

**APPROACH TOWARD
A UNIFIED HEALTH INSURANCE SYSTEM:
WHAT CAN JAPAN LEARN
FROM THE KOREAN EXPERIENCE?**

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Approach toward A Unified Health Insurance System: What can Japan Learn from the Korean Experience?

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Abstract

We discuss that Japan should make a comprehensive reform of the existing institutions of health insurance in view of the apparent structural problems centering on the financial instability of health care finance, and discrepancies in premiums and benefits among the insured. With the rapid population aging in a sluggish economy, Japan cannot afford to finance additional medical bills in a cost-ineffective manner. It seems that Japan can draw valuable lessons from the Korean experience on this regard. We argue that Japan needs to move toward a unified health insurance system, along with introducing a la Singaporean MSA as a supplementary financial mechanism.

Keywords: Reform of health insurance, privatizing health care financing.

JEL codes: I18, O57.

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1. Introduction

The number of elderly (those 65 years and older) in Japan has grown over the past several decades both in size and in proportion to the general population, and will continue to grow at an even faster rate during the 21st century. It is certain that the growth of the elderly population will have a profound effect on the health care system. As the elderly live longer, the nature and complexity of their health status change, and they should require different care than the current system is designed to provide. The issue of rapidly increasing share of the elderly population carries a vitally important implication in discussing the overhaul of the Japanese health insurance system.

This is particularly the case when Japan becomes one of the fastest countries in population aging in the world, while it is clear that the Japanese economy would show a much slower economic growth rate now and in the future than before. The reality is that senior citizens are preferentially treated in terms of costs and benefits in Japan. This implies that as far as the health insurance system is concerned, income is redistributed in favor of the elderly, thus accelerating an increasing trend of medical costs and contributing to the financial vulnerability of health care finance. As a matter of fact, elderly patients are crowding out young patients in utilizing medical resources.

In retrospect, there have been prolonged structural problems such as financial instability in health care financing, complicated government subsidies, and gaps in premiums and benefits between different programs, and among different insurance societies, among others. It is evident that because of rapid population aging all these structural weaknesses have been aggravated. It can be said that there is a consensus in Japan that the current health insurance system has insurmountable problems in making due adjustments to changing socio-economic and demographic conditions, thus calling for a fundamental reform.

Recently, some of the Japanese scholars proposed a unified health insurance system as a policy alternative to solve the system-inherent

structural problems, as well as to mitigate the impact of the population aging on ever-soaring medical expenditures. It is interesting in this context to see that Korea adopted a la Japanese health insurance system some 20 years ago, yet she is moving ahead of Japan toward integration in managing health insurance. The very basic theme of the unified approach in Korea lies in improving the equity aspect of the health insurance system by integrating the multiple insurance carriers into one.

In this paper we will closely examine and analyze the economic rationale of the Korean transition in managing health insurance from the multiple insurers to a single insurer, along with the process of such a transition. Our next goal is to draw in an inter-country policy-comparison framework relevant policy implications for Japan based on the Korean experience. We would like to ask a series of questions in this regard:

- How was the Korean transition toward unified approach possible?
- What are the important economic motivations of such a movement?
- Will it be economically justified to transplant in the future a similar version of unified approach to the Japanese soil with due modifications for the benefit of all Japanese people, rather than the vested interest groups?
- Will such integration efforts be sufficient in tackling major structural problems of the Japanese health insurance system in view of the prospect that medical expenditures in Japan should increase steadily while the economic growth rates would slow down in the future?
- If the integration approach is not sufficient, given the rising trend of medical bills, what kind of policy packages will be required to finance the additional medical expenditures for the future?

This paper consists of six sections. After the introductory section, Section 2 will briefly explain similarities and differences between the Japanese health insurance system and the Korean system. In this section, the major issues and problems of the health insurance system in the two countries will be highlighted as well. In Section 3, we will mainly examine the economic rationale and motivations of the Korean movement toward integration approach in managing health insurance. Also, we will discuss a set of

adequate policy measures to improve both equity and efficiency for Korea. The following Section will focus on the lessons, either positive or negative, that Japan can draw in moving toward a unified health insurance system. Section 5 will first pinpoint the major structural problems of the Japanese health insurance system. Then we will discuss policy options available for Japan and suggest a package of suitable policies for a fundamental reform for the future. Our discussion will be based on the results of simulation analysis. For this, a particular emphasis will be placed on the issues of integrating existing insurance programs, and developing alternative financing mechanisms for the expanded basis of health care finance. The final section will summarize and conclude discussions so far.

2. Similarities and Differences in the Health Insurance System between Japan and Korea

Japan introduced a social insurance type of health insurance in 1926, making reference to the schemes of the continental European countries, in particular, the German health insurance system, and achieved a universal coverage with due adaptations conducive to the country setting in 1961. Korea adopted the same type of health insurance system in 1977 based on Japanese experience¹. Accordingly, the health insurance systems in the two countries show many aspects in common as shown in the Table 1. On the other hand, there are some minor differences, which reflect country-specific adaptations (see Table 2)².

¹ It should be appropriate in the beginning to examine the fundamental differences in operating the health insurance system between West European countries and East Asian countries such as Japan and Korea, although they have adopted a seemingly similar type of the social insurance system. Essentially, there is a big difference between the west and the east in that the western system is flexible so that the insured are given the right to choose the insurer, while the Asian system is so rigid that there is no such right provided to the insured. Besides, European countries from the beginning covered the most needy groups as well among different segments of the population while Asian countries adopted 'the rich first, and the poor later' approach. Lastly, the Asian insurers have not played their proper role as agents for the insured due to strong government regulations. As a result, European countries could have taken advantage of the plural carriers system by gradually making up the gaps and problems while the Asian countries have not fully utilized such advantages as we will see later on.

² Here, we just make a list for a comparison purpose.

Table 1. Similarities in Health Insurance between Japan and Korea

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1. Started with a similar social insurance type of the health insurance system run by the multiple carriers based on occupation and residence;
 2. Curative medicine is emphasized, while virtually neglecting preventive medicine and health education;
 3. Low-quality medical care, in most cases, is provided at low price to facilitate an easy access to medical services for every citizen, based on the fee regulation;
 4. A high share of drug expenses out of total medical costs, compared to those of other OECD countries due to over-utilization of drugs³;
 5. A free choice of physicians and hospitals is allowed to patients;
 6. Fee-for-service reimbursement to the medical providers;
 7. No complete division of functions between medical doctors and pharmacists;
 8. No orderly referral arrangements are in practice⁴;
 9. Co-Financing scheme has been in effect to assist those health insurance societies which show financial weaknesses due to either a high percentage of the poor or (and) a high percentage of the elderly among the insured⁵;
 10. Private sector is dominant in the supply of medical services;
 11. Private health insurance plays a minor role, and
 12. A high share of time costs is involved in utilizing medical services, due to a long queue.
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³ For instance, drugs account for more than one-third of total medical care costs in Japan. See Powell and Anesaki (1990).

⁴ They are often called as a referral system as well. The establishment of such a system, first starting with primary health care facilities manned by a general practitioner and/or paramedical personnel, tends to help reduce the concentration of demand on general hospitals, for instance.

⁵ The Korean government established the Co-Financing Program, at the National Federation of Medical Insurance, and expanded it until the time when a partial integration has done. One of the main functions of the Program is to take care of additional financial burdens such as care of the elderly and expensive services using high-tech medical equipment. Contributions for the Program are made by each insurance carrier according to ability to pay while benefits are paid in proportion to actual costs, thus providing a financial transfer mechanism from the relatively rich insurance societies to the poor insurance societies. As such, Japan has a very similar program. On the other hand, the Dutch system has built up an equalization fund in the course of a comprehensive reform of health insurance. It collects income-dependent contributions from the insured and distributes the proceeds to insurers according to the

Table 2. Differences in Health Insurance between Japan and Korea

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1. Japan's health insurance societies for regional residents are administered by local and/or municipal governments. And those insurance societies for the self-employed based on occupation are organized separately. On the other hand, the Korean counterpart is run by a single carrier, the National Health Insurance Corporation, after the program for government officials and private school teachers, and Regional Insurance have been merged;
 2. Korea's integration efforts of health insurance are in the process and will be completed by the beginning of 2002, while Japan has a series of proposals on integration approach;
 3. Coinsurance rates in Korea are much higher than those in Japan⁶;
 4. A partial division of functions between medical doctors and pharmacists is in practice in Japan, while Korea has a plan to execute a complete division of functions between them by the second half of 2000;
 5. Korea has a plan to carry out the Korea-DRG (Diagnosis-Related Group) on a nation-wide scale in the latter half of 2000, based on a three-year pilot project, while Japan proceeds the Japan-DRG project for demonstration covering several hospitals⁷.
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The Japanese and Korean health insurance systems broadly comprise two major programs: Employee Insurance and Regional Insurance. All the insurance programs are similar in terms of the range of medical services covered, the procedures for obtaining medical care and the system of reimbursing medical providers. But there are significant differences in

composition of their enrolled population. See Zweifel and Breyer (1997).

⁶ On average, Koreans tend to pay approximately 44 percent of total medical expenses directly out of their own pockets in recent years. For details, see Han et al. (1999). This rate, what we call 'effective coinsurance rate' is certainly higher than those of any other countries with health insurance coverage. The high coinsurance rates have resulted in differential treatment among consumers with different income level. They certainly tend to give less financial burdens to the rich than the poor, *ceteris paribus*.

⁷ DRG is regarded as a prospective payment system. On the contrary to the retrospective reimbursements, it provides a clear incentive to the hospitals to be more efficient in the treatment of each care. See Rosen (1988).

eligibility, administration, cost-sharing, cash benefits, financing and the level of government subsidy provided to bear administrative costs and make up deficits. This is mainly attributable to the design of the health insurance system at the onset⁸.

In recent years, however, the differences have been becoming larger and diversified. This is particularly the case with respect to the policy environment, reflecting different political situation and people's preferences in the two countries⁹. Korea and Japan show a sharp contrast in terms of environment for making policy reform, among others. Two years ago, Korea experienced a drastic government change from a conservative one to a liberal one, while a conservative government remains in power in Japan. In addition, the majority of Japanese people prefer to have gradual changes¹⁰, while Koreans are willing to accept fundamental and structural changes.

Around the end of 1997, the Korean National Assembly (parliament) enacted a law, which allows the Korean government to move toward a unified health insurance system. Based on the law, the health insurance program for government officials and private school teachers, and Regional Insurance (the insurance program for the self-employed and residents in the region) have been merged on October 1, 1998¹¹. In this paper, we will choose the point of comparison of the health insurance system in the two countries as of October 1999. This means that the Korea has already put several steps toward integration.

As shown in Table 3 below, there are some gaps in terms of changes in population structure between two countries, which can be highlighted by an

⁸ For the reasons of economic viability and administrative easiness, the governments in Japan and Korea made the decision to begin with large firms. Then, medium and small sized firms followed. Lastly, farmers, self-employed, and residents in the region were insured. As a result, there emerge a contrast between financially stable insurance societies on one hand, and financially unstable insurance societies on the other, thus causing an equity issue between different health insurance programs, and among different insurance societies.

⁹ The ways in which a country organizes and finances her health care system reflects the values and ideals of that society and its political recognition.

¹⁰ Proposals suggested so far in Japan confirm that there will not be any radical departure from the current mode of health care provision for the future.

¹¹ See Planning Commission for Unifying Health Insurance (1998).

Table 3. Share of the Elderly Population (those aged 65 or more) Out
Of the Total Population for Japan and Korea (%)

	Korea	Japan		Korea	Japan
1970	3.1	7.1	1980	3.8	9.1
1990	5.1	12.1	1995	5.9	14.5
2000	7.1	17.2	2010	10.0	22.0
2020	13.2	26.9			

Source: Korea Institute for Health and Social Affairs (1999), and Ministry of Health and Welfare (1997), respectively.

increasing share of the elderly population out of the total population. It is observed that Korea is lagging behind Japan by at least 25 years or more in this particular indicator. Japan's share of the elderly is already high and rapidly rising. Although Korea's share at present is not that high, she is regarded as one of the fastest countries in the world in terms of population aging in the future.

It is also worthy to discuss similarities and differences of the structural problems which Japan and Korea face at present and for the future. Before dealing with the major problems and issues in both countries, it is worthwhile examining what is the proper role of government in health sector, in particular, regarding the financing of health care¹². Essentially, the main issue is narrowed down to 'how we design a desirable financing mechanism for health care in terms of equity and efficiency'. To be more specific, it means what kind of the financing mechanism should encourage adequate

¹² As usual, health economists have two yardsticks, namely equity and efficiency in

amount in health care utilization while maintaining quality of care. It is important to keep in mind in this context the message the OECD Research intends to deliver. It shows that socio-economic and demographic factors are playing a significant role in the health status of the population, as well as environmental, behavioral and life-style factors¹³.

Health insurance as a branch system of the social insurance system plays two important functions: insurance function, and income redistribution function. The former implies that each individual would receive approximately the same return on his or her contribution, and is related to the horizontal equity issues as well as the efficiency issues. The latter implies that for individuals of the same age, generally lower the earnings or income level, the larger the gain (or the smaller the loss), and is related to the vertical equity issues¹⁴. As Professor Karen Davis correctly points out, it is desirable for a NHI plan to be equitably financed, easy to understand and administer and acceptable to providers of medical services and to the public¹⁵. Based on these criteria, we can evaluate the health insurance system in a country whether it is on the right track or not.

Some in Japan and Korea believe that each country faces serious problems in health care financing¹⁶. In particular, it is argued that the Japanese system is facing an ever-worsening situation, thus requiring an immediate reform¹⁷. Korea has been in a similar situation in recent years. Currently both countries are undergoing the reform process. However, the reform packages of Japan and Korea may not be sufficient in genuinely improving both equity and efficiency with respect to managing health insurance. The two countries seem to have the following problems in common. 1) instability in the insurance finance, 2) escalation of national health expenditures (NHE, for short) due to a steady increase in the elderly population, development of medical technology, and increases in life-style

evaluating policy frameworks.

¹³ OECD (1999).

¹⁴ See Rosen (1988).

¹⁵ See Davis (1975).

¹⁶ From the Japanese side, we can name Professors Nishimura (1999a, and 1999c), Hiroi (1997), and Tokita (1999) among others, while choosing Professors Yang (1999), and Kwon (1999) among the Korean experts.

related degenerative and chronic diseases, 3) inequity in benefits and premiums under the health insurance system of multiple insurance carriers, 4) a limited role of the insurer for the benefits of the insured, due to excessive regulations of the government, and 5) low cost-effectiveness due to fee-for-service reimbursement¹⁸, curative medicine-oriented approach, and moral hazard induced by the third-party payment.

A high degree of uncertainty about the financial status of the health insurance system has become a priority issue in policy debate in recent years in Japan. And it becomes one of the serious issues in Korea at present. There is convincing evidence that health insurance becomes an unwieldy, highly fragmented and complicated edifice which is expensive to administer and operate. The plurality of insurance societies has moreover led to discrepancies in contributions and benefits. Rationalization of this system has been the focus of policy reform during the past decade in Japan. Being challenged by the rapid population aging and slow economic growth rates in recent years, the Japanese health insurance system has come to the point of the crisis.

There are not many differences in the nature of the structural problems of health insurance between two countries. Korea has a far less burden attributable to the increased number of elderly people, thus bringing about less serious social repercussions due to the intergenerational income redistribution in favor of the elderly. Also the amount of the government subsidies allocated to the health insurance system is much less in Korea compared to the Japanese counterpart in terms of its ratio to GDP. There are additional differences in that Japan prefers to take a gradual improvement approach while Korea has taken a rapid path of the institutional reforms.

3. The Korean Approach to A Unified Health Insurance System

The commencement of health insurance in Korea was the result of abrupt

¹⁷ See Tokita (1999) for instance.

¹⁸ Most academicians are critical of current reimbursement policies. When reimbursement is based on a fee-for-service approach, itemized services tend to be provided more than it should be necessary. See Abe (1975) for more detail. As a result., medical costs escalate while overall quality of medical services does not improve.

decision making by the political leader around the middle of the 1970s. This historical background probably explains why Korea adopted a health insurance system similar to the Japanese system with a lack of long-term perspective. In developing its health insurance plan, Korea had the benefit of watching the evolution of the Japanese health insurance system, in particular, during the period of 1930 to 1960. Korea borrowed the basic concepts, but tried to apply them to the specific Korean circumstances with due modifications¹⁹.

Since the mid-1980s, however, there has been a prolonged debate centering on whether one integrated insurer or multiple insurers should be relevant in Korea's health insurance management. For each one of these two has merits and demerits²⁰. What is important in this regard is 'how a nation in question can shape its health insurance system, that should be most appropriate to its country setting in terms of equity and efficiency'. It is quite natural that the conservative groups stand with the current scheme with many insurance carriers, while the liberal groups with unified approach. Judging from the degree of contribution burdens for health insurance, there is high possibility that people in the middle income or upper income classes feel more comfortable with the former. Nevertheless, people in the low-middle or low-income brackets support the latter.

(1) Problems of the multiple carriers system

As time goes on, the health insurance system based on multiple insurance

¹⁹ See Kwon (1993).

²⁰ It is interesting to see the trend that Asian countries either have already decided to adopt integration approach (Taiwan and Korea) or are interested in moving toward integration (Japan), while European countries have maintained the tradition of plural carriers. It appears that Asian countries have not been in the position to fully activate merits of the multiple carriers system, due to system-inherent structural problems such as 'the rich first, and the poor later' approach by system design, and strong government regulations and interventions. Thus, insurers cannot afford to represent the interests of the insured vis-à-vis medical institutions and government. On the other hand, European countries have made up demerits of plural carriers on a continuing basis while maintaining and strengthening merits of autonomous administration. Thus the insurers could have the bargaining power vis-à-vis medical institutions. Also they guarantee the insured the right to choose insurers and medical institutions for their benefits.

societies has raised numerous problems. For instance, leaving the administration of health insurance in the hands of multiple health insurance societies yields discrimination. It produces different premiums and benefits between the different types of health insurance programs, thus resulting in an equity issue among the insured. For they apply a different criteria in levying premiums of health insurance. This is also the case among different health insurance programs, which offer different benefits based on different contributions. Recall that these features are intimately related to the way the Korean health insurance system is designed²¹. Also, they are only loosely coordinated by their federation.

At present, every Korean is insured under the National Health Insurance (NHI, for short) System²², except those under the Medicaid²³ funded solely by the government. By law, one's health insurance society is automatically determined either based on one's occupation or residence. This rigid system not only restricts the risk pooling function of health insurance, but also contributes to widening discrepancies, in particular, between Employee Insurance and Regional Insurance. In addition, the presence of many financially weak insurance societies has tended to give enormous amount of pressures to lower the overall benefit level of the Korea's health insurance system.

The multiplicity of carriers is also uneconomical. Some of smaller carriers must spread their risk over a small number of people. Each one of them maintains an administrative staff that increases costs. As a result, some of the smaller sickness funds among Regional Insurance experience financial difficulties. The previous government, therefore, had tried to force many of the smaller health insurance societies to merge into larger units.

As is clear in the previous discussion, Korea's health insurance based on

²¹ For instance, those insurance societies which cover poor people such as farmers and regional residents are destined to show financial vulnerability sometime soon, simply because the insured have high risks but low-income level on the average.

²² NHI means a nationally organized financial mechanism based on social risk-sharing, that is, a public system for the collective financing of privately provided services.

²³ This program helps to provide free (or with some nominal amount of copayments) inpatient and outpatient care for the poorest citizens as a part of the public assistance

multiple carriers has revealed two thorny problems, that is, a low level of benefits provided to insured, and serious financial instability in running health insurance. Until recently, the Korean health insurance system has provided benefits to those medical services, which are frequently utilized, but relatively cheap. However, only limited benefits have been provided to those services, that are rarely utilized, but relatively expensive. This kind of sub-optimal benefit scheme has blocked a full-fledged function of risk pooling of health insurance. Together with high copayment rates, low level of benefits has made people in the low income classes have less access to medical services, thus raising the equity issue²⁴.

Thanks to sustained increase in income and enhanced educational standards, an increasing number of Korean people are demanding higher quality of health care, and are seeking for diversified health services. On the contrary to the needs of the people, the Korea's health insurance has kept the tradition of 'a low premium rate, and accordingly a low benefit level', mainly due to the presence of a group of financially vulnerable insurance societies. Some of the Korean health economists argue that the Korean NHI System has reached a crossroads in view of insurmountable problems both in terms of equity and efficiency. Thus they call for a structural reform, which is conducive to changing socio-economic, and demographic conditions²⁵.

(2) President's initiatives to move toward integrating health insurance

During the campaigning period, one of the strong presidential candidates Kim, Dae Joong clearly promised that the health insurance system should be integrated, once he would be elected. As is well known he is a reform-minded politician, who has been close to the socially weak groups, including the poor and farmers. Naturally, a group of reform-oriented scholars have been called upon to join his camp, while the conservative expert groups have joined the opponent's camp. As promised, President Kim, after being elected, launched the project of integrating the health insurance system right away, along with integration efforts in administering four social insurance schemes, health

scheme.

²⁴ See Han et al. (1999).

²⁵ *ibid.*, and Kwon (1999).

insurance, pension insurance, employment insurance, and industrial accident insurance.

Without any hesitation, President Kim Dae Joong's strategists recommended that the government should take a quick action toward establishment of a unified health insurance administration covering the entire nation, as soon as possible (see Table 4 for a detailed time schedule for integration efforts). Based on the schedule, the majority party took an initiative in passing the new National Health Insurance Law, which prescribes the process of integrating the health insurance system until the complete integration will be done by the beginning of 2002. By merging 227 health insurance societies under Regional Insurance, and the insurance program for government officials, and private school teachers, the National Health Insurance Corporation was born as a single carrier.

(3) Economic rationale of integration and expected results

Economic rationale behind the policy changes regarding health insurance administration can be summarized as follows: to enhance both efficiency and

Table 4 . Time Table to Proceed Integration Efforts

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- Promulgation of the 'new' National Health Insurance Law (December 1997)
 - By merging the insurance program for the government officials and private school teachers with Regional Insurance (October 1, 1998), the National Health Insurance Corporation was created as its sole insurer.
 - Achieving a complete administrative integration by further merging Employee Insurance by July 1, 2000.
 - Achieving a complete financial pooling by January 1, 2002.
-

Source: Planning Commission for Unifying Health Insurance (1998).

equity by improving risk-pooling function and income redistribution function of the health insurance system, thus eventually contributing to social integration in Korea²⁶. First of all, it would significantly enhance equity by applying the same criterion to the insured in assessing premiums and paying benefits. In particular, a group of proponents for integration assert that it would, as a countervailing power, assist government in resisting the demands of the near-monopoly providers²⁷. In addition, centralization of administration would reduce administrative costs and offer a way to lower the contribution burden on the poor. Such a step would also eliminate an obstacle to labor mobility throughout the nation.

According to the government plan, the basic policy directions for the integration efforts are two-fold: one is for enhancing equity, and the other for improving efficiency as shown in Table 5. The government aims at enhancing

Table 5. Basic Policy Directions for Integration

Equity	Efficiency
1. To guarantee adequate premiums and benefits level to the insured	1. Institutional changes, in lines with integration
2. To upgrade quality of medical services for all	2. To check an excessive increase in NHE, and maintain stability in NHI financing
	3. Efficient administration of NHI

Source: Planning Commission for Unifying Health Insurance (1998).

²⁶ See Planning Commission for Unifying Health Insurance (1998). The Korean approach toward integration of health insurance programs had the benefit of learning from the Taiwanese experience whose integration efforts were started in 1995.

²⁷ Kwon (1993).

equity by emphasizing two important policy changes. Primarily, the government focuses on how to guarantee adequate level of premiums and benefits. In order to achieve this goal, equitable assessment of income or earnings, and a fair levy of premiums are required. Recently, the Korean government announced that a single criterion would be adopted, which is solely based on income in premium assessment. This basic rule will be applied to employees as well as self-employed.

In addition, there will be expanded benefits by reducing the number of excluded medical service items and including some of high-tech related service items, in view of the fact that the poor suffer most among different income classes due to financial barriers when they utilize medical services. Moreover, government subsidies would be clearly targeted for providing administrative costs, and making up premiums to a group of low-income people including small farmers, and fishermen, and self-employed. Together with improving the benefits level, the government plans to assure quality of medical services. The Ministry of Health and Social Welfare also plans to reduce copayment rates, which are extremely high in Korea, compared to those of other OECD countries.

Regarding the efficiency aspect, the Korean government is looking forward to developing complementary financing schemes, and related institutional changes in lines with integration in order to maximize its effect. Complementary measures, which may get along with integration approach, include alternative financing mechanisms, such as Medical Savings Accounts (MSA, in short), and private insurance programs, and changes in payment methods, such as DRG, capitated payment systems, HMO, and global budgeting system. In addition, a complete division of functions between medical doctors and pharmacists is required to further improving efficiency. A series of such institutional changes will make contributions to enhanced cost-effectiveness in administering NHI, and strengthened financial basis of the health insurance system by checking excessive increase in NHE in the years to come.

It is particularly worthy to pay due attentions to MSA at this point in time. There are a couple of reasons why we have interest in MSA for Korea in

this context. First, Korea should solve the major problems—how to stabilize the soaring trend of the NHE, and how to finance the medical expenses for the elderly whose number is steadily increasing, and whose medical expenditures per capita are rapidly increasing over time. Second, it is related to the fact that savings rates are quite high in Korea. Third, the Korean economy is bound to show a slower growth rate from now on. Fourth, it is required that social insurance should be an efficient financing mechanism. In order to help NHI to be efficiently administered, and to strengthen stability of the health insurance system in the long run, it is advised that social insurance should be in harmony with the market principles. Therefore, some assert that MSA should be better fitted in the Korea's socio-economic, and demographic conditions²⁸.

By nature, the MSA scheme is regarded as a means of risk pooling based on personal savings. While health insurance is designed to make contribution to the cross-sectional risk pooling, MSA to the inter-temporal risk pooling²⁹. As said previously, health insurance has two important functions to play, namely, functions of risk pooling, and income redistribution. Generally speaking, health insurance as a social insurance system is subject to moral hazard problems induced by the insured and medical providers. It also brings about intergenerational redistribution in favor of the elderly, for instance. For health insurance is based on the pay-as-you-go financing approach. On the other hand, MSA discourages at the maximum the possibility of inducing moral hazard, while it is independent from the current institutional features which tend to do a favor to the elderly by emphasizing the importance of individual responsibility in utilizing medical resources. However, it does not have any direct role for income redistribution.

Some economists argue that the best way to bring health care costs under control would be to enhance the role of market forces in the health care sector³⁰. MSA is essentially based on the market principle, and is regarded as

²⁸ See Prescott (1998) and Kwon (1999). The same story can be applied to Japan. The Japanese are conscientious savers, have a strong sense of responsibility, and on the whole would not be disturbed or financially troubled by having to pay a contribution for MSA from their own saving accounts.

²⁹ See Prescott (1998) and Han, et al. (1999).

³⁰ See Rosen (1988).

an efficient financing mechanism. As the Singaporean experience indicates, the MSA scheme can be considered as one of the most effective means in solving the contemporary problems of instability in health care finance. It has been allegedly reported that MSA has contributed to solving such thorny issues as financing medical services for elderly people, and stabilization of NHE to some extent in Singapore³¹. However, the assertion on the last point is subject to further verifications.

Also, the MSA concept is perfectly in lines with the spirit of the recent OECD Report. It succinctly summarizes the future direction of health insurance policy as follows: it is desirable for the governments to pursue a balance between market forces on one hand and government regulation on the other³². In other words, policy reform of the health insurance system should be designed and proceeded to promote optimal division of works between individual responsibility and social responsibility. Though the Korean government has not officially endorsed MSA, a group of health economists strongly support its introduction to Korea as a complementary financing scheme with a long-term perspective³³.

It is critically important in this context to keep in mind that integration approach alone cannot solve all of the structural problems, such as the fundamental issues of financial instability of the health insurance system, and a rapid increase in NHE. For integration approach may provide only a necessary condition, not a sufficient condition for raising financial stability in health care finance on a long-term basis. This is the main reason why alternative financing mechanisms, and other related changes are required to permanently expand the financial basis of the health insurance system.

Once the integration would be successfully carried out as planned, it is expected that there will be a couple of important positive changes in Korea's

³¹ See Masaro and Wong (1995).

³² See OECD (1999).

³³ Some argue among the Korean health economists that health care policies from now on should be implemented via an interaction of two factors: the market and the state. For example, they assert that greater individual flexibility in choice of health care delivery should be considered through the medium of individual saving accounts. See Han et al. (1999) and Kwon (1999), for instance.

health sector. First of all, there should be clear incentives given to the medical providers as well as consumers in utilizing medical services in a cost-effective manner. Such changes would be attributable to a shift toward prevention-oriented health services, including preventive medicine, health education³⁴, and rehabilitation, deviating from the dominating status of curative services at present. As the Taiwanese experience indicates, there will be additional effects such as decrease in administrative costs of health insurance, enhanced equity in premiums assessment and benefits payment, and improved quality of medical services, and so on (see Table 6)³⁵. Among the expected results, the most important outcome of the policy reform should be the elimination of such discrepancies so that by reform every insured will confer the same level of benefits.

However, there remain a couple of thorny issues to be tackled. The primary issue should be related to how to develop a fair method of adequately assessing earnings or incomes of self-employed groups in order to levy adequate premiums for them. The next issue is how to persuade active

Table 6. Expected Results and Remaining Issues

1. Expected results of integration
- Improved cost effectiveness
- Enhanced equity
- Improved quality of medical services
- Expanded role of the insurer
2. Major issues to be solved
- To develop an adequate method of income assessment for the self-employed
- To persuade workers' groups standing against integration.

³⁴ Prevention, and health education include effective health screening and immunization programs.

³⁵ See Planning Commission for Unifying Health Insurance (1998).

leaders of labor unions and salary workers' groups in view of their strong resistance so far. These social pressure groups have engaged in a steady war against the government in order for them not to bear a heavier burden than before in terms of premium contributions as a result of integration.

4. Major Lessons Japan Can Draw from the Korean Experience

It appears that Japan can draw a couple of positive and negative lessons, respectively from the Korean experience. First, we will examine positive lessons. The first lesson could be 'a sense of timing for making policy changes and quickness in making adjustments to a changing nature of policy environments'. Once recognizing that the policy direction to move toward integration was right, and its merits were known to be quite significant, compared to its costs, the Korean government was in the right place at the right time in making such a movement. As the OECD Report clearly indicates, advanced countries are gradually reorienting their policy-making to take into account a more integrated approach to health care³⁶.

Second, Korea's movement toward a unified health insurance system may not be possible, if there was not a firm determination from the political leadership. Suppose there was no government change in the 1997 presidential election. Then, it is quite certain that Korea keeps the previous health insurance system with some minor modifications. It can thus be said that Korea could successfully shift its direction from multiple carriers to a single carrier in administering the health insurance system, mainly thanks to political leader's decision-making. A reform-minded Chief Executive takes initiatives in overhauling the existing health insurance system to improve both equity and efficiency, for the benefit of general public, in particular, economically less fortunate groups.

Third, the government correctly recognizes the fact that integration approach alone is not enough as a fundamental solution vis-a-vis the issue of financial instability of the insurance system as a whole. The Korean government in this context makes it clear that it is necessary to experiment

³⁶ See OECD (1999).

various financing arrangements. Some of the Korean health economists argue that complementary financial mechanisms and utilization of the market forces are required to improve the financial stability of the health insurance system on a permanent basis³⁷. Since we gave detail on this issue in the previous section, a few more policy measures are suggested here. For instance, the shortcomings of the fee-for service payment can be to some extent mitigated by developing a system of resource-based relative value studies (RBRVS, for short). It is also required to pursue a new approach to integrate preventive and curative services, along with reconsideration on the role of primary health care. It is particularly important to emphasize the importance of empowerment of the public in this regard³⁸. The Korean government also tries to reduce administrative costs of the health insurance system by developing a slim, yet democratic management system, and promoting competition among six regional offices when the complete integration will be done.

On the other hand, we can also point out a number of negative lessons. First, during the period of presidential election campaign, a strong political commitment has been made, all of sudden, without due preparations for policy changes of such an importance. Of course, similar proposals have been raised by a group of scholars in favor of integration since the mid-1980s. Due to the reversed order in proceeding policy changes, however, it is inevitable for the Korean government to repeat ‘trial and error’ in pushing forward integration efforts. This sort of ‘top-down approach’ initiated by the political leader’s decision turned out inefficient, because the government should change the policy directions quite often whenever facing new stumbling blocks, including political one, due to lack of preparations. Accordingly, it is considered as highly costly.

Second, it should be desirable for the government to have a sufficient

³⁷ Some of the Japanese health economists also believe that the current system could be improved by the introduction of more market forces. See Hiroi (1997) and Tokita (1999), among others.

³⁸ The OECD Report shows “fully-informed and involved patients are more likely to adopt necessary behavioral changes than if faced with a purely paternalistic approach”. Thus, empowerment of patients is a necessary component of a prevention-oriented reform strategy. See OECD (1999).

amount of feedback processes with the insured, the entire Korean citizens, in view of a significant change in policy direction. Also, it is important to take care of people's needs, whenever the government tries to change policy directions that affect people's daily living. OECD in this regard clearly depicts that it is important to focus on the needs of individuals in health policy making³⁹. Mere making a quick movement toward a unified system does not carry a significant meaning when people do not understand or cannot follow such policy changes.

As a matter of fact, there has been an organized resistance in Korea since the government officially announced the policy reform toward integration. In particular, active leaders of labor unions and salary workers' organizations took initiatives in opposing the government, simply because they have a negative expectation that as a result of policy changes they must bear heavier burden in terms of premiums than before. Recognizing that the opposition forces are not weak, the government and ruling party agreed to postpone the completion of the administrative integration by six months. For they are particularly conscious about potential negative impact on the coming election for the National Assembly. It should thus be strongly warned that political decisions, not economic decisions might ruin the steady movement toward desired goal of a unified health insurance system.

Third, there are groups of people in the Korean government, who tend to exaggerate the positive effects of integration⁴⁰. It is important in this context to point out that the movement toward integration does not necessarily bring about panacea for fundamentally reforming the health insurance system in Korea. This means that integration could provide a necessary condition, not a sufficient condition for overall improvements in health care financing. As previously discussed, if and only if there would be complementary institutional arrangements, which support integration approach, such policy changes make more sense.

³⁹ *ibid.*

⁴⁰ Theoretically speaking, integration approach should have an edge over alternative management scheme run by multiple carriers both in terms of equity and efficiency. Here, we implicitly assume that health insurance is being optimally administered. In other words, economies of scale and scope economies are realized either on a national basis or regional competition basis.

5. Policy Options for Japan: Simulation Analysis

As seen previously, the Japanese health insurance system has numerous problems at present. They are boiled down to two major issues, among others. The first issue is focused on financial vulnerability of the health insurance system. This is due to a sky-rocketed increase in NHE, that is mainly attributable to a rapidly aging population. The second issue is related to the discrepancies in benefits and premiums level among the insured. The second problem can be approached in two different ways: one is to unify health insurance, and the other is to improve co-financing scheme so that there would not be any more gaps and discrepancies in benefits and premiums among different carriers. Korea and Taiwan employed an integration approach, while Germany and Netherlands pursued the latter approach.

The first problem is more difficult to solve, in the sense that it involves a demographic shift, which the government cannot control at all. In order to solve this problem, fundamental reform packages are required in such areas as financing schemes as well as payment methods. Facing a low economic growth, it will be extremely difficult for the Japanese government to provide adequate amounts of subsidies to make up the deficit of health insurance. Also it is not easy under a sluggish economy for health insurance societies to raise premium rates on a continuing basis in order to be able to meet ever-rising benefits payments.

It is evident that the Japanese health insurance system is facing the crisis. Which way should it go in order to get out of current doldrums? The Japanese government recently has made it clear that there should be fundamental structural reform in health insurance. As far as making reform is concerned, it is advised that the Japanese government must not seek for political solutions in view of the Korean mistakes. Also, it should take particular Japanese situations into consideration, when choosing appropriate policy directions. Such country-specific conditions may include preferences of Japanese people, political atmosphere and economic reality at present and in the future, and so on.

The fundamental structure of health care financing in Japan should

undergo a significant change in the foreseeable future. We want to propose a series of measures, which point the way to future reform in health insurance. Two objectives of reform are ‘to maintain medical care expenditures at an adequate level now and for the future’, and ‘to ensure a fair distribution of benefits and contributions among the various insurance schemes’. These differences should be leveled so that the health insurance system as a whole can continue to be treated as a fair social insurance institution.

Based on the survey of the recently published Japanese literature on the health insurance reform, it can be said that Japan has several options for policy changes in reforming health care financing⁴¹. When dividing the policy reform issues into adequate provision of care for the elderly, and equity, each policy area has a couple of policy alternatives, respectively. However, we had better combine them to discuss policy alternatives on a practical basis. Table 7 shows four different plans. That is (1) a complete integration plan, (2) a partial integration plan--having two different insurance programs, one for employees and the other one for the self-employed, (3) maintenance of the present system with expanded co-financing schemes (Risk Structure Adjustment plan, RSA⁴², for short), and (4) establishment of a separate insurance program for the elderly, which is financed by consumption tax.

For the sake of simplicity, we want to use abbreviation form to facilitate our discussion on the policy reform. In short, we assume ‘elderly care, and equity’ represent the issues of provision of adequate care for the elderly, and discrepancies in benefits and premiums among the insured, while assuming that ‘efficiency’ delineates the issues of financial instability and a rapid increase in NHE. At present, there are four different proposals suggested in Japan to primarily tackle the former issues (Table 7). Regarding the efficiency issues, there are no clear policy options suggested so far, except a

⁴¹ Website of the Ministry of Health and Welfare in this regard provides a condensed form of summary on the policy alternatives. See Ministry of Health and Welfare (1998).

⁴² This plan is similar to the German RSA, which is footed on the principles of autonomy of the insurers, and social integration. The German reform measures aim at improving overall efficiency of NHE by equalizing the burden of the insurers, and enhancing competition among the insurers based on the market forces.

Table 7. Policy Options Suggested for Japan

(1) Equity Enhancing	(2) Adequate Care for the Elderly	(3) (1) + (2)
<ul style="list-style-type: none"> • Complete integration • Partial integration • RSA plan 	<ul style="list-style-type: none"> • Separate insurance for the elderly • RSA plan • Complete integration • Public assistance for the elderly • Improving present health care system for the elderly 	<ul style="list-style-type: none"> • Complete integration • Partial integration • RSA plan • Separate insurance program for the elderly financed by consumption tax

few proposals⁴³ including one by the government, which is characterized by marshalling all sorts of flowery words without providing any substantive policy alternatives.

Therefore, Japan's health care planners should be paying greater attention to the issue of financial vulnerability in health care finance. Finding it impossible to increase available funds for health care bills, a priority should be given to the improvements in financing mechanism. There are certainly some grounds for concern that more radical and comprehensive kinds of reform might be necessary if the present system is to be in a position to respond fully and to cope compassionately with the changes taking place in Japanese society. The changes are so deep as they might suggest and yet one can sense that Japan's policy-makers may be misinterpreting the evidence and indicators all around them.

In this section, we will employ simulation analysis in order to focus on the financial status of the Japanese health insurance system as a whole. Among those four proposals, three plans, except the complete integration plan, are regarded realistic in the sense that they are in lines with a gradual change, which is most likely to happen in Japan. This means that Japan would go

⁴³ For instance, see Nishimura (1999c), and Hiroi (1997).

slowly in making policy reform. However, the complete integration plan (this is what Korea chooses) can give a benchmark for our simulation exercises. Then, we will introduce MSA primarily to deal with the efficiency issues, that is, to expand the financial basis of health care finance with a long-term perspective. The MSA scheme utilized for the simulation analysis for Japan is assumed to be one, which is very similar to the Singaporean MSA scheme in terms of risk pooling function⁴⁴. It is also assumed that every Japanese citizen should take part in the MSA scheme on a compulsory basis⁴⁵.

Basically, MSA is an individual savings account from which one's medical bill for the routine services is paid. MSA is supposed to cover those services that the insured frequently utilize at relatively small costs. Also MSA has an insurance component from which premiums are paid for catastrophic illnesses, that require a large amount of medical expenses. When people are young, they rarely utilize this insurance. On the other hand, the older, the more frequently one utilizes it. Normally this type of insurance requires relatively higher copayment rates. At the practical level, however, a special consideration should be given to the possible exemption from cost-sharing allowed to the poor and elderly population, either in full or in part, depending on one's ability to pay⁴⁶.

⁴⁴ The Singaporean MSA consists of three branch programs, that is, Medisave, Medishield, and Medifund. Medisave is savings accounts from which premiums for Medishield are regularly withdrawn automatically. Medifund is a public assistance program, and is financed by the government for the medically poor. Medisave also covers routine medical services, while Medishield provides insurance against catastrophic diseases. Some of the health economists in this context assert that patients should be asked to pay most of the costs for all routine procedures, but the state should provide virtually complete insurance against catastrophes. For, very expensive treatments, albeit for a relatively small proportion of patients, could increase overall medical costs. See Rosen (1988).

⁴⁵ The MSA scheme for Japan can start with a moderate amount of savings. As the overall size of the medical bills increases, then the amount of savings for this purpose would be increased accordingly on a gradual basis. This sort of a piecemeal approach is practically desirable in reducing the degree of resistance at the initial stage of introducing a new system like MSA. Since MSA is regarded as one of the most cost-effective financing mechanisms so far, Japan can smoothly transfer a part of the high personal saving rates into MSA, provided that a slow, but steady process to persuade the insured should follow.

⁴⁶ Recall that equity in the finance of health care means that payments of health care should be positively related to a person's ability to pay. Germany, for instance, set a cap on the amount of copayments as a proportion of income. See OECD (1999).

The basic formula for our exercises can be summarized as follows: for the sake of simplification, we assume that there would be no change in premium rates, benefits level and copayments with the introduction of MSA⁴⁷. Then, we divide outpatient services into several categories in terms of utilization frequency and expenses. Up until 3,000 yen per visit, the entire medical expenses should be born by patients in order to encourage them to be cost-conscious in utilizing routine procedures, and health-conscious by inducing them to practice healthy life-style. From 3,000 to 10,000 yen per visit, those medical expenses are paid from MSA. And for those services, which exceed 10,000 yen, health insurance would reimburse.

In the case of inpatient services, there are two different categories—catastrophic illnesses and non-catastrophic illnesses. Up until 500 thousand yen (considered as non-catastrophic illness), medical expenses are paid from health insurance, except the copayments. And those services, which exceed 500 thousand yen (considered as catastrophic illnesses) would be reimbursed from MSA-attached catastrophic insurance, subtracting copayments. It should be noted that there are some variations in the pattern of the medical utilization by expenditure category between the elderly and the non-elderly. Accordingly, it is desirable to carry out the simulation exercises (both inpatient and outpatient) by differentiating the elderly group (those who are aged 70 or more) and the non-elderly group (those who are aged below 70).

Based on this formula, we will conduct simulation analysis⁴⁸ for four policy options: a complete integration plan, a partial integration plan, and a RSA plan, and a separate program for the elderly. We will first calculate the financial status of the Japanese health care finance for the future for each of the four plans without consideration of MSA. Then, we will add MSA for each

⁴⁷ Also we assume that the wage level, NHE, and interest rates do not change over time for the purpose of simplification. Calculations on the financial status will be done in 1995 constant market prices.

⁴⁸ This is based on the Suzuki model. The model is primarily designed for making projections of NHE, and is based on the 1990 model set up by Professors M. Ogura, and T. Irifune. The main feature lies in that it is able to reflect the characteristics of age groups so that one can analyze the effects of population aging on the increase in NHE. Population projections are based on the medium variant version of Population Projections for Japan (1997), published by the National Institute of Population and Social Security Research. See Suzuki (1999) for more detail.

plan, and similar calculations will be done. Thus, we will have eight different policy options in total.

Indeed, the health insurance finance in Japan is bound to face enormous difficulties. All major health insurance programs are expected to suffer from a long-ranged deficit problem. As the Ministry of Health and Welfare correctly points out, Japan could scarcely avoid the worst situation of a financial crisis, thanks to the revision of the Health Insurance Law in 1997. However, the government still worries that the rapid increase in NHE will contribute to pushing the financial status back to the old situation of instability in the years to come, if nothing will be done to check the rising trend of the medical bills⁴⁹.

As Table 8 shows, it is clear that there would be a huge amount of financial deficit accumulated in the near future unless fundamental reform measures regarding health care financing would not immediately be implemented. All four policy options, in terms of the cumulative amount of financial deficit for the health insurance system as a whole, will record -73.2 (Plan A), -101.2 (Plan B), -122.3 (Plan C), and -45.5 (Plan D) trillion yen in 2025, respectively⁵⁰. The main reason why Plan D will show the smallest amount of deficit is that elderly people will also pay consumption tax, thus making contributions to expanded financial basis of the health insurance system as a whole. Please note that the elderly at present do not pay any premiums for the health insurance programs.

This strongly suggests that an alternative financing mechanism like MSA should be necessary for Japan. Only after introducing a partial privatization scheme based on MSA, the Japanese health insurance system will be in a financially manageable shape, as Table 8 clearly reveals. Each plan will save about 20 percent of expenditures to be paid from the health insurance system with introducing the MSA scheme. Accordingly, every plan will record a significant amount of financial surplus in the long run, except the Plan C. Please remind that we assume that Japan will introduce a simple MSA scheme. And we also assume, for the sake of simplicity, the proportion of the

⁴⁹ See Ministry of Health and Welfare (1999).

⁵⁰ Plan D is identical to Plan D2 in the Table 8.

Table 8. **Results of the Simulation Exercises by Policy Option**

(1) Before Introducing MSA (the amount of annual deficit in billion yen)

	1997	2010	2025
Plan A: Complete integration	-126	-2,689 (-17,341)	-4,423 (-73,248)
Plan B: Partial integration	-126	-3,721 (-29,795)	-5,457 (-101,201)
Plan C: RSA plan	-126	-4,527 (-40,790)	-5,952 (-122,257)
Plan D1: Separate program for the elderly	-126	3,783 (54,826)	3,428 (108,560)
Plan D2: Separate program for the elderly	-126	-1,829 (-8,739)	-2,823 (-45,463)

(2) After Introducing MSA (the amount of annual deficit in billion yen)

	1997	2010	2025
Plan A	-126	1,022 (28,475)	-707 (28,673)
Plan B	-126	225 (18,889)	-1,517 (7,051)
Plan C	-126	-560 (8,156)	-1,985 (-13,379)
Plan D1	-126	6,214 (86,454)	5,589 (174,586)
Plan D2	-126	1,512 (33,005)	422 (45,832)

(Note) 1.D1 covers insurance system only for the non-elderly. This concept is included here to better explain D2. D2 covers insurance system for elderly people as well, which depends on the public financing through the earmarked consumption tax.

2. Figures in parentheses indicate cumulative amount of deficit in billion yen.

health expenditure through the MSA components out of the total medical expenditures would be constant over time. By varying the MSA version and making more realistic assumptions based on the dynamic expenditure data, Japan can choose an appropriate alternative financing mechanism.

It is also worthy to mention that when the MSA scheme will be established, one can expect that the health insurance fund could save furthermore because people would be more cost-effective in utilizing health resources and would be equipped with health conscious life-style. In this connection, it is worthwhile mentioning possible topics for further research in the future. One could be ‘the effects of MSA on intergenerational income redistribution, and cost-effectiveness’. Others might include ‘how to effectively design MSA in order to save health resources at the maximum’, and ‘how will individual contributions for the whole health care system be affected by introducing MSA’.

6. Summary and Conclusions

There is little question that Japan is facing a crisis in the financing health care. Her population is rapidly aging. The development and use of new health care technologies continues to grow. Many people are not receiving care appropriate to their needs in the most cost-effective way possible. Aging of the population alone will drive health care costs and utilization to ever-increasing levels. At present, the elderly is consuming about one third of NHE. By the year 2025, they are projected to consume 70 percent of all health care resources. Regardless of who pays for these services, this care must be managed in one way or another. Ineffective management will either bankrupt the Japanese economy or deny millions of Japanese people the care they truly need. We want to suggest a system that is sensitive to the needs of people in Japan, and conducive to the Japanese socio-economic, and demographic conditions now and for the future. It is recommended that Japan should pursue active aging approach. For this, Japanese policy-makers need to show a paradigm shift in designing the policy reform in a genuine sense.

It is interesting to see that Korea has adopted the same type of health

insurance as Japan did much earlier, yet she is moving ahead of Japan in reforming institutions. In view of apparent structural problems in terms of equity and efficiency, the Korean government has decided to move toward integration. Facing a slower economic growth rate than before, yet expecting an increased NHE year in year out, the Korean government has made a quick action for making reform. It seems that Japan lies in a more serious situation. What kind of path should Japan choose in reforming health insurance? It is worthy, as a good reference, to review what the Singaporean government has done for its health sector in the past two decades. Singapore has made it clear that the main objectives of health sector are two-fold: (1) to make the citizens healthy and productive by emphasizing the importance of preventive medicine, and (2) to encourage them to practice sound life-style, and to induce them cost-conscious in utilizing medical resources by improving the financing mechanism for health care. It is apparent that she has achieved a fair amount of success so far⁵¹.

Although the ‘aging society’ is clearly an important issue, it is not desirable to be obsessed with it. As a matter of fact, this issue has already stalked through all areas of public policy, including health sector, in Japan since 1980s. The policy makers have struggled to devise socially appropriate and financially tolerable programs to care for health needs of elderly people for the future. The challenge posed by the massive demographic shift to an aging population has already given considerable impact on health care provision. The real problem is that the negative psyche has been further reinforced by its coincidence with a downturn in Japan’s economic growth rate, which naturally restricts an increase in public spending⁵².

It is evident that the Japanese health insurance system currently faces serious structural problems in terms of equity and efficiency. In a sense, it is fighting a war for survival, particularly in view of the rapid population aging, and worsening financial status of health insurance. In a sluggish economy, it is difficult to either increase premium rates or decrease benefits level on a continuing basis. It is also not realistic to expect that the Japanese

⁵¹ See Prescott (1998), and Massaro and Wong (1995), among others.

⁵² OECD Study shows that the potential effects of aging could be compensated in part by a relative improvement in the health status of the elderly population. See OECD (1999).

government is able to increase the amount of subsidies earmarked for health insurance for many years to come. In short, the current doldrums is calling for fundamental reform for the sustainable health insurance system in the future. In essence, the Japanese problems are boiled down to the two issues. The first one is related to the possibility of insolvency in health care financing, due to ever-increasing number of the elderly, who tend to utilize medical resources heavily until the last moment of their lives. And the second one is discrepancies in premium rates and benefits payment between different insurance programs and among different insurance societies.

Given the changing socio-economic and demographic conditions, it seems that the basic policy direction for reforming the Japanese health insurance system should lie in the optimum division of works among social insurance, private insurance, and individual payment, along with movement toward integration. This means that Japan needs to rebuild her health insurance system in harmony with socio-economic, and demographic changes. Rebuilding thus demands for making a balance between individual responsibility and social responsibility in terms of overall cost-sharing. In other words, there should be an adequate balance between the government regulations and the market forces. In this line of policy frameworks, it is expected that integration could contribute to improvements in both equity and efficiency. What is fundamentally important in this context is to introduce supplementary financing mechanisms centering on MSA, and private insurance. Changes in payment methods also can improve the working of the health insurance system. These changes are primarily aiming at the expanded basis for health care finance for the future.

The results of simulation analysis show that only if alternative financing mechanisms were established, the Japanese health insurance system would be financially sound in the long run. Therefore, we would like to recommend a package of policy reform—integration of the health insurance system, and introduction of a new financing mechanism a la MSA of Singapore. Combining these two, Japan should, not only enhance efficiency, but also improve equity, thus upgrading her health insurance with a long-term perspective.

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