II 章

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エビデンスに基づく日本の保健医療制度の実証分析
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分担研究報告書

A comprehensive evaluation of health financing reforms in response to aging in Japan

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抄録

Japan has made significant gains in health since the introduction of universal health coverage, at low cost and with equity. However, the Japanese health system now faces challenges to its sustainability, cost and equity due to aging, non-communicable diseases and the rising cost of health care. In order to prepare reforms to face these new challenges, it is necessary to conduct a comprehensive review of the current health financing system and recent reforms. This report uses available data and reports from the Ministry of Health and Welfare to summarize Japan’s health financing system and to analyze recent reforms to health financing.

UHC in Japan is financed through a mixed system of government subsidies and premium contributions, divided between health insurance funds that collect premiums and disburse payments at the prefectural level. Almost a third of government revenue is spent on health and social security, and much of this is targeted at subsidies for health insurance associations with disproportionate numbers of elderly claimants. In response to growing pressure on the health budget, the Japanese government raised the consumption tax rate to 8% and introduced reforms to the subsidy system in the form of the Health Care System for the Old-Old, introduced in 2008. These reforms have helped to reduce pressure on the health financing system, but more reforms are needed and a new vision for the health care system, Vision 2035, will need to be implemented in order to ensure that Japan continues to maintain its low-cost, high equity health system as its population ages.

A. 目的

Japan has achieved significant health gains since the introduction of universal health coverage (UHC) in 1961. Japan has consistently achieved the highest-ranked life expectancy globally since the 1980s (Ikegami 2011), and has seen continued improvements in many areas of population health.

These health gains have been achieved at relatively low cost and high equity, but the country now faces considerable challenges in the years ahead as population aging, increased costs of health care, and an epidemic of NCDs threaten the sustainability of Japan's UHC system and the remarkable health gains of the past 30 years (Murray, 2011). The MHLW and Japanese government are now considering policy responses to these challenges, including through reforms of the health financing system and changes in the structure of the health workforce and institutional framework. However, in order to develop effective responses to the challenges facing Japan after the demographic transition it is necessary to review the current health financing system and the initial reforms enacted in response to Japan's changing demographics. This report summarizes the structure of Japanese health financing and gives an overview of recent responses to the specific challenges of the aging population.

B. 方法

Using available data from the Ministry of Health, Labour and Welfare (MHLW), the Cabinet Office and published papers, as well as comparative data from the OECD, this report summarized reforms to the Japanese health system over the past 10 years, and the health financing context in which future reforms will need to be conducted.

Data was obtained on taxation and health financing mechanisms for Japan and the OECD for the period 1980 – 2010. Information on key health financing reforms was obtained from MHLW documentation on the reform process and combined with health financing data to develop an overview of the reform process and challenges facing health financing in Japan.

C. 結果

1. Coverage

The proportion of people covered by types of risk of pooling mechanisms from 1980 to 2011 is presented in Table 1. The health insurance coverage rate was almost 100% in Japan. The largest proportion (58%) of the population was covered by employee health insurance, including government-managed health insurance, society-managed health insurance and mutual aid societies. Government-managed health insurance covered a larger proportion of the population (27%), followed by society-managed health insurance (23%), and mutual Aid Societies (7%). National health insurance covered 30% of the total population. This fragmentation of risk pooling between different health insurance systems differs from other countries, such as the UK, where a single payment provider covers the vast majority of the population. This system also leads to additional complexities in collection of funds for health financing, and cross-subsidies between types of provider.

2. Collection

The Japanese government budget in FY2015 was 96.3 trillion yen ($800 billion), of which social security (health care, pension, long-term care, welfare) accounts for approximately one third (31.5 trillion yen). Figure 1 Shows how the annual budget was distributed between government activities in 2015. Of the 31.5 trillion yen social security budget, health care and pension subsidies accounted for large shares, each 11 trillion yen. The share of government subsidy in the total benefit varies from system to system. The health care benefit for the means-tested indigent population was 100% financed by government subsidy whereas workers of small-to-medium sized companies and their families, insured by the Japan Health Insurance Association (JHIA), received 16.4% of their benefit from government subsidies. The distribution of the social security budget between health and non-health targets, and the distribution of the 16.4% of government subsidies to the JHIA, is shown in Figure 2.

Figure 3 shows the distribution of sources of Japanese government revenue. As much as 38.3% of the revenue is raised by debt (issuing Japanese Government Bond, JGB). Traditionally, Japan's taxation system has relied on direct tax rather than indirect taxes, but due to stagnation of the direct tax revenue stream, consumption tax is increasingly viewed as a main funding source to support the growing social security budget, and an increase in the consumption tax rate was part of the integral reform of social security and tax proposed in 2013, with the

increased revenue was ear-marked for social security. The consumption tax rate was increased from 5% to 8% in FY2014, increasing consumption tax revenue from 10.7 trillion yen (FY2013) to 15.3 trillion yen (FY2014). The consumption tax rate is scheduled to be further raised to 10% in FY2017.

Japan's health insurance system is financed from both government subsidies and premium contributions. Premium contribution of health insurance and pension must be shared equally between workers and employers. Income tax rates and premium rates are composed as follows.

Efforts continue at both national and local (prefectural) level to enhance funding for health and social care and improve the sustainability of the system, through adjustments to the mechanism for pooling funds and cross-subsidizing different components of the payment system.

3. Pooling of funds

Japan's health financing system does not have a single payer of all insurance funds, but is instead divided between health insurance funds that collect premiums and disburse payments at the prefectural level. However, with urbanization and the aging of Japanese society, the size of risk pools at the prefectural level and the risk profile they cover has changed significantly since 1961, and now many smaller prefectures face a declining funding base and increasing expenses. Since 1982 the Social Insurance Payment Fund has administered a financial redistribution mechanism that adjusts for differences in the burden of elderly care between municipalities. Many formal sector workers (employed in large companies and government agencies) have employment conditions allowing them to retire before the age of 65, and these employees are often enrolled in relatively small municipal NHIs, which may not be able to manage the financial burden of cohorts of workers retiring at the same time, especially in smaller rural areas with very large elderly populations. To ensure sustainability, NHI is subsidized through the Social Insurance Payment Fund with subsidies ranging up to as much of 41% of benefit disbursement. The redistribution mechanism transfers funds from insurers in areas with below-average enrolment of over seventy year olds to those in areas where the proportion of enrolled elderly is above the national average.

In order to manage the maldistribution of elderly people between different components of the system, the system was reformed under the Elderly Health Care Security Act in 2008. This Act separated financing for those aged over 65 into two components: The Health Care System for the Old-Old (HCSOO) and the Financial Redistribution system for the Young Old (FRSYO).

The HCSOO applies to those aged over 74. The elderly within the HCSOO will contribute premiums of approximately 10%, which are deducted from their pension. The remaining portion of revenue for the HCSOO is drawn from government subsidy and the contribution to the health insurance system of the working population. The share of the subsidy is dictated by law. The beneficiaries (15 million in FY2013) are divided into two categories: high income (approximately 1 million) and others (approximately 14 million). The distribution of funds between these beneficiaries is shown in Figure 4. The government subsidy is set at 50% of the benefit and is further shared among national, prefectural and municipal governments in the ratio 4:1:1 for beneficiaries excluding the high-income beneficiaries. Also, 1/4 of the subsidy from national government is ear-marked for financial redistribution among 47 prefectures to balance the financial disparity between them. No subsidy is provided to the high-income elderly in this age group, and all revenues except the premium contribution from the elderly will be financed entirely by contribution from the health insurance system for the working population (74 years old or younger). Overall, the government subsidy constitutes 47% of the total benefit of the HCSOO. The number of the old-old elderly population is expected to grow from the current 16 million to 20 million by 2020, while the number of working population will dwindle from 109 million to 100 million during the same period. Consequently, the contribution from the working population for HCSOO is expected to grow from 6 trillion yen (FY2014) to 10 trillion yen by 2020. The contribution levied on the working population as their add-on premium is becoming an important health policy issue. So far, the contribution is levied on health insurers on a capitation basis (the amount of contribution is determined simply by multiplying the number of enrollees by a fixed "price"). The per-capita "price" for contribution has increased consistently; from

41,587 yen in 2009 to 49,501 yen in FY2013. This is because the share of premium revenue from the elderly has not kept pace with the increasing number of the elderly population. To remedy the situation, further changes to the system are being considered.

4. Out of pocket payments and cost-sharing

Japan's health insurance has no deductibles and no maximum benefit but has cost-sharing. The cost-sharing is a fixed proportion of the cost paid for by the service user (the patient), with the insurers paying the remaining proportion. The proportion of cost-sharing is uniformly dictated by law. It is typically 30% for health insurance which covers the population younger than 75, and 10% for the HCSOO which covers the elderly 75 years or older. Cost-sharing is fixed at 20% for beneficiaries aged between 70-74 as well as pre-school age children (up to six years old). For the very poor receiving welfare payments under the means-tested Livelihood Protection Law, no cost-sharing is required.

The cost-sharing rate of 30% is relatively high by international standards, but there is a monthly and annual cap on the out-of-pocket payment for individuals and households. This cap is metered to the income of a beneficiary or a household. For beneficiaries younger than 70 years old with no taxable income, the cap is set at 35,400 yen or 30% of 118,000 yen monthly charges. Beneficiaries have to pay 30% cost-sharing up to the cap in every calendar month, but beyond pay nothing beyond the cap. This cap is further lowered from the 4th month in which the cap is reached during the most recent 12 month period. For example, if a beneficiary reached the cap in February, June and November of a given year, the beneficiary will qualify for the reduced cap starting in December. Once the cap is reduced, it becomes easier for the beneficiaries to fulfill the requirement (reaching the cap in at least three months during the recent 12 months) and they will be able to enjoy the reduced cap longer. This is advantageous for patients with chronic conditions in minimizing the OOP. Further, for certain chronic conditions, such as dialysis, the monthly cap is further reduced.

The policy of imposing relatively heavy cost-sharing (30%) for all beneficiaries at the point of visit while limiting the cost-sharing metered to one's income is an effective way of protecting households financially while controlling the entire health care expenditure because heavy cost-sharing will prevent abuse of services. Table 2 shows the structure of the cap according to the number of months of excessive payments and the income of the payee.

As a result of these cost sharing arrangements, Japanese patients face out-of-pocket expenses for health care. The proportion of total health expenditure paid from out-of-pocket expenses is an important marker of the sustainability of health financing in a health system. In countries where public funding for health services is inadequate and risk pooling mechanisms in health financing are limited or unavailable, unexpected out-of-pocket (OOP) payments and illness-related production or income loss can trigger asset depletion, indebtedness and reductions in essential consumption, leading sometimes to financial catastrophe. (McIntyre, 2006) On average 14% of health spending is paid directly by patients in Japan in 2011. The burden of OOP payments across OECD countries is presented in Figure 6.

On average in OECD countries, the OOP payment as a proportion of total household consumption was around 3%. The average share varied substantially across OECD countries in 2011, from its lowest value in France, the UK, Turkey, and the Netherlands (1.5%) to its highest in Chile, Mexico and Korea (4.6%). In Japan, 2.2% of consumption was spent on OOP health services, slightly lower than the OECD average. The low burden of OOP payments in Japan is due to sustainable health insurance polices with low co-payments and caps on maximum OOP payment size.

D. 考察およびE.結論

Japan's system of universal coverage, co-payments and capped personal costs has ensured that Japan has been able to maintain full coverage of low-cost health care with equity (Ikegami, 2011). However, population aging and the increased cost of modern medical interventions have put increased pressure on the sustainability of the health insurance system, and new policy measures are needed to respond to these pressures.

Initial policy responses have included changes to the consumption tax base, which are intended to be earmarked for health and social services spending, but the full impact of these changes is yet to be felt and the consumption tax rise alone will not be sufficient to meet the growing funding needs of the health insurance organizations. To meet these additional needs

and ensure the viability of smaller organizations, recent reforms have focused on changing the pattern of subsidies for health insurance organizations with a high proportion of elderly claimants, through the HCSOO system. Despite these subsidies, the maldistribution of the elderly population between NHI and employees' health insurance has always been at the center of Japan's health policy debate, as the available funds suffer greater pressure from an aging population and increasing health costs. Total unification of multiple health insurance systems into a single payer system has been used as a solution to this problem in Korea and Taiwan, but has not been politically feasible in Japan, leading instead to the need for a wider range of innovative health responses. Recently the Japan government convened a panel of experts, Japan Vision 2035 (Miyata, 2015), to develop new policy directions for the health system to ensure it responds effectively and equitably to the challenges of aging and NCDs. This panel recommended a new focus for the Japanese health system, with a greater focus on quality, equity and integration, and a renewed vision for global health. By building on the past reforms of the health system described here, guided by the principles of the Vision 2035 report, Japanese health policy makers can establish a sustainable, equitable platform for tackling the challenges of aging and ensuring future population health.

F．健康危険情報

該当せず。

G．研究発表

投稿準備中

H．知的財産権の出願・登録状況（予定含む）

該当せず。

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表1 Number of persons covered by health care insurance by type of insurance system

System category	1980	1990	2000	2005	2011
Number (thousands)					
Population	117060	124533	126926	127768	127799
Total insured population	117037	124260	126351	127176	126678
Employee's health insurance					
GMHI	31807	36821	36805	35675	34895
SMHI	27502	32009	31677	30119	29504
MAS	12520	11952	10017	9587	9101
Seamen	672	409	228	168	132
National Health Insurance	44536	43069	47628	51627	38313
Proportion (%)					
Proportion	100.0	100.0	100.0	100.0	100.0
Employee's health insurance	61.9	65.2	62.0	59.1	57.6
GMHI	27.2	29.6	29.0	27.9	27.3
SMHI	23.5	25.7	25.0	23.6	23.1
MAS	10.7	9.6	7.9	7.5	7.1
Seamen	0.6	0.3	0.2	0.1	0.1
National Health insurance	38.0	34.6	37.5	40.4	30.0

Source: MHLW (Ministry of Health 2013)
Notes: GMHI: Government-managed Health Insurance; SMHI: Society-managed Health Insurance; MAS: Mutual Aid Societies

図 1　Distribution of government funds, 2015 financial year

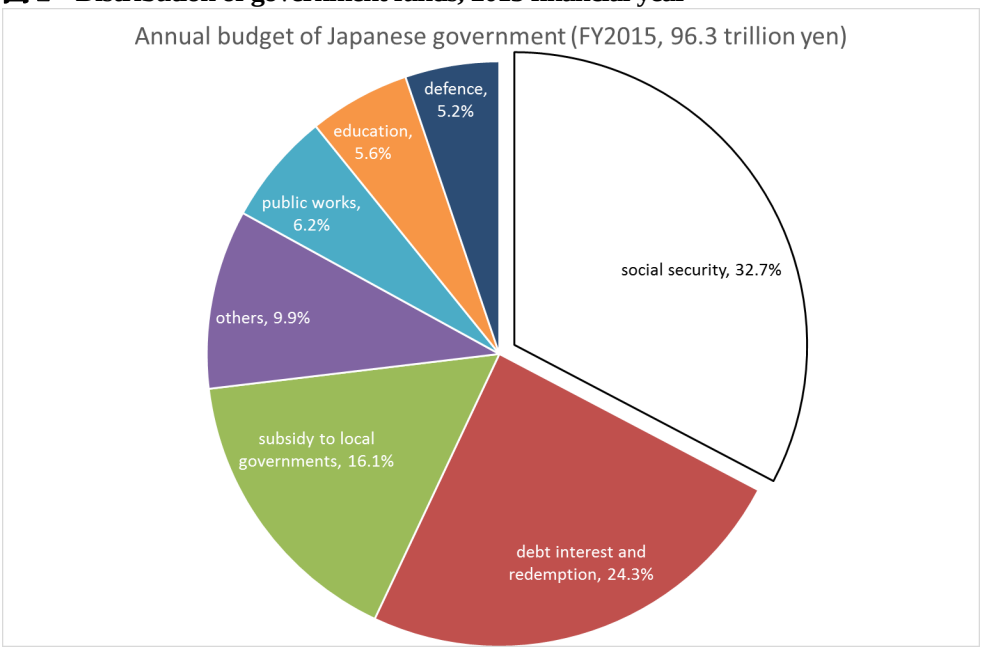
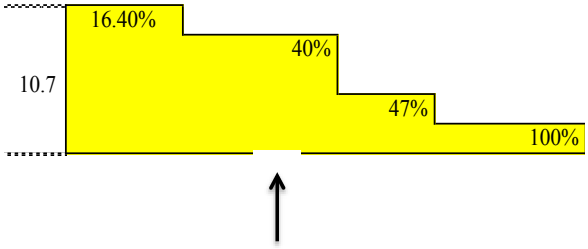


図 2 Structure of social security budget, 2015 financial year

Breakdown of social security budget in FY2015 (in trillion yen)

Subsidy to health insurance	JHIA	1.17
	Municipal NHI	3.17
	NHI societies	0.26
	HCSOO	4.76
Welfare benefit for the indigent	Health and LTC	1.41
	Others	1.49
Subsidy to pension		11
Subsidy to LTC insurance		2.63
Other social welfare	Child allowance*	1.46
	Disability assistance**	1.5
	Others	1.9
Public health		0.49
Labour		0.17
Total social security budget		31.5



Share of government subsidy in benefit

JHIA: Japan Health Insurance Association
NHI: National Health Insurance
HCSOO: Health Care system for Old-old
LTC: Long-term Care
* Child allowance includes benefits for single parenthood
** Disability assistance include health care benefit (0.2 trillion yen)

図 3 Sources of Japanese government revenue, 2015 financial year

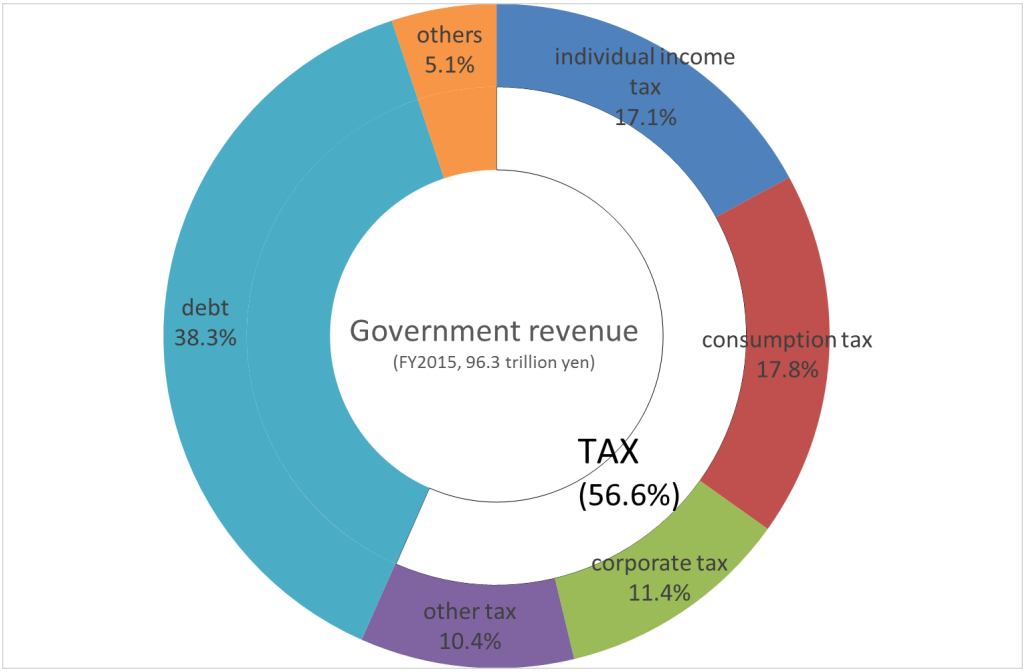


図 4 Financial sources of the HCSOO

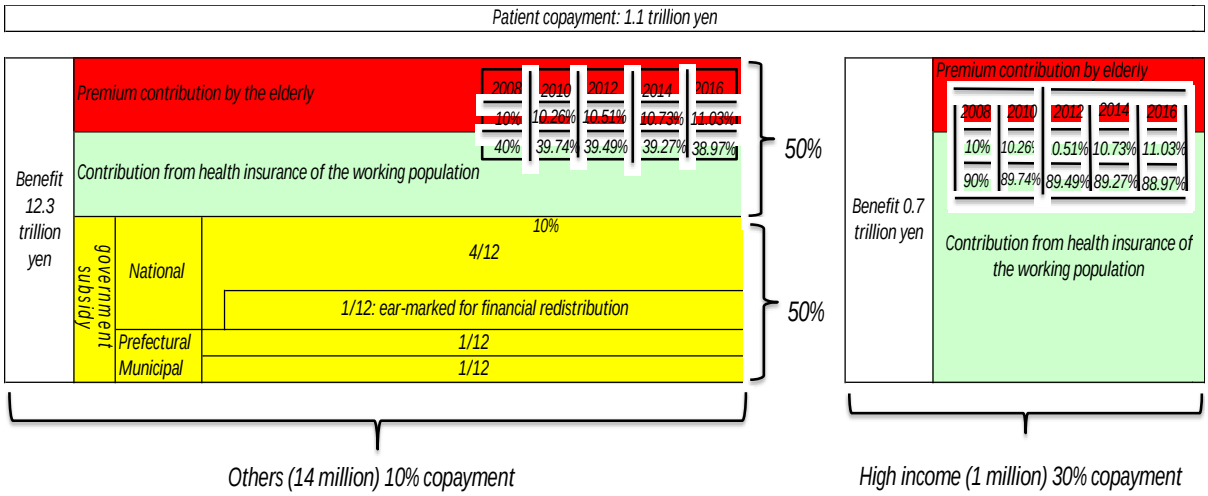


表2 Structure of the cost-sharing arrangements in Japan, 2015

OOP cap on cost sharing

<70 years old				>=70 years old			
	Monthly cap		Annual cap		Monthly cap		Annual cap
Annual income	Initial 3 months (During recent 12 months)	4th months and after	apply only to household using BOTH health and LTC insurance (During August-July)	Annual taxable income	Individual outpatient	Household	Apply only to household using BOTH health and LTC insurance
>=9 million yen	252,600 yen	140,100 yen	2,120,000 yen				
6-9 million yen	167,400 yen	93,000 yen	1,410,000 yen	>=1.45 million yen	44,4000 yen	80,100 yen	670,000 yen
2-6 million yen	80,100 yen	44,400 yen	670,000 yen	0-1.45 million yen	12,000 yen	44,400 yen	560,000 yen
<=2 million yen	57,600 yen	44,400 yen	600,000 yen	No taxable income (individual)	8,000 yen	24,600 yen	310,000 yen
No taxable income	35,400 yen	24,600 yen	340,000 yen	No taxable income (household)	8,000 yen	15,000 yen	190,000 yen

図 5 Out-of-pocket medical spending as a share of final household consumption in the OECD, 2011 (or nearest year)