Chapter VI Social Security System

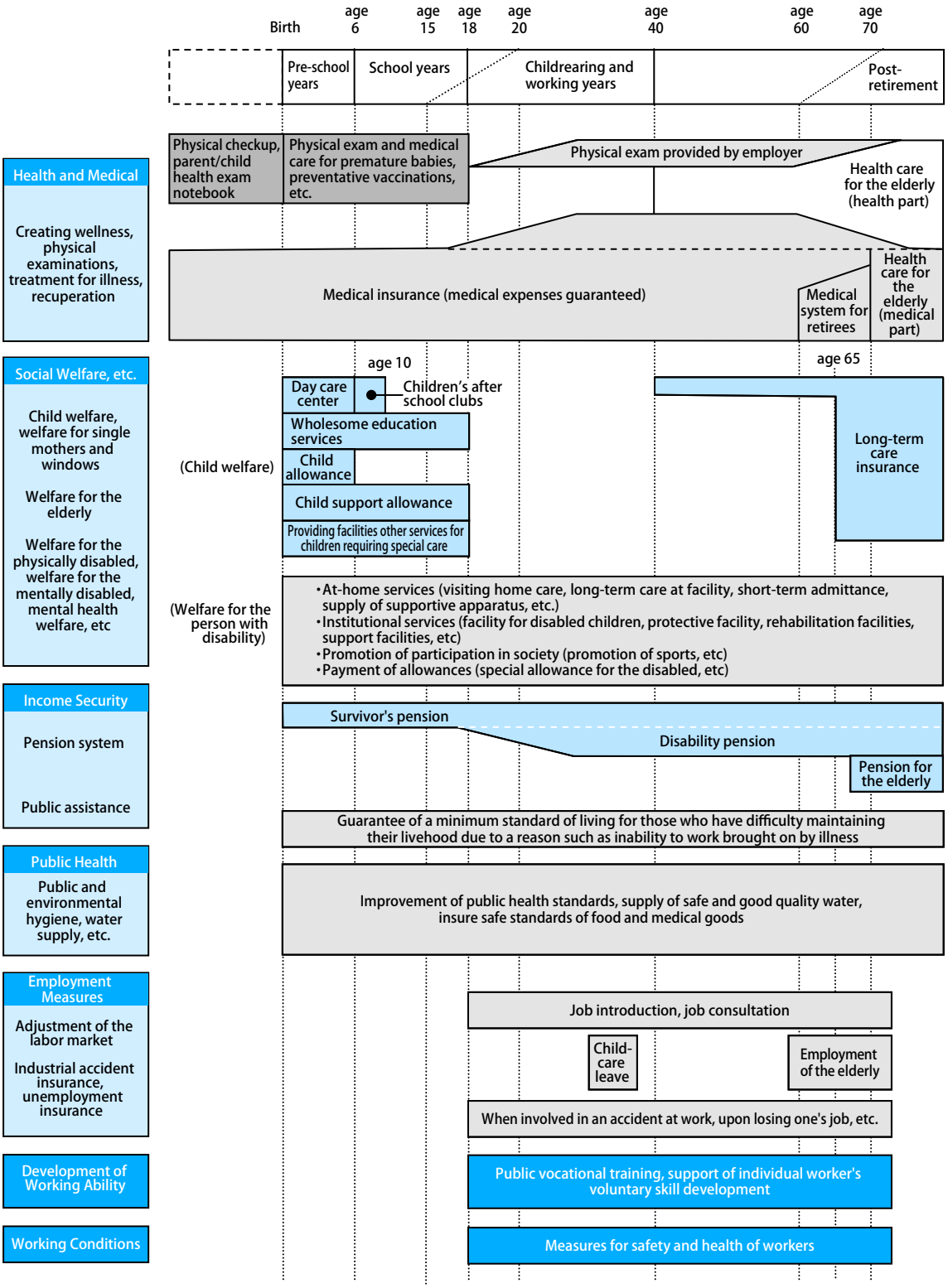
1 The Subject of Japan's Social Security System

Japan's Social Security System Responds to Socioeconomic Changes and Risks in Daily Life

The growing interdependence of the global economy is illustrated by the way in which the destabilization of European economies due to the European debt crisis has had an impact on China and other emerging economies by reducing their exports. In Japan, various policies aimed at stimulating the economy and boosting employment are being promoted with a view to reconstruction after the Great East Japan Earthquake, and a new growth strategy combining bold monetary easing with a raft of economic policies has been launched. However, owing to the time lag before positive moves on financial markets take effect on labor markets, the "Global Wage Report 2012-13" by the International Labour Organization (ILO) reports that the rate of year-on-year change in average real wages worldwide was 1.2% in 2011, down from 2.1% in 2010. Meanwhile, a fall in the labor share has been observed in developed economies, but this trend is seen as particularly marked in Japan (see JILPT "International Labor Information", December 2012). Given this state of affairs, Japan's working population has been in decline since peaking at 66.84 million in 2007, and fell to 65.55 million in 2012. Conversely, the ratio of non-regular employees to all workers continues to rise each year, standing at 35.7% in the final quarter of 2011. Because the wages of non-regular employees are lower than those of regular employees, this situation could have the effect of expanding income inequality and problems of poverty. As a result, the government has asserted need to forge close links between employment policies and welfare policies in order to revive the "large middle class" (see the MHLW "White Paper on Labour Economy 2012 (Analysis of Labour Economy)", Chapter 2).

Amid this situation, a system of social security that guarantees people's livelihoods, based on funding from taxes and social insurance, is playing an important role in addressing the various risks that arise in people's lives, including loss of income due to unemployment or retirement, sickness, disability, etc. Japan's social security system is similar to those in Europe and the U.S. in that, to satisfy each stage of people's lives, it is composed of such elements as medical insurance, public health services, social welfare services, income maintenance, and employment measures (see Figure VI-1). Of these, medical insurances, health care programs for older people, long-term care insurance and pension systems, as well as unemployment insurance and industrial accident compensation insurance are the social insurances that are mainly financed by social insurance premiums and partly subsidized by the government revenues. In contrast, welfares for the child, for single mothers and widows, for older people, for people with disabilities, and for the poor as well as public health services are all public policies provided with funds drawn from taxes. Internationally speaking, the characteristics of long-term care insurance and health care programs for older people in Japan is that they are half funded at public expense out of tax revenues although they are included in social insurance.

Figure VI-1 Social Security System by Life Stage



Source: Ministry, of Health, Labour and Welfare, ***Annual Reports on Health, Labour and Welfare***

The Benefits and Cost Burden of Social Security

In order to make an international comparison on the trend of social security, the Organisation for Economic Co-operation and Development (OECD) is disclosing information on indices of social expenditure that includes pension funds, medical care and welfare for the poor, child allowance that gets transferred, social security benefits from expenditures on welfare services and expenditures such as expenses for facility development that do not get transferred directly to individuals (OECD Social Expenditure Database 2001). Looking at the percentage of social expenditure occupying the national income, Japan's ratio is lower than European countries, but higher than the U.S. (see upper section of Table VI-2). Furthermore, based on the figures in closely related years, the percentage of national income occupied by social security costs is low when compared with that in Germany, France, and Sweden, but higher than the U.S. and the U.K. (see lower section of Table VI-2).

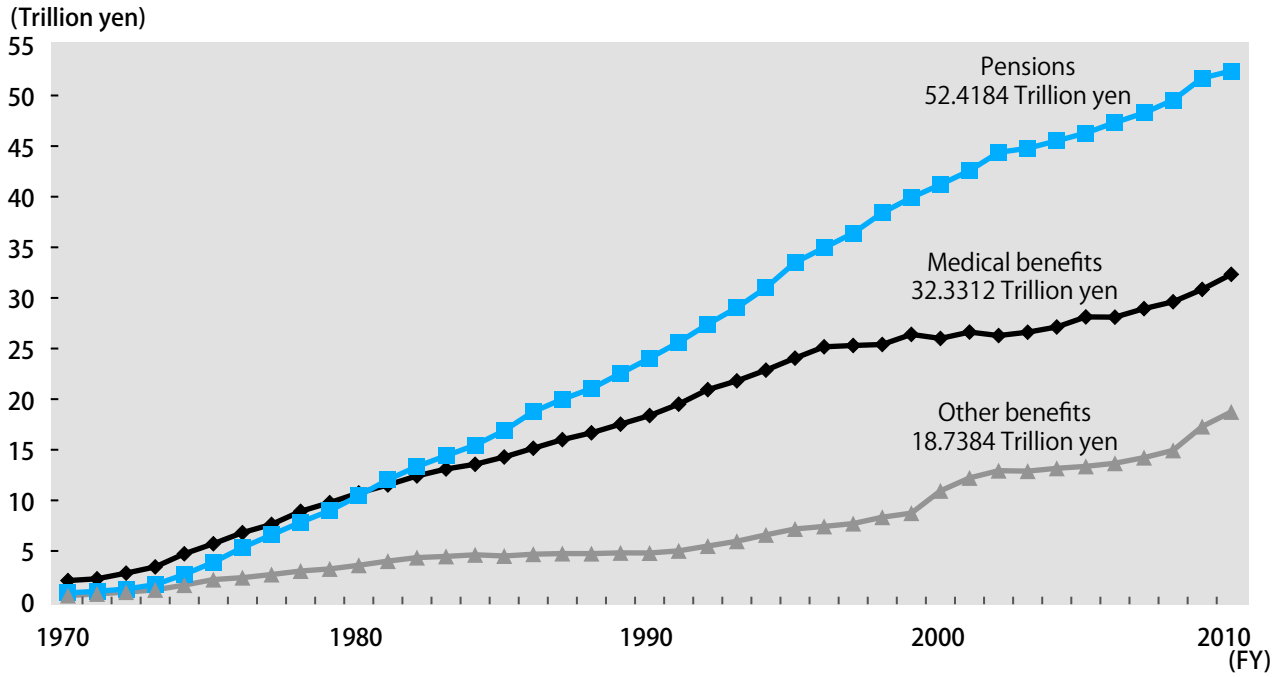
Japan's expenditure on social security benefits is rising as the birthrate declines and the population ages. As of 2011, the total population of Japan was 127.93 million people, while the population of those aged 65 or above had reached 29.6 million (Ministry of Internal Affairs and Communications, Monthly Report on Current Population Estimates, May 2011). As a result, the population aging rate (population aged 65 or above/total population x100) was below 10% in 1980, at 9.1%, but it had increased above 10% to 12.1% by 1990, reaching 23% as of 2010. This progressive aging of the population is bringing about an increase in the number of people receiving pension payments; moreover, per capita medical benefit payments are about five times higher among older people than among those of working age, so medical and healthcare costs have also increased. The growth in medical and healthcare costs declined temporarily with the introduction of nursing care insurance in 2000, but they have been on the rise again since then. As population aging is also leading to an increase in the number of older people in need of care due to the increase in number of "old-old", expenditure in long-term care insurance benefits is also rising. As a consequence, the rise in expenditure on social security benefits, including pension, health care, and long-term care insurance benefits, continues (see Figure VI-3). While expenditure on benefits (especially for older people) has risen in response to population aging, expenditure on welfare-related benefits, including child welfare, continues to account for a small proportion of Japanese expenditure on social security benefits due to the insufficient expansion of childcare-related benefits compared with Scandinavia and France, despite the importance attached to reversing the decline of the birthrate.

Table VI-2 International Comparison of Social Expenditures and National Burden Ratios

	Japan	United States	United Kingdom	Germany	France	Sweden
Social expenditure (% of national income)	26.1	20.3	27.4	35.3	39.4	37.5
Social expenditure (% of GDP)	19.1	16.5	21.3	26.2	28.8	27.7
National burden ratio (% of national income)	40.0	34.9	48.3	52.4	61.2	64.8

Sources: On social expenditure — National Institute of Population and Social Security Research, "Financial Statistics of Social Security in Japan (FY2010)"; on international comparisons of social expenditure based on OECD standards — Ministry of Finance, "International Comparison of National Burden Ratio" (for Japan, actual figures for FY2010; for other countries, OECD "Revenue Statistics 1965-2011" and *id.* "National Accounts")

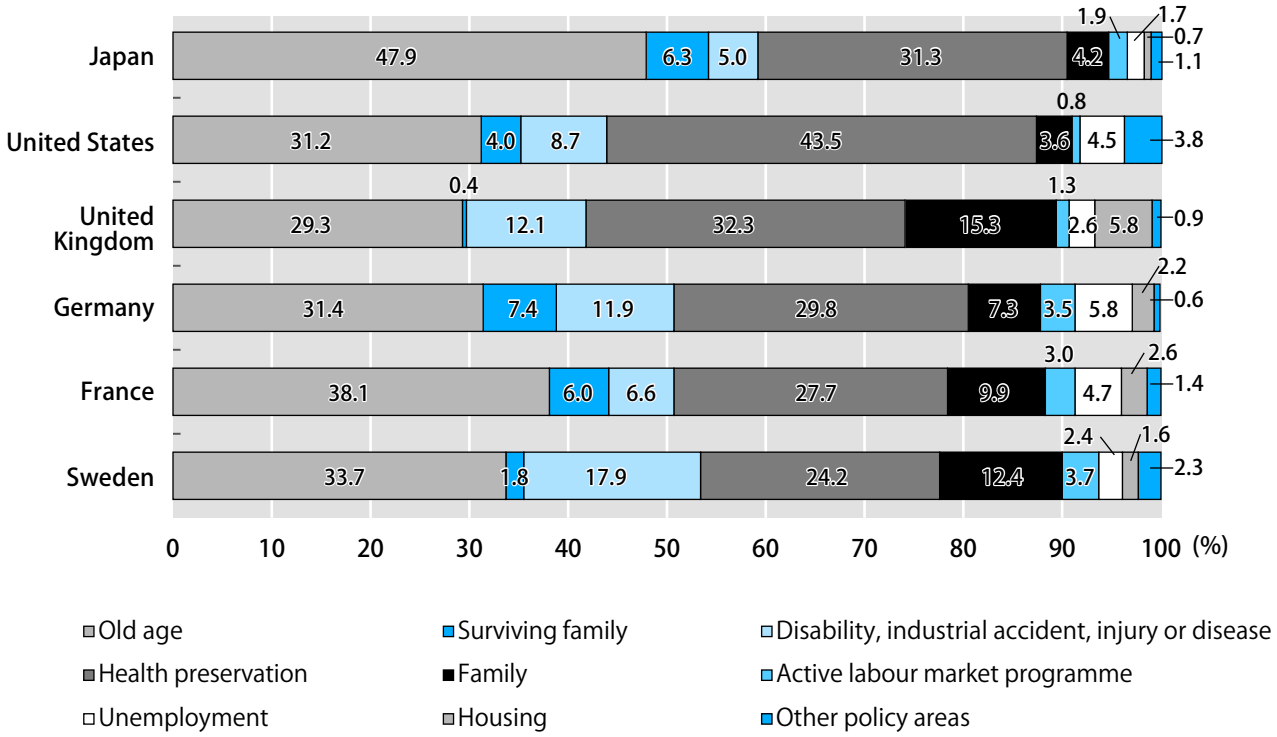
Figure VI-3 Changes in Social Security Benefits by Category



Source: National Institute of Population and Social Security Research, ***Financial Statistics of Social Security in Japan (FY2010)***

As a result, if one looks at an international comparison of the structural mix of social expenditure by government field (Figure VI-4), one can see that whereas in Japan, 47.9% of social security benefit costs are spent on social security payments to older people, the expenditure on family-related policy, including benefits for households with children, and expenditure on protecting livelihoods and other issues account for only 4.2% and 1.1% respectively. Even in the USA, where the ratio of spending on family-related policies is small, expenditure on livelihood protection and other issues is larger than Japan's at 3.8%. In Europe, the emphasis is on welfare for households with children. Here, the ratio of family-related policies to social security benefit costs is 7.3% in Germany, 9.9% in France, 12.4% in Sweden and 15.3% in the UK, more than twice Japan's level.

Figure VI-4 International Comparison of the Structural Mix of Social Expenditure by Government Field (FY2009)



Source: National Institute of Population and Social Security Research, ***"Financial Statistics of Social Security in Japan (FY2010)"***, Figure 3 International Comparison of Social Expenditure by Policy Area in FY 2009

Trends in social security benefit costs are impacted by Japan's declining birthrate and population aging, both of which are expected to continue. According to "Population Projections for Japan (Jan. 2012 estimates)" by the National Institute of Population and Social Security Research, the ratio of older persons to the general population was 23.0% in 2010 but is expected to continue growing. The ratio is forecast to reach 33.4% in 2035, when one person in every three will be elderly, and 39.9% in 2060, when the elderly population will include one in every 2.5 people.

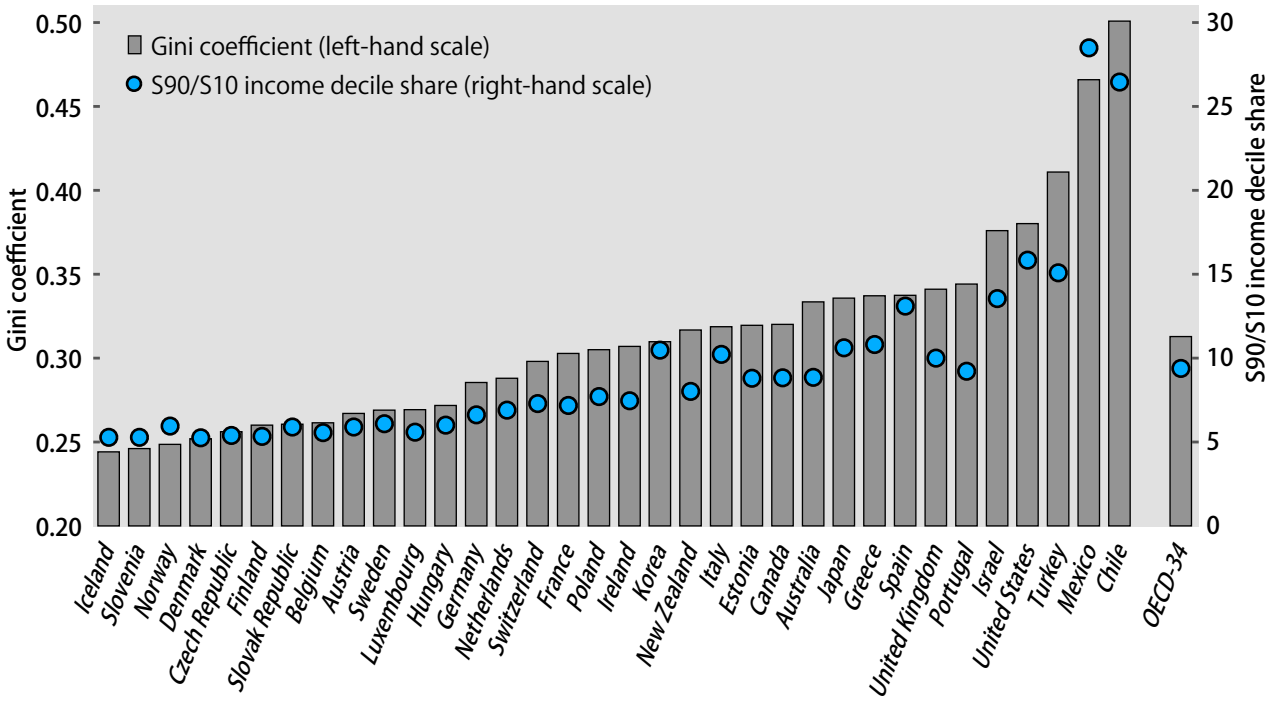
To address this progressive birthrate decline and population aging, a change of government in 2009 provided the impetus for replacing the existing income-capped child allowance (*jido teate*) with uncapped child allowance (*kodomo teate*), and taking a step toward social security reform with emphasis on child welfare. However, due to the large fiscal outlays needed for medical treatment, nursing, welfare and livelihood guarantees for victims of the Great East Japan Earthquake, as well as economic reconstruction of damage areas, child allowance (*kodomo teate*) was abolished as of payments in September 2011. Now, income-capped child allowance (*jido teate*) is again being paid to households with children. Nevertheless, even after another change of administration in 2012, integrated reforms of social security and tax are still being promoted, based on an agreement reached during the previous administration. The aim of this is to secure fiscal resources for social security spending, which is rising with the increase in older persons, while maintaining a balance both with trends in the national economy and with the tax system.

Social Security Cost Burden Based on the Increase in Income Difference and Burden Capacity

According to international comparative research on income inequality by the OECD, a comparison of

the Gini coefficients of household disposable income after taxes and income transfers via social security (equivalized disposable income per household member adjusted for household size) shows that Japan's Gini coefficient is larger than those of the Scandinavian countries, Germany and France, smaller than those of the USA and the UK, and on the same level as those of Spain, Portugal, Greece and other Mediterranean countries (Figure VI-5). The Ministry of Health, Labour and Welfare has also estimated and published Japan's poverty rate based on the calculation method employed by the OECD (Outline of the 2010 Comprehensive Survey of Living Conditions, II Income etc of various types of households, 7 Poverty rate, http://www.mhlw.go.jp/english/database/db-hss/dl/report_gaikyo_2010.pdf).

Figure VI-5 Gini Coefficient of Equivalized Household Disposable Income and S90/S10 Income Deciles in OECD Countries (2010)



Source: OECD (2013), "Crisis squeezes income and puts pressure on inequality and poverty". This note as well as all figures and underlying data can be downloaded via www.oecd.org/social/inequality.htm

Note: "Equivalized household disposable income" is the disposable income per household member, adjusted for household size.

Thus, income inequality in Japan cannot exactly be described as small compared to other OECD countries. Based on this situation, the "Comprehensive Reform of Social Security and Tax" (decided by the Cabinet in February 2012) includes the assertion that "Japan's society and social security system today (part omitted) face a number of problems, including those of poverty and income inequality, unfairness among the generations, and widening isolation and social exclusion. To address these problems, we are required to ensure the sustainability and strengthen the functions of the whole social security system, including pensions, healthcare, nursing and childcare". Various social security policies have already been adopted to reduce income inequality in addressing these policy challenges, such as increasing child allowance and raising the level of livelihood protection. As a result, the redistribution coefficient based on the Gini coefficient (i.e. the Gini coefficient before

redistribution *minus* the Gini coefficient after redistribution *divided by* the Gini coefficient before redistribution) has risen since around the mid-2000s. This shows that the income redistribution function of social security is working (Ministry of Health, Labour and Welfare, "2008 Survey Results on the Redistribution of Income"). However, because the ratio of family-related benefit expenditure (including benefits for households with children) to overall social security benefit costs is smaller than those of Scandinavian countries and France, as stated in 1 above, the redistribution coefficient in elderly households is larger and that in single-mother households is smaller.

Table VI-6 Closing of Income Gap through Income Redistribution (Gini Coefficient for Equivalent Incomes)

Year of survey	Gini coefficient				Rate of improvement in Gini coefficient		
	Equivalent initial income	(1) + social security benefits - social security contributions	Equivalent disposal income ((2) - tax)	Equivalent income after redistribution ((3) + benefits in kind)	Rate of improvement due to redistribution	Rate of improvement due to social security	Rate of improvement due to taxation
	(1)	(2)	(3)	(4)	*1	*2	*3
1996	0.376	0.327	0.312	0.310	17.7	13.7	4.7
1999	0.408	0.350	0.337	0.333	18.4	15.3	3.7
2002	0.419	0.337	0.323	0.322	25.3	19.9	4.3
2005	0.435	0.336	0.322	0.323	25.9	22.8	4.1
2008	0.454	0.343	0.327	0.319	29.7	26.2	4.7

Source: Summary Findings of the 2008 Income Redistribution Survey (Ministry of Health, Labour and Welfare).
Notes: 1) Rate of improvement due to redistribution = 1 - (4) / (1)
2) Rate of improvement due to social security = 1 - (2) / (1) x (4) / (3)
3) Rate of improvement due to taxation = 1 - (3) / (2)

2 Income Security and Childcare Services for Households with Children

Child Allowance: Under the system of Child Allowance, an allowance is paid to parents and others (including operators of children's homes) who raise children domiciled in Japan. The allowance is paid monthly until the child graduates from junior high school (age 15), the amount paid each month depending on the child's age and an income cap. The allowance is a flat 15,000 yen for children aged 0-2, 10,000 yen for children aged 3 until leaving elementary school, and 10,000 yen for junior high school pupils. The amount for children whose parents earn more than the income cap (9.6 million yen p.a.) is a flat 5,000 yen per month.

Child Rearing Allowance: Under the system of Child Rearing Allowance, an allowance is paid to children aged up to 18 (i.e. until they graduate from senior high school in March) in single-parent households (including single-mother and single-father families) if earnings are within the income cap, and single-parent households subject to court protection orders following domestic violence from a spouse. As of 2012, the amount paid is a basic monthly 41,430 yen for the first child, the basic amount plus 5,000 yen for the second child, and the basic amount plus 3,000 yen for the third child onwards.

Special Child Rearing Allowance: Under the system of Special Child Rearing Allowance, an allowance is paid to disabled children and young people up to age 20, according to the degree of disability, in households with disabled children if earnings are within the income cap. The amount paid is 50,400 yen per month for the severest type of disability and 33,570 yen for the next most severe type. For disabled people aged over 20, Basic Disability Pension is paid if earnings are within the income cap.

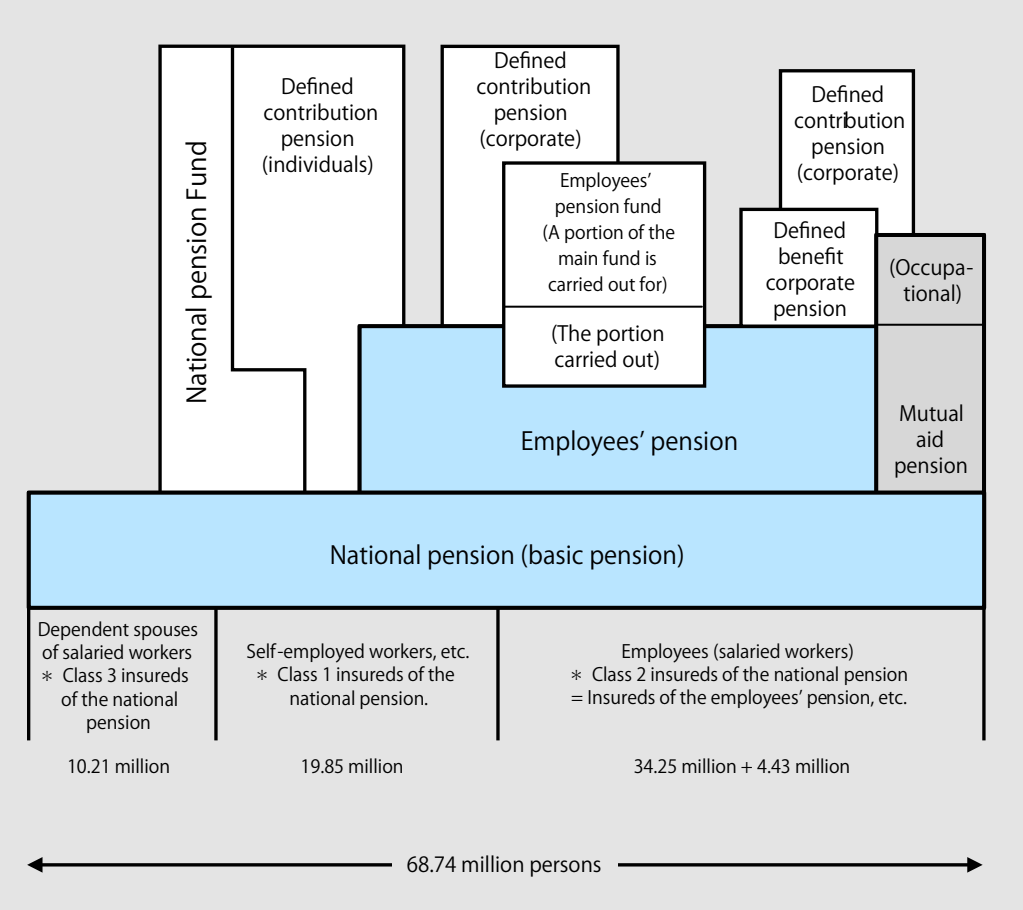
Childcare Services: Based on the Child Welfare Act, child welfare services in Japan consist of services provided at facilities for children and young people who cannot live with their families due to various problems (children's homes, nursery homes and maternal and child living support facilities), childcare services at daycare centers, and services provided to children with disabilities both at home and at facilities. This section discusses childcare services that relate to combined support for child-rearing and employment. Childcare services are mainly provided by daycare centers. Daycare centers aim to look after children each day when their guardians (mainly their parents) cannot look after them, due to such reasons as having to work; there are daycare centers that are licensed by local authorities based on the Child Welfare Act, and those that are not licensed (daycare centers that have filed a notification to the local authority). The fees are calculated based on the income of the child's guardians during the previous fiscal year, the situation regarding the taxes levied on the guardians, such as income tax and residential tax, and the age of the child concerned.

As to the state of childcare services, according to "On the State of Daycare Centers, etc. (April 1, 2009)" by the Daycare Division of the Equal Employment, Children and Families Bureau, Ministry of Health, Labour and Welfare, there were 23,711 daycare centers, 2,176,802 children using them, and 24,825 children on waiting lists. The children on waiting lists are those who, even though they lack childcare and have applied to enter a daycare center (licensed daycare center), are unable to enter a daycare center because, for example, the daycare center that their guardians would like them to enter would exceed the maximum number of children for whom it can care. The existence of children on waiting lists suggests that it is necessary to further enhance childcare services, by such means as increasing the maximum number of children who can be cared for by increasing the number of daycare center staff and increasing the number of daycare centers in areas with many children on waiting lists, in order to provide combined support for child-rearing and employment.

3 The Pension System and Public Assistance

Pension system: As can be seen from Figure VI-7, the basis of the pension system, which fulfils a role in guaranteeing income after retirement, is the basic pension, in which all citizens (those aged 20 or above but under 60) enroll and which pays pension benefits once an individual reaches pensionable age (currently 60 years old, rising to 65 for men from 2013 and to 65 for women from 2018). In addition to this, salaried employees such as company employees and civil servants respectively receive the welfare pension and mutual aid pension, which are earnings-related pension schemes paid to top up the basic pension. To distinguish it from these pensions paid to salaried employees, the basic pension that most self-employed workers and workers in the agriculture, forestry and fisheries sector receive is called the national pension. In many advanced countries (such as the U.S., Canada and Sweden), the same pension system is applied to both company employees and civil servants, and post-retirement income security does not differ according to job category. From this perspective, consideration is currently being given to integrating the welfare pension and mutual aid pension systems.

Figure VI-7 The Pension System



Source: Compiled by the author, adding the number of insured persons in 2009 to the ***2004 Key Points in Pension System Reforms*** published by the Ministry of Health, Labour and Welfare Pension Bureau

Japan's pension system is revised once every 5 years based on recalculations of pension financing. In the pension reform of 2004, it has been decided to adjust the benefits standards along with the economic situation and the progress of an aging society (however, it is aimed that the standards should not go below 50% of the income of the working generations), instead of fixing the future insurance burden to a certain level (18.3% after 2025, in the case for employees' pensions), drawing from Sweden's pension reform of 2001, etc. In the pension reform of 2009, the proportion of the basic pension paid to all citizens that is funded by the government from tax revenues was raised from one-third to one-half.

The insurance premium for the basic pension for self-employed workers is set at a fixed amount (¥15,040 monthly, as of 2013). On the other hand, the burden of the insurance premium for company employees and civil servants is borne equally by the employer and the employee, and the premium rate is set at 16.4% of total income, including salary and bonuses (from September 2013). The bereaved families of those enrolled in the pension system and those receiving pension benefits receive survivor's pensions, while those enrolled in the pension system who have a disability receive a disability pension if they meet certain conditions. The transitions in the number of people receiving pension benefits and the amount paid to them can be seen in Table VI-8. Currently (as of 2013), the basic pension benefit is 65,541 yen per month (784,000 yen p.a.), while the old age welfare pension is 239,000yen (2,771,000 yen) when combining a couple's basic pension with the husband's earnings-related component.

Table VI-8 Transitions in the Number of People Receiving Benefits and the Amount Paid under the Pension System

FY	Insured persons (10,000 persons)					Beneficiaries (10,000 persons)				Income and expenditure				
	Total	Basic pension (Self-employed workers, etc.: Class 1)	Basic pension (Full-time house wife: Class 3)	Employee's pension	Mutual aid association (Pension in these)	Total	Basic pension (National pension)	Employee's pension	Mutual aid association	National pension Income (Insurance Premiums + State Contribution) (¥100 million)	National pension Expenditure (¥100 million)	Employee's pension Income (Insurance Premiums + State Contribution) (¥100 million)	Employee's pension Expenditure (¥100 million)	Reserve balance (¥100 billion)
1987	6,411	1,582	927	2,822		2,252	112	891	149					
1990	6,631	1,758	1,196	3,149		2,500	191	1,065	96					
1995	6,995	1,910	1,220	3,328		3,236	690	1,425	40					
2000	7,049	2,154	1,153	3,219		4,091	1,307	1,307	14					
2005	7,045	2,190	1,079	3,302	460	3,995	1,337	2,316	342	37,873	43,350	300,685	353,284	1,403
2006	7,038	2,123	1,079	3,379	457	4,030	1,275	2,404	351	39,228	43,082	297,954	320,994	1,398
2007	7,007	2,035	1,063	3,457	451	4,146	1,260	2,523	363	38,466	43,435	299,463	329,875	1,302
2008	6,936	2,001	1,044	3,444	447	4,283	1,236	2,668	379	37,545	43,317	309,480	339,860	1,166
2009	6,874	1,985	1,021	3,425	443	4,414	1,205	2,814	395	37,813	39,911	320,483	365,618	1,208
2010	6,926	1,938	1,005	3,441	442	4,445	1,092	2,943	410	34,010	31,498	319,356	379,804	1,142
2011	6,774	1,904	978	3,451	441	4,539	1,067	3,048	424	34,701	34,717	326,080	375,420	1,115

Source: Ministry of Health, Labour and Welfare, Overview of Welfare Pension Insurance and the National Pension Scheme (FY2011)

Notes: 1) The integration of welfare pension schemes and mutual aid societies (pension divisions) is being considered, so the number of insured people enrolled in mutual aid societies, such as civil servants, in recent years is shown.

2) The total number of those receiving pension benefits is the number receiving the basic pension after excluding overlap with those receiving the basic welfare pension.

The corporate pensions that supplement these public pensions consist of defined benefit and defined contribution corporate pensions (arrangements for which were instituted in 2001 to protect beneficiaries and ensure the portability of reserves) and employees' pension funds, which were established prior to 2001. For the self-employed and professionals, there is also a national pension fund for supplementing the basic pension. Following the introduction of the corporate pension system in 2001, it was decided that welfare pension funds would gradually change to defined-benefit corporate pensions, so as shown in Table VI-9, the number of defined-benefit corporate pension funds and the number of those enrolled in them are increasing. Moreover, even companies that were unable to have a welfare pension fund because of their small scale have become able to offer defined-benefit corporate pensions by concluding contracts with operating agencies, and the number of contracts for this kind of corporate pension and the number of people enrolled therein are also increasing. However, although the asset management yield of corporate pensions was in positive figures before the Lehman Shock, the yield for FY2010 fell into negative figures, following the Lehman Shock, so there is growing concern among companies and those enrolled in such schemes about the reliability (or lack thereof) of the asset management of corporate pensions.

Table VI-9 Transitions in Defined-benefit and Defined-contribution Corporate Pensions

Year	No. of welfare pension funds	No. of welfare pension fund contributors (x10,000)	Number of people enrolled in defined-benefit pension schemes (10,000 people)	Number of corporate defined-benefit pension schemes by establishment type			Number of people enrolled in defined-contribution pension schemes (corporate type) (10,000 people)	Number of businesses with defined-contribution pension schemes (corporate type)
				Convention type	Fund type	Total		
2002	1,656	1,039	9	15	0	15	33	361
2003	1,357	835	135	168	148	316	71	845
2004	838	615	314	484	508	992	126	1,402
2005	687	531	384	834	596	1,430	173	1,966
2006	658	474	430	1,335	605	1,940	219	2,313
2007	626	462	506	2,479	619	3,098	271	2,710
2008	617	439	570	4,396	611	5,007	311	3,043
2009	608	431	647	6,797	610	7,407	340	3,301
2010	595	430	727	9,436	608	10,044	371	3,705
2011	577	411	801	14,377	612	14,999	422	4,135

Sources: Pension Fund Association, Statistics Concerning the Fiscal Situation, Transitions in the Number of Defined-benefit Corporate Pension Systems by Establishment Type and the Number of People Enrolled Therein, and Transitions in the Number of Defined-contribution Corporate Pension System Contracts and the Number of People Enrolled Therein

The characteristic of Japan's pension system relating to the labor market is the point that it cooperates with unemployment insurance. In the case of older workers aged between 60 and 64, therefore, elderly employment continuation benefits and elderly reemployment benefits are provided when wages fall below 85% of the level immediately prior to retirement at 60. Further, to support female workers' combining of childrearing and work activities, payment of employees' pension insurance premium is

excused for both the worker and employer during the period of child care leave (For the Assistance Measures to Balance Work and Family and for the Gender Equal Employment Policies, see Chapter V).

Public assistance: The public assistance system is designed to guarantee a minimum standard of living by providing benefits in kind according to need. These are provided by the Government through local governments when a person falls into poverty, despite employment, savings, assets, pensions, and allowances, etc., due to circumstances such as sickness, mental/physical disability, or unforeseen accident based on the principle of complementarity. In practice, the level of public assistance is determined based on the minimum cost of living calculated according to standards laid down by the Government and relative to the income of the household concerned, the shortfall being covered by the provision of benefits in cash or in kind (such as medical benefits). As of February 2013, public assistance was provided to 1,577,000 households and 2,155,000 individual beneficiaries, taking the ratio of assisted households to 1.7% of the general population. As a result of the recent stagnation of the economy and the growth of income disparities, the cost of public assistance is growing by the year. If one looks at the people receiving public assistance by age, one can see that the proportion of older people receiving such assistance has been growing in recent years, due to the fact that there are people who do not qualify to receive pension benefits, that it is difficult for older people to find employment due to the prolonged economic slowdown, and that a growing number of people are unable to pay for medical care costs as a result of being on low incomes, and can only receive healthcare through the medical benefit paid under the public assistance program.

Table VI-10 Transitions by Year in the Number and Proportion of Households Receiving Public Assistance by Type of Household

Year	Number of households receiving public assistance				Composition ratio		
	Total number	Households with older people	Households with single mothers	Households with sick or injured people, etc. (including households with disabled people)	Households with older people (%)	Households with single mothers (%)	Households with sick or injured people, etc. (including households with disabled people) (%)
1990	622	232	73	318	37.2	31.5	31.3
1995	601	254	52	294	42.3	20.6	37.1
2000	750	341	63	346	45.5	18.5	36.0
2005	1040	452	91	497	43.5	20.0	36.5
2006	1074	474	93	507	44.1	19.5	36.3
2007	1103	498	93	512	45.1	18.7	36.2
2008	1146	524	93	529	45.7	17.8	36.5
2009	1274	563	100	612	44.2	17.7	38.1
2010	1405	604	109	692	43.0	7.8	49.3

Source: Compiled by the author from Annual Transitions in the Number of Households Receiving Public Assistance by Household Type and the Household Assistance Rate, from the list of official statistical data concerning "public assistance" published by the National Institute of Population and Social Security Research

Notes: 1) This is the one-month average.
2) Does not include households whose assistance is currently suspended.
3) In the household assistance rate, the number of households receiving public assistance is divided by the number of households in the National Livelihood Survey (per 1,000 households).
4) For some years, the figure by household type and the total figure for this differs from the overall total; this is not a printing error but is rather due to the margin of error resulting from adding up the total for each month (April - March) and dividing by 12, then rounding off the figures.

4 Medical Insurance and Long-term Care Insurance

Medical Insurance: Within Japan's medical insurance there is association-managed health insurance for employees (and their families) of workplaces of five or more workers, Japan Health Insurance Association-administered health insurance for employees (and their families) of workplaces with fewer than five workers, national health insurance for the self-employed, etc., and medical insurance provided by mutual aid associations for national government employees and local government employees (see upper row of Table VI-11). Subscribers in medical insurance programs pay the insurance premium themselves, but the subscribers themselves and their families may receive medical services at the medical institution of their choice by paying only a portion of the medical expense. Furthermore, with regard to people aged 65 or over requiring long-term care and all older people aged 70 or over, there is a system of medical aid for older people (see lower row of Table VI-11) that is funded by insurance premiums paid by older people, contributions borne by health insurance societies and the national health insurance scheme. Under this system, the insurance premiums of older people on low incomes are reduced and, in the event that the local authority cannot sustain the finances alone, it is possible for a number of local authorities to form an extended association to provide medical and healthcare services to older people.

Table VI-11 Medical Insurance System

Plan			Insurer (As of 31 March, 2009)	Subscribers (As of March 31, 2008) and (subscriber's dependents) (Unit:1,000 persons)	Insurance Benefits	
					Medical Benefits	
					Payment in part	High-Cost Medical Care Benefits, and the High-Cost Medical Care & Nursing Care Benefits Combination System
Health insurance	Ordinary employees	Kyokai Kenpo	Japan Health Insurance Association	34,705 (19,496 15,210)	After the commencement of compulsory education to those 69 years of age: 30% Prior to the commencement of compulsory education: 20% 70 to 74 years old: 20% (*) (Persons with income comparable with those of an active worker: 30%) (*) For those 70 to 74 years of age, the rate will be kept at 10% from April 2008 to March 2010.	High-Cost Medical Care Benefits • Maximum amount paid by the patient Under 70 years of age: High income persons: 150,000 yen＋（medical costs-500,000 yen）×1% Average income persons: 80,100 yen＋（medical costs-267,000 yen）×1% Low income persons: 35,400 yen From 70 to 74 years of age: With income comparative with those of an active worker: 80,100 yen + (medical costs-267,000 yen)×1% , Outpatient Treatment (for each patient): 44,400 yen Average income persons(*): 62,100 yen, Outpatient treatment (for each patient) 24,600 yen Low-income persons: 24,600 yen, Outpatient treatment (for each patient) 8,000 yen Low-income persons with especially low income: 15,000 yen. Outpatient treatment (for each patient) 8,000 yen • Standard amount for aggregation of households: For those under 70 years of age, if there are multiple payments of more than 21,000 yen in the same month, reimbursement is calculated on the basis of their sum. • Burden reduction for those with multiple cases: If a household has been eligible for reimbursement three times or more within a 12-month period, the amount of payment in part from the fourth time will be: Under 70 years of age: High-income persons: 83,400 yen Standard-income persons: 44,400 yen Low-income persons: 24,600 yen 70 years of age or older with income comparative with those of an active worker and standard income (*): 44,400 yen • Burden reduction for patients suffering from long-term and high-cost illness Self-pay limit for the patients suffering from hemophilia or chronic renal failure requiring artificial dialysis: 10,000 yen Self-pay limit for high-income persons receiving artificial dialysis: 20,000 yen (*) Burden reduction for multiple cases is not applicable to persons from 70 to 74 years of age classified as standard income class as the self-pay limit will be kept unchanged at 44,000 yen (12,000 yen for outpatient treatment) from April 2008 through March 2010. High-cost medical care and high-cost nursing care benefits combination system: Burden reduction system applicable in the instances where the total of the self-pay burden under the medical insurance and nursing care insurance paid in a year (from August to July next year) become extremely high. Self-pay limits will be fixed in high details according to the income and age of the patients.
		Associationmanaged	Health insurance associations 1,497	30,337 (15,906 14,431)		
	Insured parties, as stipulated in Article 3, Par.2, Health Insurance Law		Japan Health Insurance Association	17 (11 6)		
Seamen's insurance			National government	144 (62 82)		
Mutual aid insurance	National government employees		Mutual aid associations (21)	9,023 (4,394 4,629)		
	Local government employees		Mutual aid associations (55)			
	Private school instructors		Mutual aid associations (1)			
National health insurance	Farmers, self-employed etc.		Municipalities 1,788	39,492 Municipalities 46,881 Health insurance associations 3,522		
			Health insurance associations 165			
	Retired workers eligible for employees insurance benefits		Municipalities 1,788			
Long life medical care system （Medical care system for the latter-stage elderly people)			Management body: Extended associations for medical care for the latter-stage elderly people (47)	13,458	10% (Persons with income comparative with those of an active worker 30%)	Maximum amount of payment in part / Outpatient care (per person) (Persons with income comparable to that of an active worker) 80,100 yen＋(medical cost-267,000 yen)×1% / 44,400 yen (Incase of frequent reimbursement) 44,400 yen (Average income persons) 44,400 yen / 12,000 yen (Low income persons) 24,600 yen / 8,000 yen (Very low income among low income persons) 15,000 yen / 8,000 yen

Plan			Insurance Benefits			Financial resources	
			Medical Benefits		Cash Benefits	Insurance premiums	Government subsidies
			Hospital Meal Charge Benefits	Hospitalized living expenses benefits			
Health insurance	Ordinary employees	Kyokai Kenpo	Standard payment amounts for dietary therapy: • Standard-income persons 260 yen per meal • Low-income persons Up to the first 90th day 210 yen per meal From the 91st day 160 yen per meal • Low-income person with especially low income 100 yen per meal	(Standard payment amounts for those living in hospitals) • Standard income persons (I) 460 yen per meal and 320 yen per day • Standard income persons (II) 420 yen per meal and 320 yen per day • Low income persons 210 yen per meal and 320 yen per day • Low income persons with specially low income 130 yen per meal and 320 yen per day • Applicable to persons 65 years of age or older hospitalized in the convalescent ward * For patients with greater needs for inhospital treatment due to being obstinate or other diseases, the payment amount will be same as the standard payment amounts for dietary therapy.	• Sickness benefits • Lump-sum payment for childbirth, child care etc.	9.34% (National average)	13.0% of benefits (contribution for latter-stage elderly people 16.4 %)
		Associationman-aged			Same as above (including additional Benefits)	Rates vary from one kind of health insurance to another.	Fixed amount (Budgetary aid)
	Insured parties, as stipulated in Article 3, Par.2, Health Insurance Law				• Sickness benefits • Lump-sum payment for childbirth, child care etc.	Daily rate (class 1) 360 yen (class 11) 3,020 yen	13.0 % of benefits (contribution for the latter-stage elderly people 16.4 %)
Seamen's insurance					Same as above	9.25% (Sickness insurance rate)	Fixed amount
Mutual aid insurance	National government employees				Same as above (including additional benefits)	—	None
	Local government employees					—	
	Private school instructors					—	
National health insurance	Farmers, self-employed etc.				• Lump-sum payment for childbirth, child care • Funeral services expenses	Each household is assessed a fixed amount and amount based on ability to pay Calculations vary somewhat according to insurer	43% of benefits etc.
							32-55% of benefits etc.
	Retired workers eligible for employees insurance benefits						None
Long life medical care system (Medical care system for the latter-stage elderly people)			Same as above	Same as above. • Persons on senior welfare pensions 100 yen per meal	Funeral services expenses etc.	Rates are fixed based on the equal amount per insured and the percentage of their income determined by the respective extended associations.	• Insurance premium 10% • Contribution Approximately 40% • Public Approximately 50% (Breakdown of public expenses) National : Prefectures : Municipals 4 : 1 : 1

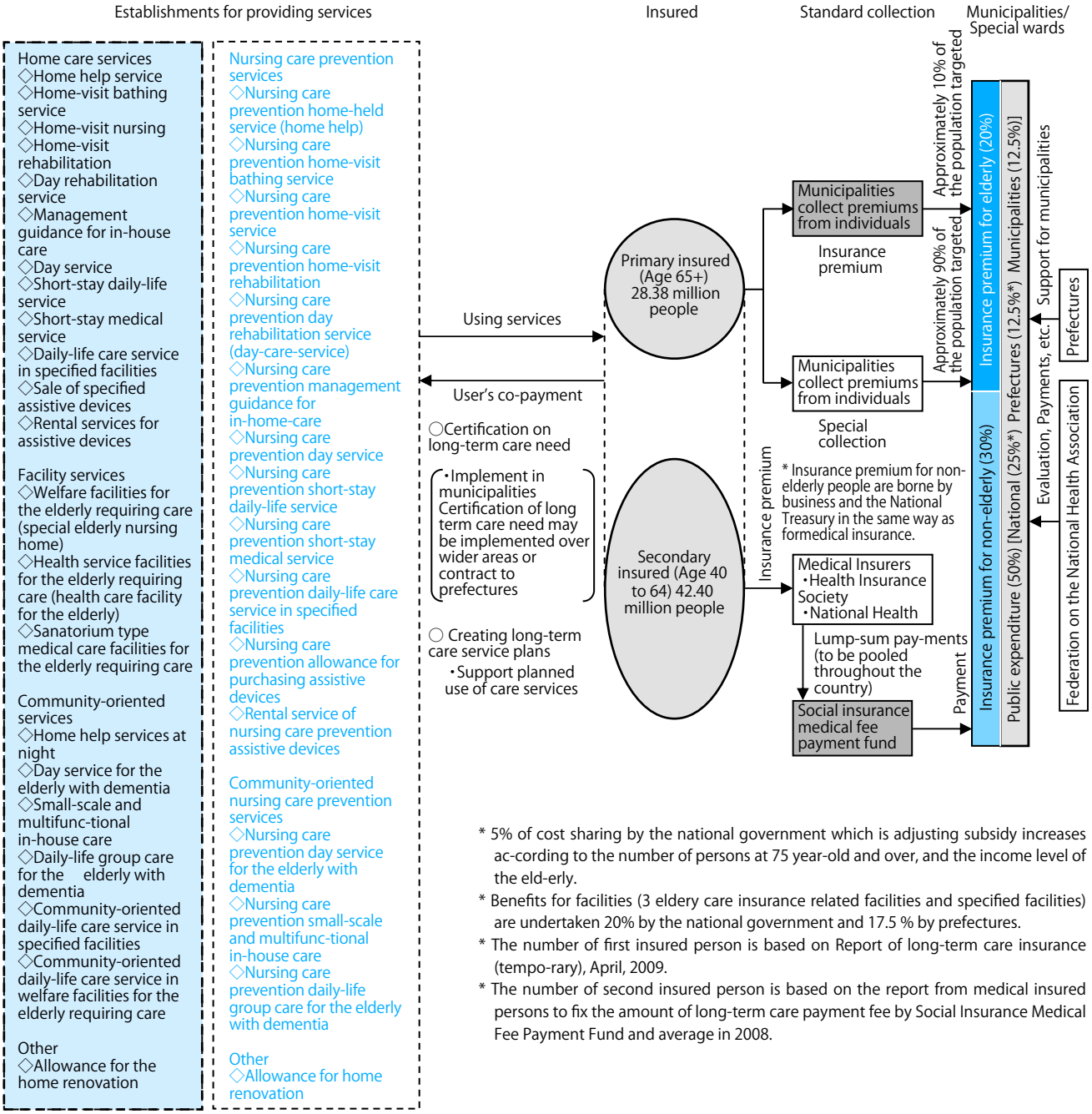
Source: "2012 Annual Health, Labour and Welfare Report", References, 2 Health and Medical Services, (1) Health Care Insurance, Outline of Healthcare Insurance System (as of June 2012)

Notes: 1) Those insured by the long-life medical care system (medical care system for the latter-stage elderly people) comprises persons of 75 years of age or older, and the persons from 65 to 74 years of age certified by an extended association to have a certain degree of handicap.
2) Persons with income comparative with those of an active worker mean their taxable income is 1.45 million yen (0.28 million yen for monthly income) and annual income is more than 5.2 million yen [family including elderly person(s)] or 3.83 million yen (single-elderly person household).
3) For new subscribers and their families who are exempt from health insurance eligibility and subscribe from September 1, 1997, the fixed-rate state subsidy to NHI Associations will be at the same level as that paid to the Japan Health Insurance Association
4) Numbers of subscribers are preliminary estimates in the case of health insurance. Sums in the breakdowns may not add up to the totals due to rounding.
5) Between July 2010 and FY2012, the state subsidy rate for the Japan Health Insurance Association (general employees and persons insured under Article 3 para. 2 of the National Health Insurance Act) is 16.4% of the benefit cost.

National health expenditure, combining the cost of medical benefits from public health insurance with that from public assistance, topped 30 trillion yen (6.1% of GDP) in 1999, creating a need for appropriate controls on the growth of healthcare expenditure. When long-term nursing insurance was introduced in 2000, growth in healthcare expenditure temporarily decreased. It subsequently turned back to an increase, however, and expenditure remains in an upward trend. In FY2010, national health expenditure reached 37.4 trillion yen, and the ratio of expenditure to GDP had risen to 7.8%. By age group, national health expenditure was 2.4 trillion yen (6.5%) for ages 0-14, 5 trillion yen (13.4%) for ages 15-44 5, 9.3 trillion yen (24.8%) for ages 45-64, and 20.7 trillion yen (55.4%) for ages 65 and over. Expenditure on the elderly accounted for the highest proportion of all national health expenditure. If this continues to be supported by a combination of public spending with contributions from national health insurance and health insurance associations, problems will arise due to a slowdown in growth of insurance premium income accompanying the reduced rate of growth in the Japanese economy. In view of this and the need to ensure intergenerational fairness between current working generations and the elderly, a revision of the system was necessary, and a reform of the elderly healthcare system was introduced in 2008. In the previous system (the system of elderly healthcare), elderly patients were only liable for copayment of costs incurred by health examinations or hospital stays (with reduced burdens for low earners), and they paid no insurance premiums. By contrast, the "longevity healthcare system" (the late-stage medical care system for the elderly) introduced in 2008, covering the over 75s and disabled elderly persons between ages 65 and 73, is a public healthcare system in which 50% of medical benefit costs are paid from the public purse (specifically, by the central government, prefectures and municipalities in proportions of 4:1:1). Besides this, 40% is borne by health insurance contributions from working generations up to age 64, and the remaining 10% is funded by insurance premiums from the elderly themselves. However, those on low incomes are exempt from paying premiums and also have lower copayment costs.

Long-term care insurance: Long-term care insurance has been in operation since April 2000 to provide public assistance to lighten the care burden for long-term care recipients' families. This assistance makes it easier for bedridden older people and other older people requiring long-term care to receive this care at home, and for others to receive long-term care at a facility outside of home. Under the long-term care insurance system, in exchange for citizens aged 40 and above paying long-term care insurance premiums, it is possible to receive specific types of long-term care service if required after reaching the age of 65, such as the dispatch of a home-helper; in order to receive these services, the older person concerned must submit an application and have it approved by the municipality's long-term care approval committee. Whereas the insurance premiums and the standards for certifying the necessity of receiving long-term care are set in a uniform manner nationwide, the task of issuing approvals based on those standards is undertaken by municipal long-term care approval committees. In addition, long-term care services are provided on the basis of care plans drawn up by care managers, by a service provider selected by the person requiring long-term care from among the long-term care service providers approved by the municipality, respecting the choice of the individual requiring long-term care (Figure VI-12). Those using long-term care services bear 10% of the cost, as a general rule. However, a maximum limit is set in order to ensure that the cost burden on the user is not too high, with the municipality paying any high-cost long-term care service fees in excess of that maximum limit.

Figure VI-12 Long-term Care Insurance System



* 5% of cost sharing by the national government which is adjusting subsidy increases ac-cording to the number of persons at 75 year-old and over, and the income level of the eld-erly.
* Benefits for facilities (3 eldery care insurance related facilities and specified facilities) are undertaken 20% by the national government and 17.5 % by prefectures.
* The number of first insured person is based on Report of long-term care insurance (tempo-rary), April, 2009.
* The number of second insured person is based on the report from medical insured persons to fix the amount of long-term care payment fee by Social Insurance Medical Fee Payment Fund and average in 2008.

Source: "2012 Annual Health, Labour and Welfare Report", References, 10 Health and Welfare Services for the Elderly, Outline of Long-Term Care Insurance System

With regard to the number of people enrolled in long-term care insurance, as of 2011, there were 29.78 million people insured aged 65 or above (primary insured persons) and 42.70 million people insured aged between 40 and 64 (secondary insured persons). As of 2011, 1.40 million persons requiring support and 3.91 million persons requiring long-term care were certified eligible to receive long-term care insurance services. The number of long-term care workers (the total of full-time and part-time) providing long-term care services to elderly persons certified as requiring support or long-term care was 177,000 for home visit type long-term care, 330,000 for daycare type long-term care, 44,000 for in-home type long-term care, and 322,000 for long-term care insurance facilities, etc. (Ministry of Health, Labour and Welfare, FY2008 Survey of Institutions and Establishments for Long-term Care).

Given these circumstances in which many older people have been certified as requiring support or long-term care and are receiving long-term care insurance services, in municipalities that have a particularly high population aging rate, a situation has arisen in which the rise in the cost of providing long-term care insurance benefits is continuing and a deterioration in the state of public finances for long-term care insurance has become unavoidable. In order to deal with this problem, an amendment to the Long-term Care Insurance Act was made in 2005. Through this, initiatives such as those focused on the prevention of illness so that people do not end up in a state in which they require long-term care and the establishment of regional comprehensive support centers to provide more cohesive services in the community were incorporated into the long-term care insurance framework. Besides this, a Community-Based Care Improvement Initiative that would make use of diverse networks connected with long-term care (such as monitoring by NPOs and others as well as by local authorities and healthcare facilities) was proposed in 2008. The aim of this was to enable the elderly to receive long-term care services while remaining in the familiar surroundings of their home communities. With this, Comprehensive Regional Support Centers were to be established as facilities where comprehensive efforts would be made to improve the health, welfare and healthcare of local residents, prevent abuse, provide management to prevent long-term care, and others in the local community. The centers would be established by local authorities, but the day-to-day running could be outsourced. In future, meanwhile, elderly residents are expected to increase in urban areas while increasing more gradually in provincial areas. To address this, a comprehensive regional care system that would guarantee five aspects in cross-linkage (securing homes for the elderly in line with local circumstances, supporting their lives, preventing long-term care, providing long-term care services, and medical care) was proposed (Elderly Healthcare and Health Promotion Project, Comprehensive Regional Care Research Group Report). Based on new ideas like this, the 2011 revision of long-term care insurance incorporated a provision to the effect that the central government and local authorities should endeavor to create comprehensive regional care systems. Today, initiatives enabling the elderly to receive long-term in-home care while living in the familiar surroundings of their home communities are being promoted in forms appropriate to the circumstances of each locality.