

Social Security of Asia

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Chapter 4: Taiwan

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1. Overview of Taiwan

Location

Taiwan lies off the southeast coast of the Chinese mainland to the west of Yonaguni-jima Island (Japan), comprises the island of Taiwan as well as the Penghu Islands and other neighboring islands, and covers an area of approximately 36,000 square kilometers. While the Tropic of Cancer passes through the center of the main island, Taiwan is home to numerous mountains with peaks over 3,000 meters. Thus, the natural environment of Taiwan is characterized by considerable diversity, consisting of forests, coastal plains, coral reefs, and more.

Population

Taiwan is home to about 23 million people. In 1960, Taiwan's population stood at about 10.85 million people. This figure increased to about 20.40 million people in 1990 and to about 23.16 million people in 2010. Let us examine some demographic indicators. First, the total fertility rate, an indicator of fertility, significantly exceeded 4 in 1960 and 1970 but thereafter dropped rapidly and dipped as low as 0.90 in 2010 (and stood at 1.27 in 2012). The average lifespan, which was around 60-something years back in 1960, has risen considerably, such that the average lifespan was 82.55 years for women and 76.13 years for men in 2010. Thus, the gap between Taiwan and Japan in terms of average lifespan has been almost completely closed. As these numbers suggest, fertility is declining and people are living longer in Taiwan.

Such changes in fertility and lifespan have an impact on the age structure of the population. In looking at the age structure of the population of Taiwan, we see that persons under the age of fifteen years accounted for over thirty percent of the population up until 1980. By 2010, this figure declined to 15.7 percent. In contrast, persons aged sixty-five years or older (aging rate) accounted for 2.5 percent of the population in 1960, 6.2 percent of the population in 1990, and 10.7 percent of the population in 2010. This trend of an aging population combined with a declining birthrate is expected to continue. In particular, Taiwan is set to age at a faster rate than Japan, such that its aging rate is projected to grow to 27.3 percent in 2035 and 39.4 percent in 2060. In other words, Taiwan's aging rate at present is at about half that of Japan but will likely rise to that of Japan in 40 to 50 years (Table 4-1).

Table 4-1. Population and economy of Taiwan

		1960	1970	1980	1990	2000	2010	2035	2060
Population (thousands of persons)		10,851	14,754	17,866	20,401	22,277	23,162	23,269	18,918
Age structure	Under 15 years of age (%)	45.4%	39.7%	32.1%	27.1%	21.1%	15.7%	11.7%	9.8%
	15–64 years of age (%)	52.1%	57.4%	63.6%	66.7%	70.3%	73.6%	61.0%	50.7%
	65 years of age or older (%)	2.5%	2.9%	4.3%	6.2%	8.6%	10.7%	27.3%	39.4%
Total fertility rate		5.75	4.00	2.52	1.81	1.68	0.90		
Average lifespan	Male	62.31	66.66	69.57	71.33	73.83	76.13		
	Female	66.40	71.56	74.55	76.75	79.56	82.55		
National accounting	GDP (hundred millions of TWD)	638	2,294	15,199	44,301	101,874	135,521		
	(millions of USD)	1,753	5,735	42,221	164,747	326,205	428,186		
	GDP per capita (TWD)	5,977	15,730	85,851	218,456	459,212	585,633		
	(USD)	164	393	2,385	8,124	14,704	18,503		

Note: Population figures for 2035 and beyond are future projections (medium-range projections).

Source: Population figures are based on Population Projections for ROC (Taiwan): 2012–2060, Council for Economic Planning and Development (presently known as the National Development Council); GDP and per capita GDP figures are based on materials provided by the Directorate General of Budget, Accounting, and Statistics.

As other examples of population characteristics associated with Taiwan, we note that the population is concentrated in urban areas, the number of foreigners in Taiwan is increasing, and there are Taiwanese indigenous peoples that have resided in mountainous areas since ancient times¹. Data for 2010 reveals that the combined populations of Taiwan's two biggest cities—Taipei and Kaohsiung—total 5.43 million people, such that one out of every four to five people in Taiwan can be found living in one of these two cities. There are approximately 562,000 foreign nationals (including those of mainland China, Hong Kong, and Macau) (accounting for 2.4 percent of the overall population) living in Taiwan, an increase of approximately 40 percent over the span of a decade. Taiwanese indigenous people number about 510,000 people (*Population and Housing Census*, Directorate General of Budget, Accounting, and Statistics, 2010).

State of the economy

Taiwan is known as a region in East Asia that has been strongly associated with exceptional levels of economic growth. Expressways, a high-speed rail network (Taiwan High Speed Rail), international airports, trade ports, and other infrastructural elements have been developed, and companies known even in Japan for producing computers, mobile phone terminals, and more are based in Taiwan. The GDP of Taiwan totaled approximately 13.6 trillion new Taiwanese dollars (TWD) (approximately 428.2 billion USD or 45.26 trillion JPY) in 2010 for per capita GDP of about 586 thousand TWD (18,503 USD or approximately 1.96 million JPY) in 2010². Compared to OECD member countries, Taiwan is about on par with Norway in terms of total GDP and at a similar level to that of the Czech Republic and South Korea in terms of per capita GDP (Table 4-1). In examining the industrial structure of Taiwan from

the standpoint of the distribution of workers, we see that workers in such primary industries as agriculture, forestry, and fisheries account for 5 percent of all workers, workers in such secondary industries as manufacturing account for 36.2 percent of all workers, and workers in the service industry account for 58.8 percent of all workers (2012 average figures, *Labor Force Survey*, Directorate General of Budget, Accounting and Statistics).

At the same time, the unemployment rate is rising and there is growing income disparity in Taiwan. The unemployment rate stayed at a low level from the 1980s until the 1990s (averaging approximately 2.1 percent from 1980 to 1999). In recent years, the unemployment rate has been both fluctuating and rising, such that unemployment averaged 4.46 percent between 2000 and 2012 and stood at 4.24 percent in 2012 (*Labor Force Survey*, Directorate General of Budget, Accounting and Statistics). There is growing income disparity, such that the Gini coefficient as determined according to OECD standards (disposable income base) rose from 0.261 in 1981 to 0.276 in 2012 (*Survey of Family Income and Expenditure*, Directorate General of Budget, Accounting and Statistics). The relative poverty rate in Taiwan rose from 5.14 percent in 1981 to 7.72 percent in 2012 (*Gross National Happiness Index*, Directorate General of Budget, Accounting and Statistics).

Politics and administrative affairs

Formerly known as Formosa (“beautiful island”), Taiwan was ruled by the Dutch and later by Zheng Chenggong (soldier and politician during the Ming era in China) in the seventeenth century before being governed by the Qing dynasty beginning at the end of the seventeenth century. The First Sino-Japanese War ended with Taiwan being ceded to Japan in 1895 under the Treaty of Shimonoseki. Japanese rule continued until the Second World War ended in 1945. With the end of the Second World War, the Republic of China (the government of China that was established in mainland China in 1912) took control of Taiwan as part of China. Subsequently, the Chinese Civil War took place and the People’s Republic of China was founded in 1949. The (central government of the) Republic of China as controlled by the Kuomintang (Chinese Nationalist Party) was reestablished in Taiwan. Martial law was instituted and the activities of parties other than the Kuomintang were not permitted.

Martial law was lifted in July 1987, at which time other parties were finally allowed to engage in activities. The president and members of the Legislative Yuan (legislature) can now be selected through democratic elections. For example, Ma Ying-jeou (Kuomintang) was elected president in general elections held in 2008 and 2012 but his predecessor, Chen Shui-bian, was elected president in elections held in 2000 and 2004 as a member of the Democratic Progressive Party. To prevail in a general election, it is important

for all parties to focus on solving issues that concern social welfare and that are otherwise close to home for citizens.

The Legislative Yuan is the unicameral legislature of Taiwan and is equivalent to the Japanese Diet. As for administrative institutions, ministries and bureaus operate under the purview of the Executive Yuan (cabinet). (However, certain ministries and bureaus belonging to the Control Yuan and Examination Yuan (branches of government) manage the public servant system, oversee public servants, and audit government accounting and operate at arms' length from the Executive Yuan.) Ministries and bureaus in charge of social security include the Ministry of Health and Welfare (in charge of the administration of social welfare and healthcare), the Ministry of Labor (in charge of the administration of labor), and the Ministry of National Defense (insurance for members of the armed forces). Ministries and bureaus have undergone reorganization in recent years, such that the Ministry of Health and Welfare was established through a merger of the Department of Health with the agencies in the Ministry of the Interior responsible for social welfare in July 2013. Originally set up as the Council of Labor Affairs, the Ministry of Labor too resulted from a reorganization that occurred in February 2014.

The system of local governments in Taiwan conforms to an organization corresponding to the system of prefectures and government ordinance-designated cities in Japan, such that Taiwan consists of special municipalities, such as Taipei and Kaohsiung cities; counties, such as Taoyuan and Kinmen counties; and provincial municipalities that are on the same level as counties, such as Keelung city (hereinafter referred to as “directly-controlled cities” and “provincial city governments”).

History and the current framework of social-security schemes in Taiwan

Social security schemes in Taiwan began to be developed as comprehensive insurance for different occupations (comparable to the seamen's insurance that used to be offered in Japan) in the 1950s³. Examples include labor insurance and military personnel insurance, which were introduced in 1950, and government employees' insurance⁴, which was introduced in 1958. Persons covered by these schemes were limited to persons employed by companies meeting certain minimum size criteria, military personnel, and government employees (including public school teachers). It is conceivable that these limitations were designed to prioritize the welfare of persons in a position to directly support the government and the workers of companies contributing to exports. This was apparently so true that this characteristic of social security in Taiwan was coined “welfare for military personnel, government employees, and teachers” (social welfare prioritizing military personnel and government employees).

Table 4-2. History and current framework of social security plans in Taiwan

History	<p>1. From the end of the Second World War to the 1960s</p> <ul style="list-style-type: none"> o Establishment of general insurance by occupation 1950: labor insurance, military personnel insurance 1958: government employees' insurance, and more <div style="border: 1px dashed black; padding: 2px; margin-top: 5px;"> Scope of covered persons limited; generous benefits; provided to covered persons "Welfare for military personnel, government employees, and teachers" </div>	
	<p>2. From the 1970s to the 1980s</p> <ul style="list-style-type: none"> o Expanded scope of persons covered by labor insurance o Establishment of healthcare insurance for enrolment by persons not covered by general insurance (e.g.: farmers' health insurance) o Development of a legal system for social welfare (examples below): 1973: Child Welfare Act; 1980: Social Assistance Act (Livelihood Protection Act), Senior Citizens Welfare Act, Physically and Mentally Disabled Citizens Protection Act; 1989: Youth Welfare Act <div style="border: 1px dashed black; padding: 2px; margin-top: 5px; float: right;"> Schemes are becoming more complicated </div>	
	<p>3. From the 1990s to the present</p> <ul style="list-style-type: none"> o Centralization and universal application of the healthcare insurance system: National Health Insurance adopted in 1995 (labor insurance, military personnel insurance, and other forms of general insurance limited to pensions, workers' compensation, and other such types of benefits) o Independence of (un)employment insurance (2003: employment insurance made independent of labor insurance) o Development of a pension system: 2008: national pension scheme adopted (universal pension system complementing labor insurance, military personnel insurance, and others) o Development of nursing-care plan: (2008: the National Ten-Year Long-term Care Plan (ten-year nursing care plan), study of nursing-care insurance) <div style="border: 1px dashed black; padding: 2px; margin-top: 5px; float: right;"> Universal social insurance schemes by area established Measures to counter declining birth rate and aging society </div>	
Current framework	Social insurance	<ul style="list-style-type: none"> o Medical insurance: National Health Insurance o Pension insurance: labor insurance (employees of private-sector companies), military personnel insurance (military personnel), government employees' insurance (government employees, schoolteachers), national pension (self-employed persons and others) o Employment insurance: employment insurance o Occupational accidents: labor insurance and others * Farmers' health insurance: disability and childbirth benefits
	Social welfare (including mode of work)	<ul style="list-style-type: none"> o Public assistance: Public Assistance Act o Welfare for senior citizens: Senior Citizens Welfare Act * National Ten-Year Long-term Care Plan (+ nursing-care insurance is being studied) o Welfare for children: Protection of the Welfare and Rights of Children and Youth Act (economic support, children's welfare services) Early Childhood Education and Care Act (preschool education and childcare provided at preschool institutions) (Parental employment patterns) Gender Equality in Employment Act (childcare leaves and more) o Welfare for the disabled: Act to Guarantee the Interests of Physically and Mentally Disabled Persons (partially addressed through *) o Welfare for households that especially require support (such as households in which a spouse has died) o Welfare for Taiwanese indigenous peoples

Source: Produced by the authors based on materials provided by the Ministry of Health and Welfare, National Health Insurance Administration, Bureau of Labor Insurance, and others.

From the 1970s to the 1980s, the scope of persons covered by labor insurance expanded and social insurance schemes targeting private-school

teachers, farmers, and others were introduced. Social welfare laws concerning the provision of welfare for children, welfare for the elderly, and the protection of livelihoods were also enacted. As social insurance schemes increased in number, however, issues of greater complexity and disparities in terms of benefits emerged. With the arrival of the 1990s, healthcare insurance schemes, which had by then become a jumbled mess, were sorted out, with the result that National Health Insurance was adopted in 1995 as a centralized healthcare insurance system. This system was implemented to provide coverage to all citizens as a means of providing universal health insurance. The pension system was one in which benefits were paid out of labor insurance, military personnel insurance, and other such schemes. Discussions on establishing a pension scheme for self-employed persons and others who were not covered by such a pension system were held beginning in the 1990s, which in turn led to the establishment of a national pension system in 2008. Despite the existence of multiple schemes, a universal pension system was finally realized. Employment insurance was adopted (independently of labor insurance) in 2003 and nursing-care insurance is being studied. As a measure for supporting childrearing, nurseries and kindergartens were integrated (as preschools) in 2012.

Having undergone this history, Taiwan's current social security schemes include social insurance schemes and schemes based on social welfare (funded by taxes) that are similar to those that have been implemented in Japan. Examples of the former consist of medical insurance (National Health Insurance), pension insurance (labor insurance, government employees' insurance, military personnel insurance, and national pension), industrial accident compensation insurance (such as through labor insurance), and (un)employment insurance (employment insurance). For the latter, welfare services have been implemented according to applicable statutes in such areas as welfare for senior citizens, welfare for children and youth, and welfare for the physically disabled. A scheme based on the Social Assistance Act is run as a public assistance scheme (Table 4-2).

Spending by social security schemes in Taiwan (social spending) amounted to 1,316 billion TWD (approximately 4,400 billion JPY), or 10.5 percent of GDP, in fiscal year 2009. In terms of the form by which benefits are provided (benefits in kind or cash), benefits in kind account for 46.8 percent of benefits provided. In terms of the system by which benefits are provided (whether through social insurance or not), disbursements from social insurance schemes account for 52.5 percent of all benefits provided. In breaking down spending by function, spending on the elderly accounts for 42.7 percent and spending on healthcare and medicine accounts for 36.8 percent of all spending (*Social Spending*, Directorate General of Budget, Accounting, and Statistics).

2. Current state of social welfare

Public assistance

Taiwan's public assistance system is referred to as *social assistance*⁵. The purpose of social assistance is to provide necessary support to persons living in low-income households and others and thereby promote independence. Covered persons (low-income households) consist of persons whose income is less than that needed to pay for minimum living expenses and whose assets are less than a certain amount (standards applicable to minimum living expenses and assets differ by region). In addition, there are also cases in which persons living in low-to-medium-income households subject to slightly relaxed versions of these standards are also covered. Persons wishing to receive support in the form of social assistance need to apply to the government of a special municipality or county-controlled city and undergo an examination.

Social assistance benefits include living assistance, medical assistance, housing assistance, emergency assistance, and disaster assistance. Living assistance consists of cash benefits to cover living expenses and other costs and is provided through the payment of fixed amounts by income level. Job training is extended. Emergency assistance constitutes support for persons who suddenly find themselves living in destitute conditions due to an unexpected accident, illness, job loss, or other such circumstances. Disaster assistance consists of support for disaster victims (such as through the provision of food and the opening of temporary evacuation centers). These schemes also include the provision of support for the homeless. Costs are accounted for in the budgets of the central government and the governments of special municipalities and county-controlled cities (funded by taxes) (Table 4-3).

Low-income households receiving support through social assistance schemes numbered 145,613 in 2012 and received 11,574 million TWD (approximately 38.7 billion JPY) in benefits. An upwards trend can be seen in terms of both the number of households receiving support and the amount of benefits being provided. (In 2000, 66,467 households received 4,998 million TWD (approximately 16.7 billion JPY) in benefits.)

Table 4-3. Outline of social assistance (public assistance)

- Purpose: To provide necessary support to and promote the independence of persons living in low-income households and low-to-medium-income households.

1. Covered persons

[Low-income households]

- Persons whose per-person household income is less than that needed to pay for minimum living expenses and whose assets are less than a certain amount

[Low-to-medium-income households]

- Persons whose per-person household income is less than that needed to pay for 1.5 times minimum living expenses and whose assets are less than a certain amount

* Whether benefits shall be paid is determined through an examination conducted by the government of a special municipality or county-controlled city

Minimum living expenses

(examples: monthly amount for FY 2013)

Taipei: 14,794 TWD (approximately 50,000 JPY)

Kaohsiung: 11,890 TWD (approximately 40,000 JPY)

Other than special municipalities (on main island of Taiwan): 10,244 TWD (approximately 34,000 JPY)

Asset standards

(examples for low-income households for FY 2013)

Taipei: moveable property (deposits):

150,000 TWD (approximately 500,000 JPY)

Real estate:

6,550,000 TWD (approximately 22,000,000 JPY)

* Standards for minimum living expenses are set to 60 percent of disposable income for the most recent year. Standards for assets differ by region.

2. Benefits

(1) Living assistance

- Assistance to cover living expenses, assistance to households with children, assistance to cover education expenses and childbirth, assistance to cover funeral expenses, and more
- Job training, job referrals, and other support for independence
- Assistance to cover education costs for secondary and higher levels of education
- (Only low-to-middle-income households) short-term living support
(Assistance when significant changes affect the Taiwanese economy)

Examples of levels of living assistance

(monthly amounts per person)

(On main island outside of special municipalities)

Type I: 10,244 TWD (same as minimum living expenses, approximately 34,000 JPY)

Type II: 5,900 TWD (approximately 20,000 JPY)

Type III: 0 TWD

(a different benefit payable where there is a child in the household is paid)

(2) Medical assistance

- Subsidization of medical insurance premiums
- Subsidization of out-of-pocket costs and other medical costs

(3) Housing assistance

- Rent assistance, assistance to cover the costs of housing repairs, and more

(5) Disaster assistance

- Provision of food, home repairs, opening of temporary evacuation centers, and more

(4) Emergency assistance

- Support where the livelihood of a person who financially supports a household suffers suddenly due to an illness or other such circumstances

(6) Support for the homeless

- Support to return home, protection in facilities, and more

Funding: budgets of the central and local governments (governments of special municipalities and county-controlled cities) (funded by taxes)

Notes: (1) Underlined benefits derived from social assistance plans can also be obtained by low-to-medium-income households.

(2) Definitions

of the types used for examples of living assistance are as follows: type I - household in which all family member have no employability, so no income/asset, type II - household in which members not more than 1/3 of all members have employability and household income per person is not more than 2/3 of minimum living expense, type III - household in which household income per person exceeds 2/3 of minimum living expense but is not more than minimum living expense.

Source: Produced by the authors based on materials provided by the Ministry of Health and Welfare.

Welfare for senior citizens (including a nursing-care scheme)

Taiwan's welfare schemes for senior citizens comprise an array of features based on the Senior Citizens Welfare Act. A broad outline of these schemes is presented below.

(1) Economic support

A low-to-medium-income living allowance for senior citizens is provided as a welfare allowance for the provision of economic support to low-income senior citizens. Senior citizens living at home with a low income and few assets are paid 7,200 TWD (approximately 24,000 JPY) or 3,600 TWD (approximately 12,000 JPY) monthly (amount varies according to income and other factors). In addition, a welfare allowance for elderly farmers (for low-income elderly former farmers) and compensation for retired military personnel (with physical or mental disabilities) are also paid (Table 4-4). Although public pensions are also regarded as an economic support measure under the Senior Citizens Welfare Act, they will be discussed in a subsequent section because they constitute a type of scheme by which social insurance is provided.

Table 4-4. Welfare for elderly persons in Taiwan (economic support; key plans)

Plan	Primary contents	Status of benefits (2012)
Low-to-medium-income living allowance for senior citizens	Allowance for low-income senior citizens; depending on income, the amount paid is either (1) 7,200 TWD a month (low-income persons; approximately 24,000 JPY) or (2) 3,600 TWD a month (low-to-medium-income persons; approximately 12,000 JPY)	Number of recipients: 120,968 persons Total amount paid: 9.24 billion TWD (approximately 30.9 billion JPY)
Welfare allowance for elderly farmers	Allowance for elderly persons who had been enrolled in the farmers' health insurance plan (such as farmers) and who satisfy low-income and other conditions; amount paid is 7,000 TWD a month (approximately 23,000 JPY)	Number of recipients: 644,870 persons Total amount paid: 56.36 billion TWD (approximately 179.2 billion JPY)
Compensation for retired military personnel	For retired military personnel who have a physical or mental disability and satisfy certain other conditions (176,460 TWD (approximately 590,000 JPY) is paid annually)	Number of recipients: 59,953 persons (persons admitted to publicly-funded facilities)

Source: Produced by the authors based on materials provided by the Ministry of the Interior, Ministry of Health and Welfare, Council of Labor Affairs (predecessor of the Ministry of Labor Affairs), Veteran Affairs Council, and others.

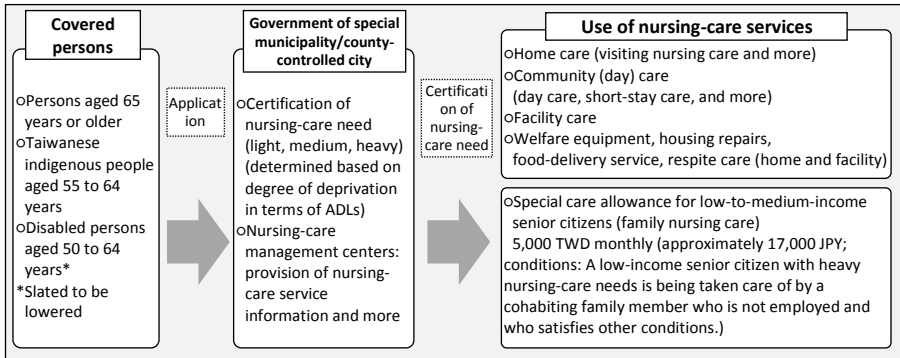
(2) Nursing-care scheme

Taiwan's nursing-care scheme is a scheme operated with tax funding according to a National Ten-Year Long-term Care Plan (ten-year nursing care plan). Covered persons include not just the elderly who require nursing care but also Taiwanese indigenous people fifty-five years of age and older and persons with disabilities between the ages of fifty and sixty-four years (with plans to expand the scope of coverage to all persons with disabilities). Persons wishing to avail themselves of nursing-care services under this scheme should

submit an application for a certification of nursing-care need to a special municipality or county-controlled city. A person granted certification of nursing-care need could utilize publicly funded nursing-care services within limits prescribed according to the degree of nursing-care need (light, medium, or heavy).

Figure 4-1. Nursing-care plans in Taiwan

- Flow of the use of nursing-care services provided through the National Ten-Year Long-term Care Plan (currently in the middle of the second period)
- Scale of executed budget: 1,854 million TWD (approximately 6.2 billion JPY, 2011)



Usage limits (by degree of nursing-care need; home and community care)		Unit subsidy amount (home and community care) 180 TWD per hour(*) (approximately 600 JPY)	Self-payment rates					Facility care (self-payment rate) Heavy degree of nursing-care need and low income (standard based on household income only) → 0 percent
Light	Medium		Household income per person	Consumption spending per person	Home/community care	Welfare equipment, home repairs	Food-delivery service	
25 hours/month	50 hours/month		Less than 1.5 times min. living expenses	Up to 1.5 times Taiwan average	0%	0%	0%	
90 hours/month			Between 1.5 and less than 2.5 times min. living expenses	Up to 1.5 times Taiwan average	10%	10%	10%	
			General	Other	30%	30%	--	

State of usage (2012)	<p>Home care, community care</p> <ul style="list-style-type: none"> 149 locations 7,118 employees Number of users: Home care: 37,994 (approximately 273 hours per person) Day care: 1,780 (approximately 1,251 hours per person) 	<p>Facility care</p> <ul style="list-style-type: none"> 1,045 locations Capacity: 57,876 persons Number of admitted persons: 42,947 21,056 employees
	<p>Special care allowance for low-to-medium-income senior citizens (monthly average figures)</p> <ul style="list-style-type: none"> Number of recipients: 9,042 Total amount received: 45.29 million TWD (approximately 1.5 trillion JPY) 	

* The idea of raising the unit subsidy rate per hour of home and community care by 200 TWD is slated to be studied. Source: Produced by the authors based on materials provided by the Ministry of Health and Welfare, Department of Social Welfare (Taipei City), and Federation for the Welfare of the Elderly.

There are three different types of nursing-care services: home care, community (visiting) care, and facility care. Home care refers to home-visiting

nursing care while community (day) care refers to day care or short-stay care obtained by visiting the location where nursing care is provided. Facilities that come within the scope of facility care consist of (1) long-term nursing-care organizations (such as medical nursing-care facilities and nursing-care facilities for dementia-afflicted elderly persons), (2) care-providing organizations (facilities for elderly persons without family members), and (3) other facilities. Transportation, food delivery, respite care, and other such services can also be used.

In Taiwan, a special care allowance for low-to-medium-income senior citizens is provided as a family nursing-care allowance. Under this scheme, 5,000 TWD (approximately 17,000 JPY) are paid monthly to a low-income household in which a senior citizen requiring nursing care to a heavy degree is cared for by a cohabitating family member (who is unemployed and who otherwise satisfies certain conditions).

A subsidy of 180 TWD (approximately 600 JPY) per hour of home care or community care for the use of these nursing-care services is paid subject to usage limits. This subsidy, however, is only offered to low-income persons. Other recipients assume a self-payment amount according to income level. The self-payment rate is ten percent for persons whose economic status is a step up from that of low-income persons and thirty percent for all other recipients. Facility care is free for low-income persons requiring nursing care to a heavy degree. Subsidies of up to 100,000 TWD (approximately 340,000 JPY) in home repairs and welfare equipment, up to fifty TWD (approximately 170 JPY) once a day per person for a food-delivery service, and up to 1,000 TWD (approximately 3,300 JPY) per session for respite care are granted (Figure 4-1).

It is said that the use of public nursing-care services increased because of the implementation of this National Ten-Year Long-Term Care Plan. At the same time, the provision of nursing care for senior citizens is assumed to a considerable extent by family members and foreign care workers.⁶ There are also numerous issues at play, such as those that exist with respect to the quality of public nursing-care services, regional discrepancies in terms of the system through which services are provided, and the securing of funding to cover the increasing costs of providing nursing care. Against this backdrop, the Long-Term Care Service Network Plan (nursing-care service network plan) was put into effect in 2012 in order to reduce such regional discrepancies in terms of the nursing-care service provision system.⁷ A new nursing-care scheme is being studied. The primary statutes to underpin this scheme—the Long-Term Care Act (Nursing-Care Service Act: a law to develop a scheme for providing nursing-care services) and the Long-Term Care Insurance Act (Nursing-Care Insurance Act)—are under review. A target of 2016 has been set for the enactment of the latter statute, the Long-Term Care Insurance Act.

(3) Other welfare services for senior citizens

Other welfare services for senior citizens include the establishment of general channels of communications for fielding inquiries on concerns affecting the elderly (governments of special municipalities and county-controlled cities), the running of Evergreen Academies and other such facilities for lifelong learning and recreational activities, and the implementation of community watch programs, programs of health consultations provided through local visits, and other initiatives. In addition, there are also hotlines to assist in the search for elderly persons who go missing while roaming about their neighborhoods.

Welfare for children (including work modes)

With Taiwan also facing its own declining birth rate, measures to support child-rearing efforts have also become important. In this section, we will examine not just welfare for children but also modes of work.

(1) Preschool education (childcare)

As is the case in Japan, places attended by children in Taiwan prior to entering the proper school system consisted of daycare centers (which used to be under the jurisdiction of the Ministry of the Interior) and kindergartens (under the jurisdiction of the Ministry of Education). Daycare centers were used by children two years of age or older while children under two years of age attended infant-care centers (which used to be under the jurisdiction of the Ministry of the Interior). Home-type services were offered by home childcare operators. Kindergartens and daycare centers were subject to integration in Taiwan in 2012, with the result that daycare centers and kindergartens were consolidated into preschools. Preschools are preschool educational and childcare facilities for children aged two or older and operate under the purview of the Ministry of Education. Children under the age of two years will continue to use infant-care centers (jurisdiction changed from the Ministry of the Interior to the Ministry of Health and Welfare). Home-type services came to be classed as home-based childcare (jurisdiction changed from the Ministry of the Interior to the Ministry of Health and Welfare) and persons providing these services are subject to administration by a community nursemaid support system operated by local governments. In 2012, there were 6,611 preschools attended by approximately 460,000 children and 402 infant-care centers attended by approximately 7,000 children. These institutions were thus collectively used by approximately thirty-nine percent of the total population of people aged 0 to 5 years of age in Taiwan (approximately 1.2 million people). There are 62 community nursemaid support systems in operation. A total of 23,066 home childcare operators are registered and their services are used by 33,270 children (Table 4-5).

Table 4-5. Outline of policies concerning the welfare of children in Taiwan

Type	Content											
<p>Childcare</p>	<p>Integration of kindergartens and daycares as preschools; facility-based and home-based services</p> <table border="1" data-bbox="224 215 985 391"> <tr> <td data-bbox="224 215 414 247">0 years old</td> <td data-bbox="414 215 565 247">2 years old</td> <td data-bbox="565 215 700 247">6 years old</td> <td data-bbox="700 215 985 295" rowspan="2"> Education/childcare facility (educational and childcare structure) </td> </tr> <tr> <td data-bbox="224 247 414 295"> Facility-based Infant-care center </td> <td data-bbox="414 247 565 295"> Preschool </td> <td data-bbox="565 247 700 295"> National primary school </td> </tr> <tr> <td data-bbox="224 295 414 359">Home-based</td> <td colspan="2" data-bbox="414 295 700 359">Home-based childcare</td> <td data-bbox="700 295 985 391"> Educational and childcare structure provided by local residents in mountainous areas and on remote islands </td> </tr> </table> <p>After-school childcare</p> <p>oJurisdiction (Central) Childcare centers and home-based childcare: Ministry of Health and Welfare; others: Ministry of Education (Local) Governments of special municipalities and county-controlled cities</p> <p>oWorkers and operators (qualifications) Early-childhood instructors, childcare workers, assistant childcare workers, nursemaid workers, and others Home-based childcare employees are subject to management by a “community nursemaid support system” as run by the government of a special municipality or county-controlled city.</p>	0 years old	2 years old	6 years old	Education/childcare facility (educational and childcare structure)	Facility-based Infant-care center	Preschool	National primary school	Home-based	Home-based childcare		Educational and childcare structure provided by local residents in mountainous areas and on remote islands
0 years old	2 years old	6 years old	Education/childcare facility (educational and childcare structure)									
Facility-based Infant-care center	Preschool	National primary school										
Home-based	Home-based childcare		Educational and childcare structure provided by local residents in mountainous areas and on remote islands									
<p>Economic support</p>	<p>oAllowance for low-income households: living allowance for vulnerable children and youth (1,900 TWD (approximately 6,300 JPY) monthly)</p> <p>oSubsidy to cover medical expenses: subsidy to cover medical expenses of vulnerable children and youth (subsidy to cover medical insurance premiums of children in low-income households)</p> <p>oSubsidy to cover childcare expenses (income and other restrictions apply) Subsidy to cover costs of childcare assumed by employed family members (for families with children under the age of two years) Allowance to cover costs of childcare assumed by families with an unemployed parent (for families in which at least one parent is not employed) Education plan to provide tuition waivers for five-year-old children: subsidy to cover costs of preschool for five-year-old children; supplemented for low-income persons</p>											
<p>(Work modes)</p>	<p>oChildbirth leave: Eight weeks total before and after childbirth (paid)</p> <p>oChildcare leave: can take two years off until child turns three years of age (unpaid); allowance from employment insurance; continuation of social insurance; prohibition against unfair treatment; resumption of duties guaranteed</p> <p>oPaternity leave (three days; paid)</p> <p>oFamily nursing-care leave; shortening of working hours; provision of childcare services by the place of employment</p>											

Source: Produced by the authors based on materials provided by the Ministry of Health and Welfare, Executive Yuan, Council of Labor Affairs (predecessor of the Ministry of Labor Affairs), and Department of Social Welfare (Taipei City).

(2) Economic support

In Taiwan, no scheme equivalent to the children’s allowance that is provided in Japan is operated. However, an allowance for children in low-income households is paid by a local government (living allowance for vulnerable children and youth) under the Protection of Children and Youth Welfare and Rights Act (1,900 TWD (approximately 6,300 JPY) monthly). In addition, a subsidy to help pay for daycare costs for low-income households and a subsidy to help pay for medical insurance premiums and charges subject to self-payment are also provided. The costs of preschool are also subsidized for all five-year-old children. The subsidy amount differs according to the

proprietor of the preschool (whether publicly or privately run) and may even be supplemented depending on the financial conditions of the household. In looking at the state of payments of the living allowance for vulnerable children and youth (2012), we see that approximately 2.88 billion TWD (approximately 9.62 billion JPY) was paid to a total of about 1,467 thousand people (Table 4-5).

(3) Modes of work

In Taiwan, childbirth leaves and childcare leaves have become institutionalized, such that eight weeks and two years in the first three years of a child's life, respectively, can be taken. Wages during a childbirth leave are paid pursuant to the relevant statute. While wages are not paid during a childcare leave, an allowance is paid from employment insurance (unemployment insurance). Persons taking such leaves will remain enrolled in social insurance plans and are protected by bans against unfair treatment. Paternity leaves that are taken when a spouse gives birth (three days; paid) have also become institutionalized.⁸ Places of business with a workforce of 250 employees or more are required to establish a daycare center or provide equivalent childcare services (Table 4-5).

If we examine the state of the utilization of these schemes through the Survey on Gender Equality in Employment and Management (2012) as conducted by the Council of Labor Affairs, Executive Yuan (currently the Ministry of Labor), places of business where employees took a childbirth leave accounted for 96.8 percent of all places of business (average of 7.5 weeks of leave taken) while persons taking a childcare leave were found in 40.8 percent of all places of business. Persons taking a childcare leave for one or more years and less than two years accounted for 43.8 percent of all persons taking a childcare leave, more than for any other group of childcare leave takers. Places of business where employees took a paternity leave accounted for 57.7 percent of all places of business (average of 3.0 days of leave taken). 77.3 percent of all places of business with a workforce of 250 employees or more provide childcare services (of which 73.1 percent utilize an outside childcare service).

Welfare for persons with physical disabilities (including welfare for persons with mental disabilities)

Approximately 1.12 million people in Taiwan have been certified as having a physical or mental disability (2012; according to the Ministry of Interior Affairs). Economic support and nursing-care services for persons with disabilities are provided, adaptive devices are disseminated, and other welfare measures for persons with disabilities have been or are being implemented under the People with Disabilities Rights Protection Act for such people.

Table 4-6. Outline (of the key elements) of Taiwan’s welfare for disabled persons

Economic support	<p>○Living allowance (monthly amount as a subsidy to cover the living expenses of physically and mentally disabled persons)</p> <p>Low-income households: 8,200 TWD (approximately 27,000 JPY; heavy or medium) 4,700 TWD (approximately 16,000 JPY; light)</p> <p>Other households: 4,700 TWD (approximately 16,000 JPY; heavy or medium) 3,500 TWD (approximately 12,000 JPY; light)</p> <p><u>* Amount paid: 20,165 million TWD (approximately 67.4 billion JPY; average number of recipients monthly: 348,656 in 2012)</u></p> <p>○Subsidies for wheelchairs and other assistive devices <u>* Amount paid: 729 million TWD (approximately 2,430 million JPY; average number of recipients monthly: 6,452 in 2012)</u></p> <p>○Subsidy for national pension and other social insurance premiums, subsidy to cover the costs of rehabilitative medicine</p>
Nursing-care services for disabled persons	<p>○Nursing-care services for disabled persons</p> <p>Home care (including physical care by visiting practitioners); total 2,529,788 users (2011)</p> <p>Community (day) care, facility care</p> <p>Number of facilities: 271 locations (capacity of 23,759 persons)</p> <p>Number of users: 19,092 persons (of which there are 6,093 partial-time users of day-care and other services)</p> <p>* Costs are subsidized by the government (between 25 and 100 percent subsidized)</p> <p>Visiting nurses: 1,300 TWD per visit (approximately 4,300 JPY; up to twice a month)</p> <p>Home care: 180 TWD per hour (approximately 600 JPY) (Limits on service usage according to degree of disability) 25 hours for light, 50 hours for medium, 90 hours for heavy</p> <p>Food-delivery service: 50 TWD (approximately 170 JPY; up to once a day)</p> <p>Visiting rehabilitation service: 1,000 TWD per visit (approximately 3,340 JPY; up to once a week and 6 times a year)</p> <p>Rate of subsidy is 100 percent for low-income persons, 90 percent for low-to-medium-income persons, and 70 percent for others</p>
Other	<p>○Job support (job training, employment support, and more)</p> <p>○School support (payment of scholarship and more)</p> <p>○Public transit discount, support through the tax system, and more</p>

Note: Low-income and low-to-medium-income standards correspond to standards for social assistance.

Source: Produced by the authors based on materials provided by the Ministry of Health and Welfare and Ministry of the Interior.

An allowance for non-institutionalized persons with disabilities is paid as a means of providing economic support (subject to income restrictions and other conditions). The amount paid depends on the degree of disability and the level of household income, such that between 3,500 and 8,200 TWD per month (between approx. 12,000 and 27,000 JPY) is paid. The costs of purchasing wheelchairs and other assistive devices are also subsidized. The subsidy contents and persons eligible to receive this subsidy are prescribed in detail by type of assistive device. In addition, premiums for national pension and other social insurance plans are also subsidized (the extent to which varies according to degree of disability).

Next, nursing-care services are provided in homes, in the community (day-care basis), and at facilities as nursing-care services for the disabled. As well as physical nursing care and living-support services, visiting services (whereby

users can undergo rehabilitation or engage in conversation) and food-delivery services are also offered. In particular, services to support the independence of users through training to adapt to society are delivered through day-care and facility-care programs. In addition, various support programs (such as advice services and respite care programs) for caretakers are carried out. While the costs of these services were subsidized by the government, they may be only partially subsidized depending on income level. Costs are subsidized at a rate of 90 or 70 percent for home care and at between 25 and 100 percent for community (day-care) and facility care. Persons with disabilities aged 50 years or older are entitled to use nursing-care services under the aforementioned National Ten-Year Long-term Care Plan. (There are plans to lower the age of eligibility as well as plans to allow persons with disabilities of all ages to use such services through the nursing-care scheme currently under study.) Furthermore, job-support and school support programs are also operated.

Other matters

In Taiwan, there is “social welfare for people especially in need of support” due to the loss of a spouse or other such circumstances. Approximately 20,000 households across Taiwan are entitled to receive this welfare (2012; according to materials provided by the Ministry of the Interior). Most of these households are headed by a woman. The heads of many of these households are in their thirties or forties and are either divorced or bereaved of their former spouses. These households are supported through the payment of an allowance for children being raised, emergency living assistance, and other such items that totaled approximately 450 million TWD (approximately 1.5 billion JPY) paid out to approximately 157,000 people in 2012. In addition, women’s welfare centers, women’s halfway houses and shelters, and welfare centers for foreign spouses have also been set up and are being operated. As of 2012, fifty-one, forty, and thirty-five locations, respectively, had been established.

The provision of welfare to Taiwanese indigenous people who have traditionally resided in mountainous areas and other remote locations is an important concern. This is because of the existence of disparities in terms of health and employment between them and other residents. Policies concerning Taiwanese indigenous peoples generally fall under the purview of the Council of Indigenous Peoples under the Executive Yuan. Measures in the area of health and welfare promulgated by this council include the provision of a subsidy to cover National Health Insurance (medical insurance) premiums, a subsidy to cover the costs incurred to visit applicable institutions, a subsidy for welfare facilities used extensively by Taiwanese indigenous people, and a pension for Taiwanese indigenous people (as provided through the national pension scheme to be discussed later).

3. Current state of medical insurance

Outline of National Health Insurance

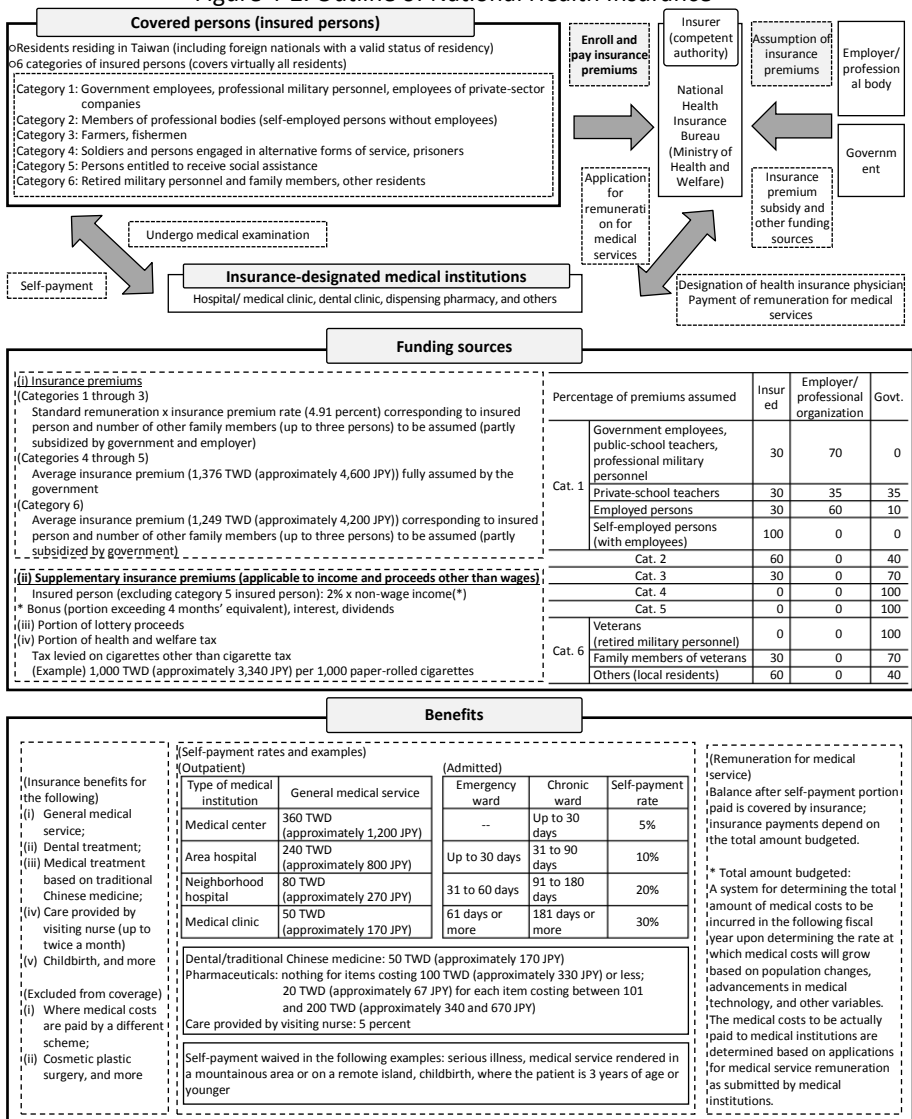
The medical insurance scheme in place in Taiwan provides coverage to residents in Taiwan under the National Health Insurance program (which went into effect in 1995). The insurer is an organ within the Ministry of Health and Welfare known as the National Health Insurance Bureau. In contrast to the system that has been adopted in Japan, the scheme in Taiwan operates through a single insurer.

Insured persons consist of persons residing in Taiwan (including foreign nationals with a valid status of residency). Prisoners are also covered. In principle, persons who return to Taiwan and persons who obtain a status of residency become insured persons 6 months (183 days) later. Insured persons are classified into six different categories according to occupation and other variables: from category 1 to category 6 insured persons. These categories are the basis for the calculation of insurance premiums and the percentage of insurance premiums to be assumed by the government and employers. For example, company employees constitute category 1 insured persons, a category that also includes the self-employed (in the case where there is an employed person) and professionals (such as attorneys and accountants). Persons in jobs in the agricultural, forestry, or fisheries industry are category 3 insured persons while unemployed elderly persons and others are category 6 insured persons. Low-income persons entitled to receive social assistance (livelihood protection) are category 5 insured persons.

With certain exceptions, insured persons assume the cost of insurance premiums. Insurance premiums for a category 1 through category 3 insured person equal the standard remuneration (such as wages) multiplied by the insurance premium rate (4.91 percent) multiplied by the percentage of premiums assumed as set forth in Figure 4-2. The amount of premiums that has been calculated accordingly and that corresponds to the insured person and to the number of other members of the family (up to 3 persons) shall be assumed. For a category 6 insured person (community residents), 60 percent of the fixed premium amount, which is referred to as the average insurance premium (1,249 TWD (approx. 4,200 JPY), shall be paid for himself or herself and other members of his or her family (average of 0.7 insured persons). Employers (including professional organizations) and the central government shall assume insurance premiums at rates set forth in Figure 4-2. The central government shall pay at least 36 percent of revenues net of certain statutory revenues (such as lottery proceeds and health and welfare tax proceeds). While insurance premiums to be assumed thusly constitute the primary sources of funding for the National Health Insurance plan, other sources of funding include supplementary insurance premiums (from insured persons, 2 percent of the sum of bonus amounts above a certain threshold as well as interest and

dividend payments received; from employers, 2 percent of the difference between the total amount of salary paid and the total amount of standard remuneration payable), the proceeds from the sale of public lottery tickets, and health and welfare tax proceeds⁹ (type of cigarette tax).

Figure 4-2. Outline of National Health Insurance



Note: Based in part on materials provided by the National Health Insurance Bureau.
 Source: Produced by the authors based on a table prepared by Katsuhisa Kojima (2011).

Insurance benefits include medical services provided by medical doctors, dentists, and practitioners of traditional Chinese medicine, pharmaceutical products, and natural childbirth. Care provided by visiting nurses is subject to benefit payments (up to twice a month). Self-payment amounts also apply, are fixed for outpatient services (fixed statutory rates), and are prescribed according to classification (such as medical or dental) and type of medical institution. For inpatient services, self-payment amounts are subject to fixed rates and are prescribed according to whether the insured person is admitted to an emergency or chronic ward and to the duration of admission. The amount to be self-paid for care provided by a visiting nurse is subject to a fixed rate (5 percent).

The medical costs to be paid by insurance are paid out of an aggregate budget. This entails a determination of the total amount of medical costs to be incurred in the following fiscal year by the government and a subsequent determination of the distribution of medical costs by type of medical care, region, and other variables in advance¹⁰. In the following fiscal year, medical costs to be paid out from insurance based on applications for medical service remuneration as submitted by medical institutions authorized to treat patients with health insurance coverage and on the results of examinations conducted accordingly shall be determined on a points-scoring basis. Since a unit amount per point is determined by comparing these scored points with the total amount of medical costs incurred, each medical institution receives medical service remuneration as calculated accordingly (Figure 4-2).

Actual state of the National Health Insurance plan

The National Health Insurance scheme is a single scheme providing coverage to the residents of Taiwan. There were approximately 19.12 million insured persons—equivalent to about 90 percent of the total population—in 1995 (the year in which this scheme came into effect). This percentage subsequently increased such that 99.9 percent of all residents came to be covered by 2011.¹¹ The implementation of the National Health Insurance scheme has facilitated the use of medical services primarily among the elderly. For example, the average number of examinations performed (on an outpatient basis) was 10.6 in 1995. This figure gradually rose thereafter to reach 16.2 in 2011. The average number of days of admission increased slightly from 9.4 in 1995 to 10.2 in 2011. In looking at the financial administration of this insurance scheme, we see that revenues rose from approximately 194.5 billion TWD (approximately 650 billion JPY) in 1995 to about 496.8 billion TWD (approximately 1,660 billion JPY) in 2011. On the other hand, disbursements increased from approximately 157.4 billion TWD (approximately 530 billion JPY) in 1995 to about 462.6 billion TWD (approximately 1,550 billion JPY) in 2011. In some years, disbursements exceeded revenues. To explain how this

happened, we note that, while the adoption of a universal health insurance scheme led to the securing of insurance premiums, premium rates have been revised only three times to date (they are systematically reviewed at least once every two years), the growth of wages has been low, and medical costs incurred for seriously ill patients and the elderly have ballooned (Table 4-7).

Current state of the system for providing medical care

The system for providing medical care in Taiwan that directly underpins the National Health Insurance scheme consists of approximately 46,000 medical doctors (including those practicing traditional Chinese medicine), about 12,000 dentists, and around 114,000 nurses (2011). For every 10,000 persons, these numbers are converted as follows: 19.6 medical doctors (including those practicing traditional Chinese medicine), 5.2 dentists, and 49.2 nurses. When compared to figures for Japan (23.0 medical doctors, 7.9 dentists, and 101.2 nurses (including assistant nurses) in 2010)¹², we see that there are far fewer medical doctors and nurses in Taiwan than there are in this country. A closer look reveals that there are also regional disparities in the system for the provision of medical care. In examining the numbers for special municipalities and county-controlled cities, it is clear that Taipei has the most number of medical doctors (including those practicing traditional Chinese medicine) for every 10,000 persons (35.1) while the lowest number of medical doctors corresponds to the remote island of Kinmen County (5.3).

Table 4-7. Status of the National Health Insurance plan

			1995	2000	2005	2011
Status of application	Number of insured persons (as a percentage of the total population)	(x 10,000 persons)	1,912.3	2,140.1	2,231.5	2,319.9
	Individuals	(x 10,000 persons)	1,121.3	1,234.7	1,341.0	1,504.5
	Family members	(x 10,000 persons)	791.1	905.4	890.5	815.4
Financial administration of insurance	Revenues	(x 100 mil. TWD)	1,945.0	2,914.0	3,660.6	4,967.6
	Insurance premiums	(x 100 mil. TWD)	1,941.6	2,907.3	3,561.0	4,694.7
	Other	(x 100 mil. TWD)	3.4	6.7	99.6	272.9
	Disbursements	(x 100 mil. TWD)	1,573.6	2,904.4	3,723.9	4,625.8
	Insurance benefits	(x 100 mil. TWD)	1,568.5	2,821.1	3,674.0	4,581.9
(Per insured person)	Insurance premiums (including portions assumed by the government and employers)	(TWD)	10,153	13,585	15,958	20,237
	Insurance benefits	(TWD)	8,202	13,182	16,464	19,751
	Average number of examinations (outpatient)	(number of visits)	10.6	14.7	15.5	16.2
Status of medical care received	Average number of admission days	(days per admission)	9.4	8.7	9.9	10.2

Notes: "Other" in the revenues section includes insurance premiums in arrear (delayed payments) and subsidies derived from lottery revenues and the health and welfare tax. "Other" in the disbursements section includes payments of interest on loans payable and money set aside in the National Health Insurance fund. The average number of examinations was obtained by dividing the number of outpatient visits by the number of insured persons.

Source: Produced by the authors based on materials provided by the National Health Insurance Bureau.

In addition, few medical doctors can be found in mountainous Hsinchu County (9.1), Miaoli County (10.9), and Taitung County (12.7). In this way, remote islands and mountainous areas are insufficiently served by providers of medical care, such that regional discrepancies in terms of the system of providing medical care are problematic. To address this issue, traveling clinics have been dispatched by designated medical institutions in cities to mountainous areas and medical treatment data are shared with the use of ITC (Table 4-8).

The use of family doctors is spreading in conjunction with the promotion of preventive medicine in Taiwan. However, residents are not obligated to find a family doctor; instead, this system is limited to persons with a history of receiving treatment for chronic conditions who wish to have a family doctor.

Table 4-8. System for the provision of medical services in Taiwan

			1995	2000	2005	2011
Main medical practitioners	Medical doctors	(No. of people)	27,495	33,169	38,657	45,516
	Dentists	(No. of people)	7,026	8,597	10,140	11,992
	Nurses	(No. of people)	56,743	70,743	92,447	114,300
Per 10,000 residents	Medical doctors	(No. of people)	12.9	14.9	17.0	19.6
	Dentists	(No. of people)	3.3	3.9	4.5	5.2
	Nurses	(No. of people)	26.6	31.8	40.6	49.2
Number of medical institutions	Hospitals	(No. of sites)	787	669	556	507
	Medical clinics	(No. of sites)	11,732	11,863	12,848	14,226
	Dental clinics	(No. of sites)	5,280	5,550	6,029	6,402
Number of hospital beds (Per 10,000 residents)		(No. of beds)	112,379	126,476	146,382	160,472
		(No. of beds)	52.6	56.8	64.3	69.1

Notes: "Medical doctors" include the number of doctors practicing traditional Chinese medicine and the number of hospitals and medical clinics include the number of hospitals and medical clinics at which traditional Chinese medicine is practiced. "Nurses" represent the sum of therapists and nurses.

Source: Produced by the authors based on materials provided by the Ministry of Health and Welfare.

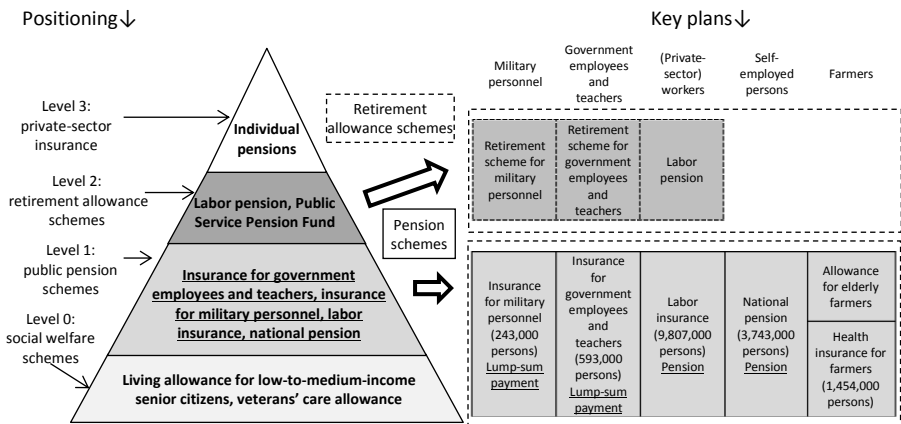
4. Current state of pension insurance

Income security for the elderly and pension schemes in Taiwan

As stated in the section on welfare for senior citizens in section 2 above, public pensions are a form of welfare for the elderly (economic support). Pension schemes in Taiwan are not centralized or integrated in the way that medical insurance (National Health Insurance) is organized. Benefits are provided by multiple schemes, including labor insurance and insurance for government workers and schoolteachers. If we include the welfare allowance for senior citizens as mentioned earlier, we see that the framework of income security for the elderly in Taiwan is more complex than it is in Japan. In this connection, let us survey the system of income security for the elderly in Taiwan and examine the positioning of pension schemes within this system.

Figure 4-3 outlines the system of income-security schemes for the elderly in Taiwan, which includes pension schemes, and the types of pension schemes that are available. This table reveals that the base scheme (level 0) is a welfare scheme for low-income senior citizens and that the living allowance for low-to-medium-income senior citizens and other such allowances fall under this scheme. Above this scheme are positioned social insurance-type pension schemes that are classified as level-1 schemes. These can be conceived as corresponding to first-tier pension schemes in Japan. Above these level-1 schemes are positioned level-2 schemes in the form of (statutorily prescribed) retirement allowance schemes. Level-3 schemes allow individuals to make provisions for their old age and correspond to private insurance plans (individual pensions), savings, and economic support as provided by family members.

Figure 4-3. Pension plans in Taiwan
(positioning in terms of income security for the elderly and key plans)



Note: Figures in parentheses represent the number of enrollees (as of December 2012). Underlined parts indicate the mode by which benefits are paid.

Source: Produced by the authors based on materials provided by the Council for Economic Planning and Development, a branch of the Executive Yuan (and currently known as the National Development Council), and the Council of Labor Affairs (currently the Ministry of Labor).

In this way, social insurance-type pension schemes are positioned as foundational elements of income security for the elderly. The adoption of a national pension scheme (2008) in Taiwan meant that all residents would be legally covered under a pension scheme. However, the pension schemes in which individuals enroll differ according to occupation. Military personnel enroll in an insurance plan for military personnel while government employees and schoolteachers enroll in an insurance plan for government workers and

schoolteachers. Persons employed by private-sector companies and other workers enroll in labor insurance while self-employed persons enroll in the national pension scheme. These schemes are divided into schemes operated through pensions by which old-age benefits can be regularly received (labor insurance and the national pension scheme) and lump-sum payment schemes (insurance for military personnel and insurance for government employees and school teachers), such that benefits are not provided according to a uniform pattern.

Level-2 retirement allowance schemes correspond to retirement allowance schemes for military personnel, government employees, and people enrolled in labor insurance plans. However, such schemes (schemes similar to the national pension fund and defined contribution-type pension for individuals that are offered in Japan) do not exist for others (Figure 4-3).

Labor insurance

As can be seen in Figure 4-3, labor insurance (under the jurisdiction of the Ministry of Labor (Bureau of Labor Insurance)) constitutes the largest social insurance program providing pension benefits in Taiwan. As a scheme that serves persons employed by private-sector companies and others, labor insurance used to be operated in such a way that benefits corresponding to a pension were paid on a lump-sum basis. Since 2009, benefits have been provided as pension payments. Persons insured under labor insurance assume insurance premiums equal to 8 percent of standard remuneration (20 percent of which is assumed by the individual).

Pension benefits include three types: old-age pensions, disability pensions, and survivor's pensions. An old-age pension can be received by anyone 60 years of age or older who has been enrolled in a labor insurance plan for 15 years or longer¹³. With respect to the level of benefits, the amount of benefits to be paid is determined according to a formula as indicated below in Table 4-9 based on the individual's average wage (average for the 60-month period during which the individual was paid his or her highest wage amounts), the length of enrollment in the insurance plan, and other factors (minimum guaranteed amount of 3,000 TWD (approximately 10,000 JPY) per month). However, a lump-sum system remains, such that an individual who has been enrolled for less than 15 years in the insurance plan would be entitled to receive an old-age lump-sum amount. This amount would be no greater than the equivalent of 45 months' of the individual's average monthly wage.

Table 4-9. Outline of labor insurance (pension benefits) and the national pension plan

Item	Labor insurance (pension benefits)	National pension
Insurer	Ministry of Labor (Department of Labor Insurance)	Ministry of Health and Welfare (entrusted to the Ministry of Labor (Department of Labor Insurance))
Insured persons	Workers 15 years of age and older and under 65 years of age (Key conditions) • Employee of a private-sector company with a workforce of 5 or more employees • Self-employed person belonging to a professional organization	Citizens under 65 years of age who are not enrolled in a social-insurance plan (Key conditions) • 25 years of age or older and has never received social-insurance benefits (old-age benefits) • 15 years of age or older and is already participating in a health insurance plan for farmers
Insurance premium	• 8 percent of standard remuneration (exclusive of portion corresponding to industrial-accident compensation) Burden of paying insurance premiums apportioned as follows: individuals (20 percent), employers (70 percent), and government (10 percent)	• Amount equal to insurance amount (17,280 TWD (approximately 58,000 JPY)) times insurance premium rate (7.5 percent) (2013). Burden of paying insurance premiums apportioned as follows: individuals (60 percent) and government (40 percent) • Rates of assumption by individuals and government will differ according to income level and other factors.
Types of benefits	oOld-age pension (min. guarantee: 3,000 TWD monthly (approximately 10,000 JPY)) Age at which benefits will start to be paid: 60 years (at least 15 years of enrolment; can be moved up or deferred)	oOld-age pension (min. guarantee: 3,500 TWD monthly (approximately 12,000 JPY)) Age at which benefits will start to be paid: 65 years
	oDisability pension (min. guarantee: 4,000 TWD monthly (approximately 13,000 JPY)) Paid where the insured person is certified as being heavily disabled	oDisability pension (min. guarantee: 4,700 TWD monthly (approximately 16,000 JPY)) Paid where the insured person is certified as being heavily disabled
	oSurvivor's pension (min. guarantee: 3,000 TWD monthly (approximately 10,000 JPY)) Paid out when the insured person or a pension beneficiary dies Beneficiaries: spouse, children, others	oSurvivor's pension (min. guarantee: 3,500 TWD monthly (approximately 12,000 JPY)) Paid out when the insured person or a pension beneficiary dies Beneficiaries: spouse, children, others
	oOld-age lump-sum payment Paid out where the individual has been enrolled in the insurance plan for less than 15 years Up to 45 months' average wages	oOther benefits (monthly) Basic old-age security pension (3,500 TWD (approximately 12,000 JPY)) Basic security pension for physical or mental disabilities (4,700 TWD (approximately 16,000 JPY)) Pension for indigenous persons (3,500 TWD (approximately 12,000 JPY)) Paid to an individual who was, at the time the national pension plan came into effect (2008), already at least sixty-five years of age, a heavily disabled person, or a Taiwanese indigenous person fifty-five years of age or older (subject to income-related and other conditions)
Benefit amount (2012)	Old-age pension: 11,170 TWD (approximately 37,000 JPY) Disability pension: 10,226 TWD (approximately 34,000 JPY) Survivor's pension: 12,305 TWD (approximately 41,000 JPY)	Old-age pension: 3,053 TWD (approximately 10,000 JPY) Disability pension: 3,517 TWD (approximately 12,000 JPY) Survivor's pension: 3,394 TWD (approximately 11,000 JPY)

* Formula for calculating the amount of labor insurance pension to be paid (key items)

Old-age pension (whichever is higher)

(1) Average wage x insurance period (number of years) x 0.775% + 3,000 TWD (approximately 10,000 yen)

(2) Average wage x insurance period (number of years) x 1.55%

* Average wage is the average for the sixty-month period during which the individual was paid the highest wage amounts; the insurance period can include the period of enrolment in the national pension plan.

Disability pension (general rule)

Average wage x insurance period (number of years) x 1.55%

(Min. guaranteed monthly amount is 4,000 TWD (approximately 13,000 JPY))

Supplemented by 25% per additional family member (up to 50%)

Survivor's pension

(1) Average wage x insurance period (number of years) x 1.55% (death during period of enrolment)

(2) 50% of above (death during period when old-age pension or disability pension is being received)

Min. guaranteed monthly amount is 3,000 TWD (approximately 10,000 JPY)

Supplemented by 25% per additional family member (up to 50%)

Apportioning burden of paying national pension insurance premiums (other than general)

- Persons eligible for social assistance: fully assumed by government
- Low-income persons:
 - Income is less than 1.5 times min. cost of living: individual 30%, government 70%
 - Income is between 1.5 and less than 2.5 times min. cost of living: individual 45%, government 55%
- Disabled persons: heavy: fully assumed by government; medium: individual 30%, government 70%; light: individual 45%, government 55%

* Formula for calculating the amount of national pension plan pension benefits to be paid (key items)

Old-age pension (general rule; whichever is higher)

(1) Insurance amount x insurance period (number of years) x 0.65% + 3,500 TWD (approximately 12,000 yen)

(2) Insurance amount x insurance period (number of years) x 1.3%

The insurance period can include the period of enrolment in the national pension plan.

Disability pension (general rule)

Insurance amount x insurance period (number of years) x 1.3%

(Min. guaranteed monthly amount is 4,700 TWD (approximately 16,000 JPY))

Survivor's pension

(1) Insurance amount x insurance period (number of years) x 1.3% (death during period of enrolment)

(2) 50% of above (death during period when old-age pension or disability pension is being received)

Min. guaranteed monthly amount is 3,500 TWD (approximately 12,000 JPY)

Supplemented by 25% per additional family member (up to 50%)

Note: Actual amounts paid may be less than what is minimally guaranteed pursuant to detailed regulations (such as in cases in which a welfare allowance is received).

Source: Produced by the authors based on materials provided by the Council for Economic Planning and Development, a branch of the Executive Yuan (and currently known as the National Development Council), and the Council of Labor Affairs (currently the Ministry of Labor).

A disability pension is paid to insured persons with a heavy disability. The minimum guaranteed amount is 4,000 TWD (approximately 13,000 JPY) a month, with the amount to be paid determined, as with the old-age pension, in accordance with the individual's average wage, length of enrollment in the insurance plan, and other factors. However, additional amounts for family members are provided where the individual in question has a spouse or other family members. The survivor's pension allows the spouse and any children of an insured person to receive benefits after the insured person or a beneficiary dies. The minimum guaranteed amount is 3,000 TWD (approximately 10,000 JPY) a month and the amount paid is determined according to a prescribed formula. As with the disability pension, additional amounts for family members are provided (Table 4-9).

The lengths of enrollment in a labor insurance plan and in the national pension plan to be discussed below can be aggregated, such that an individual who may have been enrolled in a labor insurance plan for less than 15 years but who is later enrolled in the national pension plan for long enough that the combined length of duration in both plans is at least 15 years will be entitled to receive an old-age pension under the labor insurance plan. (The pension amounts to be paid will be calculated separately under each scheme.)

National pension

Taiwan's national pension plan was put into effect in 2008. While the Ministry of Health and Welfare is in charge of this scheme, its operations have been entrusted to the Ministry of Labor (Department of Labor Insurance), which has jurisdiction over labor insurance. Persons insured under the national pension plan consist of residents under the age of sixty-five years who are not enrolled in a labor insurance plan or any other social insurance (pension) scheme¹⁴. In other words, self-employed persons, farmers, and others who are not enrolled in a labor insurance plan or other such scheme (persons who had not previously been covered by a pension scheme) constitute insured persons.

Insurance premiums equal the insurance amount equivalent to the standard remuneration (17,280 TWD (approximately 58,000 JPY)) multiplied by the insurance premium rate (7.5 percent). Since this insurance premium is applied to each insured person, the insurance premium is, for all practical purposes, a fixed amount. While the insurance premium rate was 7.5 percent in 2013, it is to be noted that the rate stood at 6.5 percent in the year in which this scheme came into effect (fiscal year 2008) and that it is set to be raised by 0.5 percentage points every two years¹⁵. In addition to insurance premiums, the national pension plan is funded in part by 1) subsidies provided by the central and local governments (by way of waiving insurance premiums payable by low-income individuals) and 2) a portion of the proceeds of public lottery sales and an amount equivalent to 1 percent of sales tax proceeds (consumption tax).

National pension benefits also include an old-age pension, disability pension, and survivor's pension. The old-age pension can be received when an insured person reaches the age of 65 years. While the amount paid is determined according to a prescribed formula, an amount of 3,500 TWD (approximately 12,000 JPY) is, in principle, guaranteed monthly. The insurance period that is plugged into this formula is added to the insurance period for the labor insurance plan. The disability pension is a pension that is paid when the insured person is incapable of making a living upon being certified as suffering from a serious physical or mental disability due to an injury or illness sustained during the insurance period. The minimum guarantee amount is 4,700 TWD (approximately 16,000 JPY) a month. The survivor's pension is a pension that can be received by surviving family members when the insured person or the aforementioned pension beneficiary dies. Persons entitled to receive this pension consist of the spouse, any children, the parents, the grandparents, any grandchildren, and any siblings, and payment is subject to the conditions based on the duration of the marriage, age of the deceased person, and other variables. The minimum guaranteed amount is 3,500 TWD (approximately 12,000 JPY) a month.

Apart from these benefits, there are also benefits that can be received by an individual who was, at the time the national pension plan came into effect, already at least 65 years of age, a heavily disabled person, or a Taiwanese indigenous person 55 years of age or older and who satisfies certain income-related and other conditions (old-age basic security pension, basic security pension for physical or mental disabilities, and pension for indigenous persons). When an insured person dies, an amount equivalent to five months' insurance amount for the month in which the person dies shall be paid to cover funeral expenses. This is received by the person paying for funeral expenses (in principle, one person) (Table 4-9).

Other schemes

Government employees and school (including private school) teachers are enrolled in an insurance plan for government employees and teachers. Insurance premiums equal to the insurance premium rate (8.25 percent) multiplied by salary are assumed. The insured individual assumes 35 percent of these premiums, with the rest assumed by the government (or the government and the employer for private-school teachers). Old-age benefits can be received when an insured person has paid insurance premiums for 15 years and retires upon reaching the age of 55 years. This is, as it were, a lump-sum payment made at the time of retirement. The amount is determined based on the length of time over which insurance premiums were paid (up to 36 months' salary). Professional military personnel are enrolled in an insurance plan for military personnel and an insurance premium equivalent to 8 percent of their salary is

paid (of which 35 percent is assumed by the insured individual). Old-age benefits constitute a lump-sum retirement allowance received in accordance with the number of consecutive service years (5 or more) accrued; up to 45 months' salary is paid.

5. Future issues concerning social-security schemes

Direction of social security measures from the standpoint of the Population Policy Guidelines of the ROC

An overview of social security schemes in Taiwan has been provided up to this point. Taiwan too has been experiencing a decreasing birthrate and aging population and its population is expected to peak in around 2025 before declining. For this reason, the issue of reforming and building social security schemes in accordance with population changes is more important than ever before.

In Taiwan, the policy applicable to population concerns and relevant measures dealing with social security and other matters is prescribed in the ROC Population Policy Guidelines. The first edition of these guidelines was drawn up in 1969. A look at the guidelines as revised in 2011 reveals a number of goals that conform to a basic line of thinking, including the goal of maintaining a reasonable population structure through the implementation of various measures (to mitigate the impact of aging) and the goal of improving the health of residents. In response, the direction taken by measures relating to social security can be seen in efforts to prevent illness suffered by senior citizens, the enhancement of nursing-care services, the enhancement of pension schemes and other income-security schemes, the promotion of health for all residents, the enhancement of healthcare services, and the enhancement of high-quality childcare-support services and welfare for the disabled and indigenous people¹⁶.

Direction in terms of the reformation of social security schemes

Some social security schemes in Taiwan, like the National Health Insurance plan, have been fully established. Even as medical costs rise, however, reviews of insurance premiums that should be conducted periodically are not being adequately carried out, such that the finances of the insurance system are hardly ample. Thus, the securing of insurance premiums and other sources of funding and the suppression of any expansion in medical costs are issues to be tackled. Budgeting total amounts of medical costs is a specific means of addressing the latter. Regional discrepancies in terms of the system of providing medical care and the discrepancy in particular between mountainous areas and remote islands on the one hand and elsewhere on the other hand are significant. While urban medical institutions are taking the lead in providing

traveling clinics with the aim of closing this gap, the elimination of regional discrepancies in terms of accessing medical services is a vital matter.

These sorts of issues can also be seen in nursing-care schemes. Nursing-care workers across all of Taiwan urgently need to improve both quantitatively and qualitatively. At the same time, there are regional discrepancies in terms of the systems through which nursing-care services are provided. Efforts to reduce these discrepancies are encapsulated in the Long-Term Care Service Network Plan. Under the National Ten-Year Long-Term Care Plan, a budget exceeding 5 billion TWD over 3 years has been committed. However, the securing of budgetary funding is hardly going according to plan. Nursing-care insurance is being studied with the aim of legislating such a scheme in 2016 in order to secure the funding that is required for nursing care. While it is said that this process has included an examination of comparable schemes in Japan, Germany, and South Korea for reference purposes, a scheme for nursing-care insurance that is suitably adapted to the current state of Taiwan is required. In this way, a nursing-care scheme in Taiwan should entail the development of social-insurance schemes alongside the development of a scheme for providing nursing-care services.

Pension schemes are fragmented and thus cause disparities in terms of the method by which benefits are paid and the levels of benefits that are paid. Studies to address these disparities are being carried out by the Council for Economic Planning and Development, a branch of the Executive Yuan (renamed the National Development Council in January 2014). As society continues to age, it will become difficult to support senior citizens on the backs of the economic vitality of their children. In order to establish a foundation that would allow people to live independently in their old age, systemic reforms designed to eliminate unfairness in terms of benefits and premium burdens among different schemes are an urgent matter.

As for the provision of support for the raising of children, we see that, while the integration of kindergartens and nurseries is proceeding at a faster clip in Taiwan than it is in Japan, no framework equivalent to the children's allowance that is paid in Japan has yet been implemented. In the area of welfare for the disabled, nursing-care services are moving towards integration with nursing-care schemes for senior citizens. The services required by the elderly and by the disabled differ. Thus, the same method for evaluating needs should not be adopted. Consideration of these points is needed.

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- ¹ Formerly known as *Takasago-zoku* in Japanese, the indigenous people of Taiwan are also known as Taiwanese aborigines. The Council of Indigenous Peoples, a body under the Executive Yuan, has recognized fourteen tribes, including the Amis, as official aborigine tribes (two new tribes were recognized in June 2014).
 - ² When converting new Taiwan dollar figures into Japanese yen in this chapter, the base exchange rate or the arbitrated exchange rate as indicated by the Bank of Japan (publicly announced in October 2013) was used. Accordingly, 1 TWD = 3.34 JPY.
 - ³ In looking at the era before the end of the Second World War, we see that a salt-workers' insurance plan (for some salt-field workers in Sichuan) was launched on a test basis in 1943; the Social Assistance Act corresponding to livelihood protection was also enacted in the same year. Before the end of the Second World War, a public healthcare scheme (involving engagement in public health measures together with medical care) was implemented. A pension act based on the Japanese system in place at the time was promulgated in 1923 and a seamen's insurance plan was put into effect in 1940.
 - ⁴ Merged with an insurance plan for private-school teachers in 1999 to become an insurance plan for government employees and teachers.
 - ⁵ While this is a system based on the Social Assistance Act (enacted in 1980), public assistance was previously provided in accordance with the Social Assistance Act of 1943. However, as coverage was limited to the elderly and others whose health condition was poor, it was inadequate as a system addressing the needs of low-income people.
 - ⁶ In Taiwan, sons account for approximately 22 percent, spouses approximately 14 percent, the spouses of sons approximately 14 percent, and daughters approximately 11 percent of the primary caregivers of elderly people; in total, these relations account for about 60 percent of all primary caregivers (*Survey of Senior Citizen Conditions in Taiwan*, Ministry of the Interior (2009)). Foreign care workers are also used to a considerable extent, such that approximately 190,000 foreign care workers were working in the homes of persons requiring nursing care in 2012.
 - ⁷ Under this plan, areas in Taiwan have been divided into communities (township and village (municipality) level), sub-regions (number of adjacent communities brought together), and regions (level of special municipalities and county-run cities). For each area level, targets for the development of nursing-care services have been formulated.
 - ⁸ In addition to provisions concerning childcare leaves and other forms of support for the raising of children as set forth in the Gender Equality in Employment Act (enforced as the Gender Equality in Employment Act in 2002; name revised in 2008), provisions prohibiting gender-based discrimination when recruiting, assigning, or promoting workers and preventing sexual harassment are also prescribed.
 - ⁹ Various items are subject to the health and welfare tax. For example, a tax of 1,000 TWD (approximately 3,340 JPY; cigarette tax is 590 TWD (approximately 2,000 JPY)) is imposed on every 1,000 rolled cigarettes. Tax proceeds are used to finance the National Health Insurance plan, to prevent damage to health caused by cigarettes, and for measures concerning systems for providing medical care to mountainous regions. The health and welfare tax raised approximately 34.3 billion TWD (approximately 114.6 billion JPY) in proceeds in 2012 (according to statistics provided by the Ministry of Finance).

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- ¹⁰ In determining an aggregate budget, population changes, changes in examination-related conduct, advancements in medical technology, and other factors are assessed to set the rates by which total costs will grow by category (such as medical care and dental care) in each fiscal year. Medical costs by category and region will then be determined based on the results of this process of assessment.
- ¹¹ Thanks to measures to enroll low-income persons in this insurance scheme and the granting of eligibility to become insured persons to prisoners.
- ¹² According to the *Survey on Physicians, Dentists, and Pharmacists* and the *Report on Public Health Administration and Services*, Ministry of Health, Labour and Welfare.
- ¹³ It should be noted, however, that there are plans to raise the age at which benefits will start to be paid beginning 10 years after the date of implementation of the current scheme, with the age at which benefits will start to be paid expected to be ultimately set to 65 years (slated for 2027).
- ¹⁴ The specific conditions are as follows: “person who is twenty-five years of age or older and who has not received old-age benefits from another social-insurance scheme to date”, “person who did not receive old-age benefits from another social-insurance scheme prior to the implementation of the national pension plan (excluding old-age benefits from labor insurance)”, “person who will receive old-age benefits associated with a labor insurance plan before his or her period of enrollment reaches fifteen years and who will not receive old-age benefits from any other social insurance plan within fifteen years of the point in time at which the national pension plan comes into effect”, and “person who is fifteen years of age or older and who is already participating in a health insurance plan for farmers at the time the national pension plan comes into effect (excluding persons who are under the age of sixty-five years and who do not engage in agricultural activities)”.
- ¹⁵ Slated to be ultimately raised to 12 percent.
- ¹⁶ More details are included in the Population Policy White Paper (2013) as produced by the Ministry of the Interior.

Chapter 5: Thailand

Masato Kawamori

1. Overview of Thailand

Location

Thailand shares national borders with Myanmar, Laos, Cambodia, and Malaysia. If the portion of Southeast Asia on the continental mainland can be likened to a folding fan, then Thailand is situated at the head and rivet of this part of the world. With a landmass spread across 513,000 square kilometers, the country is about 1.4 times the size of Japan. Thailand can be broadly divided into four regions. The mountainous north is adjacent to Myanmar and Laos. The central region comprises a delta zone built up alongside the Chao Phraya River, forming one of the world's biggest granaries. The industry of the northeast region may consist primarily of agriculture but poor conditions in terms of soil and weather account for income levels that are the lowest in the country. The peninsular south produces tin, rubber, palm oil, and other products.

Population

First, a look at changes in total population in Table 5-1 reveals that the population of Thailand increased from 27.31 million in 1960 to 69.12 million in 2010. Although this increasing trend is expected to persist for the next little while, the United Nations Population Estimates and Projections (2010) calls for the population to peak in 2039 before it begins to decline.

Next, if we look at changes in the total fertility rate from the 1960s onwards, we see that, while the total fertility rate averaged 6.13 in the period from 1960 to 1965 and 5.05 in the period from 1970 to 1975, the tendency to marry later, an increase in the number of unmarried people, and other such factors caused the total fertility rate to rapidly decrease to 2.95 in the period from 1980 to 1985, 1.99 in the period from 1990 to 1995, 1.68 in the period from 2000 to 2005, and 1.53 in the period from 2010 to 2015 to bring the country within reach of the level associated with developed countries. Thus, while the population of young people under 15 years of age went from 42.7 percent of the total population in 1960 down to 20.5 percent in 2010, the productive-age population of people aged 15 to 64 years is expected to begin shrinking in 2020 according to the United Nations Population Estimates and Projections.

Even as the birthrate declines in this manner, the average lifespan rose for men from 54.5 years in 1960 to 71.1 years in 2010 and for women from 58.9 years in 1960 to 77.8 years in 2010. Accordingly, elderly people account for an increasing percentage of the total population. The percentage of the total population consisting of those aged 65 years or older has been steadily

increasing (United Nations Estimates and Projections, 2010): 3.6 percent in 1980, 4.6 percent in 1990, 6.9 percent in 2000, 8.0 percent in 2005, and 8.9 percent in 2010. This segment is expected to account for 15.0 percent of the population by 2025 and 25.1 percent by 2050.

Table 5-1. Population and economy of Thailand

Year		1960	1970	1980	1990	2000	2010	2025	2050
Population (thousands of people)		27,312	36,915	47,483	57,072	63,155	69,122	72,884	71,037
Breakdown by age	Under 15 years of age (%)	42.7	44.1	39.4	30.1	24	20.5	15.9	14.4
	15-64 years of age (%)	54.1	52.5	57	65.3	69.1	70.6	69.1	60.6
	65 years of age or older (%)	3.3	3.4	3.6	4.6	6.9	8.9	15.0	25.1
Total fertility rate		6.13	5.05	2.95	1.99	1.68	1.53	1.47	n.a.
Average lifespan	Males	54.5	58.5	64.7	68.9	69.3	71.1	73.8	n.a.
	Females	58.9	63.6	70.7	75.9	76.7	77.8	80.0	n.a.
Gross domestic product	Real growth rate (%)	n.a.	n.a.	4.78	11.14	4.52	7.53	n.a.	n.a.
	GDP per capita (USD)	n.a.	199.8	704.8	1,327.9	1,997.4	4,934.5	n.a.	n.a.

Source: Population, breakdown by age, total fertility rate, and average lifespan figures compiled by the authors based on *Collection of Materials and Data on Employment Security in East Asia*, edited by Akira Suehiro, Institute of Social Science, University of Tokyo. Source book: United Nations, *The World Population Prospects, The 2010 Revision*. Gross domestic product figures derived from *Asia Trends Database*, IDE-JETRO. Source book: United Nations, *National Accounts Main Aggregates Database, Basic Data Selection*.

State of politics and the economy

In 1982, Thailand transitioned from an agriculturally based country to an industrially based country as evidenced by the fact that the manufacturing sector finally surpassed the agricultural sector that year in terms of its percentage contribution to the gross domestic product (GDP). Rapid economic growth was achieved thanks to an increase in direct investment from overseas beginning in the latter half of the 1980s, such that double-digit growth was seen from the end of the 1980s to the beginning of the 1990s. The new middle-class—which resided primarily in Bangkok, a city that had grown tremendously thanks to rapid economic growth—made its political influence felt in the democratization events of May 1992, which caused the military to lose its political stranglehold on the country (after the military successfully launched a coup d'état in 1991). The Asian currency crisis subsequently struck in 1997 and gave rise to neo-liberal reforms. Inaugurated in 2001, the Thaksin administration pushed through privatization and other neo-liberal reform measures and implemented populist measures benefitting farmers in the north and northeast regions of the country to cultivate its popularity. However, the Thaksin administration was felled by a coup d'état in September 2006 that was supported by the new middle-class in Bangkok, a segment of the population that had been critical of the government for its economic policies. A pattern of antagonism between the new middle-class in Bangkok and the opposing farmers of the north and northeast regions emerged and has remained in place to this day.

This dichotomy between urban and agricultural citizens is an important point for thinking about the political and administrative framework operating

in Thailand. Various initiatives have been implemented with a view to finding a remedy for this situation. An example of this can be found in stipulations made in the Constitution of 1997 and the Decentralization Act of 1999 to the effect that financial resources and personnel are to be transferred to the regions. In this context, the goal of raising the percentage of government spending accounted for by regional spending to 35 percent by 2006 was put forth. Moves towards decentralization, however, were subsequently halted and this goal has not been met. In particular, the transferring of schools and public health care centers to local governments has hardly moved forward. Underlying the lack of progress in terms of the transferring of public health care centers is the concern on the part of central government officials that the allocation of budgetary funds to healthcare will become undervalued in comparison to the allocation of funds to the field of construction. In other words, healthcare and welfare remains under the direct administration of central government officials and local offices of the central government (76 provinces and 878 districts).

2. Rapid economic development and advancements in the development of social security schemes

Thanks to the Vietnam War that raged from the second half of the 1960s to the first half of the 1970s, Thailand came to be fully integrated into the world economy. In turn, workers came to participate in the corporate economy that arose in urban areas at this time. In 1990, the state chose to prepare social-insurance schemes for the worker class. In 2002, the 30-baht healthcare program was introduced to guarantee healthcare even for farmers and others and realize a universal medical security scheme. The development of social security schemes that began in the 1990s can be traced to a number of factors, including the increase in direct investment in Thailand that was prompted in part by the Plaza Accord of 1985, favorable corporate earnings, and the higher government tax revenues that flowed from these changes in the economic landscape. In addition, while democratic events that saw civilians confronting the military occurred in May 1992 as noted above, we must also give credit to subsequent democratic movements for the enactment of the Constitution in 1997.

In examining the rapid economic growth that began in the second half of the 1980s, it is to be noted that long-term currency trends marked by a rising yen and falling dollar with roots in the Plaza Accord were formed. At that time, the Japanese economy was doing well enough that the resulting bubble spread to Southeast Asian countries and beyond. At the same time, the rising value of the yen caused Japan's manufacturing sector to relocate manufacturing plants to this region. Even as the bubble collapsed in Japan in 1991, Southeast Asian countries continued to enjoy growth for some time. Nevertheless, investments

in areas outside the core elements of the manufacturing sector (such as in land) contributed to the expansion of a bubble economy in this region as well. Consequently, a six-year lag behind Japan eventually caught up to Southeast Asia when the bubble in this region ultimately popped in what has become known as the Asian currency crisis of 1997. The catalyst for this crisis was the pullout of funds from Thailand to overseas that was carried out primarily by hedge funds in the United States.

Let us briefly review the relationship between the rapid economic growth that occurred from the second half of the 1980s and the development of social security schemes in Thailand with a focus on healthcare insurance. Lifestyle diseases spread due to the rapid economic growth of the latter half of the 1980s and caused national medical costs to rise by a breathtaking 15 percent a year. Calls to suppress national medical costs began to grow louder from people both inside and outside the country around this time. For example, the World Bank submitted a report on healthcare service policies in developing countries in 1987 wherein it recommended neo-liberal policies to increase the self-payment rates imposed on patients at national public hospitals and limit spending on medical costs by the government. Nevertheless, this World Bank report did not have much of an impact on the domestic sphere in Thailand on account of the fact that it did not accurately reflect the reality of government spending on medical care in developing countries.

Next, when we survey trends in total medical costs for the country as a whole from the middle of the 1990s, we first see that both government spending on medical care (in other words, medical costs incurred throughout the public medical-security system) and private spending on medical care continuously increased by nearly 15 percent per annum for the period from 1994 to 1996, following the second half of the 1980s. The important point to note is that the ratio of spending on medical care by the public sector and the private sector flipped to 52:48 at the time of the Asian currency crisis in 1997. Whereas government spending on medical care decreased by 1.7 percent on a year-on-year basis in 1998, private-sector spending on medical care declined by 13.7 percent. Subsequently, the growth in government spending on medical care outpaced that of private-sector spending on medical care, such that the gap in spending on medical care between the government and the private sector expanded. Of particular note is the 16.2 percent increase in government spending on medical care in 2002, the year in which the 30-baht medical-care program went into effect. To summarize, economic factors primed by economic globalization—in other words, the Asian currency crisis—played a major role in bringing about a shift in the breakdown of spending on medical care in Thailand, which meant that the government's role in terms of spending on medical care had taken on greater significance. Moreover, the adoption of the 30-baht medical-care program effectively further reinforced this trend.

Issues attributable to the aging of the population

Despite Thailand being a country in which social security is relatively more developed than it is elsewhere in Southeast Asia, it is merely the case that security in terms of medical care is offered on a universal basis in that country. However, pensions for the populace at large are not very well developed at all. Indeed, we may speak of the medical-security scheme that has been adopted but there are doubts as to whether it is sustainable in light of the declining birthrate and aging of society. Of course, the question of how the country should conceive of a framework for supporting the provision of nursing care is a pressing issue.

In this connection, if we express the speed at which societies in Western countries are aging in terms of the length of time it takes for society to transform from an *aging society* (society in which persons aged 65 years or older account for more than 7 percent of the total population) into an *aged society* (society in which persons aged 65 years or older account for more than 14 percent of the total population), then the following figures should be noted: 115 years for France, 85 years for Sweden, 69 years for the United States, and 63 years for Italy. In contrast, figures for the East Asian region (broadly speaking) as provided by the United Nations Population Estimates and Projections are as follows: 24 years for Japan, 25 years for China, 18 years for South Korea, 16 years for Singapore, 22 years for Thailand, 20 years for Indonesia, 24 years for Malaysia, 18 years for Vietnam, and 22 years for the Philippines. Thailand already became an aging society in 2001 and is expected to become an aged one in 2023.

While we can thus see that there is a difference in the speed at which societies are aging between Western countries and East Asia, it is important to note that there are different patterns at play in terms of the relationship between economic growth and aging between the developed countries of East Asia, such as Japan and South Korea, on the one hand and China and Southeast Asia on the other. That is to say, China and the countries of Southeast Asia are rapidly becoming aging societies while income levels remain relatively low and at the stage at which their social security schemes have not yet fully evolved (the problem of “getting old before getting rich”). If we dig a little deeper, it is expected that there will be a number of countries in East Asia in which a *demographic bonus* (the state in which the population structure in a given country is such that there are few children and elderly people and the working-age population is large and in which an extensive labor force enables rapid economic growth; this can be seen in the process whereby a society shifts from one that has a high birthrate and low death rate to one that has a low birthrate and low death rate) will end before per capita GDP has risen very much. These countries are likely to become mired in a *demographic onus* (the

state in which the working-age population rapidly shrinks at the same time that the population of aged persons increases rapidly) before they have had a chance to become sufficiently prosperous. In other words, countries and regions like Japan, South Korea, and Singapore will become burdened by a *demographic onus* only after reaching relatively high levels of income whereas it is expected that China as well as Thailand and other Southeast Asian countries will each have to deal with a *demographic onus* while per capita GDP remains no greater than 10,000 dollars.

If we consider the above facts in terms of their connection to social security schemes, it is conceivable that China and Southeast Asia will age at a point in time when they still have a considerably sized agricultural population in their midst, thereby likely making it necessary to think about adopting social security systems that differ from those that were adopted by the advanced countries of East Asia, where relatively generous social security systems were able to be introduced by the state. For example, the state laid the groundwork for nursing-care insurance schemes and private-sector nursing-care service operators, NPOs, and social-welfare corporations functioned as leaders in this field in Japan, South Korea, and Taiwan. In contrast, we cannot expect that such schemes will be introduced or that leaders in this field will emerge in particular for the benefit of rural areas in China and the countries of Southeast Asia. Thus, the construction of an affordable nursing-care system and the practical realization of local welfare to address the problem of aging that will arise acutely in rural areas are required.

3. Current state of social welfare

Welfare for persons with disabilities

In this section, let us take a closer look at welfare for the disabled and welfare for the elderly. First, according to a database compiled by the National Commission for the Promotion and Development of Disabled Persons' Life Quality, there were 1.42 million persons with disabilities in Thailand as of the end of September 2013 (2.2 percent of the population). Through the enactment of the Social Welfare Promotion Act of 2003 and the Persons with Disabilities' Quality of Life Promotion Act in 2007 (a statute that effectively replaced the Rehabilitation of Disabled Persons Act of 1991), various welfare policies to support the lives of the disabled have come to be developed. In particular, the Persons with Disabilities' Quality of Life Promotion Act is the focus of much attention for having been enacted based on a *disability-society model* (which posits that, as society creates obstacles and barriers, it is society that should work to eliminate these obstacles and barriers). The backdrop to these developments is the rising awareness of human rights in Thailand that began with the enactment of the Constitution in 1997. The framework of welfare

services that were rather randomly deployed under a centralized, vertical governing structure was reviewed and five-year plans to improve the quality of life of persons with disabilities have been formulated to consolidate these services under a comprehensive system that focused on improving the settings in which disabled people live. The fourth iteration of these plans (2012 to 2016) is currently underway. Basic policies in medicine, rehabilitation, education, employment, and other such fields are being drafted. The Ministry of Social Development and Human Security is carrying out enlightenment activities with a view to registering people with disabilities and eliminating discrimination. The Ministry of Labor issued a ministerial decree calling for the statutory employment rate of the disabled to be one percent and set about securing employment and providing work training through the establishment of eleven work training centers. The National Health Security Office, which oversees the 30-baht medical-care program, and the Ministry of Health have been endeavoring to consolidate medical care and welfare.

In this connection, let us examine in greater detail the thorough initiatives concerning welfare for the disabled being carried out by the National Health Security Office and the Ministry of Health in Thailand. The National Health Security Office has, mainly through district-level community hospitals, attempted to reorganize public, program-based services that had previously existed in a disorganized manner and compel community hospitals to assume functions for promoting both activities based on the participation of residents and local welfare by way of empowerment. Specifically, there is a framework in which the National Health Security Office, which operates against the backdrop of a huge pool of financial resources (budget for the 30-baht medical-care program), and the Ministry of Health, a provider of medical care (in other words, encompasses most medical-care institutions in Thailand) in this country, spearhead matters concerning medicine and welfare in communities. We can see that the National Health Security Office is attempting to organize local actors consisting of local governments and resident organizations (such as health-care volunteers organized by the Ministry of Health and home-welfare volunteers for the elderly organized by the Ministry of Social Development and Human Security) into a network for which community hospitals act as the hub.

In terms of medical security matters, we see that capitation is used by which per capita medical-care costs are prescribed in advance for the 30-baht medical-care program and that the amount of capitation per person in fiscal year 2013 was 2,755.6 baht. Since fiscal year 2003, however, this amount has included a budgeted amount for the welfare of persons with disabilities. The amount of capitation for the provision of welfare to persons with disabilities was initially set to four baht but has since then been raised to 12.88 baht. This represents the amount of budgetary funds used for welfare for the disabled within the 30-baht medical-care program and means that a total of 12.88 baht x

48.45 million people (the population of people covered by the 30-baht medical-care program) = 624 million baht has been allocated. Moreover, this is further supplemented by the budgets of local governments. In other words, this is a matching-funds framework underpinned by the National Health Security Office and local governments. Rehabilitation and other services provided in response to industrial accidents are handled separately as they are subject to the Social Security Scheme. Rehabilitation and the acquisition of adaptive devices account for 90 percent of the budget of this scheme. The remaining 10 percent is allocated to the promotion of a community-based rehabilitation (CBR) program and other initiatives. CBR is made possible by harnessing health-care volunteers, home-welfare volunteers for the elderly, and other local resources.

Welfare for the elderly

In 2002, the National Commission on the Elderly formulated the Second National Plan for the Elderly to serve as a guide for the enactment of welfare policies for the elderly. This is a long-term plan to remain in force for a period of twenty years and comprises three basic philosophies. First, the primary providers of support for the elderly are family members and the community, such that welfare provided by the state occupies no more than a supplementary position in the sense that it provides a basic guarantee for this state of affairs. Second, measures concerning health, income stability, education, and welfare are to be comprehensively promoted. Third, an evaluation system shall be developed through the setting of attainment targets and benchmarks for measuring the attainment of these targets. Next, let us examine the division of roles between families and the community. In Thailand, it is not yet common to find nursing care provided in facilities. Instead, nursing care is mainly provided at home.

First, according to the National Statistical Office (NSO), elderly persons whose primary source of income was funds received from family members (child, spouse, or sibling) accounted for 61 percent of all elderly persons in 2009. As for nursing care, elderly persons who require nursing care and who have caregivers themselves accounted for 10.9 percent of all elderly persons. A significant 80 percent of nursing caregivers consist of children (especially daughters) and spouses. While the role played by families in terms of income security and the provision of nursing care remains accordingly huge, the Second National Plan for the Elderly aims to maintain, over the course of a 20-year period, the rate at which elderly persons reside together with family members at 90 percent or above. Since money to cover living expenses can still be sent even if elderly persons reside apart from family members, the significance of maintaining the rate of co-habitation is bigger in terms of the provision of nursing care.

In this connection, let us touch on the volunteer project for home-based elderly care, which was set up in recent years to complement the provision of nursing care by families. While this was originally a project promoted by the Ministry of Social Development and Human Security's Office of Welfare Promotion and the Protection of Children, Youth, the Vulnerable, the Disabled, and the Elderly, volunteer projects for home-based elderly care were commenced on a trial basis in eight provinces between 2003 and 2004. In November 2005, the National Commission on the Elderly determined that these projects should be spread nationwide, with the result that they were implemented on a trial basis by local governments in 15 provinces in 2005 and 48 provinces in 2006 (1 model local government in each province). Forty volunteers were trained per local government with the aim of having one person engaging in health-promotion activities or the provision of rehabilitation during recovery periods for at least five elderly persons. In other words, the goal was to have volunteers establish linkages between secondary prevention and tertiary prevention elements or take charge of nursing-care functions. In January 2007, the National Commission on the Elderly decided that a policy to have these projects operated under the jurisdiction of local governments while pertinent matters are subject to coordination with the government and residents would be submitted to a meeting of the cabinet. This policy was approved at a cabinet meeting held in April 2007 and a plan to assign volunteers for home-based elderly care to all 7,778 local governments nationwide by 2013 was finalized. It was decided that the central government would provide financial support for the first two years of this program with local governments assuming costs incurred thereafter. However, this plan appears to be unfolding slower than expected. In 2011, only 568,966 elderly persons were supported by 31,272 volunteers for home-based elderly care. The government subsequently announced a plan to increase the number of volunteers for home-based elderly care to 100,000 by 2020. With respect to the training of volunteers for home-based elderly care, there are even cases in which courses are being given with funds budgeted for preventive services under the 30-baht medical-care program. Many volunteers for home-based elderly care also serve as healthcare volunteers.

Community elderly support centers have begun to be developed in order to play a key role in the provision of elderly support in the community and consist of both *centrally controlled centers* established by basic local government units in the form of *thesaban* ("municipal") or *tambon* ("sub-district") local governments and *small-scale community centers* that provide actual services under the supervision of centrally controlled centers.

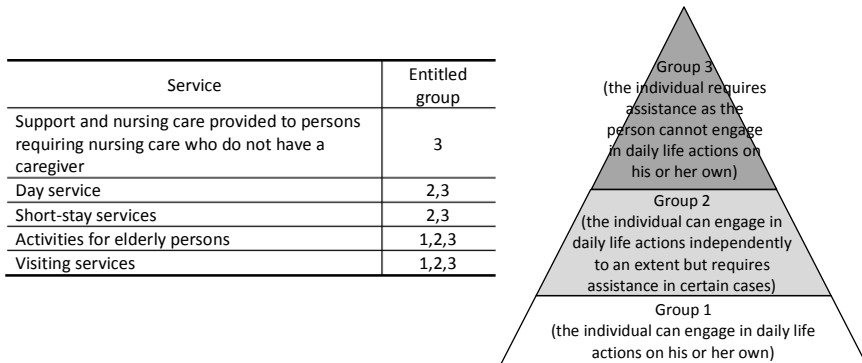
Small-scale community centers are fundamentally set up at the *muban* ("village") level. Private homes, community centers, primary care units, and other such locations are used and it is expected that services will be provided

by volunteers for home-based elderly care. An allowance of 600 baht per month is paid to volunteers for home-based elderly care. While this arrangement can be simply described as one in which healthy elderly persons (volunteers for home-based elderly care) assist elderly persons who require support, the idea behind this scheme is to rely on essentially free labor in accordance with the principle of reciprocity in that even healthy elderly persons will eventually require assistance themselves.

The services provided by small-scale community centers are outlined in Figure 5-1.

First, elderly persons aged 60 years of age or older are divided into three groups: Group 1 (the individual can engage in daily life actions on his or her own), Group 2 (the individual can engage in daily life actions independently to an extent but requires assistance in certain cases), and Group 3 (the individual requires assistance as the person cannot engage in daily life actions on his or her own).

Figure 5-1. Classifications of services provided by small-scale community centers and elderly persons



Source: Produced by the authors based on materials provided by the Ministry of Social Development and Human Security.

Five different services are provided: 1) support and nursing care provided to persons requiring nursing care who do not have a caregiver, 2) day services, 3) short-stay services, 4) activities, such as those involving avocations and rehabilitation, for elderly persons, and 5) visiting services through which support as desired by elderly persons is provided on an at-home basis. Two organizations—centrally controlled centers and small-scale community centers—provide five different services to three groups of elderly persons all week without taking any time off. Local governments are endeavoring to promote the spread of what is thus known as the “2-3-5-7 program.”

While we cannot make a simple comparison, it would be permissible to liken small-scale community centers to the small-scale multifunctional

residential nursing-care facilities found in Japan. These small-scale multifunctional residential nursing-care facilities were built around the concept of *pain* to enable elderly persons to continue living at home despite dealing with moderate difficulties by combining and providing *visits* and *stays* as needed according to the condition and preference of each person requiring nursing care.

If we were to reduce the external characteristics of the Thai framework down to their essential points by way of comparisons with Japan, we would see that this framework is similar to that of the “small-scale multifunctional residential nursing-care” that is provided in Japan. However, in regards to nursing-care insurance plans and nursing-care professionals, financing and the provision of services are based on the assumption that labor is provided virtually free-of-charge by welfare volunteers for home-based elderly care.

Nevertheless, there are a number of issues and concerns. Up to what level of services can you expect with a system that relies on virtually free labor? To what extent can volunteers be made to bear responsibility for errors perpetrated in the course of providing nursing care? To what extent can emergency care be provided in the face of a shortage of nurses and other professionals? Is it even possible for volunteers to become accepted in the personal realm of nursing care in agricultural communities where everyone knows one another?

Welfare for children

Next, let us examine the subject of welfare for children. First, facility services are provided at a number of different locations, including eight welfare facilities for infants, 15 welfare facilities for children, 1 occupational training facility, 4 juvenile rehabilitation facilities, and 76 temporary shelters for use by abused children and children who have been subject to human trafficking.

The following concerns the allowance for children and other relevant matters. Workers enrolled in a social security fund (to be discussed later) are entitled to receive a children’s allowance of 350 baht per month per child under the age of six years (up to two children). Needy families are entitled to receive 2,000 baht per time per child (3,000 baht if there are two or more children). In addition, there is a foster-parent scheme that temporarily places children residing in a facility for children with a general household. If the foster-parent household is in a needy situation, an allowance of less than 2,000 baht per month for child support costs and daily essentials valued at less than 500 baht per month are provided. If two or more children are being raised, an allowance of less than 4,000 baht per month for child support costs and daily essential valued at less than 1,000 baht per month are provided. In addition, there is a program to support adoption (including those by foreign nationals).

4. Current state of medical security

Three schemes

If the existence of universal health insurance (universalization of the provision of medical-care services) can be taken as an important indicator of a welfare state, then we can regard Thailand in recent years as a country that aspires to become a welfare state. In Thailand, universal health insurance for employed persons was realized through the mandated enrollment of all private-sector places of business in the Social Security Fund (SSS; based on a social-insurance model and operated under the jurisdiction of the Ministry of Labor) in 2002 to complement the medical security scheme that had already been in place for government employees and the employees of public-sector companies (CSMBS; based on a tax model and operated under the jurisdiction of the Ministry of Finance). Moreover, local medical security was consolidated through the introduction of the 30-baht medical-care program in 2002 (UC; based on a tax model and operated under the jurisdiction of the National Health Security Office). Thus, universal medical security has been achieved by these various means.

In this connection, let us examine the characteristics of three key medical-security schemes in Thailand: the medical security scheme for government employees and the employees of public-sector companies, the Social Security Fund, and the 30-baht medical-care program. As for funding, the Social Security Fund is funded by insurance premiums based on contributions made by the government, labor, and management (1.5 percent of wages each) while both the medical security scheme for government employees and the employees of public-sector companies and the 30-baht medical-care program are funded by taxes. If we compare these three schemes, we see that there is significant inequality among the covered populations and inequality in terms of per capita spending. In other words, while the 30-baht medical-care program covers 48.45 million people, the medical security scheme for government employees and the employees of public-sector companies and the Social Security Fund cover no more than approximately 5 million and 10 million people, respectively. Incidentally, the 30-baht medical-care program effectively covers non-wage earners, such that it has been systematically designed to include farmers and self-employed persons as well as elderly persons who have retired from a private-sector job. With respect to inequality in terms of per capita spending, we see that government employees, contract employees, and their family members are eligible to receive benefits under the medical security scheme for government employees and the employees of public-sector companies. However, per capita spending, at 11,000 baht, is almost four times as great as per capita spending, at 2,755.6 baht, for the 30-baht medical-care program. The inevitable result of this difference is a

discrepancy between schemes in terms of the medical services that are available. Thus, benefit levels under the medical security scheme for government employees and the employees of public-sector companies are exceptionally high. Doctors who frequently engage in excessive diagnostic actions and excessive treatment actions and over-prescribe drugs have been seen for quite some time as a key factor behind the rising national cost of medical care in the aggregate. Since capitation based on the prior stipulation of per capita medical costs each year is used for the 30-baht medical-care program and the Social Security Scheme, medical costs can be kept within defined limits. In contrast, since the medical security scheme for government employees and the employees of public-sector companies is a fee-for-service system, there is the risk that medical costs will continue increasing without restraint.

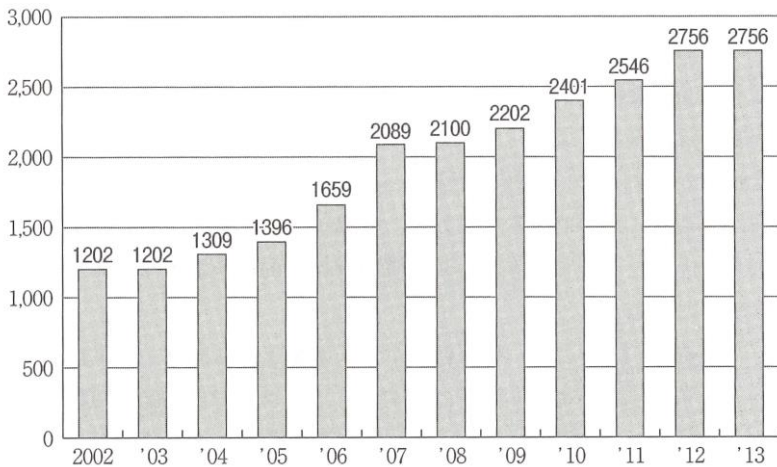
Services provided through the 30-baht medical-care program

Let us take a closer look at the 30-baht medical-care program, a scheme that provides coverage to 70 percent of the total population. In Thailand, a medical assistance program for low-income persons operated to provide public assistance and a health-care scheme operated as a voluntary insurance scheme were discontinued in 2002 and replaced with the 30-baht medical-care program, a new local medical security scheme designed to cover the 20 million persons that had been previously covered under the medical assistance program for low-income persons and the 7 to 8 million persons that had been previously covered under the health-care scheme as well as 15.50 million persons that had previously been uninsured. Under this scheme, various services are covered with the payment of a fee amounting to 30 baht per visit or admission, including the diagnosis and treatment of illnesses (including high-cost treatments for heart disease and other such conditions and traditional medical as prescribed in the Traditional Thai Medical Professions Act), childbirth (up to 2 times), meal and room costs for admitted patients, dental care, drugs indicated in the basic national pharmaceuticals list, and referrals between medical institutions (transfers). Enrolled persons pay nothing more than the fee mentioned above. While a tax-based approach is used for this scheme as noted earlier, this scheme is characterized by the fact that budget allocations are made for the prevention of illnesses and the promotion of health in contrast to the Social Security Fund, which is a scheme that fundamentally pays only for medical costs incurred.

For this scheme, capitation is used whereby yearly medical costs per person are covered. This amount is determined through negotiations conducted between the National Health Security Office, which has jurisdiction over the 30-baht medical-care program, and the Budget Bureau in the Office of the Prime Minister. Below, let us examine the changes in per capita medical costs

that have occurred since 2002 (Figure 5-2). In looking at changes in the per capita budget for this scheme as determined by the Budget Bureau in the Office of the Prime Minister, we see that the per capita budget for this scheme had been subject to exceedingly strict financial rules as enacted by the Budget Bureau in the Office of the Prime Minister until around fiscal year 2005. However, the per capita budget for this scheme has been growing at a considerably fast clip since fiscal year 2006. In particular, this figure stood at 2,089 baht in fiscal year 2007 in the wake of the coup d'état of September 19, 2006, a sudden increase of more than 400 baht in a single year.

Figure 5-2. Per capita medical costs for the 30-baht medical-care program



Source: Produced by the authors based on annual reports for each year as issued by the NHSO.

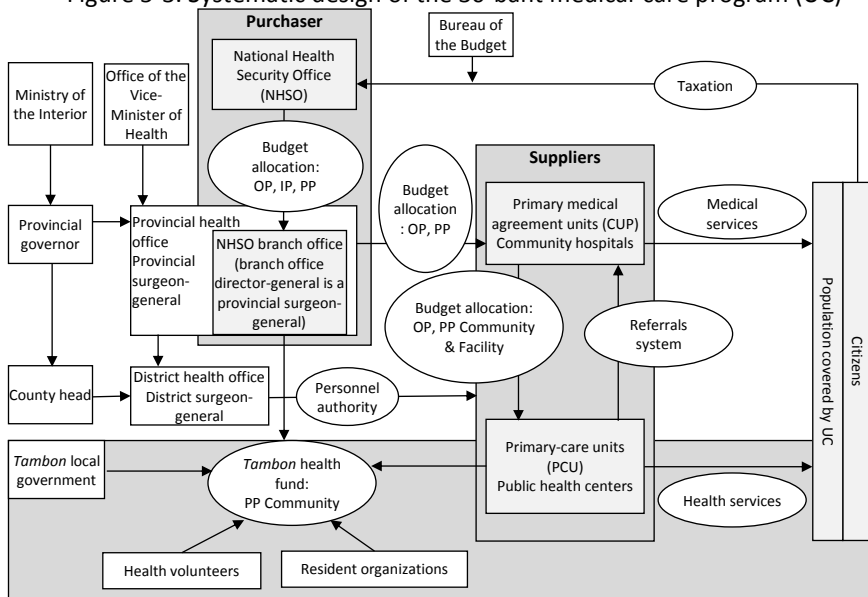
Established after the coup d'état of September 2006, the Surayud administration scrapped the per-visit 30-baht fee two months after the coup d'état took place. It is notable that the Surayud administration, by this action, reinforced rather than eliminated the 30-baht medical-care program, which had been former prime minister Thaksin's political crown jewel and a target of opposition for the new government. While the amount of capitation for fiscal year 2009 stood at 2,202 baht per person, it rose by nearly 200 baht to 2,401 baht in fiscal year 2010. The amount of capitation rose to 2,546.5 baht in fiscal year 2011 and by a further 200 baht to 2,755.6 baht in fiscal year 2012 before remaining at the same level in fiscal year 2013. The per-visit 30-baht fee was reinstated in fiscal year 2012. Accordingly, we are likely going through a period during which the sustainability of the financial base of the 30-baht medical-care program should be re-examined.

Features of the 30-baht medical-care program

There are three particular features of the 30-baht medical-care program: 1) reinforcement of the links between community hospitals and primary care units, 2) separation of the service purchaser and suppliers, and 3) illness prevention, rehabilitation, and nursing care based on the use of matching funds. Let us examine these features in order below.

As we can see in Figure 5-3, singular and multiple primary-care units (PCUs) operate at a *tambon* (“sub-district administrative unit”) level underneath district-level community hospitals under this scheme. At primary-care units, nurses, midwives, and administrators work full-time to provide healthcare and public health services, carry out elementary treatment actions, and prescribe basic pharmaceuticals. Where a matter cannot easily be handled at a primary-care unit such that the medical actions of a physician are required, the patient is referred (transferred) from the primary-care unit to a community hospital, which invariably constitutes a national medical institution. While the amount of capitation for the registered population is allocated from community hospitals (CUP) to primary-care units, the aim is to leverage this to cement the relationship between community hospitals and primary-care units and ensure that sustainable, detailed examinations are conducted by full-time family doctors and general physicians at community hospitals. As already mentioned earlier, the 30-baht medical-care program is generally characterized in terms of policies for limiting medical costs through a general-framework budgeting approach. In addition, long-term policies for limiting medical costs by way of the prevention of illnesses at a local level have also been systemized. In other words, the management of patient referrals to higher-grade institutions through the thorough implementation of illness prevention efforts in community hospitals—in other words, a gatekeeper role—came to be imposed on community hospitals. Subject to certain restrictions, management is delegated to community hospital directors (CEOs) under the 30-baht medical-care program. A neo-liberal management approach has been incorporated whereby management by results (MbR) is undertaken in place of the expansion of discretionary power over the use of management resources. At the same time, primary-care units are subject to the production of family folders and the scoring of performance in such terms as family visits made by public health nurses. Evaluations based on these processes are reflected in the allocation of budgetary funds.

Figure 5-3. Systematic design of the 30-baht medical-care program (UC)



Source: Kawamori (2009), p. 131.

In elaborating on the budgetary flow that applies to the 30-baht medical-care program, we see that the per capita budget for medical costs in the context of the 30-baht medical-care program includes the following: 1) outpatient services (OP), 2) inpatient services (IP), 3) preventive services (PP), 4) accident and emergency services (AE), 5) high-cost medical services (HC), 6) emergency medical services (EMS), 7) investment budget items for which additional remuneration is required, 8) additional amounts for remote areas, and 9) one-time ex-gratia payments for malpractice as stipulated under Article 41 of the National Health Security Act. To illustrate, the per capita budget amount in 2013 was already noted above to be 2,755.6 baht. While budget funds corresponding to the registered population are disbursed by the National Health Security Office to its branch offices, these funds specifically cover mainly 1) outpatient services, 2) inpatient services, and 3) prevention services, funding for other items is retained by the central government. Budget funds disbursed to local branches include salary for the employees of medical institutions. Budget funds for allocation are subject to revision according to the breakdown of age brackets and special circumstances in the area under the jurisdiction of each branch office. Operations at branch offices are based on a separate per-capita distribution approach whereby 1) outpatient services and 2) inpatient services are separated and the 1) budget funds for outpatient services and 3) budget funds for preventive services for the registered population are

accordingly distributed to community hospitals. These funds are distributed every two months. On the other hand, the budget funds for 2) inpatient services are managed according to diagnosis-related groups (DRG) based on global budgets at a branch office level.

Next, let us look at a second feature to be noted: the separation of the service *purchaser* and *suppliers* in the context of the 30-baht medical-care program. As indicated in Figure 5-3, the *purchaser* (specifically, the National Health Security Office) and *suppliers* (specifically, primarily consisting of national medical institutions) were separated to provide medical services to the people in conjunction with the introduction of the 30-baht medical-care program. The attempt to expand the range of options available to consumers by separating the public sector fields of education and medicine into the *purchaser* and *suppliers* to essentially create a (*quasi-*)*internal market* and thereby bring competitive conditions into interactions between the purchaser and suppliers was inspired by the National Health Service and Community Care Act (U.K.). Under the 30-baht medical-care program, people are now statutorily entitled to select their personal medical institution within a certain scope of options. In other words, a person can choose from among medical institutions situated in the district or *tambon* jurisdiction in which the person has registered a residence, medical institutions situated in an adjacent district or *tambon* jurisdiction, and medical institutions situated in the district or *tambon* jurisdiction in which the person is currently residing. However, it is arguably too early to expect a successful replication in Thailand of efforts that have been made elsewhere in a developed country to create competitive market-like conditions through the decentralization of the public sector, which is typically inefficient and which has traditionally responded poorly to needs. In particular, the creation of competitive conditions in agricultural areas is exceedingly difficult. This is because there are very few suppliers—in other words, medical institutions—to be found in agricultural areas. Given such a state of insufficiency, it is a difficult task to eject players providing inadequate services from the market.

Next, let us focus on the third feature: the *Tambon* Health Fund, which was conceived as a financial and organizational basis for the promotion of health and the provision of rehabilitation and nursing-care services at a local level. This is a matching fund operated through contributions made by three parties: the National Health Security Office, local governments, and residents. Disbursements made by the National Health Security Office are derived from the budget funds corresponding to the budget particulars for the 30-baht medical-care program as they pertain to “preventive services provided within the community (PP Community)”. With funds issued by the *Tambon* Health Fund, health volunteers can give health guidance to populations at risk of lifestyle diseases (primary prevention) and provide rehabilitation and nursing-

care services to persons with disabilities and elderly persons requiring nursing care (tertiary prevention).

5. Current state of pension security

Formal sector (government employees)

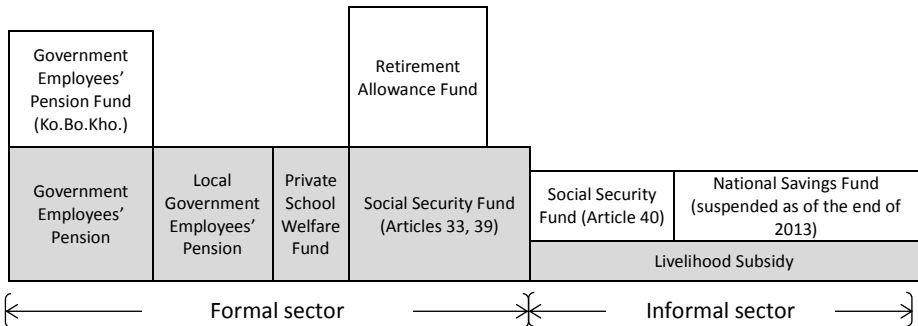
Since the Government Employees' Pension Act was enacted in 1951, government employees at the national and local levels have been receiving contribution-free pensions financed by taxes. At the same time, the government enacted the Government Pension Fund Act in 1996 to stabilize pension finances. Presently, the benefits system that is fully funded by taxes and that had existed under the Government Employees' Pension Act and the benefits system that is funded by insurance premiums under the Government Pension Fund Act coexist (Figure 5-4). With the enactment of the Government Pension Fund Act, all persons hired on or after March 27, 1997, (the date on which this statute went into effect) have been required to enroll in the Government Employees' Pension Fund (Ko.Bo.Kho.). However, persons hired prior to this date were given the choice of receiving benefits under the Government Employees' Pension Act or receive benefits through enrollment in the Government Employees' Pension Fund. Insurance premiums for the Government Employees' Pension Fund are paid at a rate of 3 percent by both the individual and the employer (government). There were 1,156,246 persons enrolled in the Government Employees' Pension Fund as of 2010.

With respect to benefits to be paid to persons who have chosen to receive benefits under the Government Employees' Pension Act, such persons can choose to receive either a lump-sum retirement allowance or a pension. For example, a person who chooses to receive a lump-sum retirement allowance upon reaching the mandatory age of retirement after putting in 25 consecutive years of service will be entitled to receive an amount equal to the final month's monthly salary multiplied by the number of consecutive service years that the person has accrued. If the same person were to choose to receive a pension, the person would be entitled to receive an amount equal to the final month's monthly salary multiplied by the number of consecutive service years that the person has accrued divided by 50.

Persons hired after the enactment of the Government Pension Fund Act and persons hired before the enactment of this law who wish to enroll in this fund are entitled to choose to receive either a lump-sum retirement allowance or a pension. A person who chooses to receive a lump-sum retirement allowance where the person reaches the mandatory age of retirement after working for at least 25 consecutive years is entitled to receive an amount equal to the final month's monthly salary multiplied by the number of consecutive service years that the person has accrued as well as the insurance premiums and investment

gains that have been accumulated by the individual and the employer (government). An individual who chooses to receive a pension shall be entitled to receive an amount equal to the average monthly salary over the 60-month period leading up to the point at which the person reaches the mandatory age of retirement multiplied by the number of consecutive service years that the person has accrued divided by 50 (no more than 70 percent of the average monthly salary over the 60-month period leading up to the retirement) as well as the insurance premiums and investment gains that have been accumulated by the individual and the employer (government).

Figure 5-4. Structure of pension plans in Thailand



Source: Produced by the authors based on Wiphan Prachuapmo ed. (2012) p. 74.

Formal sector (private-sector employees)

The Social Security Act was enacted in 1990 against the backdrop of various factors brought on by the Plaza Accord of 1985 (which resulted in currency adjustments in the form of yen appreciation against the US dollar), including an increase in direct investment in Thailand, favorable corporate performance, and increasing government tax revenues. This led to an expansion of social security benefits, which theretofore had been limited to work-related accidents and the like, to cover injuries and illnesses, childbirth, disabilities, and death. While the scope of the application of this statute was initially restricted to places of business with 20 or more employees, it was subsequently increased to places of business with 10 or more employees in 1993 and to places of business with at least 1 employee in 2002. With respect to the contents of benefits provided, old-age benefits (pension) and a children's allowance were added in 1998 and an unemployment allowance was added in 2004. There are two types of enrollment under this statute: active workers subject to Article 33 of the Social Security Act (mandated enrollment) and retired workers subject to Article 39 of the same statute (voluntary enrollment).

Guaranteed benefits under Article 33 cover occupational accidents, injuries and illnesses, childbirth, disabilities, and death and consist of a children's

allowance, old-age benefits, and unemployment benefits. The insurance premium rate paid by the individual is revised by ministerial ordinance and was set to 5 percent of salary as of 2009 (up to 15,000 baht) and 4.5 percent as of 2011. While the insurance premium rate paid by the government and the insurance premium rate paid by employers were set to 5 percent and 2.75 percent, respectively, as of 2009, they were reduced to 4.5 percent and 2.5 percent, respectively, in 2011. The right to receive old-age benefits (pension) arises when an individual reaches the age of 55 years and has paid insurance premiums for a total of 180 months or more. While the benefit rate is set to 20 percent of the average salary over the 60-month period leading up to an individual's retirement, the monthly salary shall be no higher than 15,000 baht for calculation purposes. If the individual has paid insurance premiums for at least 180 months, the benefit rate shall be increased by 1.5 percentage points for every 12 months of payments made. If the individual has paid insurance premiums for at least 12 months and less than 180 months, an amount equivalent to insurance premiums paid by the individual and the employer shall be paid on a lump-sum basis. If the individual has paid insurance premiums for less than 12 months, only the amount equivalent to insurance premiums paid by the individual will be paid on a lump-sum basis. In addition to benefits under Article 33, benefits under Article 39 are also provided. These benefits are provided to any person who wishes to enroll in the Social Security Fund even after retirement. In such a case, the individual will need to have already paid insurance premiums for at least 12 months and must submit an application within six months of retirement. With insurance premiums set to 432 baht per month, benefits covering industrial accidents, injuries and illnesses, childbirth, disabilities, and death as well as old-age benefits can be received.

For a private-sector employee, first-tier benefits under Article 33 and second-tier benefits under a retirement savings fund (Provident Fund) (voluntary enrollment) are available. The individual accumulates savings at a rate of between 2 percent or more and less than 15 percent of the salary. These savings are supplemented by an amount assumed by the employer (no less than the amount saved by the individual). As of 2011, there were 2,316,771 persons enrolled in this fund.

Informal sector (farmers, self-employed persons, and others)

In 1993, the government (Office of Social Security, Ministry of the Interior) commenced paying a livelihood assistance benefit of 200 baht per month to needy persons 60 years of age and older. This monthly amount was raised to 300 baht in 2000 and increased again to 500 baht in 2007. In 2009, a program to pay a livelihood subsidy of 500 baht a month to all elderly persons 60 years of age and older, with the exception of the recipients of a government

employee's pension and persons receiving a government employee's salary, was adopted. Since 2012, the following monthly amounts have been paid: 600 baht to elderly persons aged 60 to 69 years, 700 baht to elderly persons aged 70 to 79 years, 800 baht to elderly persons aged 80 to 89 years, and 1,000 baht to elderly persons aged 90 years or older.

Individuals belonging to the informal sector can also receive benefits under Article 40 of the Social Security Act. Enrollment for this scheme is voluntary and there are two different modes by which this scheme is offered. For the first, the individual pays an insurance premium of 70 baht per month, which is supplemented by 30 baht by the government, and is entitled to receive benefits on suffering an industrial accident, injury or illness, or death. For the other, the individual pays an insurance premium of 100 baht per month, which is supplemented to the tune of 50 baht by the government, and is entitled to receive benefits on suffering an industrial accident, injury or illness, or death as well as an old-age benefit. The old-age benefit is paid as a lump-sum amount at the time the individual reaches 60 years of age. The amount of this benefit that is paid is equal to the total amount of insurance premiums paid plus a prescribed additional amount.

The benefit under Article 40 of the Social Security Act constitutes a lump-sum old-age amount rather than a pension. To supplement this benefit, the government enacted the National Savings Fund Act in May 2011 and thereby established a savings scheme based on insurance premiums. To be eligible to enroll in the National Savings Fund, an individual has to be between 15 and less than 60 years old and shall not be enrolled in the Social Security Fund, Government Employees' Pension Fund, or any other such fund. Insurance premiums are at least 50 baht a month and are supplemented by fixed additional amounts according to age bracket as paid by the government. The monthly benefit amount equals the sum of insurance premiums paid by the individual and additional amounts paid by the government plus any investment gains earned. However, the Ministry of Finance suspended the further recruitment of enrollees in the National Savings Plan in 2013 on the grounds that benefits from the National Savings Plan overlap with benefits under Article 40 of the Social Security Act.

The Community Welfare Fund—a matching fund to which contributions are made by 3 parties consisting of the central government, local governments, and citizens—is beginning to be established throughout the country for the purpose of supplementing the above schemes. Coverage applies to pensions as well as to childbirth, education, injuries and illnesses, the maintenance of livelihoods, and job training. Fund authorization functions and the provision of guidance are to be carried out by the Community Organizations Development Institute (CODI), which operates under the purview of the Ministry of Social Development and Human Security.

6. Potential issues concerning the future of social security schemes

To this point, we have outlined what has been achieved by the various social security schemes in place in Thailand. We shall conclude by identifying potential issues that may arise in the future. The primary issue is the existence, as is the case in China, of discrepancies between cities and rural areas within social security schemes that have been established in Thailand.

First, let us take a look at medical security. In Thailand, the 30-baht medical-care program for farmers and self-employed persons was adopted in 2002 to complement the medical security scheme for government employees and the employees of public-sector companies and the Social Security Fund for the employees of private-sector places of business. With this development, universal health insurance was established. If we compare the duration required to go from the establishment of a health insurance scheme for the employees of private-sector places of business primarily in the cities to the attainment of universal health insurance in Thailand (with both points in time marked by the enactment of relevant statutes) to the length of time that this process took in other countries (127 years in Germany (1854-1981), 36 years in Japan (1922-1958), 26 years in South Korea (1963-1989), 12 years in Thailand (1990-2002)), we see that Thailand was able to offer universal health insurance in an extraordinary short period of time. Incidentally, primary industry workers accounted for 32 percent of the total workforce in Japan and 46 percent of the total workforce in Thailand as of the time that each of these countries successfully instituted a system of universal health insurance (*Yearbook of Labor Statistics*, ILO). In contrast to the West, Japan was able to offer universal health insurance at a stage when the absorption of farmers into fields of modern employment was at a relatively low level. Thailand managed to offer universal health insurance at a stage when the absorption of farmers into fields of modern employment was at an even lower level than it was for Japan.

However, if aging were to proceed at a stage when income levels are low and this issue of aging were to emerge rather acutely in rural areas, there would be questions as to the sustainability of schemes. There are two factors that could give rise to volatility or instability. First, there is the fact that, while the 30-baht medical-care program covers persons other than salary earners, it is a scheme that has been designed to allow for an inflow of low-income persons who are at a high risk of becoming ill and elderly retired persons. Second, the consolidation of the healthcare insurance system has been pushed further back amid moves to shift the dependents of workers (a spouse and children) at private-sector places of business from the 30-baht medical-care program to the Social Security Fund, such that there is the possibility that the 30-baht medical-care program will effectively become a medical assistance scheme for low-income persons primarily consisting of farmers and informal sector workers. In

other words, the system is transforming into a bipolar structure comprising, on the one end, the Social Security Fund, a scheme for those with a comparatively high level of income and relatively low risk of becoming sick, and, on the other end, the 30-baht medical-care program, a scheme for those with a comparatively low level of income and relatively high risk of becoming sick.

There are also discrepancies between urban and rural areas in the area of nursing care for elderly persons and in terms of pension schemes. For example, government policy on the question of nursing care for elderly persons entails a commitment to supporting families and communities from behind the scenes. However, the existence of elderly persons who live alone and who require nursing care is becoming a significant issue in the northeast part of Thailand, where incomes are the lowest in the country and where population outflows have become pronounced. The situation has even become difficult for the purpose of recruiting volunteers. Even for rural areas, the income-security scheme for elderly persons, which consists of a livelihood subsidy of 600 to 1,000 baht, is not sufficient. Benefits under Article 40 and other relevant provisions of the Social Security Act have not spread to their intended targets to an especially substantial extent.

The shift in political logic from the construction of public buildings and the provision otherwise of ad-hoc pork barrel to local areas as part of efforts to provide livelihood security and empowerment tools to farmers and other members of the “excluded majority”, which had previously been neglected as a political constituency, occurred with the arrival of the first decade of the new century. This can also be seen as a step towards getting in line with recent international trends in terms of human development and human security. Such consideration for the “excluded majority” was reinforced and came to assume a central part of what was seen as politically correct even as the mantle of government was passed from Thaksin to Surayud to Abhisit. The Surayud administration embraced the ideal of a society that excluded no one while the Abhisit administration eliminated means testing and income restrictions from the process of paying livelihood subsidies to elderly and persons with disabilities. In these ways, it is evident that the principle of the universality of welfare is becoming firmly entrenched in Thailand.

However, in order to sustain this move towards universalism, tax revenues based on steady economic growth as well as an expansion of the tax base through the introduction of an asset tax and a stronger ability to capture taxes will be required. The way ahead on these points is full of difficulties. The government is fettered in terms of the increasing fiscal burden that will need to be assumed as the population ages, such that it is uncertain how much longer the commitment to universalism can be maintained. Consequently, it is highly likely that, in accordance with the principle of subsidiarity, the government will take on a behind-the-scenes role in supporting local communities in which

people are subsumed. This state of affairs will be supplemented by the *Tambon* Health Fund and the Community Welfare Fund, which constitute matching funds to which contributions will be made by the government, local governments, and residents. It is expected that a system incorporating home-based welfare volunteers for the elderly and other service suppliers will emerge in time. In other words, the structure will be one in which the 30-baht medical-care program and livelihood subsidy scheme, as means of providing minimum security, will be merged with these types of matching funds. Nevertheless, there are numerous issues connected to these points. With further decentralization taking place, discrepancies in terms of the quality of medical and welfare services provided could very well emerge as a function of the fiscal competence of local governments and residents. That is to say, we may see discrepancies in terms of service arise within rural areas. Thus, the question as to how social security will be conceived in rural areas will become a key issue in the future.

Chapter 6: Japan

Masanobu Masuda

1. Overview of Japan

Location

Japan lies at the eastern edge of the Asian continent and constitutes a corner of a group of countries forming the region known as East Asia. It is an island country surrounded completely by the ocean and comprises numerous islands, including the four main islands of Hokkaido, Honshu, Shikoku, and Kyushu. The area of Japan measures 378,000 square kilometers in total. Japan is a small country in terms of area compared to China or the United State but only France, Spain, and Sweden among the countries of Western Europe can claim to be geographically bigger than Japan. If we were to take the countries of Western Europe to be our benchmark, then one cannot reasonably describe Japan as a small country in terms of area.

Mountains and forests account for about 80 percent and plains account for around 20 percent of the geographic area of Japan. The country is home to many volcanoes and experiences an exceedingly large number of earthquakes thanks to the convergence of the Pacific Plate, North American Plate, and Philippine Sea Plate at the bottom of the ocean along the Pacific coast. The Great East Japan Earthquake that struck on March 11, 2011, caused enormous damage with the loss of about 20,000 lives, the evacuation of approximately 400,000 persons, and the destruction of nuclear power generating plants attributable to major seismic activity and tsunamis.

As for the climate, Japan—with the exception of northern Hokkaido, the northernmost part of the country, and Okinawa, the southernmost part of the country—is situated in the mild temperate climate zone, which is characterized by clear changes in the four seasons of the year.

Changes in population and the aging rate

According to the national census of 2010, the total population of Japan is 127 million people, which ranks the country in tenth place in the world behind the likes of China, India, and the United States and makes her among the most populous of the approximately 200 countries of the world.

Changes in the population and the aging rate are one among many factors pushing the government to develop social security schemes.

The Japanese population rose rapidly after the country joined the ranks of modern states thanks to the Meiji Restoration that took place in the latter half of the nineteenth century. The population at the time of the Meiji Restoration is estimated to have stood at around 30-something million people and grew to 43.3 million people by 1899 (thirty-second year of the Meiji era). The very first

national census was carried out in 1920 (ninth year of the Taisho era) and yielded a count of 50 million people. The population continued to grow and surpassed 70 million people prior to the Second World War. Unfortunately, the Second World War (including the Second Sino-Japanese War and the Pacific War) resulted in a loss of about 3.1 million people and caused the population to shrink.

After the Second World War, the population rebounded rapidly, thanks in part to the first baby boom (generation born between 1947 and 1949; approximately 2.7 million people were born in each of these years; at greater than 4, the total fertility rate was very high during these years). In 1967 (forty-second year of the Showa era), the population surpassed 100 million. Growth in the population of young laborers constituted the engine supporting economic growth. Lionized as “golden eggs,” junior high school graduates flocked from Hokkaido, Tohoku, Kyushu, and elsewhere to the capital city and the Kinki region to find jobs en masse at companies and factories. The population underwent social mobility at a tremendous pace, such that cities became overpopulated while agricultural and mountainous areas suffered from depopulation. As explained later in this chapter, a period of rapid economic growth in Japan began in around the middle of the 1950s. Social security schemes evolved against the backdrop of growth in both economic and population terms.

If we take a look at the white paper on health and welfare that was issued at the time (currently known as the Annual Report on Health, Labor and Welfare), we see that matters were being discussed with an awareness of the question as to whether Japanese society could withstand the pressures of an increase in population. While this description of Japanese society back then definitely makes it feel like a different age in comparison to the society of today (characterized as it is by a declining birthrate), officials at the time regarded high numbers of children as a factor behind the poverty of families and recommended family planning to reduce childbirth numbers with a view to promoting *fewer births and encouraging parents to raise their children very carefully*. In 1952 (twenty-seventh year of the Showa era), the total fertility rate was between two and three; the rate remained at this level until the second half of the 1970s. The second baby boom (generation born between 1971 and 1974; approximately 2.0 million people were born in each of these years) occurred in the first half of the 1970s.

Thereafter, however, the total fertility rate would continue to drop over a prolonged period of time. In 1990 (second year of the Heisei era), the nation awoke to what was then called the “1.57 shock” (the total fertility rate for the previous year in 1989 was found to be 1.57, lower than the postwar record lowest level of 1.58 that was recorded in 1966 due to superstitions associated with *hinoeuma*, an inauspicious year). This caused the government and society

to take a growing interest in the issue of a falling birthrate. From around the middle of the 1990s, the government began to implement measures to counter the falling birthrate but was unable to halt the decline in the birthrate. The total fertility rate fell to 1.26, its lowest level ever, in 2005 (seventeenth year of the Heisei era). While this rate has picked up slightly in recent years (1.43 in 2013 (twenty-fifth year of the Heisei era)), the number of live births per year has fallen to around just over a million a year and is soon expected to fall below this level.

At the same time, the average lifespan of Japanese people (average number of remaining years of life at age zero) remained low throughout the Meiji and Taisho eras but began to increase with the arrival of the Showa era (which began in 1926). The average lifespan of Japanese people rapidly rose in the postwar years thanks to the increases in levels of public health and nutrition and the development of schemes for providing medical care and public medical insurance schemes.

In 1947 (twenty-second year of the Showa era), the average lifespan of men in Japan was 46.9 years and the average lifespan of women was 49.6 years; these years were thus referred to as the “era of 50-year lives.” Subsequently, the average lifespan of women surpassed 60 years in 1950 (twenty-fifth year of the Showa era), reached 70 years in 1960 (thirty-fifth year of the Showa era), and exceeded 80 years in 1984 (fifty-ninth and last year of the Showa era). For men, increases in the average lifespan lagged behind those of women. Nevertheless, it exceeded 60 years in 1951 (twenty-sixth year of the Showa era), reached 70 years in 1971 (forty-sixth year of the Showa era), and surpassed 75 years in 1986 (sixty-first year of the Showa era). The middle of the 1980s came to be referred to as the “era of 80-year lives” and both men and women in Japan were among the longest-living humans in the world. The “era of 85-year lives” arrived in 2013 (twenty-fifth year of the Heisei era), when men and women can expect to live an average of 80.2 and 86.6 years, respectively.

A decreasing number of children tied to a declining birthrate and declining number of births and an increase in the average lifespan of people have caused the aging of Japanese society to accelerate. The aging rate in the immediate postwar years (percentage of the total population accounted for by people aged 65 years or older) was 4.9 percent in 1950 (twenty-fifth year of the Showa era). In 1970 (forty-fifth year of the Showa era), Japan became an aging society when the rate of aging surpassed 7 percent. Low levels were maintained for two decades thanks to the first baby boom and to the relatively high total fertility rates (never less than 2.0) that were subsequently recorded.

From around the 1980s, however, the aging rate rapidly rose. A country becomes an aged society when the aging rate surpasses 14 percent, which occurred in Japan in 1994 (sixth year of the Heisei era). The period between

the time when a country's aging rate hits 7 percent and the time when a country's aging rate hits 14 percent is known in demographic terms as the doubling time and is used as a measure for indicating the speed at which a society ages. In the case of Japan, the doubling time was 24 years. Major Western countries took between 50 and 130 years to become aged societies. In contrast, the speed at which Japanese society aged is highly notable.

The aging rate continued to increase thereafter and exceeded 20 percent in 2005 (seventeenth year of the Heisei era). The aging rate is thought to be an estimated 25.0 percent as of October 1, 2013 (twenty-fifth year of the Heisei era), which would make the aging rate in Japan the highest in the world. One in four people is 65 years old or older and one in nine people is 75 years old or older. The White Paper on Health and Welfare of 1986, which was issued around the time when the aging rate surpassed ten percent, described a society in which elderly persons comprise one in every four persons as a *hyper-aged society*. Such a description is certainly apt for the situation in which Japan currently finds itself. The population of elderly persons has hit 31.9 million people (2013), having doubled over the last 20 years; we are now in an era in which there are over 30 million elderly persons in Japan.

There are many fields of social security in Japan that are characterized by deep links between elderly persons and pensions, medicine, and nursing care. For this reason, the ways in which social security schemes in an elderly society would be constituted and operated came to be issues of policy in the 1980s. Since that time, necessary systemic modifications have been carried out numerous times by focusing on what was shaping up to be a true aged society and while taking fairness in terms of benefits and cost burdens and the sustainability of schemes into account.

According to estimates provided by the National Institute of Population and Social Security Research, Japanese society will continue to age in the years to come. With the first baby boom generation slated to become a population segment aged 65 years or older in 2015 (twenty-seventh year of the Heisei era), the number of elderly persons and the aging rate will both rise. The aging rate will hit 29.1 percent, 31.6 percent, and 38.8 percent, or almost 40 percent, in 2020, 2030, and 2050, respectively.

As of October 1, 2013, the Japanese population was 125 million people (estimated by the Ministry of Internal Affairs and Communications). This number more or less represents the historic peak in terms of population in Japan. Thanks to declining numbers of children and an increase in the number of deaths of elderly persons, Japan has been in a state of natural attrition (population decline that occurs when the number of deaths exceeds the number of births) since 2010, such that the state of a shrinking population in Japan has become extraordinary and noted. It is already estimated that the population will have contracted by 250,000 people on a year-on-year basis as of October 1,

2013. According to estimates provided by the Ministry of Internal Affairs and Communications, the total population is on a long-term downward slope. It is expected that it will shrink to 116 million people and 107.3 million people in 2030 and 2040, respectively, before crossing below the 100 million people threshold and hitting 97 million people in 2050.

Aging in Japan is characterized by the speed with which aging is progressing, the bigger size of the population segment comprising elderly persons relative to the size of this segment in Western countries, the fact that aging is taking place as the population itself is shrinking, and the exceptionally high projections of the aging rate in the future.

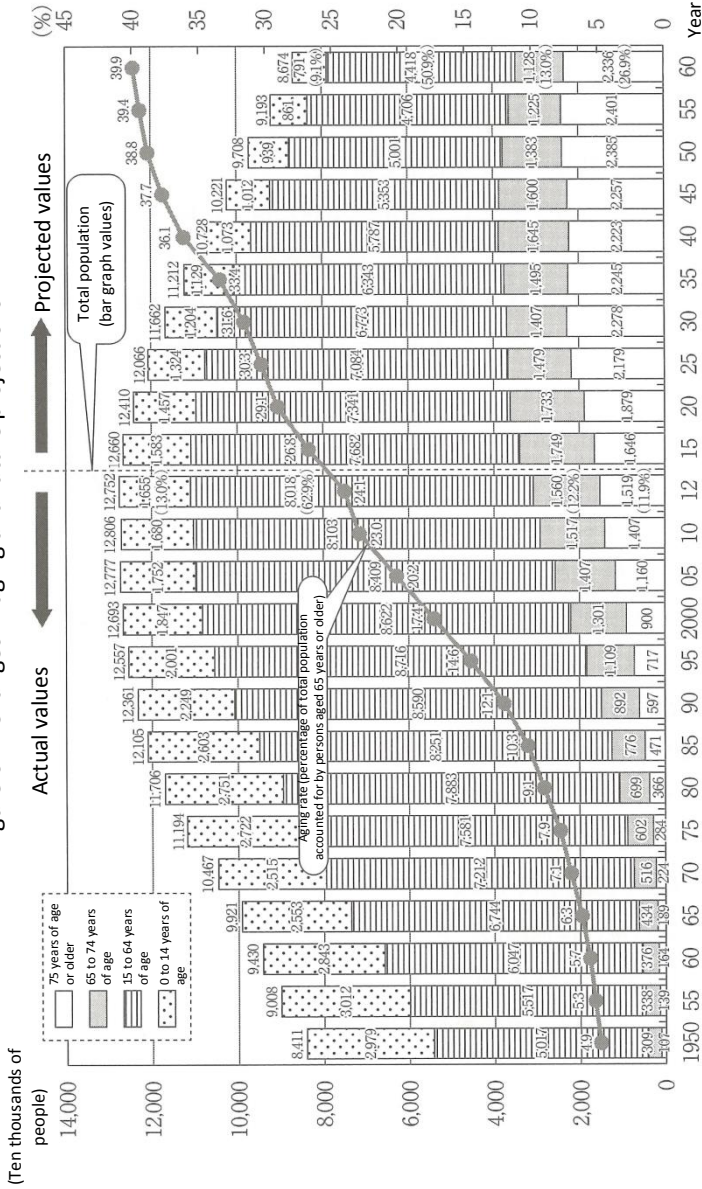
In this way, an examination of the future of social security schemes in Japan must take into account a future that will see levels of population aging and a full-scale shift to an aged society with a low birthrate unlike anything seen previously in the world today.

Political and economic situation

Japan's political system is one in which sovereignty resides with the people. There are two houses of government: the House of Representatives and the House of Councillors. A parliamentary cabinet system is in place whereby the prime minister is selected by way of the election of members of the Diet for both Houses. In this sense, Japan's political system resembles the British system among those found in advanced countries.

Beginning in around the middle of the 1950s, the "1955 system" (named for the fact that this system was formed in 1955) persisted in which the Liberal Democratic Party (LDP) constituted the governing party, the Social Democratic Party constituted the opposition, and the prime minister was selected from among the ranks of the LDP. With the arrival of the 1980s, however, these parties notably split into multiple parties. In the first half of the 1990s, coalition cabinets became the norm. In 1993, the first prime minister chosen by a party other than the LDP in 47 years was elected as the head of a non-LDP coalition government. The 1955 system in that year came to an end. In 1994, the LDP and Social Democratic Party formed a coalition government and selected the first Social Democratic Party prime minister in 49 years. Prime ministers from the LDP were subsequently chosen and this coalition government managed to survive for a few years. Nevertheless, the general election of 2009 was won big by the Democratic Party of Japan (DPJ), which campaigned for a change in government that year. The cabinet of the DPJ, which successfully drove the LDP into the role of the opposition, emerged. The LDP then scored a large electoral victory in the general election of 2012. Once again, a coalition government led by an LDP-chosen prime minister is in charge of governing the country.

Figure 6-1. Changes in aging and future projections



Note: Total figures for the period between 1950 and 2010 include persons of unknown age; persons of unknown age have been excluded from the denominator for calculating the aging rate.

Materials: Until 2010, National Census (Ministry of Public Management, Home Affairs, Posts and Telecommunications/ Ministry of Internal Affairs and Communications); for 2012, Population Estimates (as of October 1, 2012) (Ministry of Internal Affairs and Communications); for 2015 and beyond, estimates based on medium-range birth and medium-range death assumptions as outlined in Population Projection for Japan (estimates as of January 2012) (National Institute of Population and Social Security Research).

Source: 2013 White Paper on Elderly Society (Cabinet).

In this way, the government of Japan has been changing at a dizzying pace since the 1990s, such that there have been 15 prime ministers in the twenty-five-year period between 1990 and 2014¹. Such a frequent change in the government causes the political situation to suffer from instability and also affects the establishment and implementation of social security policies.

Local administrative organs consist of prefectures (47 nationwide) and municipalities (1,550 nationwide). The heads of these organs and the members of their legislative assemblies are also selected by direct vote on the part of citizens. Cities with especially large populations constitute designated cities as designated by government ordinance (20 nationwide) or core cities. In the area of social welfare, these cities possess virtually the same authority as prefectures do. Since the 1990s, the administrative authority and subsidies of the state have been flowing to local governments according to the philosophy of local decentralization.

On the economic front, Japan is the world's third largest economy after the United States and China in terms of gross domestic product (GDP).

After the end of the Second World War, a period of rapid economic growth that continued from the middle of the 1950s to the first half of the 1970s enabled Japan's economy to undergo dramatic growth. The Japanese economy was based on processing trade whereby petroleum, iron ore, and other resources were imported from other countries and products were manufactured in Japan and then exported overseas. The primary industrial goods for export initially consisted of textiles but before long came to consist of steel, automobiles, electric appliances, and other products manufactured by the heavy and chemical industries. Many world-famous companies were established during this period. At the end of the 1960s, Japan's gross national product (GNP) surpassed that of West Germany. Japan thereby became world's third largest economy in terms of GNP, after the United States and the Soviet Union. It was from around this time that Japan was acknowledged as a great economic power. In the 1980s, the Japanese economy was heating up to such an extent that the economic climate was described in terms of the existence of a bubble economy.

However, a slow-growth economy has persisted over a period of twenty years since the 1990s—known as the “lost decades”—thanks to a number of factors, including loans issued by financial institutions that turned bad due to the popping of the bubble economy, changes in manufacturing due to the evolution of IT technology in the United States, and a decline in the competitiveness of Japanese companies brought about by the growth of economies in China, South Korea, and other Asian countries. The country came to rely more on international proceeds to offset reductions in tax revenues caused by the slump in the economy, as a result of which proceeds from selling government bonds came to account for about half of all annual

government revenue and long-term debt amounting to approximately double the GDP of Japan came to be assumed, thereby worsening the state of public finances.

Changes in postwar social security schemes

Japan's defeat in the Second World War led to the installment of an occupation force by the Allies in Japan until 1952 (twenty-seventh year of the Showa era). By authority of the mandated directives issued by the General Headquarters of the Allied Powers (GHQ; headed by Supreme Commander MacArthur of the United States), the prewar militarism of Japan was dismantled and various reforms were instituted with the aim of building a democratic country. These reforms included the enactment of a new constitution (Constitution of Japan), farmland reforms, education reforms, the dismantling of corporate conglomerates, and the implementation of general elections for which women were extended the franchise. GHQ directives also encompassed the overall system of social security.

The Constitution of Japan, advisories issued by the Advisory Council on Social Security, and political elements seeking to build a welfare state can be described as having influenced the direction taken by Japan in constructing social security schemes in the postwar years. Replacing the Constitution of the Empire of Japan (which was enacted during the Meiji era), the newly enacted Constitution of Japan clarified, in Article 25, the obligations of the state in connection with the securing of the right to life of citizens and with the development of social security schemes. The first paragraph of Article 25 reads: "All people shall have the right to maintain the minimum standards of wholesome and cultured living." The second paragraph of the same article reads: "In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health." The provisions of Article 25 of the Constitution of Japan generally constitute the source of law for statutes relating to social security schemes that are enacted in Japan.

The Advisory Council on Social Security was established as an advisory council tasked with reporting on matters relating to social security schemes to the Prime Minister. In 1950 (twenty-fifth year of the Showa era), it submitted its Recommendations on Social Security Schemes and thereby proposed directions applicable to the construction of social security schemes in postwar Japan and specific proposals for schemes to be established. These Recommendations were influenced by the Beveridge report, which was authored in the United Kingdom. For example, the concept of national insurance plans for enrollment by all citizens to enable the implementation of unemployment measures and the provision of an income guarantee was put forth.

There was also political regret over the prioritization that was given to the military during the prewar years, such that the construction of a *welfare state* became a central theme of politics for both the governing and opposition parties. While funds that could be allocated to reinforcing social security schemes were limited due to the severe fiscal conditions of the postwar era, such efforts were openly declared as matters of top priority in political slogans.

Table 6-1 outlines the history of changes in social security schemes in Japan from the end of the Second World War to the present day. Let us examine this history in accordance with its division into five periods as follows. (1) Postwar emergency relief and the development of a foundation (from 1945 to around 1955)

The period from the end of the Second World War to around 1955 (thirtieth year of the Showa era) was one in which emergency relief was provided to many needy persons in a society devastated by war, war orphans, homeless children, and persons left disabled by war and in which work to develop a foundation for social security schemes proceeded. The Three Welfare Laws were enacted at this time: the Public Assistance Act (enacted in 1946; revised based on provisions of Article 25 of the Constitution of Japan in 1950), Child Welfare Act (enacted in 1947), and Disabled Persons Welfare Act (enacted in 1949). Furthermore, the Social Welfare Service Act, which formed the foundation of the development of social-welfare enterprises in the postwar years by way of defining the term “social-welfare enterprise” and prescribing the system of social-welfare juridical persons, was enacted (in 1951).

With respect to the development of a foundation, a system concerning public health centers and welfare offices as administrative organs in charge of the administration of public health and the administration of social welfare was put in place. The development of a foundation for local governments also proceeded with the enactment of the Local Autonomy Act and the creation of the Ministry of Home Affairs (1950; presently merged with the Ministry of Internal Affairs and Communications).

(2) Development of universal health insurance and pension plans and social security schemes (from around 1955 to the Oil Shock)

Triggered by the special procurement effect of the Korean War, an economic boom began in around 1955 (thirtieth year of the Showa era) and marked the start of a full-blown process of economic growth for Japan. From this point in time until the Oil Shock hit in 1973 (forty-eighth year of the Showa era), a period of rapid economic growth continued for a longer period of time than had ever before been seen in the world. The government, companies, and people were working to “catch up to and surpass” the advanced countries of the West. Various milestone events occurred during this period, including the Tokyo Olympics (1964), the opening of the Tokaido Shinkansen bullet train line (1964), the world’s fair held in Osaka (1970), and the Sapporo

Table 6-1. Changes in Japan's social-security plans (since 1945)

Period	Main changes in social-security plans
<p>○ Postwar emergency relief and the development of a foundation (from 1945 to around 1954)</p>	<p>1946: (Old) Public Assistance Act enacted, Constitution of Japan promulgated; 1947: Health Center Act enacted, Child Welfare Act enacted; 1948: Medical Service Act, Medical Practitioners' Act, and Act on Public Health Nurses, Midwives and Nurses enacted; 1949: Disabled Persons Welfare Act enacted; 1950: (New) Public Assistance Act enacted (framework of Three Welfare Laws), Mental Health Act enacted, recommendations submitted by the Advisory Council on Social Security; 1951: Social Welfare Service Act enacted; 1952: Act on Relief of War Victims and Survivors enacted.</p>
<p>○ Development of universal insurance and pension plans and social-security plans (from around 1955 to the Oil Shock)</p>	<p>1957: Universal health insurance plan; 1958: National Health Insurance Act amended (universal health insurance); 1959: National Pension Act enacted (universal pension); 1960: Welfare Act for Mentally Retarded Persons enacted; 1961: Universal health insurance and universal pension plans implemented, Child Support Allowance Act enacted; 1962: Recommendations submitted by the Advisory Council on Social Security; 1963: Act on Social Welfare for the Elderly enacted; 1964: Mother and Child Welfare Act enacted (framework of Six Welfare Laws); 1970: Basic Act on Countermeasures Concerning Mentally and Physically Handicapped Persons enacted, five-year plan for the emergency development of social welfare facilities; 1971: Child Allowance Act enacted; 1973: Act on Social Welfare for the Elderly amended (making medical costs incurred by elderly persons free of charge), Health Insurance Act amended (including 70 percent benefits for family members), pension plan revised (including raising of benefit levels and introduction of cost-of-living indexing) ("First Year of Welfare in Japan").</p>
<p>○ Period during which social-security plans were re-examined (from the second half of the 1970s to the 1980s)</p>	<p>1981: Mother and Child and Widows Welfare Act (amendment of the Mother and Child Welfare Act); 1982: Act on Health and Medical Services for the Aged (including adoption of co-payment system, health contribution plan for the aged); 1984: Health Insurance Act amended (including 90 percent benefits for insured person, medical-care plan for retired persons); 1985: Pension plan revised (including adoption of a basic pension), Medical Service Act amended (including adoption of local medical service plans); 1986: Act on Temporary Special Provisions for State Subsidies, etc., enacted (review of the division of the assumption of costs between the state and local governments); 1987: Certified Social Workers and Certified Care Workers Act enacted, Mental Health Act enacted (amendment of the Mental Health Act), Act on Health and Medical Services for the Aged amended (including health-care facilities for the aged); 1989: 10-year strategy for promoting the health and welfare of elderly persons (Gold Plan) formulated.</p>
<p>○ Period for Establishment to deal with an aged society with a low birthrate (from the 1990s to 2000)</p>	<p>1990: Eight welfare acts, including the Act on Social Welfare for the Elderly, amended (including municipality-centered welfare services); 1991: Act on Health and Medical Services for the Aged amended (including plan for providing elderly persons with visiting nurses); 1993: Basic Act for Persons With Disabilities enacted (amendment of the Basic Act on Countermeasures Concerning Mentally and Physically Handicapped Persons); 1994: Angel Plan formulated, new Gold Plan formulated, pension system revised (including raising the age at which payments corresponding to the fixed portion of an employee pension commence); 1995: Recommendations submitted by the Advisory Council on Social Security, a plan for disabled persons formulated, Basic Law on Measures for an Aged Society enacted, Mental Health Welfare Act enacted (amendment of the Mental Health Act); 1997: Child Welfare Act amended (including revisions to the system of admissions to a child-care center), Health Insurance Act amended (80 percent benefits for the insured person), Long-Term Care Insurance Act enacted, Act to Promote Specified Non-profit Activities enacted, Psychiatric Social Workers Act enacted; 1999: Act for the Welfare of Persons with Intellectual Disabilities enacted (amendment of the Welfare Act for Mentally Retarded Persons), Gold Plan 21 formulated, new Angel Plan formulated; 2000: Nursing-care insurance plan put into force, pension system revised (including re-examination of benefits and assumption of costs), Social Welfare Act enacted (amendment of the Social Welfare Service Act), Child Abuse Prevention Act enacted.</p>
<p>○ Structural reforms and social-security reforms (from 2001 to the present day)</p>	<p>2001: Defined Contribution Pension Act enacted; 2002: Health Insurance Act amended (including 70 percent benefits for the insured person and amendment of the system for health and medical services for the aged); 2003: Basic Act on Measures for Society with a Decreasing Birthrate enacted; 2004: Pension system revised (including a re-examination of benefits and the assumption of costs); 2005: Long-Term Care Insurance Act amended, Services and Support for Persons with Disabilities Act enacted; 2006: Medical system revised, Child Allowance Act amended (benefits provided for children up to sixth year of primary school); 2008: Medical-care plan for later-stage elderly persons put into effect; 2010: Children's allowance implemented; 2011: Basic Act for Persons With Disabilities amended, Long-Term Care Insurance Act amended; 2012: Act for the Provision of Comprehensive Support to Persons with Disabilities enacted, pension system revised (consolidation of employee pension plans), 3 laws for the provision of support for children and child care passed; 2013: Act on a Program for Reforming Social Security enacted.</p>

Produced by the authors.

Winter Olympics (1972). The latter half of the 1960s saw Japan overtake the United Kingdom, Germany, and others in terms of gross national product (GNP) and become the third-largest economic power in the world after the United States and the Soviet Union. Politically speaking, the LDP consistently formed majority governments in the Diet and a stable form of government rule as led by the prime minister and cabinet members selected by the LDP under the “1955 system” was applied throughout this period.

Just as we have seen happen in the developed countries of the West, Japan aspired, in line with economic growth, to become a welfare state for which ensuring enhancements in welfare for the people was a prime objective and thereby endeavored to develop various types of legal systems towards this end. Amendments made to the National Health Insurance Act and the enactment of the National Pension Act in the decade beginning in around 1955 led to the implementation of universal health insurance and pension plans, which allowed each citizen to be enrolled in some sort of public medical insurance plan and public pension scheme, from fiscal year 1961 (thirty-sixth year of the Showa era). Universal health insurance and pension schemes subsequently came to form the core of Japan’s social security system.

This was also a time when enhancements to social security schemes and the amelioration of benefits were actively undertaken thanks to the support provided by increased tax revenues made possible by economic growth. In the area of social welfare, a framework known as the Six Welfare Laws was established through the enactment of the Act on Social Welfare for the Elderly and the development otherwise of key legal systems relating to welfare. Benefits were improved, such as by raising the standards for livelihood assistance provided through livelihood protection schemes, raising pension benefit levels in pension schemes, and raising benefit rates within medical insurance schemes. In fiscal year 1973 (forty-eighth year of the Showa era), the creation of a scheme for paying medical costs incurred by elderly persons effectively exempted elderly persons from paying any portion of such medical costs on an out-of-pocket basis. However, this policy caused a dramatic increase in medical costs incurred for elderly persons and was reviewed in the period discussed below.

(3) Period during which social security schemes were reviewed (from the second half of the 1970s to the 1980s)

The oil crisis that struck in the fall of 1973 (forty-eighth year of the Showa era) drove up the price of petroleum. The economy of Japan, which relied on oil, was affected by a state of severe inflation and stagnation. The period of rapid economic growth in the country came to a halt as the country entered an era of steady growth. With the state of national finances worsening due to a drop in tax revenues and other such factors, administrative and financial reforms at the state level became a huge political concern. Social security

schemes in other advanced countries were also subject to re-examination during this period in what is referred to as the *welfare-state crisis*.

Representative of the systemic reforms that are associated with this period is the establishment (in 1982) of a healthcare scheme for elderly persons for the purpose of introducing an approach involving the partial assumption of medical costs incurred by elderly persons and ensuring the equitable assumption of medical costs incurred by elderly persons through medical insurance schemes. Medical insurance schemes were also modified with the partial amendment of the Health Insurance Act (in 1984), which introduced the idea of having insured persons assume ten percent of patient costs, which had previously not been charged to the patient. As for pension schemes, schemes that had up until then been separated according to occupation were re-examined and a basic pension scheme applicable to all citizens was introduced (in 1985).

(4) Establishment of schemes to deal with an aged society with a low birthrate (from the 1990s to 2000)

In the 1990s, social security schemes to primarily deal with an aged society with a low birthrate were constructed. The issue of providing care for the elderly in response to the rapid aging of society is a significant matter of societal concern. The government began implementing in 10-year plan for promoting the health and welfare of the elderly (“Gold Plan”) in 1990 (second year of the Heisei era). Under this plan, at-home services and facility services were set to undergo development on a systematic basis during the 10-year period until 1999 (eleventh year of the Heisei era). In around the middle of the 1990s, a nursing-care insurance scheme began to be studied. Accordingly, the Long-Term Care Insurance Act was enacted in 1997 (ninth year of the Heisei era).

As for the issue of a declining birthrate, we see that the second baby boom that occurred in the middle of the 1970s was followed by ongoing downward trends in terms of the rate of childbirth and number of children born. The total fertility rate in 1989 (first year of the Heisei era) reached a historic low, thus giving rise to what was known as the “1.57 Shock,” in response to which the government decided to launch countermeasures. The formulation and introduction of the Angel Plan (1994) and the New Angel Plan (1999) represented attempts to increase the capacity of child-care centers and the scope of infant child care. However, the decline in the birthrate has not yet been halted, such that measures to address this issue remain a pressing matter to this day.

In the field of social welfare, systemic reforms resulting in significant changes to the framework of postwar welfare schemes based on new notions—such as notions concerning the universalization of the idea of normalization; an emphasis on at-home welfare; linkages among health, medicine, and welfare;

the deployment of municipality-centered welfare administration; a user orientation and support for autonomy; and the use of private-sector initiatives—were undertaken.

Illustrative of this process were the amendments made to eight welfare-related statutes, including the Act on Social Welfare for the Elderly, in 1990 (second year of the Heisei era). These amendments led to efforts to introduce municipality-centered welfare administration and establish a systematic foundation of health and welfare for the elderly in local governments. The enactment of the Long-Term Care Insurance Act in 1997 (ninth year of the Heisei era) caused measures and schemes in the area of welfare for the elderly to shift to a mode of usage contracts according to a model of social insurance. Since measures and schemes in the area of social welfare until then had been expected as a matter of course, the introduction of a usage contract approach represented a major occurrence referred to in terms of the shift from “measures to contracts.” As part of the structural reformation of the foundation of social welfare that was carried out primarily through amendments made to the Social Welfare Service Act (renamed the “Social Welfare Act” as a result of these amendments) in 2000 (twelfth year of the Heisei era), new ideas concerning welfare services were set forth, measures and schemes were re-examined in the area of welfare for persons with disabilities, and the system was updated to one based on usage contracts that attached importance to choices made by users.

(5) Structural reforms and social security reforms (from 2001 to the present day)

The Japanese bubble economy that prevailed during the second half of the 1980s popped at the beginning of the 1990s, which led to an ongoing economic slump and persistent deflation. From the 1990s to the present day, the economic growth rate has been mired in stagnation and the unemployment rate has hovered at a relative high level compared to the period of rapid economic growth. Notably in the context of the global economy, competition with the American IT industry and the low-priced manufactured goods coming out of China intensified, companies sought to establish offshore locations to reduce costs and expand markets, and the labor force of non-permanent workers grew in response to efforts to reduce wage costs. As for state finances, a reduction in tax receipts and other factors caused greater reliance on the issuance of large amounts of government bonds to raise government revenue. Huge amounts of long-term debt came to be accrued, thus placing Japan in the worst position among advanced countries of the world by this measure. In this connection, the Koizumi administration, which was formed in 2001 (thirteenth year of the Heisei era), launched numerous systemic reforms according to the slogan of “no growth without structural reforms”, including economic structural reforms, administrative reforms, financial structural reforms, social security reforms, regulatory reforms, and postal reforms.

In the area of social security, the pension system was revised (in 2004), the long-term care insurance (nursing-care insurance) system was revised (in 2005), and the medical-care system was revised (in 2006) in the interests of ensuring the sustainability of social security schemes into the future. In the area of welfare for persons with disabilities, welfare services that had previously been provided separately to persons with physical, intellectual, and mental disabilities were consolidated and the Services and Supports for Persons with Disabilities Act was enacted in 2005 (seventeenth year of the Heisei era). At the same time, the careless manner in which pension records were handled by the Social Insurance Agency became an issue and the pension records fiasco became a significant point of political controversy. As non-permanent workers increased in number and disparities in income grew, the need to reinforce the functions of social security came to be identified.

The general election of 2009 (twenty-first year of the Heisei era) resulted in a change of government that saw the LDP-led government of the time replaced by one led by the DPJ. The DPJ government replaced the old child allowance with a new child allowance. A significant political issue arose in efforts to carry out the “integrated reformation of social security and taxes”, which involved the simultaneous implementation of social security reforms in response to the aging of society and the declining birthrate, changes in employment patterns, and other changes in socioeconomic conditions as well as taxation reforms designed to secure stable fiscal funding for social security and promote fiscal soundness. Specifically, fiscal funding for social security schemes would be secured and functions would be reinforced by increasing the consumption tax from 5 percent to 10 percent with the increased portion of tax receipts being allocated to four areas: pensions, healthcare, nursing care, and the declining birthrate. In August 2012 (twenty-fourth year of the Heisei era), bills tied to the integrated reformation of social security and taxes—including a bill to raise the consumption tax, a bill relating to children and the process of raising children, and a bill relating to revisions to the pension system—were enacted.

The general election of 2012 (twenty-fourth year of the Heisei era) once again resulted in a change in government by which the coalition government of the LDP and Komeito Party was restored to power. For the time being, social security schemes are slated to be revised according to the Act on a Program for Reforming Social Security.

Characteristics of social security schemes in Japan

Figure 6-2 outlines the changes in the costs of social security benefits in Japan (amounts paid to citizens through social security schemes in a year; child-care services, medical services, and other forms of services have also been converted into monetary amounts). In fiscal year 2011 (twenty-third year

of the Heisei era), the costs of social security benefits reached a total of 107.5 trillion JPY, surpassing the general accounting budget for the state. On a per capita basis, this amounts to 840,000 JPY per year. In breaking this figure down by field, we see that pensions accounted for 49.4 percent of the total amount while medical care accounted for 31.7 percent and welfare and other items (including nursing care) accounted for 18.9 percent. Spending on social security as a percentage of the national income has been rising in recent years. Whereas spending on social security was equal to 17 percent of the national income thirty years ago in 1985 (sixtieth year of the Showa era), this figure rose by 14 percentage points to 31 percent in fiscal year 2011.

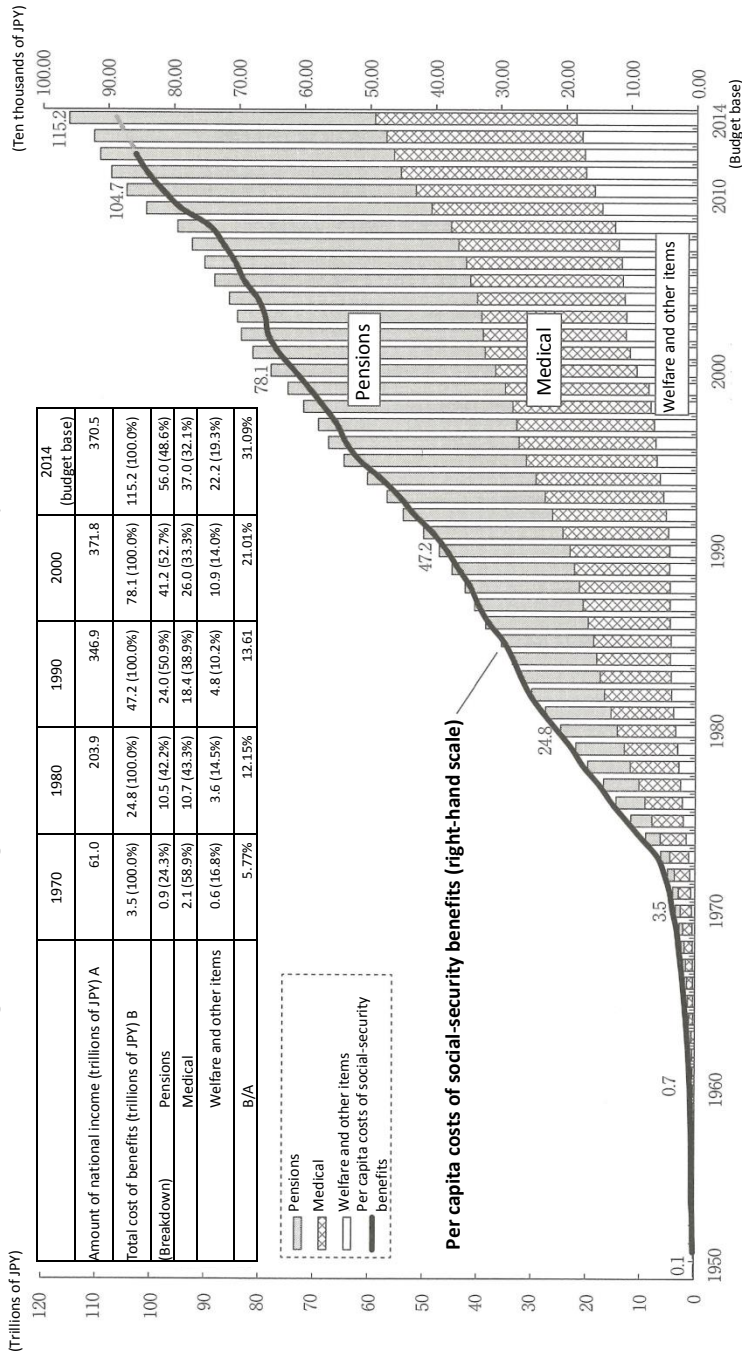
Characteristics of social security schemes in Japan can be described as follows with reference made to the situation behind the costs of social security benefits.

First, universal health insurance and universal pensions are the foundational elements of such schemes.

As of 1960, medical security was extended to over 90 percent of the population. The countries where universal pensions were offered consisted of only four countries worldwide: the United Kingdom, Sweden, Norway, and Iceland. The fact that Japan became just the fifth country in the world to provide medical insurance to all of its citizens and universal health insurance and pension plans to enable the provision of income security to the elderly at a time when economic levels at the beginning of Japan's period of rapid economic growth were still low was truly monumental. Subsequently, these universal health insurance and pension plans formed the essential backbone of the country's social security schemes.

Second, social security schemes in Japan are primarily centered on social insurance. In Japan, there are five different types of social security schemes: pension insurance, medical insurance, long-term care insurance (which is what nursing-care insurance is known as in Japan), employment insurance, and workers' accident compensation insurance. This number is the highest among advanced countries and puts Japan on par with Germany and South Korea in this respect. Benefits provided under social-insurance schemes account for about 90 percent of the costs of social security benefits. At least half of this amount comprises benefits from pension insurance plans. An outline of these five types of social-insurance schemes is provided in Table 6-2. As indicated later, these schemes are characterized, for medical insurance, by the fact that medical insurance is divided into numerous different types of schemes and the fact there are scores of insurers in this field, and, for medical insurance and long-term care insurance, by the fact that administrative organs in the form of municipal governments are the insurers.

Figure 6-2. Changes in the costs of social-security benefits



Note: Figures above constitute the costs of social-security benefits (trillions of JPY) in fiscal years 1950, 1960, 1970, 1980, 1990, 2000, 2010, and 2014 (budget base).
 Materials: *2011 The Cost of Social Security in Japan*, National Institute of Population and Social Security Research; for fiscal years 2012, 2013, and 2014 (budget base), statistical data provided by the Ministry of Health, Labour and Welfare; for the national income amount for fiscal year 2014, *2014 Economic Forecasts and Basic Stance for Economic and Fiscal Management* (Cabinet decision of January 24, 2014).
 Source: Materials provided by the Ministry of Health, Labour and Welfare.

Table 6-2. Outline of social-insurance plans

	Pension insurance	Medical insurance	Long-term care (nursing-care) insurance	Employment insurance	Workers' accident compensation insurance
Insurer	State or mutual benefit association	Japan Health Insurance Association, health insurance society, mutual benefit association, municipality, or others	Municipality	State	State
Insured person	Employee or person between 20 years of age and under 60 years of age	Employee, person with a home in the municipality, or others	Person 40 years of age or older	Worker belonging to a business subject to employment insurance (excluding government employees)	Employer operating in an applicable business
Key types of insurance benefits	Cash benefits	Benefits in kind, cash benefits	Benefits in kind	Cash benefits	Cash benefits and benefits in kind
Examples of plans	National pension, employees' pension insurance, mutual aid pension	Health insurance under the jurisdiction of a relevant society or association or the Japan Health Insurance Association, mutual benefit association, national health insurance, and others	Long-term care insurance	Employment insurance	Workers' accident compensation insurance, disaster compensation for state government employees, and others

Produced by the authors.

Third, social security schemes in Japan are primarily centered on the provision of benefits for the elderly. The costs of benefits relating to elderly persons amount to 72 trillion JPY, which accounts for 70 percent of the total cost of social security benefits. In line with the rising rate of aging in Japan, the costs of pensions, medical care for the elderly, nursing care for the elderly, and benefits relating to elderly persons are rising year after year. In contrast, the costs of benefits relating to children and families stand at approximately 6 trillion JPY (6 percent), a pittance compared to the costs of benefits relating to elderly persons in the country.

2. Current state of social welfare

Japan's social-welfare schemes have been set up and expanded for different targeted persons. A livelihood protection scheme is operated for needy persons; a children's welfare scheme is operated for infants and children; a welfare scheme for persons with disabilities is operated for persons with disabilities; a welfare scheme for mothers, children, and widows is operated for mothers, children, and widows; and an old age welfare scheme is operated for elderly persons. The statutes forming the basis for each of these schemes consist of the Public Assistance Act, Child Welfare Act, Disabled Persons Welfare Act, Act for the Welfare of Persons with Intellectual Disabilities, Mother and Child and Widows Welfare Act, and Act on Social Welfare for the Elderly. These statutes have been collectively referred to as the "Six Welfare Laws."

Since the 1990s, the enactment of the Long-Term Care Insurance Act, the enactment of the Services and Support for Persons with Disabilities Act, and other events have brought about changes whereby a long-term care insurance scheme has come to play a key role in the area of welfare for elderly persons and a scheme providing support for the independence of persons with disabilities has come to play a key role in the area of welfare for persons with disabilities. In 2012, the Services and Support for Persons with Disabilities Act was amended and renamed the Comprehensive Support for Persons with Disabilities Act.

The following table provides an overall outline of Japan’s social-welfare schemes:

Covered persons	Names of key statutes
Low-income persons, needy persons	Public Assistance Act, Act on Services and Support for the Independence of the Needy
Children, disabled children	Child Welfare Act, Child Allowance Act, Child Abuse Prevention Act
Disabled persons	Act for the Provision of Comprehensive Support to Persons with Disabilities, Act for the Welfare of Persons with Physical Disabilities, Act for the Welfare of Persons with Intellectual Disabilities, Disabled Abuse Prevention Act, Employment Promotion Act for Persons with Disabilities
Elderly persons	Long-Term Care Insurance Act, Act on Social Welfare for the Elderly, Elderly Abuse and Welfare Act

Note: The names of some statutes may be indicated here in their abbreviated form.

The Ministry of Health, Labour and Welfare operates as the administrative organ in connection with social welfare. Bureaus in charge of relevant matters have been set up in prefectures and municipalities. Welfare offices and child-consultation centers have been set up in prefectures and ordinance-designated cities and welfare offices have been set up in cities as specialized agencies for the administration of welfare.

Livelihood protection

Livelihood protection schemes guarantee a minimum level of living for needy citizens and are intended to promote the independence of such people. They are schemes designed to translate the philosophy of guaranteeing the right to life as prescribed in Article 25 of the Constitution of Japan into concrete actions. In protecting livelihoods, other laws and schemes take priority according to the principle of complementarity, such that livelihood protection only comes into play when relief cannot be found in any other laws or schemes. For this reason, it is referred to as the “safety net of last resort.”

Livelihood protection consists of 8 types of assistance: livelihood assistance (food costs, clothing costs, lighting and heating costs, and other costs necessary for daily living), educational assistance (such as the costs of school supplies), housing assistance (such as rent and land rent), medical assistance, nursing-

care assistance, childbirth assistance, occupational assistance (occupational costs, skill-learning costs, job-search support costs), and funeral assistance.

The number of persons receiving livelihood protection is a function of changes in economic conditions. The number of protected persons in the chaotic period of the immediate postwar years was high but trended downwards during the period of rapid economic growth and reached a record low point in 1995 (seventh year of the Heisei era). However, the prolonged period of economic stagnation since the second half of the 1990s caused the number of protected persons to turn around and begin rising. A record high 2.14 million persons received livelihood protection in 2012 (twenty-fourth year of the Heisei era).

The cost of providing livelihood protection in fiscal year 2011 (twenty-third year of the Heisei era) was 3,693 billion JPY, of which 46.9 percent went towards medical assistance costs, 34.5 percent went towards livelihood assistance costs, and 15.4 percent went towards housing assistance costs. This cost was covered with the state assuming three-quarters of this amount and local governments with welfare offices assuming the rest.

These days, focus is being directed towards providing support for the employment and independence of protected persons. In addition, the Act on Services and Support for the Independence of the Needy was enacted (in 2013) in order to reinforce the provision of support for the independence of low-income persons just prior to the stage at which livelihood protection comes into play.

Welfare for children

The area of welfare for children encompasses a wide range of concerns and features, including child-care centers, the sound nurturing of children, a children's allowance, and the handling of child abuse. Child-care centers have been developed to deal with the increase in dual-income households and counter the declining birthrate. As of April 2012 (twenty-fourth year of the Heisei era), there were 23,470 child-care centers in the country. Despite a decline in the number of births yearly due to a drop in the birthrate, an increase in the participation of women in the workplace has bolstered demand for child-care centers. In April at the beginning of each fiscal year, children on waiting lists who are unable to enroll in a child-care center number around 25,000, most of whom live in urban areas. The government is working to expand the capacity of child-care centers under what it calls Operation Zero Waiting Children. While the consolidation (or centralization) of kindergartens and child-care centers was a matter of concern for many years, policies promoting a shift to "certified day-care centers" that function as both child-care centers and kindergartens are being promoted.

The establishment of a children's allowance, which was set up in 1972 (forty-seventh year of the Showa era), was late by comparison to Western countries. For a long time, this allowance was limited to the third child and any subsequent children in a household and the amounts involved were on the low end. The scheme was expanded to include the first two children in each household in 1992 (fourth year of the Heisei era) but was limited to children under the age of 3 years. Since 2000 (twelfth year of the Heisei era), the age of eligibility and the levels of benefits provided have been raised as part of measures designed to counter the decline in the birthrate. The DPJ government that was inaugurated in 2009 (twenty-first year of the Heisei era) established a children's allowance for which the age of eligibility was raised to 15 years (age at which a child finishes junior high school) and benefit levels were significantly increased. This scheme, however, was highly problematic in such terms as fiscal funding. Adjustments made by the ruling and opposition parties resulted in the elimination of this version of the children's allowance and the restoration of the older version of the children's allowance. The current scheme provides coverage to children between 0 and 15 years of age (age at which a child finishes junior high school) and benefits equaling 15,000 yen per month for children under the age of 3 years and 10,000 yen per month for children 3 years of age and older.

With measures to deal with child abuse having become an issue in recent years, the Child Abuse Prevention Act was enacted and put into force in 2000 (twelfth year of the Heisei era). Child-abuse consultations are held and prevention and relief measures have been taken with child consultation centers playing a key role in these actions. Nevertheless, the number of cases of child-abuse consultations is on the rise and serious cases involving the loss of a child's life still occur. Thus, the issue of child abuse is a serious one that should be resolved by society as a whole rather than be addressed only by administrative organs.

Welfare for persons with disabilities

Nationwide, there are approximately 3.94 million children and adults with physical disabilities, 740,000 children and adults with intellectual disabilities, and 3.2 million persons with mental disabilities (estimated figures).² For many years in the area of welfare for persons with disabilities, the needs of persons with physical disabilities (18 years of age or older) were addressed through the Act for the Welfare of Persons with Physical Disabilities, the needs of persons with intellectual disabilities (eighteen years of age or older) were addressed through the Act for the Welfare of Persons with Intellectual Disabilities, the needs of children with disabilities (under eighteen years of age) were addressed through the Child Welfare Act, and the needs of persons with psychological disabilities were addressed through the Act on Mental Health and the Welfare

of Persons with Mental Disabilities. In 2005 (seventeenth year of the Heisei era), measures applicable to persons with any of three types of disabilities (persons with physical, intellectual, and mental disabilities) were consolidated. The Services and Support for Persons with Disabilities Act was enacted that year and put into force in fiscal year 2006 (eighteenth year of the Heisei era) for the purpose of reorganizing these measures into a system of user-focused services, fortifying employment support, and making support decisions transparent and clear.

This law transformed existing welfare measures for persons with disabilities but was criticized by persons associated with groups representing persons with disabilities for imposing costs equal to 10 percent of a fixed rate on users. This statute was re-examined upon the inauguration of a government led by the DPJ, which campaigned on a platform calling for the repeal of this law. Under amendments passed in 2011 (twenty-third year of the Heisei era), the imposition of costs on users according to the ability to pay was codified as a general principle to be followed. In June 2012 (twenty-fourth year of the Heisei era), this statute was amended and renamed the Act for the Comprehensive Provision of Support to Enable Persons with Disabilities to Engage in Daily and Social Living (Act for the Provision of Comprehensive Support to Persons with Disabilities). Under the Act for the Provision of Comprehensive Support to Persons with Disabilities, the scope of eligibility for persons with disabilities was expanded to include not just physical disabilities, intellectual disabilities, and mental disabilities (including developmental disabilities) but also patients with intractable diseases.

The employment of persons with disabilities is an exceptionally important point from the standpoint of providing persons with disabilities with livelihood security, a reason for living, and the opportunity to participate in society. Employment measures for persons with disabilities have consisted of the promotion of employment in companies (general employment), work in facilities and workshops (welfare jobs), and numerous other modes of work according to the physical and mental state of persons with disabilities.

The Act for the Promotion of Employment of Persons with Disabilities (Employment Promotion Act for Persons with Disabilities) was enacted in order to promote the employment of persons with disabilities in private-sector companies. This statute mandates that a certain percentage of the workforce of employers shall comprise persons with physical and intellectual disabilities. These percentages are as follows as of April 2013: 2.0 percent for private-sector companies, 2.3 percent for the public bodies of state and local governments, and 2.2 percent for prefectural boards of education. An employer that fails to meet this statutory rate of employment will be required to pay a disabled employment levy according to the given shortfall in terms of the number of persons with disabilities required to satisfy this condition while an

employer that hires persons with disabilities at a rate higher than the statutory employment rate will be paid a disabled employment adjustment subsidy according to the number of persons with disabilities hired over and above this condition. As of June 2012, the employment rates for persons with disabilities stood as follows: 1.69 percent for private-sector companies, 2.1 percent for public bodies, and 2.0% for prefectural boards of education.

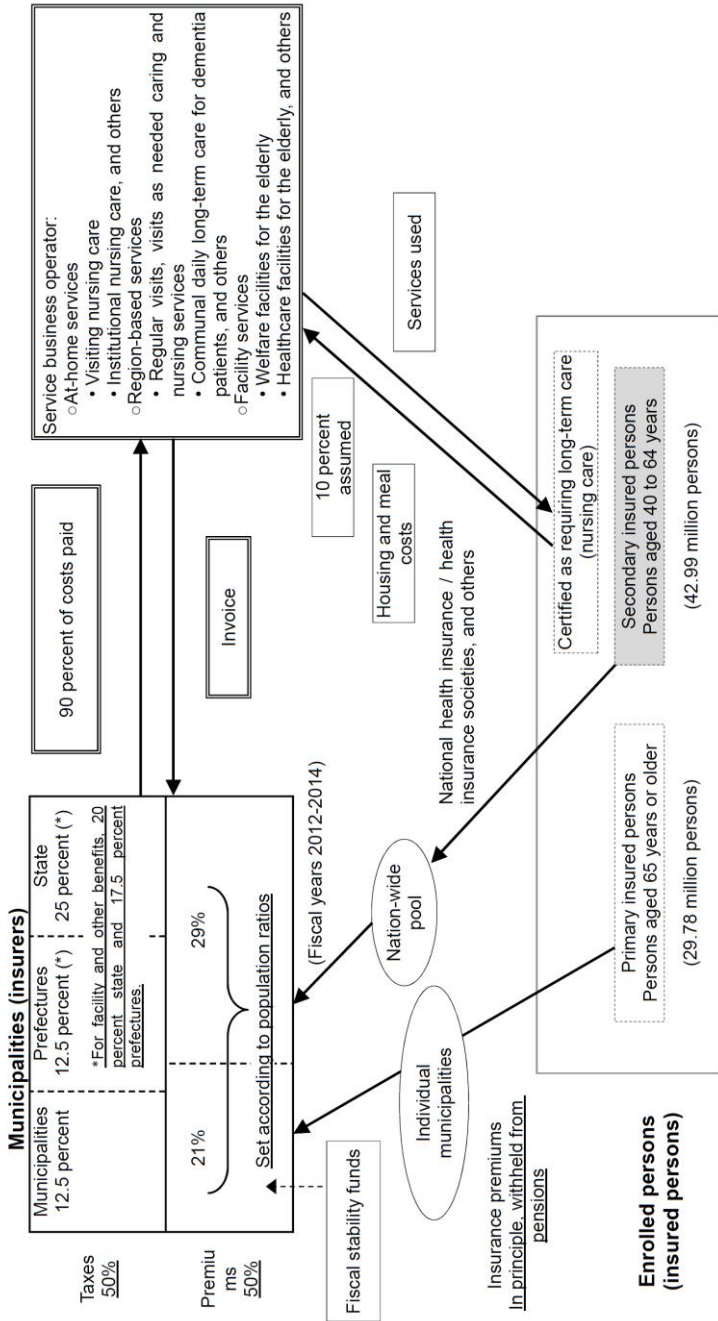
Long-term care insurance (nursing-care insurance)

With respect to the system for providing nursing-care security to elderly persons, it is to be noted that, while at-home services and facility services had been provided through a welfare scheme for elderly persons under the Act on Social Welfare for the Elderly as enacted in 1963 (thirty-eighth year of the Showa era), the Long-Term Care Insurance Act was enacted in 1997 and a long-term care insurance scheme was implemented in April 2000.

Japan's long-term care insurance scheme was studied and created with reference made to the nursing-care insurance scheme in place in Germany. However, there are many points of difference between Japan's scheme and Germany's scheme in terms of the specific contents of both. Germany's nursing-care insurance scheme should be described as one that is based on a "medical insurance-usage model" and was established based on the use of a medical insurance scheme. A medical fund constituting the insurer for the medical-insurance scheme set up a nursing-care fund and has been engaging in insurer operations for the nursing-care insurance scheme. The scope of insured persons covered under the nursing-care insurance scheme is the same as the scope of insured persons covered under the medical insurance scheme.

On the other hand, the long-term care insurance scheme in Japan was established as a separate social insurance scheme from that of the medical insurance scheme (and conforms to an "independent insurance model"). Thus, the scope of insurers and insured persons differs from the scope of insurers and insured persons under the medical insurance scheme. This scheme is based on a "local insurance model" whereby each municipality serves as an insurer and the residents living in the municipality are the insured persons to whom coverage is provided. This scheme also differs in terms of insured persons from the medical insurance scheme that applies universally to all residents of Japan in that persons aged 40 years or older are covered, with persons under the age of 40 years excluded from the scope of the long-term care insurance scheme. Persons aged 65 years or older are treated as primary insured persons and persons aged 40 years to under 65 years are treated as secondary insured persons. Conditions for receiving insurance benefits and the methods by which insurance premiums are assessed and imposed differ between primary and secondary insured persons. A secondary insured person assumes insurance premiums at the same level as that assumed by a primary insured person but insurance benefits are

Figure 6-3. Framework of the long-term care insurance plan



Notes: The number of primary insured persons is derived from the 2011 Annual Report on the State of Long-Term Insurance Businesses and is current as of the end of fiscal year 2011.

The number of secondary insured persons is derived from reports issued by medical insurers to enable the Social Insurance Medical Fee Payment Fund to determine the amount to be paid to cover the costs of long-term care insurance benefits and constitutes a monthly average value for fiscal year 2011.

Source: Materials provided by the Ministry of Health, Labour and Welfare.

limited in the event that nursing care is required owing to an injury or illness attributed to aging (including where support is required; same hereinafter). For this reason, 97 percent of persons requiring nursing care who are entitled to receive long-term care insurance benefits (including persons requiring support; the same shall apply hereinafter) consist of primary insured persons. From the standpoint of insurance benefits, Japan's long-term care insurance scheme constitutes a de-facto nursing-care insurance scheme for elderly persons.

In order to be certified as a person requiring nursing care, the individual needs to be certified as requiring nursing care by a municipality. There are seven nursing care levels in total for a finer approach to classification than has been adopted in Germany (basically 3 levels) and South Korea (initially 3 levels). This number reflects the fact that the scope of the application of this scheme to persons requiring nursing care is broad. Compared to the scheme in Japan, the nursing-care insurance schemes in Germany and South Korea are fundamentally restricted in terms of eligibility to persons with a medium or heavy need for nursing care.

Types of insurance benefits consist of at-home services and facility services as well as region-based services. There are clearly more types of services offered in Japan than are offered as insurance benefits under nursing-care insurance schemes in Germany and South Korea. On the other hand, cash benefits (nursing-care allowance) constitute a key benefit provided through at-home services in Germany but are not available in Japan.

For at-home services, a user of nursing-care services, once certified as a person requiring nursing care, will essentially have a nursing-care service plan (care plan) prepared by a nursing-care support professional (care manager) at an at-home nursing-care support business office before he or she selects a service-providing business office and uses the services in question. The user assumes costs at a fixed rate of 10 percent. For facility services, the user assumes costs at a rate of 10 percent but fully assumes the costs of meals and accommodations. From fiscal year 2015, users who report a minimum level of income will assume 20 percent of applicable costs.

With respect to the fiscal funding of long-term care insurance, public money is allocated to cover 50 percent of the costs of insurance benefits exclusive of the portion of costs assumed by the user on a copayment basis while the remaining 50 percent is covered by insurance premiums. Whereas nursing-care insurance in Germany is funded by insurance premiums alone, the fact that public money covers such a large percentage of the costs of insurance benefits in Japan is a notable feature of this country's long-term care insurance scheme. In principle, the portion paid with public money is divided as follows: the state (national government) pays half while the prefectural government and municipal government pay one-quarter each. The portion covered by insurance

premiums is split evenly between primary insured persons and secondary insured persons.

In fiscal year 2012, there were 30.94 million primary insured persons and 5.61 million persons requiring nursing care in Japan. Certified persons accounted for 17.6 percent of all primary insured persons (certification rate), such that approximately one in six elderly persons is a person requiring nursing care. Of this group of people, 87 percent consists of the so-called “later-stage elderly persons” (persons aged 75 years or older). There are 3.38 million persons receiving at-home services, 330,000 persons receiving region-based services, and 870,000 persons receiving facility services. The amount of long-term care insurance benefits provided totals 8,100 billion JPY, the cost of benefits per primary insured person equals 263,000 JPY per year, and the insurance premiums for a primary insured person equal a national average 4,930 JPY per month.

3. Current state of medical insurance

As indicated earlier, a universal health insurance system obligating all citizens to enroll in a medical insurance plan has been adopted in Japan.

While medical insurance is divided into many schemes in part due to a history that saw different schemes established for different occupations, it can be broadly divided into occupational insurance (employee insurance) and regional insurance. Occupational insurance includes health insurance for general employees (salaried white-collar workers) and mutual aid associations and seamen’s insurance for government employees, mariners, and other specific employees. Health insurance comprises insurance administered by the Japan Health Insurance Association primarily for salaried white-collar workers belonging to small and medium-sized companies and union-administered health insurance established by companies for salaried white-collar workers belonging to large companies.

Regional insurance includes national health insurance in which the residents of each municipality are enrolled. Municipalities are insurers under the national health insurance scheme. Insured persons comprise self-employed persons, farmers, part-time workers, unemployed persons, and all other residents not covered under occupational insurance. The national health insurance scheme is the foundation that underpins the universal health insurance system. Regional insurance schemes like the national health insurance scheme for which municipalities serve as insurers are uniquely Japanese schemes found in no other advanced country in the world.

Table 6-3. Outline of Japan's public medical insurance plans

Name of plan	Insurers (number)	Coverage	Number of enrolled persons (x 10,000 persons)	Contents of insurance benefits	Insurance premium rate	State subsidy
Kyokai Kenpo	Japan Health Insurance Association (1)	Employees of private-sector companies (mainly small and medium-sized companies) and family	3,488	oMedical benefits Assumed by patient: 30 percent for persons prior to commencing compulsory education or between 70 and under 75 years of age A high medical expenses system is in place to cap copayment requirements imposed on patients.	National average: 10.0 percent	16.4 percent of benefit costs
Association-provided health insurance	Health insurance unions (1,443)	Employees of private-sector companies (mainly large companies) and family members	2,950		Differs according to insurance union	Fixed amount (budget subsidy)
Mutual aid	Mutual aid associations and others (85)	Government employees and family members	919		Differs according to mutual aid association	None
National health insurance	Municipalities (1,717) National health insurance societies (164)	Self-employed persons, farm employees, part-time workers, unemployed persons, and others Professional groups	3,520 312	oCash benefits Including injury or illness allowance, lump-sum birth allowance, and funeral expenses (differs according to plan and insurer).	Differs according to insurer	41 percent of benefit costs (in addition, 9% from prefecture) 47 percent of benefit costs
Medical plan for later-stage elderly persons	Wide-area unions for the medical-care system for later-stage elderly persons (47)	Persons aged 75 years or older	1,473	oMedical benefits Assumed by patient: 10 percent (30 percent for persons whose income is on par with those of currently working individuals). A high medical expenses system is in place to cap copayment requirements imposed on patients. oCash benefits Funeral expenses and more	Differs according to wide-area union	Premiums: approximately 10 percent Support funds: approximately 40 percent Public funds: approximately 50 percent (Breakdown of public funds in terms of ratio: state:prefecture:municipality = 4:1:4)

Note: Data consist of figures current as of the end of March 2012.

Source: Produced by the authors based on the 2013 *White Paper on Health, Labour and Welfare* (Ministry of Health, Labour and Welfare).

Medical care provided through a medical insurance scheme consists primarily of benefits in kind whereby medical care can be received simply by fulfilling a copayment requirement. In addition, fixed amounts of cash benefits, such as an injury or illness allowance or lump-sum birth allowance provided as compensation for an absence from work owing to an injury or illness or to childbirth, are also available. Presently, both persons insured under a medical insurance scheme and the dependents thereof assume 30 percent of incurred costs (20 percent for dependents prior to the commencement of compulsory education and 20 percent for insured persons and dependents between the ages of 70 years and under 75 years (30 percent for currently working income earners)). However, a high medical expenses system is in place to cap copayment requirements according to income.

The characteristics of medical insurance in Japan include the following: 1) universal health insurance scheme, 2) medical insurance schemes are classified according to occupation and other variables, and 3) the fundamental principle of “free access”, such that an insured person can, in principle, exercise choice in seeing a doctor at any medical institution in the country as long as a health insurance card is presented. This last point is a significant point of differentiation between the system in place in Japan and the systems in place in the United Kingdom and northern Europe. For example, an individual who has fallen ill in the United Kingdom is unable to go directly to a hospital to see a doctor within the framework established by the National Health Service (NHS). The person must first see a local registered doctor (general practitioner) and obtain this doctor’s permission before he or she can go to a hospital. In contrast, the system of seeing a doctor in Japan is very much one that is focused on the insured person (or patient). On the one hand, this system is advantageous for making it easy to see a doctor at a medical institution and for respecting the wishes of the insured person. On the other hand, such a system is problematic in that it leads to a rise in insurance benefit costs.

In addition to the above characteristics, medical insurance in Japan is characterized by 4) the fact that medical care for the elderly is provided through a different medical insurance scheme. As medical costs for the elderly have increased to impose a large burden on the finances of the national health insurance system due to the progression of the aging of society and the increasing size of the population of elderly people in Japan, an approach to segregate the elderly from the generations still working and deal with their issues through a separate scheme was taken. The first such scheme was the old-age healthcare scheme under the Act on Health and Medical Services for the Aged that was implemented in January 1983. In reforming the medical system in 2006, the Act on Health and Medical Services for the Aged was amended and renamed the Act Concerning the Security of Healthcare Treatment for Senior Citizens (Senior Citizens’ Healthcare Security Act). Under this statute,

a medical scheme for later-stage elderly persons aged 75 years or older was established. With insurers consisting of prefectural wide-area unions for the medical-care system for later-stage elderly persons, insured persons are all elderly persons aged 75 years or older within each prefecture. With the patient assuming 10 percent of costs (30 percent where income is on par with those of currently working individuals), insurance benefits are paid for as follows: approximately 50 percent from public funds (2/3 by the state and 1/6 by each of the prefectural and municipal governments), approximately 10 percent from the insurance premiums paid by elderly persons, and approximately 40 percent from a support fund for later-stage elderly persons to which contributions are made by the generations still working through medical insurance schemes.

At the same time, an examination of Japan's system for providing medical care reveals that there were 177,769 medical facilities and 1,695,210 hospital beds nationwide as of October 1, 2013. Among medical facilities, hospitals (where a "hospital" is a medical facility with hospitalization facilities capable of accommodating 20 or more patients) numbered 8,540. Internationally speaking, Japan boasts exceptionally high levels in terms of number of hospitals and number of hospital beds per 100,000 people. Private-sector medical corporations account for a high proportion—two-thirds—of all hospital establishers. While public medical insurance guarantees medical costs, the fact that the private sector plays such a leading role in the system of providing medical care in this country is a salient feature of healthcare in Japan.

As the high numbers of hospital beds also leads to an increase in national healthcare costs, regional medical plans are being formulated at a prefectural level in an effort to regulate the total number of hospital beds. The coordination of efforts to resolve disparities among medical zones in each prefecture and promote functional differentiation on the part of medical institutions has become a challenge.

4. Current state of pension security

Figure 6-4 presents an outline of Japan's pension system.

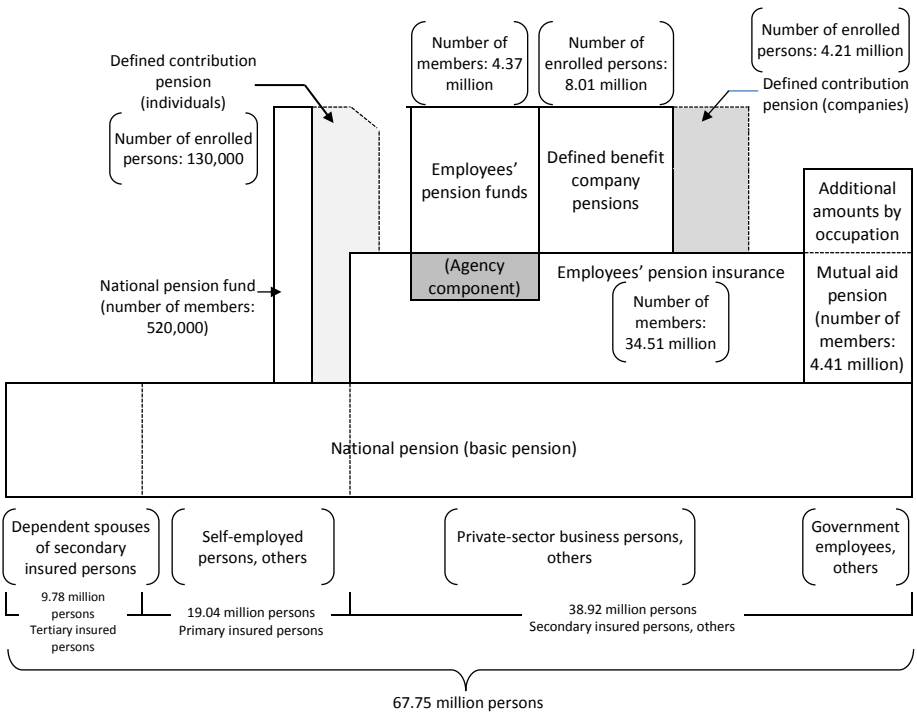
The characteristics of Japan's pension system are as follows.

First, a universal pension scheme has been in place since 1961 (thirty-sixth year of the Showa era) under which all citizens, including self-employed and unemployed persons, are enrolled in a public pension scheme.

Second, the pension system corresponds to a social-insurance system whereby enrolled persons contribute insurance premiums and receive pension benefits accordingly. Note, however, that persons who were already elderly and persons whose period of enrollment as insured persons was forced to be shortened upon the introduction of the national pension scheme in 1961 were handled through an old-age welfare pension funded by taxes.

Third, while pension finances were based on a reserve financing system at the time of the introduction of this scheme, this scheme is presently operated based on a pay-as-you-go system (as is the case in Western countries), whereby costs incurred for pension benefits are covered by the insurance premiums currently paid by enrolled persons. The government has coined the term “intergenerational support” to describe the provision of support to the generation of elderly persons by the generations of currently working people by way of the assumption of insurance premiums.

Figure 6-4. Outline of Japan’s pension plans (current as of the end of March 2012)



Source: p. 236, 2013 White Paper on Health, Welfare and Labour.

Fourth, the pension system conforms to a framework corresponding to a two-tiered structure consisting of a pension proportional to compensation received (tied to income) for employees atop a basic pension universally applicable to all insured persons.

Japan’s pension system used to be divided into the following: an employees’ pension for private-sector workers, mutual aid pension for government employees, and national pension for self-employed persons, farmers, and others. However, as the fiscal basis of such a setup of schemes came to be

unsound for some schemes, a statutory amendment carried out in 1985 (sixtieth year of the Showa era) with the aim of ensuring long-term soundness and fairness among insured persons caused this system to be reconfigured into a system consisting of the following: a national pension in which all citizens (persons between the ages of 20 and under 60 years) are enrolled and that provides basic benefits (basic pension) as well as an employees' pension or mutual aid pension for employees to whom an additional pension is provided commensurate with compensation received. The introduction of a basic pension resulted in the establishment of the "one person, one pension" general rule, thereby vesting even employees' unemployed wives (in other words, homemakers)—who had previously enrolled in pension plans on an optional basis—with the right to obtain their own pensions.

Discussions on consolidating the pension system continued. In October 2015, the employees' pension scheme and mutual aid pension scheme were merged into a single pension scheme for employees.

Fifth, pension finances have incorporated an enormous amount of state liabilities. One-half of the basic pension is based on state liabilities in part to mitigate the burden placed on premiums corresponding to the basic pension.

If we look at matters from the perspective of benefits from pension insurance schemes³, we see that the following exists for national pension plans: a basic old-age pension (for a full pension, 778,500 JPY per year), basic disability pension (for a class 1 disability, 973,100 JPY per year; for a class 2 disability, 778,500 JPY per year), and basic survivors' pension. The following exists for employees' pension plans: an old-age employee's pension (for a businessperson who had been enrolled for 40 years with an average salary, approximately 230,000 JPY a month for basic pensions for both himself and his wife), employee's pension for a disability or disability allowance, and employee's pension for survivors. In this way, while the primary purpose of pensions is to provide livelihood security for elderly persons in their post-retirement years, they also play a huge role in providing livelihood security in the event that the individual becomes disabled or livelihood security through a pension for survivors in the event that the primary breadwinner in a family dies first.

5. Issues concerning the future of the social security system

After the end of the Second World War, Japan sought to deal with the advanced countries of Europe and the United States by taking a "catch up and overtake" approach. In assessing its own social security schemes, it was these advanced countries of the West with which Japan consistently made comparisons. At the time a scheme for providing a children's allowance was set up in 1972, it was said that a social security scheme on par with those found

in Western Europe had been established. However, actual pension levels at this time were low as pension schemes had not yet reached their periods of maturation. Areas of welfare for children, welfare for the elderly, and welfare for the disabled were rife with inadequacies. Known as the First Year of Welfare in Japan, fiscal year 1973 was when pension benefit levels rose and the ratios of insurance benefits provided to dependents under medical insurance increased. With the arrival of the 1990s, a foundation of nursing care for the elderly was developed under a 10-year plan for the promotion of health and welfare for the elderly (Gold Plan) and welfare services for the disabled were enhanced under a plan for the disabled. These initiatives allowed the government to declare that Japan's "social security schemes were not inferior to those of Europe and the United States" in its 1999 White Paper on Public Welfare.

Since the 1990s, however, Japan's economic growth rate has fallen and the country has been mired in an ongoing period of economic stagnation and deflationary pressures. Tax revenues have declined at both the state and local government levels due to these factors. The environment surrounding social security schemes has become far more austere owing to a sluggish rise in proceeds from insurance premiums attributed to stagnancy in the wage levels of workers as well as to an increase in the number of low-income households and households receiving public assistance attributed to growth in the size of the non-permanent labor force.

One of the biggest issues concerning Japan's social security schemes is the securing of funds to ensure the sustainability of these schemes.

Table 6-4 presents changes in the make-up of funding for social security schemes. In fiscal year 2011, the costs of social security benefits equaled approximately 107 trillion JPY, the fiscal sources for which can be broken down as follows: insurance premiums accounted for 52.0 percent of funding and public funds accounted for 37.6 percent of funding. Both insurance premiums paid by insured persons and insurance premiums assumed by employers reached enormous sums, each surpassing in magnitude the aggregate amounts of income taxes and corporation taxes that were collected. Between fiscal years 2000 and 2011, a total of 250 trillion JPY, an amount that exceeded total proceeds from income taxes and corporation taxes, was paid out of the state coffers to fund social security schemes. Moreover, as tax revenues during this period were stagnant, annual revenues were raised by the state through the issuance of huge sums of government bonds. For this reason, proceeds from government bonds account for nearly half of all annual revenues and the balance of long-term government debt is approximately double the GDP of the country, such that this state of affairs represents a serious fiscal matter.

Table 6-4. Breakdown of social-security funding (ILO standards)

Fiscal year	Revenue (x 100 million JPY)	Breakdown ratio (%)										Social security benefit costs (x 100 million JPY)
		Social insurance premiums		Public funds		Asset income		Other	Social security benefit costs (x 100 million JPY)			
		Contributed by insured persons	Contributed by employers	State treasury	Other public funds	Asset income	Other		Benefit costs	Benefit costs		
1965	23,996	57.4	27.0	30.4	32.5	28.3	4.1	6.3	3.8	16,037		
1970	54,681	59.7	28.5	31.2	30.0	26.4	3.6	8.8	1.6	35,239		
1975	167,375	56.8	26.4	30.4	33.1	29.0	4.1	8.7	1.3	117,693		
1980	335,258	55.6	26.5	29.1	32.9	29.2	3.7	9.7	1.8	247,736		
1985	485,773	56.8	27.1	29.7	28.4	24.3	4.1	12.8	2.1	356,798		
1990	663,782	59.6	27.9	31.7	24.3	20.3	4.1	12.6	3.5	472,203		
1995	851,390	60.2	28.7	31.5	24.3	19.5	4.9	11.5	4.0	647,247		
2000	901,768	61.0	29.6	31.4	27.8	21.9	5.9	7.2	4.0	781,391		
2005	1,174,996	46.5	24.1	22.4	25.3	18.7	6.6	16.0	12.1	877,766		
2010	1,121,707	51.6	27.0	24.5	35.7	26.2	9.5	0.7	11.9	1,034,879		
2011	1,156,566	52.0	26.9	25.1	37.6	27.3	10.3	3.2	7.3	1,074,950		

Source: Fiscal Year 2011 Statistics on Social Security Costs, National Institute of Population and Social Security Research, 2013.

Under these conditions, the government undertook an integrated reform of social security and taxes through which it sought to allocate increased tax revenues obtained by raising the consumption tax rate to four areas: pensions, medicine, nursing care, and the declining birthrate. With the enactment of a relevant bill by the Diet in 2012, the consumption tax rate was raised from 5 percent to 8 percent in April 2014 and is set to be increased to 10 percent in October 2015⁴.

Based on a report issued (in August 2013) by the National Council on Social Security System Reform (which was established under the Act for the Promotion of Social Security System Reform (enacted in 2012)), the Act Concerning the Promotion of Reform to Establish a Sustainable Social Security System (Act on a Program for Reforming Social Security) was enacted (in December 2013). This statute outlines the specific direction to be taken in terms of reforming the social security system for the next several years.

However, since it is expected that tax revenues will rise by approximately 13 trillion JPY as a result of raising the 5 percent consumption tax rate, the allocation of the entire sum of this increase in tax revenues to the social security system will still fall short of what would be considered sufficient. According to the Ministry of Health, Labour and Welfare, the costs of social security benefits are estimated to equal approximately 149 trillion JPY in fiscal year 2025, a figure that is 39 trillion JPY higher than the approximately 110 trillion JPY in social security benefit costs incurred in fiscal year 2012. The securing of fiscal funding and the re-examination of benefits provided through various social security schemes are now imperative.

If we examine key issues in individual areas, we see that limiting increases in and reducing the number of recipients by promoting support for employment and self-reliance through the livelihood protection scheme, which is providing benefits to more recipients than ever before in history, are issues to be addressed in the area of social welfare. In 2014, the Abe Cabinet set forth a population target of 100 million people in 2050. The deployment of measures to counter the declining rate of childbirth—such as by reducing the number of children on waiting lists to enter childcare centers through an expansion in the number of childcare centers, providing economic support to members of younger generations, making it easier to take childcare leaves, and promoting a work-life balance in the workplace—is a concern.

Limiting the ongoing growth in national healthcare costs is the biggest issue being faced in the area of medical security. The placement of national health insurance operations under prefectural control is being studied as a measure for dealing with the structurally deficit-laden municipally run national health insurance scheme. The municipally run national health insurance scheme is the basis of universal health insurance. It is hoped that the placement of operations under the control of prefectural governments will stabilize national health

insurance operations and enable fiscal funding to be secured. For the long-term care insurance scheme, the establishment of a comprehensive local-care system in each municipality is an issue, such that linkages between medical care and nursing care are important.

In the area of pension security, it will be necessary to ensure fairness in terms of benefits and the applicable cost burden assumed between the generation of people receiving benefits and the generation of people who are currently working in order to make sure that the pension system is sustainable. To this end, the lowering of pension benefit levels and the raising of the age at which pensions can start to be paid are issues that need to be addressed.

In any case, Japan is forced to confront a huge question: how will the country be able to maintain and develop its social security system—the linchpin for ensuring the security and stability of the lives of all citizens—in the context of Japan’s status as an “advanced elderly country” for having an aging rate that is the highest in the world and even as it is expected that her population will rapidly shrink in the years to come?

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- ¹ In the period between 1990 and 2014, the United States had 5 presidents, the United Kingdom had 5 prime ministers, France had 4 presidents, and Germany had 3 chancellors.
 - ² 2011 estimates based on the *2014 White Paper on Health, Welfare and Labour*.
 - ³ National pension and employees' pension amounts shown here are figures corresponding to fiscal year 2013 (twenty-fifth year of the Heisei era).
 - ⁴ In November 2014, the Abe Cabinet decided that the raising of the consumption tax from 8 percent to 10 percent would be deferred to April 2017.

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