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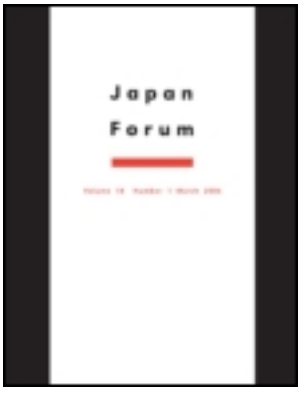

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Japan's epoch-making health-insurance reforms, 1937-1945

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Japan's epoch-making health-insurance reforms, 1937–1945

YONEYUKI SUGITA

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Abstract: This article presents an examination of Japan's epoch-making health-insurance reforms undertaken during the Asia-Pacific War between 1937 and 1945. These reforms culminated in amendments to the Health Insurance Law and the National Health Insurance Law in 1942, along with the enactment of the National Medical Treatment Law. The issues addressed in this article are, firstly, the kind of reforms of Japan's health-insurance programs that took place during this period, and secondly, the historical significance of these reforms. Focusing on three elements of the wartime health-insurance reforms – expansion of the number of insured people, transformation of payment system to physicians and provision of easy access to medical institutions – this article examines the following hypothesis: Japanese Health Insurance, established in 1922, which primarily aimed at maintaining and restoring workers' health and physical work capability, and providing them with economic assistance during those times when they suffered from sickness or injury, was qualitatively transformed to quasi-public-assistance programs with financial dependence on the state during wartime, which established an institutional setting that contributed to the rise of health-insurance expenditure in the post-war era.

Keywords: health insurance, National Health Insurance, National Medical Treatment Law, Japan Medical Association, Ministry of Health and Welfare

Introduction

Japan instituted epoch-making reforms to its health-insurance programs during the Asia-Pacific War between 1937 and 1945. This article addresses two research questions: firstly, the nature of the reforms of Japan's health-insurance programs that took place during this period, and secondly, the historical significance of these reforms. In this article, 'health-insurance programs' is used as a general term to indicate a variety of legally required sickness-insurance programs (social insurance), such as Health Insurance, National Health Insurance and so on.

This article tests and confirms the following hypotheses: Japanese Health Insurance, a prototype of various Japanese health-insurance programs, was established

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by the Health Insurance Law of 1922, primarily for the purpose of maintaining and restoring workers' health and physical work capabilities, and providing them with economic assistance during those times when they suffered from sickness or injury. The Health-Insurance program underwent a series of revisions. Moreover, different health-insurance programs, such as Clerical Employee Health Insurance and National Health Insurance, were newly established. These developments resulted in the qualitative transformation of Japanese health-insurance programs. The culmination of this transformation was several pieces of reform legislation passed in 1942: major amendments to the Health Insurance Law and the National Health Insurance Law, and enactment of the National Medical Treatment Law. These wartime reforms were actually substantive in terms of institutionalizing programs with an inevitable mechanism that would bring continuous growth in Japan's health-insurance expenditure.

In the 1930s and 1940s, welfare states began to emerge in various countries around the world. The United States took the global initiative in establishing a welfare state by passing the Social Security Act of 1935. New Zealand followed, with its own Social Security Act in 1938. Germany's Third Reich built its own welfare state, based primarily on plundered food resources, raw materials, industrial manufacture and other goods stolen from conquered countries, as well as undertaking a massive dispossession of Jewish-owned wealth (Götz 2005). In United Kingdom, the 1942 Beveridge Report created a framework for establishing a welfare state not only in that country but that also served as a post-war model applied in other industrialized countries, including Japan (Abel-Smith 1992). Japan was part of this global trend in moving toward a welfare state and the socialization of medicine. From the start, health-insurance programs constituted the central pillar of the Japanese welfare state. Consequently, when scholars examine the early stages of the Japanese welfare state, they tend to focus on Japanese health-insurance programs.

Many scholars trace the origins of Japan's post-war health-insurance system to democratic reforms implemented during the Allied Occupation of Japan (Kuroki 1959, Ōuchi 1961, Koyama 1969, Ōkōchi 1972, Kawakami 1982, Murakami 1987, Takemae and Murakami 1990, Fukawa 1994, Sugiyama 1995, Iwasaki and Takayanagi 1997). Indeed, these occupation-era reforms were important, but they were based on an institutional setting established during wartime. Because of the fact that Japan newly established or implemented major reforms of a series of health-insurance programs during the wartime period of 1937–1945, these developments had substantial effects on Japan's post-war health-insurance systems.

Some studies of the development of Japan's health-insurance programs during the wartime period have tended to focus on finding the origins of Japan's post-war health-insurance system and situating these origins in intensive wartime mobilization, thus suggesting much continuity between the wartime and post-war health-insurance system. Most of these studies describe a considerable increase in

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the state's role in health-insurance programs. Moreover, these studies commonly emphasize the emergence of these programs during the war as a positive development (Saguchi 1982, 1995, Kosaka 1995, Nakashizuka 1998, Zhong 1998, Mima 1998, Kasahara 1999, Nakamura 2006, Yamagishi 2011).

This article agrees with the contention that one can trace the origins of Japan's post-war health-insurance system to the wartime developments; however, these previous studies often underestimate the important effects of the reforms that took place during wartime in terms of their establishment of institutional mechanisms, an indispensable factor that contributed to the rise of health-insurance expenditure. In this sense, three elements in the wartime health-insurance reforms are important: 1) the increase in the number of insured people; 2) the transformation of the system of payment to physicians; and 3) the provision of easy access to medical institutions. These three wartime reform elements were critically important to the development of Japanese health-insurance programs. Their dynamics and significance will be further analyzed.

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Background

Japan enacted the Health Insurance Law in 1922 to 'solve the conflict between capital and labour, which would strengthen Japanese industry in international competition' (Yamamoto 1981). Delays attributed to the Great Kanto Earthquake in 1923 prevented the law from taking effect until 1927. The law engendered two programs, depending on the insurers: Government-Managed Health Insurance (where the government is the insurer) and Corporate Co-operative-Managed Health Insurance (corporate co-operatives are the insurers). These two programs, which provided insurance coverage for only a limited number of factory and mining workers at the time (approximately two million workers, or about 3.3 per cent of Japan's population) (Hiroumi 1974, pp. 121–22), had a limited mission: maintaining and restoring workers' health and physical ability to work, and providing them with economic assistance during those times when they suffered from sickness or injury. Both programs offered insurance against injury, disease, death and childbirth, but only to the workers covered by the program, not to their dependents. As for premiums, employers and employees were, in principle, each to pay an equal rate of the insurance expense. The government was to give them subsidies – one tenth of the insurance expenses, with an upper limit of two yen per person per year – which were expected to cover the administrative expenses.

The Government-Managed Health Insurance scheme employed a capitation payment unit contract system, a contractual arrangement between the Japanese government and the Japan Medical Association (JMA) in which both parties participated in annual negotiations to determine the amount of medical treatment fees per insured person (the unit fee). The total arrived at by multiplying the unit

fee by the number of insured people was the sum that the government was obligated to pay to the JMA. The JMA, in turn, distributed these government funds to physicians participating in the Health Insurance program and reimbursed them for their care of insured individuals, with payment based on a scoring system. The JMA devised a fee schedule that established scores for each kind of medical treatment. Insurance physicians submitted scores to the JMA in accordance with the medical treatments they provided for insured patients. In effect, the JMA assumed nearly full control over physicians in private practice participating in the insurance program, just under 32,000 or 70 per cent of all the physicians in Japan at that time (Tomonō 1950, p. 2, Sugaya 1990, p. 67). The JMA received medical-treatment fees from the government, selected and supervised the insurance physicians, and made payments to each insurance physician. However, because the government gave the JMA a block payment, the more treatments these insurance physicians provided, the lower the unit price or the fee became for each medical treatment. Consequently, this payment method fostered discontent among insurance physicians. The JMA took note of this dissatisfaction by constantly demanding higher medical-treatment fees in its annual negotiations with the government. As for the Corporate Co-operative-Managed Health Insurance program, it was free to choose any payment system, but many of the corporate co-operatives also adopted the capitation payment method.

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Health-insurance reforms in the 1930s

Reflecting the depressed economic conditions in the late 1920s, which resulted in reduced premiums flowing into the health-insurance programs, these programs were financially unstable. Nevertheless, the 1931 Manchuria Incident marked the beginning of an upswing in the business cycle, which led to an increase in the number of people in employment and a corresponding rise in the number of insured people. Also, monthly wages started to rise. These developments generated more revenue and in turn improved the financial situation of the Health Insurance program, which went from a deficit in 1933 to a capital reserve of 26.3 million yen in 1938 (equivalent to approximately 14.9 billion yen in 2009). The reserve skyrocketed to 237.92 million yen in 1945 (equivalent to approximately 57 billion yen in 2009) (Kōseishō Hokenkyoku 1958b, pp. 826–829).

With insurance finances having stabilized, in February 1934 the government submitted a revised Health Insurance Bill to the Imperial Diet to broaden coverage to more workers. The bill was passed in March. Some businesses to which the original Health Insurance Law of 1922 did not apply, such as manufacturing, packing and repair firms with five or more employees, were newly designated as business entities that now qualified for coverage under the Health Insurance program. Firms in the new coverage categories with four or fewer employees were not compelled to join but were permitted to join the program on a voluntary basis if the majority of employees and the owners agreed to join and the Home

Minister approved. As a result, the 1934 amendment increased the number of insured people by about 290,000 (Kōseishō Hokenkyoku 1958a, pp. 621–624, Araki 1976, p. 16).

In March 1937, the Social Bureau of the Home Ministry announced the results of a survey that claimed the direct and indirect effects of the ten-year implementation of the Health Insurance program. The Social Bureau trumpeted a number of positive findings it said were contained in the survey. First, the Bureau pointed to the finding of a gradual decrease in general mortality, disease and injury rates to conclude that the program had indeed succeeded in maintaining and improving the health of those insured. Second, it said the survey showed that the program had stabilized the economic well-being of insured individuals. Third, it held that the survey demonstrated that the program had improved the quality of medical institutions and made medical services more widely available. Fourth, it claimed that the program increased labour efficiency and promoted a more stable capital–labour relationship (Suzuki 1995, pp. 444–448). It is questionable, however, whether these improvements could be attributable solely to the Health Insurance program. Besides the program, other measures, such as infant homes to protect and foster less fortunate infants, child-counselling centres, improvements in nutrition and expanded public-health services, made important contributions to improving public health (Iwama 1998). However, in its belief that the Health Insurance program was largely responsible for the broad improvement in the health of the Japanese population, the Social Bureau had good reason to expand the program's scope.

Another major action to expand and restructure Japan's health-insurance programs came in 1937. At this time, the Study Group of Population Problem Foundation, a semi-private agency for analyzing population-related issues established by the Social Bureau in October 1933, began hosting annual conferences to discuss the perceived problem of Japan's overpopulation. At the third conference, held in 1939, this study group was asked by the Health and Welfare Minister 'to address particular aspects to which the government should devote attention to stabilize people's lives from the perspective of population policies'. In reply, the study group issued a report that in part emphasized the importance of improving health-insurance programs and reforming medical institutions (Kokuritsu Shakai Hoshō/Jinkō Mondai Kenkyūjo 1940, p. 86).

Whether by accident or design, the study group's report was in line with another important government priority of the time: the need for military reinforcements. At the Cabinet meeting held on 19 June 1936, War Minister Terauchi Hisaichi expressed considerable concern about the 'alarming physical condition of adult men and enlisted men'. He also stated the 'necessity for a national policy for preservation of health', especially in rural areas from where most of Japan's soldiers were recruited. Soon after this Cabinet meeting, the Medical Bureau of the Department of War was alarmed that, with this adverse trend, a majority of Japanese people would be considered to be physically weak within decades. An

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impending and critical need for healthy soldiers was in part responsible for the establishment in 1938 of the National Health Insurance program, which will be discussed in the next section (Maeda 1963, p. 229).

Introduction of National Health Insurance and Clerical Employee Health Insurance

Starting in the late 1930s, the Home Ministry, which was responsible for the Health Insurance program, sought to promote the spread of public medical institutions to provide a greater number of Japanese with health insurance through the establishment of the National Health Insurance, another legal health-insurance program that would cover a broader mass of people beyond the narrow categories of industrial workers covered under the 1922 (reformed in 1934, as already discussed above) program. The Japanese government worked to increase public support for its war efforts in part by extending the coverage of health insurance, to help reduce unaffordable individual medical costs. Additionally, in 1937 the Home Ministry authored a classified document entitled On expansion of health-care institutions. It recommended the establishment of '750 [public] clinics during a five-year plan starting in fiscal year 1937 in 1400 villages which have no access to medical institutions'. The government intended to offer easy access to medical treatment by establishing public medical institutions. The document also contained a modest recommendation to 'implement a National Health Insurance program that will cover 50 per cent of agricultural village residents and 20 per cent of urban residents' (Nomura 1981, pp. 66, 76–77).

The National Health Insurance bill was submitted to the Seventieth Imperial Diet in March 1937. The reason for submission was stated thusly:

> The most important problem for receiving medical treatment is whether one can afford it. [. . .] Because people in agricultural, forestry, and fishing villages, as well as medium- and small-scale merchants and craftsmen in urban areas have recently been seriously impoverished, medical treatment expenditures are a heavy burden for these people.
>
> (Teikoku Gikai Kaigiroku 1937)

The House of Representatives passed the bill in March 1937. On 31 March, the House of Peers was about to offer approval when Prime Minister Hayashi Senjuro suddenly dissolved the House of Representatives, which left the bill dead.

In August 1937 Kawamura Hidebumi, a Social Bureau officer, wrote:

> The National Health Insurance is a state public assistance policy [*hogo seisaku*] that is intended to mitigate the financial burden of high medical costs. Consequently, it is natural to cover primarily the middle class and those of less than modest means.

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This statement made clear that some senior government officials regarded a national health-insurance scheme as a public-assistance program. Kawamura continued, 'The National Health Insurance is designed to cover an extremely large number of people, and in the future, it should cover most Japanese people.' A large-scale national health-insurance program including numerous low-income people would inevitably function as public assistance. Kawamura concluded, 'In short, we plan to implement universal social insurance (Kawamura 1937, pp. 5–6).' Kawamura's conclusion alone contradicted the original intention of the 1922 Health Insurance Law, and if realized would fundamentally alter its character for the simple reason that it would be financially impossible to realize universal coverage under the narrow definition of 'social insurance' that applied to the existing Health-Insurance scheme. The financial cost of the program was to be borne primarily by workers and their employers while government subsidies covered only the costs of administrative fees. However, under this new National Health Insurance program as conceived by some Japanese government advocates, only the central government was in a position to pay for medical treatment of indigent people. In complete contrast to the 1922 Health Insurance program, the new National Health Insurance was intended from the outset to have a strong public-assistance character.

After a series of twists and turns, Japan's Diet approved the National Health Insurance bill in March 1938, which became effective in July. The insurers of this program were the National Health Insurance co-operatives, voluntary public corporations that were subject to approval by provincial governors. These co-operatives were to consist of voluntary members. This meant that the government could not compel any local community to establish a National Health Insurance co-operative. According to Article 13, even if a National Health Insurance co-operative was established in a given community, the eligible residents of a community were not compelled to join unless two thirds of those eligible first made the decision to join, which then made membership compulsory for all eligible community residents (Shakai Hoshō Kenkyūjo, ed. 1981, p. 137).

As *Kokumin kenkō hoken 20-nen shi* [Twenty–y*ear history of National Health Insurance*], a semi-official book on National Health Insurance, proudly offered strong praise for Japan's National Health Insurance, the establishment of the new program had 'made a leap forward in a qualitative sense', mainly for the reason that it was Japan's first widely available semi-public-assistance program (Zenkoku Kokumin Kenkō Hoken Dantai Chūōkai 1958, p. 102). For the purpose of this article, the most important clause of the new law was Article 14, which stated that 'A National Health Insurance co-operative regards its members and *those belonging to the members' households* as insured people' (Shakai Hoshō Kenkyūjo, ed. 1981, p. 137, emphasis added). In other words, National Health Insurance mandated a legally required family benefit, something that was not included in the 1922 Health Insurance program and a groundbreaking development in the history of Japanese health insurance. The purpose of the family benefit was not

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to maintain and restore the worker's ability to work and provide only employees with economic assistance during those times when they suffered from sickness or injury, which was the original purpose of the original program, but to accomplish something new: to protect the insured's household against financial difficulties arising from unaffordable family medical expenditures. That this was the purpose of the law was made fairly explicit by Kawamura, who wrote in May 1938 that National Health Insurance was mainly designed 'to contribute to the security of people's economic life and [. . .] to disseminate medical treatment' (Kawamura 1938, pp. 2–3). Thus, under the National Health Insurance program, the Japanese government was henceforth committed to spending a large sum on protecting the health and welfare of Japanese families.

Although National Health Insurance now extended health-insurance coverage to low-income and no-income people, it was not a form of means-tested public assistance. In principle, the law stipulated that insured people would pay premiums. However, Article 22 had an exception clause: 'As for those who have special reasons, the co-operative may reduce premiums or exempt [those with special reasons] from paying premiums' (Shakai Hoshō Kenkyūjo 1981, p. 137). 'Those who have special reasons' applied to those who could not afford premiums.

Therefore, the National Health Insurance program was not a simple extension of the Health Insurance scheme of 1922. The introduction of this new program ushered in a qualitative transformation of Japanese health insurance. The primary purpose of the Health Insurance bill was limited to the maintenance and restoration of workers' health and physical ability to work, and providing them with economic assistance during those times when they suffered from sickness or injury. In contrast, the main purpose of the National Health Insurance was to lessen the financial burden of medical expenses on families and secure a healthy existence. In addition, while the Health Insurance program covered only about two million factory and mining workers, who were expected to pay their own premiums, the National Health Insurance program was intended to cover not only people in rural areas but also urban residents outside the Health Insurance coverage, or about 60 per cent of Japan's population, many of whom would be unlikely to afford premiums (Yoshihara and Wada 1999, p. 79).

As the provisions of National Health Insurance expanded, the coverage of low-income and no-income people would correspondingly increase. Consequently, this program inherently included an institutional mechanism for increasing government subsidies and making the lives of the poor a social responsibility of the state. In this regard, National Health Insurance had a strong public-assistance character, rather than merely an insurance character, similar to the insurance provided under the Health Insurance programs.

The government planned another program to expand the number of insured people, which was in reality another form of public assistance. In 1935 the Social Bureau of the Home Ministry began to consider a new form of health insurance for clerical workers in urban areas, partly in response to the high ratio of medical

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expenditure in Japanese household costs. According to a survey of clerical-worker-household family budgets conducted by the Statistics Bureau during September 1935 to August 1936, medical fees had reached 6.57 per cent of total family expenditure, which was considered rather excessive by the Social Bureau (Kōseishō 20-nen Shi Henshū Iinkai 1960, p. 282).

In January 1938, the Ministry of Health and Welfare was newly established, under which the Insurance Agency was created as an extra-ministerial bureau primarily responsible for health-insurance matters. In March 1939, the Insurance Agency submitted a Clerical Employee Health Insurance bill to the Seventy-fourth Imperial Diet, which was quickly passed. The Clerical Employee Health Insurance extended coverage to clerical-class workers in designated businesses, including commerce, finance, insurance, storage, real estate, bill-collection, advertising and other enterprises with ten or more employees (Kōseishō Hokenkyoku 1958a, pp. 647–650).

Clerical Employee Health Insurance took effect on 1 June 1940. It was similar to the Health Insurance programs, with two insurers (the government and clerical employee co-operatives). Both employers and employees were to pay premiums and the government was to provide subsidies similar to those for the Health Insurance programs.

Clerical Employee Health Insurance was quite similar to the Health Insurance scheme, but in part, this new health-insurance program was experimental. An important experimental feature was the introduction of family benefits. Unlike Health Insurance, which did not provide a family benefit, this new law allowed insurers to provide *ex-gratia* benefits to those who '*sustain their lives by depending on the insured and suffer illness or injury*' (Kōseishō Hokenkyoku 1958a, p. 645, emphasis added). The primary purpose of this stipulation was to reduce household medical expenditure. Consequently, the original character of the Health Insurance system – maintaining and restoring workers' health and physical ability to work and providing them with economic assistance during those times when they suffered from sickness or injury – was markedly altered.

Another experiment initiated by the Clerical Employee Health Insurance scheme was the introduction of a new fee-for-service payment system, unlike the existing Health Insurance's capitation payment unit system. This new payment method was designed to avoid the government's annual battle with the JMA over the setting of medical unit fees and to mitigate dissatisfaction among insurance physicians (Kōseishō Hokenkyoku 1958b, pp. 289–301). The Clerical Employee Health Insurance program formulated a medical-treatment fee schedule at twenty sen (two tenths of one yen) per scoring point. Insurance physicians would be reimbursed for their care of insured individuals based on a medical-treatment scoring system maintained by each physician. Twenty sen multiplied by the point scores of medical treatments conducted by the insurance physicians was the amount these physicians would receive. However, this new payment system represented a double-edged sword. The fee-for-service system freed the Ministry of Health and

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Welfare from difficult annual negotiations with the JMA, but the new payment method was likely to increase medical expenses because the more the insurance physicians provided medical treatment to patients, the more payment they would receive. However, the Ministry of Health and Welfare became so interested in the short-term objective of terminating uncomfortable annual contract negotiations with the JMA that the Ministry ignored, or at least devoted little attention to, the long-term consequences of a new payment arrangement that would inevitably result in higher government health expenditure as long as the population grew and clerical workers became numerous.

Toward measures to reform the healthcare system

In July 1938, the Ministry of Health and Welfare established an Investigation Committee for the Medical and Pharmaceutical System. This was a group of up to forty learned people headed by Health and Welfare Minister Kido Kōichi. Kido asked the Committee to address the following question: 'Considering the current condition of national medical treatment, what are the appropriate measures to reform the current medical and pharmaceutical system?' (*Kenkō Hoken Ihō* 1938, p. 20).

As an initial idea, the Bureau of Public Health (*Eiseikyoku*) proposed two major areas of study (*kanjian*): 'expansion of public medical treatment' and 'management of physicians in private practice' (Funaki 1942, pp. 13–14). The bureau assumed that the most important health-related problem in the late 1930s was a tendency toward commercialism among physicians in private practice. In other words, the bureau was worried that physicians were paying more attention to making as much profit as possible, rather than understanding their public responsibility to make medical services widely available to the general public (Nakashizuka 1998, p. 274).

Based on this assumption, the *kanjian* included three significant proposals. First, physicians in private practice, rather than public medical institutions, should constitute the primary providers of medical-treatment services in Japan. Because these private-practice physicians were free to open medical clinics or hospitals anywhere in Japan, they tended to concentrate on urban areas where they could find the largest number of patients, enjoy urban cultural lives and provide their children with a high-quality education. As a result, Japan had 3243 local towns and villages, approximately one third of all towns and villages in Japan, with no medical institutions in 1934. It was imperative to solve this problem to extend medical treatment to all areas of Japan. The *kanjian* proposed to place a limit on this freedom of physicians to work where they pleased. Relatedly, the *kanjian* recommended the establishment of public medical institutions in agricultural, forestry and fishing villages, and planned to expand them in urban areas. A second proposal of the *kanjian*, which was complementary to the first, granted the government the authority to dispatch newly licensed physicians to designated

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areas. The third proposal was to grant the government the right to determine medical-treatment fees, because reduction of medical-treatment fees was a critical factor in the wider distribution of health-insurance programs (Funaki 1942, pp. 13–14, Kōno 1991, p. 78). The overall purpose of these three proposals was to enable the Japanese people, no matter where they lived, to gain easier access to medical institutions, especially for those living in rural areas. This development was essential to attaining universal coverage.

These *kanjian* proposals had a seismic effect on the interests of physicians in private practice, who feared that these proposals, if realized, would severely restrict their freedom in practicing medicine. Not only the JMA but also many regional medical associations throughout Japan criticized the *kanjian*. During 1938–1939, three major physician associations – the Kansai Physicians Convention, the North Kanto Physicians Convention and the Kyushu Physicians Federation – adopted resolutions that were strongly opposed to the *kanjian*. In June 1939, these three associations joined to form a united nationwide committee opposed to the *kanjian.* In September, the committee was reconstituted and named the National Physicians Federation, in an attempt to further augment its national influence (Takaoka 1997, pp. 81–82).

Despite strong opposition from private-practice physicians, the Investigation Committee for Medical and Pharmaceutical System in October 1940 approved Measures to Reform the Healthcare System, which the National Physicians Federation regarded as 'scarcely different from the *kanjian* in terms of its essence, falling much short of the expectation of 50,000 physicians in private practice' (Hyōgoken Ishi Kyōkai Kōbe Shibu 1939, p. 38). The government, however, managed to thwart the resistance of organized private-practice physicians with the support of Japan's powerful military, which viewed as imperative the revision of the medical system during wartime for the purpose of providing affordable medical care for as many Japanese people as possible. This was necessary for the production of able-bodied soldiers as well as providing benefits to the general public to obtain their support for the war. The major justifications for the recommendations in the Measures were explained in a preamble:

> It has been a long time since the establishment of various medical and pharmaceutical systems. Small reforms were made over the course of history, but no fundamental reform has been implemented. With the passage of time and changing social circumstances, we [Members of the Investigation Committee for Medical and Pharmaceutical System] have become painfully aware of the need for many reforms. In addition, considering the current grave situation [an unmistakable reference to the war in China], it is an impending necessity to take reform measures to secure a better future.
>
> (Tateno 1942, p. 8)

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The Measures to Reform the Healthcare System included two key recommendations based on the *kanjian*. One recommendation was designed to increase the availability of medical services in Japan. Accordingly, the Measures demanded the limitation of the freedom of physicians to open their own medical clinics, stating, 'The Health and Welfare Minister may limit new openings of medical clinics and correct distribution of the clinics in cities and their neighbouring towns and villages where he recognizes an excessive number of physicians.' This demand alone, however, did not necessarily signify greater access to medical services in rural areas. As mentioned above, over 3000 towns and villages had no medical institutions. Consequently, the Measures urged the establishment of public medical institutions in these unserved locations. The relevant Measures wording stated, 'The government [is] to establish local or temporary dispensaries depending on local conditions managed by prefectural governments in those regions with no access to medical institutions.' Closely related to this, the Measures called for a system to authorize the government to assign newly licensed physicians to government-designated locations:

> When he finds it necessary to hire physicians in medical institutions managed by the state, public organizations, or public-service corporations, the Health and Welfare Minister may assign newly licensed physicians to work at these institutions for two years as an obligation accepted along with the medical license.
>
> (Tateno 1942, pp. 9–10)

A second recommendation was a reduction of medical-treatment fees. The Measures advised that 'rules for medical treatment fees are to be stipulated by consulting a medical-treatment fee committee under the Health and Welfare Minister' (Tateno 1942, p. 11). This recommendation deprived the JMA of its power to negotiate medical-treatment-fee contracts with the government while at the same time giving the Health and Welfare Minister increased authority to set fees.

In October 1940, the Investigation Committee for Medical and Pharmaceutical System submitted the Measures to Reform the Healthcare System to the Bureau of Public Health. Katō Otomaru, Director of the Bureau, expressed his support for the Measures, stating that 'under the current grave conditions, I believe that reform of the healthcare system is the most urgent business. We receive with great pleasure the Measures to Reform Healthcare System today'. Katō, signifying his readiness to implement the Measures, also recommended:

> In line with the purpose of establishing the Investigation Committee for Medical and Pharmaceutical System, we will respect it and assume responsibility for making every effort to implement the system reform. [. . .] Considering the urgency of the recommendations and state finances, we [the Bureau of Public

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> Health] will make efforts to enact laws and to set aside a budget to realize the reforms as swiftly as possible.
>
> (Funaki 1942, pp. 42–43)

The effect of the Measures is that they laid important groundwork for the 1942 amendments.

The government also made another important reform concerning the Health Insurance medical-treatment policies. Because the Health Insurance program was originally aimed mainly at maintaining and restoring workers' health and physical ability to work, and providing them with economic assistance during those times when they suffered from sickness or injury, the original legal medical-treatment policy stipulated by the Social Bureau of the Home Ministry in 1928 did not cover any illnesses or injuries unrelated to this purpose. In December 1928, the Social Bureau Chief sent an official note to the president of the JMA that stated, 'Insurance physicians should conduct medical treatment within the necessary range and limitation that must be economical and the most appropriate' (Kōseishō Hokenkyoku 1958b, pp. 106–109). However, this medical treatment policy underwent an important change in June 1941, extending Health Insurance medical treatment to non-work-related illnesses and injuries. The amendment stated:

> The Health Insurance physicians must use the most appropriate medical treatment to maintain and promote the health of the insured. Whether their illnesses are congenital or acquired, if physicians consider medical treatment necessary, they are to provide such treatment
>
> (Kōseishō Hokenkyoku 1958b, pp. 121–122)

From this point forward, no longer would Japan's Health Insurance program function simply to assist ill workers to return to work; instead, it adopted and served the long-term mission of restoring, improving and maintaining workers' health in general. This is another important shift in the development of health insurance in Japan. The purpose in this case, again, was to mitigate the burden of medical expenses on the Health Insurance members. Similar to the National Health Insurance scheme, the 1922 Health Insurance program gradually acquired the character of public assistance.

Toward universal health insurance

According to a Ministry of Health and Welfare announcement in 1938, the National Health Insurance scheme had been intended to cover about 25 million people, or about 60 per cent of the population, in ten years. However, it was generally regarded as impracticable to accomplish that goal in such a short period of time (Hasuda 1960, p. 261). By fiscal year 1938, National Health Insurance only

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insured about 579,000 people. The major stumbling block preventing rapid expansion was that National Health Insurance was a somewhat slow-moving system because of its reliance on the voluntary establishment, and subsequent voluntary membership, of National Health Insurance co-operatives. In order to accelerate public acceptance the government began to contemplate measures that would call for compulsory establishment of National Health Insurance co-operatives and compulsory membership of eligible individuals.

On 22 January 1941, the second cabinet of Prime Minister Konoye Fumimaro approved the Established Outline of Population Policy, which noted the 'urgent necessity of establishing a population policy so that we may undertake rapid and enduring development of our country's population and dramatically improve its physical quality'. To increase Japan's population, the Population Policy proposed to 'extend and improve health insurance programs and make them available for the entire nation, and provide benefits necessary for prevention of illness in addition to medical care benefits' (Research Navi 1941). In other words, the second Konoye cabinet made universal coverage an explicit goal.

In May 1941, the Insurance Agency of the Ministry of Health and Welfare devised a 'Basic Outline of Social Insurance (short-term benefits) Composition', indicating the direction of the reorganization of the health-insurance programs. The Basic Outline promoted expansion of health-insurance programs to cover all low-income earners, improvement of family benefits at least to the same degree as those of insured people, and the amalgamation of the Health Insurance and Clerical Employee Health Insurance programs. Furthermore, it recommended that, in principle, all physicians be required to participate in health-insurance medical treatment. The Insurance Agency's recommendation was tremendously important, because if implemented it meant that all Japanese physicians would now be required to participate in a government health-insurance program, either National Health Insurance or Health Insurance. No physician would be permitted to reject a request from the government to become an insurance physician (Kōseishō 50-nen Shi Henshū Iinkai 1988, pp. 540–541).

In July 1941, Koizumi Chikahiko, the Army Surgeon Lieutenant General, was appointed Health and Welfare Minister in the third Konoye Cabinet. As an achievable goal that could be quickly realized, Koizumi specifically addressed large-scale diffusion of National Health Insurance. In August, the Ministry of Health and Welfare formulated a general budget framework for fiscal year 1942 that provided a budget for an increase of eight million insured people under National Health Insurance. Only two months later, in October, the Ministry increased the prospective total number of insured by fiscal year 1942 to 14 million (Nakashizuka 1998, pp. 277–278).

In December 1941, Koizumi publicly announced his intention of encouraging municipalities throughout Japan to establish National Health Insurance co-operatives within three years, starting in fiscal year 1942. The Insurance Department of the Ministry of Health and Welfare devised a draft Outline of Expansion

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of Social Insurance Systems, with the goal described at the beginning of the report:

> With the progress of the Great East Asia War, it is an impending necessity to secure people's economic stability. [. . .] To meet the current needs, the government will implement urgent reform and expansion of the National Health Insurance, a program inherent to Japan, as well as the Health Insurance system.

The Outline set a target for expansion of the National Health Insurance, stipulating that except for those covered by other insurance programs like Health Insurance, 'the National Health Insurance will cover all inland people'. For this expansion, 'the government will provide subsidies of two yen per insured person per year, amounting to 130 million yen in total each year'. To expedite the expansion, the Outline suggested 'converting the current voluntary insurance format into an all-out compulsory insurance system'. In addition, the Outline declared that 'although the National Health Insurance has been primarily targeted at agricultural, forestry, and fishing villages, rapid dissemination to urban areas should also happen'. As for a time schedule, the Outline stipulated that 'the dissemination program based on this expansion of National Health Insurance will be completed in the fiscal years of 1943 and 1944' (Zenkoku Kokumin Kenkō Hoken Dantai Chūōkai 1958, pp. 242–243).

Amendments

A series of reforms and proposals concerning the health-insurance programs – including the Measures to Reform the Healthcare System, the Basic Outline of Social Insurance (short-term benefits) Composition and the Outline of Expansion of Social Insurance Systems – set a firm ground for the epoch-making amendments enacted in 1942. In January 1942, a series of amendments to the existing Health Insurance Law were submitted to the Seventy-ninth Imperial Diet, which were passed immediately in their original form and promulgated in February. These 1942 amendments were the most significant reforms since the enactment of the Health Insurance Law in 1922.

One of the amendments abolished the Clerical Employee Health Insurance program and integrated the program's features into the Health Insurance program. An important result of the integration was to transform the family benefit from an *ex-gratia* benefit into a legal benefit that would subsidize one half of the cost of medical treatment for all family members (Kōseishō Hokenkyoku 1958a, p. 821).

Another amendment extended coverage to smaller businesses. Clerical Employee Health Insurance covered only businesses with ten or more employees, but the amended Health Insurance Law covered businesses that consistently employed five or more employees in specific industries such as manufacturing, electricity supply, cargo/passenger transportation, merchandising, real estate, finance

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and others. In addition, the revised Health Insurance Law raised the limit of annual salary for clerks from 1200 yen to 1800 yen as a qualification to join the insurance program. These revisions helped more Japanese clerks to qualify for the revised system. Moreover, those clerks with an annual salary of 1800 yen or more and those employees working for business entities that were not eligible for Clerical Employee Health Insurance would become able to join the Health Insurance program on a voluntary basis (Kōseishō Hokenkyoku 1958a, pp. 790–792).

The major purpose of the 1942 amendments was to extend the coverage of the health-insurance programs. Consequently, the number of insured people increased from about 4.27 million in 1938 to 8.03 million in 1943 (Kōseishō 20-nen Shi Henshū Iinkai 1960, p. 291). An important justification of expanding the health-insurance programs was to alleviate the financial burden of healthcare on Japanese families. As National Health Insurance had experienced a gradual expansion of its mission, the major purpose of the health-insurance programs also gradually became the reduction of medical expenditure for as many Japanese workers and their family members as possible.

A third amendment to the Health Insurance Law also underpinned critically important reforms, adopting a legal insurance physician system. The government acquired the authority to require all physicians to participate in health-insurance medical treatment. Consequently, the government became able to secure sufficient insurance physicians for the Health Insurance program (Kōseishō Hokenkyoku 1958a, p. 825).

A fourth amendment authorized the Health and Welfare Minister to determine medical-treatment fees in consultation with the JMA president, thereby transforming the payment system from a capitation payment unit system to a fee-for-service payment system to avoid the troublesome annual negotiations with the JMA over the setting of medical fees and to mitigate dissatisfaction among insurance physicians. This fee-for-service payment system was also a legacy of Clerical Employee Health Insurance (Kōseishō Hokenkyoku 1958a, p. 840). This change also opened the door to an increase of medical expenses in the future, because the more treatment physicians provided, the more they would earn.

Regarding National Health Insurance, an amendment bill was submitted to the Seventy-ninth Imperial Diet on 23 January 1942 based on the draft Outline of Expansion of Social Insurance Systems described above. Speaking at the House of Representatives preliminary session held on that same day, Health and Welfare Minister Koizumi explained the major reasons for submitting the amendment: 'All the health-insurance programs greatly contributed to securing the stability of Japanese people's lives by reducing healthcare costs on the one hand, and dispersing medical institutions in an appropriate manner on the other,' he said. Koizumi's statement helped demonstrate that the government's earlier social policy of maintaining and restoring workers' health and physical ability to work, and providing them with economic assistance during those times when they suffered from sickness or injury, as represented by the 1922 Health Insurance Law, was now of lower

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importance compared with stabilizing the lives of the Japanese people. Koizumi made plain his intention to apply health insurance to the entire nation, stating: 'Through many measures such as expansion of the insured that can be covered by insurance, we wish to extend the benefits of the social-insurance system to most Japanese people as expeditiously as practicable' (Kōseishō Hokenkyoku 1958a, pp. 314–315).

The Imperial Diet passed the National Health Insurance amendments bill in February 1942. One important change introduced was that, under the previous National Health Insurance Law of 1938, residents of local communities who wished to establish a National Health Insurance co-operative were required to make bylaws and acquire consent from would-be co-operative members. After consent was granted, the co-operative could solicit approval from the provincial governor (Shakai Hoshō Kenkyūjo 1981, p. 136). Instead, the 1942 amendment gave the power to establish local co-operatives to the provincial governor, who was allowed to order the establishment of a co-operative when he considered it necessary and at the same time was empowered to select co-operative committee members (Kōseishō 50-nen Shi Henshū Iinkai 1988, p. 546).

The 1938 National Health Insurance Law also stipulated that when a voluntary National Health Insurance co-operative was established, with two thirds or more of eligible residents in a specific region as members, all other remaining eligible residents living in the region were obligated to join the co-operative (Shakai Hoshō Kenkyūjo 1981, p. 137). The amendment reduced the requirement to one half of the local population, opening a wider and faster avenue for establishment of compulsory membership in co-operatives (Kōseishō 50-nen Shi Henshū Iinkai 1988, p. 546). Taguchi Eitarō, an Insurance Agency officer, anticipated that it would be difficult to realize the purpose of this program promptly if it continued its voluntary and liberal method of establishing National Health Insurance co-operatives (Taguchi 1942).

The 1942 National Health Insurance amendment authorized provincial governors to designate insurance physicians, who were unable to reject the appointment without due cause (Kōseishō 50-nen Shi Henshū Iinkai 1988, p. 546). In relation to the medical-treatment fee-payment system, the amendment abolished the contract system monopolized by the JMA and authorized the government to make direct payments to insurance physicians based on the fee-for-service payment system. (Kōseishō Hokenkyoku 1958b, p. 478).

Kimura Kiyoji, Director of the Social Insurance Bureau, explained the purpose of the 1942 amendment to the National Health Insurance Law:

> Because of a series of changes at home and abroad, the passive effect of National Health Insurance of providing individual benefits in private economic life [. . .] was transformed into the more vital task of fostering healthy soldiers and a population that could reproduce itself. [Consequently] the mission of the National Health Insurance has become much more important. To respond to

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> these needs, the government implemented a large-scale revision of the National Health Insurance.
>
> (Suganuma 2007, p. 41)

The Social Insurance Bureau lost no time in moving forward with wider dissemination of National Health Insurance, starting in May 1942. The Bureau directed its local agencies to exert all possible efforts to establish National Health Insurance co-operatives on a voluntary basis without resorting to legal compulsion. Once a co-operative had one half of the eligible membership, the local agency immediately began promoting compulsory membership. In addition, the Bureau requested that neighborhood associations, such as the Taisei Yokusankai (Imperial Rule Assistance Association) and other groups, help to extend insurance coverage under the new National Health Insurance scheme (Nakashizuka 1998, p. 282). Taisei Yokusankai was a para-fascist and presumably non-political public organization, established by Prime Minister Konoye in October 1940 after all political parties in Japan were disbanded. The local members of the former political parties, which numbered in the millions, were then compelled to join Taisei Yokusankai. Partly as a result of these degrees of compulsory efforts, the National Health Insurance program went from insuring 6.7 million people in fiscal year 1942 to insuring 22.66 million and then 41.16 million in fiscal years 1943 and 1944, respectively (Kojima 1961, pp. 250–51).

In late September 1942, Hirai Akira, who had been appointed Director of the Social Insurance Bureau in April 1942, explained the health-insurance policies of the Ministry of Health and Welfare in reference to the budget proposal for fiscal year 1943:

> We will have all agricultural, forestry and fishing villages establish National Health Insurance co-operatives by the end of next fiscal year. Consequently, our aim is universal health insurance through either National Health Insurance or Health Insurance co-operatives.
>
> (Nakashizuka 1998, p. 283)

Under strong pressure from the Ministry of Health and Welfare, 95 per cent of towns and villages established National Health Insurance associations by the end of fiscal year 1943 (Zenkoku Kokumin Kenkō Hoken Dantai Chūōkai 1958, p. 222).

Besides the 1942 amendments to the Health Insurance Law and the National Health Insurance Law, the government introduced another important law, the National Medical Treatment Law. This law, enacted in February 1942, was designed to exert greater control over physicians (Shakai Hoshō Kenkyūjo 1942, p. 80). It provided the Ministry of Health and Welfare with wide-ranging authority to control the establishment of medical clinics anywhere in Japan. The law itself mentioned 'guidance and supervision of healthcare and related fields',

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but in reality Article 21 stipulated that physicians had to 'acquire approval from the state minister in charge or provincial governors' to open hospitals, clinics and maternity hospitals. This article's purpose was to correct the situation in which medical institutions became concentrated in major cities (Nihon Iryōdan 1977, p. 194). Prior to Article 21, physicians who wished to establish hospitals or clinics had only to follow certain government notification procedures. However, the Measures to Reform the Healthcare System explained earlier demanded the limitation of the freedom of physicians to open their own medical clinics. This recommendation was codified as Article 21.

To rectify the situation of unevenly distributed medical institutions and to send physicians to rural areas, the Measures to Reform the Healthcare System called for a system to allow the government to assign newly licensed physicians to certain locations. This recommendation led to Article 22 of the National Medical Treatment Law, which stated:

> When the state minister in charge [. . .] considers it necessary, in accordance with the edict, the minister may order [. . .] new healthcare professionals who became qualified within a year [. . .] to engage in practices that the state minister in charge designates for two years or less.
>
> (Nihon Iryōdan 1977, p. 194)

In other words, the Health and Welfare Minister now had unprecedented authority to tell newly licensed physicians, dentists, nurses and other healthcare professionals to go to specific places to conduct designated practices.

The Health and Welfare Minister also controlled the purse strings of healthcare professionals. Earlier, the Measures recommended that the Health and Welfare Minister determine the medical-treatment fees. To give this measure effect, Article 25 of the National Medical Treatment Law was created, which read: 'The state minister in charge, in accordance with the edict, may issue necessary orders or take disciplinary actions with respect to compensation for medical treatment, childbearing, and nursing or the salary that the healthcare professionals are to receive' (Nihon Iryōdan 1977, p. 194).

Concluding observations

Starting in 1922 and then particularly during the war years of 1937 to 1942, Japan undertook a series of improvements in health-insurance programs. This culminated in amendments in 1942 to a series of existing major reforms that broadened the provision of health-insurance coverage in Japan. These 1942 amendments led to a rapid increase in the number of insured people, resulting in almost universal health-insurance coverage in Japan by the end of the war in 1945. The more pervasive health-insurance coverage became, the more the character of the original ground-breaking government Health Insurance program of 1922 was altered. The

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1922 program was mainly intended to maintain and restore workers' health and physical ability and to provide them with economic assistance during those times when they suffered from sickness or injury. The Health Insurance scheme was to be funded by paid-in worker contributions, and it was. However, by 1942 this original intent was qualitatively transformed, replaced by multiple overlapping programs that turned the provision of healthcare coverage in Japan into a form of public assistance, funded by the state. Through an analysis of three elements of wartime health-insurance reforms – 1) expansion of the scope of the insured; 2) transformation of the system of payment to physicians; and 3) provision of easy access to medical institutions – this paper has shown that these wartime reforms were actually crucial to establishing an institutional setting that went on to contribute to a continuous rise in Japanese health-insurance expenditures.

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A Note

1. It may be helpful to explain some of the secondary sources used in this article. Some contemporary authors of secondary sources had access to many important primary documents in a systematic way, and this article utilizes those primary documents cited in these secondary sources. For example, Funaki Yasuyuki, Chief of General Affairs Section of the Japan Medical Association, had access to and compiled important documents and records in his book *Kokumin iryō hō gaisetsu* [*Survey of the National Medical Treatment Law*].

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