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Insurance-Based Health and Social Care in Japan*

By

Yoshio Maya

Abstract

Social security is a system which stabilises the living standards of the nation as a whole through social means. Social insurance is a system that collects contributions as reserved money from a large number of people by various methods, applying probability calculations and redistributes the funds in the form of various kinds of benefits; in other words, cash benefits or benefits in kind, which relate to the livelihood and economy of the nation.

But in reality, "Who should be assured or cared for?" and "How should we organise our lives?" are still the most important socio-economic problems to be solved in Japan. One of the features of the social security system in Japan is the comprehensiveness of its benefits. On the other hand, as there is inadequate unification and co-ordination among various social insurance schemes, there is great disparity, inequity and inequality among them.

It is imperative to reform the social security system, including health insurance, because most of the nation can hardly make a greater personal provision for life, particularly life after retirement, in this era of uncertainty. The philosophy of reform should be that the basic needs of life that are common to all, which are based not on absolute but on relative criteria, must be met.

Key Words

disparity of benefits, health insurance, medical insurance, private insurance, public insurance, social insurance, social security,

1. Introduction: Diversified Welfare Needs and Social Insurance

As the amplitude of social development becomes greater, that is, socio-economic changes become larger and wider, people require a more stable life and the needs for economic security increases. Insurance is, however, based on the application of empirical probabilities of the past, namely, the law of large numbers, and thus there is always some kind of time-lag which insurance catches up with real social and economic changes. In addition, insurance is limited to some cases with considerably greater prospects of gaining profits so that private insurance companies dare to face

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unknown risks and to underwrite them through trial and error procedures.

Then, the state with the largest economy and the strongest political power takes the lead in the management of insurance at the time of serious social change. The process of development of social insurance and warfare insurance provides the most distinct examples. It is said that insurance at the beginning is incapable of coping with rapid social and economic changes and shows its best results in static societies. Only state-run insurance schemes can make it possible to provide insurance beyond these limitations. Nevertheless, it has already been discussed elsewhere that state-run insurance schemes have often received criticism because of their tendency to produce inflexible and less efficient management. Therefore, for social insurance to be of significance for modern times, it is necessary to avoid these problems, and for insurance to be directly connected to national welfare and to have enough flexibility and mobility to be able to respond to the diversities and complexities of national life. The feasibility of social insurance can be evaluated today; the age of convulsions and the tendency of social insurance are watched with keen interest.¹

2. The Paradoxical Development of Social Insurance

Social insurance is one of the policy instruments and socio-economic systems utilising the principles and techniques of insurance to meet social policy objectives and is intended to prevent poverty from social contingencies or human problems such as disease, injuries, being handicapped, maternity, occupational diseases and accidents, death, ageing, unemployment, etc., which are considered appropriate to be socially coped with by insurance as a responsibility of the state. Social insurance nowadays is applied as one of the measures to secure the right to live as a part of the fundamental human rights in all nations. Thus, as much as possible, equality to all citizens must be given, but a great disparity of benefits can be observed among social insurance schemes due to the hasty establishment of some. The disparity among schemes which are to provide the most basic and fundamental security cannot be acknowledged from the standpoint of accelerating social equality, even if the historical process to create such situations is taken into account. There have often been consultations and discussions to agree general policies and the unity of various social security systems, but a final conclusion has not yet been obtained. It is said that the achievement of the so-called nation-wide coverage of medical insurance and pension insurance has serious internal contradictions. The presence of inequality in social insurance which is expected to promote social equality provides a new paradoxical problem since there is the possibility of an increase in the disparity as differentiation between social classes grows more rapidly and deeply.

It has been mentioned frequently that forming the principles of insurance there are the principle of the equality of service and consideration and the principle of the equality of revenue and expenditure. Theoretically, a continuous sound operation of the insurance system can only be attained when management is carried out according to these two principles. In the historical process found in the origin of the insurance business and establishment of insurance companies together with the practical management of insurance companies, the principle of the equality of revenue and

¹Yoshio Maya, "Structures and Functions of Public Insurance in Japan", *The Study of Business and Industry*, No.7, 1990, p.93.

expenditure is the best and last technical basis to maintain. The increase of financial functions of insurance systems accelerates these tendencies more significantly. In social insurance some modifications are made to the principles of insurance in order to achieve social policy objectives but the principle of the equality of revenue and expenditure is observed here.

There are some schools of thought that recognise social insurance as insurance only from the observance of this principle, not based on the reality of operation. It is regarded as the first problem beyond efficiency for the operation of insurance to observe strictly this principle. In public medical insurance in Japan, however, constant deficits and huge amount of cumulative deficits have been seen. As the cause of such deficits, many authors point out that though medicine and insurance are essentially different from each other in quality, morally oriented medicine and economic efficiency oriented insurance were connected together which caused conflicts. This includes one aspect of the truth but waste, abuse and insufficiency in operation of medical insurance can be said to contribute greatly to these deficits. Less efficient operations taking the form of premium rises and the cutback of insurance benefits attack people and result in financial difficulties which make them suffer. Particularly in the case of compulsory insurance, people cannot find any way to escape from unfavourable compensation against these results caused by inefficient management. In social insurance, for example, when pension funds are to be invested, public interest or social welfare oriented investment of funds is emphasised rather than economic efficiency orientation, and some people accept even inefficient investment because of its public or welfare nature. Neglect of inefficiency would not contribute to the improvement of national welfare. However, excessive accentuation of efficiency will cause a cut-off of the weak.

Social insurance is often conducted to a degree beyond the limits of insurance and the contents and levels of benefits are kept low. In order to maintain long term managerial safety, even social insurance needs appropriate measures. Therefore, the contents and levels of benefits are set lower as one of the measures balancing insurance finance. In addition, coverage of social insurance tends to be restrictive and the benefit level remains low to encourage people's self-help efforts as well as to avoid competition with private insurance companies.

Conventionally, it has been claimed that public and private insurance are mutually supplementary without any thorough discussion of the problem of adjustment of the roles between them. Since the 1980s the idea of self-help, the so-called private sector welfare theory have rapidly emerged in Japan, led by government-business circles, in opposition to the voice calling for the enrichment of the content and level of social security and social services raised from the nations. Then a new problem has arisen: as to whether the relationship between public and private insurance is mutually supplementary or not.

In the general and long term tendency, coverage of social insurance has been extended, but for example, in public medical insurance, the speed of the extension of its coverage failed to catch up with the qualitative and quantitative changes of medical risks, and various types of private medical insurance to supplement public medical insurance have been actively marketed. Reform of public pension insurance schemes has had a significant influence on the individual and company pension market. Income compensation insurance to supplement public unemployment insurance

and private workmen's compensation insurance to supplement public workmen's compensation insurance have appeared. Moreover, the Government has decided on the introduction of a new public long term care insurance scheme for the elderly in the very near future and a lively discussion on the subject is under way.

Social insurance has played a part in picking up social group cover or risks which private insurance will not or cannot handle, but this relation has now been reversed. A new situation has appeared in which private insurance companies actively merchandise the portion with full profitability in the area which social insurance has cut off or failed to handle. It is as if social insurance schemes are co-operating with private insurance companies in opening up and expanding this new market.² Therefore, the private sector always advocates the restraint of social security at the fixed national minimum level so that it may expand its business because the development of social security may reduce the need for private programmes.³

3. National Health under Plural Medical Insurance Schemes

Medical insurance is one kind of insurance which covers medical expenses, medically related expenses and income loss resulting from sickness or injury, but even so people find it difficult to admit that medical insurance is an economic security system, in other words, an income security system. The following two points are just introduced here. First, medical insurance is insurance relating to expenses connected with the highest degree of general urgency, that is, the life and health of a human being. Second, such insurance function is a supplement of living costs as stated above, but however realistic this final objectives is, it cannot be attained without considering the provision of medical treatment. Modern medical treatment cannot be expected without the existence of highly trained medical personnel and medical institutions which have attained a certain level and quality. To achieve this, it is necessary to have educational or training institutions for medical personnel, and that economic power either of public or private sector should be socially accumulated to facilitate it. Furthermore, this causes at the same time or at the next step the problem of distribution of materials and resources sooner or later. For example, in areas such as remote villages or isolated islands where people do not have the chance to receive medical treatment or consultation, there is almost no point in joining medical insurance schemes. According to a survey conducted by a research committee on health and medical services of the National Land Agency in the years 1994 and 1995, there was neither any full-time nor part-time doctor in 107 islands.⁴

The premise for medical treatment is that it is desirable to cure disease and prolong life.⁵ However, modern medicine has had great success in the sense of conspicuously lowering the mortality rate. In changing the viewpoint, it could be argued that for the most part a declining mortality might mean an increasing morbidity:⁶ the change in mortality rate is not necessarily an increase in health but may simply be a prolongation of endurance. The trends of life expectancy are shown below. The life expectancy of

² *Ibid.*, pp.89-97.

³ Yoshio Maya, "Cooperative Insurance in Japan", *The Study of Business and Industry*, No.5, 1988, p.78.

⁴ *The Asahi Shimbun*, 23rd August 1996.

⁵ Erich Fromm, *Man for Himself: An Inquiry into the Psychology of Ethics*, Reinhart and Winston, New York, 1966, p.18.

⁶ Iago Galdston, *The Meaning of Social Medicine*, Harvard University Press, Cambridge, Mass., 1954, pp.74-86.

Table 1. Life Expectancy of Japanese People

Year	Age							
	Male				Female			
	0	60	65	75	0	60	65	75
1891–1898	42.8	12.8	10.2	6.2	44.3	14.2	11.4	6.7
1992	76.09	20.08	16.31	9.61	82.22	24.67	20.31	12.28
Extended years of life expectancy	33.29	7.28	6.11	3.41	37.92	10.47	8.91	5.58

Note: The figures for 1992 include Okinawa Prefecture.

Source: The life tables and abridged life tables of the Statistics and Information Department, Minister's Secretariat, Ministry of Health and Welfare (The Ministry of Health and Welfare, *White Paper on Health and Welfare (Kosei Hakusho)*, 1993 ed., Kosei Mondai Kenkyukai, Tokyo, 1994, p.323)

people who are 65 in about one hundred years since the end of the 19th century until 1994 has increased by about 6.5 (male) and 9.6 (female) years.⁷

If we consider the problems of geriatric diseases and chronic diseases, we can understand how unhealthy our situation is. Concerning this present state, there are also advocates who point out that medicine in the present situation is itself producing unhealthiness. These are what are called iatrogenic diseases.⁸ Although I do not agree with this opinion totally, this is one aspect of the truth. The phenomena of what is called over-medication, over-inspection, harmful effects of drugs and medical errors or malpractice are definitely not unusual today. Nevertheless, at least the results of modern medicine should be recognised in the treatment of the sick and wounded.⁹ For example, in the overcoming of contagious diseases, modern medicine has shown such great progress that anyone is able to recognise this. Of course, we cannot treat lightly such points as the betterment of the living environment, improvement in nutrition and the social overcoming of poverty.¹⁰

In order to illustrate the problem more concretely and clearly, I would like to develop the discussion on the premise that the present situation in Japan is where public medical insurance is carried out in principle as compulsory insurance for all citizens and that the so-called nationwide coverage of insurance has been attained. Namely, the discussion is conducted under the assumption that all citizens are conventionally secure to some extent and have equal opportunities for consultation and medical treatment, allowing freedom to choose doctors and clinics or hospitals. First of all, I would like to consider the problems of liberty and equality among the insured

⁷ The Ministry of Health and Welfare, *White Paper on Health and Welfare (Kosei Hakusho)*, 1996 ed., Kosei Mondai Kenkyukai, Tokyo, 1996, p.326.

⁸ Ivan Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health*, Penguin Books, Harmondsworth, 1984, p.14.

⁹ Thomas Mckeown, *The Role of Medicine: Dream, Mirage or Nemesis?*, Basil Blackwell, Oxford, 1982, pp.183-184.

¹⁰ J. A. Muir Gray, *Man Against Disease: Preventive Medicine*, Oxford University Press, Oxford, 1979, pp.3-23.

people. The insured actually do not have freedom to choose medical treatment except in the sense of being able to choose whether or not they will have a consultation, and after they have decided to have one, what kind of doctor or medical institution.¹¹ When emergency medical treatment is required, most of the time, patients do not have the capability to judge, the right to choose, and the right to decide. Also, the freedom to choose is diminished as in the case that patients must select a general practitioner as a family doctor before hand like in Britain. Doctors will hold an absolutely predominant position concerning medical treatment relative to the insured person as a patient after the doctor and medical institution are selected.¹² Therefore, importance is particularly attached to medical and doctors' ethics.¹³ There is, however, some space left for freedom to choose regarding the area of medical treatment concerning such matters as differential fees for hospital beds.

There are, incidentally, some possibilities of a certain inequality arising when an insured person is having a consultation as there are differences between individuals in health. If we consider this matter as a problem, the patient's share in medical cost can be considered as both fair and equal. It is also theoretically possible to have a certain waiting period for commencing the benefit. Nevertheless, the differences arising between individuals concerning consultation should be systematically allowed. The reason for this is that early consultation makes it possible to discover the sickness in the early stage, which in turn leads to cost savings in medical expenses. Furthermore, the differences between individuals regarding health should be recognised and then it cannot always be regarded as unequal to decide whether or not to have a consultation based on the differences between individuals.¹⁴ Rather, in Japan the problem is the social inequality related to the differences between systems derived from the existence of plural medical insurance systems.

4. Health and Welfare Policy in Confusion

I would like to indicate the following two points in connection with medical systems as a precondition of medical insurance. The first point is that the geographical maldistribution of medical institutions is causing an inequality of opportunity of consultation. Geographical maldistribution of medical institutions is worsened by the maldistribution of special medical items.¹⁵ The second point is that in the present restrictive and standardised system of supplying benefit in kind such as drugs, the point-unit cost system exists whereby medical technology is not properly evaluated and doctors' liberty as professionals is widely limited. In the refund system of medical fees through insurance as in France, the liberty of doctors increases but generally the burden on patients will also increase. In order to attain liberty and equality in medical insurance, the comprehensive reform of both medical insurance schemes and

¹¹ Julian Le Grand, *The Strategy of Equality: Redistribution and Social Services*, George Allen & Unwin, London, 1983, pp.31-32.

¹² Nicholas Barr, *The Economics of the Welfare State*, 2nd ed., Weidenfeld and Nicholson, London, 1993, p.309.

¹³ In Michael Lockwood (ed.), *Moral Dilemmas in Modern Medicine*, Oxford University Press, Oxford, 1985, problems related to the ethics of doctors are discussed from many angles.

¹⁴ William Beveridge, *Social Insurance and Allied Services: Report by Sir William Beveridge*, Cmd. 6404, Her Majesty's Stationery Office, London, 1942, p.162.

¹⁵ Ruth Levitt and Andrew Wall, *The Reorganised National Health Service*, 3rd ed., Croom Helm, London, 1984, pp.170-175; Clare Blackburn, *Poverty and Health: Working with Families*, Open University Press, Milton Keynes, 1991, pp.167-168.

medical service supply systems would be required simultaneously.

The matter which looms conspicuously in the recent revision of the medical insurance system is the reduction of benefits which has been made from the financial point of view and debate on whether the increase of medical costs should be restrained. The increase in medical costs should be approved if the standard of national health is increasing. Conversely, if the standard of health of the citizens is worsening and medical costs are rising, this is obviously inevitable. As to the question of why medical insurance benefits must be reduced, the answers given would be that recent increase in medical costs cannot be expected to result in the corresponding economic effect, or it is not likely to be linked to the enhancement of productivity. I also cannot ignore the relationship between war and the development of public medical insurance. The improvement of medical care and public sanitation is required in order to upgrade the health of the citizens and secure strong soldiers. Examples seen in Japan, the National Health Insurance Act was enacted in 1938 following the Manchuria Incident in 1931 and the Sino-Japanese War in 1937, whereas in Britain, the National Insurance Act was enacted in 1911 following the Boer War from 1899 to 1902, and sickness benefit by cash started to be provided. Also the First World War came as a great shock in Britain; so many recruits to the army had bad health or were malnourished.

A recent and growing tendency towards the promotion of welfare of the elderly and the handicapped led to an increase in medical and welfare expenditures. In 1993, Japan spent 56,796 billion yen or 15 per cent of GNP on social security benefits. Of these, 38 per cent was for health care, 51 per cent for pensions, and 11 per cent for others; and the national health expenditure budget was 24,300 billion yen. Of this, 7,300 billion yen or 30 per cent was for the elderly.¹⁶ But we cannot expect economic activities similar to those of normal healthy people from elderly or handicapped people, even though the resources which are consumed in the medical and related services fields for the elderly and handicapped will provide profits for part of the health-care-related industry, raise the health level of the elderly and handicapped and improve their living conditions. Furthermore, looking at the present situation in Japan, there is a higher possibility for weak and disabled people to survive while the ageing society is expanding. Resources distributed to elderly and handicapped people will definitely put production and consumption in other fields under pressure unless the economy continues to grow. The counteraction which has been taken in this matter is the reduction in medical benefits.

The next matter to which we should give attention as a recent trend is that private medical insurance has been marketed in earnest in parallel with the reform of public medical insurance. Private medical insurance is insurance which gives as its main aim security against medical-care-related expenditures, and it is not directly concerned with the supply system for medical treatment because doctors generally form a powerful pressure group and it is difficult for insurers to control them. It works on the assumption of there being an existing medical service supply system. It is well known that the present medical care supply system based on general practitioners and private hospitals is closely related to factors such as the disparity of benefits among social insurance schemes, and the inequality of opportunities for consultation

¹⁶The Ministry of Health and Welfare, *op. cit.*, pp.330, 434.

caused by social and geographical maldistribution of private medical institutions.

Private medical insurance, from a certain point of view, positively affirms the inequality of this kind, or I may say that at least it admits this inequality; and at the same time it cannot be denied that the development of company-managed welfare and recreational facilities, particularly by larger enterprises, prevented the development of social services. Similarly, private medical insurance may well become a factor that prevents the development of public health care systems and it may result in the recognition-anew of public medical care being regarded at a low standard by the citizens. Furthermore, in the case of private insurance which is supplied in the form of a group insurance system financially supported by the employer, it is possible to expand this inequality because group insurance is often closely connected with the scale and performance of the company and thus gives more privileges, from the aspect of medical care, to those who occupy better positions with regard to wages, working time and the various welfare facilities in the company. In the case of private insurance which is supplied in the form of an individual insurance system, it is possible to expand further inequality as regards health and medical care because availability of insurance depends on such differences as affordability of premiums, occupations, physical condition and age levels among individuals. Private medical insurance more or less willingly underwrites the richer and healthier, but does not the poorer and weaker. To put the matter simply, private medical insurance deliberately classifies patients into three categories: first, those who can undergo medical treatment through public insurance plus private insurance including occupational fringe benefits; second, those who can undergo medical treatment through public insurance only—this category may be subdivided because of such factors as disparity of benefits among plural public insurance schemes; third, those who can undergo medical treatment through means-tested public assistance or medical aid. According to *The Public Assistance Advance Report* by the Public Assistance Division, Social Welfare and War Victims' Relief Bureau, Ministry of Health and Welfare, the number of recipients of medical assistance in June 1996 was 687,631. In case the persons who undergo medical treatment are children who are totally dependent, the amplified inequality or discriminatory service they receive because of the differences of the economic power of their parents is a matter of extreme gravity.¹⁷

Moreover, because there is no direct concern about private medical insurance in the medical system itself, when patients classified into these various ranks receive treatment at the same hospital, no one can deny the possibility of the risk of discriminatory treatment, either visible or invisible, physical or psychological. Private medical insurance under present circumstances causes the great possibility of approving the lack of liberty of many citizens of the nation and also of increasing inequality under the name of the freedom to choose for relatively rich people. For those who will enjoy relatively long lives with wealth, the possibility is bigger, for a longer period, to be able to receive a public pension, medical care and so on in their days of advanced age. In this way, a kind of inequality will be increased.

Now I would like to add a little about self-help efforts in health care. For those who emphasise this type of self-help effort, approval cannot be given unconditionally because this argument gives too little importance to the social character of sickness

¹⁷T. H. Marshall, *The Right to Welfare and Other Essays*, Heinemann Educational Books, London, 1981, p.112.

or injury. Therefore, private medical insurance which supplies health care and medical treatment as a part of self-help effort is not acceptable basically if we consider the present situation of medical security in Japan as a premise. Before the self-help effort in health care is required, it is necessary that the social conditions under which everybody lives, regardless of occupation, living area, age or sex, provide the possibility to live a healthy life, that is, the situation where all are trying to develop their maximum physical and mental possibilities with regard to society. In order to achieve this, it is necessary to make a fundamental review in every field connected with living, not only in the medical care supply system and medical security system, but also in working conditions, employment, housing, environment, transport, education and so on.¹⁸ However, in reality, on the one hand the social situation which leads to the destruction of human health is ever worsened.¹⁹ For example, although it is nowadays generally recognised from the medical point of view that smoking is bad for health, all kinds of media are employed for the advertisement of smoking. Even worse, automatic vending machines for cigarettes have been installed enabling under-age young people easily to get hold of them. It is also extremely difficult or impossible to control it by the power of the individual, while the adequate social response is not fully implemented. Such a political technique as to kindle the sense of crisis of the citizen and resort to the instinct for self-help efforts is applied and the essence of the matter is concealed underneath.²⁰

5. Some Aspects of the Mixed Economy of Welfare

At present acute and widely ranging changes in the industrial structure have arisen, and the possibility of both frictional and structural unemployment has become more possible. Also the rapid increase in the aged population is a well-known fact. Because we are now placed under such an obvious situation, it is necessary to expand health and social welfare services and social security programmes.

The health problems of the elderly are serious. Death is unavoidable for everybody and the phenomenon of mental and physical superannuation is a bold fact that we have to face eventually. Of course, the ageing process will be different among individuals. What basically determines life after retirement is the life history of each person until he or she retires.²¹ This process of each person is socially and economically restricted beyond the control of one's will or self-help effort. If so, it is essential to provide some social measures for the health maintenance of the elderly. Even though income is maintained to some extent after retirement, health will surely deteriorate and sickness is not unusual for the elderly. Under such a situation, it is impossible to cover all the living costs by the available income after retirement. Morbidity and medical expenses of the elderly are extremely high and people cannot manage by themselves. This is why health care and social services for the elderly must be

¹⁸ Harold L. Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures*, University of California Press, Berkeley, 1975, pp.118-119.

¹⁹ Uma Ram Nath, *Smoking: Third World Alert*, Oxford University Press, Oxford, 1986, p. 171. And see Yoshio Maya, "The Public Nature and the Issue of Deregulation in the Japanese Insurance Industry", *The Study of Business and Industry*, No.8, 1995.

²⁰ John Rees, *Equality*, Pall Mall Press, London, 1971, p.129.

²¹ George A. Kaplan and Mary N. Haan, "Is There a Role for Prevention among the Elderly?: Epidemiological Evidence from the Alameda County", in Marcia G. Ory and Kathleen Bond (eds.), *Aging and Health Care: Social Science and Policy Perspectives*, Routledge, London, 1989, p.46.

reformed urgently.²² At present, a heavy burden is shouldered by family members, particularly, women caring for the elderly under the name of self-help and family responsibility. This is the Japanese style of freedom of choice or the mixed economy of welfare.

In terms of national income, Japan is quite a rich country, but it is not so easy to live there. I will give some examples which show how expensive it is to live in Japan and how odd the mixed economy of welfare in affluent Japanese society is. Life insurance is a typical personal provision for the post-retirement life. According to the investigation by the Japan Institute of Life Insurance, in Japan, the sum assured per capita as of the end of 1993 was 16,042,000 yen equivalent to about £96,800, in the UK, £12,000.²³ The Japanese pay to the life insurance companies about 9.5 per cent of their disposable income as a premium.²⁴ As to industrial life assurance, Japan also leads the UK. According to *Insurance Statistics 1988-1992* compiled by the Association of British Insurers, the sum assured per policy in the fiscal year 1992 in the UK was £557 equivalent to 134,000 yen, in Japan, 2,110,000 yen.²⁵ In order to pay such a high premium, the Japanese must work harder and longer feeling always tired. The annual working hours of the Japanese were 1,966 hours with 126 days off in 1993, those of the British, 1,902 hours with 147 days off.

Moreover, the land price in residential areas of Tokyo was 560,000 yen per square metre, in London, 30,518 yen in 1994.²⁶ The price of beef and pork per kilogram in Japan was individually 3.8 and 2.3 times higher compared with those in the UK in 1992.²⁷ Under such living conditions, if the elderly need to live at a private old people's home, according to the recent advertisement in the national newspapers, it is necessary to pay around 50 million yen equivalent to around £286,000 as a lump sum per person. Then they have to pay about 150,000 yen for management and food expenses equivalent to about £860 per person every month. In case of the bed-ridden or very frail, they have to pay monthly about 300,000 yen as living cost at the private old people's home.

It is not only the elderly who feel inconvenienced and restricted in their daily lives in an ageing society. For example, according to an estimate by the Ministry of Health and Welfare, there were 2,948,000 physically handicapped people in 1991, 385,000 mentally handicapped people in 1990 and about 1,570,000 mentally retarded people in Japan. Also according to the survey by the Ministry in 1991, of 2,722,000 physically handicapped people aged 18 and over living at home, around 489,000 or 18 per cent were under the age of 50.²⁸ Although it is possible for these people to function in society, depending on the severity of their handicap, it is highly likely that they must

²² Paul J. Feldstein, *Health Care Economics*, 2nd ed., John Wiley, New York, 1983, pp.312-313.

²³ The Japan Institute of Life Insurance, *Life Insurance Fact Book*, 1995 ed., The Japan Institute of Life Insurance, Tokyo, 1995, p.19.

²⁴ The Life Insurance Association, *Outlook of Life Insurance Business (Seimei Hoken Jigyo no Aramashi)*, 1996 ed., The Life Insurance Association, Tokyo, 1996, p.43.

²⁵ The Post Office Life Insurance Bureau, Ministry of Posts and Telecommunications, *Post Office Life Insurance Fact Book (Minasama no Kan-i Hoken)*, 1993 ed., The Post Office Life Insurance Bureau, Ministry of Posts and Telecommunications, Tokyo, 1993, p.13.

²⁶ The Economic Planning Agency, *White Paper on National Life (Kokumin Seikatsu Hakusho)*, 1995 ed., The Printing Bureau, Ministry of Finance, Tokyo, 1995, pp.43-44.

²⁷ The Statistics Bureau, Management and Coordination Agency, *World Statistics (Sekai no Tokei)*, 1995 ed., The Printing Bureau, Ministry of Finance, Tokyo, 1995, p.273.

²⁸ The Prime Minister's Office, *White Paper on Handicapped People (Shogaisha Hakusho)*, 1995 ed., The Printing Bureau, Ministry of Finance, Tokyo, 1995, pp.247-249.

live with their handicap for a longer time if they become disabled while young. The burden on their families is thus all the greater. In some cases, handicapped people may have no family or relatives, or may be unable to marry because of their handicap. "Who should be assured or cared for?" and "How should we organise our lives?" is still one of the most important health and welfare policy targets in Japan. For example, in the final report of the public long term care insurance programme published in April 1996, the Council on Health and Welfare for the Elderly puts three alternatives on the age limit of the insured and beneficiaries, 65 and over, 40 and over, or 20 and over, based on the idea of solidarity of generations.

One of the features of the social security system of Japan is the comprehensiveness of its benefits. On the other hand, it lacks adequate unification and co-ordination among the various schemes. This is especially conspicuous in the social insurance scheme that forms the nucleus of the social security system. Most social insurance is independently organised from each other as a specific economic policy instrument and great disparity, inequity and inequality are generated among classes, industries, enterprises, occupations, districts, etc. favourably covered by social insurance and those less favourably covered or not covered because of priority of policy targets and bureaucratic sectionalism of a vertical administration. Since it is forecast that social and industrial structures will be more complicated, disparity and inequality will likely increase. Naturally, correction of disparity and elimination of inequality will become controversial issues but such problems will clash with vested and expected rights of specific interest groups, followed by serious conflicts in interest since the liberty of such groups will be restrained and limited. Although equity and equality in social insurance are of great importance, it is most likely that the degree of confusion surrounding this problem will become larger as power balance relations between power and countervailing power will only produce an unstable interest balance supported by temporary power distribution regardless of how such power is executed. No matter what kind of history each scheme may have had in the past, the existence of such gaps should not be unconditionally admitted. From the viewpoint of an idealistic form of social security to promote social equality, it is desirable to provide comprehensive security through a unified scheme.

6. Conclusion: Meeting Common Needs Based on Relative Criteria

It is necessary to reform the social security and allied income security systems because most of the nation can hardly make more personal provisions for life after retirement under the present situation of society. At the same time, it is vital to improve and expand health and welfare related services and facilities to satisfy the needs of the elderly. We have already learned from the era of high economic growth that a mere increase of income causes only a debased form of the affluent society that is far different from the real welfare society. We have to make the best use of this bitter lesson in the future and construct a society where everybody can comfortably and positively spend his or her old age. Of course, it is desirable to satisfy diversified needs of diversified persons and groups, there being a wide range of freedom of choice. Before that, however, the basic needs of life that are common to all, needs based not on absolute but on relative criteria, must be met.

Appendix 1. Outline of Public Medical Insurance Schemes in Japan (As of 31st December 1995)

Type of scheme	Health Insurance	Seamen's Insurance	National Health Insurance	National Public Service Mutual Aid Association	Local Public Service Mutual Aid Association	Private School Teachers' & Employees' Mutual Aid Association
Basic act	Act No. 70, 1922	Act No. 73, 1938	Act No. 192, 1958	Act No. 128, 1958	Act No. 152, 1962	Act No. 245, 1953
Coverage (as of 31st March 1995)	General employees & day labourers	Seamen	Persons not covered by schemes for employees	Employees of National Government	Employees of Local Governments	Private school teachers & employees
Responsible body	National Government	National Government	Cities, towns & villages (3,252)	National Public Service Mutual Aid Associations (27)	Local Public Service Mutual Aid Associations (54)	Private School Teachers' & Employees' Mutual Aid Association
Insured persons (dependants) (in million)	19.50 (18.11)	11 (21)	3,414	1.64 (2.42)	3.00 (3.84)	42 (38)
	4.10%	4.40%	4.62	2.46-5.00%	4.41% (average)	4.225%
	4.10%	4.40%	Annually ¥145,969 per household (1993)	2.46-5.00%	4.41% (average)	4.225%
Total	8.2%	8.80%	Entire cost	4.92-10.00%	8.48% (average)	8.450%
Administrative expenses	Entire cost	Entire cost	Entire cost	Entire cost	Entire cost (borne by Local Government)	Part of cost
Benefits	13.0% of benefit cost (16.4% as health services for the elderly)	Subsidy for benefit cost	50% of benefit cost	None	None	None
	90%	Subsidy for benefit cost	32-52% of benefit cost	None	None	None
Sickness & injury	90%	80%	80%	90%	90%	90%
	In-patients 80% Out-patients 70%	80%	In-patients 80% Out-patients 70%	In-patients 80% Out-patients 70%	In-patients 80% Out-patients 70%	In-patients 80% Out-patients 70%

(Continued on the next page)

(Type of scheme)	(Health Insurance)	(Seamen's Insurance)	(National Health Insurance)	(National Public Service Mutual Aid Association)	(Local Public Service Mutual Aid Association)	(Private School Teachers' & Employees' Mutual Aid Association)
Benefits for high-cost medical care	When the partial cost-sharing (payment) of the insured or dependant is very high (i.e. if the amount exceeds ¥63,600 for one illness per month), the difference between ¥63,600 and the partial cost-sharing required is to be reimbursed to the insured.					
Sickness & injury allowance	Daily standard remuneration amount x 60/100 per day (for 1.5 years)	Daily standard remuneration amount x 60/100 per day (for 3 years)	None	None	Daily salary x 65/100 per day (for 1.5 years)	
Maternity allowance	Daily standard remuneration amount x 60/100 per day (for 42 days before delivery & 56 days after delivery)	Daily standard remuneration amount x 60/100 per day (for 42 days before delivery & 56 days after delivery)	None	None	Daily salary x 65/100 per day (for 42 days before delivery & 56 days after delivery)	
Rest allowance	None	None	None	None	Daily salary x 60/100 per day	
Delivery expenses and child nursing allowance	Monthly standard remuneration amount x 1/2 (min. ¥300,000)	Monthly standard remuneration amount x 1/2 (min. ¥300,000)	Voluntary benefit	Voluntary benefit	Monthly salary x 1 (min. ¥300,000)	
Spouse delivery expenses and child nursing allowance	¥300,000	¥300,000			Monthly salary x 70/100 (min. ¥300,000)	
Funeral expenses	Monthly standard remuneration amount x 1 (min. ¥100,000)	Monthly standard remuneration amount x 2 (min. ¥100,000)	Voluntary benefit	Voluntary benefit	Monthly salary (min. ¥100,000)	
Dependant's funeral expenses	¥100,000	Monthly standard remuneration amount x 1.4 (min. ¥100,000)	Voluntary benefit	Voluntary benefit	Monthly salary x 70/100 (min. ¥100,000)	
Health Services for the Aged (those aged 70 and over and those bedridden aged 65 and over)	Act No. 80, 1982 Insurer: Local Government	(Expense of patients) In-patients ¥700 per day Out-patients ¥1,000 per month (1995)			(Financial resources) 70% Contribution from individual health insurance schemes 20% Central Government 5% Prefectural Governments 5% City, Town & Village Governments	

Source: National Federation of Health Insurance Societies, *Social Security Year Book*, 1996 ed., Toyo Keizai Inc., Tokyo, 1996, pp. 12-13.
(Yoshio Maya has translated Japanese into English and made some corrections.)

Appendix 2. Long Term Care Insurance Programme for the Elderly in Japan: Basic Points for Discussion and Main Suggestions

1. Insurer
 - * Local Governments (city, town, village).
 - * Central Government.
 - * Public medical insurers (public health services for the elderly).
 - An alternative opinion favours establishing the insurer at the level of metropolitan and prefectural bodies or amalgamated municipal bodies.
2. Provider of Benefit
 - * Local Governments.
3. The Insured
 - * The elderly aged 65 and over.
 - Alternative opinions favour expanding the insured age group to ages 20 or 40 and over.
4. Beneficiaries
 - * The elderly aged 65 and over in need of nursing care and sufferers of early senile dementia under this age limit.
 - Alternative opinions favour expanding the beneficiary age group to ages 20 or 40 and over.
5. Premium
 - * Fixed amount.
 - * Fixed amount varying with income grade.
 - * Fixed amount plus income grade.
 - It is necessary to introduce measures to lighten the burden of low income earners.
6. Benefit
 - * Services, benefit in kind and cash benefit.
7. Balance of Financial Burden on Senior and Younger Generations
 - * Total financial burdens on senior and younger generations are equal. Judging from the course of things, the insurance premium for the elderly will be reduced.
 - * Individual financial burdens for senior and younger age groups are equal.
 - It is necessary to introduce measures to lighten the burden of low income earners.
8. Burden on the Younger Generation and Methods of Collection from the Younger Generation
 - * Contribution by public medical insurers which cover the younger generation.
 - Proportional division based on the number of insured people aged 0-64.
 - Proportional division based on the number of insured people aged 20-64.
 - Assessment as part of medical insurance premium.
 - Assessment by a separate method to medical insurance premium.
 - * Public medical insurers act as collecting agents.
 - Fixed amount on a uniform national basis.
 - Fixed amount on the basis of each long term care insurer.
 - Fixed amount.
 - Fixed rates, fixed amount plus fixed rate, etc.
 - Alternative opinions on collection favour systems utilising public pension funds

and residence taxes.

–It is necessary to introduce measures to lighten the burden of low income earners.

9. Employers' Financial Burden

- * Legislation in the same way as medical insurance.
- * Decision making by each medical insurer.
- * Negotiations between management and labour.

10. Users' Financial Burden

- * Fixed rate plus daily living expenses such as food allowance.
- It is necessary to introduce measures to lighten the burden of low income earners and the interim measures.
- Also, measures are needed to ensure that the burden on a family unit is not excessive.

Notes:

- (1) The main suggestions for each point under discussion have been compiled from the Council on Health and Welfare for the Elderly, "Concerning a New Elderly Care System : 2nd Report" and from draft proposals of Elderly Care Reform Project Headquarters, the Ministry of Health and Welfare.
- (2) It is emphasised that the suggestions are enumerated in no special order and that other opinions may exist in addition to those included therein.
- (3) Yoshio Maya has translated Japanese into English and made some corrections.

Source:

The Ministry of Health and Welfare.

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