Medical Care through Social Insurance in the Japanese Rural Sector

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THE IMPORTANCE of extending social security to all segments of the population and especially to the often less favoured rural sector has been repeatedly stressed [2] and has recently been the subject of a number of studies.[3] The present article attempts to examine and analyse the Japanese approach to the provision of medical care for the rural population through social insurance. It begins with a brief look at the difficulties experienced by rural dwellers in securing adequate medical care prior to the Second World War, and goes on to examine the early efforts made by the rural people themselves to remedy this situation by constituting co-operative societies and mutual aid organisations. These efforts paved the way for the eventual introduction by the Government of the national health insurance scheme, whose eventful evolution over the past 35 years forms the subject of the third and major section of the article.

The background

During the late 1920s and the early 1930s the rural population in Japan suffered the double disadvantage of a gross maldistribution of medical personnel and facilities and the high cost of such medical care as was available.

During the period 1928-36 the total number of physicians grew from 43,273 to 53,376; but whereas those working in the urban sector increased

[1] International Labour Office.

[2] See in particular *Official Bulletin* (Geneva, ILO), 1969, No. 1, pp. 64-68, and 1971, No. 3, pp. 267-268.

[3] For example, ILO: *Social security in agriculture and rural areas*, by Robert Savy, Studies and Reports, New Series, No. 78 (Geneva, 1972), and Lucila Leal de Araujo: " Extension of social security to rural workers in Mexico " and T. I. Mathew: " Social security for the rural population: a study of some social services in selected rural areas of India ", in *International Labour Review*, Oct. 1973.

from 16,440 to 30,878, those in rural areas declined from 26,833 to 22,498. The number of rural towns and villages without any physicians increased from 1,960 in 1923 to 3,243 in 1936, representing 33 per cent of all towns and villages at that time. In May 1936 the ratio of physicians per 10,000 population was 13.62 in cities and only 3.59 in villages.[1]

As a result of the nation-wide depression, the index of agricultural household income in Japan fell from 100 in 1924 to 58 in 1930. According to a survey carried out by the Ministry of Agriculture and Forestry, the average debt in agricultural households was 837 yen in 1932, at a time when the average daily earnings of factory workers were 2 yen. A survey conducted in the Niigata prefecture in the same year indicated that some 9 to 15 per cent of such debts were attributable to medical expenditures; a similar survey in 1933 in the Ehime prefecture revealed that the corresponding figure ranged from 5 to 14 per cent.[2]

One of the major factors contributing to the maldistribution of medical facilities, both geographical and social, was no doubt the traditional system of *kaigyô-i*, under which the great majority of hospitals and clinics are owned and managed by medical practitioners and run as profit-making concerns.[3] Since, in Japan, no clear functional distinction is made between general practitioners and specialists, the cost of opening even a modest private clinic is high because it must be fitted out with the minimum of equipment needed to cope with a fairly comprehensive range of medical treatment. Obviously, therefore, the depressed rural sector became less and less attractive to physicians, especially since the capital sums they had to invest tended to increase as medical science and technology progressed.

Participation by the public authorities in the extension of medical facilities to the rural sector was very limited prior to the Second World War. Indeed, one of the salient features of the Japanese system of providing medical care was (and indeed still is) the predominant role played by the private sector. Even the public hospitals were required to be self-supporting, so that their services were too highly priced for the poorer sections of the population.

In addition there were of course other factors that contributed to the unbalanced distribution of medical facilities. These included the financial difficulties experienced by local government authorities as a result of the general poverty of the rural population, the migration of able-

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[1] The rural areas comprise *machi* or *chô* (towns) and *mura* (villages). See Akira Sugawara: " Nihon Iryô Seido-shi " [History of the medical care system in Japan], in *Shûkan Shakai Hoshô* [Social Security Weekly] (Tokyo), 22 Jan. 1973, pp. 20-21.

[2] *Kokumin Kenkô Hoken Shôshi* [Short history of national health insurance] (Tokyo, Kokumin Kenkô Hoken Kyôkai, 1948), p. 10.

[3] At the end of 1971, 60,767 doctors (51 per cent of the national total) were working in their own hospitals or clinics. Medical facilities having 20 beds or more are defined as hospitals, smaller ones as clinics.

bodied persons from rural to urban areas, and the development of transportation facilities which enabled some people in the rural sector, particularly the better-off, to seek medical treatment in nearby cities.

The combined influence of these factors on the availability of medical care, both geographically and financially, led to a serious deterioration of health among the rural people, who had never had access to proper health and sanitary services. In order to break the vicious circle in which poverty gave rise to sickness and sickness to poverty it was necessary to ensure a proper distribution of medical facilities and to find some means of reducing the financial burden of medical care on rural households. At the same time measures had to be taken to liquidate the latter's debts, to liberalise the credit policies applicable to their agricultural operations and to institute public relief works to supplement their cash incomes.

The forerunners of social insurance

Long before the first social insurance scheme providing medical care to the rural population was introduced in Japan, certain spontaneous efforts had been made to set up medical facilities or to organise associations providing medical care at reasonable cost. These efforts, made by the rural people themselves without any governmental intervention, are worth examining briefly, since to some extent they paved the way for the eventual application of social insurance in the rural sector.

Co-operative societies

It was through the co-operative movement that the rural people in Japan made their earliest attempts to provide medical care facilities where none were readily available. In 1919 an agricultural co-operative in the Shimane prefecture with a membership of about 550 persons set up its own medical facility and invited doctors to provide treatment there.[1] By 1928 its example had been followed by some 15 other co-operatives. The primary objective of these agricultural societies in the early stages was generally to have their own medical service, rather than to ensure medical care at a cost their members could afford. Many of them soon went out of business, their failure being attributable to the small scale of their operations, their lack of managerial know-how and, above all, the difficulty they encountered in employing doctors on a permanent basis. Their efforts, being directed only at improving the distribution of medical facilities, were hardly compatible with the *laissez-faire* principle of free-market medical care.[2]

[1] No data are available about an agricultural co-operative society which is reported to have instituted medical services for its members in 1913.

[2] Takashi Saguchi: *Iryô no Shakaika* [The socialisation of medical care] (Tokyo, Keisô Shobô, 1964), pp. 66-67.

In 1928, however, an agricultural co-operative was organised in the Aomori prefecture (one of the poorest agricultural regions of the country) exclusively for the purpose of securing medical care for its members—and over a wider geographical area than anything attempted hitherto.[1] The modest-sized clinic, first set up with a staff of 12 (including two doctors, a pharmacist and three nurses, together with other supporting personnel), faced the same difficulties as its predecessors. Realising that their objectives could not be attained in this way, the founders of the society decided to build a full-scale hospital with 60 beds, comprising various departments. This was completed in 1930, and in spite of initial financial difficulties membership of the co-operative increased from 562 in 1928 to 3,228 in 1932. The society succeeded in eliminating the commercial elements that were unavoidable as long as the provision of medical care was dependent on the *kaigyô-i* system, and its successful example was rapidly followed by a large number of other co-operatives. In this way, by the end of 1936 a total of 738 co-operative societies were providing medical services to 502,122 members; they had 2,791 beds and employed a total of 461 physicians. Four years later it was reported that co-operative societies throughout the country were providing medical care for 1,072,452 households; their facilities included 89 hospitals and 137 clinics and their medical staff totalled 3,895 (including 520 doctors and 1,224 nurses and midwives).[2] Most of these co-operatives were organised in the more backward parts of the countryside which suffered from chronic poverty and famine, rather than in the prosperous rural areas or in agricultural villages near large cities.

Primitive forms of social insurance

The problem tackled by the co-operatives described above was mainly that of providing medical facilities in areas where the medical profession, inspired as it was by the profit motive, had little or no incentive to do so. The second problem that had to be tackled was to provide medical care at a price within the very limited means of the rural population. Its solution was found in two different but related ways, the one directed towards reducing the cost of medical care by setting up medical facilities owned by the rural population itself, and the other towards pooling financial resources and spreading the risk among the people concerned.

The co-operative facilities described above were a successful example of the first approach. However, once a certain level of development had been attained, particularly as the movement became more involved in the management of its medical facilities, it became necessary to institute a system of prepayment in order to pool the financial resources of its members.

[1] Japanese co-operatives were usually organised at the city, town or village level.

[2] *Nihon Nômin Iryô Undôshi* [History of peasant medical care movements in Japan] (Tokyo, Zenkoku Kôsei Nôgyô Kyôdôkumiai Rengôkai, 1968), Part I, pp. 224 and 293-294.

Even before the co-operative movement launched itself into the provision of medical care, however, a primitive system of insurance for medical care existed in some Japanese villages. A survey carried out by the Ministry of the Interior in 1934 in two prefectures of Kyûshû Island revealed that mutual aid organisations for medical care had long existed at the village level. The size of these organisations varied widely, the largest covering 330 households and the smallest only 18. There were an average of 118 households in each of the 22 organisations covered by the survey, some of which had been in existence for more than 100 years. The organisations usually contracted with doctors to care for their members at a predetermined annual remuneration. Some of them required their members to bear part of the cost. In many cases contributions were paid once or twice yearly, wholly in kind (usually in rice) or partly in cash, either at a flat rate or according to household income, or by a combination of the two. Some organisations required their members to make good any deficit in proportion to the medical treatment they had received.

These mutual aid organisations had in many cases been set up by community leaders in order to ensure a living to doctors who would otherwise have left the community, but also to secure medical treatment at a cost that could be borne by the pooled financial resources of their members. While their objectives were therefore similar to those of the co-operative movement, the mutual aid organisations were not a reaction against the *kaigyô-i* system, which they readily accepted as it stood.[1] In short, whereas the co-operative movement attempted to reorganise the *supply* of medical care, the village mutual aid bodies tried to organise the *demand* for medical care. In the course of development, however, the two movements merged in some cases in order to run the co-operative medical facilities on mutual aid (insurance) lines.

For its part, the Government was also seriously concerned with the deteriorating health standards and poverty of the rural people. A compulsory health insurance scheme for industrial workers in urban areas had been in operation since 1927 under legislation adopted in 1922.[2] In order to examine the possibility of extending similar social protection to the rural population, the Ministry of the Interior undertook a programme of research, starting in 1933, and came to the conclusion that the essential problem was to reduce the financial burden of medical care and that the method adopted by the rural people themselves would provide the solution. The Government was convinced at that time that the scheme should be a voluntary one based on the traditional spirit of mutual aid and

[1] In this respect they foreshadowed the structural organisation of the national health insurance scheme, which will be discussed below.

[2] For a discussion of the original law, see " The new Japanese Act on health insurance ", in *International Labour Review*, Dec. 1926, pp. 861-871, and for its recent development, ibid., Oct. 1961, pp. 296-298, and Jan. 1964, p. 86; and *Outline of social insurance in Japan (1972)* (Tokyo, Social Insurance Agency, 1972), pp. 13-25.

self-support, and should be administered by local autonomous bodies, in accordance with the provisions of Article 6 of the ILO Sickness Insurance (Agriculture) Convention, 1927.[1] Such were the origins of the national health insurance scheme, which was to be instituted by the National Health Insurance Act of 1938.

National health insurance

In his comprehensive study of national health insurance in Japan [2], George F. Rohrlich discussed in detail the efforts made by the Japanese Government to provide medical care to the rural population through social insurance under the national health insurance scheme, the original organisational structure, administration and financing of the scheme, its experience in the first ten years of operation (from 1938 to 1948) and the results it achieved. Rather than go over the same ground again, I shall attempt here to bring out the salient features of the Japanese approach to the application of social insurance in the rural sector.

Coverage

It was estimated that in 1930 there were about 14 million persons engaged in agricultural production in Japan, representing about 47.5 per cent of the total labour force; only 520,000 (about 3.7 per cent of the agricultural labour force) were employees, the remainder being self-employed or family workers.[3] This precluded the use of social insurance techniques designed for employed workers on the basis of their place of work. Social insurance for the rural population had to be organised on the basis of the family or household. Moreover, since rural society in Japan is characterised by its organisation at the level of the village, which constitutes not only a community but also (together with towns and cities) a unit of local public administration, it was the village that was chosen as the unit for implementation of the scheme.

Initially the scheme was operated by " national health insurance associations " voluntarily organised by groups of interested persons in each rural community. There were basically two different types of association acting as insurance carriers under the scheme. The first, called an " ordinary association ", was organised at the lowest level of local administration by the residents in the area concerned; once such an association covered more than two-thirds of eligible residents, the prefec-

[1] See *Short history of national health insurance*, op. cit., p. 140. Article 6 provides that: " Sickness insurance shall be administered by self-governing institutions which shall be under the administrative and financial supervision of the competent public authority. . . . "

[2] George F. Rohrlich: " National health insurance in Japan ", in *International Labour Review*, Apr. 1950, pp. 337-366.

[3] *Wagakuni Kanzen-Koyô no Igi to Taisaku* [The importance and promotion of full employment in Japan], Part IV: Statistics (Tokyo, Shiseidô, 1960), p. 40.

TABLE 1. EVOLUTION OF THE NATIONAL HEALTH INSURANCE SCHEME, 1938-72

Year [1]	Insurance carriers	Insured persons	Average number of insured persons per carrier
1938	174	523 223	3 007
1940	937	3 045 046	3 250
1942	6 596	22 661 192	3 436
1944	10 474	41 161 301	3 930
1946 [2]	9 526	41 820 949	4 390
1948 [2]	5 446	25 826 890	4 742
1950	5 050	24 353 974	4 823
1952	5 008	23 088 674	4 610
1954	3 669	26 633 438	7 259
1956	2 870	30 582 065	10 656
1958	3 167	37 238 964	11 758
1960	3 599	46 171 092	12 829
1962	3 618	45 792 064	12 657
1964	3 564	43 605 021	12 235
1966	3 495	42 876 448	12 268
1968	3 458	42 637 870	12 330
1970	3 468	43 363 252	12 504
1972 [3]	3 440	43 811 825	12 736

[1] As of 31 March of the year following that indicated. [2] As of 31 December of the year indicated. [3] As of August 1972.

Sources: Compiled from *Kokumin Kenkô Hoken Nijûnen-shi* [Twenty-year history of national health insurance] (Tokyo, Kokumin Kenkô Hoken Dantai Chûôkai, 1958), p. 581; *Shakai Hoshô Tokei Nempô* [Yearbook of social security statistics] (Tokyo, Secretariat of the Social Security Advisory Council, Prime Minister's Office), various years; and *Kokumin Kenkô Hoken Jigyô Geppô* [Monthly report on national health insurance] (Tokyo, Social Insurance Bureau, Ministry of Health and Welfare), Aug. 1972.

tural governor could order all other residents to join it. The second, called a " special association ", was organised by members of the same trade or business, for example lawyers, doctors, barbers or grocers. In addition, the original law allowed existing co-operative societies providing medical care to act as insurance carriers (" substitute associations "). All the members of a household that joined an association automatically became insured, with the exception of those covered by the employees' health insurance scheme of 1922 or by a special association on account of their trade or business.

Over the past 35 years the principles regarding coverage and insurance carriers under the national health insurance scheme have been considerably modified. Table 1 shows the trends in numbers of insurance carriers, insured persons and average numbers of insured persons per insurance carrier from 1938 to 1972. The remarkable increase in the numbers of insurance carriers and insured persons in the first six years of operation was due to substantial changes in the principles on which the original scheme was based. The principle of voluntary organisation was abandoned by

amendments adopted as part of wartime policy in 1942, when the scheme became compulsorily applicable, by prefectural governor's order, to areas not already covered.[1] The sudden decrease in the numbers both of insurance carriers and of insured persons in 1948 suggests that a large number of associations were affected by the disruption of social and economic life in the early postwar years, and that many associations artificially created after the 1942 amendments were too weak to survive the trial. A survey carried out by the Ministry of Health and Welfare shortly after the war estimated that 40 to 45 per cent of the insurance carriers had suspended active operations [2], and that the surviving carriers were having to face serious financial and administrative difficulties. In particular, all the purveyors of medical care who had been ordered to provide benefits under the scheme during the war decided to withdraw from it in October 1946. The scheme had to be reconstructed, and this was achieved both by government action and by popular initiative, which will be discussed in greater detail below.

The authoritarian elements introduced into the scheme during the war were eliminated in 1948, when primary responsibility for its implementation was transferred from the ordinary associations to local assemblies at city, town or village level, and its extension to all eligible residents was made optional. Where a city, town or village did not implement the scheme, an ordinary national health insurance association could be organised on the initiative of eligible residents as under the original law, subject to the agreement of more than one-half of them; once an association was established, all eligible residents were required to become members. Special associations of persons in the same trade or business, or non profit-making organisations with legal personality, could act as insurance carriers for the scheme only if a locality or group of localities did not implement it. The above change is therefore regarded as " a happy compromise between the completely voluntary and the conditionally compulsory features of local option ".[3] The 1948 amendments also made it possible for two or more local communities to operate the scheme jointly, with a view to spreading the risk more widely. The change in policy regarding implementation is reflected in the drop in the numbers of insurance carriers and insured persons noted in 1948 and after. The sudden increase in the average number of insured persons per carrier from 1954 onwards may be explained by the enactment in 1953 of legislation encouraging mergers of towns and villages in the interests of general administrative efficiency; this helped to reduce still further the number of insurance carriers and to enlarge the basic unit of operation.

[1] The amendments also allowed any kind of co-operative society to act as insurance carriers, whereas previously only those providing medical care had been included in the scheme.

[2] *Twenty-year history of national health insurance*, op. cit., p. 261.

[3] Rohrlich, op. cit., p. 358.

The latest and perhaps most important change affecting the application of the scheme was brought about by legislation adopted in December 1958 and made operative as from 1 January 1959.[1] Under this Act, which replaced the original legislation of 1938, all local authorities in cities, towns and villages were required to take steps to have the scheme in operation and to set up the prescribed national health insurance funds by 1 April 1961. This drastic change, which made the scheme compulsorily applicable to residents not otherwise covered, was aimed at achieving the nation-wide coverage in respect of medical care recommended by the Social Security Advisory Council in 1956. Under the new legislation only local governments and special associations of persons in the same trade or business are regarded as insurance carriers.[2] The effect of these changes is to be seen in the remarkable increase in the number of insured persons in 1959 and subsequent years.

To sum up then, the original scheme, which was to have been extended gradually under the active guidance of the public authorities as people became aware of the need for it, was very adversely affected by its hasty and mandatory wartime expansion and had to be painstakingly reconstructed before it could be effectively applied to all citizens. Moreover, in the process of extending the scope of the scheme, operational responsibility has been transferred from the ordinary or substitute national health insurance associations to local governments (the position of special associations remains unchanged).

The associations, notably co-operative societies, which in the past contributed to the development of the scheme through popular initiative and support, particularly in respect of medical care, no longer play any part as insurance carriers. The effects of this change will be discussed later in connection with the level of protection afforded by the scheme.

Finally, in considering the way the scheme has evolved, one should not overlook the fact that while it was originally introduced to protect the rural population, who had the greatest difficulties in obtaining proper medical treatment, it was also designed to protect persons in urban areas who were not covered for medical care by any social insurance scheme. Self-employed persons and employees in smaller establishments and their dependants in urban areas were equally in need of protection in case of sickness or injury.[3] Until 1950, however, no substantial progress was made in implementing the scheme in the larger cities, and its extension to all

[1] For this legislation, which is still in force, see *Industry and Labour* (Geneva, ILO), 1 Mar. 1960, pp. 174-177.

[2] The term " special associations " is replaced by " associations " in the 1958 Act.

[3] The health insurance scheme for employees, which is one of the major schemes in Japan, compulsorily covers only establishments having five or more employees in the private sector. For a general description of medical care insurance schemes for different categories of workers, including the national health insurance scheme, see " Social security policy in Japan ", in *International Labour Review*, Oct. 1961, pp. 292-301.

urban areas had to await adoption of the 1958 Act. While this may be to some extent attributable to lack of interest on the part of city administrations, it is also true that in large cities it was very difficult for insurance carriers—lacking the facilities usually available in the case of the various employees' schemes—to register insured persons and collect contributions from them or to stimulate popular interest in and support for the scheme among persons who were scattered all over a large locality. In rural areas, on the other hand, these tasks were simplified not only by the ease of identification of persons to be protected but also by the existence of organisations, such as housewives' clubs, youth associations, etc., which could be mobilised to popularise and implement the scheme.

Benefits

MEDICAL CARE

The original Act of 1938, which attempted to introduce a social insurance scheme operating at the local level, laid down an organisational structure and framework and contained a few provisions regarding the benefits to be provided. According to the Act, each insurance carrier had to provide care in the case of sickness or injury, and maternity and funeral benefits, but an association was allowed not to provide the last two benefits if its financial circumstances did not so permit. It was reported that in 1944-45 about 73 per cent of insurance carriers provided maternity benefits, whereas funeral benefits were paid by only 3 per cent of carriers. The corresponding figures immediately before the 1958 enactment were 87 per cent and 67 per cent respectively.

The 1938 Act also left each association free to determine the precise scope, duration, etc., of the medical care to be provided, including the method of payment of fees, and to enter into contracts for the provision of medical care. This arrangement remained in effect until the new legislation was adopted in 1958. Thus some insurance carriers did not cover or limited the provision of medical care in respect of the first consultation, domiciliary visiting, some prescribed pharmaceutical benefits and food expenses during in-patient care, although there was a tendency to abolish such limitations as the financial condition of insurance carriers gradually improved. For example, it is reported that as of March 1953 the first consultation was not covered by about 24 per cent of insurance carriers, domiciliary visiting by 26 per cent and some prescribed pharmaceutical benefits by 34 per cent, but these percentages were reduced to about 15, 18 and 0.2 per cent respectively by September 1956.[1] The 1958 Act eliminated the discrepancies in benefits provided by insurance carriers by raising the level of medical and related benefits to that obtaining in the

[1] *Twenty-year history of national health insurance*, op. cit., p. 438.

compulsory health insurance schemes for employees.[1] Thus the following benefits became available under the scheme as minimum coverage: medical examination; supply of medicines and other therapeutic aids; medical treatment, surgery and therapeutic care, hospitalisation and clinical care; nursing; and transportation.

The 1958 Act also laid down that benefits must be provided for at least three years, but this clause was struck out in April 1963, since when benefits have to be made available as long as the need continues. It is interesting to note, however, that long before then, in 1953, 87 per cent of all insurance carriers were already providing medical care without any limit on its duration.[2] The policy makers were evidently anxious that the scheme should be improved gradually, without jeopardising the financial soundness of the insurance carriers.

Under the 1938 Act each insurance carrier was authorised to determine the percentage of the cost of medical care which an insured person should bear. Initially the commonest rate of participation by the insured was 30 per cent, but it had subsequently to be raised in many cases, particularly when the scheme faced financial and other difficulties during the early postwar period. Thus in December 1947 about 70 per cent of insurance carriers were applying a rate of over 50 but less than 55 per cent, and 7.6 per cent of them were requiring a participation of more than 70 per cent, whereas in only 5.5 per cent of cases was the rate less than 35 per cent.[3] As the financial position of the insurance carriers improved, many of them reduced the percentage and a cost-sharing rate of 50 per cent became common. Furthermore, some insurance carriers, particularly those which had their own medical facilities—this point will be discussed later—managed to provide medical care without requiring any cost-sharing at all. For example, in the Iwate prefecture, which is one of the poorest agricultural regions in northern Japan, 18 local insurance carriers, representing about 10.5 per cent of the total in the prefecture, were providing medical care without cost-sharing in 1952.[4]

The 1958 Act eliminated the discrepancies in this regard also by prescribing that the insured's share (which each carrier was free to reduce) should not exceed 50 per cent. This maximum was subsequently reduced to 30 per cent in respect of all insured persons by an amendment dated 6 June 1966, which took effect on 1 January 1968 (earlier amendments had already applied this reduction to heads of households). The fact that it

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[1] Some insurance carriers facing financial difficulties were allowed certain limitations on the level of benefits, but from 1965 onwards such exceptions were abolished.

[2] *Shôwa Sanzyû-ichi-nen-ban Kôsei Hakusho* [White Paper on welfare, 1956] (Tokyo, Ministry of Health and Welfare, 1956), p. 196.

[3] *Short history of national health insurance*, op. cit., pp. 322-323. At that time, the scheme was described ironically as " providing insurance but no benefits ".

[4] Ryô Ohmura and Takeo Kikuchi: *Kôhai-suru Nôson to Iryô* [The desertion of agricultural villages and medical care] (Tokyo, Iwanami Shoten, 1971), p. 163.

took nearly ten years to reduce the cost-sharing burden from 50 to 30 per cent for all insured persons is also indicative of the cautious attitude adopted by the Government.[1]

SERVICES AND FACILITIES

Both the 1938 and the 1958 enactments left insurance carriers free to introduce services and facilities designed to maintain and improve the health of insured persons, as well as those necessary for providing medical care and other benefits. The introduction of such services and facilities has been actively encouraged by the Government since the earliest days of the scheme, through various technical and financial aids to insurance carriers. Their importance has also been recognised by leaders of local communities directly involved in the scheme's operation, not only for their beneficial social effect but also on the purely technical and economic grounds that effective preventive and health promotion services facilitate the smooth operation of the scheme in their localities, by helping to reduce expenditure for medical care.

Different types of services and facilities were instituted by many carriers, reflecting the topographical and social conditions in their localities. For example, even in 1948, when the scheme was still facing serious postwar difficulties, the following services were provided in various agricultural areas: tuberculin tests, BCG inoculation, periodic medical examination of expectant mothers and infants, provision of vital foodstuffs through goat breeding and poultry farming, operation of crèches during the busiest farming season, vaccination, trachoma control, study of and advice on hygiene conditions, examination of faeces, distribution of vermicides, organisation of seminars on nutrition, etc. Most important among such services and facilities are, however, the activities of public health nurses and the direct provision of medical care, both preventive and curative, at hospitals and/or clinics set up by the insurance carriers themselves.

While the history of public health nurses in Japan may be traced back to the late nineteenth century, when western medical methods replaced the traditional system, it seems that they began playing an important role in rural areas only after the introduction of the national health insurance scheme. According to a survey carried out by the Ministry of Health and Welfare in 1941, 309 of the 899 insurance carriers covered employed a total of 344 public health nurses. Five years later, 6,956 carriers were employing 9,777 nurses (including 2,191 non-qualified nurses).[2] During the difficult early postwar period, increasing importance came to be attached to the

[1] In this connection it should be noted that, under the Japanese schemes for employees, insured persons are not required to share the costs and their dependants pay a share of 30 per cent subject to a specified ceiling.

[2] *Short history of national health insurance*, op. cit., pp. 330 and 369.

role of nurses working for the scheme in rural areas, particularly those with no doctors, or too few. Their activities included the prevention of sickness, its early detection, nutrition, advice on health protection for infants and expectant mothers, family planning, and broader education in health and hygiene tailored to local conditions. These nurses had direct daily contacts with the villagers and acquired a profound knowledge of all aspects of their everyday life; they not only served the scheme faithfully, but in due course set up a nation-wide association which materially helped it to survive the postwar crisis.[1] As of August 1972, 5,689 nurses were working for 3,440 insurance carriers covering 43,811,823 insured persons throughout the country, the average number of insured persons per nurse being about 7,700 (but it seems that there were proportionally many more nurses in rural than in urban areas, since in the rural prefectures of Yamagata, Nagano and Iwate, for example, the average number of insured persons per nurse was 2,432, 2,789 and 2,827 respectively at that time).[2]

The services of public health nurses have proved particularly valuable for the scheme for the following reasons: their work includes not only health promotion and guidance in general but also the provision of first or emergency aid to sick or injured persons, particularly in rural areas lacking other medical personnel; they can be trained much more easily than fully qualified doctors; through their daily activities, it is possible to establish a co-ordinated network of medical protection, linking peasants to clinics and hospitals, through which medical care can be organised most effectively and economically; and their work in preventing disease and promoting health and hygiene in the rural areas helps, if perhaps indirectly, to reduce the cost of medical care and consequently to improve the finances of the insurance carriers.

Since the original Act of 1938 left each insurance carrier free to make its own arrangements concerning the provision of benefits, insurance carriers having their own medical facilities—particularly co-operative societies, which were allowed to act as substitute associations under the scheme—enjoyed the great advantage of being able to combine the social insurance operation directly with the provision of medical care, whereas many other insurance carriers had to make contracts with individual purveyors of medical care. In particular, the former could eliminate the profit motive from the provision of medical care and promote the health of their members through organised health control and preventive services, rather than provide care only in the case of ill-health.

In due course, many other insurance carriers set up their own facilities, staffed by full-time doctors and other medical personnel, to provide direct medical care. This tendency was stimulated at first by the introduc-

[1] *Twenty-year history of national health insurance*, op. cit., pp. 310-311.

[2] *Monthly report on national health insurance*, op. cit., Aug. 1972, pp. 2-3.

tion in 1944 of state subsidies to cover part of the cost of construction of new facilities or improvement of existing ones, apparently with a view to the reorganisation of the health services to cope with wartime conditions. In the early postwar period, however, the negative attitude evinced by the medical profession towards the scheme convinced many insurance carriers of the need to establish their own medical facilities if they were to survive, in view of the practical impossibility of operating an insurance scheme which failed to provide the promised benefits (thus, a number of insurance carriers were unable to collect contributions from insured persons who refused to pay owing to the non-availability of medical care). For its part, the Government was particularly concerned at the serious social problems arising in areas where there were no medical facilities [1], and encouraged insurance carriers to step into the breach by gradually increasing the state subsidies.

Ownership and direct management by insurance carriers of their medical facilities helped to correct the geographical maldistribution of such facilities in the rural sector; but perhaps more important still is the fact that they enabled the local community to enjoy, in addition to curative medical treatment, necessary preventive services such as health record keeping for residents, periodic examination, health counselling, organisation of educational meetings, eradication of endemic diseases, etc., which may be regarded as forming part of comprehensive rural medicine. As stated earlier, some insurance carriers having their own facilities even succeeded in providing medical care without cost-sharing, and the resulting whole-hearted popular support was naturally reflected in the successful collection of contributions. Furthermore, joint action by such carriers in some rural areas led to the establishment of an effective network of medical facilities, headed by large hospitals and backed by clinics and public health nurses.

The trend towards ownership and management of medical facilities by the insurance carriers continued and their number increased for about 15 years after the end of the war. It would no doubt have continued to increase or at least not have declined thereafter if the problem of the unbalanced distribution of medical facilities had been solved. The reality was different, however. Table 2 shows that the number of such facilities, which had continued to increase in the 1950s, started to decrease in the 1960s, the number of clinics beginning to fall in 1960 and that of hospitals in 1966. Yet during this period, the Government's financial aid for the construction or improvement of these facilities was not reduced. The decrease, which hardly seems auspicious for the future effectiveness and development of the scheme, may be due to the difficulty of employing

[1] For purposes of public administration, any area with a radius of 4 km and more than 300 inhabitants may be defined as a " doctorless area " if it stands in need of medical facilities (this depends on its population and geographical features and on the distribution of such facilities in surrounding areas).

TABLE 2. NUMBER OF MEDICAL FACILITIES OWNED AND RUN BY INSURANCE CARRIERS, 1948-70

Year [1]	Hospitals	Clinics	Total
1948	83	1 093	1 176
1957	442	2 732	3 174
1958	451	2 797	3 248
1960	518	2 538	3 056
1962	553	2 306	2 859
1964	558	2 041	2 599
1966	541	1 756	2 297
1968	522	1 662	2 184
1970	466	1 456	1 922

[1] As of 31 March.

Sources: 1948: *Short history of national health insurance*, op. cit., p. 311. 1957: *Twenty-year history of national health insurance*, op. cit., p. 441. 1958: *Shakai Hoken Jihô* [Social Insurance Bulletin] (Tokyo, Ministry of Health and Welfare), Vol. 32, Nos. 10-11, p. 89. 1960: *Shôwa Sanjyûgo nen-ban Kôsei Hakusho* [White Paper on welfare, 1960] (Tokyo, Ministry of Health and Welfare, 1961), p. 219. 1962-64: *Shakai Hoken Jiten* [Dictionary of social insurance] (Tokyo, Shakai Hoken Shimpôsha, 1968), p. 1218. 1966-70: *Kôsei no Shihyô* [Indicators of social welfare] (Tokyo, Kôsei Tôkei Kyôkai), special issues for 1968, p. 86, for 1969, p. 122, and for 1971, p. 147.

doctors in remote rural areas, to improvements in road and other transport which make urban medical facilities more accessible to country dwellers, and the establishment of other medical facilities which have replaced those run by insurance carriers.[1] While the effects of these factors should not be underestimated, it may be important to note that the beginning of the decline coincided with the gradual implementation of the 1958 Act in 1959-61. Prior to the enforcement of the Act, individual insurance carriers were free to work out a system of payment of medical fees best suited to the local conditions and, where medical care was provided directly by them, to make financial arrangements in the light of local needs and of their financial capability.[2] The 1958 Act, however, deprived insurance carriers of their autonomy in respect of the payment of medical fees, by requiring them to apply a schedule of medical fees promulgated by the Minister of Health and Welfare on the advice of the Central Social Insurance Medical Council. In addition, under the 1958 Act each local government acting as insurance carrier was required to set up a special, independent account (National Health Insurance Fund) for the operation of the scheme in its locality, including the management of its own medical facilities. These requirements left no room for running such facilities in the way best suited to local conditions and to the particular

[1] These are the reasons given for example in *Shôwa Yonjû-shichi-nen-ban Kôsei Hakusho* [White Paper on welfare, 1972] (Tokyo, Ministry of Health and Welfare, 1972), p. 183.

[2] At this time it was left to the discretion of local governments (at city, town or village level) whether to cover part of the cost of managing such facilities out of general revenues.

needs and capacity of the local government concerned, and indeed the chief consideration of the new policy appeared to be to guarantee the equal treatment of all purveyors of medical care under the scheme.[1] It has been pointed out that one result of this has been to undermine the zeal of the local people and insurance carriers in ensuring the effective running of their own medical facilities and health services.[2]

Financing

Three salient features characterise the financing of national health insurance in the Japanese agricultural sector. In the first place, in contrast to other social insurance schemes designed for the wage-earning population in Japan, there is no employers' contribution under the rural scheme, even where it covers establishments in the private sector having less than five employees, which still fall outside the compulsory coverage of the employees' health insurance scheme. Second, generally speaking, persons protected by the scheme belong to the lower income groups; although available data do not permit a direct comparison of agricultural with non-agricultural incomes, it was estimated as of 1964 that the average income of workers in the primary sector represented only 37.8 per cent of that of workers in the secondary sector.[3] Third, the cash incomes of the agricultural population become available only at particular times of the year, and the income from contributions may be nil just before these times, whereas medical fees must be paid every month.

CONTRIBUTIONS

Since the inception of the scheme in 1938, contribution rates and methods of collection have been prescribed individually by insurance carriers.[4] With effect from 1951, however, in order to improve the financing of the scheme by more efficient collection of contributions, local governments acting as insurance carriers have been authorised to impose on insured households a special tax replacing insurance contributions. As of 1 April 1970, 3,010 insurance carriers, representing 91 per cent of local governments carrying insurance, were levying this tax.

The total sum collected in the form of tax or ordinary contributions should be equal in principle to 65 (previously 75) per cent of the estimated

[1] See the statement by the Minister of Health and Welfare in submitting the bill to the National Diet, in *Twenty-year history of national health insurance*, op. cit., p. 577.

[2] See for example, Ohmura and Kikuchi, op. cit., p. 170, and *Social Security Weekly*, op. cit., 16 Oct. 1972, pp. 38-39.

[3] *Kokumin Kenkô Hoken no Shôrai* [The future of national health insurance] (Tokyo, Kokumin Kenkô Hoken Chûôkai, 1972), p. 20.

[4] The original Act contained a special provision authorising insurance carriers to reimburse part of the contributions paid by insured households whose members did not receive any medical care during a specified period. This provision, seemingly designed to make the scheme more attractive, was deleted by the 1948 amendments.

annual expenditure for medical care, minus the estimated amount of cost-sharing by patients, representing 30 per cent of the estimated total cost of medical care (the remainder being met by government subsidies). The total amount to be raised is apportioned among insured households as tax or contributions, subject to a prescribed annual maximum. The Government recommends three standard methods of apportionment, representing different combinations of two principles, namely *(a)* that the rich should pay more than the poor, and *(b)* that account should be taken of the fact that benefits are the same for all, whether rich or poor. Thus, in the first method, the total sum to be raised is divided into four parts representing 40, 35, 15 and 10 per cent of the total respectively, the largest part being apportioned proportionately to the income of each insured household and the smallest to its means (assessed on the basis of income, property and other tax criteria), whereas the second and third parts are raised by uniform levies, the amounts of which are obtained by dividing the parts by the total number of insured persons and of insured households, respectively. The second method does not take property into consideration; the part relating to income represents 50 per cent of the whole, and the uniform levies are the same as in the first method. The last and simplest method considers only the two factors, given equal weight, of income and number of insured persons. As of 1 April 1970, about 93.2 per cent of all insurance carriers were using the first method, 5.3 per cent the second, 1.2 per cent the third and 0.3 per cent some other method.

In order to alleviate the financial burden of contribution payments on lower income groups, it was decided in 1963 that the uniform levies assessed according to the number of insured households and insured persons might in certain circumstances be reduced by 60 or 40 per cent; as indicated later, the deficits caused by this reduction were in due course covered by state subsidies. As of 31 March 1971, about 24 per cent of insured households benefited from this arrangement.

PUBLIC SUBSIDIES

The manner and extent of state participation in the financing of the scheme have undergone substantial changes, reflecting different policy considerations at various stages of its development. It is however important to note that until recent years the State was not bound by any statutory obligation to subsidise the scheme, but was merely authorised to do so within the limits of the national budget. Initially, the Government granted each insurance carrier subsidies for the first year of implementation at a fixed rate per insured person, which was thereafter gradually reduced. Such subsidies were obviously aimed at encouraging as many localities as possible to implement the scheme.

This system was abandoned in 1946, when the Government started to grant subsidies to cover a part of the insurance carriers' expenditure for administrative personnel, public health nurses and medical facilities.

During the postwar crisis, when a large number of insurance carriers were going out of business, the Government was in this way able to help them to continue or embark on activities in the field of general welfare services, including, if not the provision of medical care, at least measures to improve the health and nutrition of country dwellers. Thus at a time when there were fears of serious famine, such subsidies to national health insurance carriers included grants for the purchase of cows and goats to supply milk to infants and expectant mothers, for the construction of salt-works (because lack of salt was considered to be one of the major causes of disease in rural areas), and for the production of simple pharmaceuticals.

As pointed out earlier, in the agricultural sector cash incomes do not always become available at a convenient moment for social insurance purposes, particularly where the purveyor of medical care has to be paid out of the income from contributions. The time lag between the payment of medical fees and of contributions, coupled with difficulties in collecting the latter, created serious problems during the early postwar period: carriers who did not pay up promptly had difficulty in obtaining the active co-operation of the medical profession, who were hostile to the scheme after their unhappy wartime experiences with it. In 1950 the Government accordingly introduced a system of short-term loans to insurance carriers who were unable to operate because of this time lag. This temporary measure did not prove effective, however, because the carriers had to pay back the loan in a rather short time (usually three months), so that their position remained largely unalleviated. Two years later, therefore, a law was enacted instituting a new system of long-term, low-interest loans to insurance carriers with a view to solving problems caused by arrears in the payment of medical fees as well as to encouraging the reconstruction of the scheme.

It was, however, not enough for the effective operation of the scheme merely to make good past deficits, particularly where the rate of contribution collection remained as low as 70 per cent [1], at a time when expenditures were rising as the cost of medical care in general went up. Although all the parties concerned increasingly recognised the need for direct state contributions to cover part of the cost of benefits, the condition of the national economy did not yet permit such a direct financial participation by the State in the scheme. Instead, the Government attempted in 1952 to improve the collection of contributions by introducing, in parallel with the long-term, low-interest loan system, a financial incentive from its general revenue, the amount of which was determined in accordance with the rate of contribution collection experienced by individual carriers over a given period. This incentive system was replaced in 1953 by a state grant equal to 20 per cent of the cost of medical care borne

[1] Rate of contribution collection $= \frac{\text{contributions actually paid}}{\text{estimated income from contributions}} \times 100.$

by the insurance carrier concerned. The grant—which was not a statutory measure but a budgetary arrangement—was the first in the history of the scheme to be directly related to the cost of benefits, although it still did not apply equally to all insurance carriers. This was because it was considered unjustifiable to distribute the limited amount of money available evenly among the carriers, some of whom provided a higher level of protection—as the result of various medical, financial or administrative efforts —than others who were unable to do so for a number of different reasons. Thus the grant was determined on the strength of four criteria, namely experience in collecting contributions, general financial position of the local government concerned, experience with expenditure for medical care, and level of protection (percentage of cost-sharing). It was considered that a uniform state subsidy covering part of the cost of benefits at a flat rate applicable to all insurance carriers would be justified only when they had become capable of providing more or less the same level of protection, or when the proportion of income from contributions to expenditure on benefits had become almost the same among carriers throughout the country; the immediate objectives of the grant were to overcome the financial difficulties of some insurance carriers and to maintain a reasonable level of protection, or to upgrade lower levels of protection to an acceptable standard.

The practice of keeping state participation within predetermined budgetary limits—a reflection of the principle that responsibility for the operation of the scheme rested upon each municipality (or special association)—was abandoned only when the National Health Insurance Act was amended in 1955. Ever since the end of the war, all the parties concerned, including the Ministry of Health and Welfare, the federations of national health insurance carriers, and the association of public health nurses under the scheme, repeatedly emphasised the need for direct state subsidies to cover part of the cost of medical care. The 1955 amendments, responding to this pressure, strengthened the financial basis of the scheme and established partial government responsibility for it by providing for state subsidies for all insurance carriers: the new subsidies covered 20 per cent of the cost of medical care, one-third of the cost of public health nurses and all administrative costs. The State's acceptance of responsibility for the financial operation of the scheme encouraged a number of local governments which had not implemented it to do so, and this paved the way for the compulsory application of the scheme throughout the country in the 1960s following the adoption of the 1958 Act.

After the passage of that Act, which included provisions respecting the State's financial participation, a number of further changes and improvements in the financial arrangements were made, as a result of which this participation now takes the form both of subsidies, the rates of which are fixed by law, and grants awarded within the limit of the national budget.

TABLE 3. TRENDS IN PUBLIC SUBSIDIES AND INCOME FROM CONTRIBUTIONS, 1966-70 [1]

(millions of yen)

	1966	1967	1968	1969	1970
A. *State subsidies*	*151 074*	*192 612*	*258 184*	*302 645*	*364 818*
Administration	10 934	13 146	15 128	17 331	20 152
Cost of medical care	122 435	158 157	216 784	252 794	305 252
Adjustment grants	16 636	19 419	24 905	29 773	36 593
Public health nurses, etc.	1 069	1 197	1 271	1 669	2 321
Other payments	—	693	96	1 078	500
B. *Prefectural subsidies*	*5 741*	*5 610*	*5 694*	*6 794*	*10 596*
C. *Total A + B*	*156 815*	*198 222*	*263 878*	*309 439*	*375 414*
D. *Income from contributions*	*106 612*	*126 215*	*154 365*	*182 922*	*218 154*

[1] Twelve-month periods ending on 31 March of the year following that indicated.

Source: Compiled from a table in *Yearbook of social security statistics*, 1972, op. cit., p. 143.

The State must now subsidise the administration costs of all insurance carriers at a standard annual rate per insured person, which has been increased from 95 yen in 1958 to 490 yen in 1971. State subsidies are also granted to local governments to cover 40 (previously 20) per cent of the cost of medical care, with the proviso that they may be reduced to a prescribed extent if a local government fails to secure a sufficient income from contributions without good reason. In addition, the State must provide an " adjustment grant " to help local governments that experience financial difficulties owing to the low income level of residents; such a grant is also made to local governments to cover deficits due to reductions in contributions payable by insured persons in lower income groups, or in the event of natural disasters or certain other contingencies. The special associations of persons with trade or occupational affinities acting as insurance carriers also receive state aid covering 25 per cent of the cost of medical care.

State grants payable within budgetary limits are at present available: to insurance carriers, in respect of public health nurses (one-third of the prescribed standard costs), construction and improvement of medical facilities run by carriers, and maternity benefits (one-third of the prescribed standard cost); to prefectural federations of insurance carriers, for administrative work (checking of medical bills and payment); and to the prefectural governments, for work done in generally supervising the operation of the scheme on behalf of the national Government. The 1958 Act also provides that the prefectural governments may grant subsidies or loans for the operation of the scheme in the prefecture concerned. Table 3 illustrates recent trends in financial participation by public authorities in the scheme, together with the total amount of contributions paid during the period 1966-70.

It may be observed from table 3 that the income from contributions in recent years represents about 60 per cent of total public subsidies. The increasing significance attaching to the latter may also be appreciated from the fact that in 1949 public subsidies, both state and prefectural, totalled only 572 million yen, whereas the income from contributions amounted to 4,196 million yen.

As a result of this public participation in the financing of the scheme, coupled with the improved collection of contributions, the financial position of many insurance carriers has improved considerably. For example, in 1966, of a total of 3,495 insurance carriers, 418 showed a deficit, whereas only 98 of 3,468 carriers did so in 1970.

Conclusions

Historically speaking, it was the efforts of Japanese peasants and their leaders to overcome difficulties resulting from the contradictions inherent in a " free-market " system of medical care provision, with the geographical and social maldistribution of facilities and opportunities it entailed, which paved the way for the introduction of a scheme to provide such care through the medium of social insurance. In particular, action by the co-operative movement—motivated by the keenly felt need to eliminate the profit motive in the provision of medical care on the free market—may be viewed as concentrating on the " organisation of supply " of medical care. The social insurance scheme originally designed for the rural population of Japan, however, did not actively attempt to reform the prevailing free-market system itself, but confined itself to the " organisation of demand " for medical care by spreading risks and by pooling financial resources among the protected persons so that medical care could be obtained under a prepayment arrangement, with certain exceptions as in the case of those insurance carriers who supplied medical care directly through their own facilities, particularly during the postwar reconstruction of the scheme. The scheme not only still accepts the prevailing free-market system as the basis for the provision of medical care, but has also latterly limited the scope of action of insurance carriers providing such care directly by requiring them to operate their medical facilities under the same financial conditions as apply to purveyors of medical care in the private sector. Admittedly, the problem of maldistribution of medical facilities cannot be solved merely by the introduction of a scheme of social insurance, and indeed, as industrialisation and urbanisation leave the rural areas more and more sparsely populated and relatively ill-equipped with medical facilities, the scheme will be faced in an increasingly acute form with the besetting problem of how to provide adequate medical care and protection to people living in such areas.[1] It may in fact be wondered whether

[1] See, for example, a report in the 10 November 1973 evening issue of *Asahi Shimbun* (a leading newspaper) indicating that town mayors and village headmen in some regions are now inviting Korean doctors to come to Japan and provide medical care under the scheme.

other steps may not have to be taken to organise the supply of medical care effectively in the rural sector.

Nevertheless, the achievements of the Japanese scheme of social insurance for medical protection in rural areas, at least during the period prior to its compulsory application, should not be underestimated, for this scheme provided a framework within which country dwellers could themselves initiate action to cater for their medical needs and encouraged them to tailor such action to local conditions, while in not a few cases it brought about a great improvement in the level of rural health, particularly in the poorest regions. The successful implementation and postwar reconstruction of the scheme have been achieved by the joint efforts of the public authorities and of socially motivated members of the local population. The lesson to be drawn from this is that in the operation of social insurance schemes, it is important to be able to count on popular interest, support and participation at the lowest level of implementation. In this respect, the fact that the number of medical facilities owned and run by insurance carriers started to decrease after their autonomy was severely curtailed by the 1958 Act is very significant.

The scheme now essentially covers all Japanese citizens, whether at work or not, who are not covered by any of the social insurance schemes for wage earners and salaried employees and their dependants. The importance of its contribution to the nation-wide health insurance network is illustrated by the fact that in 1970 it catered for 40 per cent of the total population of Japan. Changes in the industrial structure and the economic and social development of the country, however, affect the type and number of persons protected by the scheme, and its operation, to a considerable extent. As industrialisation progresses, more and more workers and their dependants previously covered by it are falling within the scope of the schemes for wage earners. Thus it is estimated that by 1975 it will cover only about 35 per cent of the population, and that the proportion will decrease to 25 per cent by 1985.[1] In theory, the reduction in the proportion of insured persons covered should not pose any serious problems, but it is linked in practice to the more important question of who will make up the main categories of persons protected under the scheme, assuming that the network of health insurance schemes as a whole is left unchanged.

As of September 1970, when persons 60 years of age or over represented 10.7 per cent of the total population, they accounted for 16.4 per cent of all persons insured under the scheme as compared to only 7 per cent in the case of the schemes for employees. The same source [2] estimates that in 1975 (when the scheme is expected to be covering 57.4 per cent of all the persons belonging to that age group in the country), 19.7 per

[1] *The future of national health insurance*, op. cit., p. 3.

[2] Ibid., pp. 4 and 9.

cent of the persons insured under the scheme will be aged 60 or over. Thus it is clear that the already high proportion of elderly people among the scheme's membership will increase still further in the future. This may be partly attributable to the fact that, in Japan, employees' schemes extend health protection only for the duration of the employment relationship, which means that the increasing number of persons coming under employees' schemes as rural labour is absorbed in the industrial sector will have to be taken up again by the national scheme on retirement, unless they remain in an employees' scheme as dependants of an insured person. It is, however, also important to note that within the national health insurance scheme itself, the proportion of insured persons in the occupationally active age group (15-59 years) is already relatively small (60.6 per cent of all insured persons in 1971) and is expected to fall even lower (to 57.2 per cent) in 1975.[1]

The scheme was originally launched and extended to protect the rural population, although it was designed to be applicable to any persons in urban areas not covered by the existing schemes for employees. For a long time, the major emphasis was placed on rural needs, and the populations of large urban areas have actually come within the scope of the scheme only recently—more particularly since the passage of the 1958 Act. The problems of implementing it in urban areas are, however, quite different from those arising in the rural sector, and it is reasonable to believe that these differences will become more marked as the pace of structural change in the nation's industrial and economic life accelerates. For example, in urban areas difficulties stemming from the disproportionately large number of inactive persons may not be as serious as in the rural areas, from which persons of working age tend to emigrate. It may therefore be wondered whether a different and sectoral approach may not be required in tackling various problems, rather than the uniform approach which has so far been adopted irrespective of the areas covered. In this respect, a rough distinction between rural and urban areas may not go far enough, and the rural areas themselves may have to be further classified into different categories—distinguishing for example between areas located near large cities, on level land, in mountainous regions, etc.—characterised by different problems requiring different solutions, particularly in the matter of ensuring the sound financial operation of the scheme and the effective distribution of medical facilities.

The Japanese social insurance schemes for employees enjoy relative financial stability, because they insure wage earners and salaried employees who constitute, in so far as their regular incomes are concerned, the better-off members of the population, and in addition they can rely on employers' contributions, which represent a major source of income. The national health insurance scheme, on the other hand, covers persons in the

[1] *The future of national health insurance*, op. cit., p. 4.

lower income brackets, and in respect of whom no employers' contributions are payable. From the outset, therefore, this scheme has not been operating in conditions conducive to the preservation of a reasonable balance between income and expenditure, as is customarily expected of social insurance schemes. State subsidies have accordingly been introduced, and they now cover more than 50 per cent of the scheme's expenditures. It seems pertinent, however, to wonder whether it would not be possible for the scheme eventually to provide the same level of protection as is available to the wage-earning population, for example by abandoning cost-sharing, the prevailing rate of which is 30 per cent, even for heads of households, as long as the present financial arrangements are maintained. It would seem difficult—particularly since the supreme objective of national policy is the establishment of a welfare State—to convince the persons concerned that they should be satisfied with a lower level of protection merely because they belong to lower-income groups or are not in an employment relationship; and this argument applies with especial force in the case of medical care under social security, the need for which is the same for everybody, whether they are employed, self-employed, young or old, and wherever they live.

The foregoing observations should not, however, be interpreted as underrating the contributions made by the scheme towards the medical protection of the less-favoured sections of the population. At its outset, at least, the scheme was well designed to cater for the conditions prevailing in rural Japan, and it can point to a 35-year record of success in solving the numerous challenging problems repeatedly arising from the need for it to extend the scope of its activities, improve the level of protection afforded and stabilise its financial position. Even where the solutions adopted have proved to entail certain drawbacks, useful lessons may still be drawn from them by others contemplating similar ventures. Perhaps the most significant aspect of the Japanese experience, however, is the humanitarian spirit of mutual aid evidenced by the persons and authorities directly involved in the operation of the scheme at the local level, thanks to which it has been able to survive a number of trials. The question that now arises, however, is whether and if so to what extent, in a situation of rapid industrialisation and far-reaching changes in the country's economic and social structure, the scheme will continue to attract the popular support it requires to meet the manifold needs for medical care among the different categories of persons it caters for.