

## Section 8. Establishing a Stable Sustainable Health Insurance System

### 1. Reform of the Health Insurance System

“The Act to Amend the Health Insurance Law” that was approved on June 14, 2006 aims at establishing a sustainable system which is capable of coping with the changes in the structure of the population through balancing benefits and burdens while attempting to secure the quality of medical care. Since being approved the law, it is being enforced in a consecutive manner. As The Long Life Healthcare System (health care system for elderly in the latter years of their life) commenced in April 2008, and efforts to formulate a medical expenditure control plan are currently taking place, act is now being fully enforced.

Key administrative matters in FY 2007 and from April 2008 are as follows.

#### (1) Revision of Insurance Benefits (enforced in April 2007 and April 2008)

In accordance with the reform outlined for the health insurance system which focuses on medium- and long-term measures as well as measures for the declining birth rate, following steps had been taken. (a) Benefits for sickness and injuries that are paid as guaranteed basic costs of living during periods when people are unable to work due to sickness, injury, or giving birth have been raised from 60 percent to 2/3 of the standard daily remuneration, (b) If applied in advance, cost-bearing limit for payment at medical care facility for high medical care payments, such as hospitalization (benefit in kind for high-cost medical care benefit) is now available for those under 70, (c) Low partial cost-sharing for the medical expense for infants (from 30 percent to 20 percent) has been expanded from for less than 3 years old to until entering school age. In addition, cost-sharing for patients aged 65 to 69 that have been hospitalized in sanatorium-type wards covered by health care insurance were revised in order to keep balance with long-term care insurance. Meal expenses are revised, and a new residence expense (equivalent to the cost of light, fuel and water expenses) now needs to be paid by patients. For households receiving both health care insurance and long-term care insurance, the “unitary system for high-cost medical care and high-cost long-term care” was established in order to reduce the burden on people whose annual total burden is remarkably large. A household can now apply for the new system from their health care insurer by an application form along with their annual payment certification obtained from their long-term care insurer. Households get reimbursed for any amount exceeding the maximum amount by health care insurers and long-term care insurers on a pro rata basis between their health care and long-term care payments.

In the mean time partial cost-sharing by elderly aged 70 to 74 was scheduled to increase from

10 percent to 20 percent in April 2008. However, to avoid drastic change and to facilitate smooth operation of the medical care system for the elderly enforced the same month, the revision has been postponed for a year until March 2009. Also the revision of high-cost medical care benefits has been deferred for a year.

## (2) Comprehensive Promotion of Medical Expenditure Control (enforced in April 2008)

It is estimated that approximately 1/3 of the population will be consist of elderly by 2030 due to the rapid aging of society. In order to secure appropriate medical care for the elderly, the stability and sustainability of the health insurance system needs to be improved in maintaining a universal health care insurance system.

In consideration of above, efforts to promote medium- and long-term measures for controlling medical expenditure will be made, by focusing on the factors that are increasing that medical expenditure including the prevention of lifestyle diseases and limiting long-term hospitalization. Comprehensive control of medical expenditure will be promoted combined with revising partial-cost sharing, for example, rising partial-cost sharing to 30 percent for elderly earning above a certain level of income..

In order to control medical expenditure in a systematic manner, the participation of the prefectures that are responsible for local health care systems is needed because of regional differences existing in respective medical expenditure. Hence, as the responsibility of the government, medical expenditure should be controlled in cooperation between the government and the prefectures.

The government and prefectures therefore formulated a medial expenditure control plan, a 5 year plan that commenced in FY 2008. In this plan political, goals were set for suppressing the increase in medical expenditure to a more appropriate level. The following goals were set to be fulfilled by FY 2012;

- 1) Goals for maintaining the health of citizens (residents)
  - ① Raising the implementation rates of specific health checkups to at least 70 percent
  - ② Raising the implementation rates of specific health guidance to at least 45 percent
  - ③ Achieving a drop in the rate of patients and those at high risk of contracting metabolic syndrome to at least 10 percent
- 2) The following goals for promoting effective medical care need to be achieved:
  - ① The number of sanatorium-type wards (excluding recovery period rehabilitation ward sanatoria) will be made to match that calculated using a specific mathematical equation which takes into account future medical requirements etc.
  - ② Reducing the average days of hospital stay by 1/3 of the difference between the national

average and the shortest prefecture.

In order to achieve these goals, efforts will be made as “measures for maintaining the health of citizens (residents)” and will include promoting special health checkups and healthcare guidance focused on metabolic syndrome (visceral fat syndrome) by health care insurers such as Health Insurance Societies and municipalities implementing general health promotion measures (population approach) such as disseminating and enlightening people on for health promotion. In addition, “measures for promoting effective medical care” shall include promoting the reorganization of sanatorium-type wards, promoting a division of roles and cooperation between medical institutions, and promoting in-home and community care. It is expected that patients’ and people’s quality of life will improve through implementation of these measures and that they will eventually contribute to reducing medical expenditure.

### **(3) Establishment of a New Medical Care System for the Elderly**

In order to ensure stable support of medical expenditures for the elderly that is expected to exponentially increase, and to maintain the universal health care insurance system in the future, a new independent health care system for elderly aged 75 or older (long life health care system) was established. The system was designed so that the active generation and the elderly can help support each other. In this system life support medical care for elderly aged 75 or older reflecting their respective physical and mental condition is provided. It is financed by insurance income, support coverage from the active generation, and a public fund, and is operated by regional authorities affiliated with all the municipalities in each prefecture.

Regarding the premium for new participants (Employee insurance dependents), a reduction measure will be available for 2 years after enrolment. In addition, it will be withheld for the period of 6 months from April to September 2008, and for the period of 6 months from October 2008 to March 2009 a 90 percent reduction measure will be available.

In addition, a finance adjustment system has been created to handle cost of medical expenditure for elderly aged 65 to 74 which will be determined according to the number of members of the National Health Insurance and Employee Health insurance.

Furthermore, the long life health care system is a system in which the medical expenditure on the elderly is shared by the all citizens, and is necessary to secure health care for them. In order to facilitate its smooth operation, further efforts need to be made in obtaining people’s understanding through carefully explaining the purpose and necessity for the system in close cooperation with local governments. In the mean time, with consideration to how the system has worked since being enforced in April 2008, “Regarding Reducing the Premium Burden for Smooth Operation of the Health Care System for the Elderly” was decided at a governmental and ruling party meeting held

on June 12, 2008. The decisions made were as follows:

1) Measures for reducing the premium burden

- ① For the low income households receiving 70 percent relief, if all elderly insured members in households has pension incomes of 800,000 yen or less will receive 90 percent relief.
- ② Of individuals who incur income levies those of low income (more concretely a pension income of approximately 2,100,000 yen or less) shall receive 50 percent relief on income levies.
- ③ For those who are unable to pay the premium burdens even after above measures are taken, a carefully designed consultation system will be established in municipalities which will include a special reduction
- ④ These measures will be implemented in FY 2009 but transient reduction measures will be available in FY 2008
- ⑤ The financial means for implementing the above measures will be dealt with as the responsibility of the government and ruling parties, and shall include the cost of modifying the system and related budget request guidelines

2) Premiums deducted from pensions may be changed to ordinary collection on request if the following requirements are met.

- ① The premium is paid through an account transfer by a person (subject) who has been faithfully paying the National Health Insurance premium
- ② The premium is paid through an account transfer by a person (annual income of less than 1,800,000 yen) with a joint payment obligation (householder or spouse)

(Note) Householders aged 65 to 74 participating in National Health Insurance will receive similar treatment with premium collection.

3) Handling of terminal stage consultation medical fee will be discussed by the Central Social Insurance Medical Council (Chuikyo) and measures including withholdment will be taken as needed as well as verification. Medical fees for the elderly in the latter stage of life will also be promptly verified by Chuikyo.

4) The roles and responsibilities of the regional authorities and municipalities will be clearly defined. In addition, efforts will be made to provide further publicity through the government, prefectures, the regional authorities, and municipalities as well as to clarify the role municipalities shall take in consultations, especially for premium burdens.

5) There has been a lot of discussion on the medical subsidy system originally made available by local governments and subsidy programs for comprehensive health checkups in relation to the long life medical care system. As these programs were originally made available by local governments, they will be expected to act properly based on the actual situation in their

respective region, including providing the relevant information to the elderly and making the effort to obtain their understanding. In addition, ingenious health promotion measures being made by the regional authorities and municipalities will be promoted.

- 6) Various projects based on this system shall be implemented with consideration being given to easily understandable explanations and easy-to-see printings being made available. For example, when needing to renew insurance cards, the size of the font used should be enlarged for the elderly.
- 7) The enforcement of qualification certificates will only apply to malicious cases where people that have adequate incomes refusing to pay the premium. Otherwise, the system will fully adhere to the policies as before.

In addition, ruling parties have agreed to discuss the following matters further with project team discussions being held on the health care system for the elderly.

- 1) Determining premium reductions on an individual basis will continue to be discussed along with its relation to other systems, and then concluded in a timely manner. In addition, the problem of subscription changes where members of a household have subscribed to different types of insurance will also be discussed.
- 2) Raising the requirement for premiums to be deducted from pensions (180,000 yen or more) and whether it is appropriate to deduct them will continue to be discussed along with its effect on other systems.
- 3) Regarding the increased co-payment for elderly aged 70 to 74 (from 10 percent to 20 percent) and premium burdens on dependents of Employee insurance that will take place in April 2009, discussions will continue to be made taking into consideration the outcome of the ruling parties project team discussions on the health care system for the elderly.
- 4) Prefectural participation will be discussed.

The Ministry of Health, Labour and Welfare will carefully implement measures in accordance with the decisions of the government and ruling party's project team with respect paid to the living conditions of the elderly, and make them public in conjunction with relating local governments to facilitate smooth operation of the system.

#### **(4) Prefectural integration and Reorganization of Health Care Insurers**

In order to promote the prefectural integration and reorganization of health care insurers, Government-managed Health Insurance will become the public corporation of the "Japan Health Insurance Association" in October 2008. It will be able to set premium rates that reflect the relevant medical expenditure of the different prefectures as well as offer health services according to the actual situation in the respective region.

Furthermore, National Health Insurance, collaborative projects will be increased to facilitate levelling the National Health Insurance premiums managed by prefectural municipalities and measures to improve the financial basis of National Health Insurance will continued to be implemented, including a health care insurers support system.

## (5) Summary of the FY 2008 Medical Fee Revision

### 1) Details of the medical fee revision

A medical fee revision will be discussed and determined by the Central Social Insurance Medical Council (Chuikyo), which consists of members representing health care insurers, insured persons, employers (paying members), members representing doctors, dentists, and pharmacists (inspection members), and public members based on ① the “Basic Policies” determined by the Social Security Council and ② the trend with macro-economic indicators such as wages and commodity prices, the situation with the revenue and expenditure of medical institutions surveyed by the Medical Economics Survey, and revision rates determined in the budget made by the Cabinet with consideration given to the financial situation of insurance.

The medical fee revision made in FY 2008 was based on the following:

- ① The “Basic Medical Fee Revision Policies in FY 2008” compiled by the Health Care Insurance and the Medical Care Subcommittees within the Medical Social Security Council on December 3, 2007 and the “Main Medical Fee System Points in the Medical Care System for Elderly in the Latter Stage of Life” compiled by the special subcommittee on October 10, 2007 in relation to a new medical fee system for use in the long life health care system (health care system for elderly in the latter stage of life) that was scheduled to be enforced in April 2008
- ② Revision rates determined when the FY 2008 budget was drawn up by the Cabinet: +0.38% for medical fees, (-1.2%) for the price of drugs, (-0.82%) in total.

Based on the above revision rates, intensive discussions on individual items were made by the Chuikyo and a draft revision report on points with medical fees were submitted on February 13, 2008. The revised medical fee points took effect in April 2008.

### 2) Summary of the FY 2008 medical fee revision

- ① Response to emergency issues and priority evaluation items

As described in the beginning of the “Basic Medical Fee Revision Policies in FY 2008”, in order to cope with emergency issues, in consideration of the current situation with regional medical care obstetric and paediatrics evaluations as well as measures to reduce the workload of hospital doctors have been made in terms of the medical fee, or more concretely:

- Creation of a new medical fee for medical institutions that accept pregnant and lactating women who need emergency transportation, and raising the medical fee for the medical management of pregnant and lactating women with complications
- Raising the medical fee for medical institutions and children's hospitals that provide advanced paediatric medical care and raising the medical fee for the hospital care of infants with disabilities
- As measures to reduce the workload of hospital doctors, evaluations in terms of the medical fee of local core hospitals that have reduced the workload of doctors as well as employed supportive medical office work (so-called "medical clerks")
- Further improved evaluations on very early stage of emergency medical care have taken place. These revised items were financed by raising the medical fee as a result of positive revisions and additional financial support given to hospitals from clinics through revision of clinic related medical fee items.

In addition, as priority evaluation items, obligating the issuing of receipts at hospitals obliged to establish online receipt systems, evaluation of medical cancer care in terms of the medical fee for facilitating improvements in the quality of radiation therapy and chemotherapy, evaluation of cerebral apoplexy from the critical stage through to the recovery stage, measures against suicide including promotion of early stage psychiatry and psychiatric medical care consultations at emergency and critical care centers, and improved mental care for children through outpatient services and hospitalization have all taken place.

② Medical fee for the long life health care system (health care system for elderly in the latter stage of life)

The new medical fee system was established to ensure that elderly aged 75 or older will receive the appropriate medical care that reflects their respective physical and mental condition while the same required medical care which aged 74 or younger will receive, are still available. Concrete details include:

- Evaluation of medical care for supporting in-home recuperation in terms of the medical fee including improved home-visit nursing and home-visit dental care, cooperation between medical and nursing care institutions, emergency hospitalization in the case of acute disease progression, and hospital discharge support
- Evaluation in terms of the medical fee for medical care where the primary-care physician chosen by the patient formulates a treatment plan and provides holistic and consecutive medical care to patients with chronic diseases
- Evaluation in terms of the medical fee for drug history management utilizing a "medication notebook" to prevent duplicate prescriptions and people forgetting to take medicine through the

provision of support.

③ Revised items:

With regard to outpatient care, a timeline was included in consideration of evaluating doctors providing fair and careful explanations to their patients. With regard to the 7 to 1 basic fee for hospitalization, a nursing care requirement level was added in consideration of hospitals with a large number of patients who are in need of careful acute stage nursing care. In addition, revision of prescription forms to facilitate the use of generic medicine and a revision where slight treatments are included in the basic treatment fee (first consultation fee, re-consultation fee) have taken place.