Medical Insurance in Japan

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Foreword

The practice of Kampo medicine in Japan is sustained by the country's medical system. The reason that Kampo medicine is so widely used for medical purposes is due to its acceptance by medical insurance. The medical system in Japan is not the same as that in other countries. With a unique Japanese framework, and operated through the political support of the Health, Labor and Welfare Ministry; the Japanese medical system has sustained the health of the Japanese people. When considering the role played by Kampo medicine in Japanese healthcare, it is extremely important to look at how Kampo medicine is managed within the medical system.

As noted in other parts of this journal, the reasons that physicians educated in Western medicine can practice Kampo medicine are (1) drugs used in Kampo medicine can be dispensed easily, and (2) the existence of 148 types of these drugs which have a high level of compliance in their use. After learning a certain degree of traditional medical concepts, physicians introduce these drugs into their own clinical practice. Utilizing these drugs, and the insurance system that sustains their operation, they perform clinical tests and independent research, including research based on the accumulation of case studies and comparative studies.

Meanwhile, there are medical institutions, though not many, which provide medical treatment based on Kampo medicine, at their own expense. In particular, there are many places that use herbal medicine as therapeutic drugs. While more than 160 types of herbal medicine are accepted by healthcare insurance, it is financially difficult for herbal medicine to be used with health insurance treatment. This is due to such problems as their excessively low cost, the fact that they require a great deal of manpower and shelf space, and the difficulty in securing pharmacists who posses a high degree of knowledge in this area. While providing medical treatment at one's own expense is much simpler than providing health insurance treatment, it is another form of Kampo medicine practiced in Japan.

This article, written by Ono, explains the medical system in Japan. The overall theme is much larger than Kampo medicine, and has very little to do with clinical Kampo medicine. Nevertheless, we have included it to let readers know that medical treatment is based on this system. This article also contains information that will be useful to people who intend to study about the Japanese medical system.

Editorial Staff

1. History of Development of the Medical System

(1) Medical Security System and Social Security

Broadly defined, Social Security in Japan includes protection and pensions for victims of war. Narrowly defined, it means public assistance (livelihood assistance), social welfare (for the physically disabled, mentally disabled, elderly, children, single mothers, etc.), social insurance (medical insurance, annuity insurance, nursing insurance, unemployment insurance, industrial injury insurance, etc.) and public health (tuberculosis, infectious disease, drug-related measures, waterworks and drainage, waste management, etc.). Other than exceptional cases such as people who receive livelihood assistance based on low income (0.8% of the total Japanese population), all Japanese citizens currently have a form of medical insurance, which is one of the medical services guaranteed to all Japanese citizens.

(2) History of the Medical Security System

① Structure of Universal Health Insurance System

The history of medical insurance in Japan dates back to the establishment of the Health Insurance Law in 1922. This law became institutionalized for employees at factories and elsewhere, amid the rise of the labor movement during the development period of capitalism at the beginning of the 20th century. Subsequently, in 1938, the system of national health insurance was established for individual proprietors and farmers. As a result, in 1945 approximately 60% of the Japanese population had medical insurance.

However, with the chaos of World War II, it became impossible to provide sufficient healthcare to people, and the system was in danger of collapsing. With the economic and social reconstruction after the war, the construction of a genuine system of social security began. And the system of medical insurance, which had been on the brink of collapse, was also reconstructed.

The national treasury assumed the burden of government-managed health insurance in 1954. In 1963 a 3-year period of health insurance provision which had been in place thus far was abolished, the time limitation on insurance during recuperation was eliminated, and plans to improve health insurance were discussed.

Meanwhile, based on revisions in 1954, the management of national health insurance was revamped from the regular Blue Cross system conducted by individual cities, towns and villages, to public management by municipalities. In addition, it became compulsive for municipalities managing national medical insurance to make this insurance available to residents. In order to stabilize the finances of national health insurance, based on revisions in 1955, a system of national treasury assistance equivalent to 20% of recuperation expenses became law.

Under such conditions, the National Health Insurance Law was completely revised in 1958, and a yearly plan was decided for the realization of universal health insurance over a period of four years. In 1961, a system of national health insurance was put into effect in all municipalities for individual proprietors and farmers who did not have employee's health insurance. The result was universal health insurance in Japan, based on employee's health insurance and national health insurance. After that, it became compulsive for all Japanese citizens to have either employee's health insurance or national health insurance – both of which are forms of social insurance.

② Establishment of Healthcare System for the Retired

It is a qualification requirement that people receiving employee's health insurance in Japan be employed at a place of business enumerated in the law. After an employee retires because he or she has reached retirement age or for another reason, that employee is no longer employed at the place of business, and as a general rule will no longer receive employee's health insurance – but instead will receive national health insurance.

The level of health insurance for such aged retirees drops at a time when their need for healthcare is on the rise, resulting in the problem whereby they must depend on the national treasury and national health insurance premiums to pay their healthcare expenses. For this reason, a medical care system for the retired was established in 1984 to ensure fairness in the provision of healthcare and the burden of its costs throughout the lifetime of people who receive employee's health insurance, and to correct irrationality between medical care systems. While the rate increases at which healthcare is provided to aged retirees who formerly had employee's health insurance but who have since begun receiving national health insurance, this system pays for that healthcare by the insurance premiums from retirees who had been receiving employee's health insurance and by contributions from employee's insurance.

③ Establishment of Health Insurance System for the Elderly

As mentioned above, due to the relationship between employee's insurance and National Health Insurance, the percentage of elderly people who have National Health Insurance increases as society ages. Furthermore, as the structure of employment in Japanese society changes from primary industry to secondary industry, and from secondary industry to tertiary industry, the younger segment of society switches to employee's insurance rather than National Health Insurance. As a result, the age composition of insurants with National Health Insurance has gradually risen. In 1998, the average age of people with an insurance policy was 51.3 years for National Health Insurance through municipalities, 36.9 years for government-managed health insurance, and 33.6 years for union-managed health insurance. The percentage breakdown for elderly people with health insurance is 25.3% for National Health Insurance through municipalities, 5.7% for government-managed health insurance and 2.8% union-managed for health insurance.

If the situation by which the age composition of insurants is made light of is projected into insurance area of finance, if there were no system of adjustment between types of coverage, the higher the age composition in a system of insurance the more difficult it becomes to finance that system. And overall the insurance premium revenue obtained from elderly people is not as large as that obtained from the younger segment. Meanwhile, as far as expenses are concerned, since the per-person healthcare costs for the elderly is five times that of the younger segment, as the percentage of elderly people increases so increase healthcare costs. (As a result, in 1999, healthcare costs for the elderly accounted for 38%, or 11.8 trillion yen, of the total of 30.9 trillion yen in national healthcare costs. What's more, the percentage of healthcare costs for the elderly increases each year.)

Also, in 1973, based on revisions in the Elderly Welfare Law, a system was established whereby so-called free healthcare costs for the elderly (the amount for which the individual elderly person is responsible under healthcare insurance), are paid for at public expense. With the subsequent rapid increase

in healthcare costs for the elderly, there has been more pressure for the financing of National Health Insurance.

For this reason, the difference in age composition among insurers that comes with the aging of society has been corrected – and from the viewpoint of spreading the burden of healthcare costs for the elderly fairly among the Japanese people a health service system for the elderly was established in 1983.

Also, health and medical treatment measures provide for the treatment of disease – and based on the knowledge that comprehensive measures for the health of the elderly have been lacking, not only does the health service system for the elderly deal with problems of finance, but it also has to do with comprehensive insurance for the elderly, which includes measures for preventing and detecting disease early on, during the prime of life, so that the increasing number of elderly people can live healthy lives.

④ Establishment of a System of Nursing Insurance

As society ages there has been a sudden increase in the number of people who require nurses, including those who are bedridden and those who suffer from dementia. Meanwhile, changes in social conditions, including the growing number of nuclear families and the social advancement of women, have witnessed a decrease in the function of nursing provided by families.

However, since nursing service for the elderly was formerly provided under two different types of coverage – welfare coverage for the elderly and insurance coverage for the elderly – there was a disproportion in the burden of cost and usage procedure, so that the situation was inadequate for comprehensive nursing measures. For this reason, so that elderly people who require nursing or care will be able to lead meaningful lives in accordance with their own ability, a system of nursing insurance coverage was established in April 2004, to provide comprehensive service, including insurance, healthcare and welfare services, based on user selection.

⑤ Maintenance of the System for Healthcare Provision

The modern healthcare system in Japan began in 1874 with the establishment of the medical system. The National Healthcare Law was subsequently established in 1942, and with the difference between hospitals and clinics being clarified, a system for permitting physicians to establish clinics was put into effect.

After the war, in 1948, the Healthcare Law, on which the system for healthcare provision in Japan is based, was established. Also, with the Doctor and Dental Practitioner Law being gradually put into place, there has been a quantitative expansion of healthcare provision for acute medical treatment.

Subsequently, with changes in the structure of disease and the aging of society, there has been a review of the system of healthcare provision.

In 1985, a healthcare planning system by prefecture was introduced for the purposes of revising the system of healthcare provision locally as part of the first round of revisions of the Healthcare Law, and obtaining the cooperation of healthcare facilities. Also, an adequate number of hospital beds have been realized.

In 1992, the Healthcare Law was revised a second time for the purposes of (1) realizing conceptual regulations for providing healthcare, and (2) the systemizing the function of medical facilities with technologically advanced hospitals and extended care units having been systematized.

Furthermore, when the Healthcare Law was revised for a third time in 1997, (1) informed consent regulations were realized, (2) extended care units were expanded into clinics, (3) community health support hospitals were systematized, and (4) the system of healthcare planning was reviewed.

When the Healthcare Law was revised for a third time in 2000, (1) a distinction was made between beds for general patients and beds used for the purpose of recuperation, and the provision of healthcare was promoted to suit the condition of the individual patient; (2) there was an easing of required regulations; (3) there was a securing of the observance of hospital arrangement standards; and (4) measures were adopted for easing advertising regulations.

2. Structure of Disease

The structure of disease in Japan has changed from acute infectious disease to chronic lifestyle disease, based on such things as improvement in nourishment, higher hygienic standards, advances in medicine and medical technology, and changes in health awareness. In view of the annual transition in the percentage of cases of hospitalized treatment, there has been a remarkable decrease in infectious and parasitical diseases, with a drastic increase in disease of circulatory organ systems, including cerebrovascular trouble, as well as neoplasm such as cancer. Also, death ratio according to cause of death indicates a sudden decrease in the death rate from

tuberculosis, and an increase in the death rate from cerebrovascular disease and malignant growths.

3. Healthcare Costs

(1) Total Healthcare Costs and Their Breakdown

National healthcare costs in Japan are on an upward trend, even under conditions of slumping economy. Healthcare costs reached 30,933,700 million yen in 1999, or 244,200 yen per person.

This notion of national healthcare costs represents the cost for treating ailments among the Japanese population at medical facilities over a 1-year period. These costs are calculated based on expenditures for public healthcare insurance. Included in national healthcare costs are medical treatment fees, the responsibility of patients to pay for a portion of the costs, the cost of providing medicine, nursing costs, and transportation costs. However, expenses for normal birth, expenses required for medical checkups for the maintenance and promotion of health, expenses for amenity bed, and a portion of the construction costs for public medical institutions are not included. Also, as a general rule, since healthcare costs are free of consumption tax, there are no taxes for their expense. In Japan, the details of medical practice, the administering of medication and medical examinations appear in statements submitted by medical institutions as the foundation of a progress payment system based on a nationally standardized medical treatment fee bill used by both hospitals and clinics. And so, by totaling up the amount paid based on medical fee statements, the particulars and monetary amounts of medical treatment performed at medical facilities are understood on the national level. And based on such social insurance statistics, national healthcare costs are determined with the addition of data other than social insurance, including healthcare costs paid for at public expense.

Including the cost of purchasing medicine, public health expenses (including medical checkups and vaccinations), managerial and operational costs, and research and development costs, this corresponds to the total healthcare costs of the OECD. Total healthcare costs in Japan (1998) are 7.4% of the GDP, which ranks number 18 among nations belonging to the OECD. However, in terms of monetary amount, this represents 283,558 million dollars, second only to the 1,125,555 million dollars of the United States. The per-capita healthcare cost is 2,242 dollars for Japan (ninth), with Germany at 2,697 dollars (fifth), France at 2,324 dollars (eighth), and the Netherlands at 2,172 dollars (tenth) – which means that there is not such a big difference in per-capita healthcare cost among these nations.

Looking at the breakdown of healthcare costs in Japan in terms of national healthcare costs (fiscal 1999) by consultation type, general consultation costs involving admittance to the hospital account for 36.8%, dental clinics account for 8.2%, dispensing pharmacies account for 7.8%, costs for meals and medical preparations when patients are admitted to the hospital account for 3.5%, health service facilities for the recuperation of the elderly account for 2.5%, and home nursing and medical costs for the elderly account for 0.3%.

Breaking things down by category of expense at medical institutions (fiscal 1998), personnel costs involving healthcare attendants account for 50.9%, the cost of medical supplies accounts for 19.4%, the cost of medical materials accounts for 6.1%, and consignment expenses account for 5.2%. By fiscal resources (fiscal 1999), public expenses account for 32.9%, the cost of insurance premiums accounts for 52.5%, with other costs accounting for 14.7%.

(2) Healthcare Costs for the Elderly

Healthcare costs for people of the age of 70 and older (including bedridden people between the ages of 65 and 70) (hereinafter referred to as "healthcare costs for the elderly") reached 11,804 billion yen in fiscal 1999. The trend for increasing healthcare costs for the elderly is remarkable, with these costs accounting for 38% of total national healthcare costs.

Breaking down national healthcare costs by main causes for this increase, increase in population accounted for 0.2% of the 3.7% increase in fiscal 1999, the aging population (change in the population composition by age level) accounted for 1.6%, with other increases (change in the structure of disease, advances in healthcare, etc.) accounting for 1.9% of the total increase – which means that the effect of aging is great. Also, while the total cost of national healthcare increased by 3.7%, the increase in healthcare costs for young people was 1.0%, with the increase in healthcare costs for the elderly at 8.4%.

The reasons that the cost of healthcare for the elderly causes healthcare costs to increase are because of the increase in the population of elderly people, and because of the fact that per-capita healthcare costs for the elderly are five times greater than the costs of healthcare for young people. When comparing the difference between healthcare costs for the young and old in Japan to that in American and European countries based on data from the OECD, the difference in Germany is 2.68 times (1994) and the difference in France is 3.00 times (1993), so that the difference between the young and old is generally between 2 and 4 times – which means that this difference is higher in

Japan than in Western countries. In Japan consideration must be given to the fact that the costs of nursing have traditionally been calculated as healthcare costs, due to so-called "social hospitalization," whereby people are hospitalized at medical institutions due to such factors as outdated nursing services provided to the elderly, although medical treatment might not be necessary.

The cause of high healthcare costs for the elderly has to do with each of the three elements of healthcare cost per capita. Among the three elements, the "consultation rate" is an index indicating how often a person with healthcare insurance is seen at a medical institution per month. In this case, the number of instances of consultation is the same as the number of bills for medical treatment issued by medical institutions, with one bill per patient issued by each medical institution. The consultation rate for the elderly is 6.2 times that of young people for patients who are hospitalized, and 2.6 times that of young people for outpatients.

The next element, "number of days per instance," is the average of the actual number of days of consultation per month as indicated in the consultation fee statements from medical institutions. The number of days per instance for elderly people is 1.3 times greater than that number for young people who are hospitalized, and 1.4 times greater than that number for young people who are outpatients.

The "per-day consultation cost," which is the consultation cost (billed to the medical insurance each month) divided by the actual number of days of diagnosis and treatment, means the unit price of healthcare service. This per-day consultation cost for the elderly is 0.9 times greater than that for young people who are hospitalized, which means that it is less for the elderly than for the young. The per-day consultation cost for outpatients is 1.2 times greater for the elderly than it is for young people.

As indicated above, the reason that the cost of healthcare for the elderly is higher than it is for young people is due to the fact that the consultation rate for the elderly is much higher than it is for young people, both for patients who are hospitalized and for outpatients. Amid this situation it is surmised that elderly people, who have numerous adult lifestyle diseases such as diabetes and high blood pressure, frequently consult physicians at medical institutions. Furthermore, with the free access in the Japanese healthcare system which enables patients to choose the medical institution where he or she will consult a physician, it is believed that other reasons include the fact that there is a smaller percentage of elderly people who take the responsibility of healthcare costs upon themselves, and the fact that the excessive number of hospital beds and outdated nursing services promote so-called social hospitalization.

Of course, the average life expectancy in Japan is 77 years for men and 84 years for women, both of which are the highest in the world. With the average healthy life for men and women in Japan at 74.5 years, the WHO, both in quality and equality, ranks the Japanese insurance and healthcare systems number one in the world. However, with the further advance of aging in the future, it is estimated that national healthcare costs will reach 81 trillion yen in 2025, 45 trillion yen, or 56%, of which will be accounted for by healthcare costs for the elderly. These national healthcare costs account for 12.5% of the national income, for an increase of approximately 1.7 times that of the 7.5% figure for 2000.

Before there is a sudden rise of healthcare costs for the elderly, it is important for Japan to establish measures for the prevention of disease and general healthcare, keeping in mind the matter of lifestyle disease. In addition, Japan faces the urgent task of reforming the system of healthcare for the elderly.

4. System for Providing Healthcare

(1) Amnesty for the System of Providing Healthcare in Japan

The system for providing healthcare in Japan has the following nine features. (1) There is a system in place by which physicians and dentists are free to establish clinics if they notify the prefectural governor of that establishment. (2) Hospital doctors are working doctors. (3) There are no restrictions on consultation fees. (4) There is a high percentage (approximately 80% of the number of facilities) of private hospitals (medical corporations); there is a high percentage of small and mid-sized hospitals with 200 beds or less (approximately 70% of the number of facilities). (5) Some clinics have beds, and clinics are equipped with medical equipment and facilities. (6) Hospitals take outpatients, and the consultation rate for those patients is high. (7) It is prohibited for hospitals or clinics to operate for profit. (8) People are free to choose the medical institution where they will consult a physician. (9) On the average, patients in Japan remain hospitalized for more days than patients in many of the other countries belonging to the OECD; Japanese hospitals have more beds per patient than many of the other countries belonging to the OECD; Japanese hospitals have a fewer number of physicians and nurses on staff per bed than many of the other countries belonging to the OECD.

(2) Medical Facilities

Broadly speaking, medical facilities can be divided into three categories: hospitals, clinics and maternity clinics.

Hospitals are medical facilities that have at least twenty beds, and must receive permission from the prefectural governor to be established.

Some hospitals, known as "technologically advanced hospitals," provide advanced healthcare, and based on an application submitted by the individual hospital are individually approved by the Ministry of Health, Labor and Welfare to perform development, evaluation and training in advanced healthcare. Specifically speaking, these include university hospitals and national cancer centers, with 82 such facilities having been approved as of April 2002.

Also, from the viewpoint that family doctors and dentists should be supported in order to ensure healthcare in local regions, there exists a system of "hospitals supporting local healthcare," approved by the prefectural governor. As a condition for being approved, hospitals supporting local healthcare must provide healthcare to referred patients, provide support to local healthcare facilities by such means as the joint-utilization of facilities and equipment and making facilities and equipment openly available, provide emergency medical care, and train healthcare attendants in the local region. As of April 2002, there were 35 facilities that had been so approved.

Clinics either are medical facilities that have no beds at all or have hospitalization facilities of 19 beds or less. If a physician or a dentist opens a clinic, he or she must notify the prefectural governor (the mayor of the city or special district where the public health center is set up). If a person other than a physician or a dentist opens the clinic, he or she must receive permission from the prefectural governor (the mayor of the city or special district where the public health center is set up).

Maternity clinics are medical facilities that either have no beds at all or have hospitalization facilities of 9 beds or less, and where midwives work. If a midwife opens a clinic, she must notify the prefectural governor (the mayor of the city or special district where the public health center is set up). If a person other than a midwife opens a clinic, that person must receive permission from the prefectural governor (the mayor of the city or special district where the public health center is set up). The prefectural governor must grant permission to a facility that so applies if its structural equipment and stationed personnel conform to a certain standard. However, the prefectural governor might not grant permission for the establishment of such a facility if the person applying for permission intends to operate that facility for profit.

(3) Healthcare Attendants

The number of doctors and dentists in Japan is on an upward trend each year, and as of 2000 there were 255,792 doctors and 90,857 dentists. While this is less per capita than those numbers for other advanced nations, Japan achieved the target of having "150 doctors and 50 dentists per 100,000 people by 1985," which was set in 1970. In order to ease the excessive number of personnel in the future, the university admission capacity has been decreased.

And in efforts to improve quality and raise the level of clinical ability, clinical training for graduates was systemized and enhanced.

The number of nursing personnel per capita in Japan is on the same level as that in other advanced nations, but the number of nurses per hospital bed remains low. According to the forecast regarding recipients of nursing services in December 2000, demand at the end of 2001 will exceed supply by approximately 35,000 people due to such factors as the realization of a more cordial system of nursing, improvements in working conditions, and the carrying into effect of a system of nursing insurance coverage. However, it is forecasted that supply and demand will balance out at about 1,300,000 people by 2005.

There are two types of nurses. One is the so-called associate nurse, who receives a license after passing a test offered by the prefectural governor. The other is the regular nurse, who receives a license after passing a test offered by the minister of health, labor and welfare. The former changing to the latter and the improvement of quality have become issues.

(4) Healthcare Corporations

According to the Healthcare Law, a hospital, or a clinic where doctors and/or dentists work, or a corporation or foundation that intends to establish a health service facility for the elderly may make that facility into a healthcare corporation. The approval of the prefectural governor (or the minister of health labor and welfare, for two or more businesses) is required to establish a healthcare corporation. As conditions for approval to establish a hospital, the establisher must have a capital adequacy ratio of 20% or more, and there must be three directors, one inspector, and as a general rule the chief director must be a doctor or a dentist.

A healthcare corporation is prohibited from having a dividend of surplus, and any contingent business is

limited to being within the scope of the training of healthcare practitioners. What's more, as a general rule business for profit is prohibited.

Healthcare corporations are subject to the following taxes: corporation tax (the same tax rate as a joint stock company) and enterprise tax (anything having to do with social health insurance treatment rewards is tax-free, and tax rate reductions apply to anything having to do with diagnosis and treatment chosen at the discretion of the patient).

Included among healthcare corporations are "specified healthcare corporations" which, based on the Special Taxations Measures Law, are approved by the minister of finance as a corporation which meets certain conditions, including operating a business which has a high level of public interest, and/or which is publicly managed. Also included among healthcare corporations are "special healthcare corporations" which, based on the Special Taxations Measures Law, are approved by the prefectural governor for meeting the same conditions. Special healthcare corporations receive corporation tax rate reductions. And special healthcare corporations are allowed to operate certain types of business for profit.

(5) Evaluation of Medical Practice

Against a backdrop of increased popular awareness for healthcare and rising concern among affiliates for the quality of healthcare, the Project for the Evaluation of Hospitals by a Third Party was carried into effect in 1997.

Through this evaluation project, the quality of diagnosis and treatment, nursing, and other care provided by a medical institution, patient satisfaction and the situation of management are evaluated by the Japan Council for Quality Health Care, as a third party from a neutral standpoint, based on a request from the hospital. If the results of the evaluation are of a certain standard or above, a certificate of approval is issued to the hospital. Although hospitals are not required to undergo this evaluation, 725 hospitals had received a certificate of approval as of August 2002.
From the viewpoint of improving the quality of healthcare, progress can be expected from the evaluation of medical practice by a third party. But in order to promote this trend hospitals are now allowed to publicize the results of their healthcare evaluation. And through revisions of healthcare fees in 2002, the inclusion of palliative care has become a condition for approval by the Japan Council for Quality Health Care and for ISO certification.

5. Healthcare Insurance Coverage

(1) Classification of Coverage

① Employee's Insurance

A) Beneficiaries and Insurers

Depending on the beneficiaries to whom the coverage applies, types of healthcare insurance are roughly divided into employee's insurance (occupation insurance) for employees and their families, and National Health Insurance (regional insurance) for people engaged in the agriculture and fishing industries and individual proprietors.

And depending on the difference in beneficiaries, employee's insurance is divided into health insurance (union-managed health insurance and government-managed health insurance), seaman's insurance and insurance for the different kinds of mutual aid unions. Health insurance coverage for general employees is the biggest, accounting for approximately 55% of all subscribers. Under the system of health insurance coverage, offices of the national government, corporate offices (including offices), and private offices engaged in certain types of business which regularly employ five or more people are offices of compulsive application, and all employees who work at those offices are compulsion application insurants. Nearly all types of businesses are deemed businesses to which this insurance applies. Classifying health insurance coverage from the point of view of insurers, this insurance can be divided into government-managed health insurance that is managed directly by the government, and union-managed health insurance that is managed by a health insurance union established individually or jointly by the owner or owners of the business.

Union-managed Health Insurance

Health insurance unions are public corporations not affiliated with the government, and are established individually or jointly by the owner or owners of businesses which employee 300 people or more per one or two or more places of business. (Actually an individual union has 700 or more people, while an integrate union has 3,000 or more people – in order to secure its ability to diffuse risk.) Health insurance unions are made up of business owners, employees of places of businesses who have employee's insurance, and people who have arbitrary insurance. Health insurance unions manage the union members who are insured and the heath insurance itself. Since a certain number of subscribers are needed to establish a health insurance union because of the necessity to diffuse risk, union-managed insurance is mainly for people who are insured through large corporations. The number of health insurance unions at the end of March 2001 was 1,756.

Government-managed Health Insurance

The government manages the health insurance of people with insurance that is not managed by a union. Government-managed health insurance is mainly for employees of small and medium-sized businesses who have insurance.

Other Types of Employee's Insurance

The mutual aid union is a system of healthcare insurance coverage that was established for special occupations to serve people with seaman's insurance and civil servants.

People insured under the system of seaman's insurance include captains and crewmembers of vessels which meet certain requirements. This type of insurance, which is managed by the government, accounts for 0.2% of all subscribers (as of the end of March 2000).

Mutual aid unions provide coverage for workers in specific occupations, including civil servants. This coverage is divided according to specific occupation. Currently there are three types of mutual aid unions. These are mutual aid unions for employees of the national government, mutual aid unions for employees of local governments, and mutual aid unions for personnel of private schools. Mutual aid unions account for 7.9% of all subscribers (as of the end of March 2000).

B) Benefits

Details of Benefits

Healthcare insurance is a system of coverage against financial loss, including that resulting from illness, injury, death and birth, and is provided for the purpose of treating ailments. The scope of these insurance benefits is stipulated to include medical examinations, medicine and materials used in medical treatment, medical treatment such as surgery and other procedures, the management of the recuperation of patients at home as well as nursing and other forms of care required for that recuperation, and admittance to a hospital or clinic as well as nursing and other forms of care required for recuperation. There is no time limit involved. Employee's insurance is provided not only to the employee who has the insurance, but also to a specified range of nonworking dependents.

Benefits are broadly divided into healthcare benefits and cash benefits. Healthcare benefits are the healthcare services provided through healthcare insurance. In Japan a person with insurance receives healthcare services at a medical institution designated by the Ministry of Health, Labor and Welfare as an insurance medical institution. As a general rule, that insurant only needs to pay a co-payment, while the rest of the healthcare cost is paid by the insurer to the medical institution as a benefit in kind. When an insurant cannot receive a benefit in kind – for example, in a circumstance when he or she has had no choice but to receive medical treatment overseas – the insurant pays the entire medical bill and is later reimbursed for that amount by the insurer. Cash benefits include cash benefits for sickness and maternity benefit money as compensation for taking off from work, transportation expenses as a benefit for compensation of actual expenses, lump-sum payments for childbirth and childcare, and funeral costs. Childbirth expenses are not only paid as healthcare benefits, but also as cash benefits in lump-sum payments for childbirth and childcare.

Benefit Rate

The benefit rate for healthcare benefits is 80% for the insurant, 80% if a family member is hospitalized, and 70% for outpatient treatment. However, after April 2003, all of these will be 70%, with 30% as a co-payment. (The benefit rate for infants under three years old is 80%.)

For union-managed health insurance, in order to reduce the co-payment of insurants, authorization has been granted by the Ministry of Health, Labor and Welfare to arbitrarily apply fringe benefits beyond the benefits stipulated by law, according to the financial situation of each individual union.

Responsibility for Pharmaceutical Expenses

If a patient who regularly goes to a medical institution receives medication, he or she pays a portion of that cost as a co-payment, based on the type and quantity of the medication. However, after April 2003 there will be no co-payment.

Meals During Hospitalization

Regarding the cost of meals during hospitalization, for all forms of coverage the patient pays a standard amount determined by the cost of food for the average household (780 yen per day; and for people with low income 650 yen per day for the first three months of hospitalization, and 500 yen per day after four months), and the rest is paid through the healthcare insurance as meal recuperation expenses during hospitalization.

High Medical and Recuperation Cost Coverage

Furthermore, in order to ease the effect of high healthcare costs on household finances, all types of insurance coverage have incorporated a system whereby if a patient's co-payment exceeds a certain amount, he or she is afterwards reimbursed for the excessive amount through health insurance coverage. The general limit on co-payment is 72,300 yen +

(healthcare costs – 361,500 yen) x 1%. However, the amount is determined by a person's income.
Based on the reimbursement afterwards for high medical and recuperations cost, the effective benefit rate is 80.2% for union-managed insurance, and 78.8% for government-managed insurance.

Specific Recuperation Cost

It is prohibited for healthcare service which exceeds the level provided for by the medical treatment fee point table to be claimed by being added to the usual co-payment, or to combine insured diagnosis and treatment with diagnosis and treatment outside the realm of insurance coverage and collect from the patient the cost of the diagnosis and treatment outside the realm of insurance coverage (principle of the prohibition of combined diagnosis and treatment). In other words, for diagnosis and treatment, or for the administering of medicine, which are not covered by healthcare insurance benefits – that is to say, those which are not listed in the medical treatment fee point table or among the standard prices of medicine – all of the healthcare treatment regarding the patient in question shifts from the object of the insurance claim and becomes outside the realm of insurance coverage, and the patient is responsible for the entire amount. However, a system of specified healthcare coverage has been adopted to address the emergence of new technology and the diversification of patients' needs, against a backdrop of remarkable advances in medical technology in recent years. Among the costs for lifestyle service and having a pleasant environment (amenities) (for example, special costs for private rooms, and services including special dental materials such as gold teeth), and the healthcare costs accompanying advancements in technology and research and development, the costs for normal service and healthcare are paid for through healthcare insurance as specific recuperation costs, with other costs being outside the realm of insurance coverage.

C) Fiscal Resources

Insurance premiums and the national treasury cover health insurance business costs.

Insurance Premiums

Insurance premiums are calculated by multiplying the premium rate by the standard monthly salary (determined regularly once every year) paid to an employee, and are collected monthly. Standard monthly salaries are classified from Grade 1 (98,000 yen) to Grade 39 (980,000), and each insurant falls under one of those grades depending upon his or her salary.

Premium Rates for Union-managed Insurance

Premium rates for union-managed insurance are determined by the various health insurance unions, within the range of 3.0% to 9.5%, with the approval of the Ministry of Health, Labor and Welfare. The average premium rate for all unions in March 2003 was 8.514%. As a general rule, the responsibility for the payment premium is split between the employer and the insurant. However, the maximum percentage that the insurant can be responsible for is 4.5%, and the amount that the employer are responsible for may be increased to more than half of the premium amount. As of March 2003, the average premium rate for all unions was 4.787% for business owners, and 3.727% for insurants. The premium amount for which an insurant is responsible is withheld by the employer from the insurant's pay, and the employer are obligated to make the premium payment. The level of premium payment responsibility (fiscal 1998) is 159,000 yen for insurants (364,000 yen when the amount for which business owners are responsible for is included).

Premium Rates for Government-managed Insurance

Premium rates for government-managed insurances range from 6.6% to 9.1%, and can be changed by the minister of health, labor and welfare through deliberation of the Social Security Council. In 2001 the rate was 8.5%. The insurance premium is split between the insurant and the employer. The level of premium payment responsibility (fiscal 1998) is 152,000 yen for insurants (333,000 yen when the amount for which business owners are responsible for is included).

Special Insurance Premiums

Bonuses are normally paid in Japan. The proportion of the bonus to total salary varies from individual to individual. In order to ensure fairness in premium payment responsibility, a special insurance premium is collected from the bonus, which is separate from the monthly insurance premium. Health insurance unions can set the rate of premiums for union-managed health insurance within the 1.0% range and collect those premiums accordingly. However, it is left up to the unions to decide whether to collect the premiums. The rate for special insurance premiums of government-managed health insurance is 1%, and the responsibility of paying these premiums is split between the employer and the insurants. The insurants' responsibility is exempted by 2/5, and the national government pays the difference. After April 2003, a total salary system for levying insurance premiums against bonuses as they are levied against standard salary will be introduced.

Responsibility of National Treasury

Since union-managed health insurance is left to the autonomous management of health insurance unions, as a general rule the national treasury is not responsible for making those payments, with the exception of a portion of the clerical expenses. However, Blue Cross, which faces a stringent financial situation, receives assistance for an extremely small fixed amount.

For government-managed health insurance, in addition to clerical expenses the national treasury is also responsible for paying 13.0% of benefit costs, and 16.4% of the health contributions for the elderly (to be discussed later). The reason that union-managed health insurance is so generously subsidized at public expense is because since the insurants are mainly employees of small and medium-sized business their salary level is lower than that of employees of large corporations. And so the relative burden of paying their insurance premiums is eased by the national treasury.

② National Health Insurance Coverage

A) Beneficiaries and Insurers

National Health Insurance coverage is a compulsory system of healthcare insurance for individual proprietors, people engaged in the agriculture and fishing industries, and retirees who are not eligible for employee's insurance. It represents the last opportunity for universal health insurance. Even foreigners can receive this insurance as long as they are registered as an alien and are expected to stay in Japan for a period of one year or longer.

Insurers of National Health Insurance are mainly cities, towns and villages which are basic municipalities, of which there are 3,242 nationwide. They cover 33.4% of all subscribers. In addition to this are National Health Insurance unions, which are made up of health insurance groups of individual proprietors of the same industry. Currently, the main professions and industries which have National Health Insurance unions are physicians, dentists, pharmacists, the food sales industry, the engineering and construction industries, cosmetology, the bathing industry, and lawyers. There are 166 of these unions nationwide. These do not cover all individual proprietors; and some of them cover the whole nation, while others cover individual prefectures. These unions account for 3.4% of all subscribers.

B) Benefits

There are benefits for recuperation costs. There are also benefits required by law, including those for meals and recuperation costs during hospitalization, specific recuperation costs, recuperation costs, at-home nursing and recuperation costs, high cost healthcare, lump-sum payments for childbirth and childcare, funeral costs, and transportation costs. In addition there are arbitrary benefits in the form of cash benefits for sickness and cash benefits for childbirth which may be arbitrary according to municipal ordinances or union regulations. Each of these types of insurance benefits are similar in content too those of health insurance coverage.

The rate of healthcare benefits is 70% (30% is the responsibility of the insurant). With the reimbursement that is received afterwards because of high healthcare costs, the effective benefit rate is 78.4% for National Health Insurance through municipalities.

C) Fiscal Resources

Insurance Premiums

The method and level of insurance premiums differs from municipality to municipality, and are determined by individual ordinances and/or rules. However, it is common among all municipalities to collect premiums directly from insurants. There are two types of systems of insurance premiums: one is collected as a premium literally as a National Health Insurance premium; the other is collected as a National Health Insurance tax as a type of local tax. Currently, many municipalities use the tax type of system, but aside from the difference in their legal characteristics, the calculation methods for both are basically the same.

There are two types of National Health Insurance premiums. One is the portion that an insurant is responsible for paying, based on what he or she is capable of paying (capable percentage), calculated as a levy standard on the amounts of his or her income and assets, which are determined based on the municipal citizens tax levied by the municipality in which he or she resides. The other is the portion that an insurant is responsible for paying, based on the profit that he or she earns (profit percentage), calculated by a fixed amount for each insurant or for his or her household, which is based on the amount of profit that the insurant receives. As a general rule the ratio between the capable percentage and the profit percentage is fifty-fifty. However, in actuality, in many municipalities the ratio accounted for by capable percentage is higher. Individual premiums for each insurant in a household are paid in one lump sum by the head of that household, adding together the capable percentage and the profit percentage of each insurant. The responsibility level for insurance premiums per household (fiscal 1998) was 154,000 yen for National Health Insurance through municipalities.

Since the premium imposed on low-income earners is sometimes too burdensome, measures have been taken to reduce the burden of those premiums. Those eligible for these measures are households whose income of the previous year was below the basic exemption equivalent value, and households who fell below the basic exemption equivalent value when a fixed amount was deducted per insurant, excluding the head of the household. In each case, the portion that an insurant is responsible for paying, based on the profit that he or she earns, is reduced to 60% and 40%, respectively.

Responsibility of National Treasury

The national treasury is responsible for paying 50% of health insurance contributions for elderly people. In addition, the national government also pays one half of the portion of reductions on insurance premiums of low-income earners carried out by municipalities, with the remainder being the responsibility of prefectures and municipalities.

Generally, many of the people with National Health Insurance are low-income earners, and many of those people are only capable of paying a small amount in premiums. Also, since their employer is not responsible for paying their premium as is the case for people with employee's insurance, a sound means of insurance financing is made possible through assistance by the national government for high rates and large amounts of money. In other words, in order to assure fairness regarding the benefits and responsibilities between types of coverage, the lower the financial capability of the insurance system, the higher the rate of assistance.

③ Healthcare Coverage for Retirees

Basically speaking, since elderly retirees subscribe to National Health Insurance after retirement, the level of their benefits drops at a time when their need for healthcare increases, and the burden of paying those healthcare costs lies mainly with the national treasury and other subscribers to National Health Insurance. In order to correct this irrationality, a system of healthcare coverage for retirees was established in 1984.

The entities enforcing this system are municipalities, which are the insurers of National Health Insurance. The beneficiaries are people who have National Health Insurance (except for elderly people who receive healthcare), elderly people who receive pensions based on pensioners laws (for the right to receive a total pension for an elderly, the person must have subscribed for 20 years or more; or for people beyond the age of forty, for 10 years) and their nonworking dependents.

The fiscal resources needed for this system of insurance coverage are comprised of the premiums (tax) that retired insurants pay for National Health Insurance, and recuperation benefit expense grants covered by donations of insurers of employee's insurance. The amount of the recuperation benefit expense grants is the amount remaining after deducting the National Health Insurance premiums for retirees who had employee's insurance (tax) from the amount which is half of the costs required for healthcare benefits for retirees who had employee's insurance and the contributions for the healthcare cost for the elderly who had employee's insurance, and this is delivered each year to municipalities from the Social Insurance Medical Fee Payment Fund. The costs of paperwork regarding the healthcare of retirees for the recuperation benefit expense grants and the Social Insurance Medical Fee Payment Fund are covered in part by the recuperation benefit expense contributions collected from insurers of employee's insurance through this fund, and by clerical work expense contributions. For this, the amount that each insurer must contribute is the amount of the total contributions divided by the total of the standard compensation amount paid by each insurer.

The healthcare benefit rate is 80% for retirees who had employee's insurance. For their nonworking dependents, it is 70% for outpatient care, and 80% for hospitalization. However, after April 2003, all of these benefit rates will be 70%.

④ Health Insurance Coverage for the Elderly

Under the Elderly Health Law, comprehensive health-related business, including the prevention and treatment of disease, and function training thereof, is carried out to ensure sound health maintenance and adequate healthcare for Japanese citizens in their old age, for the purpose of improving the health of Japanese citizens and improving the welfare of the elderly. And based on the spirit of self-help and unity among Japanese citizens, in addition to constantly endeavoring to maintain and improve their health, with an awareness of the physical and mental changes which accompany aging, and distributing the burden of healthcare costs for the elderly fairly, the basic philosophy of this law is to provide adequate health services to the elderly at the place of work, locally and at home, in accordance with one's age, and mental and physical condition, in order to maintain people's health in old age.

In addition to healthcare benefits, the health-related business based on this law includes the delivery of health notebooks, health education, health counseling, health checkups, function training and at-home or on-site instruction, all of which are carried out by municipalities.

Municipalities are in charge of healthcare-related matters for the elderly under the Elderly Health Law. The beneficiaries of this healthcare for elderly residents of the municipality in question are those who have healthcare insurance, and who are 75 years of age or older, or who are 65 years of age or older but have been recognized by the mayor of the municipality in question as being disabled (so-called bedridden) as prescribed by government ordinance.

The healthcare benefits received are the same as those received under the healthcare insurance laws, and the costs charged for this healthcare are based on medical fees for the elderly.

The responsibility for a portion of elderly patients has been fixed since the establishment of the Elderly Health Law in 1988, and the level of that responsibility differs from the responsibility for a portion of young patients, with a 20% or 30% portion of the responsibility being set at fixed rates lower than those for young people who require it.

The amount has been raised based on revisions to the law, and a system has been introduced for revision based on the rate of fluctuation of consumer prices since 1995. Currently, while the ability of elderly people to pay for healthcare costs has increased due to maturation of pensions, the sense of responsibility for this payment has increased among young people. An appropriate relationship of responsibility that takes root in the unity between generations is a precondition for maintaining Japanese Social Security in the future. For this reason, rather than the uniform assumption that the elderly are weak, the idea is becoming more prevalent that elderly people should be responsible for the portion of their healthcare costs that is suited to their financial ability.

With the reforms in the healthcare insurance system in 2000 came the idea that elderly people should be responsible for a suitable portion of their healthcare costs, and revisions were made to change the fixed 10% rate of responsibility for a portion of patients who had thus far been paying a fixed amount. However, so that the responsibility of elderly people would not increase to an excessive amount, a maximum monthly amount has been established, with preferential measures being established for physicians running their own practices to allow them to choose the system of fixed amount from the viewpoint of the required paperwork load.

Furthermore, with the reforms in the healthcare insurance system in 2002, the age of elderly people eligible for this healthcare increased from those 70 years of age or older to those who are age 75 or older, for a gradual increase in the rate of the public expense load from 30% to 50% over a 5-year period. Also, the percentage for which the patient himself or herself is generally responsibility was increased to 10% (20% for people whose income exceeds a certain amount). However, starting from the age of 70 patients are generally responsible for paying the same 10% as patients who are age 75 or older.

Thirty percent (to gradually increase to 50% over the 5-year period starting in January 2002) of fiscal resources for the necessary benefit costs for healthcare for the elderly are covered at public expense, with the national government responsible for 2/3, prefectures for 1/6 and municipalities for 1/6. The remaining 70% is donated by insurers of government-managed health insurance, union-managed health insurance and National Health Insurance through municipalities. In addition to the above-mentioned portion paid for at public expense, the donated funds are the responsibility of the national treasury, with 16.4% for government-managed health insurance and 50% for National Health Insurance through municipalities. This results in tax fiscal resources of about 50% of benefit costs for healthcare for the elderly, when the 30% which is paid for at public expense is combined with the donations from the national treasury.

(2) Healthcare Covered at Public Expense

Healthcare covered at public expense is a system of coverage by which the national government or local authorities compensate patients for the cost of medical treatment and/or other healthcare expenses, using taxes as a fiscal resource. In healthcare covered at public expense, for diseases which require treatment from the point of view of the national government, including tuberculosis, mental disease and legal communicable diseases, patients are compensated for the cost of medical treatment, while economically- and/or socially-disadvantaged people, including low-income earners, the physically disabled, elderly people, children, people wounded in war, and atom-bomb survivors, are compensated for all or a portion of their healthcare expenses.

Some healthcare covered at public expense includes healthcare costs for which the priority of the responsibility is with the public expense and healthcare costs for which the priority is with healthcare insurance. All or a substantial amount of healthcare costs for which the priority of the responsibility is with public expense is covered by the national government or local authorities, with the remaining portion being applied to insurance. The remainder of the insurance benefits (the portion for which the patient is responsible) or a certain amount of healthcare costs for which the priority is with healthcare insurance is covered at public expense.

(3) Nursing Insurance System

In the past there were two different types of coverage – welfare for the elderly and healthcare for the elderly. But there were disproportions in the usage procedures and the responsibility of users, and problems occurred in the provision of service based on government measures for welfare for the elderly. In addition to restructuring both types of coverage, a system of nursing insurance was established in April 2000 as a system of social health insurance which would allow users to use the service that they themselves chose.

Under the nursing insurance system, the insurers are municipalities, with the national government, prefectures, healthcare insurers, and pension insurers providing important support. The insurants are divided into two categories: first insurants, who are age 65 or older, and second insurants, who are healthcare insurance subscribers between the ages of 40 and 64. The benefit rights and responsibility for paying premiums differ between the two categories.

Benefits from nursing insurance are provided for a first insurant if it is determined that he or she requires nursing or another form of support. Benefits from nursing insurance are provided for a second insurant if it is determined that he or she is bedridden with a specific disease, as stipulated by the Nursing Insurance Law, or otherwise requires nursing or another form of support.

To obtain these insurance benefits an elderly person who is determined to require nursing or a member of his or her family applies with the municipality for these benefits, and that person might then be recognized as requiring these benefits by the nursing recognition examination committee of that municipality. Those committees are made up of people with academic backgrounds in health insurance, healthcare or welfare. The committee findings are based on results from a computer based on an examination of the physical and mental condition of the elderly person (first judgment), and a written report by the physician in charge. Then, after the applicant is notified by the municipality of the results of recognition for the requirement of nursing, if he or she has any objections to those results, that person may challenge those results with the prefectural government or the nursing insurance examination committee.

After being recognized as requiring nursing, if the nursing is to be provided at the patient's home, the patient or his or her family member may then submit a request to a company that provides at-home nursing care for a care plan to be drawn up, taking into consideration the recognized degree of nursing required, the wishes of the patient and the situation of his or her family. If the nursing care is to be provided at a nursing facility, the facility will draw up the care plan.

Service provided to patients who require care at home include home help service and day service. One of these types of service are then provided based on the care plan, with the user responsible for paying 10% of the cost. It is the same for nursing care provided at a nursing facility, with the patient responsible for paying 10% of the cost all services provided, with the exception of meals. If the user desires special services which he or she has chosen, these services may be provided if the user pays the entire cost of the services.

Fifty percent of the cost of the required nursing benefits is covered by the public expense, with the exception of that portion which is the responsibility of the user at the time that the service is rendered. The breakdown is that national government pays 25% of the total, with the prefecture or municipality paying for 12.5%. The 50% of the cost other than the portion covered at public expense is covered by the insurance premiums paid by the insurant. The breakdown between 2000 and 2002 was 17% for first insurants and 33% for second insurants.

Insurance premiums for first insurants are determined for each municipality in accordance with income level. People whose pension exceeds a certain amount have the premium deducted from their pension. All others pay the municipality on their own. Insurance premiums for second insurants are determined based on the method of calculation of the healthcare insurance to which they subscribe. The healthcare insurer collects these premiums in one-lump payments with the healthcare insurance.

(4) Financial Conditions of Healthcare Insurers

Financial conditions of the systems of healthcare insurance have shown deficits across the board.
Taking a look at the closing of accounts of government-managed healthcare insurance, net losses have appeared continuously since 1995, with losses of 316.3 billion yen in fiscal 1999. If things continue as they are, it is believed that the 803.9 billion yen reserve fund from the end of fiscal 1999 will bottom out in fiscal 2002.

Union-managed healthcare insurance has also recorded total losses of 203.3 billion yen (forecast for the end of fiscal 1999), with the total number of unions showing losses at approximately 70%. With this increase in the number of unions showing losses, insurance premiums of healthcare insurance unions

are at an average of 8.51%, which is higher than the 8.5% for government-managed healthcare insurance. There has also been an increase in the number of unions which have been dissolved.
The difference between revenues and expenditures in fiscal 1999 for National Healthcare Insurance through municipalities showed an overall loss of 119 billion yen. Amid this worsening financial situation, with individual insurers which are municipalities showing losses of an approximate 61%, many municipalities are carrying over their fiscal resources for deficit financing from general accounting to special accounting for National Healthcare Insurance.

6. Medical Treatment Fee System

(1) Mechanism of Health Insurance Treatment

A distinguishing feature of the Japanese health insurance system is that rather than the insurer concluding a contract directly with the medical institution, the medical institution is specified by the secretary-general of the local social insurance based on an application by the medical institution.

The specified medical institution is obligated to provide the insurant with recuperation benefits, including medical treatment, as a health insurance medical institution, with the medical fees being paid by the insurer to the health insurance medical institution through an examination payment organization as the cost of the examination.

When receiving medical treatment, insurants pay the portion of the cost for which they are responsible at the payment desk of the health insurance institution.
What's more, not only the medical institution but the physician who is actually in charge of the recuperation must be registered with the secretary-general of the local social insurance as a health insurance physician (double specified system of health insurance treatment). Accordingly, when receiving health insurance treatment, insurants must go to the specified insurance medical institution and receive this treatment by a registered health insurance physician.

Presently, this applies to almost all medical institutions in Japan.

Although all of the medical treatment activities for the same patient are performed by the same medical institution, the reason that insurance medical treatment is specified as double is because all of the medical treatment is administered to the patient by the physician, and based on this, that physician must personally decide what medication, injections or treatment to administer, and bear the responsibility thereof.

(2) Summary of Medical Treatment Fee System

As the cost of recuperation benefits provided by insurance medical institutions, the specified amount that must be paid to the healthcare institution is the medical treatment fee – and the amount remaining after subtracting (from the total medical treatment fee) the portion which is the responsibility of the patient is paid to the healthcare institution. The medical treatment fee is made up of those diagnostic fees specified in detail, including those for examinations, administered drugs, injections, treatment, surgery and tests, as well as the basic fees for hospitalization. The medical treatment fee is revised just about every two years. The medical treatment fee is indicated in points, with 1 point equaling about 10 yen.

Or the medical treatment fee is determined when the minister of health, labor and welfare asks the Central Social Insurance Medical Council* for its views.

In the guaranteed healthcare of Japan, as a general rule healthcare services provided for the purpose of curing disease are not for the cost of healthcare, but rather they are provided as a benefit to the insurant as healthcare services for direct diagnosis and treatment, under the principal of benefit in kind. However, aside for some exceptions, there are two systems of coverage: the system by which the recuperation costs are paid in cash afterwards, and the system of cash benefits.

The Social Insurance Medical Fee Payment Fund and the National Health Insurance Federation, after received payment consignment, pay medical fees to the insurance medical institutions for the value of healthcare treatment provided. The amount is calculated by the physician's medical treatment fee point table for physicians, the dentist's medical treatment fee point table for dentists, and the pharmaceutical fee point table for pharmacies. These point tables are characterized as unit price tables for diagnoses, used to evaluate diagnoses.

Medical fees are revised as part of the Survey in Economic Conditions on Health Care which is conducted once every two years. This revision is made to ensure sound medical business management overall, heeding the deliberation of the Central Social Insurance Medical Council, and giving overall consideration to trends in prices and wages, advances in medical science and healthcare, and the various situations surrounding medical treatment, including the financial situation of insurers.

* Central Social Insurance Medical Council: This council is made up of people involved in diagnosis and treatment (8 committee members representing physicians, dentists and pharmacists), people involved in payment (8 committee members representing insurers of health insurance, seaman's insurance, and National Health Insurance, as well as business owners and ship owners), and people representing the public interest (4 committee members representing the public interest). Appointment of committee members representing the public interest must be approved by both Houses of the National Diet.

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