HGPI Health and Global Policy Institute

JHPN Japan Health Policy NOW

3. The Health Insurance System

Second edition

What is Japan Health Policy NOW?

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As the world's attention turns to Japan, one of the world's fastest ageing countries, there is increasing interest in Japanese health policy and a growing need to share information on Japan's health policy with the world. JHPN is committed to addressing this need by delivering factual information about the Japanese health system, Japanese health policy stories of interest, recent Japanese health policy news, and a resource list for those who want to learn more about Japanese health policy.

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3.1 The Health Insurance System | Japan's Health Insurance System

Overview of the health insurance system

Japan's constitution, established in May of 1947, clearly states that citizens have the right to health, and that the advancement and promotion of social welfare, social security, and public health are within the scope of government responsibilities [i]. In 1961, as a result of government-led social welfare measures, Japan achieved universal health coverage (UHC).[1]

Characteristics of Japan's UHC system are as follows:
Enrollment in public health insurance is compulsory, regardless of citizenship, for all those who have resided in Japan for three months or more. Rather than being freely selected by enrollees, public health insurance schemes are designated according to employment status, age, and residence. If an enrollee is neither the head of household nor eligible through his or her own employer, then the scheme is designated based on the head of household's employment status, age, and residence.

Regardless of the health insurance scheme in which residents of Japan are enrolled, they are free to choose their own healthcare providers as well as their frequency of treatment. In Japan, this system is referred to as a "Free Access System," and according to Free Access, as long as residents hold proof of insurance, they may receive necessary medical services when sick or injured for a fixed contribution rate.[2]

As a result, out of convenience, some patients seek outpatient visits at secondary emergency medical facilities mainly intended for patients in need of hospitalization and surgery, despite having only minor illnesses, and such "visits of convenience" have been recognized as problematic. In order to safeguard the medical sector from exhaustion due to issues such as human resource shortages, primary care physicians and flat, per-visit copayments are being discussed as ways of helping patients to select appropriate occasions for treatment that are in line with the functions of each provider.[3]

＜Column＞ Free Access and Freedom of Practice

Patients are free to receive care from the provider of their choice. For example, a man working at a company in Tokyo can make an outpatient visit to a specialist at a university hospital near his office during his spare time and later that same weekend be seen by a physician at a clinic near his home in Kanagawa Prefecture. According to guidelines, referral letters are required for outpatient visits at large hospitals; however, in most cases, patients are free to see specialists at large hospitals as long as they are willing to pay additional fees of a few thousand yen. Physicians also have freedom of practice. Moreover, if physicians have acquired medical licenses, they may exercise freedom by practicing in any specialties regardless of whether or not they hold specialized certifications. It is possible, for example, for a surgeon to practice as an "Internist/Orthopedic Surgeon," and it is not uncommon to see signs outside clinics that list multiple specialties.

[i] Article 25 of the Japanese Constitution states that "All people shall have the right to maintain the minimum standards of wholesome and cultured living" and that "The State shall use its endeavors for the promotion and extension of social welfare and security, and of public health."

[1] Ministry of Health, Labour and Welfare "Annual Health, Labour and Welfare Report 2007" http://www.mhlw.go.jp/wp/hakusyo/kousei/07/dl/0101.pdf (accessed 25 January 2018)
[2] Ministry of Health, Labour and Welfare "Japan's Health Insurance System" http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000172084.pdf (accessed 25 January 2018)
[3] Cabinet Office, Government of Japan "The Current Situation Regarding the Primary Care System" http://www8.cao.go.jp/kisei-kaikaku/kaigi/meeting/2013/wg2/kenko/131009/item3_5.pdf (accessed 25 January 2018)

Insurance benefits and patient cost-sharing

Regardless of which of the three public health insurance schemes in which one is enrolled, benefit packages essentially remain the same. Enrollees are unable to select schemes themselves, so even though slight differences do exist between benefits, such as add-ons for disease prevention and health promotion, these differences do not influence enrollment. In all three schemes, benefits cover services such as hospitalization, outpatient visits, transportation costs for psychiatric treatments, prescription medications, home-visit nursing, and dental care.
Co-insurance rates for medical costs remain the same across all insurance schemes, and are designated, instead, depending on age and employment status. Co-insurance for residents under 70 years of age is set at 30%. It is also set at 30% for those aged 75 and over but still earning incomes comparable to the current workforce. Co-insurance is set at 20% for children under 6 (prior to compulsory education), and it is also set at 20% for residents 70 to 74, while it is set at 10% for low-income earners aged 75 and over.[4]

Overview of the High-Cost Medical Expense Benefit System

In order to prevent catastrophic medical expenses from overburdening household finances, the High-Cost Medical Expense Benefit System subsidizes medical costs in excess of monthly, out-of-pocket (OOP) thresholds. These thresholds vary depending on the ages and incomes of beneficiaries. For example, in the case of an enrollee aged 69 years or under earning an approximate income of between 3.7 and 7.7 million yen, the monthly ceiling or maximum payment is calculated as [80,100 yen + (medical costs - 267,000 yen) x 1%]. The High-Cost Medical Expense Benefit System plays a major role in ensuring Financial Risk Protection (FRP) within the healthcare system.[5] High-cost medical expense subsidies in FY2013 totaled around 1.6772 trillion yen for people under age 75 and totaled around 5.429 billion yen for people 75 and over. In the 10-year period from 2004 to 2013, those totals rose by factors of approximately 1.56 and 1.65 respectively. When viewed as a whole, total allowances for high-cost medical expenses are increasing.[6]

System of insurance premiums

The methods for calculating insurance premiums vary depending on the public health insurance scheme, so premiums paid by enrollees also vary. In schemes such as those managed by Health Insurance Societies and the Japan Health Insurance Association (JHIA), employers are responsible for half the cost of premiums. Health Insurance Society and JHIA premiums are calculated by multiplying the premium contribution rate by the average amount of monthly remuneration (such as monthly pay, delimited at reasonable intervals, received by an insured person from an employer). Premium contribution rates vary from Health Insurance Society to Health Insurance Society and from one branch of the JHIA to another.

The methods for calculating premiums within the National Health Insurance (NHI) system vary according to region. Premiums are determined based on four factors—income (levied on the head of household's income), assets (levied on the head of household's assets), equality (calculated per enrollee), and equity (calculated per household).

In this way, premiums vary depending on the enrolled health insurance scheme, but in general, premiums rise in relation to income, since they are calculated based on factors such as income. Premiums cover not only the benefits of enrollees themselves, but also the benefits of those in the age 65 to 74 bracket as well as the 75 and over bracket. Consequently, because there are gaps in the income levels of enrollees among health insurance schemes, fiscal adjustments are undertaken among schemes to stabilize financial resources.

[4] Ministry of Health, Labour and Welfare "Overview of Our Country's Healthcare System " http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000172084.pdf (accessed 1 September 2017)
[5] Ministry of Health, Labour and Welfare "To Users of the High-Cost Medical Expense Benefit System" http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000161153.pdf (accessed 1 September 2017)
[6] Ministry of Health, Labour and Welfare "Re-examination of the High-Cost Medical Expense Benefit System" http://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000138069.pdf (accessed 16 October 2017)

Overview of health insurers

Japan's over 3,000 insurers can roughly be divided based on the three types of insurance that they provide—employer-based health insurance, residence-based National Health Insurance (NHI), and health insurance for people aged 75 and over. Health insurance for people 75 and over is primarily supported by public funding as well as by contributions from employer-based health insurance and NHI.

—Employer-Based Health Insurance

Employer-based health insurance can be subdivided into 3 schemes. The first of these schemes is managed by Health Insurance Societies, aimed mainly at large companies, provided by over 1,300 insurers, and eligible for public subsidies in the case of financial difficulties. The second scheme is managed by Mutual Aid Associations (MAAs), aimed at government workers, and ineligible for public subsidies. The third scheme is administered by the Japan Health Insurance Association (JHIA) and aimed at employees of small- to medium-sized companies. Besides enrollee premiums, the majority of the JHIA's financial resources are comprised of Health Insurance Society premiums and public funding. Aspects such as the number of enrollees and standard premiums vary by scheme.[7]

Health Insurance Societies were established as public corporations under the National Health Insurance Act.[8] Societies are organized by single companies (Single Health Insurance Societies) as well as by business owners within the same industry (General Health Insurance Societies). Enrollees in Health Insurance Society plans numbered 29.17 million at the end of August, 2016, and there were 1,357 associations as of April 1, 2017. The JHIA was established based on the National Health Insurance Act as an insurer for the employees and families of small- to medium-sized businesses that are unable to establish Health Insurance Societies. Enrollees in JHIA plans numbered 37.18 million at the end of August 2016. Premium levels vary among regional branch offices. In cases where a Health Insurance Society becomes unable to operate and disbands due to reasons such as financial difficulties, beneficiaries thus far enrolled in the society-managed plan are then enroll in a JHIA association-managed plan. In other words, the JHIA assumes the role of a safety net for employer-based health insurance. Mutual Aid Associations were established based on Mutual Aid Laws as insurers for national government workers. At the end of March, 2014, there were eighty-five MAAs, and enrollees numbered 8.91 million. Similar to Health Insurance Societies, premium levels vary depending on the MAA in which one is enrolled.

—Residence-Based National Health Insurance

The residence-based National Health Insurance (NHI) system is the health insurance scheme that covers the self-employed, unemployed, and retirees under 75 years of age. In other words, the NHI acts as the medical safety net for sustaining the health of residents in the sense that it insures those not otherwise enrolled in insurance schemes. Management of the NHI was shifted from the national to the prefectural level in 2018, and the system is currently administered at the municipal level. The stated goal of this shift was to strengthen the financial foundations of the NHI, which continues to run a deficit, by placing fiscal management responsibility in the hands of prefectural governments, thus securing stable fiscal management and efficient business operations. Under the current system, NHI enrollees pay premiums, but 50% of the actual costs for benefits are covered by public funding. The system is financially unstable and faces structural challenges, including a high average enrollee age composition, low average enrollee income levels, and low average enrollee payment rates (both premiums and taxes).[9]

—Health Insurance for the Elderly

The Medical Care System for the Advanced Elderly, as mentioned in Section 1, was introduced in 2008. All people aged 75 and over are obliged to enroll, and all enrollees become insured individuals, with no distinction between

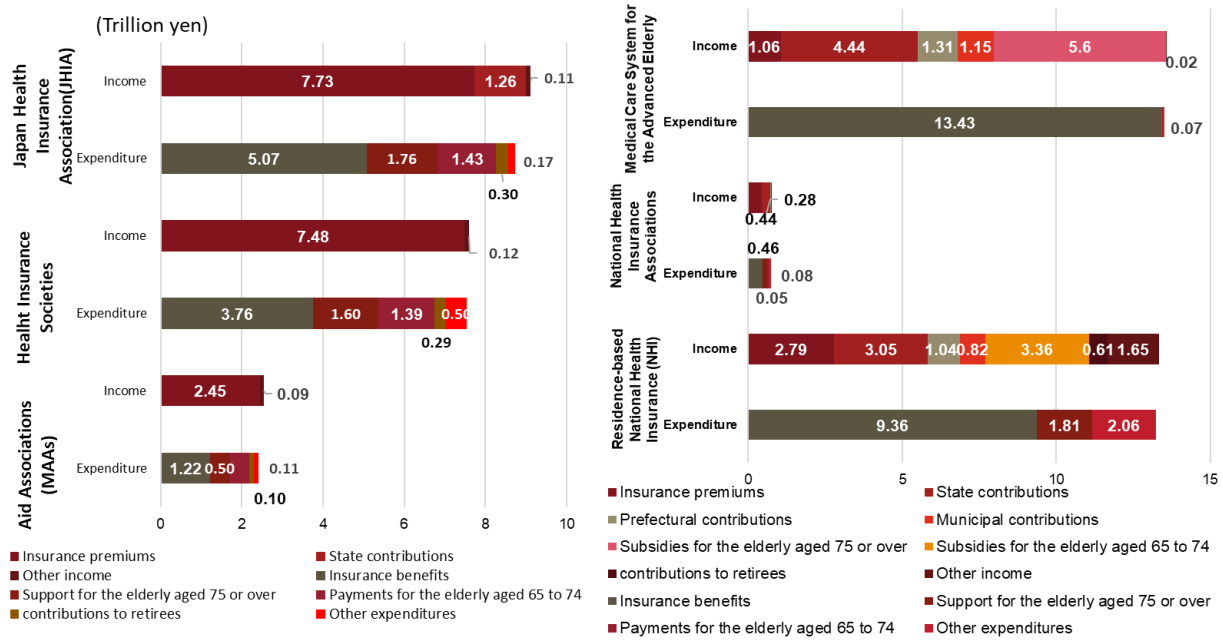
[7] National Federation of Health Insurance Societies "Healthcare Coverage Seen Through Charts, 2017 Edition," Gyosei Corporation, p.57-59.
[8] National Federation of Health Insurance Societies "Basics of the Health Insurance System" http://www.kenporen.com/health-insurance/m_knowledge/ (accessed 25 January 2018)
[9] Ministry of Health, Labour and Welfare "Reform of Health Insurance System " https://www.kantei.go.jp/jp/singi/syakaihosyou_kaikaku/dai4/siryou2.pdf (accessed 20 October 2017)

supporters and dependents. The system is administered at municipal as well as prefectural levels. To promote transparency and accountability regarding the expenses and medical costs that accompany the aging of the population, the system for people 75 and over has been made virtually independent from the NHI system. Premiums are calculated at the prefectural level based on health expenditures from the previous two years and are deducted from the individual pensions of enrollees. Since premium payments from enrollees themselves only cover around 10% of medical costs, the Medical Care System for the Advanced Elderly is supported by public subsidies along with fiscal adjustments from the two aforementioned insurance schemes.[10]

Income and expenditures by health insurance scheme

As shown in Figure 3-1-1, a process of fiscal adjustments takes place among insurers. Contributions for people aged 75 and over, payments for people ages 65 to 74, and contributions to retirement funds are designated as expenditures of the Japan Health Insurance Association (JHIA), Health Insurance Societies, and Mutual Aid Associations (MAAs). These expenditures are subsidies for people aged 75 and over from within the income of the Medical Care System for the Advanced Elderly, subsidies for people ages 65 to 74 from within the income of the residence-based NHI, and retirement premiums. As Figure 3-1-1 also shows, the ratio of income (comprised of insurance premiums and state liability funds) to expenditures (comprised of insurance benefit payments) varies among insurers. As can also be seen, the portion of income within the Medical Care System for the Advanced Elderly and the National Health Insurance (NHI) system that is covered by the National Treasury greatly exceeds the portion covered by insurance premiums. In other words, the fiscal management situation is so severe that no other choice remains but to rely on the National Treasury.

Figure 3-1-1: Income and expenditures in the health insurance system, FY2014



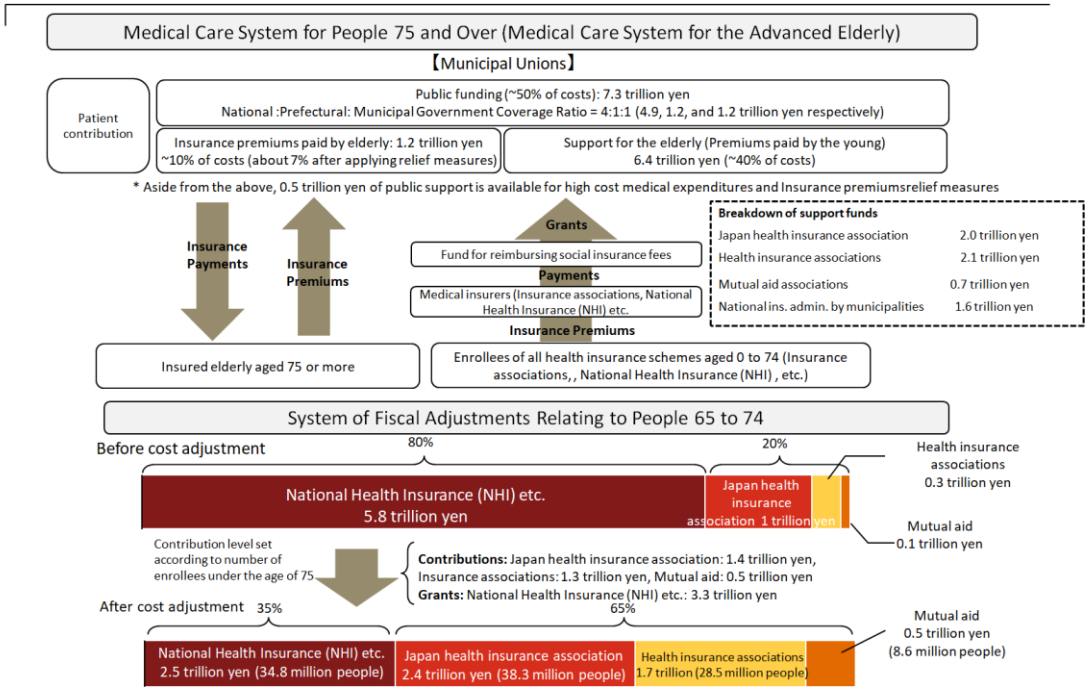
Source: Created by Specified nonprofit corporation Health and Global Policy Institute and PwC Consulting LLC, Strategy& based on basic data extracted from the "2014 state of national medical expenditures" report by the Ministry of Health, Labour and Welfare

[10] Ministry of Health, Labour and Welfare "Our Country's Health Insurance" http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/iryouhoken01/index.html (accessed 20 October 2017)

Structure of the medical care system serving people aged 65 and over

In terms of fiscal adjustments within the medical care system for the elderly, as shown in Figure 3-1-2, about 50% of the financial resources for the Medical Care System for the Advanced Elderly (75 and over) are covered by public funding (National : Prefectural : Municipal = 4:1:1), 40% are covered by contributions from individual insurers (i.e. paid from the premiums of the working class), and around 10% are covered from premiums paid by enrollees themselves. The scale of medical expenses for those aged 75 and over has reached 16.8 trillion yen (FY2017 base benefit expenses of 15.4 trillion yen combined with out-of-pocket (OOP) patient expenses of 1.3 trillion yen).[11] In principle, contributions paid out of the premiums from the labor force are determined proportionally according to each insurer's number of enrollees aged zero to 74. Since this per-capita contribution depends on the number of enrollees, insurers with weak financial standing shoulder a heavy burden. Therefore, in order to burden each insurer based on their financial capacity, the apportionment of the required contribution from each insurer has been gradually adjusted, with the proportion of the contribution required from employer-based insurers starting at one-half of what they should owe in FY2015, then rising to two thirds in FY2016, and eventually to the total amount in FY2017.[12]

Figure 3-1-2: Fiscal adjustment mechanism used for the health insurance systems serving people ages 65 to 74 and people aged 75 and over



Source: Created by Specified nonprofit corporation Health and Global Policy Institute and PwC Consulting LLC, Strategy& based on information from "The Japanese national health insurance" report by the Ministry of Health, Labour and Welfare

[11] Ministry of Health, Labour and Welfare "Our Country's Health Insurance" http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/iryouhoken01/index.html (accessed 20 October 2017)

[12] Ministry of Health, Labour and Welfare "Expense Burdens (Total Fee Allocation)" http://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000140159.pdf (accessed 25 Jan 2018)

To resolve imbalances among the fiscal burdens shouldered by insurers that result from the unequal distribution of enrollees ages 65 to 74, each insurer's burden is fiscally adjusted based on the proportion of the population ages 65 to 74 that they enroll. As a result of these fiscal adjustments, unlike in the Medical Care System for the Advanced Elderly, people ages 65 to 74 remain insured under the same various schemes in which they were previously enrolled. As shown in Figure 3-1-2, prior to fiscal adjustment, the benefit payments for those ages 65 to 74 are initially shouldered 80% by schemes such as residence-based National Health Insurance (NHI) and 20% by the other insurers, but this imbalance is fiscally adjusted among insurers such that in the end, benefits are shouldered 35% by schemes such as residence-based NHI, and 65% by the other insurers.[13]

System of publicly insured medical services

As previously mentioned, under Japan's system of Universal Health Coverage (UHC), citizens are enrolled in at least one of the public health insurance schemes. The following section explains Japan's system of insurance-applicable services as well as the payment system for incurred medical expenses. The premise of this payment system is a medical service fee scheme. Medical service fees are the fees received by insured healthcare providers as compensation for publicly insured medical services and pharmaceuticals. After a patient visits a provider and pays the co-insurance portion of the incurred medical expenses (the total medical service fee), the provider then requests the remaining portion of the medical service fee from the insurer.

As also described in detail in Section 7, medical service fees are set based on discussions held by the Ministry of Health, Labour and Welfare at the Central Social Insurance Medical Council, and a fee review is conducted once every 2 years. Medical service fees are scored using a system of points, with one point valued at 10 yen.[14]

[13] Ministry of Health, Labour and Welfare "Our Country's Health Insurance" http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/iryouhoken01/index.html (accessed 20 October 2017)

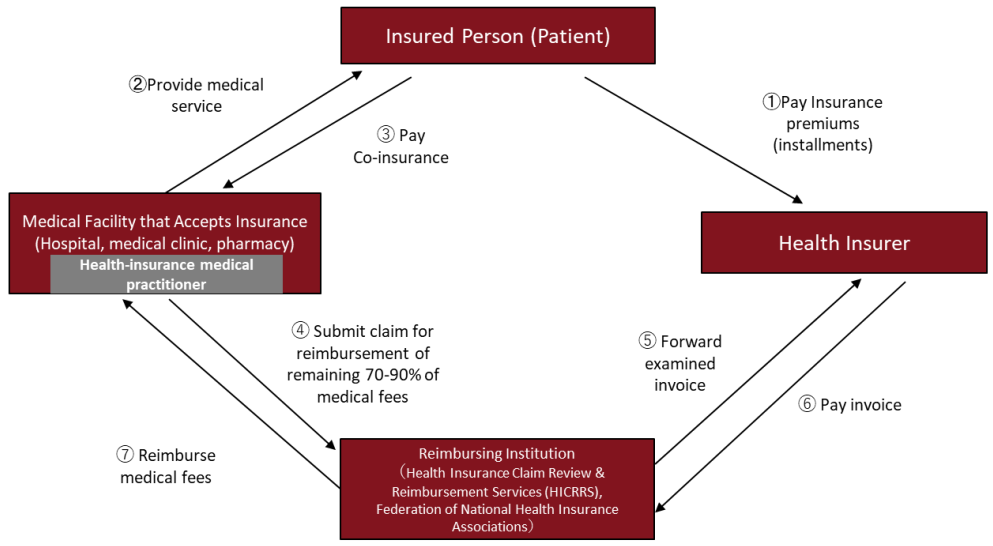
[14] Ministry of Health, Labour and Welfare "The Medical Service Fee Scheme" http://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/dl/01b.pdf (accessed 25 January 2018)

Figure 3-1-3 shows the flow of charges and payments for medical services covered by public insurance. When a patient carrying proof of insurance visits a medical provider, they pay co-insurance of 10% to 30% to the provider for received treatments based on their age and income. The 70% to 90% of the incurred medical fees that are excluded from co-insurance are covered by public funding from sources such as paid insurance premiums and taxes. Providers covered under the health insurance system submit claims for reimbursement of this 70% to 90% to Claims Review and Reimbursement Organizations (CRROs) such as the Health Insurance Claims Review & Reimbursement Services (HICRRS) and the National Federation of Health Insurance Societies (Kenporen). CRROs review whether insurance claims are reasonable, charge insurers for the remaining portion of medical service fees to be paid to the provider, receive these payments from health insurers, and pay them as reimbursement to providers. In other words, the role of CRROs is to review medical service fee statements (detailed insurance claim receipts) submitted by medical providers and process medical service fee payments based on the results of those reviews.

＜Column＞ Insurer functions are entrusted to Claims Review and Reimbursement Organizations?

Claims Review and Reimbursement Organizations (CRROs) established in each prefecture are in charge of sending invoices to insurers and receiving reimbursement for providers. Under this system, after a service is provided and co-insurance is received from the patient, the provider requests reimbursement from the insurer for the remaining portion of the medical service fee. In order to facilitate payment of medical service fees, the Health Insurance Claims Review & Reimbursement Services (HICRRS) and the National Federation of Health Insurance Societies (Kenporen) have established prefectural branches that handle the processing of medical service fee payments.

Figure 3-1-3: Flow of charges and payments for publicly insured medical services



Source: Created by Specified nonprofit corporation Health and Global Policy Institute and PwC Consulting LLC, Strategy& based on data from the "System of reimbursement of medical fees" report by the Ministry of Health, Labour and Welfare

CRROs confirm whether or not services provided to patients conform to insurance rules (E.g. Rules for Professionals in Charge of Insurance-Covered Healthcare Services and related notices). One issue that has been raised is that although all claims must be reviewed according to the same set of rules, reimbursement disparities

remain among prefectural branches of CRROs because criteria for determining the validity of claims often vary by branch.[15]

[15] Ministry of Health, Labour and Welfare "Improving Operational Efficiency of the Payment Fund / Development Plan—Schedule Overview" http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000169999.pdf (accessed 16 October 2017)

3.2 The Health Insurance System | Japan's Long-Term Care Insurance System

Overview of the Long-term Care Insurance System

The Long-term Care Insurance System was launched in 2000 as a system for society as a whole to support the long-term care of the elderly. Municipalities operate as insurers, and all citizens over the age of 40 are covered by this system. In comparison to other countries, this system is quite generous in terms of the levels of coverage and benefits. More than 5 million people were eligible for Long-term Care Insurance as of April 2016.[16]

Foundations of the Long-term Care Insurance System

The foundations of Japan's Long-term Care Insurance are described in detail in Section 1. Under the Elderly Welfare System that existed in the past, municipal governments were given the final say in the selection of services, and since users could not select services, the content of services tended to be uniform. In addition, since service fees were based on a patient's ability to pay, people with middle- and high-level incomes shouldered heavy burdens, and general hospitals began to face problems related to long-term hospitalizations for long-term care.
Along with the rapid aging of the population, the number of people requiring long-term care as well as the length of care itself increased, and long-term care needs grew greater and greater. At the same time, the status quo in which families traditionally met the needs of the elderly began changing, with shifts toward nuclear families and the aging of the generation that provided care.[17]
After taking into account issues and changes such as these, Japan developed the Long-term Care Insurance System as a way for society as a whole to support the long-term care of the elderly.

Basic principles of the Long-term Care Insurance System

○ Independence support: To go beyond simply providing necessary long-term care and also support the independence of elderly people.

○ User-oriented system: To provide users integrated access to health and welfare services from diverse entities at the their own discretion.

○ Social insurance system: To employ a social insurance scheme with a clear relationship between benefits and burdens.

Long-term Care Insurance enrollees and premiums

Enrollees in Long-term Care Insurance are divided into two categories—Those aged 65 and over (Category 1 Insured) and those ages 45 to 64 who are concurrently enrolled in other medical insurance schemes (Category 2 Insured).

○ Category 1 Insured: Eligible for services regardless of whether they receive Certification for Long-term Care Need or Certification for Support Need.

○ Category 2 Insured: Eligible for services only after they receive Certification for Long-term Care Need or Certification for Support Need due to aging-related diseases (specified diseases).

[16] Ministry of Health, Labour and Welfare (2016) "A survey on the state of current long-term care benefits" http://www.mhlw.go.jp/toukei/saikin/hw/kaigo/kyufu/16/index.html (accessed 19 November 2017)
[17] Ministry of Health, Labour and Welfare "The current and future role of the public Long-term Care Insurance System" http://www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/201602kaigohokenntoha_2.pdf (accessed 19 November 2017)

At the end of FY2015, Category 1 Insured numbered 33.82 million people, and Category 2 Insured numbered 42.04 million people (according to retrospective, monthly averages published in 2017).[18,19]

Category 1 enrollees (age 65 and over) pay their health insurance and Long-term Care Insurance premiums separately. Premiums and insurance rates are set by municipalities and pegged to nine standardized levels of income.[20] For Category 2 enrollees (ages 40 to 64), health insurance and long-term care insurance premiums are paid together in a lump sum.[21]

<Column> Why age 40 and over?

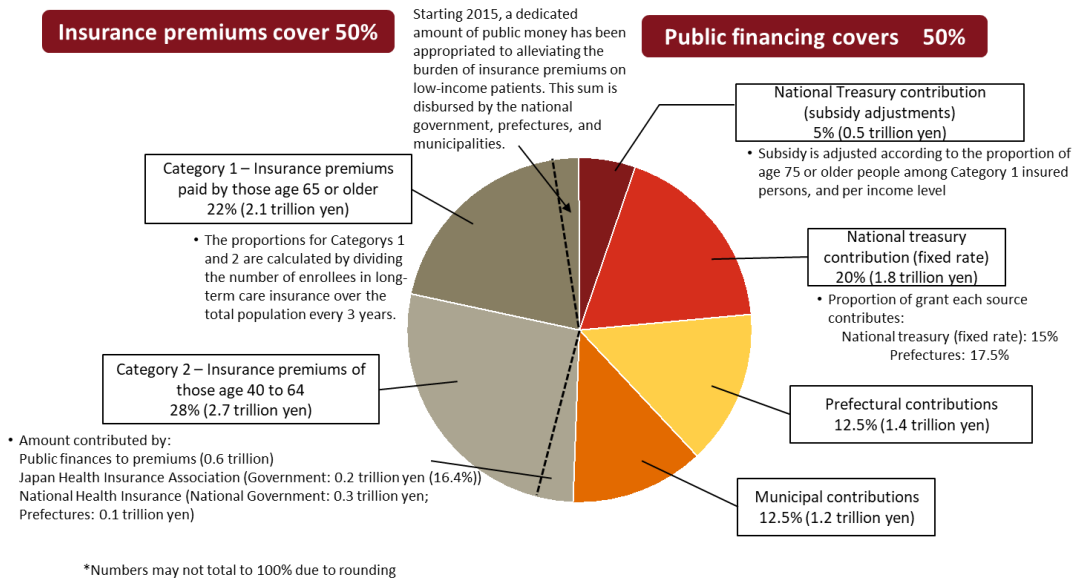
Surrounding the establishment of the Long-term Care Insurance System, there was a great deal of debate centering on the justification behind targeting people aged 40 and over. Amidst various opinions, there was support for targeting people aged 20 and over or 60 and over, but it was pointed out during consultations on the Long-term Care Insurance System in 1996 at the Council on Health and Welfare for the Elderly that once people pass the age of 40, the likelihood that they will have to care for their parents and thus need social support increases. As a result, the decision was made to enroll people aged 40 and over since long-term care costs should be supported by society as a whole. It was through such discussions that the current system took shape. (MHLW, 2006)

[18] Ministry of Health, Labour and Welfare (2015) "Annual report on Long-term Care Insurance" http://www.mhlw.go.jp/topics/kaigo/osirase/jigyo/15/dl/h27_gaiyou.pdf (accessed 25 January 2018)
[19] Ministry of Health, Labour and Welfare "Long-term Care Insurance premiums for the Category 2 Insured persons" http://www.mhlw.go.jp/topics/kaigo/osirase/jigyo/15/dl/h27_hihokensha.pdf (accessed 25 January 2018)
[20] Ministry of Health, Labour and Welfare "Overview of the FY2018 Budget (Draft) (Health and Welfare Bureau for the Elderly)" https://www.mhlw.go.jp/wp/yosan/yosan/18syokanyosan/dl/gaiyo-13.pdf (accessed 6 July 2018)
[21] Ministry of Health, Labour and Welfare "The Long-term Care Insurance System" http://www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/2gou_leaflet.pdf (accessed 21 November 2017)

Cost of Long-term Care Insurance

As show in figure 3-2-1, half of the financing for Long-term Care Insurance comes from enrollee premiums, while the other half comes from public funding. The budget for long-term care benefit pay-outs was set at 9.6 trillion yen in FY2016. Funds were sourced from Category 1 premiums (2.1 trillion yen), Category 2 premiums (2.7 trillion yen), the national treasury (2.2 trillion yen), prefectures (1.4 trillion yen), and municipalities (1.2 trillion yen). Similar to medical expenses, long-term care expenses are increasing annually along with increasing benefit costs, and this trend is expected to continue in the future given the ageing of society in Japan.[22]

Figure 3-2-1: The framework and scope of funding for Long-term Care Insurance



Source: Created by Specified nonprofit corporation Health and Global Policy Institute and PwC Consulting LLC, Strategy& based on data from the "Current state of nursing-care insurance system and its future role" report by the Ministry of Health, Labour and Welfare

Imbalances in funding and financial burdens exist among prefectures as a result of the fact that prefectures with high proportions of people over age 75 face rising benefit pay-outs, and prefectures with low average income levels face falling revenues. Financial actions are being taken, with five percent out of the 26% share of funding provided by the National Treasury subject to fiscal adjustments. The system of adjustments bears close resemblance to initiatives within the Medical Care System for the Elderly (explained in Section 1.2) in the sense that both systems are designed to help reduce imbalances among the fiscal resources of different insurers.

[22] Ministry of Health, Labour and Welfare "The current and future role of the public Long-term Care Insurance System" http://www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/201602kaigohokenntoha_2.pdf (accessed 21 October 2017)

Usage of care services and the Certification of Long-term Care Need

To use long-term care services, applications are submitted to municipal government offices or Comprehensive Community Support Centers. To qualify, applicants must receive Certification of Long-term Care Need or Certification of Needed Support. Upon receipt of certification, care managers prepare plans for applicants, enabling them to use a variety of services.

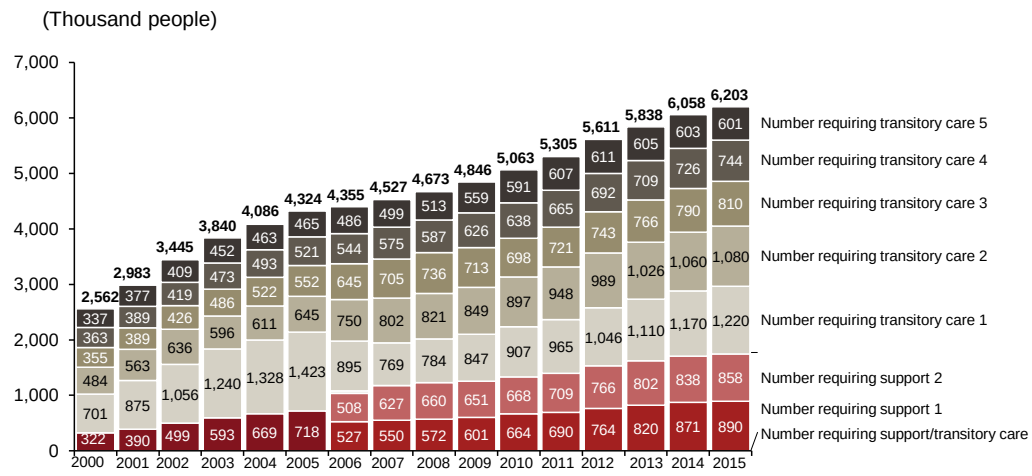
A person's level of required care (classified as Preventative Support Level 1 or 2, or Long-term Care Level 1 through 5) is determined by a committee of specialists that takes into consideration a written diagnosis from an attending physician and an on-site survey that addresses 74 items related to the activities of the person's daily life. The appropriateness of the person's level of care is then re-evaluated every two years or following marked deterioration in health.[23] The yearly trend in the number of people requiring care is shown in figure 3-2-2.

To address the fact that demand for long-term care does not decrease and to curb the continual growth in the population requiring light degrees of care (Preventative Support Level 1 / Long-term Care Level 1), the 2006 revision of the Long-term Care Insurance Act introduced preventive care services. At that point, recipients previously certified to receive Care Level 1 were split into Long-term Care Level 1 or Preventative Support Level 2 depending on whether their condition seemed likely to improve or remain the same.

<Column> The number of users at the time of the establishment of the Long-term Care Insurance System

Before establishing the Long-term Care Insurance System, care for the elderly was split between a system of welfare for the elderly and a system of healthcare for the elderly. To ensure that people who had been receiving welfare services could continue to use the same services in the new system, certification criteria were relaxed. This led to an immediate increase in the number of users requiring in-home care or light care (Preventative Support Level 1 / Long-term Care Level 1), thus creating bottlenecks and long-waiting lists at intensive care nursing homes. (Ikegami Naoki, 2017)

Figure 3-2-2: Yearly trend in number of people requiring care/support



Source: Created by HGPI and PwC based on data from the "2015 annual report on the state of the nursing-care insurance system" by the Ministry of Health, Labour and Welfare

[23] Ministry of Health, Labour and Welfare "The Long-term Care Insurance System" www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/2gou_leaflet.pdf (accessed 21 September 2017)

3.3 The Health Insurance System |Private Health Insurance

Roles played by private health insurance under universal health coverage

Private health insurance mainly plays roles complementary to the public health insurance system such as guaranteeing services that are not covered by public benefits, guaranteeing additional expenses incurred during periods of illness, and guaranteeing income security during leaves of absence.[24,25]

In addition, when taxpayers pay life insurance premiums, long-term care insurance premiums, or individual annuity insurance premiums, they can receive certain income-based deductions. These are called life insurance deductions, and they reduce the burdens of income tax and residence tax.

Background of rapid growth in the private health insurance sector

Insurance policies such as those for healthcare and cancer are classified as third-sector insurance policies (For additional information, please refer to the Glossary). Entry into the third-sector insurance industry was first permitted only to foreign life insurance companies in the early 1970s, but after drastic industry reforms in 1995 and the full liberalization of the third-sector insurance market in 2001, domestic companies were also allowed to sell insurance.[26] The number of in-force health insurance contracts in the third-sector has been consistently on the rise,[27] and such contracts have become the main life insurance product. In recent years, new product types such as special medical insurance (medical insurance with relaxed underwriting regulations) for "people with chronic illnesses and pre-existing conditions" have been developed for people who previously had difficulty joining private health insurance plans. Against this backdrop, the number of in-force contracts in the private health insurance sector has been increasing annually. In 2016, the number of medical insurance contracts that specifically covered services such as hospitalization and surgical security in their main life insurance sections had grown to 35.29 million.[28]

Future expectations for the role of private health insurance

The current public health insurance system in Japan offers a wide range of benefits and is a Free Access system. The fact that private health insurance plays a limited role compared with other countries can also be explained by factors such as the High-cost Medical Expense Benefit System and the ban on mixed medical treatments. The need for private health insurance is gradually changing due to epidemiologic shifts, increasing demand for treatments of cancer, which is now the leading cause of death in Japan, and the expansion of advanced medical care services. As a result, the role of private health insurance is expected to transition in the future alongside reforms to the public health insurance system.[29,30] Japan's declining birth rate, aging population, and technological innovations

[24] Tajika Eiji, Kikuchi Jun (2012)"The Role of Government and Private Insurance in Medical Security: A Theoretical Framework and Case Studies by Country" http://www.mof.go.jp/pri/publication/financial_review/fr_list6/r111/r111_02.pdf (accessed 21 November 2017)

[25] Nakahama Takashi (2006) "The Role of Private Medical Insurance—Through Comparison Between Japan and the United States" https://www.jstage.jst.go.jp/article/jsis/2007/596/2007_596_596_69/_pdf (accessed 21 November 2017)

[26] Serizawa Nobuko (2010) "Third-sector insurance market" http://dspace.lib.niigata-u.ac.jp/dspace/bitstream/10191/16657/1/90_249-271.pdf (accessed 21 November 2017)

[27] The Life Insurance Association of Japan "2017 Life Insurance Trends" http://www.seiho.or.jp/data/statistics/trend/pdf/all.pdf (accessed 21 November 2017)

[28] The Life Insurance Association of Japan "2017 Life Insurance Trends" http://www.seiho.or.jp/data/statistics/trend/pdf/all.pdf (accessed 21 November 2017)

[29] Nakahama Takashi (2006) "The role of private health insurance -through comparison between Japan and the US- " https://www.jstage.jst.go.jp/article/jsis/2007/596/2007_596_596_69/_pdf (accessed 21 November 2017)

[30] Kawaguchi Hiroyuki, "International Comparison of Public Medical Security System and Private Medical Insurance - Role Sharing of Public and Private Funding and Its Function –" Retrieved from http://www.seijo.ac.jp/pdf/faeco/kenkyu/196/196-kawaguchi.pdf (accessed 21 November 2017)

are also expected to raise national medical care expenditures, so revisions of public health insurance may result in reduced ranges of coverage. The private insurance plans currently offered in the market primarily cover limited services for fixed fees; however, it is predicted that in the future, these private plans will expand to cover medical services no longer covered publicly.