

# Chapter 2

## Social Protection in Japan: Current State and Challenges

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March 2010

**This chapter should be cited as**

Hayashi, M. (2010), 'Social Protection in Japan: Current State and Challenges', in Asher, M. G., S. Oum and F. Parulian (eds.), *Social Protection in East Asia – Current State and Challenges*. ERIA Research Project Report 2009-9, Jakarta: ERIA. pp.19-54.

## CHAPTER 2

# Social Protection in Japan: Current State and Challenges

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*This study systematically describes the current arrangements for social protection in Japan, including the key elements of coverage, benefits, and management. Special attention is paid to the roles assumed by local governments in social protection schemes. With the exception of public pensions, local governments are involved in every aspect of social policy, covering residuals that fall from upper layers of social safety nets. This study examines the Japanese system in terms of its effectiveness as a social safety net in the face of changing economic and demographic environments in the country, identifies the issues the current Japanese system faces, and offers possible policy proposals.*

## 1. Introduction

The upper layers of social safety nets in Japan are built around full-time employees. Work-related insurance was primarily designed for established businesses and their full-time employees. Mainstream programs for public pensions and health insurance are run by employment-based associations. Those excluded from these mainstream programs are taken care of by residual social insurance programs. This mainstream-residual dichotomy may also be created when a distinction is made between premium-financed programs and tax-financed programs. Here, the residuals are tax-financed programs which include public assistance and a variety of other assistance services. Conceptualized as such, local governments in Japan are responsible for the safety nets at the bottom, covering residuals that fall from upper layers of social safety nets.

While the Ministry of Health, Labor and Welfare (MHLW) at the central government designs and oversees social policies, local governments are involved in almost every aspect of social policy, except public pensions.<sup>1</sup> Municipalities manage the National Health Insurance (NHI), the Long-term Care Insurance (LTCI) and the health care system for the elderly. Premiums for the NHI and the LTCI differ across municipalities and municipalities conduct eligibility assessment for the LTCI. In addition, localities implement a variety of social programs prescribed by national laws. The local social programs are geared toward the following targets: (1) low-income households, (2) children, (3) single mothers and widows, (4) the elderly and (5) the physically and mentally disabled. Furthermore, a substantial number of social programs are planned and implemented at the local governments' discretion. The Ministry of Internal Affairs and Communication (MIC) reports that such local social spending in FY2007 amounts to more than JPN¥ 7 trillion, almost three times as much as Public Assistance expenditure (JPN¥2.5 trillion). There are many cases where a national law simply assigns a specific social program to a locality without specifying

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<sup>1</sup> However, we note that municipalities had been collecting premiums for the National Pension in place of the central government until the task was taken over by local offices of the Social Insurance Agency in April 2002.

either benefit levels or eligibility criteria. In such cases, localities have considerable discretion in implementing social programs.

**Table 1.1. Shares of Local Spending**

Unit: billion JPN yen and percent

	(A) central	(B) local	(C) Social security funds	(D) Local	(E): (B)+(D)	(F): (A)+(B) +(C)	Local share: (E)/(F)
Collective consumption	12,365	27,766	674	0	27,766	40,805	68.0%
Social transfers in kind (1)+(2)	1,984	15,974	34,364	25,778	41,752	52,321	79.8%
(1) Social benefits in kind (i)+(ii)	0	0	33,500	25,778	25,778	33,500	76.9%
(i) Social security benefits, reimbursements	0	0	1,323	919	919	1,323	69.5%
(ii) Other social security benefits in kind	0	0	32,178	24,859	24,859	32,178	77.3%
(2) Transfers of individual non- market goods and services	1,984	15,974	863	0	15,974	18,821	84.9%
Social benefits other than social transfers in kind (3)+(4)+(5)	1,708	9,649	49,018	5,583	15,232	60,375	25.2%
(3) Social security benefits in cash	0	0	48,994	5,583	5,583	48,994	11.4%
(4) Unfunded employee social benefits	624	3,206	25	0	3,206	3,855	83.2%
(5) Social assistance benefits*	1,084	6,443	0	0	6,443	7,527	85.6%
Other current transfers**	3,313	3,985	397	0	3,985	7,696	51.8%
Capital transfers	6,506	3,041	62	0	3,041	9,609	31.7%
Gross capital formation	4,097	11,503	61	0	11,503	15,661	73.4%
Purchase of land	216	1,617	-7	0	1,617	1,825	88.6%
Total	30,189	73,535	84,569	31,360	104,895	188,292	55.7%

Source: Economic and Social Research Institute, Cabinet Office, *Annual Report on National Accounts of 2007*.

Notes: \* includes social transfers in kind.

\*\* excludes intergovernmental transfers.

Table 1.1 indeed substantiates the local roles in social spending. While localities share 55 percent of the total expenditure, their share of social spending is even higher. Although the local share of social security benefits in cash (pension benefits) is small, its share of social transfers in kind and social assistance is 79.8 and 85.6 percent respectively. Indeed, local governments in Japan are more responsible for social expenditure than those in other countries. Japan's share is one of the highest, after only Denmark and even higher than the combined share of state/ province and local expenditure in the federal countries.

This study describes the current arrangements for social protection in Japan<sup>2</sup>, including the elements of coverage, benefits and management. Special attention is paid to the roles assumed by central and local governments in these schemes. We examine the system in terms of its effectiveness as a social safety net in the face of the changing socio-economic environment of the country. The rest of this paper is structured as follows: Section 2 discusses the upper layer of social safety nets which are managed by the central government, i.e. public pensions and unemployment insurance. Section 3 then delineates the scheme for public health care insurance. Section 4 explains the social protection scheme at the bottom, implemented by local governments. Section 5 then concludes the paper by identifying the issues the current Japanese system of social protection faces, along with possible policy proposals.

## **2. Public Pensions and Unemployment Insurance**

### **2.1. Public Pensions**

#### *2.1.1. General Description*

Pensions and work-related insurance are managed by the center in Japan. The Japanese public pension system is two-tiered.<sup>3</sup> The first tier is *Kiso Nenkin*, or the Basic Pension (BP), which aims to provide a base-line income for the retired. All residents, including foreigners in Japan between the age of 20 and 60 are expected to pay premiums for the BP. The second tier is *Kosei Nenkin* or the Employees' Pension Insurance (EPI). Its premiums are proportional to income earned and benefits increase in line with premiums paid during the working life of the employee. Those who work

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<sup>2</sup> The concept of social protection should be associated with the Japanese terms *Shakai Hosho*, the literal translation of which is social (Shakai) security (Hosho). The MHLW schematizes policy for "social security" in terms of (1) social insurance (public pensions, public health insurance, long-term care insurance, work-related insurance), (2) public assistance (poverty relief), (3) social welfare (personal social services and income support for the elderly, the disabled, children and single mothers), (4) health (medical service delivery, health promotion, and epidemic prevention) and (5) medical care for the elderly.

<sup>3</sup> On top of these, large firms or employers sometimes provide corporate pensions as the third pillar.

at firms with more than 5 employees and their employers are required to participate in the EPI.

The two-tiered system applies only to employees and their spouses. Employees are automatically enrolled in the BP when they join the EPI. Their premiums include those for the BP and the EPI and are single-scheduled.<sup>4</sup> When the two-tiered scheme applies to those employed in the public sector, the scheme is called *Kyosai Nenkin* or the Mutual Aid Pensions (MAP). In these two-tiered systems, if subscribers are married, premiums paid by employees also entitle their non-working spouses<sup>5</sup> to receive future benefits from the BP.

The public pension for those excluded from the EPI (e.g., self-employed, farmers, and unemployed) is a single-tier system where the BP is the only component. This scheme is called *Kokumin Nenkin* or the National Pension (NP). The NP premiums are uniform and independent of individual characteristics (JP¥ 14,460 per month in 2009). The BP does not cover the subscribers' non-working spouses. They have to pay premiums for their benefits, even if they do not earn. Low-income (or no income) subscribers can choose to exempt themselves from paying premiums, either partially or entirely but their benefits will be reduced accordingly.

The public pension system thus divides the insured into the following three categories:

- Category 1: Those who are excluded from Categories 2 and 3 (e.g., the self-employed, farmers and students)
- Category 2: Those who work for companies with more than 5 employees
- Category 3: Non-working spouses of Category 2 subscribers

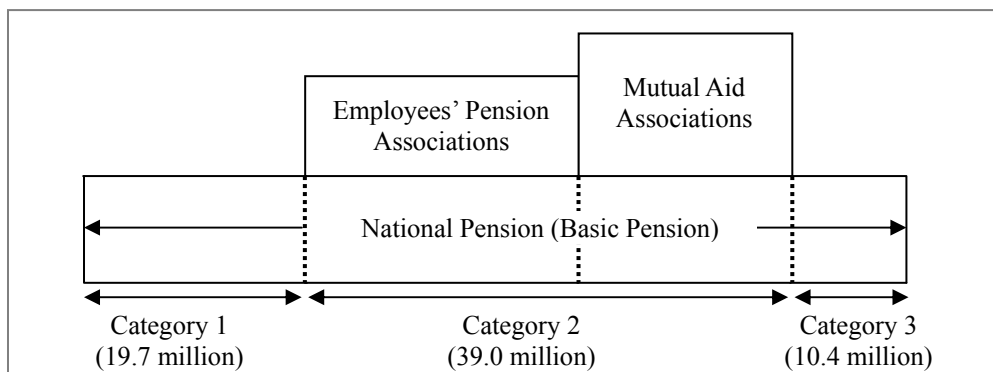
The public pension schemes that cover each of the above three categories are illustrated in Figure 2.1 along with the number of subscribers to each.

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<sup>4</sup> Given this treatment of the BP within the EPI, the very same name “Employees’ Pension Insurance” is somewhat confusingly used to denote the two-tiered system in the private sector.

<sup>5</sup> “Non-working” spouses refers to spouses who earn less than 1.3 million Yen a year.

**Figure 2.1. Basic Schemes for the Public Pension in Japan**



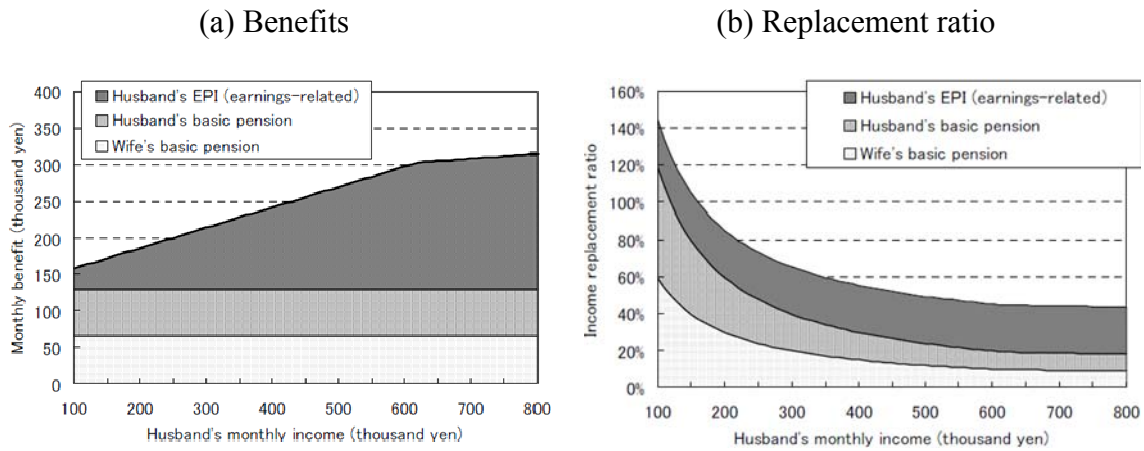
Source: Social Insurance Agency

### 2.1.2. Benefits

Currently, 96 percent of all persons aged 60 and above receive the monthly average BP benefits of JPN¥52,500. While the starting age of eligibility for pensions varies from 60 to 65,<sup>6</sup> a prerequisite for receiving the benefits is at least 25 years of premium payments. Benefits are proportional to the number of years of premium payments, with a ceiling at 40 years of contributions. Nakashima (2009) calculated the combined EPI and BP benefits and their replacement ratio (monthly benefits per monthly earnings) for a couple with a non-working wife with 40 years of contributions, as in Figure 2.2. The BP benefits are flat at JPN¥65,000 for each individual in the couple. While Panel (a) shows that monthly benefits are increasing in line with average monthly earnings, Panel (b) shows that the replacement ratio is decreasing. For example, the combined monthly benefits are JPN¥227,000 for a couple who earned JPN¥348,000 on average with the replacement ratio of 0.652. If earnings were halved (JPN¥174,000), the monthly benefits are reduced to JPN¥179,000 with the ratio of 1.03. If they earned double (JPN¥696,000), the benefits are JPN¥315,000 with the ratio of 0.435.

<sup>6</sup> Over the years, the government has increased the starting age for eligibility. In particular, the starting age for males born after April 1, 1949 and females born after April 1, 1954 is set at 65 for the BP, while that for the EPI (net of the BP) remains at 60. The starting age for the EPI will also be delayed gradually over coming years, until it reaches 60 for males born after April 1, 1961 and females born after April 1, 1966.

**Figure 2.2. Pension Benefits**



Source: Excerpts from Nakashima (2009).

### 2.1.3. Financing

For the BP, current benefits are paid out of a pool of collected premiums and transfers from the budget of the central government. The 2004 reform raised the tax-financed portion from one third to one half of the BP benefits. For the EPI, both employers and employees contribute 7.32 percent of employees' monthly salary which includes premiums for the BP. The EPI premiums are capped at a monthly salary of JPN¥620,000.

Administrative costs are all tax-financed<sup>7</sup> both for the EPI and the NP. While the public pension is effectively pay-as-you-go, premiums that are collected but not disbursed are pooled and invested in order to yield returns. The MHLW sets performance goals for this investment. The Government Pension Investment Fund (GPIF) is entrusted by the MHLW to develop an investment strategy that will attain a long-term rate of return which is sufficient to maintain a stable ratio of reserves to annual public pension expenditure. The 2004 Pension Reform set inflation rate at 1.0% and real wage increase rate at 1.1%, and set investment yield at 2.2% so that

<sup>7</sup> The 2004 reform introduced an automatic adjustment of benefits to balance revenues and payments.



nominal investment yield will be 3.2%. The GPIF is thus required to achieve a real yield of 1.1%. Investment performance after FY2004 is listed in Table 2.1.

**Table 2.1. Return on Investments**

Fiscal Year	2004	2005	2006	2007	2008	Average (2004-8)	1 <sup>st</sup> Qtr. 2009	2 <sup>nd</sup> Qtr. 2009
Return on total investments (%)	3.39	9.88	3.70	-4.59	-7.57	0.77	3.89	1.06
Return on Market investments (%)	4.60	14.37	4.75	-6.42	-10.03	1.08	4.85	1.24

Source: Government Pension Investment Fund (2009a, b).

Notes: 1. "return on total investments" includes returns on FILP bonds.

2. The returns are reported as gross of fees.

3. The five year averages are annualized geometric mean.

## 2.2. Unemployment Insurance

### 2.2.1. General Description

Unemployment insurance is called the Employment Insurance (EI) or *Koyo Hoken* in Japanese. With some exceptions, employers are required to participate in the scheme to cover their full-time workers below the age of 65. Part-time and temporary workers who work for 20 hours or more per week are also enrolled in the scheme if it is expected that they will remain in their job for more than six months.

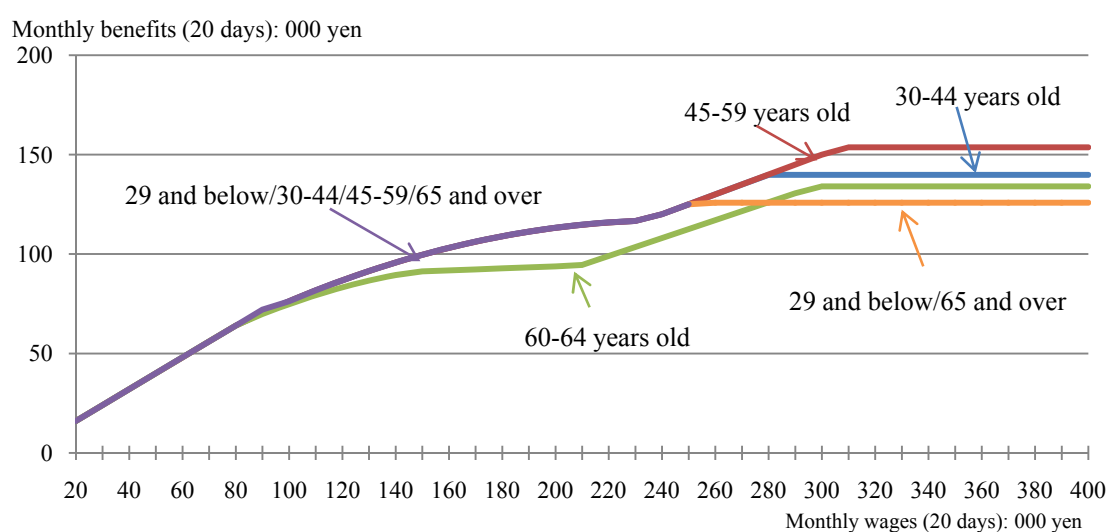
### 2.2.2. Benefits

When unemployed, the insured are expected to file applications at the "Hello Work" (Employment Security Office) in order to receive the EI benefits. To be eligible, unemployed people are required to have been enrolled on the EI program for a period of at least 6 months during the 2 years prior to leaving their job. The main component of the benefits is the Basic Allowance for the Job Applicants (BAJA), which is proportional to each applicant's most recent salary, prior to becoming unemployed. The proportion ranges from 50 to 80 percent with high-income earners receiving a lower proportion. If the insured are aged between 60 and 65, the proportion is reduced further to 45 percent. Figure 2.3 shows the different benefit schedules.

The BAJA is paid with the condition that recipients are actively seeking new jobs. The EI also provides other types of benefits for job-skill training programs and maintaining current employment status. Once deemed to be eligible, the insured

receives the benefits *after* a seven day waiting period. If unemployment is voluntary, the waiting period can extend to between one and three months, depending on the specifics of the case. In addition, the duration of benefits varies depending on the age of recipient, the period of enrollment in the EI and the reasons for job termination. Benefit duration increases with enrollment period and recipient's age. Voluntary unemployment results in a shorter duration. The details are summarized in Table 2.2.

**Figure 2.3. The EI Benefits Schedule**



*Source:* Author's calculation based on the formula by the Ministry of Health, Labour and Welfare.  
*Note :* While the allowance is calculated on daily basis, the figure translates the schedules into those on monthly basis, assuming one month consists of 20 working days.

### 2.2.3. Financing

All administrative costs are financed from the general account of the central government. A certain proportion of the benefits payments are also tax-financed, with varying subsidizing rates across the types of benefits, typically 25 percent for the BAJA. The rest is financed by premiums (payroll taxes). The standard premium for the EI is 1.5 percent of employees' earnings (monthly salaries and bonuses), of which employers' and employees' share are 0.9 percent and 0.6 percent respectively, with different rates for businesses in the agricultural and construction industries. Due to the recent economic slowdown, the standard rate was temporarily reduced to 1.1 percent with 0.7 percent for employers and 0.5 percent for employees in 2009.

**Table 2.2. Duration (Days) of the EI Benefits**

Years ( $x$ ) of the EI enrollment		$x < 1$	$1 \leq x < 5$	$5 \leq x < 10$	$10 \leq x < 20$	$20 \leq x$
Voluntary	All ages	n. a.	90		120	150
Involuntary Unemployment	30	90		120	180	n. a.
	30-35	90		180	210	240
	35-45	90		180	240	270
	45-60	90	180	240	270	330
	60-65	90	150	180	210	240
Disabled	-45	150	300			
	45-65	150	360			

Source: Mukuno and Tanaka (2009), Ministry of Health, Labour and Welfare (various years).

### 3. Public Health Insurance

#### 3.1. The System

##### 3.1.1. General Description

Public health insurance in Japan consists of two schemes which cover different groups within the population. The first is an occupation-based scheme called *Hiyosha Kenko Hoken* or the Employees' Health Insurance (EHI). The EHI is a generic term for workplace-based health insurance and is categorized into (a) *Kumiai Kansho Kenko Hoken* or the Association-managed Health Insurance (AMHI), (b) *Zenkoku Kenko Hoken Kyokai Kansho Kenko Hoken* (*Kyokai Kempo* for short) or the Japan Health Insurance Association-managed Health Insurance (JHIA-mHI), (c) *Kyosai Kumiai Kenko Hoken* or the Mutual Aid Association Health Insurance (MAAHI) and (d) *Sen-in Hoken* or Seamen's Insurance (SI). These occupation-based insurance types cover employees and their dependents.

The other scheme is called *Kokumin Kenko Hoken* or the National Health Insurance (NHI). The NHI is a region-based scheme. The insurers are municipalities which cover residents who are excluded from the EHI. The insured typically include self-employed, farmers, workers of smaller firms and their families. They account for around one third of the total population. Since the NHI covers those who are not covered by the EHI, the system as a whole apparently boasts its universal coverage.

### 3.1.2. *Benefits*

The coverage of medical services by the public insurance is standardized by law. Except for some special medical treatments, the coverage is quite wide. There are no differences in co-payments or coverage for medical services, whether they are provided by clinics or hospitals, both private and public. Any people of comparable characteristics receive standardized medical services at identical prices (co-payments), regardless of the type of public health insurance. Patients are free to choose any medical service providers regardless of location, facility type or other factors such as having referral<sup>8</sup> or not. The public health insurance covers 70 percent of medical costs, i.e., co-payments are 30 percent.<sup>9</sup>

Medical service providers are paid for the services and medicine they provide. The fee schedules for medical treatments covered by public insurance are identically set by the central government and are subject to revision every two years based on recommendations from the Central Social Insurance Medical Council (CSIMC). Providers are reimbursed in a centralized manner. Each month, bills for medical treatments and drugs covered by the EHI and the NHI are examined by the Social Insurance Medical Fee Payment Fund (SIMFP) and the National Health Insurance Federation (NHIF) respectively. However, their reviewing capacity is limited and intensive reviews are limited to only high-cost and suspicious cases. To counteract some adverse effects<sup>10</sup>, the 2006 reform introduced package payment for the medical treatment of the elderly with the hope of limiting the number of longer hospital stays.

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<sup>8</sup> Patients are required to pay an initial installment fee (usually less than JPN¥10,000) when they choose to receive medical services at designated, usually large-scale, hospitals without a referral issued by a non-designated clinic or hospital.

<sup>9</sup> Co-payments were increased in a series of reforms. For those below the age of 69 in the EHI, the rate was raised from 20 to 30 percent (NHI subscribers had already faced 30 percent rate then). The premium base was also imposed on bonuses, thus applied to the entire annual salaries. For the high-income elderly aged above 70, the co-payment rate was raised from 10 to 20 percent in 2002 and again increased to 30 percent in 2006. In that year, the rate for those aged between 70 and 74 was also raised from 10 percent to 20 percent. The ceilings on co-payments were also raised, in line with personal earnings.

<sup>10</sup> In addition, there has been a gradual shift in the usage of medical resources, from acute to chronic diseases. It is suspected that there is an incentive for medical providers to over-examine and over-prescribe medicine.

### 3.1.3. Financing

Benefits are financed by premiums, taxes and co-payments whose shares were 52.9 percent, 32.2 percent and 14.9 percent respectively in 2007 with all the programs combined. The premiums for the EHI differ among associations within the EHI. They are levied as a fixed percent of employees' earnings and are shared equally by employers and their employees. The premiums for the NHI differ among municipalities and are based on income level and the number of family members.

The Japanese system of public health insurance is summarized in Table 3.1, each item of which is explained in what follows in this section.

**Table 3.1. Public Health Insurance in Japan**

Institutional Type		Insurer/ Managing Organization	Coverage	
Employees' Health Insurance	JHIA-managed	Japan Health Insurance Association	34 million	
	Association-managed	Employees' health insurance associations (1,541)	28 million	
	Seamen's Health Insurance	Japan Health Insurance Association	0.16 million	
	Mutual Aid Association	Central Government Employees	mutual aid associations (21)	9 million
		Local Government Employees	mutual aid associations (54)	
		Private School Teachers and Employees	Private School Teachers and Employees Association	
National Health Insurance		municipalities (about 1,800)	42 million	
		National Health Insurance Associations (165)		
Health Care Service for the Old-Old		prefecture-wise large area unions (47)	13 million	

### 3.2. Employees' Health Insurance

The EHI covers employees and their dependents. The EHI consists of multiple health insurance programs managed by work-place based associations formed by employers and employees in private firms with five or more employees. These multiple health insurance programs are categorized as follows:

a. Association-managed Health Insurance

The *Kumiai Kansyo Kenko Hoken* or the Association-managed Health Insurance (AMHI) is operated by health insurance associations organized by members of large firms for their employees and family members. A single firm with more than 700 employees is eligible to establish its AMHI. More than one single firm can form a single association if their combined number of employees exceeds 3000. In 2009, 1,485 AMHIs (as of April 1<sup>st</sup>) cover approximately 30 million individuals.

b. Insurance managed by the Japan Health Insurance Association

Employees who are not covered by the AMHI and their family members are covered by health insurance managed by the Japan Health Insurance Association (JHIA). The JHIA insurance was formerly called *Seifu Kansho Kenko Hoken* or Government-managed Health Insurance (GMHI) and was administered by the Social Insurance Agency of the Japanese Government. As one of the reforms in the Social Insurance Agency, in October 2008 the GMHI was revamped into a new public health insurance managed by the JHIA.<sup>11</sup> The JHIA is an independent administrative agency whose functions are defined by national law. As of March 31 2009, about 19.5 million employees and their 15.2 family members are covered by the JHIA Insurance. The JHIA manages the Seamen's Insurance, which covers mariners and their family members with benefits in the event of sickness, injury, childbirth, death and unemployment. It also covers incidents of occupational disability and cases of missing mariners.

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<sup>11</sup> The system started with a premium rate of 8.2 percent. In October 2010, the rate will consist of special and basic rates. The special rate is fixed at 3.2 percent in every prefecture and is used to finance *Koreisha Iryo Seido* or the Elderly Health Care Service (to be explained later). The basic rate differs across prefectures with the highest at 5.06 percent in Hokkaido and the lowest at 4.97 percent in Gunma, Saitama, Chiba, Yamanashi and Shizuoka. These differences are supposed to reflect differences in medical expenditure, after adjusting for differences in age-composition and income factors. Also, additional adjustments are made if the combined rate of the special and basic rates deviates by a pre-determined amount from the original rate of 8.2 percent.

c. Insurance managed by the Mutual Aid Associations

The other type of association that provides occupation-based public health insurance is *Kyosai Kumiai* or the Mutual Aid Association (MAA). There are three MAAs: the National Government Employees' Mutual Aid Association, the Local Government Employees' Mutual Aid Association and the Private School Teachers and Employees' Mutual Aid Association.

### 3.3. National Health Insurance

Every municipality sets up and manages its NHI insurance association to cover those residents who are excluded from the EHI. Municipalities can choose between two methods of premium collection: a subscription fee system and a local tax system. The fee system has more flexibility in setting premium schedules, while the tax system has more coercive power in collecting contributions<sup>12</sup>. The premiums are levied on income, property and number of insured within a household. Municipalities have discretion over the premium schedule which differs among municipalities. The premiums are reduced for low-income individuals. While the premium schedule is set by municipalities, the rule for premium reduction for low-income households is set by the central government. Currently, the premium is reduced by up to 60 percent (70 percent in some municipalities).

### 3.4. Health Care for the Elderly

Dependent elderly with family members enrolled in the EHI were also covered by the EHI. The other elderly were covered by the NHI, the cost of which was an increasingly heavy burden on the NHI. In 1983, *Rojin Hoken Seido* or the Elderly Health Care Service (EHCS) was created to lessen the burden on the NHI. In the EHCS, the elderly continued to be enrolled in either the EHI or the NHI and contributed according to the schemes' respective premium schedules as before. But a different scheme was introduced to finance the medical costs for those aged 70 and over<sup>13</sup>. Municipalities not only financed medical costs for the elderly but developed health

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<sup>12</sup> Urban municipalities tend to employ the fee system, whereas rural municipalities tend to opt for the tax system (Nishikawa 2006).

<sup>13</sup> The EHCS also applies to those aged between 65 and 70 years who are bed-ridden or seriously disabled.

promotion programs to contain increasing medical costs. Half of the costs were financed by taxes: central, prefectural, and municipal governments share 40 percent, 10 percent and 10 percent of the total costs respectively. The other half is filled by cost sharing among the insurers of public health insurance (employees' associations in the EHI and the NHI) along with co-payments from the elderly.

Since April 2008, those aged 75 and above (called "old-old") have been separated from their public health insurance and covered by *Koki Koureisha Iryo Seido* or the Health Care Service for the Old-Old (HCSOO). A *Koiki Rengo* or large-area union composed of all municipalities within a prefecture manages health care for their old-old. The old-old pay 10 percent co-payments, while 30 percent is applied to the high-income. The benefits are financed from premiums (10%), transfers from public insurance associations (40%) and taxes (50%). The taxes are financed proportionally from the center (4/6), prefecture (1/6) and municipalities (1/6). Premiums differ among prefectures. The average value of annual premiums as of 2008 is JPN¥72,000, with the lowest figure of JPN¥46,374 in Aomori and the highest of JPN¥92,750 in Kanagawa. Premiums are collected by municipalities and are withheld from pension benefits if the pension benefits are more than JPN¥180,000 a year. Premiums are reduced for low-income elderly in three stages (30, 50 and 80% reductions).

For those aged between 65 and 74 (called "young-old"), the EHCS scheme is essentially retained, although the scheme is now called *Zenki Koureisha Iryo Seido* or the Health Care Service for the Young-Old (HCSYO). The young old continue to pay premiums for their public health insurance but their medical costs are taken care of by municipalities through tax-financing and an inter-insurer cost sharing scheme. The 2008 reform has effectively separated the old-old from the then-existing EHCS<sup>14</sup>.

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<sup>14</sup> However, due to its unpopularity and changes in the Japanese political map (i.e., the new Liberal administration), these new schemes are under serious review. In addition, the inter-association cost-sharing scheme has caused unintended effects. As the economy is rapidly aging, net contributions from health insurance associations to the cost-sharing scheme are increasing, since its mechanism is such that associations with larger shares of younger (older) generations contribute (receive) more. In addition, continuous economic slowdown has reduced wages of employees, thereby decreasing premium revenues which are fixed proportions of labor incomes. These have conspired to cause deficits in some associations to such an extent that they would be better off by dissolving themselves (and joining the JHIA) than by increasing their premium rates.



## **4. Long-term Care Insurance, Public Assistance and Other Welfare Services**

In addition to the NHI and the health care system for the elderly, localities are responsible for the Long-term Care Insurance (LTCI) as well as other social welfare services. The local social programs are geared toward the following targets: (1) low-income households, (2) children, (3) single mothers and widows, (4) the elderly and (5) the physically and mentally disabled. Furthermore, a substantial number of social programs are also provided at local discretion.

### **4.1. Long-term Care Insurance**

#### *4.1.1. General Description*

Before the introduction of the long-term care (LTC) insurance, Japan was suffering from inequitable care services, since municipalities with different fiscal resources provided different levels of care services according to their local standards. The Long-term Care Insurance (LTCI) was introduced in 2000 to cope with the difficult task of standardizing care benefits and containing expanding care expenses.

#### *4.1.2. Benefits*

The LTCI covers persons aged 65 years and over (Category I) and those aged between 40 and 64 years (Category II). To receive LTCI benefits, prospective recipients first apply to have their needs assessed by their municipality of residence. Upon application, an examiner visits and interviews the applicant to check various aspects of his/her physical and mental state. The checklist, filled in by the examiner, is compiled into a computer program that automatically assesses the applicants' needs. The computer results are then sent to a committee of local experts. They review the results with the written notes from the first-stage examiner and the applicant's doctor and alter the results if necessary. In all of these assessments, only the applicant's physical and mental condition is supposed to be considered.

Those who are found to be eligible are classified into several stages according to the severity of their needs. Until 2005, there had been six categories of LTC needs,

consisting of one stage of Support Required (SR) for the least severe and five stages of Care Required (CR) from 1 to 5 with 5 being the most severe. Since the SR category was divided into Support Required 1 (SR1) and Support Required2 (SR2) in 2006, there has been a total of seven categories. Applicants are informed of the results within 30 days of application. If dissatisfied with the decision, they can appeal to an agency at the prefectural level and ultimately to the courts. Eligibility and its categories are reevaluated every six months.

When certified as eligible, subscribers are entitled to “purchase” long-term care services from providers of their choice,<sup>15</sup> in exchange for co-payments amounting to 10 percent of actual cost (i.e., the LTCI benefit amounts to 90 percent of the expense). Those who are eligible can receive benefits up to a ceiling for which there are seven stages according to the severity of individual needs, from about JPN¥49,700 to PNY¥358,300 for actual per-month service expense.

#### *4.1.3. Financing*

Municipalities set up special accounts for their LTCI programs and set budgets that are required to balance on a three-year basis. The three-year period for budget planning is called the “program management period (PMP)”. When drawing up budgets for a coming PMP, municipalities estimate their LTCI expenditures for the next three-year PMP.<sup>16</sup> After expenditure forecasts are obtained, revenues are considered. The basic scheme is given as follows. First, the central government covers 20 percent of the benefit expenses through the “Long-term Care Benefits Subsidy (LTC-BS).” Secondly, the central government also disburses an additional grant called the

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<sup>15</sup> Providers are either public or private, though private providers have to be certified by the prefecture. While a variety of LTC services are covered by LTCI benefits, some services are not covered by the LTCI. For example, meal expenses for those who are hospitalized or institutionalized are excluded from the coverage. Also, the benefits for Category II subscribers are restricted to some specific age-related diseases. In addition, persons classified in the two lowest stages (SR1 and SR2) are not eligible for institutional care services. Of course, the beneficiaries, if they desire, can self-finance the purchase of additional services.

<sup>16</sup> Because LTC prices are set by the central government and are effectively held constant, the expenditure forecasts boil down to the volume of demand for LTC services. Forecasting the volume of institutional care is relatively straightforward since it is capped by the capacity of existing or planned LTCI facilities. On the other hand, estimating the amount of home care is rather complicated, because it involves forecasting the number of eligible people and the extent to which they utilize their entitlements.

“Adjustment Subsidy (AS)”. The AS allocates central funds that equal 5 percent of the national total of all LTCI benefits. The AS grants are distributed with matching rates that depend on the percentage of those aged 75 years and over, and the average income of those aged 65 and over. The minimum value of the matching rates is zero and its maximum value differs from year to year.<sup>17</sup> Thirdly, prefectures, through the Cost-sharing Subsidy (CSS), cover 12.5 percent of municipal benefits in their jurisdictions. Finally, another 12.5 percent is financed by intra-municipal transfers from the general account to the LTCI account within a municipality. These four factors are all financed through taxes and these tax-financed shares exclude extra benefits that municipalities provide over and above the national standards.

The remaining part of the LTCI benefits is financed from two types of premium. The first type of premium is paid by those aged between 40 and 64 years (Category II premiums) and are nationally pooled in the Social Insurance Medical Fee Payment Fund (SIMFPF) and then allocated as the Fee Payment Fund Grants (FPFG) to cover 31 percent of LTCI benefits in every municipality. Therefore, this grant works as an equalizing device since it favors municipalities where Category II shares are less than the average.<sup>18</sup>

The second type of premium is paid by municipal residents aged 65 years and over (Category I subscribers) to cover the remaining part of the revenues which varies depending on the size of the AS matching rate. The premium schedule is progressive and consists of products of a standard rate with adjustment coefficients. The national guideline sets out six income brackets and applies a set of adjustment coefficients (0.50, 0.50, 0.75, 1.00, 1.25 and 1.50) with larger values for the upper brackets.<sup>19</sup> The standard rate applies to the fourth bracket.

In each municipality, its standard rate is set so that its budget for the coming three-year PMP is balanced. As such, the standard rates are different across municipalities.

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<sup>17</sup> For example, the percentage was 12.03 in 2003, 11.08 in 2004, and 11.65 in 2005.

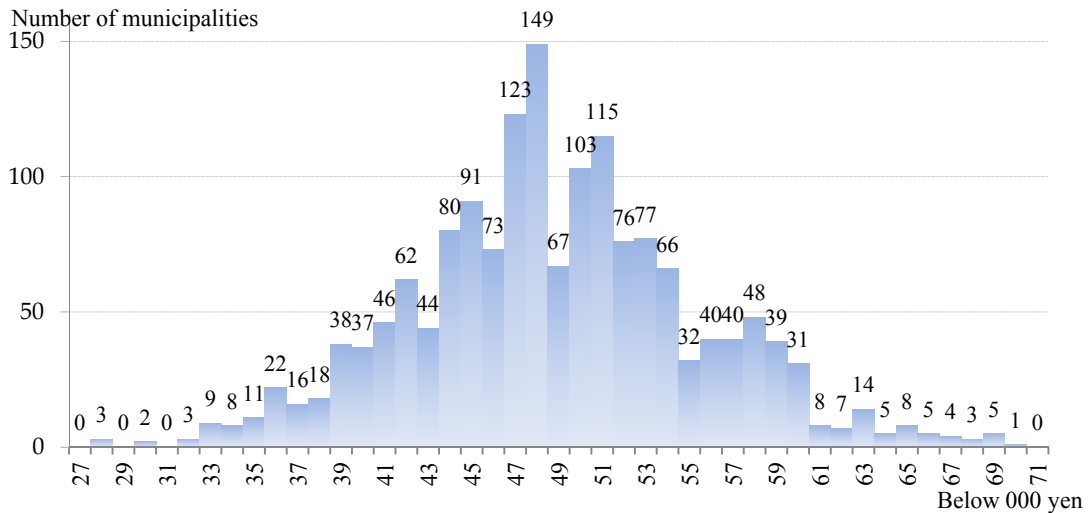
<sup>18</sup> The Category II premiums are collected as a surcharge on public health insurance premiums. In fact, this is a payroll tax and is split equally between employers and employees. The rate is 0.95% of salary for Government-managed Health Insurance and 0.88% for Association-managed Health Insurance.

<sup>19</sup> Some municipalities subdivide brackets higher than the fourth bracket and apply a complex premium schedule to those they consider well off.

Figure 4.1 shows the distribution of the annual standard rates for the current (i.e., 2010-2012) program management period. The rates vary from JPN¥27,180 to JPN¥69,240 with a median of JPN¥48,000.

Since the premium rates are fixed for three years, annually realized budgets do not usually balance. When surpluses occur, they are saved in the Long-term Care Benefits Funds (LTC-BF) against future deficits. If deficits are severe enough to exhaust the funds, loans are made from the Fiscal Stabilization Funds (FSF), which are managed by prefectures. The loans borrowed in a given PMP are repaid in the next PMP with funds financed from Category I premiums. Receiving loans thus implies a future hike in the premiums.

**Figure 4.1. Annual LTCI Standard Premiums for the 2010-2012 Management Period.**



Source: Available at <http://www.mhlw.go.jp/houdou/2009/04/h0423-1.html>, the Ministry of Health, Labour and Welfare.

## 4.2. Public Assistance

### 4.2.1. General Description

The Public Assistance (PA) or *Seikatsu Hogo* is the *last* safety net in Japan. The Public Assistance Law requires local governments to implement public assistance. Cities and prefectures are required by law to set up welfare offices to implement the PA,

while towns and villages are not. Prefectural welfare offices provide public assistance for towns and villages that do not have their own welfare offices.

#### *4.2.2. Benefits*

The PA intends to guarantee the minimum cost of living for Japanese citizens. The minimum costs refer to living expenses for what is referred to in Article 25 (1) of the Constitution as “wholesome and cultured living” and is more than mere subsistence levels. The MHLW determines the costs which apply nationally but vary depending on regional prices and the characteristics of recipients’ households, including the size of household and its occupants’ age, gender and mental and physical conditions. The minimum costs are calculated for each of the following eight categories of assistance: (1) livelihood, (2) education, (3) housing, (4) medical care, (5) long-term care, (6) childbirth, (7) employment and (8) funerals and other ceremonies. Depending on the circumstances of the needy, the total living costs are given as combinations of these categories of assistance. Most of the assistance is transferred in cash but funds for medical care assistance and long-term care assistance are paid directly to their service providers. In addition, shelter, if applicable, is provided in kind.

The PA payments are equal to the minimum cost of living in excess of what an individual can earn with his/her best effort. To receive the benefits, applicants are required to fully exhaust their available resources, including financial support from family and relatives, as defined by the Japanese Civil Code. The benefits are provided only if such income and resources are insufficient to cover the minimum costs of living. As such, public assistance is provided only after a careful examination or means-test, of the financial situation of the applicants. Most of the assistance is paid in cash but the cost of medical and long-term care assistance is paid directly to service providers. In addition, housing and shelter are provided in kind, if applicable.

#### *4.2.3. Financing*

The PA is financed out of general revenues of national and local governments. As explained later in detail, there are two types of fiscal transfers to local governments: The Central Government Subsidy (CGS) and the Local Allocation Tax (LAT). The CGS is purpose-specific and sometimes matching, and is directly disbursed from the budgets of

central line-ministries to local governments. The CGS for public assistance is disbursed from the budget of the MHLW and covers 75 percent of PA benefits. The remaining 25 percent is borne by local governments. But, this local burden is effectively eased in localities with poor fiscal capacity, which receives LAT grants. As explained later, the amounts of the LAT grants are determined to reflect the local burden of PA benefits.

### **4.3. Other Welfare Services**

The Japanese system of income support and personal social services is largely defined by *Fukushi Roppo* or the Six Laws for Social Welfare (SLSW) which consist of (1) Public Assistance Law (as discussed), (2) Child Welfare Law, (3) Law for the Welfare of Single Mothers and Widows, (4) Law for the Welfare of the Elderly, (5) Law for the Welfare of the Physically Handicapped and (6) Law for the Welfare of the Mentally Challenged, the targets of which are self-explanatory. These laws define local governments as providers of social assistance and services.

In addition, the Social Welfare Services Law requires larger municipalities (cities) and prefectures to set up *Fukushi Jimusyo* or welfare offices to implement social assistance and services (as briefly explained in the subsection on public assistance). Smaller municipalities (towns and villages) are not required to do so but there are a small number of them with their own welfare offices. The prefectural welfare offices have their own functions but also cover the functions for towns and villages that do not set up their own welfare offices.

Social assistance and services provided by local governments may broadly be categorized into (1) income support for low-income households and (2) personal social services. The former includes public assistance, which has already been explained, and Child Allowance (*Jido Teate*) as explained below. The latter mainly consists of targeted services for children, females, the elderly and the handicapped.

#### *4.3.1. Income Support (other than Public Assistance)*

The Child Allowance also requires a means test, but the threshold is much higher, and the examination process is less strict. The system prescribed by national law targets lower income families with children up to the third grade of elementary school (nine

years of age). Municipalities examine eligibility and make payments. As long as income is below the threshold, the amount of payments only depends on the number of children. An additional allowance, the Child Rearing Allowance (*jido fuyo teate*), is distributed to single mothers with dependents less than 18 years old.

There is also a variety of income support for the handicapped. In most of the cases, municipalities examine eligibility and make payments within institutional structure prescribed by national law. But in others, municipalities may themselves provide their own supplementary assistance.

#### 4.3.2. *Social Services*

Social services are mainly targeted at (1) mothers and children and (2) handicapped people. The services for (3) the elderly are mostly provided through the LTCI, while there are still services provided directly by local governments. The social services for mothers and children include personal services for handicapped children, facilities for maternity and day-care and shelters for abused children or children without guardians. The Child Welfare Law requires prefectures and designated cities to set up *Jido Fukushi Jimusho* or Child Counseling Office (CCO) to implement social services for children. In addition, municipalities provide day-care for children who do not have proper parental care. Fees for these day-care services vary across municipalities but usually depend on income and number of children.

The handicapped are categorized into physically disabled, mentally disturbed and intellectually disabled. Additional special care is given to children with these handicaps. Comprehensive measures are available, ranging from facility-based to in-home services. Roughly speaking, municipalities consult with the users, provide relevant services directly and/or make arrangements with welfare agents. Meanwhile, prefectures build and manage facilities and other infrastructure.

The providers of targeted services include local governments and *Shakai Fukushi Hojin* or the Social Welfare Foundations (SWFs). The SWFs are non-profit agents whose functions are defined in the Social Welfare Service Law. In many cases, local governments commission the SWFs to deliver personal social services. The majority of facilities are managed by non-governmental entities like the SWFs.

Traditionally, local governments assessed individual needs and decided the types to be applied. The service provider was the local governments or the SWFs commissioned by local governments. However, the trend in welfare reform is toward a regime where beneficiaries choose the providers based on their own needs. This philosophy is reflected in the introduction of the LTCI, where private firms play important roles as service providers. Local governments monitor and control those private agents that provide welfare services.

#### *4.3.3. Other Discretionary Assistance and Services*

Local governments in Japan are not prohibited from developing their own social programs. First, there are many cases where national laws simply mandate that localities conduct specific programs but the central government does not specify either benefit levels or eligibility criteria explicitly. In such cases, localities have full discretion in implementing social programs. An example is the School Expense Assistance (SEA). While the central government mandates that municipalities implement the SEA programs to help children in low-income households attend their primary and junior high school, municipalities have full discretion over eligibility criteria and benefit levels for families with children that marginally fail to qualify for PA benefits. As such, the SEA programs differ greatly among municipalities.

Second, localities often provide supplementary benefits over and above those that the central government mandates. For example, there is a variety of supplementary income support for the handicapped. While there is a national system of benefits for the handicapped, in 2008, the Tokyo metropolitan government provided additional monthly benefits of JPN¥15,500 to the severely handicapped. Furthermore, the special district of Ohta adds JPN¥2,000 on top of the benefits from the metropolitan government. In addition, municipalities in Tokyo also provide monthly additional benefits to the less severely handicapped, with amounts varying from JPN¥ 4,000 (Showa city) to JPN¥13,500 (Bunkyo special district) in 2008.

#### **4.4. Financing Decentralized Social Expenditures**

Municipalities and prefectures vary in size in terms of both population and economy. Such disparities make it difficult for most local governments to finance their



expenditures out of their own locally-financed revenues. In fact, only a small number of municipalities are considered to be self-financing. Local governments thus need fiscal transfers from upper levels of government to finance their expenditures. The flows of fiscal transfers take a variety of forms. For local expenditures on income support and personal services which are accounted in local general budgets, the Central Government Subsidies (CGS) and the Local Allocation Tax (LAT) are the two main transfer mechanisms. As for FY2007, the LAT and the CGS account 16.7 and 11.2 percent respectively of the total revenues for the general account (which excludes the special accounts for the LAT and the NHI), while the share of own revenues (local taxes plus miscellaneous revenues) is about 60.5 percent.

#### *4.4.1. Central Government Subsidies*

The CGS is a generic term for categorical grants disbursed directly from the budgets of line-ministries in the national government. The subsidies, which are purpose-specific and sometimes matching, are categorized into the following three functions: First, the subsidies help local governments maintain the standards required by national law for specific public services and transfers to individuals. For example, the central government bears 75 percent of PA benefits and 1/3 of disbursements for child and child rearing allowances. The center also provides 50 percent of capital and current expenditures for designated facility services for the handicapped. These cost-share ratios are all prescribed in related national laws. Second, the CGS serves as incentives for local governments to adopt specific projects that contribute to national policy objectives. While the majority of such projects are infrastructure projects, redistribution-related projects are also supported by this type of CGS. For example, in-home services for the handicapped are subsidized by this type of CGS with a maximum matching rate of 50 percent. Also, additional assistance is given to local projects that encourage PA recipients to enter labor markets. Third, the CGS finance services that local governments are required to supply on behalf of the national government (i.e. national elections). In addition, the CGS are disbursed to the special accounts of local governments. Municipalities, as insurers, set up special accounts for the NHI and the LTCI. The central government subsidizes 17 percent of the NHI payments and 24 percent of the LTCI payments through the CGS system.

#### 4.4.2. *Local Allocation Tax*

The CGS are supposed to help local governments maintain national standards for such local public services. But the subsidies are partial, and the remaining part is borne by local governments. The LAT effectively takes care of the remaining part for localities with insufficient revenue capacities. The LAT is a general-purpose grant which is financed (partially) out of a set of five national taxes (32 percent of personal income tax and liquor tax, 35.8 percent of corporate income tax, 25 percent of tobacco tax and 29.5 percent of consumption tax). The LAT consists of two components. First, the Ordinary Local Allocation Tax (OLAT), which constitutes 94 percent of total disbursements, is distributed according to a gap-filling formula where an amount equal to fiscal needs in excess of revenue capacity is transferred. The scheme is gross in the sense that no revenues are taken from a local government whose gap is negative. Second, the remaining 6 percent of all LAT disbursements goes to the Special Local Allocation Tax (SLAT), which is set aside against unexpected fiscal shocks that may not be accounted by the OLAT. Here, OLAT will be discussed.

The amount of OLAT transferred to a local government is calculated as a non-negative difference between what are called the Standard Fiscal Demand (SFD) and the Standard Fiscal Revenues (SFR), i.e.,  $OLAT = \max\{SFD - SFR, 0\}$ . The SFD estimates the level of local expenditure required to maintain standard quality of public services within a local jurisdiction. The SFR is an estimate of the revenue ‘capacity’ of a given jurisdiction. The SFR is made up of a fixed portion of estimated local tax revenues plus some specified transfers. What is important here is the fact the SFD includes the costs that local governments are supposed to share with the CGS, especially when the subsidies assume the first function described above. In other words, LAT recipients obtain additional financial supports through the LAT system for expenditures subsidized through the CGS system.

#### 4.4.3. *Special Schemes for the NHI and the LTCI*

Local governments are required to set up special accounts for the NHI and the LTCI. There are also additional subsidizing and equalizing schemes that are designed for those two special accounts. The NHI and the LTCI are also supported through the LAT. Municipalities, as insurers, make transfers from their general accounts to each of

their two special accounts. Designated parts of such transfers are accounted for in the SFD for the LAT disbursements. However, the share of the transfers in the total NHI payments was as small as 1/75 in FY2005. We also note that prefectures share 7 percent of the total NHI payments and 12.5 percent of the total LTCI payments by transferring their funds as revenues in the two municipal special accounts. Such transfers are also accounted for in the SFD.

Over and above the CGS and the LAT, additional schemes are in place for the NHI and the LTCI. Among the schemes for the NHI, the most sizable is the Fiscal Adjustment Grant (FAG). Like the LAT, the FAG has two components. First, the Ordinary FAG (OFAG) which occupies 80 percent of the total FAG is intended to equalize fiscal capacities among the municipal special accounts with a LAT-like gap-filling formula which depends on differences between estimated demands and revenues. Second, the Special FAG (SFAG) sets aside 20 percent of the total disbursements for unexpected fiscal demands such as natural disaster. The FAG accounts for 9 percent of the total NHI payments and is financed out of the central budget.

For the LTCI, as explained, the contributions from Category II subscribers are pooled at the SIMFPF and disbursed among municipalities as the FPFPG which makes up 32 percent of the standardized LTCI expenditures. Since the share applies uniformly to every municipality, the grants work as an equalizing device and affect municipalities favorably where Category II shares are less than the national average. In addition, there are the AS grants which are distributed with matching rates that depend on the percentage of the old-old and the average income of those aged 65 and over.

## **5. Issues and Challenges**

### **5.1. Changing Environments**

A set of social safety nets should operate as a system, effectively connecting basic services and assistance together. However, the following changes in socio-economic environments conspire to make the safety nets in Japan disjointed. First, the

population is rapidly aging. The National Institute of Population and Social Security Research (2007) forecasts that the elderly proportion of the population (65 and above) will be 31.8 by the year of 2030 (As of 2005, the share was 20.2). This rapid aging would result in significantly higher demands for medical care, long-term care and income support. At the same time, it also implies that the financing side of population is being eroded, increasing the per capita fiscal burden on the younger generations.

Secondly, Japan has been experiencing structural changes in its labor market. In particular, the share of non-regular workers has been continuously increasing from 15.3 percent in 1984 to 34.1 percent in 2008. Non-regular workers usually have little job security and are typically paid with lower wage rates. In particular, their wage differential has been increasing since the early 1990s. In addition, more youths are “non-active”; being out of both school and labor markets at the same time. While the number of such youths varies depending on its definition, the *Labour Force Survey* by the MHWL estimates the number to be 640 thousand, which is 3.2 percent of 19.84 million labor force aged between 15 and 34 in 2008. This is a 20 thousand increase from the previous year and its share is increasing.

Lastly, there has been an increase in poverty in the country. Its poverty rate (the proportion of the population with income below a half of median income level) increased from 14.6 in 1997 to 15.7 in 2007. In fact, the poverty rate in Japan is the fourth highest among OECD countries only after Mexico, Turkey and the United States. This increase in poverty should be related to those in aging population and non-regular employment, since income differentials are higher among the aged and non-regular employees tend to receive lower wages. These two factors are expected to continue to increase, as is the amount of poverty.

## **5.2. Holes in the Safety Nets**

Upper layers of the social safety nets in Japan are social insurance programs built around full-time employees (EI, EPI, EHI). Those excluded from the mainstream programs are covered by residual social insurance programs. Pensions are provided by a nation-wide scheme whose benefits are smaller than those of the mainstream scheme (BP). Medical services are covered by public health insurance managed by municipalities (NHI). Those excluded from these social insurance programs are

covered by the residual programs provided by local governments. In particular, an increasing number of the elderly that are excluded from the EP and the BP are covered by the Public Assistance. In other words, local governments are responsible for the safety nets at the bottom, covering residuals that fall from upper layers of social safety nets.

Our contention in this paper is that, since the system has traditionally been built around full-time employees and the residual functions are left to local governments, a rapid aging of population, changes in labor market structure and an increase in poverty conspire to make the pieces of safety nets operate separately, leaving the needy caught in the holes without help.

Let us see some examples of such holes in the safety nets:

a. Pension Benefits

The NP covers those who are excluded from the EPI. Its annual benefit amounts to JPN¥792,000, with the full years of subscription (40 years) in FY2009. The benefits fail to reach the poverty line (JPN¥1.27 million) for single-member households. The poverty line for two-member households is JPN¥1.80 million, which is still higher than the combined benefits for an elderly couple (JPN¥1.58 million). Furthermore, the NP premiums are difficult to collect. First, they are not automatically levied on payrolls. Second, it would be difficult for the poor to pay the flat-rate premiums (JPN¥14,660 per month) on a regular basis. In fact, defaults and exemptions are continuously increasing. Since the benefits depend on the accumulated premium contributions, an increasing number of retirees are expected to receive pension benefits that are far smaller than the poverty threshold.

b. Public Health Insurance

An increase in the number of non-regular employees as well as non-active youths increases the number of those who are covered by the NHI. Its premiums are also based on fixed amounts and paid directly by its subscribers. On average, its subscribers with annual income of JPN¥1.03 million had to pay an annual premium of JPN¥93,799 in FY2007. Despite reductions in premiums for low income households, it is unsurprising that they tend to fail to contribute premiums. The defaulters can

continue to receive the benefits for some time but eventually they will be excluded from the insurance scheme.

c. Unemployment Insurance

Analogous issues apply to the EI which was originally designed for full-time regular employees. Only 20 percent of the involuntarily unemployed received EI benefits in 2006, which would be due to either exclusion from the system from the outset, or the insufficient duration of benefit payments. A survey in 2005 also showed that the EI program excluded 47 percent of non-regular workers. A good example of such exclusion may be found with single-mothers. According to a survey by the MHLW in 2006, 43.7 percent of single-mothers are not enrolled in unemployment insurance. Likewise, 6.5 and 17.5 percent of them are not enrolled in public health insurance and public pension respectively (Komamura, 2009).

d. Public Assistance

If upper layers of safety nets fail to maintain the minimum costs of living, the *last* safety net is expected to seal the holes. The PA is the last safety net in Japan. The largest group among its recipients is the elderly and its proportion among recipient households (46.1% in 2007) is steadily increasing. With the increase in the protection rate since the beginning of the 1990s, the PA may seem to be working properly. However, a further examination indicates otherwise. In fact, the minimum costs of living guaranteed by the PA are in the vicinity of the poverty line. If the PA had functioned properly, therefore, the poverty rates would have remained minimal. However, as we have mentioned, the fact is that the poverty rate in Japan is in the top four among the OECD countries.

The above argument shows that there are a number of holes in the upper layers of the social safety nets. Those excluded from the EHI are covered by the NHI and those excluded from the BP are covered by the PA. Localities are thus responsible for the safety nets at the bottom, covering residuals that fall from upper layers of social safety nets. In what follows, let us discuss how such holes are to be sealed.

### 5.3. Sealing Holes in the Safety Nets

#### 5.3.1. Basic Pension Benefits

One of the major problems in the Japanese system of social safety nets is an increasing number of defaults and exemptions from the NP. While the EPI premiums are collected as withholding (payroll) taxes, the NP premiums are paid directly by those who are excluded from the EPI. The performance of the NP premium collection has been aggravated since local offices of the Social Insurance Agency (now Japan Pension Service) took over the task in 2002 from municipalities which had been collecting the NP premiums.

It would be more desirable to finance all of the BP benefits through an increase in VAT, along with the integration of the collection agencies. There are good reasons for tax-financing. First, it evidently strengthens collecting capacities of the authorities. In addition, tax enforcement would be less costly in the case of an increase in VAT.<sup>20</sup>

Second, financing the BP through taxes would not make significant differences from what it is now. If participation in social insurance is compulsory and intends to cover all individuals, its premiums are effectively taxes. All citizens pay VAT as long as they consume, which means that they all, in effect, subscribe to the social insurance that the VAT finances. In this sense, this tax-financing maintains the link between benefits and contributions, if appropriate budgetary arrangements (e.g., setting up a special account) are made.

Third, the existing BP is already redistributive in the sense that the half of it finances are derived from taxes. Financing through VAT changes the distribution of burdens among “subscribers” since VAT payments will be proportional to individual consumption, whereas the current premiums for the NP (BP) are fixed at a single rate. But if the *social* insurance aims to be redistributive, the tax-financing would contribute to the cause since the VAT can be made less regressive than the current NP (BP) premiums.

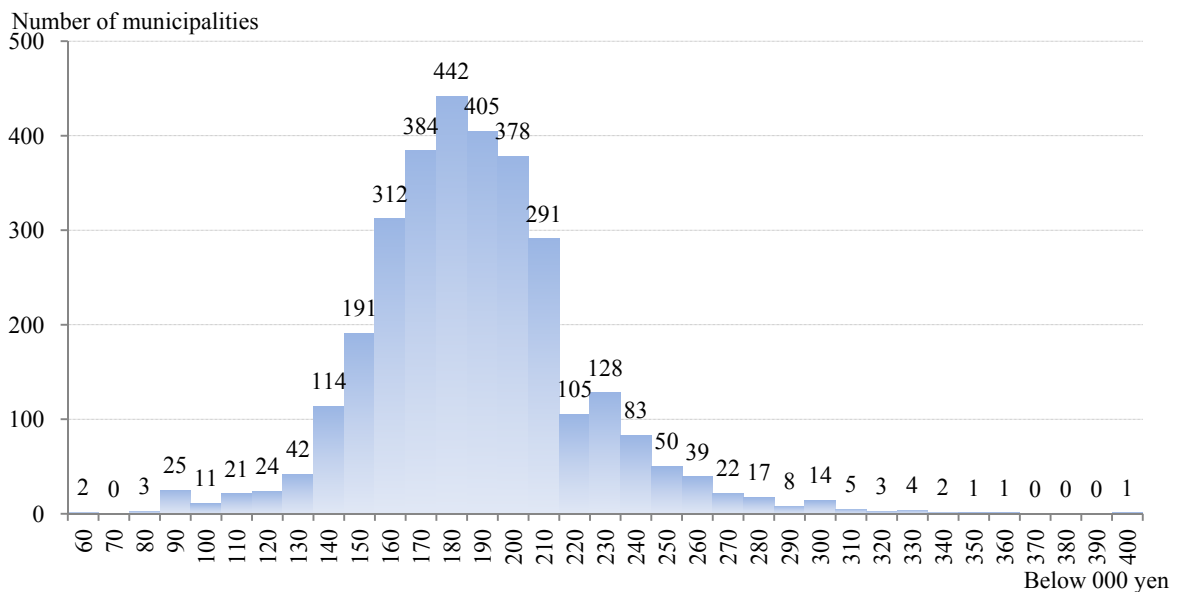
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<sup>20</sup> There are three different tax/premium collecting bodies: local offices of the National Tax Agency, those of the Japan Pension Service and tax collection offices of local governments. Pension premiums are basically taxes on income. It is clear that we will benefit from the economies of scale and scope in collecting taxes/premiums by integrating the three collecting bodies into a single enforcement entity.

### 5.3.2. National Health Insurance

There are three major problems in the NHI system, which originate from the fact that the NHI covers those who are excluded from the EHI and are on average low-income. First, despite the fiscal transfers that help municipal NHI programs, large disparities exist among municipalities. This reflects uneven spatial distribution of the unhealthy and the poor. The former increases medical expenditures and the latter decreases premium revenues. This results in households with identical characteristics paying different premiums in different municipalities. Kitaura (2007) calculated annual premiums for a couple with annual income of JPN¥2,306,000 as in Figure 5.1. Depending on where they live, this household faces a variety of annual premiums ranging from below JPN¥60,000 to JPN¥400,000. This evidently compromises horizontal equity.

**Figure 5.1. Annual NHI Premiums for a Couple with Income of JPN¥2,306,000**



Source: Kitaura (2007).

Second, municipalities are too small to pool risks. In small municipalities, an expensive medical treatment, even on a small number of patients, would lead to an unexpected hike in deficits in the NHI accounts to be covered either by an increase in premiums or ex-post transfers from the municipal general account. Since an increase



in the premiums is usually avoided, this leads to a further increase in municipal deficits, imposing restrictions on other municipal expenditures.

Third, NHI programs are also suffering from premium collection problems: the average subscribers are low-income and are often reluctant to contribute premiums. The percentage of defaulting households in the NHI hit 20.8 percent in 2009;<sup>21</sup> the highest since records began in 1998. As a result, there are an increasing number of people who are excluded.<sup>22</sup>

The MHLW now encourages parties involved to integrate the NHI at the prefectural level. For example, Kyoto Prefecture has initiated talks with municipalities in its jurisdiction with the prospect of integrating NHI programs at the prefectural level. Pooling risks at the prefectural level will make things better. Nonetheless, such integration at the prefectural level might not help small prefectures much. In addition, many prefectures may not want to share fiscal burden the NHI currently imposed on municipalities. Offsetting such fiscal burden would require a substantial cost-sharing scheme whose funds are transferred from the central budgets. Since such a cost-sharing would, in effect, pool prefectures at a national level, it might be more straightforward to integrate the municipal programs at a national level. Of course, doing so might leave little incentive for localities to develop their own health promotion to contain health expenditures. If such disincentives exist at all, it would be difficult to hit a balance between what the law dictates and what the incentive for a regional health promotion requires. Still, an overhaul of the current NHI is in order.

### 5.3.3. *Public Assistance*

Elderly households are the largest category of the PA recipients, being excluded from the current old-age pension. Their number is expected to increase, if aging

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<sup>21</sup> While this may be due to the fact that those aged 75 and above are transferred to the newly established system of the HCSOO, the seriousness of the issue is clearly highlighted by this figure.

<sup>22</sup> It is reported by the MHLW that there were 32,930 children (those aged 15 and younger) in September 2008 that had no public insurance policy. Reform in 2009 mandates municipalities to cover such children (though not their parents). Another mandate was issued in 2010, stipulating that municipalities must provide additional cover to those aged below 18, starting on July 1, 2010. Although they made the situation better than previously, these central mandates do not solve the problems.

progresses and holes in the old-pension system remain as they are. In addition, the PA also covers medical expenditures of the poor. Medical assistance (MA) covers full costs of medical treatments and constitutes almost half of total PA expenditures (49.3 percent in 2007). Given the fact that the elderly, the ill, the injured and the handicapped are major recipient groups, it is no wonder that MA occupies such a large portion.

The Japanese system of social protection has no separate institutional schemes for (1) income maintenance for the elderly and (2) medical assistance for the poor. The PA in Japan covers larger groups of recipients than social assistance implemented by local/ state governments in countries like Canada, United State, France and Italy. Our proposal here is to remove the two functions (i.e., assistance for the elderly and medical care assistance for the poor) from the PA, by setting up an independent national scheme for each of the two. In addition, there are no reasons why those two functions should be implemented by local governments. First, disbursing benefits to the elderly, like benefit payments to the retired, would simply require following a set of standard operating procedures without a high degree of discretion. We have already mentioned the creation of tax-financed universal old-age allowance that replaces the current BP benefits. Second, medical assistance for the poor would effectively be administered within a general scheme of public health insurance. We have also mentioned the need to overhaul the NHI. The overhauled NHI would cover those who are currently covered by the PA.

With the two functions being removed, the local fiscal burden for the PA will be reduced significantly. More than 40 percent of recipient households are the elderly, and almost 50 percent of PA expenditures are medical assistance. Furthermore, the sick and injured, by definition, receive MA and so do many of the handicapped. The PA will be targeted mainly at those who can, in principle, work if their problems are dealt with. For example, single mothers would be encouraged to work if local governments could provide good child care for their children. Single mothers may need counseling and continuous encouragement from social workers. Such functions are more than just giving monetary benefits following a uniform set of standards. They involve providing personal social services that require a high degree of discretion as well as coordination with other social programs implemented within the same local

government. In addition, an effective performance of such functions may well be required to take account of local characteristics.

#### *5.3.4. Distribution of Local Revenues*

While many social programs are prescribed by central government, there is also a substantial part of services that is at the discretion of local governments. These local functions are more or less financially supported by transfers like the CGS and the LAT grants from the central government. Although the aggregate amount of these transfers is not small, the equalizing effects of them are weakening as the central government is now decentralizing local revenues through tax-point transfers and the replacement of the CGS with the LAT. This is because the tax-point transfers are more advantageous for localities with larger tax bases and the LAT formula is gross so that the LAT cannot take revenue away from rich localities. Discretionary local social programs are very much affected by the differences in local revenue capacity. For example, rich localities in Tokyo have a more generous menu of social services and benefits, while localities with meager revenue sources in rural areas may not. Since the system of central grants is losing equalizing capacities, disparities in discretionary social programs are expected to be aggravated. While it is impossible and possibly undesirable to make every discretionary service identical across localities, we need an alternative scheme of intergovernmental transfers that equalize local funds for redistributive programs.

## **6. Concluding Remarks**

This study has described the current arrangements for social protection in Japan, including the key elements of coverage, benefits and management. We have paid special attention to the roles assumed by local governments in these schemes. Since the system has been traditionally built around full-time employees and most of the residual functions of social safety nets are left to local governments, recent changes in socio-economic factors have made the pieces of safety nets in the country operate separately, leaving the needy caught in the holes without help. To seal the holes in the

nets, we have proposed the setting up of separate institutional schemes to guarantee income and public health insurance for the elderly. We have also mentioned the need for an alternative scheme of central grants that equalizes local funds for discretionary social programs. Of course, since such reforms involve securing more funds, an increase in taxes is unavoidable.

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