Social Health Insurance as a Health Safety Net in Japan, the US, and France : An introduction

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Social Health Insurance (SHI) in Western Europe has developed in the long tradition of social solidarity (Hinrichs 1995, Saltman and Dubois 2004). Countries in other place of the world, often lacking such tradition, also have developed health systems using similar compulsory health insurance as a tool of expanding health insurance coverage with their own ideas to the original German model (Brown 1996). For example, Japan uses residence-based and employment-based mandatory health insurance to cover almost all the population (Shimazaki 2011).

SHI works well in covering the population with mandatory enrollment, particularly in developed countries, although well-off people are allowed to opt out in some countries. Patients, however, often have to pay significant user charges in SHI health systems. Legal mandatory coverage, thus, does not automatically means universal coverage, or effective coverage to quality health care without fiscal hardships in reality (Savedoff, de Ferranti et al. , International Labor Organization 2010). With changing socio-cultural demography and increasing economic and sustaining health inequalities, whether SHI works well as a health safety net or not, or whether SHI makes it possible for vulnerable populations to have access to health care or not, is an issue to be seriously considered. This is a matter of empirical study and the theme of this special section of Ritsumeikan Journal of Social Science.

The section consists of three original articles analyzing health systems in Japan, France and the United States, and a commentary. They were presented and discussed at a symposium, “Social Health Insurance as a Health Safety Net”, held on 16 January 2015 at Suekawa Memorial Lecture Hall, Ritsumeikan University. The symposium was one of special events to celebrate the 50th anniversary of the College of Social Sciences, Ritsumeikan University.

Several reasons exist for the choice of the three systems. First, the three health systems are more or less based on social insurance. Japan and France has compulsory insurance covering almost entire population (Chevreul, Durand-Zaleski et al. 2010, Ikegami, Yoo et al. 2011), which can be regarded as achievement of universal coverage (Ikegami 2014).

France has compulsory insurance that covers health services with complementary insurance covering most of the population, based on a strong tradition of mutual societies (Chevreul, Durand-Zaleski et al. 2010). Mandatory health insurance has limitedly developed in the US. Instead, voluntary private insurance, whether contracted collectively or individually, has played an important role of mitigating financial burdens of healthcare payments.

Second, they show interesting contrasts in institutionalizing social health insurance. While Japanese and

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French health systems are based on universal coverage by mandatory enrollment (Rodwin 2003, Chevreul, Durand-Zaleski et al. 2010, Ikegami 2014), the US system, having a complex mixture of voluntary and mandatory insurace, is still on the way toward achieving equitable access with universal coverage (Davis and Ballreich 2014, Smith and Medalia 2015). Meanwhile, within the two system achieving universal coverage, roles of complimentary insurance quire differs: it is an essential part of the French health system by making out-of-pocket payments affordable, but is of marginal importance in Japan (OECD 2004).

Third, the three countries have been facing with problems of coverage. An issue of *de-fact* "uninsured" has been emerging in Japan, where achievement of universal coverage is assumed (Hasegawa, 2015). Health insurance coverage of socially marginalized population were problematized in France (Steffen, 2015). The United Stated has been exceptional in developed countries because of its high proportion of the uninsured (Takayama 2015). The three systems more or less faced the problem of underinsurance and/or uninsurance in the last decade, although their contexts are quite different.

The last reason was rather practical: excellent researchers joined our symposium, which are really grateful. Monika Steffen (Senior CNRS Researcher, PACTE-Political Science, Grenoble University, France) and James Warner Björkman (Professor Emeritus, Institute of Social Studies, The Hague, The Netherlands) simultaneously stayed in Kyoto as visiting professors for 2014 Autumn term at the College of Social Sciences, and the College of International Relations, respectively. The two internationally renowned researchers in comparative health policy readily participated in the symposium. Kazuo Takayama (Professor, Faculty of Contemporary Business, Kyoto Tachibana University), who has more than ten years' experience in analyzing US health policy from economic perspectives, and Chiharu Hasegwa (Associate Professor, College of Social Sciences, Ritsumeikan University) were also willing to give their papers there. It is my pleasure that results of our collaborative work are published in this volume.

As the organizer of the symposium, I asked contributors to analyze each health system with a concept of "health safety net". It broadly refers to achievement of effective universal health insurance coverage, which enables vulnerable people, e.g. individuals and families with low-income, to use healthcare without financial hardship. The three papers with qualitative analysis here were extensively revised after the symposium, with the insightful commentary by Jim Björkman (2015) which discusses the two papers on practical reasons.

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