に医療機関に通院している人がいる。いわゆる多受診や重複受診といわれる受診行動である。多くの高齢者が慢性疾患を有する今日、われわれがアンケート調査対象とした持病がある高齢者は、高齢者の中で多数派であり平均的な高齢者像といえる。厚生労働省「国民生活基礎調査」(1998年6月調査)によれば70歳以上で医療機関へ通院している人は879万9千人で、これは70歳以上人口の64.5%に相当する。その中では慢性疾患の持病を持った人が大多数で、1年以上継続して通院している人が86.5%を占める。そして日本全国のこれら持病持ちの高齢者の一部はアンケート回答者同様に非常に旺盛な通院行動をしているものと思われる。

このような頻繁な通院回数は支払い医療費(自己負担)が低く抑えられているために発生していると考えられる。月4.4回の通院に対して、アンケート対象者が支払う医療費は平均4,006円に過ぎない。1ヶ月に約3,000円の限度額を超えれば、それ以降の通院は実質的に無料という自己負担制度が頻繁な受診を招いている可能性が大きい。このような現状からは、高齢者の自己負担引き上げは支持される。今回の医療制度改革によって2002年10月から高齢者にも1割自己負担が厳格に実施されることになったが、これは医療を患者側から効率化していくための有効な改革といえよう。

しかしながら自己負担引き上げにまったく問題がないとはいえない。現状では自己負担が小さく給付の不平等は起きていないことは今回の分析で確認されたとおりであるが、自己負担が今後さらに引き上げられ続ければ不平等はいつか必ず発生する。実際、自己負担引き上げのテンポは速く、2003年4月に高齢者(70歳以上)と乳幼児(3歳未満)を除くすべての国民の自己負担が、外来、入院を問わずすべて3割へ引き上げられることが決まっている。自己負担一律3割は世界的にみてもかなり高い水準である。給付の平等性が損なわれる危険性が大きい。今後は外来、入院、薬剤などの別にどこまで平等性を保持すべきか、医療のどの部分を民間に任せていくかなど、きめの細かい検討が必要となってくるだろう。医療経済の分析においても、これまでは自己負担引き上げなど制度変更の影響については財政改善効果に終始する傾向があったが、今後は負担と給付の平等性の検証に注力すべきである。

<参考文献>

van Doorslaer・Wagstaff他 (2000), "Equity in the delivery of health care: Further international comparisons", Journal of Health Economics

Wagstaff and van Doorslaer (2000), "Equity ain Health Care Finance and Delivery", Culyer and Newhouse ed. "Handbook of Health Economics", Elsevier Science

遠藤久雄・駒村康平・篠崎武久 (2001) 「医療費自己負担の分析――支出比率とカクワニ指数の国際比較と時系列分析」医療経済研究機構報告書

小椋正立・千葉友太郎 (1991)「公平性から見たわが国の社会保険料負担について」『フィナ

ンシャル・レビュー』1991年3月号
金子能宏（2000）「高年齢者の所得構成と医療需要」国立社会保障・人口問題研究所編『家族・世帯の変容と生活保障機能』、東大出版会
澤野孝一朗（2000）「高齢者医療における自己負担の役割：定額自己負担制と定率自己負担制」『医療と社会』Vol.10, No.2
澤野孝一朗（2001）「外来医療サービスにおける医療供給の役割—昭和59年と平成9年改定の違いとその理由」『大阪大学経済学』Vol.50, No.4

松本邦愛、長谷川敏彦（1999）「所得階級でみた日本の健康の公平性の分析」第36回日本病院管理学会遠大抄録集『病院管理』vol.36 supplement
吉田あつし・伊藤正一（2000）「健康保険制度の改正が受診行動に与えた影響」『医療経済研究』Vol.7

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「医療保険給付における公平性と削減可能性に関する実証的研究」

Inequity in the Health Care System of Japan

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研究要旨　The author investigates whether there is inequity in the Japanese health care system, which was planned to make sure every citizen had the same access to health services through the universal coverage of public insurance. The elderly have the same opportunity to visit physicians' offices regardless of their income level. There is no inequity in the delivery of outpatient health care. The author argues that excess usage of health care services might be caused by the generous provision of benefits.

A．研究目的

Recently the government announced another increase scheduled for the spring of 2003. The Japanese people have long believed in equity in providing health care, but the notion has rapidly spread that the recent increases in co-payments have caused difficulties in access to health care among the poor, especially those who are old and ill from chronic diseases. Therefore, there is an urgent need to measure the magnitude of inequity in health care delivery

B．研究方法

The author together with colleagues conducted a survey on the utilization of outpatient care by elderly patients with chronic diseases in Japan. According to this survey, the average frequency of visits to a physician was 4.4 per month. It was amazing that 11% of all participants visited a doctor 10 times or more and the top figure was 35 times a month. Excess use is a serious problem in elderly outpatient care. In order to test the effect of income on outpatient care utilization, the author estimated an econometric model.

C．研究結果

The estimation shows that the parameter for family income is not statistically significant. Family

assets, which are in a sense accumulated income, is also insignificant. That means income does not determine the utilization of outpatient care. This result suggests that there is no inequity in the delivery of outpatient care for the elderly.

D. 考察

The fact that income does not determine the utilization of outpatient care might mean the benefit to the elderly is too generous. The low co-payments seem to induce an excessive demand among the elderly. Therefore the reform of the policy to raise the co-payment rate to 10% of the total cost is judged to be acceptable.

E. 結論

The author conducted an econometric analysis using an original survey and found that neither income nor assets have an influence on elderly patients' behavior in determining the frequency of their visits to physicians' offices. Contrary to expectations, the result does not demonstrate inequity in health care delivery at present.

F. 健康危険情報

なし。

G. 研究発表

The Japan Center for Economic Research 「JCER PAPER」 No.74, November 2002

H. 知的財産権の出願・登録状況

なし。

Inequity in the Health Care System of Japan

November, 2002

Reiko Suzuki
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Overview

The author investigates whether there is inequity in the Japanese health care system, which was planned to make sure every citizen had the same access to health services through the universal coverage of public insurance. The elderly have the same opportunity to visit physicians' offices regardless of their income level. There is no inequity in the delivery of outpatient health care. The author argues that excess usage of health care services might be caused by the generous provision of benefits.

Background

Since the early 1990s the government has gradually raised the out-of-pocket payments or co-payments of the patients when it faced a serious deficit in the public health insurance budget. Recently the government announced another increase scheduled for the spring of 2003. The Japanese people have long believed in equity in providing health care, but the notion has rapidly spread that the recent increases in co-payments have caused difficulties in access to health care among the poor, especially those who are old and ill from chronic diseases. Therefore, there is an urgent need to measure the magnitude of inequity in health care delivery.

Argument and Methodology

In the first half of the paper, the author shows cross-country comparisons of inequity reported in previous studies. Concerning inequity in health care finance, the progressivity indices show that most countries are neutral and the proportion of income spent on health care is the same for every income

group. Japan and Germany are slightly regressive. The U.S. and Switzerland are highly regressive with the burden being heavier for the poor. In health care utilization, equity is more important because most developed countries want every citizen to have good access to health services regardless of their income. According to previous studies, outpatient care utilization is distributed pro-rich, but inpatient care shows an opposite pro-poor distribution pattern in most countries. These cross-country studies do not include Japan because of data unavailability.

The author together with colleagues conducted a survey on the utilization of outpatient care by elderly patients with chronic diseases in Japan. The number of participants, all aged 70 or over and staying home with chronic diseases, was 1,095. Family members assisted them in filling in the answers. According to this survey, the average frequency of visits to a physician was 4.4 per month. It was amazing that 11% of all participants visited a doctor 10 times or more and the top figure was 35 times a month. Excess use is a serious problem in elderly outpatient care.

In order to test the effect of income on outpatient care utilization, the author estimated an econometric model. In the model, frequency of physician visits is explained by income and other factors, such as patient characteristics (sex, age, disease, educational background and social activities) and opportunity costs (time to travel to hospitals, time waiting to be seen and the need for an attendant (= family member's costs)). The estimation shows that the parameter for family income is not statistically significant. Family assets, which are in a sense accumulated income, is also insignificant. That means income does not determine the utilization of outpatient care. This result suggests that there is no inequity in the delivery of outpatient care for the elderly.

Findings

The author conducted an econometric analysis using an original survey and found that neither income nor assets have an influence on elderly patients' behavior in determining the frequency of their visits to physicians' offices. Contrary to expectations, the result does not demonstrate inequity in health care delivery at present.

The benefit of the public health care system, however, will be reduced considerably due to financial difficulties. We have to keep an eye on the consequences of system changes from the viewpoint of equity.

Figure 1 Frequencies of Physician Visits by the Elderly (Histogram)

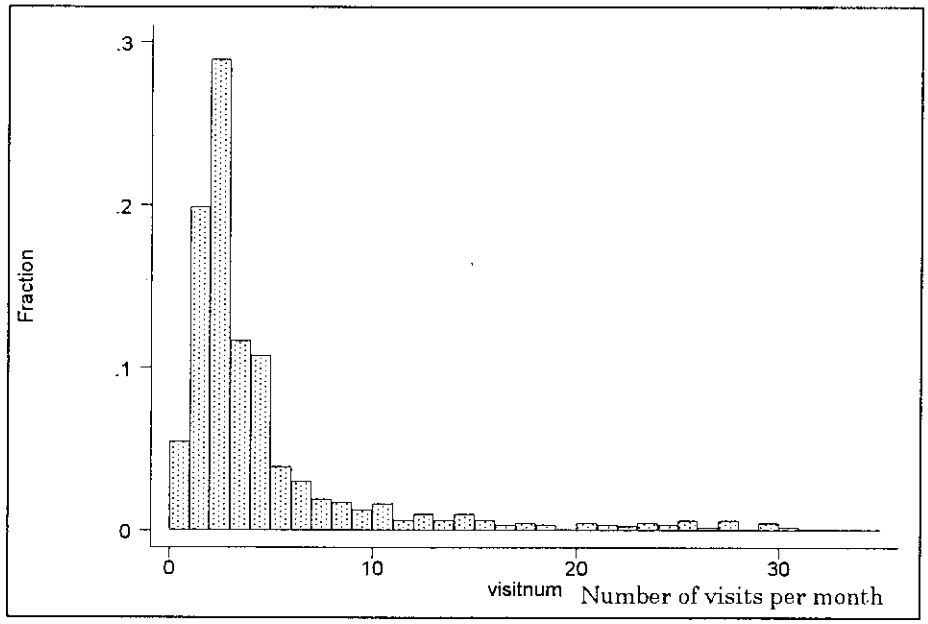

Table 1 Determinants of Physician Visits by the Elderly

Dependent variable:
Frequency of physician visits

Independent variables:	Parameters	t-value
Family Income	0.0351	0.55
Family Assets	0.0114	0.35
Male Dummy	-0.0901	-1.18
Age 75-79 Dummy	0.0117	0.15
Age 80-84 Dummy	0.2033	2.24
Age 85-89 Dummy	0.0683	0.64
Age 90- Dummy	-0.1439	-0.72
High School Graduate Dummy	-0.1694	-2.43
University Graduate Dummy	0.0149	0.13
At-Work Dummy	-0.1288	-1.57
Blue Color Dummy	-0.0143	-0.18
Social Activity Dummy	0.0201	0.26
Company Dummy	-0.2527	-2.86
Clinic Dummy	0.2939	3.90
Time to Travel	-0.0972	-2.17
Total Waiting Time to Be Seen	-0.0916	-2.30
Constant	0.8446	1.90
Number of Observations	953	
Adjusted R-square	0.1968	

- At-Work Dummy is for the present working conditions, while Blue Color Dummy is for the past when he/she was working.
- Company Dummy is 1 if the elderly needs to be accompanied when visiting doctors.
- Clinic Dummy is 1 if the most frequently visited facility is a clinic (not a big hospital).
- Ten disease dummies are included in the estimation, but they are omitted in the table.

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「医療保険給付における公平性と削減可能性に関する実証的研究」

Evaluating Japan's Health Care Reform in the 1990s and Major Issues Coping with the Aging of the Population

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研究要旨　Although the Japanese health care system has been successful, it will face difficulties in the future mainly because of rapid aging of the population. The government has done a series of health care reforms in the 1990s including the announcement of the new reform in 2003. This paper, firstly, explores the recent official demographic projection, which showed us the magnitude of aging is more serious than the former projection had predicted, secondly summarizes the series of health reforms in the 1990s, thirdly estimates the fiscal impacts of the 2003 policy reform for the budget of various health insurance policies, and lastly surveys the major issues to be solved in the future reform.

A．研究目的

The government has done a series of health care reforms in the 1990s and is announcing the new reform in 2003. However, it has not been fully investigated whether or not the reforms were effective from economic point of view. There is also an urgent need for an objective forecast of the assumed impact of the proposed reform to be launched in 2003, because the official forecast, which does not make the background data open to the public, might have a bias.

B．研究方法

In order to evaluate the effect of policy reforms, 1) we surveyed a thorough list of previous economic papers, 2) we built a proprietary Health Insurance Budget Model to estimate the effects by utilizing announced figures and information, as the government does not make the basis of their estimates clear. The model has five blocks of major public health insurance programs in Japan, so that it is possible to make future forecast of fiscal balance of each insurance.

C. 研究結果

The major results of the estimation are: 1) the baseline case with no institutional changes indicates widening deficit from 1.4 trillion yen in 2002 to 16.9 trillion yen in 2025, 2) after the reform, the aggregated health insurance budget would be improved in the coming few years, but it turns red and the deficit will reach 13 trillion yen in 2025, 3) the effects on the self-employed insurance is exactly the opposite of those on employees' health giving difficulties to self-employed.

D. 考察

First, the change for the worse of the self-employed insurance comes from the increase of elder enrollees aged 70 to 74 who are shifted from the elderly health policy. Second, the estimated effect by an increase in patient's co-payments to 30% is relatively small, since a ceiling of patient payment is set at a low level. Third, the impact of lowering the fee schedule to doctors by 2.7% is uncertain, because under the fee for service system doctors would easily recover their income by increasing the quantity of the medical services.

E. 結論

Japan's health care system, which has been successful, is now facing a series of structural problems mainly arising from the aging of the population. The combination of fees for service with free-access to health services has a potential pressure on increasing expenditures with an increasing number of the elderly. The government has tried to alleviate the pressure by raising the co-payment ratio, but they had only once for all effects. Our simulation results indicate that the recent reform on health insurance schemes is not an exception, and that the effect is merely a shift of the fiscal costs between government and various insurance programs. In order to make the health care system to be sustainable even at the peak of aging, the current fee for service system has to be changed into prospective payment system based on the standardization of medical treatments. Substituting the public insurance partly with private health insurance is another policy goal. The 2003 reform in health insurance is just a first step toward the supply-side reform in the health care services.

F. 健康危険情報

No

G. 研究発表

To be presented at the JCER-NBER joint conference in coming May 2003.

H. 知的財産権の出願・登録状況

No.

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「医療保険給付における公平性と削減可能性に関する実証的研究」

Evaluating Japan's Health Care Reform in the 1990s and Major Issues Coping with the Aging of the Population

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Introduction

In reviewing Japan's overall health care system, it is important to balance its remarkable achievement in the past and the gloomy prospects in the future. On one hand, the average life- expectancy, which was revised in the early 2002, indicates the further improvement from the top level among OECD countries. This has been achieved with relatively low ratio of the health expenditures to GDP among major OECD countries, implying the efficiency of the existing health care system. On the other hand, it is obvious that the current health system cannot be coping with a rapidly proceeding aging society. The official population estimates which was published in January 2002 indicates the higher ratio of the elderly in the total population by 3% points at its peak of the aging from the previous projection in 1997.

The effect of the aging is already reflected in the growing fiscal deficits in health insurance budgets, which are closely related with an increasing number of the elderly who are heavy user of health resources. It is also aggravated by Japan's generous health insurance schemes. Japan's health care system is known as "universal" i.e. every citizen (including the self-employed) is supposed to have some form of health insurance as well as public pension. This is based on German social insurance model, but unlike those in many European countries, the "free access" of patients to hospitals is assured with no gatekeepers and long waiting lists. In this sense, it is surprising that Japan's National Health Expenditures have remained at relatively low level, despite the above wasteful system, particularly under the "fee for service" fee schedule in the health insurance scheme.

An interpretation of the above combination of low costs and high achievement of the medical services is that Japan used to have a successful socialism in the field of health. The system has been efficient so long as there is an externality of health care services, strong asymmetry of information, and people's strong preference for egalitarianism.

However, with the aging of the population, the major portion of the diseases have shifted from infectious disease or acute disease to chronic disease, which reduces the element of externality as well as the extent to an asymmetry of information. Also, the preference of patients has changed to demand for better medical information and second opinions in order to choose from a variety of health services. It is in this background that major reform in the health system is called for in Japan.

Comparing with the United States Health Care System, Japan' current system resembles to the U.S. Medicare scheme for the elderly, though the former covers all the people based on social insurance scheme unlike the U.S.'s welfare systems. How to reform the current welfare-like health scheme in Japan should have many problems in common with the U.S. health care reform.

The government of Japan has done a series of health care reforms in the 1990s including the recent 2003 health insurance reform. However, the favorable fiscal effect of the reform by raising the patient's share of medical costs is quite limited with the health budget falling into deficit again within five years. By the time the fiscal effect is gone, the reform of the medical service provision has to be achieved for an efficient health scheme to be established. Major issues for the reform include standardization of medical treatments, the better provision of private health insurance replacing partly the role of public health insurance, introduction of the partial managed care system, and introduction of for profit hospitals.

The first section in this paper explores the recent demographic projection which is more pessimistic than the previous ones. The second section summarizes a series of the health reforms in the 1990s. The third section investigates the fiscal impacts of the 2003 health reform across major institutional changes and across different public insurers. The fourth section surveys the current major policy issues for reform with are mostly in common with those in the U.S. The final section concludes the paper.

1. Retrospect on Japan's Health System and the Effect of the Aging

(1) More rapid pace of the population aging

Japan's official demographic projections are revised for every five years, and the most recent 2002 population estimates indicates the more pessimistic scenario in the coming decades.

First, the total fertility ratio (TFR), which has been revised downward repeatedly in the previous projections, is estimated to rise from the 1.33 in 2000 and eventually stabilize at 1.4. The level in the medium projection (the most likely

scenario) is comparable to the 1.6 in the 1997 estimates and 1.8 in the 1992 estimates[1], Implying that the possibility for the further under-revision is not excluded. Behind these developments, there is a constant increase in the female labor force participation of the working age. This results in an increasing opportunity costs for women for child-raising, and lowering the demand for women to have a child. Thus, there is no concrete evidence that the fertility ratio would stabilize at the current level as in the 2002 official projection. Rather, the lower population estimates indicating that the fertility ratio will not recover in the future to be stabilized at 1.1, the lowest level among OECD countries, can be more likely to happen.

Second, the average life-expectancy at birth, which has continuously been extended, is projected to rise again from the current level of 77.7 years to 79.8 years for men, and from 84.6 years to 87.5 years for women in 2025. The recent increase is not mainly due to the fall in infant mortality, but mainly due to the extension in the elderly's life-expectancy; for example the males' life-expectancy at age 65 is to estimated to increase from 17.5 years in 2000 to 18.9 years in 2025. Also, a particular characteristic is a widening gap between male and female life-expectancy, which is projected to rise from 6.9 years in 2000 to 7.8 years in 2025. The factor behind this increasing longevity is still unclear, possibly due to the mixture of nutrition, smoking behavior and health service factors.

As the result, the speed of Japan's aging of the population has been accelerating in the 1990s, which is far exceeding that of the United States (Figure 1). The acceleration of the speed of aging, particularly of the very elderly, should impose larger pressure on the health cost expansion.

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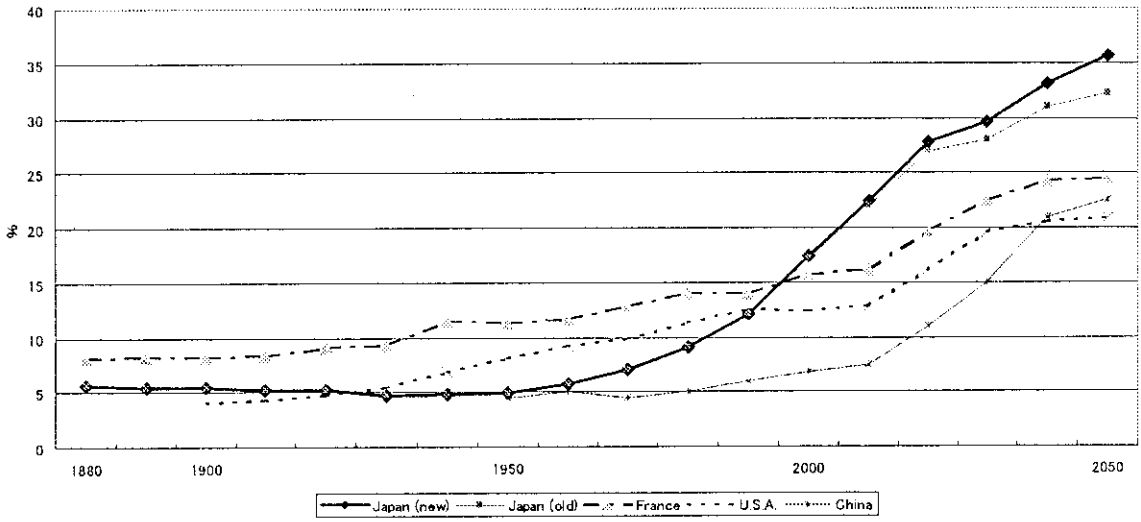
[1] An economic interpretation of the continuous decline in the fertility ratio is an increase in the college enrollment of women which rose from x % in 1980 to x % in 2001, and the associated increase in their labor market participation. This increases the opportunity costs of women to raise children, particularly in the rigid labor market practices of long-term employment and seniority-based wages, which implies that one who left the firm for child-raising finds it difficult to be employed at full-time after the child-rearing period (Yashiro 1998).

Figure 1 International Comparison of the Elderly Ratio (age 65 and above)



2) Aging and health expenditures

The share of the health costs for the elderly accounts for nearly one-third of the total, but 90% of the marginal increase of the expenses is attributable to the elderly whose par capita expense is close to 5 times of the average in 2000. This is mainly due to the fact that a half and two-thirds of the life-time medical expenses are spent for those 70 years and 60 years and above respectively (Figure 2). It is natural that the average medical expenses grow with one's age, as the older people generally have higher risk to be hospitalized. A major factor for the large increase in health expenditures with age is attributable to the following factors:

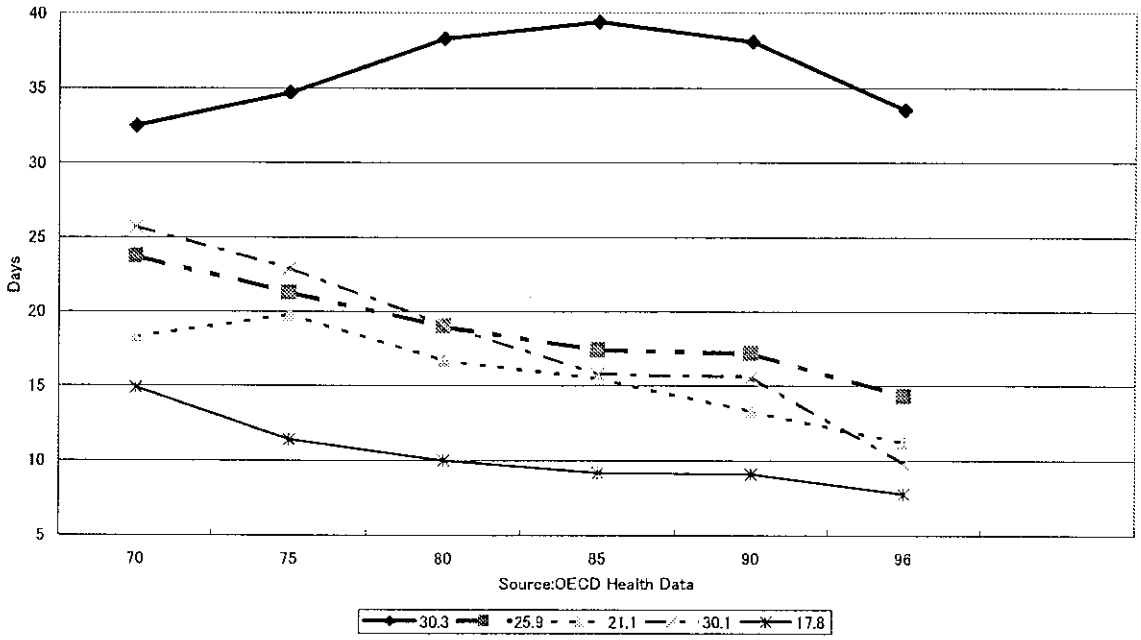
--- First, what makes the hospital costs for the elderly more expensive is their longer stay in hospital. The average stay in hospital in Japan is five times longer than that in the U.S., and the number of hospital beds per population in Japan is much larger than that in the other major OECD countries, which is related to the longer average duration of hospitalization (Figure 3). This reflects the fact that hospitals are de fact used as nursing care homes for the elderly, mainly due to the limited supply of care services for frail elderly. This misallocation of medical resources is a result of inconsistent policies between free access to health services and limited provision of nursing for frail elderly.

--- Second, the higher costs for the terminal care is another factor for age-related medical expenses. For example, hospital expenses for those who are age 70 and above during one year before death accounts for 19.2% of the total hospital costs for

the elderly (Ogura, Fukawa and Suzuki 1994). Another study shows that the health costs for the elderly controlling for terminal medical care costs are not different from those in other age groups (Suzuki and Suzuki 2002). This implies that medical cost increases with aging may well be avoided with appropriate measures are taken for terminal care.

··· Third, impacts of an increasing number of the elderly vary across health insurance groups with their different shares. Unlike pension schemes, health insurance plans

Figure 2. Average duration of hospitalization



for employees are established on their company-based, so that workers would move to the city-based insurance plan with their retirement, resulting in the heavy burden on local authorities with the concentration of the higher risk membership. Thus, how to construct the better risk-sharing mechanism across different insurance plans is an important issue in the health reform.

(2) Health insurance schemes

Japan's health insurance schemes are complicated reflecting their long-run historical developments. Originally, public servants and employees (including their family members) in large firms are first to be covered by their health insurance plans which are provided by their employers as the fringe benefits. This is followed by the government policy for establishing the "universal" health care system, and the employees in small firms and the self-employed have their health insurance schemes managed by the Ministry of Health and Welfare and the local authorities respectively.

The individual contribution to the health insurance is based on their monthly earnings (shared equally by the employer) regardless to their risk of diseases unlike the case of private health insurances. The earnings here include wages for the employee and entrepreneurship incomes for the self-employed, but exclude public pension benefits of the retirees. The contribution to the health insurance is more like a tax on wages targeted to finance the national health insurance. The scheme has a vertical distribution of incomes, as the medical plan beneficiaries are tend to negatively related with their incomes. This is contrasted to the "forced-savings" of the earnings-related pension of which the benefits are related to the individual's past contribution records.

The difference in the origin of the health insurance schemes has affected their revenues. The Society-Managed Health Insurance (SMHI) was established in 1922 consisting of individual company-based insurers. Their fiscal balances have been better reflecting growing employees' as well as the employers' contributions, while the average age of the membership used to be low and are generally in healthy conditions. On the other hand, the Citizens' Health Insurance (CHI) was established in 1938 and regionally organized with cities and towns as insurers. The majority of the membership are self-employed, who have less incomes and the higher risk of diseases. Also, unlike the case of the public pension insurance, most of the members of the SMHI and GMHI move to CHI after their retirement. This diversification in the membership by age group is de facto "cream skimming" of SMHI and GMHI by letting the risky elderly group kept in the CHI.

Thus, there are various mechanisms needed to level off per household contributions across health insurance schemes despite the differences of their medical costs arising from the variations of the elderly ratios (Table 1).

··· First, there are subsidies from the general government revenues. The largest subsidies are to CHI accounting for half of the health costs. The rationale behind is that the majority of the membership are the self-employed with relatively low incomes and without employers' contributions[2];
··· Second, the transfers of incomes between different insurance plans are made. The Health System for the Elderly (HSE) was introduced in 1973 for pooling the health costs for those who are age 70 and above across various health insurers. The adverse effect arising from the differences in the elderly ratios among insurers is partly

[2] Several comments are needed on this authorities view as follows: one, the self-employed have better chance to manipulate their incomes; two, they are half-employees and half-employers; three, rich self-employed such as doctors are also included in CHI.

compensated by re-distributing the revenues to the HSE[3]. The 70% of the costs of EHS are shared by other insurers based on the rule that they would have paid in benefits if their elderly ratio in insurance plan were the same as the national average. This is the scheme for pooling the fund for the elderly health care costs mainly from the employee health insurance and the government budget. The remaining 20% share comes from the national government and 10% from the local government.

··· Third, an additional income re-distribution mechanism through the Retiree Health System (RHS) within CHI which was introduced in 1984. It is to reduce the burden of the CHI which still suffers from an increasing number of those who are age 60-69 shifting from the employee-based health insurance plans. Both the SMHI and GMHI give transfers to CHI in proportion to the population who are retired and join the CHI under age 70;

As a whole, the transfers to CHI from both the SMHI and GMHI have increased with

Table 1. Health Insurance Schemes in Japan (2000)

	Membership	Average age	Average household income	Contributions per household (added by employers' contributuoins) 1000yen	Medical expenses per individual	Subsidies from the government (billion yen)
Society-Managed Health	3.2million (25.2%)	33.6	3.8million	159(364)	102000	Fixed amount (26.2)
Government-Managed Health Insurance	3.7million (29.3%)	36.9	2.5million	152 (303)	123000	13% of medical expenses (959.2)
Citizens' Health Insurance (CHI)	4.7million (36.5%)	51.3	1.8million	154	164000	50% of medical expenses (3057.7)
Mutual Aid Associations (MAAs)	1.0million (7.9%)	N.A.	N.A.	N.A.	N.A.	N.A.
Others (Salers and Minimum income assistance)	1.3million (1.0%)	N.A.	N.A.	N.A.	N.A.	N.A.

[3] This is only for the scheme of distributing health benefits, and the premiums, if any,

an expansion of the elderly population mainly in CHI, amounting to 4.6 trillion yen for HSE and 1.1 for RHS.

These schemes are in a sense a compromise between the two contrasted ideas: One is to make the EHS entirely independent of other health insurance plans, and is financed by the general government budget, which is like the U.S. Medicare. This EHS scheme is getting more costly for employees' health insurance, and is a major factor for the health insurance budget to be running into deficit. Thus, a major purpose for the current measure to raise the age of the elderly which is applicable to EHS by 5 years is to reduce the burden of the SMHI and GMHI for the time being.

(2) Quality of medical services and costs

Even accounting for the favorable demographic composition in the past, and the high level of incomes as well as egalitarian distribution of incomes, it is still difficult to account for the relatively low health expenditures under fee for service system in Japan. According to Ikegami (1999), the comprehensive and mandatory fee schedule is a major factor in Japan's low health spending. That is, usually expensive procedures such as surgery and other capital-intensive treatments are often priced much below the U.S. level. Also, most of the surgeries are conducted in the public sector hospitals with rigid prices, though there are subsidies from the general budget to the public sector hospitals, which are not counted for medical costs[4]. .This is contrasted to the prices determined in the market for health service in the U.S.

A key to understand the relatively low medical costs in the past is the low quality of the services per patient. An internationally comparative indicators relating to the

Table 2. International comparison of indicators relating health care provision (1995-96)

	Hospital beds	Average duration of hospitslizatio n	Nuber of medical staff	Number of doctors	Number of nurses
	per 1000 population	days	per patient	per 1000 population	per 1000 population
United States	3.37	6.5	5.5	2.59	8.04
Norway	3.29	6.3	4.35	2.79	13.92
Canada	3.62	7.5	2.8	2.13	8.92
Italy	5.13	8.4	3.15	5.37	5.47
France	4.46	5.8	1.52	2.93	5.89
Germany	6.74	11.5	1.88	3.35	9
Japan	10.16	29.2	1.15	1.84	7.38

Source: OECD Health Data

are imposed on the individuals in their insurers;

[4] There are varieties of the public sector hospitals managed by the local authorities as prefectures and cities, national universities, labor injury insurance, and so on.

quality of health services show that Japan's medical staff per patient is quite low, and is almost one fifth of that in the United states (Table 2). However, this does not mean that doctors and nurses are insufficient, and the ratio to the population is just slightly low among major OECD countries. It is simply that the number of hospital beds per population is excessive, reflecting an excessively long duration of hospitalization as a major factor for the low intensity of hospital care with insufficient number of medical staffs. Although the average days of the hospitalization has been declining, the gap vis-à-vis other major countries have not narrowed, as the others have also reduced it since long years ago. This is why the reform in health insurance is closely related with the institutions for the nursing care of the elderly, which is to be discussed in the following section.

3. Long-term nursing care insurance for the frail elderly

The public nursing care insurance system was established in April 2000 as a major pillar of measures to improve the system of long-term care for the frail elderly. In Japan, the share of welfare services in the social security benefits has been relatively low compared with health insurance costs and public pension. This is closely related to the general acceptance that family should play a major role in providing elderly care services. However, with changing economic and social environments, social infrastructures are needed to provide care services for the elderly, the share of which should expand rapidly.

A major aim for the new nursing care system is the division of roles between medical treatments and nursing care. Long-term care requires an appropriate blend of treatment and welfare services. Until now, people needing care and their families have tended to make use of health insurance, which allows unlimited coverage of care costs as actually incurred, rather than public welfare, which is hedged around with requirements that must be met in advance. As the result, many people not actually in need of treatment have been hospitalized. This is mainly attributed to a limited supply of long-term care facilities and lack of support for families taking care of the elderly. The insufficient supply of care services compared with medical services comes from their sources of funds, i.e. medical costs are based on insurance premiums directly linked to wages, while public welfare is based on general tax revenues with severe budget constraints. In the new system, applicants for nursing care benefits will be assessed to determine the level of care they require. A ceiling will be put on the benefits to be covered by the insurance, and people needing care will be shifted from hospitals to care-providing institutions or their own homes (to receive care there). This would contribute not only to reduce medical costs, but to improve the environment of long-term care compared with a limited spaces in a hospital.

Financing the cost of the long-term care for the elderly, which used to rely on general revenue, is now funded by premiums, thus changing people the costs and benefits in various ways. Also, it is expected that improved services will lighten the load on families, reduced treatment costs should make it possible to reduce health insurance premiums, and the provision of care services will become more efficient. The introduction of nursing care insurance will also lighten the load on the state and local governments, which so far have borne the entire cost of care from general revenue; under the new system they will foot only half the bill.

The burden will, however, increase in near future in two ways: new insurance premiums and users payments (10% of the cost of the services). Nursing care insurance premiums will be withheld from the health insurance premiums of people 40 years of age and over, and from the public pensions paid to people 65 years of age and over. The average premium level is set to 2900 yen per month per individual. In the case of people whose pension benefits are too low to allow such withholding, premiums will be collected directly from the individuals by municipal governments instead accounting for their economic background. Only people of age 40 and over are required to pay into the system, on the grounds that young people are unlikely to require care before that age. This is a result of political compromise, but is not consistent with the logic of the long-term care insurance for lightening the care load on families. Also, exempting young people is inconsistent with the fact that they have to pay health insurance premiums even though they are at relatively low risk of falling ill.

As we can see from the fact that those eligible for nursing care insurance benefits include everyone age 65 and over and those age 40 and over who require care because of aging-related causes, the grounds for differentiation on the basis of age are shaky. A more clearly logical setup would provide care for anyone 20 or over who requires it, regardless of cause. The fact that this sort of setup has not been adopted seems to reflect one of the flaws of the present segmented welfare system, which puts people with physical disabilities or handicapped into a separate category of welfare.

Still, the nursing care insurance system does aim to meet the criterion of divorcing the provision of services from income level and other socioeconomic considerations and determining the kind and level of services solely on the basis of the condition of the person requiring care. That it allows people to pay additional expenses out of their own pockets to the benefits provided by the insurance, which is prohibited in the health insurance based on uniformity-driven egalitarianism. Also, it marks a major departure from present public welfare, whose major aim is relief for the