CHAPTER 11

Challenges in Reforming the Japanese Health Care System

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Countries around the world are anxiously searching for better health care systems. The development of health care systems has followed a different route in each country, influenced by differing cultures, histories, and ideas. One distinction that is particularly vital when developing a health care system is whether health care is considered to be a merit good (a good that everyone should receive) or a general resource (something that should be allocated depending on the ability of the users to pay for it). Since 1961, Japan's health insurance system has been predicated on the first of these two approaches.

Experience shows that when a health system works well, it produces good results. Japan has achieved some of the world's best scores on health indicators, with low infant mortality rates and very long average life expectancy. Weaknesses in the Japanese health care system include an inefficient primary care system, a lack of differentiation among health care providers, and a lack of standard clinical guidelines.

Currently, Japan's health care system is facing a financial crisis. Health care costs are increasing partly as the result of the aging of Japanese society, the development and utilization of new health care technologies, and patients' increasing demand for quality and safety in health care. Health sector reforms have been discussed for more than a few decades, but they have made slow progress and have not been very effective because of the outdated decision-making process that has been preserved. Meanwhile, the Republic of Korea (in 1989) and Taiwan Province of China (in 1995) have adopted national health insurance, following the Japanese health insurance model, and have been moving ahead of Japan through various reforms, such as integration in the management of health insurance and the introduction of information technology infrastructure.

This chapter first gives an overview of Japan's health care system and then discusses current challenges and lessons that can be drawn from the Japanese experience. A brief history of the country's health care system is included in Appendix 11.1.

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OVERVIEW OF THE HEALTH CARE SYSTEM

Health Care Provision and Financing

One of the characteristics of the Japanese health care system is the high number of hospital beds per capita. As a result, employee-bed or nurse-bed staffing ratios are lower than the Organization for Economic Cooperation and Development (OECD) average, and to maintain the utilization rate of all these beds, hospital stays are also longer than the OECD average (Table 11.1).

During the 1990s, most of the OECD nations greatly reduced the number of acute-care hospital beds, the average length of acute-care hospital stays, and the number of acute-care hospitals per capita. In Japan, those figures are also decreasing, but they are still the highest. A lack of differentiation among types of health care providers and a lack of standard clinical guidelines both contribute to these rather high figures. For example, in Japan a hospital is defined as any medical facility with at least 20 beds, including long-term geriatric care facilities.

Another characteristic is a free-access system that allows people to be examined and treated at the medical institutions of their choice, regardless of their symptoms. This has led to the problem of excessive demand from patients who visit doctors too often. The frequency of doctor visits per patient in Japan far outstrips the OECD average.

Private hospitals dominate the hospital system, accounting for 80 percent of the hospital market and 70 percent of total hospital beds. The government's control over prices for all procedures, drugs, and devices applies uniformly to all physicians and hospitals, both public and private.

Hospitals operate as closed systems, and clinic-based doctors do not have visiting privileges at hospitals. Exclusive specialty board certification is nonexistent, and doctors practice in any specialty they choose. Hospitals and physicians

TABLE 11.1

International Comparison of Health Care Systems

	Number of hospital beds per 1,000 people	Number of physicians per 1,000 people (% of GP)	Number of nurses per 1,000 people	Average length of stay in hospital: acute care (days)	Number of doctor visits as outpatient (times/year)	CT per 1 million	MRI per 1 million
United States	3.1	2.43 (12%)	10.75[b]	5.5	4.0	34.3	25.9
Japan	13.8	2.15 (–)	9.54	18.8	13.4	97.3	43.1
Germany	8.2	3.56 (18%)	10.68	7.6	7.8		
United Kingdom	3.4	2.61 (29%)	9.52	7.1	5.9	7.4	5.6
France	6.9	3.34[a] (49%)	7.93[b]	5.2	6.9		
Canada	3.5	2.27[a] (48%)	9.20	7.5	5.7	13.9	8.0
Republic of Korea	7.8	1.86 (37%)	4.36	10.6[c]	13.0	37.1	19.0
The Netherlands	4.3	2.88 (24.9%)	11.24	5.9	5.9	10.3	10.4
Australia	3.9	2.97 (51%)	10.08	5.9	6.4	38.8	5.9

Source: Organization for Economic Cooperation and Development, OECD Health Data 2010.

[a]Professionally active physicians.

[b]Professionally active nurses.

[c]Data are for 2003.

freely choose their practice mode and are paid on a fee-for-service basis. Referrals and an organized distribution of functions between facilities have been sorely lacking. Clinics frequently provide both primary and more-specialized care. This lack of differentiation of providers and the lack of an efficient primary care system are serious weaknesses in the system. Since the Japanese do not have a sound system of primary care provided by well-trained family doctors (note that the number of general practitioners [GPs] in Table 11.1 is missing for Japan), it is quite common for patients to visit a general hospital or even a university medical center for minor illnesses without referral.

Japan has no postgraduate training system for primary care. Traditionally, Japanese primary care has been managed by specialists who are self-trained to be generalists. The Japan Medical Association, which represents mainly doctors working at clinics, has strong vested political power, and this has delayed various health care reforms, including the establishment of formal training in family practice.

Sophisticated medical technology has spread to small clinics and general hospitals, both of which compete for outpatients. Fee-for-service payment further induced demand for new medical technologies, such as computed tomography (CT) and magnetic resonance imaging (MRI), causing their wide proliferation. Although bureaucratic control helps the Japanese government contain health care expenditure, the high prevalence of CTs and MRIs is extraordinary (Table 11.1).

Remuneration is fundamentally through a fee-for-service system, but a diagnosis-based per diem payment system, called diagnostic procedure combination in Japan, has gradually been introduced in acute-care hospitals. The payments that doctors receive for medical services are the same nationwide, with rates set by the central government. Therefore, there are few incentives for quality improvement and little competition among providers on quality (Tatara and Okamoto, 2009).

A country comparison of health expenditure data (Table 11.2) reveals wide variation in the ratio between public and private expenditure, with Japan at the

TABLE 11.2

Proportion of Health Care Expenditure by Funding Source

	Japan	Germany	France	Republic of Korea	United Kingdom	United States	Sweden	Canada
Public spending on health (%)	81.3	76.7	78.4	54.7	81.9	45.3	81.6	69.9
General taxation (%)	15.4	9.2	5.1	12.9	81.9	32.6	81.6	68.5
Social health insurance (%)	64	67.5	73.4	41.8		12.7		1.4
Private spending on health (%)	18.7	23.3	21.6	45.3	18.1	54.7	18.4	30.1
Out-of-pocket (%)	15.1	13.4	7	36.5	11.4	12.3	16.2	14.9
Private health insurance (%)	2.6	9.2	12.9	3.8	1.4	35.1	0.1	12.3
Expenditure on prescription drug/total health care expenditure	17.3	13.3	13.5	16.4		10.3	9.7	14.3
Total health care expenditure/GDP	8.3	11.3	11.7	6.5	9.3	16.2	9.9	10.9

Source: Organization for Economic Cooperation and Development, OECD Health Data 2010.

high end of public expenditure (81.3 percent) and the Republic of Korea less committed to public funding (54.7 percent).

A more-detailed breakdown of the sources of health care financing shows that while public expenditure in Japan is made up of general taxation and social health insurance, private expenditure is a mix of out-of-pocket spending for coinsurance and for services not covered by health insurance, together with the premiums paid by families and individuals for private health insurance. As shown in Table 11.2, the share of total health spending that is privately financed varies considerably across countries. The range is as high as 45.3 percent in the Republic of Korea to as low as around 18 percent in Japan, Sweden, and the United Kingdom.

The aging of Japan's population is causing severe problems for the country's public finances. The elderly often suffer from multiple symptoms, and given the lower copayments required of the elderly, they often visit specialists for each episode of an illness.

The elderly in Japan account for a significant portion of the country's health care expenditures. People age 65 and over make up 22 percent of the total population but account for 54.6 percent of the total expenditure, and in 2008 the per capita health expenditure among the elderly was almost four times higher than the amount spent on the 0–64 age group.[1] As will be discussed in the next sections, financing structures for the elderly do not have incentive mechanisms to contain health expenditure among the elderly.

Organizational Structure of Health Insurance Programs in Japan

The most important health care policy in postwar Japan was the establishment of equality through guaranteed health care access for all Japanese. Under the universal public insurance system, people can receive universal medical service any time, anywhere throughout the country at a relatively low cost. In addition, in 1997 the coinsurance rate for employees' health insurance and community health insurance was made equal, with the insured paying 30 percent and insurers paying 70 percent of medical costs. Benefits are uniform nationally.

However, there are large regional differences in the actual amount of health care services that people receive, which are reflected in both medical expenses and the amount of public insurance premiums. Unequal contributions are one of the most serious issues in the health care insurance system (Table 11.3).

Japan's universal health insurance system is composed of four main insurance systems, namely, (1) community health insurance for the self-employed and unemployed (National Health Insurance—NHI), (2) society-managed employees' health insurance, (3) public-corporation-run health insurance, and (4) the medical system for the elderly, age 75 and over. Each system comprises multiple insurance plans or subschemes with differing premium rates. Insurance premiums

[1]Since 2000, long-term care insurance has been in effect, and benefits offered under this insurance are not included in these statistics.

TABLE 11.3

Japanese Health Care Insurance Schemes

	National Health Insurance	Society-managed health insurance	Public-corporation-run health insurance	Medical system for the elderly (age 75 and over)
Number of insurers (2009)	1,788	1,497	1	47
Number of members (2009)	35.97 million	30.34 million (insured: 15.91 million) (dependent: 14.43 million)	34.7 million (insured: 19.5 million) (dependent: 15.22 million)	13.46 million
Average age of members (2008)	49.2 years	33.8 years	36.0 years	81.8 years
Average income (total compensation) (2008)	¥0.79 million per member (former provisory income)	¥2.93 million per member (total compensation)	¥2.18 million per member (total compensation)	¥0.758 million per member (former provisory income)
Health care expenses per member (2008)	¥282,000	¥126,000	¥145,000	¥865,000
Premium per member (2008)	¥83,000	¥91,000 (¥203,000 including the employer's payment)	¥89,000 (¥177,000 including the employer's payment)	¥64,000
Proportion of public subsidies	50%	—	16.4%	50%
National budget (2010)	¥3,027.4 billion	¥2.4 billion	¥1,044.7 billion	¥3,734 billion

Source: Japan, Ministry of Health, Labor and Welfare.

are calculated based on the insured person's income (ability to pay) regardless of his or her risks and the amount of benefits paid out to him or her. The method of calculating the premium rate for each system is different, depending on its insurers. The number of such insurers in Japan now exceeds 3,000 (Table 11.3).

The employees' health insurance programs have relatively high ratios of healthy and wealthy enrollees. The society-managed health insurance is a scheme for employees of large corporations and their dependents (1,497 insurers). Employers deduct the employees' premiums directly from their paychecks and bonuses. Premium contributions are typically borne equally by employers and employees. However, for society-managed health insurance, many companies pay more than half of their employees' premiums. In 2009, premium rates for this form of health insurance ranged from 3.12 percent to 10 percent of an employee's (indexed) monthly earnings, with the average rate at 7.45 percent. Employers that year paid 55 percent of the total premiums. In the same year, the average premium rate for public-corporation-run health insurance, covering employees of small and medium-sized firms and their dependents, was 9.34 percent of an employee's monthly salary, with half the contribution paid by the employer.

NHI covers the self-employed, the unemployed, workers at companies with fewer than five employees and retirees. This insurance is managed by the municipalities and 1,788 insurers all over Japan. NHI has a relatively high ratio of ill

and poor enrollees. Most of the self-employed declare their own earnings, and NHI premiums are collected on the basis of household income, fixed assets, and other wealth. Premium rates vary among insurers. On average, NHI enrollees have the lowest incomes, followed by enrollees of public-corporation-run health insurance and society-managed health insurance, respectively. Governments, both central and local, subsidize 16.4 percent of public-corporation-run health insurance benefits and 50 percent of NHI benefits.

The health insurance system is structured such that fiscal resources are transferred from workplace-based employees' insurance (whose members tend to be younger and have higher incomes) to the health insurance systems run by the national government (many of whose members are elderly or unemployed) and the public corporations.

The health care costs of the elderly are shared among insurers by a mutual adjustment scheme based on the proportion of people insured age 75 or over. About 50 percent is financed by government subsidy and about 40 percent by contributions from NHI and employees' health insurance. The large increase in costs for the elderly has been the most serious problem, because insurers pay the cost for adjustment. It is very difficult to devise financing mechanisms for the elderly. To contain health expenditures for the elderly, the most effective method is to promote a policy for cost-effective, efficient, and high-quality primary care systems with a combination of fee for service and capitation fee. Such a policy will prevent the elderly from making unnecessary visits to specialists and still detect diseases at the early stage and enhance the health of the elderly.

ISSUES FACING THE JAPANESE HEALTH CARE SYSTEM

Issues Related to Health Care Insurance

Since the national universal insurance system was introduced in 1961, medical expenditure has grown rapidly as the result of increased access to medical care, provision of benefits for high-cost medical care,[2] and free medical care for the elderly (since 1973). This has put increasing pressure on the country's finances. It took almost 30 years to correct the 1973 policy; since 2002 the elderly have been required to pay 10 percent (or 20 percent, based on income) of their medical costs up to a relatively low payment limit.

The National Health Insurance system's coverage has changed dramatically since 1961. NHI was originally targeted at farmers when universal insurance was introduced. In 1965, two-thirds of the workforce was either self-employed or in the agriculture, forestry, or fishery industries. Further, lifetime employment and seniority-based corporate structures were a norm, and within corporations

[2]If total copayment to a hospital or clinic exceeds the over-the-payment limit, the excess over the limit will be reimbursed.

employees' health insurance systems were established as a unit. However, in subsequent years the aging of the population and changes in the industrial structure fundamentally altered the situation. Currently, more than half of the people insured by NHI are unemployed, 24 percent are employees of offices with fewer than five employees or are part-time workers, and 19.3 percent are self-employed or farmers (Japan, Ministry of Health, Labor and Welfare, 2009). For NHI, each municipality operates as the insurer. Since 2000, mergers have led to a decrease in the number of municipalities, from more than 3,200 to 1,788 in 2009.

The aging of the population, which started around the time the universal insurance system was established, also placed greater pressure on the finances of the National Health Insurance system. People who were insured under employee health insurance were then turned over to National Health Insurance upon retirement, and this entailed a decrease in these people's income and increase in medical expenses for the retirees. The Japanese government established a new medical system for the elderly (age 75 and older) in April 2008. The insurers in this new system for the elderly are designated as an extended association joined by all municipalities in their prefectural governments. Government subsidy becomes available, but the subsidy cannot cover the medical expenses of everyone.

Every time a financial crisis occurs, new financial support measures are adopted in order for the system to keep up with the changes. The insurance premiums for NHI and health insurance for the elderly combined cover only one-third of the programs' operating cost, and only a small amount of municipal financing is used to cover the revenue shortages created by NHI. This trend is more pronounced in rural compared to urban areas.

Since 1988, the National Health Insurance Law has been amended several times, and various ad hoc financial assistance measures have been introduced. As a result, the mechanism for financing the costs of the National Health Insurance system has become extremely complicated and involves joint subsidies between central and local governments. This system now includes an insurance-based stability system for people with low incomes, a joint project to mitigate the effect of high medical expenses, and financial measures to stabilize municipal finances.

Because of their experience of being provided with additional financial support by the central government, municipalities now expect new support measures to be implemented whenever new crises arise, which creates moral hazard for the National Health Insurance system. Thus, overly supportive financial measures have reduced the incentives for municipalities to ensure the collection of insurance premiums and improve the efficiency of health care services. As a result, municipalities' responsibility as insurers remains ambiguous. Moreover, people have come to accept the system without clearly understanding who actually pays for their medical expenses. As a result, the government's share of medical expenditure has continued to grow over the years.

Many of the problems facing the Japanese health care system today are due to the incapacity of the insurers. Insurers and health care providers should be the main actors in insurance contracts that involve the delivery of health care, in determining the insurance premium and benefit package, in reviewing and

approving benefits, and in selecting health care facilities. However, in the current system, the government appoints health-insurance-qualifying hospitals and doctors without adequate evaluations, physician service fees are determined in line with administrative guidance, and the original purpose of the insurance contract is ignored. It should be possible for insurers to exclude inefficient health care providers individually from the list of health insurance service providers. However, the Japanese system makes that impossible, and such a system is rare in the world. It is difficult to encourage competition between health care providers and to evaluate them under a system such as Japan's.

The strong correlation between the number of hospital beds and length of hospital stay has been repeatedly pointed out by researchers and government officials. Lack of standardization has also led to excess investment in expensive medical equipment. It is important that insurers, as a responsible party, should become more than just the payers and become involved in responding to their area's medical needs.

Currently, financial support for NHI and the medical system for the elderly come from both national and local governments, as mentioned earlier. In the current system, it is the insurers that receive reductions or exemptions. However, it is the individuals with low incomes who receive such subsidies. In other words, the government should stop subsidizing the budgets of insurers and instead subsidize and reimburse individuals with low incomes.

Issues Related to Health Care Statistics

The Japanese health care system is often considered to be efficient since the Japanese enjoy longevity and the country has a relatively low health care expenditure among OECD countries. However, it is important to note that Japan's total health care expenditure is underestimated, since the "national health care expenditure" published by its Ministry of Health, Labor, and Welfare (MHLW) is an estimate only of the expenditure under Japan's public medical insurance system and the scope of the estimate is limited to treatment costs for injuries and diseases. The figure is essentially an estimate only of the health care expenses covered by public insurance. Items normally included in the medical costs of other countries are not included in Japan's figures. Such excluded costs include those associated with normal pregnancies and birth, noninsured dentistry, health checkups, vaccinations, and other procedures aimed at maintaining and promoting health. They also include excess room charges when hospitalized, elective therapy charges, the costs related to nonprescription drugs (over-the-counter medicines), administrative costs for operating medical insurance, capital costs of local-government-run hospitals, and transfers from the general accounts of local governments to local-government-run hospitals.

While the current estimate of national health care expenditure may be adequate as an explanation of the range of activities under the jurisdiction of the MHLW, it is wholly inadequate for gaining a clear understanding of the use of health care services by Japanese citizens. This is particularly important when we compare health sector expenditures internationally. Every year, OECD reports

the health expenditure for each member country using its System of Health Accounts. However, because of the unavailability of the data as described above, Japanese health care expenditures are underestimated.

For example, in 2007, the national health expenditure reported by the Ministry of Health, Labor, and Welfare was ¥34.1 trillion, whereas Japan's total health care expenditure as reported by OECD was ¥41.9 trillion.[3] According to the Japanese national accounts, in 2007 economic activities in the health sector amounted to ¥47.1 trillion. This number is the sum within the health sector of the general government's final consumption expenditure (¥35.3 trillion) and households' final consumption expenditure (¥11.9 trillion).[4] With this simple calculation, it is clear that Japan's national health care expenditure is underestimated by approximately one-third.

It is important that health care policy be based on a solid understanding of the current reality. However, it is hard to claim that health care policies to date have been formulated and implemented on the basis of solid, readily acceptable evidence. To get beyond the current situation it is vital for the Japanese government to take responsibility in conducting statistical studies and publicly disclosing the resulting data.

CONCLUSION

Fifty years have passed since universal insurance was implemented in Japan and, in light of the current institutional fatigue, today's Japanese health insurance system needs drastic reform. Changing and enhancing the role of the insurer would be a core task in such a reform.

One of the major issues that Japan's health care system is facing is how to contain the escalating medical costs for the elderly. Health care for the elderly has received substantial subsidies from both central and local governments and transfers from other insurers. Government subsidies finance about 50 percent, and contributions from NHI and employees' health insurance finance about 40 percent.

In Japan, with the free-access system, many patients with primary care problems tend to rush into secondary/tertiary care hospitals. This has interfered with the function of these hospitals too much, and it has contributed to the increasing medical costs, particularly for the elderly. What the Japanese health care system needs in this aging era is good collaboration between specialists in the hospitals and community-based primary care physicians. Japan does not have sound systems of primary care provided by well-trained family doctors. Such countries as Canada, Australia, the United Kingdom, the Netherlands, Singapore, and Malaysia have strong systems for training family doctors as key players to

[3]Total health expenditure is estimated using OECD's System of Health Accounts by the Institute for Health Economics and Policy.

[4]It does not include the fixed capital formation for the health sector, since figures on this are not available.

provide continuous, comprehensive, person-centered care in the community (WHO, 2008). An efficient primary care system is important for any country in any stage of development, since primary care usually covers more than 80 percent of health and medical problems.

Another critical challenge for Japanese health care is to create a sustainable financing mechanism for the elderly. In 1983, the central government established elderly insurance, a common fund for elderly medical care that transferred the cost burden from poorer community health insurance to corporation-based workers' insurance through pooled contributions from all the insurance schemes and tax revenues. In 2008, the Japanese government introduced the medical system for the elderly age 75 and over. However, the basic financing structure remains the same. The rapid aging of the population is a major challenge in the sustainability of this financing system.

Other challenges for the Japanese health care system include the need to introduce economic incentives to ensure quality and to improve efficiencies, particularly in primary care systems, based on a solid database and with an adequate payment system. Japanese health care relies too heavily on hospital care. Health care reforms have been focusing on hospital reforms with the aim of controlling hospital costs, but without introducing an efficient primary care system, it will not be possible to maintain the country's health care system given its rapidly aging population.

APPENDIX 11.1. BRIEF HISTORY OF THE JAPANESE HEALTH INSURANCE SYSTEM

The Japanese health insurance system started in the early 1900s when mutual aid associations began to form at both private and government factories and mines. As the first legislation for the protection of workers in Japan, the Factories Act was enacted in 1911. Japan introduced a social insurance type of health insurance in 1922, making reference to the Bismarckian model of German sickness funds. However, this insurance was applicable only to workers in the manufacturing and mining industry at factories or mines with 15 or more employees. Workers at small-scale factories, government officials, bank employees, and some others were not covered.

In rural villages in Japan, organizations resembling health insurance cooperatives had existed as mutual-aid organizations since the Meiji era. The government introduced the National Health Insurance Law[5] in 1938 to expand it into a national system to cover several tens of millions, mostly farmers, who

[5]The municipalities formed the National Health Insurance Associations and became the insurers, or in other words, the chief operator of the system. One of the reasons why a municipality-based association was adopted was that many people in rural areas already had a sense of community through irrigation and rice farming activities in each village, and therefore strong social bonds and mutual assistance already existed. Many rural areas traditionally had mutual financing associations as well, and the National Health Insurance system reflected these social realities (Shimazaki, 2005).

were then about 60 percent of the total population. The National Health Insurance Law was developed and implemented without difficulty because of the enactment of the National Mobilization Law in the same year and the wartime "Healthy Soldier Healthy People" provision. The National Mobilization Law allowed the government to direct orders for the mobilization of labor power, determine wages and other working conditions, and give directives on the production and distribution of goods. Under this law, all resources and materials came under government control (Nakamura, 1995).

In 1939, employees' health insurance was inaugurated, covering salaried workers in the cities. By the end of 1943, the National Health Insurance system already covered 95 percent of the municipalities throughout Japan. This period was considered to be the first universal health insurance era. Although some of the municipal associations were created for number-crunching purposes and the reality was far from universal coverage, a basic framework for the current health insurance system in Japan—such as the fee-for-service system without a ceiling on the maximum total service fee and the medical fee under a national uniform schedule—was established during the Second World War, a period when the government was given a great amount of power over the operation of the system.

With the exception of pension schemes for the farming sector population and the self-employed, a social insurance system that covered almost all citizens was completed during this war period. Although most of the social insurance systems were on the verge of breaking down toward the end of the war, these systems survived and were reconstructed even while many of the prewar institutions and laws were being abolished. In sum, Japan's social insurance systems were a legacy created and fostered by recessions and wars during the early twentieth century.

One of the major changes that took place immediately after the war was that the National Health Insurance Law was amended to ensure that municipalities took responsibility for administering NHI, with the aim of promoting NHI programs across the country. Since the work required to implement this law was similar to the municipalities' routine tasks, municipalities took over the administration of NHI, in principle.

Because there were individuals with low incomes who could not pay the premiums, to make insurance universal the government has subsidized insurers. In this scheme, insurers receive reductions or exemptions.[6] An amendment to the Local Tax Law in 1951 created the National Health Insurance Tax, and the method of collecting NHI premiums then became the same as that of municipal taxes. The purpose was to increase the collection rate, and as about 90 percent of the municipalities still choose the National Health Insurance Tax as the method of collection, people tend not to think of NHI as an insurance system.

In the mid-1950s, about one-third of the Japanese population that engaged in agriculture and other self-owned businesses was not covered by health insurance.

[6]As discussed in this chapter, instead of having insurers receive reductions or exemptions, the government should subsidize those individuals with low incomes directly, allowing them to pay lower insurance premiums or nothing at all.

Uninsured people then numbered approximately 30 million, of which 10 million were low-income earners who had no choice but to go on social welfare once they became ill.

In 1953, the government finally introduced subsidies equivalent to 20 percent of medical care benefits. This established the financial base of health insurance and laid the foundation for universal insurance. A new National Health Insurance Law was enacted in December 1958, going into effect in 1959, and was enforced all over the country in 1961. The National Pension Law was also enacted in 1959. Universal health insurance and pension schemes were thus achieved in April 1961.

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