that “the burden will be greater than expected, and we demand a lightening of the burden through the use of public funds”.

In the face of this reaction on the part of public opinion, the opposition party in the Diet proposed the cancellation of the scheme for a special health insurance system for advanced elderly persons, and the ruling party announced that they would take a year to “reexamine” the introduction of the new system. Metaphorically speaking, the Health Insurance System for the Elderly is like a ship which set out from harbor, but far from sailing before the wind, was caught in a hurricane and has been driven to undergo repair work.

That a variety of problems should have arisen out of the proposal to divide up categories of people belonging to a health insurance system according to age is unavoidable, and to a certain extent, it was expected that there would be a public

reaction against the proposal. This being so, the question that must be asked is why the decision was taken to establish such a system for elderly persons. In the first case, it has to be pointed out that the new Health Insurance System for the Elderly is not something that has suddenly arisen within the space of 2 or 3 years. There is a history of debate that goes back for at least 10 years or more. During the course of this debate, many different kinds of ideas were advocated, but because difficulties were attached to each idea, no decision could be reached, so that you could say that the system arose through a process of elimination. It follows from this that even if the new system is “reexamined”, it can be presumed that the old arguments that have been made in the past will be recapitulated, and that there will be a need for criticisms of the proposed new system to be evaluated coolly and calmly. It is from this kind of perspective that this paper sets out to examine and comment on the history of the developments that led to the attempt to establish a new Health Insurance System for the Elderly and the various issues involved.

The question may also be asked as to why this theme has been taken up within the framework of a series of “Papers on the Local Governance System and its Implementation in Selected Fields”. I would like to make 3 points concerning the significance of this choice.

Firstly, the theme of this paper does have a connection with the system of local governance. In the case of the healthcare system in countries like Germany and France, while the number of countries that employ a social insurance system is by no means small, it is usual for the insuring body to be a corporate person separate from local government. However, in the case of Japan, for historical reasons among others, the insuring parties in the case of the National Health Insurance system are the municipalities. Moreover, the most difficult point that occurred during the process of formulating a draft of the new health insurance system for the advanced elderly was that of deciding which body should be the insuring party. The decision reached after many convoluted negotiations was that a new body should be created as a wide-area union consisting of all the municipalities in the unit of a prefecture, and that unions created in this way should be the insuring parties. Such wide-area unions are also local governments (special local public bodies). The fact is that in Japan, the important role played by local governments in the health insurance system is a major characteristic of this system.

The second point concerns the significance of adopting this theme. It goes without saying that the healthcare system of a given country has attributes of the history, politics, economy, culture and climate of the country concerned. It follows that the

trends that can be discerned in the reform of the health insurance system in Japan cannot immediately be seen as a case study that will serve as a reference for other countries. However, that said, all countries grapple with the common problem of how to apportion fairly among and within generations the medical costs for the elderly in a context in which the number of elderly persons continues to increase. The speed at which the population in Japan is ageing is unparalleled elsewhere in the world, and the policy-level implications for healthcare system reformers in other countries of the debate surrounding the recently introduced health insurance system for the advanced elderly in Japan are by means small.

The third point concerns the meaning of taking up this theme at this point in time¹. As already mentioned, a “reevaluation” of the Health Insurance System for the Elderly is inevitable, and it is not out of the question that changes may be made in future. However, in reality, the system has been implemented as a new system from April 2008, and this has become a major controversy at a political level. And within this framework, one major point of debate is that of how to evaluate the wide-area union as the insuring body, and what the relationship of this body to prefectures should be. In short, both the implementation and the reevaluation of the new Health Insurance System for the Elderly have very great meaning for local governments.

2. The Relationship between the Characteristics of Health Insurance in Japan and the New Health Insurance System for the Elderly

I will begin by focusing on the main points of the special characteristics of the medical insurance system in Japan and the new medical insurance system for the elderly.

2.1. The Special Characteristics of the Health Insurance System in Japan

A healthcare system can be divided into 2 parts, “delivery”, which is concerned with how medical treatment is supplied or delivered, and “finance”, which is concerned with how the costs of that treatment should be provided and settled. Figure 1 is a simple comparison of the mechanisms of medical systems in the main Western countries. There are 2 points in particular arising from this comparison that the writer of this paper wishes to emphasize.

The first is a particular characteristic of the Japanese system. The most conspicuous feature of this system is the way in which universal coverage for all the Japanese people is achieved by allowing an employees’ health insurance system and a locality-based system to act in parallel. Explaining this more accurately, employees’ insurance comprises a Health Insurance Union, to which the employees of all large,

private-sector firms and their families belong, a nationwide Health Insurance Association, to which the employees of small and medium-sized firms belong. and a Mutual Union for Public Officials. In every case, the insurance applies to full-time, regular staff members. Persons other than those covered by these various schemes are covered by a National Health Insurance scheme, in which the insuring bodies are municipalities which cater for people who do not belong to one of the schemes specified above².

Figure 1 : General International Comparison of Medical Care Systems

	Japan	Germany	France	UK	Sweden	US
Source of delivery	Private sector-centered (public sector share approx. 30%)	Public sector-centered (approx. 90% share)	Public-sector centered (approx. 70% share)	Almost entirely public sector	Almost entirely public sector	Private sector-centered (public sector share approx. 25%)
Finance	Public (Social insurance formula)	Public (Social insurance formula)	Public (Social insurance formula)	Public (Tax-based formula)	Public (Tax-based formula)	Private (except for Medicare and Medicaid)
Design of the financial system	<ul style="list-style-type: none"> ○ Insurance for all citizens (universal coverage) ○ Social insurance formula ○ High percentage from "tax" in addition to insurance charge 	<ul style="list-style-type: none"> ○ 90% of citizens targeted (self-employed workers and high-income earners may participate voluntarily) ○ Social insurance formula ○ In principle "insurance premium" 	<ul style="list-style-type: none"> ○ 99% of all citizens targeted ○ Social insurance formula ○ Insurance premium 80% approx; general social contribution fund 20% approx. 	<ul style="list-style-type: none"> ○ All citizen targeted ○ Health service formula ○ Tax formula 	<ul style="list-style-type: none"> ○ All citizen targeted ○ Health service formula ○ Tax formula 	<ul style="list-style-type: none"> ○ Public medical insurance system only available for elderly persons, the disabled and low-income earners ○ Medicare social insurance formula ○ Medicaid covers low-income workers from tax
	<p>From 75</p>	<p>90% of citizens covered by social insurance formula</p> <p>Self-employed workers may participate voluntarily</p> <p>*All citizens scheduled to be covered by insurance by 2009.</p>	<p>Insurance for self-employed persons</p> <p>Employees' insurance for public officials and others (special system)</p> <p>Private-sector employees' health insurance (general system)</p>	<p>All citizens covered by tax formula</p>	<p>All citizens covered by tax formula (Unit: province)</p>	<p>Public medical insurance (Medicare)</p> <p>Private medical insurance on voluntary basis</p> <p>From 65</p>

Source: Compiled by the author on the basis of data from Yoshinori, Hiroi (1994), Iryou no keizaigaku [The Economics of Medical Care], Nikkei Publishing Inc. (table on p 240), and Shuukan Shakai Hoken [Social Insurance Weekly], No. 2282, p 76.

A comparison of various countries shows that in the case of Britain and Sweden, in the same way as with a public health service, the public sector provides medical treatment sources directly, financed by fiscal revenue. At the opposite extreme is the U.S.A, where with the exception of Medicare, which targets seniors and others, and Medicaid, which targets specified categories of low-income persons, there is no public insurance system for medical expenses. And with regard to finance, even in countries which have adopted a social insurance system, the pattern is different from that of Japan. To take Germany as one example, in that country, since 1996, a choice of insuring parties (sickness funds) by insured persons has been approved, with the stipulation, as a precondition, that a structural adjustment of risk (a device to adjust such factors among insured persons as age, income, percentage of persons contracting major diseases, and so on) to put competing conditions on an equal footing is carried

out. However, the medical insurance system in Germany was constructed fundamentally as an aspect of labor law, and it still retains that character today. In short, it is not a system like that of Japan, where an employees' health insurance system and a locality-based system function in parallel.

The second point is that there is no parallel anywhere in the world for a device that divides membership of a system on the basis of a fixed age. Of course, this is not the case in countries like Britain and Sweden, but even in France and Germany, which have adopted a social insurance system, a process of financial adjustment is carried out among insuring parties, so that it is not the case that an independent system targeting only older people is constructed. Moreover, an analogy has been made with Medicare in the U.S.A., which targets senior citizens of 65 and over, but the analogy is not an accurate one. The reason why it is not accurate is that in the U.S., there is no public insurance system for medical expenses for people under the age of 65, so the essential system is different from that of Japan, whereby advanced elderly people will move into a different category of insured persons simply because they have reached a fixed age. Be that as it may, the attempt to establish a system targeted only at the advanced elderly is without parallel in the world.

2.2. An Overview of the Health Insurance System for the Elderly

The following is a simple explanation of the main points of the Health Insurance System for the Elderly, implemented from April 2008.

Regarding firstly the basic framework of the system, it is divided into 2 parts, one for the younger elderly and one for the advanced elderly, and the 2 parts differ from one another in their character and their structure. Specifically, there is no change in the Health Insurance System for the Younger Elderly in terms of the category of insured persons, and the device used is still one of financial adjustment among the insuring parties. In contrast to this, the Health Insurance System for the Advanced Elderly aged 75 and over changes in that an independent insurance system provides cover as a single insurance organization. It follows from this that when an insured person reaches the age of 75, that person will withdraw from the system that has provided insurance cover hitherto and become a member of the new Health Insurance System for the Advanced Elderly (the eligibility qualifications of the insured person change). The big difference is that until March 2008, even advanced elderly persons were covered by insurance from the National Health Insurance system³.

The second point is concerned with the structure of the revenue source needed to cover the costs. The thinking is that the division of costs to pay for the Health Insurance System for the Advanced Elderly will be made up of insurance charges

levied on the advanced elderly (10%), and for the remainder, supporting funds taken from insurance premiums levied on the active generation (40%) and a public subsidy (50%)⁴. The supporting funds will in principle be charged on a proportional basis to the persons participating in each existing insurance program. Furthermore, because the population structure of advanced elderly and younger people changes, the insurance premium percentage (10%) to be charged to advanced elderly persons is not fixed. Specifically, from fiscal 2010, the premium will be raised by half the percentage decline in the population of younger persons, and the percentage of supporting funds will be lowered in a way that corresponds to this.

With regard to younger elderly, their medical costs will be apportioned on a proportional basis as a charge on the insurance scheme in which they are participating. In short, a financial adjustment among insuring parties will be carried out (insuring parties that cover a low percentage of “younger” elderly will make a payment, while insuring parties that cover a high percentage of “younger” elderly will receive a grant).

The third point concerns the payment, as a percentage of the total costs, made by the elderly at a medical institution after receiving treatment. For persons aged from 70 through 74, the percentage is set at 20%, and for persons aged 75 and older, 10% (however, in the case of persons who have an income which is above the average of persons presently working, the rate, in both the categories referred to above, is 30%). However, the rise from 10% to 20% for persons aged from 70 through 74 (taking the current charge as, in principle, 10%) has been frozen until March 2009. Furthermore, under the high-cost medical treatment system, a limit has been set on the percentage payment.

The fourth point is concerned with the insurance premium charge on the advanced elderly. This not a household charge, but a charge levied on and collected from each individual. It is divided, in very broad terms, on a fifty-fifty basis, into a means-related portion (i.e. a portion levied in accordance with the income level of an insured person) and a “benefit-related” portion (i.e. a portion which is levied equally on each insured person, in other words, on each beneficiary of insurance). However, there is a provision whereby the benefit-related portion can also be lowered for persons on a low income. In addition, the insurance premium is capped at an annual limit of ¥500,000 a year. It should also be noted that in principle, the insurance premium is automatically deducted from an insured person’s pension, but in the case of a person whose pension is less than ¥180,000 a month, or the case of a person for whom the combination of the insurance premium for the medical system for elderly persons and the charge for nursing care is greater than half the person’s pension, collection will be made in the

usual way.

The fifth point concerns the operational management of the Health Insurance System for the Advanced Elderly. The operational management of the system is carried out by newly established wide-area unions, divided up by prefecture and comprising all the municipalities within a given prefecture. The wide-area unions have management responsibility for deciding insurance charges, but clerical duties such as the collection of charges are carried out by municipalities.

3. The background to Debates concerning Medical Service for the Elderly

There are 2 main reasons to explain why the problem of what form the system of medical care for the elderly should take has become a subject of debate in Japan.

Figure 2: Basic Population Indicators (1965-2055)

Year	Total population (A)	3 population divisions			(ref.) Advanced elderly within (D) (75 and over)	Aging percentage (D/A)	old-age-dependency ratio (D/C)	(Ref.) figures for aged dependents if productive population is set at 20-69 and elderly population at 70 and over
		child population (B) (14 and under)	working-age population (C) (15~64)	Elderly population (D) (65 and over)				
1955	89.28 (69.9)	29.8 (169.5)	54.73 (64.8)	4.75 (18.4)	1.39 (11.9)	5.3%	8.7% (1 supported by 12)	5.8% (1 supported by 17)
1980	117.06 (91.6)	27.51 (156.4)	78.83 (93.4)	10.65 (41.3)	3.66 (31.4)	9.1%	13.5% (1 supported by 7)	9.0% (1 supported by 11)
2005	127.77 (100)	17.59 (100)	84.42 (100)	25.76 (100)	11.64 (100)	20.2%	30.5% (1 supported by 3.3)	21.5% (1 supported by 4.7)
2030	115.22 (90.2)	11.5 (63.4)	67.40 (79.8)	36.67 (142.3)	22.66 (194.7)	31.8%	54.4% (1 supported by 1.8)	41.7% (1 supported by 2.4)
2055	89.93 (70.4)	7.52 (42.7)	45.95 (54.4)	36.46 (141.5)	23.87 (205.0)	40.5%	79.4% (1 supported by 1.3)	61.8% (1 supported by 1.6)

Unit: million persons.

(N.) For the total population and the 3 population divisions figures for 2005 are set at 100.

Source: Compiled by author on the basis of average statistics for births and deaths issued by the National Institute of Population and Social Security Research (Dec. 2006), and the National Census issued by the Ministry of Internal Affairs and Communication.

3.1. The Population Structure and Medical Charges in Japan

Figure 2 brings together in one Figure the basic population parameters in Japan. It is clear from this how the population structure changes completely when the previous half-century and the next half-century are compared. In particular, 3 important factors deserve special attention: ① Because an increase in the number of elderly persons has been accompanied by a lowering of the working population, the

number of dependent elderly has increased sharply: ② Because the baby-boom generation reaches the age of 75 around 2023, the population of advanced elderly almost doubles between 2025 and 2030; and ③ If the period during which people belong to the category of “productive population” is changed from “persons aged from 15 to 65” to that of “persons aged from 20 to “70”, the speed of the increase in the numbers of dependent elderly will be attenuated, but its momentum will still be significant.

From another perspective, we cannot expect a period of high economic growth. The driving forces underlying economic growth can be reduced to 3 factors: ① capital accumulation; ② labor capacity; and ③ technical progress. The ongoing increase in elderly persons and a declining population are factors that will lower the rate of economic growth, and the potential growth rate can be expected to be at most around 2%. In this sort of environment, questions of how to secure the sustainability of a medical insurance system and how to apportion the costs of this system fairly between the younger generation and that of elderly persons are ones that cannot be avoided.

In Figure 3, taking as a basis the national medical expenses by age cohort in fiscal 2005, these have been calculated by extrapolation to show the position in 2030. But because this is a very rough calculation and because medical costs change as a result of policies, the figures themselves do not have a great deal of meaning. However, it is clear from these calculations that ① even if the per capita medical costs within each age cohort remain the same as in fiscal 2005 (zero growth), because of the change in the population structure, national medical costs in fiscal 2030 will increase by about 20%; ② in fiscal 2030, one-third of the total population will account for two-thirds of the medical costs; and ③ the advanced elderly, comprising just under 20% of the total population, will account for about half of the overall medical costs. Moreover, progress in medical technology as a factor increasing medical costs is also important, and if we assume that the medical costs for each age cohort rise by 2% a year, the medical costs in fiscal 2030 will be about double the figure for fiscal 2005.

Another reason why the problem of the system of medical costs for the elderly has become a subject for debate derives from the structure of the health insurance system used in Japan. As pointed out above, a characteristic of the Japanese health insurance system is that its fundamental design enables cover to be provided for all the Japanese people by means of employees’ health insurance schemes for people who are employed, and National Health Insurance for the remainder who are not covered in this way. This is the reason why, when people retire from employment, they move into the National Health Insurance program and maldistribution of the middle-aged cohort arises.

Hence voices are now being raised from the side of the National Health Insurance program demanding that a “fair” burden be instituted.

Figure 3 : Rough calculation of national medical costs in fiscal 2030

	Population		National medical costs				
	2005	2030	Fiscal 2005	Fiscal 2030			
				Rate of expansion 0%	Rate of expansion 1%	Rate of expansion 2%	Rate of expansion 3%
0~64	102.01million persons (79.8%)	78.55million persons (68.2%)	1,620billion yen (49.0%)	1,330billion yen (34.0%)	1,710billion yen (34.0%)	2,190billion yen (34.0%)	2,790billion yen (34.0%)
65~74	14.12million persons (11.1%)	14.01million persons (12.2%)	740billion yen (22.2%)	730billion yen (18.7%)	940billion yen (18.7%)	1,200billion yen (18.7%)	1,530billion yen (18.7%)
75 and over	11.64million persons (9.1%)	22.66million persons (19.7%)	950billion yen (28.8%)	1,860billion yen (47.4%)	2,380billion yen (47.4%)	3,050billion yen (47.4%)	3,890billion yen (47.4%)
Total	127.77million persons	115.22million persons	3,310billion yen	3,920billion yen	5,030billion yen	6,430billion yen	8,210billion yen

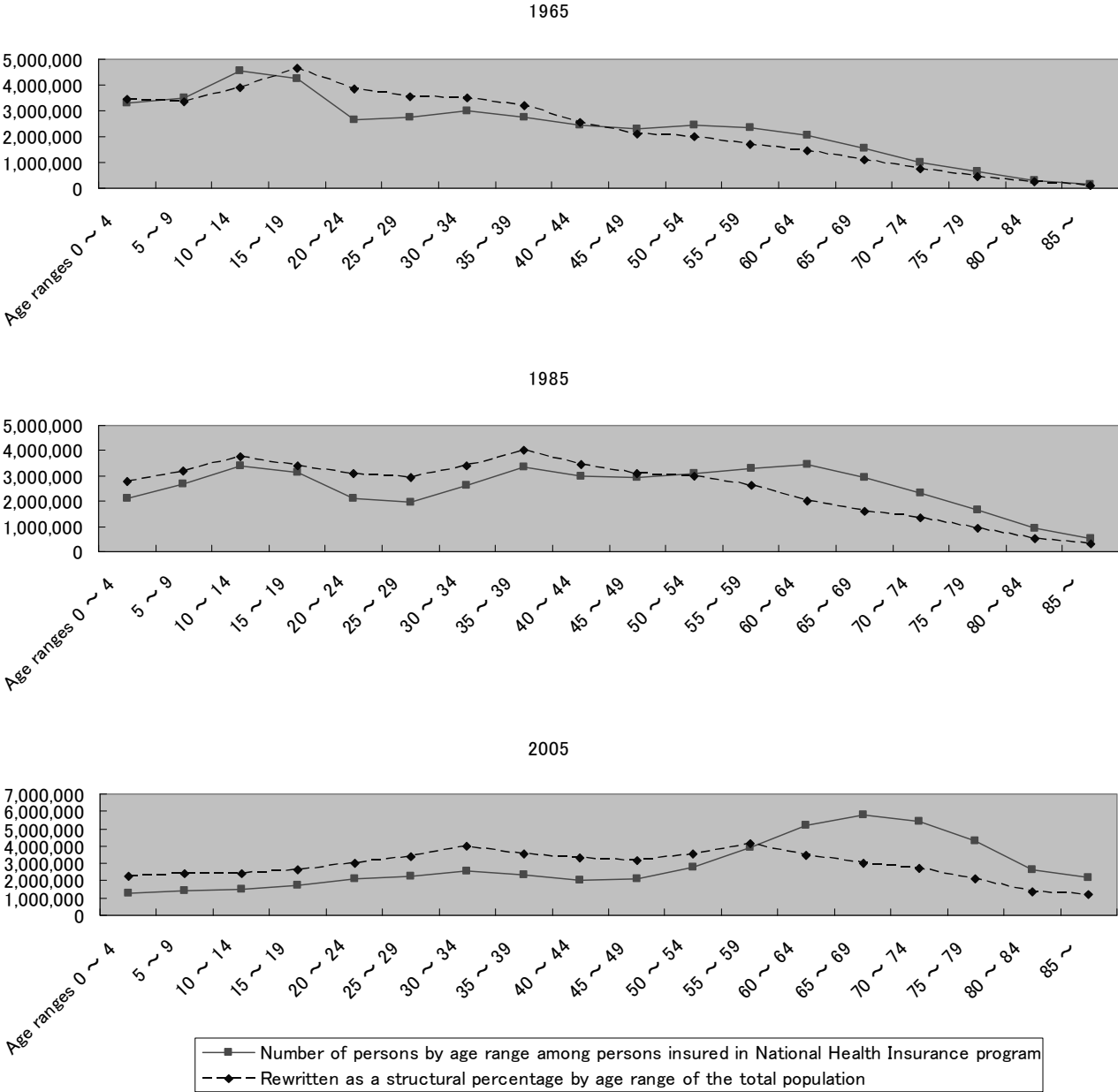
This very rough calculation (mechanical calculation) takes as a base the national medical costs (basically measured at 5-year intervals) applicable to each age division, and by simple application of the average rate of expansion, 0%, 1%, 2%, 3%, of such costs, calculates the medical costs for each age division, and presents these in relation to the total population in 2020.

Source: compiled by the author.

I will first explain what Figure 4 means. The unbroken line joins points measuring the number of participants in the National Health Insurance program at five-year intervals for each of 3 fiscal years (1965, 1985 and 2005). In contrast to this, the broken line joins the values, shown at the measured points, resulting from first dividing the total number of participants in the National Health Insurance program by the total Japanese population, and then multiplying the resulting percentage by the population in the age group concerned (measured at intervals of 5 years). For example, taking the example of fiscal 2005, the percentage resulting from dividing the total number of participants in the National Health Insurance program by the total Japanese population is 37.4% (Figure 5, “Structural Changes in National Health Insurance in Municipalities” will serve as reference). It follows that the broken line shows values based on the hypothesis that the total number of persons insured under the National Health Insurance program in each year group is distributed according to a set proportion of the total Japanese population in that year group (37.4% for fiscal 2005). In other words, the broken line should show a reducing line for population distribution for the whole of Japan (reduced to 37.4% for fiscal 2005). However, this is not in fact the case. As is clear if we look at the unbroken lines, the percentage of persons participating in the National Health Insurance is low for the younger

generation and high for the middle-aged and older generation. As Figure 4 shows, in fiscal 1961, when insurance cover for all the Japanese people was achieved, there is no gap between the unbroken and the broken lines, and in fiscal 1965, almost no distance between them. In fiscal 1985, the distance between the two lines is noticeable. And in 2005, the gap has widened still further. In particular, the part of the line indicating the younger elderly forms the shape of a hump⁵.

Figure 4: Age structure distribution for National Health Insurance program(1965・1985・2005)



N. Because the structural percentage data by age division for persons insured by the National Health Insurance program for 1965 and 1985 are put into one category for persons aged 70 and over, they are divided proportionally in accordance with structural percentages by age division for the total population.
 Source: Ministry of Internal Affairs and Communication, "International Survey Report", Ministry of Health, Labour and Welfare, "Report on the Actual State of National Health Insurance".

The maldistribution pointed out above in the age structure of the National Health Insurance program is also linked to the shift in the Japanese industrial structure from primary production to secondary and tertiary production. Figure 5 looks at the shift in occupation of the head of households enrolled in the national health insurance program. In fiscal 1965, the total of heads of households engaged in farming, forestry and fishery-related occupations and self-employed persons accounted for more than two-thirds of those enrolled in the National Health Insurance program. However, in fiscal 1985, the percentage of people in these three sets of occupations dropped sharply, and at the same time, the percentage of unemployed persons (elderly persons and others) rose sharply. And looking at the picture in fiscal 2005, the number of unemployed has risen to more than 50%, and among those registered on the National Health Insurance program, the percentage of the combined total of farming, forestry and fishery-related occupations and self-employed people is outnumbered by such people as employees in private enterprises with less than 5 employees or part-time

Figure 5: Structural changes in National Health Insurance in municipalities

Fiscal year		1965	1985	2005
Number of participants (percentage of population)		4 1 . 9 3 mill. (4 2 . 7 %)	4 1 . 7 3 mill. (3 4 . 5 %)	4 7 . 7 8 mill. (3 7 . 4 %)
Percentage of aged participants		5 . 0 %	1 2 . 4 %	2 9 . 7 %
Number of persons per household		3 . 7 8	2 . 6 5	1 . 8 9
Occupation of head of household	Agriculture, forestry, fisheries	4 2 . 1 %	1 3 . 5 %	4 . 4 %
	Self-employed	2 5 . 4 %	3 0 . 1 %	1 4 . 9 %
	Employed	1 9 . 5 %	2 8 . 7 %	2 4 . 0 %
	No Occupation	6 . 6 %	2 3 . 7 %	5 3 . 8 %
	Other	6 . 4 %	4 . 1 %	2 . 8 %
Percentage of households with no income		—	1 5 . 1 %	2 7 . 1 %

N. 1. The reason for choosing the year 1965 is that the data from the “Report on the Actual State of National Health Insurance” dating from before 1965 are unstable.

2. “Households with no income” denotes households with no income at the time of collecting the National Health Insurance charge (tax).

3. Figures for the number of participants are taken from the “Report on the Actual State of National Health Insurance” and do not match the figures in the “National Health Insurance Activity Annual Report”

Source: Compiled by the author on the basis of the “Report on the Actual State of National Health Insurance”.

workers. The National Health Insurance program was launched initially as a health insurance program for farming, forestry and fisheries-related workers as well as self-employed people, but the current form of the program has moved completely away from that original image.

4. The Road to the Establishment of the Health Insurance System for the Elderly

Three points have been listed above concerning the background to the debate that has been generated on medical treatment for the elderly. However, understanding of the reasons that led to the creation of an independent insurance program in the form of the Health Insurance System for the Advanced Elderly cannot be achieved without tracing the development of a health insurance system in Japan. The main points in the development of this system are as follows.

1) The framework of a two-tier health insurance program, with an employees' and a locality-based insurance program established in parallel, was constructed in the days before World War II (enactment of the Health Insurance Law of 1922, and enactment of the National Health Insurance Law of 1938). It is clear from the evidence that the lawmakers at that time envisaged the development of an employee-based insurance program suited to the perspective of workers' insurance, and a locality-based insurance program which would cover everyone not included in the former program.

2) After the end of World War II, against the background of the remarkable recovery of the Japanese economy, the realization of medical insurance for the entire Japanese population became a political issue, and this objective was achieved in 1961. The framework completed at this time was one whereby all the Japanese people would be covered by insurance through the establishment of the National Health Insurance program to provide cover to those not covered by the employees' health insurance program.

3) Following the achievement of medical insurance cover for all Japanese citizens, against a background of high economic growth, progress was made in strengthening the supply side (medical institutions, medical personnel, etc.) and raising the benefit rate in the National Health Insurance program, and medical treatment costs increased. An additional spur to the rise in costs was given to these by the implementation of free medical treatment for the elderly in 1973. As a result of this, the percentage of elderly persons receiving treatment increased sharply, and the financial situation of insurance programs, primarily that of the national health insurance program, which provided cover to many elderly persons, worsened sharply.

4) Ironically, it was in the autumn of 1973, the year in which free medical

treatment for the elderly was implemented, that the first oil shock occurred. With that as a trigger, the Japanese economy entered a period of low economic growth. And then in 1983, a healthcare system for the elderly was created, and in 1984, a healthcare system for retired persons was established. There are important differences between these two systems on the one hand and the current Health Insurance System for the Elderly on the other, and these will be dealt with under a separate heading.

5) In the 1990s, while on the one hand, medical fees increased to the extent of 1 trillion yen a year, on the other hand, the economy continued to stagnate after the bursting of the bubble. As a result, medical insurance finances worsened rapidly, and reaction against insurance contributions for the elderly widened, centered on the health insurance unions, and in 1999, this reaction widened to the extent of a movement advocating the non-payment of contributions. The 3 main reasons for this reaction were the following: ① the burden imposed by the payment of contributions increased every year with no means of halting the increase; ② the municipalities were not the insurers, but simply a mechanism that did not assume responsibility for payment; and ③ there was a lack of transparency regarding how the payment of medical expenses for the elderly should be divided between elderly persons themselves and the younger generations.

6) In addition to the matters mentioned above, as part of the process of continuing legal reform that accompanied the worsening of medical insurance finances, debates concerning the form that should be adopted by a system to deal with healthcare expenses for the elderly in place of an insurance scheme for elderly persons. For example, in 1997, in a Conference on the Reform of the Health Insurance System organized by the ruling part in government, the “creation of an independent health insurance scheme for elderly persons”, targeting persons over 70 years of age was proposed. Subsequently, the problem of a “paradigm” for medical treatment for elderly persons was firmly identified as the central issue of radical reform. And in the reform in 2000 of the Health Insurance Law and other matters, a supplementary resolution was adopted in the Diet (with the agreement of all parties except the Communist Party) to the effect that “urgent examination should be made of the creation of a new medical treatment system for elderly persons in place of the insurance program for the elderly, and that it should be implemented without fail in fiscal 2002”.

7) In the revision of the Health Insurance Law and other matters in 2002, no decision was reached on a “paradigm” for a Health Insurance System for the Elderly, but the perspective adopted was one of giving consideration to reducing the burden of health insurance contributions on the elderly and prioritizing a policy for the advanced

elderly. In terms of changes to be made from this perspective, it was decided that the target age for the provision of medical treatment under the Health and Medical Service Law for the Aged should be changed from 70 to 75, and the percentage to be borne by a public subsidy should be raised from 30% to 50%, the rise to be implemented in stages over a 5-year period. However, with regard to the burden on patients aged 70 or over in receipt of medical treatment, no change was to be made in the percentage, which remained at 10% (30% for persons with an income which is above the average of persons presently working).

This reform proposal engendered a great debate at the stage of investigation by the ruling party with reference to the introduction of a 30% charge for employees and the period of implementation, and opinions were strongly expressed to the effect that “Before seeking to impose a 30% burden (co-payment) on the people, radical reform of the health insurance system should be carried out”. As a result of these views, the “basic direction” of reform of the medical insurance system, including the creation of a new Health Insurance System for the Elderly, was formulated in a supplementary provision of the revised Health Insurance Law, and a rule requiring examination of the policy during fiscal 2002 was inserted.

8) In December 2002, a document entitled “Ministry of Health, Labour and Welfare Draft (hereafter MHLW Draft)” was published, containing 2 drafts: “A” Draft (Risk Structural Adjustment Formula), and “B” Draft (Creation of an independent system for persons aged 75 and over). However, the result of negotiations with the ruling party was a statement in the “Basic Direction” (Cabinet decision) of March 2003 that “in terms of a healthcare system for elderly persons, new systems should be constructed for advanced elderly persons aged 75 and over and for younger elderly persons from 65 through 74 respectively”. With regard to differences between younger elderly and advanced elderly, the following differences were noted in documents at this time: ① Almost all advanced elderly had their main living base in local areas (according to estimates for fiscal 2007, of the advanced elderly, 250,000 belonged to employee-based insurance schemes, a figure estimated at being about 2% of all advanced elderly persons; this figure excludes dependants); ② the average income (ability to bear a burden) of a younger elderly person showed almost no difference from the income of someone younger than 65, but in contrast to this, the income of advanced elderly persons showed a large drop; and ③ The character of medical treatment received by younger elderly and advanced elderly persons was different and there were noticeable differences in the per capita medical costs.

9) One basic pillar in the reformed medical care system of 2006 was the creation in

April 2008 of a Health Insurance System for the Elderly. This is fundamentally based on the “Basic Direction” referred to above, and in accordance with its classification as a “paradigm”, the health insurance system for the advanced elderly was constructed as an independent system, while the health insurance system for the younger elderly was categorized under an age-related risk structure adjustment formula.

Bringing together the above points, it is clear that the debate over a Health Insurance System for the Elderly is not something that has been going on for only the past 2 or 3 years. In fact, the debate over the form that medical care for the elderly should take dates from almost immediately after the achievement of providing insurance cover for all the citizens of Japan. More specifically, we can trace a path from the provision of free medical service for the elderly, through the creation of a healthcare system for the elderly as well as a system for retired persons, to the reaction against the massive increase in healthcare contributions from the elderly, through the debate over the “paradigm” of a health insurance treatment system for aged persons in place of the post-1997 healthcare system for the elderly, to the raising of the age of elderly persons targeted for healthcare for the elderly in 2002, to the formulation of the “Basic Direction” and finally to the creation of the current Health Insurance System for the Elderly, brought about by the reform in 2006 of the health insurance system.

5. The Differences between the Healthcare System for the Elderly as well as the Healthcare System for Retired Persons on the One Hand and the Current Health Insurance System for the Elderly on the other

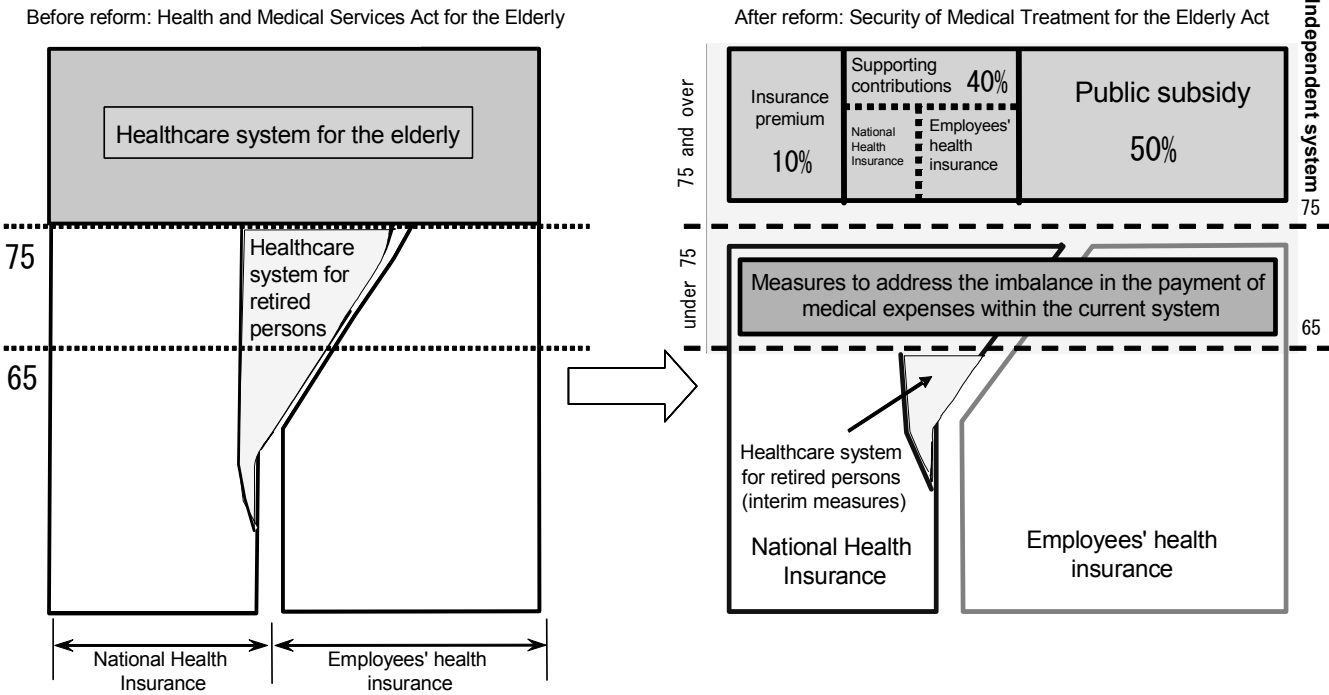
5.1. The Healthcare System for the Elderly as well as the Healthcare System for Retired Persons

In order to understand the new Health Insurance System for the Elderly, it is necessary to understand the differences between this on the one hand and the Healthcare System for the Elderly as well as the Healthcare System for Retired Persons on the other.

Firstly, the Healthcare System for the Elderly is not an insurance system constructed separately to target elderly people. Since the provision of medical services for the elderly is managed by municipalities, the mechanism of healthcare for the elderly has been called “dual participation”, but participation in the Healthcare System for the Elderly does not mean participation in a healthcare system specifically for the elderly and is in fact no different from participation in an employees’ insurance program. The fundamental character of the Healthcare System for the Elderly is that

of a joint project comprising the employees' health insurance scheme and the National Health Insurance scheme. In contrast to this system, the new medical system for the advanced elderly is an insurance scheme of an independent type, and for persons aged 75 and older, the insurance scheme to which they belong will change. (refer to Figure 6 to see how the insurance systems will divide at the age of 75). Metaphorically speaking, the previous Healthcare System for the Elderly was made up of 2 "countries", one "country" comprising members of employees' insurance programs, and one "country" comprising members of the national health insurance program, and for persons aged 75 and older, it was as if both countries had "joint jurisdiction". By means of the reforms of the new scheme, this "joint jurisdictional area" will be made independent, so that the entire system will be composed of 3 "countries", namely a "country" comprising a medical system for the advanced elderly, a "country" comprising an employees' system for persons under the age of 75, and a "country" comprising a national health insurance system for persons under the age of 75. Furthermore, under the Healthcare System for the Elderly, "nationality" did not change when participants reached the age of 75, but under the new medical system for the advanced elderly, "nationality" does change at the age of 75.

Figure 6: Mechanism of the health insurance system for the elderly



Source: Ministry of Health, Labour and Welfare, "Annual Report for f.y. 2007"

Secondly, there is the question of the mechanism for financing the former Healthcare System for the Elderly. Since this system has a joint character, each insuring party bears the burden of health insurance contributions for the elderly. With regard to the contributions, when detailed elements are abstracted (e.g. medical costs falling outside the adjustment targets), the calculation is carried out according to the formula in the box below.

Formula for Calculating Contributions to Healthcare for the Elderly

[Formula “A”]

The total medical expenses of the insuring party concerned for the elderly person \times (average participation percentage in all insuring party schemes \div participation percentage by elderly persons in the insurance scheme of the insuring party concerned) \times (1 – share borne by a public subsidy)

[Formula “B”]

The per capita medical expenses for each elderly person insured by the insuring party concerned \times the number of persons registered with the insuring party concerned \times the average registration rate of elderly persons with all insuring parties \times (1 – the percentage borne by public subsidy)

※ The item in [Formula “A”] comprising “the total medical expenses of the insuring party concerned for the elderly person” is changed in [Formula “B”] to “the per capita medical expenses for each elderly person insured by the insuring party concerned \times the number of persons registered with the insuring party concerned”, and the item in [Formula “A”] comprising “participation percentage by elderly persons in the insurance scheme of the insuring party concerned” is changed in [Formula “B”] to “the number of elderly persons registered with the insuring party concerned \div the total number of persons registered with the insuring party concerned”.

If we look at Formula “B”, it is clear that if the medical expenses for each elderly person registered with an insurance program of any of the insuring parties were the same, then the insuring party would make contributions in accordance with the number of people registered with the said party, regardless of the percentage of elderly people actually participating in the insurance program. Putting this simply, leaving aside the burden on public funds, what this means is that the cost of medical charges

for the elderly would be divided by the number of participants in the program of each insuring party.

On the other hand, the New Health Insurance System for the Advanced Elderly is supported by each insuring party. The total amount which each party has to bear is what remains after excluding the charges on elderly people, the insurance premiums, and the public subsidy. That amount is supported by each party in proportion to the persons registered with the party concerned. A point to which attention should be paid is that the insurance charge to be paid by the advanced elderly person is separated from the target burden of contributions (supporting funds), but the mechanism of the calculating method is analogous to elderly healthcare contributions.

5.2. The Healthcare System for Retired Persons and the Health Insurance System for the Advanced Elderly

Next, I would like to give an explanation of the reasons for the creation of the Healthcare System for Retired Persons and of its characteristics.

When people retire on reaching a fixed age, they leave the employees' insurance system and join the national health insurance system. However, when people retire from employment due to reaching retirement age, their ability to bear the burden of insurance charges falls sharply, while on the other hand, they belong to the age category in which the risk that they will need medical treatment rises sharply. In this situation, there were criticisms from the side of the national health insurance providers to the effect that it was irrational that salaried workers, who had for many years belonged to an employees' insurance scheme should be embraced by the National Health Insurance program on reaching a fixed retirement age. This is why retired insured persons who were members of an employees' insurance program for a long period (for example, someone who has been a member of a contributory, employees' insurance program for a period of 20 years or longer) pay insurance charges in accordance with the criteria adopted by a given locality for imposing the national insurance premium. However, in cases where the medical charges are not covered by these payments, the remaining medical expenses are covered by contributions made by the respective insuring party of the employees concerned (proportional division of the total of all remuneration made to the insuring party concerned). What is described here is the Healthcare System for Retired Persons. The composition of the system adopted is therefore one in which the retired persons who are objects of medical expenditure are insured under the national insurance program, but because these persons are scattered over the whole country, there was no other option, if retired insured persons were to be administered accurately and the collection and provision of

insurance premiums was to be implemented, but to utilize, for reasons of convenience, the device of the municipality-based national insurance scheme. Speaking metaphorically, the Healthcare System for Retired Persons borrows “shelter under the eaves” from the National Health Insurance scheme; essentially, it is a device for sharing the medical expenses of retired insured persons with employees’ health insurance schemes.

On the other hand, under the health insurance system for younger elderly persons is targeted at medical premiums levied on all younger elderly from the age of 65 through 74, not limited to retired persons. Specifically, each insuring party, taking as a base the total amount comprised by the payment of insurance fees in respect of younger elderly plus supporting payments for advanced elderly charged to younger elderly persons (i.e. the portion for young elderly included in the total amount of supporting payments for advanced elderly borne by the insuring party concerned), bears the amount calculated by looking at the national average in terms of the percentage of younger elderly participants. The result of this is that insuring parties (=insurance providers) to which a low percentage of young elderly belong, make payments, while insuring parties to which a high percentage of young elderly belong receive grants. The financial adjustment process comprised in the medical system for younger elderly is fundamentally different from the Healthcare System for Retired Persons, and is analogous to the mechanism used in the Healthcare System for the Elderly.

6. Points of Debate concerning the Health Insurance System for the Advanced Elderly and Evaluation of the System

Among the many criticisms directed at the Health Insurance System for the Advanced Elderly, there are some that are justified, and others that are not. Consideration of the main points of debate now follows.

6.1. Design of the Independent Health Insurance System for the Advanced Elderly

The following are the points in the Health Insurance System for the Advanced Elderly at which the greatest number of criticisms are directed.

Firstly, there has been a reaction alleging discrimination against the elderly in that the basis of generational solidarity will be weakened by the use of a specific age to divide up groups of insured persons. The question that asks why hostility between generations is being stirred up is also related to this category of criticisms. The writer of this paper does not agree with the view of those making the criticisms.

Even before the creation of the new system, since the establishment of the

healthcare system for the elderly, support among generations was practiced within insuring parties in the form of joint support by insurers. However, as the population structure of Japan continued to undergo severe change, the question of how the burden of medical expenses for the elderly should be shared among the generations became an issue that had to be squarely faced. Accordingly, it can be argued that it is precisely because a comparatively cool and rational debate is still possible that it is necessary to reconfirm awareness of inter-generational support in the context of the medical insurance system by heightening the level of transparency surrounding the structure of medical charges for the elderly and at the same time, establishing rules for sharing the burden among generations.

Secondly, there are criticisms of the new burden that has arisen because of people reaching the age of 75, although there has been no change in the actual pattern of daily and the structure of households. The writer of this paper is of the opinion that it is with regard to this point that a significant number of correct criticisms can be found.

For example, insured persons who belong to the advanced elderly category have to move out of employees' health insurance when they become 75 and older. As a result of this, the insurance charge burden previously borne by employers (in principle, employers bear one half of the insurance costs) is no longer borne by them, and the insured persons have no guarantee of receiving the legal provision of employees' insurance (for example, allowance for the sick and wounded), and this change lacks rationality. With regard to persons of 75 and over who are working and are members of an employees' insurance program, it may be considered that there is no alternative but to exclude them from applicability of the Health Insurance System for Advanced Elderly.

A further problem is that of how to deal with elderly persons who become recipients of support by persons insured by employees' health insurance. In the Health Insurance System for Advanced Elderly, it is the advanced elderly person who must himself or herself make payments as the recipient of insurance cover. Up to the point of entering that system, the elderly person has been supported by the employees' health insurance program, but on reaching the age of 75, a new obligation arises whereby each elderly person must pay the insurance premium. A fixed interim measure has been established, but this is one major discussion point that must feature on the agenda at the time of re-evaluation.

6.2. Imposition of an Insurance Premium on Advanced Elderly Persons

A further point which attracted much criticism was the imposition of an insurance premium on advanced elderly persons. However, this point has been confused with a

problem of an entirely different character.

Firstly, the unit on which an insurance premium is levied is not a household, but an individual person. Because of this, if households are taken as a base, then there will be cases where sharp increases will arise compared to previous practice. For example, there are cases where in the case of a couple, the ceiling for the burden is ¥500,000 (1 million yen if you look at the household). The explanation will probably be given that in the case of high-income earners, this cannot be helped, but the insurance premium ceiling in the case of the National Health Insurance system is ¥540,000 for a household, so in the case of a household, the increase is about double when compared with previous practice. It is reasonable to think that some device should be arranged so as to ameliorate severe changes.

Secondly, it is not the case that practice based on individual units has been completely attained; there are cases where thinking in terms of household units has been partially adopted. For example, the measure for ameliorating the burden on insured persons arising from the principle of equal division is calculated on the basis of a household unit. Or for example, when a husband has an income which is above the average of persons presently working (assessed as having to bear a burden of 30%), while the wife simply has a basic pension, the insurance charge is paid separately by the husband and the wife, but the charge that the wife pays after receiving medical treatment at an institution is not 10% but 30% (because the husband has a high income from working). Dissatisfaction will probably arise from the issue of why the amount paid after treatment is assessed on the basis of the unit of a household, while the insurance premium is levied on the basis of an individual. Of course, the daily living conditions in this case are significantly different from those of a case where, for example, a couple are living only on their basic pension, and it is likely that there would be criticism in such a case to the effect that it would be unfair if the application of a unit as an individual was strictly enforced. Theoretically, the concept of taking an individual as a unit should be strictly enforced, but daily life is managed with the couple as a unit, and the writer of this paper is of the opinion that to exclude completely assessment of the couple as a unit in cases of health insurance and long-term care insurance would not be appropriate.

Thirdly, there is criticism of the special collection method of the insurance premium (automatic deduction from the pension). However, the writer of this paper does not understand rejection of the special collection method as such. In the first place, a payment obligation exists, regardless of the method of collection. Moreover, ensuring implementation of the insurance premium collection is the foundation of the

medical insurance system, and the issue of clerical efficiency including collection costs can certainly not be overlooked. From this perspective, a special collection system is clearly something that must be created, and consideration has also been taken so that the usual collection method is employed in cases where the pension amount is less than ¥180,000 or where the combined total of the insurance premium for the Health Insurance System for the Advanced Elderly and the long-term care insurance premium is more than half that of the annual pension amount. There are many aspects of the reaction against the special collection method that are due to an inadequate explanation of the system, and it goes without saying that there is a need to make a fuller explanation of the thinking underlying the insurance charge calculation and of the collection method (automatic deduction), but one cannot go so far as to say that the special collection method is unfair or that it disregards the spirit of the public pension system.

6.3. The organizing bodies of the new Medical System for the Advanced Elderly

In the Healthcare System for the Elderly, municipalities are the bodies which implement the provision of medical care, but they are not the insuring parties. The point here is that if the healthcare system for the elderly went into the red, a contribution to the insurers would be levied in the form of an “adjusted amount”, and the municipalities did not bear financial responsibility for this. This point was also one issue in the criticism levied against the healthcare system for the elderly, and the establishment of insuring parties was indispensable to the creation of the new Health Insurance System for the Advanced Elderly, which replaced the former healthcare system. However, because nobody wanted to accept financial responsibility, it was very difficult to bring this matter to a conclusion. In fact, content to the effect that the municipalities were fundamentally the operating bodies of the system appeared in the “MHLW Draft” of October 2005, but there was a strong reaction against this from the side of the municipalities. As a result, thinking that surfaced during the debate was that the prefectures should be the unit responsible for financial operations, while the municipalities should be responsible for collection of the insurance premium. In the course of seeking a more precise formulation, it was proposed that wide-area unions, each covering the area of a prefecture, should be created as the operating entities, and that all the municipalities within a given prefecture would be members of the wide-area union concerned. It was to this proposal that the agreement of the municipalities and other concerned parties was obtained⁶.

The problem that remained was that of how the wide-area unions were to develop appropriately the role of insuring parties. Essentially, the insuring parties are agents

of the insured persons, and have a mission to maximize the benefit to the insured persons to the maximum possible extent. Looking in specific terms at the role and functions of insurers, the fundamental points can be set out as follows: ① Making an appropriate estimate of provision and setting charges in line with this as well as implementing collection; ② Implementing health activities (e.g. medical check-ups); and ③ Working and pressurizing for the implementation of medical care with a view to obtaining efficient and high-quality medical services. Among insuring parties in Japan at present, there are many that have not achieved the level of the function set out in ③, but since the insuring parties are, so to speak, joint purchasers of medical services, grasping the function set out in ③ is a very important issue in the context of heightening an “evaluation that matches the expenses contributed” (getting value for money). Furthermore, when you think that medical services are organized on the basis of units corresponding to a prefecture, then thinking of insurers in terms of prefectural units is a correct way of thinking. However, collection of insurance charges and over-the-counter clerical work must be carried out by municipalities (since they have the basic register of residents and information on taxpayers). It follows that close liaison between the wide-area unions, which constitute the insurers, and municipalities, is indispensable.

Looking at the recent state of confusion, in addition to inadequate PR on the part of MHLW, there are a significant number of cases where the cause of the confusion is poor liaison between municipalities and the weak clerical organization of a wide-area union as a collection of people dispatched from municipalities and elsewhere. There is a need to aim at reconfiguring the management structure including positive involvement on the part of prefectures. In addition, within the framework of the mechanism as currently set up, the effort put into the collection of insurance charges by municipalities is not directly reflected in the finances of each municipality concerned. When one reflects, however, on the importance of appropriate collection of insurance premiums, it is reasonable to think that there should be a re-examination of distribution of collection costs in line with the percentage of collection achieved.

Moreover, in Japan, due to historical and other reasons, both the state (government-run health insurance) and local public bodies (municipalities) are insuring parties⁷. In addition to this, wide-area unions are also special public bodies. However, from the standpoint of suitably grasping the independence and autonomy of insuring parties, it is desirable to have insuring parties that have medical policy specialists at the core and to adopt a management system that allows insured persons to further express their opinions as persons who bear the costs of the system. Putting

the issue in very frank terms, an issue that, in the view of the writer of this paper, should be examined is to make the insuring parties publicly incorporated persons, and on the basis of the reality of the management of the Japan Health Insurance Association, which is the “successor organization” to government-run health insurance, make the insurers of the new Medical System for the Advanced Elderly into prefectural corporate persons.

6.4. The Health Insurance System for Younger Elderly

In contrast to the new Health Insurance System for the Advanced Elderly, under which persons aged 75 and over will be directly influenced by an increase or decrease in the insurance charge, in the case of the Health Insurance System for the Younger Elderly, the insuring parties function as a cushion or buffer to ease the impact, so the government does not bear the full brunt of criticism by the people. However, that does not mean that the Health Insurance System for the Younger Elderly is free of any problems. This system does have a great influence on the finances of insured people.

In point of fact, expenditures on Contributions for Healthcare for the Elderly as well as on the Provision of Contributions for the Fund for Retired Persons (renamed after the revision as Supporting Funds for Advanced Elderly Persons, Provision for Younger Elderly Persons, and Transitional Contributions for Retired Persons) accounted for around 40% of all expenditures. For example, of the total income (including national treasury subsidies) of the Government-Managed Health Insurance (Japan Health Insurance Association following the revision of October 2008), the percentage of contributions to the items mentioned above accounted for 40.2% in fiscal 2008, with 13.0% being taken up by Provision for the Younger Elderly, and 6.2% by Transitional Contributions for Retired Persons⁸. The total of 19.2% is equal to the Supporting Funds for the Advanced Elderly. The Health Insurance Unions are also groaning under the burden of contributions of this kind. In fact, among health insurance unions with a low percentage of younger elderly persons as members, there will be some cases of unions which will inevitably have to be dissolved. Moreover, in the Healthcare System for Retired Persons, the proportional distribution among insured parties represented a proportional distribution of the total of all remuneration made to the insuring party concerned. In contrast to this, financial adjustment in the case of the younger elderly is carried out on the basis of proportional distribution of the number of persons (number of registered participants in the program). As a result, in the case of a health insurance union where the percentage of participating younger elderly persons is low, and where in addition, the wage level of the insured persons is low, it will become necessary to raise the level of insurance charges very considerably.

It can therefore be anticipated in the future that when the concept and the actuality of younger elderly merges with that of the “baby-boom generation”, the burden borne by insured people will increase, and it is reasonable to assume that not only financial adjustment on the part of insuring parties, but also the injection of a public subsidy will be an important issue for consideration in the future.

It should also be mentioned that the rise of the insurance premium to 20% (from the current rate of 10%) for persons aged 70 through 74 will be frozen until March 2009, but it is the view of the author of this paper that when we think about striking a balance with the younger generation, a rise to 20% is inescapable.

7. The Debates over 4 Formulae for Medical Services for the Elderly

The debate over the “paradigm” for medical services for the elderly that has been conducted since 1997 was set out in Section 4 above; more specifically, the choices can be divided into the 4 formulae shown below. Of these, the “independent formula” is the pattern used for the Health Insurance System for the Advanced Elderly, while the “risk structure adjustment formula” is that used for the Health Insurance System for the Younger Elderly. If a serious look is taken at reevaluating medical services for the elderly, then one of these 4 formulae will be chosen. However, each of the formulae has strong points and weak points. The thinking underlying each of the formulae and problem points are set out below.

7.1. Unified Formula

Because the distortion in ages and income structures among the clients of the various insuring parties has its origin in the dual system of health insurance in Japan, there is one way of thinking which argues that all health insurance systems should be unified without regard to differences in age and income structure among the clients (or unified within prefectural units even if not necessarily in the country as a whole).

The biggest problem with this formula is that as a problem on the political level, there is an increase in the charges levied on insured persons, and theoretically, because there is a problem with grasping the amount of net taxable income resulting from differences in the amount of tax-deductible expenses (hereafter net taxable income) among, for example, employed persons and self-employed persons, it is impossible to create a common “yardstick” for levying insurance charges. The percentage of net taxable income among self-employed persons can be designated as the percentage of income as such in a narrow sense, and the problem can be eliminated to a significant extent by the introduction of a number system for taxpayers, but a deep-rooted problem with the designation of net taxable income derives from the

difficulty of determining necessary expenses (for example, whether a self-employed person's car is for working purposes or private purposes). Moreover, even if the system were to be unified, a major remaining problem would be how to deal with the employer's share of the insurance premium. This point is not limited to health insurance systems, but influences the ideal form of the entirety of social insurance. Furthermore, the system of insuring parties has the specific merit that by means of healthcare administration, efforts are made to reduce the cost of medical charges and insurance charges, but it is questionable whether this function of the insuring parties can be suitably grasped if the system is unified. It is worth noting that Korea is said to have completed "medical insurance integration" by merging occupation-based and locality-based insurance, but a common system of insurance charges has not been constructed, so the system is simply the "outward appearance of integration".

7.2. Penetration Formula (Two-track Formula)

This is a formula in which the medical charges levied on persons formerly insured through the employees' health insurance program are supported by all such insured persons, and is at the diametrically opposite pole to the unified formula. There has been a proposal that by making the dual system of employee-based insurance and national health insurance penetrate the aged sector (purification), it would be possible to see a system in which in a sense, the Healthcare System for Retired Persons did not stop at age 75, but was further extended.

The difficulty with this formula is that the burden on the National Health Insurance program would become excessively heavy. In addition to this, 3 further critical questions have been posed: ① Within the working generation, company employees can be distinguished from self-employed workers by the form of their earnings, while among the generation of elderly people (the generation in receipt of a pension), cannot the basic pattern of life on a pension be said to be the same for everyone?; ② In a context in which the pattern of employment has become more dynamic and flexible, is it not more appropriate to differentiate between those who were previously company employees and those who were not, and to construct separate systems of medical insurance?; and ③ Is a system that is fundamentally beneficial for the group of employee-based insured people not contrary to the ideal of social solidarity which says that aged people should be supported by the population as a whole? It should also be said that the mechanism of this system is very different from the system currently in operation, hence transferring to this system would require a very large burden in terms of clerical and administrative effort. It is also possible to envisage a pattern of "borrowing" the pension system of employed insured persons, but

even this would be significantly complicated in terms of the processing machinery.

7.3. Risk Structure Adjustment Formula

The thinking underlying this formula is that because the difference in the age structure of participants results from the medical insurance system in Japan, it is not the responsibility of the insuring parties, hence adjustments should be made to medical expenditures with age structure differences seen as the cause. This formula is the one adopted by the Health Insurance System for the Younger Elderly, and it belongs to the age risk structure adjustment formula used by the healthcare system for elderly people.

The difficult point about this formula is that the payment that participants in the employees' health insurance program have to make is excessively large, and there is no upper ceiling. As explained above, at the present time, the burden of payments by younger elderly persons is exerting considerable pressure on the finances of employees' health insurance schemes. Because the Health Insurance System for the Advanced Elderly has been unfavorably evaluated, the idea has been put forward of abolishing it and extending the Health Insurance System for the Younger Elderly to cover the advanced elderly. There is also a close resemblance between the basic ideas of the Healthcare System for the Elderly and the Health Insurance System for the Younger Elderly, and it should be noted that a proposal was also put forward to expand the Healthcare System for the Elderly (but the idea was rejected in the course of the debate on radical reform). A further issue for debate is how the public subsidy should be inserted.

In addition to the above, a further problem with this formula is the ripple effect. A point that will inevitably arise is the need to adjust the maldistribution that applies to all ages, not just to the elderly and is not the responsibility of insurers. Furthermore, because differences in income are also not the responsibility of insuring parties, the point arises that these too should be adjusted. A further point concerns the need to make adjustments to compensate for structural differences in illnesses (for example, differences among insuring parties in the percentage of patients with mental illness or patients needing artificial dialysis). This is an entirely natural point of view, but with regard to income adjustment, there is the problem of differences in the percentage of net taxable income, as explained above under the "unification formula" heading. There are differences according to whether adjustments are made among insuring parties or whether insurers are unified and internal adjustments are made subsequently, but the result in real terms is the same.

7.4. Independent Formula

The main point about the independent formula is that it clarifies the rule of a different burden of expenses for the younger generation and the generation of elderly persons. On the other hand, the most difficult point about this formula is that the category of insured persons changes on reaching the age of 75 even though there has been no change in their lifestyle. I will not repeat here the discussion points and questions of influence, which have already been gone over at great length. Furthermore, from the perspective of unifying the different system designs for the younger elderly and the advanced elderly, and from that of coordinating the starting age for the provision of a public pension and the qualifying age for the provision of long-term care insurance, it can be argued that the age of 75 as marking a change of systems should be reduced to 65. However, note should be taken of the following three points: ① the confusion that has arisen with regard to the currently introduced scheme will recur as a problem affecting the younger elderly; ② compared to the advanced elderly, the proportion of the younger elderly who are still working is comparatively high, and if the principle of the exclusion of applicability is approved for those covered by an employee-based insurance scheme, the percentage of “exceptions” will become a very large system; and ③ it will be necessary to reexamine from basic principles redistribution of the insurance charge including the ideal pattern for the burden on public funds.

8. Closing Words

What the writer of this paper has done above is to offer a commentary and a detailed consideration of the various issues involved in the process of development leading to the introduction of the new Health Insurance System for the Advanced Elderly. Within this context, the writer would like to emphasize in particular the following 3 points.

1) In the near future, the population structure of Japan will change sharply, and it cannot be expected that this will be accompanied by a period of high economic growth. In order to provide insurance for all the people of Japan within this kind of framework, the problem of how to share the burden of medical care for the elderly among and within generations will have to be faced head on. It is also true that medical insurance should be managed with insurance charges as the main source of finance, and the author of this paper cannot agree with the tendency to “rely on consumption tax” for everything. That said, the debate about how to inject a public subsidy in the context of trying to find the ideal way of apportioning the burden of charges is not one that can be

avoided. In short, it is impossible to avoid a fundamental debate when discussing ways of taking a fresh look at the system of medical care for the elderly.

2) When we look at past experience, we see that every time a financial crisis over medical insurance charges seemed to be impending, expectations of radical improvement rose, and the debate over financial policy adjustments or separation of charges unfolded. The system of healthcare for the elderly that was considered in contexts of this kind was indeed a very ingenious system (this is why it continued in existence for 25 years), but particularly after 1997, the central theme became one of the radical reform needed to create a system to replace this, in other words, how to reach a decision on the “paradigm” (4 formulae) of a health insurance system for elderly persons. However, each of the formulae had strong points and weak points, and it was not just that the basic ideas were different, but that the structure of apportioning the burdens among the parties involved changed with each case, so it was not easy to reach a conclusion. The newly introduced Health Insurance System for the Advanced Elderly is the conclusion of 10 years of debate, and leaving aside the question of whether it is the best option, it cannot be denied that it contains points which have received a certain degree of approval.

3) A system cannot be constructed as if you were starting from scratch with a blank sheet of paper. (For better or worse), once a given reality has come into existence, you cannot simply ignore it and proceed to the next step. There is an argument that the debate about the newly introduced Health Insurance System for the Advanced Elderly should be pushed back to square one, but to use the analogy of backgammon, it won't do just to go back to the starting line. This is because the structure of the burden of charges has changed from what it was in 1997 or 2002 and the position after the recent system reforms.

Taking the above points as a foundation, even if people talk facetiously about reevaluating the system, it is necessary to distinguish between the 2 alternatives: ① making minor amendments to remove any irrationalities that have sprung up in the existing system; and ② re-arranging the fundamental structure (in simple terms, the “paradigm”) of the existing system. In the former case, there is no alternative but to carry out the minimum necessary amendments, but the latter case raises the problem of the need to get to grips with the issues in a very thorough and systematic way. As reasons for this, it can be pointed out that to rush ahead, valuing speed above quality, and present a half-baked scheme would have the reverse effect of causing more confusion, and while it is not possible to avoid the debate about the injection of a public subsidy, the outlook regarding public finances is by no means clear. A more important

reason is that this problem is connected with the fundamental ideas of the system of health insurance, or with the root and branch of the system in terms of choosing a “fair and equitable” way of apportioning the burden in a super-aged society.

But that said, thoughts about what constitutes a “fair and equitable” way will differ according to who is doing the thinking. It also has to be said that in a medical system, autonomy and efficiency are also important characteristics, so “fairness” is not the only value criterion. Furthermore, when it comes to a detailed examination of system design, the problem will arise of striking a balance with the existing system and of the ripple effect. Grappling with system theory is like solving complicated, multi-dimensional simultaneous equations, and is a long way from a simple choice such as the “popular vote”. But the problem is not one that can be indefinitely postponed, and with that point in mind, the only thing that the concerned persons can do is make efforts to seek a solution against the background of a shared problem consciousness. And if one postulates that a major cause of the confusion was that awareness of a “common problem” was not in fact present for those concerned, then the first thing that has to be done, in addition to “vicariously experiencing” the policy choices of the past is to envisage the scenario of events that will occur in the near future and form a “common understanding”. It is in an effort to assist with this process that I have written at length in this paper about such areas as changes in population structure and developments in the various systems.

Notes

- ¹ As a point of reference, the manuscript of this paper was completed at end October 2008.
- ² However, persons who are in receipt of welfare (livelihood protection) are excluded from the National Health Insurance Program. Their medical expenses are met in full by an allowance that forms part of the welfare payment.
- ³ Up to that point, many advanced elderly persons were enrolled in the National Health Insurance scheme. Advanced elderly persons covered by an employees' insurance scheme fell into 2 categories: ① persons who fall into the advanced elderly category in terms of their age, but continue to work of their own volition and belong to employees' insurance; and ② advanced elderly persons who are dependents of their son or other family member who belongs to an employees' insurance scheme. It is estimated that around 2% of advanced elderly persons belong to category ①.
- ⁴ Precisely speaking, for advanced elderly persons with an income comparable to when they were employed, the provision of expenses will not be made from public funds (this portion will also be covered by support from the working generation). As a result, the division of funds in fiscal 2008 was 44% from supporting funds and 46% from public funds.
- ⁵ It is estimated that this "hump" will become even larger between 2012 and 2014, when the "baby boom generation" comes into the young elderly category.
- ⁶ Because of this lengthy procedure that led to agreement, there is no clear specification in law that the wide-area unions are the insuring parties for the advanced elderly. However, in addition to answers given in the Diet, it is specified in the 2007 MHLW White Paper (paragraph 136) that wide-area unions "are categorized as the insuring parties". It is therefore unmistakably the case that the wide-area unions bear the responsibility of being the insuring parties.
- ⁷ There are historical reasons why both the state and local public bodies are insuring parties. For further details, see Shimazaki (2005), *op. cit.*
- ⁸ Taken from the record of the meeting (30th meeting held on September 12, 3008) of the Medical Insurance Sub-Committee of the Social Insurance Commission.

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