

Japan: Health Care System Overview and SWOT Analysis

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Abstract

This is the fifth article of the International Health Care Systems series. The first part of the article provides an overview of the Japanese health care system, including its historical evolution, health financing, service delivery, and aspects like equity, cost-control, and health technology. The second part analyses the strengths, weaknesses, opportunities, and threats for the Japanese health care system.

Keywords: Japan health care, citizen's health insurance, society managed health insurance, universal health coverage, SWOT analysis

An Overview of the Japanese Health Care System

Japan is the world's third largest economy in nominal GDP terms. About 11.1% of the GDP was spent on health in 2019,^[1] making it among the highest spenders on health among OECD countries. Public share of total health spending was 84.27% in 2019.^[2]

Japan's health system is based primarily on a multi-payer social health insurance model broadly divisible into two categories: employment-based health insurance (EBHI) and national health insurance (NHI), also called citizen's health insurance.^[3] The former began in 1922 with a national legislation to cover workers; the latter was started in 1938 for the self-employed and unemployed.^[3,4] The drive for universal health coverage (UHC) began as part of preparation for the world war 2 and continued after the war in the spirit of post-war recovery and social solidarity. UHC was achieved in 1961, supported by the income doubling plan (1960) and favorable economic growth after the war.^[5] Previously voluntary insurance was made mandatory with the roll-out of UHC and patient cost-sharing was reduced subsequently.^[3]

Health insurance is mandatory by law and there is 100% coverage. A comprehensive range of preventive, promotive, and curative services (around 5000), including drugs and dental care, are covered.^[3] Fee schedules are decided nationally by the Ministry of Health, Labour and Welfare (MHLW) in consultation with the Central Social Insurance Medical Council (CSIMC).^[3,4] The fee schedule is stringently applicable across the nation; reviewed/revised every two years; and also sets the terms of patient cost sharing. Balance billing and extra billing are prohibited.

Table 1: Cost Sharing Scheme:^[3]

Age category	Co-payment rate (% of total spending)
Pre-elementary school	20
Elementary school to 69 years	30
70-74 years	20
75 years and above	10

EBHI has multiple categories. Employees in large firms (with 700 or more employees) are covered under the society managed health insurance (SMHI), which is based on employee-employer premium contributions and is run by employers individually or jointly with others. Workers in small- and medium firms are

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covered by national health insurance managed by the Japanese Health Insurance Association (JHIA), and is based on employee-employer contributions and government subsidies.^[3,4] Others include mutual aid societies (MAS) covering public servants and Seaman's health insurance covering seamen.^[3] The NHI is operated at the municipality-level and covers the self-employed and unemployed, funded through premium contributions and government subsidies. To ensure more equitable financing, the Elderly Health Security Act (EHSA) 2008 created the early- and late-stage medical care system (LSMCS) for elderly individuals aged 65-74 years and above 75 years respectively - thus separating their risk pools from the NHI. Care under LSMCS is funded through co-payments (10%-30% of total, depending on income), beneficiary premiums (10% of remaining costs after co-payment), government subsidy (0-50% of remaining, depending on income), and subsidies from EMHI and NHI (40-90% of remaining, depending on income).^[3] A long-term care insurance program for the elderly (65 years and above) was started in 2000, financed by general and earmarked taxes.^[3,4] In 2015, the EBHI, NHI, and LSMCS covered 58.69%, 28.32%, and 12.42% of the population respectively. Private insurance mainly covers income losses due to care and is quite common.^[3]

Significant financial inequity between EBHI and NHI has been a perennial problem owing to different beneficiary composition, compounded with economic stagnation and rapid ageing. To address the same, subsidies and redistribution systems have been effected across insurance plans. Public subsidies constitute 50% of the NHI budget. Subsidies are also provided towards premiums for poor households, for insuring municipalities with greater proportion of poor households, and to level varying premium rates between them.^[3] Payroll taxes are waived for the unemployed, and those below poverty line receive 100% government subsidy.^[3,4] Also, income related, monthly and annual caps on copayments exist. Prior to separating risk pools of the elderly in 2008, the Elderly Health System (EHS) redistributed funds from plans with lesser enrollment of elderly to those with greater shares. Financially deficient JHIA-managed plans are also entitled to government subsidy upto a maximum 16.4%.^[3]

The MHLW, prefectural, and municipal governments are all actively involved in health services provisioning, regulation, and supervision. Under the Health Care Structural Reform Act, 2006 and the aegis of MHLW, prefectural governments prepare and operate regional Medical care Plans (MCP) to promote

effective liaison across levels of healthcare providers through 'disease-specific integrated clinical pathways' encompassing emergency to long-term care services. MCPs may also involve structural and process indicators for quality assessment. Prefectural governments are responsible for ensuring quality of care and compliance with regulatory requirements by hospitals.^[3] The Japan Council for Quality Health Care, which undertakes hospital accreditation, was founded in 1995.

The healthcare delivery organisation is fluid and dispersed. There is no gatekeeper; general practice isn't widely prevalent; healthcare is specialty-oriented; and the lines between primary and secondary care, and clinics and hospitals, remain vague. Clinics are largely privately-owned (94%) specialist practices and may have a varying number of inpatient care beds. Hospitals can vary from small nursing homes owned by physicians to large institutes, and are majorly private (80%) and non-profit.^[3,4] Payment for services is as per fixed fee schedule, and Diagnosis-Procedure Combination (DPC) based on hospital admission is used to pay for inpatient care. Patients have free choice of physician, and hospitals are subjected to limited government regulation. A limited referral system, whereby visiting large hospitals without clinic referral attracts a minimum \$50, is in place to encourage use of lower level facilities.^[3] Nationally-negotiated fee schedules remain the prime instrument of cost control. Due to a historical dominance of clinic based primary care providers in the Japan Medical Association, the fee-schedule has traditionally favoured clinic services over hospital services with higher payments.^[6]

The Director-General for Statistics and Information Policy reports 7 fundamental statistics (including vital statistics, patient survey etc.) and 23 general statistics, which inform planning, policy, and programme implementation.^[3] As of October 2019, 63.1% hospitals had implemented electronic health records (EHR).^[7] EHR adoption is non-uniform and favors large hospitals.^[8] Rising demands and fiscal challenges have increasingly brought Health Technology Assessment (HTA) into focus. Backed by a 2015 cabinet decision on introducing HTA, the Special Committee on Cost Effectiveness (SCCE) under the CSIMC has implemented a new HTA programme and has subjected multiple drugs and devices to the appraisal process.^[3]

Rapid ageing, rising demands, and economic stagnation have inspired a number of recent reforms. To facilitate comprehensive, integrated care at the community level, the 'Integrated Community Care System'

began in 2006. 'The Comprehensive Reform of Social Security and Tax' (CRSST) 2010, aims to reform the revenue and social security system for better fiscal sustainability. The 'Regional Healthcare Vision' (2014) requires prefectures to have a regional vision with respect to healthcare demand and supply. Also, a 'Japan Vision: Health Care 2035' has been conceived with the aims of sustainable, quality, efficient, and integrated healthcare.^[3]

SWOT Analysis

Strengths

Japan fares well with respect to all the three components of UHC, namely breadth (extent of coverage), depth (number of services covered), and height (extent of financial protection). Its UHC service coverage index was 83 in 2017.^[9] Post roll-out of UHC, it has made significant strides in population health. Japan has the highest life expectancy at birth among OECD countries. Its infant mortality rate (1.9 per 1000 live births in 2018) and potential years of life lost (2994 per 100000 inhabitants aged 0-69 years in 2017) are among the lowest in the OECD.^[10,11] Deaths from cancer (168 per 100000 persons in 2017) are also modest by OECD standards.^[12] What is particularly interesting is that this has been achieved with a modest doctor-population ratio, especially when Japan ranks among the highest in OECD in terms of doctor consultations per capita. Significant improvements have also occurred in terms of transport accident deaths and stroke mortality.^[3]

Despite cost sharing, out of pocket (OOP) expenditure amounted to only 11.7% of total spending in 2014. Age- and income categorized rates and caps on OOP are held to be responsible for the same. OOP accounted for 2.2% of total household consumption expenditure in 2013, which is below the OECD average.^[3] Affordability of care, however, doesn't impinge on free access. Patients have free choice of physicians and waiting times are modest. This is partly attributable to high hospital capacity: Japan has the highest number of hospital beds per capita in the OECD (13 per 1000 in 2018).^[13] Hospital admission and surgical rates are low, the latter partly owing to cultural reasons.^[4]

Cost control through fee schedule has been successful, and favors clinic services over hospital services, which positively incentivizes desirable workforce distribution. Prices are manipulated to encourage or discourage certain services. The DPC system of inpatient care payment has been shown to have improved technical efficiency in surgery.^[3] Japan is one of the largest pharmaceutical and medical devices markets.

Weaknesses

Financial inequities between insurance programs (primarily the EBHI and NHI), and in terms of contributions as a share of income, persist despite redistribution systems in place.^[3,5] With no gate-keeping and weak general practice, the system provides few disincentives to excessive use of costly, specialized care. It has been noted that deficient general practice is also responsible for the relatively poor quality of chronic disease care in Japan.^[3] Fee schedules remain the only major tool of cost control and there are generous caps on OOP spending, making the system prone to demand- and supply-side moral hazard. There are few checks on the purchase of sophisticated equipment. As of 2017, Japan had the highest number of CT and MRI units per 100000 inhabitants in the OECD.^[14,15] Also, there has been a relaxed approach towards quality and patient safety,^[16] although this is changing.

Japan has highest average length of hospital stay in the OECD (16.1 days in 2018),^[17] even though it has decreased in recent years. Fewer physicians and a high number of consultations per capita result in shorter consultations and increases waiting times for physician consultation.^[4] Disparities exist between prefectures in terms of life expectancy, which has been attributed to differences in risk factors like smoking and socioeconomic conditions across prefectures.^[3] The nation also has a considerably high suicide rate.

Opportunities

Recent reforms (discussed before) offer promise towards sustaining UHC in the face the many challenges facing Japanese healthcare today. Besides, they convey a renewed focus on improving quality, efficiency, responsiveness, transparency and accountability in care. They aim at strengthening community-level care through integration of services; having a more region-specific and sensitive approach; and improving care experience for the elderly. The CRSST which envisions tax and social security reforms lists a number of pertinent priority areas, including support of children and child raising, reform of medical and long term care services, measures against poverty and income inequality etc.^[3] Certain systems currently in place, such as the limited referral system to encourage local care, can provide a foundation for future reform, in this case a full-fledged gate-keeping system.

Threats

Rapid ageing, negative population growth, and economic stagnation present the main threats to the sustainability of Japan UHC.^[3] 28.4% of the popula-

tion in 2018 was aged 65 years and above.^[18] Rising chronic and degenerative conditions place increasing demands on the health system, and increasing use of costly technologies projects rising expenditures. On the other hand, there is shrinkage in the working population and increase in the number of unemployed dependents. Healthcare spending rose from 6.3% of GDP in 1995 to 10.9% in 2015,^[3] and to the current level. The poor population which receives public assistance went from 0.7% of the population in 1995 to 1.7% in 2014 (accounting for 4.2% of the total health spending).^[3]

Resistance to change and an inflexibility to adapt to changing circumstances and emerging challenges can present a threat to the health system. Merging fragmented insurance schemes into a single payer model presents a political challenge. Also, interest-group lobbying may impede much needed reform, as seen with the JMA's opposition to HTA implementation.^[3]

References:

1. OECD.Stat [Internet]. Health expenditure and financing. [Cited 2020 Sep 9]. Available from: <https://stats.oecd.org/Index.aspx?DataSetCode=SHA>
2. Countryeconomy.com [Internet]. Japan - Government Health expenditure. [Cited 2020 Sep 9]. Available from: <https://countryeconomy.com/government/expenditure/health/japan>
3. Sakamoto H, Rahman M, Nomura S, Okamoto E, Koike S, Yasunaga H et al. *Japan Health System Review*. Vol. 8 No. 1. New Delhi: World Health Organization, Regional Office for South-East Asia, 2018.
4. Bodenheimer TS, Grumbach K. Health Care in Four Nations. Understanding health policy: a clinical approach. 5th ed. United States of America: *McGraw-Hill*; 2008. p. 163-80.
5. Maeda A, Araujo E, Cashin C, Harris J, Ikegami N, Reich MR. Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies. Directions in Development. Washington, DC: World Bank. doi:10.1596/978-1-4648-0297-3
6. Ikegami N. Achieving universal health coverage by focusing on primary care in Japan: lessons for low and middle-income countries. *Int J Health Policy Manag*. 2016;5(5):291-93. doi:10.15171/ijhpm.2016.22
7. Statista [Internet]. Share of hospitals in Japan that implemented electronic medical records (EMR) as of October 2019. [Cited 2020 Sep 9]. Available from: <https://www.statista.com/statistics/1121012/japan-share-hospitals-electronic-health-record/>
8. Kanakubo T, Kharrazi H. Comparing the trends of electronic health record adoption among hospitals of the United States and Japan. *J Med Syst*. 2019;43:224. <https://doi.org/10.1007/s10916-019-1361-y>
9. World Health Organization [Internet]. Global Health Observatory data repository. Index of service coverage. [Cited 2020 Sep 9]. Available from: <https://apps.who.int/gho/data/node.main.INDEXOFESSENTIALSERVICECOVERAGE>
10. OECD Data [Internet]. Infant mortality rates. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthstat/infant-mortality-rates.htm#indicator-chart>
11. OECD Data [Internet]. Potential years of life lost. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthstat/potential-years-of-life-lost.htm#indicator-chart>
12. OECD Data [Internet]. Deaths from cancer. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthstat/deaths-from-cancer.htm#indicator-chart>
13. OECD Data [Internet]. Hospital beds. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthstat/hospital-beds.htm>
14. OECD Data [Internet]. Computed tomography (CT) scanners. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthstat/computed-tomography-ct-scanners.htm#indicator-chart>
15. OECD Data [Internet]. Magnetic resonance imaging (MRI) units. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthstat/magnetic-resonance-imaging-mri-units.htm#indicator-chart>
16. Hirose M, Imanaka Y, Ishizaki T, Evans E. How can we improve the quality of health care in Japan? Learning from JCQHC hospital accreditation. *Health Policy*. 2003;66(1):29-49. doi:10.1016/s0168-8510(03)00043-5
17. OECD Data [Internet]. Length of hospital stay. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/healthcare/length-of-hospital-stay.htm#indicator-chart>
18. OECD Data [Internet]. Elderly population. [Cited 2020 Sep 9]. Available from: <https://data.oecd.org/pop/elderly-population.htm>

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