# Is the safety net for healthcare in Japan fraying? : Employment, health insurance, and public assistance

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**Abstract :** This study discusses how the public health insurance system works as a safety net in Japan, based on the characteristics of the public health insurance system. Japan's universal health insurance system is operated using a social insurance scheme. The twin pillars of this system are employment-based health insurance (*Kyokai-kempo, Kumiai-kempo,* and *Kyosai*) and area-based health insurance (National Health Insurance and the medical care system for the latter-stage elderly). However, unstable employment and persistent unemployment could increase the number of employees without employment-based health insurance (most are non-regular workers). Those who cannot participate in public employment-based health insurance could find alternative public health insurance, namely, National Health Insurance, as a safety net. However, more NHI insured lose their premium payments, because the ratio of premiums to income is rising and the burden is excessive for low-income earners. The state needs to improve accessibility for employment-based health insurance, and improve affordability for National Health Insurance.

**Keywords :** Universal health insurance system, Employment-based health insurance, National Health Insurance, Non-regular (non-traditional) employee, Uninsured, Accessibility, Affordability

## Preface

About 50 years ago, the Japanese government adopted a "universal health insurance" system Public health insurance transformed comprehensive and universal compulsory health insurance for all residents, regardless of occupation, age, sex, and area. Nevertheless, more "uninsured" are emerging in the 21st century. However, the Japanese government's public stance is that there can be no uninsured in Japan, and more employees are facing **accessibility** problems for employment-based health insurance by diversification of work arrangements and increasing mobility of employment. More insured people face problems of insurance premium **affordability.**

The present study discusses how the public health insurance system works as safety net in Japan, based on the characteristics of the public health insurance system.

## Ⅰ. Characteristics of Japan's public health insurance system

### 1. Universal health insurance using a social insurance scheme

Universal compulsory public health insurance for all is a distinctive feature of Japan's "welfare state."

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This universal health insurance system is operated using a social insurance scheme. The twin pillars of Japan's universal health insurance system are employment-based health insurance and area-based health insurance.

The history of the health insurance system (intended for blue-collar workers) dates from 1922. The National Health Insurance Act (intended for farmers) was enacted in 1938, but municipalities were not required to set up the foundations of National Health Insurance (NHI). By amending the National Health Insurance Act in 1958, the Japanese government has extended coverage of NHI to all Japanese people, eliminating only those who are covered by employment-based health insurance, to be managed by local governments, thereby realizing universal health insurance coverage (except for welfare recipients).

From the start of the universal health insurance system, the national government has provided subsidies and contributions to ensure that NHI finances remain healthy.

## 2. Distinctive features of Japan's health insurance systems

The Japanese universal health insurance system has three characteristics. First, it is classified into employment-based health insurance and area-based health insurance. Second, multiple insurers operate independently. Third, the type of public insurance cover depends on employment patterns and age. Dependent families are covered by the insurance that applies to the household head.

With regard to the characteristics of the insured groups' contributions, the majority of people (about 60%) are enrolled in employment-based health insurance (Figure 1).

Japan has three primary employment-based health insurance programs: health insurance administered by the Japan Health Insurance Association (JHIA) (*Kyokai-kempo*, a government agency established in

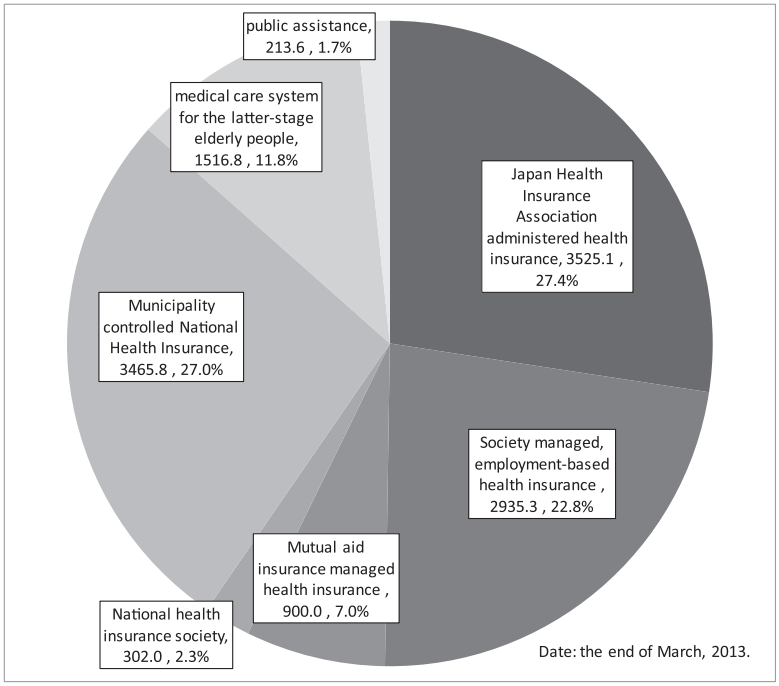


**Figure1: Composition ratio of public health insurances in Japan, 2013**

Source; Ministry of Health, Labour, and Welfare (2014a).

October 2008) for employees of small and medium-sized enterprises; a society-managed, employment-based health insurance (*Kumiai-kempo*, employee health insurance management societies established by a large company or group of companies) for employees of large enterprises; and health insurance managed by a mutual aid association (*Kyosai*) for national and local public officials and private school staff. Employees' family members are able to receive employment-based health insurance as non-working dependents.

There were 1,443 insurers of *Kumiai-kempo* at the end of March 2012, and 1 insurer of *Kyokai-kempo* (47 branches in each prefecture). If companies do not establish societies, employees are enrolled in JHIA-administered health insurance. Thus, JHIA-administered health insurance acts as the safety net in Japan's employment-based health insurance.

Every individual below the age of 75 years who cannot join one of these employment-based health insurance programs subscribes to the area-based health insurance (NHI managed by local governments). Specifically, farmers, the self-employed, non-workers (e.g., pensioners), and employees and their families not covered by employment-based health insurance are enrolled in NHI. There are 1,717 insurers, the same number as the number of municipalities in Japan.

A medical care system for those aged 75 years and over has been operating since April 2008. The insurer has extended associations for latter-stage elderly health insurance in each prefecture.

### 3. Health insurance benefits and patient contribution (copayment)

Multiple public health insurance associations share common health insurance benefit payments (Table 1). Health insurance benefit payments are classified into healthcare payments (in-kind benefits) and cash payments. When insured patients visit medical service providers under NHI, they pay 30% of their medical costs for services. Through the claims of these providers, NHI pays the remaining 70% of the medical costs to providers. However, health insurance payments vary by age bracket as follows: up to primary school entry (80%), those aged 70–74 years (80%), those aged 75 years and over (90%), and those whose taxable income is more than the average taxable income of the workforce of 1,450,000 yen per year since April 2008 (70%).

Historically, patient payments have been 30% of medical costs for NHI insured, with fixed fees for employees enrolled in employment-based health insurance, and 50% of medical costs for employees' dependents until 1972 (Table 2). By welfare reform in 1973 (the first year of welfare), free medical care for the elderly started. However, this ended after 10 years, and a fixed fee for the elderly was adopted (hospital stay: 300 yen/day; outpatient: 400 yen/month). In 1997, that fee was increased (hospital stay: 1,000 yen/day; outpatient: 500yen/day, four times a month + prescription drug copayment). In 2001, the patient copayment for the elderly was changed to 10% of medical cost, and 1 year later, the copayment for the elderly whose income was that of working income level was increased to 20% of medical cost. In 2006, this increased to 30%). Since 2008, the patient copayment for those aged 70–74 years has been 20% of medical cost, and that for those aged 75 years and over has been 10%.

In 1973, a high-cost medical care expense program, with individual limits, was introduced, and the patient copayment for the working generation under the age of 70 years was reduced (10% for employees enrolled in occupational health insurance, and 30% for employees' family members). In 2003, the patient copayment for the working generation was 30% of medical cost across the board.

There are four categories of cash payments: lump-sum allowances for childbirth; lump-sum allowances for burial costs; invalid benefits; and maternity allowances. Invalid benefits and maternity allowances are voluntary benefits for NHI, and are not implemented by any local government. Even though many

**Table 1: Health insurance benefits (health care payment and cash payment)**

| | Payment | National healthcare insurance (local authority) | Healthcare insurance | |
|---|---|---|---|---|
| Healthcare payments | Healthcare Benefits Visiting nursing healthcare | Until the entry into primary school: 80%<br>After junior high school to 69 years: 70%<br>70-74 years: 80%* (those whose taxable income is more than average taxable income of the active workforce (1,450,000 yen per year): 70%) | | |
| | Meals during hospitalization expenses | Standard amount borne for meals: ¥260 per meal<br>Low income persons after the 90th day of hospitalization: ¥160 per meal | Low-income persons: ¥210 per meal<br>Persons of particularly low income (70 years old and over): ¥100 per meal | |
| | Living care during hospitalization (65 years old and above) | Living care standard fee:<br>¥ 460 per meal (meal cost)* + ¥320 (residential cost)<br>Particularly low-income persons:<br>¥130 per meal (meal cost) + ¥320 (residential cost)<br>(*) ¥420 at the insurance medical institutions that calculate living care during hospitalization (II) | Low-income persons:<br>¥210 per meal (meal cost) + ¥320 (residential cost)<br>Persons receiving senior citizens welfare benefits:<br>¥100 per meal (meal cost) + ¥0 (residential cost)<br>Note: The amount borne by patients with serious diseases will be the living care standard fee | |
| | High-cost medical care expenses (with individual limit) | Aged under 70 years<br>(High income) ¥ 150,000＋(medical expenses – 500,000) × 1% (¥ 83,400)<br>(General) ¥ 80,100＋(medical expenses – 267,000) × 1% (¥ 44,400)<br>(Low income) ¥ 35,400 (¥ 24,600)<br>(Figures in parenthesis are for the fourth month onwards) | Aged 70 to 74 years<br>(Working income level) Hospitalization: ¥ 80,100＋(medical expenses – 267,000) × 1% (¥ 44,400); Outpatients (per person): ¥ 44,400<br>(General*) Hospitalization: ¥ 44,400; Outpatients (per person): ¥ 12,000<br>(Low income) Hospitalization: ¥ 24,600; Outpatients (per person): ¥ 8,000<br>(Particularly low income) Hospitalization: ¥ 15,000; Outpatients (per person): ¥ 8,000 | |
| Cash payments | Lump-sum allowance for childbirth | Contents of benefits are decided by separate regulations.<br>(Most insurers pay ¥420,000 (¥390,000 if the additional payment set out in the maternity medical care compensation scheme does not apply.) | Lump-sum allowance for childbirth | ¥420,000 paid in the instance of the insured person or their dependent giving birth<br>(¥ 390,000 if the additional payment set out in the maternity medical care compensation scheme does not apply) |
| | | | Lump-sum allowance for childbirth and nursing | |
| | Lump-sum funeral allowance, burial costs | Contents of benefits are decided by separate regulations.<br>(Most local authorities pay at a rate between ¥10,000-50,000)<br>Practiced by most local authorities | Burial costs | Fixed amount of ¥50,000 paid in the instance of the insured person dying |
| | | | Family burial costs | Fixed amount of ¥50,000 paid in the instance of the insured person's dependent dying |
| | Invalidity benefit | Voluntary benefit<br>(Not practiced by any local authorities) | In the case that the insured person becomes unable to work because of medical treatment being received for a cause not related to work, an amount approximate to two thirds of that persons standards daily wage will be paid daily for a maximum period of 1 year and 6 months. | |
| | Maternity allowance | | During the maternity leave taken by the insured person, an amount approximate to two thirds of that persons standards daily wage will be paid daily for a maximum period of from 42 days prior to the birth to 56 days after the birth. | |

Source: Ministry of Health, Labour, and Welfare, *An outline of the Japanese Medical System* (English) <http://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/dl/01_eng.pdf>. Accessed 2015 Jan 6.

**Table 2: Patient contribution (copayment),**

<table>
<tr><td></td><td>~Des. 1972</td><td colspan="2">Jan. 1973</td><td>Feb. 1983</td><td>Sep. 1997</td><td>Jan. 2001</td><td>Oct. 2002</td><td>Apr. 2003</td><td>Oct. 2006</td><td colspan="2">Apr. 2008</td></tr>
<tr><td></td><td>before the free medical care for the elderly</td><td colspan="2">the free medical care for the elderly</td><td colspan="7">the healthcare programs for the elderly</td><td colspan="2">medical care system for the latter-stage elderly people</td></tr>
<tr><td>NHI</td><td>30%</td><td colspan="2" rowspan="2">the elderly 70 years old and over</td><td rowspan="2">free</td><td rowspan="2">hospital stay ¥1000/day, out-patient ¥500/day (limited 4 times/month) + prescription drug copay</td><td rowspan="2">10% (cap monthly copay)</td><td rowspan="2" colspan="2">10% (working income level 20%)</td><td rowspan="2">10% (working income level 30%)</td><td>75 years old and over</td><td>10% (working income level 30%)</td></tr>
<tr><td rowspan="2">employee</td><td rowspan="2">fixed fee</td><td rowspan="2">70~74 years old</td><td>20% (working income level 30%)</td></tr>
<tr><td rowspan="3">employee's dependents</td><td rowspan="3">50%</td><td rowspan="3">working generation under 70 years old</td><td>NHI</td><td colspan="2">30%</td><td colspan="3">hospital stay 30%, out-patient 30% + presctiption drug copay (children under 3 years old 20% (Oct. 2002~)</td><td rowspan="3">30%</td><td rowspan="3">under 70 years old</td><td rowspan="3">30% (prior to the start of compulsory education 20%)</td></tr>
<tr><td>employee</td><td colspan="2">fixed fee → 10% (1984~)</td><td colspan="3">hospital stay 20%, out-patient 20% + prescription drug copay</td></tr>
<tr><td>employee's dependents</td><td colspan="2">30% → hospital stay 20% (1981~), out-patioent 30% (1973~)</td><td colspan="3">hospital stay 20%, out-patient 30% + prescription drug copay (children under 3 years old 20%)</td></tr>
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Source: Ministry of Health, Labour, and Welfare, *An outline of the Japanese Medical System* (English) <http://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/dl/01_eng.pdf>. Accessed 2015 Jan 6.

employees are enrolled in NHI, they have no economic security if they become unable to work because of accidents or sickness unrelated to their jobs.

## Ⅱ. Funds for medical expenditure

### 1. Insurance premium and contribution

Each public health insurer implements fiscal management independently. Calculation methods for health insurance premiums differ for occupational insurance, area-based insurance, and the medical care system for latter-stage elderly people. Major sources of revenue are premiums (paid by the insured and employers), public expenditure for health benefits (state, prefectural governments, and municipal governments), and copayments by patients.

In 2012FY, health insurance benefits were about 47% of national health expenditure, health insurance benefits for the latter-stage elderly were about 32%, public expenditure for health benefits was about 7%, and copayments by patients was about 13% (Figure 2). For the share of national health expenditure by financial resource, premiums were about 49%, public expenditure about 39% (state 26% and local 13%), and copayments by patients about 12%.

The calculation method of occupational health insurance premiums depends on the principle of ability

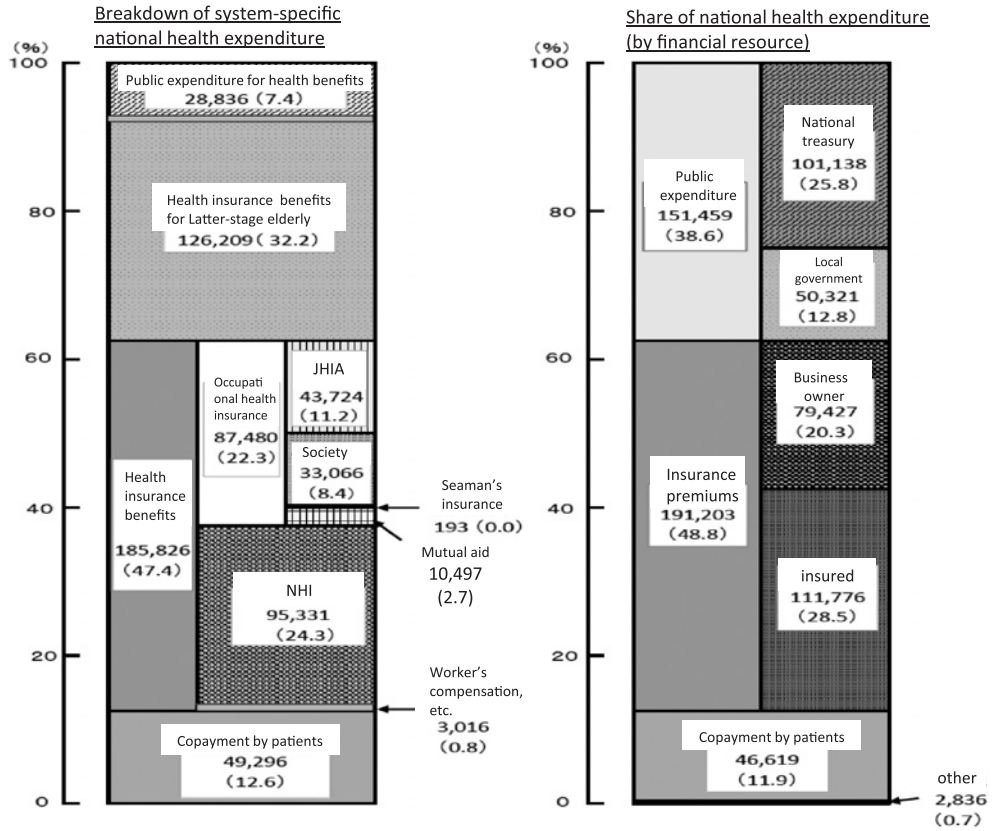



**Figure 2: National health expenditure (2012FY)**

Source; Ministry of Health, Labour, and Welfare (2014b).

to pay (index monthly earning and bonus × premium rate). The average premium rate of JHIA-managed health insurance is 10%, whereas society-controlled insurance is 8.9% (2014FY). Occupational insurance premiums consist of this premium and specific premiums for supporting medical costs of the elderly (4.07% in the case of the JHIA, ~March 2014). Insured employees and their employers share the costs of premiums 50–50, and in the case of society-controlled health insurance, most employers shoulder more burdens. Occupational health insurance is not calculated on the benefit principle and does not charge family premiums (Shimazaki 2011).

Most of the insured enrolled in JHIA-managed health insurance are employees of small and medium enterprises and their average wages are lower than those of employees of large enterprises; thus, the JHIA has weak funding. As long as compulsory participation prevents employees from choosing their preferred occupational health insurance, it is necessary to narrow the funding gap between the JHIA and societies (*Kumiai-kempo*) by state government subsidy (Shimazaki 2011). Therefore, the state subsidizes the health benefit expenses (16.4%) for the JHIA to control the growth of the JHIA's premium rates.

The calculation method of NHI premium depends on both the principle of ability to pay and the benefit principle. NHI premiums are determined by a formula based on the insured's ability to pay (a fixed percentage of total household income and property tax), and is calculated for each household according to benefits received (fixed amount per capita and fixed amount per household). Levy calculation formulas, premium rates, and fixed amounts differ among insurers. For example, in the case of Kyoto city, NHI premium consists of a fixed percentage of total household income, a fixed amount per capita, and a fixed amount per household.

NHI has weak funding because the average age of the insured and the level of medical care costs are higher than occupational health insurance; moreover, the average income of NHI insured is lower. Thus, NHI takes national government subsidies amounting to 50% of benefits, a fixed-rate state contribution of 32%, state adjusting subsidies of 9%, and prefectural adjusting subsidies of 9%. The other 50% of benefits are covered by premiums. To adjust the gap of premium income and spending between municipal governments, there are joint projects to strengthen the financial basis of NHI. The state, prefectures, and municipalities jointly take on the financial burdens of high-cost medical receipts and low-income insured. Even so, most NHI insurers have fiscal deficits and many municipalities transfer a part of their general account expenditure to NHI special account.

**2. Financial adjustments of medical expenditure for the elderly**

Aging population and the resulting expansion of medical expenditure are common issues shared by developed countries. In Japan, those who are enrolled in employment-based health insurance move to area-based health insurance after retirement, and so, there is uneven distribution of the elderly between insurers. In particular, there are very big elderly populations in NHI managed by local governments, and NHI covers the financial burden of medical expenditure for the elderly. To ease the burden of NHI, a financial adjustment system is required for medical expenditure for the elderly among all insurers, including occupational health insurance.

By health insurance reform in 2006, the state introduced a financial adjustment system for the early-stage elderly and a medical care system for the latter-stage elderly to achieve equitable sharing of medical costs among insurers, equitable premium burdens among the elderly, and clarification of the ratio of the premium amounts between aged and young generations.

Through the financial adjustment system for the early-stage elderly, some insurers pay levies and other

insurers receive grants related to national average participation rates of the elderly aged 65–74 years to adjust imbalance among insurers due to the uneven distribution of the elderly aged 65–74 years. In fact, insurers of employment-based health insurance pay levies and NHI insurers receive grants (Figure 3).

Under the medical care system for the latter-stage elderly, this elderly group makes a premium payment equivalent to 10% of insurance benefits for the latter-stage elderly, young generations contribute 40%, and general public expenditure makes up the remaining 50% (Figure 4). The latter-stage elderly pay a

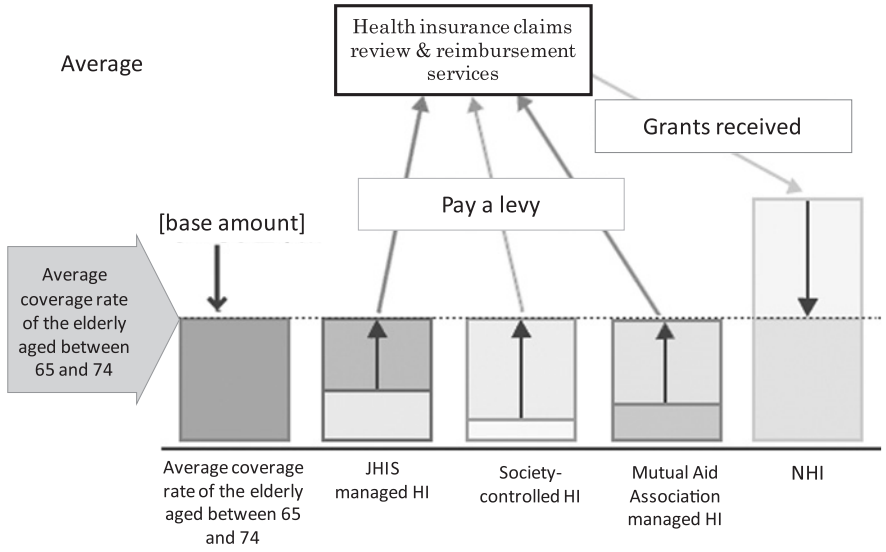



**Figure 3: Finance adjustment system for the early-stage elderly (conceptual diagram)**

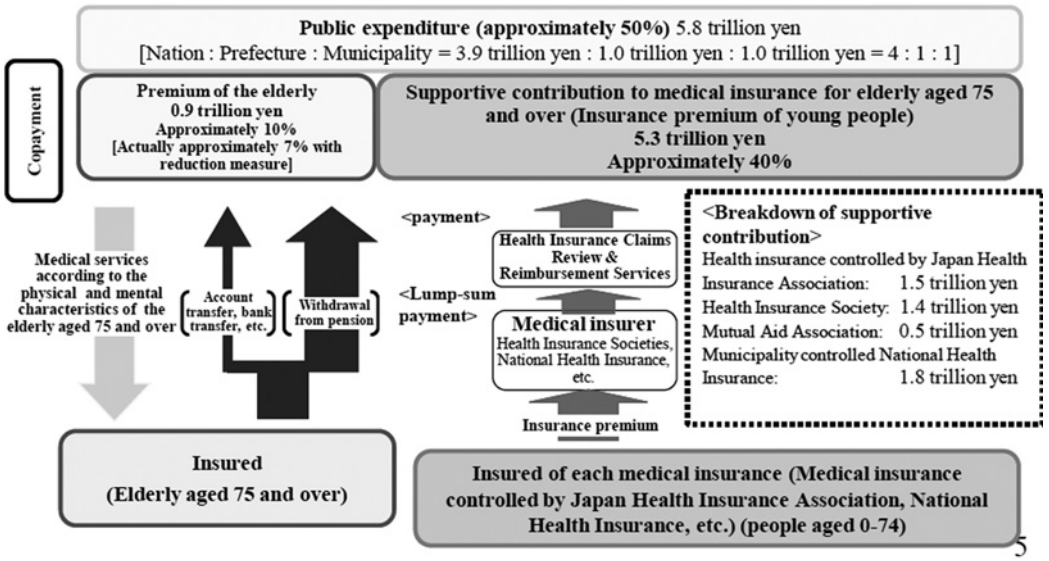



**Figure 4: Medical care system for the latter-stage elderly**

Source; Ministry of Health, Labour, and Welfare, *An outline of the Japanese Medical System* (English) <http://www.mhlw.go.jp/bunya/iryouhoken/iryouhoken01/dl/01_eng.pdf>. Accessed 2015 Jan 6.

flat premium rate in each prefecture, calculated as a fixed percentage of total household income and fixed amount per capita.

### 3. Gradual reduction systems of premium payments by low-income households

NHI and the medical care system for the latter-stage elderly act as safety nets of public health insurance, and so, these comprise gradually reducing premium payments by low-income households.

NHI premiums calculated by the benefit principle (fixed amount per capita and fixed amount per household) are discounted by 70%, 50%, or 20%, designated by national law. Some municipalities have original discount systems in their ordinances. If household income is less than 330,000 yen, that household NHI premium calculated by the benefit principle is discounted by 70%. If household income is less than 330,000 yen + (245,000 yen × number of people per household), it is discounted by 50%. If the household's income is less than 330,000 yen + (450 000 yen × number of people per household), it is discounted by 20%.

The medical care system for the elderly aged 75 years and over has a premium discount system for low-income insured, whose premium payment is only a fixed amount per capita and that amount is discounted gradually. In addition, a special reduction premium measure has operated since 2008.

## Ⅲ. Structural factors creating the uninsured[1]

### 1. Employees without employment-based health insurance

Employees (those employed by a company with more than five employees in a workplace covered by social insurance) and their dependent families are enrolled mandatorily in employment-based health insurance. However, more employees (non-regular workers) are eliminated from applying for employment-based health insurance.

An "employee" is assumed by occupational health insurance to be a full-time worker and would have lifetime employment and a seniority-based wage (Figure 5). A "regular employee" is defined as a worker entering into a contract of employment for more than 2 months or without term, and who works more than three-quarters of scheduled working hours on prescribed working days[2]. Thus, short-term contract workers and part-time workers do not apply to be employees, as defined by employment-based health insurance, as a general rule. Thus non-regular employees have been enrolled in NHI or employment-based health insurance as family dependents. Kurata (2004) offers two systemic reasons why employment-based health insurance essentially is available only to regular employees. First, legal provisions do not apply to day workers, some contingent workers,

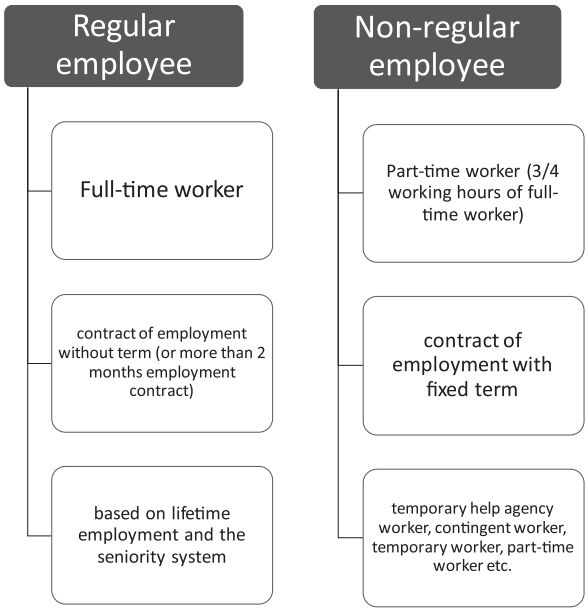



**Figure 5: Classification between Regular employee and Non-regular employee**

seasonal workers, and temporary workers employed for less than 6 months. Second, the pay base on which insurance premiums are calculated pertains only to regular employees.

Figure 6 shows the employment characteristics of Japanese workers. In 1984, 84.7%, excluding board members, were regular employees. That average percentage eased between 1994 and 2008 and declined to 63.3% in 2013. Conversely, Japan's 19.06 million non-traditional employees now comprise 36.7% of the workforce. Since 1985, amendments to the Manpower Dispatching Business Act and to the Labor Standard Law have deregulated hiring practices, and the number of non-traditional workers is increasing without labor protection, such as equal treatment with full-time employees.

Table 3 shows that all full-time regular employees have employment-based health insurance, but less than half of non-traditional employees do. More specifically, about 95% of employees on temporary assignment applied for employment-based health insurance, but only 88% of contract or temporary workers, 78% of temporary help agency workers, 35% of part-time workers, and 14% of contingent workers applied.

Temporary help agency workers have short and intermittent employment agreements and no access to occupational health insurance from the company they are assigned to or from the personnel agency that assigned them. Recognizing the growing number of temporary help agency workers, the Health Insurance Society for Temporary Workers (*Haken-Kempo*) was founded in 2002 "in order to strive for the stability of

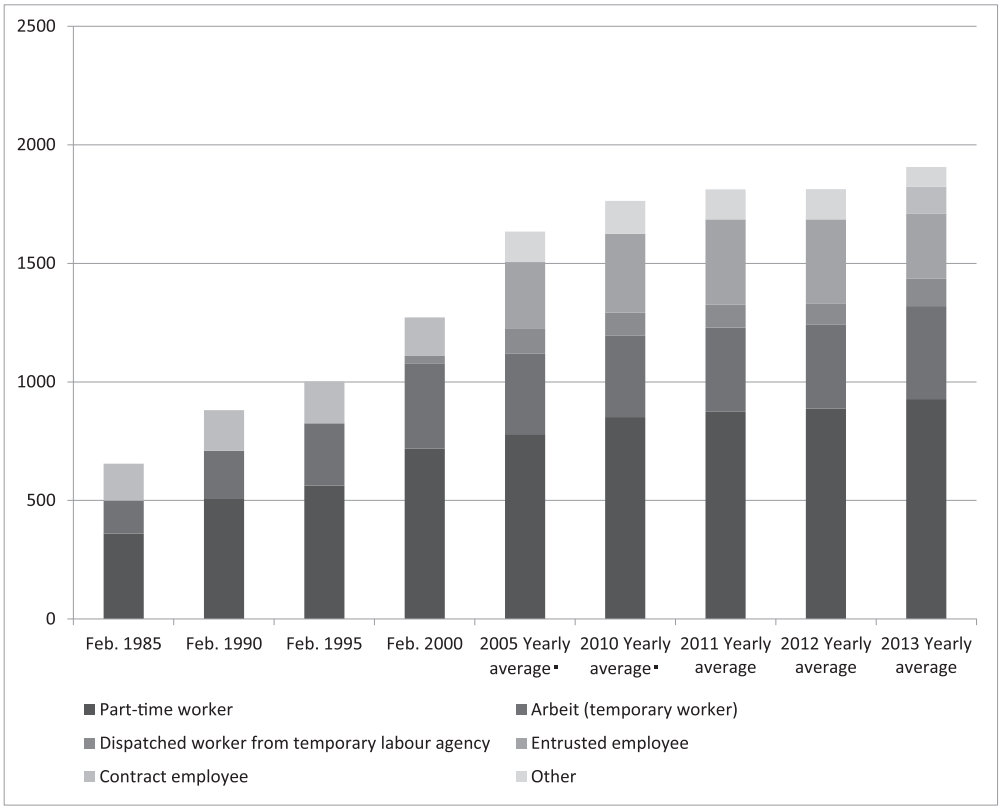



**Figure 6: Annual changes in the actual number of non-traditional employees in Japan (Ten thousand persons), 1985–2013**

Note: "part-time" and "arbeit" are internal name, so both are part-time workers.
Source: Ministry of Internal Affairs, and Communications (2002–2014).

**Table 3: Percentage of workers with unemployment, employee health, and employee pension insurance, in Japan, 2010**

| | Total | | | men | | | women | | |
|---|---|---|---|---|---|---|---|---|---|
| | Unemployment insurance | Employee health insurance | Employee pension insurance | Unemployment insurance | Employee health insurance | Employee pension insurance | Unemployment insurance | Employee health insurance | Employee pension insurance |
| full-time regular employee | 99.5% | 99.5% | 99.5% | 99.3% | 99.3% | 99.3% | 99.8% | 99.8% | 99.8% |
| non-traditional employee | 65.2 | 52.8 | 51.0 | 66.1 | 64.4 | 61.3 | 64.7 | 46.0 | 44.9 |
| contract worker | 85.1 | 88.5 | 85.4 | 83.2 | 88.6 | 85.0 | 87.3 | 88.5 | 85.8 |
| temporary worker | 84.0 | 87.8 | 85.2 | 82.7 | 88.0 | 85.1 | 88.6 | 87.1 | 85.3 |
| employee temporarily transferred to the affiliated company | 90.3 | 94.9 | 92.6 | 90.3 | 95.6 | 93.0 | 90.3 | 89.7 | 89.8 |
| temporary help agency worker | 84.7 | 77.9 | 75.6 | 84.7 | 81.4 | 77.8 | 84.6 | 75.3 | 74.0 |
| temporary workers registered in temporary help firm | 80.9 | 76.7 | 73.0 | 79.3 | 75.1 | 66.5 | 81.5 | 77.4 | 75.6 |
| temporary workers employed by temporary help firm | 89.0 | 79.3 | 78.6 | 87.7 | 85.0 | 84.1 | 90.7 | 71.1 | 70.8 |
| contingent worker | 16.6 | 13.5 | 11.0 | 33.4 | 15.9 | 11.2 | 10.3 | 12.5 | 10.9 |
| part-time worker | 55.3 | 35.3 | 33.8 | 45.5 | 39.1 | 35.6 | 58.8 | 34.0 | 33.2 |
| other | 74.6 | 70.0 | 67.9 | 72.2 | 69.6 | 68.4 | 76.3 | 70.2 | 67.6 |

Source: Ministry of Health, Labour, and Welfare (2010).

**Table 4: Distribution of employees' main source of income, by work status, 2010**

| | all workers | full-time regular employee | non-traditional employee | contract worker | fixed-term employee | employee temporarily transferred to the affiliated company | temporary help agency worker | temporary workers registered in temporary help firm | temporary workers employed by temporary help firm | contingent worker | part-time worker | other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **both** | | | | | | | | | | | | |
| own income | 100 | 73.6 | 26.4 | 3.6 | 2.9 | 1.9 | 2.9 | 1.4 | 1.6 | 0.2 | 10.9 | 3.9 |
| income of spouses | 100 | 29.7 | 70.3 | 2.9 | 1.1 | 0.3 | 2.8 | 2.0 | 0.8 | 1.1 | 56.0 | 6.2 |
| income of children | 100 | 2.5 | 97.5 | 7.0 | 9.3 | 0.0 | 8.0 | 8.0 | – | – | 72.0 | 1.2 |
| income of parents | 100 | 37.1 | 62.9 | 3.4 | 0.2 | 0.2 | 3.9 | 2.8 | 1.1 | 1.5 | 45.7 | 8.0 |
| income of brothers and sisters | 100 | 48.4 | 51.6 | 1.4 | 2.3 | 1.8 | 3.7 | 3.7 | – | – | 34.3 | 8.1 |
| other | 100 | 34.9 | 65.1 | 4.1 | 4.0 | 0.2 | 2.4 | 1.4 | 1.0 | 0.6 | 42.7 | 11.1 |
| **males** | | | | | | | | | | | | |
| own income | 100 | 78.6 | 21.4 | 3.0 | 3.3 | 2.3 | 2.1 | 0.7 | 1.4 | 0.2 | 7.5 | 3.0 |
| income of spouses | 100 | 40.6 | 59.4 | 7.8 | 6.9 | 1.8 | 4.3 | 2.0 | 2.3 | 2.3 | 27.0 | 9.3 |
| income of children | 100 | – | 100.0 | 29.0 | 16.8 | – | 15.3 | 15.3 | – | – | 38.9 | – |
| income of parents | 100 | 29.1 | 70.9 | 3.0 | 0.1 | 0.2 | 2.6 | 2.0 | 0.6 | 0.9 | 57.7 | 6.3 |
| income of brothers and sisters | 100 | – | 100.0 | – | – | – | 24.9 | 24.9 | – | – | 75.1 | – |
| other | 100 | 23.2 | 76.8 | 5.9 | 8.8 | – | 3.0 | 1.2 | 1.8 | 0.0 | 43.2 | 15.9 |
| **females** | | | | | | | | | | | | |
| own income | 100 | 57.5 | 42.5 | 5.5 | 1.7 | 0.6 | 5.5 | 3.5 | 2.1 | 0.3 | 22.0 | 6.8 |
| income of spouses | 100 | 29.5 | 70.5 | 2.8 | 1.0 | 0.3 | 2.8 | 2.0 | 0.8 | 1.1 | 56.4 | 6.1 |
| income of children | 100 | 3.2 | 96.8 | 1.3 | 7.4 | 0.0 | 6.0 | 6.0 | – | – | 80.6 | 1.5 |
| income of parents | 100 | 43.4 | 56.6 | 3.8 | 0.2 | 0.2 | 4.9 | 3.4 | 1.5 | 1.9 | 36.2 | 9.4 |
| income of brothers and sisters | 100 | 55.8 | 44.2 | 1.7 | 2.6 | 2.1 | 0.4 | 0.4 | – | – | 28.0 | 9.4 |
| other | 100 | 42.5 | 57.5 | 2.9 | 0.8 | 0.4 | 2.1 | 1.6 | 0.5 | 1.0 | 42.4 | 7.9 |

Source: Ministry of Health, Labour, and Welfare (2010).

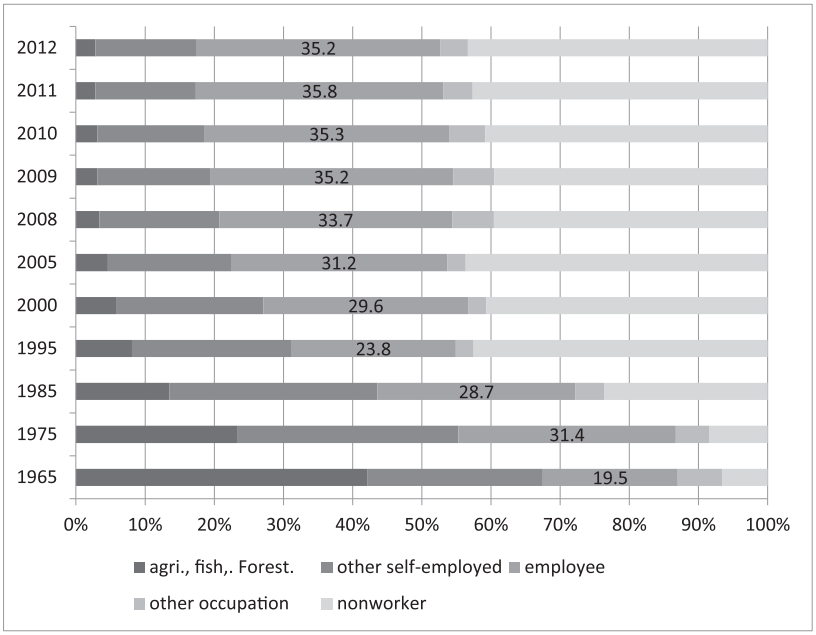



**Figure 7: Composition rate of household with NHI, by work status of family head, 1994–2012**

Source: Ministry of Health, Labour, and Welfare (2014c).

life and the improvement of welfare of temporary employees...” Unlike *Kumiai-Kempo*, *Haken-Kempo* allows the insured to retain coverage despite interruption in employment if they remain registered with the same dispatching agency, have definitive employment agreements for 1 month or longer, and start work within 1 month after their previous employment agreements end. When switching to a different dispatching agency or if the interval between assignments exceeds 1 month, these insured are not eligible to continue coverage.

It would appear that some non-regular workers do not want their own employment-based health insurance because they are enrolled in their spouses' employment-based health insurance as a dependent family member, with annual income of less than 1,300,000 yen. If non-regular employees are not the family's primary breadwinner, these conditions of employment might present problems. However, Table 4 shows that quite a number of non-regular workers specify their own wages as their main sources of income.

Workers that are not eligible for employer-sponsored insurance can enroll in NHI, but vulnerability to wage loss differs under these two programs. Workers with employer-sponsored health insurance could receive cash for a time if they miss work because of illness, injury, or childbirth. Workers with NHI receive no such benefits, and they are endangered by losing all wage income through illness, injury, and childbirth. Figure 7 shows certain characteristics of households covered by NHI. Among households, the percentage of households in which family heads are employees was 35.2% in 2012 compared to 23.8% in 1995. The sharp increase is explained by individuals aged 75 years and older who shifted from NHI to the latter-stage elderly health care system in 2008.

### 2. Loss of employment-based health insurance through unemployment

Workers who lose their jobs also lose their employment-based health insurance. Certain former

employees, retirees, spouses, and dependent children have the right to temporary continuation of employment-based health insurance; if they have held the same employment-based coverage for more than 1 year, they can continue with it for up to 18 months with proper notification (voluntary continuation program). The former employee must pay the entire premium and loses coverage if he/she is in payment arrears for at least 1 month.

Workers who do not choose the voluntary continuation program must newly notify for NHI. If they fail to make the proper notification or to apply for NHI within a specified time (within 14 days after losing their insurance card), they lose coverage from their previous employers. Thus, increased possibility of unemployment increases the danger of losing health insurance.

As Figure 8 indicates, Japan's unemployment rate remained at 2% until the early 1990s, increased gradually to 5% in the 2000s, and now stands around 4%. The unemployment rate was 4.1% in the fourth quarter of fiscal 2008 and rose to 5.4% in the third quarter of fiscal 2009. In July 2009, unemployment reached a record high of 5.6%. Despite a modest decline, unemployment remains high, particularly among workers age 34 years and younger. The risk of unemployment is acute for non-traditional workers. According to the Ministry of Health, Labour and Welfare, contract expirations, workforce adjustments, and other terminations amounted to 4,262 Japanese businesses between October 2008 and December 2009, and cost 244,000 non-traditional workers their jobs.

If displaced from residences provided by former employers, the unemployed without other fixed addresses cannot apply for NHI because they must declare local addresses when applying for NHI. Even if the unemployed retain previous employer-sponsored coverage or join NHI, they may have difficulties affording premiums. Part of the premium for NHI is based on the previous year's earnings, even for those

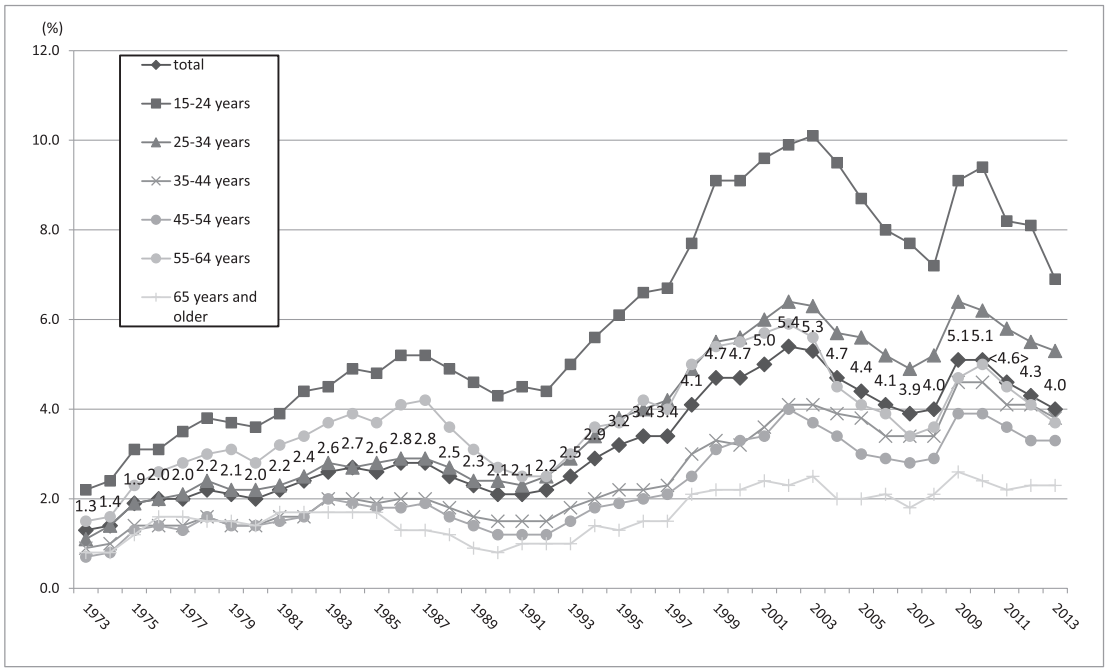



**Figure 8: Umemployment rate in Japan, by age group, 1973–2013**

Source: Ministry of Internal Affairs, and Communications (2014).

who lost their jobs and have no income[3]. Because premiums for NHI are rising, even those covered by NHI are in danger of becoming uninsured through inability to pay premiums.

### 3. Uninsured risk for NHI insured

Since people are covered by NHI when they cannot receive employer-sponsored health insurance, the Japanese government's public stance is that there can be no uninsured in Japan. However, since NHI is a social insurance system, premium payments and benefits are applied. If the insured cannot pay premiums for an extended time, their health insurance ceases and they could become uninsured.

In April 2000, the government required municipalities to issue certificate cards of NHI eligibility to the insured who have defaulted on premiums for 1 year or more; if the insured are dispossessed of insurance cards, they instead receive certificate cards of NHI eligibility, but then, they cannot receive insurance benefits for healthcare services or prescription drugs. Moreover, some individuals changed to NHI cards with limited effective dates; these cards expire sooner (after less than 6 months, mostly after 1 month) than the general NHI insurance card (more than 1 year). Those holding the NHI card with limited effective dates must pay premium arrears continuously. If the card is not updated, it expires, and the insurance benefit is forfeited. This is an instance of becoming uninsured by not paying premiums.

Non-payment of premiums has increased since the 1990s and 2000s. The percentage of premiums paid for the NHI has fallen since the end of the 1990s. Nationally, the percentage of premiums paid in fiscal 2009 averaged 88.01%, down 2.48 percentage points from fiscal 2007 and the lowest since fiscal 1961.

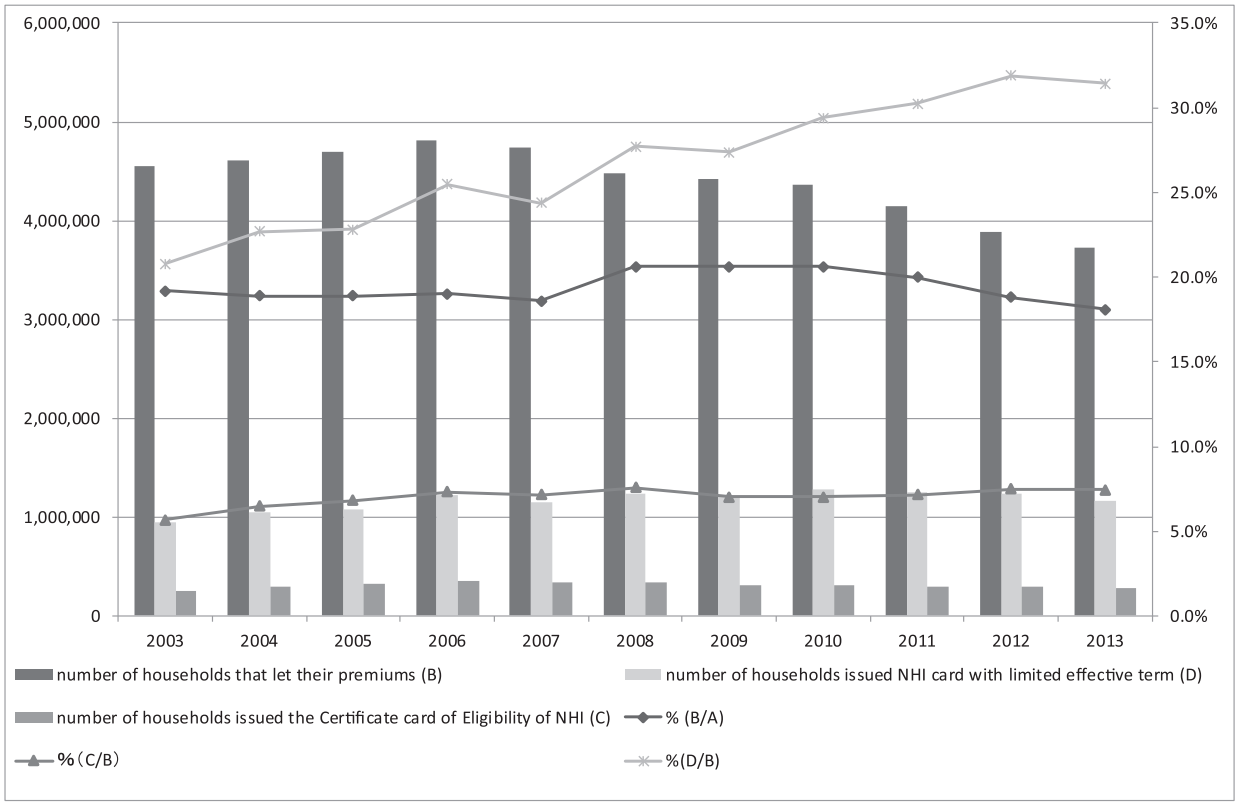
Table 5 itemizes the percentage of paid premiums of total charged premiums of NHI, by age group of family head and family income. The percentage rises with age, but as income declines, the percentage of premium paid is lower for all age groups except for people aged younger than 25 years.

As Figure 9 shows, households that failed to pay premiums for NHI grew to 20.6% of all NHI households between 2008 and 2010, but thereafter declined. In 2013, 3,721,615 households failed to pay premiums (18.1% of all NHI households). In addition, 277,039 households (7.4% of non-paying households) changed from the general NHI card to the certificate card of NHI eligibility, and 1,169,533 households changed to the NHI card with limited effective term (31.4% of non-paying households). Compared with 2003,

**Table 5: Percentage of payed premiums among total charged premiums of NHI, by age group of family head and family income class, 2011**

| family income class | age group of family head | | | | | | |
|---|---|---|---|---|---|---|---|
| | total | Under 25 years | 25–34 years | 35–44 years | 45–54 years | 55–64 years | 65–74 years |
| | % | % | % | % | % | % | % |
| total | 90.3 | 59.1 | 72.7 | 79.9 | 82.3 | 90.1 | 96.9 |
| no income | 84.6 | 61.5 | 64.7 | 72.4 | 77.2 | 88.3 | 94.5 |
| less than ¥300,000 | 85.7 | 46.7 | 71.5 | 77.2 | 78.1 | 85.4 | 93.9 |
| ¥300,000-less than ¥500,000 | 87.5 | 61.6 | 68.4 | 77.9 | 81.1 | 90.0 | 93.5 |
| ¥500,000-less than ¥1million | 89.8 | 62.2 | 66.0 | 75.0 | 79.4 | 89.7 | 95.8 |
| ¥1million-less than ¥2million | 90.7 | 57.4 | 72.6 | 74.0 | 78.3 | 88.3 | 97.2 |
| ¥2million-less than ¥3million | 90.6 | 78.6 | 77.5 | 81.5 | 78.8 | 89.6 | 97.2 |
| ¥3million-less than ¥5million | 93.3 | 89.5 | 89.0 | 85.0 | 86.9 | 93.5 | 97.8 |
| more than ¥5million | 97.1 | – | 92.9 | 95.6 | 94.9 | 97.2 | 98.7 |
| unknown | 70.2 | 44.8 | 50.7 | 63.3 | 65.6 | 71.1 | 89.8 |

Source: Ministry of Health, Labour, and Welfare (2014c).




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| total household with NHI (A) | 23,713,339 | 24,436,613 | 24,897,226 | 25,302,112 | 25,508,246 | 21,717,837 | 21,446,473 | 21,136,752 | 20,711,375 | 20,637,360 | 20,583,682 |

Source: Ministry of Health, Labour, and Welfare (2014d).

**Figure 9: Number and the percentage of households with NHI that fall behind on their premiums, 2003-2013**

the number of households that failed to pay premiums and received the certificate card of NHI eligibility increased about 2%, and households that changed to NHI with limited effective terms increased by 10%.

The increase of households that failed to pay premiums is attributable to rising NHI premiums. According to *Mainichi* newspaper (June 8, 2009), 801 municipalities (44.6% of all cities, towns, and villages) raised NHI premiums in 2008FY, and 204 municipalities increased premiums by more than 50,000 yen for a model case of an insured household[4]. The ratio of premiums to income is rising and the burden is excessive for low-income earners (Figure 10). Although the average fixed amount of the premium is 10.1% of income, the percentage for households with yearly income of less than 5 million yen exceeds that. About 79% of households with NHI have annual income of less than 2 million yen, and their premium burden is overloaded.

The social aid system is leaving behind a substantial number of impoverished uninsured who cannot pay premiums for extended periods. The rapid increase in recipients of public assistance since the end of the 1990s suggests that the social insurance system inherited from the 20th century is ceasing to function, particularly as the employment structure since the mid-1990s has changed.

Although the number of households receiving public assistance (monthly average) decreased from the mid-1980s until the mid-1990s, it has risen rapidly since the end of the 20th century (Figure 11), reaching 1,558,510 households, with a coverage rate of 32.4‰ in fiscal 2012. The number of households receiving public assistance has increased since 1996.

By type, 677,577 assisted households were "elderly households" (43.7%), defined as non-working households, and 475,106 (about 30.6%) were "sick, injured, and disabled person households." However, the

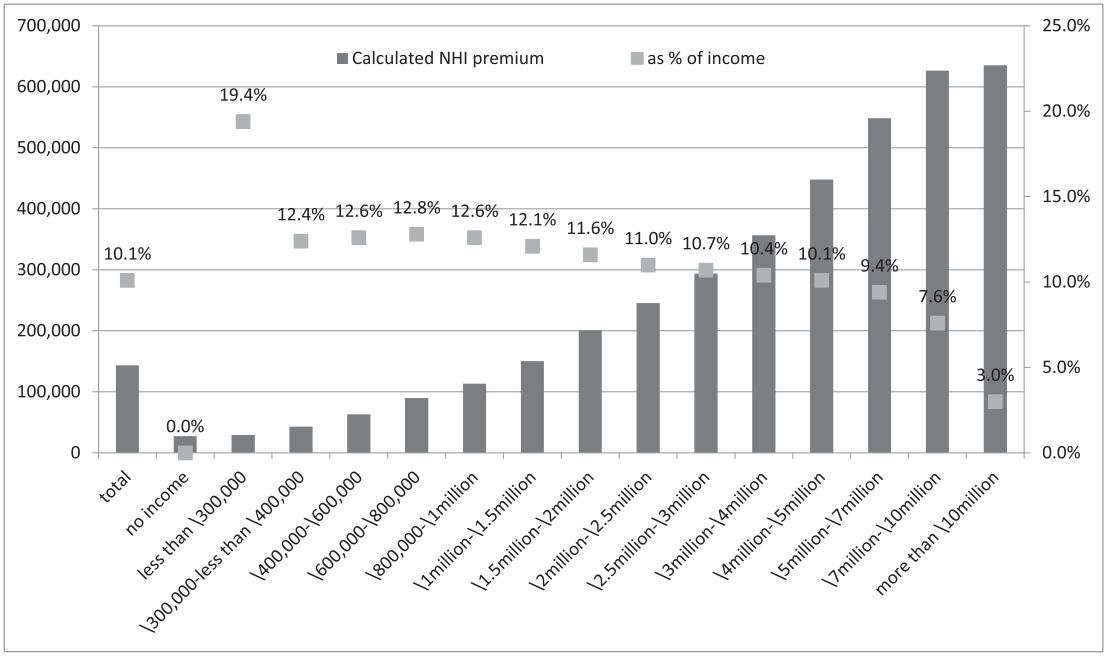



**Figure 10: Calculated NHI premiums per household, and those as a percentage of income, by family income class (premiums for own health insurance and medical care system for the latter-stage elderly people), 2012**

Source: Ministry of Health, Labour, and Welfare (2014c).

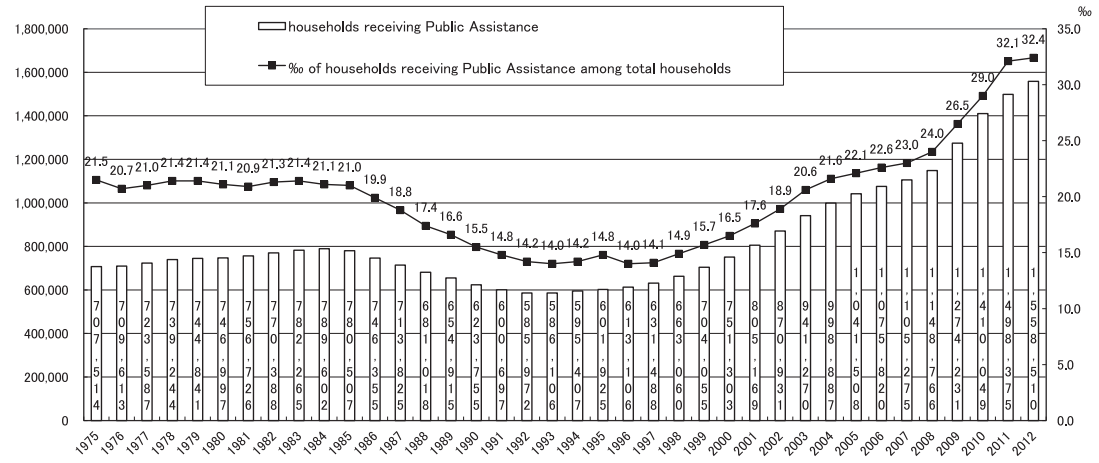



**Figure 11: Actual number and percentage of households receiving Public Assistance (monthly average), 1975–2012**

Source: Ministry of Health, Labour, and Welfare (2014e).

increase in fiscal 2012 increase of "other households"—those that included a person able to work—was remarkable: 284,902 households, an increase of 31,162 (12.3%) over fiscal 2011.

## Ⅳ. Discussion

The characteristics of insured groups show that a majority of people (60.3%) are enrolled in employment-based health insurance. Unstable employment and persistent unemployment could increase the number of employees without employment-based health insurance. Thus, the state needs to improve accessibility for employment-based health insurance.

Those who cannot participate in public employment-based health insurance could find alternative public health insurance, NHI, as a safety net.

However because the ratio of premiums to income is rising and the burden is excessive for low-income earners, more NHI insured are losing their premium payments. This could prove to be the breakdown of NHI as more Japanese could become "uninsured." Thus, the state needs to improve the affordability of the NHI.

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**Notes**

1 This paper is based on Hasegawa (2011) updated by using new statistical data, altered, and refined.

2 "The three-quarters requirement" was mandated by the former Ministry of Health and Welfare in 1980 (Shimazaki 2011).

3 Japan's national government established a program for workers who left their jobs involuntarily (e.g., through company bankruptcy, dismissal, and non-renewed contracts). Under this program, which came into force in April 2010, workers who lost their jobs and their employment-based health insurance could subscribe afresh to NHI by paying lower-than-customary premiums from the date of unemployment to the end of the following year.

4 According to the *Mainichi* survey, the model case of an insured household is as follows: annual household income is 2 million yen and fixed asset tax is 50,000 yen for a family of four with a husband and wife aged in their 40s and two children aged less than 20 years.

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# 日本医療のセイフティネットは擦り切れているか
## ―雇用，健康保険，公的扶助に目配りして―

長谷川　千春[i]

本稿では，日本の医療保険制度の特徴を踏まえた上で，「無保険」を生み出す構造的要因について検討し，公的医療保険のセイフティネットとしての機能について考察する。日本が国民皆保険の国として歩み始めてから，50年以上が経過した。それは，職業，年齢，性別，地域にかかわらず加入できるよう，公的医療保険を包括化，一般化する道であった。しかし，21世紀に至り，日本において「無保険」問題が発生している。日本における「無保険」問題とは，大きく二つの側面でとらえることができる。第１の側面とは，雇用形態の多様化，失業を伴う雇用の流動化により職域保険から排除されることで，保険入手可能性に問題が生じている。そして，第２の側面とは，医療費の増加に伴って保険料そのものが上昇しており，とくに公的医療保険の最後のセイフティネットである市町村国民健康保険（以下，市町村国保）に加入する人の保険料負担可能性に問題が生じ，実質的に保険診療が受けられない事態が生じている。国民皆保険とはすべての国民にいずれかの公的医療保険に加入することを義務付け，被保険者とその被保険者を雇用する事業主に対し保険料の納付義務を課すことを意味する。すなわち，社会保険方式に基づく医療保障システムは，社会保険料の拠出を給付の根拠とする側面をもつ。公的医療保険を包括化，一般化することは，負担能力の低い被保険者や財政力が低水準の保険者をも社会保険に包摂することを意味しており，保険料の負担可能性の追求と国家負担は不可欠である。しかし，雇用構造が変化する中で職域保険から排除される被用者（主に非正規雇用の被用者）が増加している。すなわち，非正規雇用（パート・アルバイト，派遣，契約，臨時など）とされる労働者は，同じ被用者であっても雇用先で職域保険への加入資格が認められない現状がある。非正規雇用の職員・従業員の割合は35.7％（20013年平均）を占める一方で，職域保険である健康保険の適用は半数に達しない。職域保険に加入できない労働者は，被扶養者として健康保険に加入する人を除き，市町村国保に加入することになるが，両者で賃金喪失リスクへの対応が異なっている（「傷病手当金」「出産手当金」の有無）。また，失業の可能性の高まりは，医療保険喪失の危険性を高めることにもつながっている。職域保険に加入できない場合，セイフティネットとしての市町村国保に加入することになるため，「無保険」という状況は生じないというのが建前である。しかし，市町村国保への加入は保険料納入の義務を伴うものであり，保険料を納付できない状態が長期にわたれば，保険からの給付が停止され，保険医療を受けられない実質的な「無保険」状態が生じうる。経済的困窮により保険料納付が困難ということになれば，被保険者証から短期被保険者証あるいは資格証明書に切り替えられることとなり，その期間が長期にわたれば，ラストリゾートとして生活保護制度が残されるだけとなる。公的医療保険のセイフティネットとしての機能を高めるためには，職域保険への加入可能性（保険入手可能性）を高めること，そして市町村国保の保険料負担可能性を高めることが不可欠であろう。

**キーワード**：国民皆保険，職域保険，国民健康保険，非正規雇用，無保険，保険入手可能性，保険料負担可能性

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