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## ► To cite this version:

Ryozo Matsuda, Monika Steffen. Learning from variations in institutions and politics: the case of social health insurance in France and Japan. First International Conference on Public Policy (ICPP), Jun 2013, Grenoble, France. halshs-00936082

**HAL Id: halshs-00936082**

**<https://shs.hal.science/halshs-00936082>**

Submitted on 24 Jan 2014

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# **Learning from variations in institutions and politics: the case of social health insurance in France and Japan**

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## **Panel n° 63.1 “Social Health Insurance” (Claus Wendt)**

First International Conference on Public Policy (ICPP),  
Grenoble, France, 26-28 June 2013

*Work in progress, preliminary draft.*

*Please do not quote*

## **Introduction: Comparing atypical systems?**

The comparative literature on healthcare systems, policy and reforms has grown considerably during the last decade. The comparative studies aimed first at classifying the various types of healthcare systems into the three classical categories derived from the welfare state literature (Esping-Andersen 1990): Bismarckian social health insurances, national health services and private healthcare system. Second, in order to integrate reforms and changes, the comparative literature proposed renewed versions the established categories as illustrated by a “neo-bismarckian” category (Hassenteufel and Palier 2007). The classical subordination of healthcare systems to the logic of the welfare state model has, however, been criticized for long, especially by the concept of the “healthcare state” (Moran 1999), which established the autonomous logic of healthcare developments in advanced democracies, a perspective that goes beyond the fact that healthcare constitutes a sector, delivering complex and highly qualified service, unlike most welfare schemes, like retirement and unemployment, which deliver financial benefits (Bamra 2005).

A new orientation started with the evidence that a growing number of national cases did not enter the established or revised categories. The description of new cases, in particular Asian healthcare systems (Gauld 2005), with different types of institutional arrangements and functioning, led to the conceptualization of a new category, the “national health insurance” (Lee et al. 2008), where the state centrally administers health care financing. In fact, recent research shows that all mature healthcare systems are mixed systems; they “have evolved in ways that blur the boundaries of the established typology”, shifting variously “the balance of power, the mix of instruments, and the organization principals of earlier models to yield distinct hybrids” (Tuohy 2012a, p. 618 and 627). Growing hybridization is mainly seen as resulting from reforms or the international diffusion of policy receipts, both responding to the problem of cost containment, in terms of activity-based hospital financing, public management, quality assessment and more targeted intervention to secure access for underprivileged populations. However, as the French and Japanese cases will show, the mix results also from original institutional arrangements. Healthcare systems evolve not only under external pressure, but incrementally according to domestic limits and opportunities (Steffen 2010a).

Extensive reviews of the comparative literature have also been undertaken (Marmor, Freeman, and Okma 2005; Marmor and Wendt 2012; Tuohy 2012b). These studies conclude that the important comparative investment did not provide the expected results, especially as to the question whether the reforms and international transfers during the last three produced convergence or not. Two specific reasons may explain the unclear outcome. The first is a methodological problem. There is necessarily a trade-off between a large number of cases needed for the construction of models and theory that can be generalized, on the one side, and the necessity of in-depth studies providing sufficient contextual data for the understanding of complex systems (Mair 2008). The second problem is linked to the system of actors in each health care system. The “same” actors, such as trade-unions, employers-unions or government departments, may follow different strategies, aims and values, despite a similar institutional position (Marmor and Wendt 2012; Steffen 2010b; Steffen and Jobert 1994). Furthermore, the new politics to design reforms depend on “institutional entrepreneurs”, which are necessarily of different types varying with the national public policy regimes (Tuohy 2012a).

Despite these methodological difficulties, a combined approach, taking into account complex evolutions, hybridization, and the aim of model constructing, has recently been

undertaken in a systematic way (Götze and Schmid 2013; Rothgang et al. 2010; Wendt, Frisina, and Rothgang 2009). Its approach is based on the “hierarchy” between the three main dimensions of healthcare systems, placing governance in the dominant position, followed by financing and, last, service delivery. As a result, a new category has appeared, to which many, if not most advanced healthcare systems seem to correspond: it links strong public governance with the institutional framework of a social health insurance. Japan and France figure in this category of “statist social health insurances”.

This paper compares two particularly complex healthcare systems, Japan and France, both little known. Language and complexity make access and comparing indeed difficult. Their classification in the internationally used models has so far been highly uncertain. Japan has been coined as a “hybrid model between SHI and NHI”, because of the massive involvement of the state in financing and its broad and strong state intervention on private sectors (Ikegami et al. 2011; Lee et al. 2008). France stands out by its specific combination of what the literature considers as contradictory and theoretically not conceivable, namely free choice and universalism (Steffen 2010a).

This paper proceeds from a classical two-country comparative methodology, limited to two cases in order to gather the necessary contextualization. It compares two countries that seem similar when looking at the most common dimensions of financing and the extent of universal cover. Both countries are established democracies, and show a comparable level of economic development, two dimensions essential to health system development. These similarities provide a plausible comparative framework to observe how similar “policy problems” (Peters 2005) are addressed in their respective political and institutional context. The paper will insist on who governs cost-containment and how, with what impact on financing and service provision. These questions bring the relationship between the SHI and the state at the center of the analysis.

The first part provides comparative statistics, the second outlines the institutional set-up, the third part analyses the main problems that have been addressed. The fourth and last part is devoted to the comparative assessment of the two cases and explanatory factors.

## 1 - The Japanese and French health systems at a glance

Before analyzing institutional arrangements and reforms in the two countries, we made comparisons of selected critical statistics: social and health expenditures, size of public employment, and healthcare resources. Although we tried to find best comparable indicators, due to inevitable heterogeneities in statistics of France and Japan, some statistics should be carefully interpreted.

### *Social and health expenditures*

France has always spent more of DGP for social redistribution than Japan. The difference amounts to more than 10 percent, for comparable statistics. Differences in health expenditures were initially rather small between the two countries, but the growth between the 1980 and 2010 is much quicker in France than in Japan [Table 1].

**Table 1: Social and Health Spending**

In % of GDP*	France 1980	France 2009-10	Japan 1980	Japan 2009-10
Social spending*	20.8	32.07	10.2	22.4
Health expenditure**	7.0	11.7	6.4	9.5
Health per capita PPS \$***	1,031	3,974	857	3,034

Sources: \*OECD Social expenditure data, \*\*OECD Health data,  
\*\*\* 1985 earliest available

Concerning the financing of this expenditure, Japan has a larger public part, since decades, with even an increase of 0.4 % during the 2000s. Inversely, France privatized slightly over the last two decades; private spending increase by 1.6 % during the 2000s [Table 2]. A major difference between France and Japan exists in the way private spending is organized: it is mostly out-of-pocket payment in Japan, whereas complimentary health insurance (CPHI) covers the major part in France. Today, CPHI covers only a little more than 3 % of the expenditure in Japan, but nearly 15 % in France<sup>1</sup>.

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<sup>1</sup> Those figures suggest privatization is easier in France since there is an institutional fitting for it, not in Japan. This French particularity is a traditional feature, not a reform result, but it serves today's reforms: it allows to lower reimbursements, introduce entrance-fees and the like, and it allows raising more contribution, whilst maintaining a certain level solidarity within the private financing, because collective.

**Table 2: Public and private financing of Health Spending**

% of total health expenditure	France 2003	France 2009	Japan 2003	Japan 2009
Public part (SHI +public authorities)	79.2	77.6	79.8	80.2
Private Complem. HI or similar	13.9	14.8	3.3	3.6
Private out of pocket	6.8	7.7	16.9	16.3

Sources: OECD Health data

**Table 3: Extent of Public Service**

2008	France	Japan
Public employment, share of total employment*	21.9%	6.7%
% of DGP for salaries*	13.3 %	6.5 %
Public administration density**: Number of functionaries per 1,000 inhabitants	88 (2004: 94.2*)	40 (2004: 42.2*)
Level of membership in trade unions**		
in public service:	15.2 %	43.2 %*
in private sector:	5 %	17 %
DGP per inhabitant, 2011, in PPP \$***	35.247	33.668

Sources: \*OECD(2011) Government at a glance 2011. Figures are for 2008.

\*\*CAS Paris, 2010,p 14 and 18. \*\*\*World Bank Data

### ***Public Service***

The two healthcare systems operate in totally different environments, despite a comparable level of GDP per capita. Public sectors differ in size between the two countries. France appears as a heavily state-dependent society. More than 1 job out of 5 has the state as employer, generally in lifetime position. Japan, on the contrary, is one of the OECD countries with a small public sector. In the both countries, public administration density is stable over 30 years, but it varies by more than one to two between them. Both tried to lower the number of functionaries, and succeeded to cut

respectively 5.5 % (Japan) and 6.8 % (France)<sup>2</sup>. France spends a lot of public money: 13,3 % of its DGP to pay salaries, and another 32 % for redistribution via social policy (including the 10 % of public health expenditure). Second, the membership in trade unions varies very much. The French rate of membership in trade unions is only a third of the Japanese one, in the public as well as private sector<sup>3</sup>.

These considerable differences in state-dependency, social organization, taxation and public spending do certainly condition the ways each country perceives and treats the problem of cost-containment and growing healthcare demands.

### ***Health resources***

Compared to France, Japan has a *bed-centered* health care system. It has more than double beds for curative care, and even three times more for psychiatry. The average length of stay there is three times more than that in France. Nevertheless, the number of practicing physicians is less in Japan, whereas the number of nurses is higher, yet far from the proportion of bed numbers. The share of the pharmaceutical consumption within the total health expenditure is slightly larger in Japan. It remains to be clarified to what extent this is due to prices or volumes.

These figures, however, should be carefully interpreted because of the different definitions of health resources. The statistical categories are not strictly comparable as to their content. Especially, the OCDE data does not provide any breakdown of the Japanese lengths of stay according to precise treatments, such as acute myocardium infarction or birth delivery. Nevertheless, it can be concluded that the Japanese health care system is still heavily bed-centered compared to French one. The latter has succeeded in intensifying considerably its turnover rates for beds.

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<sup>2</sup> This has been mainly done by not replacing departure for retirement, in the both countries.

<sup>3</sup> Raisons for the very low membership in trade unions in France, one of the lowest within the OEDC, are as follows: First, trade unions are ideologically deeply divided by ideology. Second, every worker benefits from trade-union success, without having to be a member and to pay membership. Third, trade unions are directly dependant on state subsidies, rather than on membership fees. A list dating from 1948 recognizes five trade unions officially as « representative », list not up-dated according to election results. Source: Dominique Perrin, *WWW.challenges.fr (observateur)*

**Table 3: Selected health resources**

<b>Per 1,000 inhabitants (2011)</b>	<b>France</b>	<b>Japan</b>
Number of physicians	3,3	2.2
Number of nurses	8.5*	10.1**
Number of curative hospital beds	3.5	8.1
Number of psychiatry bed	0.9	2.7
Number of all beds	6.4	13.6
Average length of stay, all beds, in days	5.7	18.2
Pharmaceutical consumption, share of health expenditure	16.0 %	20.8 %

Source: OCDE Health data, 2010 or latest

\* all, including managing nurses. \*\* Only practicing nurses

## **2 – Institutional architecture and governance structures**

The Japanese and the French healthcare systems share a common origin, both in the Bismarckian social insurances implemented in Germany the 1880s. The conditions however in which the model was imported and adapted to domestic circumstances contrast strongly. In the Japanese case, the state organized the intellectual transfer in the context of modernization during the Meiji period. A political project similar to the original Bismarckian perspective, aiming at social peace with the working class and a healthy population, accompanied the Japanese interest for the German model. In France, the introduction of social insurance was a historical accident and controversial issue. The specific history explains many of the institutional particularities in each country.

### **2.1 Institutional arrangements in France**

After World War I, the two provinces Alsace and Lorraine that had been under German authority and social security system, returned to France. This confronted the government with an uncomfortable choice, either deprive the returning population of its social rights or extend to the whole country an institution inherited from the enemy, and

which that did not fit the patterns of domestic social policy. The latter focused on voluntary membership in private non-for-profit mutualist societies, for those who could afford it, and public medical assistance for the poor delivered by local authorities (Hatzfeld, 1970). The law on social insurances was finally passed in 1928, but medical leaders and the mutualist societies together fiercely fought the health insurance included in it. They obtained a substantial revision; the new law passed in 1930 allowed doctors to set tariffs, prescribe, settle and organize practice as they saw fit, without any obligation to collaborate with public policy or authority. After 1945, when a renewed social security scheme was set up, in the context of Liberation and important communist influence, the new institution was seen as a victory of the working class and a laboratory for “social democracy”. The trade unions had a statutory majority in the governing boards, whilst the employers had to pay the major part of the contributions. When the 1967 reform corrected this asymmetry, the trade unions refused to “collaborate with the class enemy” and practiced systematic opposition. This situation lasted for three decades, until 1996, depriving the health insurance of developing capacities for cost control and management.

Furthermore, when medical unions finally engaged in a National Medical Agreement with the health insurance (1970), with fixed tariffs, they only signed after the government had issued a “Solemn Declaration” guarantying that it would protect the independent practice of doctors (*médecine libérale*), and that the health expenditure would not be indexed on economic situation (Hatzfeld, 1963) (Text of Declaration). In the French context, the social health insurance appears as an institutional misfit, reduced to administrative reimbursement, transforming regulation and cost containment to an “ill-structured problem” (Simon 1973) and most critical policy issue.

The health insurance is a unique national institution covering the entire population. Concurrence between funds is therefore impossible. For historical reasons, it is composed of three distinct branches: the main branch for employees, one for agriculture and one for independent professions, each covering also its respective pensioners. The state has always fixed the contribution (a percentage from work income), the benefit basket and most of the pricing (cf below).

Access extended beyond the initial Bismarckian limits from the mid-1960s onwards, achieving universalism in the early 1980s. The payment system combines third party payment, applied in hospitals, laboratories and pharmacies, without necessarily following a public-private divide, and a direct payment system by the patient in

ambulatory care and in commercial private hospitals, especially the physician's honorary. The direct payment system allows over-charging as well as over-prescription. Reimbursement is limited to the official tariff, but even for this official part it has never been complete, except for specifically defined heavy illnesses<sup>4</sup>. The gap has historical reasons: it assigns a "complementary" role to the pre-existing mutualist insurances<sup>5</sup>. Consequently, today 94 % of the population have a "complementary" private health insurance (CPHI), in addition to the statutory health insurance from which no-one can opt out. As non-for-profit organizations, the mutualist CPHI used to have the monopoly for complementary health insurance in France, until the European Union imposed free market and concurrence for insurances. However, as the mutualist organizations enjoy public trust in France, the market share for commercial insurance companies has remained limited. In 2010, they collected, mostly via collective employer-based contracts, 27 % of the premiums paid to PCHI (DRESS data, quoted by Bras and Tabuteau 2012, p 59).

Tariff setting is a complex system. The ministry in charge of health sets fees for hospitals directly; prices for medicines are negotiated between the government and the producing companies; and tariffs for ambulatory care between the health insurance and the different professional unions, within the framework of the Medical agreement for private doctors and similar agreements for the various paramedical professions. In fact, pricing illustrates the dual architecture of the French system, with the institutional tension between the health insurance and the state, and the institutional frontier between ambulatory care and hospital care. The terms of the Medical agreement are negotiated every five years, with tariff-rounds each year. Although this is the competency of the health insurance, the government, whose final validation is necessary, often intervenes to favor higher or lower tariffs according to election agendas or lobby pressure.

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<sup>4</sup> A list of thirty illnesses exists, for 100 % reimbursement of the official tariff by the statutory health insurance. In 2010, 16 % of the insured are concerned, representing 63 % of the total reimbursement sum of the statutory HI (quoted by Palier, 6<sup>th</sup> ed. 2012, p. 35 and Bras/Tabuteau p.35: original data: *Comptes nationaux de la santé, DRESS n° 161/2011*, later edition ?)

<sup>5</sup> Reimbursement by the public health insurance amounts to approximately 70 % for medical fees, 65 % for most medicines (variant from 15 % to 100 % according the "level of medical efficiency" of each medicine), and 65 % for most biological analyses. For severe illness reimbursement is 100 % for all items. The CPHI reimburse the charge non reimbursed by the public health insurance. A main difference between the CPHI is whether reimburse or not, and to what level the part of fees doctors over-charged compared to the official tariffs.

Hospitals are now financed according to their precise activity, with the same tariffs for public and private hospitals. The latter are of two kinds: non-for profit hospitals, which can "*participate in the public service*" and share the same rules than public hospitals, and commercial for-profit hospitals, which may overcharge the patient<sup>6</sup>. Hospital tariffs are fixed each year, for each "activity", on the base of a complex combination of elements, including homogeneous groups of patients and of hospital stay, all data originating from the medical computing systems in the hospitals. A complex national method exists for the continuous surveillance of how costs are generated in the three different types of hospitals, to provide national average costs. Operating such tools requires the active collaboration of hospital physicians and directors. The ministry is therefore not independent from the professional elites, especially those working in the prestigious public hospitals linked to university.

The 1996 reform introduced, for the first time, a mechanism to limit the health budget. Since then, Parliament votes an annual law on the financing of the social security system, which fixes the allowed growth rate for the health insurance expenditure, and the allocation of the available resources to the main sectors of healthcare. The High Council on the Future of Health Insurance (*HCAAM*) has an alert function in case of imminent over-spending of the voted "National Objective for Health Insurance Spending" (*ONDAM*). Despite these measures, over-spending has been systematic and rather heavy, except the years following a reform aiming at cost containment (1997, 2004, 2009), but improvement seems now on the way (Table 5).

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<sup>6</sup> The profit rate of commercial hospitals is rather low in France: in average 1.9 % in 2010 compared to the annual *chiffre d'affaires*, with a maximum of 3.1 % in 2005 (DRESS, *Etudes et Resultats*, n° 798, mars 2012, p. 1 and 4). Commercial hospitals account for 10 % of full-time beds and 20 % of day-care beds; their main activity is standardized short stay and day surgical intervention (Chevreul et al. 2010, p 185).

**Table 5: The French Health budget (ONDAM)**

Year	Growth rate voted by Parliament, in %	Real growth rate in %
1997	1.7	1.5 ↓
1998	2.5	4.0
2001	2.5	5.6
2002	3.2	7.1
2004	4.4	4.9
2006	1.8	3.1
2007	1.3	4.2
2008	2.5	3.4
2010	2.9	2.6 ↓
2011	2.8	2.9
2012	2.9	2.9 expected
2013	2.7 proposed	

Source: Cours des Comptes 2012

The evolution reflects the changing relationship between the social health insurance and the state. A constitutional change was necessary in 1996 to introduce a parliamentary annual vote on the social security budget. The latter is proposed by the government and then voted by the political majority, which is generally the same than the party in power. Two reformist trade unions, the employers union and the federation of mutualist PCHI supported the reform. Yet, this last tentative to save the model of “social democracy” failed in terms of cost containment. In 2002, the employers left the Bismarckian institution. What follows is the complete take-over by the central state.

The 2004 law (13<sup>th</sup> August) changed the governance structures of the health insurance. It abolished the governing boards of all funds (national, regional and local), transforming these former executive bodies into simple advisory bodies without any

decision power. The directors of the funds, up to then appointed by these former boards, merely according to local political equilibriums, are now nominated by and responsible to a centralized hierarchy: the general director of the national fund of the main branch of the health insurance. The highest political level nominates the holder of the position: the Cabinet (not the Health ministry). He has hierarchical authority over all local funds and their directors. His competency has been enlarged and includes the coordination between the three branches and with the PCHI. The reform responds to a political choice of the employers' union to focus henceforth only on those social policies that have a direct link to employment, and to the previous integration of social budgets into the ambit ministry in charge of public finance (Bras and Tabuteau 2012, p 45). It ends the ambiguous relationship between the health insurance and the state.

Two conclusions can be drawn from the French institutional arrangements. First, the unclear relationship between the state and the social health insurance, the dual regulatory system, separate for hospitals and ambulatory care, and the politicians' respectful attitude towards "*médecine libérale*" delayed regulation and cost containment. Second, patients paid, and continue to pay for the government's hesitation, in terms of high contributions, incomplete reimbursement and medical over-charges<sup>7</sup>, and in terms of unequal territorial distribution<sup>8</sup> of physicians, and shortage of physicians in the near future<sup>9</sup>.

## 2.2 Institutional arrangements in Japan

Learning from German experiences, the state imported the idea of social health insurance and gradually developed its statutory health insurance system with, of course, its own modifications (Yoshihara and Wada 2008). With voluntary health insurances

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<sup>7</sup> The 1980 Medical Agreement created a new category for doctors who wanted to systematically overcharge, the so-called "Sector II". Entry to sector II was eventually regulated, from 1990 onwards, but new possibilities for over-charging are in discussion. In 2012, in average un out of four physicians is enrolled in sector II and entitled to overcharge, with important disparities between disciplines: 10.4 % of GP and 41.4 % of specialists, up to 77 % of surgeons).

<sup>8</sup> Medical installation is concentrated in big cities, near medical faculties, and in the south of France, following the hours of sunshine per year (Comptes nationaux de la santé 2011, *Série Statistique*, 2012 (172) : 143-144).

<sup>9</sup> Confronted with institutional limits to regulate, the government introduced as regulatory tool a severe limitation of the number of medical students, already in 1971, with the support of the medical unions (*médecine libérale*) and the health insurance. With retirement of the numerous generations of doctors, and the actual policy of closing small hospitals, shortage is now starting in rural and other disadvantaged areas. Admission numbers are now slowly augmented since the end of the 1990' (forthcoming book, paper Marc-Olivier Déplaudé 2012).

already existing, organized by industries, the state first introduced compulsory employment-based health insurance (EBHI) in the 1920s. Then the state added a new type of statutory health insurance, community-based health insurance (CBHI), which was operated by municipalities and spread countrywide, for agricultural, self-employed, unemployed people and others who were not covered by the EBHI in the 1930s (Ministry of Health and Welfare 1976).

In the 1950s, after World War II, the government increased the covered population by making more employees eligible for the EBHI and amending the expansion of eligibility for the EBHI, and by obliging all municipalities to establish and manage community-based health insurance (Ikegami et al. 2011). In 1961, the universal coverage was declared: it became compulsory for all people, except those receiving social assistance<sup>10</sup>, to enroll in a statutory health insurance.

The institutional arrangement of the Japanese health policy has originated from this historical dualism of the EBHI and the CBHI. There have been complex regulatory and financial relationships between the national and local governments and statutory health insurers. For the EBHI, the government works as an insurer, a funder, and a regulator (Tatara and Okamoto 2009<sup>11</sup>) Up to 2008, the government was the largest insurer in the EBHI that covered workers and their dependents at small- and medium-sized companies. The management of the insurance is now devolved to a special agency, the National Health Insurance Association, under the supervision of the government. The government allocates funds from the general budget to the insurance, and it regulates insurance societies that are established by large companies to provide the EBHI to their workers and their dependents. Every municipality operates the CBHI for their residents who are not enrolled in the EBHI. Municipality is a democratic institution with elected representatives, and a mayor or village head (Councils of Local Authorities for International Relations -CLAIR- 2005). The national government, municipalities, and recently also *Kens* (Prefectures) grant subsidies to the CBHI, through again complex rules and formulas. The national government also subsidizes local governments to stabilize their funds.

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<sup>10</sup> Social assistance: funded by tax and including provision of medical services.

<sup>11</sup> The former was called the Government-Operated Health Insurance; the latter the Society-Operated Health Insurance.

With complex financial arrangements, the division between the two types of insurance has made it difficult to develop policies, particularly funding policies to meet the increasing demand for care. There have been strong objections of insurance societies based on large companies against cross-subsidies between insurances for undermining their autonomy. A policy response to this objection was the establishment of the “Health Care Programs for the Aged” in 1982, which introduced a common pool of funds for health care for the aged people, by collecting money from insurers as well as from the national and local governments.

The dualism also seems to have influenced private funding of health care through once heterogeneous out-of-pocket payments. There were huge differences in out-of-pocket payments in the 1960s: employees covered by the EBHI paid minimal co-payments and those covered by the CBHI initially paid half of total fees. Such differences can explain why complementary private health insurances have not developed in Japan, but instead “supplementary” insurances as additional parts in life insurance contracts<sup>12</sup>.

Healthcare provision is organized via a complex and accidental public-private mix. Mixtures differ between regions. One city may have two public (national and city) hospitals; the other may only have private hospitals. Different regulations can be applied to different types of providers. For example, the Ministry of Health, Labor and Welfare makes regulations on all hospitals; while the Ministry of Internal Affairs and Communication issues rules on local government hospitals; and, finally, the Ministry of Education, Culture, Science, Sports and Technology on university hospitals. Meanwhile there have been no geographical boundaries or gate keeping for patients. In urban areas, providers compete with each other, with the same price rules.

The political representation of citizen is weak in the governance of the complex health care system. Bureaucratic structures are fragmented, as illustrated by the case of hospital regulations mentioned above (Kodate 2012). With quickly changing governments and the complexity of the policy field, most issues but funding are discussed in numerous councils under the Ministry of Health, Labor and Welfare, involving policy officers at the Ministry, representatives from relevant organizations

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<sup>12</sup> It usually pays a lump sum when insured persons are hospitalized over a defined period and/or diagnosed with cancer or any of a number of other specified chronic diseases. More than 70 percent of adults hold this kind of insurance (Life Insurance Association of Japan, 2012 : *Life Insurance Business, 2011*. Tokyo : Edition of the Life Insurance Association of Japan).

(such as medical associations), experts in relevant academic fields, and recently someone who is expected to represent the voice of patients.

The strongest part of the state regulation has always been on pricing, and on the benefit basket to be paid for by the statutory health insurance. The government decides the payment rules applied to all statutory health insurance every two years. This decision includes the definition of the overall rate of expenditure increase, and decisions on detailed payment rules for services. Because of those subsidies from the general budget, as we wrote above, the Treasury Department and the ruling party, in addition to insurers and health care professions are involved in decision-making on the overall rate of increase (Ikegami and Anderson 2012; Ikegami and Campbell 2004). Furthermore, arguments on general budgets such as the necessity for decreasing public debts have also been influential in making payment rules. The payment rules are considered to be a policy tool to implement the government's goals. Extra charges by physicians or other providers are strongly prohibited by law, except for some services designated by the Ministry of Health, Labor and Welfare. Those exceptions include private or semi-private hospital rooms, drop-in services at facilities with appointment systems, and « services under development ». Medical liberalism has been limited and controversial (Rodwin 2011)

### **3 - Policy problems and tools**

This part selects the most salient problems addressed through reforms or other policy action. The issues are not comparable at first sight, but deliver a comparative assessment of how two different systems deal with most relevant problems.

#### **3.1 Problems addressed and tools in the French reforms**

French reforms started in the early 1980', with limited hospital budgets. Many reforms followed, but did rarely produce the expected results. The reform process is a step-by-step one, with effective implementation since the mid-2000s. Three policy problems have been addressed, rather successfully: providing new finance; securing access; regulating, restructuring and managing the service offer.

Since cost containment proved difficult, new finance was essential. During the 1990', new compulsory contributions have progressively been introduced, applicable to other

than work income. In 1996, the social contribution of employees was replaced by an income-tax-like “general social contribution” (GSC)<sup>13</sup>. The latter applies to all income, including lottery winning, social benefits, capital income, etc., with various levels of taxation ranging from 3 to 10 %. The employers’ contribution is still taken exclusively from the pay roll (7.5 %). A specific contribution for the “reimbursement of the social security debt” was also introduced (0.5 % on all income, payable since 1997 and up to 2017). The mix in financing by work-based and tax-like contributions illustrates the ambiguous institutional model of the French health insurance.

In addition, new private finance has been mobilized, especially via the 2004 reform. Reimbursement rates were lowered, or modulated for medicines according to their medical effectiveness, and various entrance tickets were introduced or augmented. This policy has enlarged the market for the complementary private health insurances. To reimburse these additional private participations, they have augmented their premiums. However, they are not allowed to reimburse certain of these new copayments, those introduced to limit consumption. This reveals the ambiguous role of CPHI: they have become a complementary tool in the government’s regulatory policy, for slowing down demand and shifting costs towards private finance.

Prior to these copayments, access for the poor population was secured. The scheme for “universal medical cover” was introduced in 2000. This law replaced the old medical assistance delivered by local authorities by free affiliation to the health statutory health insurance, for anyone with income below a defined threshold<sup>14</sup>. A second step added free affiliation to a freely chosen complementary private health insurance, the contribution being paid by a public fund, specially created to pool the financial subsidies from all public and private HI funds. The final step has provided public subsidies to people whose income is up to 35 % above the threshold, in order to help them buy a private complementary health insurance. The public-private mix in the French institutional arrangements is particularly evident here.

Both reform directions, high contributions and access for all, corresponds to a large majority in public opinion, which is regularly surveyed since 2000 on behalf of the

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<sup>13</sup> The question whether the GSC was a “tax” or a “social contribution” was brought before the law courts, which made contradictory judgments (if it was a tax, it had to be included into and treated under the tax law). Finally the European Court of Justice defined it as “contribution” (*add source...*)

<sup>14</sup> The threshold is (2012) 661 € income per month for a single person, 992 € for a couple, plus 265 € each child or other dependent person.

government: 39 % are favorable to paying even higher health insurance contributions to maintain the actual level of benefits, 77 % are favorable for access to healthcare for all without distinction of their contributive status<sup>15</sup>.

**Regulation was made effective** by new institutional arrangements, organized by the major 2009 law. The latter transformed the 1996-created regional agencies for hospital planning into “Regional HEALTH agencies”, with all-compassing competency over the entire health sector, each agency in one of the 22 regions. All previous public administrations for healthcare, hospital planning, prevention, public health, and part of the social administrations have been *absorbed* by these new Regional health agencies (RHA)<sup>16</sup>. The latter have thus taken over the competency of the regional level of the health insurance, and gained authority over the long term and the so-called “medico-social” (homes for elderly, handicapped, addicts, heavy behavioral cases). These care institutions are financed by local authorities, and run or owned, most of them, by private non-for profit organizations. The longstanding local and national policy networks between elected politicians and civil society organizations are now obliged to negotiate their projects, interests and budgets with the RHA.

The ARS are bodies of the central state administration with regional competency. A long debate proceeded to their creation concerning the question of the best equilibrium between national policy and the agencies’ autonomy in promoting it within and adapting it to each region. The solution has been a national coordination body (*Conseil national de pilotage*) and a plural-annual contract signed between the ministry in charge of health and each agency fixing objectives and resources. The directors are nominated at highest government level, directly by the Cabinet. Their main task is restructuring and stirring the service offer: closing small hospitals or overcapacities in care units, foster merges, new technology, and public-private partnerships). They have powerful tools: each care institution has to negotiate a plural annual project and its budgets with the RHA, on the base of precise projects defining objectives, resources and appropriateness to geographical needs. All activities and institutions, public as well as private, have to obtain prior authorization from the RHA. An operational and already much used tool are the “*groupements de cooperation sanitaire*”, collaborative projects with legal status and proper management structures. These “groups” need to be

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<sup>15</sup> “Baromètre DRESS”, *Etudes et Résultats*, n° 821, December 2012)

<sup>16</sup> The total represents 9,000 functionaries, in terms of “equivalence full-time employment”, now attributed to the RHAs (Cours de compte 2012, p. 235).

validated by the RHA and can concern what ever is useful: partnerships between hospitals, whether public or private, for sharing technical equipment, territorial care networks, or redistribution of beds, or medical and non-medical joint activities, or collaborative projects between hospitals, long term and ambulatory care, or prevention.

Last but not least, the internal governance of hospitals has been reformed, together with the modes of financing. Like in the health insurance funds, the former governing boards of the hospitals (traditionally chaired by the local major), have been transformed into consultative body. The general director of the hospital, nominated by the ministry in charge of health, has full authority and chairs of the new “Directory”. The formerly rather autonomous hospitals departments have been joined into big “pools”, each headed by a managing doctor, who has to elaborate a development project for the pool and negotiate it as an contract with the General Director, who in turn has to present a plural annual project for the entire hospital to the RHA, which after negotiation and signature become a binding contract. The large contracting on all levels, together with the financing according to activity leaves no choice but to engage into new public management. This does not exclude the doctors, especially not the elite of medical professors heading the pools, but foos on the professional interests. The hospital directors have become a most powerful professional group, the elite of the “public hospital service”, one of the three sections of the French functionaries.

Much has been achieved during the last ten years, mainly a total revision of power structures, in order to operate cost containment, which is not supported neither by public opinion nor the healthcare workers and their trade unions. The change had to be organized with the support of high rang professionals that can identify with it. It should be recalled here that the prestigious hospital directors, who enter their training after a highly competitive entry exam, not only work in public hospitals, but also in the RHA, the ministry and private hospitals.

### **3.2 Problems addressed and tools in Japanese reforms**

In the last two decades, Japan carried out incremental policy changes rather than a big bang reform (Klein 1991). The exception was the establishment of the Long-Term care provision in 2000 (Campbell and Ikegami 2003), which has enabled the delivery of home help services by for-profit companies, and has expanded the demand their supply.

A major policy problem in the last two decades is unquestionably how to sustain funding for resource allocation to supply healthcare for increasing demands due to changes of citizens' expectations and to demographic changes. Within the existing health care system, health care expenditure is expected to increase markedly. A recent government projection estimated the medical care expenditure for the aged will increase 4.3 percent per year in average from 2010 to 2025, while the total medical care expenditure, for the entire population, is expected to raise 2.3 percent per year (Bureau of Insurance Ministry of Health 2010). This expansion of health spending has been problematized as a part of the rising costs for social security.

The following policy measures have been taken around this problem: raising additional funds within the existing institutions, development of a common pooling of funds with risk- and income-adjustments between insurers, and "*Tekisei-ka*"<sup>17</sup>, which means accountable healthcare costs.

First, measures have been taken to increase funds from the three major sources: contributions, tax, and user charges. A clear rule for funding has been introduced by the Health Care Insurance for the "Old-Old" people: a compulsory public insurance for those aged 75 and over was established in 2008. It increased transparency and horizontal equity in financing as well as opened a window to increase contributions from the Old-Old (Izumi 2010)<sup>18</sup>. To raise funds from the general budget, the government led by the Democratic Party of Japan passed an act that increases the Consumption Tax rate from 5 % to 8 % in April 2014 and to 10 % in October 2015. The tax will be earmarked for social security benefits, including health care and pensions, and policy measures to address declining birth rates. User charges have been gradually increased in the last three decades. Co-payment rates for beneficiaries of the EHBI were increased from 10 % to 20% in 1998, then to 30 percent in 2005. User charges for the elderly, for whom care was once free (in the 1970s), have also been increased. Consequently, the proportion of patient's cost-sharing in the national health expenditure statistics increased from 10.5 % in 1982 to 14.8 % in 2003<sup>19</sup>.

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<sup>17</sup> The Japanese term "*Tekisei-ka*" means making appropriate, reasonable, valid or right, whilst leaving open the ways to achieve it. Therefore, the word is often used by politicians and high officials to persuade relevant actors. Here we use the word "accountable" with a kind of simplification.

<sup>18</sup> Fifty, ten, and forty percent of health care benefits of the Health Insurance for the Old-Old shall be funded, respectively, by tax, contributions and transfers from other statutory health insurers. The average monthly contribution increased slowly from 5,332 yen in 2008 to 5,561 yen in 2012 (Ministry of Health, Labor and Welfare 2012). This rule has increased particularly transfers from other insurers, which has raised a political concern.

<sup>19</sup> The figure slightly decreased to 13.9 in 2009.

Second, the Health Care Insurance for the Old-Old not only maintained a common pool of healthcare funds for the Old-Old, but also introduced risk adjustment between insurers. Despite the strong objections of the insurance societies based on large companies, this (for Japan) new mechanism was introduced by the government though the adjustment is limited to the insured people between 65 and 74 years old.

Third, in response to the argument that healthcare expenditure should be made more efficient, the government has introduced a National Plan for Making Healthcare Cost Accountable in 2008. The plan set two major areas for action. One is promoting healthy behavior by increasing the utilization of personal preventive services, including screenings for diabetes and hypercholesterolemia; the other is making health care delivery more efficient and decreasing the number of beds (Ministry of Health Labor and Welfare 2008).

The cost of health care has been well contained in Japan compared to the OECD countries, particularly because of the all-payer price setting mechanism (Hashimoto et al. 2011; Ikegami and Anderson 2012). So far, public opinion polls have indicated a majority preference for keeping contributions within the actual limits and provide standard treatment. Only high income groups, which are a minority, would prefer more choice against higher contributions (Health Policy Institute 2009; Murata 2012). However, concerns about the “quality of care” and “physicians shortages” arise with anecdotal news on cases of malpractice or failure-to-access. Furthermore, increase of the old-old population is entailing changing demands for healthcare and a more ethical delivery of care for dying patients. These issues are now seriously debated.

Those concerns lead to the perspective and the search of an efficient and appropriate local delivery system. Among local governments, the *Kens* (Prefectures) have been gradually emerging as a key player to achieve such goals. First, some statutory health insurances have established an operating unit at the Ken level. The National Health Insurance Association established a branch for every Ken. The new Health Insurance for the Old-Old is operated by purposefully established insurers at the *Ken* level. In addition to that, activities and results of the plans for making healthcare costs accountable are used as incentives to those insurers. All *Kens* are now required to make their own plans for making healthcare costs accountable.

## 4 - Comparative assessment

The comparative results can be summarized following a classical plan, first the assessment of each case, distinguishing the main achievements and the still unsolved problems. The second part concentrates on the comparative assessment and proposes explanatory factors of the differences and similarities between the two national cases. This preliminary paper provides evidence to argue that the Japan as well as France, despite their important differences, when analyzed within their respective environment and evolution, are best classified as “statist social health insurance” systems.

**For the French case, the main reform achievements** have been:

- 1) New and rather sustainable finance has been provided, sharing the burden between public and private payers, whilst limiting negative impacts on access or quality.
- 2) The central state has finally taken over the Social Health Insurance, stepwise but mainly through the 2004 and 2009 reforms. The SHI continues to exist as an institutional facade, for reasons of lack of other legitimacy and institutional commodity (the practical function of reimbursement, and new control functions).
- 3) Cost containment as well as NPM is finally under way. The operational center is the centrally organized institution of “Regional Health Agencies”. Their powerful tools are contracting, authorizations and budgets.
- 4) The process of modernizing is an extension of the “public hospital service logic” to the entire health service sector. Implementation foots on the professionnelle collaboration of the “public hospital elites”.
- 5) Gate keeping has finally been installed, in 2004. It is efficient although voluntary, because based on the direct financial interest of the patients.

**The main unsolved problems in the French case** are, without surprise, linked to the ambulatory care sector dominated by “*médecine libérale*”: over-charging, bad geographical distribution and a foreseeable shortage of doctors in disadvantaged territories. Neither reforms nor incentives have succeeded so far in implementing on large scale the strict respect of medical recommendations, the much advertised integrated care paths, or the rational distribution of doctors. What would be needed is the rewriting the political contract between the private doctors’ unions and the government (Barbier, Guilloux, and Le Guilly 2010; Tabuteau 2010), which would mean yet another major redistribution of power.

**For the Japanese case, the main reform achievements** have been as follows:

- 1) By making the once varied co-payment rate into a common rate across all statutory health insurances, all statutory health insurances have the same co-payment rate, i.e. 30 % of the total fees in general.
- 2) The state has continuously and incrementally expanded virtual cross-subsidies between statutory insurers, particularly those between community-based health insurers and employment-based health insurers. It finally introduced a formal and explicit cross-subsidy (or a risk- and income-adjustment mechanism) between insurers through the 2008 health care reform.
- 3) The establishment of the new Health Care Insurance for the “Old-Old” people has opened the window for increasing contributions from the aged population without further legislations.
- 4) A part of personal preventive services have been moved from the public health system to the health insurance system, in order to achieve a higher level of utilization.
- 5) Through the 2008 health care reform, the state has been developing the *Ken*-level governance structure, including financial arrangements within insurance and subsidies available for *Kens*, planning of health care delivery, and modification of price levels.
- 6) The reform has also established the authority of the state to collect detailed information, such as activities of hospitals, which is critical to measure performances of each *Ken* in the NPM and develop incentives to influence provider behaviors.

**The main unsolved problems in the Japanese case** concern funding sustainability. This « problem » is raised, and growing in the context of containing social expenditure, in order to decrease the massive public debts while maintaining the competitiveness of industries. The lack of clear principles on who should pay, and how much for healthcare, can be regarded as the hidden problem in the Japanese politics of healthcare reform. Meanwhile, the managerial responsibility for “citizen health insurance” still exists within municipalities. Therefore, the *Ken*-level governance structure is to be developed further to include these responsibilities.

Although the question of how to increase efficiency of healthcare has been only qualitatively discussed, arguments for cost-effectiveness evaluations, which are

essentially quantitative, have emerged in policy making in the last couple years. Furthermore, with the expansion of aged population and accompanying increase of mortality, an expanding demand for more coordinated ethical care is expressed. This would require transformation of palliative care in terms of places of care, human resources, and more financing. Another open question is whether gate-keeping can be stronger regulated in the near future, together with the official qualifications for general or family practitioners, which has been developed only recently, by the newly created professional bodies of GPs. Before, the gate-keeping function was technically difficult, if not impossible to organize, because of the lack of an official category and recognition of these front-line physicians.

Deregulation on extra billings by providers has been a controversial issue during the entire last decade, but yet to be decided (Ikegami 2006). The policy has been supported by « pro-choice » policy advocates around the government, and physicians working at hospitals with highest reputation; but it has been objected by the Japan Medical Association, and by health policy scholars arguing that it would undermine the universal coverage.

**The comparative assessment** shows slow-pace change in Japan, geared toward renewed governance structures with the goal to lower bed capacities, whilst the French case witnesses the late but cumulating effects of many reforms, centered on the public hospitals and extending from there over the entire health system. The types of changes observed in both countries combine the renewing governance and of decision making structures, accompanied by changes in delivery structures, both with lesser amplitude in Japan, and in the French case with varying amplitude according to the sub-sectors of the system. The changes in both countries constitute a mix of “first” and “second-order” changes in Hall’s classification of reforms (Hall 1993). They are often limited incremental changes in the way the various tools are being used, but techniques and policy instruments are also changing. Wendt, Frisina and Rothgang (2009) proposed a scale that aims to integrate, and even measure change. They note that modest changes can prepare more important shifts. Using these authors’ scale, the observed changes in Japan and France correspondent to a mixture of “internal change of levels” and “internal system change”, the latter especially in France.

Both cases show growing, multiple and strong State intervention, in a formally still social health insurance model. The two cases should therefore be considered as a “statist

social health insurance” model (Götze and Schmidt, 2013). The new state regulation is concentrated at an intermediate level, between the national government and many local interests: the *Ken* in Japan, the *Région* in France. The political system however makes these regional levels more statist in France, and more regional in Japan. The distance to local lobbies and politicians therefore varies between the two cases.

## Conclusion

The main differences can be clearly identified. First, the spending level differs considerably: high spending in France, lower spending in Japan. Both options are firmly supported by public opinion. The steady growth of health expenditure enjoys a large and stable public consensus in France, just as lower spending is in Japan.

Second, whilst the two countries have well trained policy professionals, who may be called “programmatically elites” (Genieys and Hassenteufel 2012; Genieys and Smyrl 2008)<sup>20</sup>, in the top level of ministries and public administration, they need political support for getting their programs voted and implemented. In Japan they depend on other actors from within the circle of power, including politicians, business leaders, distinguished professionals, and media persons (Schmidt 2005). In France, in the case of health policy, they need active support from sectoral elites.

Concerning explaining factors, Olivier and Mossialos noted already that “a single explanatory theory would not account for all of the health sector developments that have occurred within any individual country, let alone across (...) different countries with diverse culture, histories, institutions and interest (Oliver and Mossialos 2005: 25)”. In our comparative study, the explaining factors are of the same type for the two healthcare systems, but have to be drawn from different theories:

- the propensity for high or only low taxation (political culture);
- the level of centralized or fragmented governance (institutions); and
- the capacity of senior policy officials to mobilize effective support for their programs (actors, politics).

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<sup>20</sup> A “programmatically elite” means “a group of actors with direct access to policy-making positions that is self-consciously structured around a common commitment to a concrete and coherent programmatic model for a given policy sector” (Genieys and Smyrl 2008: 76). To what extent senior officials in Japan can be called “programmatically elites” remains open, no empirical research being available on Japanese elites with this concept so far.

In other words, public preferences, veto points and the channels through which divergent interests can be negotiated and aggregated explain the two cases. If France will succeed its cost containment from now onwards, as it may be possible, it will be because of the now-existing central institution that operate this aggregation locally, the Regional Health Authorities. Whether Japan will succeed in converting its many beds into adapted facilities for the many frail elderly remains still a question, but it would need to be via the emerging Ken level.

The future is open. The historical legacy in both countries can provide opportunity as well as handicaps for necessary reforms. The private complementary health insurance in France allows bridging the gap between high public expectation and public cost containment, whilst the weak regulation of *médecine libérale* remains the still negative part of path dependency. Weak political representation in the Japanese health policy may make it possible to avoid too much politicization of healthcare. The complex mixture of funding in Japan can lead to flexible responses to economic downturns. Services for changing demands concerning the aging population can be promptly and flexibly developed, with little new regulations on already competitive healthcare providers if satisfactory funding will be allocated.

With changing policy environments, however, legacy and opportunities may change. In France, the liberal conception of physicians' work may finally be questioned. Internal changes within the medical profession may favor changes (feminization, changing division of labor between professions, new professional skills around medical management, etc.). If Japan opts to leave people raise additional funds privately for increased demands, rather than to make the public system raise them, then complementary and supplementary health insurance linked to the existing statutory health insurance may develop in the near future. If physicians in Japan want to gain more power or money with increased global and local demands, they may want a Japanese version of "*médecine libérale*" for their interest. Finally, despite or because of successful state regulation, it may ultimately occur that healthcare systems that are institutionally prepared to develop a more interwoven public-private mix may have an advantage in search for sustainability.

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