The Path to Universal Health Coverage

– Experiences and Lessons from Japan for Policy Actions –

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Foreword

How has universal health insurance coverage in Japan been achieved, what are the key factors that made it possible and what are the lessons other countries might find useful? This paper has been written in response to these questions.

The achievement of universal health coverage has been becoming increasingly important in the development agenda, for it constitutes an important part of social protection, which strengthens the stability of the society by sharing the fruit of the development of a country among its people and reducing risks in their everyday life. Equitable access to health services at affordable costs is being pursued by many countries.

Japan chose to employ a social health insurance model and achieved universal health coverage in 1961, less than twenty years since the end of the Second World War, when a relatively large part of the population were engaged in the informal sector. Analysis on the key factors which contributed to the expansion of a public health insurance to include the informal sector, we believe, would contribute to policy discussion in the countries aiming to achieve universal health coverage.

The Japan International Cooperation Agency asked Professor Kenji Shimazaki at the National Graduate Institute for Policy Study in Japan to undertake this important analysis. I would like to express my deep appreciation for his in-depth knowledge and great insight based on his excellent career both as health official and scholar. I hope readers will find this paper a source of inspiration and good ideas.

June 2013

Kiyoshi Kodera
Vice President
Japan International Cooperation Agency

Summary

1. Purpose of this paper

Japan's universal health insurance coverage has been receiving great interest from other countries. However, how and why Japan achieved universal health insurance coverage about half a century ago has not been unraveled. This paper aims to analyze Japan's path to universal health insurance coverage from various perspectives and draw policy lessons for developing countries striving to attain universal coverage.

2. Key mechanisms and its policy impacts of Japan′s universal health insurance coverage

There are two models to achieve universal coverage, namely, the social insurance-based model and the tax-based model. Japan has achieved universal health insurance coverage through the social insurance-based model of two programs, namely, the Employees' Health Insurance and the Community-based Health Insurance. The Community-based Health Insurance has made it possible to cover the entire population (achievement of "rigid" universal coverage).

The Employees' Health Insurance and the Community-based Health Insurance have different insurers, but, they are highly integrated because the range of benefits covered, the proportion of co-payments and medical fees are uniformly structured. The private sector provides most of the medical services whose delivery and finance are aligned by the mechanism of benefits-in kind and the medical fee schedule. Nearly 100 percent of medical institutions participate in the public health insurance, because their financial bases greatly depend on the regulated medical fees. Such integrity of the system as a whole is important, in addition to the most significant characteristic of universal health insurance coverage, which is found in its function as a safety net to support the stability of people's living.

3. Historical development

The historical development for Japan's achievement of universal health insurance coverage can be divided into three periods. The first period refers to the stage of establishing the foundation from 1922 to 1945, when Japan was defeated in the Second World War. During the period, the basic framework of two programs was formed: the Employees' Health Insurance Law was established in 1922, followed by the Community-based Health Insurance Law in 1938 aimed to cover the informal sector such as farmers. The second period refers to the stage of recovery and reconstruction from 1945 to approximately 1955.

Efforts were made to recover and rebuild the health insurance system devastated by the Second World War. In 1948, municipalities became the insurers of the Community-based Health Insurance in order to enhance the administrative foundation. In 1953, the government started subsidizing benefit payments. The third period refers to the stage of planning and achievement from around 1955 to 1961, when Japan finally achieved universal health insurance coverage. While achieving rapid economic recovery, Japan was facing a persisting social problem, which was poverty among those who were not covered by any health insurance and had to cover their medical expenses. In this context, achieving universal coverage was brought up as a political priority. The 1958's revision of the Community-based Health Insurance Law led to the establishment of the insurance in all municipalities across the nation in April 1961, when universal health insurance coverage was attained.

There are three key points in the process of achieving universal coverage.

First, the achievement of universal health insurance coverage in 1961 did not simply stem from previous efforts up to then. The 1958's overall revision of the Community-based Health Insurance Law was a significant step, different from other measures previously taken. It not only obliged all the municipalities to establish health insurance, but also included such measure as stipulating that the proportion of the costs covered should be 50 percent or more, which was crucial for the achievement of universal health insurance coverage.

Second, the government officials chose a social insurance-based model with the full understanding of the significance of social insurance (the importance of independence and self-help, the financial discipline of benefit payments and cost-sharing, and the authority to give the insured the right to receive benefits in return for paying premiums).

Third, while the Employees' Health Insurance is based on "*kaisha* (companies)," the Community-based Health Insurance is based on "*mura* (villages)." Companies and villages are communities where the members share a strong sense of solidarity. The framework consisting of two programs based on such communities was adopted for the following reasons: (a) the primary industries accounted for a large share among all the industries in Japan at that time; (b) in health insurance, a larger group of insurers does not necessarily mean that it works better; and (c) there are differences in the income-earning structures as well as the income reporting between employees and the others, such as the self-employed and farmers.

4. Lessons from Japan's experience

The following five factors contributed to Japan's attainment of universal health insurance coverage.

The first is economic growth. Raising sufficient financial resource is critical. It was high economic growth that enabled Japan to bear the increased financial burdens. It was not until Japan achieved rapid economic recovery around 1955 that universal coverage was brought up as a more realistic political goal.

The second is a sense of solidarity. Social insurance can be more easily run in a society with a relatively large middle-income population and a very strong sense of equality that the Japanese share. The Japanese society was equipped with both at the stage of achieving and developing universal health insurance coverage.

The third is strong political leadership. In Japan, the achievement of universal coverage came up as a milestone policy when politicians wanted an "uplifting symbol" for postwar recovery. It is also important that local governments, especially municipalities as the insurers of the Community-based Health Insurance, supported the achievement of universal health insurance coverage.

The fourth is meticulous designing of the system. For example, the government officials at the time studied foreign systems and developed the Community-based Health Insurance that suited the Japanese context. Furthermore, the fact that the Ministry of Health and Welfare was the sole authority of designing the system helped avoid lack of overall consistency in its design.

The fifth is accumulation of prior achievements in developing basic administrative systems. Of particular importance is the fact that approximately 70 percent of the population had been covered by the Employees' Health Insurance and the Community-based Health Insurance by the time of the revision of the Community-based Health Insurance Law at the end of 1958. In addition, with efforts from prewar time, the health insurance market had been dominated by the public health insurance, which resulted in no competition with the private health insurance. Furthermore, such administrative systems as an accurate information management system on residents' addresses and a tax system based on residents' income flows existed in Japan before the war.

As mentioned in the fourth factor above, to achieve universal health insurance coverage, meticulous designing of the system is required. The following six points are keys to success.

The first is making a choice between the social health insurance-based model and the tax-based model. Japan established the Employees' Health Insurance targeting employees before the Second World War, then enacted the Community-based Health Insurance Law to cover the informal sector, and attained universal health insurance coverage in 1961 based on this framework consisting of two programs. The inclusion of the informal sector based on a social insurance-based model is not easy, because such measures as reducing premiums for low-income persons and considerations for administrative work are required. What was possible in Japan may not necessarily be transferred in other countries in the same way.

The second is targeting the entire population or the majority. In the case of developing countries, it may be feasible to progressively expand the coverage of social insurance. It is, however, important to bear in mind that universal health insurance coverage for the entire population may not be achieved by merely expanding the coverage.

The third is deciding whether or not the persons insured by private health insurance can be excluded from public health insurance. In theory, it would be better not to let private health insurance holders opt out from public health insurance, however, such decision may provoke a political backlash. It is critical to decide on policy before the problem becomes more profound.

The fourth is setting up the range of services offered and the proportion of the costs covered. Once the range of service and the proportion of the costs covered are set up, reducing them would be very difficult, as it may provoke strong protests from service users. Therefore, it would be safer to set a lower "launching platform" and gradually expand it according to economic growth.

The fifth is ensuring the efficient and effective administration. Important mechanisms include deciding the eligibility and updating the information of each insured person and collecting premiums, as well as setting, examining and paying medical fees.

The sixth is aligning delivery and finance in designing the system. It is critical to take into account how to develop a system to deliver medical services, specifically, how to properly deploy medical institutions and how to develop medical professional in a planned manner.

Achieving universal health insurance coverage is a challenge, but the efforts are worth making. Japan's experience shows that a strong commitment and careful consideration are crucial in the endeavor.

The Path to Universal Health Coverage

— Experiences and Lessons from Japan for Policy Actions —

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I. Introduction - Purpose of this paper -

The health care system in Japan has gained high international acclaim for its performance.[1] One of the major factors for this is the achievement of universal health insurance that ensures equitable access to health services at affordable costs, which contributes to the stability of the people's living and provides an important safety net against diseases and injuries, which are amongst the major risks in everyday life.

Universal health insurance coverage was achieved in Japan in 1961. In September 2011, half a century later, an internationally renowned medical journal, "The Lancet", published a special issue titled "Japan: Universal Health Care at 50 Years". It has contributed to increase international interest in Japan's universal health coverage.[2] Many of the papers in the special issue, however, focused on current issues and the path to health care and public health policies after the 1961's attainment of universal coverage, and did not unravel how and why it was possible.

The purpose of this paper is to analyze Japan's path to universal health insurance coverage from various perspectives. The analysis attempts to draw policy lessons for developing countries striving to attain universal coverage. Section II describes the mechanism of the Japanese health insurance system and discusses its policy implications. Section III analyzes the process Japan took towards universal coverage, by dividing it into three stages. Section IV discusses the main factors contributing to the success of universal coverage and lessons in designing a universal coverage system. Finally concluding remarks follow in Section V.

The following points should be clarified at the beginning of the paper.

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[1] WHO (2000), for instance, ranks the Japanese health system at the top in the world in health system attainment. This favorable assessment is based on Japan's low infant mortality rate and long average life expectancy. However, it is questionable to use the infant mortality rate and average life expectancy as evaluation indicators to assess the level of health system performance, because Japanese healthy diet and hygienic environment have also contributed to its low infant mortality rate and long average life expectancy. Nevertheless, there is no question that the characteristics of the Japanese health system (especially good access to medical services) have contributed to the improvement of these indicators.

[2] Ikegami *et, al.* (2011), however, discusses the history of universal coverage in Japan.

First, this paper covers only the years before 1961, when universal health coverage was attained in Japan. Thus, it will not discuss a number of issues Japan's health system is facing today, such as the unprecedented aging of the population or responses to technological innovations in medical services.[3]

Second, this paper is not dedicated to any particular state or region. Developing countries are enormously diverse in terms of national income, economic growth, demographic and industrial structure, as well as culture, disease structure, level of public health, resources for medical services, and political, administrative and financial systems and so on. While some countries are taking specific actions to attain universal coverage, others may be not yet at that stage. The paper is definitely relevant to the latter countries as well, which may have a wider range of future policy options.

Third, developing countries have "new" problems, which Japan did not half a century ago. In some developing countries, for example, a smaller proportion of the rich population have been enrolled in private health insurance and enjoy high-level medical services, while, the rest of the population does not even receive sufficient primary care. When these countries design a universal health system, challenging questions will arise whether the system should include the rich enrolled in private insurance. Although Japan's experience is not directly applicable to today's developing countries, Japan's progressive path to universal health coverage can provide useful lessons and hints to identify and overcome obstacles for other countries that are tackling to improve health coverage for their entire population. Challenges Japan faced during the path may be similar to those many developing countries are having in their own contexts.

Fourth, this paper is written for those without background knowledge of the Japanese health system. Understanding the health system in other countries is not an easy task. Universal health coverage in Japan is a complex structure made up of a variety of components. This paper drastically slashes minor details of the system so that the big picture would not be overlooked. Furthermore, a literal translation of legal and technical terms is avoided to help readers evoke a clear image of each word.[4]

[3] For details on this point, please refer to Shimazaki (2009a), (2009b) and (2012).
[4] For example, the Health Insurance Law is translated as the Employees' Health Insurance Law, the National Health Insurance Law as the Community-based Health Insurance Law to articulate the difference.

II. Key Mechanisms and Policy Impacts of Japan's Universal Health Insurance System

II-I. Characteristics of the Japanese health finance system

The health finance system is very much different from the pension system though both systems are two major pillars of social security. The pension system is a financial mechanism aimed solely at intra-/inter-generational income transfers. In contrast, the health finance system has to deliver services as well as finance the costs of such services. Therefore, the difference of health finance systems among countries is much greater than that of the pension systems.

1) Two models to attain universal health coverage: social insurance and tax-based

Table 1 compares the health finance systems in six developed countries. Health finance systems in developed countries can be broadly categorized into three types. The first is a social insurance-based model of the type used in Japan, Germany and France. The second is a tax-based model in which the public sector, including the central and local governments, directly provides medical services financed through taxation. This type is implemented in the United Kingdom and Sweden. These two types are mainly used to attain universal health coverage. The third is a private insurance model in which the risks of medical expenses are basically diversified by private insurances. A typical example is the United States where health finance is left to the private sector, except for the Medicare scheme for the elderly and the Medicaid scheme for the poor.

2) Differences in how the insurers are organized

Even among countries with a social insurance-based model, insurers are differently structured. In Japan, the universal health coverage system consists of two pillars; the Employees' Health Insurance and the Community-based Health Insurance. Germany's health insurers (Krankenkasse) are basically employees-based. This is because Germany's health insurance is based on the Health Insurance bill, which was passed as labor legislation under the leadership of Chancellor Bismarck in 1883. The legislation has since been expanded to cover a wide range of people. However, the insurance is still characterized today as the insurance for workers. In France, insurers (caisses d'assurance maladie) are organized by profession or industry. Employees who do not belong to any of these individual health-care insurances are obliged to participate in employees' insurance known as the general program. Germany and France have no insurance equivalent to the Community-based Health Insurance in Japan.[5]

[5] In Germany and France, the person insured by the employees' health insurance continue to be covered, in principle, by the same insurance after their retirement. In France, universal coverage was achieved through CMU (Couverture Maladie Universelle) established in 1999, under which people who were not covered by any employees' health insurance (including the unemployed and welfare benefit recipients) were covered by the general program of the employees' health insurance.

Table 1: Comparison of health finance system in the six developed countries

	Japan	Germany	France	U.K.	Sweden	U.S.
Medical service provision	Provided largely by the private sector (The public sector accounts for 30% of beds at hospitals.)	Provided largely by the public sector (The public sector accounts for 90% of beds at hospitals.)	Provided largely by the public sector (The public sector accounts for 70% of beds at hospitals.)	Provided almost all the beds at hospitals by the public sector	Provided almost all the beds at hospitals by the public sector	Provided largely by the private sector (The public sector accounts for 25% of beds at hospitals.)
Finance	Publicly financed (social insurance)	Publicly financed (social insurance)	Publicly financed (social insurance)	Publicly financed (tax-based)	Publicly financed (tax-based)	Privately financed (except for Medicare/Medicaid)
Structure of financial scheme	・Universal coverage through a social insurance ・Financed largely by insurance premiums as well as taxes	・90% of the population covered by the health care insurance (Self-employed/high-income persons participate in the insurance on a voluntary basis.) ※Those who are not enrolled in the public insurance have been obliged to participate in the private insurance since 2009. ・Funded largely by "insurance premiums"	・Universal coverage through a social insurance model ※The unemployed and low-income persons have been also enrolled in the insurance since the system was reformed in 1999. ・About 80% is financed by insurance premiums and about 20% by social security tax, etc.	・Universal coverage based on a state-run tax-based medical services ・Funded by taxes	・Universal coverage based on a county-run tax-based medical services ・Funded by taxes	・Public medical care programs are provided only to the elderly, persons with disabilities, the poor and children. ・Medicare is based on a social insurance model. ・Medicaid is funded by taxes.
	75 yrs old: Medical system for the elderly aged 75 and over; Employees' Health Insurance; Community-based Health Insurance	Covering 90% of the population through social insurance; Voluntary enrollment for self-employed, etc.	Work insurance for the self-employed; Employees' Health Insurance for public employees, etc. (special programs); Employees' Health Insurance in the private sector (general programs)	All the population covered (state-run medical services)	All the population covered (county-run medical services)	65yrs old: Public medical insurance (Medicare); Voluntary enrollment in private insurance

Source: Kenji Shimazaki (2011) p.23 (partially revised)

3) Hospital management by the private or public sector

In many European countries, whether they employ a tax-based model or a social insurance-based model, hospitals are run mainly by the public sector. In Japan, however, the majority of medical institutions are run by the private sector, which means non-profit healthcare corporations or private foundations. [6] Approximately 70 percent of beds belong to the private sector, most of which are non-profit healthcare corporations. This is because: (a) in Japan, a system under which physicians can freely open their clinics was adopted, when the basic framework of health care delivery was set in 1874; and (b) after the Second World War, especially after the 1950s, many such clinics increased the number of beds and came to be categorized as hospitals.[7]

[6] In Japan, stock companies are not allowed to run medical institutions, unlike the USA and majority of European countries. Healthcare corporations are also prohibited by law from distributing their profits to the investors. Nevertheless, they are allowed to use their profits for reinvestment in their medical services. A regulation for Healthcare Corporations was established in the 1950's revision of the Medical Law. The purpose was (a) to promote the stability of health care management by increasing financial sustainability and accountability to financial institutions, (b) to expand the health care delivery by investing the profits to purchasing medical equipment or increasing the number of beds.

[7] These reasons are also linked to the fact that free access to health care is highly respected in Japan. In Japan's Medical Law, a hospital is defined as a medical institution with 20 beds or more; a clinic is defined as a medical institution with 19 beds or less. The number of small sized hospitals is larger than in Europe and USA (Small sized

II-II. Key Mechanisms (as of April 2013)

1) The insurers and the insured

Japan's universal health insurance system has two pillars, namely: the Employees' Health Insurance (employees-based) and the Community-based Health Insurance. The insurers of the Employees' Health Insurance include: (a) health insurance societies participated by employees working at large corporations and their dependents; (b) the Japan Employees' Health Insurance Association participated by employees working at small and medium-sized enterprises and their dependents; and (c) mutual aid associations participated by public employees and others. Those who are not covered by the Employees' Health Insurance, such as farmers, the self-employed and the unemployed, are obliged to enroll in the Community-based Health Insurance run by municipalities where they reside. All Japanese people are obliged to enroll in any one of the public health insurance programs according to their employment and residential status.[8] Japan's universal coverage is a "rigid" system in the sense that the entire population is automatically enrolled into the Community-based Health Insurance which functions as a "casting net", and excludes those who are covered by the Employees' Health Insurance from the Community-based Health Insurance.

As for welfare benefit recipients who are unable to pay contributions and co-payments, the Community-based Health Insurance is not applied, because they are covered by medical assistance based on the Public Assistance Law. The health care benefits of the Public Assistance Law are the exactly the same as the Community-based Health Insurance.

2) The benefits and co-payment rate

In Japan, the public health insurance provides all medical treatments that people generally need. Japan uses a cost-sharing mechanism in health insurance scheme and the co-payment rate is the same for all, except for the elderly and children. In principle, 70 percent of the overall medical expenses are paid by the health insurance and 30 percent paid by the insured (patients).[9] While this fixed-rate payment (the insured pay a fixed proportion of the incurred overall medical expenses) has an upside that can make the insured more cost-conscious, it has a downside that imposes too much financial burden on the patient, when medical expenses are too high. To avoid the financial burden, the maximum amount of co-payment is set according to age or income.

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hospitals with less than 100 beds make up 40 percent of the all hospitals in Japan.) This is another feature of health care delivery in Japan)

[8] The medical system for the elderly aged 75 and over has been implemented since 2008. Thus, today, individuals aged 75 or older leave their health insurance system in which they were enrolled till the age of 75, and participate in the medical system for the elderly. For more details on this, please refer to Shimazaki (2009b).

[9] 10 percent co-payment for the elderly aged 75 and over. The rate of co-payments is higher in Japan than in European countries. These are two reasons for this. First, Japanese medical services are mainly delivered by the private sector. Thus, it is difficult to take mandatory measures for their delivery methods. Second, free access by patients is highly valued, and the consultation rate (especially in outpatient treatment) is high. Therefore, it becomes necessary to take measures to control the demand side's behavior (to make patients more cost-conscious), in order to curb medical expenses.

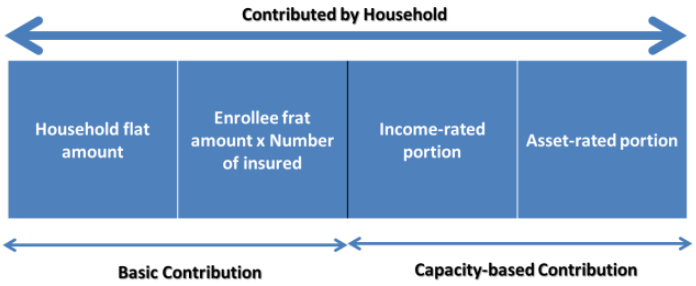
When the monthly co-payment exceeds the maximum amount, the difference is reimbursed by the insurers.[10]

3) Financial resource for health expenditure

Financial resource for health expenditure consists of three parts: (a) patients' co-payments; (b) insurance contributions; and (c) government subsidies mainly from the central government budget.[11] "Patients' co-payments" is as already explained above.[12]

Insurance contributions

Figure 1. Components of contributions of the Community-based Health Insurance



The mechanism of insurance contribution collection methods differs between the Employees' Health Insurance and the Community-based Health Insurance. In the Employees' Health Insurance, each insurer is authorized to apply its own contribution rate to employees' wages and bonuses within the limit stipulated in the law. The contribution is shared evenly between the employee and his or her employer. In the Community-based Health Insurance, the contribution is levied on a per-household basis. The contribution demanded of each household consists of two portions: basic contribution and capacity-based contribution. Included in the basic contribution are a per-household flat rate that is equally applicable to all households, and an amount obtained by multiplying the enrollee flat rate by the number of insured individuals in the household.[13] The capacity-based contribution is also subdivided into two parts: an income-rated portion and an asset-rated portion. Insurers (municipalities) have their own methods of setting contributions out of these four components.

Government subsidies from general revenues

Age and income disparities among the insured result in imbalanced financial consequences among different insurers. The insurers that cover beneficiaries who are older and/or with lower

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[10] This is referred to as the "high-cost medical care treatment system" and has an important role to make patients' co-payment affordable. The limits of high-cost medical treatment benefits have been meticulously set up depending on patients' age, income level, etc.

[11] 50 percent of the benefit payment of the Community-based Health Insurance is currently financed by subsidies (taxes) not only from the central government but also local governments. The central government finances 41 percent, while 9 percent is financed by local governments.

[12] Japan's medical expenses for 2010 is broken down into premiums 48.5 percent, public funds 38.1 percent and patients' co-payments, etc. 13.4 percent. Public funds dominate a larger part in Japan than other developed countries which employ a social insurance model. This is because the Japanese health insurance system consists of two programs, the Employees' Health Insurance and the Community-based Health Insurance, and public funds are used to adjust differences in financial capacity. It is inappropriate to discuss how much public funds are used, not considering these systemic differences.

[13] The basic contribution was initially collected even from low-income households when Japan's universal coverage was attained in 1961. However, due to the increased municipality demand that the amount of the basic contribution should be reduced for low-income households, a measure to reduce the amount was introduced in 1963.

incomes would face higher costs and risks of lower revenues. These imbalances are reduced through government subsidies to such insurers to adjust their financial burdens. Government subsidies are not provided to health insurance societies for employees of large corporations or mutual aid associations for government employees, which have enjoyed the participation of relatively healthy persons with higher incomes. The central government subsidizes 16.4 percent of benefit payments to the Japan Employees' Health Insurance Association, which is financially weaker. In contrast, the government subsidizes 50 percent of benefit payments to the Community-based Health Insurance, which has a larger number of elderly people and people with lower income and receives no direct contributions from employers.

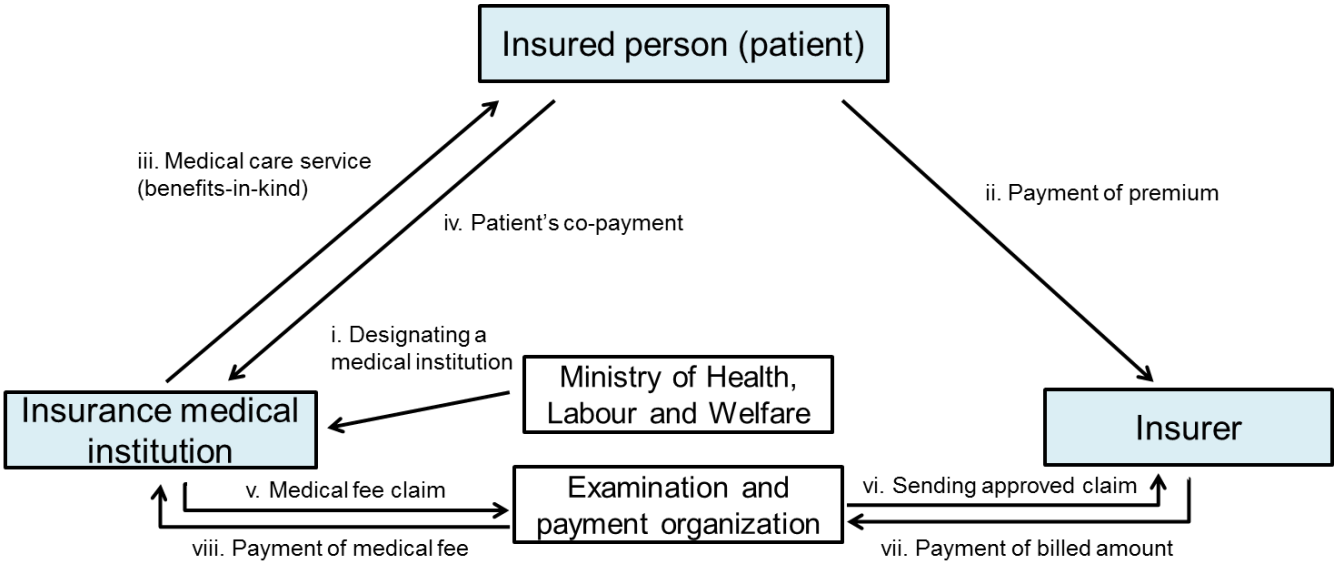
4) Medical services and medical fees set for physicians and hospitals

Japan's public health insurance employs the benefits-in-kind method as shown at Figure 2. The central government (the Ministry of Health, Labour and Welfare) designates medical institutions which accept the public health insurance (Figure 2-i).[14] The designated medical institutions provide medical care services (benefits-in-kind) to the insured (patients)(Figure 2-iii). Patients pay a certain proportion (as a rule, 30 percent) of the overall medical expenses calculated in accordance with a uniform national medical fee schedule (Figure 2-iv). The medical institutions send bills for the rest of the expenses to the insurers via examination and payment organizations (Figure 2-v). The examination and payment organizations review the details in the bills, and then request the insurers to pay the amounts and send collected money to the medical institutions (Figures 2-vi, vii and viii). As stated above, the fees must conform to a uniform national fee schedule (a sort of official fee table). For any particular service, the same fee is paid by all insurers to all providers. The medical fee schedule is revised every two years in the following process. The central government determines the rate of decreases/increases in the total level of medical fees, considering trends in salaries, commodity prices, and financial situation of medical institutions. Within the rate, the Ministry of Health, Labour and Welfare (MHLW) revises individual fees for respective medical treatments based on the recommendations from the Central Social Medical Care Council.[15]

[14] A medical institution has an option of not being designated (in other words, they don't accept the public health insurance). In reality, however, almost all of them choose to be designated, because it is difficult for them to secure financial resources without the public health insurance.

[15] 20 members who represent a cross section of health care interests: seven providers, seven payers (four insurers, including government representatives, employers and labor representatives), and six public interest representatives. The purpose of the council is to negotiate the medical fee schedule.

Figure 2: Mechanism of insured medical treatment



Box 1. Receiving methods of insurance benefits

Insurance benefit is provided in two major methods when the insured receive medical care: the reimbursement method and the benefits-in-kind method. In the reimbursement method, patients first pay all the medical expenses incurred when they visit medical institutions and then request the insurers to reimburse their payments, and get them reimbursed (insurance benefits). In the benefits-in-kind method, medical treatments are provided as insurance benefits-in-kind. When the insured (patients) visit medical institutions, they only pay their co-payments. The benefits-in-kind method is superior in terms of access to medical services by the insured (patients).

II-III. Impacts of Japan's universal health policy

Japan's universal health insurance system has contributed to the stability of people's living. Even if they suffer serious diseases or injuries, they can receive necessary health services at affordable costs. Unlike in the USA, even when people lose jobs, they do not lose health insurance coverage, because they are covered by the Community-based Health Insurance.[16] In addition to the important role Japan's universal health insurance plays as a safety net, it has brought about the followings impacts, which are significant from the viewpoint of health policy.

[16] In the USA, some corporates provide help for employees to enroll private health insurance but the help will not be continued when unemployed.

Impact on management cost

The Japanese health insurance system has two pillars: the Employees' Health Insurance and the Community-based Health Insurance. There are more than 3,000 insurers. However, despite multiple insurers, the same benefits covered and medical treatment fee are applied to all of them across the nation since 1959. The system is highly integrated, thus has been successful in keeping its management cost lower than that of other developed countries.

Impact on total health expenditure

Japan's health insurance system enables the central government to control over the total health expenditure. In Japan, medical institutions are run mainly by the private sector whose financial bases mostly depend on medical fees paid by the public health insurance. Therefore, the central government can control health expenditure to a great extent by adjusting the rates of medical fees. The mechanism of benefits-in-kind reinforces this control.

Impact on service delivery

The central government can induce the behavior of medical institutions in a desirable direction by adjusting medical fees to individual treatments and requirements for medical institutions regulated in a medical fee schedule. This contributes to the way the services are actually delivered. For example, when a medical fee for a hospitalization per day decreases as the duration of hospitalization becomes longer, a hospital will have a financial incentive to shorten the hospitalization by giving intensive high quality medical treatment to patients.[17]

Alignment of service delivery and finance is one of the difficulties in designing a health system. In Japan, delivery and finance are aligned by the mechanism of payment based on benefits-in-kind and medical fee schedule.

[17] The adjustment of medical fee schedule has been the main policy instrument in the reforms of medical service delivery in Japan. However, in addition to the medical fee schedule which is not regarded as perfect, a combination of policies including the allocation of medical resources at local level as well as the revision of medical education is needed to induce the favorable changes in medical service delivery.

III. Historical development

The Japan's universal health coverage was not achieved overnight. Prior to the achievement of Japan's universal health insurance coverage in 1961, it had a nearly 40-year history since the Employees' Health Insurance Law was enacted in 1922 (refer to Table 2). This section describes the three stages to attain universal coverage.

Table 2: Timeline of universal health coverage

Stages	Major events	Background
1. Building the foundation (1922 – 1945) In this stage, the basic framework consisting of two programs, the Employees' Health Insurance and the Community-based Health Insurance, was established.	1922: Employees' Health Insurance Law enacted (Covering factory workers. Put in force in 1927) 1938: Community-based Health Insurance Law enacted (Focusing on the protection of poor farmers) 1942: Employees' Health Insurance Law revised (Covering white-collar workers as well) 1943: Community-based Health Insurance provided in 95 percent of the municipalities	1918: End of the First World War 1920: Plunge of the Tokyo stock market (Postwar depression) 1929: Great Depression 1937: Entry into the Sino-Japanese War 1941: Entry into the Pacific War 1945: End of the Second World War
2. Recovery and reconstruction (1945 – approx. 1955) In this stage, Japan recovered and reconstructed the health insurance system, while tackling catastrophic damages caused by the war.	1948: Community-based Health Insurance Law revised (Introducing the principle of public management by municipalities) 1950: Recommendation by the Advisory Council on Social Security 1953: Government subsidies introduced for benefit payments of the Community-based Health Insurance (Into law in 1955) 1955: Community-based Health Insurance provided by all the municipalities in Iwate Prefecture	1946: Promulgation of the new Constitution of Japan (Put into force in the following year) 1950: Korean War 1952: San Francisco Peace Treaty into effect
3.Planning and achievement (around 1955 – 1961) In this stage, universal coverage was brought up in the political process, and then universal coverage was attained, after a number of plans and bills were created.	1956: PM announced the policy goal of achieving universal coverage 1957: Headquarters for the promotion of universal health established at the Ministry of Health and Welfare (Promoting the four-year plan for nationwide implementation) 1958: The Community-based Health Insurance Law fully revised 1961: Universal coverage achieved	1955: Reunification of the Japan Socialist Party (Merger of the right and the left of the Socialist Party), which had stayed as an opposition party for the next 40 years 1955: Establishment of the Liberal Democratic Party, which stayed in power for the next 40 years 1960: Signing of the revised Japan-U.S. Security Treaty 1960: Income-Doubling plan announced

III-I. 1st Stage: Building the foundation (1922 - 1945): expanding coverage to the informal sector[18]

The basic framework of two programs, the Employees' Health Insurance and the Community-based Health Insurance, was formed before the Second World War. In terms of legal basis, the Employees' Health Insurance Law was introduced in 1922 to protect factory workers (implementation in 1927). The Law was modeled on Germany's Health Insurance Law. The basic framework included the same elements such as compulsory enrollment of workers, a contribution calculation system according to wages, and the adoption of service provision in kind[19]. In 1938, the Community-based Health Insurance Law was enacted to cover the informal sector including farmers and the self-employed, who were not covered by the Employees' Health Insurance Law.

The Employees' Health Insurance Law

Challenges around 1922 were a deteriorated economic situation after the First World War and frequent labor disputes. This Law was applied only to factory workers at the time of its enactment. The law later expanded its coverage to a wider range of people including white-collar workers and, in 1942, to most employees working at private companies and their dependents.[20] In any form of system, its first design influences its future development. The enactment of the Employees' Health Insurance Law paved the way for establishing a social health insurance system as a key source of health finance in Japan. Accordingly, the Community-based Health Insurance Law in 1938 adopted a similar insurance model, despite typical difficulty in extending social insurance to the informal sector.

The Community-based Health Insurance to cover the informal sector

While the Employees' Health Insurance Law was modeled on the Health Insurance bill in Germany, the Community-based Health Insurance Law was Japan's own creation. It covers the informal sector including farmers and the self-employed. The primary beneficiaries of the Community-based Health Insurance were intended to farmers rather than the self-employed due to farmers' poor health and hygiene conditions caused by an uneven distribution of medical care facilities and doctors. Some parents suffering from serious crisis caused by the Great Depression of 1929 and serious crop failure in 1931 even sold their daughters to pay for food or medical fees.

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[18] The definition of informal sector varies. This paper defines informal sector as workers except for employees covered by the Employees Health Insurance such as the self-employed, workers in the agriculture, forestry and fisheries industry.

[19] The difference between the German and Japan's Employees' Health Insurance is that the insurer for workers working in small and medium-sized enterprises, which could not organize insurance societies, was the state, as the number of small and medium-sized enterprises was large in Japan. For state-managed health insurances, the current insurer is the Japan Health Insurance Association established in October 2008 by the 2006's revision of the Employees' Health Insurance Law.

[20] Government employees were covered by the mutual aid association. In Japan medical benefits for government employees are the same as those for the Employees' Health Insurance. No big disparities were found before the war.

The insurers of the Community-based Health Insurance Law at that time were not municipalities, but associations whose establishment and participation by residents were decided on a voluntary basis. Furthermore, it was left to individual autonomous associations to decide the range of services offered and the proportion of the costs covered, both of which were not regulated in the law. Thus, the Community-based Health Insurance system can be said to have started in a very "flexible" fashion. This flexibility left uncertain the effective implementation of the system at first. Nevertheless, the Community-based Health Insurance was provided in as much as 95 percent of the municipalities by 1943.

Main factors contributing to the rapid expansion

The fact that 95 percent does not mean that universal health insurance was nearly attained in Japan before the war. The range of services offered and the proportion of the costs covered by many of the associations were very low. In reality, many associations provided services mainly on health-care activities by health nurses, because there were shortages of financial resources, as well as difficulties to secure doctors, many of whom were recruited as combat surgeons on a war footing. It is, however, worth noting that 95 percent of the municipalities provided the Community-based Health Insurance just five years after the Law was put in force. There were seven contributing factors.

First, the strong political backing supported the promotion of the policy "Healthy people create healthy soldiers" on a war footing (Ensuring people's health is critical to secure healthy soldiers.). The government promoted the Community-based Health Insurance as part of the policy.

Second, the mass media and local governments strongly advocated for the Community-based Health Insurance.

Third, a sense of social solidarity was strong, especially in the rural communities.

Fourth, feasibility studies, including the implementation of pilot projects in twelve locations nationwide and interviews with local government officers, were conducted prior to developing the Community-based Health Insurance.

Fifth, a number of "grass-roots" activities for medical services were carried out, including the "Campaign for medical services for farmers"[21] although rural areas suffered from more serious shortages of medical care facilities and doctors than in urban areas.

Sixth, the "infrastructure" for accurate information management on the insured and effective contribution collection existed. In Japan, the household registration system was started in 1868 to identify residents' addresses. The distribution of food rations during the war time called for thorough address management. Moreover, the mechanism already existed in 1938 to know

[21] The campaign was initiated by the industrial association (currently the Federation of Agricultural Cooperatives) before the war. The activities included establishing and managing medical facilities for farmers.

income flows at the level of municipalities to collect local resident taxes, which enabled the insurers to set the amount of the contributions and reduce the contribution from low-income population.

Seventh, existing management mechanisms in the Employees' Health Insurance program were utilized[22] to set the medical fees and, make payments to medical institutions.

Box 2. Importance of accurate information management on beneficiaries' address

In the Employees' Health Insurance, contributions are deducted from paychecks. In the Community-based Health Insurance, contributions are collected based solely on where the insured actually live. In other words, the Community-based Health Insurance does not function without accurate information management on beneficiaries' addresses, which allows the insurers to identify beneficiaries and collect contributions from them.

III-II. 2nd Stage: Recovery and reconstruction (1945 to approximately 1955)

The Japanese health insurance system was devastated by the defeat in the Second World War. Management of the health insurance system faced enormous difficulties such as shortages of medical supplies and, soaring medical expenses caused by inflation. More and more contributions of the Community-based Health Insurance were left unpaid due to the people's hardship. Under these circumstances, many associations suspended their insurance services one after another. In this context, reforming the Community-based Health Insurance system emerged as an urgent priority, which led to a major revision of the Community-based Health Insurance Law in 1948.[23]

Key points and effects of the reform

The revision was made on two points. Firstly, the insurers of the Community-based Health Insurance were transferred from voluntary associations to the municipalities.[24] The rationales in this change were threefold: (a) the municipalities got directly involved in the management of the Community-based Health Insurance, which made its public characteristics more distinct; (b) the municipalities increased their dealing with disease prevention and public health programs. Synergy between these programs and the management of the Community-based Health Insurance by municipalities increased the efficiency in their administration; and (c) while associations cannot execute compulsory collection of unpaid contributions, municipalities can do

[22] The calculation method of the medical fee treatment rate was shaped a few years before the war, while the payment of the Community-based Health Insurance differed per insurers across Japan.

[23] At that time, Japan was under occupation by GHQ (General Headquarters) of Supreme Commander for the Allied Powers (SCAP), which basically supported strengthening of the Community-based Health Insurance.

[24] For discussion of the upside and downside of making local municipalities as insurers of the Community-based Health Insurance and today's issues, please refer to Shimazaki (2009a).

so. Therefore, this revision was expected to reduce financial cost in the Community-based Health Insurance.[25]

Secondly, unlike when the insurers were voluntary associations, residents had no choice but to be enrolled in community-based health insurance, when municipalities decided to implement it.

Changing the insurers to municipalities brought about spill-over effects, which encouraged municipalities in remote areas to increase the number of medical facilities in underserved areas (shortage of social resources as well as medical services). Municipalities had to respond to the criticisms among residents who thought that they would not actually receive any health services even though they had to pay contributions.

Introducing and expanding the government subsidies to the Community-based Health Insurance

Another policy action of great importance in restructuring the Community-based Health Insurance is the introduction of government subsidies for benefit payments to some of the municipalities and its subsequent expansion. In 1953, the government started providing subsidies for benefit payments to financially weak municipalities (insurers). The government subsidies amounted to approximately 20 percent of the benefit payments of the Community-based Health Insurance. It was a groundbreaking policy action in that it was the first time for the government subsidies to be provided to the municipalities with an aim to support the Community-based Health Insurance. In 1955, two years later, the Community-based Health Insurance Law was revised to stipulate that the government had to subsidize 20 percent of benefit payments for all the municipalities which implemented the Community-based Health Insurance.[26] The expansion of the government subsidies to all the municipalities, including financially strong ones, contributed to the promotion of Community-based Health Insurance in urban areas which slightly lagged behind in its implementation.

III-III. 3rd Stage: Planning and achievement (around 1955 – 1961)

Under the new constitution promulgated in November 1946, the establishment of a social protection system became an important policy issue. Different government committees made various recommendations for social protection. One of the important recommendations was the one published in 1950 by the Advisory Council on Social Security to achieve universal coverage.

[25] The 1951's revision of the Local Taxation Law enabled the insurers to collect insurance contributions of the Community-based Health Insurance as an insurance tax. This revision was to respond to the demand by municipalities that insurance contributions should be mandated as tax, otherwise contributions would be unpaid. Considering the relationship between services and contribution, contribution should not be collected per tax, however, this payment system was not replaced and 90 percent of municipalities still collect contributions per tax.

[26] In 1959 the subsidy was 64 billion yen which was 0.6 percent of the general budget (1.348 trillion yen) of the same year, and about 7 percent of the budget of the ministry of health (903 billion yen). The amount is not small.

However, the Ministry of Health and Welfare (MHW) did not buy in these recommendations. Universal health insurance coverage emerged as a political priority around 1955 against the following background.

First, while achieving rapid economic recovery after the war, Japan was still facing a persisting social problem, which was poverty among those who were not covered by any health insurance and had to cover their medical expenses. In 1955, 30 percent of the population was not covered by health insurance. In addition, there was increasing criticism from the people over inequality of opportunities for medical insurance across municipalities.

Second, universal coverage became a popular political priority of the ruling party to gain more people's support. After the recovery of its independence in 1952 by the San Francisco Peace Treaty, the confrontation between the conservative ruling parties and the reformist opposition parties became more apparent over the issues of national security and constitutional revision. Against this backdrop, the Liberal Democratic Party was established through the merger of the two conservative political parties, the Liberal Party and the Democratic Party of Japan, in 1955.

Under these circumstances, in his policy speech in January 1956, Prime Minister Ichiro Hatoyama announced the goal of providing "comprehensive health insurances which cover the entire population". The government took steps to realize this goal. In 1957, MHW established the headquarters to promote universal health insurance coverage, and in the following year, submitted to the Diet a bill to implement it. Then, the bill was passed at the end of 1958. From a legal point of view, this bill was a revision of the Community-based Insurance Law. In reality, however, it should be recognized as a new law due to its drastic changes to the original law. (Therefore, hereinafter, this will be referred to as the "new law," while the before-revision version of the Community-based Insurance Law referred to as the "old law". (The new law will be discussed in III-IV as well.)

Key points of the revision

The revision aimed to achieve the following objectives.

First, it was to obligate all the municipalities to organize and manage its own community-based health insurance before April 1961, and to make enrolment mandatory for those who were not covered by employee-based insurance. One of controversial issues in designing the universal coverage system was to decide whether employees working at small-sized businesses should be covered by employee-based or community-based insurance. It was decided that the employees at small-sized businesses with less than five workers were to be covered by the Community-based Health Insurance.[27]

Second, it was to strengthen the central government's responsibilities for the Community-based

[27] There were two reasons why the Community-based Health Insurance was applied to employees working at small-sized businesses. First, quite a few of the employees at small-sized businesses were the family members of the business owners. Second, it was difficult to exactly know and update the information on the revision or abolition of these businesses. Later, the Employees' Health Insurance came to be applied to employees at small-sized businesses with less than five workers by the revision of the act, if those businesses were run as corporations.

Health Insurance. For instance, it stipulated that the central government had to subsidize benefit payments and increase the subsidy rate from 20 percent to 25 percent. While 20 percent out of 25 percent of benefit payments was to be subsidized to all municipalities, the remaining 5 percent should be pooled and distributed depending on their financial capacity.

Third, it was to expand the range of services covered by the Community-based Health Insurance as to be the same as that in the Employees' Health Insurance, specifically the increase of the costs coverage to more than 50 percent. In the old law, municipalities had the authority to decide this. Thus, many of the benefit payments under the Community-based Health Insurance were less generous than those in the Employees' Health Insurance.

To elaborate on the first point, in this revision (as aforementioned, it was virtually a "new law"), the existing framework of the Community-based Health Insurance was utilized to expand coverage of the informal sector. That is to say, as described in III-II, the 1948 revision of the Community-based Health Insurance Law established the mechanism for compulsory enrolment of residents in the municipalities' Community-based Health Insurance. By the end of 1958, in seven out of forty seven prefectures, all the municipalities achieved universal health insurance coverage through compulsory enrolment, while among the other forty prefectures, some municipalities had not yet implemented the insurance. It meant that universal health insurance coverage would be attained if the remaining municipalities launched the insurance as well. The revised law of 1958 which obligated municipalities to implement the insurance, however, did not necessarily ensure that all municipalities would actually start the insurance. Implementation in municipalities with large urban areas such as Tokyo area was particularly difficult. The central government, therefore, proactively approached the prefectures with such municipalities. For example, the central government (MHW) committed to the governor of Tokyo to continue a government subsidy for 20 percent of benefit payments in even large urban areas, and to coordinate with the JMA over issues requested by them. As a result, all twenty three wards in the central part of the metropolitan Tokyo area started the implementation in December 1958, which provided significant momentum toward universal health insurance coverage. In the municipalities including rural areas that had not implemented the Community-based Health Insurance, the following activities were implemented: (a) advocacy campaigns that responded to residents' concerns; (b) proactive approaches to mayors, councilors and key persons of communities by showing the data such as the projected premium and financial situation;[28] and (c) commitment to secure the government subsidy (equivalent to 5 percent of

[28] In the fiscal year 1962 (there is not sufficient data for 1961), the year after the attainment of universal health insurance coverage, the average of annual insurance premium per household was 4,800 yen, and the average annual household income (after deducting necessary expenses, before the basic exemption) was 209,292 yen, which makes the average rate of insurance contribution in the household income about 2.3 percent. In the same year, under the government-managed health insurance which covered employees working at small and medium-sized enterprises and their dependents, the employees' contribution rate was set at 3.15 percent (the employers also contributed other 3.15 percent). Considering the fact that the contribution was levied on wages without the deduction of necessary expenses, the contribution rate of the Community-based Health Insurance at about 2.3 percent is relatively low. However, just comparing these two figures can be misleading, because there was a difference in the cost covered by these two insurances (employees' health insurances covered the total cost

benefit payments) that was to be allocated to municipalities depending on their financial capacity, in addition to the subsidy for 20 percent of benefit payments (see Second above), against the strong objection by the Ministry of Finance. As a result of these activities, all the municipalities established the Community-based Health Insurance, and universal health insurance coverage was attained in April 1961. The relationship between "the new law" and "the old law" will be discussed in III-IV, and the measures taken to include the informal sector will be elaborated in IV-I.

Attitudes of major stakeholders

In general, the revision of the health insurance system is said to run into political trouble because of conflicting interests among stakeholders. This is even more so for the development of universal coverage. In Japan, however, there was almost no opposition from the stakeholders, which is quite uncommon. The attitudes of major stakeholders were as follows.

The opposition parties (reformist camp): The opposition parties supported the development of universal health insurance coverage,[29] despite tensions with the ruling party (conservative camp) when a bill for the new law was submitted to the Diet.

MHW: MHW was reluctant to the development of the universal health insurance coverage at the beginning for the following reasons. First, the ministry perceived that achieving universal coverage would be unrealistic because the coverage had not expanded as desired despite the previous government support for the Community-based Health Insurance. Second, MHW was concerned about difficult challenges, for instance, how to handle employees working at small-sized businesses (whether to cover them by the Employees' Health Insurance Law or the Community-based Health Insurance). Third, the ministry had other pressing priorities, such as reduction of budget deficits in the government-managed health insurance which covers employees working at small and medium-sized enterprises and their dependents.[30]

Medical professionals: The Japan Medical Association (JMA) (physicians' association) showed dissatisfaction with the new law, but did not strongly object to it.[31] Why? Given the level of medical services at that time, there were too many medical doctors in Japan.[32,33] It appears that the JMA

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of the insured employees' medical expenses, while the Community-based Health Insurance covered slightly over 50 percent of that of the insured).

[29] It has to be noted that the opposition parties supported specifically "universal coverage of health insurance". In 1961, universal coverage of pension was also achieved. However, the opposition parties objected to it out of the fear that accumulated insurance premiums would be used for defense expenditures.

[30] Refer to Koda, et al. (2011) pp.7 – 20. Masataka Koda (former Vice-Minister for Health and Welfare) started working at the Ministry of Health and Welfare in 1954. (In addition, his first workplace was the Health Insurance Bureau.) Thus, his remarks were very useful as a "testimony" of a person who knows well the context at the time.

[31] To put it differently, the medical association took a strategy to fight for the abolition of limited treatment, from a perspective of professional freedom, in return for accepting universal coverage.

[32] Refer to Koda et al. (2011) p.18 and the "1956 Annual Report on Health and Welfare" pp.125 – 126, Ministry of Health and Welfare (1956). Later, however, the government adopted the policy to increase the number of trained doctors by the 1980s, because the demand for medical services was increasing.

[33] Japan established many medical schools in order to train a large number of doctors during the war. Furthermore, doctors recruited at the front during the war were demobilized and sent home. As a result of these, around 1954, the number of doctors per capita reached to the level equivalent to that of Western countries.

accepted universal health insurance coverage because it would provide doctors with secure stable income flows from insurers, while being cautious of the possibility that government officials might increase their control over medical services once universal coverage had been achieved. The JMA feared that future practitioners might experience a financial difficulty if they continued depending on direct payments from patients.

Local groups, business community and mass media: They supported universal coverage. Enthusiastic supporters from mayors and local politicians emerged to promote universal coverage. Their support had a strong impact on changing the attitude of MHW to a more committed one after 1957.

III-IV. Discussions

Having described the historical development of universal coverage in Japan, three turning points in the path taken towards the universal health coverage are discussed here.

1) What is the significant difference between the old law and new law?

The most substantial difference between the old and the new law was the obligation of municipalities to establish the Community-based Health Insurance and regulate the range of services offered and the proportion of the costs covered. Under the old law, individual municipalities not only had liberty of choosing whether to provide the Community-based Health Insurance, but also could decide the range of services offered and the proportion of the costs covered. Therefore, the old law would have attained only “nominal” universal coverage. The new law stipulated that the range of services offered should be equivalent to that in the Employees’ Health Insurance, and the proportion of the costs covered should be set at least more than 50 percent.[34] This revision was made in order to make universal coverage more substantial. Therefore, the new law was not a mere extension of the old law, although the achievement to prior to the change was crucial in achieving universal coverage in 1961.

[34] Therefore, while more than half of the pages were dominated by how to organize the insurers in the old act, the new act focuses on practical stipulations, such as the range of services offered and the proportion of the costs covered in the insurance. The revision was continued to give universal coverage more substance. In the early years, doctors’ discretion was greatly regulated in dealing with the details of benefit payments. Later, such limited treatment was gradually abolished. Furthermore, the proportion of the cost covered was also raised to 70 percent.

2) Why did Japan employ a social health insurance for universal coverage?

There were three major advantages in adopting a social health insurance.

First, the concept of independence and self-help is embodied by making people prepare for future risks by paying premiums on their own responsibilities.[35] The concept, which is the fundamental socio-economic principles of the free economy that Japan is based on, was highly respected in designing the health system.

Second**,** social health insurance can maintain financial discipline, because the contribution level is established in such a way as to balance revenues and expenditures, and expenditures are in principle controlled within the amount of revenue.

Third**,** the social insurance model, compared with the tax-based model, enables the beneficiaries to more strongly claim their right to receive health care, because the benefits are given in return for paying premiums.

Achieving universal coverage targeting the entire population through social health insurance is not easy. Contribution of insurance premium from the insured is indispensable for social health insurance, although the insurer receives subsidies from the government unlike private insurances. In reality, there are those who cannot (or won't) afford to do so due to their low income.[36] This problem becomes more serious in the informal sector,[37] in which many of the workers have lower income. Despite this difficulty, government officials valued the above mentioned advantages and developed the social health insurance system over years since the prewar time.

3) Why were the insurers of the two insurances (Employees' Health Insurance and Community-based Health Insurance) not integrated?

The main characteristic of the health insurance system in Japan is that it consists of the two insurances, the Employees' Health Insurance and the Community-based Health Insurance. Since the public health insurance has a redistributive effect, it is appropriate to organize the insurers by groups that allow them to have a sense of community. While the Employees' Health Insurance has been formed based on the groups of "*kaisha* (companies)," the Community-based Health Insurance was formed based on the groups of "*mura* (villages)." Integrating the insurers of these two insurances into a single organization would serve more not only to the principle of equality, but

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[35] In other words, unlike private insurance, social insurance does not consist only of the "independence and self-help" factor, but also of the "solidarity and mutual assistance" factor.

[36] Under the pension system, one does not receive benefits without paying premiums. Such a clear-cut solution is possible because pension is a system for ensuring income security through "transfer of money". Health services are directly concerned with people's well-being, thus they are required to cover "the entire population" more than the pension system. In short, there is a serious problem that sick or injured people cannot be neglected even if they cannot or won't pay premiums.

[37] In collecting the premiums for the Community-based Health Insurance, while the amounts of premiums for low-income persons have been reduced, penalties are imposed on those who do not pay premiums with malicious motives. Even with these measures, the Community-based Health Insurance has collected about 90 percent of its premiums, not 100 percent. Japan has also been facing difficulties in collecting premiums from the informal sector.

also to the higher integrity of the insurance system in achieving universal coverage.[38] MHW, however, kept the two insurance systems for universal coverage for the following four reasons.

First**,** it was more appropriate to make the most of the existing framework, in order to achieve universal coverage for a short period of time.

Second**,** it was not practical to integrate either one of the insurances into the other, because each of these two different systems was well functioning independently and covered almost the same number of beneficiaries. In Japan at that time, a relatively large part of the workers belonged to the primary industries and they were covered by the Community-based Health Insurance, There was little difference in numbers between the population covered by the Employees' Health Insurance (about 38 million persons) and those covered by the Community-based Health Insurance (about 37 million persons).

Third**,** in health insurance, the larger number of insured persons does not necessarily mean it is better, unlike pension insurance in which the larger size of insured persons means a higher level of risk-sharing. Health insurance has aspects of medical service delivery as well as risk-sharing. There are differences in medical service delivery among municipalities. In this regard, the Community-based Health Insurance, the insurers of which are municipalities, can reflect such differences more directly in the level of insurance premiums. In addition, with the smaller number of insured persons, health promotion activities can reach them more easily, which enables the insurer to better control expenditures.

Fourth**,** integrating or unifying the Employees' Health Insurance and the Community-based Health Insurance would cause much more inequality in the real level of cost-sharing. There are differences not only in the income-earning structures, but also in the income reporting between employees and others such as the self-employed and farmers.[39]

The third and the fourth are the major reasons, which even today help maintain the framework of the two programs.

[38] The author's position is that it is unrealistic and inappropriate to integrate the Employees' Health Insurance and the Community-based Health Insurance, because there is the problem of differences in income reporting. Quite a few researchers, however, advocate the integration, for example, Ikegami, *et al.* (2011), advocates the integration of the insurers by prefecture.

[39] While employees' income (salaries) can be identified 100 percent, it is difficult to identify the exact amounts of income and necessary expenses among the self-employed and farmers, etc. Korea has integrated all the insurers (single payer system). However, it has employed different ways to collect premiums from employees and the others, due to the problems of differences in income reporting.

IV. Lessons from Japan's experiences

A health system is a product of politics, economy, history, culture, and the environment, and well reflects each country's own idiosyncrasy. Therefore it is inappropriate to generalize the experience of Japan's universal coverage; however, it would still provide lessons for other countries. In this section, two points are discussed: (a) major factors contributing to Japan's achievement of universal coverage; and (b) key points in designing the system to achieve universal coverage.

IV-I. Factors that contributed to Japan's achievement of universal coverage

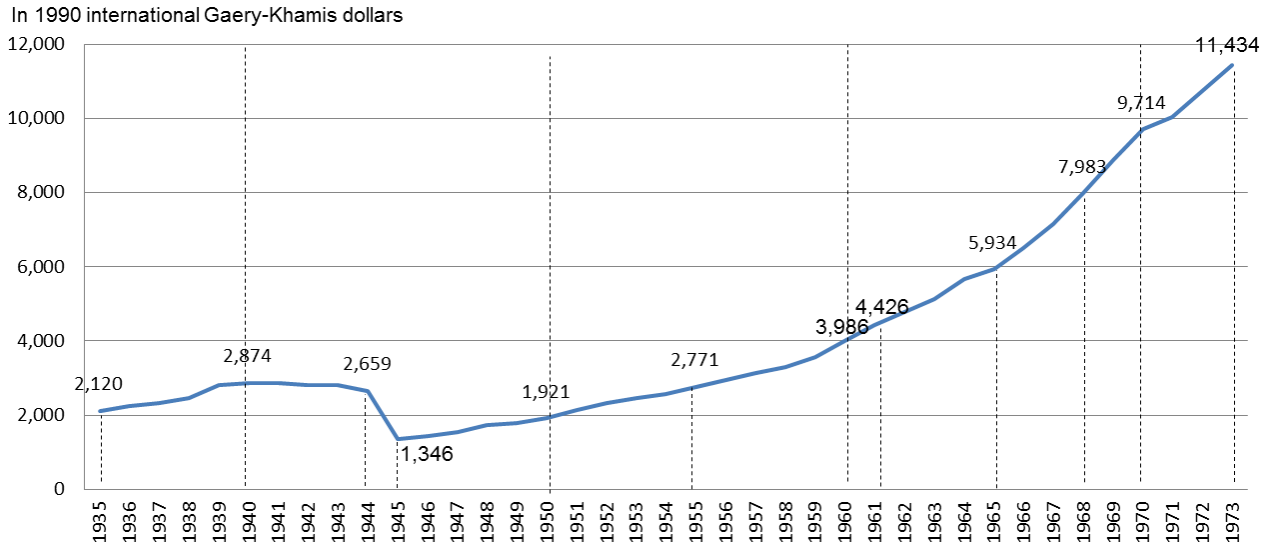
If universal coverage is likened to an airplane, five things were needed to fly an airplane (to achieve universal coverage) in Japan's case: (a) a powerful engine (economic growth); (b) huge wings (a sense of solidarity); (c) a talented pilot (leadership); (d) a brilliant mechanic (person who designs and controls the system); and (e) a long runway (basic administrative systems and prior achievements).

First: Economic growth

Social insurance scheme cannot work properly unless the level of national income has reached a certain level. When people's basic needs are barely met, they cannot afford to pay contributions. Thus it is impossible to collect contributions. It was not until the Japanese economy recovered up to the point where it could "no longer be termed postwar" (excerpt from the "1956 Economic White Paper") that universal coverage became a more realistic goal in Japan. High economic growth enabled Japan to have sufficient financial resources to achieve and improve universal coverage. Figure 3 shows the transition of Japan's GDP per capita (in 1990 international Gaery-Khamis dollars) based on the Maddison Project Database. This figure shows: (a) GDP per capita in 1950 was still in a level lower than that of 1935 or so. It was not before around 1955 that Japan's GDP per capita recovered to the level of the prewar economy; and (b) Japan's high economic growth started around 1955. Its GDP per capita kept surging until 1973 when the first oil crisis hit the country.[40] Japan's GDP per capita increased from about 1,300 dollars in 1945 to about 4,400 dollars in 1961. After the end of the war, Japan achieved universal coverage during almost the same period of time, as it achieved its economic growth and transitioned from a low-income country into a middle-income country.

[40] In 1960, Prime Minister Hayato Ikeda announced the "National Income Doubling Plan" (plan aiming to double the national income per capita in ten years), which was actually achieved three years earlier than planned due to rapid economic growth.

Figure 3: Transition in Japan's GDP per capita
(based on the Maddison Project Database)



Source: Bolt, J. and J. L. van Zanden (2013). The First Update of the Maddison Project; Re-Estimating Growth Before 1820. Maddison Project Working Paper.
Maddison Project Database (http://www.ggdc.net/maddison/maddison-project/data.htm)

Second: A sense of solidarity

A strong sense of solidarity is crucial for social insurance. Social insurance is not the same as private insurance. From a perspective of social policies, premiums for social insurance are levied according to the ability to pay, not on the risks of injuries and diseases of individuals. As a result, income is transferred from the healthy to the sick, as well as from the rich to the poor. The Japanese citizens shared a very strong sense of equality.[41] In fact, one of the key factors which contributed to achieving universal coverage was that the public opinion denounced inequality in medical services. Furthermore, social insurance can be more easily run in a society with smaller inequalities between the rich and poor, and with a larger middle-income population. Japanese society was in those conditions at the stage of achieving and developing universal coverage.

Third: Political leadership/commitment

Political leadership is vital for achieving universal coverage. In Japan the achievement of universal coverage came up as a flagship policy when politicians wanted an "uplifting symbol" for postwar recovery. Also importantly, local governments, especially municipalities, supported the policy. Many may imagine that municipalities would not be so enthusiastic about universal coverage, because they have to take financial responsibilities as the insurers of the Community-based Health Insurance. However, this was not the case. Not only were mayors and councilors of the

[41] As pointed out in Section III, while the Employees' Health Insurance has been formed based on the groups of "kaisha (companies)," the Community-based Health Insurance formed based on the groups of "mura (villages)."

municipalities unable to disregard the desperate voices of the people who wanted the financial protection, but also the promotion of the Community-based Health Insurance was appreciated by residents. Especially enthusiastic supporters among them were engaged in aggressive activities, demanding more government subsidies and the earlier achievement of universal coverage.

Fourth: Career civil servants to design and control the system and treating MHW as a champion

Universal coverage requires meticulous system design. While it is of some help to study different systems in developed countries, it is important to analyze similarities and differences and avoid employing the other country's system without adjustments. In Japan's case, there were career civil servants who understood the nature and essence of social insurance through a thorough study of foreign systems. They came up with a system of the prewar Community-based Health Insurance which suited for the Japanese circumstances and implemented a model project to verify the feasibility of the designed system. Government efforts were coordinated by MHW as the main authority for designing the health insurance system. Fragmentation of government organizations and responsibilities would create a patchwork system lacking overall consistency. However, this was not the case in Japan. The responsibility of designing a social insurance system was under the single authority, which was MHW.

Fifth: Basic administrative systems and prior achievements

Japan's universal health insurance coverage has a long history before its achievement. In particular, the following three points are important: (a) the framework consisting of two programs, the Employees' Health Insurance and the Community-based Health Insurance, was formed before the war, and expanded to a certain extent; (b) the support for the Community-based Health Insurance was shored up after the war. The Year 1955 saw the first prefecture to establish the Community-based Health Insurance across all its municipalities; and (c) by the end of 1958, when the new law was enacted, all the municipalities in seven out of 47 prefectures established the insurance and approximately 70 percent of the population was covered by the public health insurance, including those covered by the Employees' Health Insurance. Thanks to these prior achievements since the prewar periods, the public health insurance successfully "dominated" the market of health insurance before the private one did so. As a result, in Japan, the public health insurance did not experience any problem of competing with the private health insurance.

The basic system and prior achievements also include infrastructures other than the health system, such as the administrative and tax system. This point should be emphasized especially in designing an insurance system for the informal sector.

Accurate information management system：In Japan, accurate information management systems on residents' addresses and income flows were already in place before the war.

Advocacy campaign：In Japan, there were many cases that not only government officials but also

medical doctors and health nurses reached out to local influential stakeholders, and explained the significance of the health insurance system. At the same time, community-specific medical services and health activities were carried out by the medical doctors and health nurses, which led the residents to feel the "real benefits of the system."[42] Those activities are very important because the health insurance system will not infiltrate and prevail with only general promotional campaigns (e.g. distribution of leaflets).

IV-II. Key points in designing the universal coverage system

Universal coverage requires meticulous system design. Hereinafter, the key points in designing the system are discussed.

First: Choosing between a social health insurance or a tax-based system

Choosing a model to achieve universal health coverage is critical. As pointed out in Section III, the government officials chose social health insurance, fully understanding the advantages of the model (the importance of independence and self-help, the financial discipline by balancing out between benefits and contributions, and the authority to give the insured the right to receive benefits in return for paying premiums), despite a difficulty in designing or managing a system through social insurance, especially inclusion of the informal sector. It is necessary to take meticulous regulatory actions, such as reducing premiums for low-income persons and developing activities for medical services and health care matched with the resources and needs in respective communities.[43] Japan modeled its Employees' Health Insurance on Germany's Health Insurance Act before the war and enacted the Community-based Insurance Law to cover the informal sector. In 1961, Japan achieved universal health coverage through social health insurance based on the two insurances.[44]

Second: Targeting the entire population or the majority

Japan's universal coverage is a "rigid" mechanism that covers the entire population without exception. Making a choice on who should be covered by universal coverage has two meanings: whether to seek 100 percent coverage like that of Japan; or whether it is considered adequate if the majority of the population (e.g. 80 or 90 percent) is covered. This is basically a question of policy-making. Still, future system design will depend on which option is taken. For example, option (a) cannot be achieved without mandatory enrollment of the entire population in the insurance. In contrast, when option (b) is chosen, the population may be encouraged to enroll themselves in the insurance, but it is not compulsory. In the case of developing countries, it may

[42] For more information, please refer to the National Health Insurance Association (1948) pp.277 – 292.
[43] In social health insurance, it has to be decided for the insurers to be independent from each other, or to be integrated into a single organization, as already discussed in Section III.
[44] Experience of one country cannot be applicable to other countries. In some countries, the influence of their former colonial powers might have paved the way for a tax based model.

be feasible to progressively expand the coverage of social insurance. UHC can be achieved only when enrollment is made mandatory.

Third: Sorting out how to cover the entire population by public or private health insurance

The point is whether to allow those insured by the private health insurance to opt out of the public health insurance. If an opt-out policy is taken, the following three problems would come up.

(a) Revenue base for the public health insurance becomes smaller

(b) The redistributive effect becomes smaller, because the rich are essentially excluded.

(c) The problem of adverse selection comes up. People tend to enroll in private insurance while being healthy, but participate in public insurance when more prone to illnesses.

If a decision is made not to allow the opt-out, the decision would be theoretically correct, but politically difficult. It would draw strong protests not only from private insurance companies, but also from the private health insurance holders, because they would inevitably have to make double payments of premiums. If the private health insurance already dominates the market, the public health insurance would face difficulties in entering (taking back) the market. In other words, for these reasons, it becomes more important to decide how to cover the population by the public or the private health insurance before the problem becomes bigger.

Fourth: Setting up the range of services offered and the proportion of the costs covered

In designing universal coverage, it is quite a challenge to decide the range of services offered (e.g. whether to include advanced medical services), and proportion of the costs covered (or the proportion of patients' co-payment). If insurance offers a narrower range of services and a lower proportion of the costs covered, it will not function as effective health protection. In contrast, if the insurance offers too generous benefit payments in terms of both the range and the proportion, the system would not be financially sustainable. Once the range of service and the proportion of the costs covered are set up, reducing them would be very difficult as it may provoke strong protests from service users. Therefore, it would be safer to set a lower "launching platform" and gradually expand it in line with economic growth.

Fifth: Ensuring the efficient and effective administration

Administrative works to manage the system tend to be underestimated in designing universal coverage. A universal health insurance system operates with a set of different mechanisms, such as (a) a mechanism to decide the eligibility and update the information of each insured person, (b) a mechanism to set premiums, (c) a mechanism to collect premiums, and (d) a mechanism to set the fee schedule, to check the bills from medical institutions, to reimburse medical fees. Therefore, it should be noted that troubles in a small building block in the system could make the whole system paralyzed. For example, accurate contribution collection and update of the information of

the insured in the informal sector are essential for the insurance system to fully work. Without appropriately setting the level of contribution (including reduced contribution for low-income persons), contributions cannot be collected and obligatory enrollment could become just insubstantial. Both the fee schedule and the mechanism of reimbursement of medical fees are very important for the efficient financial operation of medical institutions.

Sixth: Aligning service delivery and finance in designing the system

While the pension system is strictly a financial scheme, the health system involves both delivery and finance of medical services. Therefore, in developing universal coverage, it is critical to take into account how to develop a system to deliver medical services (specifically, how to properly deploy medical institutions and develop medical professionals in a planned manner). This point becomes critical in achieving universal coverage no matter which of the two systems, social insurance or tax-based system, is chosen. Citizens will have no incentive to pay premiums if availability and quality of medical services are insufficient. As a result, social insurance cannot function well, and the goal of universal coverage, which is to ensure full access to medical services, cannot be achieved.[45]

V. Concluding remarks

Japan's universal coverage has gained high international acclaim, as well as the population's strong support. But the path to universal coverage was not smooth. The government officials came up with a system which suited Japanese circumstances before the war, while studying thoroughly the developed countries' systems. Before the achievement of universal coverage, Japan experienced a number of challenges in rebuilding a health insurance system totally destroyed by the war. After the mid-1950s, achieving universal coverage was brought up as a political priority, and the laws were formulated. During that period of time, stakeholders had many challenges in designing universal health coverage in order to make it substantial, not nominal. Japan's universal coverage is the fruits of these predecessors' efforts and knowledge.

Achieving universal coverage is a challenge. However, the efforts are worth making as it greatly contributes to the stability of people's social and economic lives. Japan's experience is a rich repository for other countries with different contexts. The most important thing that the experience shows is to have a strong commitment and careful consideration of its design.

[45] In Japan, medical services have been delivered mainly by the private sector. As described in Section III, a number of efforts have been made to equally provide medical services to the entire population, in the process of achieving universal coverage. Those efforts include building public hospitals in remote areas from which the private sector stays away because of low profitability. It seems to be also noteworthy that an attempt has been made to provide not only medical services, but also public health services, long-term nursing care and welfare services in a coordinated manner.

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