



1. Background

Second edition

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
<http://japanhpn.org/en/jhpn/>

1.1 Background | Japan's geography and demographics

Japan is an island nation in eastern Asia with an area of 377,887 square kilometers that is comprised of over 6,800 islands, including Honshu, Hokkaido, Kyushu, Shikoku, and Okinawa. Japan contains 47 self-governing administrative divisions referred to as prefectures.

The total population hovers around 127 million people, with about 90% living in urban areas. As of 2015, about 36.5% of the total population resided in Tokyo, Kanagawa Prefecture, Osaka, Aichi Prefecture, or Saitama Prefecture. Among these, the largest proportion was in Tokyo, which was home to 10.7% of the total population of Japan.¹

An ageing population with a declining birthrate^{2,3}

An ageing population coupled with a low birth rate are two major concerns facing Japan and its healthcare system.

Those aged 65 and over comprised 27.3% of the total population as of October 1, 2016. This figure is expected to approach 40% by 2060.

The old-age dependency ratio (the ratio of people aged 65 and over to people between the ages of 15 and 64) in 2015 was highest in Akita Prefecture (60.7) and Kochi Prefecture (59.2), and lowest in Okinawa Prefecture (31.2) and Tokyo (34.3).

The overall fertility rate in Japan was 1.45 in 2015. This rate was lowest in Tokyo (1.24) and highest in Okinawa (1.96).

Life expectancy and main causes of mortality

The people of Japan enjoy one of the highest life expectancies in the world, with the average being 91.35 years for females and 84.95 years for males.⁴ Mortality rates for the top nine causes of death in 2015 are listed in the following table (according to data from the Ministry of Health, Labour and Welfare (MHLW) and the Organisation for Economic Co-operation and Development (OECD)).

According to the World Health Organization (WHO), 79% of all deaths were related to non-communicable diseases (NCDs) in 2014. Amongst these, 30% of deaths were caused by cancers, 29%, by cardiovascular diseases, and 12%, by other NCDs.⁵

<Column> Ageing in Tokyo

Japan is not ageing across all regions at the same rate. Large metropolitan areas, such as Tokyo, Osaka, and Nagoya are at the forefront of aging in Japan.

According to Tai Takahashi*, between 2010 and 2025, the population of those aged 75 and over will grow by 7 million people, more than half of whom will reside in the Greater Tokyo Area (Tokyo, Kanagawa, Chiba, and Saitama), Osaka, and Nagoya. These three regions, however, comprise a mere 2% of Japan's total land area, underscoring the urban nature of Japan's "super-ageing society." Takahashi also points out that Tokyo faces serious additional challenges regarding the number of care facility beds, which is equal to just half the national average. This shortage may become increasingly serious as the population continues to age.

*Reference: "Regional Differences in the Peak of Healthcare Demand and the Level of Medical-Social Resources: Rebuilding a Medical-Social Service Delivery Structure," Presentation by Professor Tai Takahashi of the International University of Health and Welfare at the 9th Meeting of the Committee on National Social Security Reform, 2013.

¹ Statistics Bureau, Ministry of Internal Affairs and Communications (14 April 2017). Demographic forecast. (accessed 15 September 2017) Retrieved from: <http://www.stat.go.jp/data/jinsui/2016np/index.htm#a05k28-b>

² Cabinet Office (2017). White paper on ageing society. (accessed 24 July 2017) Retrieved from: http://www8.cao.go.jp/kourei/whitepaper/w-2017/zenbun/29pdf_index.html

³ Director General for Policy Planning and Evaluation, Ministry of Health Labour and Welfare (2017). Vital statistics in Japan. (accessed 24 July 2017) Retrieved from: <http://www.mhlw.go.jp/toukei/list/dl/81-1a2.pdf>

⁴ Cabinet Office (2017). White paper on ageing society. (accessed 24 July 2017) Retrieved from: http://www8.cao.go.jp/kourei/whitepaper/w-2017/zenbun/29pdf_index.html

⁵ World Health Organization (2014). Noncommunicable diseases country profiles 2014: Japan. (accessed 24 July 2017) Retrieved from: http://www.who.int/nmh/countries/jpn_en.pdf?ua=1

Cause of death	Mortality rate (per 100,000) ⁶	OECD average mortality rate (per 100,000) ^{7*}
Cancer	290.3	211
Heart disease	156.5	122
Pneumonia	97.8	n/a
Cerebrovascular disease	94.1	69
Senility	55.5	n/a
Accident	31.5	n/a
Suicide	20.7	12.4 in 2011
Liver disease	12.7	n/a
Tuberculosis	1.7	n/a

*Where available

Ranked by the burden that each disease places on the lives of sufferers as measured in DALYs (Disability-Adjusted Life Years)*, the most critical diseases within the Japanese population are cancers, cardiovascular diseases, diabetes, neuro-psychiatric diseases, musculoskeletal diseases, respiratory diseases, other NCDs, external injuries, and infectious diseases.⁸ It is expected that the burden of life-style related diseases and degenerative diseases will increase alongside demographic changes such as ageing.

The World Bank estimated in 2015 that the under 5 mortality rate (U5MR) for Japan stood at 3 per 1,000 live births and the maternal mortality ratio was 6 per 100,000 live births. These figures reflect a decrease of nearly 50% when compared to data from 1990.⁹

*DALYs are an indicator of disease burden which assesses the amount of harm caused to health by specific diseases and injuries. DALYs are calculated by adding the total of years of life lost (YLL) due to premature death and the years of life lived with disability (YLD).

<Column> A population on track to decline, with low expectations for growth even among the population aged 65 and over
Between 2010 and 2040, the population aged 65 and over will increase by 9 million. Over the same time period, the population under age 65 will decrease by 30 million. Starting sometime around the year 2040, it is expected that growth in the older population will plateau, while the working population will sharply decrease, causing the overall population to shrink by around 15%. This will increase the proportion of people aged 65 and over in Japanese society.

⁶ Ministry of Health Labour and Welfare (2017). Vital statistics in Japan. (accessed 2 February 2018) Retrieved from: <http://www.mhlw.go.jp/toukei/list/dl/81-1a2.pdf>

⁷ OECD (2015). Health at a Glance 2015: OECD Indicators. Paris: OECD Publishing, 2015.

⁸ World Health Organization (2015). Japan: WHO statistical profile. (accessed 24 July 2017) Retrieved from: <http://who.int/gho/countries/jpn.pdf?ua=1>

⁹ The World Bank (2015). Mortality rate, under-5 (per 1,000 live births). (accessed 24 July 2017) Retrieved from <http://data.worldbank.org/indicator/SH.DYN.MORT>

1.2

Background | The history of public healthcare insurance

The current Japanese healthcare system can be best understood by reviewing its origins. The public health insurance program in Japan is a combination of three separately developed structures—the employment-based health insurance system, the residence-based National Health Insurance system, and the medical insurance system for those aged 75 and over. Today, these three structures combined form the basis of one of the largest healthcare insurance programs in the world, covering nearly all Japanese citizens and long-term residents, over 127 million people. In light of historical circumstances and following numerous revisions to the Health Insurance Act since its introduction in 1922, these insurance systems are administered by a variety of insurers.

The history of the public health insurance program in Japan

The beginnings of Japan's system of public health insurance system

After sweeping through England from the second half of the 18th century and throughout the 19th century, the industrial revolution finally reached Japan. Japan's industrial revolution began in earnest when state-owned enterprises were privatized in the second half of the 19th century. Just like the rest of the world, this caused a sharp increase in the number of Japanese laborers working in environments such as coal mines and factories. As a result, issues surrounding the improvement of working conditions and the protection of workers' rights became urgent due to labor movements and social movements. This led to the enactment of the Factory Act in 1916, which regulated employment and compelled factory owners to provide support to workers in the event of workplace injury or fatality.

However, labor movements started by labor unions were based on socialism, and resistance to socialism remained a major hurdle for the Japanese government. The government did not view the labor movement as entirely dangerous. It distinguished between moderate reform and radical reform and worked to prevent confrontations between social classes by permitting moderate labor movements using a Bismarck-style "Carrot and stick" approach. The "stick" in this approach refers to actions that suppressed labor movements. The first "carrot" appeared in 1922, when the Health Insurance Act came into effect. The main purpose of this act was to provide compensation to workers or their families in the event that a worker had a workplace accident or fell ill while not on the job. The concept of the Health Insurance Act itself dates back to the 1890s, when Minister of Home Affairs Shinpei Goto started discussions within the government after recently returning to Japan from a study trip to Germany. However, the topic did not become a priority issue for the government, so many years of effort were required before it was finally enacted. Also, at the time, health insurance for laborers was considered more strongly an industrial policy rather than a medical policy, so it was under the jurisdiction of the same ministry as the Factory Act, the Ministry of Agriculture and Commerce.

Meanwhile, the Great Depression began in the United States in 1929. Shockwaves were sent through Japan's farming communities when export prices for agricultural products to the U.S. fell one after another, starting with exports of raw silk thread. An additional blow fell when a bumper crop in 1930 sent the price of rice plummeting, further compounding the economic problems already facing Japan's farming communities. Entering the 1930s, farming communities became an important source of manpower for the Japanese military, so the health and nutritional status of their people became an issue of military strength. The Ministry of Home Affairs began to consider establishing an insurance system for the general populace starting with those in farming villages that would provide wide coverage for people who were not employees. It is said this decision was based upon the fact that the long-established "Jorei" system for providing community healthcare similar to medical aid associations already existed in every region of Japan, particularly in farming communities. The decision was also influenced by the fact that the Health Insurance System that had been created for employees was already starting to show

results. It is also said that the Japanese government made this decision after seeing the results of similar systems in Sweden and Denmark.

The former National Health Insurance Act was submitted to the Diet in 1937, but ended up classified as unresolved and rejected after the dissolution of the House of Representatives. When the Ministry of Health and Welfare (now the Ministry of Health, Labour and Welfare) was formed the following January, in 1938, income restrictions that had been an insurance prerequisite were abolished, and insurance became available to non-employees. The condition that insurance be employment-based was also abolished for both the insured and those not covered by employee insurance. This system was replaced by a system in which insurance was provided through location-based insurance associations that viewed municipalities as independent units. This formed the basis of the current system of residence-based National Health Insurance that was enacted in March 1938.

The successful establishment of universal health coverage(UHC)

After World War II ended in 1945, the Supreme Commander for the Allied Powers (SCAP) issued the "Three principles of public assistance" for Japan, making the government responsible for ensuring equality and minimum standards of living. This meant the government had to be more proactive in maintaining the health of the people. In 1948, the previous National Health Insurance system was revised, making it a rule that the insured were under the jurisdiction of local governments rather than regional associations. However, given the economic situation after the war, there were still problems that prevented National Health Insurance from becoming widespread. Even by 1956, one-third of the population of Japan was still unenrolled in any form of health insurance. Due to this, the then Prime Minister Ichiro Hatoyama declared the establishment of "Comprehensive health insurance that covers all citizens" in his annual speech on policy guidelines. This was a massive step forward in the effort to insure everyone. The current National Health Insurance Law was enacted in 1958. It made regional governments legally responsible for the administration of insurance associations and compelled all citizens to enroll in the public insurance scheme if they were not already covered by employee's insurance or a Mutual Aid Association (MAA). That same year, a new Public Health Insurance act was enacted. After a grace period of 3 years, public health insurance unions were established in all municipalities, allowing Japan to successfully achieve a world-class system of universal healthcare in 1961.^{10,11,12}

Coverage for the older population

In 1973, Japan forged a unique health insurance structure for its older population, reallocating public funds to subsidize the 30% of costs typically covered by patients within the NHI cost-sharing scheme and effectively making healthcare free for people aged 70 and over.¹³ Japan simultaneously introduced a high-cost medical care benefit system which at first covered only family members of employees via the employment-based health insurance, not extending to employees themselves. Later, employees along with their families came to enjoy the benefits of this system via National Health Insurance, when employment-based health insurance finally grew to also cover employees. Between 1973 and 1980,

<Column> Free healthcare for people aged 70 and over: The "biggest mistake" in the history of health policy in Japan

Free healthcare for the elderly is now considered by the Government of Japan to be the "biggest mistake in the history of health policy in Japan" (according to a former MHLW official). While drastically improving access to healthcare among the older population, the system resulted in over-provision of care and medical products, including pharmaceuticals. Older patients flooded hospital waiting rooms to the extent that they essentially became centers of social activity for some people. During that era, it was not uncommon to hear two older people in a waiting room joke, "Ms. Yamada isn't here today. She must not be feeling well!" The moral hazards created by free healthcare were so extreme that the government moved to revise the policy for people aged 70 and over, re-requiring cost-sharing. However, this proved tremendously

¹⁰ Kitayama, T. (2011). Explaining the Institutional Change of Health Politics in Japan: Localities Nationalized?. Yukikaku Publishing Co., Ltd.

¹¹ Sakaguchi, T. (1977). The History of Japan's Social Insurance Systems. Keiso Shobo

¹² Yoshihara, K., & Wada, M. (2008). The History of Japan's Health Insurance Systems. Toyo Keizai Inc.

¹³ Ministry of Health, Labour and Welfare (2016). The status of medical care for the elderly. (accessed 29 January 2018) Retrieved from http://www.mhlw.go.jp/file/05-Shingikai-12601000-Seisakutoukatsukan-Sanjikanshitsu_Shakaihoshoutantou/0000125580.pdf

healthcare spending for people aged 70 and over increased more than fourfold, leading to sustainability concerns and the eventual passage of the 1982 Public Aid for the Aged Act. This act, implemented in 1983, put an end to free healthcare for the elderly by requiring that they pay small copayments.¹⁴ In addition, this legislation helped to subsidize the NHI program by transferring revenue from employment-based health insurance to NHI. As a result, the Public Aid for the Aged Act is considered one of the most critical pieces of healthcare legislation in the history of Japanese health policy.

The Health Services Scheme for the Aged and the medical care system for the retired

The Public Aid for the Aged Act of 1982 created the basis for the Health Services Scheme for the Aged. This scheme, which was administered by municipalities, covers people aged 75 and over as well as those bedridden aged 65 and over (People aged 70 or over born prior to September 30, 1932, were covered by the Health Services Scheme for the Aged). Funding for the scheme was provided by contributions from medical insurers, public funds, and partial contributions by the insured. This scheme was in place for nearly 25 years, only being revised in 2008. There were many reasons for the revision. Chief among them was the lack of transparency regarding distribution of medical expense burden between the young and the old. Through the scheme, a part of every premium contributed by the members of any health insurance plan was transferred to municipal governments. In other words, the groups collecting premiums (insurance schemes) were not the same as the groups paying contributions (municipalities), making it difficult to know how contributions were actually spent. This scheme was finally discontinued in April 2008 alongside the creation of the Medical Insurance System for the Latter-Stage Elderly targeting people aged 75 and over.¹⁵ The cost-sharing details between the young and the old are much more transparent in this system. Furthermore, this system established governmental unions in prefectural associations across the country to act as central locations for the collection and payment of insurance premiums. This system also has clearly defined regulations regarding the responsibilities of management and the use of public finances. In addition to the previously mentioned systems, in 1984, the Government created the Retired Persons Healthcare System to relieve the building pressure on public finances brought on by increasing numbers of retirees leaving employment-based insurance schemes and coming under the coverage of NHI. The Retired Persons Healthcare System covered people aged 65 and under who were enrolled in NHI, people on employee pensions for over twenty years, and people who elected to receive retirement pensions after the age of forty and had done so for 10 years or more. Dependents were also covered by this system if they satisfied a fixed set of accreditation criteria. This system was administered by municipal governments, and funding was sourced from premiums contributed by system members, as well as premiums paid to employment-based health insurance plans. The Retired Persons Healthcare System itself was discontinued following the establishment of the Medical Insurance System for the Latter-Stage Elderly in April 2008¹⁶.

A new medical insurance system framework for the older population

The 2006 reform of the Japanese medical system is tremendously important when trying to understand health policy in Japan. This reform created a new healthcare system for people aged 75 and over. A number of reasons led to the creation of this new system. The first was related to Japan's residence-based insurance, a part of NHI that covers people residing in Japan who are not enrolled in employment-based health insurance plans. The health insurance system was set up such that when people retired who had formerly been enrolled in employment-based health insurance plans, they would then be enrolled in Community Health Care Plans.¹⁷ Since people generally retire at older ages, the average age of the population enrolled in NHI (via these plans) grew older and older as

¹⁴ Ikegami Naoki (2014). Universal Health Coverage for Comprehensive and Sustainable Development – Synthesis of research in 11 countries. Japan Center for International Exchange. (accessed 29 January 2018) Retrieved from <http://www.icie.or.jp/japan/pub/publst/1453/1453all.pdf>

¹⁵ Ministry of Health, Labour and Welfare. Changes to the healthcare system for the elderly. (accessed 22 August 2017) Retrieved from <http://www.mhlw.go.jp/bunya/shakaihoshoho/iryouseido01/info02d-25.html>

¹⁶ Ministry of Health, Labour and Welfare. Amendments to the medical insurance system. (accessed 22 August 2017) Retrieved from <http://www.mhlw.go.jp/bunya/shakaihoshoho/iryouseido01/taikou05.html>

¹⁷ Ministry of Health, Labour and Welfare. The medical insurance system of Japan. (accessed 22 August 2017) Retrieved from <http://www.mhlw.go.jp/file/06-Seisakujouhou-12400000-Hokenkyoku/0000172084.pdf>

time passed. This shift placed enormous financial pressure on the NHI since older people tend to incur greater medical expenses. The 2006 reform aimed to respond to this structural challenge by establishing a framework that allowed people aged 75 and over to be supported by society as a whole. Specifically, a new system was set up requiring people aged 75 and over to cover 10% of their medical expenses, while the remaining 90% is covered by the working population and public funds. A framework was also created by insurers to adjust costs for people aged 65 to 74 by having them enroll in either Community Health Care Plans or employment-based health insurance. The framework for those aged 75 and over came to be known as the Medical Insurance System for the Latter-Stage Elderly, while the framework for those aged 65 to 74 supports people considered to be “Early-stage” elderly.

The Long-Term Care Insurance System

Prior to the establishment of the Long-Term Care Insurance System, welfare and medical care for the elderly were delivered via separate systems. In terms of welfare, municipal governments selected the types of services people were eligible for as well as the institutions from which they could receive the services. Service recipients had no say in these matters. Service fees were decided according to the incomes of recipients and the incomes of their dependents, leading to heavy burdens for middle-class households. As for medical care for people aged 75 and over, a lack of infrastructure for welfare services limited society’s ability to provide long-term care to people in need of services, including daily care in hospitals and care related to specific medical treatments which required longer periods of hospitalization.¹⁸

As the Japanese population has aged, the focus of the healthcare field has shifted from acute illnesses toward the provision of integrated and continuous medical and nursing care for those with chronic conditions. Fewer and fewer families are now living with their elderly relatives compared to in the past, and the average age of family members providing care to elderly relatives is increasing. The combined effect was an increase in the number of people with no option for medical care but a long-term hospital stay, which put a strain on public finances. The Long-Term Care Insurance Act of 1997 was created to address this issue. This act established the Long-Term Care Insurance System, which covers all people aged 65 and over, as well as people aged 40 and over who are in need of long-term care. This system gives users the freedom to select the type of services they need, as well as their service providers. This act also created the position of “Care Managers” who are able to assist users in selecting care providers.¹⁹ Users are charged 10% of the medical fees for the services they select, irrespective of their income (although above a certain level of income, they are charged 20%). The system differs from NHI by mandating a “maximum amount of financial support.” After a certain level of support, users must cover the costs of all excess services.

Other healthcare legislation

Implemented in 1948, the seminal Medical Care Act defined criteria for the basic medical services to be provided by public hospitals.²⁰ The Medical Care Act has since undergone eight revisions in order to better align the provision of medical facilities with community needs as well as to introduce the system of Medical Care Plans.

A more recent piece of major health policy legislation is the Health Care System Reform Act of 2015, which changed the shape of the healthcare insurance system. This act, which will go into effect in 2018, moves oversight of the residence-based NHI from the municipal level to the prefectural level. To support the transition, this act provides prefectures with increased authority and responsibility related to financing and healthcare delivery

¹⁸ Ministry of Health, Labour and Welfare (2015). The current state of the public nursing-care insurance system and its future role. (access 22 August 2017) Retrieved from http://www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/201602kaigohokenntoha_2.pdf

¹⁹ Ikegami Naoki (2017). Medical care in Japan; Its history and organization – Direction of future reforms. Nikkei Book Publishing Company.

²⁰ Ministry of Health, Labour and Welfare (2007). 2007 White Paper of the Ministry of Health, Labour, and Welfare. (accessed 29 January 2018) Retrieved from <http://www.mhlw.go.jp/wp/hakusyo/kousei/07/dl/0101.pdf>

systems. As one MHLW official put it, it is “the biggest change to healthcare in Japan since the establishment of the modern healthcare system.”

1.3

Overview of major legislation

Year	Policy	Details
1922	Establishment of the Health Insurance Act	<ul style="list-style-type: none"> • Provided health insurance to employees with a certain level of income
1938	Establishment of the National Health Insurance Act	<ul style="list-style-type: none"> • Established National Health Insurance (NHI), a residence-based insurance program for farmers, the self-employed, the retired, and the non-employed, administered by municipal governments on a voluntary basis
	Establishment of the Ministry of Health and Welfare	
1939	Establishment of Health Insurance for Employees Act	<ul style="list-style-type: none"> • Provided health insurance to employees working at financial companies etc.
1942	Health Insurance Act amended	<ul style="list-style-type: none"> • Integrated the Health Insurance Act and Health Insurance For Employees Act • Introduced a system of partial cost-sharing
1948	Establishment of the Medical Care Act	<ul style="list-style-type: none"> • Legislated the establishment and management of hospitals, clinics, and other facilities, as well as their scope and number of personnel
1958	National Health Insurance Act amended	<ul style="list-style-type: none"> • Mandated that all municipalities establish and administer residence-based NHI programs • NHI became compulsory for those not covered by other plans
1961	Universal Healthcare achieved	<ul style="list-style-type: none"> • 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 • Out-of-pocket responsibility becomes 0% for insured people with employee insurance, 50% for dependents, and 30% for those enrolled in NHI • Establishment of high-cost medical expense system
1963	Establishment of the Act on Social Welfare for the Elderly	<ul style="list-style-type: none"> • Establishment of special elderly care homes • Legislation related to home help
1972	Act on Social Welfare for the Elderly amended	<ul style="list-style-type: none"> • Created a new structure for those 70 and over and made care free for nearly all people age 70 and over • Reduced copayments within NHI for other enrollees
1973	Health Insurance Act amended	<ul style="list-style-type: none"> • Establishment of medical expenses for the elderly payment system • Fixed rate of state aid for Government-Managed Health Insurance
1982	Public Aid for the Aged Act	<ul style="list-style-type: none"> • Retracted free care for those aged 70 and over by imposing a small co-payment

		<ul style="list-style-type: none"> • Stipulated coverage of medical expenses for the elderly via fiscal adjustment among insurers. Treated people aged 70 and over separately from the existing health insurance system, subsidizing costs via public funding (national government 2/3, prefectural governments 1/6, municipal governments 1/6) and contributions from insurers in the existing health insurance system.
1985	The first revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Introduced regional medical planning for the management of hospital beds
1990	“Eight Acts” ²¹ related to welfare amended	<ul style="list-style-type: none"> • Municipalities were obligated to formulate municipal healthcare plans for the elderly
1993	The second revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Specified “advanced care hospitals” and created a new structure for “health facilities for long-term recuperation”
1997	Establishment of the Long-Term Care Insurance Act	<ul style="list-style-type: none"> • Launched a mandatory social insurance program that covers care for older people with health issues, partially relieves caregiver burdens, and addresses the needs of the aging population
	The third revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Launched the regional medical care support hospital system • Set general regulations for informed consent
2000	Partial revision of the Health Insurance Act	<ul style="list-style-type: none"> • High-cost medical expense system amended • Revised the upper limit for health insurance premium rates • Abolished out-of-pocket expenditures on medicine related to the elderly • Revised a portion of expenditures related to the elderly
	The fourth revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Introduced a bed classification system that required hospitals to report hospital bed use under the categories of “general” or “treatment” • Implemented 2-year mandatory clinical training period for doctor licensing • Made medical safety management systems legally mandatory for all medical facilities
2002	Partial revision of the Health Insurance Act	<ul style="list-style-type: none"> • Revised out-of-pocket expenditures • Introduced total compensation system for health insurance premiums • Increased insurance premium rate for Government-Managed Health Insurance • Revised calculation method for medical expense contributions for the elderly • Other measures, including those to strengthening the financial foundation of NHI

²¹ Eight welfare-related acts: (1) Act on Social Welfare for the Elderly, (2) Act on Welfare for Physically Disabled Persons, (3) Act on Welfare for Mentally Retarded Persons, (4) Child Welfare Act, (5) Act on Welfare for Mothers with Dependents and for Widows, (6) Social Welfare Act, (7) Aid for the Aged Act, and (8) Social Welfare and Medical Business Corporation Act

2005	Long-Term Care Insurance Act amended	<ul style="list-style-type: none"> • Established preventive benefit and regional support projects for the creation of a preventative medicine system • Following a review of facility benefits, it become no longer possible to use benefits for expenses relate to food and housing at long-term care facilities. A supplementary benefits program for low income users is set up • Created of community-based services to establish new service systems, enhance residential services, improve the integrated community care system, strengthen support for middle-income households, and coordinate medical care and nursing care / establish a clearer division of roles • Established insurance fees for primary beneficiaries that reflected, in detail, the ability of that person to pay expenses, following a review of the state of medical expenditures and the management system for such expenditures. Also revised the long-term care licensing system, strengthened insurer functions, and revised cost-sharing schemes and other issues.
2006	Health Care Reform Act	<ul style="list-style-type: none"> • Established a new medical care service system targeted at people aged 75 and over • Establish a public corporation to hand over the administration of Government-Managed Health Insurance for employees of SMEs from the national Government to the prefectural governments
	Partial revision of the Health Insurance Act	<ul style="list-style-type: none"> • Formulated a medical cost optimization plan to optimize medical expenses over the medium- to long-term, such as lifestyle disease measures and the correction of long-term hospitalization fees • Revised the content and scope of insurance benefits • Abolished medical facilities that only provided long-term care • Established a new medical care service system for the elderly
	The fifth revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Promoted public information about healthcare facilities at the prefecture level
2008	Long-Term Care Insurance Act and Act on Social Welfare for the Elderly amended	<ul style="list-style-type: none"> • Created a business management system under laws and regulations for nursing care service providers • Issued advance notification on the suspension or abolition of nursing care service providers • Made the clarification of services at the time of a nursing care service provider suspension or abolition mandatory.
2008	Cabinet Order to revise part of enforcement ordinance for the Health Insurance Act etc.	<ul style="list-style-type: none"> • Revised the calculation criteria for high-cost medical expenses • Established requirements for payment related to high cost long-term care and calculation standards related to nursing care
	Summary Report of the National Conference on Social Security	<ul style="list-style-type: none"> • Established the introduction of a hospital bed function reporting system and a vision for community care • Called for the strengthening of the roles of prefectures and transitioning of NHI management to prefectures

		<ul style="list-style-type: none"> • Revised the medical corporation system and social welfare corporation system • Called for collaboration between medical care and nursing care and construction of an integrated community care system • Called for Financial support to promote the reform of the provision of medical and nursing care services • Called for a studies on training general practitioners, communicating information to the public, the duties of medical professionals, and the establishment of team medical care. Emphasized that data should be continuously collected and periodically reevaluated. • Called for the stabilization of the health insurance system, ensuring fairness in cost-sharing related to insurance premiums • Called for prioritization and efficiency improvements related to medical benefits (a correction of the range of eligible medical treatment etc.)
2009	Cabinet Order to revise part of enforcement ordinance for the Health Insurance Act	<ul style="list-style-type: none"> • Revised the Childbirth Lump-Sum Allowance and benefit for the childbirth of a family member (increase of 40,000 yen)
2011	Establishment of the Act Revising a Portion of the Long-Term Care Insurance Act to Strengthen the Foundation of Long-Term Care Services	<ul style="list-style-type: none"> • Strengthened collaborations between medical and nursing care providers. Promoted comprehensive support (integrated community care system) for caregivers etc. who cooperate with medical care, nursing care, prevention, housing, and living support services. • Established Long-Term Care Service Plans based on an understanding of the regional needs and issues in the places where people live, created a 24-hour regular and periodic care services and complex services • Extended the date for the elimination of hospital beds used only for long-term care • Promoted the supply of housing with in-home care services for the elderly
2012	National Health Insurance Act amended	<ul style="list-style-type: none"> • Transferred the financial administration of NHI programs from the municipal level to the prefectural level to strengthen the financial basis of NHI
2013	Partial revision of the Health Insurance Act and other acts	<ul style="list-style-type: none"> • Took measures including the two-year extension of fiscal support for the Japan Health Insurance Association which was previously in place from 2010 to 2012 (These include: 1. government subsidies, and 2. methods by which insurers could handle money owed to support healthcare for those age 75 and over) • Raised the share of healthcare expenditures incurred by the Japan Health Insurance Association that were covered by Government subsidies from 13% to 16.4% for two years

	Establishment of social security reform program	<ul style="list-style-type: none"> • Clarified items to be examined for a reform of the healthcare system and the long-term care insurance system • Established a system for the reporting of hospital bed functions • Considered all aspects of the total compensation ratios for supporting people aged 75 and over • Revised out-of-pocket expenditures among people aged 70 to 74 years old • Revised the high-cost medical expenditure system
2014	Establishment of the Law to the Related Acts for Securing Comprehensive Medical and Long-Term Care in the Community	<ul style="list-style-type: none"> • Set up new funds within prefectures that utilize consumption tax revenue to promote strong collaboration between medical care and nursing care • Created the requirement that medical institutions report the functions of hospital beds (beds for intensive , acute, recovery, or chronic patients) to prefectural governors in order to ensure the efficient and effective provision of healthcare in each community. Also created the requirement that prefectures formulate a regional medical vision for their local healthcare systems based on that. • Enhanced community support projects and shifted funds for preventative medicine benefits to community support projects in order to foster a comprehensive regional care system and ensure fair cost-sharing.
2014	Cabinet Order to revise part of enforcement ordinance for the Health Insurance Act	<ul style="list-style-type: none"> • Revised the Childbirth Lump-Sum Allowance. • Revised criteria for calculating high-cost medical care benefits and combined medical treatment costs for high-cost long-term care
	The sixth revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Promoted integrate care and the analysis of hospital bed information through the creation of the Bed Classification System and Integrated Community-based Care Plan • Introduced measures to address physician and nurse shortages • Introduced a classification renewal system for hospitals recognized as “advanced treatment hospitals” • Introduced measures to improve the work environment for healthcare workers • Promoted home healthcare • Promoted the improvement of the clinical trial system • Introduced a system to investigate medical accidents • Revised the healthcare corporations system
	Establishment of Act for Securing Comprehensive Medical and Long-Term Care	<ul style="list-style-type: none"> • Implemented measures aimed at ensuring the efficient and effective provision of medical care at the community level • Established the integrated community care system and revised cost-sharing to be more fair.

2015	Establishment of the Act Revising a Portion of the National Health Insurance Act to Build a Sustainable Health Insurance System	<ul style="list-style-type: none"> • Transferred responsibility for the fiscal management of NHI from municipal governments to prefectural governments • Increased insurance premiums for employees of large corporations and civil servants • Established "patient offer system" that allows users to cover medical expenses through a combination of insurance benefits and out-of-pocket funding.
	The seventh revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Established a system for the creation of corporations to promote regional medical collaborations • Revised the medical corporation system
2017	The eighth revision to the 1948 Medical Care Act	<ul style="list-style-type: none"> • Established regulations on governance reforms at advanced treatment hospitals • Established restrictions on what medical institution websites, publications, and so on, can say (restrictions on false or exaggerated claims).
2017	Cabinet Order to revise part of enforcement ordinance for the Health Insurance Act	<ul style="list-style-type: none"> • Revised calculation criteria for high-cost medical expenditures among insured people over 70 years old
	Establishment of the Act Revising a Portion of the Long-Term Care Insurance Act to Strengthen the Integrated Community Care System	<ul style="list-style-type: none"> • Created a system to make it possible for municipal governments to make use of insurer functions and work toward helping patients live independently and toward preventing sick patients from growing worse. • Established a new kind of nursing-care insurance facility that combines functions such as daily medical management and end-of-life care and terminal care with living facilities. • Set out requirements for people using Long-Term Care Insurance with high-cost medical expenditures who were previously asked to cover 20% of their expenses to now cover 30%.
2018	Prefectural Unitization of NHI	<ul style="list-style-type: none"> • Transferred responsibility for fiscal management of NHI from municipal governments to prefectural governments.