Social Health Insurance as a Health Safety Net : Comments on Analyses of Health Care in Japan and the United States

James Warner BJÖRKMAN [i]

Compliments are due to Kazuo Takayama (2015) for his coherent summary of the US health 'non-system' that is often described as a "patchwork on a patchwork" and to Chiharu Hasegawa (2015) for her succinct summary of Japan's system of social insurance and its complicated mechanisms for financing health care. As a preface to comments about their insightful analyses, let me share two short stories.

The first is a fable from the ***Panchatantra*** – a compilation of tales about animals in the South Asian subcontinent, originally written in Sanskrit about 3,000 years ago, that became the basis for folk tales by the Greek slave Aesop and by the German Brothers Grimm. The story is entitled **"Six Blind Men & an Elephant"** in which (as many already know) each blind man describes the elephant differently depending on what he touches: its side is a wall, its trunk is a snake, its tusk is a spear, its leg is a tree, its ear is a fan, and its tail is a rope. According to John Godfrey Saxe's clever 19th century poem:

It was six men of Hindustan
To Learning much inclined,
Who went to see the Elephant
(Though all of them were blind),
That each by observation,
Might satisfy his mind.

The moral is, of course, that we each describe things according to what we perceive as well as what we value – and that we are each limited in our understanding of the total subject matter.

The other story is much shorter: an observation by Allen Schick, one of my mentors decades ago, who regularly said: **'Budgeting is the art of letting someone else pay for your benefits'**. Its corollary is that the more complicated the system of finance, the less likely someone will notice that his or her pocket is being picked! Therefore, whenever someone claims that a financial arrangement is a "win-win" situation, it's time to look at the fine print for details.

Before commenting on each paper, let me outline my own viewpoints so that you understand (as they say) where I'm coming from. The first is a simple triad of goals in any system of health care or (more accurately) of medical care … since rarely do we talk about 'health' or wellbeing per se. The triad is: **Access, Cost, Quality** – and each element impacts on the other two. The triad aims are to obtain greater access to health/medical services, at lower cost, and higher quality.

i Professor Emeritus, Institute of Social Studies, the Hague, the Netherlands

However, when one seeks greater access, costs rise and/or quality declines … even if one dimension is held constant. If one seeks lower cost, then either access or quality must diminish – perhaps both. And higher quality can be obtained either by higher (not lower) costs or by restricting access. Greater efficiency may, of course, allow all of those goals to be improved – but there is a limit to the potential miracles wrought by efficiency.

There is a second triad of actors rather than goals; it includes **Payers, Providers & Patients** and entails looking at the same issues from a different perspective. Sources of **payers** include one's own cost (out-of-pocket), governments (through taxes) and insurance (through premiums). In addition to increasing 'own cost', taxes can be raised (earmarked taxes or general taxes), insurance premiums can be raised, and deductibles (co-payments) can be required. None of these options is popular. Once again, the question is: who should pay for services … yours or those of others.

Providers include the usual categories: professionals & institutions. Professionals are doctors, nurses, technicians, the whole set of skilled persons who supply health care or medical services. And it should be understood that care comes in a variety of forms – acute or immediate care; long term care for convalescence; long term care for those with chronic diseases and disabilities as well as the elderly; rehabilitative care; and finally custodial care at the end-of-life or mental issues or no likelihood of improvement.

Institutions are hospitals, clinics, nursing homes and any location where health services are provided. Institutions require managers/administrators/bureaucrats – the term chosen indicates your implicit bias. In current usage, managers denote a label with high affect (that is to say, people admire them), administrators have neutral affect (people tolerate them), and bureaucrats have a negative connotation (people dislike them).

The same can be said about political actors: if you dislike them, they are politicians; if you regard them as neutral, they are leaders; if you like them, they are statesmen … or statespersons, to be political correct in terms of gender.

These "affect loaded" observations remind me of a useful insight by Robert Redfield, an eminent anthropologist at the University of Chicago during the first half of the 20th century. Redfield said that **the most important thing to know about people is what they take for granted**! We all carry all sorts of unspoken, unarticulated, often unconscious, views that need to be teased out and clarified.

The behavior (activities) of **providers** can be guided through the regulation of their wages – through the price of their services. Japan is fascinating in that physicians' fees for office visits and examinations are low because the government sets these fees. Whatever their seniority or geographic locale, all Japanese doctors are paid the same amount for the same procedures. Changes in medical fees are negotiated by the Central Social Medical Care Council in the Ministry of Health & Welfare although, given budgetary limits, the Ministry of Finance makes the final decisions about fees (Cockerham and Cockerham 2010: 94) .

Patients are the recipients of health care and of medical services. Broadly speaking, they include all

people – all citizens – who are potential patients in the future or who have been in the past. The cost of services to patients can be controlled by limiting the basic package to which they are entitled; benefits can be reduced or increased according to the resources available. In January 2015 the ***Japan Times*** reported that the Abe Administration has proposed to overhaul the National Health Insurance system by (a) shifting responsibility for payment from municipalities to prefectures; (b) by introducing NHI (*Kokuho*) for those without either corporate or civil service public health insurance; and (c) by phasing out the special discounts on NHI premiums for people aged 75 and older. Unfortunately, despite my suggestions to the authors, neither paper mentions these options.

Having described two 'triads' that inform my own analyses of the health sector, two other major **dimensions** need to be comprehended before any system (or non-system) of health care can be understood. The first dimension concerns available resources – which relies on the rate of economic growth and the taxes can be levied; it also involves the structure of government debt – past, present & future. The second dimension concerns the demographic structure of a population. What is the size of a population, its actual numbers? What is the composition of its age brackets – how many dependents (both young & old) versus those producing goods, services & taxes? What are the changes over time? In brief, we need a strong understanding of actuarial probabilities in order to comprehend any health system or non-system.

Turning to the contributions themselves, **Chiharu Hasegawa** provides a trenchant analysis of Japan's public health insurance system. Her paper on "The safety net for healthcare in Japan is fraying: Employment, health insurance and public assistance" describes Japan's "twin pillars" of employment-based and area-based health insurance and the fascinating history of their development. It is important to note that insured patients in Japan pay 30% of their medical costs with, of course, a diminishing amount based on age – a situation that is evidently due to change in the near future. Despite almost excessive detail, Hasegawa is to be complimented for her thorough exposition. After presenting a dizzying array of data, she concludes that insurance pays about half (49%) of health expenditures in Japan, public expenditure is about two-fifths (39%) and copayments by patients are just over one-tenth (12%).

A major issue is the imbalance between the two pillars because, after retirement, those formerly enrolled in employment-based health insurance move to area-based health insurance and the elderly with their additional medical costs are unevenly distributed. Therefore, despite financial adjustment reforms introduced in 2006, local governments bear the major burden of Japanese aged 64–75. There is a clear empirical basis for the "frayed" safety net in Japan.

Interestingly the percentage of 'regular' employees has declined during the past two decades from 85% to 63% while non-traditional employees (less than full-time) now comprise over one-third (37%) of the workforce. While the problem has been recognized by the formation in 2002 of a "Health Insurance Society for Temporary Workers" (*Haken-Kempo*), it has not been resolved.

A larger issue is the loss of employment-based insurance cause by unemployment. Workers who lose their jobs also lose their employment-based health insurance, and it is not evident who covers the unemployed. Given the increasing rate of jobless Japanese, the problem is becoming acute. Furthermore, as section 3:2 on 'Loss of employment-based health insurance through unemployment' observes, "because

premiums for NHI are rising, even those covered by NHI are in danger of becoming uninsured through inability to pay premiums". Without wishing to sound overly dramatic, perhaps Japan's health finances are about to experience the proverbial 'House of Cards'.

For me, the nub of Hasegawa's analysis appears in section 3:3 on 'Uninsured risk for HNI':

"Since people are covered by National Health Insurance when they cannot receive employer-based health insurance, the Japanese government's public stance is 'The uninsured cannot exist in Japan'. However, since NHI is a social insurance system, 'the burden of premium payment and benefit' is applied. If the uninsured cannot pay premiums for an extended time, their health insurance ceases and they could virtually become 'uninsured'."

Nonpayment of premiums has increased since 1990; in 2013 18% of all NHI households failed to pay premiums – largely because the ratio of premiums to income is rising and the burden is excessive for those with low-incomes. "The social aid system is leaving behind a substantial number of impoverished uninsured who cannot pay premiums for an extended period". The number of households receiving public assistance has more than doubled since 1996.

As a bottom-line: in Japan the safety net of National Health Insurance is breaking down because its high premiums mean that more Japanese are becoming uninsured.

Kazuo Takayama's paper on "Health Insurance and the Health Safety Net: The Affordable Care Act and its Effects on the Safety Net Providers in the United States" is particularly fascinating because, although I have lived for more than a quarter-century in the Netherlands, I remain an American citizen – with the 'privilege' of currently paying taxes in three countries: Holland, Japan & the USA.

The strength of Takayama's account is not the shameful fact that over 13% of US citizens lack health insurance (a situation that is, as he says, better than five years ago) but his description of "underinsured" people who lack insurance coverage for needed services. It is easy enough to observe that the US lacks a national insurance system for health services; it is equally easy to observe that the US lacks a 'system' altogether – being a patchwork on a patchwork (as previously mentioned). But, to paraphrase Charles Dickens' in ***A Tale of Two Cities***, health care in the United States is the best of worlds and the worst of worlds. If you have wherewithal (that is to say, money), then the world's best medical care is available; if you lack money, then you may as well live in the Third World because you cannot afford medical care except of the lowest quality – and then only if access is available through a public hospital … and public hospitals have been declining in numbers for decades.

Takayama introduces the role of Safety Net Providers (SNPs) – a term that I had not previously encountered – comprised basically of hospitals financed by state and local governments. While he lauds many features of the recent Patient Protection and Affordable Care Act (ACA), also known as 'Obama Care', he notes the limitations of ACA for the uninsured, for the indigent, and for those without US citizenship. His paper provides background on the socio-economic characteristics of the uninsured as well as details about government programs like Medicare and Medicaid (both now a half-century old) but lacks attention to the financial dimension in terms of how the new law is financed. He underestimates the power of institutional providers whereby hospital administrators easily drive up costs because of their bargaining power over

insurers and patients (Teachout 2015).

In the final section of his paper, Takayama hazards a guess about possible policy implications of ACA for Japan and other advanced (presumably OECD) countries. In particular he admired the concept of a 'health insurance exchange' that can regulate insurance companies that provide supplemental or complementary coverage. I am not convinced but, as they say, the "jury is still out".

The concept of Accountable Care Organizations (ACO) is even less persuasive; it is, in my opinion, only the relabeling of an old-fashioned charity organization. Whether the US provides any credible services for its immigrant population – including its 'illegal' immigrants – seems unrealistic. But, as they say, 'hope springs eternal' since Pandora opened her dread box.

In summary, I compliment both scholars for excellent papers that provide 'grist for the mill' in terms of discussion. They are well worth reading and well worth further analysis.

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