

# Health Care Reforms in Japan and Canada in the 21<sup>st</sup> Century

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## Summary

Japan and Canada have basically similar health care systems of publicly funded and privately delivered, although the funding and delivery mechanisms in detail are slightly different. Both countries have experienced the common health care problems of rapid growth in health care costs, changes in disease structure from acute to chronic diseases, increasing demands for better-quality health care and greater choice and empowerment of patients.

In this essay, I will briefly sketch the current health care systems in Japan and Canada and provide an overview of some current policy issues in them. It is based on my essay prepared for the Canada-Japan Social Policy Symposium held at Kwansei Gakuin University in June 2001 (1) and revised, taking the developments afterwards into account. Such comparative studies on the health care systems in the two important market economies across the Pacific will be useful not only for academics but also for policymakers in considering the future health care reforms. I hope this brief essay will contribute to the development of comparative health care study in the two countries.

**Keywords:** Categorization of welfare states, Health care expenditures trends since 1960, Canada Health Act's five principles, Sustainability and funding, Quality and access, Leadership, collaboration and responsibility

## 1. Comparative Health Data

In order to compare the health care systems in Japan and Canada, I will examine in this chapter major health statistics of both countries, using Organisation for Economic Co-operation and Development (OECD) Health Data (2). Although it has some problems and limitations, it clearly provides one of the most useful internationally comparative health databases. Taking into account technical difficulties in international comparison, the following statistics should be read as providing a general outline of the characteristics of the health care in the two countries rather than providing in-depth comparative information.

Table.1 shows female and male life expectancy at

birth in major six OECD countries. In 1997, Japan has the highest for both men (77.0 years) and women (83.8 years). Canada also enjoys relatively long life expectancy rates, with 75.8 years for men and 81.4 years for women. Both Japan and Canada are already "long life" society (3).

Table.1 also shows infant mortality rates in the same OECD countries. Japan has the lowest rate after Sweden. Canada has attained the average level in the OECD countries, which is lower than those in the United States and the United Kingdom.

These health data seem to show relatively good health status or health outcomes in both Japan and Canada,

**Table 1. Male and Female Life Expectancy at Birth and Infant Mortality Rates (The Number of Deaths per 1,000 Births) in Major OECD Countries (1997)**

	Life expectancy at birth		Infant mortality rates
	Male	Female	
Japan	77.0	83.8	3.7
Canada	75.8	81.4	5.5
United States	73.6	79.4	7.2
United Kingdom	74.6	79.7	5.9
France	74.6	82.3	4.7
Germany	74.1	80.3	4.8
OECD	73.5*	79.6**	8.9

\*Weighted average

\*\* Weighted average for 29 countries except for Korea

resulting high ratings for them in the World Health Report 2000, which will be discussed in chapter 2.

Health care supply data are shown in the following three tables. In health economics, the quantity of health care supply is determined by basic inputs such as capital and labor through production function. The first two tables show the number of inpatient beds representing capital and the last table shows the number of doctors and nurses representing labor. First, Table.2 shows the number of total inpatient beds per one thousand population in major OECD countries. Canada has a very few inpatient beds per population after the United States , while Japan has exceptionally many (4). The Continental countries with social health insurance like France and Germany are in the middle. The difference between Japan and Canada has increased since 1960. As Table.3 shows, the number of total inpatient beds per 1,000 population was 9.0 for Japan and 6.2 for Canada in 1960. Since then the number of total inpatient beds per population in Japan has continuously increased, while that in Canada has decreased particularly rapidly in the 1990s.

Second, Table.4 shows the number of practicing physicians and nurses per one thousand population in the same OECD countries. Japan and Canada are almost at the same level in these statistics. Since the definition and work of medical professionals differ according to coun-

tries, simple international comparisons should not be made. For example, in Japan, the percentage of practical nurses compared to the total number of nurses is high and the medical acts by nurses are strictly limited. However, at least, according to OECD data, the labor supply of medical professionals in Japan and Canada is almost at the same level, smaller than in the United States and Germany, but larger than in the United Kingdom.

## 2. Health Care Systems in General

According to the World Health Organization (WHO) [2000], the health care systems both in Japan and Canada are highly rated in the world. In the ranking of overall goal attainment, including level of population health, health system responsiveness and fairness in financial contribution, Japan ranks first and Canada ranks 7th among 191 countries in the world. As for the overall health system performance, Japan ranks 10th and Canada ranks 30th. There is much discussion about the selection of performance indicators to measure health systems in each country and the objectivity of ranking in the WHO assessment. However, relatively speaking, Japan and Canada no doubt have two of the most highly rated health care systems in the world. In all nine performance indi-

**Table2. Number of Total Inpatient Beds per 1,000 Population in Major OECD Countries (1998)**

Japan	16.5
Canada	4.1
United States	3.7
United Kingdom	4.2
France	8.5
Germany	9.3
OECD*	6.9

\*Average for 25 Countries

**Table3. Trends in the Number of Total Inpatient Beds per 1,000 Population in Japan and Canada**

	1960	1970	1980	1985	1990	1995	1998
Japan	9.0	12.5	13.7	14.7	16.0	16.2	16.5
Canada	6.2	7.0	6.8	6.7	6.3	4.8	4.1

**Table4. Number of Practicing Physicians and Nurses per 1,000 Population in Major OECD Countries (1998)**

	Physicians	Nurses
Japan	1.9	7.8
Canada	2.1	7.5
United States	2.7	8.3
United Kingdom	1.7	5.0
France	3.0	6.0*
Germany	3.4	9.6

\*1997Data

cators and composite ones used by the WHO report, both Japan and Canada show good performance.

As for the categorization of welfare states, Esping-Andersen [1990] provides a classic framework of three types of welfare capitalism ; liberal, corporatist and social democratic. Canada is classified in the liberal category, which consists of Anglo-American countries like the United States, the United Kingdom, Australia and New Zealand. Japan does not seem to belong to any single category and is called a "hybrid" type. Esping-Andersen's categorization itself raises many questions. In particular, health care seems to be problematic. It is not convincing to classify the health care systems in Canada, the United States and the United Kingdom into the same liberal type category. There is much difference in coverage, funding, delivery and expenditures level of health care among these countries.

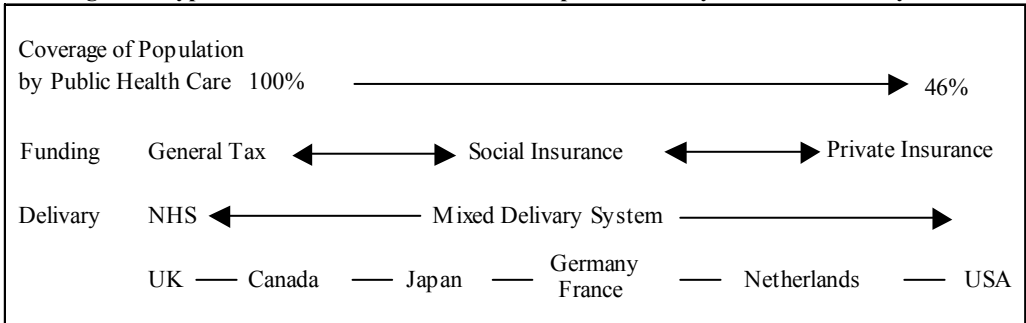
A hypothetical classification of health care systems in the major OECD countries is proposed in Figure.1 in order to make a clear comparison of health care systems between Japan and Canada. The percentage of public health care coverage over the total population is measured along the horizontal axis from 100% (the United Kingdom, Canada and Japan) to 46% (the United States). In this coordinate axis, the left represents a more "public" character and the right represents a more "private" one.

The funding system is divided into three categories ; general tax, social insurance and private insurance. The United Kingdom and Canada have adopted general tax system for financing health care expenditures. Ger-

many and France are typical social insurance type systems mostly financed by social insurance contributions. Japan has a mixed funding system of social insurance and general tax. As shown in Figure.2, the share of social insurance contributions in the total health care costs in Japan is less than 60% and the share of subsidies by both central and local governments exceeds 30%. On the other hand, the Netherlands has a mixed system of social insurance and private insurance, in which the former is larger (5). The United States has adopted basically a private health insurance system, while it has public health care systems for specific populations such as the elderly, disabled and low-income families through Medicare and Medicaid.

Finally health care service delivery system is classified into A) national health service and B) mixed delivery system. The former is a public health care service delivery system managed by public health authorities such as NHS(National Health Service) in the United Kingdom. The latter is a mixture of public and private providers in which the role of general practitioners in private clinics is particularly important. Canada and Japan clearly belong to this latter category. The Canadian health care system is often described as "publicly funded and privately delivered". This generalization basically applies to the Japanese health care system, although its public funding system is different from the Canadian one. In conclusion, Japan and Canada seem to have rather similar health care systems in comparison with other OECD countries.

**Figure1. Hypothetical Coordinate Axis for Comparative Study of Health Care Systems**



**Figure2. Sources of Funds for the Health Care Costs (FY1996)**

Subsidies(32.0%)		Premiums <Social Insurance Contributions> (56.1%)	Copayments and Others (11.7%)
Central Government (24.2%)	Local Govnt (7.7%)		

### 3. Recent Health Care Expenditures

#### Trends

Table 5 shows the total health care expenditures and GDP growth trends in major OECD countries. Several interesting features are found in statistics about Japan and Canada in the four decades since 1960 shown in the Table.

First, the health care expenditures in Japan increased much more rapidly than GDP during the 1960s and 70s. This relative growth rate of health care expenditures was higher than OECD average. But it was not far from the general OECD trends during the 1960s and 70s. Through the relatively high economic growth periods of the 1960s and 70s, health care expenditures also grew very rapidly in Japan. This contrasts with the Canadian experience in the same periods. The health care expenditures in Canada showed relatively low growth in the 1960s and almost kept pace with GDP in the 1970s. Taking into account the fact that both countries introduced universal coverage into their health care system during those periods (Japan in 1961 and Canada in 1972), this contrast seems very interesting (6).

Second, such trends considerably changed in the 1980s and 90s. In Japan, health care expenditures grew more slowly than GDP and its percentage of GDP decreased in the 1980s. This contrasts with the OECD average trends in health care expenditures, which still continued to grow faster than GDP in the same period, although the pace of growth substantially slowed down. However, this situation reversed in the 1990s. Health care expenditures in Japan began to grow again faster than GDP and its percentage of GDP rapidly increased (7). This again contrasts with the OECD trends as a whole, which followed almost the same tendency in the 1980s. Such changes in trends of health care expenditures in Japan during the 1980s and 90s constitute the basic background of the deterioration of public health insurance finance and the resulting discussion about health care reform these days. This seems to be similar to the German

experience during the same periods. On the other hand, Canada has experienced just the opposite trends in health care and economy during the same period. In Canada, health care expenditures relative to GDP grew faster than in other OECD countries except for the United States in the 1980s. This reversed in the 1990s. Canada has seemed to control health care expenditures, keeping pace with economic growth at least until 1997.

Third, as a result, the percentage of health care expenditures in GDP in Japan increased from 3.0% in 1960 to 7.4% in 1997, almost a two-and-half-fold increase. The same figure in the OECD as a whole grew from 3.8% to 7.6% (twofold) during the same period. Japan experienced a little higher growth in health care relative to economy than the OECD average. Canada, on the other hand, recorded 5.4% in 1960 and 9.0% in 1997, resulting in a little lower growth than the OECD average. Canada ranked first or second at the beginning of the 1960s and ranked fifth in 1997 in its spending on health care as a share of its GDP.

### 4. Reform Discussions

In February 2002, Commission on the Future of Health Care in Canada created by Prime Minister Jean Chretien submitted an interim report titled "Shape the Future of Health Care". The objective of the Commission is to undertake dialogue with Canadians on the future of Canada's public health care system and to recommend policies and measures required to ensure over the long term the sustainability of a universally accessible, publicly funded health system. The work of the Commission is conducted in two stages, the first focusing on fact-finding resulting in the interim report and the second emphasizing dialogue with the Canadian public and interested stakeholders based on the interim report (8). The final report, based on the interim report and the work conducted in the stage two, with recommendations is to be submitted on or about

**Table 5 The Growth of Nominal Health Spending (%)**

	Average annual growth in excess of GDP (Percentage of GDP)				1960	1997
	1960-70	1970-80	1980-90	1990-97		
Japan	5.0	4.1	-0.8	2.4	3.0	7.4
Canada	2.8	0.3	2.6	-0.4	5.4	9.0
United States	3.5	2.5	3.4	1.3	5.1	13.0
United Kingdom	1.5	2.6	0.6	1.8	4.0	6.7
France	3.9	3.0	1.8	1.3	4.1	9.4
Germany	2.2	3.8	-0.1	2.6	4.7	10.5
OECD	4.1	3.6	1.1	1.2	3.8	7.6

November 2002.

In Japan, sweeping health care reforms have been discussed since 1997, when co-insurance of salaried persons in public health insurance schemes was raised from 10% to 20% of the total health care costs. The growth of health care expenditures in Japan exceeded that of GDP in the 1990s as shown in Table.6 and financial difficulties of the public health insurance schemes have worsened. Traditional cost containment measures such as raising co-insurance rates are not enough for the long-term stability and sustainability of the schemes. Ministry of Health, Labor and Welfare (9) issued a report in March 2001 and made public its views over the health care reforms. The report was based on the policy discussions in several government Councils including former Health Insurance and Welfare Council, in which not only scholars and experts but also stakeholders participated. It explains the present status and issues of health care and health care system in Japan and provides the points of view for health care reforms, focusing on the health care system for the elderly (10).

Canadian interim report addresses four key themes :

1. Canadian values and how they are and should be reflected in the *Canada Health Act* ;
2. Sustainability and funding ;
3. Quality and access ; and
4. Leadership, collaboration, and responsibility.

These four themes are relevant to the health care reform in Japan. In the following part of this chapter, I will compare the recent health care reform discussions in Japan and in Canada according to the four themes.

First, the *Canada Health Act*. The present Act has famous five principles :

1. Public Administration
2. Comprehensiveness
3. Universality
4. Portability
5. Accessibility

As for the first principle of public administration, Japan has adopted a public health insurance system, in which co-exist a Franco-German type of social insurance schemes for employees and, for others, a Canadian type of regional health insurance schemes managed by local governments. All insurers are public or semi-public organizations and the administration of the health care plan is carried out on a non-profit basis .There seems to be no plain opposition nor criticism to this principle both in Japan and in Canada, although some economists prefer a

more mixed system of public and private insurance.

The second principle means that all medically necessary services must be insured. The *Canada Health Act* covers only hospital and physician services. Home care, long-term care, dental care, prescription drugs unless provided in hospitals, preventive health programs and community-based initiatives are not generally covered in Canada. The extension of coverage to important health services other than hospital and physician services has been an issue in Canada. On the other hand, generally speaking, Japan offers a broader insurance coverage in comparison with Canada (11). Since April 2000, under the new long-term care insurance system , *Kaigo-hoken*, home care and long-term care have, in principle, been covered (12). Both dental care and prescription drugs have been covered under health insurance. Preventive health programs, in particular, group medical checkups under health insurance system have been very popular in Japan. The reduction of coverage has been implemented in Japan mainly in amenity-related services, including private sickrooms and meals.

The third principle of universality is deeply rooted in the health care systems of both Japan and Canada. Universal coverage by public health care was established in 1961 for Japan and in 1972 for Canada. National Health Insurance (NHI) schemes managed by municipalities including cities, towns and villages, are the cornerstone of the whole Japanese universal system. The NHI, which is similar to the Canadian Medicare, covers all the residents other than those who are already covered by other public health insurance schemes such as the Government-managed Health Insurance (GHI) and the Society-managed Health Insurance (SHI). The remaining differences in co-insurance rates among public schemes have been reduced in the consecutive reforms since 1961 and there remains only very little differences between the NHI and other schemes. The principle of universality does not seem to be challenged in either country, although some argue that the private sector should play a more active role in meeting the needs of people.

The fourth principle of portability means that the coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country. Japan has maintained full portability in public health insurance benefits within the country from the beginning and extended it to outside the country afterwards.

The fifth principle of accessibility means that rea-

sonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers. In Canada, in principle, neither coinsurance nor co-payments are required when insured persons receive insured medical services. On the other hand, in Japan, although the insurance coverage seems to be broader in comparison to Canada, the Japanese health insurance system imposes relatively higher coinsurance or co-payments on patients (13). In the recent health care reform laws which passed the Diet in July 2002, a raise in coinsurance rate for employees from 20% to 30% was included and is going to be implemented from April 2003. However, the Ministry of Health, Labor and Welfare (MHLW) thinks that such policy of increasing the out-of-pocket payments by the patients is to the limit at least for the working population. Higher coinsurance rate may reduce moral hazard and improve efficiency of the health insurance system. But it is likely to harm solidarity of the society and have a bad influence on equity. One possible policy option for the Japanese policymakers is rethinking of the role of public health insurance and narrowing of the insurance coverage like Canada has already adopted, although it is a politically difficult decision-making.

The second theme is sustainability and funding. As shown in Table.6, Canada has successfully achieved cost-containment in health expenditures in the 1990s. However, total health expenditures again began to increase significantly after about 1997 mainly because of the increase in other expenditures than hospital and physician services. For all provinces, the proportion of their program spending that goes to health has increased considerably since the mid-1970s. Currently, provinces devote on average more than 35% of their program spending to health and some are worried that the requirements of the health care system are crowding out other essential services like education, roads, housing and social services. In order to maintain the sustainable health care system in the long run, not only effective cost control measures but also additional way of funding is necessary. The interim report raises some questions on this point for Canadians : Do we need to spend more money on Canada's health care system and if so, where should the additional funding come from? Should it come from provincial and/or federal budgets, from new sources of revenue such as new or dedicated taxes, or should individuals be expected to contribute more to the costs of their own care?

The questions raised in the interim report are almost common to the Japanese health care system. Japan currently spends relatively smaller portion of GDP on health care in comparison with other OECD countries (Table.5). However, it is expected that the portion will rapidly increase because of technological developments and the rapid population aging. Additional funding is necessary even when cost containment measures are implemented. As shown in Figure.2, general tax, social insurance contributions and coinsurance and co-payments are the three main sources of funding for health care expenditures in Japan. In the recent health care reforms since the middle of the 1980s, raises both in coinsurance and co-payments paid by the patients and in social insurance contributions paid by the insured persons have been proposed and implemented. On the other hand, some argue that more government subsidies should go to health care expenditures in particular for the elderly, and others argue that new sources of revenue such as earmarked taxes on alcohol or tobacco should be introduced. However, taking into account the general government spending pressures from pensions and social services in an aging society and the current public finance crisis in Japan, it is unrealistic to think that it is easy to get new additional funding for health care. This question needs to be tackled and solved in the broader policy perspective over the future of the society as a whole (14).

Third theme : quality and access. Excessive delays for health care services have become one of the main worries of Canadians. Concerns about waiting lists are especially high in specialist services, diagnostic procedures such as MRI tests, elective and non-emergency surgery, emergency rooms and long-term care facilities. Canadians have been famous for highly rating the health care system of their own country. However, according to several recent surveys, both providers' and consumers' confidence in Canadian health care clearly dropped in the past few years (15).

Japan seems to face another problems in the quality of health care. Under the "free access" to hospitals and physicians by patients without referral system and fee-for-service payment system, medical facilities are almost always overcrowded with patients. Consultation time per visit is very short. On the other hand, the number of inpatient beds and of MRIs and CTs per population is the highest among OECD countries. Japan has relatively abundant capital in health care resources, which results in the supply of a high volume of services. In-

stead of waiting lists problems, quality of services delivered has been under question here. Japan has to streamline its swollen supply system and put policy emphasis on the improvement of the quality of care rather than delivering a large quantity of care. However, in that process, undersupply of services should be avoided by careful policy implementation. Canadian experiences in this area seem to be very helpful and informative.

As for access, although both Japan and Canada have universal health care system, those who live in rural and remote areas often feel they are not getting sufficient access to the health services they need. This problem is common to both countries. In Canada, vast northern territories and in Japan tens of thousands of small islands are particularly difficult areas for policymakers to address. Steps are being taken to recruit and retain health care providers to rural and remote areas and provide incentives for them to stay. Advanced technologies such as telemedicine are being experimented as pilot projects in a number of those areas. One solution may be broader implementation of primary care models in the integrated health care networks with making greater use of telemedicine and information technology, as suggested in the interim report. Effective securing of access to necessary health care services by all residents will continue to be one of the ultimate goals of health care policy in developed countries like Japan and Canada.

Fourth : leadership, collaboration and responsibility. The interim report stresses the importance of dialogue among central and local governments, stakeholders such as provider organizations, experts and the general public. During the fact-finding phase, the meetings with the people from provincial and territorial governments, health care experts including foreign scholars and interested stakeholders have already been held and hearings from the Canadian public have been made by e-mail through the Internet. In the second consultation phase which follows the interim report, a full-scale dialogue will take place.

In Japan, policymakers within the government have experienced a very tough period since 1997, when consensus making process among interested parties has been very difficult due to several reasons (16). The traditional consensus making process within government Councils has not functioned well. For example, stakeholders proposed four reform ideas for the health care system for the elderly to the Health Insurance and Welfare Council. These were discussed for a long time, but

no conclusion was reached (17). Lack of leadership, collaboration and responsibility may have been the salient features of recent health care policy in Japan. In 2002 health care reforms including cost containment through the lowering of fee schedule and the raise of coinsurance are to be implemented after long chaotic political process. It is stipulated in the reform laws that the sweeping health care reforms be examined after the 2002 reforms are realized (18). Again, MHLW has to tackle the problem and work out its reform plan. After that, sooner or later, the consultation process with stakeholders has to begin. Japan can learn a lot from the Canadian policy making process.

## 5. Conclusions

As examined above, Japan and Canada have basically similar health care systems of publicly funded and privately delivered. Although there are several differences, their positions seem to be very near in the health care system spectrum of OECD countries as shown in Figure.2.

Health care expenditures in Canada have already surpassed 9% of GDP, while that in Japan still remains a little more than 7%. It is generally recognized that there exists consensus among Canadians that health care expenditures in Canada are consuming an appropriate fraction of society's resources (19). According to Nayl's publicly funded health care system is more than a social program ; it is a unifying force, a national obsession (!), and, not least, one of the few features that allows Canadians to differentiate themselves from their neighbors to the South. In Japan, the positive rating of the universal public health insurance system seems to be common not only among the experts but also the general public beyond their positions. However, no consensus seems to have been made on the appropriate level of health care expenditures that should be spent from society's resources. Health care providers put great emphasis on the fact that Japan's health care expenditures as percentage of GDP are still low compared to OECD countries, while insurers and government policymakers stress the looming financial crisis in health insurance schemes to be caused by the rapid population aging. The former is concerned with the present and the latter with the future. Both views are correct. The problem is how to make national consensus on these seemingly incompatible views. Canadian experiences as a frontrunner in health care spending will be helpful for

Japan in making consensus over this difficult question.

As for the reform methods in health care policy, “big bang” type approach and cumulative incremental change can be differentiated (20). Policymakers often tend to adopt “big bang” approach to cut the Gordian knot. However, as Hutchinson et al. However, as Hutchinson et al. “big bang” change under unfavorable circumstances may not simply be futile but may result in missed opportunities for cumulative incremental change. Both Japan and Canada can learn from the past experiences and the importance of carefully assessing opportunities for change should be stressed.

According to OECD competition and the creation of internal markets, both of those were very popular policy approaches in the OECD countries in the 1990s (21). Rather, Canada has pursued cost containment policies by using the monopsonistic control afforded to provincial governments as principal payers of health care and by focusing on quality assurance. Canadian approach to health care reform which acknowledges the limited effectiveness of market forces in health care seems to be relevant to Japan.

On the other hand, Canada can learn from the Japanese experiences, in particular, in the long term care insurance introduced in 2000. It is too early to evaluate fully the whole system with only two and half year experiences. However, the problem of long term care for the increasing frail elderly has been common and urgent to both countries. Of course, there are several policy options to this problem. Long term care insurance adopted in Japan is only one of them. But I believe that it will provide useful information to Canada with regional public health insurance (Medicare), because Japan’s long term care insurance is also a region-based system. More exchange of information and views between the two countries should be promoted.

## Notes

- (1) Hiroya Ogata, *Publicly Funded and Privately Delivered: A Comparative Study on the Health Care Reform in Japan and Canada*, Issues for the 21<sup>st</sup> Century, Think Social Harmony, Canada-Japan Social Policy Symposium, June 2001
- (2) OECD Health Data 2001 and OECD [2001a]
- (3) In Japanese, “chou-ju” (long life) literally means not only long (chou) but also happy (ju) life. This connotation seems to reflect the long Oriental tradition of reverence for the elderly.

- (4) *Inpatient beds* are defined as including all available beds in public and private inpatient institutions, including nursing homes. However beds in nursing homes are not included for Canada and the United Kingdom.
- (5) As for the health care system in the Netherlands, see Mossialos and Le Grand [1999] and OECD [2000].
- (6) This contrast may be explained by the fact that there was much difference in the level of health care expenditures between Japan and Canada in those days.
- (7) In the 1980s, Japan experienced relatively high economic growth rate, while several cost containment policies in health care, including the increase in co-payments by patients, were implemented. This explains the decline in health care expenditures as a percentage of GDP during the period. But after the collapse of so-called “bubble economy” in the early 1990s, the situation reversed. The economic growth rapidly slowed down and the Japanese economy fell into the longest recession since World War II. Radical health care reforms were proposed but not implemented.
- (8) Canada Privy Council, 3rd of April 2001 (Commission on the Future of Health Care in Canada [2002])
- (9) As a part of administrative reforms of the central government, Ministry of Health and Welfare and Ministry of Labor have been united since January 2001.
- (10) See Ministry of Health, Labor and Welfare [2001a].
- (11) According to OECD [2001a], public funding as a percentage of total health expenditure was 78.5% for Japan and 70.1% for Canada in 1998.
- (12) There are some transitional problems in the newly established long-term care insurance system. One of the most important problems is the phenomenon known as so-called “social hospitalisation”, which means that many acute care beds have taken on the long-term care function for the elderly (OECD [2001c]). It was expected that the introduction of the new long-term care insurance would solve the problem. However, the switch from hospital beds to long-term care beds has occurred less than expected, partly because of the more advantageous fee system for hospitalisation and partly because of the favorable coinsurance for the patients in health insurance. This difference was substantially reduced in the revision of the fee schedule in public health insurance in April 2002, in which fees were generally lowered for the first time since World War II. The patients who stay longer than six months in hospital will, in principle, have to pay additional co-payments



after some transitional periods.

- (13) The coinsurance rate is currently between 20 to 30% for the working population and 10% for the elderly in principle. However, with a relatively low level of ceiling, the effective co-payment rate is about 14%. In the health care reform laws which passed the Diet in June 2002, the coinsurance rate for the working population will be unified into 30% and that for the elderly will be between 10 to 20% according to income level.
- (14) Generally speaking, funding by general taxation is likely to be effective to contain health care expenditures as the United Kingdom and Canada have shown in the past four decades (Table.5). The competition among various needs for public funds including defense, public works, education, pension and other social services may control the increase in health care expenditures. On the other hand, funding by social insurance is a kind of earmarked taxation at least from the viewpoint of economics, and generally speaking, earmarked taxation is likely to expand expenditures. Japan seems to be in the middle-of-the-road with social insurance with a large amount of government subsidies from general taxation.
- (15) See The Commonwealth Fund [1998] and Naylor [1999]
- (16) The in-depth analysis of the changes in the policy making process in Japan in the late 1990s goes beyond this essay. Several reasons why politics have prevailed over administration in the period may be given. One of them may be payoff scandals involving high-ranking government officials in the Ministry of Health and Welfare and the Ministry of Finance, which resulted in the loss of prestige for the bureaucrats and the weakening of their policy making power.
- (17) As for the four reform ideas submitted to the Council, see Ministry of Health, Labor and Welfare [2001a].
- (18) In the 2002 reform laws, several items are listed as should be examined from now on, including:
- health insurance system as a whole, including unification and reorganization of existing schemes
  - establishment of new health care system for the elderly
  - the system of fee schedule
- (19) OECD [1994]
- (20) See Hutchinson et al. [2001], Ikegami and Campbell [1996] and Niki [2001]
- (21) See OECD [1999] and Saltman et al. [1998]

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