Social Security Reform and Public Health Policy Reform Chronology

Year	Reform	Notes	World/Country Events
1927	Public Medical Care Insurance System		
1938	1. Establishment of Ministry of Health and Welfare 2. National Health Insurance		
1939	Employees Health Insurance Law		
1941	Workers Pension Insurance		Pacific War
1944	Employees' Pension Insurance		1945 End of War
1947	1. New Health Center Law 2. Food Sanitation Law 3. Child Welfare Law		First Baby Boom
1948	1. Preventive Vaccination Law 2. Medical Care Law 3. Medical Doctor Law, Dentist Law		
1949	Law for the Welfare of People		
1950	Mental Hygiene Law		Korean War
1951	1. New Tuberculosis Prevention 2. Social Welfare Service Law 3. Children's Charter		
1954	Employees' Pension Insurance	Introduction of fixed amount in the pension to the 60	

1957	Water Supply Law		
1958	National Health Insurance Law	Insurance coverage for whole population	
1959	National Pension Law	Pension for whole population	1960 Income double plan
1961	1. Implementation of insurance for whole population 2. Child Rearing Allowance Law 3. 10-year Water Supply Plan	1. Compulsory coverage public medical insurance schemes 2. Physician's freedom choice of medical services 3. Reduced patient's co-payment	
1963	Welfare Law for the Elderly		
1964	Law for maternal and Child Welfare		
1965	1. Employees' Pension Insurance 2. Maternal and Child Health Law	¥10,000 pension, Employees	
1966	National Health Insurance Law	70% benefit introduced	
1967	Pollution Control Basic Law		
1969	1. System for dispatching helper elderly 2. Employees' Pension Insurance	¥20,000 pension	
1970	5-year Plan for the Emergency Welfare Facilities		Aging Rate exceed 7%, Dollar Shock, 2nd baby boom
1971	Child Allowance Law		
1973	1. Free medical care for the elderly 2. Health Insurance Law 3. Pension System Reform	1. Age 70 and older are guaranteed for free medical care; their co-payments under the public insurance scheme were compensated for central, prefectural, and municipal government through general tax revenue	Oil Shocks

		2. Amendment for dependents (70% insurance benefits and high cost medical care expenses) 3. ¥50,000 pension, commodity price sliding scale introduced	
1978	National health improvement measures		
1979	Law on the Drug Fund for Adverse Reaction		
1981	Child Welfare amendment	Implementation extended and night child care	US-Japan Trade Friction
1982	1. Long term plan concerning Measures for people with disabilities 2. Home helpers 3. Health Medical Service Law for the elderly	1. Home helpers substantial income restrictions 2. Covers the elderly aged 70 and older and the bedridden elderly between 65 and 70 years of age 3. Placing financial burden of medical services for the aged to the municipalities	
1983	Comprehensive 10-year Strategy for Cancer Control		
1984	1. Health Insurance Law amendment 2. Retired Health Insurance (RHI)	1. 90% benefit for insured persons and medical care system for the retirees (10% co-payment) 2. Insured retirees younger than 70 years old transfers from EHI to RHI under NHI scheme	
1985	1. Pension system reform 2. Medical Service Law amendment	1. Introduction of basic pension etc 2. Medical care plans	Yen Appreciation
1986	1. Health and Medical Service Law for the elderly amendment 2. Health Services Facilities for the Aged	1. Health services facilities for the elderly (44.7% redistribution ratio contribution between EHI/NHI) 2. Raising the statutory co-payment (¥800 per month for	Steep Rise in Land Prices

	(HSFA)	outpatient care and ¥400 per day for inpatient care) 3. HSFA receive a fixed amount per inpatient per month from public insurance schemes (¥300,000 per month)	
1988	1. Second national health improvement measures 2. National Health Insurance Law amendment	Stabilization of municipalities with management of high-cost medical care	Bubble Economy, Tax Reform
1989	1. Prevention of AIDS Law 2. Pension System Reform 3. Formulation of ten-year Gold Plan	1. Completely automatic commodity price sliding scale system National Pension Fund 2. Gold Plan include: reducing bedridden elderly to zero and improve health care and welfare services for the elderly	Change of Era
1990	1. National Health Insurance Law amendment 2. Eight Laws on welfare services for the elderly amendment	1. Establishment of an insurance base stabilization system 2. Including welfare for elderly	
1992	1. Health Insurance Law amendment 2. Medical Service Law amendment 3. Law to Promote the Securing Manpower	1. Introduction of mid-term financial management 2. Introduction of the idea of providing medical care such as nurses	Land prices began to fall
1993	1. Pharmaceutical Affairs Law and the Drug Fund 2. New Long-term Program for Government Measures for Disabled Persons	Adverse reaction relief and research promotion law amendment	
1994	1. The 21st Century Welfare Vision	1. Reinforcement of functions of health centers	Aging Rate exceeds 14%

	2. Community Health Law 3. Health Insurance Law Amendment 4. Pension system reform 5. Mental Health Law Amendment	2. Review of a benefit for inpatient dietary therapy, discontinuance of nursing offered by nursing attendants 3. Review of the old age employees' pension for people in their 60s	
1995	Formulation of the government action plan for persons with disabilities		
1996	1. Leprosy prevention Law abolished 2. Amendments to the Employees' Pension Insurance Law 3. Amendments to the Pharmaceutical Affairs Law	1. Reorganization of employees' pension system 2. Improvement of measures to ensure drug safety	
1997	1. Amendments to the waste management and public cleanliness law 2. Amendments to the Child Welfare law 3. Amendments to the Health Insurance Law 4. Long term care insurance law	1. Clarification of procedures for establishing facilities, countermeasures against illegal dumping 2. Child care system reform 3. 80% benefits for the insured	Social Security Reform
1998	Agreement between Japan and Germany on Social Security		
1999	Infectious Disease Prevention Law		

TBC was the common illness during 1950's and 1960's. The health pattern changed drastically in 1970's from infectious disease to hypertensive disease, mental disorder, cerebrovascular disease, liver disease, diabetes, and malignant neoplasms. Preventive health care is one of major public health policy, which includes health education, health consultation, check-ups, immunization, and other activities. Rehabilitation, day-care service, home help, and recreational activities promoted by local government are viewed to improve preventive health care.

Local government is primarily responsible for health centers that carry out preventive health program. Health centers advise the municipal health sections, which have been executing agencies of the program.

Throughout the reform the following basic elements of policy have remained in place:

- Universal coverage for all inhabitants and employees
- Collective financing through public medical care insurance scheme
- Largely private provision of services
- A uniform fee schedule applied to all medical facilities and insurers under the public medical care insurance schemes

Statistics and Information Bureau of the Ministry of Health and Welfare estimates the National Medical Expenditures (NME). Medical expenditures are roughly defined as the information on the aggregate expenses paid by third parties or patients to providers of medical care in the year.
NME is limited to payments to medical institutions and tends to be smaller. It does not include public expenditure except for payments made through public medical care insurance schemes. It does not include subsidies to public healthservice providers, expenditure onpreventive methods or other public health activities, administrative costs of public schemes, and so on. Household expenditures, out-of-pocket are not included either..

Hospitals are health facilities that can take 20 in-patients or more. Clinics are health facilities that only take fewer than 20 in-patients or no in-patients at all.

Medical facilities by type of establishment, 1991

	Hospitals	General Clinics	Dental Clinics
Private	81	93.7	99.4
Individual	29	73.1	93.1
Medical juridical corporations	43.5	11.8	5.6
Public	19.	6.3	0.6

Total	100	100	100

Source: MHW (1993) Medical Institution Survey

(The Reform of Health Care System, OECD).

Health Insurance Schemes:

- Employees' Health Insurance System (EHI)
  - ✧ Government managed Social Insurance Agency
    Covers employees of medium-sized and small industries
  - ✧ Society managed (individual-company based)
    Covers employees of large industries
  - ✧ Seamen's Insurance
  - ✧ Mutual Aid Associations for central, prefectural or municipal government employees
- National Health Insurance (NHI)
  Covers self-employed retired employees, etc.

Patients receive benefits in-kind such as out-patients care, hospital inpatient care, drugs. Cash are available for sickness, injury allowances, and maternity allowances. The benefits are equal (at equal cost) for all insured irrespective of their income.

Medical services are based on the uniform fee schedule regulated by Ministry of Health and Welfare.
Fees schedule include:

- Operational costs
- Consultation
- Examination
- Diagnosis
- Treatment
- Surgery
- Medication
- Injection
- Hospitalization

The fee schedule are attempted to reimburse the management of an ordinary medical facility. Capital investment cost are not included, and usually provided by loan from commercial bank or Social Welfare and Medical Corporation, a semi-governmental financial organization.
The fee schedule allows the patients to have a suitable treatment. But, it also allows the practicioners to

do more examinations and prescribe more unnecessary drugs. More reforms on the reimbursement system have been placed to control for the drawback of the fee schedule systems.

The major financing of health insurance is from health insurance contributions (56%), central government (25%), local government (7%), and patients' co-payment (12%). **(1994**) The financing scheme varies by type of insurance. National Health Insurance (NHI) receives more subsidy from the government (50%) and other health insurance schemes (EHI, Social Insurance Agency (EMI)) receive less. Despite of large contributions of National Health Insurance (NHI) system received from the government, the scheme offers fewer benefits compare to those of EHI. NHI largely consist of elderly and low income population. Because of heaviliy concentrated on the elderly insured participants on NHI, as well as high contributions from the government, central government (Ministry of Health and Welfare) bear for heavy financial burden, particularly the proportion of elderly are increasing with growing rates.

National Medical Expenditures, accounted for 6% to 6.3% of National Income, have been increasing for several reasons; population increase, demographic change in disease patterns, advances and availability of medical technology, behavior of doctors and others under enacted laws and rules. Under lack of restrictions on the medical establishment, inefficient medical resources allocation and excessive number of hospitals beds are growing. Doctors earn more by dispensing more pharmaceuticals that are fully reimbursed. Therefore, they are motivated to dispense excessive pharmaceuticals.