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Social Security in Japan

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National Institute of Population and Social Security Research

Preface

Japan has entered the phase of population decline and the proportion of the elderly is the highest in the world. Yet the life expectancy of Japanese is high and the health expenditure per capita is low compared to other industrialized nations. The social security plays an important role to maintain the Japanese society as it is.

This booklet aims to provide foreign researchers and specialists with an introductory explanation of aspects of the social security system in Japan: pensions, health and long-term care insurance, public assistance, family policy, policy for people with disabilities and labor insurance. The first edition was published in March 2000, and this is the sixth version updated as of January 2014.

Along with evolving needs and challenges, the social security system in Japan has been, and will be constantly revised and reformed. The complexity of the system needs clear and concise explanation to facilitate international comparison and provide some hints for ameliorating existing institutions elsewhere. We sincerely hope that this booklet will be useful for those who care for the welfare of people and betterment of the society.

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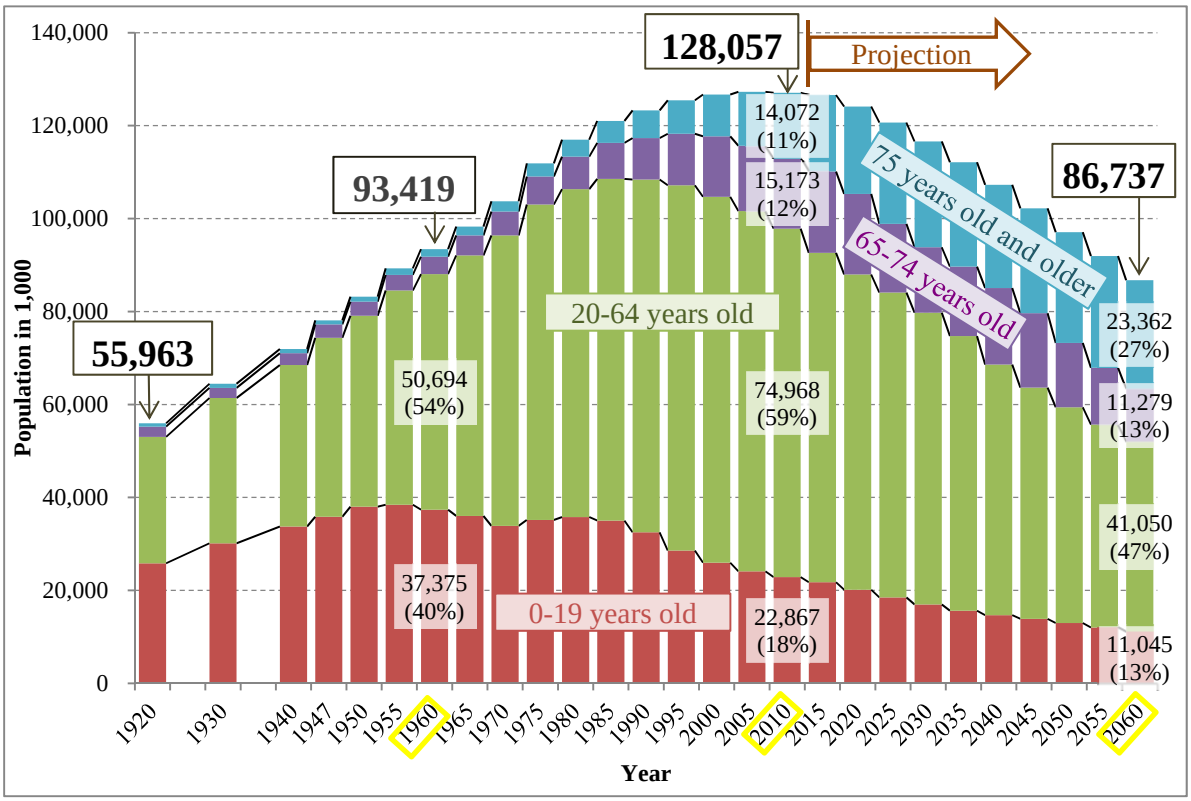
Contents

Chapter 1 Overview of Population Trends in Japan

1.1 Total population and change of age structure

As of September 1st 2013, the population of Japan counted 127,263,000, shrunk by 224,000 from the previous year. Population decline has become a reality[1]. In 1920 when the first population census was carried out, the population of Japan was 56 million. The population growth continued until around 2010, and then it would decline almost at the same pace as it increased, according to the population projection of IPSS[2]. Japan is the most aged society in the world, with 25.0% of the population aged more than 65 years old in 2013, and this rate would further increase to 40% in 2060, and the increase of "oldest-old", namely aged 75 and more would be more than double from 11% in 2010 to 27% in 2060. Naturally, the young people (aged 0-19), comprising 40% of the total population in 1960 is shrinking to 18% in 2010, and 13% in 2060.

Figure1.1 Population trend by age group in Japan (1920-2060)



Source : For data up to 2010, Census data by Statistics Bureau of Ministry of Internal Affairs and Communication (http://www.stat.go.jp) . For data from 2015, "Population Projections for Japan", IPSS (see footnote)

1.2 Vital statistics trend

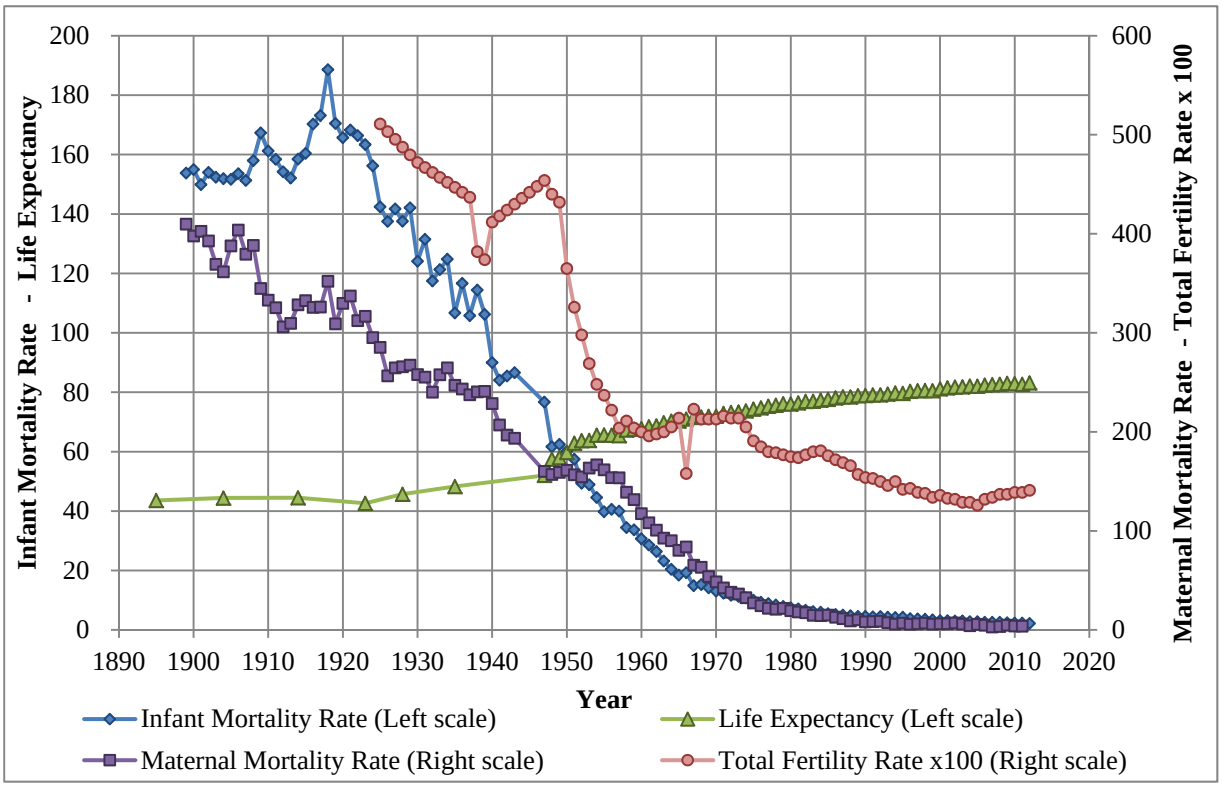
The change of Japanese population is the result of the fertility and mortality evolution. Before the end of the World War II (in 1945), the level of fertility and mortality was high. The total fertility rate was as high as 5.11 in 1925, but steadily decreased until 1937, followed by significant fluctuation due to the war

[1] " Monthly Report" of Result of the Population Estimates, Statistics Bureau, Ministry of Internal Affairs and Communications, http://www.stat.go.jp/english/data/jinsui/tsuki/index.htm

[2] "Population Projections for Japan (January 2012), IPSS, http://www.ipss.go.jp/site-ad/index_english/esuikei/gh2401e.asp

and population policies. As for the mortality, the improvement since 1920 is notable especially for the level of infant mortality and maternal mortality. The extension of life of the Japanese continues up to now and the life expectancy is one of the highest in the world at 79.94 for males and 86.41 for females in 2012.

Figure 1.2 Trend of mortality and fertility in Japan



Source : Statistics and Information Department, Ministry of Health, Labour and Welfare (http://www.mhlw.go.jp/)

A sharp decline of total fertility rate was observed in 1966, which was due to the Year of the Fire Horse. The traditional belief that girls born in this year would eat up the husband refrained parents not to have babies this year. Customs, superstition, tradition still dominated the reproductive behaviors of Japanese even during the latter half of the 20th century.

1.3 Population distribution – centralization and decentralization

The Japanese archipelago consists of the main island (Honshu) and the three major islands (Kyushu, Shikoku, Hokkaido) with 6,848 lesser islands, totaling 377,960 km^2 in area. Administratively it is divided into 47 prefectures (都道府県 To-Do-Fu-Ken) and subdivided into 1,742 municipalities[3] (市区町村 Shi-Ku-Cho-Son) as of 1 Jan. 2013. In 1889 when municipality was institutionalized by law, there were 13,386 municipalities, but due to population urbanization along with domestic migration, the number of municipalities has been reduced. The population concentration proceeds and now the three Major Metropolitan Areas namely Kanto (around Tokyo), Kinki (Around Kyoto, Osaka), and Chukyo (around Nagoya) contain 51 % of total population of Japan.

The level of population aging is different from municipality to municipality mostly due to

[3] Local Authorities Systems Development Center, https://www.lasdec.or.jp/cms/1,19,14,151.html

emigration of younger people to urban areas. As shown in Figure 1-3, municipalities in urban areas have much less proportion of the aged than in rural areas.

1.4 Family structure

The Japanese family structure changes through history. As an agrarian society in 19th century, when 88% of the working population were in the agricultural, forestry, and fishing sectors[4], a family was a production unit, and normally large, with more than two generations. The Civil Code enacted in 1898 institutionalized *ie* (family) system and authorized the head of the household, mostly the eldest male sibling, to be fully responsible for the family affairs. After the WWII, the *ie* (家) system was gradually transformed to the nuclear family, with fixed role of the husband at work, the wife at home to take care of the children. Along with the global trend of empowerment of women, the Equal Employment Opportunity Law was enacted in 1986 and roles of women and men were transformed to a direction of individualization of family. Recently, even though the total population is decreasing, the number of households is still increasing due to the increase of single households, mainly with elderly who have lost their spouse or young and middle aged people who are not married or divorced. The average number of household members keeps on decreasing from 4.99 in 1920 to 2.46 in 2010.

1.5 International migrants

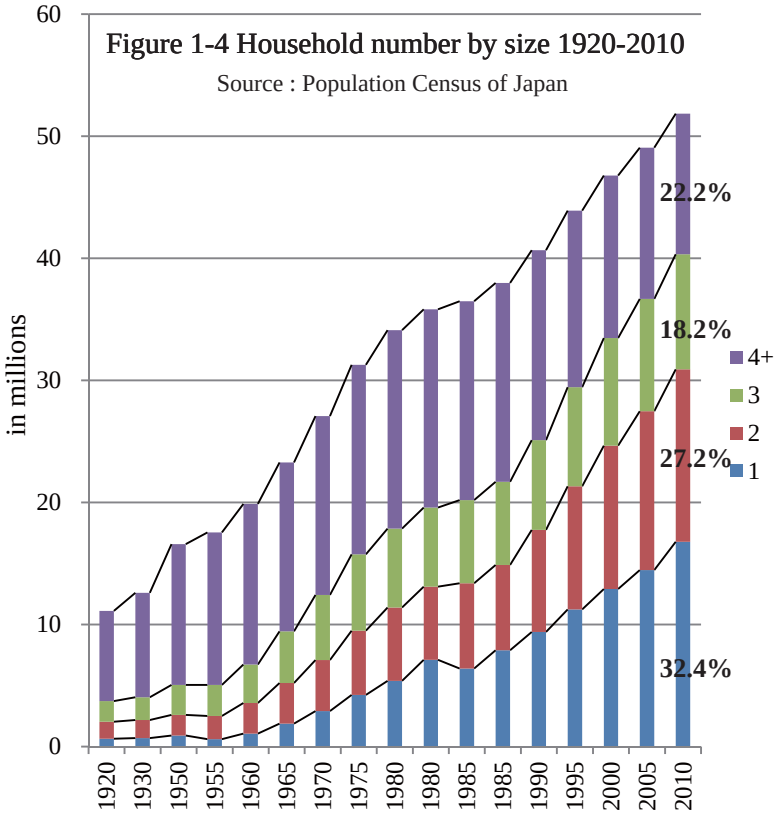
Although the proportion of foreigners is 1.6% of the total population of Japan, which is much lower than the rate of other industrialized countries, the number of foreigners steadily increased until 2008. Since then, the total number of foreigners decreased due to the global economic crisis and the Great East Japan Earthquake, which hit Tohoku in 2011. However, permanent foreign residents keep on increasing, to a level close to 1 million in 2011 (Figure 1.5).

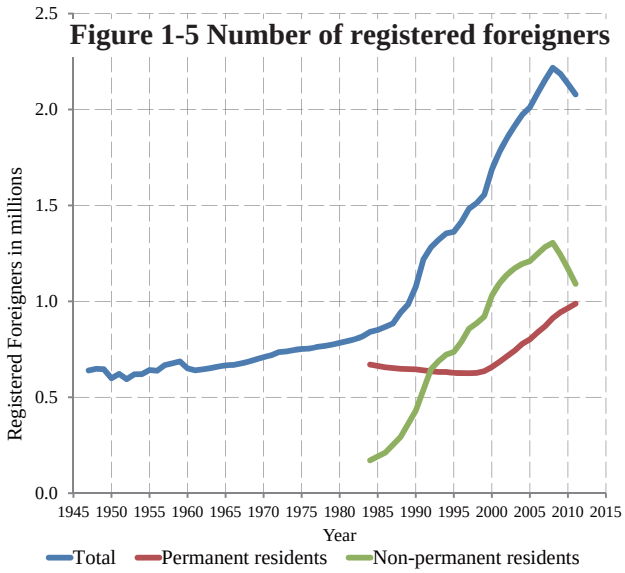
1.6 Population data sources

The correct statistics on population is the prerequisite for good governance and policy formulation. In Japan, there are three sources of population statistics, namely Population Census, Basic Resident Registration, and Family register (戸籍 Koseki). The Population Census has been organized since 1920 and every five years, with wider range of questions asked every ten years. The registration based population statistics is used to estimate yearly population figures. Family register, the East Asian traditional population registration system, was re-instated in Japan since 1871 by law, and now used as personal identification in conjunction with the family status.

As for the vital statistics, since 1872, each birth, death and marriage of people living in Japan has been registered at the municipality level and compiled at the national level. Together with various government surveys including those carried out by IPSS, population information is gathered, used, and disseminated for everybody through the internet, on web sites such as ; www.e-stat.go.jp or www.ipss.go.jp .

[4] Toshiko Himeoka (2008) “Changes in family structure”, in *The Demographic Challenge – A Handbook about Japan*, Florian Coulmas et al. ed. Brill,





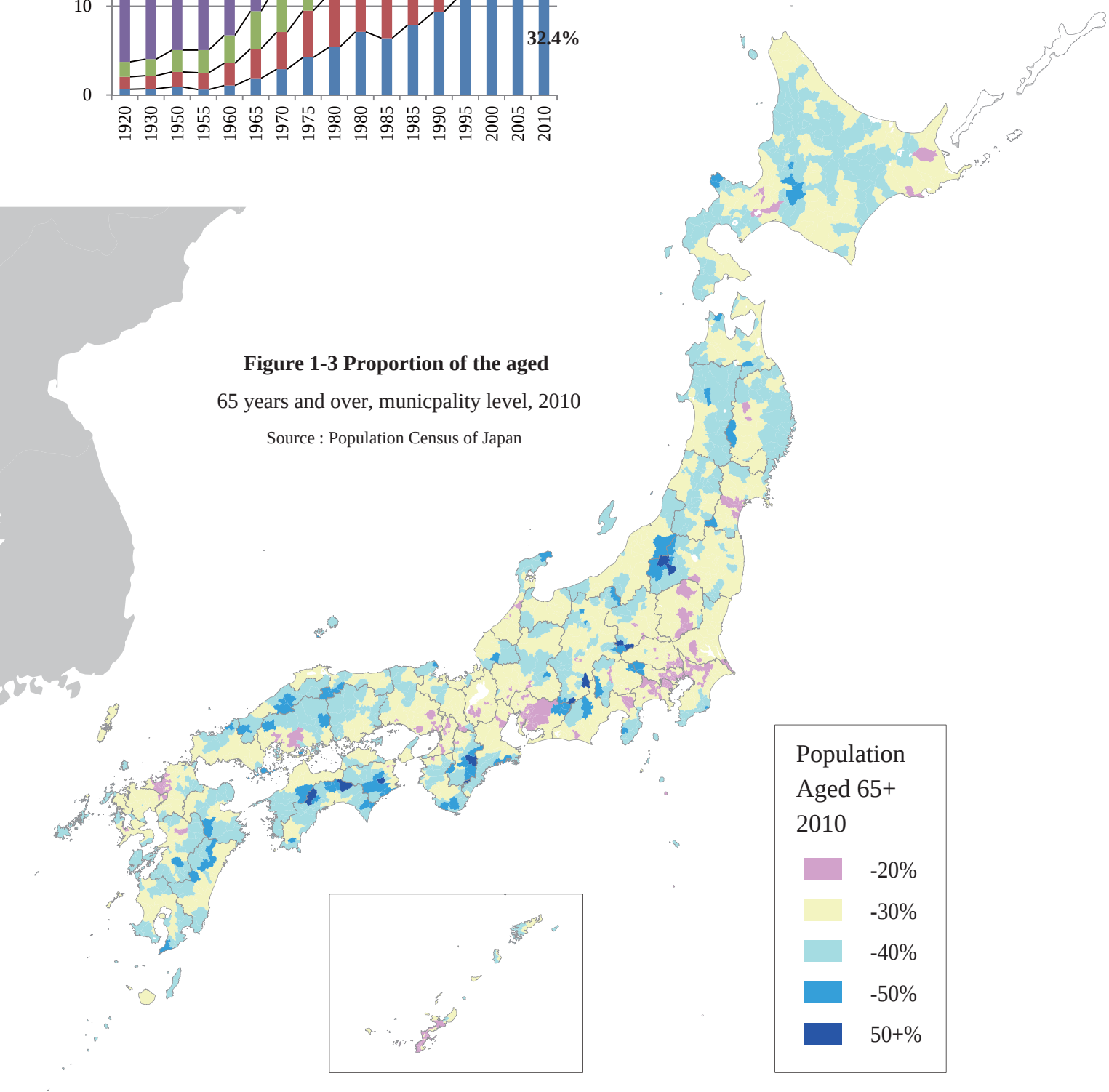


Figure 1-3 Proportion of the aged

65 years and over, municpality level, 2010

Source : Population Census of Japan

Chapter 2　Overview of Social Security in Japan

2.1 History of the social security system in Japan

2.1.1 Pre-Modern Era (before 1868)

As with other countries, the source of social security in Japan could be found in charity-oriented communal activities for the poor in a pre-modern era. The "Shikain（四箇院）" (four institutions for the frail elderly without family etc.) set up in 539 was an example of it. The Imperial court, Shogunate, and feudal lords had provided relief to the poor. Buddhist temples also had provided relief to them. These measures were based on the charity ethics of Confucianism and Buddhism. However, the beneficiaries had been severely limited (ex. the poor elderly without family). It was because the mutual aid had been a principal of the society in those days. For example, "Gonin-gumi（五人組）" (five members group in the Edo Era) might not only be a group for the render (Nengu 年貢) payment, but also that of mutual aid in the community during this era. This can be one form of the social capital of the pre-modern society.

As for the healthcare, during the time from the ancient to the Edo Period, traditional medicine had been imported from the Chinese continent, with certain original development within Japan. In the latter period of Edo, western medicine had been imported from the Netherlands through Nagasaki. Private schools (Rangaku Jyuku 蘭学塾) had been set up in Nagasaki and Sakura (Chiba) etc. Some of them are the origins of the notable medical faculties of the University of the present time.

Table 2.1 in page 10 lists the detailed chronological events.

2.1.2 From the Meiji Era to the End of World War II (1868-1945)

In the Meiji Era (1868-1912), Japan had started to develop for modernization. But poverty had increased because of instability in society. The government had to cope with it. Indigent Person's Relief Regulation had been enacted (1884). But this regulation had a principle of "mutual aid for the poor" and the beneficiaries were severely limited. The amendment of it to expand the beneficiaries had been discussed in the Imperial Parliament, but we had to wait for the enactment of the Poor Relief Law (1929). It was still an inadequate system compared to the present system.

In the Meiji Era and the Taisho Era (1912-1926), poor health and bad working conditions of the factory workers including boys, girls, and women had been a serious social problem. It had led to the introduction of the Factory Law (1911). This law is an origin of Labour Standards Act (1947). After that, a social insurance scheme was introduced for workers. These were Health Insurance Act (1927), National Health Insurance Act (1938), Labor Pension Insurance Act (1941). During this period, the Ministry of Health and Welfare was established in 1938. Social welfare, health care, public health, and labour policy had been transferred from the Home Ministry. Local governments also had made efforts to cope with poverty. Commissioned welfare volunteer had been introduced in Okayama prefecture (Saisei-komon-seido in 1917) and Osaka prefecture (Houmen-iin-seido in 1919). This system had been spread throughout Japan and has led to the present welfare commissioner and commissioned child welfare volunteers. In addition to these, many charitable persons had set up welfare institutions like orphanages, facilities for the mentally disabled persons, and nursing homes for the elderly.

However, these systems were inadequate compared to the present system in terms of population coverage and so on. (Refer to Annex Table 2.1)

In terms of medicine, the Meiji government had decided to introduce western medicine (mainly from Germany) and had developed the medical doctor license qualification system, educational institutions, and so on. The government also had constructed the mechanism of modern public health (for example, Act on Prevention of Infectious Diseases in 1897). Maternal and Child Health Act has been enacted in 1937. Based on this act, “Maternal Handbook” (present “Maternal and Child Health Handbook”) had been issued from 1942. The purpose of this handbook was to protect and promote the health of mother and child through recording the health checkup. (Refer to Annex Table 2.1)

2.1.3 After the End of World War II to present (1945-2013)

The social security system in Japan developed dramatically after the end of World War II. During the social turmoil just after the World War II, measures to assist the needy, to improve nutrition and to prevent infectious diseases were implemented, along with infrastructure development related to social welfare policies. In the Constitution of Japan enacted in 1947, Article 25 stipulates the fundamental principles of developing a social security system, and this served as the foundation for social security-related laws created in the post war era. In 1947, the Ministry of Labour had been separated from the Ministry of Health and Welfare to be in charge of labor policy independently (These ministries have been re-integrated in 2001 as the Ministry of Health, Labour and Welfare). In this year, unemployment insurance had been introduced.

During the rapid economic growth period that followed, the public pension and health insurance was expanded to cover more people, and the so-called “Universal Coverage in public pension and health insurance” extending to all citizens was introduced in 1961. The Act on Social Welfare Service for Elderly and the Maternal and Child Welfare Act were also enacted in 1963 and 1964 respectively, and benefits from various systems were enhanced. The social security system was reviewed during the period of stable economic growth since the late 1970s. Meanwhile, developing a social security system in response to the aging population became an important challenge.

Since the 1990s, measures against the declining birthrate, in addition to the aging society, surfaced as an important policy issue. Pension and health insurance system reforms were implemented. Long-Term Care Insurance Act was introduced to support the elderly with long-term care needs and their family by the society. Enhancement of childcare services and financial support are being promoted to assist child care. In addition, due to changes in the employment situation and widening difference in economy, employment policies have also become important. (Refer to Annex Table 2.1)

2.2　Social security schemes in Japan and its characteristics

A social security scheme is primarily a system that supports the livelihood of the people by providing necessary support against conditions that lead to poverty, illness, injury, death, aging and unemployment, and so on. There are various social security schemes in Japan. The public pension system is to provide income security for the elderly, the survivors, and disabled persons. Healthcare systems to protect public health include the health insurance, public health and maternal and child health systems. Meanwhile, social

welfare for the elderly include long-term care insurance, while family policies include childcare services and financial support such as child allowance, and support for single-parent households. Policies for persons with disabilities include the provision of care services and financial support. Public assistance is available as part of the financial support system for the poor. As part of the system to protect workers, employment insurance, work-related accident insurance, and others are available.

Kinds of benefits provided through these social security schemes are either in-kind or in-cash. Table 2.1 lists major social security schemes by types of benefits and in-kind/in-cash classification based on International Labour Organization (ILO) classification standard.

Table 2.1 Schemes of Social Security

Scheme	Finance	Benefit *		Main Type of Function (ILO Standard)
		In-kind	In-cash	
Public pension	Social Insurance		*	Old Age, Survivors, Invalidity Benefits
Health Insurance	Social Insurance	*		Sickness and Health
Public health	Tax	*		Sickness and Health
Long-term care insurance	Social Insurance	*		Old Age
Services for the elderly (except for long-term care insurance)	Tax	*		Old Age
Family Policy	Tax	*	*	Family Benefits
Policy for persons with disabilities	Tax	*	*	Invalidity Benefits
Public assistance	Tax	*	*	Social assistance and others
Employment insurance	Social Insurance		*	Unemployment Family Benefits
Work-related accident insurance	Social Insurance	*	*	Employment Injury

* Benefit does not show all kinds of benefits.

Many social security schemes in Japan adopt the social insurance system. There are five social insurance systems, namely the public pension, health insurance, long-term care insurance, employment insurance, and work-related accident insurance. Of these insurances, all citizens are enrolled in the public pension and health insurance programs. This universal coverage in public pension and health insurance is a main characteristic of the Japanese social security system. Furthermore, citizens aged 40 and over are covered by the long-term care insurance, and employees are covered by the employment insurance and work-related accident insurance.

The social insurance systems mentioned above are financed by social insurance premiums and supplemented by the tax revenue in forms of subsidy. The social insurance premiums is shared by all insured, in most cases, according to their ability to pay (the level of income). Thus, the function of social insurance is to share the risk among insured persons, and at the same time, to redistribute income among

them.

On the other hand, other schemes, such as public assistance (poverty alleviation measures in Japan), services/benefits for the family, children, and the disabled are paid out of the general budget of the government (tax).

2.3　Administration organizations and service providers

The Ministry of Health, Labour and Welfare holds jurisdiction over the social security systems. The Ministry sets national standards and promotes projects deemed necessary to be implemented from a national perspective. The Cabinet Office is in charge of planning the governmental basic policy plans related to social security such as population aging and child care policy and so on. Local governments such as prefectures and notably municipalities (cities, towns and villages) execute and implement the social security services. Local governments have social welfare office, public health centers. In recent years, decentralization proceeds in the form of delegating the financial resources from central to local governments. It is based on the idea of “Local autonomy.”

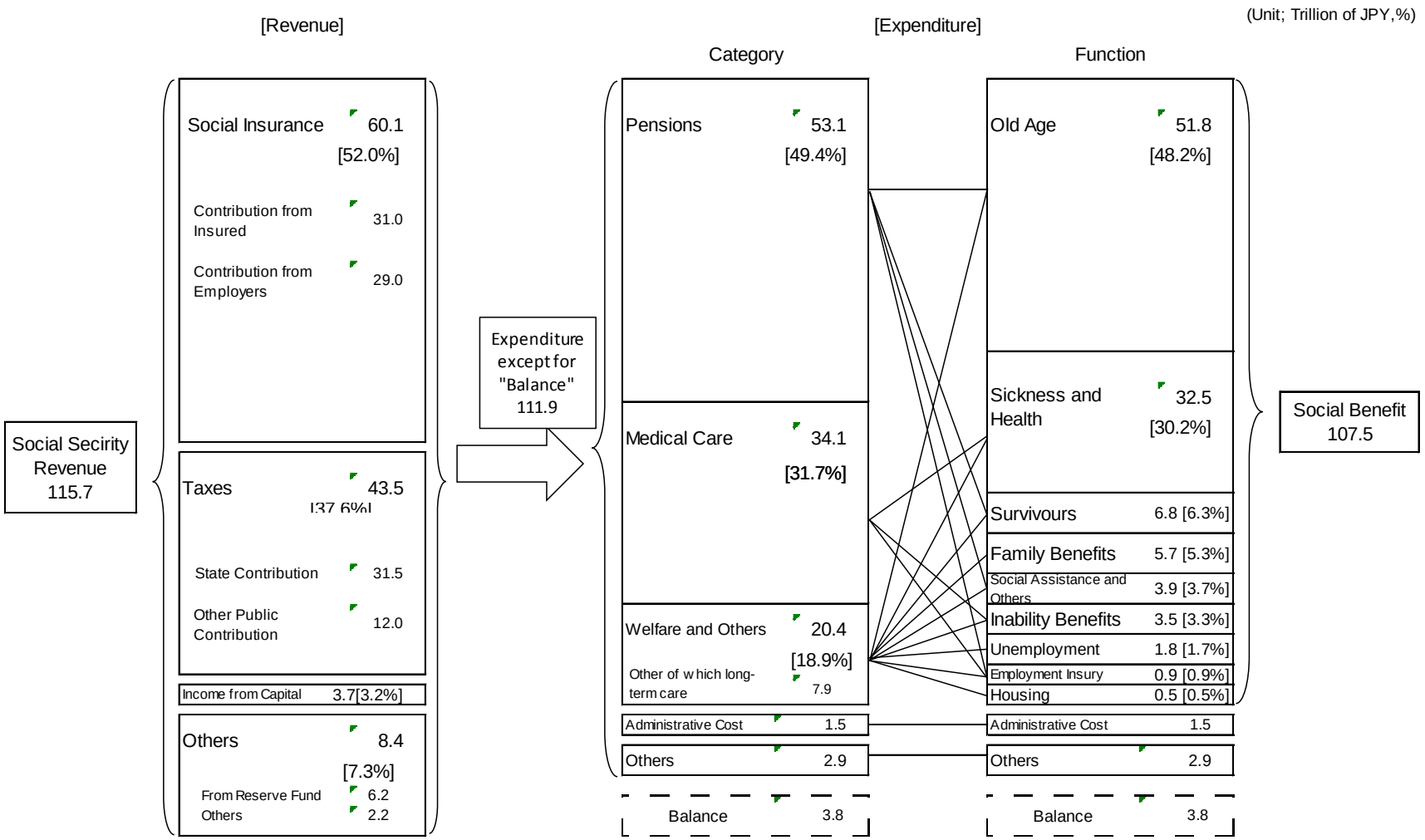
Social security system has many schemes. Managements of beneficiaries and contributions has been done separately only to lead to inconvenience for people and inefficiency in management. To solve these problems, the Social Security and Tax Number Law was approved in 2013 and planned to be enacted in January 2016. A unique number will be given to all persons, including foreign residents, and companies in Japan. Keeping the maximum attention to the privacy protection, this “My Number” system will be used for service management in the tax and social security.

Service providers of social security such as hospitals and clinics for health care, day-care centers and institutions for the elderly long-term care, rehabilitation centers and support centers for the disabled, and so forth, can be both public and private. However, private institutions are not allowed to gain profit and distribute it. Public and private institutions are both operated under the supervision of the Ministry of Health, Labour and Welfare (MHLW) and the local governments.

2.4　Financial statistics of social security

Japan now collects and spends two sets of financial statistics of social security. The Social Expenditure of Japan based on the OECD standard was 112.0437 trillion JPY in FY2011, which was 23.67% to GDP and 876,700 JPY per capita. The Social Benefit based on ILO standard, which does not include facility maintenance costs, pre-school education costs and so on, was 107.4950 trillion JPY in FY2011 which was 22.71% to GDP and 841,100 JPY per capita. The ILO standard social security statistics can grasp the flow of revenue and expenditure in social security. Fig. 2.1 shows a breakdown of social security revenue and expenditure by this ILO standard. Insurance premium accounts for 52.0% of the total revenue and the taxes for 37.6%. The expenditure for the public pension takes up around half of the entire expenditure, and for the medical care, around one third. As for the expenditure by function, old age takes up around 50 %.

Figure 2.1 Diagram of Social Security Revenue and Social Benefit based on the ILO Standards, fiscal year 2011



Notes

1. "Others" in the Revenue include transfers from the reserve funds, etc. Others in the Expenditure includes maintenance expenses for the facilities, etc
2. Balance refers to the difference between Social Security Revenue (115.7 trillion yen) and the sum of Social Benefit, administrative costs, operating losess, and others (111.9 trillion yen), and does not include any transfer to and from other systems; in particular, balance represents transfers to the reserve fund and the balance carried forward to the following fiscal year.

Annex Table 2.1. History of Social Security in Japan

Period and Year		Main Events
Ancient to the Edo Era	593	"Shikain" was set up by Shotoku Taishi (member of Imperial Family)
	718	"Yoro Ritrsuryo" Act (showed mutual aid for the elderly etc.)
	1642	"Osukuigoya" set up (Relief institution in famine)
	1722	"Koishikawa Youjojo" had been opened (Medical Institute for the Poor in Edo city)
	1791	"Shichibu-tsumikin" (Fund to relief for the poor, Edo city)
The Meiji Era to the World War II	1874	Indigent Person's Relief Regulation
	1897	Act on Prevention of Infectious Diseases
	1911	Factory Law (an origin of Labour Standards Act (1947))
	1922	Health Insurance Act
	1929	Poor Relief Law
	1937	Maternal and Child Health Act
	1938	National Health Insurance Act (amended in 1958), Social Services Act Ministry of Health and Welfare was established
	1941	Labor Pension Insurance Act (present Employees Pension Insurance Act)
Just after World War II	1946	Public Assistance Act (old act)
	1947	the Constitution of Japan Child Welfare Act, Unemployment Insurance Act Industrial Accident Compensation Insurance Act Health Center Act (present Community Health Act) Ministry of Labour was established
	1949	Act for the welfare of Persons with Physical Disabilities
	1950	Public Assistance Act (present act)
1950s to 1970s	1951	Social Welfare Service Act
	1958	National Health Insurance Act (Amendment of 1938 act)
	1959	National Pension Act (Implemented in 1961)
	1960	Act for the welfare of persons with intellectual disabilities
	1961	Universal Coverage in pension and health insurance
	1963	Act on Social Welfare for the Elderly
	1964	Act on Welfare of Mothers with Dependents
	1971	Child Allowance Act
	1973	Amended Act on Social Welfare for the Elderly (Free Medical service for the elderly) "Fukushi-Gannen" (improvement of social security benefit)
	1974	Employment Insurance Act (replacement of Unemployment Act)
1980s to 2000	1981	Act on Welfare of Mothers with Dependents and Widows (Amendment of Act on Welfare of Mothers with Dependents)
	1982	Health and Medical Services Act for the Aged (New scheme for the finance of the health care costs for the elderly)
	1990	Major amendments of eight acts about social welfare
	1991	Act on the Welfare of Workers Who Take Care of Children
	1995	Basic Law on Measures for the Aging Society
	1997	Long term care Insurance Act (Implemented in 2000)
	2000	Social Welfare Act (Amendment of Social Welfare Service Act)
From 2001	2001	Ministry of Health, Labour and Welfare was established (re-integration of Ministry of Health and Welfare and Ministry of Labour)
	2003	Basic Act for Measures to Cope with Society with Declining Birthrate
	2005	Services and Supports for Persons with Disabilities Act
	2008	Late-stage medical care system for the elderly (New Scheme of the health insurance for the persons aged 75 and older)
	2011	"Kodomo Teate" (Child Allowance) under the Democratic Party Government
	2012	Child Allowance (present system by Liberal Democratic Party Government)

Chapter 3 Pensions

3.1 History of pension in Japan

Like other advanced countries, the Japanese pension system was first introduced by the Army, the Navy, and the authority for the civil servants. At the end of the 19th century, the Imperial Army's Pension was started in April 5th 1875, followed by the Imperial Navy's Pension in Aug. 24th 1875, which were united in 1890 and abolished in 1945. The pension of white color workers started later in 1884, and the pension of blue color workers' in public fields started in 1919. The military pensions required no individual contributions and was completely financed by general revenue of the national government. The scheme was then expanded to civil servants. In those days, the pension (the old-age benefit 恩給) for military and civil workers was based on the salary just before the retirement, and its level was generous. The disparity between the civil workers' pension and private sector workers' pension had been large, and this will be completely corrected only when the private sector workers' pension (EPI: Employees' Pension Insurance) and civil workers' pension (Mutual Fund) will be united in Oct. 2015.

The private sector's employee's pension started in 1942. In those days, the pension premium and benefit was in proportion to the wages. In the beginning, the name of the private sector's employee's pension was Labour's Pension Insurance（労働者年金保険） which covered only male blue collar workers. However, after only one year, the name changed to the Employees' Pension Insurance（厚生年金保険） which covered female and white collar workers too. In those days, the contribution rate was 11% based on the perfect funding system. The contribution rate was then reduced from 11% to 3% after WWII as poverty prevailed.

Why did the Japanese Government introduce the pension system for private sector's workers during wartime? The reason is clear. During wartime, the government needed controlled and stable manpower to maintain steady production and to control inflation by reducing the household purchasing power through imposing pension premium. The EPI was reformed in 1954 shifting from an earnings-related pension to a two-tier benefits system including flat-rate benefits. As for the rest of the population, in 1961, National Pension was introduced for the self-employed, fishermen/farmers, unemployed, house wives, and so on, thus the Japanese pension system achieved Universal Coverage. In terms of the payment of contribution and the receipt of the benefit, National Pension has not changed from how it was started.

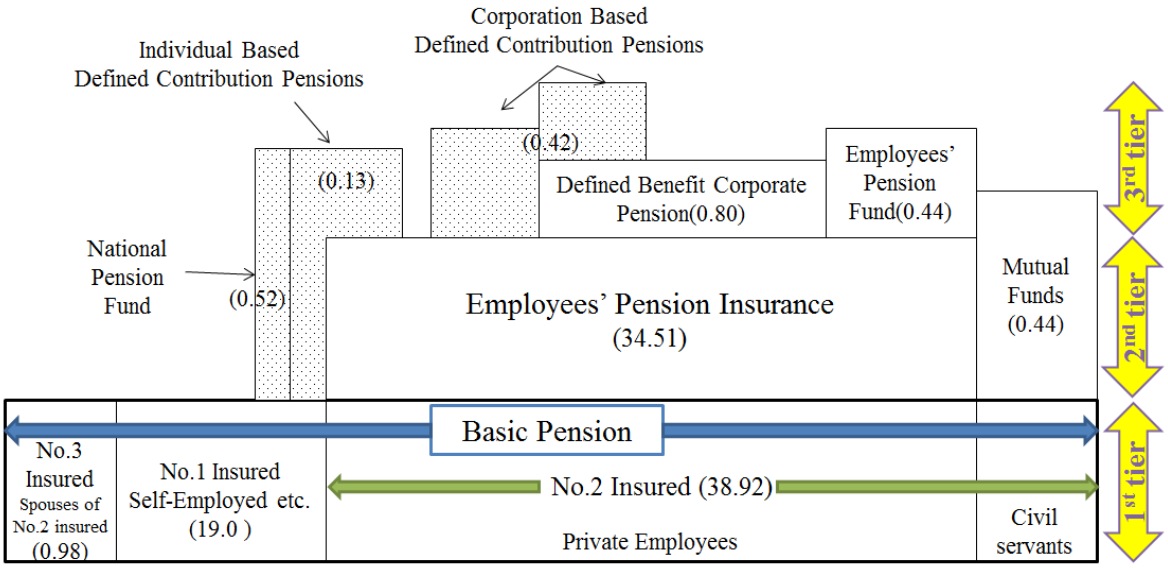
3.2 Pension system overview

Nowadays, the Japanese pension system is multi-tiered, consisting of public and private pension schemes (Figure.3.1). In this booklet, the distinction between public and private pension is whether the insurer of the pension is the government or not. The first tier is the *Basic Pension* (基礎年金), which provides the flat rate basic pension of a universal coverage. As a non-income-related pension, it aims to provide a basic income guarantee for old age, and the participation is mandatory to all residents of Japan. The second tier, the *Employees' Pension Insurance* (厚生年金保険) covers most employees and is income-related in both premium and the benefit structure. Its provision is mandatory to all corporations over a certain size, and the premium is shared by employers and employees. The first and the second tier

pensions are both operated by the government and thus are public.

The third tier is an optional scheme. It is provided either by private corporations (employers) for their employees (Employees' Pension Funds), or by the National Pension Fund for the self-employed, for which the government is the insurer. The Employees' Pension Funds are operated by employers, but has a large portion of financial resources from the Employees' Pension Insurance and thus has a quasi-public character. There are also personal pensions operated by organizations such as private insurance corporations and trust banks, but these are not covered here, as they do not fall under the category of a social security system.

Figure 3.1 Pension System in Japan



Note: 1) Shaded boxes indicate optional Defined-Contribution pensions.
2) Numbers in ( ) are the number of subscribers in millions. All numbers are as of March 2012.
Source: Web-site of Ministry of Health, Labour and Welfare (MHLW)
(http://www.mhlw.go.jp/topics/nenkin/zaisei/01/01-01.html in Japanese Access Aug. 25th 2013)

Similarly, the Basic Pension for the self-employed, farmers, and other non-employed (Category No.1 Insurer) is called the National Pension (国民年金), which is now operated by the Japan Pension Service (日本年金機構) under the responsibility of the government. The pension system for civil servants is called Mutual Aid Pensions (共済年金), which covers both the Basic Pension portion and the income-related portion. Thus, the entire adult population, in principle, is insured either by the Employees' Pension Insurance, the National Pension, or the Mutual Aid Pensions.

The coverage of the Basic Pension is universal, i.e. it is intended to cover all residents 20 years old or above in Japan including foreigners. For the National Pension, the eligibility to receive pension benefit requires a minimum of 10 years of premium payment, and the maximum enrollment period is 40 years.

3.3 Pension system financing

There are three resources for financing pension; the premium, the government subsidy, and the reserve.

Concerning the premium, in case of the *Employee's Pension Insurance*, the premium is paid by both

employees and employers, and is set at a fixed rate of the salary (see the table on pp. 20-21). The premium also covers the dependent spouse who earns less than 1.3 million yen per year (called No.3 insured). In case of the National Pension, the premium is paid by the insured only, and is a flat rate for all. Both husband and wife have to pay the premium if he/she is not working as employees.

As for the government subsidy, for the first tier (Basic Pension), 50% of the benefits and all of administrative costs are paid from the general budget of the government. For the second tier (Employees' Pension Insurance and Mutual Aid Pensions for central and local civil servants), the administrative costs are paid by the central government. For the third tier, there is no subsidy from the government.

3.4 Pension system by scheme

3.4.1 The National Pension

As described above, all residents in Japan between ages of 20 to 60 are eligible and required to become a subscriber of the Basic Pension. The amount of pension payment varies depending on the enrollment period and can be calculated as follows.

¥792,100 × ((insured months + 1/2 × exempt months) / 480)

Whereas employees who are covered by the Employees' Pension Insurance are automatically enrolled in the Basic Pension, those who are not employees are covered by the National Pension. A fixed amount (¥15,040 per month in 2012) is levied on each subscriber to the National Pension as a premium (41.4% of Category 1 subscribers are fully exempted and 2.6% are partially exempt from paying premiums as Japan Pension Service Statistics). Current benefits are paid out of currently collected premiums (pay-as-you-go system), but as much as one half of the benefits are subsidized from the general budget of the government. The benefit is flat rate to all, and the scheme is a defined-benefit scheme.

Due to the impact of the recent economic downturn, the National Pension is facing an issue of contribution evasion, especially among younger people. However, with the introduction of a multi-level premium exemption system in 2002, some subscribers can prepare for future pensions by using a partial waiver program. As a result, the average monthly pension benefit by the National Pension amounts to ¥54,612 in 2011, which is around 83% of the full amount. As the system becomes more mature, this amount may increase.

3.4.2 The Employees' Pension Insurance

The Employees' Pension Insurance forms the core of the income security for retirees. All workplaces with more than five employees and their employers are required to participate in this scheme. Both employers and employees contribute 7.5%[1] of employee's monthly salary as premiums (including a premium for the National Basic Pension), and the pension benefit is income-related. There is no discount system for low-income persons/household (or his/her employer), but employers of those who are on maternity leave (up to 1 year) are exempted from paying premiums[2].

[1] The premium rate applies to monthly salary as well as bonus.
[2] Employees who are on maternity leave typically do not receive salary, except unemployment benefits (40% of their pay), and thus do not

The average monthly pension benefit by the Employees' Pension Insurance is about ¥149,334, which amounts to 49.0% of the average monthly salary of subscribers (2011).

3.4.3 National Pension Fund

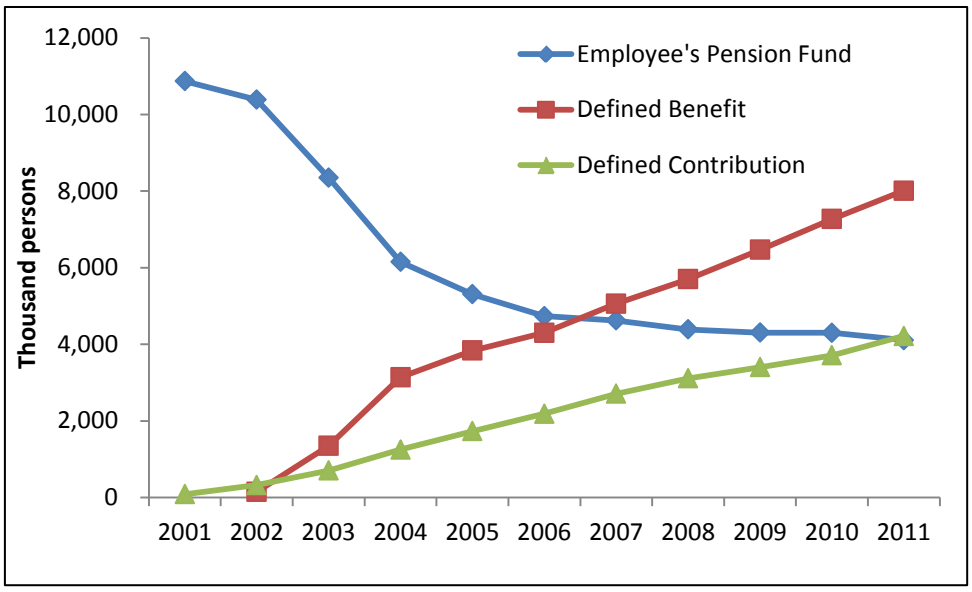
The National Pension Fund is an optional pension for the self-employed (Category No.1), and is designed to give additional pension coverage to the self-employed who do not have the third-tier pension (Employees' Pension Insurance). However, only about 3% (0.61 million) of Category No.1 subscribers (20 million) are currently subscribing to the Fund.

3.5 Pension system reforms

3.5.1 Change of third-tier pension schemes since 2000

In line with the introduction of international accounting standards in 2000, the third-tier pension schemes underwent a major reform. The Employees' Pension Fund was streamlined, and instead, the Defined-Benefit Corporate Pension (2001) and Defined Contribution Plan (2002) were newly established. The principal reason for the introduction of these schemes was to accurately reflect a firm's outstanding pension liabilities in the financial statements. The Defined Contribution Plan, in particular, facilitates the portability when changing jobs and responds to changes in the employment situation.

Figure 3.2 The transition of Employee's Pension Fund, Defined Benefit and Defined Contribution member



Source: The Data on Corporate Pensions (企業年金に関する資料), Pension Fund Association, 2012

As shown in Figure 3.2, the number of subscribers to the Defined-Benefit Corporate Pension and Defined Contribution Plan (corporate type) are on the increase, while that of the Employees' Pension Fund

need to pay a premium. The duration of maternity leave is counted as insured months in calculating a benefit level.

has steadily been decreasing.

The defined-contribution (DC) pension schemes have two types: individual-based and corporation-based. The individual-based defined-contribution scheme is for self-employed persons (Category 1 subscribers) and is designed to give optional pension coverage to the self-employed. It is operated by the National Pension Fund Association, and its premium is paid by the subscribers themselves. The second type of the defined-contribution pension schemes, the corporation-based DC pension, is a type of corporate pensions. Corporations may provide this type of pensions to its employees. The premium is entirely borne by the employer.

Corporations welcomed the introduction of DC schemes and many have shifted from the Defined-benefit (DB) corporation pension to the DC corporate pension. This is because corporations are realizing a huge burden of future pension payments, which is now labeled as liabilities under the new accounting system. Suffering from low-returns on their funds, corporations are eager to convert their DB pension schemes to DC schemes, in which future payments are related to the investment performance of funds, as opposed to the current system in which future payments are fixed at the beginning.

However, in the UK, there was a noticeable trend to convert to DC schemes in recent years, by closing the DB plan and providing the DC plan to new subscribers. But because a DB scheme is of value to the employees, and could serve a firm to differentiate itself from others when hiring new employees, business owners are shifting to a stance to maintain the DB scheme while also pursuing a more economical approach. As shown in Table 3.1, the DB and DC schemes both have their advantages and disadvantages, and it is desirable for both management and labor to consider which to adopt.

Table 3.1 Comparison of Defined-Benefit (DB) and Defined-Contribution (DC) Plan Characteristics

	DB Plan	DC Plan	Dominant Plan
Investment Choices	Participants have no control over the investment of pension money.	Usually participants make their investment decisions	DC
Investment Risk	Participants do not need to bear investment risk.	Participants have to bear all investment risk.	DB
Investment Returns	Participants can only collect the benefits defined in the DB formula even if the investment has favorable returns.	Participants are entitled investment returns.	Not Clear
Termination Portability	Participants leaving their job forfeit future indexation of benefits already accrued.	Participants could rollover and keep investing investment savings.	DC
Incentives	Participants have greater incentive to sustain a high level of effort over the entire career in order to achieve high career-end salary.	Participants have less incentive over their entire life than in the DB plan since their DC benefits depend upon the wage trajectory over their entire life.	DB
Wage-Path Risk	Benefits tied to wage used in the formula, mostly the final wage.	Benefits tied to career average earnings.	Not Clear
Life Annuity	Usually offers life annuity with favorable mortality rates	Most DC plans' distribution is lump sum. Participants might face unfavorable mortality rate when purchasing annuity in market due to adverse selection problem.	DB

Source: Tongxuan (Stella) Yang(2005), "Understanding the Defined Benefit versus Defined Contribution Choice," Pension Research Council Working Paper, Pension Research Council

3.5.2 Consecutive pension reforms

Aggravated by rapid aging, a low rate of economic growth, and near-zero interest rates, the National Pension and the Employees' Pension Insurance are facing difficulty in securing enough funds to meet the future burden of pension benefits. Various reforms to guarantee the sustainability, including the cutting back of future benefits, raising of premiums, or raising the pensionable age had taken place in order not to put too much burden on the future generations.

Recent reforms were made in 2004, 2009, and 2012. The reform of 2004 was as follows,

○Reviewing the benefit payment and contribution

(Introducing the insurance premium level fixation method and the macro-economy indexation, utilizing the pension reserve as resource funds, and raising the proportion funded by the national subsidy for the Basic Pension to 1/2. (* This will be implemented gradually as specified in the law.)

○Reviewing the system of the Old-Age Pension for Active Workers

(Reviewing the system of the Old-Age Pension for Active Workers who are in their early 60s, introducing the system of delaying pensionable age for those who are 65 years or over, and adjusting the amount of benefit payment of the Old-Age Employees' Pension for those insured employees who are 70 years and older.)

○Enhancing measures for the insured who engage in childcare

(Exempting premium payment for those who are on child-care leave and adjust the standard monthly remuneration during the childcare period)

○Reviewing the Survivors' Pension system

○Introducing the division of benefit payment and of the duration to be No.3 insured category in cases such as divorce.

Due to the political confusion, the reform of 2009 remained minimal and only the national subsidy proportion of the basic pension is raised to 1/2. Instead, the reform of 2012 was a major one and the contents were as follows,

Reform details	Implementation from
○The minimum requirement period for the premium payment is reduced from 25 years to 10 years	Oct.. 2014
○The national subsidy ratio is set permanently 1/2 for the basic pension	Apr. 2014
○Expanding the application of Employees' Pension Insurance to part-time workers	Oct. 2016
○Premiums are exempted during maternity leave	Apr. 2014
○The survivor's basic pension is paid to the motherless family	Apr. 2014
○The employee pensions(EPI, Mutual Aid Pensions) is made to be uniform one	Apr. 2015
○The pensioner support benefit is paied to the lower pensioner	Apr. 2015

3.6 Current issues of pension system

3.6.1 Non-compliance and difficulties of the National Pension

As noted before, one of the biggest problems of the *National Pension* is that there are a growing number of eligible and required persons who have not paid the premium in full. According to the survey in 2009, as much as 0.33 million persons have not subscribed to the National (Basic) Pension at all. In addition, in 2009, the ratio of persons who fully paid the monthly premiums was only 60.0%. The unpaid premium is especially found among the younger generation. To raise the compliance, the government had put in place a mechanism to exempt paying premiums for low-income persons. In 2006, the four-level exemption status was introduced, where previously there were only two levels. However, the number of people fully exempted from premium payment reached 5.21 million, and partially exempted was 0.52 million people. Of these people, if we exclude students (1.65 million people) and the legally exempted such as the disabled (1.14 million people), about 11.9% of persons required to pay a premium are exempted, which is placing a heavy burden on National Pension finances. Every effort is being made at central, prefectural, and municipal government levels to increase the premium payment rate.

3.6.2 Financial pressure on corporations

At the same time, corporate pension schemes are also facing a number of problems. The first problem is financial. Not only did the continuing recession of the Japanese economy and a very low interest rate make it difficult for corporations to keep defined-benefit corporate pensions, but it has also made it difficult for some corporation to keep paying the employers' contribution for the Employees' Pension. It is required by law to participate in the Employees' Pension Insurance for corporations of certain sizes and over, but some corporations have taken a drastic measure to dissolve their Employees' Pension Insurance, and make their employees subscribe to the National Pension, which does not require employers to share a part of the premium.

3.6.3 Accommodating various employment arrangements and life-styles

As mentioned before, the traditional Japanese working pattern of life-long employment with a single employer has been gradually diminishing. Many people now switch jobs and thus their pension status; therefore, change over the life-course. The pattern is more evident among women who tend to leave and re-enter labor force during raising children. Thus, it is becoming increasing harder to put in the required payment period for pension premiums. For the National Pension, to get the full benefit, one has to pay the premium for 40 years, and the Employees' Pension Funds also have, albeit shorter, required premium paying periods. Many people, especially women, are unable to put in the required duration, and are not qualified to get the full amount.

There has been also a big shift of employment arrangements from full-time to part-time, especially among women workers. However, the Employees' Pension does not include part-time workers, and many women adjust their working style in order to remain as Category No.3 (dependent spouse of subscribers of Employees' Pension). The 2004 Reform did not actually implement measures to correct this, but it has mandated the government to review and take necessary action within five years.

The 2004 Reform implemented the following changes to accommodate the changing life-styles: 1) extending the period of premium exemption for those taking maternity or paternity leave from one year to three years, 2) making it possible to divide the pension benefit of the Employees' Pension between husband and wife if they divorce, and 3) putting a time limit of five years for survivor's pension benefit for widows (widowers) younger than 30 years old and with no children.

Currently, 83.9% of all Japanese corporations offer retirement packages for their employees. A retirement package can be either a one-time lump-sum retirement allowance, or a life-long or limited duration pension, or both. The breakdown shows 26.8% of corporations combine lump-sum payment and pension, 10.7% offer pension only, and 46.4% offer lump-sum payment only. Even though the pension is gradually spreading its share, the traditional style of the lump-sum allowance is still the mainstream, and most employees choose to take a part or the entire amount of the retirement money as the lump-sum payment. In any case, it will be important for the private and public sectors to work together to offer pension and retirement benefit schemes that respond to increasingly diverse lifestyles.

3.6.4 Pension system adaptation to the globalized world

Due to the increasing number of foreigners living and working in Japan, or Japanese abroad, the internationalization of the pension system is required. The minimum requirement period for the premium payment was shortened from 25 years to 10 years in August 2012. Also, Japan had concluded social security agreements with other countries with an aim to resolve issues related to dual-enrollment in social security systems and international calculation methods of pension enrollment period. Currently in 2013, Japan has signed the social security agreement with 17 countries and is under negotiation or preparing to begin negotiation with 8 countries, as listed in Table 3.2. The number of countries entering the agreement is expected to increase in line with developments in the economy, globalization, and implementation of social security systems in developing countries.

Table 3.2 Status of International Social Security Agreements

Implemented	Germany, U.K., Republic of Korea, U.S.A., Belgium, France, Canada, Australia, Netherlands, Czech Republic, Spain, Ireland, Brazil, Switzerland
Signed	Italy, India, Hungary
Under negotiation	Luxembourg, Sweden, China, Philippines
Under preparatory negotiation	Austria, Turkey, Slovakia, Finland

Source: Ministry of Health, Labour and Welfare website at;
http://www.mhlw.go.jp/topics/bukyoku/nenkin/nenkin/image-shakaihoshou-gaiyou4.html accessed 25 Nov.2013

Source for Table 3.3 (next page)
The Data on Corporate Pensions (企業年金に関する資料), Pension Fund Association, 2012
Web-site of Ministry of Health, Labour and Welfare (MHLW)
http://www.mhlw.go.jp/topics/nenkin/zaisei/01/01-01.html in Japanese Access Aug. 25th 2013

Table 3.3 Outline of the public pension system in Japan

(All numbers are as of 2011, unless otherwise noted)

	Note	Public Pension			Semi-Private Pension	
		Basic Pension	Employees' Pension Insurance	Mutual Aid Pension	Employees' Pension Funds	National Pension Funds
Type of Insurance		Basic 1st Tier Mandatory	Supplemental 2nd Tier Mandatory	Supplemental 1/2/3 Tier Combined Mandatory	Supplemental 3rd Tier Optional	Supplemental 3rd Tier Optional
Insurer		Government	Government	Mutual Aid Associations	Employers of more than 500 employees	Government
Eligible persons	①	All residents (categories 1-3)	Category 2 private-sector workers under 65 who work at workplaces with more than 5 employees	National and local civil servants, teachers, etc.	Employees of above	Category 1
Number of subscribers (millions)	②	72.72	34.41	4.44	4.11	0.61
% to all residents(20-59years)	②/pop	90%	43%	6%	6%	1%
Number of current pension recipients	③	69.43	31.98	4.29	2.68	0.42
% to all subscribers	③/②	95%	93%	97%	65%	69%
Premium Type		Flat rate	Fixed % of salary	Fixed % of salary	Fixed % of salary	Subscriber's choice
Average contribution (% to total salary) Employee		--	7.50%	6.04～7.754%	1.2 ～ 2.5%	--
Employer		None	7.50%	6.04～7.754%	1.2 ～ 2.5%	None
Average contribtion (¥)	⑤	¥15,020(for Category 1 & 2),¥0 (Cat.3)	(including premium for National Pension)	(including premium for National Pension)		¥5,500～¥16,910
Average monthly salary of subscribers	⑥	Not Available	¥304,589	¥415,227		Not Available
Tax exemption Employee		Exempt	Exempt	Exempt	Exempt	Exempt up to ¥68,000
Employer		Exempt	Exempt	Exempt	Exempt	
% of subscribers exempt from paying premium		16.8%	0%	0%		
Benefit (Old Age) Type		Flat rate	Income-related	Income-related	Income-related	Premium-related
Calculation method		\792,100 x ((insured months + 1/2 x exempt months)/480)	(Monthly income * 0.55% * insured months * slide rate)+ dependants allowance	(Monthly income * 0.55% * insured months* slide rate)+ dependants allowance	Average monthly salary during insured months * fixed rate + alpha	Depending on premium & age at the time of entry
Average monthly benefits	⑦	¥54,612	¥149,334	¥264,011	¥40,658	
Replacement ratio (average)	⑦/⑥	Not available	49.0%	64%	Not available	Not available
Starting age	years	65	65	65	65	65
Benefits (Disability) Type		Flat rate	Income-related	Income-related		
Calculation method		¥990,100 (1st degree) or ¥792,100 (2nd degree) + dependents allowance	1st degree old age pension * 1.25 + dependents allowance, 2nd degree: old age pension + dependents allowance, 3rd degree: old age pension	1st degree old age pension * 1.25 + dependents allowance, 2nd degree: old age pension + dependents allowance, 3rd degree: old age pension		
Average monthly benefits		¥73,882	¥100,139			
Benefits (Widow/Widower) Type		Flat rate	Income-related	Income-related		
Calculation method		¥792,100+ children allowance for wives w/children	3/4 of old age pension for spouse or close family	3/4 of old age pension for spouse or close family		
Average monthly benefits		¥64,927	¥73,490			

Chapter 4 Health Care

4.1 Introduction

The health care service system in Japan is delivered by mandatory, non-profit public health insurance systems, and not by the service providers for profit. Japan's public health insurance system is composed of three types of health insurances: occupation-based, municipality-based, and a separate system for persons 75 years old and over. Every resident in Japan must belong to a public insurance as an enrollee. All health insurers are not-for-profit organizations. Health services are provided not only by public providers, but also private ones which satisfies the "non-profit" principle. Patients enjoy "freedom of choice," which assures people can select and contact the physicians in any medical institutions. The cost of medical care is financed through insurance premiums, tax revenues, and copayments. Elderly, infants and low income people are completely or partially exempted from copayments. Other people must pay copayments which are 30% of the total medical cost when they use medical services. According to income level and age of patients, the maximum amount of copayment is determined. Sustainability of the system depends on whether the inter-institutional redistribution of the burden can work or not, and whether enough human resources are available for service provision to elderly.

4.2 Public Health Insurance

4.2.1 History

Health insurance system in Japan has been continuously developing since the 1920s. At first, the Health Insurance Act was enacted in 1922. While occurrence of the Great Kanto Earthquake in 1923 made the enforcement of the law delayed until 1927, this public health insurance covered "blue color" workers in the factory and the mine. Secondly, the National Health Insurance act was enacted in 1938. This law widened the coverage of public health insurance not only to farmers, but also to the general public not covered by the Health Insurance Law. The National Health Insurance Law prescribed that municipalities could be insurers of the national health insurance for the people living in their regions. However, the law permitted that municipalities could choose not to establish the national health insurance, and that people could enroll the public health insurance by their decision. Hence there remained non-insured people. From 1939 through 1941, other public health insurance law started to cover the "white color" workers, including government officials. Furthermore, the public health insurance system also started to cover seaman by Seamen's Insurance Act in 1940. In summary, before WWII, the public health insurance system in Japan gradually developed by enacting different health insurance laws for each sub-group in the whole society.

Public health insurance developed further after WWII. Laws on public health insurance which had been enacted before the end of the WWII were consecutively used after the war. Hence the public health insurances had been taking over the characteristics before. Each law of public health insurance regulated its own financial budget, therefore their managements had been independent from each other. More importantly, lack of the law for comprehensive health insurance coverage implied that there remained the possibility that non-insured people existed. This defect was improved by the enforcement of the new National Health Insurance Act in 1961, with which Japan attained universal coverage. The new National

Health Insurance Act mandated all residents in Japan to enroll in the national health insurance, except in the case that they have already enrolled in other public health insurances.

The next issue of development of the public health insurance was the improvement of the insurance benefit, and improvement of the inequality in insurance benefit among different schemes. In the early 1960', expensive antibiotic drugs some steroid drugs and drugs for chemotherapy had been prohibited to use in public health insurance system. This restriction was abolished in 1962. It raised the health care cost, but the expanded cost was absorbed into the expanded financial surplus in the public health insurance system, owing to the high rate of economic growth.

In the early 1960', copayment rate was 50% for all of enrollees in the national health insurance, while it was 0% for the head of the household (principal enrollee) of the *Society-managed Health Insurance* and *Association-managed Health Insurance*. Thus the amount of the subsidy from the government to the insurers in the national health insurance was increased, in order to lower the copayment rate for the enrollees in the national health insurance.

The burden of copayment tended to be lager for patients with severe diseases or with chronic diseases. In 1960s, the municipalities started to subsidize the elderlies (over 70 years and older) so that their copayment rate became 0%. This subsidy to copayment for the elderly became universal in 1973. For people less than 70 years old, the High-cost Medical Care Benefit System was introduced also in 1973 to cap the burden of copayment.

In early 1970s, the oil crisis hit the Japanese economy. To prevent the rapid price increase, the government implemented policies to control economic activities, such as cutting public spending. These policies were successful, and then the recession came next year. It reduced the financial revenue of the government as well as the premium revenue of the insurers of the public health insurance system. The government started to fill the annual financial gap by issuing the national bond, and the governmental spending started to be reduced. Social security spending also started to be contained, along with the governmental subsidy to it.

In spite of the reduction in social security spending, the health care expenditure for elderly had been rapidly increasing. One of the reasons was the governmental subsidy to the copayment for the elderly. The health care cost for the elderly increased from 40 billion yen in 1973 to 67 billion yen in 1974, and to 87 billion yen in 1975. After 1975, the growing rate was very high. To contain the rapid cost increase, the new health care system for the elderly was needed. But the cost increase was not the only reason for the introduction of the new system. At that time, the elderly had only medical care services, not the services for the health promotion, preventive measures such as health check-ups, rehabilitation or nursing care. These services in collaboration with the medical care were needed to be supplied in a more integrated manner. Hence in 1983, the Health Service System for the Elderly was introduced. Per-diem basis copayment was introduced for medical care utilization.

The Health Service System for the Elderly is a part of inter-institutional fiscal adjustments with respect to health care cost for elderly. Since the mid-1980s, cost containment policies had been employed. Inequality of copayment rates between the different public health insurances were equalized to 30% in 2003. Inter-institutional fiscal adjustments with respect to health care cost for elderly had been strengthened,

and it developed to the Medical Care System for Elderly in the Latter Stage of Life in 2008.

4.2.2 Public health insurance system: Today

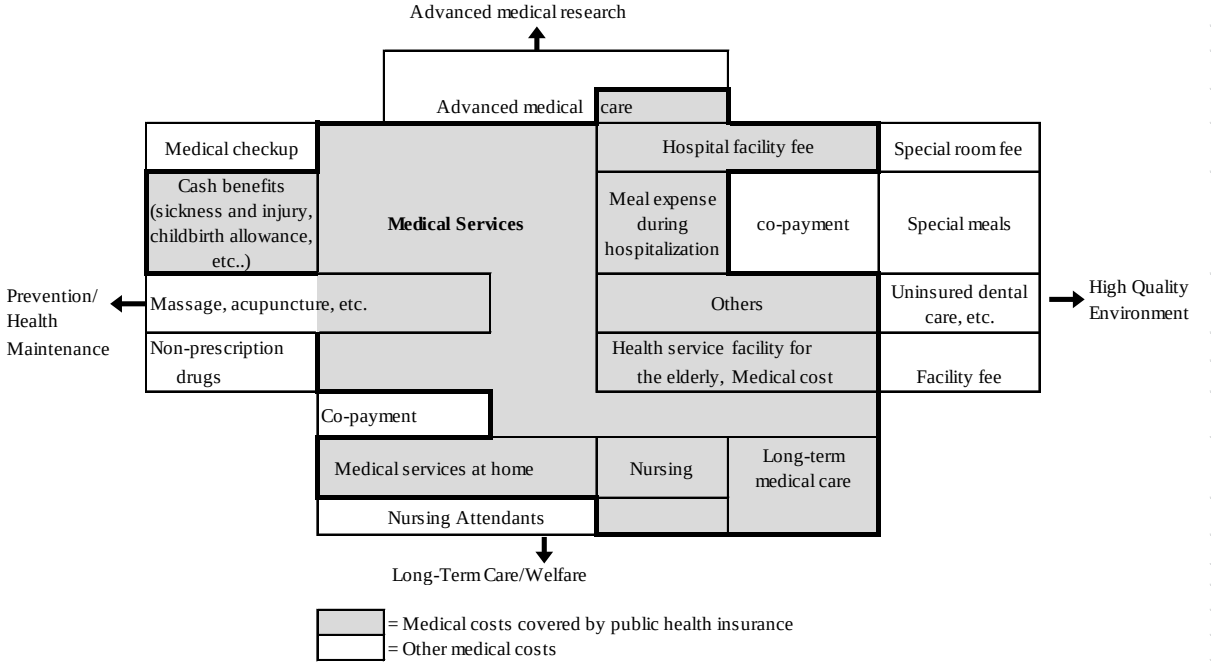
As stated before, Japan's medical services are financed through a public mandatory health insurance system, which is composed of three types of public health insurances: occupation-based, municipality-based, and separate health insurance for persons 75 years old and over. The elderly aged 75 or over enroll in public health insurance, which is called Medical Care System for Elderly in the Latter Stage of Life. Those who are below 75 years old enroll in occupation-based public health insurance or National Health Insurance. There are three types of occupation-based public health insurance. One is the health insurance for workers at firms of a certain size which are called the *Society-managed Health Insurance*. Each Large company has a duty to establish each firm based non-profit public health insurers to provide public health insurance coverage to their employees. For those who work at smaller firms, the Japan Health Insurance Association, which is the public association for the health insurance, provides a collective health insurance, which is called the *Association-managed Health Insurance*. In addition, special professions such as civil servants, private school teachers and employees, day laborers and seamen, form separate nation-wide professional associations.

Those who are below 75 years old and not covered by occupation-based public health insurance are covered by a National Health Insurance. The insurers of National Health Insurance are the municipalities, the local government which are closet to the community. This scheme covers self-employed people, workers engaged in agriculture, forestry and fisheries, workers of small businesses, the unemployed and pensioners.

These public health insurances provide universal coverage of the population in Japan. The outline of each system is shown in Table 4.1 (located at the end of this chapter). The National Health Insurance covers 31% of the total population, 27% for the Association-managed Health Insurance, 24% for the Society-managed Health Insurance, and 11% for the Medical Care System for Elderly in the Latter Stage of Life.

Insurance benefits are standardized throughout all public health insurance schemes. As shown in the Figure 4.1. The extent of the medical services covered by the public health insurance is discussed in the Central Social Insurance Medical Council, which members are consisted of representatives of clinical physicians and hospitals, of insurers in public health insurances, and of the general public. The council also discusses about the official tariffs of medical services. Based on the suggestions from the council, the Ministry of Health, Labor and Welfare decides the coverage and prices of the medical services.

Figure 4.1 The structure of the health care coverage by and beyond the public health insurance



4.2.3 Financing of health insurance

Generally speaking, the individual's health care expenditure is higher as her/his age is higher. This is also true in Japan. Hence the average health care expenditure per enrollee is highest in the Medical Care System for Elderly in the Latter Stage of Life (¥844,382 /year), because individuals more than 75 years old enroll in it, as we have already explained. Most of individuals aged between 65 and 74 enroll in the national health insurance, so that average health care expenditure per enrollee is ¥168,658 /year, higher than the ones in other occupation- based health insurances. The costs of the health benefit in public health insurances reflect this difference of enrollees' age structure as shown in the upper part of the Table 4.2.

Table 4.2 Financial situations of public health insurances (year 2009)

	Government-managed Health Insurance/ JHIA-managed Health Insurance	Society-managed Health Insurance	National Health Insurance (municipalities)	Seamen's Insurance	Late-stage medical care system for the elderly
Insurance benefit expenses	122,646	111,423	168,658	159,873	844,382
Late-stage elderly support coverage	41,519	41,105	31,102	40,764	
Levies for early-stage elderly	30,201	35,949	89	29,936	
Contributions for retirees	7,555	9,238		7,643	
Others	3,700	19,242	36,734		4,367
Total	205,621	216,954	236,584	238,217	848,750
Premium (tax) revenue	164,090	193,360	55,112	221,656	65,507
State subsidy	26,666	126	57,657	19,108	274,126
Late-stage elderly subsidy					361,262
Early-stage elderly subsidy			52,618		
Others	1,380	6,504	59,191		151,717
Total	192,139	199,994	224,576	240,764	852,620
Balance of ordinary revenue and expenditure	-13,482	-16,960	-12,006	1,911	3,862

Unit: yen per enrollees
Source: Ministry of Health, Labor and Welfare (MHLW), "Annual Health, Labor and Welfare Report 2012"

The public health insurance schemes are financed by premiums, subsidies from the general budget of the government, and co-payment from patients. Insurance premiums are one of the main financial resources for the public health insurance. Their methods of premium collection are different among the public health insurance schemes. Insurers of occupation-based public health insurance collect the premium by deducting the salaries. The lower and upper limits of the premium are set at 30/1000 and 120/1000, respectively. The premium of the National Health Insurance is collected through the direct payment to the municipality government by the subscribers on household basis. The premium consists of a proportional part based on the income, assets, and number of people in the household and a fixed part per household. Insurers in Medical Care System for Elderly in the Latter Stage of Life collect the premiums mainly by deducting the pension paid to the elderly.

Central, prefectural, and municipal governments subsidize the insurers of the National Health Insurance for their running cost. Central government subsidizes the 41% of the health care benefits, and the prefectural governments subsidize 9% of that. This amounts to ¥57,657 per enrollee as shown in Table 4.2. In case the insurance finance faces a deficit, the managing municipality will bear the cost as a form of subsidy to the insurer. This amount is included in the category “others” in revenue in Table 4.2.

We can see in Table 4.2 that insurance benefit cost is higher in the National Health Insurance and the Medical Care System for Elderly in the Latter Stage of Life, but premium revenue is lower in these two insurances. This causes a fiscal imbalance in these two insurances. To adjust the fiscal imbalance, inter-institutional fiscal adjustments have been introduced. Under this scheme, burdens of the health care cost for the elderly aged between 65 and 74 are reallocated among the insurers of public health insurance. The amount which the National Health Insurance receives from this fiscal adjustment is ¥52,618 per enrollee.

The Medical Care System for Elderly in the Latter Stage of Life for those aged 75 and older itself can be regard as a scheme for inter-institutional fiscal adjustments. The elderly aged 75 and over enroll in this system, and they must pay premiums. This premium finances 10% of the medical costs. Of the remaining 90%, 50% is covered by central and local governments’ subsidies and 40% by contributions from insurers of other insurance programs. The amount which the medical care system for elderly in the latter stage of life receives from this fiscal adjustment is ¥361,262 per enrollee.

Table 4.2 does not show the co-payment but the total amount of copayment is not negligible, as the co-payment rate is basically 30% for public health insurance systems in Japan. Payment is made every time a visit is made to a medical institution. Co-payment rate varies according to patients’ age and income, such as 20% for children below school age, or 30% for the high-income elderly more than 70 years old, who earn the same level of income as the working generation, 10% for most of the elderly more than 75 years old. The statutory co-payment rate is 20% for the elderly aged between 70 and 74, whose income levels are not so high. However, the co-payment rate for these people is temporally at 10% mobilizing a budgetary measure.

The High-cost Medical Care Benefit is applied to all public health insurance. This system aims to hold down the co-payment amount by setting a cap according to age and income, and the insurer bears the

difference between the cap and the payable co-payment amount. The cap amount is set lower for low-income earners. For example, the monthly cap for a low-income earner aged under 70 is ¥35,400, and under the Medical Care System for Elderly in the Latter Stage of Life, low-income earners only pay up to ¥8,000 for outpatient treatment, and up to ¥24,600 for hospitalization.

4.2.4. Problems in the public health insurance financing

As the aging of the population is still proceeding, the health care costs for the elderly will increase accordingly. This automatically increases the occupation-based insurances' burden of subsidy to the Medical Care System for Elderly in the Latter Stage of Life. The increased burden should be covered by increased amount of insurance premium in those insurances. However, the insurers' financial situations vary and it may be too heavy burden for some insurers. To make the burdens more equitable, the policy has changed to determine the amounts of subsidy by the total amount of enrollees' income. By this policy, insurers of occupation-based health insurances raise the premium rate only when their premium level is too low for the income level of their enrollees.

The National Health Insurance has a larger number of lower income subscribers and elder subscribers than the occupation-based health insurances. As a result, the relatively poorer enrollees are confronting the relatively higher premium rate. This leads to an increase of the unpaid insurance premium in the national health insurance. In 2011, the amount of unpaid insurance premium was 10.6% of the total amount of levied premiums. In social insurance system, the unpaid insurance premium means they lose the eligibility, and moral hazard occurs. To avoid this, target groups of the premium payment exemption have been enlarged. Also, extremely poor households are guaranteed access to medical services without the payment of premiums, based on the Public Assistance system.

4.3 Service provision

4.3.1. Overview

The fundamentals of the medical care provision systems were constructed before WWII. Management of the medical institutions satisfies the "non-profit" principle while owners of the medical institutions include the public and the private. Medical doctors are educated with a six years university education program and trained with five years training program after graduation. They can educate themselves to deepen their clinical specialties. General practice has not been explicitly recognized as one of clinical specialties, so that there are no general practitioners as clinical specialists. There has been no gate-keeping system. Patients can choose the medical institutions they want to visit. Therefore, the roles of community clinic and specialized hospitals have not been clearly separated. A patient can choose for their first contact the specialist in hospital outpatient department. In the mid-1970s, the copayment rate for elderlies was set at 0%. Evidently, it had inflated the usage of medical care among the elderlies. However, this was a precarious measure taken due to the scarcity of long term care facilities in those days. The 0% copayment rate was abolished in 1983 and together with the policies of increasing the long term care facilities, the efficiency in provision of the inpatient care services for elderly has been improved by the policies amendment of the medical institution law, and the policy inducement by the changing tariff for

medical care services. Introduction of the Long Term Care Insurance created many alternatives for elderly who need life support services other than inpatient care in hospitals. Now the issue is how to coordinate the medical care and the long term care.

4.3.2 Healthcare service provision: History

Before the Meiji era, physicians existed in Japan who were called “Kusushi” based on the oriental medicine at that time. They made diagnose, decided the prescription, and sold the pharmaceuticals to the patients. However, they were excluded from the practice by the certification regulation which replaced them by the physician educated by Western medicine introduced in the Meiji era.

Medical doctors sold pharmaceuticals to patients while they were educated on Western medicine. This was because there were few pharmacists at that time. Pharmacists hoped to achieve the separation of medical practice and drug dispensing, but it could not be attained, because of their weaker political power.

Hospitals based on Western medicine were first established at Nagasaki in 1861. The number of hospitals increased to 106 in 1878. Hospitals were established by the central government, local governments, and private citizens and organizations. In those days, there was no public health insurance. Hence poor people could not access medical care services. Japan Red Cross was established as the Hakuai-sha in 1878, and Social Welfare Organization Saiseikai Imperial Gift Foundation (The Saiseikai) was established in 1911. They constructed hospitals and started to provide the medical services to the poor.

In those days, physicians could start their private practice where they preferred (free-entry). Hence medical institutions were located densely at the urban areas because the medical doctor as the manager of medical institution wanted to keep their financial status better. This made accessibilities to the medical care unequal among geographic areas. In rural areas, for example, physicians could not earn enough bread because farmers were relatively poorer than other people, and could not pay the fee of the medical care services. On the other hand, it was said that physicians were so competitive in urban areas that they also could not earn their enough bread in those areas.

After WWII, the hospitals and clinics lost their functioning, personnel working in them, and even their buildings due to the results of the war. To increase the supply of medical care services, various policies were employed. Medical institutions controlled by the Department of the Navy and by the Department of War were merged into the Ministry of Health and Welfare, and those medical institutions were made available for utilization of the general public as the National Hospitals. The central government of Japan decided to make financial subsidy to private (but not for profit) medical institutions for their investment to hospital/clinic construction and/or medical equipment. Because of these policies and the effects of the long-lasting economic booms, the number of private hospitals and clinics expanded.

Local governments, as before WWII, established their hospitals and clinics. The Japan Red Cross, the Saiseikai, and other non-profit organizations also established medical institutions. These new investments contributed partly to the gradual improvement of the distribution of medical institutions. However, there has been no effective method to cure the geographical inequality of medical institutions distribution. In the mid-1980s, it was pointed out that regional variations of the inpatient care cost correlated to the supply of the inpatient beds. The medical institutions law was amended so that the

government could specify the area where the inpatient beds were over-supplied relative to the number of population in 1985.

Among the amendments of the medical institutions law since then, the second amendment of the law introduced the hospital categorization of Special Functioning Hospitals and the bed type categorization of "Long-term Care-type Beds" in 1992. Special Functioning Hospitals is a classification of the hospitals which provided high-technology and intensive inpatient care. The bed type categorization of "Long-term Care-type Beds" was introduced because the utilization of the beds was not necessarily based on the medical needs. In those days, as we have seen in section 4.2.1, the copayment rate for the elderly was 0%. This policy made the patients who needed support for living rather than medical care, utilize the unnecessarily inpatient care.

The Long Term Care Insurance law was enforced in the year 2000. Since that time, utilization of most long-term care beds was reimbursed not by the public health insurance, but by the Long Term Care Insurance. By the introduction of Long Term Care Insurance, the patients who had relatively less need for inpatient medical care were induced to use life support services.

The acute inpatient care was also reformed so that the services could be more efficiently supplied. In 2003, Diagnosis Procedure Combination (DPC) was introduced for trial as the classification tool of diseases. The reimbursement system for the acute inpatient care started to use the DPC in 2006. Reimbursement based on DPC is per diem basis. Hence it has no direct effect to shorten the average length of stay.

4.3.3 Healthcare service provision: Today

One of the characteristics of the Japanese health care system is the availability of beds and the long duration of stay in medical facilities. By definition, in the medical institution law, clinics can have less than 20 beds, while hospitals must have 20 beds or more. In 2012, there were 8,565 hospitals, 100,152 clinics, and 68,474 dental clinics in Japan. The number of beds in hospitals is 1,578,254 (12.4 beds /1,000 people), and the number of beds in clinics is 125,599 (0.99beds / 1,000 people). The average length of stay in the hospital is 31.2 days for hospitals and 17.5 days for clinics, which is much longer than 8 days for OECD countries.

Secondly, there exists no explicitly defined general practitioner, so that we have essentially no gate-keeping system. Medical doctors are educated for medicine in six year undergraduate courses. They must pass the National Medical Practitioners Qualifying Examination. After passing the examination, they are trained as a medical doctor in a five year post-university education course. After finishing the post-university education course, they are educated as specialists in their clinical specialty. The total number of medical doctors working in medical institutions is 288,850 (2.4 persons /1,000 people), 188,306 working in hospitals, and 100,544 in clinics. There are few foreigners who are working as clinical medical doctors; 1,580 in hospitals and 828 in clinics.

Thirdly, there is no nationally qualified nurse practitioner, who can practice nursing care independently, while the number of registered nurses who are working in hospitals is 725,560. They can work as registered nurses after a minimal three years education, and passing the national nurse qualifying

examination. In recent years, nurse-education is transferred from the vocational school to the university. Nurse education in the university takes 4-years. Graduation of the university nurse education course gives the eligibility requirements for the national nurse qualifying examination, not only for the nurse, but also for the public health nurse. Eligibility requirements for the national nurse qualifying examination for the midwife are given by finishing the university nurse education course with additional education courses for midwives. A nurse profession association issues the certificates of specialties of nursing in some areas; emergency nursing, cancer chemotherapy nursing, and so on. These may be seen as the same as clinical nurse specialists in other countries.

Fourthly, freedom of choice to utilize any medical institution is guaranteed by laws for all enrollees in the public health insurances. By this, patients by their decision can select a clinic or an outpatient department of hospitals. The free access is assured but it might cause inefficiency in the functioning of clinics and hospitals differentiated. Hospitals with high clinical functioning charge patients for extra fees in addition to the price based on the tariffs for medical care services. This charge is legally permitted. The amount of the surcharge varies from hospital to hospital.

Fifth, the tariffs for medical care services are determined in the Central Social Insurance Medical Council. The Council consists of the representatives of clinical physicians and hospitals, of insurers in public health insurances, and of public interest. Once in two years, the Council determines and updates the tariffs for medical care services as publicly regulated prices. The updates were made by evidences using the results of the Survey for the Financial Situation of the Clinics and Hospitals, and the results of the Survey for the Medical Care Utilization. The update is also the result of the political negotiation, and it is a political inducement tool. When the committee recognizes that there is need for expanding the utilization of some services, but that the low profitability inhibits the provision of the service, then the committee determines to increase its price to induce more medical institutions to provide it. The Ministry of Health, Labor and Welfare decides coverage and tariffs of the medical services, based on suggestion from the council.

Lastly, the medical institution must be non-profit. The notion “non-profit” means that financial surplus from running the medical institution cannot be shared to capital subscriber and/or investor. Financial surplus, if any, must be used for investment to the medical equipment, facilities, etc. or reserved as internal reserves. Exceptionally, private companies own the medical institutions, in order to promote employees’ health. In these cases, the management of those medical institutions must obey a non-profit principle.

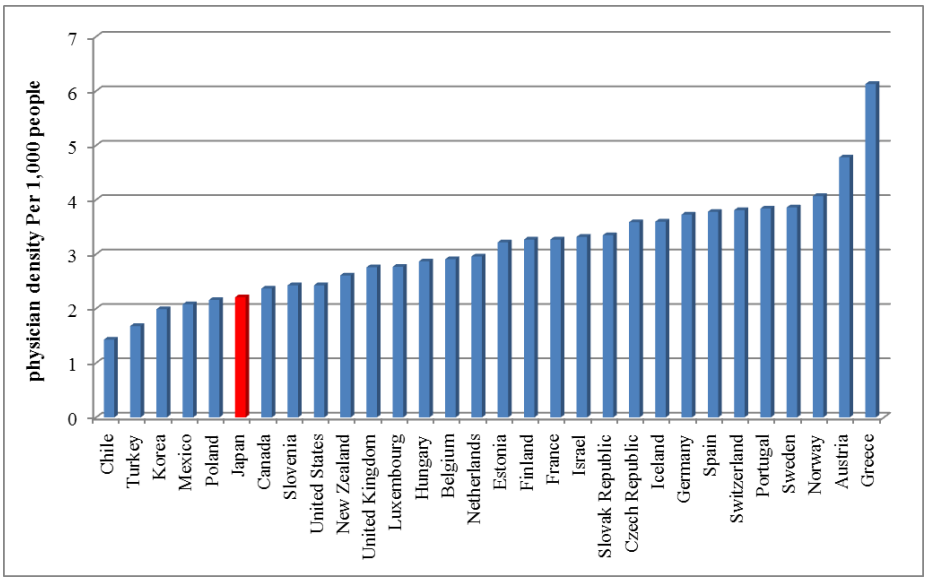
4.3.4 Current Issues in Healthcare service provision system

4.3.4.1 The lack of physicians

Aging implies that the number of elderly is increasing, who will need not only care for chronic diseases, but also acute care. Since the 1970s, at least one university with a department of medicine was established in each prefecture. It is thought in those days that this policy would satisfy the future need for physician services. However, the increase in medical doctors may not have caught up to the growing need due to rapid aging. As we have seen in section 4.3.2, the total number of medical doctors working in

medical institutions is 2.4 persons/1,000 people. This figure is relatively smaller than the ones in OECD countries (Figure 4.3).

Figure 4.3: International comparison of the number of physicians by OECD Health Data (in year 2010)



This problem is serious in the Tohoku area, which was hit by the Great East Japan Earthquake in 2011. Even before the earthquake, there were relatively few physicians in the Tohoku area. The earthquake hit not only people, but medical personnel and medical institutions as well, so that the number of physicians was decreased after the earthquake. Now it is under the discussion whether a new medical school should be established in the Tohoku area or not.

4.3.4.2 Establishment of an integrated community care system

Elderly people need medical care services and long term care services to support the independent living of the elderly. It is natural to think that both services are supplied to users with good coordination. In this point of view, the establishment of an integrated community care system is needed. To succeed in the establishment of it, communication should be promoted between the personnel in the long term care sector, and the ones in the medical care sector when their services are provided. Section 5.3.2 further explains other points on this.

Table 4.1 Outline of the Health Insurance System in Japan

		Health Insurance		Seamens' Insurance	National Govt Employees' Mutual Aid Association
1)	Name	Association-managed Health Insurance	Society- Health Insurance	Seamen	National Govt Civil Servants
2)	Eligible subscriber	Employees of Small-Medium firms	Employees of Large firms		
3)	Number of subscriber	19.496	15.906	0.062	1.077
	(millions) Dependents	15.210	14.431	0.082	1.234
4)	Insurer (number of organizations)	Japan Health Insurance Association	Health Insurance Associations (1,497)	Government	Mutual Aid associciation of each ministry (21)
5)	Premium rate:				
	Subscriber	4.75%	3.582% (avg)	4.55%	3.14 ～ 5.16%
	Employer	4.75%	4.358% (avg)	4.90%	3.14 ～ 5.16%
6)	Gov't Subsidy to:				
	Administrative cost	All	All	All	All
	Medical cost	13%	Fixed amount	Fixed amount	--
	Contribution for the health care for elderly	16.40%	--	--	--
7)	Co-payment:				
	Subscriber	30%			
	Dependents	30%（Children below school age 20**%**）			
	Inpatient meal expense	¥260/meal (for low-income family ¥210/meal for first three months, ¥160/meal after 3 months,			
	Maximum amount of copayment (inpatient care)	For patients under 70 years old; ¥150,000+(total cost of medical care services - 500,000)*0.01 (for high-income people) ¥80,100+(total cost of medical care services - 267,000)*0.01（General) ¥354,6000（Low-income people) ¥15,000（Very low-income people)※2			
8)	Allowance:				
	Childbirth allowance	¥420,000		¥420,000	¥420,000
	Funeral expense	¥50,000		¥50,000	¥50,000
	Fun.exp. for dependents	¥50,000		¥50,000	¥50,000
9)	Unemployment benefits:				
	Due to sickness	Standard daily remuneration * 2/3 per day		Standard daily remuneration * 2/3 per day	Standard daily remuneration * 2/3 per day
		Up to 18 months		Up to 3 years	Up to 18 months (except for TB 3 yrs)
	Due to childbirth	Standard daily remuneration * 2/3 per day		Standard daily remuneration * 2/3 per day	Standard daily remuneration * 2/3 per day
		42 days before birth, 56 days after		Unemployed days before birth, 56 days after	42 days before birth, 56 days after
	Due to unemployment	--		--	50% of avg. salary
10)	Disaster Relief:				
	For death			--	1 month of avg. salary
	For death of a family member	--		--	70% of monthly avg. salary
	For disaster	--		--	0.5 to 3 months of avg. salary, due to severness

Source: Ministry of Health, Labour and Welfare (MHLW) "Annual Health, Labour and Welfare Report 2009", National Institute of Population and Social Security Research (IPSS) "Shakai Hosho Tokei Nenpo, 2009"

All numbers are as of March 2009 unless otherwise noted.

Local Govt Employees' Mutual Aid Association	Private School Teachers & Employees' MAA	National Health Insurance			Medical Care System for Elderly in the Latter Stage of Life
Local Govt Civil Servants	Private School Teachers & Employees	Self-employed, farmers,etc.		Retired	Elderly aged 75 or over, and persons aged under 75 with a certain level of disability
6.027	0.507	35.97	3.522		13.458
2.944	0.348				
Mutual Aid associciation of each local govt (55)		Municipality (1,788)	National Health Insurance Associations (165)	Municipality (1,788)	Extended associations for the Medical Care System for Elderly in the Latter Stage of Life (managing entities)
6.08% 6.08%	3.84% 3.84%	Avg.premium per family ¥164,679 --	--	--	10%
All (by local govt) --	Partial --	All 43%	All 32～55%	All --	All 90%(※1)
--	--	--	--	--	
		30%（Children below school age 20%）			10%(※2)
		--	--	--	
or for most low-income family (70～74 years old)		¥100/meal)			Same as left
For patients aged 70-74 years old; ¥80,100+(total cost of medical care services - 267,000)*0.01 (for high-income people) ¥62,100（General) ¥24,600（Low-income people) ¥15,000（Very low-income people)					¥80,100+(total cost of medical care services - 267,000)*0.01 (for high-income people) ¥44,400（General) ¥24,600（Low-income people) ¥15,000（Very low-income people)※2
¥420,000	¥420,000	standard amount ¥420,000			
¥50,000	¥50,000	Set according to the law			
¥50,000	¥50,000	--			
Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient Up to 18 months (except for TB 3 yrs)	Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient Up to 18 months (except for TB 3 yrs)	Standard not set			
Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient 42 days before birth, 56 days after	Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient 42 days before birth, 56 days after	Standard not set			
60% of salary	60% of avg.salary	--			
1 month of avg. salary	1 month of avg. salary	--			
70% of monthly salary	70% of monthly avg. salary	--			
0.5 to 3 months of salary, due to severness	0.5 to 3 months of avg. salary, due to severness	--			

※1
Public funds approx. 50%
Contributions approx. 40%

※2
Co-payment rate is 30% for those earning the same level income as the working generation

Co-payment limit
¥80,100＋
(Medical expenses-
¥267,000) * 1%

Chapter 5 Welfare for the Elderly

5.1 Overview of the Welfare for the Elderly

Before the enactment of the Act on Social Welfare for the Elderly in 1963, welfare for the elderly had been mainly to accommodate frail elderly persons in asylum under the public assistance system. The Act of 1963 aimed to maintain physical and mental health of the elderly and to stabilize their livelihoods, and various welfare services for the elderly including intensive care homes and home help services were developed during 1960s. As free healthcare for those who were 70 years old and over was introduced in 1973, healthcare expenditure for the elderly expanded, and increased a financial burden on the government. The Health and Medical Service Act for the Aged in 1982 started to impose copayment for healthcare on the elderly, and also emphasized the importance of health promotion from the middle aged over 40 years old.

Around the same time, more people were getting aware of the problem of “social hospitalization” and bedridden elderly, which means that the elderly tended to be hospitalized even after their conditions no longer required medical care, because long-term care facilities and services were not enough and co-payment of these facilities were more expensive than that of the hospitals. In order to tackle this problem, in 1989 the Ministry formulated the Gold Plan (10-year strategy for the promotion of health and welfare for the elderly) so as to promote urgent development of care facilities and in-home services, and it was revised in 1994 as the New Gold Plan (new 10-year strategy for the promotion of health and welfare for the elderly), which enhanced home based care and led to argument of new long-term care system for the elderly.

Starting in April 2000, Japan introduced the Long-Term Care Insurance. This social insurance system covers the long-term care of the elderly, which was previously provided partly through the health insurance system and partly by the welfare measures for the elderly. The Long-Term Care Insurance grew out of the recognition that, due to changes in the society such as weakened community ties, increase in small-sized families, and increase of working women, financial and psychological burden of family facing the care for the elderly has become unbearably large. Furthermore, there was the limit of service provision under the existing health and welfare system because of increasing number of the elderly requiring long-term care for longer periods. The Long-Term Care Insurance is designed to share the burden of caring for the elderly among all members of the society.

5.2 Long-Term Care Insurance System

5.2.1 Principle of the Long-Term Care Insurance System

There are three basic principles for the Long-Term Care Insurance; support for independence, user-oriented system, and social insurance. Firstly, the system does not intend to simply provide personal care to the elderly who need long-term care, but emphasizes supporting the independence of them. Secondly, service users can receive comprehensive health, medical, and welfare services from diverse agents based on their own choices. Thirdly, those who are 40 years and over are compulsorily insured, and thereby the relationships between benefits and contributions are made clear, and the stigma of welfare

services is removed.

5.2.2 Insurer

Municipalities and special wards (hereinafter referred to as simply “municipalities”) are the insurers, because they have been engaged in health and welfare services for the elderly, and were expected to deliver services in harmony with community values. Insurers collaboratively work with the national government, prefectures, medical care insurers, and pension insurers, and take the role of (1) collecting insurance premiums, (2) managing fund, (3) assessing care needs, and (4) paying remuneration to service providers through a prefectural health insurance organization. For the sake of fiscal stability and administrative efficiency, some smaller municipalities organize an extended association as a regional insurer.

5.2.3 Insured

The primary insured persons are those who are aged 65 and over (Category I), and the subscribers of health insurance whose age are 40 to 64 years old are the secondary insured persons (Category II). Currently, about 29.86 million persons are subscribed as Category I and about 42.99 million persons, as Category II (as of the end of FY 2012). The premium is collected through municipality and deducted from pensions for the Category I, and through additional premium to be paid to health insurance for the Category II. Premium amount of the Category I is determined by each municipality, and thus differs from a municipality to another. Premium is income-related, and there will be measures to moderate the burden for low-income persons.

Those eligible to receive long-term care are all persons in Category I who are certified as requiring support or long-term care based on the Certification of Long-Term Care by the Certification Committee. Meanwhile, for Category II persons, care is limited to those requiring long-term care or support due to age-related diseases (=specified diseases) such as dementia and cerebrovascular disorder.

5.2.4 Service provision

Services provided by the Long-Term Care Insurance are mainly divided into two categories, preventive services and care services. Preventive services are provided for those certified as Support Level 1 or 2, and care services are for those certified as Care Level 1-5.

Types of preventive services include home-visit care, outpatient rehabilitation service, and short-term stay at a care facility. Types of care services include in-home services such as home help service and day care, and facility services such as intensive care home, long-term care health facilities, and sanatorium-type care facilities, and community-based services such as home-visit at night, day care for dementia patients, and small-sized multifunctional in-home care. According to the level of care needs, users can choose the type of services and providers, either publicly or privately managed.

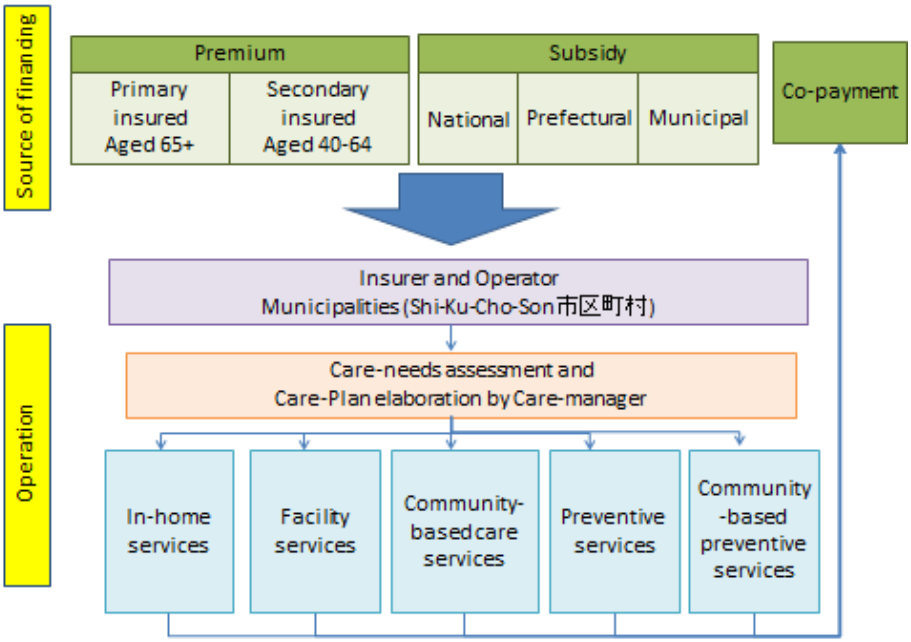
5.2.5 Source of financing

The cost incurred in the Long-Term Care Insurance is financed by premiums, public expenditure, and co-payment of users. Apart from the co-payment of the users, the cost is financed 50% by premiums (21%

by Category I, 29% by Category II) and 50% by public expenditure (for in-home services 25% by national treasury, 12.5% by prefectures, and 12.5% by municipalities, and for facility services 20% by national treasury, 17.5% by prefecture and 12.5% by municipalities). Within this framework the municipality can determine the rate of premium for the insured of Category I. The premium for Category I is charged based on total income of the insured, and reviewed once every three years. It was around ¥2,900 per month on average in 2000-2002 then the amount increased to ¥4,972 in FY2012-2014. For the Category II insured the rate will be 1.55% of salary and annual bonus in case of the Japan Health Insurance Association.

As a fiscal support for municipalities, prefectures set up the Fiscal Stability Foundation (financed from national treasury, prefecture and municipality) to give a temporary loan or grant when insurance budget deficit occurs because of more-than-expected service increase and unpaid premiums.

Figure 5.1 The overview of the Long-Term Care Insurance



5.2.6 Assessment of the care-needs

The users are classified into seven categories (“Support Level 1 and 2” and “Care Level 1 to 5”), depending on the severity of the care need. The limit of services provided is determined according to these categories. The user must be assessed by the municipality into one of the categories before applying for the services. For example, when a person faces a condition requiring support or care, the person or a family member must first submit an application for a long-term care requirement certification to the municipal office. Upon receipt of this application, a municipal investigator visits the applicant’s home for an interview on the physical/mental state, and aspects of daily life. The interview results are analyzed based on computer system so as to generate a preliminary assessment.

This assessment and opinion letter of the primary physician are then reviewed by the Certification Committee of Long-Term Care Needs, comprised of health, medical, and welfare experts. This Committee conducts a secondary assessment and decides the required care/support level. The municipality notifies the

applicant about the decision. Applicants who are not certified as requiring preventive or care services covered by the long-term care insurance can be eligible to receive long-term care prevention services under the community-support project conducted by the municipality.

5.2.7 Care Management

Once the care (support) level is decided, a personal Care Plan is created, which combines packages of care and support within the limit of services for each category. The creator of the Care Plan varies depending on the category. The Care Plans for those eligible to receive care services and requiring care level 1 to 5 are created by Long-Term Care Support Specialists (Care Managers) at in-home long-term care support businesses or care facilities. The Care Plans for those eligible to receive preventive services and requiring support level 1 to 2 are created at Integrated Community Care Support Centers (地域包括支援センター).

The Integrated Community Care Support is a scheme created in line with the emphasis on the preventive services when the law was revised in 2005. It serves as the center for elderly care, and is responsible for care management to prevent long-term care, creating Care Plans for preventive long-term care services, providing consultations to the elderly and their family, protecting elderly rights and early detection of abuse.

5.2.8 Remuneration for services

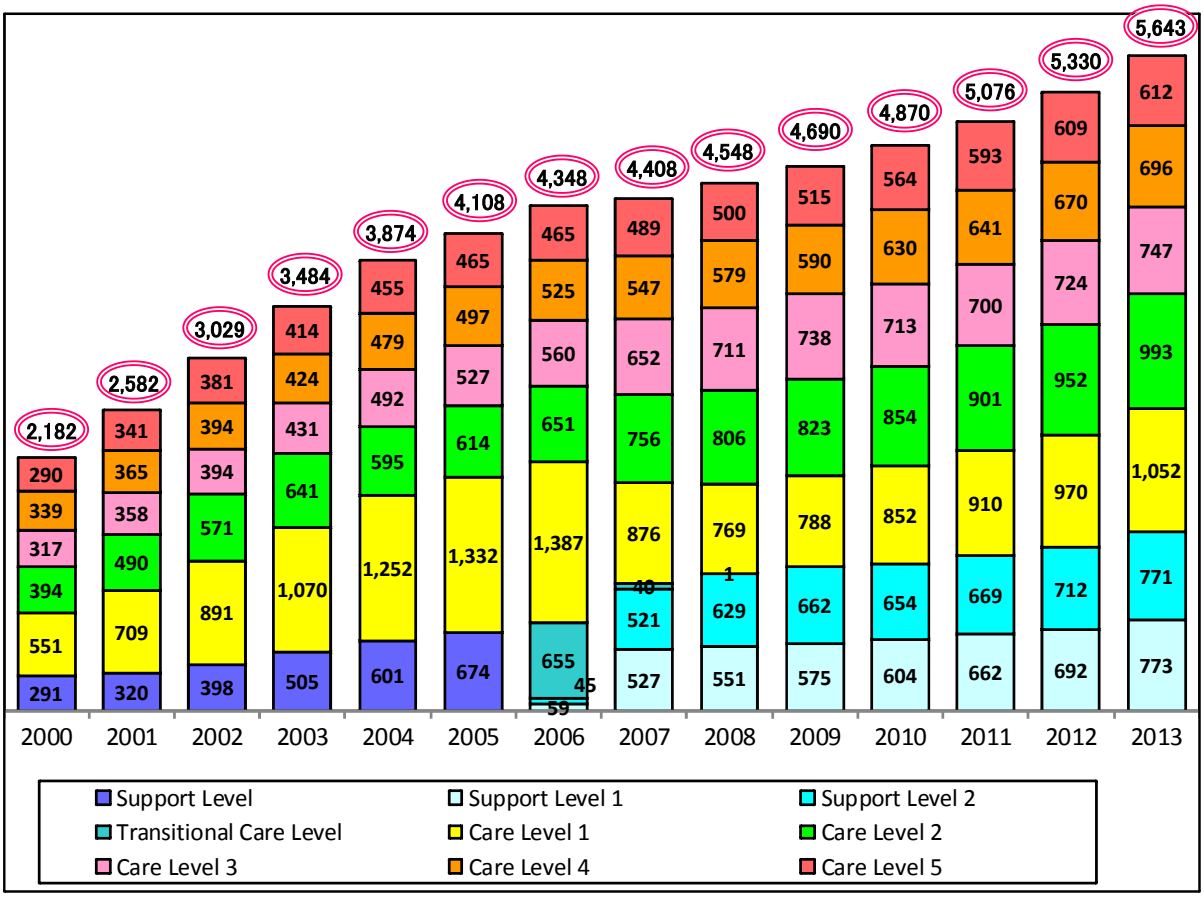
When long-term care providers deliver preventive or long-term care services for recipients, they receive remuneration for services based on the official price list of the Long-Term Care Benefit Expense, which is decided by the Minister of Health, Labour and Welfare according to a recommendation of Social Security Council. The price list consists of in-home long-term care/preventive services and facility services, and is revised every three years. 90% of a price is paid to a provider through a prefectural health insurance organization, and 10% by recipients as the co-payment.

5.3 Current Issues in the Long-Term Care Insurance

5.3.1 Financial Strain and the Reform of FY 2011

Soon after its enactment, it has become evident that the initial financial arrangement was not enough to meet the cost of the long-term care. As shown in Figure 5.2, the number of persons certified for the long-term care increased by more than 140% from 2000 (2.18 million) to 2013 (5.64 million). The number of care recipients also grew from 1.49 million (0.52 in facilities and 0.97 in-home care) in September 2000 to 4.80 million (0.88 in facilities, 3.56 in-home care and 0.35 in community-based services) in September 2013. The financial outlay grew steadily from ¥3.6 trillion (2000) to ¥8.2 trillion (2011).

Figure 5.2 The number of persons certified for the long-term care by care/support level (in 1,000)



Source: Report on the Status of Long-term Care Insurance, etc.

Notes: Data are of April each year. Due to the Great East Japan Earthquake, 11 and 3 municipality's data are not included in the data of 2011 and 2012, respectively.

With such circumstances, the long-term care insurance was reviewed and several reforms were put in place. The recent reforms in 2011 aimed to construct an integrated community care system which provides seamless supports comprised of healthcare, long-term care, prevention, housing, and livelihood support services, and to achieve sustainability of the system with a balanced relationship between contributions and benefits. The Act for Partial Revision of Long-Term Care Insurance refers to (1) enhancing collaboration between health and long-term care, (2) securing human resources for long-term care and improving quality of services, (3) improving housing for the elderly, (4) promoting measures to support people with dementia, (5) enhancing functions of insurers and promoting their autonomy, and (6) mitigating increase of insurance premium.

5.3.2 Establishment of an integrated community care system

The long-term care insurance system initially aimed to support the independent living of the elderly, and even if the elderly entered a state that required long-term care, it aimed to develop an environment where the elderly could receive treatment in the community with which they were familiar. To this end, the 2005 revision in the law established community-based care services and Integrated Community Care

Support Centers to ensure enhanced services and coordination at the municipality level.

However, the target has not achieved, as many issues remain such as elderlies having to enter a care facility even if they requested in-home care due to non-availability of proper service providers in the familiar community, lack of collaboration between medical institutions, care facilities, and in-home service providers, and insufficient number of elderly-friendly housing.

The integrated community care is defined as a community-based system that can appropriately provide various support services including healthcare, long-term care, prevention, housing, and livelihood support within daily living spheres in order to ensure safety, security, and health of people. The area of community is generally regarded as that accessible within 30 minutes, which are almost as large as junior high school districts. To establish this system, the following five aspects of action were set up: (1) enhancing collaboration with medical facilities, (2) improving and enhancing capacity and flexibility of long-term care services, (3) promoting prevention, (4) ensuring advocacy and livelihood support services such as meals provision service or housework assistance, (5) constructing and improving elderly-friendly housing. Central and local governments are involved in coordinating all the related programs to realize people living in the familiar community independently as long as possible.

5.3.3 Securing human resources of long-term care

The number of care workers has increased since the start of the Long-Term Care Insurance System, and it reached approximately 1.33 million workers (head count) in FY2010, increased sharply from 0.55 million (head count) in FY2000. Although the number has grown, long-term care providers always suffer shortages of long-term care human resources, as the demand for services continuously increase. It is regarded as a big challenge to secure the necessary personnel, and to improve their working environment. Basically, a majority of workers are female in the long-term care services, and most of them work part-time especially for in-home services, while most workers in facilities are full-timers.

In order to raise their wages, the Ministry took several measures such as additional payments for long-term care providers to improve working conditions. Providers can receive additional payments, if they could meet the requisite of improvement programs including a pay raise plan.

5.4 Welfare for the elderly other than the Long-Term Care Insurance

5.4.1 Housing for the elderly

Table 5.1 shows the outline of housing services for the elderly; 1) intensive care home, 2) group home for dementia person, 3) nursing home, 4) moderate-fee home, 5) fee based home, and 6) elderly housing with care services.

Intensive Care Home for the elderly is a day-care facility for persons aged 65 years and over who require constant nursing care services due to serious physical or mental disabilities. This service is provided mainly by the Long-Term Care Insurance benefits. Group homes for the elderly with dementia is a small facility in which dementia patients live together and receive care and supports with a homely atmosphere under the Long-Term Care Insurance. The capacity of a group home is defined as 5-9 persons.

However, based on the conventional system defined by the Act on Social Welfare Service for Elderly,

institutional services for the elderly are still provided. The nursing homes for the elderly are admission-type facilities for economically deprived elderly. In addition, moderate-fee homes for the elderly (care houses) provide residence and support services including meal services at low-cost.

In recent years, there are more fee-based homes for the elderly run by the private sector. These are considered as housing facilities rather than social welfare facilities for the elderly. When the elderly enters a contract with a service provider of fee-based home, they must pay the full expense by themselves, which sometimes causes financial trouble between a provider and a resident. The in-home service provided by the long-term care insurance can be used at these facilities.

Elderly housing with care services introduced in 2011 are run by the private sector, and required to register with the prefecture. The criteria for registration are (1) dwelling floor area 25 m^2 or more per dwelling unit in principle and barrier-free design, (2) provision of services including safety confirmation and daily life consultation, (3) extra consideration on contract to secure residence in case of long hospitalization, etc. There are subsidies to promote elderly housing with care services, and 3,478 buildings comprised of 111,966 units are registered by May 2013.

Alternatively, Silver Housing has been developed jointly by the Ministry of Health, Labour and Welfare and the Ministry of Land, Infrastructure, Transport and Tourism since 1986. It is a collective housing for single-person and married-couple households aged 60 years old and over, and usually Life Support Advisors are attached on site for counseling, consultation, safety confirmation, temporary home help, and emergency response. There is also public housing for low income households, and some of them are purpose-built for the elderly or disabled persons.

Table 5.1 The outline of housing service for the elderly

	1) Intensive care home for the elderly	2) Group home for the elderly with dementia	3) Nursing home for the elderly	4) Moderate-fee home for the elderly (care house)	5) Fee-based home for the elderly	6) Elderly housing with care service
Legal basis	Act for Welfare of the Aged, Long-Term Care Insurance Act	Act for Welfare of the Aged, Long-Term Care Insurance Act	Act for Welfare of the Aged	Act for Welfare of the Aged	Act for Welfare of the Aged	Act on Securement of Stable Supply of Elderly Persons' Housing
Basic Characters	Facilities for the elderly requiring constant long-term care	A shared house for the elderly with dementia	Facilities for environmentally and economically deprived elderly persons	Housing for the elderly with low income	Housing for the elderly	Housing for the elderly
Established by	Local governments, special welfare corporations	Business corporations	Local govenments, social welfare corporations	Local governments, social welfare corporations, corporations approved by prefecture	Business corporations	Business corporations
Area per dwelling	10.65 ㎡	7.43 ㎡	10.65 ㎡	21.6 ㎡	13 ㎡	25 ㎡

Source: Ministry of Health, Labour and Welfare (2013), The current situation and the future direction of the Long-term Care Insurance System in Japan: with a focus on the housing for the elderly.
(http://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ri_130311-01.pdf)

5.4.2 Five-year plan to support for people with dementia

In 2012 the Ministry of Health, Labour and Welfare published "Future Directions of Dementia Support," and announced the five-year strategic plan to support people with dementia. This plan aims to

create a society that respects dignity and makes people able to live in a familiar environment in the community as long as possible, even if they have dementia. In order to achieve the goal, the Ministry positively pursues new programs to change the conventional culture of care which often treats people with dementia to be in a psychiatric hospital or facility. The programs include newly developed standard care paths for dementia, early diagnosis and treatment, appropriate health and long-term care services to support living in the community, enhanced livelihood support for the persons with dementia and their family members, and personnel training.

5.4.3 Prevention of elderly abuse

Act on the Prevention of Elder Abuse, Support for Caregivers of Elderly Persons and Other Related Matters was enacted in 2005 for respecting the dignity of the elderly, preventing abuse, protecting those abused, and supporting caregivers. The Act defines that the elderly abuse includes abusive behavior by both family members and care workers. It specifies that municipalities are primarily responsible for implementing abuse prevention programs, while prefectures take the role in liaison and coordination of municipalities, collection and provision of information, and construction of facilities.

The following items are emphasized as the fundamental perspectives of abuse prevention program; (1) seamless supports from prevention of abuse to recovery from abuse (2) respect for the elderly persons' own decision making, (3) positive approaches to abuse prevention, (4) early detection and protection, (5) support for the elderly and their caregivers, (6) collaboration and cooperation of related organizations.

5.4.4 Relationship with other public care and support services

In regard to the relationship between the long-term care insurance and elderly services under the Services and Supports for Persons with Disabilities Act or Public Assistance, benefits of the Long-term Care Insurance Act have priority according the principle of placing priority on insurance. The services such as hearing aid, prosthetic hand/leg which are not covered by the long-term care insurance, are provided to the elderly with disabilities according to the Services and Supports for Persons with Disabilities Act. With regard to Public Assistance, for the extreme poor elderly, the benefits of the long-term care insurance are given priority, and the co-payment portion is covered by the Public Assistance system.

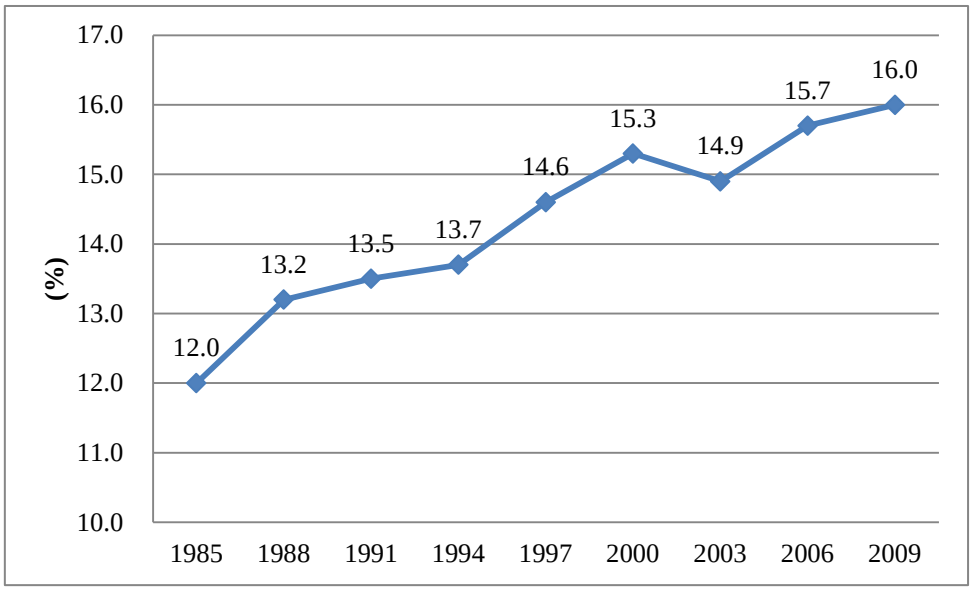
Chapter 6 Public Assistance

6.1 Re-emergence of poverty in Japan

Until recently, it was widely believed that Japan had solved the poverty problem. The notion that Japan had achieved economic growth and achieved an egalitarian society has sunk deep into the Japanese public consciousness so much so that it has become a source of national pride and identity. In fact, already back in the 1960s, the living standard of people was rising rapidly and problems of food shortage after World War II had become things of the past. The term “a middle-class nation” was coined to describe Japan in the 1970s and it was believed that all people, even the most disadvantaged, had benefited from the economic growth. The government stopped collecting and publishing statistics on poverty in the 1960s, and poverty dropped from the policy discourse.

However, Since the 1970s, Japan’s poverty rate has been rising steadily. As in Figure 1, the relative poverty rate of Japan has increased 4 percentage points from 1985 to 2009, making Japan one of the top five countries among the OECD countries with a high poverty rate.

Figure 6.1 Relative Poverty Rate of Japan



Note: relative poverty rate was calculated as percentage of population who fall below 50% of median equivalised household income.
Source: Ministry of Health, Labour and Welfare (2011).

The government has finally recognized the problem of poverty in the late 2000’s. In 2009, the Ministry of Health, Labour and Welfare announced the relative poverty rate and a number of measures to assist the poor started in late 2000’s and in 2014, the Law on Measures to Counter Child Poverty was enacted.

In this section, the Public Assistance program which still serves as the pillar of Japan’s policy against poverty will be described.

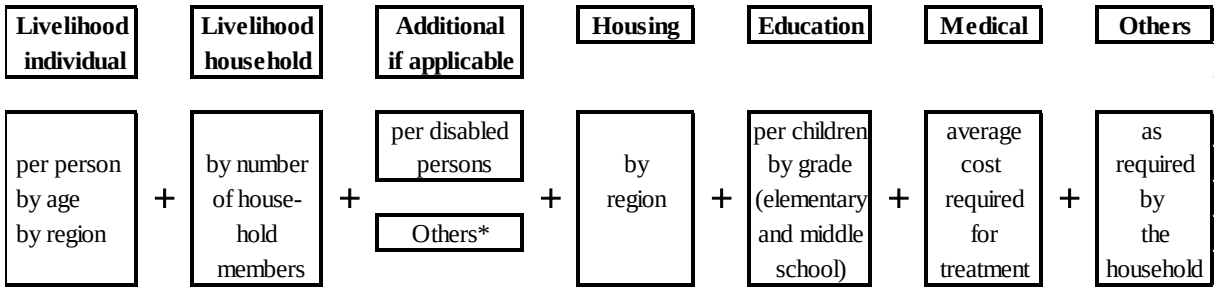
6.2 The Public Assistance program

6.2.1 General characteristics

The root of Japan's Public Assistance program goes back to poor relief before World War II. Today's Public Assistance program has its legal basis on the Public Assistance Act enacted in 1950. The Law stipulates four fundamental principles: (1) public assistance to the people in need is a responsibility of the state, (2) all citizens[1] have a right to claim public assistance without discrimination of sex, social background, and reasons for falling into hardship, and only the economic condition is the criteria of receiving assistance, (3) the state guarantees to all citizens a minimum level of healthy and cultural life, and (4) public assistance is a supplement to all resources available and the best efforts exerted by the applicant.

The Public Assistance is provided upon a receipt of an application from a household in need, and after a careful examination of the application. The assistance is calculated by subtracting the household's final income from the minimum cost of living (See Figure 6.2). In case the minimum cost of living exceeds the final income, the difference is given as the assistance. The minimum cost of living is calculated from seven categories of expenses: livelihood, housing, educational, medical, maternity, occupational, and funeral expense. The calculation of the minimum cost of living takes into consideration the differences in living costs among different regions of the country, and household members' age. All assistance is provided as cash transfers, except a few such as medical costs, which are provided as in-kind.

Figure 6.2 Determination of Monthly Minimum cost of Living



* Others include children under age of 3, pregnant women & sick persons being treated at home requiring special meals.

Items seen as One-Time Requirements and is provided in addition to monthly expense

1 Bed (if not in possession), clothes for new-born, diapers, etc.
2 Expenses for entering school
3 End-of-year expenses
4 House maintenance for electricity, water, etc.
5 Others

6.2.2 Means test

The principle (4) of Public Assistance states that Public Assistance must be a supplement to the

[1] The Public Assistance Law (New) excludes foreigners from this right, but currently, by order, legal foreigners are given "equal treatment as citizens". Illegal foreigners are not covered.

person's best efforts and available resources. In other words, the person is required to use all available resources, including assets, ability to work, as well as assistance from those who are required to support the person by law. Assets such as land, houses and farms must be sold, except in the case where the person is actually living or utilizing it and the value of the assets is higher when it is utilized than when it is sold. Household goods such as TVs are allowed if more than 70% of the population in the region possess the item.

As for the ability to work, the person will not be able to receive assistance if he/she is judged as capable to work. If the person has a will and ability to work, but is unable to find work, it is unlikely that he/she would be given assistance.

The civil law states that certain relatives and family members are required to support a person in need. Thus, public assistance is given only after it is judged that this support is not available. In practice, spouses and parents of a minor (less than 20 years old) have strong responsibility to support the person.

6.2.3 Statistics of recipients of Public Assistance

As of July 2013, 1,581 thousand households or 2,159 thousand persons (1.7% of the population) received some types of public assistance (monthly average). The share of the population receiving the assistance had declined until 1995, but since then there has been a continuous rise. Among those receiving assistance, elderly household make up the largest share, accounting for 45.2% of all recipient households, and has been increasing for some years. The share of households with a disabled or sick individual is also large, at 29.4%. About 7.0% are single-mother households, and the rest, 18.3%, are classified as "other types of households." The large share (87.5% in 2010) of households who receive Public Assistance have no working household members.

By age, those above 70 years old comprise the largest share (28.0%). Those between 60 and 69 years of age also consist 22.9% of the recipients. The elderly in general have high coverage rate (i.e. % of those who are recipients of Public Assistance among the general population of that age group). Little more than 2.0% of the elderly above 60 years old are the recipients of the assistance, where only about 0.88% of the children aged less than 5 and 0.39% of those aged between 20 to 29 years old were the recipients (Table 6.1).

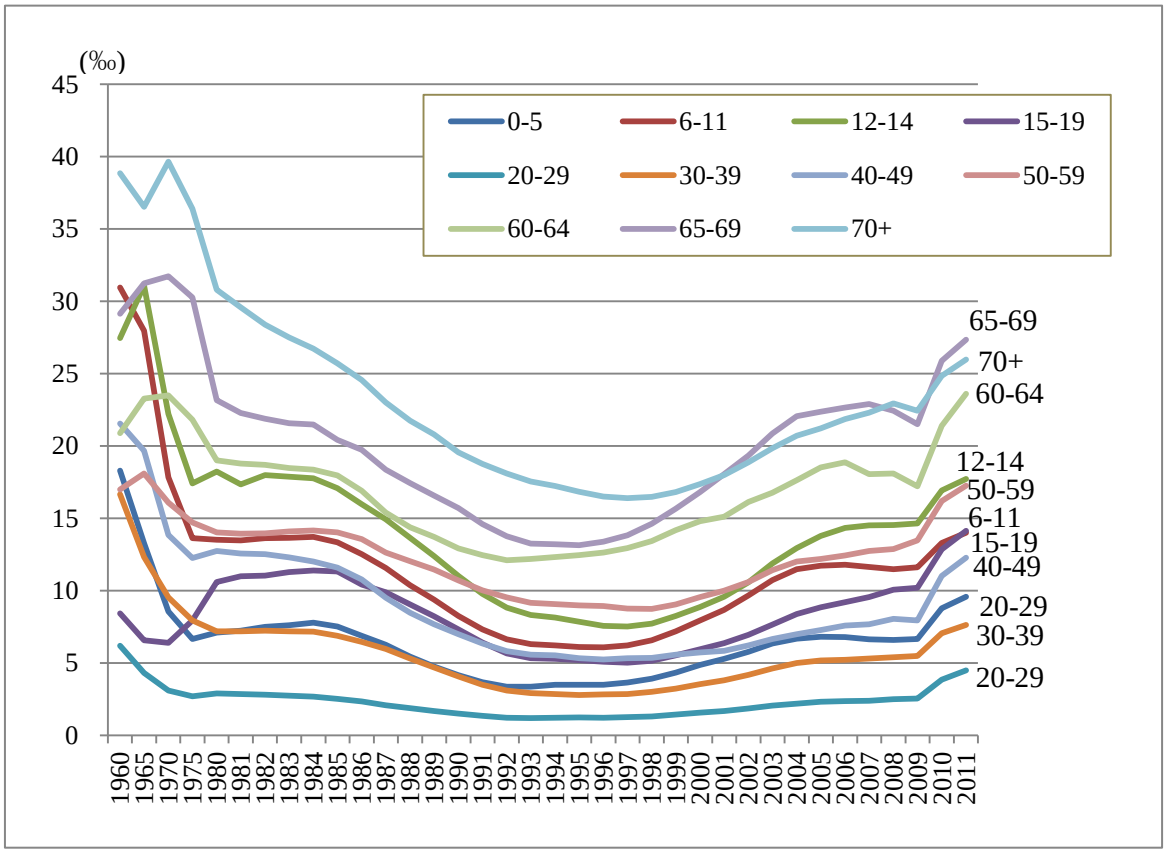
Table 6.1 Break-down by age, Public Assistance Recipients (2010)

Age	Share (%)	Coverage rate (‰ in Assistance)
<5	3.0	8.78
6 to 11	4.9	13.30
12 to 14	3.2	16.92
15 to 19	4.2	12.85
20 to 29	2.9	3.85
30 to 39	6.9	7.05
40 to 49	9.9	11.02
50 to 59	14.2	16.20
60 to 69	22.9	21.40
70+	28.0	23.41
Total	100.0	14.67

Source: Ministry of Health, Labour and Welfare (MHLW) "National Survey on Public Assistance Recipients"
Note: Data are compiled by National Institute of Population and Social Security Research (IPSS).

Figure 6.3 shows the number of recipients by age groups. The number of recipients dropped sharply after the 1960s in all age groups, reaching an all-time low in the mid-1990s, and increased again from the late 1990s to 2011. The sharpest increase in the number of recipients was seen in the 65 to 69 age bracket.

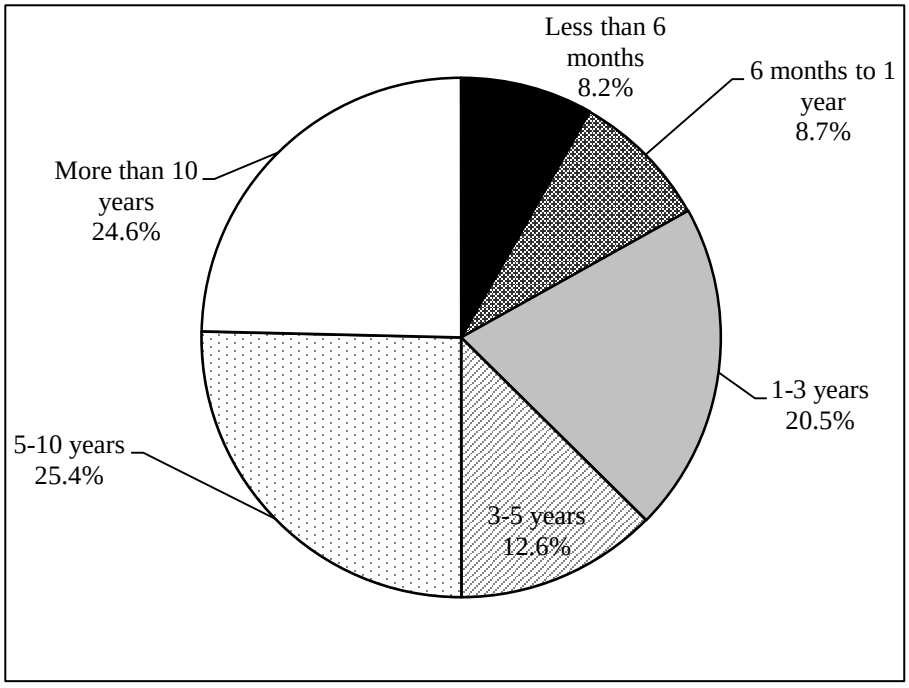
Figure 6.3 Percentage of those receiving Public Assistance, by age (1960-2011)



Source: National Institute of Population and Social Security Research, “Official Statistics on the Public Assistance System” http://www.ipss.go.jp/site-ad/index_Japanese/securityAnnualReport.html, based on the data of Ministry of Health, Labour and Welfare 2011

Figure 6.4 shows the duration of receiving the assistance, and while those who have been receiving for less than a year comprise nearly 17% of recipients, those who have been receiving for more than 10 years also comprise nearly 25%. The duration tends to be long because the majority of the recipients are elderly and there is not much prospect of them finding work.

Figure 6.4 Duration of Receiving Public Assistance



Source: Ministry of Health, Labour and Welfare (MHLW) "National Survey on Public Assistance Recipients"
Note: Data are compiled by National Institute of Population and Social Security Research (IPSS).

6.3 Current Issues

6.3.1. The 2013 Reform of the Public Assistance

The Public Assistance is one of the oldest programs among social security system in Japan. The recent upward trend in the number of recipients and expenditure of Public Assistance has become controversial, and the Public Assistance program has become one of the main targets for budget restraint in the policy debate. One of the criticisms of the program was that the benefit level is too high, compared to the income level of people who do not receive Public Assistance benefits. For example, the benefit level for single-mothers was pointed out to be higher than many single-mothers who are "managing on their own." While many scholars argue that this is not the problem of the benefit level, per se, the problem is the fact that many people do not receive the benefit even though their income level is so low (i.e. the take-up rate of the program is rather low. The take-up rate is the percentage of those who are actually receiving the benefit among who are eligible to receive the benefit.). The government had demolished the additional benefit which was previously given to single-mothers and elderly households by March 2007. However, the benefit for single-mothers was reintroduced in December 2009. From August 2013, the government decided to reduce the amount of Livelihood assistance, the major component of the minimum standard of living, by as much as 10% for some households, to compensate for the declining consumer price index. There is a wide spread outcry against this measure.

6.3.2 Emerging policies toward poverty alleviation

There have been a number of policy initiatives which target the poor in recent years. One of which, the Law to Assist those Experiencing Hardship (生活困窮者支援法), was debated extensively in 2012 and 2013, and was enacted in 2014. This law aims to establish comprehensive welfare service offices throughout the nation. It is intended as a one-stop service provider for those in need. Another initiative is the enactment of the Law on Measures to Counter Child Poverty as previously mentioned. It mandates the Japanese government to plan comprehensive policy to combat child poverty and to implement the plan. It states as the guiding principle that the aim of policies to combat child poverty is to realize a society in which a children's future is not influenced by circumstances in which they are born into. The law calls for basic policy framework to be enacted by the Committee on Combating Child Poverty which will be assembled within a year after its enactment, and mandates the government to announce the state of child poverty and policies every year.

Chapter 7 Family Policy

7.1 Family policies in Japan

Japan has faced a rapid aging of the population, which is caused by both a decrease in the fertility rate and an increase in life span. In order to stop the trend toward a society with few children, it is necessary to create an environment favorable to child rearing.

The major reason behind the rapid fall in the birthrate is the situation whereby women have to choose between either continuing to work or quitting working and having children, and are not able to choose various working styles. The increase in temporary employees and long working hours made it very difficult for the Japanese to achieve the lifestyle and the working style they wished for.[1]

Due to criticism against the pronatalist policy during World War II, the Japanese policies at present to tackle low fertility are oriented towards promotions for gender equality, life-work balance, and support for families with children. The Gender Equality Bureau of the Cabinet Office is in charge of the family policy together with related policies run by other ministries such as the Ministry of Health, Labour and Welfare or Ministry of Economy, Trade and Industry.

Japan ratified various international conventions related to human rights. The Convention on the Elimination of All Forms of Discrimination against Women in 1985, and the Convention on the Rights of the Child, 1994 were ratified. As a member of the international community, Japan improves various social measures for families.

7.2 Income support for families with children

7.2.1 Universal Child Allowance

Under strong political initiatives, a new Act of Child Allowance was enforced in April 2010, and soon after in April 2012 it was amended and an income threshold was reintroduced. The amended child allowance is paid to households with children up to 15 years old, with the income threshold as listed in Table 7.1. The amount varies from 5,000 yen to 15,000 yen according to the age of children and the income level of the households.

Table 7.1 Income Threshold for Child Allowance (2012)

Number of Dependents[1)]	Household income threshold (in 10,000 yen) after tax deduction (A) [2)]	Household income threshold (in 10,000 yen) before tax deduction (B)[3)]
None	622	833.3
1 person	660	875.6
2 persons	698	917.8
3 persons	736	960.0
4 persons	774	1,002.1
5 persons	812	1,042.1
More than 6 persons	+38.0/person	

[1] "White Paper on Society of Declining Birthrate 2013" (少子化社会対策白書 平成25年), Cabinet Office, Government of Japan

1) The number of Dependents include a spouse and other family members who can be eligible to receive income deduction under the tax act.
2) Annual Income of previous year (unit: ¥10,000)
3) (A) +tax exemptions = (B)

7.2.2 Child Rearing Allowance (for single-parent households)

The Child Rearing Allowance is given to a single-parent with limited income who is rearing a child/children of 18 years old or younger. The monthly allowance is ¥41,430 in the case of one child, ¥5,000 for the second child, and an additional ¥3,000 for each child including the third and subsequent children (2012). Before August 2010, only single-mother households were eligible for this allowance, but now both single-mothers and fathers can receive the allowance. The income threshold for the Child Rearing Allowance is calculated according to the number of children in a household. The income of family members other than the parent are also taken into consideration.

7.2.3 Special Child Rearing Allowance (for parents of children with disabilities)

Special Child Rearing Allowance is given to parents who look after their children with disabilities at home. The monthly allowance of child under the age of 20 is ¥50,400 for first degree, and ¥33,570 for second degree disabilities. In addition, the Welfare allowance for children with heavy disabilities is given to parents who take care of them at home. The monthly allowance is ¥14,280. On the other hand, the monthly allowance is ¥26,260 for those children who are over 20 years old. Children over 20 years old receive entitlements to the national disability pension according to their degree of disability.

Table 7.2 Family Allowances (2011)

	Child care allowance	Special child care allowance	Special allowance for persons with disabilities, etc.
Persons eligible	Mothers who take custody of and bring up a child who does not live with his/her father due to the divorce between his/her parents (a child is defined as a person who has not reached the year of his/her 19th birthday or a person who is younger than 20 years of age and has a disability) or other persons (e.g., grandfather or grandmother) who bring up such a child. Fathers who take custody of and lives with a child who does not live with his/her mother due to the divorce between his/her parents.	Fathers or mothers who take custody of a child younger than 20 who has mental or physical disabilities or other persons who bring up such a child (persons who live with, take custody of, and support such child).	i. Special allowance for persons with disabilities Persons with severe disabilities of 20 and older who are at home and are regularly in need of special nursing care in their daily life. ii. Welfare allowance for children with disabilities Persons with severe disabilities younger than 20 who are at home and are regularly in need of special nursing care in their daily life.
Monthly amount of allowance (Fiscal 2010)	First child: Income under ¥1.3 million: ¥41,720 Income ¥1.3 million or more but under ¥3.65 million: ¥41,710 to ¥9,850 (Monthly amount reduced in units of ¥10 depending on the income of the persons eligible) Second child: ¥5,000 added. Third child and after: ¥3,000 added.	First child: Grade 1 (in serious conditions): ¥50,750 Grade 2 (in moderate conditions): ¥33,800	i. Special allowance for persons with disabilities: ¥26,440 ii. Welfare allowance for children with disabilities: ¥14,380 Welfare allowance by interim measures: ¥14,380
Income limits (Income basis) (Fiscal 2010)	Persons eligible: (Two-member households) ¥3.650 million Supporters, etc. (Six-member households) ¥6.100 million	Persons eligible: (Four-member households) ¥7.707 million Supporters, etc. (Six-member households) ¥9.542 million	Persons eligible: (Two-member households) ¥5.656 million Supporters, etc. (Six-member households) ¥9.542 million

Sources: Japanese Social Security Statistics DB, http://www.ipss.go.jp/ssj-db/e/ssj-db-top-e.asp

7.3 Services for families with children

7.3.1 Day care centers for children

Municipal governments are required by the Child Welfare Law to provide day care centers for children whose parents are not capable of taking care of them for reasons such as work, illness, and care of other members of the family. Day care centers for children typically provide 8 hours of care for children aged from 0 to the age of kindergarten or primary school, but the demand to extend the hours has been increasing. The staffing and other quality measures are tightly regulated by the municipality. Fees for day care centers for children varies from 20,000 to 50,000 yen per month, according to municipality, the age of children, and the income level of the parents.

A long waiting list to enter day care centers for children is one of the urgent issues to be solved by the government, especially at the municipality level. To tackle the shortage of facilities, the municipality

governments are introducing new schemes of child day care at home by women with child rearing experience or who possess a license. On the other hand, as the total number of children is decreasing, the government has been integrating kindergartens and day care centers for children since 2006.

The Cabinet Office set a special task force to solve the shortage of nursery care service in October 2010. Approximately 2.2 million children are taken care of at the day care centers for children in April 2012, an increase of 36,000 since 2011. There are approximately 25,000 children who are on the waiting list in April 2012 according to the government estimation. That number has been decreased by 731 between 2011 and 2012. However, there are still long waiting lists, especially in urban areas in relatively big cities.

7.3.2 Foster homes (for Children of DV victims and without parents or guardians)

There have been increasing numbers of children suffering from domestic violence during the past decade, from 26,569 in 2003 to 66,701in 2012. Younger children are more likely to be victims (Table 7.3).

There are 58 facilities for protecting and supporting children in Japan where approximately 1,600 children were supported in 2011. An additional 4,3000 children were supported by foster parents in 2011.

Table 7.3 The number of Abuses against Children cases taken care by foster homes between April 2012 to March 2013

	Total	Physically	Sexualy	Mentary	Negrecterd	Abandand (republished)	Left behind (republished)
Total	66,701	23,579	1,449	22,423	19,250	44	209
Age 0-3	12,503	3,517	47	4,612	4,327	21	69
Age3-5	16,505	5,412	189	6,161	4,743	13	64
Age6-12	23,488	8,864	449	7,738	6,437	7	59
Age 12-15	9,404	3,777	409	2,613	2,605	3	13
Age 16 and over	4,801	2,009	355	1,299	1,138	-	4

Source; “Report on Social Welfare Administration and Services” of the Ministry of Health, Welfare and Labour, 2012

7.3 Work Life Balance

Japan as an “Ageing Society” was a consequence of a long declining fertility after World War II. Japanese women have a tendency to leave the labor market when they are rearing children. However, the female labor participation rate of those aged 30 to 34 increased from 74.8% in 1990 to 82.4% in 2012, and aged 25 to 29 increased from 79.0% in 1990 to 85.8% in 2012. However, there is a gap between married and single. The increase of single women’s labor participation contributed largely to raising the labor participation rate of those age groups. More women postpone their marriage in order to avoid cuts in opportunity cost by quitting their job. Therefore, the Work Life Balance measures supporting women to take both work and family responsibility became an important part of policy.

Besides promoting daycare service for pre-primary school children as well as low grade pupils in primary school, parental leave is the major support for households with children. 87.8% women take parental leave in 2011, however, among those who had the first baby between 2005 and 2009, only 38.0% of those stayed in the labor market in 2011. There are many women who quit their job after child birth and took parental leave. On the other hand, only 2.63% of men took parental leave in 2011. Therefore, the

government enforces measures to promote Work Life Balance by encouraging fathers to take leave. In principle, those who have children under age one can take parental leave (see the Table 7.4).

Table 7.4 The Continued employment benefits

As of September 2012

	Parental leave	Family-care leave
Eligibility	Insured persons who took a maternity leave to care for their infant under one year had, during the two years before such a leave started, 12 or more of a month which included 11 or more days used as the basis of wage payment.	Insured persons who took a family-care leave to care for a family member had, during the two years before such a leave started, 12 or more of a month which included 11 or more days used as the basis of wage payment.
Amount	Generally, 50% of the wage before the leave (30% during the leave and the remainder after employed for six months after reinstatement). If the child-care leave started on or after April 1, 2010, the benefits will be integrated and the total amount will be paid during the leave.	Generally, 40% of the wage before the leave.
Payment period	The period during which the individual care for an infant under one year (under one year and six months if it is considered that there are special needs).	Three months from the day the family-care leave started (93 days in total if the prescribed requirements are met).

7.4 Public health measures for mother and children

Mother and child are protected by the Maternal and Child Health Act enacted in 1965. Health check-ups and counseling are provided by local governments to expecting mothers from the 23rd week-pregnancy and up-to three year old children free of charge. The Mother and Child Health Notebooks, called “Boshitecho（母子手帳）” in Japanese, are given to all expecting mothers. Japan's infant mortality used to be as high as 150-160 per thousand births until the early 20th century, but declined sharply since the 1920’s and attained an extreme low level below 10 in 1975. Japan's current figure of 2.3 (2011) is one of the lowest even among developed countries. This may well be regarded as a triumph of Japan's MCH policy.

Right after the end of World War II, due to the post-war baby boom together with prevailing poverty, the health condition of mothers and children deeply worsened. Under such circumstances, the Eugenic Protection Act was enacted in 1948, which authorized certified doctors to perform induced abortion on women pregnant 21 weeks or less, under the condition that the pregnancy or delivery is likely to jeopardize the pregnant woman’s health either physically or economically, or the woman became pregnant as a result of rape. The certified doctors are required to report the number of abortions performed, and if the aborted fetus is 13 weeks or older, it must be registered as still birth. The law has since been amended, and is now called the Maternity Protection Act, and the practice continues although induced abortion is and should be regarded as a last resort to terminate the pregnancy.

7.5 New perspectives for Family Policy in Japan

There were 241 children who lost both their parents, and 1,483 children who lost one parent due to the Great East Japan Earthquake which hit the Tohoku area in Japan on March 2011. According to the government report, the counseling needs were high among victims of the disasters due to the difficulties they faced during evacuation. An act for supporting children and victims of disaster[2] was enacted in June 2012. This act was focused on the victims of nuclear power plants accidents.

The measures for improving the birth rate are implemented not only in the fields of social measures but also of health services. For instance, financial support for couples suffering from infertility started in 2006, which would grant the twice a year 150,000 yen operation cost of in vitro fertilization with a maximum duration of 5 years. A new scheme of compensation for delivering accidents was introduced in 2009. Lump sum payments are given to families who raise children with heavy cerebral palsy caused by delivering accidents.

The poverty of households with children is one of the major issues which the Japanese government is tackling. In June 2013, the Law on Measures to Counter Child Poverty was promulgated.

[2] Official name is "Act Concerning the Promotion of Measures to Provide Living Support to the Victims, including the Children, who were Affected by the TEPCO Nuclear Accident in Order to Protect and Support their Lives（被災者生活再建支援制度）"

Chapter 8 Policy for People with Disabilities

8.1 Policy for people with disabilities in Japan

Internationally, the government of Japan signed the Convention of Rights of People with Disabilities in 2007, but it has not been ratified yet. Since the number of countries who have ratified this convention is as many as 138 (as of October 2013), the Japanese government improves various social measures for people with disabilities, and is preparing conditions so that ratification of the convention may be made.

Under six welfare acts, including the Public Assistant Act, Child Welfare Act, Act on Welfare of Physically Disabled Persons, Act on Welfare of Mentally Retarded Persons, Act on Social Welfare Service for Elderly, Act on Welfare of Mothers with Dependents and Widows, services are provided to people with needs of such services. The welfare system according to the type of disability (physical disability, mental retardation, mental diseases) caused the difference that the level of the facilities accommodation and the user-charge of the medical expense are different in each type of disability. Since the number of people with physical disabilities, people with mental retardation, and people with mental diseases amounts to 3,663,000, 547,000, and 3,233,000 respectively in the middle of the 2000s (Table 8.1), it is necessary to unify systems and to reduce differences between the systems by the kind of disability.

Table 8.1 The number of people with disabilities in 1,000 (2013)

		Total	At home	Institutionalized
Persons with physical disabilities	Younger than 18 years of age	98	93	5
	Older than 18 years of age	3,564	3,483	81
	Total	3,663	3,576	87
Persons with intellectual disabilities	Younger than 18 years of age	125	117	8
	Older than 18 years of age	410	290	120
	Age unknown	12	12	0
	Total	547	419	128
		Total	Outpatient	Inpatient
Persons with mental disorders	Younger than 18 years of age	179	176	3
	Older than 18 years of age	3,011	2,692	319
	Age unknown	11	10	1
	Total	3,201	2,878	323

Sources: Cabinet Office *White Paper on People with Disabilities, 2013*, Table 1“The Number of People with Disabilities (Estimated values)”. http://www8.cao.go.jp/shougai/whitepaper/h25hakusho/zenbun/h1_01_01_01.html#z1_01(in Japanese). The data in this table are based on the following statistics: “Persons with physical disabilities” living at home: Ministry of Health, Labour and Welfare (MHLW) “Survey on the Actual Status of Children/Persons with Physical Disabilities” (2006), Living in an institution: MHLW “Survey of Social Welfare Institutions” (2006), “Persons with intellectual disabilities” living at home: MHLW “Comprehensive Survey on Children/Persons with Intellectual Disabilities” (2006), Living in an institution: MHLW “Survey on Social Welfare Institutions” (2005), "The Mental Disorder", The Survey of the Patient’s: MHLW (2011)

In order to establish the coordination between such systems classified by the type of disability, the Services and Supports for Persons with Disabilities Act (SSPDA) was enacted in 2005. Based on this act, a new scheme of service for three types of disabilities, including physical disabilities, mental retardation, and

mental diseases, was introduced in 2006. However, there was a strong resistance to introduce cost sharing among people with disabilities. Under the Democratic Party, the discussion of reforming SSPDA was started and the amendment bill including the reexamination of cost sharing (i.e., mitigation of user charge according to income) was approved in the Parliament in December 2010. Finally the effort of such law revision bore fruit, and a new law (the Act for Comprehensive Welfare for Persons with Disabilities) that corrected various incompleteness of SSPDA was enacted in June 2012.

8.2 Various forms of support

8.2.1 Income support

The National Pension includes a scheme for adults with disabilities. It is called the Disability Basic Pension. The pensioners include the persons who obtained disabilities in his/her childhood and those who were born with disabilities. The Employee Pension includes a scheme for former employees who became disabled while they were employed. Under the mutual aid associations, there are similar schemes for former employees with disabilities including civil servants both of central/local governments and teachers/employees of private schools. Also, under the Workers' Accident Compensation Insurance, employees can receive pension for the loss of ability due to injury and sickness at work. There are also similar workers' accident compensation schemes for civil servants.

Table 8.2 Income support for the People with Disabilities, 2012

Pensions	National Basic Pension	Employees' Pension Insurance
Type	Flat rate	Income-related
Amount (Yearly amount)	¥983,100 (1st degree) or ¥786,500 (2nd degree) + dependents allowance	1.25 * Amount of Old Age Pension (1st degree) or 1.00 * Amount of Old Age Pension (2nd degree)
Eligibility	Over 20 years of age, who have paid 2/3 of premium period, and those who are under 20 at the time of becoming disabled and who have turned 20	For those who have become disabled during insured months (for those under 300 months of insurance period, 300 is applied)

Source: Annual report on social security statistics 2009, National Institute of Population and Social Security Research (IPSS)

Other than public pension benefits, there are allowances paid under certain conditions of disability by local authorities. However, the allowance is not a universal scheme, but an individual local authority provides it out of its own budget.

8.2.2 Service to support people with disabilities

The Act for Comprehensive Welfare for Persons with Disabilities was promulgated in June 2012, and reorganized the scheme of service for people including children under 18 years old with disabilities. The Act aims at three goals. The first is an inclusive policy of three types of disabilities, i.e. physical, intellectual, and mental disabilities. The second is a reorganization of services providing schemes in order

to position the people with disabilities in the center. The third is enforcement of active labor participation of people with disabilities.

Table 8.3 Scheme of service under the Services and Supports for Persons with Disabilities Act (SSPDA)

Nursing care services	Home nursing care (Home help)	Assist with bathing, toileting, and eating at home
	Nursing care for the severely disabled	Assist severely disabled persons who require constant nursing care with bathing, toileting, and eating at home, and also provide outing assistance
	Support for activities	Outing assistance and necessary support to avoid danger surrounding persons with disabilities who have limitations in making personal judgments
	Comprehensive support for the severely disabled	Comprehensive program to provide multiple services including at-home care for persons having substantial need for nursing care
	Day services for children	Training on basic daily activities and orientation to adjust to group living offered for children with disabilities
	Respite care service	Respite care (daytime and nighttime) at facilities with bathing, toileting and eating, in case family caregivers become ill or unable to provide the necessary nursing care
	Nursing care	Daytime assistance for persons who require medical attention and constant nursing care including functional training at medical institutions, medical management, nursing care, and personal care
	Personal care	Daytime assistance for persons who require constant nursing care including support with bathing, toileting and eating, and provision of opportunities for creative/productive activities
	Nighttime care at support facilities for the disabled (Facility entrance support)	Nighttime support for persons entering care facilities including bathing, toileting, and eating assistance
	Care home service	Nighttime or holiday support at group living residences including bathing, toileting, and eating assistance
	Independence Training (rehabilitation, daily life training)	Training provided for a certain period of time to improve physical function and daily living abilities so that the person can achieve an independent daily/social life
Training services	Employment shift support	Training provided for a certain period of time to enhance necessary knowledge and skills for employment, offered to persons who wish to be employed in an ordinal corporation
	Continuous Employment Support (Type A: Employment, Type B)	Provide work place and necessary training to enhance knowledge and abilities for persons who have difficulties working in an ordinal corporation
	Group living support (Group homes)	Nighttime or holiday services at group living residences including consultation and daily support
	Transportation support	Assist disabled persons who have difficulties in transporting themselves outdoors
Community life support services	Community activity support center	Facility offering opportunities for creative/productive activities and promoting social interaction
	Welfare homes	

Source: Web-site of Ministry of Health, Welfare and Labour (http://www.mhlw.go.jp/bunya/shougaihoken/service/taikei.html).

The residential service regrouped with two types, which is day activities and residential support. Within the day activities, there are the care benefit, the training benefit, and the community based support programs. (See the Table 8.3)

8.2.3 Promotion of vocational rehabilitation services and employment of people with disabilities

As there are lots of challenges for people with disabilities to be employed, vocational rehabilitation services that include vocational evaluation and guidance, work preparation support, assessment of persons with intellectual disabilities, and comprehensive employment support for persons with mental disabilities are very important. These services are provided by Local Vocational Centers and Large Region Vocational Centers for People with Disabilities under the Law for Employment Promotion of Persons with Disabilities.

The employment of people with disabilities in many cases requires employers to pay extra costs for preparing special accommodation in the workplace facility, equipment, and environment modifications, and adoption of special personnel management programs. In order to promote and secure employment of people with disabilities, the government provides the subsidy that fills up these costs of the company employing the people with disabilities. On the other hand, the government imposes a surcharge if a company does not attain the employment rate for the people with disabilities. This system (The levy and grant system for employing people with disabilities) is enforced under the “Law for Employment Promotion of Persons with Disabilities.”

8.3 Current Issues

There are similarities between welfare services for people with disabilities and long-term care for the elderly in terms of offering care to the person who has needs. The recent reform of the long-term care insurance for the elderly greatly promoted replacing the facility centered services with the integrated community care support coupled with home care services. A similar trend is now starting for the environment surrounding persons with disabilities, so that they can continue to live in the community which they got used to. According to the flow of such reforms, the Law for Promotion of Dissolution of the Discrimination for People with Disabilities was enacted at last in 2013. By this law, one of the conditions of ratifying the Convention of Rights of People with Disabilities is filled, and the day of ratification is approaching even in Japan. The welfare policy for people with disabilities in Japan is continuing to develop along with the current improvement of global welfare, though there are remaining various tasks.

Chapter 9 Labour Insurance

9.1 Overview

Although Japan's unemployment rate continues to remain at a relatively low level compared to other advanced countries, it has gradually risen since the late 1990s. The length of job tenure that used to be regarded as one of the characteristics of the Japanese labor market has also declined in recent years[1]. As stable jobs have decreased, there is a growing need for support for unemployed persons. This chapter lays out two social security programs: Employment Insurance and Workers' Accident Compensation Insurance. In Japan, the term "Labour Insurance" is used to indicate these two social insurances. Schemes of the two insurances are independent of each other, but both have similar characteristics in that the government is the insurer, and the prefectural labour bureau collects the insurance premiums.

9.2 Employment Insurance

9.2.1 Basic Scheme

Employment Insurance consists of three main pillars: unemployment benefits, service for employment stabilization, and service for developing human resources. Through the unemployment benefits, cash benefit is provided in case an employee loses the job, which can be used as livelihood support, and for the promotion of reemployment. The unemployment benefits include a variety of benefits such as the Job Applicants' Benefits, Employment Promotion Benefits, the Education and Training Benefits, and the Continuous Employment Benefits. These items are further explained below. The service for employment stabilization is provided to support employers to prevent them from laying off their employees. The service for developing human resources assists both employed and unemployed persons to acquire skills.

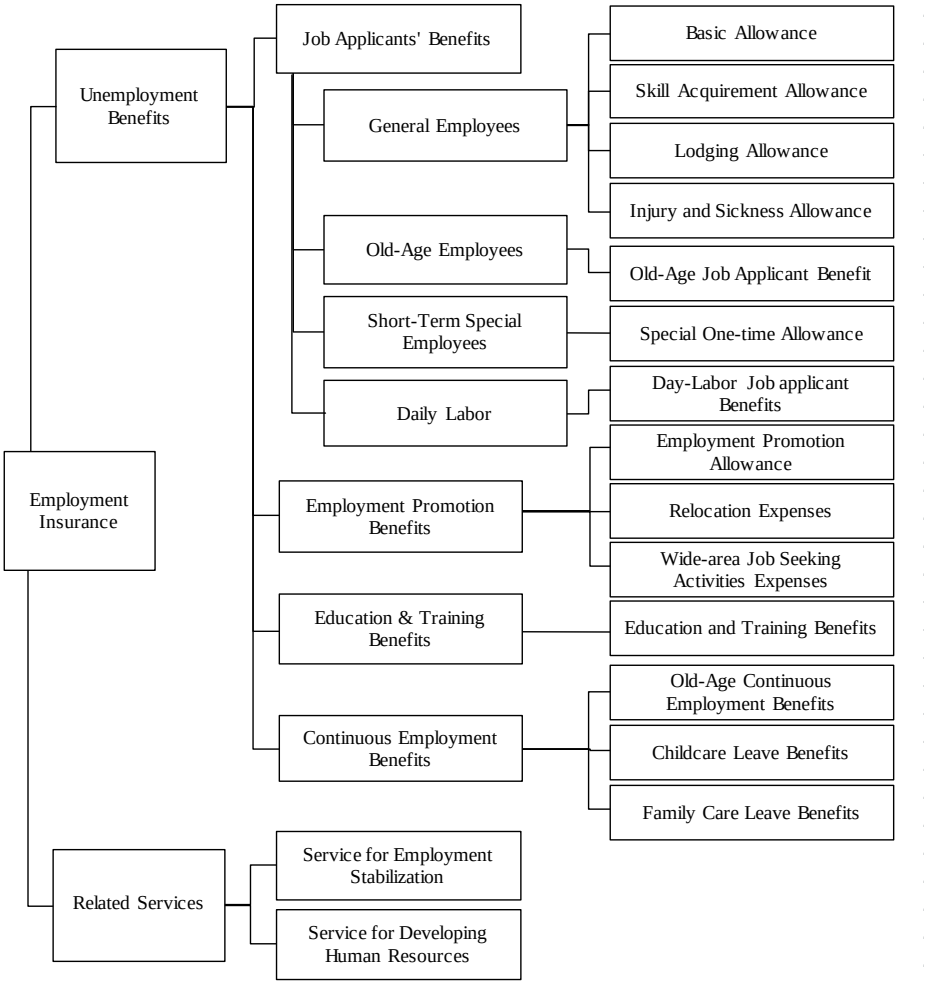
The entire scheme is shown in Figure 9.1.

Since April 2010, any employee 1) whose scheduled working hours are 20 hours or more per week and 2) who is expected to be employed for 31 days or more, is considered as insured under the employment insurance.

The employment insurance is funded by both insurance premium and tax revenue. The insurance premium is paid in principle by both the employer and employee. Based on a balance of expenditure and revenue, insurance premium is determined systematically within a defined range, with the approval of Minister of Health, Labour and Welfare[2].

[1] Japan is believed to be a country in which it is the most difficult for employers to fire their employees owing to the regulations for protecting workers, but whether the regulations are actually strict or not is still debatable.
[2] The insurance premium does not vary by individual firm.

Figure 9.1 Employment Insurance



9.2.2 The Basic Allowance for the Job Applicants

The Basic Allowance is one of the Job Applicants' Benefit, and the most common benefit of the employment insurance[3]. The basic allowance is paid when the insured former employee lost his/her job. The benefit payment period of the basic allowance is between 90 and 330 days[4], and varies by reason for unemployment, insured period, and age of the beneficiary. The benefit period is basically longer if the insured period is longer. If unemployment is due to "company bankruptcy," or involuntary leaving such as "termination," or "expiration of contract term," the benefit period is basically set longer than unemployment due to other reasons and is set longer with higher age (excluding people aged 60 or older). The Tables 9.1 to 9.3 show the number of days the allowance is paid for each kind of recipient.

In case of job separation for his/her own reasons, benefits start approximately three months after the unemployment (if the person is still unemployed at that time). The benefit amount is 50 to 80% of the average wage for the six months prior to unemployment (45 to 80% for persons aged 60 and 64), and the rate is higher if the wage prior to unemployment is lower.

[3] It is often referred to simply as the "Unemployment Benefits."
[4] For those difficult to get employed such as disabled persons, the benefit period is between 150 and 360 days.

Table 9.1 Duration of Basic Allowance (for involuntary terminated employees)

(unit: days)

Years of being insured / Age of beneficiary	Less than 1 year	More than 1 year and less than 5 years	More than 5 years and less than 10 years	More than 10 years and less than 20 years	More than 20 years
Less than 30	90	90	120	180	-
30 ~ 34		90	180	210	-
35 ~ 44				240	270
45 ~ 60		180	240	270	330
60 ~ 64		150	180	210	240

Table 9.2 Duration of Basic Allowance (for those leaving jobs for reasons other than above)

(unit: days)

Years of being insured / Age of beneficiary	Less than 1 year	More than 1 year and less than 5 years	More than 5 years and less than 10 years	More than 10 years and less than 20 years	More than 20 years
All	90			120	150

Table 9.3 Duration of Basic Allowance (for those difficult to get employed)

(unit: days)

Years of being insured / Age of beneficiary	Less than 1 year	More than 1 year and less than 5 years	More than 5 years and less than 10 years	More than 10 years and less than 20 years	More than 20 years
Less than 45	150	300			
45 ~ 64		360			

In the fiscal year 2012, an average number of those who received the job applicants' benefit per month were 576,000, and the total amount of the benefit payment was approximately 930 billion yen.

9.2.3 Employment Promotion Benefits, Education and Training Benefits

Employment Promotion Benefits are paid for those who are finding regular jobs and non-regular jobs. Those qualified to receive the basic allowance and are successful in finding employment with a certain benefit period remaining are eligible to receive these benefits.

Education and Training Benefits are paid to those who have been covered by employment insurance for a certain period when they attend and complete education or training that is provided by the private sector and designated by the Minister of Health, Labour and Welfare. It compensates 20% of the education and training expenses (up to ¥100,000).

9.2.4 Continuous Employment Benefits

The Continuous Employment Benefit has three programs: Old-Age Continuous Employment Benefits, Childcare Leave Benefits, and Family Care Leave Benefits. The Old-Age Continuous Employment Benefit

is provided to insured persons aged 60 to 64 years old who have been covered by the employment insurance for five years or more. If a person's wage drops to less than 75% compared to the wage at age 60, then up to 15% of the monthly wage is paid. The benefit period is provided up to the 65th birthday.

The childcare leave benefit is a benefit for insured persons taking childcare leave to care for infants under the age of one (or the age of one and a half if extension is permitted). They receive benefits equivalent to 50% of the wage before taking leave (with an upper limit), assuming that the person was insured for a certain period prior to the start of the leave. In the past, part of the benefit was paid six months after returning to work, but the benefit is currently paid in full during the leave.

The family care leave benefit, as in the case of the childcare leave benefit, is a system for those taking leave to provide nursing care for his/her family. The benefits are equivalent to 40% of the wage before taking the leave (with an upper limit) for a maximum of three months.

9.3 Workers' Accident Compensation Insurance

The Workers' Accident Compensation Insurance is a system to provide benefits to compensate for workers' injury or sickness while at work or commuting to and from work. It also has programs to promote the social rehabilitation of the afflicted worker. All employees regardless of employment type or business size are covered by this insurance, which is in principle funded by premiums paid by employers. The premium rate varies greatly by industry as shown in Table 9.4. For firms with more than 100 employees, the premium increases or decreases, based on the number of accidents caused in the firm for the past three years.

Table 9.4 Premium Rates of Workers' Accident Compensation Insurance by Industry

(unit: ‰)

Industry	Premium Rate
Forestry	60
Fishery	20 ~ 40
Mining	5.5 ~ 88
Construction	7.5 ~ 89
Manufacturing	2.5 ~ 26
Transportation	4.5 ~16
Energy (electricity, gas, water or heat supply)	3
Others	2.5 ~50

Benefits include medical treatment (compensation) received at medical institutions, temporary disability benefit to compensate for wages during the treatment period, injury and disease benefit or physical disability benefit for injuries/diseases that are not cured or leave disabilities, and survivors benefit paid to the family in case a worker dies due to a work-related reason.

9.4 Current Trends

Since the employment insurance were amended several times to expand eligibility for being insured to non-regular workers from the relatively early days, the proportion of insured persons to all employees

remains at approximately 70% despite the recent rapid increase in non-regular workers[5]. Nevertheless, the recipient rate (ratio of those who receive unemployment benefits to all unemployed persons) has consistently declined since the enactment of the current unemployment insurance law of 1975, and has been below 30% in recent years. This long-term decline is attributable to the increase of the number of those who were employed only for a short period, and therefore did not meet the required insured period before becoming unemployed, as well as the government's policy of aiming to reduce unnecessary claims for benefit[6]. Against this backdrop, in October 2011, the government introduced Job Seekers Support System which offers job training and allowances to unemployed persons who are ineligible for unemployment benefits, or whose benefit period has expired, relying on the employment insurance fund.

[5] Also in recent years, expected period of employment required for being insured, which used to be one year, was shortened to 6 months in April 2009, and 31 days in April 2010.

[6] Another factor behind this decline is the increase in the number of those who have been unemployed for a long period, and therefore have exhausted the benefits.

Outline of the Employment Insurance System in Japan

1)	The Insured	(a) General Employees	
2)	Number of the insured		38.91 (million)
3)	Number of employers		2.06 (million)
4)	Insurer		Government
5)	Premium rate:	(General)	(for Agro-Forestry)
	The Insured	0.5%	0.6%
	Employer	0.85%	0.95%
6)	Gov't Subsidy:		
	Administrative cost		All
	Benefits paid	13.75% of benefits, none for Employment Continuation benefits (c)	
7)	Unemployment Benefits		
(A)	Job Applicants' Benefits		
	① Basic Allowance		
	Requirements	1) Scheduled weekly working hours are 20 hours or more and 2) is expected to be employed for 31 days or more	
	Amount	50 to 80% of previous wage	
	Duration	See Table 9.1-9.3	
	② Skill Acquirement Allowance	(1) ¥500/day for course fee, (2) up to ¥42,500 of transportation cost	
	③ Lodging Allowance	¥10,700/month	
	④ Injury & Sickness Allowance	Same as the day rate of the Basic Allowance	
(B)	Employment Promotion Benefits	[I] Employment Promotion Allowance (1) Reemployment Allowance: Remaining number of payment days x 50-60% x Basic daily allowance (2) Employment Allowance: Scheduled working days x 30% x Basic daily allowance (3) Outfit Allowance for Regular Employment (for disabled, etc.): Remaining number of payment days x 40% x Basic daily allowance [II] Relocation Expenses [III] Wide-area Job Seeking Activities Expenses	
(c)	Education & Training Benefits		
	Requirements	Those who have completed the study & training designated by the Minister with more than 3 years of insured period	
	Amount	20% of expense (up to ¥100,000)	
(D)	Continuous Employment Benefits		
	① Old Age Continuous Employment Benefits		
	Requirements	Those aged 60 to 64 year olds who have been insured for at least 5 years, and whose wage is less than 75% of the wage at 60.	
	Amount	15% of the wage after 60 (in case the current salary is 61-75% of the wage at 60, the rate is reduced gradually)	
	Duration	Until the 65th birthday (In case re-employed after receiving unemployment benefits, 2 years if the remaining days of unemployment benefit is more than 200 days, 1 year, if 100 days.)	
	② Child Care Leave Benefits		
	Requirements	Those who have taken child care leave to raise a child of less than one year old (one-and-a-half-year old if extension is permitted), and who have worked more than 11 days in a month for more than 12 months in the past two years	
	Amount	40 (currently 50)% of wage before the leave	
	Duration	During the child-leave	
	③ Family Care Leave Benefits		
	Requirements	Those who has taken family care leave and who have worked more than 11 days in a month for more than 12 months in the past two years	
	Amount	40% of wage before the leave	
	Duration	Up to three months	

Schemes are as of April 2013.

(b) Short-term special employees	(c) Continuously Employed Older Persons (Over Age 65)	Day-Laborers
		19 (thousand)
(for Construction) 0.6% 1.05%		In addition to the left items ¥48～88/day ¥48～88/day
		All 1/3 of benefits
Special One-time Allowance: 30 (currently 40) days worth of the Basic Allowance	Has been employed since before turning 65, and till after 65, and insured for 6 months in 45 to 80% of previous wage For 30 days if the insured period is less than 1 year, for 50 days if insured for 1 year or more	Paid 26 days of premium in the past 2 months ¥7,500～¥4,100/day 13～17 days
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For More Information (web-sites)

National Institute of Population and Social Security Research

http://www.ipss.go.jp/index-e.asp

(Our Publication) http://www.ipss.go.jp/site-ad/index_english/publication-e.html

(Survey: Annual Population and Social Security Surveys)

http://www.ipss.go.jp/site-ad/index_english/Survey-e.asp

(Japanese Social Security Statistics DB) http://www.ipss.go.jp/ssj-db/e/ssj-db-top-e.asp

(Population & Household Projection) http://www.ipss.go.jp/site-ad/index_english/population-e.html

Government and related organizations

Ministry of Health, Labour and Welfare http://www.mhlw.go.jp/english/index.html

Cabinet Office (Policies on Cohesive Society) http://www8.cao.go.jp/souki/index-eng.html

Statistics Bureau (Ministry of Internal Affairs and Communications) http://www.stat.go.jp/english/

Portal Site of Official Statistics of Japan http://www.e-stat.go.jp/SG1/estat/eStatTopPortalE.do

National Statistics Center http://www.nstac.go.jp/en/index.html

Japanese Law Translation (Ministry of Justice) http://www.japaneselawtranslation.go.jp/?re=02

Japanese Organization for International Cooperation in Family Planning http://www.joicfp.or.jp/en/

Research Institute (related to MHLW)

National Institute of Public Health http://www.niph.go.jp/index_en.html

National Institute of Infectious Diseases http://www.nih.go.jp/niid/en/

The Japan Institute for Labour Policy and Training http://www.jil.go.jp/english/index.html

International Medical Center of Japan http://www.ncgm.go.jp/eng/

National Institute of Health Sciences http://www.nihs.go.jp/english/index.html

National Institute of Biomedical Innovation http://www.nibio.go.jp/english/

National Institute of Health and Nutrition http://www.nih.go.jp/eiken/html/index.html

National Cancer Center, Japan http://www.ncc.go.jp/en/index.html

National Rehabilitation Center for Persons with Disabilities http://www.rehab.go.jp/english/index.html

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