Vierteljahrshefte zur Wirtschaftsforschung
70. Jahrgang, Heft 4/2001, S. 571–585

Japanese Welfare State Reforms in the 1990s and Beyond: How Japan is Similar to and Different from Germany

By Tetsuo F u k aw a *

Summary

Beginning with a review of Japanese welfare state reform in 1990s, we discuss similarities and differences between Japan and Germany in the implementation of three major reforms: public pension reform, health care reform and introduction of long-term care insurance.

The latest public pension reform in both countries has the same aim: to establish middle- and long-term stability of the system against ageing of the population. The 1999 Japanese Pension Reform has continued the effort to expand the funding basis and to reduce the future benefit level, and two laws passed in 2001 in the field of occupational pension have paved the way for heavier reliance on private arrangements. Germany's pension reform of the year 2000 invented a new formula to offset the reduction of public pension benefits through introducing a tax-supported private pension system. This approach may have a strong impact on Japanese reform debates.

The freedom of choice of sickness funds by the insured in Germany since 1996 has stimulated discussion in Japan as to how to strengthen the role of the insurers. In Japan, the activities of insurers have been marginal so far, and further strengthening their functions is expected to promote a break-through in health care reform in Japan. Case payment to hospital services and the assessment of hospital budgets using the DRG (Diagnosis Related Groups) method, both now being carried out in Germany, are viewed with keen interest in Japan. The issue of who pays for the health insurance is becoming controversial, and efforts to correct false incentives built in the fee-for-service system will continue in Japan.

Since long-term care insurance started in April 2000, a smooth implementation of the system has been the main concern in Japan. Conversion of hospital beds from health insurance coverage to long-term care coverage, and a wide variation across municipalities in the amount and quality of services provided are among the key issues. The Japanese system is to be reviewed every 5 years, and issues similar to those raised in the German system are also very much relevant to Japan: a) to assure the quality of services provided; b) to decrease cost pressure due to ageing; and c) to divide the burden fairly among the population.

Social protection is more extensive in Germany, while ageing of the population is taking place faster in Japan. The financing of the welfare state is still one of the key issues in both countries, and thus both are currently reviewing new options, including new approaches to the needs of the elderly, broadening the financing basis of social benefits, and greater reliance on private arrangements. Japan and Germany share many of the same features, such as ageing of the population and dominance of social insurance system, and both countries share many issues in their welfare state reforms.

Japan's total fertility rate is very low (1.35 in 2000), and Japanese life expectancy is among the highest (77.6 years for males and 84.6 years for females at birth in 2000) in developed countries (Ministry of Health, Labor and Welfare, 2001). Consequently, the population is ageing rapidly, which has a heavy impact on welfare state reform in Japan. In this paper, after reviewing characteristics of the Japanese welfare state, we focus on three

* National Institute of Population and Social Security Research (IPSS), 2-2-3 Uchisaiwaichou, Hibiva-Kokusai Bldg., Tokyo, Japan; phone: +81-3-5253-1111, ext. 4440, fax: +81-3-3502-0635; e-mail: fukawa@ipss.go.jp

major reforms which occurred in the 1990s: public pension reform, health care reform and introduction of long-term care insurance. The welfare system in general needs a structural reform to be more effective, sustainable and user-friendly. The Japanese social insurance system is based on the German model in principle, and Japanese welfare state reform shares many issues in common with Germany.

1. Characteristics of Japanese Welfare State

In Japan, the entire working population has been covered by the public pension system since 1961: Employees Pension Insurance (EPI) for private sector employees (33 million), national pension for self-employed, farmers and others as well as dependent spouses of employees, and Mutual Associations for public sector employees (IPSS, 2001). Public pension spending is currently 7% of GDP, and for retired people, public pension benefits are the most important income source. Moreover, while these benefits together with earnings constitute the two dominant sources of income for the elderly in Japan, employer-sponsored pensions have not yet played a major role in terms of benefits. Benefit reduction in various forms as well as the improvement in efficiency and fairness of the system has been the main focus of the recent reforms. A reform package including a reduction of the benefit accrual factor was passed in March 2000 in order to maintain contribution levels acceptable to working generations in future years (Fukawa, 2000b).

Since the universal coverage of the nation through public health insurance in 1961 as well, the benefit level has been improved considerably through the 1960s and 1970s. Cost containment has become the main objective of health system reforms in the 1980s, and quality care has emerged among the most important objectives thereof in the 1990s. Most health services are reimbursed on the fee-for-service basis in Japan, and the price of each service is specified in the medical fee schedule. The elderly people are heavy user of health services, and the question of how to finance health expenditure of the elderly is among the hot issues in recent reforms in Japan.

Japanese welfare services remain underdeveloped. A ten-year Strategy to promote health care and welfare for the elderly (the so-called “Gold Plan“) was formulated in 1989 and revised in 1994 to stimulate services in this area. Another major effort was the introduction of public long-term care insurance, which was implemented in April 2000. The main purpose of the program is to share the burden of caring for the elderly among all members of the society in a more coherent manner, but the new system also aims to separate the long-term care from the health care insurance.

Japanese social protection benefits are still limited compared to the other developed countries, but their potential volume is already similar to continental European countries. Japanese social protection schemes are dominated by social insurance such as health insurance and pensions, which is similar to Germany. However, it is characteristic of Japan to treat employees and non-employees, such as self-employed or farmers, differently in the social insurance system, and to support the social insurance system for the latter through numerous government subsidies. There are two reasons for this government subsidy: 1) the non-employees system is financially unstable; and 2) the government is substituting non-existing employers’ contribution, although this second reason differs from international standards. The objective in Japan has been to keep the total of taxes and social contributions below 50% of national income throughout the first half of 21st century. Currently, related to welfare state reform, the funding issue is discussed widely, including an option to finance all of the basic pension (mentioned below), health expenditure on the elderly (mainly 70+), and new long-term care insurance by the increase in consumption tax (Fukawa, 2000b).

2. Public Pension Reform

2.1 Present situation in Japan (Fukawa, 2000b)

Japanese public pensions are a multi-tiered system. The first tier is the basic pension, which provides universal coverage. Participation in this scheme is mandatory for all residents between the ages of 20 and 60, and monthly premium per participant is a flat rate of 13,300 yen. The system provides an individual benefit proportional to the number of years of contribution, and the benefit for those with 40 years of participation has amounted to 67,000 yen per month per person since 1999. In order to help finance the first-tier pension, tax revenues, equivalent one-third of the actual benefit expenditure, are transferred to this scheme by the central government. The national pension provides only the basic pension.

The Employees Pension Insurance (EPI) covers most of the employees in the private sector, although it does not cover part-time workers. The contribution to the EPI is 17.35% of monthly earnings (excluding bonuses) since October 1996 and 1% of bonuses since April 1995, both shared equally by employees and employers. In other words, the contribution rate is about 13.6% of annual earnings. This second-tier contribution includes the premium of the first-tier for both employees and dependent spouses of employees. The second-tier earning-related pension benefits are proportional both to the number of years of contribution and the average level of earnings,

and benefits accrue at the rate of 0.75% of earnings per year. The amount of old age pension received by retired employees is the sum of basic pension (basic part) plus the earnings-related part, which was 108,000 yen per month on average in 1999. Past earnings are revalued every five years to reflect the growth in post-tax earnings. Between reevaluations, the amount of the benefit is indexed to the increase in the CPI. After retirement, the same indexation rules apply to benefits as apply to the revaluation of past earnings. An additional flat rate benefit of about 20,000 yen per month is paid for dependent spouse.

According to the household survey of the Ministry of Health and Welfare (MHW), the share of public pension benefits to the total income for the elderly households (elderly singles or couples aged 65 and over) was 64% in 1997, and about 60% of elderly households depended completely on public pension. Expenditure on public pension was 7% of GDP, and model replacement rate of EPI old age pension was about 60% of net annual earnings of active employees.

2.2 Public pension reform in Japan

Public pension reform has been one of the major issues for years in many developed countries. The issue is especially serious in Japan because of the very rapid ageing of the population as well as the structural issues within the system. The Japanese public pension system is statutorily required to review its financial stability at least once every 5 years. In fact, the Japanese public pension system has been reformed every five years, and the most recent reform was in March 2000 (1999 Reform). Because of the rapid deterioration of the relation between the number of insured and beneficiaries that faces Japan in the near future, the Japanese system has been forced to reestablish its long-term financial stability by cutting future benefit levels, in combination with other measures (Fukawa, 1999).

Public pension reform has been carried out together with the above-mentioned financial review in Japan. Benefit improvement was the main issue in the 1960s and 1970s. However, benefit reduction in various forms as well as the increase in efficiency and fairness of the system have been the main focus of the reforms since the 1980s. The basic pension was introduced in 1985 in order to provide a certain amount of benefits to every elderly person and to reduce financial burden of the national pension. Hereafter, we discuss public pension reform in Japan, mainly focusing on EPI.

1. 1994 Reform

The normal pension age was increased from 60 to 65 years old for the basic part of the EPI in 1994 Reform (gradual implementation between 2001 and 2013 for males; five years later for females). The following measures were also introduced in 1994 Reform: a) revaluing past earnings in line with net wage increase (from gross wage increase); b) levying a contribution from bonuses, although the rate is only 1%; c) increasing work incentives for working pensioners aged 60–64; and d) exempting contributions (employee part only) during the child rearing period.

2. 1999 Reform

The most serious problems in EPI are 1) the height of eventual contribution rate in order to maintain the present benefit level and 2) the degree of inter-generational inequality in the contribution-benefit relation due to the funding system (PAYG), which is vulnerable to demographic changes and economic fluctuations. The key issue in the 1999 reform was the reduction of future pension expenditures in order to keep contribution levels acceptable to active generations in future years.

The Japanese government showed five options for EPI reform in December 1997, and three alternatives to realize Option C (mentioned below) were made public in November 1998. Among the five options, Option A was to maintain the present benefit level, which meant that the contribution rate would ultimately increase to 34.3% of monthly earnings, or 26.4% of annual earnings. Option B was to reduce the final contribution rate to 30% of monthly earnings, which was agreed as the upper ceiling of contributions in the 1994 Reform. Option C was to reduce the final contribution rate to 20% of annual earnings, which meant reducing the total pension expenditure by 20% from Option A. Option D was to freeze the contribution rate almost at its present level, requiring a significant benefit reduction. Options A to D were all based on the present system, but Option E was completely different from the other options. Option E was to privatize the earnings-related part of the EPI, and the following points were argued by the government as the problems involved in this option (Sakamoto, 1998):

1. Income security for those who work at middle or small companies may be seriously damaged.
2. Benefits cannot be protected against inflation.
3. It is estimated that the unfunded liabilities to be borne by the EPI are about 350 trillion yen, or 70% of GDP, in 1999, and the double burden borne by the transitional generations is huge.

The 1999 pension reform bill was passed by the Diet in March 2000, and its main features are summarized as follows:

1. (EPI) benefit reduction of 5% in the earnings related part and benefit adjustment in line with price increase (not net wage increase);

2. (EPI) gradual increase of normal pension age for earnings related part to 65 years over the period 2013–2025 for males and five years later for females;
3. (EPI) expansion of contribution base from monthly earnings to annual earnings;
4. (BP) increase in government subsidy from present one-third to one-half of basic pension expenditure by the year 2004.

It is estimated by the government that these measures combined would reduce the total pension spending in 2025 by 20%, keeping the final contribution rate at 20% of annual earnings.

2.3 Japan and Germany in comparison

The main characteristics of the Japanese EPI are summarized as follows: a) earned benefits depending on former contributions; b) combination of flat rate benefit (basic part) and earnings related benefit; c) income redistribution based on lifetime earnings; d) partial funding method with accumulated fund payable for five years of benefits; and e) protection against inflation through adjusting benefits in line with net wage increase every five years and with a price increase for intermediate years (although the net wage adjustment is suspended by the 1999 Reform).

The public pension systems for employees in private sectors in Japan and Germany have much in common: pay-as-you-go financing method; earnings-related contributions and benefits; defined benefits; etc. However, there are some remarkable differences between the two countries. The Japanese system has a flat rate benefit part, which of course increases the degree of income redistribution but also causes problems concerning contributions and the national subsidy. The German system places more weight on supporting childcare and long-term care, and it suffers more from early retirement and high unemployment than Japanese system (OECD, 1999a; Schmaehl, 1999; Schmaehl, 2000). Public pension spending is 7% of GDP now in Japan, which is considerably lower than that in Germany (12%: OECD, 2001a). However, the potential spending level promised by the system in Japan is more or less the same as in the German system. The contribution level in Japan is still low, but it is expected to increase rapidly (IMF, 1996). Japanese public pension expenditure without reform would eventually reach about 14% of GDP (OECD, 1997a), which is similar to the French and German systems but dramatically different from what may be expected in the future in the UK and USA.

Private occupational pensions became the norm in most regular reasonably paid jobs in the UK (Glennerster, 2000), whereas public pension has been the norm for most employees in Japan and Germany. This is clearly shown in Table 1. In Japan, for the bottom 80% of the elderly, public pension benefits provided 80% of total income, and 40% for the top fifth of the elderly (Fukawa, 1999). In Germany, the share of occupational/private pensions was lower than in the UK and the USA, and public pension benefits were dominant for most elderly households (Scharze and Frick, 1999; Johnson, 1992; SSA, 1998).

The latest public pension reform in both countries has the same aim: to establish middle- and long-term stability of the system against ageing of the population. In Germany, the financing basis has been actively extended to taxes, and public pension benefits will be reduced by 4%, which is to be made up by a voluntary occupational/private pension with tax support (Bertelsmann Foundation, 2001). Japan is also trying to redefine the role of public pension system and make the system less vulnerable to economic and demographic changes. Obvious options

Table 1

Share of different income sources of the elderly (65+) by income quintile

In %

Income sources	Japan 1994					Germany 1996					UK 1987					USA 1996				
	Bottom	2	3	4	5	Bottom	2	3	4	5	Bottom	2	3	4	5	Bottom	2	3	4	5
Earnings	5	7	9	10	42	2	6	10	14	19	0	1	2	4	13	1	3	7	12	31
Public pension benefits	84	81	83	84	42	87	80	72	64	55	90	87	78	65	25	81	80	66	47	21
Occup./ private pension	–	–	–	–	–	3	3	3	5	8	3	7	13	20	31	3	7	15	24	21
Income from assets	1	2	3	3	12	6	10	14	16	18	6	6	8	12	31	3	6	9	15	25
Others	10	10	5	3	4	2	1	1	1	0	–	–	–	–	–	12	4	4	2	2

Note: Public pension benefits in the UK include all social security benefits.

Sources: Fukawa (1999); Schwarze and Frick(1999); Johnson (1992); SSA (1998).

are to increase the pension age, to improve the management of the assets held by the state pension funds in order to raise the rate of return, to change the post-retirement indexation of benefits, to reduce the rate at which pension benefits accrue, and to raise the share of national subsidy. All of these options are included in the 1999 reform in full or to some extent (Fukawa, 1999).

3. Health Care Reform

3.1 Present situation in Japan

Most health services in Japan are provided through the public health insurance system. The total population has been covered by public health insurance since 1961: government-managed health insurance for employees of medium- and small-sized companies and their families (30% of the population); society-managed health insurance for employees of large companies and their families (26% of the population); national health insurance for self-employed people, farmers, retired people, etc. and their families (35% of the population); and mutual associations for public sector employees and their families (9% of the population). Although the private sector is important in delivering health services and maintaining public health, the role of the private sector is relatively minor in terms of health service financing (Fukawa, 1998).

The average contribution rate of employer-based health insurance was 8.5% of wages in 2000, shared evenly by employers and employees. While society-based plans may offer extra benefits, the government-managed plan offers only one package. The state contributes 13% of benefit costs and all administrative costs in the government-managed plan. National health insurance is a community-based health insurance, and the health services covered are generally the same as those for employer-based insurance. However, the patient cost sharing is higher, and cash benefits are usually somewhat more limited than those provided under employer-based insurance. Contributions vary from community to community and are based on both individual income and assets in the national health insurance, and the state pays 50% of the benefit costs.

Health insurance for the elderly (70+ or 65–69 and disabled) was introduced in 1983 to equalize the burden of health costs of the elderly among various health insurances and to ask elderly patients for reduced cost sharing. Membership in this plan is for those who are aged 70 and over as well as disabled persons aged 65–69. These persons may be in any fund, although they are most likely to be in national health insurance. Patient cost-sharing aside, 70% of the total cost is covered by all sickness funds, 20% by the national government, and 10% by local governments.

Table 2 shows health-related indices in six countries (OECD, 2001b). The number of beds per thousand population was very high and the number of physicians was relatively low in Japan. As a natural consequence of many beds, the average length of stay in hospitals was very long in Japan. On the other hand, the number of physicians (3.5 per thousand) and nurses was high in Germany. The health expenditure as percentage of GDP was low in Japan and UK and higher in Germany (1.4 times than Japan). The consumption of pharmaceuticals was higher in Germany than Japan.

Table 2

Health-related indices in six countries

		France	Germany	Japan	Sweden	UK	USA
Total population (in million)	2000	58.9	82.1	127.0	8.9	59.6	275.1
Proportion of 65+ (%)	1999	15.9	16.8	16.7	17.8	15.7	12.3
Per thousand population							
Physicians	1998/99	3.0	3.5	1.9	3.1	1.8	2.7
Nurses	1997/98	5.9	9.6	7.8	10.2	5.0	8.3
Beds	1998/99	8.5	9.3	16.4	3.7	4.1	3.6
Rate of solo practice among GPs (%)		58	67	–	2	0	–
Average length of stay in hospitals (day)	1998/99	10.6	12.3	39.8	6.6	9.8	7.0
Health expenditure as percentage of GDP	1998/99	9.4	10.3	7.4	7.9	6.9	12.9
Public expenditure as percentage of GDP		7.3	7.8	5.8	6.6	5.8	5.7
Pharmaceutical prescriptions							
As percentage of GDP	1992	1.56	1.48	1.2	0.76	1.03	0.99
Share in health expenditure (%)	1992	17.3	16.5	17.5	8.3	12.9	7.7
Rate of patient cost-sharing[1)]	1990	a	a	a	b	b	c

[1)] a: 10–30%, b: 30–50%, c: 70–100%.

Sourse: OECD Health Data 2001.

3.2 Health care reform in Japan

Japanese health expenditure as percentage of GDP is low among major developed countries, which might imply the efficiency of the Japanese health care system. However, health care reform has been a big issue in Japan since 1980s, and more emphasis has been put on quality aspects in the 1990s.

The medical fee schedule, which plays the central role in the Japanese health insurance system, from economic evaluation of medical technology to delineation of the role of the public system, has been the main tool for cost containment although its limitations are becoming more apparent. Main reform issues in the Japanese health care system are: 1) reorganization of the health service delivery system; 2) reforms of the reimbursement system of medical fees and pharmaceutical pricing system; 3) financing of health care for the elderly; and 4) quality assurance of health services and empowerment of patients.

The classification of hospitals according to their functions and streamlining of patient flow have been pursued seriously in Japan since the 1990s (Fukawa, 1998). Because of the economic incentives involved as well as the tradition, the percentage of pharmaceuticals to total health expenditure is high in Japan (White, 1995). Japanese doctors not only prescribe drugs but also dispense them. There are certain differences between the discount price doctors pay for drugs and the official price by which they are reimbursed by the insurance for the drugs they prescribe. Therefore, one of the major issues in Japanese health reform today is how to improve the reimbursement mechanism for pharmaceuticals.

Because of the cap, patient cost sharing was low: about 15% on average for non-elderly and 5% for elderly. Therefore, cost sharing has so far not been a major problem in Japan. Patient cost sharing has been increased several times without lasting effects for cost containment in Germany (OECD, 1997b). Because there is no other effective way to influence patients' behavior, Japan is doing the same thing. The most recent government proposal, made public in September 2001, contains the following items: a) increasing patients' cost sharing to 30% of the cost; b) increasing the eligible age for the special program for the elderly from 70 to 75 years old; c) introducing a total budget system to the special program for the elderly. The improper use of hospital beds cannot yet be easily measured, although the issue itself has been the subject of discussion since 1980s in Japan. The reduction in improper use of hospital beds is necessary for quality care as well as for cost containment. The measurement and assurance of quality of health services is becoming an important policy area. Per capita health expenditure of the elderly is much higher than that of other segments of the population (Fukawa, 2000c), and they stay in hospitals much longer. Given the rapid ageing of the population, the question of how to finance the health expenditure of the elderly is certainly a serious issue.

3.3 Japan and Germany in comparison

Table 3 is a summary table of health insurance in Japan and Germany. In Japan, public health insurance covers the total population, but there are different schemes for employees and self-employed. They differ in terms of contributions, national subsidy, and benefit levels. There is a special program for the elderly in Japan which reduces patient cost-sharing remarkably. Therefore, it could be said that risk adjustment is done in Japan according to age. About 90% of the population is covered by public health insurance in Germany, on the other hand, and employees and self-employed are treated equally. In Germany, insured persons have been free to choose their insurer since 1996, and risk adjustment is done according to age, sex, number of dependents, and income of the insured. The role of private insurance, which so far remains marginal, is expected to grow in Japan. On the other hand, private risk-based health insurance and solidarity-based public insurance co-exist in Germany, although the latter is dominant (OECD, 1997b).

Benefits are more comprehensive in Germany, especially on preventive services and rehabilitation (Maydell et al., 2000), and accordingly the effective benefit level was higher there (92%) than in Japan (84%). Access to physicians and hospitals is free in both countries. Patients can go directly to hospitals in Japan, which is not the case in Germany. However, both countries offer free choice of GPs and hospitals. Health expenditure as percentage of GDP was higher in Germany, but health expenditure for the elderly (65+) was similar in both countries (Fukawa, 2001b).

Both inpatient and outpatient services are provided in Japanese hospitals. While hospitals can enjoy economy of scope on the one hand, there is severe competition in outpatient services between hospitals and GPs on the other. In order to correct excessive competition, it has been considered that hospitals be classified by function and patient flow streamlined in Japan. Starting from a clear division between inpatient and outpatient services, more coordination is sought between primary and secondary care in Germany. The same nationwide fee schedule is applied to GPs and hospitals in Japan. The Japanese reimbursement system is basically fee-for-service with partial price bundling mainly for chronic diseases of the elderly. Price bundling is applicable monthly for outpatient care and daily for inpatient care on clinical tests, pharmaceuticals, injections, and nursing charges (inpatient only). Total inpatient per diem is bundled only in special cases such as hospice care. On the other hand, different reimbursement systems are applied to GPs and

Table 3

Public health insurance in Japan and Germany

	Japan	Germany
Coverage	– 100% of population – different schemes for employees and self-employed – special program for the elderly	– 90% of population – co-existence of public insurance (88.5%), private insurance (9%) and other (2.4%)
Choice of insurers	– no	– yes, since 1996
Risk structure adjustment	– health insurance for the elderly (age)	– according to age, sex, number of dependents and income of the insured
Benefit in kind	Employees	
Prevention	– none	– health screening of cancer and geriatric diseases
Outpatient	– payment of 80% of the cost for the insured and 70% for the dependent, with additional cost-sharing for pharmaceuticals	– payment of 100% of the cost with some patient's cost-sharing for pharmaceuticals, medical appliances, dental filling, transportation, etc.
Impatient	– payment of 80% of the cost with additional cost-sharing for pharmaceuticals and meals	– payment of 100% of the cost with patient's cost-sharing of DM 17 per day up to 14 days a year
Others	– there is an upper ceiling for patient's cost-sharing per month per household	– benefit for childbirth support, housekeeping support, Kur treatment, transportation, etc.
Effective benefit level	– 84% in 1993	– 92%
Access to physicians and hospitals	– free	– free
Health expenditure (% of GDP)	– 7.4% in 1998 (OECD) – 5.8% in 1998 (national source)	– 10.3% in 1998 (OECD) – 8.7% in 1997 (national source: Cure)
Health service deliverly	– bed pop ratio is quite high, but physician pop ratio is lower than that of Germany – ALOS is long	– physician pop ratio is high, and nurse pop ratio is low – price of pharmaceuticals is high
Prospective payment in reimbursement system	– per day (per month for outpatient care) – only partially applied mainly to the elderly care, which was estimated about 13% of elderly inpatient expenditure in 1995	– per case – 20–25% of hospital account
Improper use of hospital beds	– among health service for the elderly 70+ 17.5% of inpatient care 13% of inpatient expenditure	– about 20% of bed-days
Share of pharmaceutical prescriptions	– 1.20% of GDP – 17.5% of health expenditure	– 1.48% of GDP – 16.5% of health expenditure
Issues concerning benefits	– 14.6% of the population used 43.6% of health expenditure = per capita expenditure for 65+ was 4.5 times of per capita expenditure for 0–64	– 15.8% of the population used 37.6% of health expenditure = per capita expenditure for 65+ was 3.2 times of per capita expenditure for 0–64
Issues concerning funding		to reduce total social insurance contribution rate from 41.3% in 1999 (health 13.6%, pension 19.5%, employment 6.5%, long-term care 1.7%) to less than 40%

hospitals in Germany (Matsumoto, 1998). The number of physicians per 1,000 population is high, and the price of pharmaceuticals is high in Germany (Institute for Health Economics and Policy, 2001).

Another important issue in both countries is reduction of the improper use of hospital beds, which is generally known in Japan as a social hospitalization. Among inpatient care of the Japanese elderly aged 70+, the propor-

tion of those patients who required hardly any medical treatments is about 17% in terms of number and about 13% in terms of health expenditure (Fukawa, 2000c). In Germany, it is reported that about 20% of bed-days are improperly used (Schneider, 2000).

4. Long-term Care for the Elderly

4.1 Background in Japan

One-third of the elderly aged 65 or over live alone in many developed countries, and this rate is more than 40% in Germany and Sweden (Table 4). In Japan, however, the co-residence rate of the elderly with children is high, and the rate increases with age. Among those elderly who live in their own home , the ADL-dependent rate of the Japanese elderly is low, although this kind of comparison is not free from the issue of comparability. The proportion of those elderly who live in institutions (institution rate) has been declining in many countries, owing to such policies as expansion of home care services instead of institutional services. The institution rate increases remarkably at age 80+ or 85+, and is higher for females than for males (OECD, 1998). As a matter of fact, hospitals provide long-term care services in Japan, as well as in France and the Netherlands (OECD, 1996). The Japanese institution rate is 4%, fully including those elderly who stay at hospitals for more than six months (Fukawa, 2000a). Concerning home care services, there are more diversities among countries than institutional services.

The rapid ageing of the population has been increasing the demand for formal long-term care services in Japan. The elderly have sometimes been staying in hospitals much longer than the medically appropriate period. Such cases are called “social hospitalization“, an induced stay in hospitals for social reasons (not medical). Moreover, there has been a significant inequality in user charges among different facilities caused by the separation of the welfare system and the health care system in general. This is neither an efficient way nor a fair way to deliver care to the elderly.

In December 1989, the Japanese government formulated a large scale plan called the Gold Plan, a 10-year strategy designed to increase both facility-based and home care services for the elderly by FY 1999 (March 2000). The purpose of this plan was to develop long-term care services at the municipal level, with a major emphasis on home- and community-based care options. Owing to this plan and follow-up plans, the capacity for both home care and institutional care has increased dramatically. However, the Gold Plan was a budgetary allocation and not a legislative initiative.

4.2 Introduction of long-term care insurance in Japan (Fukawa, 2000b)

In the mid-1990s, long-term care became one of the highest priority issues in Japan. The government set up a study group in 1994 to investigate options of the long-term care for the elderly and to propose a solution to the issue. Various approaches including a tax-based approach and a public insurance approach were examined, and newly implemented public care insurance in Germany in 1995 had a strong influence on the discussions in Japan. A tax-based approach was rejected because of the stigma attached and the fact that such a financing system would be strongly influenced by the general budget. A private insurance approach was also considered and was rejected because it was not suitable to the culture and values of the Japanese people. The majority of the Japanese people supported the idea of public long-term care insurance, and the Long-term Care Insurance Act was passed in November 1997 and implemented in April 2000.

The principles underlying this new program are universality of coverage (although benefits are available mainly

Table 4

International comparisoon of the elderly

In %

	France	Germany	Japan	Sweden	UK	USA
The proportion of those who live alone	1982 32	1985 41	1995 15	1990 41	1991 37	1991 31
Co-residence rate with children	1990 17	1987 14	1998 50	1986 5	1980 16	1987 15
The proportion of those who r eceive public home services	6	10	5	11	6	16
ADL-dependent rate of non-institutional elderly	2	7	5	18	8	12
Institution rate	6	3	4	5	5	5

Source: OECD (1998); Alber (1994); Fukawa (2000a).

for the elderly), financing through social insurance (although the public fund finances about 45% of the cost), freedom of choice by service users, and reliance on a service market. The main purposes of the program are to divide the burden of caring for the elderly among all members of the society and to lessen the burden upon family caregivers. But it is also intended to relieve some of the financial pressures on the health expenditure of the elderly, in which long-term stays of the elderly patients in hospitals have been included.

The insured are divided into two categories (Table 5): persons aged 65 or older (category 1), and persons aged 40 to 64 years old who are subscribers to health insurance (category 2). For category 1, persons requiring any long-term care will receive services. For category 2, however, only those who suffer from age-induced illness, such as the early stages of dementia and cerebro-vascular disorder, will be able to receive services. The municipal committee comprised of professionals specializing in elderly care determines eligibility and assessment of the care needs for either home- and community-based or institutional care. Beneficiaries are classified into one of six levels of care needs according to their physical and mental functioning. The income and family situation of the elderly are not considered in determining the level of care needs. Benefit amounts vary according to this level. It is possible to combine services which are covered by insurance with those which are not covered, although such flexibility is not usually allowed in the public health insurance. Home care services include home aid services, respite care for caregivers, and day care services. Facility-based services are provided at skilled nursing facilities, health service facilities for the elderly (primary for rehabilitation), and skilled nursing wings of geriatric hospitals. From the point of view of providing service properly and efficiently, a care management approach is adopted and a care service plan is to be prepared for each beneficiary.

Table 5

Long-term care insurance in Japan and Germany

	Japan	Germany
Insurer	Municipality	Care funds
Insured	Persons aged 65 or older (category 1) and persons aged 40–64. All subscribers of health insurance ??? years old and subscribers of health insurance (category 2)	
Contribution (rate)	Category 1: yen 2,900 per month Category 2: government-managed health insurance: 0.95% society-managed health insurance: 0.88% on average (between 0.4% and 1.7%) National health insurance: yen 1,280 per person on average	1.7% (decided by law)
Financial source	Government subsidy: 45% Contribution: 45% User charge: 10%	Contribution: 100%
Beneficiaries	All category 1 and those category 2 who suffer from age-induced illness will get beneficiaries when they need long-term care	All insured and their family who need long-term care
Care assessment	Municipal committee	MDK *(Medizinischer Dienst der Krankenversicherung)*
Insurance benefits	Benefit in kind only Home-care services: yen 1,000 per month Frail: 60 Level 1: 140–160 Level 2: 170–180 Level 3: 210–200 Level 4: 230 Level 5: 230–290 Facility-based services: upper limit, yen 1,000 per month Skilled nursing facilities: 290 Health service facilities for the elderly: 320 Skilled nursing wings of geriatric hospitals: 430	Benefit in kind or in cash Home-care services: DM ??? per month Level 1: care services up to 25 hours per month (max. DM 750) or cash benefit of DM 400) Level 2: care services up to 50 hours per month (max. DM 1,800) or cash benefit of DM 800) Level 3: care services up to 75 hours per month (max. DM 2,800); DM 3,750 for especially serious cases) or cash benefit of DM 1,300) Facility-based services: up to DM 2,800 per month; DM 3,300 for especially serious cases
Responsible authority	Municipality	Provincial government

The program is financed through a combination of contributions from the insured, government subsidies and user charges. Service users must pay 10% of expenses, although there is an upper ceiling for this user charge. Apart from user charges, half of the funding is from the mandatory insurance contributions, and the other half is from the public tax revenues. The contribution is collected through municipalities and a deduction from the pension for category 1, and through an additional contribution paid to the health insurance for category 2. For category 1, the level of contribution is determined by each municipality, and thus differs depending on facilities and services available and take-up rate of insured persons within the municipality. However, it is income-related, and there are some measures to reduce the contribution for low-income persons. The average monthly contribution for the first three years is estimated to be 2,900 yen. The ratio of the public funding among the national, prefecture, and municipal governments is 2:1:1. For institutional care, the beneficiary also pays for meals based on the average amount consumed by the elderly at home (23,000 yen per month). The total long-term care expenditure is estimated to be 4.2 trillion yen when the program begins in 2000, and it is expected to grow to 6.9 trillion yen by 2010.

4.3 Comparison with the German system

The proportion of those elderly aged 65+ who were institutionalized was about the same in Japan and Germany (Alber, 1994; Fukawa, 2000a). The proportion of those non-institutional elderly who live alone was low in Japan and high in Germany. ADL-dependent rate among non-institutional elderly was similar in both countries.

The Japanese system was influenced strongly by the German system, and there are many similarities between the two systems. However, there are several important differences between the two (Table 5): a) main beneficiaries in the Japanese system are those aged 65 and over; b) cash options are not available in the Japanese system; c) contribution rate is determined by the law and universality in terms of benefits is intended in the German system, while this is not the case in Japan. Quite contrary to the German system, there is no cash option in the benefit package in the Japanese system. Arguments against this alternative included 1) negative effects of cash benefit on the development of care service infrastructure; 2) increase in contribution due to cash optio;, 3) general concern about misuse of cash; and 4) specific complaints from feminist advocates that a cash option would put more pressure on women to remain primary caregivers. While these concerns have merit, the availability of a cash option may have alleviated some of the pressure to create a comprehensive, formal service system throughout the municipalities in a relatively short time period (Stone, 1999).

The cost of long-term care for the elderly is around 1% of GDP in many countries, although it is quite high in Nordic welfare states (OECD, 1999b). Among the public costs of long-term care, the share of institutional services is about 70% or more in most countries including Japan. Because of the strong emphasis on home care services, however, the share is as low as 45% in Germany. The cost of long-term care for the elderly in the future will depend on the health status of the elderly. According to OECD (1998), the future public cost (compared to GDP) of long-term care for the elderly will not increase remarkably in developed countries except Japan.

5. Discussion

5.1 Pensions

Japan's 1999 Pension Reform would surely contribute to the stability of the public pension system, but many problems still remain unsolved. Other than the serious problems mentioned previously, there are several inconsistencies in the present system: 1) dependent spouses of employees are treated favorably; and 2) most pensioners do not pay taxes. The most important unsolved problem would be the people's lack of trust in the public pension system. The public pension system is a long-term social institution, which should be supported by most of the population. How to redefine public pension system is the issue here, which needs a broad national consensus.

The following functions are built into the public pension systems in most developed countries:

— income transfer from persons of short-lived to persons of long-lived;

— avoidance of sex discrimination although females have longer life expectancy;

— income redistribution based on lifetime earnings in order to secure a lifetime standard of living (relevant only to countries adopting social insurance model) (Kingson and Schulz, 1997).

Whether to preserve these functions or not is also an important issue. It is especially desirable for the Japanese public pension system to be as neutral as possible against very rapid ageing of the population. Working longer is an obvious solution, and tax and social security policies that discourage women and the elderly from working should be revised as soon as possible.

There is a growing recognition that pension programs need to reflect the profound changes which have occurred in society such as higher labor force participation of women, smaller family size, much longer periods spent in education and elderly people who are healthier in their later years than previous generations. This implies taking more explicitly into account a life-cycle perspective which

will permit people to opt more readily for non-traditional work patterns, for family care periods, for lifelong learning and for gradual retirement (Hoskins, 1998). Reform discussions should also take into account such factors as a) intergenerational equity; b) individualization of social security rights for men and women; and c) consistency of social security with regard to work incentives.

More significant reform of the public pension system in Japan is to reduce the extent of the imbalance in the intergeneration transfers that occurs in the current system. This could be accomplished by reducing contributions to the state system to the actuarially fair level and then funding the remaining cost by general taxation (OECD, 1997a). Most political parties except the LDP (Liberal Democratic Party) agree to have a re-distributive flat rate pension financed by general taxation. Many economists are in favor of having a second-tier system based on actuarially fair contributions that accumulates a full pension fund under private management. A number of other reforms are necessary to improve the equity of the system. To this end, it is indispensable to coordinate pension policy with other policies such as tax, employment, and family policy. The tax treatment of pensions, for example, should be aligned with that of income from employment (OECD, 1997a).

In Germany, the pension reform of 2000 invented a new formula to offset the reduction of public pension benefits through introducing a tax-supported private pension system. This approach may have a strong impact on Japanese reform debates, although Japan is undertaking such efforts as 1) expanding the financing basis; 2) reducing the benefit level; and 3) relying more on private arrangements. In Japan, intergenerational inequality is perceived as a more serious problem (Ministry of Health, Labor and Welfare, 2001) and effects of population ageing are faster. These factors increase the necessity for the Japanese system to rely more on funding elements.

5.2 Health care

Japanese health insurance is divided into various programs, and there are certain inequalities among them in terms of benefit level, patient's cost sharing, contribution, etc. But everyone is part of the same delivery system, and payments are strictly coordinated. Coverage is quite egalitarian in terms of burdens as well as benefits through an intricate set of cross-subsidization mechanisms (Campbell, 1996). The fee schedule clearly favors physicians in private practice over hospitals, and fees are especially low for the services that more advanced hospitals provide, such as surgery and intensive care (Hsiao, 1996). Therefore hospitals compete with the clinic doctors by promoting their outpatient care. Clinic doctors and small hospitals counter by trying to buy prestige in the form of high-tech equipment (White, 1995). In sum, Japanese hospitals compete with the clinic doctors on the one hand, but on the other, they are not eager to perform those services which are undervalued by the fee schedule.

Japanese experience has shown so far that fee regulation on virtually any service, combined with utilization review, can control costs even without supplementary measures to limit volume (White, 1995). Examination of fee claims, through third party examination organizations as well as the check by the insurers, functions to contain the health expenditure increase in the Japanese fee-for-service system. Even the scale of utilization reviews is limited, the existence of such a review itself has an important impact on prevention of excessive utilization and fraud in Japan. There are a very large number of beds in Japan. Nevertheless, Japanese health care system operates at relatively low cost seen in international terms largely because of the relatively low prices of the resources used (Mooney, 1996). However, this approach faces serious limitations in 1990s, and Japanese government is currently searching for new measures to affect volume of health services.

Japan is trying to correct false incentives in the fee-for-service system through introducing partial price bundling without including physician's fee, but this effort is only at an initial stage and actual situations are far from prospective payment such as capitation and HMO. A final goal may be a transformation of the reimbursement system from fee-for-service to payment per case. Concerning health expenditure of the elderly, it is assumed that a large share of pharmaceuticals for outpatient care and a not negligible number of long-term inpatients were two major sources of inefficiency in Japan. How the long-term care insurance will affect the health expenditure of the elderly is another very interesting topic in Japan. Empowerment of the user is another weakness of the Japanese health system, although it is important for the improvement of the quality of medical services especially from the user's point of view.

The freedom of choice of sickness funds by the insured in Germany since 1996 has stimulated discussions in Japan of how to strengthen the functions of the insurers. In Japan, activities of insurers have been marginal so far, and it is expected to be a tool for a break-through of the health care reform in Japan to strengthen the functions of the insurers. Case payment to hospital services and assessment of hospital budgets using the DRG-method (Diagnosis Related Groups), both now being implemented in Germany, are viewed with keen interest in Japan. The issue of who pays for health care is becoming controversial in Japan, and the function of coordinating different opinions from medical professions, insurers, and others has become weak. Efforts to correct false incentives built into the fee-for-service system will continue in Japan.

5.3 Long-term care

After the implementation of the long-term care insurance since April 2000, Japanese use of home care services still remains at a low level. Conversion of hospital beds from health insurance coverage to long-term care insurance coverage, which is another key issue for the successful development of the Japanese long-term care insurance, is also below anticipation. Despite all efforts, shortage of supply continues in both institutional services and home care services. Therefore, the quality issue is overshadowed by the quantity issue. A smooth implementation of the long term care insurance has been the main concern so far. Since the German system started earlier, such issues raised in German system are highly relevant to Japan: a) to assure the quality of services provided; b) to decrease cost pressure due to ageing; and c) to divide the burden fairly among the population. The system is to be reviewed every five years in Japan, and several issues have already emerged. There is a wide variation across municipalities and between urban and rural communities in the amount and quality of service providers. While the legislation relies heavily on care management to coordinate and monitor care, such a system still needs to be developed (Campbell and Ikegami, 2000). Concerns about the quality of care provided by the private sector are fundamental here.

According to an assessment of a potential scale of health and long-term care expenditures of the elderly in Japan, we found that even if the conversion of hospital beds to long-term care beds had gone well, there was a possibility that Japanese long-term care expenditure would rise substantially (Fukawa, 2001b). Long-term care expenditure is quite related to ageing (sometimes much more sensitive to ageing than health expenditure), and it is quite important to reduce the number of dependent elderly in future through better prevention, in order to contain the total cost of health and long-term care under the circumstances of rapid ageing of the population.

6. Final Remarks

The German social security benefits (ILO-defined) as percentage of GDP were about 1.9 times than that of Japanese (IPSS, 2000). The German benefits are larger than Japanese in each benefit area: 1.6 times for public pension and 1.4 times for health. Accordingly, the sum of taxes and social security contributions as percentage of GDP was higher in Germany than in Japan. Social protection in Germany is larger, which makes reforms more urgent . Ageing of the population in Japan is faster, which make reforms more difficult. As shown in Table 6, the cost of pension, health and long-term care for the elderly (65+) is low now in Japan and the USA, but the cost in Japan is expected to reach the present level of Continental European countries in a decade (Fukawa, 2001a). Besides improving fairness and efficiency of various systems, the following are the common basic issues of welfare state reforms in Germany and Japan:

a) to put the right incentives into the systems;
b) to improve intergenerational equity and financial stability in the public pension system; and
c) to emphasize prevention in health and long-term care.

Financing of the welfare state is still one of the key issues in Japan, and currently new options are being reviewed, including new ways of approaching the issues of the elderly, broadening the financing basis of social benefits, and greater reliance on private arrangements. In considering a new approach, it is worth keeping in mind that cutting social expenditures will not necessarily lead to a reduction in the total resources which a society devotes to such ends, though it will change the distribution of burden (OECD, 1997c).

Japan and Germany share similar features — ageing of the population and dominance of social insurance system. Germany takes the lead in many fields of welfare state reform, and reform experiences in Germany have been and will continue to be very useful for Japanese debates.

Table 6

The cost of pension, health and long-term care for the elderly (65+) as percentage of GDP: public system

In %

	France	Germany	Japan	Sweden	UK	USA	Japan[5]		
							2000	2020	2040
Pension (1998)[1]	12.8	11.9	7.4	12.9	11.4	6.4	8.0	11.0	–
Health (1998)[1]	2.7	2.6	2.7	2.6	2.3	4.5	2.7	3.6	3.6
Long-term care[2] (1992–95)	0.5	1.0[3]	0.8[4]	2.7	1.0	0.7	0.9	2.5	2.9
Total	16.0	15.5	10.9	18.2	14.7	11.6	12.0	17.0	–

[1] Fukawa (2001a). — [2] OECD (1998). — [3] 1997 (Schneider, 2000). — [4] 2000. — [5] Fukawa (2001b, case 4).

At the same time, as Japan is trying to solve similar problems, Japanese experiences may have some relevance for Germany. However, there are also several remarkable differences between Japan and Germany. People's preference for equality is stronger in Japan, and some Japanese systems such as basic pension and special health care program for those who are 70+ are quite different from German systems. Because the ageing process is faster in Japan, Japan is obliged to solve such issues earlier than Germany 1) to raise the labor force participation of those who are in their 60s and 2) to improve the health care performance through better coordination between inpatient and outpatient care. After all, both countries share many issues in their welfare state reforms.

References

Alber, J. (1994): Paying for Long-Term Care in a Social Insurance System: The Example of Germany. OECD discussion paper. Paris.

Bertelsmann Foundation (ed.) (2001): International Reform Monitor No. 4 and No. 5. Gütersloh.

Campbell, J. C. (1996): The Egalitarian Health Insurance System. In: Ikegami and Campbell (eds.): Containing Health Care Costs in Japan. Ann Arbor, Michigan.

Campbell, J. C. and N. *Ikegami* (2000): Long-Term Care Insurance Comes to Japan. In: Health Affairs, 19 (3), 26–39.

Fukawa, T. (1998): Public Health Insurance in Japan. Submitted to the World Bank. Washington, D. C.

Fukawa, T. (1999): Japanese Social Security Reform from an International Perspective. Discussion paper submitted to the Annual Meeting of the Gerontological Society of America, San Francisco.

Fukawa, T. (2000a): Long-term Care for the Elderly in OECD Countries. Social Security Research Abroad No. 131, IPSS. Tokyo (in Japanese).

Fukawa, T. (2000b): Japanese Welfare State Reform in Recent Years. Paper submitted to Seigakuin University Symposium "The Role and Limitations of Market Forces in the Health and Welfare System: the British Experience and Japanese Response", Tokyo, 31 March – 1 April 2000.

Fukawa, T. (2000c): Health Expenditure and Age. In Maydell and Tezuka (eds.): Entwicklung der Systeme sozialer Sicherheit in Japan und Europa. Berlin, 343–355.

Fukawa, T. (2001a): Low Fertility and Social Insurance (in Japanese; to be published).

Fukawa, T. (2001b): Total Cost of Health and Long-term Care for the Elderly in Japan (in Japanese). Tokyo.

Glennerster, H. (2000): The United Kingdom's New Health and Welfare Policy: A changed role for markets. paper submitted to Seigakuin University Symposium "The Role and Limitations of Market Forces in the Health and Welfare System: the British Experience and Japanese Response", Tokyo, 31 March – 1 April 2000.

Hoskins, D. D. (1998): The Redesign of Social Security. ISSA document. Geneva.

Hsiao, W. C. (1996): Costs — The Macro-Perspective. In: Ikegami and Campbell (eds.): Containing Health Care Costs in Japan. Ann Arbor, Michigan.

IMF (1996): Ageing Populations and Public Pension Schemes, Occasional Paper 147. Washington, D. C.

Institute for Health Economics and Policy (2001): Health Related Data for Germany (in Japanese). Tokyo.

IPSS (2000): The Cost of Social Security in Japan FY 1998. Tokyo.

IPSS (2001): Social Security in Japan. Tokyo.

Johnson, P. (1992): Pension Reform in Britain: Problem and Possibilities. Tokyo.

Kingson, E. E., and J. H. *Schulz* (eds.) (1997): Social Security in the 21st Century. Oxford University Press. New York.

Matsumoto, K. (1998): Structural Reform of German Social Security. Tokyo (in Japanese).

Maydell, Bernt von, T. *Shimomura* and K. *Tezuka* (eds.) (2000): Entwicklung der Systeme sozialer Sicherheit in Japan und Europa. Berlin.

Ministry of Health, Labor and Welfare (2001): White Paper on Health, Labor and Welfare. Tokyo (in Japanese).

Mooney, G. (1996): An International Perspective on Health Services Reform. In: Journal of Japanese Society on Hospital Administration, 33 (2), 81–107.

OECD (1996): Caring for Frail Elderly People: Policies in Evolution. Paris.

OECD (1997a): OECD Economic Surveys, Japan. Paris.

OECD (1997b): OECD Economic Surveys 1996–1997, Germany. Paris.

OECD (1997c): Family, Market and Community: Equity and Efficiency in Social Policy. Social Policy Studies No. 21. Paris.

OECD (1998): Long-term Care Services to Older People. A Perspective on Future Needs: The Impact of an Improving Health of Older Persons. Ageing Working Papers 4.2. Paris.

OECD (1999a): Early Retirement in OECD Countries: The Role of Social Security Systems. OECD Economic Studies No. 29. Paris.

OECD (1999b): A Caring World: The New Social Policy Agenda. Paris.

OECD (2001a): Pension Systems and Retirement Incomes across OECD Countries. Paris.

OECD (2001b): OECD Health Data 2001. Paris.

Sakamoto, J. (1998): Pension Reform and the Funding Alternative. Second Seminar for social security actuaries and statisticians from industrialized countries, ISSA. Tokyo, 20–21 May 1998.

Schmaehl, W. (1999): Public Pension Reforms in Germany — Major Post-War Reforms and Recent Decisions. Social Security Research Abroad No. 126, IPSS. Tokyo.

Schmaehl, W. (2000): New Developments and Future Directions of the Public Pension System in Germany. IPSS study series 2000.3. Tokyo.

Schneider, M. (2000): Improper Use of Hospital Beds in Germany. IPSS study series 2000.3. Tokyo.

Schwarze, J., and J. R. *Frick* (1999): Old-Age Pension Systems and the Income Distribution among the Elderly — Germany and the United States Compared. New York.

Social Security Administration (1998): Income of the Population 55 or Older. U.S. Department of Health and Human Services. Washington, D.C.

Stone, R. I. (1999): Long-Term Care in Japan: A Window into the Future? The Public Policy and Ageing Report, Fall 1999. National Academy on an Ageing Society. Washington, D. C.

White, J. (1995): Competing Solutions — American Health Care Proposals and International Experience. Washington, D. C.

Zusammenfassung

Japans Sozialstaatsreformen in den 90ern und später — Unterschiede und Gemeinsamkeiten zwischen Japan und Deutschland

Ausgangspunkt der vorliegenden Studie ist die überblicksartige Darstellung japanischer Sozialreformen der 90er Jahre. Im Anschluss daran werden die Gemeinsamkeiten und Unterschiede in Japan und Deutschland bei der Implementierung dreier wichtiger Teilreformen diskutiert: der Rentenreform, der Gesundheitsreform und der Einführung der Pflegeversicherung.

Die aktuelle Rentenreform hat in beiden Ländern das gleiche Ziel: die Sicherstellung der mittel- und langfristigen Stabilität des Alterssicherungssystems vor dem Hintergrund einer alternden Gesellschaft. In Japan wurden 1999 die Ausweitung der Beitragspflicht und die Absenkung der Rentenansprüche vorangetrieben; 2001 wurden zwei Gesetze im Bereich der betrieblichen Altersicherung verabschiedet, die im Wesentlichen auf eine Stärkung der privaten Verantwortung zielen. Deutschlands Rentenreform aus dem Jahr 2000 führte zur Durchsetzung einer neuen Rentenformel, die eine Absenkung zukünftiger Rentenansprüche gegenüber der staatlichen Rentenversicherung und die Einführung einer steuerbegünstigten privaten Altersicherung bewirkte.

Die in Deutschland 1996 eingeführte Wahlfreiheit in Bezug auf die Krankenkassen hat auch in Japan zu einer Diskussion über die Rolle der Versicherer geführt. Dabei wird erwartet, dass durch eine Stärkung ihrer Position die Gesundheitsreform insgesamt forciert werden könnte. In Deutschland angewandte Fallpauschalen und Budgetierungen von Krankenhäusern werden auch in Japan mit großem Interesse betrachtet. Kontrovers werden auch Fragen nach der Finanzierung der Krankenversicherung und der richtigen Anreizstruktur in einem Zuzahlungssystem in Japan diskutiert.

In Japan stellt die eigentliche Umsetzung der Pflegeversicherung, die im April 2000 eingeführt wurde, ein Problem dar. Die Umwandlung von Krankenbetten in Pflegeplätze und große regionale Unterschiede in der Bereitstellung und Qualität des angebotenen Service sind hierbei die wichtigsten Punkte. Die japanische Pflegeversicherung wird alle fünf Jahre neu bewertet. Im Mittelpunkt stehen dabei ähnliche Problemfelder wie in Deutschland: a) Sicherung der Qualitätsstandards, b) Senkung des durch die Alterung entstehenden Kostendrucks und c) die gerechte Verteilung der Lasten auf die ganze Bevölkerung.

In Deutschland ist der soziale Schutz umfassender. In Japan schreitet die Alterung der Gesellschaft schneller voran. Vor diesem Hintergrund stellt in beiden Ländern stellt die Finanzierung des Sozialstaates ein herausragendes Problem dar. Dabei wird jeweils über neue Optionen nachgedacht. Dazu gehören auch die Neudefinition der Bedürfnisse von Älteren, die Ausweitung der Finanzierungsbasis von Sozialleistungen und die Stärkung der privaten Alterssicherung. Japan und Deutschland haben viele Gemeinsamkeiten. Dazu gehören vor allem das grundlegende Problem der Alterung der Gesellschaft und die Dominanz staatlicher Absicherung; auch zeigen die Reformansätze erhebliche Ähnlichkeiten.