Papers on the Local Governance System and its Implementation in Selected Fields in Japan No.17

The Position of Local Governments in the National Health Insurance System and Associated Problem Areas

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Foreword

The Council of Local Authorities for International Relations and the National Graduate Institute for Policy Studies have been working since FY 2005 on a “Project on the overseas dissemination of information on the local governance system of Japan and its operation”. On the basis of the recognition that the dissemination to overseas countries of information on the Japanese local governance system and its operation was insufficient, the objective of this project was defined as the pursuit of comparative studies on local governance by means of compiling in foreign languages materials on the Japanese local governance system and its implementation as well as by accumulating literature and reference materials on local governance in Japan and foreign countries.

In FY 2010, we will continue to compile “Statistics on Local Governance (Japanese/English)”, “Up-to-date Documents on Local Autonomy in Japan”, “Papers on the Local Governance System and its Implementation in Selected Fields in Japan” and “Historical Development of Japanese Local Governance”. We will also continue to conduct a search for literature and reference materials concerned with local governance in Japan and overseas to be stored in the Institute for Comparative Studies in Local Governance.

If you have any comments, suggestions or inquiries regarding our project, please feel free to contact the Council of Local Authorities for International Relations or the Institute for Comparative Studies in Local Governance of the National Graduate Institute for Policy Studies.

November 2010

Yoko Kimura
Chairperson of the Board of Directors
Council of Local Authorities for International Relations

Tatsuo Hatta
President
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Preface

This booklet is one of the results of research activities conducted by the Institute for Comparative Studies in Local Governance (COSLOG) as one part of a project that started in FY 2005 entitled "Project on the overseas dissemination of information on the local governance system of Japan and its operation", in cooperation with the Council of Local Authorities for International Relations (CLAIR). For the purpose of implementing this project, a "Research committee for the project on the overseas dissemination of information on the local governance system of Japan and its operation" has been set up, and a chief and deputy chiefs with responsibility for the project have been designated from among the members concerned with each research subject.

Volumes 15-18 of "Papers on the Local Governance System and its Implementation in Selected Fields in Japan", started in FY2009, were written under the responsibility of the following four members. (Title of members as of March 2010)

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This booklet, the 17th volume in the series, is about the position of local governments in the national health insurance system and associated problem areas, and was written by Prof. Shimazaki.

The booklet trace the formation and changing development process of a universal insurance system, and within this context, examines reasons for the origin of a locality-based insurance system that is unparalleled anywhere else in the world, as well as the central problems comprised within the national health insurance system. With this as a foundation, the author argues that it is necessary for the wide-area principle to be applied to the management of the national health insurance system. At the same time, he makes a case for the examination of public corporations (public unions) as the insuring bodies of the system, quite apart from wide-area unions and prefectures, in consideration of the importance of autonomous and democratic decision-making.

Finally, I would like to express my appreciation to Prof. Shimazaki, and also to other members of the research committee for their expert opinions and advice.

November 2010

Hiroshi Ikawa
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Research committee for the project on the overseas dissemination of information on the local governance system of Japan and its operation
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1. Introduction

The purpose of this paper is to discuss the position of national health insurance in local public bodies (hereafter, local governments) in Japan, and problem areas associated with this. I will begin by briefly explaining the nature of the problem areas.

In Japan, universal insurance comprising health insurance for all the people of Japan is achieved by means of the parallel existence of employees' health insurance and locality-based health insurance (national health insurance). Putting this more precisely, employees' health insurance is divided into health insurance unions, to which the employees of large companies and their families belong, a National Health Insurance Association, to which the employees of small and medium-sized firms belong, and various types of mutual unions to which public officials (civil servants), the educational staff of schools and universities, and so on, belong. In each of these three cases, however, health insurance is extended to the users (employees) in the category involved. Further, because everyone who does not fall into one of the three categories enumerated here is a member of the national health insurance system, in which municipalities are the insuring bodies, universal insurance for the entire Japanese population is achieved[1]. This system is thought of within Japan as being an entirely natural state of affairs, but from a global perspective it is very unusual indeed, as I will now make clear.

Medical care can be broadly divided into 2 parts, comprising delivery, denoting the way in which medical care services are provided, and finance, denoting the way in which the costs of providing medical care are met. It is also the case that medical care systems have historical, cultural, political and economic aspects, and take different forms depending on the country which houses them. One type is that in which medical care is provided directly by the public sector on the basis of funding from taxation revenue in the same way as the public health service system. This is the system in the U.K. and in Sweden. The second type is one in which the risk of medical care costs is dispersed and is basically borne by private-sector insurance. For example, in the U.S.A., apart from Medicare, which covers elderly persons, and Medicaid, which covers low-income families, there is no public system for guaranteeing medical expenses. The third type is one in which medical costs are guaranteed by a social insurance system. However, the medical insurance system in Japan is an amalgam of employees' insurance (insurance for persons covered is by virtue of their belonging to a workplace or the equivalent) and locality-based insurance (the qualification of being insured is by virtue of residing in a specific location). In contrast, in Germany and France, the system of insurance is solely employee-based. For example, in France, the insurance union (ex: the farmers' union) is composed of many different unions, and it is a basic principle that after retirement, persons will

continue to be covered by the union to which they formerly belonged. Furthermore, unemployed young people are insured by what is called a general system for employees of small and medium-sized firms (if this were to be given a name in Japan, it would be called the National Health Insurance Association); neither in Germany or France is there a locality-based insurance such as exists in Japan. In Germany as well as in France, the insurers are public corporations, called in Germany the Krankenkasse, and in France the caisse maladie; in neither case is the local government the insurer. Be that as it may, the health insurance system in Japan has the following two outstanding characteristics: (1) the parallel existence of employees' insurance and locality-based insurance (national health insurance); and (2) the role of local governments (municipalities) in providing locality-based insurance (national health insurance).

The aim of this paper is to consider why this kind of uniquely designed system has been adopted in Japan (Chapter 2 and Chapter 3), and with this consideration as a foundation, to offer some theories on what form the insuring bodies of national health insurance should take in future (Chapter 4 through Chapter 6). Furthermore, the reason for taking up this issue here is that it has become a major policy issue. For example, on January 27, 2009, Kyoto Prefecture (responsible for areas apart from Kyoto City) issued a report suggesting that the national health insurance system should be unified on the basis of prefectural units. Furthermore, when the reform of the national health insurance system of March 2010 was implemented in April of the same year, it was indicated that "prefectures can decide the direction of support concerning the wide-area extension of the operation of the national health insurance system". In the background to these developments is the way in which, when the medical care system for the advanced elderly was established in fiscal 2008, wide-area unions within prefectural units were designated as the insuring bodies[2]. It seems likely that in 2 or 3 years' time, in parallel with a discussion on re-examination of the medical care system for the advanced elderly, discussion on what form the insuring bodies of national health insurance should take will be the major point at issue in discussions on reform of the medical care insurance system.

2. The background to the national health insurance system and the insuring bodies

As a prerequisite to the following discussion, I will now focus on three points concerned with the development of the national health insurance system as well as the insuring bodies.

The first point is the background to the enactment of laws and the process of development in wartime. In 1922, the Health Insurance Law, targeted primarily at workers, was enacted against the background of frequently occurring labor disputes. Without any intention of referring only to the medical care system, one can say that any system is subject to regulation both at its outset and during its subsequent development. The striking significance of the enactment of the Health Insurance Law can be found in the fact that Japan chose the social insurance system as the means of guaranteeing medical costs. This is the background against which the National Health Insurance Law was enacted in 1938. The reasons for enacting this law at this time can be found firstly in a worsening of health and hygiene conditions among persons engaged in agriculture, and together with this, the occurrence

of tragic cases of children from farming villages being sold into bondage because of the inability of their families to pay medical costs. National health insurance targeted self-employed and similar persons, and its main focus was on relieving the burdens of farmers. The important point in connection with the objective of this paper is that at the time of the enactment of the National Health Insurance Law, the insuring bodies were not municipalities, but public corporate bodies in the form of unions. It should also be noted that these unions were established voluntarily, not by compulsion, and participation in the unions was also in principle voluntary. That said, a Union Conference was established as the decision-making organ, and was given considerable authority with regard to decisions on insurance charges and other matters. It is also worth noting that the designation of unions as the insuring bodies in the National Health Insurance Law was rooted in the intention to choose units which would maintain feelings of solidarity[3]. Furthermore, while the National Health Insurance Law was enacted after surmounting very considerable difficulties, national health insurance enterprises were supported by the national wartime government, and the system was disseminated all over the country. In point of fact, by around 1942-1943, national health insurance unions were established over the country as a whole in about 98% of all towns and villages, and if cities are included, in about 95% of all cities, towns and villages. In relation to the postwar achievement of the national health insurance system, this was termed the “completion of the first stage of the comprehensive health insurance system”. However, among the unions created at this time, in addition to those created in name only with the aim of making up the numbers, there were many which had inferior content compared to the standard health insurance system, making it impossible to say that universal health insurance cover for all the citizens of Japan had been achieved.

The second point is the change in the insuring parties in the immediate postwar period from unions to municipalities. Japan’s defeat in World War II dealt a crippling blow to the national health insurance system. Specifically, along with continuing failure to pay insurance coats, health insurance union bankruptcies followed one after the other, resulting from such factors as the rise in medical costs and administrative expenses that derived in turn from the impoverishment of medical resources and inflation. As a result, the rebuilding of the finances of the national health insurance system became a major policy issue. This is the real reason why, under the revision of the National Health Insurance Law in 1948, the insuring bodies of the national health insurance system were made public bodies in the form of municipalities in place of the hitherto existing system of unions. At the time of this law reform, Kojima Yonekichi, secretary of the National Health Insurance Division of the Insurance Bureau of the then Ministry of Health, enumerated the following merits and demerits of public management by municipalities (Kojima (1948), pp. 48-49), abbreviated here because the original text is too lengthy to reproduce in full. As merits of this system, Kojima pointed out that 1) it could be expected that as a result of the reform, the public character of the national health insurance system would become stronger, and become more effective as a system of social insurance; 2) by carrying out, at one and the same time, duties of disease prevention and public health as well as daily life support and, inseparably linked to these factors, national health insurance, the comprehensive operation of their duties by municipalities and the efficiency of their

administrative ability would be enhanced; and 3) because municipalities would be able to deal with the collection of insurance charges and the disposal of the non-payment of such charges at the same time as dealing with municipal taxation, such matters as compulsory collection would be facilitated, and financial problems could be alleviated. On the other hand, as demerits of the system, the following points can be cited: 1) the operation of national health insurance, given that it is carried out through the medium of decisions made by municipal assemblies, is often easily swayed by factional emotions, so that its political neutrality may be lost and it may become the "nourishment for factional disputes" (original language), and 2) there is a fear that if national health insurance is handled mechanically in municipal offices, like other general administrative matters, then in municipalities in which there is a frequent change of chief, the operation of health insurance may become overly formalized, and disposed of on a procedural level, with the result that the growth of liberal broadmindedness is impeded. The points that Kojima makes have deep significance from our present-day perspective as well, at a time when the form that should be taken by the insuring bodies of national health insurance is a matter for discussion.

The third point is the reality of national health insurance in 1961. After the war, Japan accomplished a remarkable economic recovery, but on the other hand, in 1955, approximately 30 million people were without health insurance cover. Even in the report issued by the Social Insurance System Commission in 1950, mention was made of the possibility of a universal insurance system, but the sharp rise of the issue to one of political significance happened after 1955. Specifically, the "Recommendations of the Committee of Seven" were issued in October 1955, and incorporated into these recommendations was the suggestion that "a national health insurance system should be compulsorily established for all persons falling outside the category of insured persons". The Social Insurance System Commission took note of the suggestion, and a full-scale investigation was launched[4]. The results of the investigation bore fruit in the form of a "Report concerning a medical insurance system", and the central pillar of the recommendations contained in this report was the establishment of a universal insurance system. On the political front, in November 1955, the Liberal Democratic Party was formed by a merger of the Liberal Party and the Democratic Party of Japan, and in January 1956, Prime Minister Ichiro Hatoyama made a policy speech, in which he made it clear that it was his intention "to take forward a plan aimed at achieving a comprehensive scheme to provide a guarantee of medical care for all the citizens of Japan". In the following year, the then Ministry of Health established the Headquarters for the Promotion of a Universal Insurance System, and set to work on a full-scale revision of the National Health Insurance Law, subsequently enacted as the New National Health Insurance Law in 1958. Under the law, it was stipulated that by April 1, 1961, municipalities were to implement national health insurance. In this way, a universal insurance system was realized. The important point to notice in this context is that it was by making locality-based insurance, which was the form taken by national health insurance, into a comprehensive mold, that it became possible to realize a universal insurance system. In other words, in order to achieve a universal insurance system, it was made compulsory for municipalities to implement national health insurance, and at the same time, to compel the enrolment of those persons who resided in the municipality concerned, insofar as they were not already insured persons. It was

also stipulated that on such occasions, municipalities were the bodies that provided insurance under the national health insurance program. The reason for this stipulation was that in addition to the shift to the principle of public management as a result of the reform of 1948 to the National Health Insurance Law, the bodies with jurisdiction over the residential addresses that constitute the qualification to be an insured person under locality-based insurance are municipalities, and in order to "cast the net" in such a way that no citizen of Japan was left without public medical insurance cover, it was appropriate for municipalities to be stipulated as the insuring bodies for national health insurance.

The above is an explanation of the main points of the historical development of the national health insurance system and of the insuring bodies. It is clear from this that the shift from the union formula to the municipal public management principle as well as the realization of a universal insurance system, which had this shift as its precondition, can be seen as an entirely natural flow of events. However, from the perspective of a system of democratic control within the framework of social insurance, attention must be drawn to one major problem. This is the fact that it is a municipal assembly that constitutes the decision-making organ of the municipal national health insurance program, but a municipal assembly is composed of representatives of the residents of the municipality concerned, and is not an organ that represents the persons who are insured under national health insurance. Putting this in extreme terms, in a case in which all the members of a municipal assembly were insured persons under an employees' insurance scheme or the dependents of such persons, the insurance rates and other matters in respect of the national health insurance program would be decided solely by persons not in any way concerned with the program. Such a situation would not be excessively incongruous, but there is no doubt that it would be far removed from the principle of autonomy of the persons concerned with social insurance, and from the principle of democratic decision-making by insured persons.

3. The reasons for the success of the dual-structure system

As explained in the previous section, a dual insurance system, comprising employees' insurance and locality-based insurance, was constructed in prewar Japan, and the universal insurance system was designed on the basis of this foundation. It should be noted that the persons who drafted the prewar National Health Insurance Law consciously formulated a dual structure consisting of employees' insurance and locality-based insurance. For example, at the time of enactment of the law, Hidefumi Kawamura (Chief of the Planning Section, Social Bureau, Ministry of Home Affairs) made the following statement: "If I give my private view on what should be the future shape of the system of health care (disease prevention) insurance in Japan, I would say that I think it should be developed as a binary or two-part system, with one part consisting of national health insurance aimed at the general population and one part consisting of labor insurance for employed persons. From the perspective of labor insurance for employed persons, the system of labor insurance was created, because it was deemed necessary for participation to be obligatory" (Kawamura et al., 1939, p. 7 ff)[5]. If one considers the subsequent development process of the medical insurance system in Japan, Kawamura's remarks may be seen as very perceptive. However, that said, when one reads

Kawamura's memoirs, one can see that even though he and others understood sufficiently well the significance and the necessity of creating a national health insurance system, he went as far as to note a very high level of unease and a lack of confidence in the possibility of realizing it. It is not that there were no reasons for this. Firstly, there was a powerful model for health insurance in the form of the German Sickness Insurance Law, but there was no model which could serve as a foundation for locality-based insurance. Secondly, in wartime Japan, large sums of money had to be invested in military costs, and however much the country advocated "healthy soldiers, healthy people" as a slogan, the climate was not one in which a policy that encouraged the expansion of public welfare would have been permitted. Thirdly, as a fundamental problem, there was no assurance that the concept of insurance would be accepted in farming villages. Furthermore, in terms of the grounds for establishing a contractual insurance relationship, on the one hand, in the case of employees' insurance, there is the employment relationship of insured persons (more specifically, employees) with their employers, while on the other hand, there is locality-based insurance, which rests solely on the very loose relationship of residing (having an address) in a particular locality. However, that said, the medical insurance system in the form of a dual system of employees' insurance and locality-based insurance has come to be fully accepted as appropriate to the circumstances of Japan. The reason for this, in the opinion of the writer of this paper, is that the insuring organizations were based on the foundation of social reality in the form of the existence of two strong collective entities in the form of the "company" (embracing both a private-sector enterprise and local government) and the "village" (village community). The meaning of these concepts is elucidated below.

In the case of social insurance, as distinct from private-sector insurance, there is a transfer of income from healthy persons to those with a tendency to become sick. Because insurance charges are also established in line with the ability to pay, there is a further transfer from high-income earners to low-income earners. It follows from this that in order to avoid giving tangible form to the dissatisfaction of healthy people or high-income people, it is rational, at the point of establishing the insuring organizations, to select bodies or communities that inspire some kind of sense of belonging, or some kind of feeling of solidarity, among the persons who are members of such bodies or communities. In the case of Japan, a "village" society was formed through the medium of the collective activities involved in irrigation and rice cultivation, and within this society, the core element was a strong communal consciousness, or in other terms, an awareness of mutual help and dependence. For example, there were a significant number of farming village localities in which, even after the advent of the Showa era (from 1926), the tradition persisted of having a mutual aid device (called a credit association) in the form of operating the distribution of financial contributions to residents of the village who had fallen on hard times. Moreover, in the neighborhood of Fukuma Town in Fukuoka Prefecture, there had existed since the Edo era a kind of prototype of a national health insurance system called in Japanese "*jourei*" (fixed thanks). Essentially, the system consisted of a mechanism whereby farmers could pay doctors for medical services with the rice that they produced. It is reasonable to think that it was because the national health insurance system was so well suited to the reality of this kind of agricultural society that it was accepted. Adopting another

perspective, there is one more powerful collective organization that exists in Japan, called in Japanese "*kaisha*" (literally translated, it means "company"). It cannot be claimed that at the time of enactment of the Health Law, mutual aid associations were sufficiently developed in Japan, but bodies like Kanebo Mutual Aid Association did exist, and were able to serve as a model for health insurance associations. And after World War II, particularly during the period of Japan's high economic growth, as the various factors that characterized the "Japanese management model", including lifetime employment, the seniority system, company-based labor unions, and so on, became an accepted part of the economic scene, the sense of belonging to an employment-based collective organization grew stronger. In the context of a growing economy, it became possible for company-based businesses to expand and, accompanying this expansion, the development of posts with benefits attached or of substantial welfare programs, became possible.

Summarizing the above, the existence of strong communal organizations in the form of employees' insurance (*kaisha* or company) and locality-based insurance (village) was matched by, and contributed greatly to the prewar and postwar general acceptance and development of a medical insurance system in Japan.

4. The problems encompassed by national health insurance and ways of responding to them

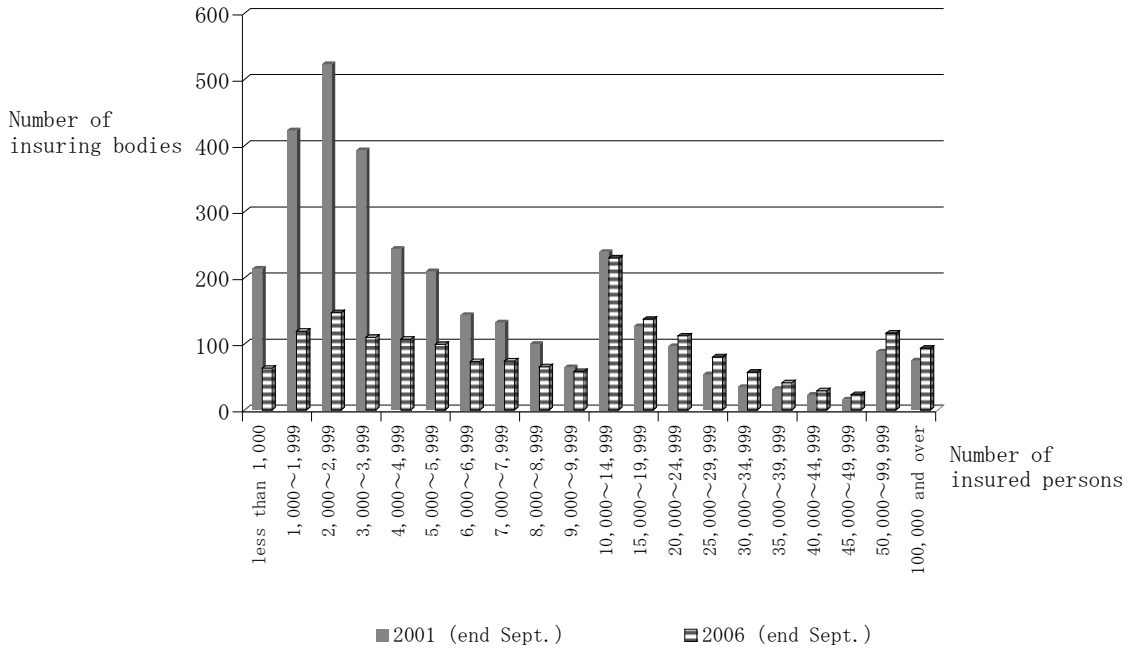
A medical insurance system is a superior-order structure in society. If social realities change, the medical insurance system is disturbed. In particular, the influence of changes in the population structure and the industrial structure is strongly reflected in the shape of the national health insurance system as it is finally formed. In this section, the author considers the problems contained in the national health insurance system from the perspective of a lack of homogeneity, and at the same time, explains what kind of responses are made to these problems.

4.1 The lack of homogeneity in national health insurance

The larger the number of users of a health insurance scheme, the more stable its management becomes. Furthermore, in a case where participation in the scheme is obligatory, it is desirable for the level of homogeneity among users to be high, and income distribution to be clustered around the midpoint. However, in the national health insurance system as it exists today, there is no uniformity in the scale of insuring bodies, in the professions of heads of households, or in income distribution. The situation is one in which there is a lack of uniformity in three senses.

1) There is a striking disproportion in the scale of insuring bodies. Diagram 1 shows the scale of insuring bodies (by the number of insured persons) before and after the Great Heisei Consolidation (merger of cities, towns and villages). Even though it is true that the number of small-scale municipalities (cities, towns and villages) is smaller after the consolidation compared with the situation before the consolidation, there are still large differences in the number of insured persons[6].

Diagram 1：Number of insuring bodies by insured persons



2) Unlike employees' insurance, the only condition which must be met by insured persons in the national health insurance scheme is that they reside (have an address) within the municipality concerned, and the members are comprised of persons with individual differences in terms of the type of income and the pattern of daily living. Table 1 shows clearly that national health insurance today is a changed world compared to the time when universal insurance cover was achieved. A particularly interesting point is that an examination of the occupational structure of heads of households shows that in 1965, immediately after the achievement of universal insurance, nearly 70% of heads of households were either self-employed or engaged in agriculture, forestry or fisheries work. Today however, a majority are unemployed (mostly elderly persons), while those in the 2 categories mentioned above, namely persons employed in agricultural industries and the self-employed, make up less than 20%. There can be no doubt that the national health insurance system of today insures not "a village", but "an assorted miscellany" of people.

Table 1：Changes in the structure of national health insurance by residents of municipalities

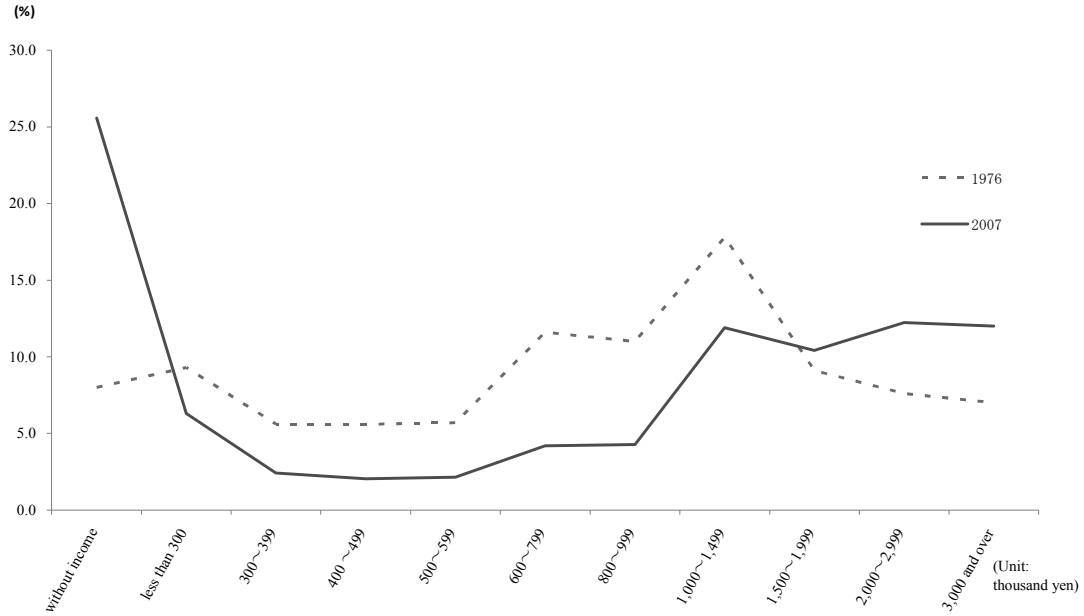
		FY1965	FY1985	FY2005
Number of participating persons (percentage of national population)		41.93 million persons (42.7%)	41.73 million persons (34.5%)	47.78 million persons (37.4%)
Percentage of elderly participants		5.0%	12.4%	29.7%
Number of persons per household		3.78	2.65	1.89
Occupation of the head of the household	Agriculture, forestry and fisheries	42.1%	13.5%	4.4%
	Self-employed	25.4%	30.1%	14.9%
	Persons employed on a non-regular basis	19.5%	28.7%	24.0%
	Unemployed	6.6%	23.7%	53.8%
	Other	6.4%	4.1%	2.8%
Percentage of households without income		—	15.1%	27.1%

[Notes] 1. The reason for choosing fiscal 1965 is that data from previous years (reports of investigations into the actual state of national health insurance) lacks stability.
2. The words "households without income" denote households from which there was no collection of insurance charges (tax).
3. The number of participants is the numerical value derived from "investigations into the actual state of national health insurance", and does not agree with the "Annual Report of National Businesses", representing an annual average.

[Source] Compiled by the author on the basis of "Reports of the Actual State of National Health Insurance", issued by the Ministry of Health, Labor and Welfare.

3) In terms of the income distribution of persons insured under the national health insurance program, households categorized as “having no income” under the Tax Law occupied a quarter of the total, while among those “in receipt of income”, 10.7% had an annual income of less than 500,000 yen, 10.6% an income of between half a million and one million yen, 11.9% an income of between 1 million and 1.5 million yen, 10.4% an income of between 1.5 and 2 million yen, and 12% an income of more than 3 million yen. This cannot therefore be regarded as a normal distribution. Looking at Diagram 2, compared to 1976 (the first year for which income distribution data is available), it can be interpreted from such factors as the increase in the number of households “having no income” under the Tax Law, that the distortions in the pattern of income distribution are becoming still more marked.

Diagram 2：Income distribution of households covered by national health insurance



[Source] "Reports of the Actual State of National Health Insurance", issued by the Insurance Bureau, Ministry of Health, Labor and Welfare

4.2 The problems comprised in national health insurance and ways of responding to them

The lack of homogeneity among insuring bodies is the fundamental problem of the national health insurance system. Specifically, 3 factors can be noted.

1) There is a striking variation in medical costs and insurance charges among insuring bodies. In fiscal 2009, taking first the difference in medical costs between different areas, the highest per capita costs (723 thousand yen in Tonaki Village in Okinawa Prefecture) are 4.5 times higher than the lowest per capita costs (159 thousand yen in Mikura Island in Metropolitan Tokyo). And the highest per capita insurance charges (118 thousand yen in Rausu Town in Hokkaido) are 4.7 times higher than the lowest per capita charges (25 thousand yen in Aguni Village in Okinawa Prefecture). Of course, insurance charges are decided according to how high or how low medical costs are, and a degree of variation in insurance charges cannot be avoided. However, even if one concedes that point, the occurrence of a difference of nearly 5 times among municipalities cannot be justified. It is worth noting in this context that if one takes prefectures as the units of measurement, the difference in medical costs per insured person shrinks to 1.6 times (between the highest cost of 492,000 yen for Kochi Prefecture and the lowest cost of 308,000 yen for Okinawa Prefecture), and also to 1.6 times in respect of insurance charges (between the highest cost of 89,000 yen for Tochigi Prefecture and 55,000 yen for Okinawa Prefecture).

2) In small-scale municipalities (cities, towns and villages), there is a likelihood that risk analysis will become difficult to operate and financial management will become unstable. For example, artificial dialysis costs more than 5.5 million yen a year. Nor is it strange to find costs in excess of 10 million yen in one month occurring in respect of heart operations, or several million yen a year for

the use of the latest drugs in cancer treatment. If patients requiring such kinds of treatment move into or out of the area of a small-scale insuring body, insurance charges will fluctuate wildly. Furthermore, it is inevitable that in small-scale insuring bodies, it will be impossible to locate staff with highly specialist, professional knowledge of health insurance, so that the administrative support system will be weakened. For example, the reality is that the establishment of health insurance charges depends completely on regulations set out in prefectural bylaws.

3) The decrease on the one hand of persons working in agriculture and the increase on the other hand of unemployed elderly persons is a cause of pressure on the revenue of the national health service system. The pressure arises from the fact that along with the increase in medical costs that comes with advancing age, many elderly people have a low level of financial resources. For example, there is a difference of 4.5 times in respect of the medical costs for a person aged over 65 compared with a person who has not yet reached that age. Furthermore, many people aged over 65 have only their pension, and on average their financial resources are lower than for someone who is employed. There are a rising number of voices, speaking from the perspective of the insuring bodies of the national health insurance system, claiming that this situation is not the responsibility of the insuring bodies as such, and that a solution depends on reforming the system.

Of course, faced with the problems in the national health insurance system as identified above, central government has not simply stood by and done nothing. For example, the following can be cited as classic examples of countermeasures: 1) In contrast to health insurance unions, which are in principle financed only by health insurance charges, in the case of the national health insurance system, investment from public funds has been set in principle at the high rate of 50%; and 2) In response to the growth in the number of elderly persons, a health insurance system for the elderly was established in 1973, and following this, a new medical care system for elderly persons was established in 2008. In addition, a further point regarding 2) is that it is fair to see the new medical care system for elderly persons as a mechanism to help or give relief to the national health insurance system. The reason for saying this is that the new system in fact comprises 2 systems; one is a system created for medical care for the advanced elderly, and the other is a financial adjustment system for the younger elderly. The former system is separate from the national health insurance system because it was created as an independent system targeting the advanced elderly over 75 years of age, while the latter system aimed at a transfer of money (financial adjustment) from the employees' insurance system to the national health insurance system, necessitated because the costs concentrated on medical care for the younger elderly had become an excessive burden on the national health insurance system. In addition to this, as distinctive financial support measures for the national health insurance system, under an agreement reached in December 2005 between the Minister for Internal Affairs and Communications, the Minister of Finance, and the Minister of Health, Labour and Welfare, the following 2 systems were established: 1) a support system provided by the insuring bodies (a mechanism for support from public funds in line with the percentage of low-income families that are members of the scheme) and 2) a kind of re-insuring system in the form of a mutual aid project to cover high-cost medical care (a project aimed at adjusting the cost borne by prefecture in cases where the costs exceeded 300,000 yen). It is also worth noting that these 2

systems were agreed to as provisional systems up to fiscal 2009, and that this period was extended to fiscal 2014 as a result of a revision of the law in 2010.

5. Debate concerned with application of the wide-area principle to national health insurance insuring bodies

5.1 The history of the debate concerned with the wide-area principle applied to insuring bodies

In the preceding Chapter, it was explained that, in response to changes in the increased number of elderly persons and in the industrial structure of the country, the law was revised in such a way as to lighten the financial burden on the national health insurance system. However, the problems arising from the small scale of the insuring bodies of the national health insurance system were not resolved. This is the reason why the debate about application of the wide-area principle arose.

Two points must be noted. One problem is said to be "old and new". For example, the report entitled "The future fundamental direction of administrative reform", issued on June 10, 1986 by the Provisional Administrative Reform Council included the following passage: "With regard to national health insurance, with a view to ensuring the long-term stability of the locality-based insurance system, we recommend, in the light of the operational situation of small-scale insuring bodies, that at the same time as aiming to apply the wide-area principle to the managing bodies, urgent consideration be given to setting up a debate on such matters as the preferred pattern of the role that should be played by prefectures in insurance management". Further, a report entitled "Concerning the reform of the national health insurance system in 1995", issued on December 9, 1994 by the Medical Insurance Commission, included the following points: "It is necessary to take forward reforms of the national health insurance system on the basis of an examination of how to strengthen measures directed at low-income families and of a re-appraisal of the position of small-scale insuring bodies. In these circumstances, there is a need for prefectures and municipalities, alongside the insuring bodies, to undertake a re-appraisal, while giving due consideration to the role they have played up until now in the management of national health insurance, and to the issue of how their respective future roles, within the context of reform, can contribute to fairness in terms of sharing the burden, and increasing the stability of the system of national health insurance." Against this background, it was stipulated in a Cabinet decision of March 2005, entitled "The fundamental direction concerning the national health insurance system as well as the medical examination remuneration system" that with regard to the national health insurance system, "prefectures and municipalities should consult together, and should aim to establish a more stable insurance operation within the framework of prefectures, by means of activating the system of wide-area unions, and taking forward, within this framework, the planned reorganization and integration of the insuring bodies".

The second problem concerns the medical system for the advanced elderly created after the issuing of the above "Basic Direction" in March 2005; it was stipulated in this document that the insuring bodies of this system were to be wide-area unions, organized by prefecture, in which all the municipalities of the prefecture concerned would participate. The wide-area unions themselves are

local public bodies (=local governments) (special local public organizations under the Local Autonomy Law), but the question that has to be asked is why wide-area unions, which are neither prefectures nor municipalities, were designated as the insuring bodies. Putting it simply, the reason is that they are a "compromise construction". Specifically, because neither prefectures nor municipalities wanted to accept financial responsibility for medical care for the advanced elderly, wide-area unions were a way of "passing the buck"[7]. In the course of the debate on this topic, it was proposed that responsibility for financial management should fall to prefectures, while responsibility for the collection of insurance charges should fall to municipalities. It was as a result of this that wide-area unions in which all the municipalities within a given prefecture would participate were stipulated as the insuring bodies. However, despite this stipulation, the manifesto of the Democratic Party of Japan made it clear that they would abolish the medical care system for the advanced elderly, and consequently that scheme is now being re-appraised. It follows from this that, beginning with the form that should be taken by the insuring bodies of the national health insurance system, the final decision on the insuring bodies for the medical care system for the advanced elderly has not yet been taken, and this matter too will be examined in the forthcoming debate. This is why the point was made in Chapter 1 of this paper that over the next 2 to 3 years, along with the debate on a re-appraisal of medical care for the advanced elderly, the biggest area of controversy within the context of reform of the medical insurance program will be that of what form should be taken by the insuring bodies of national health insurance.

5.2 The options for application of the wide-area principle to the concept of insuring bodies

As already explained, the preferred pattern for insuring bodies in the national health insurance program is closely linked to that of insuring bodies for the system of medical care for the advanced elderly. With regard to the latter point, the debate has centered on which of the following 3 options is most suitable: 1) municipalities; 2) wide-area unions; and 3) prefectures. The merits and demerits of each option, as generally indicated, can be listed as follows.

The first option is that of municipalities. The merits of stipulating municipalities as the insuring bodies can be cited as the following: 1) Because municipalities are the bodies that implement decisions on insurance charges and the like, their responsibility to provide explanations of charges and the like to a local assembly or to local residents is clear; 2) As administrative bodies which are very close to the lives of ordinary residents, they have information about the residents who live in the municipality concerned, and it is entirely appropriate for them, in the course of their normal duties, to have contact with the said residents in connection with such matters as the collection of insurance charges and clerical procedures concerned with the receipt of various kinds of applications, etc. On the other hand, one can cite, as demerits of municipalities as the insuring bodies, the unevenness in insurance charges among municipalities, as already referred to in this paper, and in particular, the difficulties faced by small-sized municipal insuring bodies in conducting financial management of the program.

The second option is that of wide-area unions. As merits, the following points are cited: 1)

Compared to municipalities, wide-area unions are in a position to be able to aim at achieving greater stability because of the application of the wide-area principle to their financial management: and 2) The clerical and administrative duties of wide-area unions can be carried out primarily by municipal employees who are thoroughly familiar with national health insurance and with the health insurance system for the elderly, making it also possible for procedural matters concerned with decisions on insurance charges and on the collection of such charges to be dealt with on the basis of close liaison between wide-area unions and municipalities. On the other hand, what is cited as a demerit is the fact that compared to prefectures and municipalities, local residents are not sufficiently apprised of the nature of wide-area unions[8]. An additional aspect is that because decisions on insurance charges are carried out by wide-area unions and because municipalities do not intervene directly, the situation that has arisen is one where accountability and an obligation to explain the system of insurance charges to the municipal assembly and to local residents are not demanded, hence there is no revenue collection policy incentive for municipalities to bear the burden of collecting charges.

The third option is that of prefectures. Cited as merits of this option are the following points: 1) Prefectures are in a position to be able to make an organic connection between an appropriate adjustment of medical charges and policy on such matters as the provision of medical services; and 2) prefectures are able to aim at the application of the wide-area principle in financial management as well as at greater stability. On the other hand, demerits cited are: 1) There is no accumulated know-how in prefectures concerned with administrative procedures in the area of medical insurance; and 2) because decisions on insurance charges are carried out by prefectures, and municipalities do not intervene directly, the situation that has arisen is one where, as in the previous option, accountability and an obligation to explain the system of insurance charges to the municipal assembly and to local residents is not demanded, hence there is no revenue collection policy incentive for municipalities to bear the burden of collecting charges.

6. The management of national health insurance and the preferred pattern of the insuring bodies

Up to and including the previous section, this paper has concentrated on setting out the issues for debate. From this point on, taking as the foundation an explanation of the area of operation of national health insurance as well as of the multi-layered nature of administrative duties, the paper will debate the question of what form should be taken by the insuring bodies of the national health insurance system.

6.1 The area of operation of the national health insurance system

On this point, each prefectural unit can be thought of as appropriately corresponding to an area of operation of the national health insurance system. The reasons for this were set out in detail in Chapter 4 and Chapter 5 of this paper, so will not be repeated here, but the major reasons are as follows: 1) The gap between municipalities as insuring units is too large, while on the other hand, in the case of blocks that are larger than a prefecture, the “distance” that separates such blocks as operating units from residents is too large; and 2) The main reason for the importance of prefectures

is that since they are also the insuring bodies for medical care too, they can also intervene positively in matters of medical insurance.

6.2 The multi-layered nature of the procedural duties of the national health insurance system

In the case of employees' insurance, with particular reference to health insurance unions, the duties concerned with the administration of insured persons, the establishment and collection of insurance charges, and so on, are handled by the insuring body, which also accepts financial responsibility. In contrast to this, in the case of the national health insurance system, the insuring body cannot accept complete responsibility for insurance, hence there is no alternative to a multi-layered system. The term "multi-layered system" means specifically that the responsibility for the implementation of duties is divided, and in particular, that it is inevitable that management of the national health insurance program is spread over a wide area. The reason for this is that duties concerned with the supervision of insured persons, has to be handled by municipalities as the organs which hold information about the addresses of such persons. Of course, it is possible for the information in the Basic Residents' Register (BRR) to be passed to another body (e.g. prefectures), and for a formal decision to be made by the prefecture. At the present time, however, procedures such as obtaining confirmation that the address concerned is held by the municipality cannot be carried out without the cooperation of the said municipality. Furthermore, such procedures as collection of insurance charges also have to be carried out by municipalities. In practice, in the context of medical care for the advanced elderly, it has been decided that even though wide-area unions are the insuring bodies, these procedures can be carried out by municipalities.

However, the above does not mean that bodies other than the insuring bodies have no responsibility for distributed duties. On the contrary, it is important that a set amount of financial responsibility in respect of distributed duties is laid upon the body with authority. For example, if a prefecture becomes the insuring body, the prefecture indubitably accepts financial responsibility, but on the basis of the principle that the national health insurance system supports the universal insurance system, central government accepts responsibility for the basic design of the system as a matter of course, and in addition, for a set percentage of the costs, and for making adjustments to correct the imbalance in income among prefectures. Furthermore, there is no alternative to having the duties of supervising insured persons and collecting insurance charges shouldered by municipalities, and it should be possible to ensure that municipalities take responsibility for financial problems resulting from slowness of efforts in making collections. It should also be noted that at present, the kind of mechanism referred to here has not been realized within the context of the medical care system for the advanced elderly, but it is possible to adjust the system so that efforts made by municipalities in making collections are appropriately reflected, and the opinion of the author of this paper is that this is what should be done.

6.3 The insuring bodies of national health insurance

In a case where the operational management area of the national health insurance system is

extended to cover the unit of a prefecture, there are 3 candidates for the role of insuring bodies, namely 1) wide-area unions; 2) prefectures; and 3) public corporations (mutual aid associations).

Looking first at the option of wide-area unions, there is a precedent for this in the medical care system for the advanced elderly, and it is reasonable to think that this option could be relatively easily adopted. However, the problem points set out in Chapter 5 above apply without change to the national health insurance program. Specifically, problems likely to arise are the following: 1) Prefectures do not participate in wide-area unions, so it is difficult for them to make wide-area adjustments; 2) There will be no incentive to raise the level of collection of insurance charges by municipalities; and 3) The employees of wide-area unions are made up, in addition to municipal employees, of persons who are "temporarily detached" from prefectures or from the National Health Insurance Federation, and who lack specialist skills. It follows from this that even if wide-area unions were to be made the insuring bodies for the national health insurance system, it would be necessary to ensure that the same mistake was not made as in the case of the wide-area unions for medical care for the advanced elderly (e.g. by ensuring that prefectures also participate in wide-area unions, by taking into account the receiving proportion at the time of calculating the burden to be borne by municipalities, and by appointing proper employees with specialist skills.).

The second option is that of using prefectures directly as the insuring bodies. As the reason for this can be cited the fact that wide-area unions are half-way solutions, not having the status either of prefectures or of municipalities, and it cannot be denied that their possession of responsibility is ambiguous. Moreover, looking at the application of the wide-area principle to national health insurance, such factors as the difference in medical costs within a prefecture, or the maldistribution of medical care institutions constitute bottlenecks, but the implication is that prefectures can urge that these imbalances within an area are positively tackled. However, even if prefectures were made the insuring bodies, the cooperation and intervention of municipalities would be indispensable. Moreover, while the collection of insurance charges has to be entrusted to municipalities, there is a fear that if some mechanism is not introduced whereby the consigned charges are made to reflect the actual position of the preceding year, the management of national health insurance will become a matter which can be "left to prefectures", and the process of governance will be loosened.

The third option can be thought of as making public corporations (mutual aid associations) the insuring bodies[9]. Reasons adduced in favor of making this choice are that, as explained at the end of Chapter 2, in the case of both wide-area unions and prefectures, the problem of deviation from the principle of autonomy of the parties directly concerned with social insurance or from democratic decisions taken by insured persons, cannot be eliminated. An outline of the choice of the public corporations option comprises the following 4 points: 1) Compulsory establishment of public corporations on the basis of the National Insurance Law, and provision of the authority to enforce participation by all residents (other than those covered by employee-based insurance) as well as the compulsory collection of insurance charges; 2) Election by the people insured by national insurance (since administering independent elections requires a great deal of money, elections should be carried out in conjunction with the election of prefectural assemblies) and establishment of a decision-making organ comprising representatives of persons chosen by this method, with decisions

on such matters as the insurance charge percentage and budgetary calculations to be made by this body; 3) 4 implementation bodies to be stipulated, comprising the representatives of insured persons, the representatives of prefectures, the representatives of municipalities, and representatives of public corporations, with a stipulation that the personnel employed must have proper specialist qualifications; and 4) A clear stipulation in the National Insurance Law of regulations concerning the financial obligations of central government and of prefectures, and along with this, consignment to municipalities of the duty of supervising elected persons as well as of the collection of insurance charges (the collection percentage of insurance charges to be reflected in the consigned collection charge). However, it is reasonable to assume that there will be criticisms as to whether sufficient cooperation can be obtained from prefectures and municipalities, and whether the election by insured persons can realistically be implemented.

In short, there are strong points and weak points in each of the three options listed above. It is likely that the easiest option to move to from the present situation is the wide-area union formula, that the option which is most able to administer in a sound and dependable way adjustments to the financial management of national insurance and the system of providing medical care is the prefectural formula, and that the option which reflects most accurately and loyally the ideas of social insurance is the formula of public corporations. On the other hand, every option has problem points, as indicated above. The writer of this paper feels an attraction toward the idea of making public corporations into the insuring bodies, but accepts that it may be necessary to adopt the wide-area union formula or the prefectural formula in the first instance, and then move to the formula of public corporations (a two-stage process). Alternatively, if election by insured people proves difficult, it may be possible to introduce a "proxy" mechanism in the form of establishing a management consultation council composed of representatives of insured persons. Whatever the route chosen, the mechanism for establishing an insuring body and its governance is one of the most important items to be discussed in designing a medical insurance system, and there is a need to return to basics and to make a thorough and adequate examination of all the issues.

7. Conclusion

In the course of tracing the formation of the national health insurance system and the changing process of its evolution, this paper has explained the reasons why a system, unparalleled in the rest of the world, came into being in Japan in the form of locality-based insurance, and has set out the debate on the basic problem points faced by the national health insurance system today as well as points such as the necessity of application of the wide-area principle and the preferred pattern to be adopted by insuring bodies. In the final Chapter, the paper set out the need to examine the option of making public corporations the insuring bodies at the same time as applying the wide-area principle. It is likely that the number of people connected with the national health insurance system who agree with the paper's analysis will be few in number. However, given that, to put the issue in its most basic terms, the insuring parties act as a mouthpiece for the interests of the insured persons, the author feels a sense of incongruity at the complete lack of a perspective of procedural justification from the debate on what form the said insuring bodies for national health insurance should take. The

essential significance of social insurance is to be found in the fact that the insured persons participate in decision-making, and decide in a democratic fashion the relationship between the provision and the burden; in this context, the significance of this kind of autonomous, democratic decision-making will become more important as financial restrictions are strengthened. Assuming that to be the case, the option of choosing public corporations as the insuring bodies of national health insurance should not be excluded as if it is something completely absurd. At the very least, a perspective which explores what kinds of methods are possible to ensure that the will of the insured persons is appropriately reflected in the management of national health insurance must be put in place.

Notes

1 Putting this more precisely, unions of self-employed persons such as the National Health Insurance Medical Union, or persons in receipt of welfare benefits are excluded from the applicability of municipal national health insurance. Further details can be found in Article 6 of the National Health Insurance Law.

2 As will be explained later in the paper, these wide-area unions were established with a view to the implementation of the Medical Care System for the Advanced Elderly, and constitute bodies in which all the municipalities within a given prefecture participate.

3 A further point is that municipalities at this time were smaller in size than at present, and the area (range of jurisdiction) of the union was established so as to match the area of the municipality.

4 The popular name of the Commission was the “Seven-Man Commission”, since it was made up of 7 selected persons of learning and experience and established to investigate the financial policy of health insurance.

5 The style of writing used in the quotation [in the original Japanese version] has been amended to reflect modern usage without altering the meaning.

6 At the end of fiscal 2007, the smallest unit of insured persons under the national health insurance program was Mikura Island (104 persons), while the largest unit was Yokohama City (1.18 million persons), so the largest unit was more than ten thousand times the number of the smallest.

7 In an “extension” of the debate on the medical care system for the advanced elderly, with regard to the rights and wrongs of the reorganization of the insuring bodies of national health insurance on the basis of prefectural units, in the hypothetical event of such reorganization, the problem of who will become the insuring body still remains. Scrutinizing the matter a little more deeply, the establishment of insuring bodies for the medical care system for the advanced elderly has the implication of having been a preliminary skirmish to the real battle of whether municipalities should remain as the insuring parties of the national health insurance system as at present, or of whether in the future they should be prefectures. That is the reason for the sharpening of the antagonism between prefectures and municipalities.

8 Furthermore, under the Local Autonomy Law, it is possible for the chief of wide-area unions to be directly elected by popular vote, but in the case of the wide-area union for the system of medical care for the advanced elderly, the chief cannot be directly elected by residents.

9 It is reasonable to think that persons connected with the national health insurance system will feel a sense of incongruity, but in the case of the insuring bodies of employee-based insurance, corporate bodies such as the health insurance unions or the national association of health insurance unions bear the burden of the costs. Seen from such a perspective too, it is necessary for there to be a foundation in law, but an interpretation has been made to the effect that it is possible to confer the authority to enforce participation or to make collections on such bodies.

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