Some structural issues in the Japanese social security system

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1. Introduction

The Japanese population is ageing rapidly with a very low fertility since the 1990s. This low fertility together with a long life expectancy makes it more serious and difficult to reform the social security system in Japan. Table 1 shows a brief history of the social security reforms in Japan since 1961, although this paper deals with only recent ones.

The Japanese public pension is a multi-tiered system. The first tier is the Basic Pension (BP), which provides universal coverage. The system provides an individual benefit proportional to the number of years of contribution, regardless of income level. The public pension system for employees in private sector is called the Employees' Pension Insurance (EPI), which has such features as a pay-as-you-go financing method, earnings-related contributions and benefits, defined benefits, etc. Part time workers are not covered by the EPI. After their retirement, the self-employed are provided only the Basic Pension benefit. Benefit reduction in various forms as well as the improvement in efficiency and fairness of the system has been the main focus of the recent public pension reforms in Japan. The task of reform is to establish middle- and long-term stability of the system against aging of the population and to maintain contribution levels acceptable to the working population in future years.

Table 1.History of Social Security System in Japan

Year	Social Secuity	References
1961	Universal coverage Introduction of National Pension	
1973	Healthcare Reform (Improvement of benefit level, Introduction of the upper ceiling for patients cost-sharing) Pension Reform 1973 (Improvement of benefit level, Introduction of CPI indexation) Free healthcare services for the Elderly	First Year of Welfare State, First Oil Shock
1983	Introduction of Health and Medical Services for the Elderly (HMSE)	"National burden should be less than 50 % of the National Income"
1984	Ten percent cost-sharing by the insured	
1985	Introduction of the Basic Pension (1986)	
1988		Introduction of Consumption Tax (3%)
1989	Gold Plan (Ten-year Strategy to promote Health and Welfare Services for the elderly)	
1990	Welfare Reform (Home services, Health and Wefare plans for the elderly by municipalities)	1.57 Shock (TFR=1.57 in 1989)
1991	Child allowance for the first child	
1994	Patient charge on inpatient meals Pension Reform 1994 (Gradual increase in normal pension age, Net wage indexation, etc.) New Gold Plan, Angel Plan	Increase in Consumption Tax to 5% (beginning April 1997)
1997	Healthcare Reform (20 % cost-sharing by the insured, Introduction of the patient charge on prescription drugs)	Administrative Reform Council
1999		Economic Strategy Council
2000	Increase in the patients cost-sharing Pension Reform 2000 (Reduction of future benefit exp., Expansion of contribution base, Increase in govt. subsidy) Implimentation of the Long-term Care (LTC) Insurance	
2001		Economy and Finance Council
2002	Healthcare reform (Repeal of the patient charge on prescription drugs, Contribution based on annual earnings)	
2003	Experiment of DPC Reform proposal on healthcare system of the elderly	
2004	Pension reform 2004 (Ceiling on contribution rate, macro economy adjustment)	
2005	LTC reform	

Although there is a difference in pension benefits between the self-employed and employees, people's preference for equality is strong in Japan especially for healthcare services. In an effort to control the increase in health expenditure, patient's cost-sharing has been increased to 30 percent of the cost, although there is an upper ceiling. The average spell of inpatient is longer than that in the other developed countries and this is one of the reasons for increasing health expenditures. One way of improving healthcare performance is through better coordination between inpatient and outpatient care. Main reform issues in the recent Japanese healthcare system are: (1) reorganization of the healthcare service delivery system; (2) reforms of the reimbursement system of medical fees and pharmaceutical pricing system; (3) financing of healthcare for the elderly; and (4) quality assurance of healthcare services and empowerment of patients.

The Long-term Care Insurance was implemented in April 2000, and the system has been reviewed in 2005. Among the key issues are so-called conversion of hospital beds from health insurance to long-term care coverage and a wide variation across municipalities and between urban and rural communities in the amount and quality of services provided.

Besides improving fairness and efficiency of various systems, the following two points are the key issues in the Japanese social security reforms: (a) to put the right incentives in the systems, including to improve the consistency of the system with work incentives and to emphasize prevention in health and long-term care, and (b) to improve intergenerational equity and financial stability of the system. Although aging of the population is faster in Japan, issues are more or less common in social security reforms in the other developed countries.

This paper aims to identify incentive issues in the Japanese social security system under the 3 broad headings: Sustainable scale of the social security system; Functions of the social security system; and Division of roles between public and private systems. Of course, these issues are mutually related, and the purpose of this paper is not to make an exhaustive list of issues but to identify real issues, which we believe will provide the basis for the fruitful discussion of social security reform in Japan.

2. Sustainable scale of the social security system

Japanese social protection was 17.5 percent of GDP in 2001, which was still low compared to European countries (Table 2). Fig. 1 shows the scale of each program in social protection (public and private): Old age and survivor pension, Health, Elderly care, Incapacity-related, and Family. From this chart, it is rather clear that elderly care, incapacity-related benefit, and family benefit, most of which are provided through public programs, are underdeveloped in Japan and the US. It should be noted in viewing Fig. 1 that sometimes private pension benefits are not well-captured in this data source.

Table 2 Social protection as percent of GDP: 2001

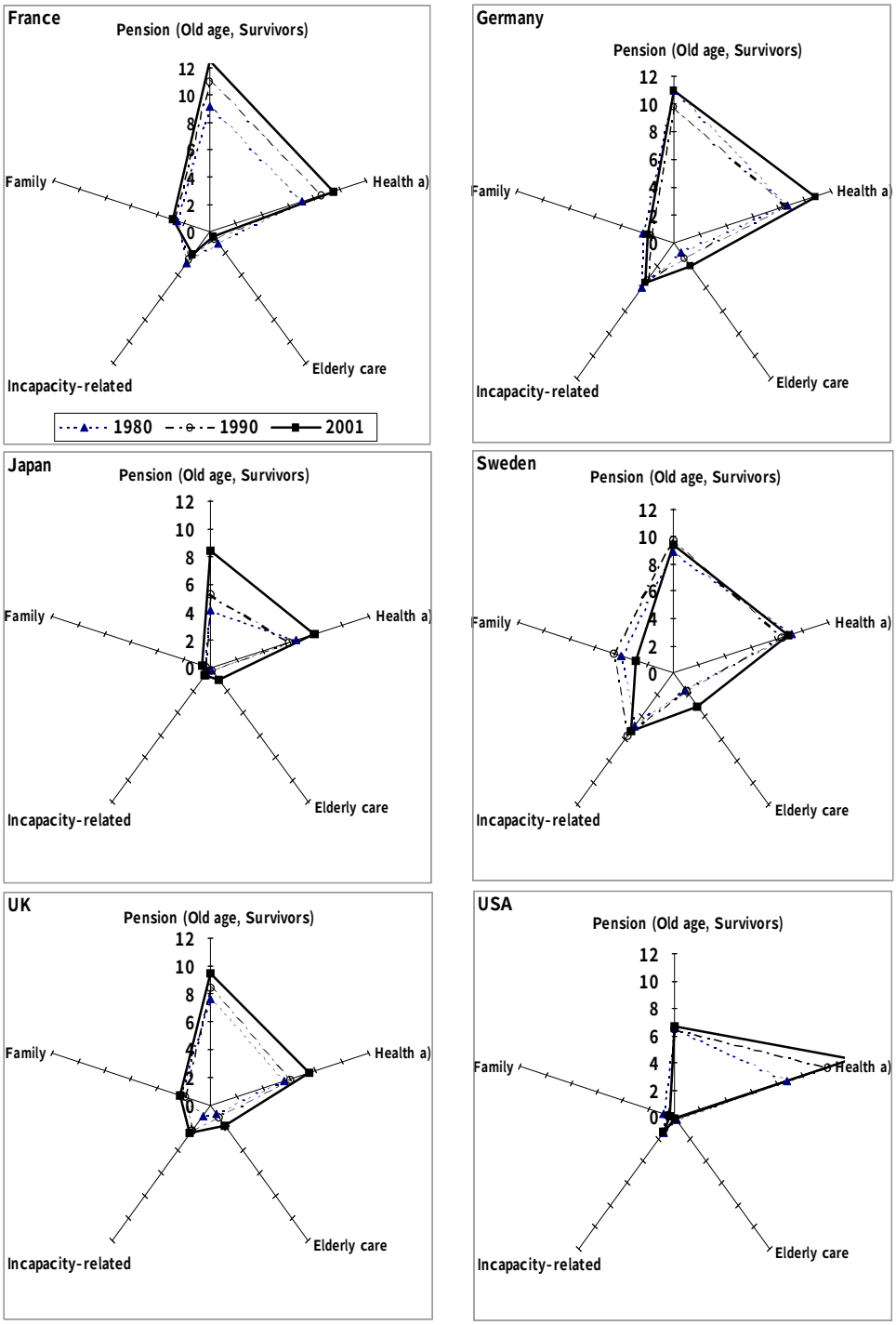
(In %)

	France	Germany	Japan	Sweden	UK	USA
Public	28.5	27.4	16.9	28.9	21.8	14.8
Pension (Old age, Survivors)	12.5	11.0	7.9	9.3	9.0	6.6
Health	7.2	8.0	6.3	7.4	6.1	6.2
Elderly care	0.4	2.0	0.9	2.4	1.8	0.1
Incapacity-related	2.1	2.3	0.7	5.2	2.5	1.1
Family	2.8	1.9	0.6	2.9	2.2	0.4
Private		1.4	0.6	0.6	0.5	0.4
Pension (Old age, Survivors)			0.5		0.5	0.0
Health						0.2
Elderly care			0.1	0.6		
Incapacity-related		1.3			0.1	0.2
Family		0.1				
Total (Public + Private)	28.5	28.8	17.5	29.5	22.4	15.2
Pension (Old age, Survivors)	12.5	11.0	8.3	9.3	9.5	6.6
Health	7.2	8.0	6.3	7.4	6.1	6.4
Elderly care	0.4	2.0	1.0	3.0	1.8	0.1
Incapacity-related	2.1	3.6	0.7	5.2	2.6	1.4
Family	2.8	2.0	0.6	2.9	2.2	0.4
Total exp. on health a)	9.4	10.8	7.8	8.8	7.5	13.8
Public	7.2	8.5	6.4	7.5	6.2	6.2
Private	2.3	2.3	1.4	1.3	1.3	7.6

a) OECD Health Data

Source : OECD(2004), Social Expenditure Database 1980-2001.

Fig.1 Social protection as percent of GDP: 1980, 1990, 2001

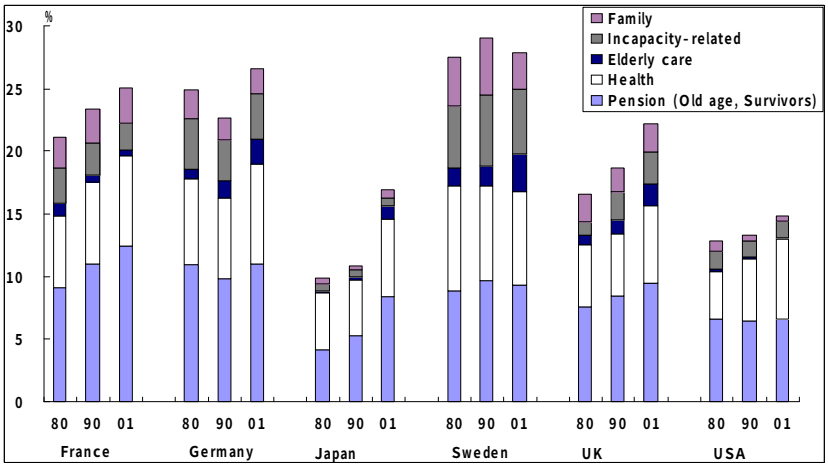


a) OECD Health Data

Source : OECD(2004), Social Expenditure Database 1980-2001.

Fig. 2 focuses on public expenditures, and again the Japanese low level is featured, although Japan surpassed the US in 2001. Japanese public expenditure level is due to (a) still low level of public pension benefit, which is expected to continue increasing after 2004 reform; (b) low level of health expenditure; and (c) quite low level of incapacity-related and family benefits. In fact, the total amount of social security benefits in 2025 is estimated to be twice as large as that in 2004. The sustainability of social security system depends on the attitude of the people toward the relationship between benefits and costs of social security.

Fig. 2. Public expenditures by function as percent of GDP: 1980, 1990, 2001



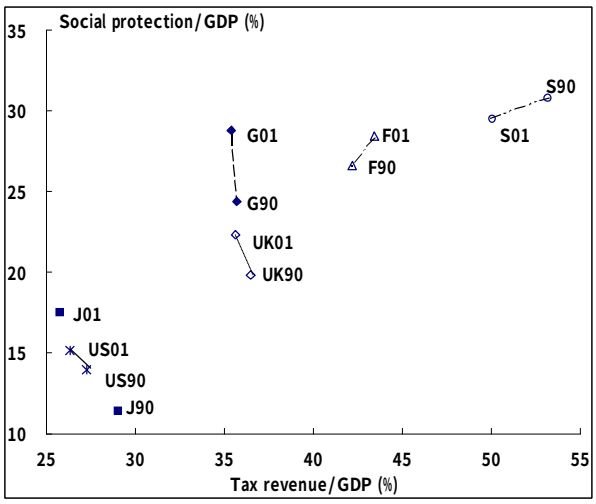
Source : OECD(2004), Social Expenditure Database 1980-2001.

The public pension spending in 2001 was about 8 percent of GDP in Japan. In order to help finance the first-tier pension, tax revenues equivalent to one-third of the BP benefit expenditure are transferred to this scheme by the central government. Public pension reform is necessary to maintain a long-term balance between benefits and revenues of public pension system. A kind of automatic balancing mechanism has been introduced in the 2004 pension reform, which adjusts benefit level according to socioeconomic changes including falling birth rate, extending life expectancy and economic growth rate. However, this measure is employed to contain pension expenditure for a certain period of time (not a permanent one). More significant reform of the public pension system in Japan is to reduce benefit accrual rate, which will also reduce the extent of the imbalance in the inter-generation transfers that occurs in the current PAYG system.

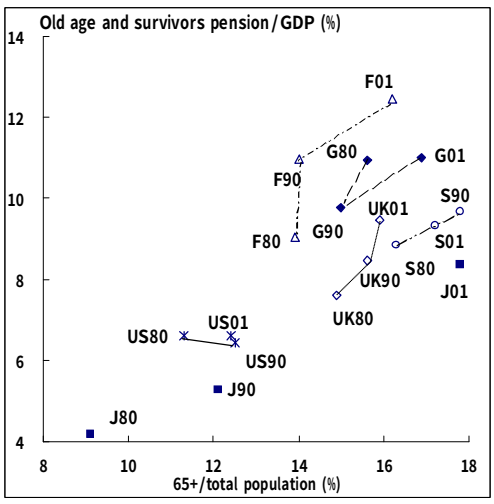
The level of social protection is quite related to the level of tax revenue (Fig. 3 a). However, it is interesting to note that Germany and the UK have increased social protection without increasing tax revenue and Sweden has reduced social protection between 1990 and 2001. Aging of the population has inevitably increased old age and survivor pension benefits (Fig. 3 b). Long-term care expenditure is more related to aging, and it is quite important to reduce the number of dependent elderly in future through better prevention, in order to contain the total cost of health and long-term care under the circumstances of rapid aging of the population. How the long-term care insurance will affect the health expenditure of the elderly is a very interesting topic in Japan.

Fig. 3. Social protection and pension benefit

(a) Social protection vs Tax revenue both as percent of GDP : 1990, 2001



(b) Old age and survivors pension benefit as percent of GDP vs. Proportion of 65+: 1980, 1990, 2001



F= France, G= Germany, J= Japan, S= Sweden.

One obvious way to control public expenditures is to coordinate benefits among social security systems and improve the efficiency of the system. To this end, it is indispensable to coordinate pension policy with other policies such as tax, employment, and family policy. The tax treatment of pensions, for example, should be aligned with that of income from employment. Financing of the welfare state is still one of the key issues in Japan, and currently new options are being reviewed, including broadening the financing basis of social benefits, and greater reliance on private arrangements. In considering a new approach, it is worth keeping in mind that cutting social expenditures will not necessarily lead to a reduction in the total resources which a society devotes to such ends, though it will change the distribution of burden (OECD, 1997). Concerning the relation between the scale of social protection and economic growth, Kaneko (2005) found a slight tendency that countries with high public pension growth have lower real GDP growth. However, it is not clear yet that a large public retirement program in the US has a long-lasting distorting effect on US economy (Burtless, 2005). In the international research field, no substantial links have been found, in either direction, between the size of a country's public sector and its economic growth (Palme, 2005).

3. Functions of the social security system

The functions of social security system are manifold and have historical aspects. Poverty relief was the most important role of the social security system after the World War II in Japan. Income redistribution has become important in the economic growth and aging society. The function of risk-pooling through public health insurance and long-term care insurance has been well appreciated by the Japanese people, and the safety-net function is perceived to increase the quality of life throughout lifecycle.

The Basic Pension provides a flat rate benefit regardless of income level. Therefore, the Basic Pension has a strong income redistribution effect. Social security plays an important role in income redistribution. In most developed countries, income redistribution through public pension system is larger than that through tax system, so far as single year redistribution is concerned. However, if we focus on life-time income redistribution, the function of public pension system is much more modest. The recent increased unemployment rate caused by the prolonged slack economy has been increasing the number of the people subject to unemployment insurance and public assistance since 1995.

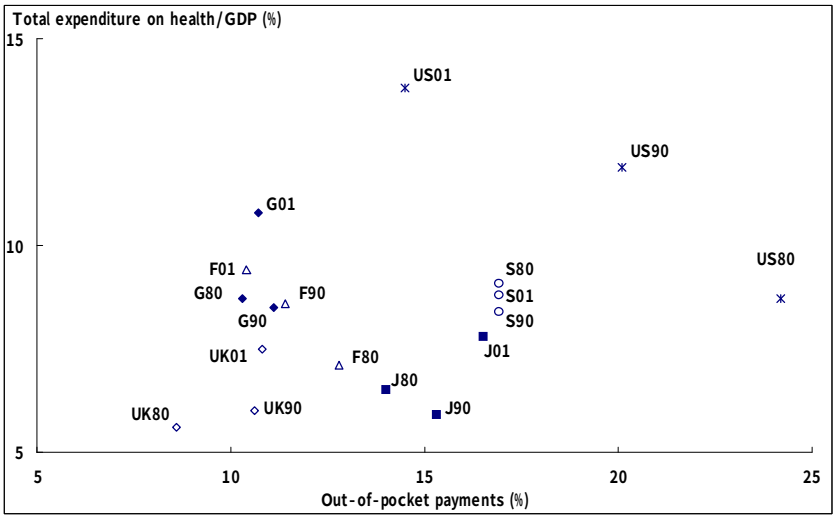
Public pension benefits have an influence on retirement decisions of the aged persons. One reason for earlier labor force withdrawal was the increased generosity of programs that replace lost earnings when older workers leave their jobs (Burtless, 2004). Studied in recent years have uncovered sizeable effects of disability pension programs and special unemployment benefits for older workers on the activity rates of people past age 55. Countries with early pension ages, generous income replacement, and heavy implicit taxes on earnings in old age tend to have earlier exit from the labor force than countries with pension systems that provide fewer work disincentives (Burtless, 2004). An OECD survey of pension reform shows that a large number of countries, including Australia, Italy, Japan, and the United States, have changed the incentives in their pension systems to discourage early retirement or encourage pension recipients to continue working while collecting a pension (Casey et al. 2003). In order to cope with aging of the population, it is necessary to mitigate the strong pressure on social security through postponement of retirement. Now, earnings are reviewed as one of important income sources in old age in many developed countries.

Both inpatient and outpatient services are provided in Japanese hospitals. While hospitals can enjoy economy of scope on the one hand, there is a severe competition in outpatient services between hospitals and GPs on the other. In order to correct excessive competition, it has been considered that hospitals are classified by function and patient flow is to be streamlined. The reimbursement system of medical fees is a crucial tool to put right incentives in the system. The Japanese reimbursement system is basically fee-for-service with partial price bundling mainly for chronic diseases of the elderly (Note 1), and the same nationwide fee schedule is applied to GPs and hospitals. The reform efforts in the reimbursement system of medical fees in Japan are only at an initial stage and actual situations are far from prospective payment such as capitation and HMO. Utilization reviews, even the scale of which is limited, has so far an important impact to contain the health expenditure increase in the Japanese fee-for-service system, this approach faces serious limitations in 1990s. Case payment to hospital services and the assessment of hospital budgets using the DRG (Diagnosis Related Groups) method are viewed with interest in Japan as a new measure to affect volume of healthcare services.

There is a wide range of variation in health expenditure (the US is the highest and the UK is

the lowest among 6 countries), and the proportion of out-of-pocket payments also differ country by country (Fig. 4). US health expenditure has increased substantially in the past 20 years with a remarkable reduction of the proportion of out-of pocket payments. To the contrary, the proportion of out-of-pocket payment has increased steadily in Japan.

Fig. 4. Total expenditure on health (%) vs. proportion of Out-of-pocket payments: 1980, 1990, 2001

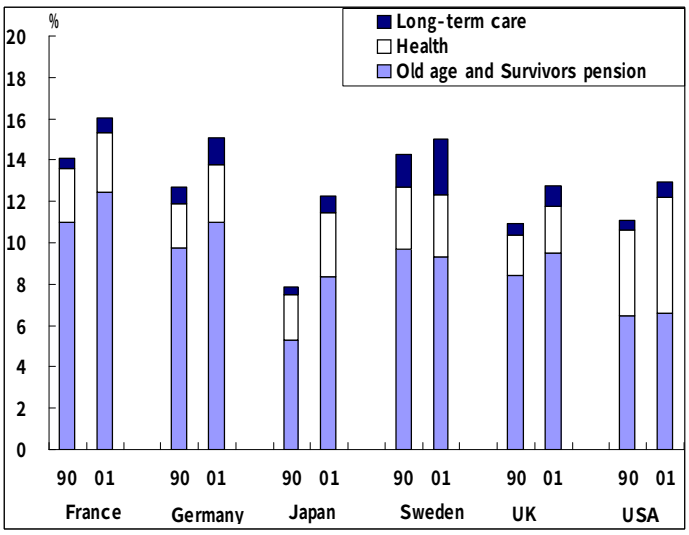


F= France, G= Germany, J= Japan, S= Sweden.

There are contradictory pressures at work within Europe, with public systems such as Denmark and England seeking to expand and enhance levels of patient choice of provider and treatment, whilst social insurance systems such as Germany and France are seeking ways to restrain traditionally high levels of choice in order to promote cost containment and improve coordination of care (Smith, 2004). There is considerable evidence that the traditionally high degree of patient autonomy regarding choice of provider is an important reason for the high levels of popular satisfaction with the social insurance systems in Germany, France and elsewhere. However, there is equally a recognition of free patient choice can also impose substantial costs on the system (Smith, 2004).

Fig. 5 shows the cost of public programs for the elderly (65+) as percent of GDP. There is only some room to increase old age and survivor pension in Japan. Japanese health expenditure for the elderly is not low compared to the other developed countries. Long-term care expenditure will increase according to the population aging. Therefore, this chart implies that there is no reason to believe Japan can keep the cost of aging low.

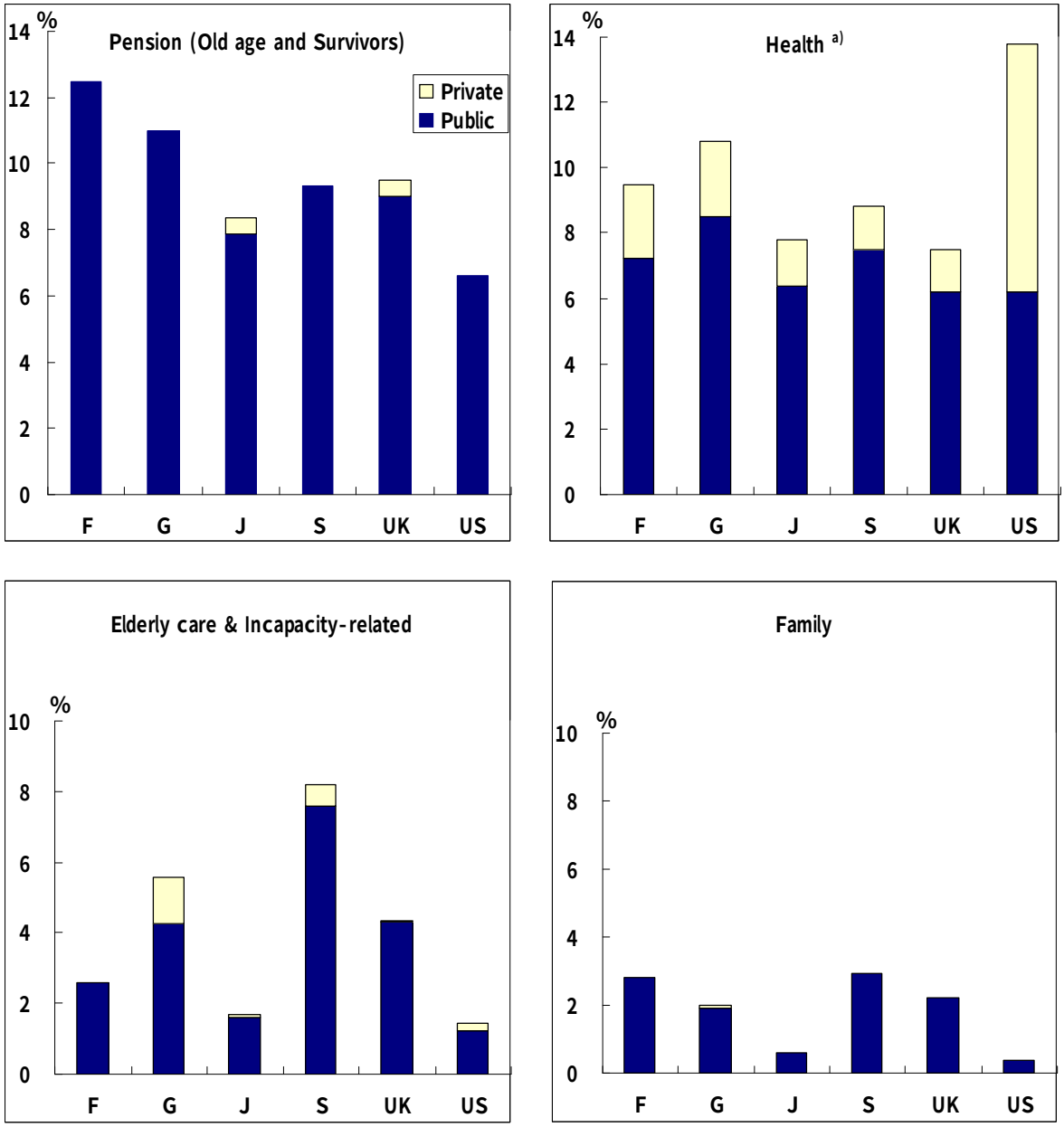
Fig. 5. Cost of public programs for the elderly (65+) as percent of GDP: 1990, 2001



4. Division of roles between public and private systems

Companies pay not only social insurance contribution but also fringe benefit including company pension, and these expense born by companies are focused from the point of view of international competition. Although dominant, public program is not the only one in social protection, and the functions of social security should be considered from broader perspective including the roles of companies and families. Typical examples of public-private mix are company pension and healthcare system. There is no clear distinction between public pension and nationwide compulsory company pension, and the latter is included in public expenditure in Fig. 6 (France and UK, for example). Some part of healthcare services are paid outside public system, and the share of private sector is in fact larger than public in the US healthcare (Fig. 6). The role of private health insurance, which so far remains marginal, is expected to grow in Japan as patient's cost-sharing has been increased in general to 30 percent of healthcare cost (with upper ceiling).

Fig. 6. Public and Private expenditures as percent of GDP : 2001



F= France, G= Germany, J= Japan, S= Sweden.

a) OECD Health Data

Source : OECD(2004), Social Expenditure Database 1980-2001.

Under the circumstances of trimming public program, curtailment of fringe benefit by company, and enlargement of individual responsibility, a better interface between public system and private arrangement is indispensable. In this regard, means-testing benefits in public pension system will become a big topic of incentive issues. In Japan, the possibility of corporate and/or individual pension schemes has been enlarged. However, there is no explicit coordination so far to offset the reduction of public pension benefits through private pension.

5. Discussion (Note 2)

In public pension reforms in many developed countries, it has been shifted from a system where contributions have been adjusted to finance an agreed-upon level of benefits to a system where benefits will be adjusted to keep the contribution within an agreed-upon level. A similar paradigm shift has also occurred in Japan. A driving force behind this shift is the concern about long-term sustainability of the public pension systems. Pension policies in such countries as Germany and Japan have to confront the incentive effects of lower pension benefits at a time when there is a strong pressure on contribution increase. There is such opinion as to restrict the roll of the government to provide minimum benefits. However, it is also true that those countries where pubic pension provide only minimum benefits have sooner or later been obliged to create some kind of system to provide income related benefits (Schmaehl, 2002). In reducing the generosity of ageing-related programs, a balanced reform is needed: spread the cost of reform equitably across generations; improve the willingness to save for retirement; and consider the impact of reform on low income households (OECD, 2003).

As mentioned above, there are indeed many problems in the Japanese healthcare system. However, its performance is not so bad as to redesign the system fundamentally. Healthcare system has been changed incrementally almost every year in Japan. What is needed is to reach consensus on what should be maintained and what should be changed among principals underlying in the Japanese healthcare system. The reform of reimburse system is especially important to place right incentives in the system. Although information asymmetry is inevitable in healthcare system, the fact that patients rights and choice are not well observed explains, at least to some extent, why quality of healthcare services are not widely published in Japan.

As population is aging, how to provide long-term care for the frail elderly is an increasing concern to the whole society in the developed countries. The need to long-term care is quite common among super-old. It is quite remarkable event in Japan that the provision of long-term care has been changed from welfare and rationing services to needs-based insurance benefits. Long-term care for the elderly is related not only to the dignity of an individual elderly but also to the "shape" of a society. As long-term care cost is more closely related to the aging of the population than healthcare cost of the elderly, it is indispensable to prevent and reduce the incidence as much as possible.

As shown in Fig. 1, the shape of social security differs country by country. The scale of the social security is determined by the degree of solidarity and public-private interaction. Solidarity contribution is required to finance solidarity benefits in social security. The prerequisite for this is that social security system is consistent and fair, and purpose of the system is supported by the general public. Pension benefits and benefits in kind are competing with each other for financing. What is a desirable scale of social security? Do we attach more importance to cash benefits or to benefits in kind? To what extent do we expect social security perform income redistribution? All these questions should be eventually answered by the people, and they need to be well informed to do so properly. People tend to choose an option with least burden, if they have little confidence in the system. Even if burden to social security (tax, contribution, utility charge) is reduced, curtailed social protection should be complemented by individual effort, because the cost of old age will not disappear.

The incentive structure in the social security also changes with country context and national character. In order to gain public support, benefits from public pension system need to be income related in most developed countries. Linkage between contribution and benefit is sought in healthcare and long-term care services to some extent. Each country tries hard to place such incentive as to increase quality of healthcare. Incentives within the system should be explicit and clear.

It is all the more important to consider a desirable division of rolls between public system and private arrangement within each country context. In planning a system suitable for Japanese society, the following points are worth mentioning:
(1) To promote flexible employment of the elderly, taking into consideration of their high participation rate in the labor market;
(2) To make use of female labor force through

improvement of labor market and better social services for child rearing;
(3) To allow flexible working and eliminate any kind of discrimination between full-time and part-time workers in employment conditions and social security coverage;
(4) To increase accountability to the public on contents and degree of solidarity involved in the present system.

Whether to put the stress on solidarity or on self-help is not a matter of choice but a matter of weight. Although how to balance solidarity and individual responsibility relates to an issue of principle, it is not to neglect social justice and solidarity to put the stress on individual choice and responsibility in the social security system. In fact, each country gropes for a better balance between solidarity and individual responsibility. Utility of the people will differ depending on contribution and benefit structure of social security, even if the scale of it is the same. Therefore, the scale of social security and the structure of social security are the face and back of a single coin.

(Note 1) Price bundling is applicable monthly for outpatient care and daily for inpatient care on clinical tests, pharmaceuticals, injections, and nursing charges (inpatient only). Total inpatient per diem is bundled only in special cases such as hospice care.
(Note 2) This part is rewritten based on Fukawa (2005).

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