This paper analyzes changes and continuities in two financial institutions of the universal health insurance in Japan. The universal health insurance, established in the 1960s, was divided between employment-based health plans (EHPs) and community-based health plans (CHPs). They had different administrative structures, benefits levels, and rules for premium-setting without formal risk adjustments for each other. Despite that, the Government established and maintained the idea of universality with a nationwide fee-table and subsidies for CHPs.

After three decades, differences in benefits become shallower: both EHPs and CHPs have identical co-payment rates since early 2000s. However, the division in funding still continued to exist. Although cross-subsidies between the two plans have been introduced, they have been insufficiently developed to adjust demographic and income differences between them. Because insured citizens in CHPs have more medical needs and less income, the sustaining division in funding makes CHPs face serious financial difficulties. Now CHPs levy unaffordable premiums on disadvantaged citizens in CHPs.

Why has the division in benefits become shallower while that in funding not? The paper analyzes differences and relations between them.
Introduction

Most OECD (Organisation for Economic Co-operation and Development) countries have established universal health systems since the mid twentieth century. Although universal health systems have universal health coverage, with which at all people have access to services and do not suffer financial hardship paying for them (World Health Organization, 2010), countries have developed the healthcare systems in different contexts and process and have established different economic, political and social institutions. Historically, a broad classification recognizes two types of universal health systems. Some countries have tax-based healthcare systems and others have statutory social or statutory insurance-based systems, most of which have mandatory elements in their systems.

Comparing a health care system at present to that when it achieved universal coverage, both continuities and changes can be found. On the one hand, health care systems have similar principles and mechanisms of funding, providing and regulating health care. For example, the British National Health Services was funded mainly by tax at its inception as well as today and has maintained the principle that health care services are fee at the point of service delivery. The Japanese health system consisted of mandatory employment- and community-based statutory insurance with the common payment rules decided by the Ministry of the Government in charge and significant amount of subsidies from general budgets when it was established in 1961 and still is in 2012.

On the other hand, healthcare systems in the OECD countries have undergone significant big and small changes since their initial development. The National Health Service in the United Kingdom changed its organizational structure, with introduction of “market mechanism”, and payment rules from the Government to NHS bodies times since its inception (Ham, 2009; Klein, 2010). The Japanese health systems had different co-payment rates between employment-based and community-based health insurance until recently but now have common rates across statutory health insurances. All hospitals were paid from insurances by fee-for-services, including per-diem part; now many large hospitals are paid on per-diem payments with case-mix adjustment using DRG-like classification.

Looking at historical continuities and changes in the Japanese healthcare system, I found a long-term incremental or gradual institutional changes in coverage and financing policies, which are quitre relevant to the idea of 2Kai-hoken, universal

2 Japanese words and phrases are given their Romanised equivalents in italics, followed by English translation in double quotation marks.
I would like to focus on changes in co-payment rates and introduction and development of cross-subsidies between insures, which have been taking place again and again intermittently. From a long-term point of view, those changes can be ideally interpreted as a transformation from a divided universal health system to a unified universal health system.

The aim of this paper is to (1) describe institutional structures of the health system in the 1960s, (2) describe changes in co-payment rates and in cross-subsidies and analyse qualitative changes in health care system, and (3) discuss the transformation that gradual changes has made. The next section will provide a brief overview on theories on policy and institutional changes in the health care fields.

1. Changes and continuities of health care systems

Theoretical analysis has developed both on continuities (or stabilities) and changes of healthcare system. The idea of path dependency is used to explain difficulties of reforming health care systems with the theory of increasing returns; conjectural factors used to explain overcoming structural economic and cultural impediments(Pierson, 2000; Wilsford, 1994). Also, big changes are explained to be difficult with the idea of institutional inertia: the influence of existing power structures and limited cognitive capacity of human actors make existing institutions more stable(March & Olsen, 1989; Vrangbaek & Christiansen, 2005). In addition to rational arguments, institutional structures such as existence of veto points, and the broader economic and political contexts are critical to understand changes and continuities(Hacker, 2004; Immergut, 1990).

On the other hand, theories on policy making processes have developed analysis on factors influencing policy changes. Setting agenda for successful policy making are relevant to three streams of policy making: problem stream, policy stream and politics stream (Kingdon, 2003) Social Learning, values and ideas as well as economic and sociological forces has been developed discussed to understand the process (Béland, 2009; Contandriopoulos, Lauriston, & Leibovich, 1998; Frisina Doetter & Götze, 2011). The advocacy coalition framework maps the belief systems of political elites and analyses the conditions of policy-oriented learning across coalitions within a given political system(Sabatier & Jenkins-Smith, 1993). Different types of gradual changes have been categorized and political contexts, political institutions and type of dominant
change agent are considered to be influential on those changes (Mahoney & Thelen, 2010).

2. Divided and Universal: the Japanese Healthcare System in the 1960s

Japan drastically introduced western medicine since the mid-nineteenth century. Although mutual societies and community-based financing developed, it was not until 1927 that the first statutory employee-based health insurance covering manual workers, Kenko hoken, "Health Insurance for Workers” was implemented. Because both employees and employers paid premiums, the insurance was social health insurance. Since the late 1930s, the Government developed Kokumin kenko hoken, “Citizens’ Health Insurance”, community-based health plans on voluntary basis, in which each municipality 3 was asked to establish insurance association with subsidies (Ikegami et al., 2011).

The idea of universal coverage explicitly appeared in policy documents of the Government in 1941 (Naikaku (The Cabinet), 1941). Decreased income during the Second World War, however, made it difficult for municipalities in rural areas to maintain community-based insurance plans. In the mid-1950s, establishment of universal health insurance system became a political issue. At that moment, one-third of the entire population, ca. thirty million people, lacked health insurance (Yoshihara & Wada, 2008). Those without health insurance included agricultural, fishery, and forestry people, self-employed, and employees at the smallest companies. Responding to this problem, the Government made it obligatory for each municipality to establish a community-based plan covering those lacking of statutory health insurance. The result was the achievement of Kai-hoken, “universal coverage” in 1961.

The universal coverage was achieved by the establishment of the additional mandatory insurance as a new layer. Therefore policy making on EHPs and CHPs were regarded as different and inter-related issues except payment rules to physicians and hospitals. For example, different logics were used to support respective structure of different statutory insurance. On EHPs for large company employees, financial and managerial autonomy were emphasized. On the EHP for small company employees and the CHPs, state intervention such as expenses and subsidies from the general revenue were supported to maintain premiums affordable and stabilize financial conditions provided that people

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3 Local governments in Japan are two-tiered. Municipalities (Shi, cho, or son, “cities, towns, or villages”) are local governments. Kens, “Prefectures, are local governments spread over wider areas consisting of several municipalities.
with lower income and higher health risks enrol. Also, in this system the state has multiple roles as payer from general budget, insurer of the EHP for employees of small companies, provider of national hospitals, and providers.

Statutory health insurance plans collectively achieved universal health insurance in terms of legal coverage. Choice of statutory health insurance is not allowed: employers have to enrol their EHPs and others have to enrol CHPs. But critical division in benefits rates and in risk and income distribution between employee-based and community-based plans existed from the inception of the mandatory community-health insurance. Put simply, the Japanese health system at the moment of achieving universal coverage was divided. In the following section, we will see differences in funding and lack of cross-subsidies and difference in benefit rates, plausibly resulting in differences in access to health services.

Division between Employee-based plans and Community-based plans

Differences Co-payments

First, although statutory health insurance covered the entire population, co-payments significantly differed between EHPs (almost free for workers but 50% for dependents, which was reduced to 30%) and CHPs (50% of the total fees, reduced to 30% later). The high co-payment rates in CHPs implied that the insured in the plans had more economic barriers and probably more financial burden to use health services. It was thought by policy makers, including senior officials, academics and politicians, that everyone insured have a common co-payment rate over 70% (Shakai Hosho Seido Singi Kai (Social Security Council), 1956). Considering political and financial feasibility, however, the Government chose lower benefit rate to achieve smaller premiums and subsidies. Because those insured by CHPs had lower income and higher health risks such as retired or unemployed people, a legally defined proportion (initially 20%, later up to 40%) of health care expenses were paid by the treasury to CHP insures.

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4 Co-payments differed between beneficiaries and dependents in the case of employment-based health insurance. Dependents had to face higher (e.g. 30%) co-payment rates. Clearly, there were gendered differences in financing health care, which I cannot discuss further here.

5 The divided universal health insurance may be regarded as an expression of “dual structure” of the post-war Japanese capitalism.
(municipalities) to make premiums affordable. Therefore financial situation of CHPs have been influenced by the proportion defined by the law.

Lack of cross-subsidiary mechanisms between CHPs and EHPs

When the universal coverage was achieved, CHPs and EHPs are divided in financial terms, Therefore, income and risk differences were not mitigated by cross-subsidies but by expenses from the general budget. The necessity of financial adjustments by cross-subsidies was recognized by the Government and policy elites (Shakai Hosho Seido Singi Kai (Social Security Council), 1962). However, because the health insurance was divided between CHPs and EHPs, cross-subsidies between health insurers, particularly between CHPs and EHPs have been a very controversial issue from the 1950s to the present.

The CHP insures and EHP insurers have representative organization, Kenpo-ren “The National Federation of Health Insurance Societies (NHIS)” and Koku-ho chu-oh-kai, “The All-Japan Federation of National Health Insurance Organizations (JFNHI)”, respectively. Each body represents interests of member organization. It may be too much simplification that the NHIS represents large profit companies and that the JFNHI represents municipalities. Although the size and risk- and income-distribution of health insurers varied within each group, the two organizations have expressed contrasting position as to cross-subsidies: the NHIS were against risk- and income- adjustment between insures; while the NHIS, already subsidised by the general budget of the Government, sought additional subsidies from any sources.

Single common fee-table regulated by the government

The healthcare system has common rules for setting fees and payments across all the statutory insurers. In this sense, the system has been universal. Everyone can enjoy health care services in the same positive list of services and pharmaceuticals, although co-payments clearly differed. While there existed numerous and varied statutory health insurers, the government had (and has) the power to set a fee table for health care services

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6 The abbreviations are given by the author.
7 Japan has a two-tier local government system: 47 prefectures and municipalities. In the 1980s, there were more than three thousand municipalities, each of which operated community-based health insurance. Both prefectures and municipalities have elected governors and mayors, respectively, and members of councils who are also elected by the residential people.
(Campbell & Ikegami, 1998). The common fee table has been symbolically and functionally critical in the universal health insurance in Japan. Whichever health insurance a person is enrolled in, he or she can expect the same health care services covered by statutory health insurance. In this sense, the common table nurtured the idea of universalism in health insurance.

On the other hand, the Government has ultimate power of deciding the price level of health services and essential financial incentives to health care providers. The power, however, was usually hidden under consensual decision making process involving relevant stakeholders: payers or insurers (the NHIS and the JFNHI), providers (the Japan Medical Association), and neutral experts. Since the government must spend statutory subsidies\(^8\) by itself, it was not neutral particularly in the time of austerity.

**Mixture of Public- and private- providers, Market Mechanism in provision and Patient choice**

There are two important structural issues in Japanese health care: market-based mixed provision without price competition and national and local relationship in health policy making.

Because health care was provided by a mixture of public and private providers\(^9-10\) and both providers mostly operate under the universal health insurance, they compete in the “market” highly regulated by the government. There, however, existed important differences between public- and private- providers. Public providers received funding from general budgets of national or local governments in addition to payments from insurers, for example, to establish new facilities or to make up deficits. On the other hand, public providers were expected to deliver loss-making health care services and, thus, politically visible. Therefore public providers were likely to respond to policies in different ways from those of private providers.

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\(^8\) This means the Government must pay the stable **percentage**, given by law, of total health benefits to statutory health insurers. The subsidies to community-based health insurance gave **a most financial burden** to the general budget.

\(^9\) Although distribution of profits were virtually prohibited, hospitals pay higher rewards to their owners (who were often physicians) and employed staff. There were no regulations on higher remunerations.

\(^10\) In detail, private hospitals established by designated bodies, such *Saisei-kai*, an not-for-profit organization established by a member of the imperial family, and the *Seki-juji*,”Red-Cross” were regarded as “pseudo-public”. They were expected to take roles similar to ones of public hospitals and may be provided tax-relief.
Health care services were delivered through a “market mechanism” regulated in terms of qualifications, payments and marketing behaviours. The market had been generated by two factors in Japanese health care system: patients’ choice and discretional power of providers. On the one hand, because there had been little geographical and administrative restrictions of using health care providers, patients, or physicians as patient agents, mostly choose freely providers by themselves. On the other hand, providers had wide discretions to establish or enlarge clinics and hospitals as long as minimum requirements of facilities, staffing, and other structures were met. Since funding mechanisms of public- and private- hospitals was different in the health care “market”, restrictions of increasing beds in public hospital had been introduced so that private hospitals grew up. After the establishment of the universal health insurance, the “market” was broadened; in other words, national health expenditure increased in the 1970s.

National policies, local supplements

Health policy was a matter of the national government. It has a power to decide almost every points of the universal health insurance: the fee-table, benefits and a possible range of premiums for statutory health insurers, and standard of buildings, equipment and staffing of providers. Meanwhile, local governments had developed supplemental policies. They established clinics and hospitals, set up subsidies for needed health services, and provided public health services because the country-wide fee-tables did not finance needed health care in some areas and, therefore, the health care “market” mechanism did not work well. They also can provide supplemental benefits such as children benefits for health care that reduce payments at the point of services. The national government often subsidized those local policies: it promoted supplemental policy developments so long as those are on its line.

Local governments have limited capacities to develop health care policies because Japanese health care system had not been well fit to general administrative framework of local governments. First, because EHPs covered people living in different geographical area, financial accountabilities had not existed in geographical areas. Secondly, providers

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11 I use quotation marks to suggest that the word “market” has been unpopular in discussing health care policies in Japan.
12 In the case of some kind of infectious diseases, patients were compulsorily hospitalized to designated special wards.
13 When local governments’ policies deviated from the national government’ policy, it created conflicts. For example, when a local government made outpatient services for the aged free, the national government introduced financial incentives against the policy).
were permitted to deliver health services wherever patients lived if possible. This principle was quite different from that of usual public services: local government having providers sometimes faced problems of accountabilities to their residents, particularly if those providers went into red. Finally, they did not have enough human resources for health policy developments.

3. Changes between the 1960s and the 2000s

Since the 1960s the general structure of healthcare has been maintained except services for the elderly. Although number of insurance plans decreased, the following major features of the system have been maintained: mixed funded universal coverage with compulsory enrolment to EHPs and CBPs; common rules for pricing services set by the government; and mixed provision with non-price competition.

Within the stable structure, however, gradual changes that have transformed the system have occurred: division between insurance plans has been diminishing. EHPs and CHPs have common co-payment rates now and cross-subsidies between EHPs and CHPs have been developed. In other words, policy makers can regard the health system as a literally single system rather than a system with different layers more and more. Nevertheless, there seem differences in the extent to which virtual unification of the system has advances between co-payment rates and cross-subsidies.

Co-payment rates

Co-payment rates generally decreased during the 1960s and 1970s. Until the mid-1970s co-payment rates for those in CHPs and for dependents or insured family member in EHPs decreased to the present level, 30% of the total fees. Meanwhile, catastrophic coverage was introduced in all plans. By the coverage, once the monthly amount of fees

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14 In the early 1980s, a new programme for health care for those aged 70 years and older was established in addition to the existing insurance plans. It collected funds from CBPs and EBP, and the national and local budget and maintained co-payment rates for the aged lower than the other population. In 2008 the programme has been converted to a separate statutory insurance, the Health Care Insurance for the Old-Old (HCIO) that covers those aged 75 years and older). Another fundamental change is the establishment of the Long-Term Care Insurance in 2000.
exceeds ¥30,000 (US $83 in 1973), no more co-payments were not charged to patients (Ikegami, et al., 2011). Furthermore, the Government introduced the free-at-the-point-of-services for the aged programme, which expanded demands for health care.

Increased health expenditure and decreased growth rate lead to cost containment in public administration and health care that spend part of the general budget in addition to contributions. In consequences, the free-at-the-point-of-services for the aged programme was abolished and co-payments rates for the aged gradually increased but still maintain lower than the usual co-payment rate.

On the other hand, the Ministry of Health and Welfare had a plan to make 20% a common co-payment rate in all plans. Due to financial difficulties in the 1990s, however, co-payment rates in EHPs increased gradually. Finally the 30% common rate was set in 2006 silently (15) Meanwhile, reduced rates with policy intention, e.g., for those with low-income and children have been developed, which suggests policy makers can handle co-payments of the entire system without complex negotiations.

Cross-subsidies to adjust risk and financial differences

The division between EHPs and CHPs had increasingly become a problem within a universal health insurance. As the population aged, CHP insures had faced financial difficulties more and more, which lead to serious conflicts between the two groups. Nevertheless, strong opposition against crossing the division continued to exist particularly in insurance societies based on large companies.

The establishment of the Health Care for the Aged Programme gave an example as to how the government coped with such a situation. The Government established a new and complex system, the Health Care for the Age (HCA), to finance health care services for the aged in the early 1980s.

The HCA was essentially a policy tool to introduce cross-subsidies between the EHPs and the CHPs without clearly stating it (16), which made the policy politically doable. In order to sufficiently finance the CHPs, both insurers must pay contributions to the financial pool of the HCAs according to the number of insured persons in each insurer.

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15 Some exceptional cases exist: autonomous and financially healthy plans set lower rates.
16 The government emphasized its intention of establishing the EHPA was integration of health care, financed by statutory health insurers, and preventive services and health promotion, financed by local governments.
The EHP, particularly, were obliged to contribute newly incurred fund, which later lead to an issue in the 2000. When the new Health Insurance for the Old-Old (HIOO) was established, cross-subsidies for risk and income adjustment have been formally introduced in the 2000s. All statutory health insurers except the HIOO are involved in risk and financial adjustments, but the scope of the adjustments are limited to the insured aged between 65 and 74. However, funding has continued to be a critical issue for CHP insures. Cross-subsidies within CHPs have been already developed to stabilize financing of CHP insures. CHP insures have faced two difficult problems: affordability of premiums and financial deficits. In FY2010, almost three million households, 1.4% of the insured households by CHPs, did not pay premiums and were made temporarily ineligible for CHPs and had to pay full amount of fees if they use health services\(^{17}\) (Insurance Bureau Ministry of Health Labour and Welfare, 2012). In FY2007, 71.1% of 1,804 CHP insures experienced financial deficits.

Overall, division between health plans have been becoming vaguer, although risk and income differences continue to be large between insurance plans.

4. Discussion

Although the general structure of the Japanese health system has been maintained since the 1960s, the division between employment-based health plans and community-based health plans has become vaguer and more unified. The difference in co-payments, one of the most visible differences between them, has disappeared and almost all people experience the same co-payment rates according to his/her age and income. The introduction of formal cross-subsidies between all health plans also has made the entire health system towards more unified, although practical issues are to be scrutinized in the next decades and problems of affordability and deficits continue to exist. The unification of the system will decrease costs for policy making because relevant actors expect the unified policy and narrow the possible policies. In other words, there may be no necessity to consider each policy options, e.g. co-payment rates, for each

\(^{17}\) Once they become eligible by paying due amount as premiums, the amount of fees they paid to healthcare providers can be reimbursed.
sub-system or insure groups when policy makers discuss possible solutions, though this hypothesis shall be examined by empirical research in the future.

With visible unification such as co-payment rates, actors share the recognition that the health system is not a mere patchwork of financial organization, providers and regulations, but a system with societal values.

Both changes of co-payments and cross-subsidies took many years, almost half of a century. The unification of co-payments has been completed, while cross-subsidies have been just formally introduced even after 50 years from the achievement of universal coverage. How can we explain the similarities and differences in both changes?

Achievement in the long-term arises two questions. The first is why a policy change can occur in such a long-term? The answer to this question can be made from ideational forces. The idea of common co-payment rates and risk adjustment through cross-subsidies have close link to the idea of kai-hoken, “universal coverage”. They are so strong that they have continued to influence policy making process through policy elites and public expectations.

The second question is why changes take so long time within the path of (in this case) statutory health insurance? In the case of co-payments rate, financial difficulties with slow growth of the economy and rapid increase of health expenditures made quite difficult to decrease co-payment rates of CHPs. Because increasing co-payment rates of EHPs were clearly considered to raise conflicts between relevant actors, the policy was not made until fiscal necessity was clearly recognized and shared within them. Visible and simple characteristics of the policy made possible to accomplish it.

Technical necessity of cross-subsidies was clearly recognized by policy elites when universal coverage with combinations of different mandatory health insurances was discussed. They were problematic, however, because they violate autonomy of insurers. Off course, in a universal health system, autonomy of insurers shall be limited in whichever ways. That universal coverage was achieved by additional mandatory community-based health insurance without establishing general principles of managing the entire system. Put simply, disparities between technical necessities and political recognition made it difficult to introduce cross-subsidies. However, financial pressures in the 1970s made cross-subsidies necessary to treat and prevent problems in affordability and deficits in CHPs.

Cross-subsidies are very technical and not easily understood by the public. Therefore, support for the idea of shared responsibilities of funding among insurers is different support for practical implementation of cross-subsidies. That can be a reason why they
have been introduced so slowly. Another reason may be that most autonomous insurers are based on large companies and have largest political voices in policy arena. In the case of co-payments, companies may be worried about expenditures of their employees but may support increase co-payment rates because it decrease financial burden of insurers. So co-payment rates are theoretically controversial for them. But cross-subsidies bring new financial burdens on them. There is no reason to support the policy if shared responsibilities of funding are not recognized.

Another reason may be the societal values that support social security, including health insurance, in Japan. Ideas that support cross-subsidies had not been well developed and shared in Japanese society. The idea of solidarity was not influential in Japan. Rather, limited state intervention for those in poverty was considered appropriate (Shakai Hosho Seido Singi Kai (Social Security Council), 1950). Therefore, the counter idea to the idea of autonomy was lacked until the 1990s, when the Social Security Council emphasized the idea of solidarity (Shakai Hosho Seido Singi Kai (Social Security Council), 1995).

The changes described in this paper originated layering characteristics of the universal coverage achieved that have maintain autonomy of EHPs thus division between EHPs and CHPs. In this sense, the long-term gradual changes were programmed by the initial situation. The two cases suggest that visibility of policies and ideas to support changes as well as power distribution between concerned actors have important roles in occurrence of gradual changes.

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