Qualitative Research on access to health and medical services of people with vulnerability under COVID-19 pandemic in Japan

Masaki Inaba[1], Chie Matsumoto[2], Naoko Tsuyama[3], Kaori Hirouchi[4]
Africa Japan Forum

Abstract

(1) Introduction

Globally, Japan has been recognized as a champion of Universal Health Coverage (UHC). However, with the impact of COVID-19, it faces a variety of difficulties in providing its people with universal access to health and medical services, especially people in vulnerable situations.

Japan's social model has shifted from a middle-income majority with lifetime employment for men since the 1990s to one that exacerbates income disparity due to widespread casualization of the workforce. Japan enjoyed rapid economic growth from the 1960s until the 1980s. This is when the government developed a social security system using households as the main units as Japan was a strongly patriarchal society. Companies shared the costs of public medical insurance and public pensions mainly for male employees as part of assumed lifetime employment, which guaranteed the stability of the system. The changes in social structure in the following decades have destabilized this system, but no drastic improvements were made. The transformation of the nation's social model has, therefore, disproportionately affected women and other marginalized communities.

The current health insurance scheme gives a false impression that it equally covers anyone who lives in Japan; however, it has encountered some systemic challenges. Our objective is to review the situation of health and medical access of people with vulnerability and identify key obstacles of UHC.

(2) Methods

We conducted a series of interviews with the leaders of key vulnerable communities in the social context of COVID-19 and HIV/AIDS, including migrants, elderly people, youth, urban poor, people with disabilities, women and girls, sex workers, people using drugs, and men who have sex with men about access to health and medical services. We also asked about their access to public medical insurance, social welfare programs and public assistance schemes based on Public Assistance Act (mainly medical assistance), all of which ensure the people's access to health and medical services, as well as public health and the Independence Support System for the Impoverished. We also interviewed social workers and staff members at public health centers. After the interviews we had two consultation meetings with the interviewees to analyze the key obstacles to universal health coverage in Japan. We use pseudonyms in our report to protect the privacy of our interviewees.

Following the COVID-19 prevention measures, each interview, as well as two consultation meetings, was conducted remotely using an online application. The interviews, which lasted between 60 and 90 minutes, were digitally recorded and transcribed into both Japanese and English.

(3) Results

1. **From the interviews and discussions at the consultation meetings, we found that the greater the vulnerability of an individual, the greater the time, cost, labor, and psychological burden required for that person to expend to access health and medical care.** This was mostly due to the complicated and bureaucratic architecture of social welfare and public assistance programs. The majority of those in the middle- to higher income bracket with stable employment can access

[1] Corresponding Author, Director, Global Health Program, Africa Japan Forum, ajf.globalhealth@gmail.com
[2] Corresponding Author, Journalist, Editor, Media Cooperative *Unfiltered*, labor union organizer, chie.m.matsumoto@gmail.com
[3] Co-Chair, Africa Japan Forum
[4] Executive Director, Africa Japan Forum

health services provided by public health insurance almost automatically. The insurance premiums are also divided equally between the employers (company, etc.) and the workers. On the other hand, the minority and the more vulnerable populations who are often low-income and on unstable employment often experience impediments caused by heavier insurance premiums and complex procedures of application, assessment and implementation to receive social welfare subsidies and other public assistance programs The community leaders also reported often encountering authoritarian and paternalistic responses and causing the patients psychological burden when accessing medical services.

2. Many people in Japan don't have correct information on public health and medical insurance, social welfare and public assistance programs because they have only limited opportunities to learn about these systems both through public educational institutions and everyday life experiences.
3. Japan is no stranger to the “Shadow Pandemic,” reported in the April 2020 issue of UN Women on gender-based violence. Experiences of discrimination and abuse often plague vulnerable communities including women and sexual minorities with mental illness. However, low quality of mental health care and prioritization of mental health in Japan lead to discrimination and prejudice, which hamper people's willingness to access health services. Furthermore, Japanese psychiatric treatment still continues to isolate patients from society through long-term hospitalization. This leaves Japan behind the international trend of treating patients while allowing them to participate in society.

(4) Conclusion

Japan's ageing and low birthrate will continue to contribute to population decline. With about 30 percent of its population aged 65 and older and the low birthrate recorded for five consecutive years at 1.34, the vulnerable population would inevitably increase.

Whereas public mechanisms to ensure health and medical access for the people have been generally working, especially for the majority, the vulnerable communities have been struggling for easy access to health services due to various obstacles, including the complicated nature of the systems and the lack of correct information. COVID-19 has degraded the system by imposing a heavier burden.

The interviews with leaders of vulnerable communities revealed that the Japanese system suffers from economic, systemic, social and cultural challenges. In a way, this research and analysis is timely because it helps address flaws in the systems, which were exposed during this pandemic. Although Japan’s systems have long been believed to be universal in terms of coverage, they have left many vulnerable communities behind.

Strained by an ageing population and a low birthrate, Japan’s social insurance systems have faced difficulties with sustainability and have been facing the threat of privatization. As access to medical services and social security should be considered basic human rights, these schemes should remain in the public domain. “Community-based comprehensive care," which is promoted as a solution to aging and low birthrate, introduces the idea of primary health care that involves citizens of the community to exercise their rights to access the necessary medical and welfare services. We can positively evaluate this new idea; however, the government should be held accountable for citizens' access to medical and welfare services.

The Japanese systems still have potential, if implemented properly and to their full capacity, to provide completely universal coverage to its people if the redesign includes transparency and dialogue with marginalized communities, rather than resorting to privatization. At the same time, the government needs to allocate resources to educate and inform the public, especially its vulnerable communities, about the systems such as public medical insurance, social welfare and public assistance programs. Education and information dissemination can effectively help the vulnerable communities develop literacy as they attempt to navigate the services offered to find what they need in a timely manner.

It is time to review the system, identify the key obstacles for consumers and find the pathway to universal health coverage that leaves no one, especially vulnerable people, behind.

1. Overview: Loopholes of Japan's UHC: The more vulnerable, the harder the access

(1) Objective

Universal Health Coverage (UHC) has become an important pillar of international health policy since the 2010s. The World Health Organization (WHO) defines UHC as "a situation in which all people have access to the quality insurance and medical services they need without facing financial hardships.

Japan is internationally recognized as having achieved a high level of UHC. However, the marginalized, their support groups, and other concerned parties have reported that people in economically, institutionally, socially and culturally vulnerable situations in Japan are experiencing many difficulties when accessing health and medical care. In addition, the coronavirus (COVID-19) pandemic, which began in 2020, has resulted in limited resources in testing, treatment and prevention. It also affected those who were not vulnerable prior to the pandemic because demand has exceeded supply and UHC became unfeasible. Access to measures to treat non-communicable diseases and other infectious diseases was also hampered as the COVID-19 response impeded other health services.

This research was conducted in response to the State of UHC Commitment called for by UHC2030, an international organization dedicated to the realization of UHC, and "Civil Society Consultation based on each country" called for by the Civil Society Engagement Mechanism (CSEM), a network of civil society participants in UHC2030. It is an attempt to collect and analyze more comprehensive information from not only the government but from civil society and other stakeholders on the progress of UHC in each country and on the implementation of the ambitious Political Declaration adopted at the UN High-Level Meeting on UHC in September 2019. The countries subject for the Voluntary National Review, which is part of the UN's SDGs Progress Review in 2021, were selected for this research. In collaboration with the NCD Alliance, PHM and UNAIDS, CSEM then invited a "Civil Society Consultation" in each country. In the end, civil societies in 20 countries in regions such as Asia and the Pacific, Sub-Saharan Africa, the Middle East and North Africa, North and Latin America, Eastern Europe and Central Asia conducted the consultation. This research was conducted in Japan as part of this initiative.

(2) Methods

We interviewed 19 experts in public health-care systems and public health administrations, and leaders and members of various demographics and social groups (hereafter "communities") in institutionally, socially, economically and culturally vulnerable situations about the challenges of access to health and medical care under COVID-19 in Japan. All interviews were conducted online for 60-90 minutes due to COVID-19. Two consultation meetings followed, with 17 of the interviewees, to clarify the current status of health care access especially among vulnerable communities. During the two-hour consultation meetings, we explained the main objective and the results of the interviews in a plenary session, followed by discussions in small groups to provide a more multifaceted analysis of the findings. In order to protect the privacy of the collaborators, their names and names of organizations are kept anonymous in this report. They are identified in the descriptions of their activities.

(3) Japan's Public Medical Security System

Japan is internationally regarded as a country that has achieved a high level of UHC. Contributing to this are public medical insurance (health insurance and national health insurance), supplementary social welfare systems and public assistance among Japan's social security systems. The public assistance includes free medical care that is provided to those in need, based on the Public Assistance Act that guarantees "the minimum standards of wholesome and cultured living" (Article 25 of the Constitution). On the other hand, medical costs of tuberculosis (TB) have been borne at public expense since the days of the former Tuberculosis Prevention Law, while those for designated infectious diseases such as COVID-19 are borne at public expense under the Infectious Disease Prevention and

Medical Care Law. In the social welfare system, the "medical care for independent living for the disabled," which is a public system to reduce medical costs for the physically and mentally disabled, helps reduce the biggest barrier to accessing medical care; the out-of-pocket medical expenses. The subsidies for medical expenses for the disabled provided by local governments (prefectures) also help with the financial burden as they are funded by tax revenue. There is also the "free, low-cost medical service," stipulated in the Social Welfare Act and the Corporate Tax Law, which designates medical institutions to extensively provide medical care to the needy by reducing the amount of co-payment.

Public assistance based on the Public Assistance Act, especially medical assistance, is the most comprehensive guarantee of medical care for the needy. Thanks to this system, a certain level of access to medical care is guaranteed even to the poorest in Japan: it is the foundation of UHC.

Those with economic hardships and medical needs must first rebuild their lives in order to access medical care in a sustainable manner. The government established housing subsidies and reviewed the loans for the low-income residents after the number of impoverished people increased as a result of the 2008 world recession. In 2013, the law for the independent support for the impoverished was enacted to combine various systems and provide support according to the circumstances of each person in need. The local governments set up sections and began implementing the support system.

(4) Vulnerable communities

This research looks at the challenges of these systems faced by vulnerable communities in accessing health and medical care. From the high economic growth during the 1960s and 1970s until the early 1990s, Japanese society had a large middle-class that enjoyed relatively little economic disparity. This middle class was created based on the long-term stable (often lifetime) employment adopted by corporations that flourished during this period of high economic growth. Also contributing to this was the highly homogeneous society that Japan has been building since the war ended. This homogeneity was founded upon a nationality and family register system based on lineage, patriarchy, heterosexism, productivity and loyalty to corporations. As a result, the people and communities outside of this homogenous system were not, even during this period, effectively treated as equal.

Since the 1980s and the stagnation of the Japanese economy, its aging population, the declining birthrate and installment of the Labor Dispatch Act, which encouraged labor mobility, long-term stable employment could no longer be sustained. All of these factors converged in a perfect storm of falling income, increased spending needs, and corporate lobby pressures that contributed to the breakdown of the middle class and the increase of vulnerable communities. This trend is expected to continue in the future.

Mental illness and mental instability are common among a wide range of marginalized people. This has to do with the inherently unstable lifestyles associated with various hardships, such as childhood abuse, and the experiences of physical and psychological violence. In post-war Japan, mental health and medical care for mental illness were perceived mainly as a public-safety issue, which delayed the quality improvement of medical care. In order for people to access health and medical care and work to recover physical and mental health, it is necessary for them to discover their own health and medical issues, find and reach medical institutions that can help solve the problems, accept the care, and undergo at least a certain period of treatment based on trust. This process is achievable only by the joint efforts of the service recipients and the service providers in welfare, health and medical institutions. Vulnerable populations meet inevitable barriers when faced with challenges of medical institutions, their accessibility, and their costs. Availability of outreach programs for health and medical services and quality of care are both factors that discourage people from accessing medical and health services. Also impeding them are the obvious or subconscious discrimination and micro-aggressions that can occur when receiving care or a lack of effort to build trust. This research examines the impediments to health care by focusing on the existence of institutional, social and cultural barriers, in addition to economic barriers, such as medical costs.

(5) Overall Issues

a) The greater the vulnerability, the greater the cost, time spent, effort, and patience

The most significant challenge found in this research is that the greater the vulnerability of an individual, the greater the total cost in terms of funding, time, effort, and patience spent for their recovery through health care services. Therefore, vulnerable people are more likely to abandon access to health care. In fact, for those in long-term stable employment, still the majority in contemporary Japan, access to health care is almost automatically achieved through public health insurance. The premiums are automatically deducted from their salaries, and the cost is usually registered unnoticed. People can automatically access medical care by presenting their insurance card at the hospital and paying up to 30% of the medical costs on their own. If the cost is larger than a certain amount, the reduction system for high medical costs sets the cap on the co-payment, and the patients need not pay more than the limit. However, as soon as people become marginalized, access to health and medical care is blocked and the cost rises sharply. One of the main reasons for this is that the social welfare system and public assistance funded by tax revenues are not flexible enough for the users because the systems prioritize the convenience of the administrators. The system is structured in such a way that it causes a large mental and emotional burden for the applicants and is not convenient for the service users. The information about how to apply for these services is also not easily available.

b) Lack of education or information about the social security system

In Japan, there is almost no opportunity to obtain comprehensive information about the social security system, including public medical insurance, social welfare, and public assistance. Social security is taught in civics classes in junior and senior high schools, but the Education Ministry’s teaching guidelines rather prioritize the issue of "improving and stabilizing social security in an aging society with low birthrates" rather than the systems’ main objectives, mechanisms, and ways to apply for and implement them. Opportunities to learn and raise awareness of these issues are scarce. As a result, citizens lack a basic understanding of their country's social security and social welfare systems. Because few people have a prior knowledge of how to properly utilize these systems including social welfare and public assistance, they essentially have to gather information on their own and negotiate with local government offices before applying for them.

These systems were established with an aim to guarantee the basic human right to "healthy and culturally affluent, minimum standards of living." However, the government has failed to administer these systems in accordance with this aim. In particular, public offices have long administered these systems with the goal of reducing the number of recipients and cutting costs as much as possible as a priority, rather than providing necessary support to applicants. The information about public assistance circulating on social network services (SNS) and other media is biased, emphasizing the difficulty to access and encouraging people in need to give up applying. The true objective of the public assistance systems is not widely shared, leading to the spread of misinformation. In fact, information about public assistance available on SNS contains false and fake information, which is one reason people are steered away from applying.

While Japan's public medical care system, which makes UHC possible, is highly regarded by the international community, the lack of effort to educate and inform citizens about the system only undermines the stability of the system. We need to raise awareness among policymakers.

2. Discussions: Barriers to health and medical services in Japan

(1) Economic barriers

a) Low-Waged Unstable Employment and Access to Health and Medical Services

In Japan, over the past 30 years, the number of full-time workers in long-term, stable employment has continuously decreased due to deregulation and other factors. On the other hand, the number of informal workers has increased from 15.3% in 1984 to 38.4% in 2020. The informal employment rate varies greatly by gender and age, with women making up 56.0% in 2019, compared to 22.8% for men. While informal employment among men is higher both for youth (under 24 years old: 21.6% in 2019) and the elderly (65 and above: 73.3% in 2019), the number of women working in informal jobs starts increasing at the age 35, reaching 51.6% between the ages 35-44; 57.7% between ages 45-54, and 82.0% for 65 and above. For people aged 65 and older, the percentage is 82.0%. There is also a gap in wages between regular and non-regular workers. According to 2019 statistics, the average monthly wage of regular workers, including those in the public sector, is 325,000 yen. That of non-regular workers is 212,000 yen (65.2%), which amounts to a difference of nearly 100,000 yen. Gender also presents a gap, with the average monthly wages of regular male employees at 351,000 yen, compared to 269,000 yen for regular female employees (76% of men's). In terms of irregular employment, men earn 235,000 yen on average, compared to 189,000 yen for women (80.4%).

For people with precarious employment and low wages, the burden of premiums for public health insurance and pensions weighs heavy. The premiums are set at a fixed rate of 14-18% of wages, which is regressive for lower income groups and constricts their disposable income. They must pay 30% of the medical expenses on top of the premium. In the case of the National Health Insurance (Kokumin Kenko Hoken) and the National Pension Plan, in which self-employed and small business employees are enrolled, they may have to pay the full amount of medical expenses by returning their insurance cards or replacing them with "short-term insurance cards" if they fail to fulfill their premium payments.

> *"What people let go as soon as they become impoverished is their health insurance. And this becomes a problem when they get sick. Women working at street corners (prostituting) are most often not paying into the National Health Insurance. Many have not transferred their residency, and that adds extra burden when trying to join back." (a journalist reporting on labor and women in poverty)*

> *"If you keep failing to pay insurance, you cannot go to see doctors and must buy medicine over the counter. It costs more without the insurance. (a member of support group for domestic abuse survivors)*

b) Gender disparity and failing systems, medical services outside of insurance coverage

Unstable employment and declining wages have had a particularly serious impact on women. As seen above, the number of informally employed women is more than double that of men. Furthermore, their wage is only 80% of that for men, which has a significant impact on access to health care, especially for single women and single mothers. Since the National Health Insurance program is administered on a household basis, children in poor households are not able to receive medical care due to their parents' failure to pay premiums. Women and children are also hesitant to access health care if they have abusive men who are heads of their household.

Many medical services in Japan are covered by public medical insurance; however, a number of preventive and testing services are not. Another major problem for women is the cost of abortion is not covered by public health insurance, except when the pregnancy is caused by sexual assault. Even then, it is only covered when reports are filed and approved. Filing a report inflicts a huge mental burden and

anguish on the woman, which discourages women to report in the first place. This has resulted in marginalized women abandoning newborns because they could not get an abortion when they needed one. Mental health problems (mental illness) are common among vulnerable populations, but since most psychiatric counseling is not covered by insurance, many people shy away from getting counseling.

"When a woman is having a baby, she can make do as long as she has a residence. There is no public assistance for getting an abortion for someone without a stable residence. If she receives welfare assistance, the funds will be provided as long as it is an unwanted pregnancy or one caused by sexual assault. However, unless a woman is a sexual violence survivor without social welfare assistance, she must pay for it on her own. This results in murdering newborns. Providing public funds for abortion would help reduce child abuse." (a member of support group for domestic abuse survivors)

"If parents have held off on paying health insurance and their children wanted to go see a doctor, they would have to initially pay the full cost and get reimbursed. Once this happens, they would never go back to a doctor." (a case worker for youths)

"It's best if health insurance pays for counseling. Mental illness cannot be treated only with medicine. Many young people need counseling and other medical treatment that are not covered by insurance. (a member of support group for young women)

c) Impact of COVID-19

Japan's impoverished are strongly affected by the social and economic consequences of COVID-19. Even after the pandemic, the government has not been able to increase testing, quarantine and treatment capacities. Testing is sporadic, unsystematic and difficult to understand how to access. People are not eligible for free, government-provided testing and must pay for the cost unless they show symptoms such as high fever or they are considered as having close contact with COVID positive patients. If they get tested at a local private clinic, the cost can be 20,000 to 30,000 yen. Medical care for COVID-19 also becomes free if the result turns out positive. Otherwise, they must pay the fee. Meanwhile, the public health centers are constricted due to the COVID-19-related duties, and they have suspended free HIV anonymous tests since last April. This discourages people from getting tested for HIV and leads to an increase of HIV patients who learn about the infection at the onset of AIDS. Due largely to the increase of COVID-19-related medical needs, other medical needs were impacted, thereby impeding access to health and medical care, not only for HIV but also for non-communicable diseases (NCDs).

"When people are hospitalized at mental institutions, they are asked to get a PCR test. If they cannot receive a government's test, they must pay about 25,000 yen for it. Unless they pay, they cannot be hospitalized." (a member of support group for young women)

"The Japanese government does not place importance on public health policies. That is why the number of public health centers was halved. When the pandemic spread, the government could only think about Corona and nothing else. With so little capacity, they ended up abandoning HIV tests, and no one is accounted for. (a member of community center for HIV awareness)

(2) Systemic Barriers 1 : Nationalities and patriarchy

For people living in Japan with various vulnerabilities, systemic barriers are one of the major impediments to accessing health and medical care, coupled with economic barriers.

a) Foreign residents of Japan

Among the foreign residents in this country, about 83,000 people live without any visa, as of the beginning of 2021. Out of those, tens of thousands of people have a "Designated Activities" visa (1-3 months) or "Short-term" visa (90 days or less). They are systematically excluded from public medical insurance, social welfare, and public assistance and are only covered for some infectious diseases such as TB by public subsidies for medical expenses. “Free and low-cost medical services” for the impoverished have allowed a certain level of access to foreigners, but the number of hospitals that provide such services is limited. makes the access even more difficult. Due to the government's policy to promote "medical tourism," many major public hospitals have raised the fees two to three times for uninsured foreigners compared to those for the Japanese, treating them as wealthy "medical tourism" customers. As a result, uninsured patients with serious health conditions flooded free and low-cost medical services, causing the cost of treating uninsured people to exceed the budget allocated for free and low-cost treatment at many hospitals. Moreover, due to the deterioration of hospital management after the pandemic, numerous hospitals have excluded foreigners from the service, making it extremely difficult for foreigners living in Japan to receive care through free and low-cost medical services.

The Japanese government has adopted a "no exception" policy in which all undocumented foreigners are detained, regardless of grounds. Although some are released on "parole" due to prolonged detention or poor health, they are prohibited from working. They must also report any outings across prefectural borders. Many people suffer from physical and mental illnesses due to extended incarceration with no fixed term, but access to medical care inside detention facilities is inadequate. Accessing medical care for parolees is also extremely difficult because they live with limited support from friends and civil society and are excluded from almost all public medical security systems.

The nearly 400,000 technical interns currently working in Japan under the technical training program for foreigners face labor issues such as low wages and restrictions on transferring jobs. Under the guise of "technical training," they also have problems accessing healthcare. Normally, pregnancy, TB or any other diseases should not affect the legal status of "technical trainees,” but prior to their departure, their supervising organizations in their home countries or employers in Japan tell them that they must discontinue the program if they become pregnant or that they will be dismissed if they contract TB. They are not told about their rights or how to exercise them. So they cannot consult anyone or access medical care when they become pregnant, which, in many cases, has led to unsafe abortions. . There have also been cases of people being sent home without treatment for contracting TB, even though they could have received treatment in Japan at public expense. The Japanese government has repeatedly expressed that it would not adopt an "immigration policy" for such technical trainees and has not made any legal amendments such as expanding the program or establishing the "designated skills" visa. There is little support for the trainees and other foreigners to stay in Japan. As a result, the trainees are less informed about social security and often lack support from local communities. They are often placed at a disadvantage compared to other foreigners when faced with health and medical problems such as pregnancy and illnesses. This is the result of systemic and policy inadequacies.

“Those without visas or only with permits for less than three months are not eligible for medical insurance and social welfare or any other support system. Nor are they eligible to work. Under such circumstances, they don’t even have the least they need to lead a basic life and, therefore, are endangered. They are faced with the most hardships.” (a member of advocacy group for foreign residents)

“The people who have been detained suffer from mental illnesses, namely depression. Their mental health deteriorates as they are only given drugs without ever receiving adequate medical treatment inside the detention centers. Even when they are out on parole, they can hardly ever access doctors as they are not able to afford the high medical cost without insurance. (a member of advocacy group for foreign residents)

“’Medical tourism’ continued to be promoted where resident foreigners were not getting sufficient access to medical treatment. Medical institutions began to serve richer tourists from outside Japan

than impoverished foreigners living in Japan. As a result, the poor are flooding the hospitals that offer "free and low-cost medical services," straining the hospitals' finances and causing more hospitals to discontinue such services. A vicious cycle is perpetuating." (a doctor who treats foreigners)

"The technical trainee program was designed on the principle that the government would not adopt an immigration policy, so all the trainees must return home at the end of the training. Foreign residents rely on communities of their own people when faced with problems. However, many trainees come from countries that do not have communities in Japan. They are vulnerable in that they fall out of any systems or communities. Many are dismissed or forced to go home when they were infected with TB or got pregnant. The government should prevent unfair treatment by establishing a social system to accommodate multicultural communities before it accepts them. Because there is no such system, it overlooks policies that allow exploitation. (a doctor who treats foreigners)

b) **Public medical security system built on a household basis**

Japan's social security system has basically been administered on a household basis. In the case of a nuclear family -- a husband, wife and children -- which is common in Japanese households, the head of the household is often the husband. There are cases, especially in health insurance, where women and children delay access to health and medical care for fear that the man or other members of the family will find out about it. This poses a systemic barrier to access, particularly in cases of pregnancy and mental illness and other issues related to sexual reproductive health/rights (SRHR).

On the other hand, with regard to public assistance based on the Public Assistance Act, the inquiry system (see next page) to verify whether any family member can provide support to the applicant, has pushed many people away from applying for the subsidies. The inquiry system was introduced in the name of reducing the users of public assistance to ease public expenditures and eliminating anyone "illegally receiving the subsidies." This has resulted in delays in applying for medical assistance and delays in access to healthcare.

In addition to the public medical security system in times of peace, most of the financial aids and benefits related to COVID-19 and other disasters are distributed on a household basis in principle. So the emergency allowance of 100,000 yen, which was provided by the government under the pandemic and supposed to reach each person, went to each household instead. This is why many survivors of spousal violence could not receive the money: The money was deposited in the husbands' accounts.

"Many of our clients leave their health problems untreated due to 'parental barriers.' It means that they don't want to tell their parents. They'd rather not go to the hospitals if their parents could learn about it through health insurance. Survivors of parental abuse in high school, for instance, experience the 'parental barriers' like this. Many of them who have witnessed the way their parents lived or were disturbed by the relationships between their mothers and the mothers' partners often endure health problems because they don't want to tell their parents." (a care worker supporting youths)

"The problems with 'parental barriers' occur even outside of impoverished households. The families who (have sufficient income to) own homes face more serious issues, though a very few reach out for help. Children of such families are often convinced this is only happening to them. Or the people who consult youths respond in a condescending tone because they are not used to responding to such cases. This type of attitude hinders children from speaking up. And that delays a proper response as it is difficult to identify the problem." (a care worker supporting youths)

"The children are supposed to make their own decisions, but the members of medical institutions sometimes even demand to speak with the parents. Medical institutions tend to be defensive in this way. (a member of group supporting young women)

(3) Systemic barriers 2 : Challenges in the social security system

a) Design and Implementation of Social Welfare and Public Assistance

People who cannot afford medical expenses but are not covered by public health insurance (health insurance, national health insurance) need to sign up for social welfare and public assistance (especially medical assistance) to access medical care. Needless to say, people who try to apply for these programs have some vulnerability. However, these systems are not designed for easy access for such people. The problems lie in the "household-based" application structure noted in the previous section. Under the deteriorating finances of the central and local governments, the state has been particularly reluctant to provide public assistance for various reasons, rather than f proactively providing benefits to those who need it. As a result, the barriers became larger , and the greater the vulnerability, the harder it became to apply for and use the system. This has led to situations where people end up accessing medical care only after their symptoms worsen.

"People who have stable employment most often understand how the system works. However, those who do not quite understand it end up dealing with everything on their own. The more vulnerable they are, the more laborious and time consuming it is to them as they have to put together many forms of documents to apply for the assistance." (a member of group supporting the impoverished)

i. Public assistance

Public assistance based on the Public Assistance Act is a comprehensive system that guarantees "the minimum standards of wholesome and cultured living," including the minimum living expenses (livelihood assistance), rent (housing assistance) and medical care (medical assistance). Medical assistance, which provides welfare users with access to free medical services, is of vital importance in ensuring medical care for the low-income and the impoverished due to the various vulnerabilities they possess, and in realizing UHC in Japan as a service that "leaves no one behind." However, the central and local governments, which bear the cost of public assistance, have tried to minimize their financial burden by conducting "shoreline operations" to shove applications away at city hall. They have also launched campaigns on "illegal receiving" of subsidies to impose prejudice against welfare users. The 2014 amendment to the Public Assistance Act enforced the "inquiry system," where the welfare office checks whether the applicant's relatives have the ability to support them. Because of this, many marginalized people avoid applying for public assistance. In Japan, only between 9% and 20% of low-income households who are eligible for public assistance actually receive it.

Even at local welfare offices, hiring of workers that specialize in welfare has slowed down, while local governments are increasingly placing non-regular and temporary workers in charge of employment support. Non-regular employees, while suffering from low wages and unstable employment themselves, are working without any expertise in welfare. As the number of staff is reduced, the amount of responsibility per person rises, meaning each person must take care of many users alone and is overworked as a result. These people then tend to fall into confrontational relationships with welfare users.

"Even prefectural capitals don't hire people with expertise in welfare. Hence, many work without a high level of awareness or sense of mission. Moreover, full-time staffers in the offices are replaced with precarious workers. Many of these informal workers end up directing their anger toward welfare users -- the more vulnerable of the society -- because the yare frustrated about their unstable working conditions. The under-represented are divided, and it causes the poor to shy away from applying for welfare assistance. (a care worker supporting the impoverished)

"When welfare assistance users go see a doctor, they show their cards and tell the receptionists they are using public assistance. The receptionists then call the welfare office to confirm before they can access medical treatment. Many say this process is humiliating so they don't want to go to the

hospitals. There are even some medical institutions where receptionists purposely identify welfare users in a loud voice. That doesn't make them feel like they 'want to go' back." (a member of group supporting domestic abuse survivors)

ii. Independence Support System for the Impoverished

The number of poor people rose since the 2008 world recession. In 2015, the government launched the Independence Support System for the Impoverished' with the aim to help people rebuild their lives by combining and utilizing multiple systems that met their needs before receiving public assistance. A consultation counter was set up in each local government to provide necessary public services along with services offered by NPOs, etc. Especially for those who are unable to seek medical care, the system can refer them to free and low-cost medical services. The system helps to rebuild lives by offering special loans for welfare funds and housing security benefits to pay for rent. This examines the availability of systems and the support people need with various vulnerabilities in order for them to rebuild their lives. The quality of this consultation services varies greatly depending on municipalities. One municipality, for example, is able to provide companionship and support to young people who are experiencing hardship, while another municipality can only offer a counter for applications for housing benefits.

"Japan's social welfare program is not accessible unless someone applies for it. One must file a proper application after finding the program (out of all the other public services). The Independence Support System for the Impoverished should be a service where counselors figure out the problems impoverished citizens are faced with and set the right directions. It should be a partnership-type support. However, there are some municipalities that resort to simply processing papers as the support was reduced to formality." (a case worker in support of the impoverished)

"It was good to see the counters at local governments that deal with the Independence Support System, but there are still very few options available for workers in social welfare. That's why people in need of help ended up relying on the loan for welfare funds. That generates more problems. There are also problems that arise when the local governments outsource welfare consultation to the private sector. Social welfare has become a market for these private sector businesses as local governments set bids too low." (a member of support group for the impoverished)

b) Public hygiene, medical system and Impact of COVID-19

i. Weakening public hygiene and medicine for infectious diseases

When COVID-19 initially spread in the first half of 2020, Japan faced a problem due to a delay in expanding testing, quarantine, and medical response. One of the main reasons for this is that the public health system administered by public health centers has suffered downsizing and restructuring since the late 1990s. Other reason is that the number of beds for infectious diseases was massively cut during the same period. The Community Health Act, which was revised from the Public Health Center Act in 1994, led to the division of public health centers into those established by prefectures and government designated cities with a population of more than 500,000 and those established by other smaller municipalities. As a result, the number of public health centers was halved to 469 in 2020, down from 852 in 1992. The number of public health nurses and other staff is limited due to that. However, their responsibilities have broadened and diversified, and executing duties has been difficult even during ordinary times.

The number of beds for infectious diseases, which exceeded 10,000 nationwide in the early 1990s, plunged to around 3,000 at the end of the decade, and further dropped to 1,800 in the 2000s. As a result, hospitals were unable to accept COVID-19 patients, which increased by the day. This disturbed the cooperative relationship between public health centers and medical institutions as the centers were not able to make referrals to the hospitals. There was no way to secure quarantine facilities. Depending

on the region and timing, many COVID-19 patients were forced to stay at home.

"The government continued cutting the workforce at public health centers. It was not just public health nurses but workers in hygienic and social welfare were reduced. Even in ordinary times, it's been difficult to do our tasks. Emergency situations with infectious diseases and natural disasters are increasing. We need more workers or we can't respond to these emergencies." (a worker in an organization for public hygiene)

"Public health centers have had such a hard time dealing with hospitals under COVID-19. There are an unexpectedly large number of hospitals that refuse to treat Corona patients. Originally, hospitals designated to treat infectious diseases were to accept Corona patients: They don't want to spend extra time and work preparing to treat these patients. (a worker in an organization for pulic hygiene)

"Public health centers have been targeted for restructuring and downsizing, which put more work on each person. The pandemic spread as public health was experiencing cutbacks. More outsourcing to the private sector and imposed efficiencies has pushed many talented public health nurses to resign. Mishandling of policies ended up causing damage to this system, but no one is accountable." (a member of HIV prevention and awareness center in support of HIV patients)

ii. Impact of COVID-19 on response to HIV

The vulnerable people are largely impacted in terms of meeting health and medical needs as testing, quarantine, and medical care are strained. HIV testing is one such need that has been disrupted due to public health centers being overwhelmed. In Tokyo and many other areas where COVID-19 infections have spread, HIV testing has been suspended since April 2020 as the public health centers were inundated with contact tracing and other Corona-related work. As a result, the number of HIV tests at public health centers nationwide has been halved to 68,990 in 2020 from 142,260 in 2019. Even in Tokyo, the number of HIV tests plummeted to 17,370 from 32,016. In 2019, 26.4 percent of new HIV infections were detected by the onset of AIDS, but in 2020 the figure rose to 33.0 percent.

"The HIV testing is conducted by the same department that responds to Corona at public health centers. Because available resources are limited, anonymous testing for HIV was suspended. And it was suspended in all of the 23 wards in Tokyo.(a member of community center for HIV awareness)

"It has become more difficult to get tested for Corona, which led to less testing. That's why the number of new HIV infections plunged. We can expect that the number of people who learn about HIV infections through opportunistic infections in the future, in other words, through the onset of AIDS, will increase. This is worrisome. In Kyushu or Tohoku regions, to begin with, half of the infected learn about it at the onset of AIDS. We should all have the right to get tested for HIV even during the pandemic." (a member of HIV prevention and awareness center in support of HIV patients)

iii. Disabled and Elderly Care and COVID-19

Elderly and disabled people also face difficulties. Due to the strained medical services, some elderly COVID patients are forced to receive home care depending on the region and timing, despite the fact that they are at a greater risk of getting severely ill and dying from COVID-19. In some cases, elderly people with dementia or disabilities are refused services at hospitals, but the support system for elderly patient home care with COVID-19 is inadequate. In addition, during the pandemic, day-care and short-stay facilities that provide elderly with support for their daily lives are closed, and therefore, they could not receive necessary care. Many elderly people cannot participate in rehabilitation exercises, resulting in noticeable deterioration of their physical and mental functions. Prolonged care at home without proper support inevitably leads to an increase in elderly abuse by family members. The government is trying to establish a "community-based comprehensive care system" based on the autonomy and initiative of local communities in response to the increasing demand for care amidst declining birthrate

and an aging population. At the same time, however, the elderly's rights to diverse and high-quality medical and welfare services that meet their demands must be guaranteed by the government, and this must not be overlooked.

People with severe physical disabilities have been able to live independently by obtaining face-to-face assistance. In terms of avoiding the risk of COVID-19 infection, care-providers are trying to reduce exposure by shortening the service or by not sending care-givers altogether. Disabled people are forced to endure a lack of support under this circumstance. Mentally disabled and intellectually challenged people have suffered from prolonged hospitalization or forcible institutionalization at mental hospitals. It posed a serious issue as they were poorly treated. With the spread of the Delta variant, the outbreak has become more serious. The closed nature of these mental hospitals interferes with full disclosure of the situation inside.

"The impact of the coronavirus is big. There are many cases where hospitals refuse services to people with dementia or disabilities. Families are experiencing heavier burdens due to insufficient support for medical services at home or by home visit. Some elderly have no place to go as day-care centers and short-stay facilities are closed. Their physical ability deteriorates because they cannot work on rehabilitation exercises. Some have to put up with urine all over the house, or others suffer from not being able to come down the staircase. And these situations put a lot of stress on family members and cause elderly abuse. (a member of elderly support and advocacy group)

"People with mental illnesses face long-term hospitalization. Mentally disabled people also face institutionalization. Even if they wish to live independently in the community, they were forced to live in the institution and became part of virus clusters. . If clusters are confirmed in an institution, people are often refused access to medical services for infectious diseases and faced with the worst-case scenario, which exacerbates their condition and leads to death. Meanwhile, we should emphasize that complete prevention measures would make it more difficult for clusters to occur, although there is still a risk of infection by people coming in and out. (a member of disabled group)

(4) Social and cultural barriers：gender, mental illnesses, access to healthcare

a) Violence and mental illnesses based on gender

Apart from informal employment, low wages and lack of public financial support for SRHR services, many women experience abuse and sexual assault at home, and that causes gender disparities in access to healthcare and medicine. Domestic abuse causes mental illnesses and deterioration, which interferes with women's access to necessary healthcare services.

When applying for social welfare programs available to victims of domestic abuse, they are required to disclose to government officials details about their upbringing, marriage, and parenting to determine their eligibility. This process creates painful experiences for the applicants. If applicants are informal workers, it is difficult to consult with the workplace about their mental or physical ailments for fear that they will be terminated or shoulder a financial burden. Due to the pandemic, it has become difficult to use public assistance programs such as social welfare and to access medical services.

Even when they have access to hospitals, women are more likely than men to experience harassment and other problems. Doctors or healthcare providers may be told to review lifestyle, or they may deny explaining about a treatment. The accumulation of such micro-aggressions (see footnote 7 on page 4) becomes a social and cultural barrier when accessing health and medical care.

"Before blaming informal jobs or low wages, we must recognize that so many women experience violence. They may have experienced parental abuse since childhood, sexual or power harassment at workplaces, and spousal abuse when they get married. Many women suffer from damaged mental health due to multiple types of abuse in their lives. (a journalist who reports on women and poverty

and labor)

"Up until the pandemic, people felt at ease receiving welfare assistance and going to the doctors even for small health concerns. But hospitals are no longer easy to access due to Corona. Many are troubled as it costs more to buy over-the-counter drugs." (a member of group supporting DV survivors)

"Doctors don't explain things to patients, even about the smallest things. They may be trying not to confuse their patients or worry them. But just a little explanation could help lift a psychological burden, so we often wish they'd be more considerate. (a member of group supporting DV survivors)

b) Sex workers and access to medical care

Sex workers often face difficulties in accessing medical care and welfare assistance due to discrimination, prejudice, stereotypes, and a lack of public understanding. Some local governments distribute handbooks on sex work, which were put together by organizations of sex workers, to medical institutions and public health centers and educate the staff. However, only a few put them into practice. For instance, testing for STDs (sexually transmitted diseases) is only offered during the hours sex workers cannot visit the public health centers. Testing should be provided at the hours and places that are easy to access for the people who are concerned. Another problem is the exclusion of the sex industry from government subsidies and even the application process for these subsidies. For example, employees and owners of sex-related businesses could not apply for various benefits for Corona-induced loss.

"Women who work in the sex industry need to regularly get tested for STDs. But they hesitate to go to the doctor or public health centers for fear of discrimination. Some women intentionally choose remote hospitals to remain anonymous." (a member of support group for sex workers)

"It is reported that the pandemic spread from the entertainment district in Osaka City, which triggered prejudice against sex workers. At first, they were excluded from government subsidies. Eventually sex workers gained eligibility. However, when they had to apply for compensation due to their children's school closure, they had to write the name of the school as well as their place of work and job description. They also needed signatures from the business owners, but they couldn't get that either. (a member of support group for sex workers)

c) Drug use and access to medical care

Drug use in Japan is divided into the use of illegal drugs such as stimulants and the use of prescribed medication and over-the-counter (OTC) drugs at a users' discretion. Recently, the latter use of drugs has become more widespread. This is because prescription drugs can be purchased at low prices through public medical insurance and OTC drugs can be purchased online. The instructions for how to take them are available via SNS.

Illegal drug users are often hesitant to access medical and welfare institutions for fear of being reported. Mental disorders caused by dependency on illegal drugs are regarded as crimes, which makes it impossible for them to receive disability pensions. This, in turn, makes it difficult for them to talk about their drug use at medical institutions, which leads to inappropriate treatment and induces mental and physical health problems. On the other hand, people who use prescription drugs at their own discretion access hospitals to secure them and exacerbate their dependency. In many cases, drug addiction is induced by mental disorders, mental illnesses, or trauma because they have been placed in vulnerable situations. Since psychological counseling is rarely covered by insurance, it becomes too expensive and inaccessible for low-income groups. Harm Reduction measures have not been adopted in the government's drug policy, making it difficult for drug users to access appropriate welfare, health and medical services.

"Information on SNS plays a major role in how more young people are taking prescribed medicine and OTC drugs. The use is not illegal, and people are concerned about income disparity and their not-so-bright future. If they can even temporarily overcome this fear with these drugs, the information on SNS is essential for them" (a member of advocacy and support group for drug uses)

"Access to care and support for trauma and painful experiences is insufficient in that psychological counseling is not covered by public health insurance and expensive. This leads to an increasing number of people seeking and resorting to prescription and OTC drugs. We need to make it easier to access (medical and welfare services)." (a member of advocacy and support group for drug uses)

d) Discrimination and Prejudice on Social Welfare Assistance

The public assistance program has been implemented for so many years in a way that its objective has led to a widespread sense of discrimination against the service users and also led users to internalize this sense of prejudice against the program itself. Even the impoverished who actually need the service, as well as health and medical services, do not recognize their eligibility for public assistance. Even if they did, they are reluctant to apply for it. In the face of the economic crisis caused by COVID-19, the Ministry of Health, Labor and Welfare (MHLW) finally declared that "public assistance is the people's right" and that it would respect the wishes of the applicants not to contact their relatives to ask whether they can offer financial support even in the case of the infamous "inquiry system" requirement. However, it is difficult to change a system that has been tainted for decades and the prejudices that have been ingrained.

"There is a serious risk facing the people who need help as they have not learned how society works. Even if they are dismissed from work, they have no knowledge of the law that stipulates requirements of dismissal that employers must comply with. They fail to apply for unemployment insurance as they lack knowledge of how the system or other systems work. It is necessary to teach about the safety net in junior and senior high schools." (a care worker in support of the impoverished)

"Many people believe that one cannot discontinue social welfare assistance or one cannot be eligible if s/he owns a car or a house. Many refuse to sign up for assistance if they wanted to work even a little bit." (a care worker in support of the impoverished)

"People became more sympathetic (toward the poor) under the pandemic, and media coverage of the poverty issue increased. It was a turning point when the MHLW declared that welfare assistance is a right. (a member of group supporting the impoverished)

3. Conclusion：Proposal for UHC that leaves no one behind

(1) Challenges

The issues we found in this research regarding access to health and medical care for vulnerable populations are as follows:

a) With public medical insurance, social welfare, and public assistance that guarantee access to health and medical care in Japan, there is a paradox: the greater the vulnerability, the greater the effort, time and cost to reach these services.
b) In Japanese public educational institutions, they don't teach about these services enough, nor is sufficient information provided in general. The government does not provide information about these services, their meaning, or their guarantee of human rights. Nor does it provide information about how people can use these services when necessary. Thus, people have to figure out how to apply for them only when they are faced with a problem without prior knowledge.

The vulnerable populations' access to healthcare is interfered with by the two challenges stated above and institutional failures, as well as the barriers they face such as the following:

a) **Economic barriers** : The middle class that enjoyed long-term, stable employment is shrinking, and the number of people in informal and precarious employment with low wages is increasing. The impact of this has been particularly significant for women due to gender inequality and discrimination.
b) **Systemic barriers** : First, undocumented foreigners, especially those without residence, are systematically excluded from most of these public services programs. Since they are administered on a "household basis," it is difficult for women and children, who tend to be dependents, to use it proactively. For the social welfare and public assistance, it is difficult to apply, and with regard to public assistance in particular, rather than encouraging those who are eligible to apply for the benefits, the government has taken measures to discourage them from applying. As a result, the program itself tends to be stigmatized.
c) **Social, cultural barriers** : In a society with strong homogeneity, people with heterogeneity have been left vulnerable due to discrimination, prejudice, and social exclusion. Many women in vulnerable situations have been exposed to violence, including gender-based violence and power harassment. Vulnerable groups, including men, also suffer from mental illness and mental health problems due to such violence and uncertainty. Together, these factors lead to hesitation and abandonment of access to health and medical care.
d) **Low investment in public health and infectious disease control** : Public health and infectious disease control has been systematically weakened, especially since the 21st century. Underinvestment has caused insufficient capacity. This is where the pandemic occurred, resulting in the failure of countermeasures to expand supply to meet the rapidly increasing demand for testing, isolation and medical care.

(2) Future prospectives and proposals

In order to overcome the above challenges and achieve Universal Health Coverage (UHC) that includes people in vulnerable situations, we make the following recommendations. The sustainability of Japan's public health insurance system has become an issue due to the declining birthrate and aging population, and the system is under pressure from privatization. However, access to health and medical care for vulnerable groups cannot be achieved through profit-oriented privatization. We believe that the way forward for true UHC can be found in reviewing and redesigning existing programs based on the following recommendations:

a) **Economic barriers:** For those who have lost their jobs and are impoverished, as well as those who work irregular or unstable jobs, to access social welfare and public assistance, it is necessary to a) make it easier for them to apply for these services, b) adopt appropriate services for the needy by combining the Independent Support System for the Impoverished and other services, and c) proactively disseminate information through commercial facilities and media that they usually access. It is also important to consider options of adopting health insurance coverage and other public medical coverage for SRHR services, including abortion and psychological counseling.
b) **Systemic barriers:** Ensure that undocumented foreigners without residence receive the medical care they need, including emergency medical care. Reduce language barriers to the greatest extent possible when they access medical services by offering medical interpretation. Proactively distribute information through social media and other media that foreigners living in Japan are known to use, so that they and multinational residents can access information. Remove the negative effects of the household-oriented social security system.
c) **Social and cultural barriers:** Conduct a review of systems to reduce institutional and social/cultural barriers for vulnerable populations. Being mindful of multicultural diversity and gender equality, the government should also improve these services by considering care for the aged and the disabled; treatment and care of HIV and other infectious and non-communicable diseases and

mental illnesses; prevention of abuse and violence; reduction of their negative impact; and reduction of health hazards due to drug use through dialogues with civil society organizations that provide support to these communities.

- In carrying out a) - c), actively engage in dialogue with relevant stakeholders, such as the concerned organizations, support groups, and experienced NGOs/NPOs and institutions implementing the systems in the field as well as potential users. This is necessary to understand what impedes access to health and medical care, and then reform the system.
- In implementing the system, the central and local governments should systematically accumulate experience and knowledge to improve the system. They should do this through active dialogue and collaboration with the organizations -- support groups and experienced NGOs/NPOs and users -- that actually implement and receive the benefits of these systems in the field.

d) **Underinvestment in public health and measures against infectious diseases:** Strengthen the capacity to respond to future crises, such as infectious diseases and disasters, by investing more in public health and infectious disease control and also by improving the systems of public health centers and local health laboratories. Ensure the capacity in prevention, testing, quarantine and treatment to meet rapidly growing demand, especially in response to pandemics.

e) **Education and information dissemination about the system:** Public systems for access to health and medical care (public medical insurance, social welfare and public assistance) should be sufficiently taught in compulsory education courses (junior high schools) and senior high schools. People need to learn in their early years that these systems are part of their basic human rights and accessing the systems would be a legitimate exercise of rights. Also, more time should be allocated to effectively teach how to apply for and utilize these systems by incorporating participatory learning methods. The government should publicize the systems and raise awareness in a way that anyone can access information about them anywhere.

To practice the true meaning of "UHC that leaves no one behind" in Japan, it is essential to rebuild its public insurance and medical security systems into one that the growing vulnerable communities can properly use by incorporating the systemic reforms in the ways mentioned above.