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Population and Social Security in Japan

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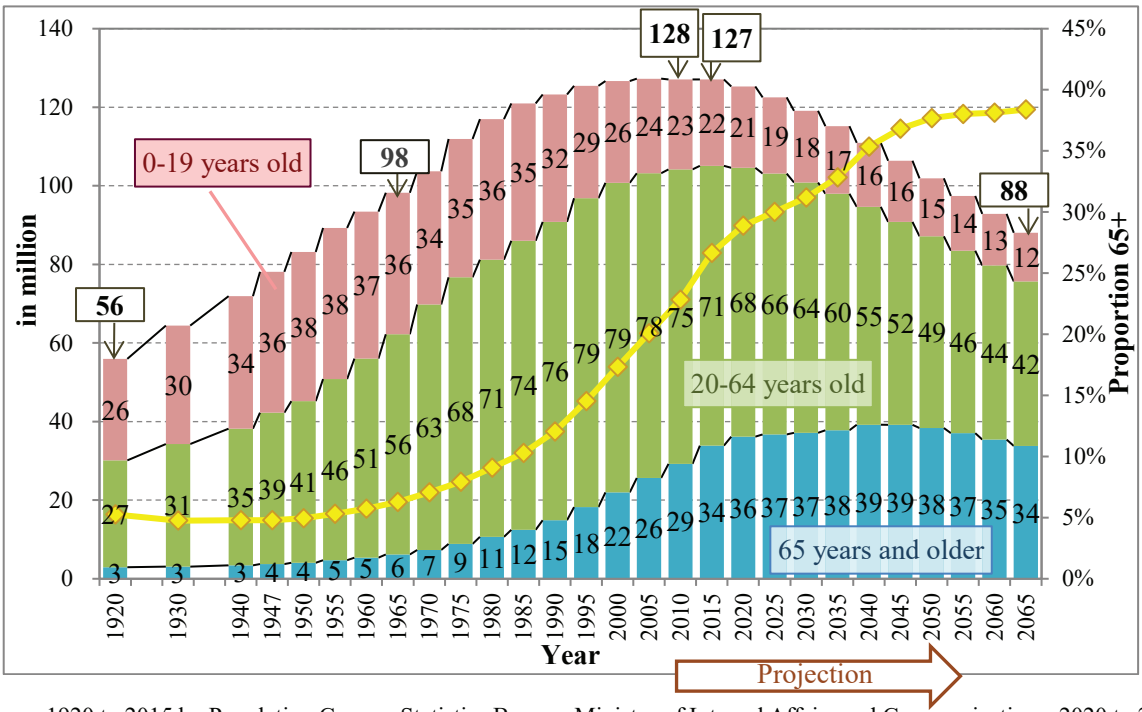
Contents

Chapter 1 Population

1.1 Overview of population trends

The Japanese population is ageing. Although the straight forward decline of the total fertility rate stopped in 2005 at the level of 1.26, the rebound is modest and it remained 1.43 in 2017. On the other hand, life expectancy is increasing slowly but steadily. These factors made the Japanese population's age structure and trends; in 2017, the proportion of the elderly (aged 65 years and over) was 27.6%, the highest in the world, and census counts recorded a decline of 962,607 persons from 2010 to 2015. This trend is expected to continue, and the total population is projected to reduce to 88 million in 2065, with the proportion of the elderly as high as 38.4%. Based on these demographic realities, Japan faces enormous challenges.

Figure 1.1 Population by age group and proportion of 65 years and over (1920-2065)



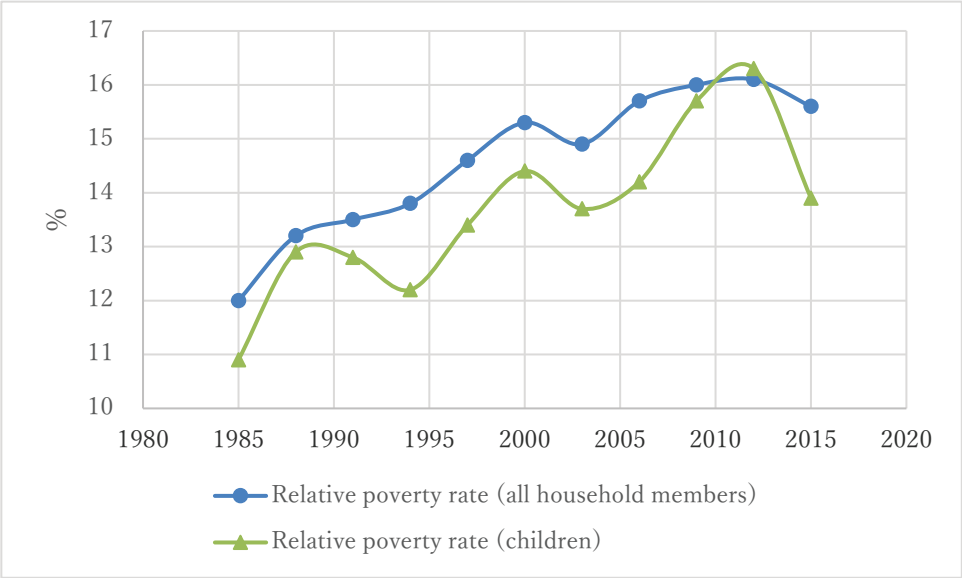
Source: 1920 to 2015 by Population Census, Statistics Bureau, Ministry of Internal Affairs and Communications. 2020 to 2065 by Population Projections for Japan, medium-fertility and medium-mortality assumption (2017) National Institute of Population and Social Security Research

This chapter is based on the draft paper prepared for the *Country Report of Japan* for the Mid-Term Review of the Asian and Pacific Ministerial Declaration on Population and Development, held by the United Nations Economic and Social Commission for Asia and the Pacific in November 2018. However, the contents of this chapter are neither identical to the Country Report nor represent the view of the Government of Japan. The following paragraphs are in the order of the items listed in the Asian and Pacific Ministerial Declaration on Population (APMD). SDGs (Sustainable Development Goals) indicators are used wherever possible. Those items are denoted according to the respective APMD paragraph number as (APMD x) or (SDGs x.x.x).

1.2 Poverty eradication and employment

It is difficult to compute the absolute poverty rate (SDGs 1.1.1), but the trend of relative poverty rate (SDGs 10.2.1) has been a widespread public concern. From 2002 to 2012, the relative poverty rates increased for all household members and for children. This trend reversed from 2012 to 2015, and the relative poverty rates diminished (Figure 1.2). Elderly women and single-parent households, particularly those in which the mother is the head of the household, are the most vulnerable groups; poverty rates for such households are high.

Figure 1.2 Trend of relative poverty rate (1985-2015)

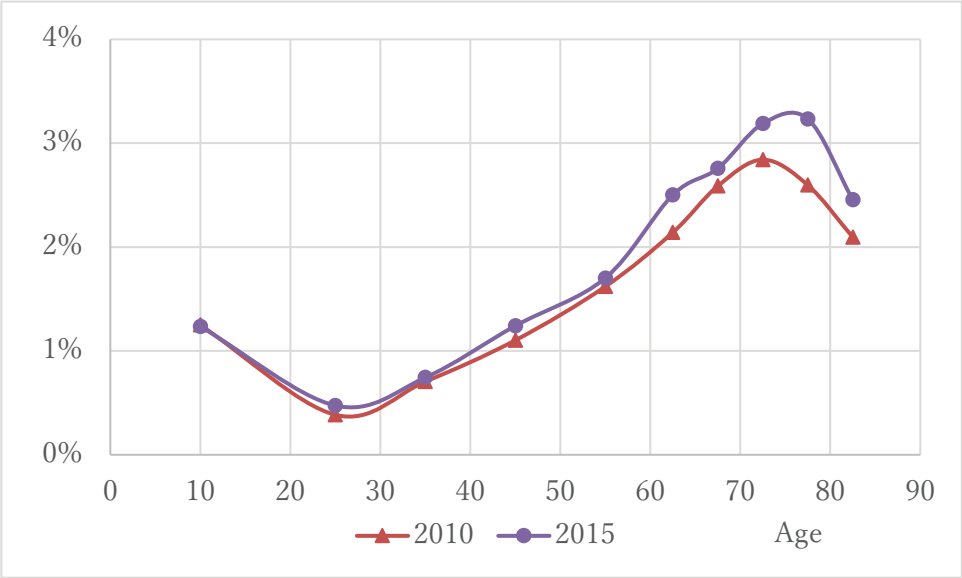


Source: Comprehensive Survey of Living Conditions, Ministry of Health, Labour and Welfare

Those who do not have enough income and suffering from poverty receive cash payments, free medical care, and other benefits under the scheme of the Public Assistance. Recipients of the Public Assistance (SDGs 1.3.1) comprised 1.7% of the total population in 2015, up from 1.5% in 2010. This proportion is even higher for the elderly (Figure 1.3). It is estimated that almost 80% of those who are in economic need are receiving the Public Assistance.[1]

[1] Ministry of Health, Labour and Welfare (2010) "On the estimation of the number of low-income households below Public Assistance threshold (生活保護基準未満の低所得世帯数の推計について)".

Figure 1.3 Proportion of recipients of public assistance by age (2010, 2015)

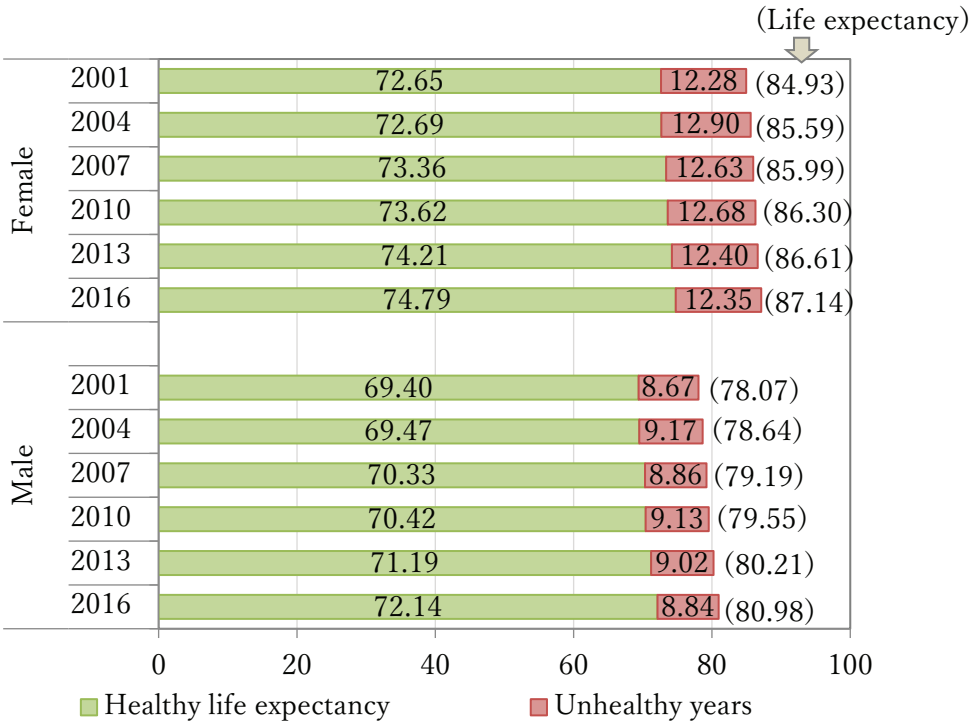


Source: National Survey on Public Assistance Recipients, Ministry of Health, Labour and Welfare

1.3 Health

Life expectancy in Japan in 2016 was 87.14 for women and 80.98 for men, and it was among the longest in the world. However, the governmental goal is to extend not only life expectancy but also healthy life expectancy. This goal is stipulated in Health Japan 21 (the second term) and *Japan's Plan for Dynamic Engagement of All Citizens*. "Health" is defined as not to have the daily activity limitation because of the health problem, measured by a consistent question in the "Comprehensive Survey of Living Conditions" (Ministry of Health, Labour and Welfare). Using this definition, healthy life expectancy has increased from 2001 to 2016 (Figure 1.4), from 72.65 to 74.79 for women and from 69.40 to 72.14 for men. Since 2010, the unhealthy years are shrinking, which means that healthy life expectancy is increasing even more than life expectancy.

Figure 1.4 Trend of healthy life expectancy (2001-2016)



Source: Life Tables and Comprehensive Survey of Living Conditions, Ministry of Health, Labour and Welfare

As for catastrophic spending on health (SDGs 3.8.2), the High-cost Medical Expenses Payment System guarantees that out-of-pocket payments exceeding 80,100 yen per month per household[2] will be reimbursed by health insurance, and it is assumed that all households are free from the risk of catastrophic spending on health.

Both the maternal mortality ratio (SDGs 3.1.1) and the under-5 mortality rate (SDGs 3.2.1) decreased from 2010 to 2016 (Table 1-1).

Table 1-1 Under-5 mortality rate and maternal mortality ratio (2010, 2017)

	2010	2017
Under-5 mortality rate (per 1,000 live births)	3.16	2.59
Maternal mortality ratio (per 100,000 live births)	4.20	3.49

Note: The Maternal mortality ratio published in the Vital Statistics of Japan slightly differs as its denominator is the number of birth (still birth and live birth).
Source: Number of live birth and death by Vital Statistics, Ministry of Health, Labour and Welfare

The number of new HIV infection cases (SDGs 3.3.1) was 1,075 in 2010 and 1,011 in 2016. The number of new AIDS incidences was 469 in 2010 and 437 in 2016.[3] These figures show no significant increase or reduction.

[2] For households with yearly income of over 3.7 million yen: The out-of-pocket upper limit is 57,600 yen per household per month for yearly income of 1.56 to 3.70 million yen, 24,600/15,000 yen for lower income households.
[3] AIDS Prevention Information Network (2018) *The report of AIDS Trend Committee.*

1.4 Sexual and reproductive health, services and rights

Since the total fertility rate hit its lowest at 1.26 in 2005, it increased slowly until 2015 to reach 1.45 and again decreased to 1.43 in 2017. Low fertility with the consequent ageing population is one of the top concerns of the country, and policies to mitigate the low fertility rate are abundant. The *Outline of Measures against the Declining Birthrate* sets the targets concerning the environment to support child care, and *Japan's Plan for Dynamic Engagement of All Citizens* sets the "desirable birthrate" as 1.8 and stipulates support for marriage, pregnancy/childbirth/childcare, as well as single-parent families.

The use of contraceptive practices of never-married persons (SDGs 3.7.1) aged 18 to 34 is increasing both for men and women and decreasing for married couples (Table 1-2). The decreased rate of contraceptive practices could be caused by an increasing age at marriage which may increase the number of married couples who wish to have a baby as soon as possible, but decreased use may also be caused by an increasing number of sexless couples.[4]

Table 1-2 Contraceptive practices

	1997	2005	2015
Never married men（18-34）	76.4	84.7	89.1
Never married women（18-34）	70.5	82.4	87.4
Married couples	59.9	53.9	39.8

Note: The use of contraceptive practices defined by the most recent sexual experience for never-married persons and the usual practice for the first-marriage couples with wives under 50 years old.
Source: The National Fertility Survey of Japan, National Institute of Population and Social Security Research (IPSS)

Concerning the universal coverage of reproductive services (SDGs 3.8.1), normal birth delivery is not considered as a sickness and hence not paid by fee-for service; instead a lump-sum payment is made as the childbirth allowance. For antenatal care and examinations, municipality financial support exists. Abortion is not covered by health insurance, and the fee is completely paid out-of-pocket.

Concerning the laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive information and education (SDGs 5.6.2), the curriculum guidelines of sexual education are stipulated by the Ministry of Education, Culture, Sports, Science and Technology (MEXT). However, the average total fertility knowledge score was 34%, much lower than the 64.3% average of the high Human Development Index countries.[5] The *Outline of Measures against the Declining Birthrate* has set a target to raise this score to 70%.

Due to delay in marriage and consequent difficulties in pregnancy, the proportion of births using ART (Assisted Reproductive Technology) to total births increased rapidly from 2.70% in 2010 to 4.93% in 2015.[6] To ease the economic burden of couples who suffer from infertility, a partial grant for ART treatment is provided through a

[4] National Institute of Population and Social Security Research (2017) Marriage and Childbirth in Japan Today : The Fifteenth Japanese National Fertility Survey, 2015 (Results of Singles and Married Couples Survey), Survey Series No.35.
[5] Laura Bunting et al. (2013) "Fertility knowledge and beliefs about fertility treatment: findings from the International Fertility Decision-making Study", *Human Reproduction*, Vol.28, No.2 pp. 385–397.
[6] Japan Society of Obstetrics & Gynecology, ART Registry of Japan, https://plaza.umin.ac.jp/~jsog-art/ (accessed on 14 June 2018).

government program, and the number of approved cases rose from 96,458 in 2010 to 148,659 in 2013[7] (APMD 110).

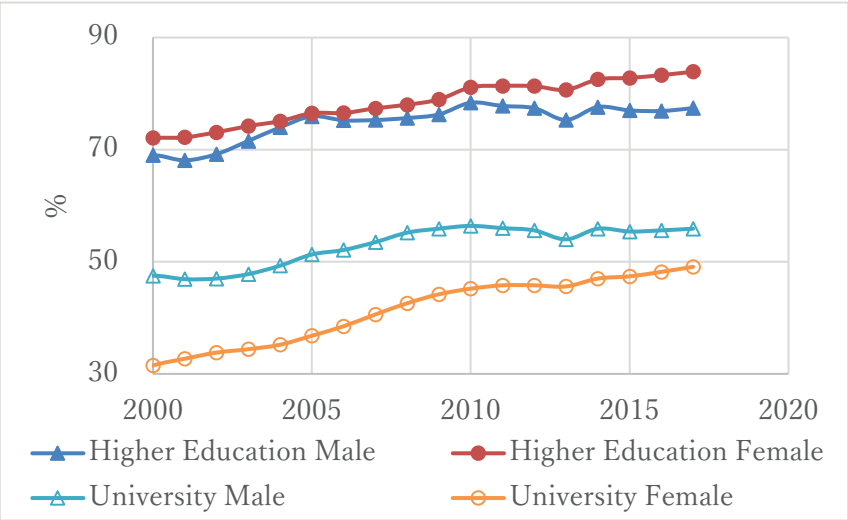
In 2004, the *Act on Special Cases in Handling Gender Status for Persons with Gender Identity Disorder* came into effect, and a total of 6,906 persons changed gender in the family register by the end of 2016. There are ongoing debates about whether the conditions which are applied to these special cases should be eased (APMD 84).

1.5 Education

Compulsory education in Japan covers elementary school and lower secondary school for those aged 6 to 15. The rate of enrollment for compulsory education (SDGs 4.1.1) is 99.96% (2010) and 99.95% (2017) for elementary school and 99.97% (2010) and 99.96% (2017) for lower secondary school. These rates indicate close to full enrollment. However, this enrollment rate does not include foreign children living in Japan. According to sample surveys, the proportion of foreign children not receiving compulsory education was 1.1% in 2006 and 0.7% in 2009. Considering this situation, the MEXT implements support programs through the boards of education for Japanese students returning from overseas and for foreign children.

The advancement rate to higher education including university, junior college, college of technology, and specialized training college by sex (SDGs 4.3.1) was 78.4% (2010) and 77.4% (2017) for men and 81.1% (2010) and 83.9% (2017) for women. The women's rate increased but men's rate did not. The women's rate has also been higher than the men's throughout the period. However, the advancement rate only to a university was 56.4% (2010) and 55.9% (2017) for men and 45.2% (2010) and 49.1% (2017) for women. So, the university advancement rate of women increased while the rate of men remained stagnant, but the rate of women entering university was significantly lower than that of men (Figure 1.5).

Figure 1.5 Higher education advancement rate by sex (2000-2017)



Source: School Basic Survey, Ministry of Education, Culture, Sports Science and Technology (MEXT)

[7] Ministry of Health, Labour and Welfare, http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000047270.html (accessed on 14 June 2018).

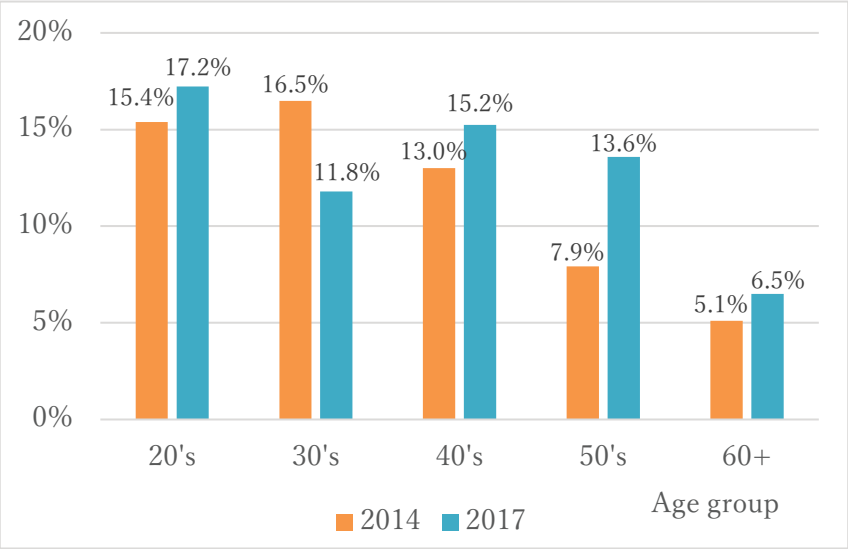
1.6 Gender equality and women's empowerment

The proportion of seats held by women (SDGs 5.5.1) increased from 2015 to 2018. Specifically, the increase was from 8.1% to 10.1% in the House of Representatives, 16.1% to 20.7% in the House of Councillors, 8.8% to 9.9% in the prefectural parliaments, and 11.8% to 12.8% in municipal parliaments. However, internationally, these rates remain low, and the rate in the House of Representatives ranked 157th among the countries of the world in 2018. In response, the *Act on Promotion of Gender Equality* was enacted in 2018 to encourage political parties to make efforts to increase female members in parliaments.

Other legal frameworks to promote, enforce, and monitor equality and non-discrimination on the basis of sex (SDGs 5.1.1) exist; these include *the Act on Securing, Etc. of Equal Opportunity and Treatment between Men and Women in Employment* (1972), the *Basic Act for Gender Equal Society* (1999), the *Act on the Prevention of Spousal Violence and the Protection of Victims* (2001), and the *Act on Promotion of Women's Participation and Advancement in the Workplace* (2017).

The proportion of married women who experienced physical, sexual, or psychological violence by their spouse in the previous year (SDGs 5.2.1) was 8.8% in 2014 and 10.3% in 2017. This proportion tends to decrease by age, but the proportion of all age groups, except those in their thirties, increased from 2014 to 2017 (Figure 1.6). The number of consultations to Spousal Violence Counseling and Support Centers also increased from 102,963 to 106,367 in the same timeframe.[8] This data may not necessarily mean that actual violence increased but could rather indicate that there is an increasing perception that domestic violence is something about which to speak out.

Figure 1.6 Proportion of married women who experienced physical, sexual, or psychological violence by their spouse in the previous year (2014, 2017)



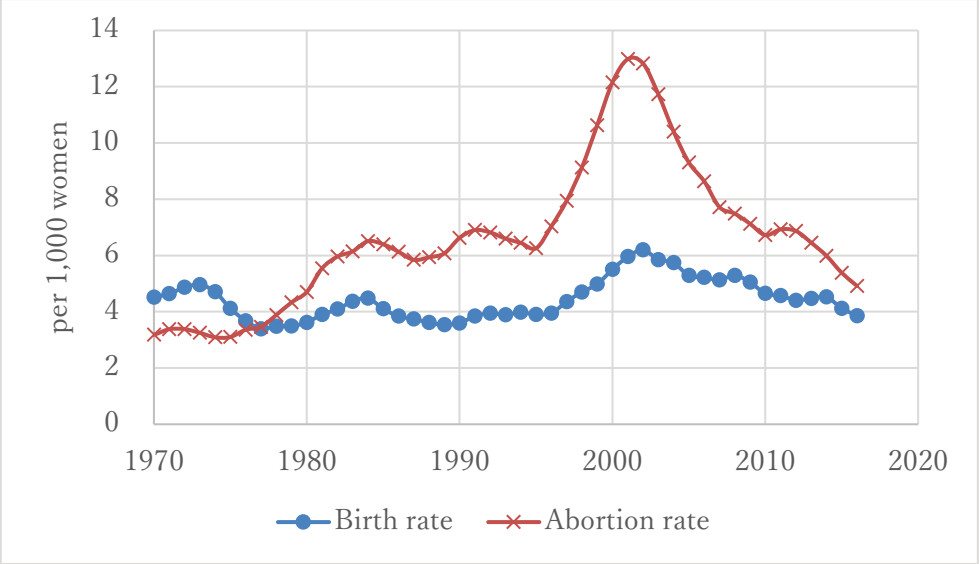
Source: Survey on Violence between Men and Women, Cabinet Office

[8] Gender Equality Bureau, Cabinet Office.

1.7 Adolescents and young people

The adolescent birth rate (SDGs 3.7.2) is declining in recent years in Japan. The birth rate of those aged 15-19 was 4.6 in 2010, 4.5 in 2014, and dropped further to 3.8 in 2016. The abortion rate of the same age group is generally declining since 2002, and it has been higher than the birth rate since 1977 (Figure 1.7). Although abortion remains a crime under the Japanese Penal Code, it is legal when either the continuation of pregnancy would harm the health of the mother physically or economically or in cases of rape under the *Maternal Health Act* (started as *Eugenics Protection Law* in 1948). Although abortion is not covered by health insurance, the provision of safe abortion services are maintained under the *Maternal Health Act*. In view of the higher abortion rate of adolescents compared to the birth rate, comprehensive sexual education and the adoption system should be properly implemented.

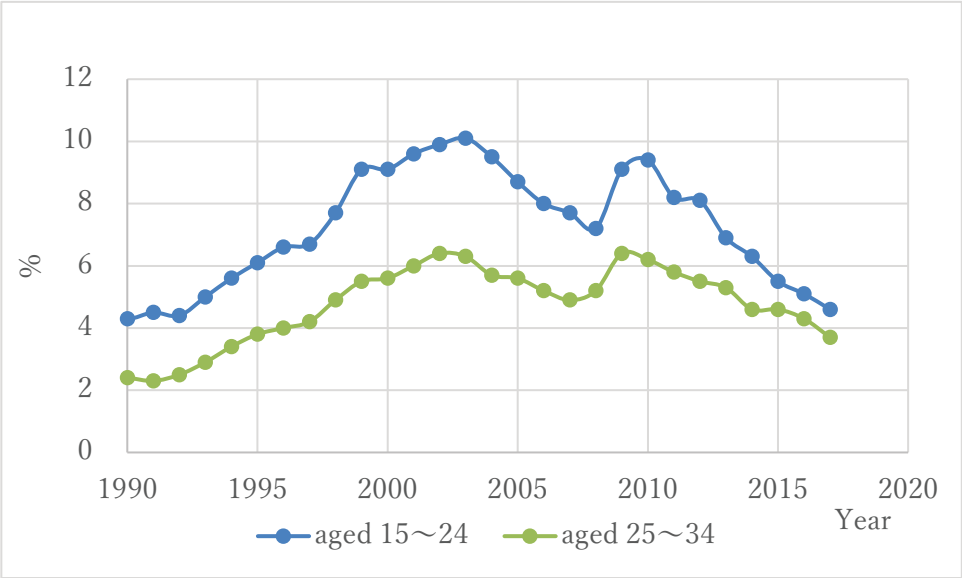
Figure 1.7 Birth rate and abortion rate per 1,000 women aged 15 to 19 (1970-2016)



Note: Abortion of women aged 15 and less are included until 2002. The births of foreign father and foreign mother are not included until 1994.
Source: Vital statistics (birth rate) and Report on Public Health Administration and Services (abortion rate), Ministry of Health, Labour and Welfare

The unemployment rates (SDGs 8.5.2) of youths aged 15 to 24 and those aged 25 to 34 show similar trends, sharply increasing during the global economic crisis of 2009, then decreasing smoothly afterward. In 2017, unemployment was 4.6% for those aged 15 to 24 and 3.7% for those aged 25 to 34, the lowest level since the end of the 1990s (Figure 1.8). The unemployment rate of women is lower than that of men.

Figure 1.8 Youth unemployment rate (1990-2017)



Source: Labour Force Survey, Statistics Bureau

Since 2015, the Law on the Employment Promotion for Youth encourages youth employment through the dissemination of information on youth recruitment and awarding companies with good youth employment practices.

The proportion of NEET (not in education, employment, or training) of youth aged 15-24 (SDGs 8.6.1) was 1.9% in 2010 and decreased slightly to 1.8% in 2015.[9]

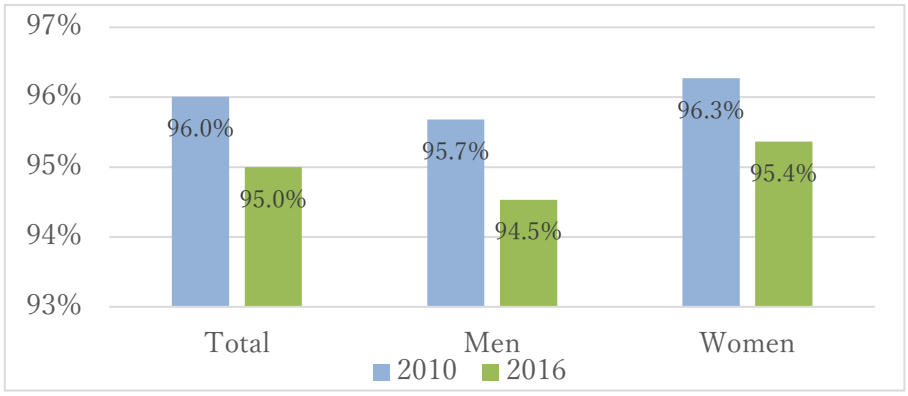
1.8 Ageing

The proportion of the elderly (persons aged 65 years and over) rose from 23.0% in 2010 to 27.8% in 2017.[10] It is projected that this proportion will rise further to 30.0% in 2025 and 38.4% in 2065.[11] This proportion is the highest worldwide as of 2017.

As one of the indicators on the proportion of population covered by social protection floors (SDGs 1.3.1), the proportion of the elderly who are receiving public pension was 95.7% for men and 94.5% for women in 2016 (Figure 1.9). This proportion has decreased for both men and women since 2010. In addition to older persons still working and hence not yet receiving pension, there are people who have not paid the pension premium and therefore do not receive pension.

[9] Cabinet Office *White Paper on Children and Young People 2017.*
[10] Population Estimates, Statistics Bureau.
[11] Population Projections for Japan, medium-fertility and medium-mortality assumption (2017) National Institute of Population and Social Security Research.

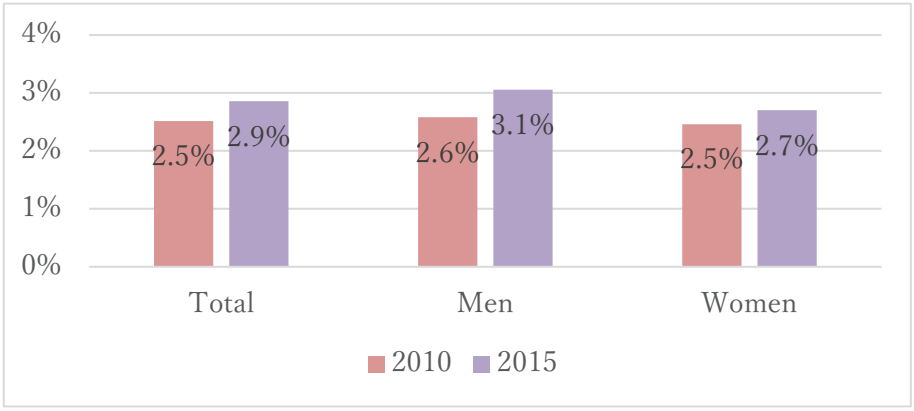
Figure 1.9 Proportion of persons aged 65 years and over who are receiving public pension



Source: Household questionnaire, Comprehensive Survey of Living Conditions, Ministry of Health, Labour and Welfare

Another indicator of SDGs 1.3.1 is the proportion of persons aged 65 years and over who are the recipients of the Public Assistance. This proportion was 3.1% for men and 2.7% for women in 2016, and these rates had increased for both sexes since 2010 (Figure 1.10).

Figure 1.10 Proportion of older persons aged 65 years and over who are recipients of the Public Assistance

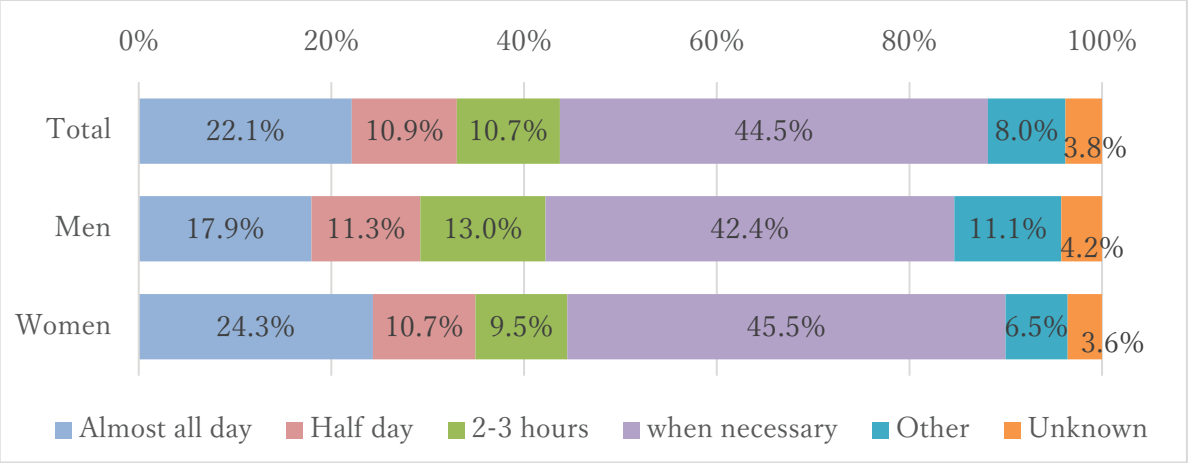


Source: National Survey on Public Assistance Recipients, Ministry of Health, Labour and Welfare

Since there are an increasing number of young people who are not paying pension premiums and who are not married and have no children, it is assumed that there will be an enormous challenge to ensure the social protection floor in the future.

The public long-term care insurance system started in 2000, and the number of persons certified as recipients of the insurance increased from 2.18 million in 2000 to 4.87 million in 2010 and then to 6.33 million in 2017. The service provision system including finance, elderly facility, and care personnel is expanding as well. However, the role of family is still important. In 2016, 58.7% of the elderly receiving care at home are cared for by family members who are living together. Of these family caregivers, 66% are women and 22.1% spent almost all day giving care; this proportion is higher for women (24.3%) than men (17.9%) (SDGs 5.4.1, Figure 1.11).

Figure 1-11 Time spent for the care by the family care giver by sex (2016)



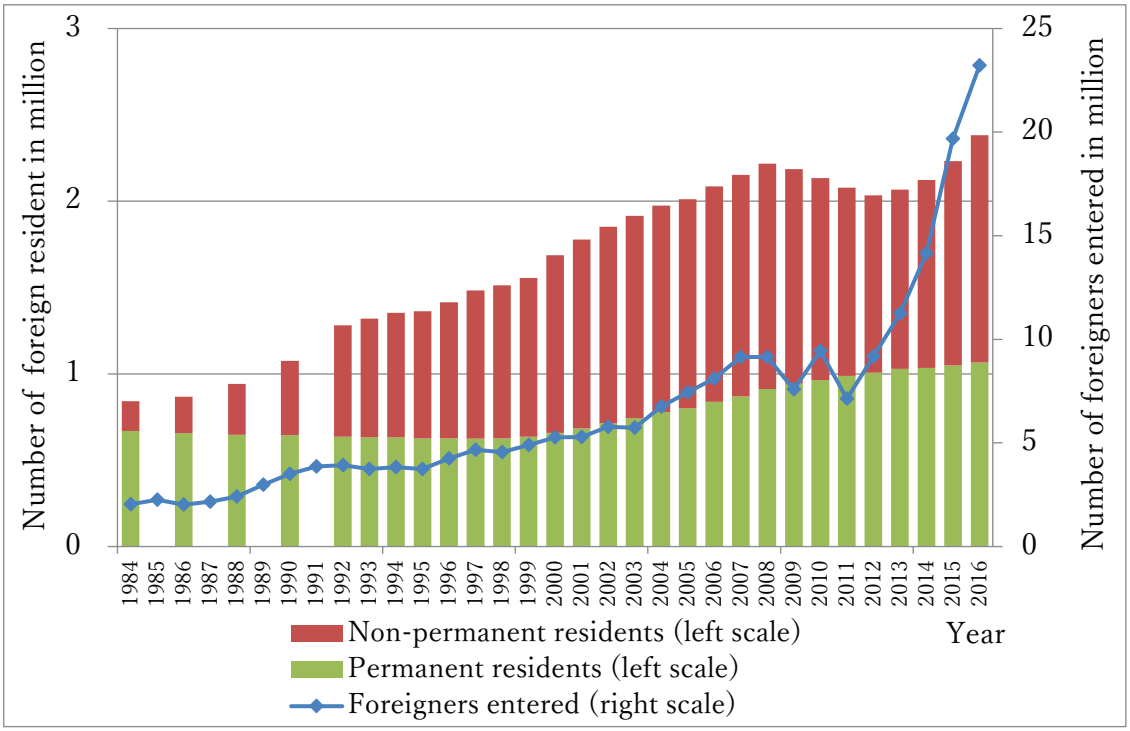
Source: Comprehensive Survey of Living Conditions, Ministry of Health, Labour and Welfare

There has been substantial development of the long-term care system in Japan, especially since 2000. In 2016, the government of Japan launched the *Asia Health and Wellbeing Initiative* (AHWIN) to promote bilateral and regional cooperation for the development of a long-term care system through the mobility of personnel as well as through the exchange of technology and information such as long-term care protocols, appliances, IT, and robotics.

1.9 International migration

Although the proportion to the total population is still small, the number of foreigners in Japan continues to increase. The number of foreign residents staying more than three months in 2017 was 2.47 million, up from 1.69 in 2000 and 2.13 in 2010 (Figure 1.12). Furthermore, the total number of entries by foreigners, including short-term tourists, was 5.27 million in 2000, almost doubled to 9.44 in 2010, and quadrupled to 23.22 in 2016. This sharp increase is explained by the national policy on tourism promotion.

Figure 1-12 Number of foreign residents (permanent and non-permanent) and foreigners who entered Japan (1984-2016)

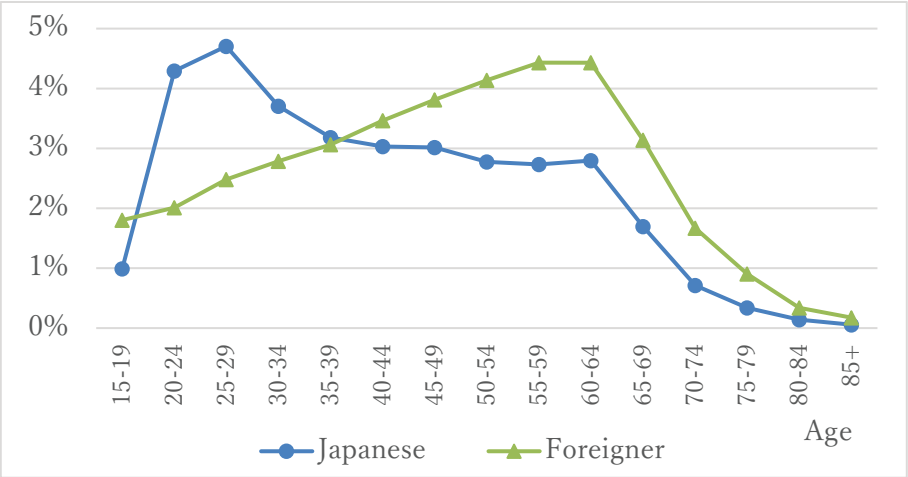


Note: Foreign residents are defined as those who stay more than three months. Foreigners who entered includes short-term tourists.
Source: Ministry of Justice

As for social integration, since 2012, foreign residents are integrated into the Basic Resident Registration for the smooth delivery of municipal services. As of May 2018, Social Security Agreements have been enacted with 17 countries, signed with 4 countries, negotiated with 3 countries, and discussed preliminarily with 1 other country.

The unemployment rate of foreigners (SDGs 8.5.2) was 3.0% in 2015, slightly more than the 2.4% of Japanese nationals. By age, the youth unemployment rate is higher for the Japanese than for foreigners, whereas the unemployment rate of the middle and older aged is higher for foreigners than for the Japanese (Figure 1.13).

Figure 1.13 Unemployment by age and by nationality (2015)

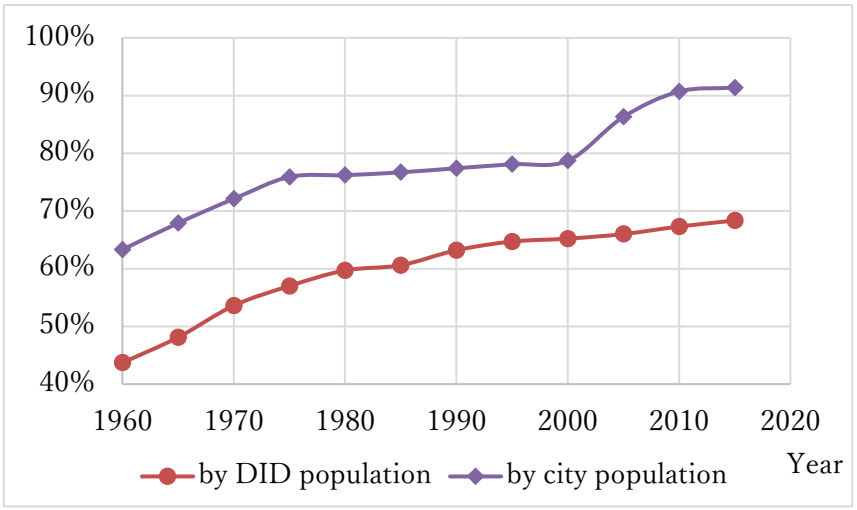


Source: Population Census, Statistics Bureau

1.10 Urbanization and internal migration

The urban population rate of Japan was 91.4% in 2015, when the population of "city" is defined as urban population, and 68.3% if the population of Densely Inhabited Districts (DID) is defined as urban population. Both rates are increasing (Figure 1.14).

Figure 1-14 Urban population rate (1960-2015)



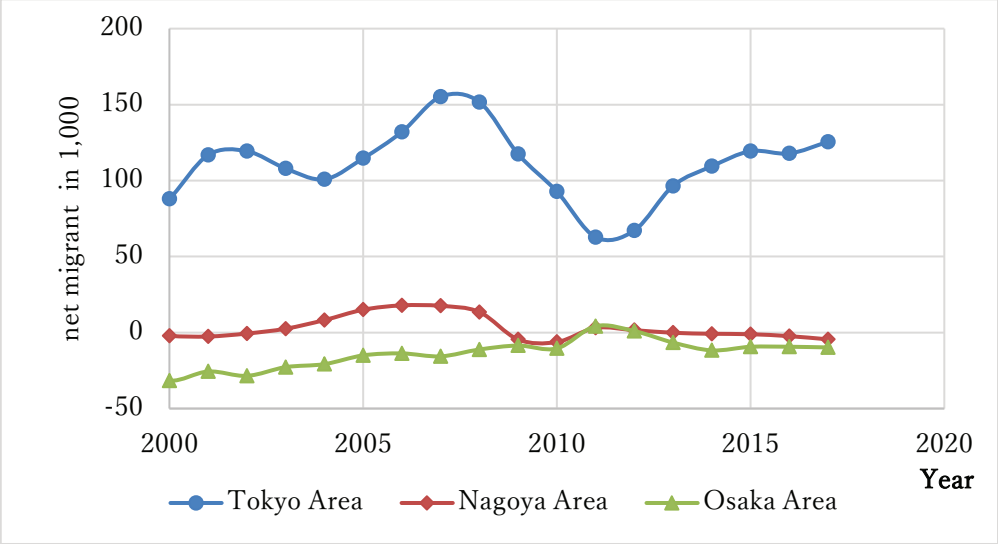
Source: Population Census, Statistics Bureau

In spite of the total population decline, the Tokyo area, the largest urban agglomeration in the world,[12] continues to have net in-migration (Figure 1.15). To ease the concentration of population to Tokyo area, the *Comprehensive Strategy for Overcoming Population Decline and Vitalizing the Local Economy* was implemented

[12] United Nations, Department of Economic and Social Affairs, Population Division (2018). World Urbanization Prospects: The 2018 Revision, Online Edition.

since 2014 to promote local innovation, the return migration of retirees, and the promotion of local universities and industries. However, the trend of excessive in-migration to Tokyo is difficult to reverse so far.

Figure 1.15 Net migration in the three major urban agglomerations (2000-2017)



Source: Report on Internal Migration in Japan Derived from the Basic Resident Registration, Statistics Bureau

Although the total population is declining, urban area, defined as the area of Densely Inhabited Districts, is increasing slightly. The ratio of land consumption rate to population growth rate (SDGs 11.3.1) was 6.4 from 2005 to 2010. The ratio was -0.4 from 2010 to 2015 when this rate is defined as the ratio of DID area change rate to total population change rate (Table 1-3). In other words, despite the total population decline, both the DID population and the population density of DID are increasing.

Table 1-3 Population and Densely Inhabited Districts

Year	Population in 1,000		DID area (km^2)	DID pop. density	Change rate			Ratio	
	Total	DID			Total pop. (a)	DID pop. (b)	DID area (c)	c/a	c/b
2000	126,926	82,810	12,457	6,648					
2005	127,768	84,331	12,561	6,714	0.66%	1.84%	0.83%	1.3	0.5
2010	128,057	86,121	12,744	6,758	0.23%	2.12%	1.46%	6.4	0.7
2015	127,095	86,868	12,786	6,794	-0.87%	0.87%	0.33%	-0.4	0.4

Source: Population Census, Statistics Bureau

The proportion of municipalities which have a direct participation structure of civil society in urban planning

and management (11.3.2) is 45.4%.[13] Community development by civil society is promoted through the *City Planning Act*, the *Land Readjustment Act*, the *Urban Renewal Act*, and the *Act on Special Measures Concerning Urban Renaissance*.

1.11 Population and sustainable development

The number of deaths, missing persons, and directly affected persons attributed to disasters (SDGs 11.5.1) are counted, registered, and published by several official sources. These sources are the Fire and Disaster Management Agency, the National Police Agency, and the Vital Statistics of the Ministry of Health, Labour and Welfare. The Great East Japan Earthquake caused 19,630 disaster-related deaths, 2,569 missing persons, and 6,230 injured persons, according to the Fire and Disaster Management Agency (15,895 deaths, 2,539 missing persons, and 6,156 injured persons according to the National Police Agency; and 3,647 disaster-related deaths according to the Reconstruction Agency as of 30 September 2017). The complexity of these statistics shows that accounting for victims of a disaster is not an easy task.

Based on data released by the National Police Agency, the age structure of deaths caused by the Great East Japan Earthquake was primarily of the aged, with 64.3% of deaths of persons who were 60 years and over and 45.5% who were 70 years and over.[14] In addition, the mortality rate of persons with disability was 1.9%, twice as high as the total mortality of 1.0%, according to the survey conducted by NHK, the national broadcasting corporation.[15]

In line with the Sendai Framework for Disaster Risk Reduction 2015-2030, the Basic Act for National Resilience was enacted in 2016; the Fundamental Plan for National Resilience and the Action Plan for National Resilience were created; and the Central Disaster Prevention Council was established (SDGs 13.1.2).

In May 2016, the Sustainable Development Goals (SDGs) Promotion Headquarters was established within the Prime Minister's Office. Since then, public comments were gathered to formulate the *Implementation Guiding Principles*; and in December 2017, SDGs *Action Plan 2018* was released, and the first Japan SDGs Award was granted to twelve parties including municipalities, civil societies, universities, and private companies. Through the implementation of the *Action Plan 2018*, a Japanese SDGs model will be created and disseminated. A follow-up of the *Implementation Guiding Principles* is planned for summer 2019 which will be revised further for the achievement of the SDGs by 2030.

1.12 Data and statistics

The number of people who failed to be registered to the family registry was 702 persons in 2016, which corresponds to 0.0006% of the total population (SDGs 16.9.1). Although this count is small, the cause of these unregistered people/children is mainly due to family registry legal procedures. Per Civil Code Article 772-2, a child born within 300 days after a divorce was presumed to be the child of the former husband, and unregistration to

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[13] City Bureau, Ministry of Land, Infrastructure, Transport and Tourism (2016) "Materials for the first study group on the maintenance of stakeholders for the community development" Material 4-1.
[14] Ushiyama, Motoyuki (2012) "Jinteki Higai no Tokuchou", Saigai Jouhou, No.10.
[15] Tatsuki, Shigeo (2013) "Koureisha, Shougaisha to Higashi Nihon Daishinsai : Saigaiji Youengosha Hinan no Jittai to Kadai" *Kikan Shoubou Bousai no Kagaku*, Institute of Scientific Approaches for Fire & Disaster.

family registry occurred when the mother did not wish to register her former husband as the father. This procedure was judged by the Supreme Court in 2015 as an excessive constraint and unconstitutional, so the Civil Code was amended in 2016 to reduce the time period to 100 days.

The *Statistics Act*, originally enacted in 1947, was revised in 2007 and came into effect in 2009 (SDGs 17.18.2). The Japanese national statistics plan was first established in 2009 as the *Basic Plan concerning the Development of Official Statistics*. Since then, the Basic Plan continued to be updated, and in March 2018, the Third Basic Plan was decided by the Cabinet. These Basic Plans are fully funded and implemented (SDGs 17.18.3).

The last population census was conducted in 2015 (SDGs 17.19.2 a), and the next is planned for 2020. The population census with the longer set of questions has been conducted every 10 years on years ending with 0 since 1920, and the population census with a shorter set of questions has been conducted every 10 years on years ending with 5, except 1945. Birth and death registration are considered almost complete (SDGs 17.19.2 b). However, some birth unregistrations occurred, as mentioned above. As for death unregistration, there were cases in which the family did not register the death of the family member, so that they could continue receiving the pension. These cases were highly mediatized in 2010. However, to receive a pension, periodical existence verification is required, and the Japan Pension Service conducted surveys and stopped pension payments in suspected cases. Without death registration, a funeral is impossible, and the body was either left as it was or disposed of illegally. Such instances are criminal, and the actual number of unregistered deaths is considered low.

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 in other countries, the source of social security in Japan could be found in charity-oriented communal activities for the poor in the 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 this. The Imperial court, the Shogunate, and the feudal lords provided relief to the poor. Buddhist temples also provided relief. These measures were based on the charity ethics of Confucianism and Buddhism. However, the beneficiaries were severely limited (e.g., poor elderly without family) because mutual aid was a principle of the society in those days. For example, "Gonin-gumi (五人組)" (a five-member group in the Edo Era) might not only have been a group for the render (Nengu 年貢) payment but also that of mutual aid in the community during this era. This was one form of the social capital of the pre-modern society.

As for healthcare, from ancient times to the Edo Period, traditional medicine had been imported from the China, with some original development within Japan. In the latter Edo period, Western medicine had been imported from the Netherlands through Nagasaki. Private schools (Rangaku Jyuku 蘭学塾) were set up in Nagasaki and Sakura (Chiba), and from these, the notable medical faculties of the University in Japan originated.

Table 2.2 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 started to develop in modernization. However, poverty had increased because of instability in society, and the government had to cope with this. The Indigent Person's Relief Regulation was enacted (1884), but the principle of this regulation was "mutual aid for the poor," and the beneficiaries were severely limited. An amendment to expand the beneficiaries was discussed in the Imperial Parliament, but they had to wait for the Poor Relief Law (1929) to be enacted. It was still inadequate compared to the present system.

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

However, these systems were inadequate compared to the present system in terms of population coverage. (Refer to Table 2.2)

In terms of medicine, the Meiji government decided to introduce Western medicine (mainly from Germany) and had developed a medical doctor license qualification system and educational institutions. The government also constructed the mechanism of modern public health (for example, the Act on Prevention of Infectious Diseases in 1897). The Maternal and Child Health Act was enacted in 1937. Based on this act, the "Maternal Handbook" (presently, the "Maternal and Child Health Handbook") began to be issued in 1942. The purpose of this handbook was to protect and promote the health of mother and child by recording health checkups (refer to Table 2.2).

2.1.3 After the End of World War II to Present (1945-2018)

The social security system in Japan developed dramatically after the end of World War II. During the social turmoil just after the war, measures to assist the needy, improve nutrition, and 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 for 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 was separated from the Ministry of Health and Welfare to independently oversee labor policy (These ministries were re-integrated in 2001 as the Ministry of Health, Labour and Welfare). In the same year, unemployment insurance was also introduced.

During the rapid economic growth period that followed, the public pension and health insurance were expanded to cover more people, and the so-called "Universal Coverage in Public Pension and Health Insurance" that extended to all citizens was introduced in 1961. The Act on Social Welfare Service for the Elderly and the Maternal and Child Welfare Act were 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 starting in 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 have surfaced as an important policy issue. Pension and health insurance system reforms have been implemented. The Long-Term Care Insurance Act was introduced and amended five times to provide societal support to the elderly with long-term care needs and their families. Enhancement of childcare services and financial support are being promoted to assist in childcare. In addition, due to changes in employment and the widening differences in the economy, employment policies have also become important. (Refer to Table 2.2)

2.2 Social Security Schemes in Japan and Their Characteristics

A social security scheme is primarily a system that supports the people's livelihood by providing necessary support against conditions that lead to poverty, illness, injury, death, aging, and unemployment. There are various social security schemes in Japan. The public pension system provides income security for the elderly, 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 includes 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.

The 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 the 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, 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 long-term care insurance, and employees are covered by employment insurance and work-related accident insurance.

The social insurance systems mentioned above are financed by social insurance premiums and supplemented by tax revenue in the form of subsidies. Social insurance premiums are 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) and services/benefits for families, 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 (MHLW) 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 governmental basic policy plans related to social security such as population aging and childcare policy. Local governments such as prefectures and, notably, municipalities (cities, towns, and villages) execute and implement social security services. Local governments have social welfare offices and public health centers. In recent years, decentralization has proceeded in the form of delegating financial resources from central to local governments. This is based on the idea of "local autonomy."

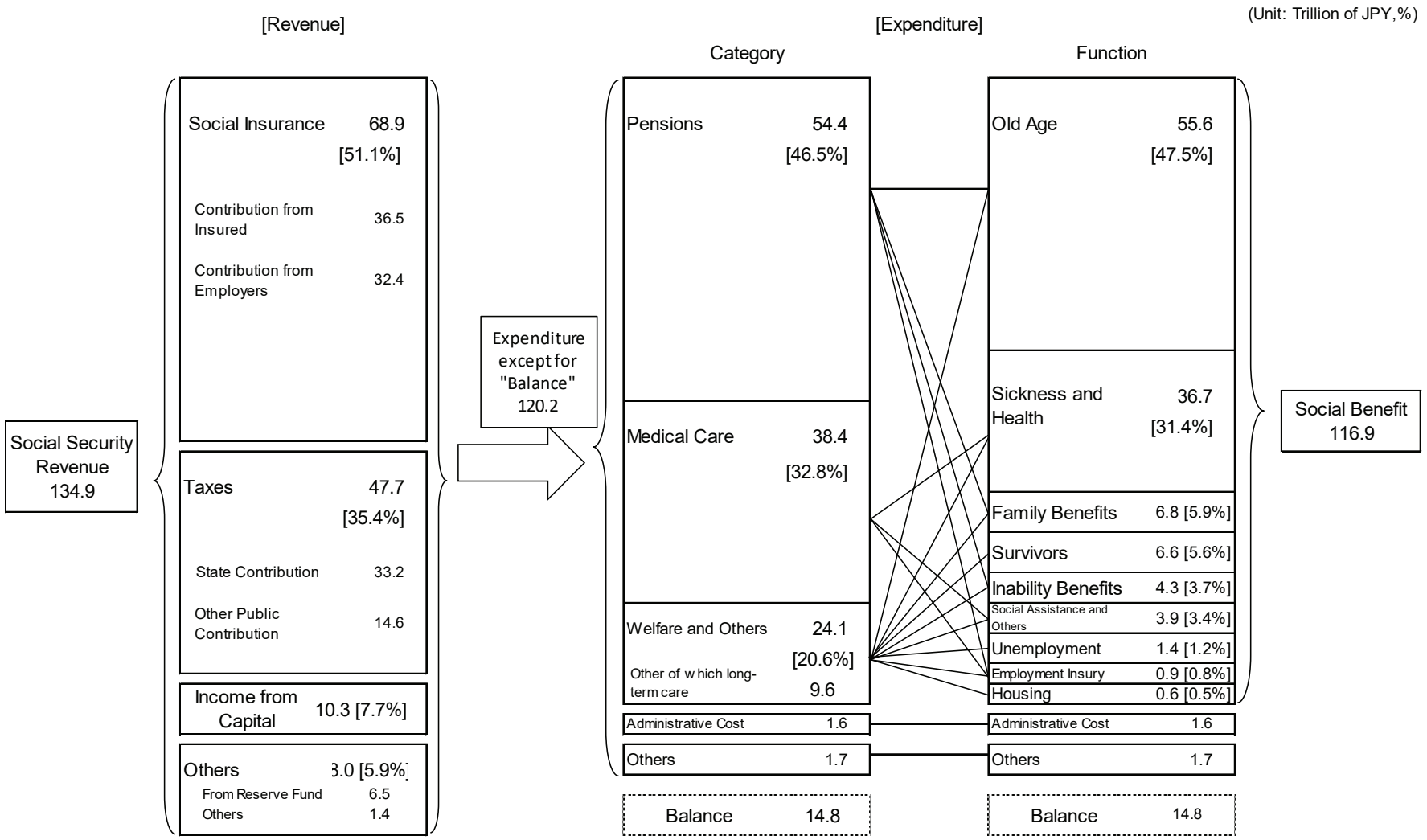
The social security system has many schemes. Beneficiaries and contributions have been managed separately, but this has led to inconvenience for people and inefficiency in management. To solve these problems, the Social Security and Tax Number Law was approved in 2013 and enacted in October 2015. A unique number is given to all persons, including foreign residents, and companies in Japan. Paying maximum attention to privacy protection, this "My Number" system is used for tax and social security service management.

Social security service providers such as hospitals and clinics for healthcare, daycare centers and institutions for 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. Both public and private institutions are operated under the supervision of the MHLW and the local governments.

2.4 Financial Statistics of Social Security

Japan now collects and spends two sets of financial statistics for social security. The Social Expenditure of Japan based on the OECD standard was 119.6384 trillion JPY in FY2016, which was 22.17% of the GDP and 942,500 JPY per capita. The Social Benefit based on the ILO standard, which does not include the costs not transferred directly to individuals such as facility maintenance costs, was 116.9027 trillion JPY in FY2016, which was 21.68% of the GDP and 921,000 JPY per capita. The ILO standard social security statistics can grasp the flow of revenue and expenditure in social security. Figure 2.1 shows a breakdown of social security revenue and expenditure by this ILO standard. Insurance premiums account for 51.1% of the total revenue and 35.4% of taxes. The expenditure for the public pension takes up around half of the entire expenditure, and for the medical care, around one third. As for 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, FY2016



Note:

1. "Others" in the Revenue includes 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 (134.9 trillion yen) and the sum of Social Benefit, administrative costs, operating losses, and others (120.2 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.

Table 2.2 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 the Imperial Family)
	718	"Yoro Ritrsuryo" Act (showed mutual aid for the elderly, etc.)
	1642	"Osukuigoya" was set up (relief institution in famine)
	1722	"Koishikawa Youjojo" was opened (medical institute for the poor, Edo city)
	1791	"Shichibu-tsumikin" (fund for relief for the poor, Edo city)
Meiji Era to World War II	1874	Indigent Person's Relief Regulation
	1897	Act on Prevention of Infectious Diseases
	1911	Factory Law (an origin of the 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	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 to finance healthcare costs for the elderly)
	1990	Major amendments of eight acts on 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)
Since 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 for health insurance for 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)
	2015	Act on the Independent Life Support for Needy Persons

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 was completely corrected only when the private sector workers' pension (EPI: Employees' Pension Insurance) and civil workers' pension (Mutual Fund) were 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

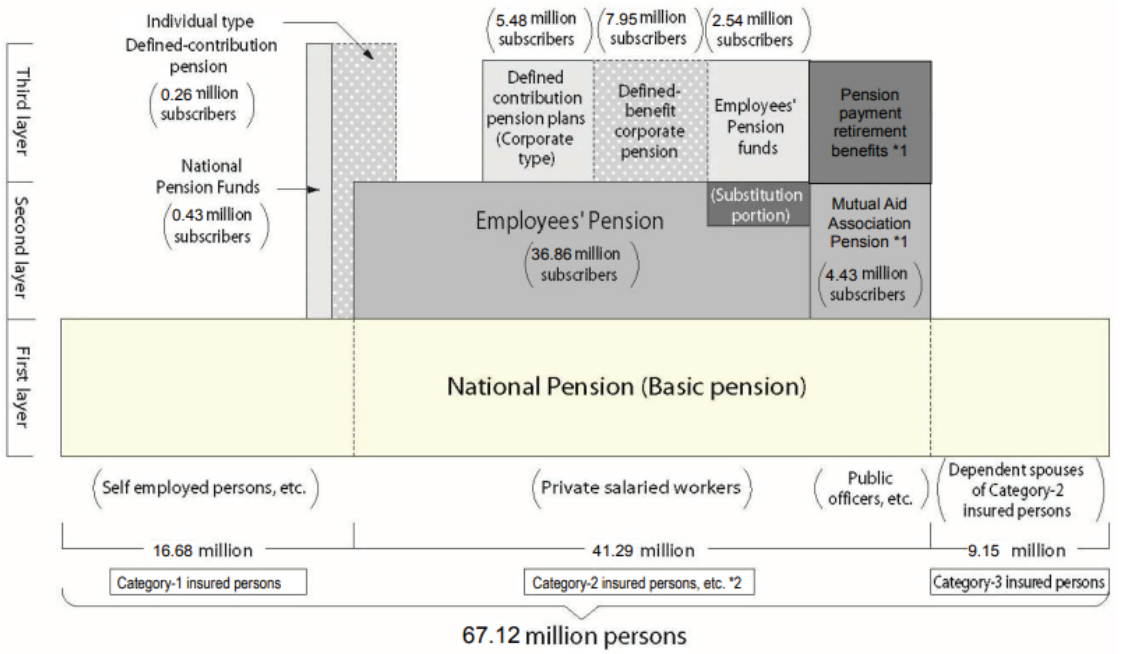
Nowadays, the Japanese pension system is multi-tiered, consisting of public and private pension schemes (Figure 3.1). In this booklet, the distinction between public and private pension is whether the insurer of the pension is the government or not. The first tier is the *Basic Pension* (基礎年金), which 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

(The figures are as of the end of March 2016)



Note:

*1 In response to the integration of the Employee's Pension Schemes, public officers and private school teachers joined Employees' Pension from October 1, 2015. Moreover, the portion added according to job category in Mutual Aid Pension was abolished and retirement benefits payment in pension were newly introduced. However, as for the portion for the subscription period of Mutual Aid Pension by September 30, 2015, the portion added according to job category is paid according to subscription period even after October 2015.

*2 Category-2 insured person, etc. refers to the insured persons of EPI (including beneficiaries aged 65 years or above of pension benefits for old-age or retirement in addition to Category-2 insured person).

Source: Annual Health, Labour and Welfare Report 2017, https://www.mhlw.go.jp/english/wp/wp-hw11/dl/11e.pdf

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. 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), 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.

$$¥779{,}300 \times \left((\text{insured months} + 1/2 \times \text{exempt months}) / 480 \right)$$

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 (¥16,340 per month in 2018FY) is levied on each subscriber to the National Pension as a premium (37.5% of Category 1 subscribers are fully exempted and 2.8% 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 ¥55,518 in 2017, which is around 85% 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 9.15%[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].

The average monthly pension benefit by the Employees' Pension Insurance is about ¥144,903, which amounts to 46.7% of the average monthly salary of subscribers (2017).

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

3.4.3 National Pension Fund

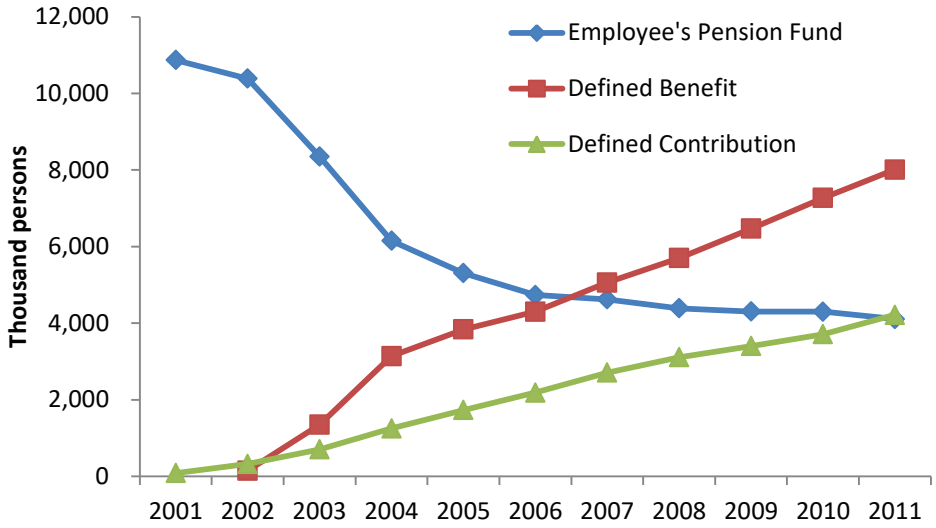
The National Pension Fund is an optional pension for the self-employed (Category No.1), and is designed to give additional pension coverage to the self-employed who do not have the third-tier pension (Employees' Pension Insurance). However, only about 3% (0.43 million) of Category No.1 subscribers (16.68 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 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 paid 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, Hungary, India, Luxembourg, Philippines
Signed	Italy, Slovakia, China
Under negotiation	Sweden, Turkey, Finland
Under preparatory negotiation	Austria, Viet Nam

Source: Ministry of Health, Labour and Welfare website at;
https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/nenkin/nenkin/shakaihoshou.html (accessed on 22 Feb. 20)

Chapter 4 Health Care

4.1 Introduction

The health care service system in Japan is delivered by mandatory, nonprofit public health insurance systems and by nonprofit service providers. Japan's public health insurance system is composed of three types of health insurance: occupation based and municipality based, and a separate system for people aged 75 years old and over. Every resident in Japan must belong to the public insurance system as an enrollee. Health services are provided by not only public providers but also private ones, which satisfies the "nonprofit" principle. Patients enjoy "freedom of choice," meaning that they can select and contact physicians in any medical institution, including outpatient departments of hospitals. The cost of medical care is financed through insurance premiums, tax revenues, and co-payments. The elderly, infants, and low-income people are completely or partially exempted from co-payments. Other people must pay co-payments that are 30% of the total medical cost when they use medical services. The maximum amount of co-payment is determined based on the income level and age of patients. The sustainability of the system depends on whether the inter-institutional redistribution of the burden can work and whether enough human resources are available to provide services to users.

4.2 Public Health Insurance

4.2.1 History

The health insurance system in Japan has been continuously developing since the 1920s. First, the Health Insurance Act was enacted in 1922, but the Great Kanto Earthquake in 1923 delayed the enforcement of the law until 1927. This public health insurance covered "blue-collar workers in factories and mines. Next, the National Health Insurance Act was enacted in 1938. This law widened the coverage of public health insurance to not only farmers but also the general public not covered by health insurance law. The National Health Insurance Law prescribed that municipalities could be insurers of national health insurance for the people living in their regions. However, the law also stated that municipalities could choose not to establish a national health insurance system and that people were free to make the decision to enroll or not to enroll in public health insurance. Hence, some people remained without insurance. From 1939 through 1941, other public health insurance laws started to cover "white-collar workers, including government officials. Furthermore, the public health insurance system started to cover seamen based on the Seamen's Insurance Act of 1940. In sum, before WWII, the public health insurance system in Japan was gradually developed by enacting different health insurance laws for each sub-group in society.

Public health insurance developed further after WWII. Laws on public health insurance that had been enacted before the end of WWII were consecutively implemented after the war. Hence, public health insurance began to assume prewar characteristics. Each public health insurance law regulated its own financial budget; therefore, the laws' management was independent of each other. More important, the lack of laws for comprehensive health insurance coverage led to the existence of noninsured people. This issue was resolved by the implementation of the new National Health Insurance Act in 1961, through which Japan attained universal coverage. This act mandated all residents in Japan to enroll in national health insurance, except in cases where they had already enrolled in other public health insurance systems.

The next issue in the development of public health insurance was the improvement of insurance benefits and elimination of inequality in insurance benefit through different schemes. In the early 1960s, expensive antibiotic drugs, some steroid drugs and drugs for chemotherapy were prohibited by the public health insurance system. This restriction was abolished in 1962, raising health care costs. However, the expanded cost could be absorbed into the expanded financial surplus in the public health insurance system thanks to the high rate of Japan's economic growth.

In the early 1960s, the co-payment rate was 50% for all enrollees in national health insurance, and 0% for the head of the household (principal enrollee) in society-managed health insurance and association-managed health insurance. Thus, the amount of the subsidy from the government to national health insurance insurers was increased to lower the co-payment rate for enrollees in national health insurance.

The burden of co-payment tended to be larger for patients with severe diseases or chronic diseases. In the 1960s, municipalities started to subsidize the elderly (over 70 years and older) so that their co-payment rates became 0%. This subsidy became universal in 1973. For people less than 70 years old, a high-cost medical care benefit system was introduced in 1973 to cap the burden of co-payment.

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

Despite the reduction in social security spending, health care expenditure for the elderly was rapidly increasing. One of the reasons for this was the government subsidy for co-payments 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 of health care expenditure was also very high. To contain the rapid cost increase, a new health care system for the elderly was needed. However, the cost increase was not the only reason for the introduction of the new system. At the time, the elderly could only utilize medical care services, not services for health promotion, preventive measures such as health check-ups, or rehabilitation. These services, in collaboration with medical care, needed to be supplied in a more integrated manner. Hence, in 1983, a health service system for the elderly was introduced. Per-diem-basis co-payment 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 the elderly. Since the mid-1980s, cost containment policies have been employed. Inequality in co-payment rates between different public health insurance systems was equalized to 30% in 2003. Inter-institutional fiscal adjustments with respect to health care cost for the elderly were strengthened, and the old system developed into a medical care system for the elderly in the latter stage of life in 2008.

4.2.2 Public health insurance system: Today

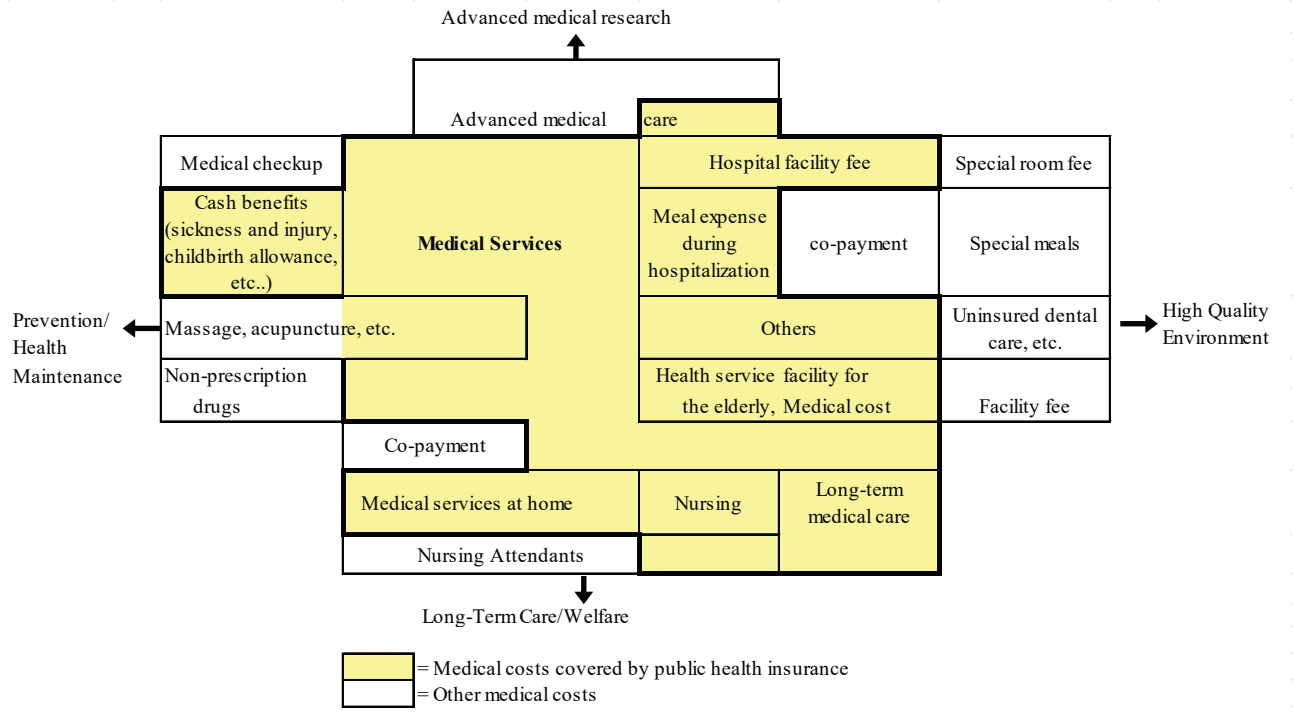
As stated before, Japan's medical services are financed through a public mandatory health insurance system, which is composed of three types of public health insurance: occupation based and municipality based, and separate health insurance for people aged 75 years old and over. The elderly aged 75 or over enroll in public health insurance, which is called the medical care system for the 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 health insurance for workers at firms of a certain size; these are called society-managed health insurance. Large companies have a duty to establish firm-based nonprofit public health insurers to provide public health insurance coverage to their employees. For those who work at smaller firms, the Japan Health Insurance Association, a public association for health insurance, provides collective health insurance, which is called association-managed health insurance. Additionally, people in special professions such as civil servants, private school teachers and employees, day laborers, and seamen, form separate nationwide professional associations.

Those who are below 75 years old and are not covered by occupation-based public health insurance are covered by a national health insurance. Before April 1, 2018, national health insurance insurers were municipalities and local governments, which are closest to their communities. The national health insurance covered self-employed people, workers engaged in agriculture and forestry and fisheries, workers in small businesses, the unemployed, and pensioners. After April 1, 2018, prefectures, the second-tier local government in Japan, became collaborative insurers in municipalities.

These public health insurers provide universal coverage for Japanese population. The outline of each system is shown in Table 4.1 (located at the end of this chapter). National health insurance covers 27% of the total population, association-managed health insurance covers 29%, society-managed health insurance covers 23%, and the medical care system for the elderly in the latter stage of life covers 13%.

Insurance benefits are standardized throughout all public health insurance schemes, as shown in Figure 4.2. The extent of the medical services covered by public health insurance is discussed by the Central Social Insurance Medical Council, whose members consist of representatives of clinical physicians and hospitals, public health insurance insurers, and the general public. The council also discusses official tariffs for medical services. Based on the council's suggestions, the Ministry of Health, Labor, and Welfare decides the coverage and prices of medical services.

Figure 4.2 The structure of health care coverage by and beyond public health insurance



4.2.3 Financing of health insurance

Generally, an individual's health care expenditure becomes higher as he/she ages. This is also true in Japan. Hence the average health care expenditure per enrollee is highest in the medical care system for the elderly in the latter stage of life (¥844,382/year) because individuals who are more than 75 years old are enrolled in it, as we have already explained. Most individuals aged between 65 and 74 enroll in national health insurance, and the average health care expenditure per enrollee is ¥300,229/year, higher than the expenditure in other occupation-based health insurance systems. The costs of health benefits in public health insurance reflect this difference in enrollees' age structure, as shown in the upper part of Table 4.3.

Table 4.3 Financial situations of public health insurance systems (year 2015)

	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	145,197	133,059	300,229	217,500	853,473
Late-stage elderly support coverage	47,678	56,641	56,150	53,333	
Levies for early-stage elderly	39,805	50,182	57	31,667	
Contributions for retirees	4,467	5,600		5,833	
Others	4,930	21,972	147,665	55,000	4,199
Total	266,217	267,453	504,101	363,333	857,672
Premium (tax) revenue	236,678	267,281	92,722	300,833	64,963
State subsidy	35,750	1,164	129,231	25,000	432,533
Late-stage elderly subsidy					354,329
Early-stage elderly subsidy			109,358		
Others	382	17,875	186,006	54,167	1,416
Total	272,810	286,321	502,319	380,000	853,242
Balance of ordinary revenue and expenditure	6,592	18,868	-1,782	17,500	-4,424

Unit: Yen per enrollees
Source: Ministry of Health, Labor and Welfare (MHLW), "Annual Health, Labor and Welfare Report 2017"

Public health insurance schemes are financed by premiums, subsidies from the general budget of the government, and co-payments from patients. Insurance premiums are one of the main financial resources for public health insurance. The methods of premium collection are different among public health insurance schemes. Occupation-based public health insurance insurers collect premiums by deducting them from salaries. The lower and upper limits of the premium are set at 30/1000 and 130/1000, respectively. The national health insurance premium is collected through direct payment to the municipality government by subscribers on a household basis. The premium consists of a proportional part based on the income, assets, and number of people in the household, and it constitutes a fixed part per household. Insurers in the medical care system for the elderly in the latter stage of life collect premiums mainly by deducting them from the pension paid to the elderly.

Central, prefectural, and municipal governments subsidize national health insurance insurers for their running costs. The central government subsidizes 41% of the health care benefits, and prefectural governments subsidize 9% of that. This amounts to ¥129,231 per enrollee, as shown in Table 4.3. 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 "others" category of the revenue in Table 4.3.

Table 4.3 shows that insurance benefit cost is higher in national health insurance and the medical care system for the elderly in the latter stage of life, but the premium revenue is lower in these two insurance systems. This causes a fiscal imbalance in these two insurance systems. To adjust the fiscal imbalance, inter-institutional fiscal adjustments have been introduced. Under this scheme, health care cost burdens for the elderly aged between 65 and 74 are reallocated among the insurers of public health insurance. The amount that the national health insurance receives from this fiscal adjustment is ¥109,358 per enrollee.

The medical care system for the elderly in the latter stage of life for those aged 75 and older can itself be regarded as a scheme for inter-institutional fiscal adjustments. The elderly aged 75 and older are enrolled 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 government subsidies, and 40% is covered by contributions from insurers of other insurance programs. The amount that the medical care system for the elderly in the latter stage of life receives from this fiscal adjustment is ¥354,329 per enrollee.

Table 4.3 does not show co-payments, but the total co-payment amount is not negligible because the co-payment rate is basically 30% for public health insurance systems in Japan. Payments are made every time a visit is made to a medical institution. The co-payment rate varies according to patients' age and income, such as 20% for children below school age, 30% for the high-income elderly who are more than 70 years old and who earn the same level of income as the working generation, and 10% for most of the elderly who are 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 very high. However, the co-payment rate for these people has been temporarily kept at 10%obilizing a budgetary measure.

The high-cost medical care benefit is applied to all public health insurance. This system aims to restrict the co-payment amount by setting a cap according to age and income. 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 the 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 with public health insurance financing

As the population rapidly ages, health care costs for the elderly increase accordingly. This automatically increases occupation-based insurance's burden of subsidy in the medical care system for the elderly in the latter stage of life. The increased burden should be covered by an increased amount of insurance premium in those insurances. However, insurers' financial situations can vary, and the burden may be too heavy for some insurers. To make the burden more equitable, the policy to determine the subsidy amount based on the total amount of enrollees' income has changed. According to the new policy, insurers of occupation-based health insurances raise premium rates only when their premium level is too low for the income level of their enrollees.

National health insurance has a larger number of lower-income subscribers and elderly subscribers than occupation-based health insurance. As a result, relatively poorer enrollees are confronting relatively higher premium rates. This is leading to an increase in unpaid insurance premiums in national health insurance. In 2016, the amount of unpaid insurance premium was 8.08% of the total amount of levied premiums. In the social insurance system, an unpaid insurance premium means losing one's eligibility. To avoid this, target groups for premium payment exemption have been enlarged. Further, extremely poor households are now 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 medical care provision systems were constructed before WWII. Management of medical institutions satisfies the "nonprofit" principle. Owners of medical institutions can include public and private entities Medical doctors are educated using a six-year university education program and trained using a five-year training program after graduation. They can educate themselves to deepen their clinical specialties. General practice has not been explicitly recognized as a clinical specialty, so there are no general practitioners who are clinical specialists. There is no gatekeeping system. Patients can choose the medical institutions they want to visit. Therefore, the roles of community clinics and specialized hospitals are not separated. A patient can choose for his or her first contact a specialist in a hospital outpatient department. In the mid-1970s, the co-payment rate for the elderly was set at 0%. Evidently, this inflated the usage of medical care among the elderly. However, this was a drastic measure taken because of the scarcity of long-term care facilities in those days. The 0% co-payment rate was abolished in 1983, and the efficiency of the provision of inpatient care services for the elderly has been improved by amendments to the medical institution law together and by the implementation of policies for increasing the number of long-term care facilities, as well as by policy inducements though changing tariffs for medical care services The introduction of long-term care insurance created many alternatives for the elderly who needed life support services other than inpatient care in hospitals. Today, the issue is how to coordinate medical care and long-term care.

4.3.2 Health care service provision: History

Before the Meiji era, physicians existed in Japan who were called “kusushi” because of their oriental medicine practices. They made diagnoses, prepared prescriptions, and sold the pharmaceutical medicine to patients. However, they were forbidden from practicing medicine by certification regulations implemented by physicians educated using Western medicine in the Meiji era.

Medical doctors sold pharmaceutical medicine to patients based on Western medicine practices. This was because there were few pharmacists in the Meiji era Pharmacists hoped to achieve the separation of medical practice and drug dispensing, but they were not successful because of their weak political power.

Hospitals practicing Western medicine were first established in 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. The Japan Red Cross was established as the Hakuai-sha in 1878, and the Social Welfare Organization Saiseikai Imperial Gift Foundation (The Saiseikai) was established in 1911. These organizations constructed hospitals and started to provide medical services to the poor.

In those days, physicians could start a private practice where they preferred (this was known as free entry). Hence, medical institutions were located in dense urban areas because medical doctors, as managers of the medical institutions, wanted to keep their financial status high. This made accessibility to medical care unequal across geographic areas. In rural areas, for example, physicians could not earn enough because farmers were relatively poorer than other people and could not pay for medical care services. At the same time, physicians were reportedly so competitive in urban areas that they could not earn enough either.

After WWII, hospitals and clinics lost equipment personnel, and even buildings because 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 the Department of War were merged into the hospital department of the Ministry of Health and Welfare, and these medical institutions were made available for use by the general public in the form of national hospitals. The central government of Japan decided to provide financial subsidies to private (but not-for-profit) medical institutions for investment in hospital/clinic construction and/or medical equipment. Because of these policies and the effects of long-lasting economic booms, the number of private hospitals and clinics increased.

Local governments, as was the case before WWII, established hospitals and clinics. The Japan Red Cross, the Saiseikai, and other nonprofit organizations also established medical institutions. These new investments contributed partly to the gradual improvement of the distribution of medical institutions. However, there was no effective method to resolve essentially the issue of the geographical inequality of the medical institutions’ distribution. In the mid-1980s, it was pointed out that regional variations in inpatient care cost were correlated to the supply of inpatient beds. In 1985, the medical institutions law was amended so that the government could specify areas where inpatient beds were over-supplied relative to the population.

Among the amendments to the medical institutions law since then, the second amendment to 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 was a classification of hospitals that provided high-technology and intensive inpatient care. The bed-type categorization of long-term care-type beds was

introduced because the utilization of beds was not necessarily based on medical needs. In those days, as we have seen in section 4.2.1, the co-payment rate for the elderly was 0%. This policy made patients who needed support for living rather than medical care utilize inpatient care unnecessarily.

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

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

4.3.3 Health care 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, according to medical institution law, clinics can have less than 20 beds, while hospitals must have 20 beds or more. In 2017, there were 8,412 hospitals, 101,472 clinics, and 68,609 dental clinics in Japan. The number of beds in hospitals was 1,554,879 (12.3 beds/1,000 people), and the number of beds in clinics was 198,355 (0.78 beds/1,000 people). The average length of stay in the hospital was 28.2 days for hospitals, which is much longer than eight days for OECD countries.

Second, there exists no explicitly defined general practitioner so Japan essentially has no gatekeeping system. Medical doctors are educated about medicine in six-year undergraduate courses. They must also pass the National Medical Practitioners Qualifying Examination. After this, they are trained as medical doctors in a five-year postuniversity education course. After finishing the postuniversity education course, they are educated as specialists in their clinical specialty. The total number of medical doctors working in medical institutions is 304,759 (2.4 people/1,000 people), the total number of medical doctors working in hospitals is 202,302, and the total number of medical doctors working in clinics is 102,457. There are almost none foreigners working as clinical medical doctors: 1,595 in hospitals and 755 in clinics.

Third, there are no nationally qualified nurse practitioners who can practice nursing care independently. The number of registered nurses working in hospitals is 796,830. They can work as registered nurses after a minimum of three years of education and after passing the national nurse qualifying examination. In recent years, nurse education has transferred from vocational schools to universities. Nurse education in university takes four years, and graduation from a university nurse education course meets the eligibility requirements for the national nurse qualifying examination not only for nurses but also for public health nurses. Eligibility requirements for the national nurse qualifying examination for midwives are met by finishing the university nurse education course with additional education courses for midwives. A nurse profession association issues certificates of specialties for nursing in some areas such as emergency nursing, cancer chemotherapy nursing, and so on. These may be considered the same as clinical nurse specialties in other countries.

Fourth, freedom of choice to utilize any medical institution is guaranteed by law for all enrollees in public health insurance. Patients can select any clinic or outpatient department of a hospital. Free access is assured, but it

can cause inefficiency in the functioning of clinics and hospitals. Hospitals with high clinical functioning charge patients extra fees in addition to prices based on tariffs for medical care services. This charge is legally permitted. The amount of surcharge varies from hospital to hospital.

Fifth, the tariffs for medical care services are determined by the Central Social Insurance Medical Council. The council consists of representatives of clinical physicians and hospitals, public health insurance insurers, and the general public. Once in two years, the council determines and updates the tariffs for medical care services as publicly regulated prices. The updates are made using the results of the Survey for the Financial Situation of Clinics and Hospitals, and the results of the Survey for Medical Care Utilization. The updates also depend on political negotiation and can be used as a political inducement tool. When the committee acknowledges that there is need for expanding the utilization of some services, but low profitability is inhibiting the provision of the services, then it decides to increase prices to induce more medical institutions to provide the services. The Ministry of Health, Labor and Welfare decides coverage and tariffs for medical services based on the council's suggestions.

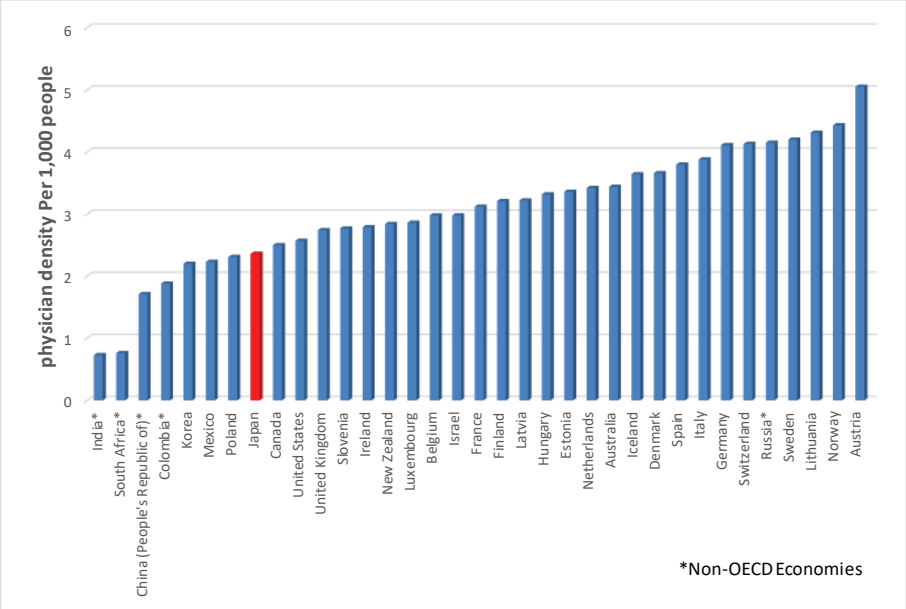
Last, the medical institution must be nonprofit. This means that the financial surplus from running the medical institution cannot be shared with capital subscribers and/or investors. Financial surplus, if any, must be used for investment in medical equipment, facilities, etc., or must be kept as internal reserves. Private companies can own medical institutions to promote their employees' health. In these cases, the management of the medical institutions must obey a nonprofit principle.

4.3.4 Current issues in the health care service provision system

4.3.4.1 The lack of physicians

Aging implies that the number of elderly people is increasing. These people will need not only care for chronic diseases but also acute care. Since the 1970s, at least one university with a department of medicine has been established in each prefecture. It was thought in those days that this policy would satisfy the future need for physician services. However, the increase in medical doctors may not have be able to keep with the growing medical needs of the elderly 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 people/1,000 people. This figure is relatively smaller than the ones for OECD countries (Figure 4.4).

Figure 4.4: International comparison of the number of physicians by OECD Health Data (in year 2014)



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, and the number of physicians decreased after the earthquake. The issue of whether a new medical school should be established in the Tohoku area or not is being discussed.

4.3.4.2 Establishment of an integrated community care system

Elderly people need medical care services and long-term care services to support their independent living. It is natural to think that both services are supplied to users in an orderly fashion. For this the establishment of an integrated community care system is needed. To achieve this, communication should be encouraged among personnel in the long-term care sector and personnel in the medical care sector when their services are provided. Section 5.3.2 elaborates further on this view.

Table 4.1 Outline of the Health Insurance System in Japan

All numbers are as of March 2015 unless otherwise noted.

	Health Insurance		Seamens' Insurance	National Govt Employees' Mutual Aid Association	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
1) Name	Association-managed Health Insurance	Society- Health Insurance								
2) Eligible subscriber	Employees of Small-Medium firms	Employees of Large firms	Seamen	National Govt Civil Servants	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
3) Number of subscriber (millions)	21.577	15.842	0.054	1.079	2.413	0.566	31.822	2.864		16.457
Dependents	15.587	13.282	0.066	1.164	2.171	0.349				
4) Insurer (number of organizations)	Japan Health Insurance Association	Health Insurance Associations (1,409)	Government	Mutual Aid assocciation of each ministry (20)	Mutual Aid assocciation of each local govt (64)		Municipality (1,716)	National Health Insurance Associations (164)	Municipality (1,716)	Extended associations for the Medical Care System for Elderly in the Latter Stage of Life (managing entities)
5) Premium rate:										
Subscriber	3.80%	41.14%	4.55%	6.00%	6.00%	3.84%	9.90%	--	--	8.3%
Employer	3.80%	49.15%	6.10%	6.00%	6.00%	3.84%	--	--	--	
6) Gov't Subsidy to:										
Administrative cost	All	All	All	All	All (by local govt)	Partial	All	All	All	All
Medical cost	16.4%	Fixed amount	Fixed amount	--	--	--	43%	32%	--	90%(※1)
Contribution for the health care for elderly	16.40%	--	--	--	--	--	--	--	--	
7) Co-payment:										
Subscriber	30%						30%(Children below school age 20%)			10%(※2)
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, or for most low-income family (70～74 years old) ¥100/meal)									Same as left
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) ¥35,400(Low-income people) ¥15,000(Very low-income people)※2			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
8) Allowance:										
Childbirth allowance	¥420,000		¥420,000	¥420,000	¥420,000	¥420,000	¥420,000		standard amount ¥420,000	
Funeral expense	¥50,000		¥50,000	¥50,000	¥50,000	¥50,000	Set according to the law			
Fun.exp. for dependents	¥50,000		¥50,000	¥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	Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient	Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient	Standard not set			
	Up to 18 months		Up to 3 years	Up to 18 months (except for TB 3 yrs)	Up to 18 months (except for TB 3 yrs)	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	Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient	Amount of "Standard daily remuneration * 2/3 per day" multiplied by a constant coefficient	Standard not set			
	42 days before birth, 56 days after		Unemployed days before birth, 56 days after	42 days before birth, 56 days after	42 days before birth, 56 days after	42 days before birth, 56 days after				
Due to unemployment	--		--	50% of avg. salary	60% of salary	60% of avg.salary	--			
10) Disaster Relief:										
For death			--	1 month of avg. salary	1 month of avg. salary	1 month of avg. salary	--			
For death of a family member	--		--	70% of monthly avg. salary	70% of monthly salary	70% of monthly avg. salary	--			
For disaster	--		--	0.5 to 3 months of avg. salary, due to severness	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%

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", Zenkokuhokenkyokai website https://www.kyoukaikenpo.or.jp/

Chapter 5 Welfare for the Elderly

5.1 Overview of 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 asylums under the public assistance system. The act of 1963 aimed to maintain the 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 the 1960s. As free healthcare for those 70 years old and over was introduced in 1973, healthcare expenditure for the elderly expanded and increased the financial burden on the government. The Health and Medical Service Act for the Aged in 1982 imposed a copayment on the elderly for healthcare, and it emphasized the importance of health promotion for the middle-aged over 40 years old.

Around the same time, more people were becoming 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 copayments for those facilities were more expensive than those for hospitals. To tackle this problem, the ministry formulated the Gold Plan (10-year strategy for the promotion of health and welfare for the elderly) in 1989 so as to promote the urgent development of care facilities and in-home services; 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 the argument for a new long-term care system for the elderly.

In April 2000, Japan introduced Long-Term Care Insurance. This social insurance system covers long-term care for the elderly, which was previously provided partly through the health insurance system and partly by the welfare measures for the elderly. Long-Term Care Insurance grew out of the recognition that, due to changes in the society such as weakened community ties, an increase in smaller family size, and an increase in working women, the financial and psychological burden of families facing care for the elderly had become unbearably large. Furthermore, there was a limit on service provision under the existing health and welfare system because of the increasing number of elderly requiring long-term care for longer periods. 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 Principles of the Long-Term Care Insurance System

There are three basic principles of 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 their independence. 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; 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 are 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 responsibility for (1) collecting insurance premiums, (2) managing funds, (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

Primary insured persons are those aged 65 and over (Category I); secondary insured persons are those subscribers who are 40 to 64 years old (Category II). About 34.4 million persons are subscribed as Category I, and about 42 million persons are subscribed as Category II (as of the end of FY2016). The premium is collected through the municipality and deducted from pensions for Category I and through an additional premium to be paid to health insurance for Category II. The premium amount for Category I is determined by each municipality and, thus, differs from one municipality to another. The premium is income-related, and there are 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 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 Levels 1-5.

Types of preventive services include home-visit care, outpatient rehabilitation service, and short-term stays at a care facility. Types of care services include in-home services such as home help service and day care; facility services such as intensive care homes, long-term healthcare facilities, and sanatorium-type care facilities; and community-based services such as home visits 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.

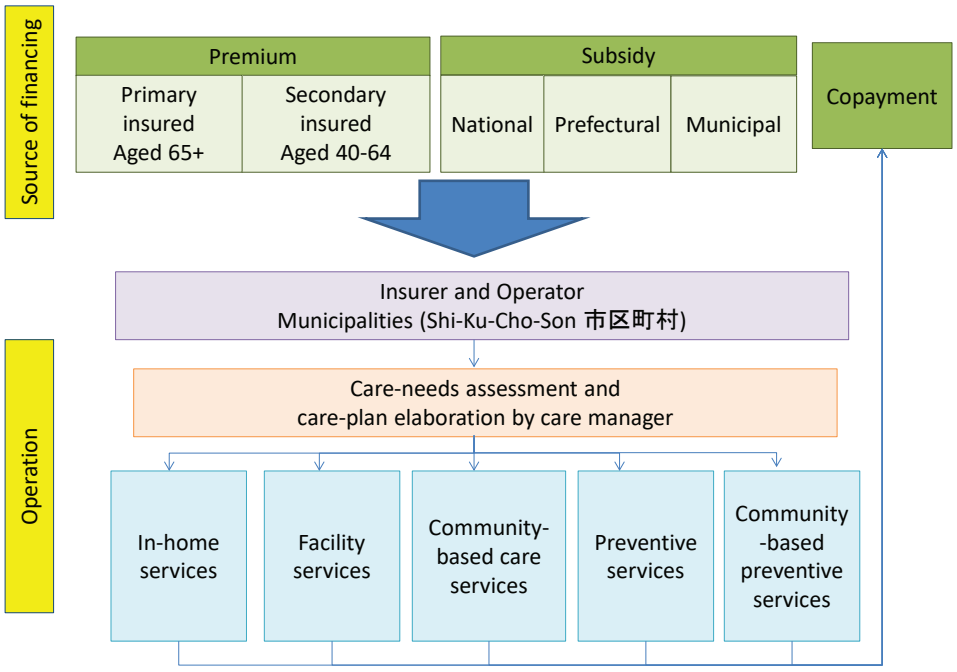
5.2.5 Source of Financing

The cost incurred in Long-Term Care Insurance is financed by premiums, public expenditure, and copayments from users. Apart from the copayments, the cost is financed 50% by premiums (23% by Category I, 27% 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 premium rate for the insured of Category

I. The premium for Category I is charged based on the total income of the insured and is reviewed once every three years. It was around ¥2,900 per month on average in 2000-2002; the amount has increased to ¥5,869 for FY2018-2020. For the Category II insured, the rate will be 1.57% of the salary and annual bonus as determined by the Japan Health Insurance Association.

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

Figure 5.1 Overview of Long-Term Care Insurance



5.2.6 Assessment of Care Needs

Users are classified into seven categories (“Support Levels 1 and 2” and “Care Levels 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 regarding the physical/mental state and aspects of daily life. The interview results are analyzed by a computer system to generate a preliminary assessment.

This assessment and an opinion letter from the primary physician are then reviewed by the Certification Committee of Long-Term Care Needs, which comprises 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 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 levels 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 levels 1 to 2 are created at integrated community care support centers (地域包括支援センター).

When the law was revised in 2005, Integrated Community Care Support was created as scheme that was in line with the emphasis on preventative services. . It serves as the basis 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 families, protecting elderly rights, and detecting 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 the recommendation of the Social Security Council. The price list consists of in-home long-term care/preventive services and facility services and is revised every three years. Ninety percent of the price is paid to the provider through a prefectural health insurance organization and 10% by recipients as the copayment. For high-income elderly, 20% or 30% copayment is applied, and the rest of the cost (80% or 70%) is paid through a prefectural health insurance organization.

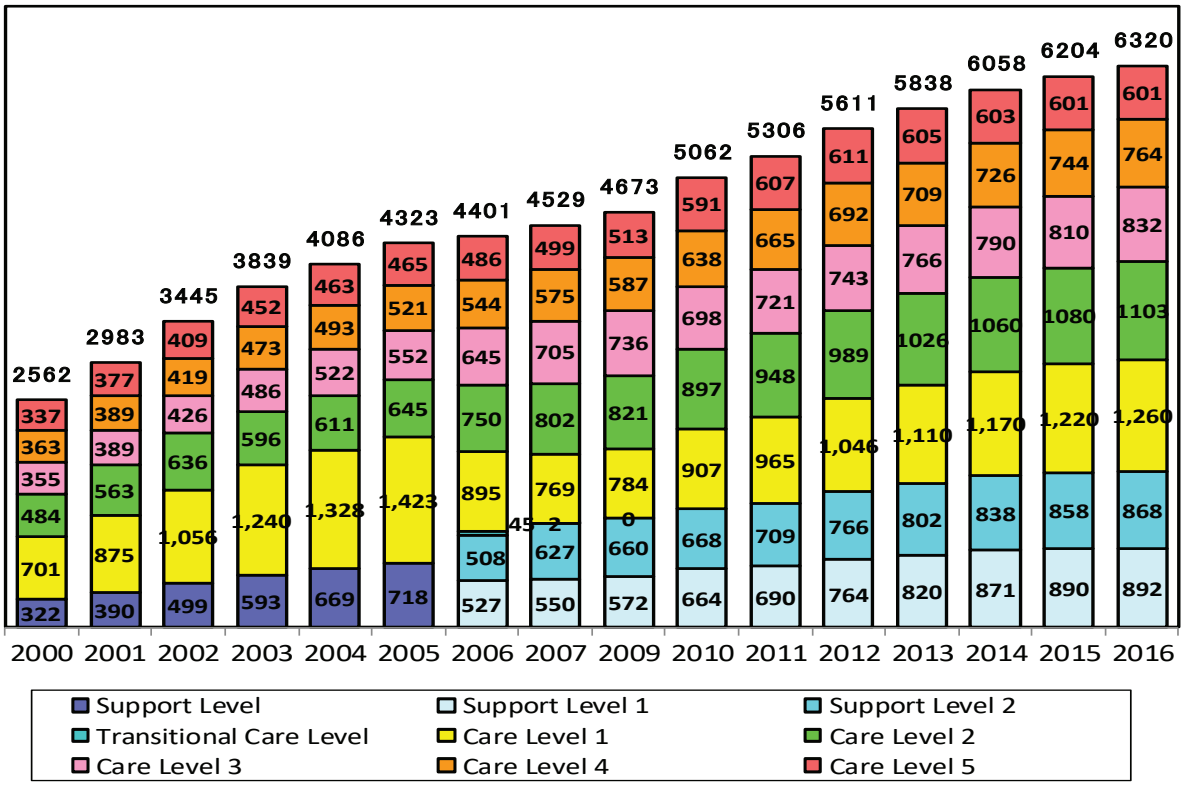
5.3 Current Issues in Long-Term Care Insurance

5.3.1 Financial Strain and Construction of the “Integrated Community Care System”

Soon after its enactment, it became evident that the initial financial arrangement was not enough to meet the cost of long-term care. As shown in Figure 5.2, the number of persons certified for long-term care increased by more than 247%, from 2000 (2.56 million) to 2016 (6.32 million). The number of care recipients also grew from 1.84 million (0.60 in facilities and 1.24 in in-home care) in the FY2000 average to 5.60 million (0.92 in facilities, 3.91 in in-home care, and 0.77 in community-based services) in the FY2016 average. The financial outlay grew steadily from ¥3.6 trillion (2000) to ¥10.0 trillion (2016).

With such circumstances, Long-Term Care Insurance was reviewed, and several reforms were put in place. For example, the 2011 reforms aimed to construct an integrated community care system that provides seamless supports comprising 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 the increase of the insurance premium.

Figure 5.2 Number of Persons Certified for 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 end of each fiscal year (end of March next year). Due to the Great East Japan Earthquake, 11 and 3 municipalities' data are not included for 2011 and 2012, respectively.

5.3.2 Establishment of an Integrated Community Care System

The Long-Term Care Insurance system initially aimed to support independent living for 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 been achieved as many issues remain such as elderly persons having to enter a care facility, even if they requested in-home care, due to a lack of available proper service providers in the familiar community, a lack of collaboration between medical institutions, care facilities, and in-home service providers, and insufficient elderly-friendly housing.

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 to ensure the safety, security, and health of the people. A community is generally regarded as that which is accessible within 30 minutes, an area almost as large as a junior high school district. To establish this system, the following five aspects of action were set up: (1) enhancing collaboration with medical facilities, (2) improving and enhancing the capacity and flexibility of long-term care services, (3) promoting prevention, (4) ensuring advocacy and livelihood support services such as meal provision service or housework assistance, and (5) constructing and improving elderly-friendly housing. Central and local governments are involved in coordinating

all related programs so that people can live independently in the familiar community for 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 1.83 million workers (head count) in FY2015, a sharp increase 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 increases. It is regarded as a big challenge to secure the necessary personnel and to improve their working environment. Basically, most 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.

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 meet the requisite of improvement programs, including a pay-raise plan.

In addition, long-term care equipment with ICT and robot technology has been developing; some of them are used in long-term care workplaces or in the home. We can expect that these devices will improve service efficiency and working conditions in long-term care. One of the hot topics in Japan is attracting foreign-born care workers. In Japan, care workers should be covered by domestic human resources on principle. However, Japan has accepted nurse and certified care-worker candidates from Indonesia, the Philippines, and Vietnam based on an EPA (Economic Partnership Agreement). The numbers of candidates for nurse and certified care-worker were 1,203 and 3,492, respectively, from FY2008 to FY2017. In 2017, care service was included in the “Foreign Technical Internship Program,” and a new category, residence permission “care service,” was started.

5.4 Welfare for the Elderly Other Than Long-Term Care Insurance

5.4.1 Housing for the Elderly

Figure 5.3 shows the outline of housing services for the elderly: 1) intensive care home, 2) group home for those with dementia, 3) nursing home, 4) moderate-fee home, 5) fee-based home, and 6) elderly housing with care services.

An 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 Long-Term Care Insurance benefits. Group homes for the elderly with dementia are small facilities in which dementia patients live together and receive care and supports in a homely atmosphere under Long-Term Care Insurance. The capacity of a group home is defined as five to nine persons.

However, based on the conventional system defined by the Act on Social Welfare Service for the Elderly, institutional services for the elderly are still provided. Nursing homes for the elderly are admission-type facilities for the economically deprived. 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 have been more fee-based homes for the elderly run by the private sector. These are considered as housing facilities rather than social welfare facilities. When an elderly person enters a contract with a service provider of a fee-based home, they must pay the full expense, which sometimes causes financial trouble

between the provider and the resident. The in-home service provided by 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 are required to register with the prefecture. The criteria for registration are (1) dwelling floor area of 25 m^2 or more per dwelling unit in principle and a barrier-free design, (2) provision of services including safety confirmation and daily life consultation, and (3) extra consideration on contract to secure the residence in case of long hospitalization, etc. There are subsidies to promote elderly housing with care services, and 7,138 buildings comprising 236,428 units were registered by October 2018.

Alternatively, Silver Housing has been developed jointly by the MHLW 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.

Figure 5.3 Outline of Housing Services 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: MHLW (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.

5.4.2 Five-Year Plan to Support People with Dementia

In 2012 the MHLW published “Future Directions of Dementia Support” and announced a five-year strategic plan (Orange Plan) to support people with dementia. This plan was revised as the “Comprehensive Strategy for Promotion of Dementia Policy” (New Orange Plan) in 2015. This plan aims to create a society that respects dignity and enables people 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 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 persons with dementia and their family members, and personnel training.

5.4.3 Prevention of Elderly Abuse

The 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 "elderly abuse" to include abusive behavior by both family members and care workers. It specifies that municipalities are primarily responsible for implementing abuse prevention programs, while prefectures play the role of liaison, coordinating municipalities, collecting and providing information, and constructing facilities.

The following items are emphasized as the fundamental perspectives of the 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, and (6) collaboration and cooperation of related organizations.

5.4.4 Relationship with Other Public Care and Support Services

Regarding the relationship between 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 to the principle of placing priority on insurance. Services such as hearing aids and prosthetic hands/legs, which are not covered by Long-Term Care Insurance, are provided to the elderly with disabilities according to the Services and Supports for Persons with Disabilities Act. As for service provision, "Elderly and Persons with Disability Coexist Type Care Provider" was created in the 2018 reforms of Long-Term Care Insurance. This is a new type of long-term care or disability welfare service provider. If a welfare service provider is designated as one of the above, it will be easier to be designated as another. With regard to public assistance, for the extremely poor elderly, the benefits of Long-Term Care Insurance are given priority, and the copayment portion is covered by the public assistance system.

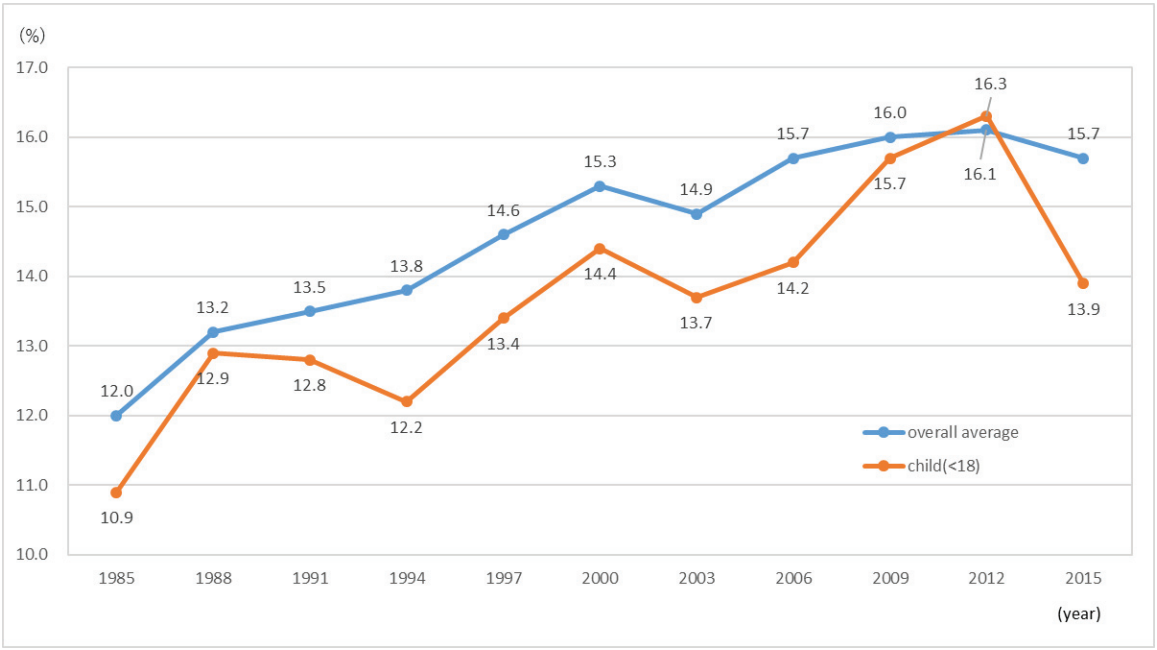
Chapter 6 Public Assistance

6.1 Re-emergence of Poverty in Japan

Until the middle of the 2000s, it was widely believed that Japan had solved the poverty problem. The notion that Japan had achieved economic growth and an egalitarian society had sunk deep into the Japanese public consciousness so much so that it had become a source of national pride and identity. In fact, in the 1960s, people's living standard rose rapidly, and the food shortage problems after World War II had become things of the past. The term "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 1980s, Japan's poverty rate has risen steadily. As shown in Figure 6.1, the relative poverty rate in Japan increased four percentage points from 1985 to 2015, 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 the percentage of the population falling below 50% of the median equivalized household income.
Source: MHLW (2017)

The government finally recognized the problem of poverty in the late 2000s. In 2009, the MHLW announced the relative poverty rate, and several measures to assist the poor were implemented in the late 2000s; in 2014, the Law on Measures to Counter Child Poverty was enacted.

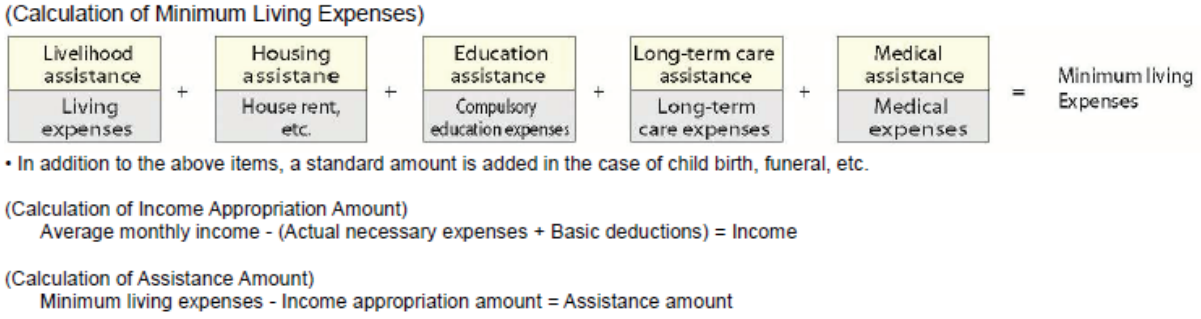
6.2 Public Assistance Program

6.2.1 General Characteristics

Public assistance is the last safety net to secure poor and needy persons. The history of public assistance in Japan 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, and it has four fundamental principles: (1) public assistance to all citizens in poverty is a responsibility of the state, (2) all citizens may receive public assistance in a nondiscriminatory and equal manner as long as they satisfy the requirements prescribed by this act, (3) the State guarantees a minimum standard of living where a person is able to maintain a wholesome and cultured standard of living, and (4) public assistance is provided based on a requirement that a person who is living in poverty shall utilize his/her assets, abilities, and every other thing available to him/her for maintaining a minimum standard of living.

The public assistance program comprises eight types of assistance, namely, livelihood assistance, education assistance, housing assistance, medical assistance, long-term care assistance, maternity assistance, occupational assistance, and funeral assistance. The assistance amount is calculated by subtracting the household income from the minimum living expenses (see Figure 6.2). The minimum living expenses are different depending on region, the number of household members, household members' ages, etc. All assistance is provided as cash transfers except medical care and long-term care, which are provided as in-kind.

Figure 6.2 Determination of Monthly Minimum Cost of Living



Source: MHLW (2018) "Annual Health, Labour and Welfare Report 2017"

6.2.2 Means Test

Public assistance is basically provided upon receipt of an application from a household in poverty after the means test. As mentioned, the fourth principle of public assistance requires that a household should manage all available resources including assets, ability to work, and 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 living in or utilizing it and the value of the assets is higher when it is sold.

Regarding the ability to work, if the person is able to work and there is an adequate job for him/her where he/she is living, he/she is required to use that ability in precedence over public assistance. However, he/she can receive public assistance if the household income including working income does not reach the minimum living expenses.

Any supports given by relatives and family members have precedence over public assistance, although it does not necessarily mean that he/she is not eligible to receive public assistance when supports from relatives/families

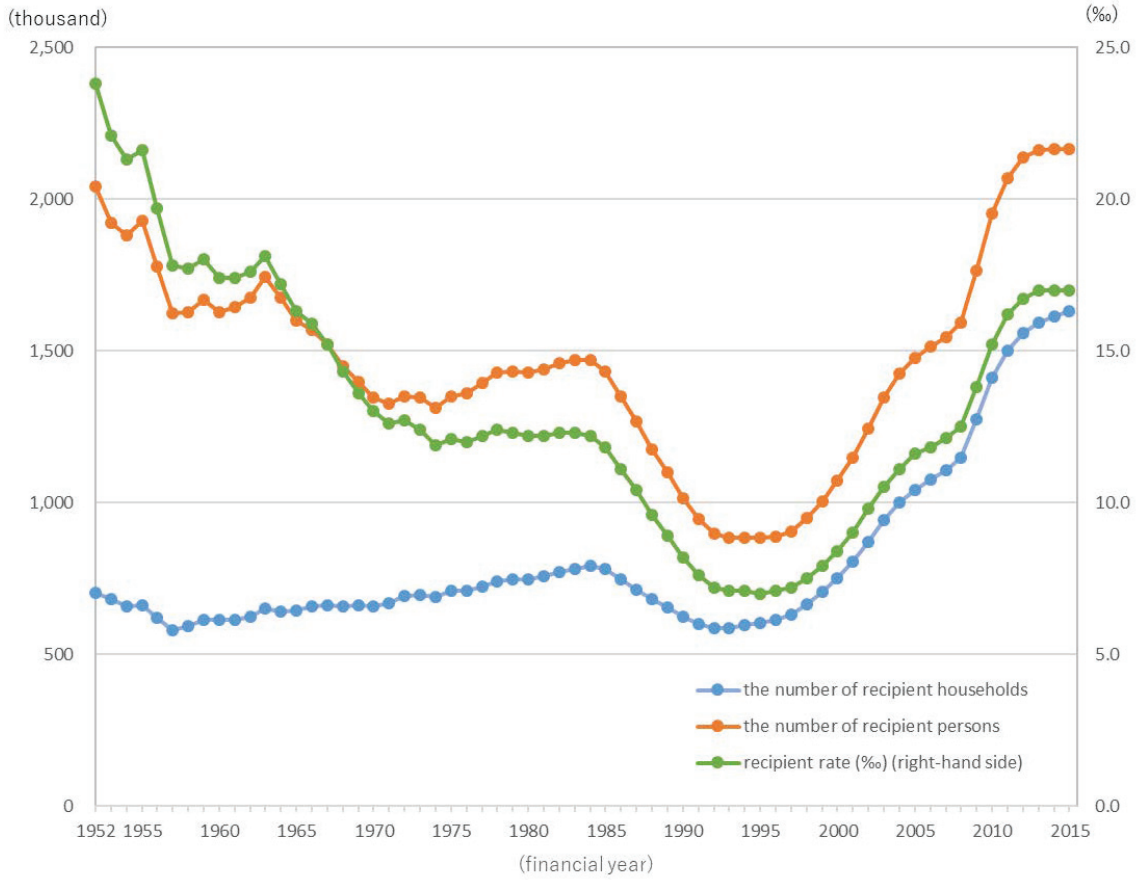
are available.

6.2.3 Statistics of Recipients of Public Assistance

As of July 2016, 1.6 million households or 2.2 million persons received public assistance. The number of recipients has been increasing since the middle 1990s, and it has exceeded the numbers right after World War II, although the recipient rate is still slightly lower (see Figure 6.3).

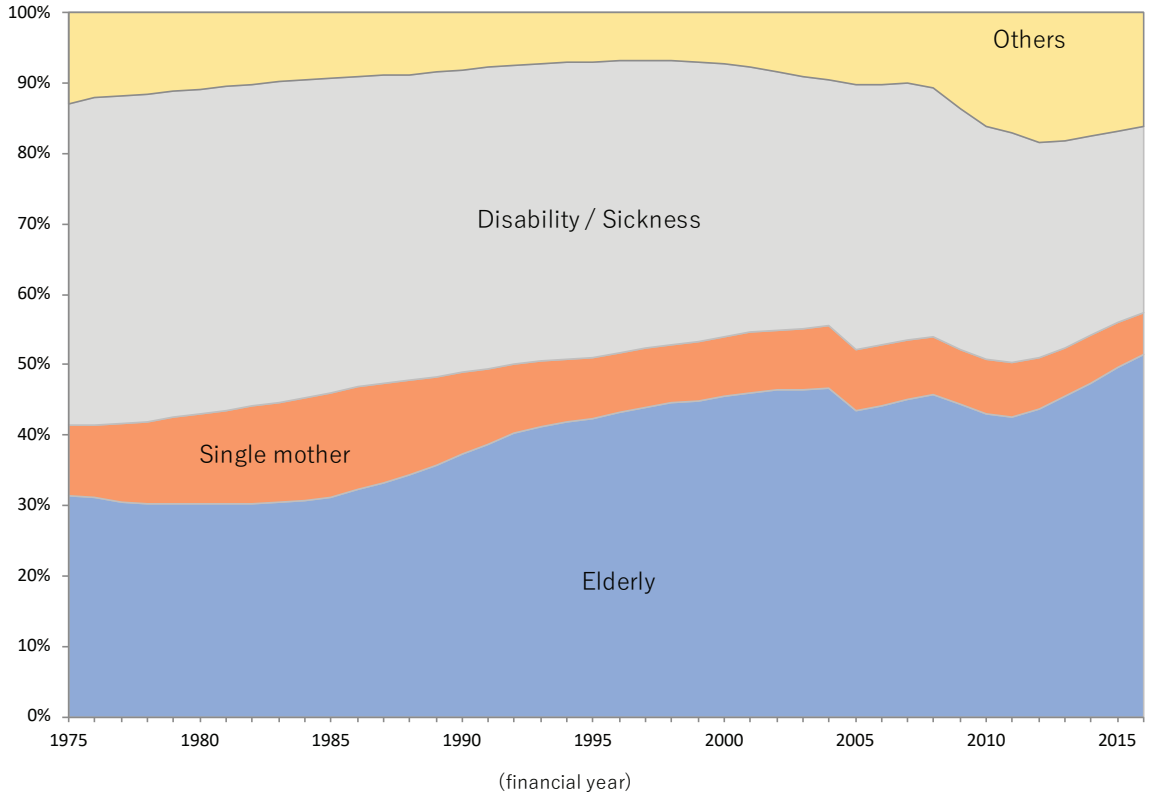
Figure 6.4 shows the share of recipients by household type. Among those receiving assistance, elderly households make up the largest share, accounting for over 50% of all recipient households, and this has increased over the last few decades. The share of households with a disabled or sick individual is also large, at 26.4%. About 6% are single-mother households.

Figure 6.3 Trends in Number of Recipients and Recipient Rate (1952-2016)



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

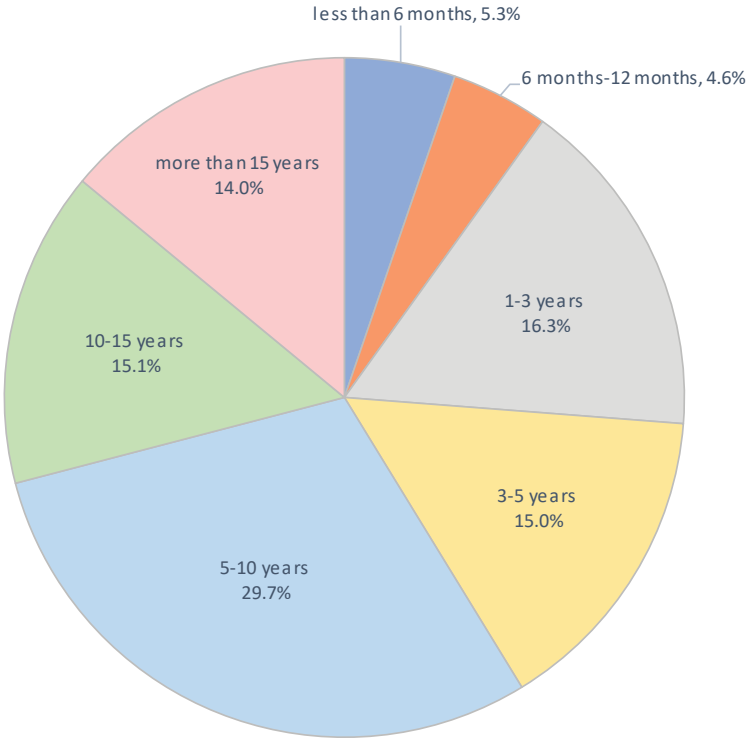
Figure 6.4 Share of Recipients by Household Type (1975-2016)



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

Figure 6.5 shows the duration of receiving assistance. Households that have been receiving for less than a year comprise nearly 10% of recipients, and those that have been receiving for more than 10 years comprise nearly 30%. The duration tends to be longer because most recipients are elderly, so it is not expected that they can improve their economic situation.

Figure 6.5 Duration of Receiving Public Assistance



Source: 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. 2013 Reform of Public Assistance

Public assistance is one of the oldest programs of the 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 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 those who are eligible to receive the benefit.). The government had demolished the additional benefit that was previously given to single mothers and elderly households by March 2007. However, the benefit for single mothers was reintroduced in December 2009. In 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 was a widespread outcry against this measure.

6.3.2 Emerging Policies Toward Poverty Alleviation

There have been several policy initiatives in recent years that target the poor. 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 that the Japanese government plan a comprehensive policy to combat child poverty and 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 child's future is not influenced by the circumstances into which they are born. The law calls for a 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 that the government announce the state of child poverty and policies every year.

Chapter 7 Family Policy

7.1 Introduction – History of Family Policies in Japan

7.1.1 Brief History

The basic system for children and families in Japan was developed after World War II from the 1940s to the 1970s, and six laws were enacted during this period: the Child Welfare Act (1947), the Child Rearing Allowance Act (1961), the Special Child Rearing Allowance Act (1964), the Lone-Parent Family and Widow Welfare Act (1964), the Maternal and Child Health Act (1965), and the Child Allowance Act (1971). Since the 1980s, women's participation in the labor market has progressed, and the demand for childcare has increased gradually.

In the 1990s and beyond, in the policy framework of "Countermeasures against the Declining Birthrate," from the viewpoint of removing obstacles in marriage, childbirth, and child rearing, the government aimed to expand child allowance and childcare services, and the parental leave system was enacted in 1991. The reconciliation of work and child rearing is becoming one of main issues in family policy.

In 2014, the Law on Measures to Counter Child Poverty was enacted[1].The act obligated both central and local governments to make comprehensive plans to combat child poverty.

As mentioned above, policies for family and children have been developed since World War II according to the changes in families and society. In Japan, those policies are not referred to as “Family Policy.” Instead, “Support (or Welfare) System for Children and Child-Rearing” or "Countermeasures against the Declining Birthrate" are used officially, according to the context. It can be considered that those policies almost correspond to “Family Policy,” which is used generally in international organizations or European countries (Masuda, 2008) [2].

As for international law, Japan has ratified various international conventions related to human rights. The Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child were ratified in 1984 and 1995, respectively. As a member of the international community, Japan has sought to improve various social measures for families.

7.1.2 Policies to Cope with the Declining Birthrate Since the 1990s

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

One of the major reasons behind the rapid fall in the birthrate is the situation whereby women are not able to choose various work styles. The increase in temporary employees and long working hours has made it difficult for the Japanese to achieve the lifestyle and work style they desire.[3] Other reasons for low fertility are inactive dating behavior, increases in direct and indirect costs of raising children, increased risk of income instability, and a deep-rooted consciousness of gender role divisions in labor.

Due to criticism against the pronatalist policy during World War II, the present Japanese policies to tackle low

[1] The relative poverty rate of children had been rising since 2000s and scored 16.3% in 2012, which was ranked high among OECD countries (OECD Family Database, CO2.2).
[2] 増田雅暢（2008）『これでいいのか少子化対策』ミネルヴァ書房
[3] “White Paper on Society of Declining Birthrate 2017” (少子化社会対策白書 平成 29 年), Cabinet Office, Government of Japan

fertility are oriented toward eliminating the divergence between desire and reality, such as promotion policies for gender equality, life-work balance, and support for families with children.

The Japanese government responded to the "1.57 shock" in 1990, when the total fertility rate as of 1989 was the lowest since World War Ⅱ, and recognized the low fertility rate as a socio-economic problem. Since 1995, national basic plans against the declining birthrate have been devised every five years: Angel Plan (FY1995-1999), New Angel Plan (FY2000-04), Plan for Supporting Children and Childcare (FY2005-09), Vision for Children and Childcare (FY2010-14), and Third Outline of Measures against the Declining Birthrate (FY2015-19).

After the 2000s, as legal bases for policy planning against the declining birthrate, new acts were established to promote countermeasures against the low birthrate. The Basic Act for Measures to Cope with Society with Declining Birthrate was enacted in 2003. In addition, to implement concrete reforms toward further reconciliation of work and child rearing, the Act of Measures to Support Raising Next Generation Children was enacted in 2003, which obligated prefectures, municipalities, employers of private companies, and public authorities to formulate "next generation development support plans."

7.2 Income Support for Families with Children

7.2.1 Child Allowance

Under strong political initiatives, a new Act of Child Allowance without income restriction was enforced in April 2010; it was amended in April 2012, 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 to 15,000 yen according to the age of the children and the income level of the households.

Table 7.1 Contents of Current Child Allowance System (2018)

Subjected children	From newborn through the age of junior high school graduation (until the first March 31 after their 15th birthday)
Income limit	Exists (For example: An annual income of ¥9.6 million for a household with a husband, wife, and 2 children)
Benefit amount	[1] For a household below the income limit - Younger than 3 ¥15,000/month - Age 3 or older but before elementary school graduation first/second child ¥10,000/month third or later child ¥15,000/month - Junior high school student ¥10,000/month [2] For a household above the income limit (special benefits for the time being) ¥5,000/month
Share of expenses	National government, local governments, employer (younger than 3 and for employees' allowance)
Benefit expenses	Total benefit amount ¥2,221.6 billion (FY2017 budget)

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 18 years old or younger. The monthly allowance is ¥42,290～9,980 for one child, ¥9,990～5,000 for the second child, and ¥5,990～3,000 for each additional child. (Full payment is provided below the income limit. If it is over, there will be a range in the amount of payment because it will be paid in 10 yen increments until a certain income.) 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 the household. The income of family members other than the parent is also taken into consideration.

7.2.3 Special Child Rearing Allowance (For Parents of Children with Disabilities)

The Special Child Rearing Allowance is given to parents who look after their children with disabilities at home (there are income limits). The monthly allowance for a child under the age of 20 is ¥51,700 for first-degree and ¥34,430 for second-degree disabilities. In addition, the welfare allowance for children under the age of 20 with heavy disabilities is given to parents who take care of them at home. The monthly allowance is ¥14,650. On the other hand, the monthly allowance is ¥26,940 for those persons with heavy disabilities who are over 20 years old. They are eligible for the national disability pension according to their degree of disability.

7.3 Services for Families with Children

7.3.1 Childcare Services

Municipal governments are required by the Child Welfare Law to provide daycare centers for children whose parents require childcare for reasons such as work, illness, and care of other members of the family. Daycare centers for children typically provide 8-11 hours of care for children from newborns to the age of primary school, but the demand to extend the hours has been increasing. Staffing and other quality measures are tightly regulated by the municipality. Fees for daycare centers for children vary according to parents' income, from 0 to about 100,000 yen per month, according to municipality, children's age, and the income level of the parents.

A long waiting list to enter daycare 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 government started a new system for supporting children and child-rearing in 2015[4]. In addition to certified daycare centers, small-scale daycare services that only keep children up to two years old, daycare services at offices, family style daycare services, and in-home daycare services were eligible for public financial support. The certified childcare center system was improved (kindergarten and daycare center cooperation-type certified childcare centers were legally established as school and child welfare facilities.). Because the wait-listed children problem is mostly an issue only in urban areas, in areas where the child population is decreasing, the certified childcare center system is also a means of consolidating daycare centers and kindergartens.

The government set a special task force to solve the shortage of daycare services in 2001, 2008, 2010, and 2013. Approximately 2.6 million children were cared for at daycare centers in April 2018, an increase of 68,000

[4] Mariko Ichii Abumiya, "New Trends in Preschool Education and Childcare in Japan: Transition to a 'Comprehensive Support System for Children and Child-Rearing'" (https://www.nier.go.jp/English/educationjapan/pdf/201503NTPECJ.pdf)

since 2017. There are approximately 20,000 children who were on the waiting list in April 2018. That number had decreased by 6,186 between 2017 and 2018[5].

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, from 11,631 in 1999 to 133,778 in 2015 (the number of consultations on child abuse). Younger children are more likely to be victims (see Table 7.2).

There are 605 foster homes in Japan where approximately 25,000 children were present in 2017. An additional 5,400 children were supported by foster parents in 2017.

Table 7.2 The number of consultations on child abuse by age of children from April 2016 to March 2017

Age group	Total	Physical	Sexual	Psychological	Witnessing Violence (regrouped)	Neglected	Abandoned (regrouped)	Left behind (regrouped)	Forbidden go to school (regrouped)
Total	133,778	33,223	1,537	72,197	43,422	26,821	37	682	235
Age 0-2	27,046	4,001	47	17,353	11,498	5,645	23	166	7
Age 3-5	25,892	5,356	122	15,008	8,931	5,406	6	197	22
Age 6-12	52,725	14,141	519	27,403	16,151	10,662	7	262	146
Age 13-15	18,677	6,419	496	8,313	4,655	3,449	-	41	50
Age 16-18	9,438	3,306	353	4,120	2,187	1,659	-	16	10

Source; “Report on Social Welfare Administration and Services” of the MHWL, 2017

7.4 Work-Life Balance – Parental Leave System

Japanese women tend to leave the labor market when they are rearing children. The female labor participation rate of those aged 30 to 34 increased from 51.7% in 1990 to 75.2% in 2017, and that of women aged 25 to 29 increased from 61.4% in 1990 to 82.1% in 2017[6]. However, there is a gap between married and single women. The increase of single women’s labor participation contributed largely to raising the labor participation rate of those age groups. More women postpone marriage or childbearing to avoid the opportunity cost of quitting their job. Therefore, work-life balance measures to support women in taking both work and family responsibilities have become an important part of family policy.

Besides promoting daycare service for pre-primary school children as well as low grade pupils in primary school, parental leave is one of the major supports for households with children. The percentage of employed mothers who gave birth from October 2015 to September 2016 and began to take parental leave by October 2017 was 83.2%[7]. The rate of continued employment before and after the first child of a woman who gave birth to a child in 2010 – 2015 (a woman who worked when a pregnancy was known) was 53.1%[8]. Still, there are many women who quit working after child birth. On the other hand, only 5.14% of employed fathers whose spouses gave birth

[5] “Summary of Current Situation of Childcare Services” (April 1, 2018), MHLW. (https://www.mhlw.go.jp/stf/houdou/0000176137_00002.html (in Japanese only)
[6] “Labor Force Survey,” Statistics Japan. (Data in e-Stat [portal site of official statistics of Japan, https://www.e-stat.go.jp/en)
[7] “Basic Survey of Gender Equality in Employment Management 2017,” MHLW. (Data in e-Stat, https://www.e-stat.go.jp/) (in Japanese only). This survey covers private sector employees only.
[8] “15th Japanese National Fertility Survey,” Institute of Population and Social Security Research. (http://www.ipss.go.jp/site-ad/index_english/Survey-e.asp)

from October 2015 to September 2016 began to take parental leave by October 2017[9]. Therefore, the government enforces measures to promote work-life balance by encouraging fathers to take parental leave. In principle, those who have children under the age of one can take parental leave (see Table 7.3).

Table 7.3 Outline of the Parental Leave System

As of December 2018

	Parental leave	Family-care leave
Implementation	Establishment: 1991 Enforcement: 1992	Establishment: 1995 Enforcement: 1999
Duration	○ Guarantee the right to take parental leave until the child reaches one year old (two years old under certain conditions, such as being unable to enroll the child in daycare center) ○ One year before the child reaches one year and two months in case both parents take childcare leave (Papa/Mama Parental Leave Plus) ○ In the case a father takes childcare leave within eight weeks after the childbirth, he can take another childcare leave	○ Guarantee the right to take family-care leave up to three times within a total of 93 days for one family member
Compensation benefits	○ Payment will be covered by the labor insurance ○ Up to 180 days, 67% of previous wages ○ From 181 days to the day before the child's first birthday, 50% of previous wages (if the leave is extended up to two years old, it will be paid until two years old) ○ Exemption of social insurance premiums	○ Payment will be covered by the labor insurance ○ 67% of previous wages

7.5 Public Health Measures for Mothers and Children

The mother and child are protected by the Maternal and Child Health Act enacted in 1965. Health check-ups, health guidance, and medical aid (including a subsidy for specific infertility treatment expenses) are provided by local governments. The Mother and Child Health Handbooks, called "Boshitecho (母子手帳)" in Japanese, are given to all expectant mothers. Japan's infant mortality was as high as 150-160 per thousand births until the early 20th century but has declined sharply since the 1920s and attained an extremely low level, below 10, in 1975. Japan's current figure of 1.9 (2017) is one of the lowest, even among developed countries[10]. 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 and the prevailing poverty, the health condition of mothers and children deeply worsened. Under such circumstances, the Eugenic Protection Act was enacted in 1948, which certified doctors to perform induced abortions on women 21 weeks or less pregnant, under the condition that the pregnancy or delivery was likely to jeopardize the woman's health either physically or

[9] See note 7.
[10] "Vital statistics of Japan," MHLW. (Data in e-Stat (portal site of official statistics of Japan, https://www.e-stat.go.jp/en))

economically, or the woman had become pregnant as a result of rape. The certified doctors were required to report the number of abortions performed, and if the aborted fetus was 12 weeks or older, it was to be registered as a still birth. The law has since been amended and is now called the Maternity Protection Act (1996).

In 1996, support for infertility treatment was added to maternal and child health policy. Since that time, centers for specialized infertility counseling have been established nationwide, and there were about 70 locations as of 2017. A subsidy for specific infertility expenses was also started in 2004. This is an economic support measure for infertility treatment, and its contents have been revised many times so far. Currently, couples receive a subsidy of 150,000 yen per woman who underwent in vitro fertilization before 43 years of age. (Women under 40 years old at the time of treatment start can apply six times in total, but women aged 40-42 can only apply three times in total. Women aged 43 and over are not eligible.) In the case of in vitro fertilization, if the couple receiving the subsidies also takes care of the male side infertility treatment, there will be a subsidy of 150,000 yen. There are income restrictions (the income for married couples is within 7.3 million yen). The number of applications has increased each year. In 2004 when the system was started, the number of grants was 17,657, and in 2013 it had risen to 148,659[11].

[11] Data from the MHLW official web site. (MHLW) (in Japanese only)

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
(https://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 Labor Insurance

9.1 Overview

Japan's unemployment rate continues to remain relatively low compared to other advanced countries. However, 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 "labor insurance" is used to indicate these two social insurances. Schemes of the two insurances are independent of each other, but they have similar characteristics in that the government is the insurer, and the prefectural labor 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, a 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 Job Applicant Benefits, Employment Promotion Benefits, Educational Training Benefits, and Continuous Employment Benefits. These items are further explained below. The service for employment stabilization is provided to support employers in preventing them from laying off their employees. The service for developing human resources assists both employed and unemployed persons in acquiring skills.

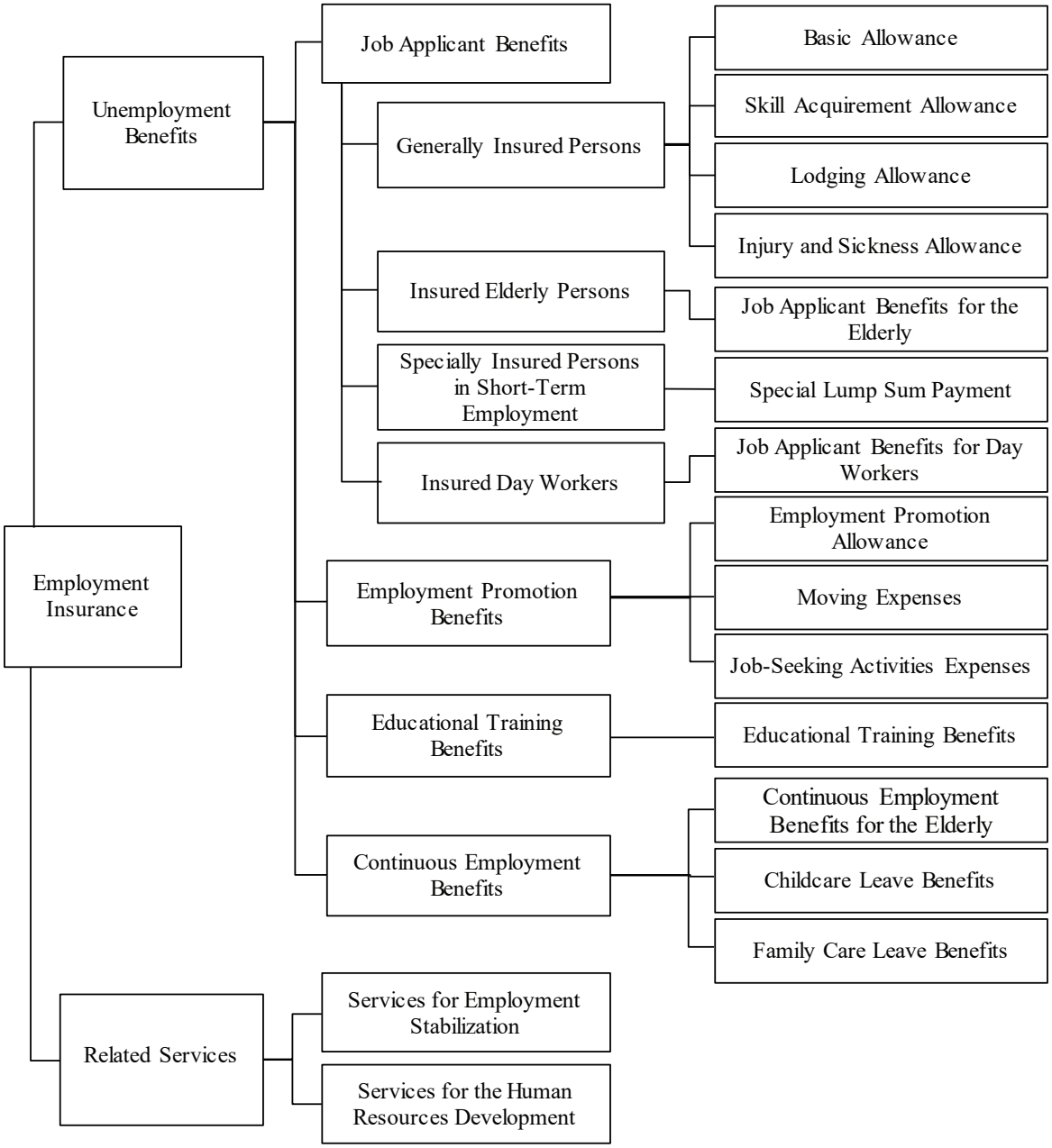
The entire scheme is shown in Figure 9.1.

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 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, the insurance premium is determined systematically within a defined range with the approval of the MHLW[2].

[1] Japan is believed to be a country in which it is 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 Basic Allowance for Job Applicants

Basic allowance is one of the Job Applicant Benefits and the most common benefit of employment insurance[3]. The basic allowance is paid when the insured former employee has lost his/her job. The benefit payment period of the basic allowance is between 90 and 360 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

[3] It is often referred to simply as “Unemployment Benefits.”
[4] For those who have difficulty in finding employment, such as disabled persons, the benefit period is between 150 and 360 days.

contract term," the benefit period is basically set longer than unemployment due to other reasons and is set longer with higher age. 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 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.

Table 9.1 Duration of Basic Allowance (for involuntarily 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				210	240
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 employ).

(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 FY2017, the average number of those who received the job applicant benefit per month were 378,344, and the total amount of the benefit payment was approximately 584 billion yen.

9.2.3 Employment Promotion Benefits, Educational Training Benefits

Employment Promotion Benefits are paid to those who find regular jobs and non-regular jobs[5]. Those

[5] Generally the meaning of "regular" and "non-regular" jobs are "permanent" and "temporary" jobs. See 9.2.5 more specifically.

qualified to receive the basic allowance and who are successful in finding employment with a certain benefit period remaining are eligible to receive these benefits.

Educational 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 MHLW. It compensates 20% of the educational training expenses (up to ¥100,000).

9.2.4 Continuous Employment Benefits

Continuous Employment Benefits are paid to insured persons who have experienced difficulty in continuing employment such as aging, child rearing, or nursing care. There are three programs in Continuous Employment Benefits: Continuous Employment Benefits for the Elderly, Childcare Leave Benefits, and Family Care Leave Benefits.

The Continuous Employment Benefits for the Elderly is provided to insured persons aged 60 to 64 years old who have been covered by 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 for insured persons taking childcare leave to care for infants under the age of one (or the age of one and a half or two if extension is permitted). They receive benefits equivalent to 67% 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, like the Childcare Leave Benefit, is a system for those taking leave to provide nursing care for his/her family. The benefits are equivalent to 67% of the wage before taking leave (with an upper limit) for a maximum of three months.

9.2.5 Employment Situation and Current Issue of Employment Measures

In recent years, non-regular workers such as fixed-term contract workers, part-time workers, and dispatched workers have been an increasing trend, accounting for about 40% of the total employees. These factors are mainly attributable to an increase in non-regular employment due to continued employment in the elderly and an increase in workers such as women who start working mainly part-time with the economic recovery. However, especially in young people aged 25 to 34 years old, there are quite a few workers who work as non-regular employees even if they wish for regular employment.

Workers with non-regular employment have problems such as unstable employment, low wages, and poor ability-development opportunities. For this reason, it is important to promote regular employment of irregularly hired workers who wish regular employment and work on improving employment stability and treatment.

9.3 Workers' Accident Compensation Insurance

9.3.1 Outline of Workers' Accident Compensation Insurance

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	19 ~ 38
Mining	3 ~ 88
Construction	6.5 ~ 79
Manufacturing	2.5 ~ 26
Transportation	4.5 ~ 13
Energy (electricity, gas, water, or heat supply)	3
Others	2.5 ~ 49

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.

9.3.2 Current Trends in Industrial Accidents

Generally, industrial accidents tend to decline over the long term. However, regarding brain/heart disease and psychiatric disorders due to work, both the number of claims for workers' compensation insurance benefits and the number of payment decisions have increased. Therefore, prevention of long-term work of workers and mental health measures are important subjects.

Table 9.5 Outline of the Employment Insurance System in Japan

Schemes are as of April 2018.

1) The Insured	(a) Generally Insured Persons	(b) Specially Insured Persons in Short-Term Employment	(c) Continuously Employed Elderly Persons (Over Age 65)	Insured Day Workers
2) Number of Insured	42.89 (million)			13 (thousand)
3) Number of employers	2.23 (million)			
4) Insurer	Government			
5) Premium rate:	(General) (for Agro-Forestry) (for Construction)			In addition to the left items
The Insured	0.3% 0.4% 0.4%			¥48〜88/day
Employer	0.6% 0.7% 0.8%			¥48〜88/day
6) Gov't Subsidy:				
Administrative cost	All			All
Benefits paid	25% of Job Applicant Benefits(except Job Applicant Benefits for Day Workers), 12.5% for Employment Continuation benefits			1/3 of benefits
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	Special Lump Sum Payment: 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 the year	Paid 26 days of premium in the past 2 months
Amount	50 to 80% of previous wage		45 to 80% of previous wage	¥7,500〜¥4,100/day
Duration	See Table 9.1-9.3		For 30 days if the insured period is less than 1 year, for 50 days if insured for 1 year or more	13〜17 days
② Skill Acquirement Allowance	(1) ¥500/day for course fee, (2) up to ¥20,000 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] Moving Expenses [III] Job-Seeking Activities Expenses	Eligible for [I](3) in the left column	---	Eligible for [I](3) in the left column
(c) Education & Training Benefits				
Requirements	Those who have completed the study & training designated by the ministry with more than 3 years of insured period	---	---	---
Amount	20% of expense (up to ¥100,000)			
(D) Continuous Employment Benefits				
① Continuous Employment Benefits for the Elderly				
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 (if the current salary is 61-75% of the wage at 60, the rate is reduced gradually)			
Duration	Until the 65th birthday (if re-employed after receiving Basic Allowance, 2 years if the remaining days of Basic Allowance is over 200 days, 1 year, if 100 days or more and less than 200 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 or two years 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	67%(50% from 6 months after the leave) of wage before the leave			
Duration	During the child care leave			
③ Family Care Leave Benefits				
Requirements	Those who have 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	67% of wage before the leave			
Duration	Up to three months			

Source : HelloWork Internet Service, https://www.hellowork.go.jp/insurance/insurance_continue.html

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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

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/en/

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

National Institute of Biomedical Innovation, Health and Nutrition http://www.nibiohn.go.jp/index_e.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

The views expressed herein are those of the authors and not necessarily those of the National Institute of Population and Social Security Research, Japan.

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