New Health Insurance for the Elderly

Country: Japan
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Survey no: (12) 2008
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Health Policy Issues: Funding / Pooling

Current Process Stages

| Idea | Pilot | Policy Paper | Legislation | Implementation | Evaluation | Change |

1. Abstract

In April 2008, the Government implemented a new insurance scheme for the elderly aged 75 and older, named 'Health Insurance for the Old-Old'. It established new insurance bodies and intended to ensure funding health care for the elderly by clarifying responsibilities. Despite the apparent necessity of handling increasing health expenditures, the policy received strong objections by the opposition parties, media and the elderly when implemented.

2. Purpose of health policy or idea

The new insurance scheme for the elderly, named 'Health Insurance for the Old-Old', mainly aims at handling the growth of health expenditure for the elderly in order to maintain affordable universal coverage of health insurance. Due to the rapid population aging, the amount of healthcare expenditure for the aged over 75 amounted to 29.2% (9.6 trillion yen) of national health expenditure in 2006, and is continuously growing. In 2006, almost half of the citizen health insurances, which are covering a larger population of the elderly than the other insurances, got a deficit.

New insurance scheme for the old-old is to increase transparency...

In order to achieve the main objective, the new scheme has two sub-purposes:

One is to increase transparency of who pays for the healthcare cost of the elderly by establishing the new insurance, separated from other insurances, and making explicit rules for who contributes how much to the health care for the aged. In the previous system, the elderly were enrolled either with various public health insurers or were co-insured with their working children at no charge, as well as covered by the Health Care for the Aged scheme. It received cross-subsidies from public health insurers as well as subsidies from the general budget of national and local governments. Therefore, the relationship between who pays the premium and who gets reimbursed by the insurance was complex and difficult to understand. Since those subsidies to the Health Care for the aged scheme were projected to increase dramatically in the next 10 years, the new insurance scheme establishes a more accountable and transparent system.

Under the new insurance scheme, newly established insurers directly receive premiums from the elderly and, as in the previous scheme, subsidies from other health insurances and the general budget. But now, the proportions of revenues coming from contributions of the elderly, other public health insurances and tax are explicitly set by law. The increase of transparency is expected to make the elderly more concerned with management of the health insurance and with efficient use of health care. The premium of the new insurance is related to how much money was paid to care for the elderly in each prefecture in the past two years. Therefore, how much the elderly used is directly related...
to how much the elderly have to pay for the premium.

...and accountability

The other purpose is to achieve a balanced budget and to clarify the responsibilities in financing of care for the elderly. In the previous scheme, it was often obscure who was accountable for the scheme. Although municipalities paid to providers, the money for it came from general budgets of national and local governments as well as from cross-subsidies from public health insurers. The new healthcare insurance for the elderly has been introduced with the intention to make responsibilities clearer by forming new insurance bodies that are run by coalitions of prefectures and municipalities. This scheme is expected to result in more responsible and efficient management.

The Health Insurance for the Old-Old has the following features:

First, new insurance bodies for the scheme were established. All municipalities in each prefecture jointly set up one insurance body, named 'Kouiki Rengou', to manage health insurance covering their populations aged 75 and older. 47 insurance bodies have been established in the 47 prefectures.

Secondly, financial arrangements have been explicitly formulated. Half of the total revenue shall be subsidized from general budgets of the Government, prefectures, and municipalities; the remaining half shall come from the premiums and cross-subsidies from other public health insurances. At the inception of the scheme, premiums paid by the elderly are to finance 10% of the total revenue. The percentage will gradually increase according to the percentage decrease of the younger population in the total population. It is estimated to be 10.8% in 2015 and 12% in 2025 (The Japan Research Institute 2007).

Thirdly, a new rule for setting a common premium rate for individual old-old citizens within each prefecture has been introduced. Under this rule, all the elderly in a prefecture have to pay the premium following the rule set by the insurance body of the prefecture. The premiums shall be determined for individual old-old citizens based on community- and income-rating, with due consideration for achieving a balanced budget every two years. Previously, the amount of the premium depended upon the insurance the elderly joined; family dependents were exempted from paying the premium. This caused substantial horizontal inequity in setting the premium among the elderly. Although the inequities were not precisely revealed, the circumstance that the most expensive premium was about five times higher than the cheapest suggested the existence of inequity. The new common rule is expected to reduce the relative difference by half.

Finally, automatic collection of the premiums by deducting them from the pension has been introduced. This method aims at reducing transaction costs in collecting premiums. Moreover, it will reduce the number of unpaid premiums.

Main objectives

Main objectives of the policy are:

- to increase the transparency of who pays for the expense of health care costs for the elderly; and
- to adopt a balanced budget and to clarify the responsibilities in financing of the care for the elderly.

Type of incentives

Financial:

The elderly: For a part of the elderly premiums will go down.

Non-financial:

The municipalities and the prefectures can avoid shouldering the responsibility and cost to run the insurance for the elderly by transferring management of the insurance to the new health insurance bodies.
Health insurers can securely plan the amount of contributions to the insurance fund for the elderly, which previously was not so clear. They will no longer complain about the justification of the amount of the duty, which was previously disputed as uncertain.

**Groups affected**
Central and local governments: prefectures and municipalities, the elderly aged 75 and older and their families, health insurers (citizen health insurance, occupation-based insurance)

### 3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
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<tbody>
<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
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<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
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<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
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<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
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This new scheme will be an improvement compared to the previous insurance scheme for the elderly in terms of responsibility for managing the fund for elderly care, and in terms of transparency regarding the proportion of the burden of contribution. Increased transparency could raise awareness of persisting problems of increasing costs of care for the elderly in public. However, actual implementation of the policy was controversial due to the strong opposition from opposition parties, the elderly and media. The failure to provide sufficient information to the actors, especially to the elderly, and the lack of deliberate consensus formation among actors including media could be the major cause for controversial implementation.

### 4. Political and economic background

In forming this policy from 2002 to 2006, the ruling parties, LDP and New Komeito, held a large majority of the Diet and exercised strong power to pass the bills in order to promote policy reforms. The Government aimed at containing cost in health care by reforming the system with regard to its basic policies of economic operation and its structural organization. During the process of policy formation, a strong leader, Prime Minister Junichiro Koizumi, had exercised the power but stepped down. Afterwards, post-Koizumi governments have continued the reform.

A second driver for reform is that the aged population is constantly increasing. It appears to have increased the burden on the young and the companies which pay a certain amount of the premium for their employees. As mentioned in the (10) 2007 report, in Japan, the proportion of the population aged 75 and older increased from 4.84 percent in 1990 to 10.0 percent in 2007. In FY 2006, 29.2 percent of national health expenditure was spent on health care for those aged 75 and older, which was around 9.6 trillion yen.

The new insurance scheme for the elderly is based on the Health Care Reform Act 2006. The act emphasizes the core value to provide appropriate care for the elderly in order to support their daily lives. In terms of healthcare delivery, the act stipulates the reform of providing comprehensive assessment, home care, palliative care, and integrated care as critical areas.
5. Purpose and process analysis

Origins of health policy idea
As the (9) 2007 report pointed out, principles of health care for the aged have been continuously debated since the 1980s. In August 1997, the health insurance reform committee of the ruling party (LDP was ruling in partnership with other parties: Social Democratic Party & Sakigake from outside of the Cabinet) publicized 'National health in the 21st century: the guideline for high quality health care and maintenance of universal health insurance'. This policy document elucidated firstly the introduction of the independent health insurance system for people aged 70 or older. The main purpose of the proposal was to maintain affordable universal coverage of health insurance by balancing the burden of healthcare expenditure, the increasing demand of health care for the elderly and harsh economic circumstances due to recession.

Initiators of idea/main actors

- Government
- Payers
- Patients, Consumers
- Scientific Community
- Media
- Others
- Political Parties

Approach of idea
The approach of the idea is described as: new: Separated insurance funding bodies for elderly health care have not been seen in other countries.

Stakeholder positions
In November 2000, the House of Councillors passed supplementary resolutions of the national welfare committee. All parties agreed on the resolutions except the Japan Communist Party. It stated that the introduction of the new health insurance for the elderly instead of the current insurance would be discussed as soon as possible. The new health insurance should be implemented in FY 2002.

In June 2002, the cabinet decision, namely the Basic Policies for Economic and Fiscal Management and Structural Reform 2002 was issued. It stated that in FY 2002, the outline for the introduction of the new health insurance for the elderly would be drawn up.

In July 2002, the Bill to Revise a part of the Health Insurance Law (H14 the law issue no. 102) was passed and enacted. It stated that the Government would formulate the basic policies for the introduction of the new health insurance for the elderly, which includes the contents, the processes and the annual plans (in the supplement to the law, second clause of Article 2).

In September 2002, 'Private plan' with regard to health insurance reform was submitted by Dr Sakaguchi, Ministry of
Health, Labor and Welfare. It illustrated that a risk adjustment scheme in terms of demographic status and income was required to achieve fairness in the burden in the health insurance for the elderly.

In November 2002, LDP Investigation Committee on the basic problems of health care issued an interim report of the working group for the revision of the health care system: the new health care insurance for the elderly. It mentioned that the new health insurance for the elderly should combine new measures from the view of mutual support among generations. Moreover, it defined eligibility criteria for the new insurance scheme, ie. that the new insurance covers all individuals aged 75 and older.

In December 2002, 'Draft policies of the Ministry of Health, Labor and Welfare' concerning 'the structures of the system of health insurances' was announced. It proposed two plans for the health insurance for the elderly namely plan A (risk adjustment) and plan B (the introduction of independent insurance for people aged 75 or older). Plan B finally got implemented.

**Actors and positions**

*Description of actors and their positions*

**Government**
- Ministry of Health, Labour and Welfare
  - The Cabinet: very supportive
  - The Minister of Health, Labour and Welfare: very supportive
  - Ministry of Finance: very supportive
  - Council on Economic and Fiscal Policy: very supportive

**Payers**
- All-Japan Federation of National Health Insurance Organizations: very supportive
- National federation of health insurance society: very supportive

**Patients, Consumers**
- The elderly: very supportive

**Scientific Community**
- Japan Medical Association: very supportive

**Media**
- Newspapers: very supportive
- Broadcasting: very supportive

**Others**
- Japanese Trade Union Confederation (Rengo): very supportive
- Nippon Keidanren: very supportive

**Political Parties**
- Liberal Democratic Party: very supportive
- New Komeito: very supportive
- Democratic Party: very supportive
- Japan Communist Party: very supportive
- Social Democratic Party: very supportive
Influences in policy making and legislation

The “Securing Health Care for the Elderly Act” was legislated, which includes the introduction of the new health insurance for the elderly. This law is the rename of Law of Health and Medical Services for the Aged (the law issue no 80, 1982).

The legislative process was as follows:
In March 2003, The cabinet decision: 'The Basic Policies based on the supplement to the law, second clause of Article 2, in order to revise a part of the Health Insurance Law' was issued. It stated that the new health insurance would be an insurance responding to the characteristics of both the latter-stage elderly aged 75 or older, and the early-stage elderly aged 65-74. As for the latter-stage elderly, they would belong to the new health insurance, which is covered by their premiums, contributions from citizen health insurances, occupation-based insurances and public funds.

In December 2005, the Government and the ruling party put together 'The outline of health system reform' at the committee of health care system reform. It mentioned that the independent health insurance (the new health insurance for the elderly aged 75 or older) would be introduced in 2008. The lifestyle and the specific conditions of the mind and body of the elderly should be reflected in the insurance.

In February 2006, in the 164th regular Diet session, 'A partial review of amendments to the Health insurance Law' was submitted. It was passed and enacted in June 2006, and then effectuated in April 2008. It included the new health insurance for the elderly to be introduced.

Prior to the process mentioned above, in 1999, large and strong protests against paying contributions to health care for the elderly was lodged. 1739 (about 97%) of society-managed insurances (occupation-based insurance) refused to pay the contribution, complaining about the increasing burden of the contribution. This circumstance pushed the policy formulation of the new health insurance scheme for the elderly.

Legislative outcome

major changes

Actors and influence

Description of actors and their influence

**Government**
- Ministry of Health, Labour and Welfare: very strong
- The Cabinet: very strong
- The Minister of Health, Labour and Welfare: very strong
- Ministry of Finance: very strong
- Council on Economic and Fiscal Policy: very strong

**Payers**
- All-Japan Federation of National Health Insurance Organizations: very strong
- National federation of health insurance society: very strong

**Patients, Consumers**
- The elderly: very strong

**Scientific Community**
- Japan Medical Association: very strong

**Media**
Adoption and implementation

At the beginning, the Health Insurance for the Old-Old earned unexpected unpopularity by the public. A separated insurance and individual-based premium setting apparently created isolated feelings among the elderly. Also changes of the premiums were troublesome. Automatic collection of the premiums was particularly unpopular.

An opposition bill was formulated by the alliance of opposition parties, namely Democratic Party, Japan Communist Party, Social Democratic Party and The People's New Party. It claimed the abolition of the new health insurance scheme for the elderly. However, the opposition parties did not propose an alternative measure to tackle the problems of health care system for the elderly.

The opposition bill was firstly proposed to the House of Representatives in February 2008, but voted down. Then, in May 2008, it was proposed again to the House of Councillors and passed. It is still on continued consideration at the House of Representatives.

Out of parliament, the opposition parties emotionally insisted that this new scheme means abuse or discrimination of the elderly by separating the elderly from the younger population. Responding to this, media widely broadcasted and supported the opposition to the new insurance scheme for the elderly.

Responding to the situation, the Government modified the implementation process and has strengthened efforts to explain the rationale for the new scheme more actively and politely. At the same time, it gathered more detailed information on the implementation process from the insurance bodies and local governments.

The actors involved in the implementation process are municipalities, prefectures and the insured aged 75 and older as well as the Ministry of Health, Labour and Welfare. Municipalities were obliged to collaboratively formulate the new insurance bodies in each prefecture, and this process was supported by each prefecture government and the Ministry of Health, Labour and Welfare.

Monitoring and evaluation

In terms of funding, the Government will review the balance of the burden of payment and contributions every two years.

Results of evaluation

n/a
6. Expected outcome

1. Reduce horizontal inequities in premiums: In the previous insurance scheme, premiums differed up to five times among the municipalities. But the new scheme is expected to reduce the inequalities around twice if the prefectures, which include larger insurers than the municipalities, can manage the fund.

2. Sustainability: The new scheme seems to make the public health insurance system more sustainable in financial terms. The process of implementation, however, revealed that this drastic change in the public health insurance scheme had not been well understood, which may raise reflections of difficulties in conducting health care reform.

Quality of Health Care Services

marginal  fundamental
Since the new scheme is primarily concerned with financing mechanisms, it will probably have little impact on quality of care and efficiency. Horizontal equity in financing seems to improve. It is difficult to project the impact on equity in delivery.

### 7. References

**Sources of Information**


**Reform formerly reported in**

[Delivering appropriate care for the aged](http://www.hpm.org/survey/jp/a12/4)

**Author/s and/or contributors to this survey**

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**Suggested citation for this online article**