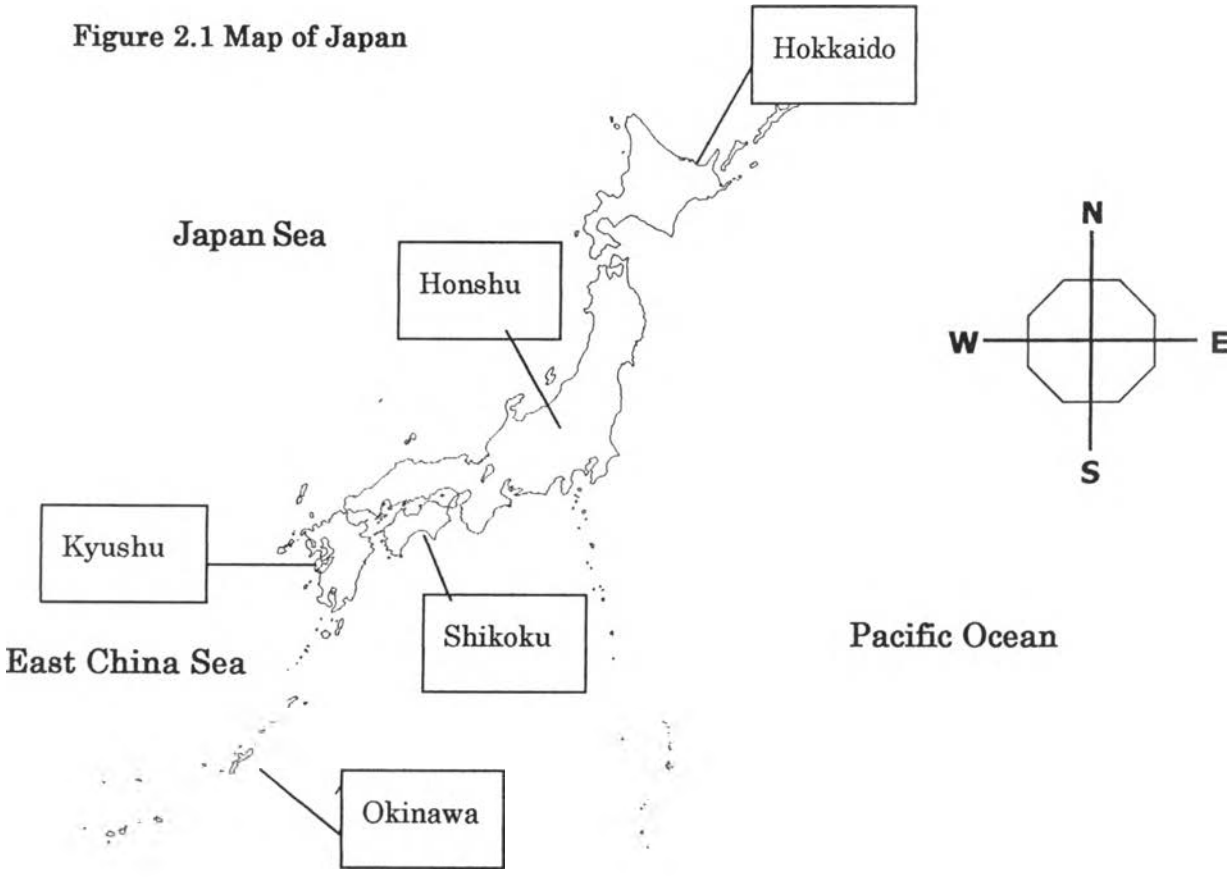
CHAPTER 2

BACKGROUND ABOUT JAPAN AND ITS HEALTH CARE SYSTEM

2 .1 Geography

Japan is an island located in the north east quadrant of the continent of Eurasia. The country forms an arc and contains four large islands and many smaller ones. The total land area is about 378,000 sq km. The Pacific Ocean lies to the east while the Sea of Japan and the East China Sea separate Japan from the Eurasia continent. Approximately 75% of Japan's land mass is mountainous. Most of the land has a Cfa[8] climate (Humid Subtropical East Coasts) except that Hokkaido has a Dfa[9] climate (Subarctic)(Ninomiya Shoten ed., 2002).

Figure 2.1 Map of Japan

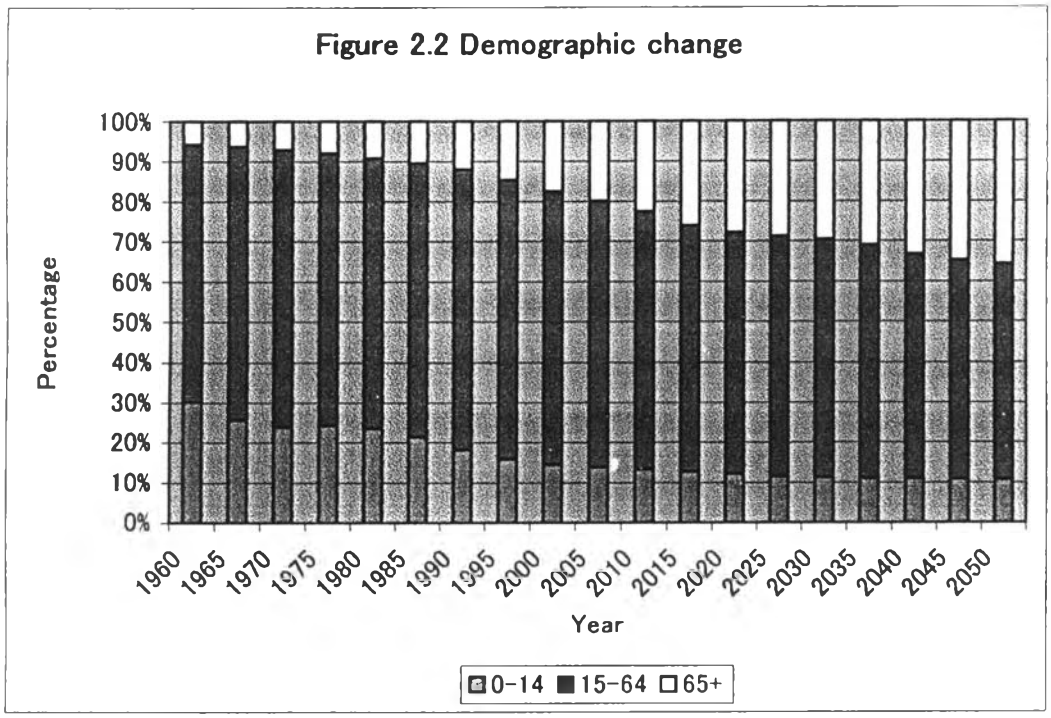


[8] Cfa is the climate zone that has an average temperature in the warmest month over 22 degree Celsius, and that of the coldest month is less than 18 degree Celsius and above –3 degree Celsius. Rainfall is equally distributed throughout the year.

[9] Dfa is the climate zone that has an average temperature in the coldest month of –3 degree Celsius or below, and that of the warmest month is higher than 10 degree Celsius. Rainfall is equally spread throughout the year.

2.2 Demographic Trends

According to the 2000 population census, the total population of Japan was 126.93 million. Based on the results of the medium variant projection by National Institute of Population and Social Security Research, the population is expected to increase gradually in subsequent years, reaching its peak of 127.74 million in 2006, then it expected to enter a longstanding depopulation process. The population is expected to drop to 100 million by 2050. (National Institute of Population and Social Security Research, 2002)



Source: National Institute of Population and Social Security Research (2002)
Health and Welfare Statistics Association (2001)

Japan approached an aged society in 1994[10]. In 2000 those aged 65 years and over comprised 17.4% in the total population. The ratio is expected to increase to above 25% of the whole population by 2015 and will reach about 33% of the total population by 2040. The causes of the rapid aging are the increase in longevity and the decrease in the fertility rate. The average longevity has been extended to the highest in the world as a result of the universal coverage of health insurance, medical advancement and socio-economic improvements. In 2000, it reached

[10] When a country's aged population (65 years old or over) exceeds 14% of total population, the country is called an aged society.

77.64 years old for males and 84.62 years old for females. The number of babies in the year 1999 was about 1,178,000, the lowest in the century. The total fertility rate for women in Japan is 1.34; below the rate of 2.14 which is required to maintain the population size. The fertility rate has continued to decrease for 35 years. (Ministry of Health, Labour and Welfare, 2002).

2.3 Measures for Aged Society in Japan

Basic framework of Japan's measures and policies for elderly is based on the Fundamental Law of Measures for Elderly implemented in December 1997. The aim of this Law is to promote the measures for elderly comprehensively and to stabilize the society for economic development. As principles of the measures for elderly, develop an affluent society that people have fairness and vitality with the mind of self-reliance and solidarity. The law stipulates the responsibility for both nation and regional government to realize the society with the effort of civil. The Hawser of Measures for Elderly depicts the specific areas for measures as "employment and income", "health and welfare", "learning and social participation", "life environment " and "research". Regarding "health and welfare", the key measures are to endeavor health promotion, to enrich health and welfare services, and to enhance the infrastructure for long-term care services.

Today, the Ministry of Health, Labour and Welfare considers that timely prevention of adults diseases, now primary physical menace to Japanese people, is essential to promotion of health and extending life span. Based on this idea, the MoHLW stepped in to the 21st Century National Health Campaign (Healthy Japan 21)" to support people in improving living custom and practice. With regard to elderly population, Gold Plan 21 (5 year plan for the guideline of measures for elderly) implemented in 2000, after the completion of the former national health plan (New Gold Plan). The aims of the Gold Plan 21 are as follows: 1. to establish a vital eidolon of elderly, 2. to improve the quality and quantity of long-term care services, 3. to establish a society with support mutually in each region, 4. to secure the reliability of long-term care services newly provided by contract

2.4 Health Insurance

2.4.1 History of Health Insurance

The history of Japan's health insurance goes back to the Health Insurance Act that was established in 1922 and was implemented in 1927. Ad initium, it did not cover dependents and the period of benefits was limited to 180 days. It became compulsory for all companies employing more than 10 employees to provide health care insurance. Thereafter, the coverage of the service and population has gradually expanded by way of the National Health Insurance Act of 1938 and the various mutual aid association acts established from the 1950s to the beginning of the 1960s. Universal coverage under a public medical care insurance system was achieved in 1961 with the amendment of the National Health Insurance act. In 1972 all fees for elderly medical care were eliminated. As a result, the frequency for the elderly to visit health care facilities increased sharply. With the coming of 1980s, however, it became necessary for health care reform because of the stagnant economy after the oil shock and the health expenditure expansion. Because Japan's health insurance has developed through the various schemes described above, there were more than 5,244 insures (health insurance organizations) in 2001.

2.4.2 Overview of Health Insurance System

Health insurance schemes are broadly divided into two entities: Employees Health Insurance and Community-based Health Insurance. (See Figure 2.2) Employees Health Insurance is composed of the employees of companies that hire one or over workers. On the contrary, Community-based Health Insurance (National Health Insurance) is composed of the rest of population such as unemployed (including elderly), self-employed, farmers and so on. Employees Insurance composed of several schemes depending on the line of business and the scale of the companies. Details of each scheme is as follows:

(a) Employees Health Insurance

Government-managed Health Insurance (1 insurer, 36.8 million participants)
Employees who work at small and medium-sized companies and their dependents participate in this scheme with the government as the insurer. The premium rate is 8.5 % of monthly salary with the costs shared equally between the employer and the employee. Co-payment rates for Employees Health Insurances are the same; 20% for the insured and for inpatient services for their dependents, 30% for outpatient services for dependents.

Society-managed Health Insurance (1,756 insurers, 31.7million participants in 2000)
Employees who work at large companies and their dependents participate in this scheme with one of the societies as the insurers. The criterion for companies to establish a health insurance society is that the company employs 700 or more people. When an industry composed of similar businesses establishes a health insurance society, the criterion is 3,000 employees or more. Each insurer determines the premium rate. However, the average premium rate is almost same as the Government-managed Health Insurance.

Seamen's Insurance (1 insurer, 228,000 participants in 2000)
This scheme covers seamen and their dependents. This scheme is integrated with other social security such as employment insurance and workers compensation insurance. It was an integrated type of health insurance with pension, however the pension sector was merged with the employee pension scheme.

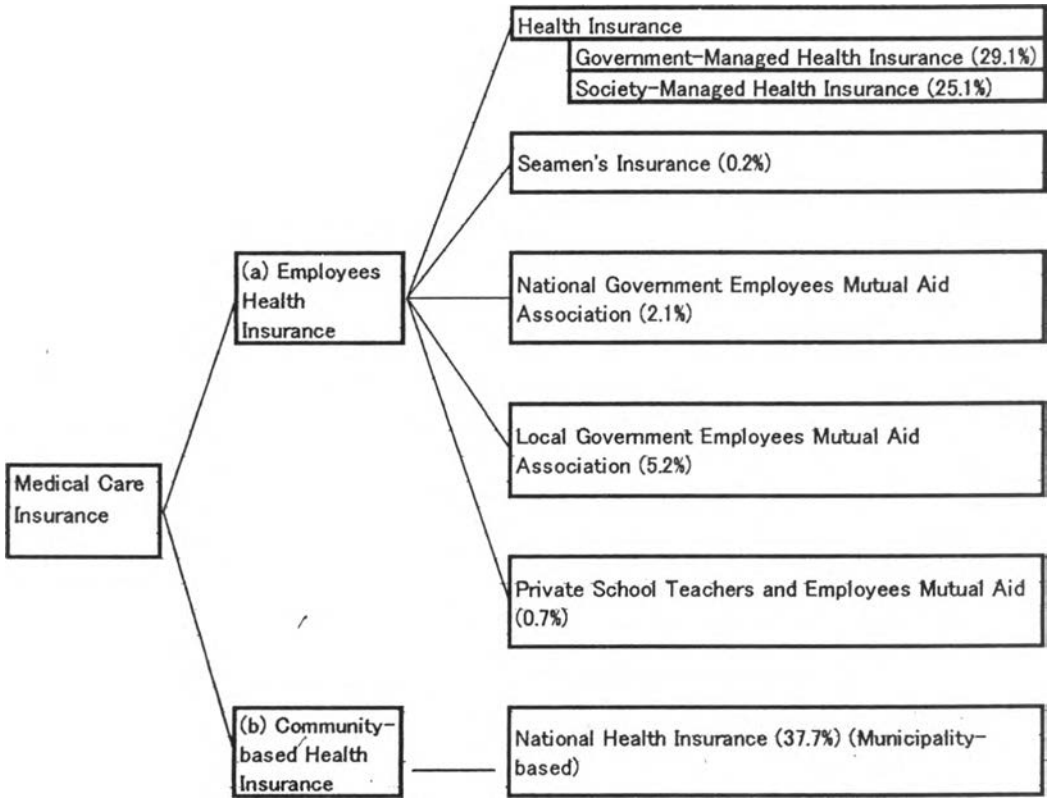
Mutual Aid (23 insures for National Government Employees and their dependents, 54 insurers for Local Government Employees and their dependents, and 1 insurer for the employees and dependents of private schools, total 10 million participants in 2000)
These schemes are an integrated social security system composed of health insurance, pension and welfare program.

(b) Community-based Health Insurance

National Health Insurance (3,242 insurers, 43.4 million participants in 2000)

This scheme is organized by municipalities[11] (cities, towns and villages). The participants are unemployed (including elderly), self-employed, farmers and so on. Although the dependents of employees covered by Employee Health Insurance are not levied premiums, all family members who participate in National Health Insurance must pay contribution (social insurance tax). The amount of contributions is determined by combining the portions called "ability response burden", which participants pay in accordance with their income and assets, and "benefit response burden" under which the contributions are paid according to the number of family members. The amount of contribution differs amongst municipalities. The co-payment rate is 30% for all of the insured including family members.

Figure 2.3 Structure of Health Insurance System in Japan (2001)



Source: National Federation of Health Insurance Societies, 2002

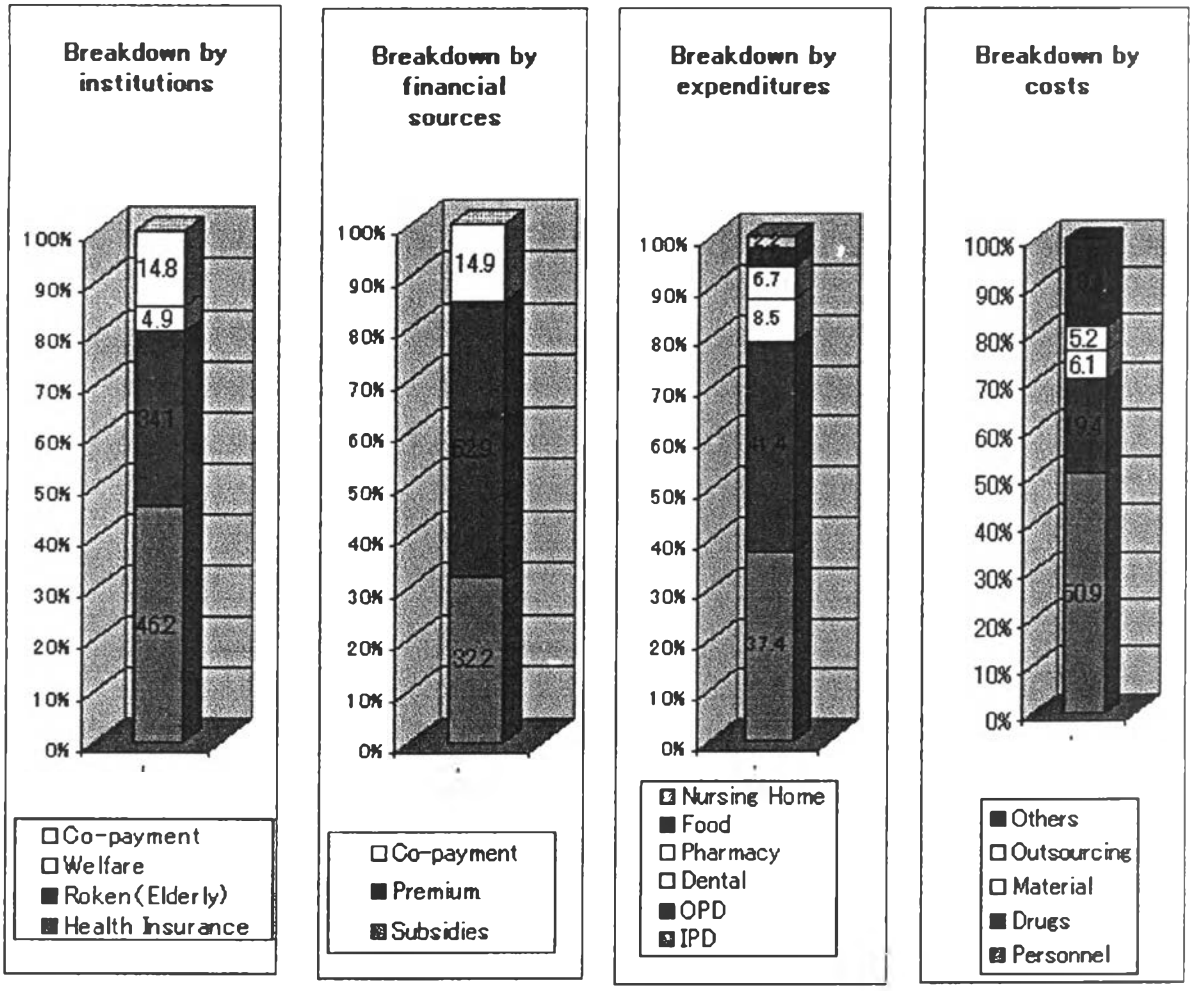
*The percentages in parenthesis are the ratio amongst total population

[11] Japan's local administrative system adopts two-tiered system; prefectural administration (47 prefectures) and municipal administration (3218 cities, towns and villages).

2.4.3 Benefits of Health Insurance

Patients who participate in any health insurance scheme are eligible to receive medical care services at any health institution by showing their health insurance card. Medical care benefits for sickness or injury of an insured and their dependents are comprised of: (1)medical consultation (2)supply of drugs and materials (3)treatment, surgery and other medical care (4)management of medical treatment through home health care and nursing services (5)admission to a hospital or clinic and the care and nursing accompanying treatment. Although medical care benefits are services-in kind, patients are expected to pay a co-payment[12]. Other services such as maternity allowances, funeral expenses, injury and sickness allowance are cash benefit[13].

Figure 2.4 Breakdown of Total Health Expenditures



Source: Health Insurance Study Group ed. (2001)

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[12] Co-payment rates were unified to 30% for all of the health insurance schemes in April 2003.
[13] Cash benefits are a service of Employees Health Insurance.

2.4.4 Medical Fee Reimbursement System

Medical fee are the amount to be paid to a health care facility to cover the expenses required for medical care service benefits. Japan's medical fee system is based on the fee-for-service (FFS) payment. Generally speaking, this payment system is prone to invite excessive treatment. For example, the average length of inpatient stay is higher in Japan than other OECD countries. The average length of stay at general wards in Japan is 30.8 days in 1999 (MoHLW, 2002) whereas the number is less than 15 days in most of the other OECD countries. Medical fee schedules are revised every two years by the Ministry of Health, Labour and Welfare after deliberation by the Central Social Insurance Medical Council which is comprised of the representatives of insurers and insured, representatives of doctors, dentists and pharmacists, and academic experts.

2.4.5 Examination and Payment Organizations

There are two examination and payment organization for Health Insurance Reimbursement. The first one is Social Insurance Medical Payment Fund and latter one is Federation of National Health Insurance Associations. Both payment organizations have similar functions. Social Insurance Medical Payment Fund is a quasi-governmental organization, which manages the reimbursement and examination of claims from Employees Health Insurance. While Federation of National Health Insurance Association engage in dealing the claims from National Health Insurance. Each month medical care facilities submit claims to the Social Insurance Medical Payment Fund and the Federation of National Health Insurance Associations for reimbursement in the prefecture. Both organizations have been played an important role in helping to avoid the complicated claims procedures, because there are 160,000 health care facilities including hospitals, clinics, dental clinics etc. On the other hand, there are over 5,000 insurers in Japan.

2.4.6 Health Services System for the Aged (Roken)

The percentage of the elderly within health insurance organizations varies considerably. The elderly comprise 22% of National Health Insurance participants, 5.5% of Government Managed Health Insurance participants, and 3% of Society Managed Health

Insurance participants. The Health Services System for the Aged was established in 1983 for the purpose of adjusting the discrepancies in financial burden for elderly health care. It equalizes the burden of elderly health expenditures amongst health insurance organizations. When insured people reach 70 years of age, their medical fee is financed by Roken, even though their insurance status remains with the former health insurance organizations. Roken also aims to provide comprehensive preventive health activity beginning at age 40 and medical care services for people 65 years or over who are bedridden. The co-payment rate is 10%. About 70% of the budget of Roken is financed by contributions from every health insurance organization. The national government subsidizes 20% of the budget with prefectural and municipal governments subsidizing 5% of the budget each. The amount of contributions from health insurance organizations is calculated by the national average percentage of elderly instead of the actual number of elderly in each health insurance organization.

Figure 2.5 Structures of Health Insurance, Roken and Long-Term Care Insurance in 2001

<table>
<tr><td colspan="2">Health Services System for theAged (70yr or over)</td><td colspan="2">(Roken)</td></tr>
<tr><td colspan="2">Long-Term Care Insurance (65 yr or over)</td><td colspan="2"></td></tr>
<tr><td>National Health Insurance
(Municipality based)
(37.7% *of total population)</td><td>Government Managed
Health Insurance
(29.1%* of total population)</td><td>Society Managed
Health Insurance
(25.1%* of total
population)</td><td>Mutual Aid
and other
schemes
(8.3%*of
total
population)</td></tr>
<tr><td>Community Health Insurance</td><td colspan="3">Employees Health Insurance</td></tr>
</table>

Note:*Ratio in the total population of 126million

Source: National Federation of Health Insurance Society (2002)

2.5 Long-Term Care Insurance

2.5.1 Role of Long-term Care Insurance

The Long-Term Care (LTC) Insurance Law was enacted in Japan in December 1997 and implemented in April 2000. It is a compulsory social insurance based on national solidarity same as the social health insurance. One of the major reasons for the establishment of this scheme was the aging. The number of elderly people who are unable to live on their own is continuing to rise. The number of elderly who are certificated for long-term care need is 2.47 million in 2000 (MoHLW, 2002), and it is expected to be more than double to 5.2 million in 2025 (MoHLW, 1999). Previously, frail elderly were kept in hospitals for extended period of time, not necessarily because their conditions require medical attention in hospitals, but rather, they lacked appropriate care at home or at a care facility. The insurance system covers the long-term care for the elderly, which was previously provided through the health insurance system, the welfare schemes and by their families. It was expected to reduce the high medical costs for such hospitalizations by providing appropriate care at home or at lower-cost nursing facilities.

One special feature of the LTC services which draws a line of demarcation from the former welfare service is the consumer sovereignty. Welfare services have provided a long-term care as a public assistance; the government selects the provider, the amount of care and so on. Users must take a means test, and are obliged to receive a stigma of indigent welfare users. It induces the barrier to use these services even though they deserve to receive the care. It also makes the possible users select hospitalization or receiving care at home by their families. As a matter of practice, when the quality of the service is bad, users of welfare services can not complain about it.

However, LTC insurance is a social insurance. Users have a right to select and purchase the services with the co-payment of 10%, because all of the insured citizens pay premium every month. It creates a competition among providers and incentives for the providers to improve their quality of services. Although users do not always have enough information about the providers and their services, a Care Managers support them in selecting the services amongst various providers and their services. Care Manager is a profession which is nationally licensed to support LTC users in making a LTC service utilization plan (Care

Plan)[14]. In addition, LTC users are allowed to complain to the insurers about the services, price etc.

2.5.2 Insurers of Long-term Care Insurance

LTC insurance is a system which enhances the autonomy of providing LTC among municipalities. The insurers of the LTC insurance are municipalities[15]. Each municipality investigates the regional demand for LTC and estimates the budget for the LTC insurance. Then they determine the amount of premium for the elderly in the municipality through the municipal assembly. The total amount of premium is 17% of the total budget[16], while the other 83% of the budget is financed through the pooled fund.

2.5.3 Insured of Long-term Care Insurance

The insured people are divided into two categories: Primary Insured are those who are aged 65 and over, Secondary Insured are those who are between 45 years of age to 64 years of age who are participants of health insurance[17]. Premium amounts are determined by each insurer (municipality), and thus differs depending on available facilities, in-home care services provided, and demand for care in each municipality.

2.5.4 Financial Sources of Long-term Care Insurance

The cost incurred in LTC insurance is financed by the government and insured equivalently: Half of the costs are subsidized by the government, while the other half are paid through insureds' premiums. Unlike the medical care insurance, the amount of utilization has caps depending on the care required level. Therefore, it prevents the LTC expenditure expansion and avoids bankruptcy of insurers. The breakdown of the sources of finance is written in detail in figure 2.6.

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[14] Making Care Plan with consult to the Care Manager is required to prepare in advance for utilizing LTC insurance. The fee for the Care Manager to make a Care Plan is fully covered by LTC insurance.

[15] Municipalities can collaborate with neighbor municipalities to comprise a joint insurer.

[16] Except for co-payment.

[17] In reality, it means all population of this generation except for the people under public assistance

Figure 2.6 Financial Sources of Long-term Care Insurance

Public Expenditure	National government (25%)	Prefectures (12.5%)	Municipatilies (12.5%)
Premium	Premium for non-elderly (Secondary insured) (33%)		Premium for elderly (Primary insured) (17%)

Source: MoHLW 2002

2.5.5 Benefits of Long-term Care Insurance

Screening and Judgment

When the insured people (mainly Primary Insured people)[18] use the LTC insurance services, they need to be certified in need of care. The Certification Committee for Long-term Care Need classifies the need of insured into 6 categories depending on the time required for care[19]. There are two-stage screening procedures. In the first step, an examiner from the municipal office visits the home of a person seeking LTC service. The examiner asks the person or family members about the physical and mental condition. The inquiry is based on 85 questions listed on an examination sheet. This basic inquiry is processed by computer and used by the municipality as a material for judgment. In parallel with this examination, the applicant asks his/her family doctor to write a physician's opinion. In the second step, specialists in the Certification Committee for Long-term Care Need established by the municipalities screen the application on the basis of the basic examination conducted by the examiner and of the family physician's opinion. The declaration of nursing care requirement is reviewed once every six months.

Utilization of the Services

The users are classified into six categories ("Support Required" and "Care Required Level 1 to 5") depending on the severity of the care need. The upper limit of services provided is

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[18] Only when Secondary Insured people need a long-term care due to disease caused by aging such as presenile dementia or Parkinson's disease etc., they could be certified to receive LTC insurance services. Only 0.3% of the total certified users were the Secondary Insured people in 2000.(MoHLW, 2002)

[19] It is not necessarily in proportion to the severity of disability or disease. For instance, physically healthy elderly with dementia might require more care than that of elderly with dementia who are bedridden.

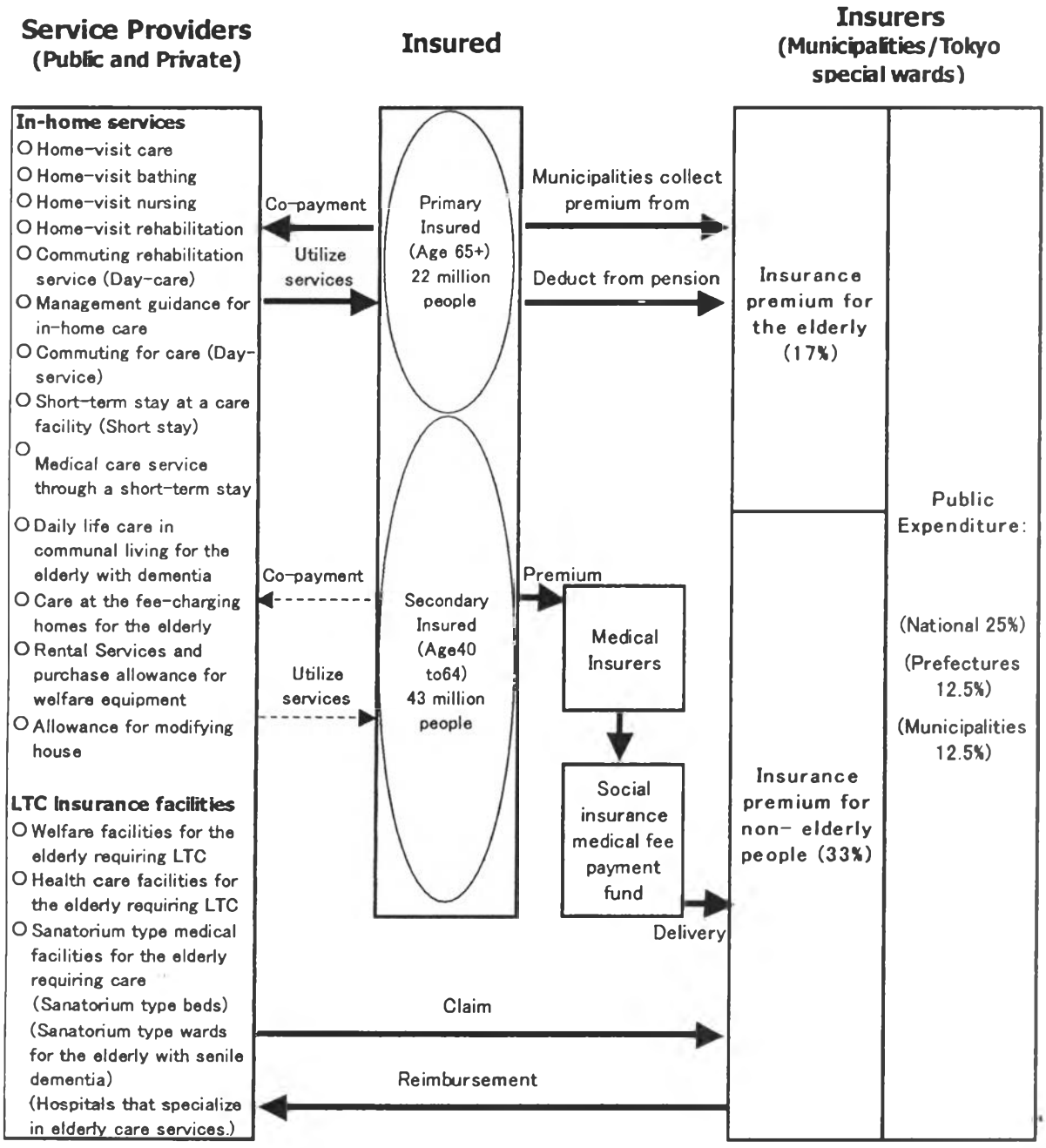
determined according to this category. Even though the Certification Committee for Long-term Care determines the maximum amount of care depending on the needs of insured people, the insured people are allowed to select the providers of the services, the item of the services and the amount of them. The amount is up to 358,000 yen[20] in the category of Care Required Level 5, which is for a person in the most serious condition requiring nursing care. The services covered by the LTC insurance are listed in Table 2.1. The co-payment rate is 10% of the service fee.

Table 2.1 Benefits of LTC Insurance Services

In-home services	
1	Home-visit care
2	Home-visit bathing
3	Home-visit nursing
4	Home-visit rehabilitation
5	Commuting rehabilitation service (Day-care)
6	Management guidance for in-home care
7	Commuting for care (Day-service)
8	Short-term stay at a care facility (Short stay)
9	Medical care service through a short-term stay
10	Daily life care in communal living for the elderly with dementia
11	Care at the fee-charging homes for the elderly
12	Rental Services and purchase allowance for welfare equipment
13	Allowance for modifying house
LTC insurance facilities	
1	Welfare facilities for the elderly requiring LTC
2	Health care facilities for the elderly requiring LTC
3	Sanatorium type medical facilities for the elderly requiring care
	(Sanatorium type beds)
	(Sanatorium type wards for the elderly with senile dementia)
	(Hospitals that specialize in elderly care services)

[20] 1 baht = approximately 3 yen (in February 2003)

Figure 2.7 Flow of Finances and Services Delivered under the LTC Insurance[21]



Source: MoHLW 2002

[21] When Secondary Insured people require a long-term care due to disease caused by aging such as presenile dementia or Parkinson's disease etc., they would be certified to receive LTC insurance services. Only 0.3% of the total certified users were the Secondary Insured people in 2000.(MoHLW, 2002)

2.6 Other Sources of Health Care Financing

Usually health insurance is applied to most medical services in Japan. However, there are some exceptions. About 5 percent of total health expenditure in Japan is covered by public welfare scheme. Roughly 70 percent of welfare expenditures are utilized for public assistance for indigent people. The other 30 percent of the expenditures are for tuberculosis and other intractable diseases. (Health and Welfare Statistics Association, 2001)

2.7 Health Care Services Provision

2.7.1 Medical Service Law

Medical Service Law was implemented in 1948. The Law stipulates the rules for inauguration and management of hospitals, clinics and other health care facilities. It aims to establish a system that provides preventive, curative and rehabilitative medicine effectively. The Law also establishes the philosophy for the provision of medical services. Both the national and regional governments are obliged to systematize the provision of health care facilities according to the function of these facilities.

2.7.2 Health Services Facilities

Medical Service Law defines hospitals as any health care facilities which can accommodate 20 or more patients. In contrast, health care facilities with more than one bed and fewer than 20 beds are called clinic with beds. Hospital are supposed to be equipped with consultation rooms, operating rooms, clinical examination rooms, X-ray rooms, pharmacy, sterilization rooms, facilities for providing meals, air conditioning, laundry rooms, sanitation facilities etc. The Law stipulates that there will be one doctor per 16 hospitalized patients. By Law, there must be a doctor within the hospital 24 hours per day.

The provision of sanatorium type beds and their related LTC services was established by the amendment of the Medical Service Law in 1992, and are differentiated from general hospital beds. These beds are utilized to provide not only medical services but also comprehensive long-term care services for patients in need of long-term care. At the present day,

both health insurance and long-term care insurance are applicable for reimbursement. By Law, one doctor per 48 hospitalized patients is required. Because of this, the ability of medical care for sanatorium type beds is lower than general beds. However, the law requires the establishment of a rehabilitation room, conversation room, restaurant and bathroom. For preventing bedridden situations, it is recommended that patients eat meals at the restaurant. Sanatorium type beds care encourage a high quality of life as well as providing medical assistance.

2.7.3 Regional Health Plans

The amendment of the Medical Service Law in 1985 implements Regional Health Plans. This clause states that prefectural governments must plan the system for provision of health services (Regional Health Plans). In concrete terms, the chief roles of the Regional Health Plans are to set the Secondary Medical Area and to calculate the number of beds needed in these areas. The roles of Regional Health Plans were expanded by an amendment in 1998. Currently, these eight items should be included in a Regional Health Plan: 1.Set the Secondary Medical Area, 2. Calculate the number of beds needed in the Secondary Medical Area, 3. Set target numbers for the Regional Health Support Hospitals and the number of Sanatorium type beds, 4. Work cooperatively to effectively assign roles for health care facilities and share information regarding patient care amongst health care facilities, 5. Assure emergency medical care, 6. Assure health services in extremely rural areas, 7. Provide enough personnel for health services, 8. Others

2.8 Long-term Care Services Provision

2.8.1 Nursing Care Facilities

Nursing care facilities, which are covered by the Long-term Care Insurance, are divided into three categories: Special Nursing Homes, Health Services Facilities for the Aged and sanatorium type beds. Special Nursing Homes are facilities for the elderly who need round the clock nursing care. Nursing care such as bathing, excretion, support to eat meals etc. as well as health monitoring and rehabilitation are provided at the Special Nursing Homes. The space of the room per person must be more than 10.65 square meters. At least one care worker per

three elderly is obliged to work there. Health Services Facilities for the Aged are facilities for the convalescent elderly who require nursing care and rehabilitation rather than acute medical care. The space of the room per person must be more than 8 square meters. This facility functions as a bridge between inpatient care and home care. At least one care worker per three elderly is obliged to work there. A Care Manager is also required to be employed at Health Services Facilities for the Aged. Sanatorium type beds are beds at hospitals or clinics for the convalescent elderly who need medical care and long-term care (covered by either Health Insurance or Long-term Care Insurance). As opposed to the care in the general hospital beds, medical fees are mainly paid by Per Diem basis rather ban than Fee for Service. The area per patient is 6.4 square meters. (Japan Medical Plan 2001)

2.8.2 Home Care Services

Home care services include home-visit care, home-visit bathing, home-visit nursing, home-visit rehabilitation, commuting rehabilitation services (Day Care), management guidance for in-home care, commuting for care (Day Services), short-term stay at a care facility (Short Stay), medical care services through a Short Stay, daily life care in communal living for the elderly with dementia, care at the fee-charging homes for the elderly, rental services and purchase allowance for welfare equipment, and allowance for modifying house. Various institutions including private companies enter this service because of its relatively lower entry barriers. For example, there is no limit to the number of entities who can enter home care service provision, there is no total amount control for home care service providers, capital cost is lower for initiating home care services than for building nursing facilities, any entities including private companies are allowed to provide this service etc.