FACT SHEET

Healthcare financing in Japan

(as at 30 August 2010)

1. Background

1.1 The healthcare system in Japan has been highly rated by the Organisation for Economic Co-operation and Development (OECD) as one of the best in the world in terms of access, effectiveness and efficiency. According to the OECD, the system provides health insurance coverage to all citizens, allowing them universal access to medical care services from any institution at any time, subject to a co-payment at the time of services. Regarding effectiveness, the health status of the Japanese people ranked at the top of the OECD countries in a number of categories in 2007[1]. As to efficiency, Japan's total health expenditure accounted for only 8.1% of GDP in 2006-2007, which was lower than the OECD average of 8.9%.

1.2 The healthcare system in Japan features the presence of about 3 560 health insurers at end-March 2008. In 2006-2007, insurance payment accounted for 49% of Japan's total health expenditure, followed by government subsidies to various health insurance schemes (36.6%) and co-payments by the insured (14.4%). Against the above background, the purpose of this fact sheet is to provide the Panel on Health Affairs with background information on healthcare financing in Japan, with special reference to the operation of the health insurance system in the country.

[1] In 2007, Japan enjoyed the highest life expectancy among the OECD countries, with 82.6 years for the whole population. In the same year, Japan's infant mortality rate was among the lowest in the OECD area with 2.6 deaths per 1 000 live births (approximately half the OECD average of 4.9). See OECD (2009a).

2. Overview of the healthcare service delivery system

2.1. In Japan, healthcare services are delivered through clinics and hospitals[2], most of which are operated in the private sector by medical practitioners. Nevertheless, private clinics and hospitals are not allowed to operate for profit. Under the healthcare system, patients in Japan can choose either a clinic or a hospital as their first point of contact and may choose any provider of their choice. There is no established referral system with general practitioners playing the role as the gatekeeper to specialist or hospital services, and the distinction between generalists and specialists within the healthcare system is weak.

2.2 In 2007, there were 8 862 hospitals in Japan, of which around 80% were in the private sector, offering some 1.62 million hospital beds in total[3]. Comparing to the OECD average in 2007, Japan had a higher number of acute care hospital beds per 1 000 population (8.2 comparing to the OECD average of 3.8), a longer average length of stay for acute care (19 days comparing to the OECD average of 6.5 days) and a higher number of doctor consultations per capita (13.6 comparing to the OECD average of 6.8)[4]. On the other hand, Japan only had 2.1 doctors per 1 000 population in 2007, which was below the OECD average of 3.1[5].

2.3 There are six National Centers for Advanced and Specialized Medical Care responsible for clarifying the causes and symptoms, researching on new diagnosis and treatment methods, developing advanced and pioneering medical care, and training specialized medical professionals relating to diseases that constitute high percentages of deaths and medical expenditure in Japan. The six National Centers, including the National Cancer Center, National Cardiovascular Center, National Center of Neurology and Psychiatry, International Medical Center of Japan, National Center for Child Medical Health and Development, and National Center for Geriatrics and Gerontology, offered 4 959 beds nationwide in 2009[6].

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2 According to the government classification, hospitals are medical institutions with 20 or more beds while clinics are medical institutions without beds or with 19 or less beds.

3 Ministry of Health, Labour and Welfare (2010).

4 OECD (2009a).

5 Ibid.

6 Ministry of Health, Labour and Welfare (2010).

3. Overview of the health insurance system

3.1 The healthcare financing system in Japan is based on a social health insurance model[7], with the first health insurance scheme coming into place as early as 1927 to cover blue-collar workers. The health insurance scheme for the self-employed was introduced in 1938, and universal health coverage was achieved in 1961.

3.2 The Health Insurance Bureau under the Ministry of Health, Labour and Welfare is responsible for planning and regulating the health care insurance system to ensure that all people in the country are covered and sustainability of the system can be maintained.

3.3 Enrolment in the health insurance system is compulsory in Japan and applies to all residents including foreigners (short-period visitors are excluded) on condition that they are legally residing in the country[8]. The participants of the system are covered under either one of the following categories of insurance:

(a) Employee Health Insurance provided by their employers;

(b) Community-based National Health Insurance (NHI) provided by the municipalities where they reside; or

(c) Long Life Medical Care System for people aged 75 or above.

3.4 Under the universal coverage of health insurance, supplementary private health insurance is also available for covering co-payments or non-covered costs required for hospitalization and surgery.

Employee Health Insurance

3.5 The Employee Heath Insurance is an employment-based insurance scheme, which can be broadly separated into the Society-managed Health Insurance (SHI) and the Government-managed Health Insurance (GHI)[9].

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7 Social health insurance, popularly known as the "Bismarck Model", is a type of insurance originating in Europe that covers health care costs from funds collected from individuals, employers and government subsidies. According to Kutzin (2009), options for health financing reform are often portrayed as a choice between general taxation and social health insurance.

8 In Japan, illegal immigrants are not covered by the health insurance system. See Tatara & Okamato (2009).

9 There are also the Seamen's Insurance and the Mutual Aid Association Insurance (covering civil servants and teachers) under the category of Employee Health Insurance.

Society-managed health insurance

3.6 SHI is a corporate-managed programme for employees of large corporations (with more than 700 workers) and their dependents. Under the *Health Insurance Act*, a large corporation can establish an insurance society to establish and manage its own health insurance programme. These insurance societies operate within government regulations to determine their own benefits and contributions.

3.7 In Japan, there are about 1 541 insurance societies managed and funded by employers and employees. Premium rates range from 3% to 10% of the monthly salary of workers (with a ceiling), reflecting the difference in the income levels of the insured in each SHI. Monthly contributions to SHI are shared equally by employers and employees.

Government-managed health insurance

3.8 GHI is a government-managed programme covering employees of small and medium-sized firms (between five and 700 workers) and their dependents. GHI is managed by a public corporation established in October 2008 – the Japan Health Insurance Association – which is responsible for, among other things, setting the premium rates for GHI schemes run in various prefectures of the country. The premium rates, ranging from 9.26% to 9.42% of the monthly salary of workers, are determined based on the health expenditure, demographic structure and income level of each prefecture.

3.9 Since employees of small and medium-sized firms tend to have a salary level lower than those working in large corporations, the premium revenue alone is not enough to sustain the operation of GHI. To supplement the deficit so incurred, the Japanese government provides subsidy to finance the healthcare cost of GHI (currently set at 13% of the healthcare cost). Monthly contributions to GHI are shared equally by employers and employees.

National Health Insurance

3.10 In Japan, legal residents who do not qualify for the Employee Health Insurance are required by law to enrol in NHI run by the municipal government in the area where they reside. The insured include the self-employed, the unemployed, farmers, retirees[10] and workers at companies with fewer than five employees[11].

3.11 Each municipal government has its own way of calculating insurance premiums for its NHI scheme. In general, the calculation is based on the number of persons insured in a household and the annual income of the family. The insurance premiums typically account for around 2% of the average wage, although there is a wide variation among municipalities[12]. Same as GHI, the Japanese government provides subsidy to help finance the healthcare cost of NHI (currently financing 43% of the healthcare cost).

Long Life Medical Care System

3.12 In Japan, a resident will no longer be covered by the Employee Health Insurance or NHI when reaching 75 years of age. He or she will be transferred to a third health insurance scheme – the Long Life Medical Care System – run by the prefecture where he or she resides[13].

3.13 Annual insurance premiums for the Long Life Medical Care System consist of two components: (a) a fixed amount paid by the insured, and (b) an income-based amount determined by the insured individual's ability to pay. The premiums so collected finance 10% of the healthcare cost of the Long Life Medical Care System. The remaining 90% is covered by subsidies from the government (50%) and cross-subsidization from the insured under the age of 75 (40%).

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10 In general, an employee is first enrolled in the Employee Health Insurance. Upon retirement, he or she will be transferred to a municipal NHI managed by the municipal government based on his or her place of residence.

11 Foreigners who are staying in Japan for more than a year are required to enrol in NHI if they are not covered by any other public health insurance scheme.

12 According to OECD (2009b), the highest premium, in the town of Rausu in Hokkaido, is 4.7 times higher than that in the lowest.

13 People aged 65 or above with certain disabilities are also eligible to enrol in the Long Life Medical Care System.

4. Coverage of the health insurance schemes

4.1 All the health insurance schemes offer the insured and their dependents a free choice of service providers[14], and a similar range of medical services. Mandatory coverage includes ambulatory and hospital care, extended care, dental care and prescription drugs. In addition, various forms of cash benefits are also available under the heath insurance schemes, such as lump sum payment for childbirth and childcare allowances, as well as funeral and hospital meal expenses.

4.2 Health services not covered by the health insurance scheme include medical checkups, vaccinations, abortion, cosmetic surgery, certain hospital amenities (e.g. a private room), and some high-technology procedures.

5. Fees and charges

5.1 All health insurance plans pay health services providers (e.g. hospitals, clinics and pharmacies) according to the national fee schedule set by the government. The schedule lists all the procedures and products covered by the health insurance and the prices charged for them[15]. Payment to the providers is based on the listed prices for each service or product delivered to the patient, multiplied by the number of services or products provided. Balance billing – billing the patient for fees not covered by health insurance – is strictly prohibited.

5.2 The national fee schedule applies to all patients regardless of (a) the health insurance scheme they belong to, and (b) the provider from whom they receive services. In other words, medical fees are uniform throughout Japan with little concern for differences in the types of medical facilities, level of wages or cost of living in various municipalities.

5.3 The national fee schedule is revised every two years based upon the recommendations of the Central Social Health Insurance Council, an advisory committee to the Minister of Health, Labour and Welfare consisting of representatives from health services providers and payers, and academics.

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[14] Patients have universal access to any public or private medical institution in the country on the production of a valid health insurance card.

[15] According to Ikegami (2008), "the [national] fee schedule plays a key role in linking the financing and delivery systems by serving as the valve that controls the money flowing from insurance plans to service providers. It has maintained equity by making the benefit package essentially the same for all insurance plans, contained costs by restricting other sources of revenue to the providers, and reduced administrative costs."

6. Cost sharing by patients

6.1 While the extent of coverage and payment mechanism varies little under the health insurance schemes, there are differences in the level of cost sharing by the insured and their dependents. Patients aged 3 to 69 are required to pay 30% of the medical costs, and the co-payment rate is reduced to 20% for children aged under 3. For elderly aged 70 or above, they are required to pay 10% or a higher rate of 30% if their income exceeds a particular level.

6.2 All health insurance schemes have built in a catastrophic cap feature that limits the amount of monthly out-of-pocket medical expenses, thereby reducing a patient's financial burden and making it easier for the economically disadvantaged to receive treatment. When a patient's monthly co-payment exceeds a certain ceiling, the excess will be refunded upon request. The **Table** below shows the ceiling of co-payment by patients aged below 70 under different income groups.

Table – Amount of co-payment over which patients are eligible to apply for reimbursement

	Monthly co-payment ceiling (for the first three months of treatment)	**Monthly co-payment ceiling (beginning with the fourth month of treatment)**
General households	¥81,000 (HK$6,723[(1)]) + A × 1% (A = covered medical expenses minus ¥267,000 (HK$22,161))	¥44,400 (HK$3,685)
Low income households[(2)]	¥35,400 (HK$2,938)	¥24,600 (HK$2,042)
High income households[(3)]	¥150,000 (HK$12,450) + B × 1% (B = covered medical expenses minus ¥500,000 (HK$41,500))	¥83,400 (HK$6,922)

Notes: (1) Based on the average exchange rate of HK$0.083 per Japanese Yen in 2009.
(2) Including households living on public assistance.
(3) Households with an annual income exceeding ¥6 million (HK$498,000).

7. Issues of the health insurance system

7.1 According to a report published by the OECD in 2009[16], the healthcare system of Japan was facing serious challenges as technological changes, rapid ageing of the population and rising income were putting upward pressure on healthcare spending. Besides, the government was attempting to contain public healthcare expenditure to cope with the fiscal condition of the country.

7.2 The report also suggested that patients in Japan had limited opportunities to obtain differentiated treatment for similar health problems or advanced medical services under the healthcare financing system which emphasized equitable access to "necessary and adequate" medical services for the entire population at a relatively low cost. Given the low regulated fees and a fee-for-service payment system, doctors might generate a high volume of services such as medical consultations, drug prescriptions or prolonged length of stay in hospitals to boost their income.

Research and Library Services Division
22 April 2010
Updated on 30 August 2010
Tel: 2869 9343

[16] OECD (2009b).

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