Legal access rights
to health care

COUNTRY PROFILE
JAPAN
Legal access rights to health care: country profile – Japan

(UHC Law in Practice)

ISBN 978-92-4-005643-5 (print version)

© World Health Organization 2019

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.


Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris. Sales, rights and licensing. To purchase WHO publications, see http://apps.who.int/bookorders. To submit requests for commercial use and queries on rights and licensing, see http://www.who.int/about/licensing.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers’ products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.
Acknowledgements
The country profile was written by Simone Bosch, independent health policy consultant and lawyer based in London (UK) under the technical supervision of David Clarke, Team Leader UHC and Health Systems Law, Department of Health Systems Governance and Financing, World Health Organization, Geneva, with indispensable input on the Japanese health care system by Haruka Sakamoto, Department of Global Health Policy, Graduate School of Medicine, The University of Tokyo.
Legal recognition of access rights to essential health services, medicines and vaccines

Citizens and residents

Citizens are required to enrol with either National Health Insurance1 or Employees’ Health Insurance2. Enrolment is based on age, employment status and/or place of residence. [1]

Employed persons and their dependents are covered by the Employees’ Health Insurance System run by the Japan Health Insurance Association and Society-Managed Health Insurance, which is regulated by the Health Insurance Act. [1, 2]

Self- and unemployed people are covered by the National Health Insurance (NHI) run by municipal governments, based on the National Health Insurance Act. Some professional groups are covered by their own insurers based on respective laws. [3] Citizens and residents 40 years of age and older are mandatorily enrolled in long-term care insurance provided by municipalities, based on Art. 9f of the Long-Term Care Insurance Act. [1, 3, 4]

Elderly aged 75 and above are required to enrol in the late-stage medical care.

Elderly aged 75 and above are required to enrol in the late-stage medical care system for the elderly instead of NHI. This separation was introduced in 2008 with the Act on Assurance of Medical Care for Elderly People. [1]

NHI enrolment must happen within two weeks of becoming eligible for coverage. This might happen because of immigration from overseas, moving to another municipality, birth to parents not covered by an employees’ scheme, losing coverage through an employees’ scheme (e.g. due to redundancy or becoming self-employed), or increased income (i.e. not being eligible anymore for coverage under the social welfare system). [5]

Foreigners moving to Japan are required to enrol in the NHI after three months of residency in Japan, unless they are covered by Employees’ Health Insurance. [5]

The co-payment rate is 30% for all insured persons aged 6 to 69 years. To prevent financial hardship, monthly out-of-pocket thresholds exist which vary according to the insured’s age and income. In addition, annual household out-of-pocket ceilings are in place, which also vary according to age and income. Payments above the ceilings get reimbursed. Monthly ceilings also exist for people on low income. Persons insured through NHI (unemployed, retirees and self-employed) are entitled to reduced premiums if they are on a low income; if they are on a medium income, they are eligible if they face major, unexpected income reductions. Beneficiaries of the Employees’ Health Insurance System do not pay premiums during parental leave. [6]

People living below the poverty line are covered by the social welfare system based on the Public Assistance Act (Articles 15 and 34). They receive the same care for free (100% governmental subsidy) than those insured under the statutory health care system. The criteria to define the poverty line vary among prefectures. [1, 7]
Co-payment reduction programmes exist for various population and disease groups to reduce catastrophic health expenditure:

- Patients suffering from 331 specified intractable or chronic diseases pay reduced co-insurance rates (varying by income) as long as they use designated health care providers. [1]

- Persons suffering from disabilities and mental health issues are also eligible for co-payment reductions based on the Services and Supports for Persons with Disabilities Act; however, this is restricted to those falling below pre-defined limits of household income. [8, 9]

- Based on the Child Welfare Act and the Maternal and Child Health Act, co-payment reduction is granted for children with low birth weight, tuberculosis or chronic diseases. [10, 11]

- Diagnosis and treatment for some infectious diseases is covered by prefectures for all. For more information, see below under title “Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage”. [12]

Japan’s private health insurance companies do not provide traditional private health insurance but offer supplemental income in case of illness (sick pay). Most of Japan’s population buys private health insurance to supplement or complement their statutory cover with cash benefits in case of illness. Private health insurance companies pay lump-sum payments or daily payments over a defined period, mostly for specific chronic diseases. [6]

**Undocumented migrants and visitors**

Undocumented migrants and visitors are not covered by Japan’s statutory health care system and need to pay for health care out of pocket. [6]

People living below the poverty line are covered by the social welfare system. They receive the same care for free.

**30%**

Co-payment rate for all insured persons aged 6 to 69 years.

**Documented migrants**

Documented migrants are treated the same as residents (foreigners living in Japan for more than three months) based on Article 7 of the NHI Act and Article 35 of the Health Insurance Act. Both acts do not distinguish documented foreigners based on their legal status. [2, 3]
The benefit package for both the NHI and Employees’ Health Insurances schemes are the same.

The benefit package covers hospital, primary, specialty, and mental health care; hospice care; physiotherapy; most dental care; approved prescription drugs; ante-natal care and delivery in case of pregnancy complications (normal pregnancy is not covered); and home care services by medical institutions (if provided by non-medical institutions, then home care services are covered by long-term care insurance). Optometry services are only covered if provided by physicians; corrective lenses are excluded except for children aged under 9 if recommended by a physician. [6]

Based on the Maternal and Child Health Act, parents receive the Maternal and Child Health Handbook, which contains information and all data on their ante- and post-natal check-ups, delivery and complications; continued guidance and consultation from public health nurses during pregnancy; screening for congenital metabolic diseases after delivery; three well-baby check-ups (at 3-4 months, 18 months and 3 years of age); hepatitis B vaccination; and, if the mother lives with hepatitis B, free immunoglobulin. Most municipalities provide up to five additional health check-ups for babies and children. [1]

Preventive services, such as general medical check-ups, screening, counselling and health education, are not included in the NHI scheme, but covered by municipal governments (Art. 82 of the National Health Insurance Act). In addition, employed persons have a right to yearly health check-ups, including mental health, paid for by their employer based on the Industry Safety and Health Act. [1, 3]

Ante-natal care and delivery for pregnancies without complications are excluded but covered through the municipal governments which grant lump sum payments upon application (Article 58(1) of the National Health Insurance Act and Articles 101 ff. of the Health Insurance Act). [2, 3, 9]

Immunization services are also excluded from the NHI benefit package but covered through municipal governments who pay for children’s vaccinations and the pneumococcal vaccine for persons aged above 65. Orthodontics, cosmetic surgery and treatments as well as single-patient bedrooms are excluded from the NHI benefit package and have to be paid for out-of-pocket. [5, 9]

Work-related injuries and conditions are also excluded as they are covered by the workers’ accident compensation insurance plan, run by the Government. The insured entities are private companies. The legal basis is the Industrial Accident Compensation Insurance Act. [13]

Coverage can be limited or refused for injuries or conditions incurred intentionally or as a result of extreme misconduct, crime, fighting or drunkenness. [2, 3]

Medical costs are not reimbursed if patients fail to follow instructions regarding their treatment or do not provide necessary paperwork or undergo necessary examination to support reimbursement claims without a justifiable reason. [2, 3]

Persons suffering from pollution-related diseases can receive various benefits based on the Law Concerning Pollution-Related Health Damage Compensation and other Measures: medical expenses, medical care allowance, disability compensation, survivors’ compensation, survivors’ lump-sum compensation, child compensation allowance, and funeral expenses. [14]
Legal mechanism to enforce access rights to health care

Health care providers enter into contracts with insurers and directly claim for reimbursement for treatments provided to persons insured through the NHI. If insurers refuse to pay for provided services, health care providers can use the complaints process set out in Articles 91ff. of the National Health Insurance Act. Health care providers may file an application for examination verbally or in writing with the responsible National Health Insurance Examination Board within 60 days of the insurer’s decision to refuse payment of an insurance claim (or other decisions or actions deemed unrightful, e.g. how the monthly or annual cap is applied). An application for examination must be filed with the Examination Board of the prefecture governing the location of the insurer or municipality which took the disputed action; if a complaint is submitted to an Examination Board without jurisdiction, it must promptly transfer the application to the correct Examination Board, notifying the claimant of the transfer. Each prefecture has a National Health Insurance Examination Board composed of nine part-time members representing insured persons, insurers and the public (three each). Examination Board members serve three-year terms and can be reappointed. The majority of an Examination Boards’ members must be present to have quorum, and decisions are taken by majority; in case of a tie, the Chairman decides. Decisions cannot be appealed by health care providers and they are required to cover the costs not reimbursed by insurers. If the insurer and health care provider cannot come to an agreement, then the beneficiary could claim for reimbursement directly from their insurer. However, this is quite rare given the fact that health care providers need to cover unpaid fees, not the beneficiaries. [3, 9]

The complaints process for the Employees’ Health Insurance is similar to the one of the NHI. Health care providers claim for reimbursement, and in case of disagreement with the insurers’ decisions, they can submit a complaint to the Social Insurance Examiner. A total of six examiners are appointed by the Ministry of Health, Welfare and Labour. Health care providers can demand for a re-examination if they disagree with the Examiner’s decision. A decision following re-examination is final. If a request for examination is not decided within two months, dismissal of the examination is assumed. If a complaint is dismissed, health care providers must cover the amount not reimbursed by insurers. If the insurer and health care provider cannot come to an agreement, then the beneficiary could claim for reimbursement directly from their insurer. However, this is quite rare given the fact that health care providers need to cover unpaid fees, not the beneficiaries. [2, 9]
Anti-discrimination provisions applicable to health care

Ratification of international human rights instruments

Japan has acceded to the International Covenant on Economic, Social and Cultural Rights and has ratified the International Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities. [15]

National anti-discrimination provisions and complaint mechanisms

The Japanese Constitution stipulates in Article 14 equality before the law and prohibits discrimination with political, economic or social consequences based on race, creed, sex, social status or family origin. [16]

The Public Assistance Act’s Article 2 contains a non-discrimination and equality clause with respect to receiving public assistance through the Ministry of Health, Welfare and Labour. The clause does not list the characteristics based on which discrimination is prohibited. [7]

The Basic Act for Persons with Disabilities includes an anti-discrimination clause in Article 4 to prohibit discrimination based on disability. The Act for Eliminating Discrimination against People with Disabilities defines measures applicable to both government authorities and private companies to eliminate discriminatory behaviour and access barriers for people living with disabilities. [17, 18]

The Act on Securing Equal Opportunity and Treatment between Men and Women in Employment sets out measures in Articles 12 and 13 requiring employers to protect women from discrimination during pregnancy and after child-birth. [19]

In February 2019, parliamentary endeavours started to develop a basic law governing health care, which might include anti-discrimination provisions protecting patients from discriminatory treatment. [9]

Japan has acceded to the International Covenant on Economic, Social and Cultural Rights and has ratified the International Convention on the Elimination of All Forms of Racial Discrimination.
Access barriers

Foreigners residing in Japan have a higher mortality rate than Japanese citizens. The language barrier impedes access to health care and a legal framework mandating medical language interpretation does not exist. In view of the 2020 Olympics in Tokyo, efforts are under way to minimise language barriers, introducing interpretation services in various languages. However, these seem to be mostly aimed at relatively wealthy foreigners. [20-22]

An additional access barrier is a lack of understanding of how the Japanese health care system works, how to access insurance and what benefits the statutory insurance system provides. Many foreign residents, for example the Nepalese who are the largest immigrant group in Japan, lack awareness on the system and their rights and are not informed appropriately by their employers, the Japanese municipalities where they live and the immigration agencies they use. In addition, companies employing vulnerable groups such as visa overstayers, foreign trainees and Nikkeijin (Latin Americans of Japanese descent) oftentimes discourage enrolment in the Employees’ Health Insurance in violation of labour laws to avoid payment of the employer’s half of insurance premium. [22, 23]

Ethnic minorities and other minority populations also face economic access barriers to the health care system. Citizens and residents eligible for NHI but who do not enrol or keep up their NHI enrolment are required to pay two years’ worth of premiums upon re-entering the system. If they cannot afford the payment, they cannot enrol in the insurance scheme and have to pay out-of-pocket for treatment. [6]

A scarcity of systematic empirical evidence impedes an accurate estimate of access barriers to the Japanese health care system. [1]

Clinics and physicians are required by law to provide treatment and may not refuse treatment without just cause.

Clinics and physicians are required by law to provide treatment (except cosmetic surgery, preventive measures and normal delivery) and may not refuse treatment without just cause. However, hospitals are encouraged by the Government to strictly check identity documents and insurance cards prior to treatment. This creates access barriers to anyone not covered under one of the insurance schemes or who is in arrears with premium payments. Some hospitals deny care to people without insurance because they are left with unpaid bills, prioritising fee payment over provision of care; charge higher fees to uninsured people; or discharge them earlier. In addition, identity checks raise fears of undocumented migrants, visa overstayers and some asylum seekers being reported to immigration officials. [20, 22-24]

Physicians treating people for a legally defined set of infections must report the cases to authorities, including the patients’ name, age and gender, which constitutes another access barrier for patients with an irregular legal status. [12]
Limited set of essential health services, medicines and vaccines accessible to all, including groups without health coverage

Based on the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases, prefectures are mandated to bear costs for anyone irrespective of legal status for diagnosis, medicines and therapeutic materials, medical procedures, surgery and other therapy as well as care and other nursing incidental to medical treatment for class I or class II infection, new infectious diseases or novel influenza. For tuberculosis treatment, the prefecture bears 95% of costs. If a patient or relative is deemed able to cover costs partly or wholly, the prefecture can mandate the patient or relative to bear the costs (wholly or partly). Treatment for listed infectious diseases is covered if it is received in designated hospitals, unless the prefectural governor permits treatment in another medical facility or in cases of emergency. Treatment costs are directly reimbursed to health care providers by local governments for those patients unable to bear costs wholly or partially: health care providers send their reimbursement applications to the prefectural governor via the chief of the public health centre responsible in the area of the patient’s residency. [12, 25]

If a patient does not seek treatment for a class I or class II infection, tuberculosis or novel influenza, the prefecture has the right to forced hospitalization for up to 72 hours. If the prefecture considers continued hospitalization necessary after 72 hours, it must convene an expert committee to decide if continued forced hospitalization up to ten days (30 days for tuberculosis) is necessary. [12]

Physicians treating people for infections included in the Act on the Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases must notify the prefectural governor via the chief of the nearest public health centre, including the name, age and gender of the patient. Health care providers’ applications for reimbursement to the local governments also include personal details of the patient. Consequently, patients who are undocumented or in Japan illegally might not seek health care even though they have a statutory right to receive free treatment for listed infections. [12]

References

1 国民健康保険 Kokumin-Kenko-Hoken.
2 健康保険 Kenko-Hoken.
3 E.g. Mariners Insurance Act, National Public Servants Mutual Aid Association Act, Local Public Officers Mutual Aid Association Act.
4 Restrictions are based on income and number of dependents:
   0 JPY 3,604,000 (around USD 32,600) / 1 JPY 3,984,000 (around USD 36,000) / 2 JPY 4,364,000 (around USD 39,500)
   3 JPY 4,744,000 (around USD 43,000) / 4 JPY 5,124,000 (around USD 46,400) / 5 JPY 5,504,000 (around USD 49,800)
   ≥6 JPY 5,504,000 + 380,000 per additional dependent (around USD 49,800 + USD 3,440)
5 Asylum-seekers entering with three-month tourist visas often wait up to two years for a decision on their legal status. They are denied provisional visas and become visa-overstayers during the asylum application process.
6 Class I infections include Ebola haemorrhagic fever, Crimean-Congo haemorrhagic fever, smallpox, South American haemorrhagic fever, plague, Marburg virus disease and Lassa fever. Class II infections include acute poliomyelitis, tuberculosis, diphtheria, severe acute respiratory syndrome (limited to the one involving SARS coronavirus within the genus Betacoronavirus as a pathogen), Middle East respiratory syndrome (limited to the one involving MERS coronavirus within the genus Betacoronavirus as a pathogen) and avian influenza (limited to influenza A virus within the genus Influenza A virus as a pathogen and involving a serosubtype which is specified by Cabinet Order as being highly likely to mutate into a pathogen of a novel influenza infection).
7 New infectious diseases are defined as a disease transmittable between persons involving pathological conditions or therapeutic outcomes apparently different from any already known infectious disease, that could cause serious health outcomes and that would in all likelihood seriously affect the public’s health if they spread.
8 Lineal relatives with a duty of support according to Article 877 of the Japanese Civil Code.


[9] Information provided by Haruka Sakamoto, Department of Global Health Policy, Graduate School of Medicine, The University of Tokyo.


