Overview of Japanese Health Policy

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What is Japan Health Policy NOW?
Created in 2015 by Health and Global Policy Institute (HGPI), Japan Health Policy NOW (JHPN) is the only centralized platform in the world on Japanese health policy available in both Japanese and English.

As the world’s attention turns to Japan, one of the world’s fastest ageing countries, there is increasing interest in Japanese health policy and a growing need to share information on Japan’s health policy with the world. JHPN is committed to addressing this need by delivering factual information about the Japanese health system, Japanese health policy stories of interest, recent Japanese health policy news, and a resource list for those who want to learn more about Japanese health policy. For more information, please see www.Japanhpn.org.
Contents

1. Background
   1.1 Demographic Overview
   1.2 Historical Overview
   1.3 Major Legislation

2. Process and Players
   2.1 Government Structure
   2.2 Health Policy Making Process
   2.3 Health Policy Players

3. Insurance System
   3.1 Health Insurance System
   3.2 Long-term Care Insurance
   3.3 Private Insurance

4. Financing
   4.1 Health Expenditures
   4.2 Payment System
   4.3 Cost Control
1.1 Background | Demographic Overview

Japan is an island nation in eastern Asia with an area of 377,887 square kilometers (145,902 square miles) and comprised of over 6,800 islands including, Honshu, Hokkaido, Kyushu, Shikoku, and Okinawa. There are 47 administrative divisions referred to as prefectures.

The total population exceeds 127 million people with over 90% living in urban areas. As of 2014, 36.2% of the total population resided in Tokyo Metropolis (Tokyo, Kanagawa, Chiba, and Saitama) Osaka Prefecture, and Aichi Prefecture. Among these, the largest proportion was in Tokyo, with 10.5% of the total population.1

Population ageing coupled with a low birth rate are two major concerns facing Japan and Japan’s health care system.

- Those 65 and over comprised 26.6% of the total population as of August 2015.2 This figure is estimated to approach 40% by 2060.3
- The aged dependency ratio (ratio of persons 65 and older to persons between 15-64) in 2013 was highest in Akita Prefecture (54.9) and Shimane Prefecture (54.7). The ratio for the same year was lowest in Okinawa Prefecture (28.7) and Tokyo Metropolis (32.8).
- The fertility rate was 1.42 in 2014. The rate was lowest in Tokyo (1.15) and highest in Okinawa (1.86).

Japan has one of the highest life expectancies in the world at 87 years for females and 80 years for males.4 Death rates amongst the nine leading causes of death in 2013 are as follows. According to the WHO, in 2014, 79% all deaths were related to NCDs. Amongst these, 30% of deaths were caused by cancers, 29% caused by cardiovascular diseases, and 12% caused by other NCDs.5

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Death rate (per 100,000 population)</th>
<th>OECD average death rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>290.3</td>
<td>211</td>
</tr>
<tr>
<td>Heart disease</td>
<td>156.5</td>
<td>122</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>97.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>94.1</td>
<td>69</td>
</tr>
<tr>
<td>Senility</td>
<td>55.5</td>
<td>n/a</td>
</tr>
<tr>
<td>Accidents</td>
<td>31.5</td>
<td>n/a</td>
</tr>
<tr>
<td>Suicide</td>
<td>20.7</td>
<td>12.4 in 2011</td>
</tr>
<tr>
<td>Liver disease</td>
<td>12.7</td>
<td>n/a</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>1.7</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The main causes of DALYs (Disability-Adjusted Life Years)* lost due to disability include cancer, cardiovascular diseases, diabetes, neuro-psychiatric conditions, other NCDs, musculoskeletal diseases, injuries, and respiratory diseases and infections.8

The World Bank estimated in 2013 the under 5 mortality rate (USMR) at 3 per 1,000 live births and the maternal mortality ratio at 6 per 100,000 live births. These figures reflect a decrease of nearly 50% when compared to data from 1990.9

It is expected that disease burden caused by life-style related diseases and degenerative diseases will increase due to slow population growth and prolonged life expectancy.

*One Disability-Adjusted Life Year (DALY) is considered equivalent to one year of “healthy” life lost. DALYs are calculated by combining the Years of Life Lost (YLL) to premature mortality with Years Lost to Disability (YLD) related to a health condition.10

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1.2 Background | Historical Overview

The current Japanese healthcare system can be best understood by reviewing its origins. Japan’s health insurance program is a combination of two separately developed structures: employment-based health insurance and residence-based National Health Insurance ( kokumin kenko hoken). Today, these two structures combine to form the basis of one of the largest health insurance programs in the world covering nearly the entire Japanese population and Japan’s long-term residents, over 127 million people.

Employment-based health insurance- Securing military and labor power
Prior to the 1920s, a form of health and life insurance was offered to workers through what were known as private mutual aid associations ( minkan kyosai kumiai) for private sector workers and public mutual aid associations ( kango kyosai kumiai) for public sector workers. Employers and workers could voluntarily contribute to these associations although benefits and contribution rates varied. This system transitioned to the current government regulated employment-based health insurance system in 1927 after the 1922 Health Insurance Law, which mandated that health insurance be offered to employees of firms with ten or more employees through what are known as corporate health insurance associations ( kenko hoken kumiai). Like other parts of the health insurance system, these associations offer beneficiaries benefits and rates decided by the government. Despite its shaky start and initial financial instability, the program gained momentum as military labor needs increased and was further expanded to include firms with five or more employees in 1934. These programs have evolved into the two employer-based health insurance schemes that exist today: one for the public sector and employees of large companies and one for employees of small to medium sized companies.

National Health Insurance- The system that led to universal health coverage in the 1960’s
Residence-based health insurance was delivered prior to the twentieth century through a system called the Jyorei system. Residence-based National Health Insurance (NHI) in its current form was established after the passage of the National Health Insurance Law in 1938, the same year the Ministry of Health and Welfare (the current MHLW) was established. The implementation of residence-based health insurance was, however, largely complicated by World War II. In addition, NHI was not successful in covering the entire population because municipalities, which were charged with local administration of NHI, were not mandated to establish local programs. As a result, approximately one-third of the population remained uninsured in 1956. To address this, an amendment to the National Health Insurance Law was passed in 1958 mandating that all municipalities establish and administer residence-based NHI programs. This push led to full coverage of the population by 1961. NHI covered 50% of healthcare costs at that time. In 1968, the benefit increased to cover 70% of healthcare costs. Overtime, cost-sharing has been adjusted. See “Health Insurance System” for more information.

Coverage for the older population
In 1972, Japan forged a unique health insurance structure for older persons when it subsidized their 30% cost-share burden within NHI, effectively making healthcare free for most of those 70 and over through the reallocation of public funds. Between 1973 and 1980 healthcare spending for the older population increased more than fourfold leading to sustainability concerns and the eventual passage of the 1982 Health Care for the Aged Law. This law, which was implemented in 1983, put an end to free care for the elderly by

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requiring that older persons pay a small copayment. In addition, this legislation cross-subsidized the NHI program by transferring revenue from employment-based health insurance. As a result of these two reforms, the Health Care for the Aged Law is considered one of the most critical pieces of healthcare legislation in Japanese health policy history.

Long-term care
As health care needs shifted from acute to chronic health issues, the need for a system that allows for health care and long-term care to be provided continuously grew increasingly important. However, the financial burden associated with long-term care made it difficult to fold this system into the existing health care insurance system, so a new system was established.

The Long-term Care Insurance Act was passed in 1997 providing coverage for institutional-based care, home health care services, and community-based services for those over 65 as well as those between 40 and 64 with aging-related disabilities. Long-term Care Insurance spurred the growth of a new profession known as “care management,” which is covered under this scheme. Care Managers serve as the central access point for benefits. Long-term care insurance, in contrast to health care insurance, places a limit on the benefits that beneficiaries can receive. After beneficiaries surpass this limit, all services must be paid out-of-pocket.

Other healthcare legislation
Other notable healthcare legislation includes the 2006 Health Insurance Reform, which established a separate insurance scheme for those over 75, and the 1948 Medical Care Act, which is one cause of the current geographical imbalance of healthcare facilities. The Medical Care Act has since undergone six revisions, each of which has attempted to better align facility use with community needs. See “Major Legislation” for more information on the Medical Care Act and subsequent revisions.

The most recent major health policy legislation is the Health Care System Reform Law of 2015. This law, which will go into effect in 2018, moves oversight of the residence-based NHI from the municipal level to the prefectural level. To support this transition, this law provides prefectures with increased authority and responsibility related to financing and the health care delivery system, making this “the biggest change to health care since the establishment of the modern health care system,” as stated by an official of the MHLW.

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Health Care Policy Shifting toward Prefectures?

Prefectures have long been involved in designing health care strategy, but their role is increasingly growing. Because vast differences related to population dynamics, hospital structures, medical and long-term care needs, and health care resources persist between regions, health policy must be responsive to local circumstances if it is to adequately meet people’s needs. The Community-based Care Plan, which outlines policies directly related to the design of the health care delivery system, including the number and location of hospital beds and hospitals, requires significant input from prefectures in confronting issues such as the misdistribution of physicians. In addition, the Strategy for Realigning Health Care Costs* requires action at the prefectural level. Prefectures acknowledge that there is much they could and should be doing, but a common concern among these governments is the lack of human resources, specifically those with knowledge about health policy. Developing these resources and supporting them to remain in local areas is an issue that is expected to become more urgent.

*In order to control health care costs (or as the government phrases it, “realign costs”), prefectural governments are required to create 5 year plans. The purpose of these plans is to encourage governments to establish a variety of measures, including those related to tobacco control, the use of generic drugs, the reduction of hospital stay length, and the delivery of health check-ups and health guidance.
## Overview of Major Legislation

<table>
<thead>
<tr>
<th>Year</th>
<th>Policy</th>
<th>Details</th>
</tr>
</thead>
</table>
| 1922 | Health Insurance Law | ・ First introduction of national health insurance  
 ・ Provided health insurance to laborers and employees of small firms |
| 1938 | National Health Insurance Law | ・ Established National Health Insurance (NHI), a residence-based insurance program for farmers, self-employed, retired, and non-employed administered by municipalities on a voluntary basis |
| 1948 | Medical Care Act | ・ Legislated the establishment and management of hospitals, clinics, and other facilities; mandated medical care provision |
| 1958 | Amendment to the National Health Insurance Law | ・ Mandated that all municipalities establish and administer residence-based NHI programs |
| 1961 | Universal Health Care achieved | ・ Landmark achievement in Japanese health policy history made possible through the expansion of NHI after all municipalities were mandated to administer a NHI program in 1959 |
| 1972 | Free health care for those 70 and over | ・ Created a new structure for those 70 and over and made care free for nearly all those 70 and over  
 ・ Reduced copayments within NHI for other enrollees |
| 1982 | Health Care for the Aged Law | ・ Retracted free care for those 70 and over by imposing a small co-payment  
 ・ Cross-subsidized the NHI program by transferring revenue from employment-based health insurance |
| 1985 | The first revision to the 1948 Medical Care Act | ・ Introduced regional planning for controlling hospital beds |
| 1993 | The second revision to the 1948 Medical Care Act | ・ Specified “advanced care hospitals” and created a new structure for “health facilities for long-term recuperation” |
| 1997 | Long Term Care Insurance Law | ・ Launched a mandatory social insurance program that covers care for older persons with health issues, partially relieves caregiver burden, and addresses the needs of the ageing population |
| 1997 | The third revision to the 1948 Medical Care Act | ・ Launched the regional medical care support hospital system  
 ・ Set general regulations for informed consent |
| 2000 | The fourth revision to the 1948 Medical Care Act | ・ Introduced a bed classification system that required hospitals to report hospital bed use as “general” or “treatment”  
 ・ Implemented 2-years mandatory clinical training to become a licensed doctors  
 ・ Made compliance with Health Safety Standards mandatory |
| 2006 | Health Care Reform Act | ・ Promoted public information about health care facilities at prefecture level  
 ・ Established the Medical Safety Support Center |
| 2006 | The fifth revision to the 1948 Medical Care Act | ・ Promoted public information about health care facilities at prefecture level  
 ・ Established the Medical Safety Support Center |
| 2012 | Amendment to the National Health Insurance Law | ・ Promoted of integrate care and analysis of hospital bed figures through the creation of the Bed Classification System and Integrated Community-based Care Plan  
 ・ Introduced measures to address physician and nurse shortages |
<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>The sixth revision to the 1948 Medical Care Act</td>
</tr>
<tr>
<td></td>
<td>• Introduced classification renewal system for hospitals recognized as “advanced treatment hospitals”</td>
</tr>
<tr>
<td></td>
<td>• Introduced measures to improve health care worker work environment</td>
</tr>
<tr>
<td></td>
<td>• Promoted home health care</td>
</tr>
<tr>
<td></td>
<td>• Promoted clinical trial system improvement</td>
</tr>
<tr>
<td></td>
<td>• Introduced a system to investigate medical accidents</td>
</tr>
<tr>
<td></td>
<td>• Transferred the financial administration of NHI programs from the municipal level to the prefectural level to strengthen its financial basis</td>
</tr>
<tr>
<td>2015</td>
<td>Health Care System Reform Law of 2015</td>
</tr>
<tr>
<td></td>
<td>• Transferred oversight of NHI from the municipal level to the prefectural level in an effort to achieve increased fiscal management</td>
</tr>
<tr>
<td></td>
<td>• Increased the cost of health insurance for those employed by large firms and the government</td>
</tr>
<tr>
<td></td>
<td>• Provided for “mixed-billing,” care that combines services and products that are covered by health insurance with services and products that are not covered by insurance</td>
</tr>
</tbody>
</table>
2.1 Process and Players | Government Structure

The Constitution of Japan, created in 1946 and implemented in 1947, laid the foundation for Japan’s parliamentary system of government, which is divided into three branches: the legislative branch, the executive branch, and the judicial branch. Power is separate and checks and balances exist between the three branches.

The Legislative Branch
The legislative branch is comprised of the country’s sole law-making body, the National Diet. The Diet has two Houses, the House of Representatives and the House of Councillors, both comprised of members elected by the public. Members of each House are required to serve on at least one standing committee during ordinary sessions, which begin in January and last 150 days with one possible extension. See the figure below for more information about the Houses of the National Diet.
The Executive Branch
The executive branch is led by the Prime Minister, who is nominated through a Diet resolution followed by official appointment by the Emperor. The Prime Minister’s office is supported by the Cabinet, which is comprised of Cabinet Ministers and Cabinet State Ministers designated by the Prime Minister and must be Diet Members. These Ministers remain in office until they are dismissed by the Prime Minister or the Lower House passes a no-confidence resolution (or rejects a confidence resolution) dissolving the entire Cabinet including the Prime Minister. A no-confidence resolution of the Cabinet does not result in dissolution when the Lower House is dissolved within ten days of the resolution. The Cabinet includes the Cabinet Office, Cabinet Agencies, and 11 Ministries, including the Ministry of Health, Labour, and Welfare and the Ministry of Finance. These central government offices (chujo shocho) steer Japan through implementation of various policies and Cabinet-initiated legislation.

The Judicial Branch
The judicial branch is comprised of the Supreme Court and four types of lower courts. The Supreme Court ensures that legislation and actions taken by the Cabinet and the Diet are constitutional. The Supreme Court’s chief justice is appointed by Cabinet nomination and official appointment by the Emperor. The other 14 justices are appointed by the Cabinet. Justice appointments are reviewed periodically within the House of Representatives and can be terminated through a majority vote, although this has yet to happen. Mandatory retirement age of Supreme Court justices is 70. The current Chief Justice is Itsuro Terada, who was made Chief Justice in April 2014.

Below the Supreme Court are high courts, district courts, family courts, and summary courts. Most trials involve one to three judges. In 2009, criminal trials began to include the general public through the use of lay judges.

Frequent National Elections
In Japan, national elections are held quite frequently. If we take into account Parliamentary (Diet) elections, there were 7 elections between 2005 and 2010, which means there was an election once every 1.5 years. Lower House elections are held so frequently (once every 2.5 years over the past 10 years) that it is not uncommon for Members of the Lower House to leave office without completing a full four year term. In addition, every three years, an election is held for half of the Upper House. This election has significant impact as it serves as a mid-term evaluation of the administration. Add to this local elections held nation-wide every four years and elections to determine the heads of the majority and minority political parties, the number of elections further increases. As a result, the government, the ruling party, and each political party must pay critical attention to elections, which leads to a certain level of instability in politics and, what some consider, to an avenue for the influential voices of older persons to affect policy.

2.2 Process and Players | Health Care Policy Making Process

Legislative Process
Although a significant part of Japanese health policy is dictated by revisions made to the fee schedule, bills passed through the legislative process form the structural base of policy, which includes government budget. The Japanese fiscal year starts in April and ends in March. The legislative process follows this timeline with budget bills prioritized to meet the start of the next fiscal year every April. Health legislation and other bills are submitted to the Diet by either the Cabinet or by a member of the Diet. In fact, 70% of proposed bills originate in the Cabinet. Of those bills submitted. In addition, 80% of bills that originate in the Cabinet will pass as opposed to 20% of those submitted by a Diet member leading to a significant number of successful Cabinet-driven legislation.23

Cabinet Process
Bills reach the Diet after a lengthy process that typically includes the following steps.24,25

- **Problem definition and information gathering**
  Cabinet members survey stakeholder interests and gauge media reports. To inform discussions, cabinet members often consult healthcare practitioners and interview various stakeholders and experts.

- **Cabinet council discussions**26,27
  Inside the Japanese cabinet there are more than a few hundred councils on topics ranging from space policy to suicide prevention. Councils that hear health policy related discussions include standing councils, such as the Social Security Council and the Committee on Health Insurance, and ad-hoc councils, which are convened to address matters that require a particular level of expertise or to gather a broad range of opinions. These council meetings are usually open to observers or media.

- **Evaluation of policy draft by Cabinet Legislation Bureau**
  Cabinet members work to gain support for the bill amongst ministries and interested parties since the bill needs to be submitted unanimously.

- **Evaluation of proposed bill by ruling party**
  The Evaluation Committee of the ruling party, which has mostly been the Liberal Democratic Party, conducts an evaluation of the bill. Without support from the ruling party, the bill dies at this stage. If the ruling party backs the bill, it is returned to the cabinet.

- **Prior to submission to the Diet, a cabinet decision on the bill is made.**
  Factors used in cabinet decisions include the urgency of the bill and how the bill will fit alongside existing laws. Once the Cabinet decides to proceed with the bill, the bill is submitted to the Diet in February or

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March by the Prime Minister.

Diet Process
Other bills are submitted by a member of the House of Representatives or a member of the House of Councillors. The member who is officially proposing the bill signs the bill alongside the signatures of members who support the bill. The bill is then given to the Presiding Officer of the proposing member’s House.

Once a bill enters the Diet, deliberations take place in both the House of Representatives and the House of Councillors. Deliberation usually includes discussions in a Standing Committee, an explanation of the bill by a minister or Diet member, a public hearing and debate. Bills pass at this stage in one of the following three ways:
- When at least half of all members in both the House of Representatives and the House of Councillors pass the bill, the bill passes.
- When one house approves the bill but the other house rejects it, a Conference Committee of both houses can be called to develop a proposal on which both Houses can agree.
- A bill that fails to pass both Houses can be passed by the House of Representatives with a majority of at least two-thirds of members present. Known as the “superiority of the House of Representatives (syuugin no yuuetsu),” this special privilege exists because the House of Representatives is viewed as more reflective of national opinion given that terms are shorter and dissolution of the House of Representatives is always an option.

Once a bill is approved, it is implemented into law between March to June and within 30 days after the bill’s approval by the Diet.

The 2006 Health Care Structural Reform Bill is one example of the legislative policy making process. This bill was drafted by the Ministry of Health, Labour and Welfare and submitted through the Cabinet to the Diet on February 10, 2006. Because the Diet was consumed with budget bill reviews, the Minister of Health, Labour and Welfare did not have a chance to explain the bill in the House of Representatives until April 6. The Subcommittee of Health, Labour and Welfare reviewed the bill and the House of Representatives passed it without revision on May 18. The House of Councillors then received the bill and subsequently passed it on June 14. The bill became law and began being implemented in April 2008.

Bi-annual Fee Schedule Review
Another important process that shapes health policy takes place in Japan once every two years is the fee schedule revision. For information about this process, please see “Cost Control.”

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2.3 Process and Players  |  Health Policy Players

Health policy in Japan, similar to other advanced countries, is a high-stakes arena involving a variety of actors each with their own interests in the health policy process. The following is an overview of the main health policy players.

Central Government
The central government supervises and regulates health care through control of the health insurance system. Specifically, the central government oversees health insurance contracts between the government and providers. This power is provided through the 1922 Health Insurance Law.

The central government is also responsible for regulating pharmaceutical industry practices, including clinical trials, post-market research, and manufacturing. These regulations are created and carried out by various bureaus of the Ministry of Health, Labour and Welfare (MHLW). The evaluation of new drug and medical device applications is left to the Pharmaceutical and Medical Device Agency (PMDA).

Ministry of Health, Labour and Welfare
The Ministry of Health, Labour and Welfare (MHLW), a Ministry of the central government, was originally established in 1938 as the Ministry of Health and Welfare and came into its current form after it merged with the Ministry of Labour in 2001. As of July 2015, the MHLW includes over 143 national hospitals, 8 national social welfare offices, 6 research institutes, and 16 councils. The 47 labor bureaus and 47 social insurance bureaus (one of each for each prefecture) are also within the MHLW organization. In addition, the MHLW has multiple bureaus, each with its own function. The bureaus that influence health policy include the following.

- **Health Insurance Bureau (HIB)** plays an active role in the bi-annual fee schedule revision and supports health care system improvements.
- **Health Policy Bureau** researches and proposes various policy options in relevant policy areas, including responsiveness, service provision, workforce, and health technology.
- **Health Service Bureau** focuses on regional health care, health promotion, measures to address infectious diseases, sanitation, and organ transplantation.
- **Pharmaceutical and Food Safety Bureau** establishes policies to ensure the safety and efficacy of pharmaceuticals, medical devices, and cosmetics. It also establishes safety regulations for hospitals and manages the blood supply. This bureau is also charged with addressing illicit substance use.
- **Social Welfare and War Victims' Relief Bureau** addresses a myriad of social welfare issues including homelessness and poverty. This bureau also administers services for families affected by war.
- **Health and Welfare Bureau for the Elderly** proposes policies to support the growing ageing population with a focus on health insurance and support care services.
- **Pension Bureau** oversees the provision of pensions to pension recipients. This bureau also plans and implements the public pension system and corporate pension system.

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31 Tatara, p. 74
32 Tatara, p. 29
- Labour Standards Bureau oversees the health and safety of workers, including working hours, workers’ compensation, and wages.\(^{42}\)
- Equal Employment, Children and Families Bureau plans policies that support working families and child well-being.\(^{43}\)

Pharmaceutical and Medical Device Agency (PMDA)
The PMDA established in 2004, is a government regulatory agency responsible for evaluating new drug and medical device applications, post-market safety, and addressing damages related to adverse health effects. The agency is comprised of multiple offices, including the Office of International Programs, which liaises with non-Japanese applicants and inquiries; Office of Regulatory Science, which works to build Japan’s regulatory science capacity, and the Office of Cellular and Tissue-based Products, which focuses on biologics. Through various policies and organizational strategies, the PMDA has been successful at bringing average review time of standard review products down from 22 months in 2008 to 11.5 months in 2011. The average review time of priority review products went from 15.4 months in 2008 to 6.5 months in 2011.\(^{44}\)

Central Social Insurance Medical Council
The Central Social Insurance Medical Council, or Chuikyou in Japanese, is run by staff of the MHLW’s HIB and convenes to advise the Health Minister on health insurance and health services. The council has representatives from the payer side, the provider side and the public interest who serve on the council. While there are various discussions that take place throughout the year, the main role of this council is to debate and set fee schedule revisions of medical services and pharmaceuticals.\(^{45}\)

Ministry of Finance Budget Bureau
The Budget Bureau (BB) of the Ministry of Finance is included in the list of health policy players because it oversees the subsidy provided to national health insurance by the government. This subsidy, which is in essence government spending, is comprised of revenue from taxes as well as government borrowing. The BB has the most influence during the biannual fee-schedule revision process when it works with the MHLW’s HIB to establish the global rate of price revision, global revision rate of pharmaceuticals and global revision rate of medical services. As stakes are high in the process, these revisions involve lengthy negotiations that involve a variety of actors.\(^{46}\)

Lining up from early morning to see Chuikyo
Some say that “Chu-i-kyo” is the one Japanese health policy term that non-Japanese people working with the Japanese health care industry should certainly remember because the Chuikyo, or the Central Social Insurance Medical Council (CSIMC), is one of the most important government-related groups. Regulations stipulate that meetings proceedings be open to the public with attendance open to the general public. The bulk of CSIMC’s work takes place once every two years between fall and February before the fee schedule revision which takes place the following April. During this short time period, the council members engage in detailed discussions. In order to stay informed of discussions, members of the media, pharmaceutical industry, and health care sector line up from the very early morning to get a ticket to sit in the meeting room (tickets are handed out in order of arrival). It has become common to see the council’s meeting room, which comfortably seats 10 people, become filled with over 100 people up to 3 hours before the meeting is scheduled to begin.

Liberal Democratic Party
The Liberal Democratic Party (LDP) has been at the forefront of health policy since the end of the Occupation in the early 1950s. At that time, with political parties veering for power, health care emerged as a point of debate and LDP leaders took the lead by emphasizing increased access to health insurance, a concept that was highly favorable in Japan. In fact, it was the LDP that championed universal health coverage by pressing forward the 1958 amendment to the National Health Insurance Law that expanded NHI by requiring all municipalities to establish programs for their non-employed, retired, and independently or irregularly employed, retired, and independently or irregularly

\(^{46}\) Ikegami, p. 103

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employed residents. Since then, the LDP has continued to play an active role in health policy through legislative action and political leadership built atop relationships with bureaucratic circles and interest groups. Since the start of Japan’s current health care system, the LDP has dominated politics and held the majority almost the entire time, with exception of an 11-month period between 1992 and 1994 and the 3 years between 2009 and 2011.

Japan Medical Association
Approximately 55% of physicians in Japan are members of the Japan Medical Association (JMA), by far the most prominent health policy interest group. Within the JMA, private practice physicians are known to be the most vocal and active. The JMA works closely with bureaucrats, government agencies, and the majority party (which has overwhelmingly been the LDP) to protect physician autonomy, revenue, and professional interests. The JMA has seats on the Central Social Insurance Medical Council, which sets the fee schedule. In addition to official appointments, informal leadership and lobbying from the JMA is present and critical to a majority of health policy legislation. When the JMA is not on board a proposed change, it is not uncommon for concessions or compromises to be made to ensure smooth relations. For example during the Koizumi Administration (2001-2006), attempts to introduce market-based approaches into the health care field by lifting the ban on the mixed billing and approving management of hospitals by investment institutions were met with major push back from the JMA. As a result, this opportunity for major reform concluded with very minor changes to the existing system.

Prefectural Governments
Through the 1948 Medical Care Act, prefectural level governments oversee medical facilities and providers within the prefecture. As opposed to the central government, which regulates using contractual and payment levers, prefectural governments regulate management issues including facilities and workforce. Prefectural governments’ role in hospital planning was introduced in the 1985 revision of the Medical Care Act. Prefectural governments also manage public health centers that lead sanitation, disease control, and environmental issues. Governments of over 70 major Japanese cities share in these public health responsibilities.

Municipal Governments
Municipal governments set public health policy related to disease prevention and family health through community health centers. The 1982 Health Care for the Aged Law increased municipal involvement by asking municipal governments to increase health services for older persons, such as prevention education and health screenings. The 2002 Health Promotion Act called for municipal governments to actively participate in community health planning.

3 Doctors’ Association
As is the case in other countries, physicians groups have a large amount of influence on health policy. In Japan, the Japan Medical Association, the Japan Dental Association, and the Japan Pharmaceutical Association are referred to collectively as the “3 Doctors’ Association” because of the unrivaled presence these groups have. There are nearly 50 other professional associations, including the Japanese Nursing Association, the All Japan Hospital Association and the Japan Pharmaceutical Manufacturers Association, that work to maintain favorable relationships with the government and the ruling party in order to affect the policy environment.

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47 Ikegami, p.19
49 Ikegami, p.3
50 Ikegami, p.20
51 Ikegami, p.24
3.1 Health Insurance System | Japanese Health Insurance System

Japan’s constitution, executed in May of 1947, expressly declares that citizens have a right to health and that it is the state’s responsibility to ensure this right can be realized.\(^{54}\) The government’s commitment to health for all led to universal health care coverage in 1961.\(^{55}\)

Characteristics of the Japanese health insurance system include:\(^{56}\)
- **Mandatory coverage** for anyone who permanently resides in Japan for three months or more. This includes both Japanese citizens and non-Japanese citizens.
- Enrollees have **no choice of health insurance programs**. Plans are designated according to the enrollee’s employment status, age, and residence. If the enrollee is not head of household and not eligible through his or her own employer, then the plan is dependent on the head of household’s employment status, age, and residence.
- There are **no restrictions on access**. Regardless of the plan, enrollees can receive care from any medical provider as frequently as they would like.
- **Benefit packages are essentially the same**. Although some packages offer preventive or health promotion add-ons, these benefits do not serve to affect enrollment since enrollees cannot choose between plans. **Benefits include** hospital care, outpatient care, mental health care, prescription drugs, home health care, and dental care.
- **Copayments are the same across all plans**. Cost-sharing varies according to age. Children under 3 have a 20% copayment and persons over 70 with low incomes have a 10% copayment.\(^{57}\)
- The **premium rate varies between plans**.
- An out-of-pocket threshold **protects enrollees from catastrophic costs**. For people of working age, the average limit on out-of-pocket payments is 90,000 yen per month (approx. $724 at 1 dollar equal to 124 yen). The threshold and post-threshold co-payment varies dependent on age and income. The mechanism ensures financial risk protection within the health care system.
- **Central administrative offices** have been established in each prefecture to serve as the intermediary between providers and insurance companies. They evaluate and process claims from providers, then send bills to insurance programs.
- Japan’s health insurance schemes **cross-subsidize each other** in order to financially stabilize the plans due to the variation in enrollee income level across schemes.

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54 Article 25 of the Constitution declares that “all people shall have the right to maintain a certain standard of healthy and cultured life” and that “the state shall try to promote and improve the conditions of social welfare, social security, and public health” for this purpose.


There are over 3000 health insurance funds divided between three insurance schemes: employer based health insurance, residence-based National Health Insurance (NHI), and health insurance for persons over 75. Each scheme contributes to a common fund that is used to support the other schemes.\(^5\)

**Employer based health insurance** is further divided into three groups. The first group covers employees of large companies through over 1400 plans. If a plan faces financial hardship, it is eligible for a government subsidy. The second group covers public sector employees and is not eligible for any government subsidization. The third group covers employees of small to medium-sized companies and contains only one plan, the National Health Insurance Association. Subsidies from taxes and contributions from large employers are combined with employer and enrollee contributions within this plan.

**NHI** covers the self-employed, unemployed, and retired persons under 75. These plans are currently administered through municipalities, but administration will be transferred to prefectural offices in 2018. Enrollees contribute to these plans through premiums, but nearly half of benefit expenditures are covered by tax subsidies. Due to the significant increase in retired persons under 75, the rise in part-time workers not covered by employer-based insurance, and the decline in the number of farm, forestry, and fishery workers, this scheme is the most fiscally unstable of the three as the number of enrollees who may not or cannot pay has increased.

**Health insurance for persons 75 and older** was instituted in 2008 and requires that all people in this age group, even the employed and dependent, enroll. This scheme is administered at the prefectural and municipal levels. This scheme effectively moved the oldest of the older population from NHI to an independent system to increase transparency and accountability surrounding healthcare costs and payments for the growing older population. Enrollees pay a premium, which is deducted from their pensions, that is set based on healthcare expenditures by the prefecture for this population segment during the previous two years. In addition to premium contributions, which cover about 10% of total costs, this scheme is supported by government subsidies and by subsidies received from the two schemes listed above.

3.2 Health Insurance System | Long-term Care Insurance

Long-term care insurance (LTCI) was launched in Japan in 2000 and, as of January 2015, provides benefits to over five million persons 65 years and older, about 17% of this age population.\(^59\) Japan’s LTCI is a mandatory program that provides benefits for the long-term care of older persons (as opposed to programs that offer benefits to younger persons with disabilities).

Distinctive characteristics of this program include:

- **The program is public.** All persons aged 40 and over contribute by paying a premium that varies according to income.

- **All persons aged 65 and over can access benefits.** Persons 40 and over with disabilities related to aging, such as cerebrovascular disease, are also eligible to access benefits. Everyone, regardless of income, has the same benefits. Coverage for those over 65 begins once people turn 65 regardless of need or income.\(^59,60,61\)

- **Benefits, which include institutional, home and community-based services,** are accessed through a care manager. The results of a standardized questionnaire on activities of daily living and a report from the enrollee's physician are reviewed by a local committee that determines the beneficiary’s level of need and corresponding quantity of services. Each level of need has its own service ceiling after which individuals and families pay most costs with benefits for low income individuals. Need levels are reassessed every two years or upon request following a change in health.

- **All services are subject to a 10% copayment.**

- **Enrollees can choose between care managers as well as service providers.** This freedom of choice services as an important way to control quality. This of course is less effective in areas with fewer case managers and service providers.\(^62\)

- **The program is administered by municipalities,** which sets premiums and licenses providers.

- **Providers** range from for-profit companies to non-profit companies. **Fees** for services are established by the federal government and are reviewed once every three years.

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**Dementia**

As in the case in several other countries, Japan is expecting to see an increase in the number of persons with dementia. According to government estimates, in 2025, there will be 7 million people with dementia comprising 20% of the 65 and older population. Effective prevention and treatment is still under development making care for persons with dementia a major issue. Under the leadership of Prime Minister Abe, the Comprehensive Strategy for the Promotion of Dementia Measures (also called, “New Orange Plan”) was established in January 2015 signaling a sense of urgency. Another issue that will require attention is "the old caring for the old," which refers to instances where, for example, an 80 year-old wife is caring for her 85 year-old husband. Leaving the workforce to care for older persons is yet another issue that is expected to grow increasingly serious as the number of persons with dementia increases.

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\(^{60}\) Campbell, J.C., Ikegami, N., Gibson M.J. (2010). Lessons from Public Long-term care insurance in Germany and Japan, Health Affairs, 29(1): 87-95


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Long-term care insurance faces the following policy challenges:

- Despite great demand for services, human and financial resources as well as government regulations that restrict the building of new facilities leave would-be residents on long waitlists. Residents of the largest and most populated urban areas will face the greatest shortage of care facilities due to the expected increase in older residents.

- There is a health worker shortage that leaves care facilities, including short-term respite facilities, understaffed. The Ministry of Health, Labor and Welfare (MHLW) predicts that there will be a shortage of 300,000 workers by 2025. Low wages contribute to the small number of workers in this sector and the MHLW has proposed various initiatives to address this situation.

- Attitudes toward labor market expansion to include care workers from other Asian countries are shifting. In 2008 and 2009, Japan signed trade agreements with Indonesia, the Philippines, and Vietnam in order to increase the number of workers from these countries.

- The LTCI’s effect on carer burden has yet to be extensively evaluated. Factors that may affect carer burden could include service availability, community engagement, and emotional support.

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3.3 Health Insurance System | Private Health Insurance

Despite the generous benefits and coverage provided by the public health insurance system, private health insurance is a growing segment of the private insurance industry in Japan with much of private health insurance delivered alongside life insurance. Previously, private health insurance was limited in use to coverage of orthodontics and other high cost cosmetic procedures; yet, as the life insurance industry has grown larger, private health insurance as a supplementary service product has also grown.\(^{64}\)

Plans on the market today include insurance to cover chronic diseases and hospitalization. These plans provide the insured with a lump sum upon diagnosis of, for example, cancer or upon long-term hospitalization. Private health insurance policies can be divided into three categories: medical insurance purchased independent of life insurance, medical riders upon a new or existing life insurance policy, and complementary medical care insurance that covers copays for services provided within the public health insurance system. The Life Insurance Association of Japan, to which all life insurance firms operating in Japan belong, estimated that 29.98 million stand-alone medical insurance policies, 94.52 million medical riders (for surgery and hospitalization), and 1.72 million complementary medical insurance policies were active in 2013 via a life insurance company. Cancer insurance has gained traction in Japan with 21.16 million cancer insurance policies in effect in 2013.\(^{65}\)

Private health insurance in Japan continues to be a niche sector and is not projected to expand widely in the near future.\(^{66}\) Reasons for this include the public health insurance system’s generous out-of-pocket pay cap, extensive coverage of health services, and provision of open access to medical providers.\(^{67}\) On the other hand, the changing disease structure and increased health policy focus on cancer,\(^{68}\) the leading cause of death in Japan, may have some effect on the demand for these services.

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\(^{65}\) Figures from Life Insurance Association of Japan


4.1 Financing | Health Expenditures

Health spending in Japan is generally considered low when compared to other advanced economies, yet costs exceed OECD averages in terms of public expenditures on health and pharmaceutical expenditures. In Japan, where public sources fund 83% of health spending, health expenditures have great implications for health care sustainability.\(^{69}\)

**Expenditure overview**

In recent years, total health expenditures (all money spent on medical goods and services) as a part of GDP has been on the rise in Japan. Between 2008 and 2013, health spending rose from 8.5% to 10.2% of GDP surpassing the 2013 OECD average of 8.9%.\(^{70}\) And while the OECD reports that health spending is expected to slowdown, Japan remains one of the few OECD countries where health spending to GDP has increased since 2009.\(^{71}\) Part of this increase is in part due slow economic growth. However, while public and private spending per capita continues to hover close to the OECD average, the annual average per capita health expenditure growth rate between 2009 and 2013 was well above the OECD average growth rate for the same years.\(^{72}\)

**Growth in expenditures**

Similar to other advanced economies, growth in health expenditures can be attributed to increasing healthcare costs associated with population ageing as well as increasingly specialized and advanced medicine. For example, in 2011 64% of hospital expenditures were used to care for the 65 and older population, which comprised 23% of the total population in 2012.\(^ {73}\) By 2020, the share of the 65 and older population is expected to reach 30% and health expenditures for this population is projected to increase to 66% of national health expenditures.\(^ {74}\) Enrollment in health insurance for the oldest of the old increased by 3% between 2011 and 2012 and the number of long-term care benefit recipients increased by 5.5%, or 2.85 million people, between 2011 and 2012.

**Pharmaceutical and medical devices sector**

Japan is one of the world’s largest medical device markets estimated in 2012 at $32 billion, an increase of 8.7 percent from 2011. The market size is expected to continue to grow given the ageing population.

Japan continues to see increased growth in pharmaceutical spending while other countries have seen a slowdown in recent years. Public spending on pharmaceuticals increased by 5% annually between 2009 and 2013 and, in 2013, per capita spending on pharmaceutical was second highest within the OECD.

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\(^{70}\) Data extracted on 12 November 2015 02:36 UTC (GMT) from [OECD Stat](http://www.oecd.org/els/health-systems/Focus-Health-Spending-2015.pdf).


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One reason often attributed to high spending on pharmaceuticals is the low penetration of generics in the market. In 2013, generics comprised 11% of pharmaceutical market value compared to the OECD average of 24%. Japan also ranks low in terms of market volume of generics at 28% compared to the OECD average of 48%. In contrast, generics comprise over 80% of the pharmaceutical market in terms of volume in Germany, the UK, and the US.  

The Japanese government has been working for years to accelerate the use of generic drugs in Japan. In 2002, there were a few changes made to the fee schedule and prescription methods intended to increase use of generics drugs. However, the government’s intentions were unclear until the goal to increase pharmaceutical market volume share of generics to 30% was declared as a part of the Cabinet-led 2007 economic and fiscal reform legislation. The MHLW followed up later that year with the “Action Plan to Promote the Safe Use of Generics,” which set policies related to patient understanding of generics, generic drug quality, and dispensing of generic drugs. Between 2008 and 2012, various adjustments were made to the fee schedule and to prescription regulations to further encourage the use of generic drugs. In 2013, the MHLW released its new goal of increasing the share of generic in the market (where generic replacement is possible) from the 2010 figure of 40% to 60% by 2018 in its “Roadmap for Further Promotion of Generic Medicine Use” released that year. In addition to setting a new goal, this “roadmap” set policy to strengthen the system to monitor progress toward this goal and clearly identified actions to be taken by the government, industry, and health care providers in order to achieve this goal. In 2015, the government announced a new goal to bring generic drug use to over 80% (where generic replacement is possible).

Japan - the best market?

When executives of non-Japanese pharmaceutical companies and organizations come to Japan, they often are heard saying, “Japan is the best market!” One reason for this is because the health care system and administrative issues are highly predictable. In Japan, although pharmaceutical prices are revised one every two years, the market price and the extent of price revisions can be forecasted, in turn, making sales for the coming years relatively easy to predict. In addition, compared to the US and Europe, a greater sense of trust of pharmaceutical industry exists amongst the general public, regulators, and policy makers providing for a certain level of leeway. And Japan’s previous issue with long drug approval times (referred to as the “Japanese drug lag”) has been resolved for the most part. Against this background, the saying “Japan is the best market, US is the biggest market” emerged.

However, major debate has sparked around market expansion-related repricing being introduced in 2016 that will affect novel and innovative pharmaceutical products. Within this repricing system, post-market annual sales that significantly exceed manufacturer estimated sales will be subject to a price reduction of up to 50%. Also referred to as “the repricing rule for huge-seller drugs,” this system was developed following the 2015 market release of the drug to treat Hepatitis C virus (HCV), a ground-breaking treatment that those with HCV had been waiting several years for. However, in contrast to the 100 billion yen annual sales estimated by the manufacturer, actual annual sales estimates quickly approached 500 trillion yen. To address situations like these, government and health insurance officials viewed the introduction of a market pricing control system as the only choice. The pharmaceutical industry, on the other hand, was vehemently opposed and pleaded to have the system revised. One industry group leader commented, “A system that adds uncertainty to innovation cannot be approved. This will rob business of its ability to properly forecast.” Moving forward, new drugs and regenerative medicine products categorized as “huge-seller” drugs are likely to continue to enter the market. Alongside several other countries, Japan is now facing the question of how to best confront the dilemma of innovation and the sustainability of health care financing.


76 Japan Generic Medicines Association, http://www.jga.gr.jp/medical/about/generic07/
4.2 Financing | Payment System

Medical service fees are defined as the fees received by a medical facility or pharmacy in exchange for insured medical services or products provided to an insured person. These fees are overseen by the Ministry of Health, Labour and Welfare (MHLW), which sets the fee schedule and determines the billing conditions for medical services, medical devices, and pharmaceuticals all providers must adhere to. There are prohibitions against setting fees higher than those in the fee schedule and providers are restricted from combining non-listed services and products with listed ones, with very few exceptions. Mixed medical care series (MMS or kongo shinryo) is currently being introduced and further exceptions to these restrictions are expected in 2016.

Fee for service
Since the system was established in its current form in 1961, healthcare fees have been administered on a fee-for-service (FFS) basis. When a service, pharmaceutical product or medical device is provided through the insurance system, the provider calculates reimbursements based on the number of points allocated for each item. The provider is then reimbursed for the service or product based upon the number of points.

Diagnosis Procedure Combination
Diagnosis procedure combination (DPC) is a uniquely Japanese payment system that first emerged in the early 2000s amidst growing concerns over healthcare costs, length of hospital stays, and the healthcare needs associated with the growing aging population. The goal of DPC is to support improvement in health care standards and transparency. Through the collection of objective treatment information made accessible through a database, this system strives to not only help hospital administrators and providers better understand the outcomes related to the care they are delivering, but also to improve quality of care and address disparities between hospitals. Patients also have access to data-based care standards as well as pricing information. DPC was also designed to shorten the average hospital stay length. As of 2012, this payment system was estimated to cover nearly 53% of general hospital beds in Japan (Ishii 2012).

Similar to the diagnosis related groups (DRG) prospective payment system (PPS) found in the U.S., DPC is prospective and uses codes based on diagnosis categories and diagnosis groups. As of April 2012, there were 2,927 DPC codes. The unique part of this payment system, however, is that it is per-diem and integrates standard FFS payments. Providers are paid a flat-rate prospective fee per day of inpatient hospital stay for certain DPC services and paid FFS for non-DPC services.

More specifically, DPC payments:
- Are dispersed for hospital stays, diagnostics, injections, pharmaceuticals, and medical treatments valued at less than 1,000 points. Payments are calculated on a per-day basis depending on the DPC code and medical institution’s coefficient, which was previously unique to each institution. This coefficient is currently being revised to reflect hospital type giving hospitals of similar type across Japan the same coefficient.
- Do not cover surgery, radiation therapy, anesthesia, and

Has episode-based payment resulted in lower costs?
Another goal of the Japanese system of episode-based payment was to drive down costs, but is that goal being achieved? Actually, there is a possibility that health care costs have increased as a result of DPC. While DPC was successful in reducing the average length of hospital stay, an increase in the per-diem rate of inpatient care created an incentive for hospitals to increase the number of inpatients. The introduction of DPC also saw the start of “DPC consulting” services that, in some cases, help facilities manipulate coding, or up-code, in order to yield greater returns per patient.

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medical treatments valued at more than 1,000 points. These instead are paid FFS.

- Differ according to hospitalization period within the specified period of hospital stay.* Per-day payments for the first period of hospital stay are higher than the latter two periods. Per-day payments within the second period, which lasts until the average length of stay, are set lower effectively neutralizing the higher payment provided in the first period. Per-day payments within the third period are lower than the payment rates of the second period. If length of stay becomes exceptionally extended, all payments become FFS.

Various analyses have been conducted to determine whether DPC is succeeding in achieving its intended purposes. While it has largely been shown that DPC has not resulted in lower costs due to its unique mix of PPS with FFS, there is strong opposition against further integration of PPS. 

79,80,81

What is the specified period of hospital stay?

The specified period of hospital stay divides a hospital stay into three periods. Period 1 refers to the length of time equal to the 25th percentile of the average length of stay (ALS) for the specific episode. Period 2 extends from the 25th percentile to the ALS. Period 3 begins after the patient remains in the hospital after the ALS and lasts until a period equal to the ALS plus 2 standard deviations. Under the DPC system, after a patient exits period 3 and leaves the specified period of hospital stay, medical expenses are reimbursed fee-for-service. See figure below.

Source: Kinki Regional Bureau of Health and Welfare, 2010 Payment System Revision Overview

4.3 Financing | Cost control

Bi-annual fee schedule review
Fees for medical services, products, and pharmaceuticals delivered by almost all providers are dictated by a national fee schedule. Every two years, the fee schedule along with conditions for billing are reviewed and revised by the MHLW. This process, which begins in the spring of odd-numbered years and finishes in April of the following year, sets fees and policies that dictate the healthcare benefit package as well as nearly all provider and medical facility income. This policy tool acts as the government’s cost control lever as both overall costs and line-item costs can be adjusted affecting provider behavior. With clear objectives and ongoing oversight, this mechanism acts as a strong rein on the healthcare system’s associated costs, supply, and service provision. Interestingly, it also extends to ensure the financial health of providers.

Revision to the fee schedule
Revision to the fee schedule takes place first at a global level before moving on to the item level. The global level process signals the government’s health spending intentions over the next two years. Specifically, the Ministry of Finance’s Budget Bureau and the Health Insurance Bureau (HIB) of the MHLW decide on the global revision rate, which is the combination of volume-weighted adjustments to prices of services and pharmaceuticals. The figures are based on discussions between various stakeholders, including the ruling party and the JMA, and estimates based on the Empirical Survey of Medical Care Economics (Iryou Keizai Jittai Chousa) and the Pharmaceutical Price Survey (Yakka Chousa). Economic, social, and political considerations are also taken into consideration. Because these rate changes only reflect adjustments in pricing, it may be more helpful to think of these figures as signals rather than a reasonable estimates because changes in volume and product availability ultimately affect overall costs over the next two years.

Central Social Insurance Medical Council (Chuikyou)
After global rate reductions are finalized in December, line item revisions are made to the fee schedule and pharmaceutical prices by the Central Social Insurance Medical Council (Chuikyou), an advisory group to the MHLW Minister that is staffed by the HIB and includes members who represent payers, providers and the public. This group is one of the most critical groups within Japanese health policy. These price adjustments are made in order to achieve specific outcomes. For example, medical service rate increases are used as provider incentives and decreases are used to contain high-volume services. These rates are also adjusted to ensure income and costs are relatively equitable across the various health specialties. Because these revisions directly affect provider income, this process includes the reflected interests of the ruling party and finance ministers as well as extensive negotiations between interest groups and MHLW bureaucrats.

When are the fee schedule revision “winners and losers” decided?
In the lead up to the fee schedule revision held once every two years, most health policy stakeholders are holding their breath (See: “Lining up from early morning to see Chuikyo”). In fact, the anticipation of which fees will be cut and which areas will see increases amidst limited resources brings forth a “slash or be slashed” mentality reminiscent of a Japanese historical drama. So, when are the winners and losers officially decided? The global revision rate that outlines the foundation of the fee schedule revision is released in December of the year before the revision. Consequently, the scramble for pieces of the “fee schedule and pharmaceutical pricing pie” takes place between October and December.

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83 Maeda, p.103-104
84 Maeda, p.103
85 Maeda, p.111
Pharmaceutical rate revisions are a unique and important part of the cost control process. Once the volume-weighted average price is set, the new price is decided by adding a certain percentage onto the average price. Because the difference between these rates and provider purchase price is equivalent to provider income, purchase prices have been pushed down by provider negotiations leading the MHLW to further push down the payment rates to control costs.86

Revision of conditions for billing
Unlike the fee schedule, revisions to the conditions for billing are not limited to once every two years, but can be revised by the MHLW at any time. Through these conditions, the provision of products and services can be controlled enabling an additional method of cost control. These conditions also serve as the main source of quality control on healthcare services. By setting certain standards that must be met before a service can be billed, the MHLW is able to ensure that, for example, the proper equipment is used for a specific service or the appropriate number of staff is available to each inpatient receiving treatment.87

86 Maeda, p. 77
87 Maeda, p. 73