ESRI International Collaboration Projects 2007

Health Care in Germany and Public Pensions in Japan

March, 2008

Noriyuki Takayama, Hitotsubashi University (Leader)
Katsuyuki Matsumoto, Hitotsubashi University
Hideaki Tanaka, Hitotsubashi University
Kousuke Shiraishi, Hitotsubashi University
Reiko Aoki, Hitotsubashi University
Toshie Ikenaga, Hitotsubashi University
Iichiro Uesugi, Hitotsubashi University
Sachiko Kuroda, Hitotsubashi University
Kengo Yasui, Hitotsubashi University
Chapter 1

Introduction¹

There are many challenges in social security health care and pensions of the developed countries where further population aging is expected to continue for some decades ahead.

In this paper we will focus on the latest 2007 German health care reform, and social security pensions in Japan.

Chapter 2 analyzes the 2007 German reform of the health care system, examining its financial stability, impacts of the change in the medical fee system, implications of expanding insurees' choice and the effects on the quality of medical care. We will draw some lessons from health care reform in Japan, as well.

Chapters 3 to 5 studies several aspects of social security pensions in Japan. Chapter 3 addresses pension issues in the context of intergenerational equity. Special attention is paid to the following two problems: first, how to find an intergenerationally equitable remedy for the mistakes made in the past; second, what pension schemes will be preferable for a nation to avoid iniquities between generations arising from uncertainties in the future.

Chapter 4 discusses the integration issues of social security pensions, public assistance and taxation, to balance the insurance role with the redistribution role. First it labels the Japanese pension system as "inefficient" in terms of both smoothing income (insurance role) over a lifetime and providing adequate income (redistribution role) with international comparisons, although the overall income level of Japanese elderly relative to young workers is higher than the OECD average. Second, it reveals that the inefficiency above mentioned derives from fragmentations within the pension system, between social security pensions and public assistance, and between pensions and taxation. Finally, it argues the urgency of integration of relevant systems for ensuring old-age

¹ Chapters 1 and 3 are written by N. Takayama, Chapter 2 by K. Matsumoto, Chapter 4 by H. Tanaka, and Chapter 5 by K. Shiraishi. The authors are very much grateful to the appointed discussants (Professors John Piggott and Seiritsu Ogura) for their insightful comments and helpful advices.
income security in the context of rapidly changing economic and social circumstances and discusses major issues in proposing several alternatives for integration with reference to major OECD countries' experiences.

Chapter 5 introduces a new microsimulation model (PENMOD) of Japan which takes individual’s economic conditions into account. It asserts that a microsimulation is a promising alternative for quantitative pension analyses and a step toward “personalization,” while presenting some preliminary simulation results.
Chapter 2

Germany’s 2007 Health Care Reform: An Assessment and Lessons for Japan

2.1 Introduction

A major issue on the agenda of the grand coalition government formed in Germany in autumn 2005 has been the reform of the health care system. The point of departure of debates on this issue has been the accord in the coalition agreement which concluded at the inauguration of the coalition government to “ensure the continuing function of the health care system through a stable financial structure.” However, because of major disagreements between the coalition parties – the Christian Democratic Union/Christian Social Union (CDU/CSU) on the one hand and the Social Democratic Party (SPD) on the other – finding a consensus on the concrete contents of the reform, and especially on the future shape of the financing structure, has proved to be a serious challenge. For this reason, it was not until February 2007 – more than a year after it had been agreed upon – that the ruling parties, which together hold about 70 percent of parliamentary seats, passed the “Bill for the Strengthening of Competition in the Public Health Insurance” to implement the reform.

The background to the reform are challenges posed to Germany’s health care system by demographic changes. Health care costs per insured member of the health care system increase with insurees’ age, and as the German population ages, this alone will cause health care expenditures to rise. In addition, however, the discovery of new diseases and the development of treatments through advances in medical science will put further upward pressure on health care expenditures. Yet another challenge concerns the actual supply of medical care service: it has been pointed out that medical care resources are not always deployed efficiently, resulting in an excess or shortage of supply in some areas, considerable variations in the quality of medical care, and a suboptimal

---

2 Source: “Gemeinsam für Deutschland - mit Mut und Menschlichkeit: Koalitionsvertrag zwischen CDU, CSU und SPD” (Coalition agreement between CDU, CSU and SPD), November 11, 2005, p.87.
distribution of medical resources.³

To address these problems and ensure that in future all citizens, independent of their age and income, can still receive medical care that keeps pace with advances in medicine, it has been deemed necessary to revise the financing structure of the health insurance system and to raise the efficiency and effectiveness of medical supply. It is against this background that the Law for the Strengthening of Competition in the Public Health Insurance with the aim of a broad-based reform of the health care field and with a view to increasing competition was enacted.

The law has the following objectives:

- to ensure that all residents are covered either by public or private health insurance;
- to preserve the financial sustainability of the health insurance system;
- to promote competition between “health insurance funds” (Krankenkassen) and between health care suppliers and, by increasing transparency, to raise the quality of health care and restrain costs; and
- to expand the extent of insurees’ self-determination.

In order to achieve these goals, the law covers a large number of areas, revising the scope of insurees covered, the structure of health care supply, the organization of insurers, and the financial structure of the public health insurance, and revises regulations for private health insurance. While some of these measures address problems specific to the German health insurance system, such as revisions relating to the scope of insurees covered, they also include measures to resolve issues that Germany and Japan have in common. Reform of the health care system to respond to socioeconomic changes, first and foremost demographic changes, and the ability to ensure the provision of quality medical care and the financial sustainability of the health care system, are challenges faced not only by Germany, but also Japan. Consequently, the aim here is to analyze Germany’s 2007 reform of the health care system (Gesundheitsreform) by focusing on especially pertinent issues and to draw potential lessons for health care reform in Japan.

This chapter is organized as follows. Section 2.2 concentrates on the reform of the financing

---

³ Source: Bundestagsdrucksache 16/3100, p.85.
structure of the health insurance system, providing an outline of the current system, illustrating the problems that it faces, presenting the content of the reforms, and finally offering an assessment and discussions of potential lessons for Japan. Section 2.3 turns to the reform of the medical fee system, again presenting the current system, the associated problems, the contents of the reform, and then an assessment and discussions of lessons for Japan. Section 2.4 then focuses on the expansion of choice through the reforms, the type of competition which the 2007 German reform is intended to generate, the exact nature of the reforms, and, again, an assessment and discussions of the implications for Japan. Section 2.5 summarizes the discussion.

2.2 Transformation of the financing structure of the health insurance system

2.2.1 The current financing structure

Public health care in Germany, as in Japan, is based on the pay-as-you-go system. That is, medical care expenditures in each year are basically covered by the revenues generated in that year. However, in contrast with Japan, where health insurers receive substantial public funds, in Germany, insurance premium revenues account for the greatest part of health insurance revenues. The premium contribution paid by each insuree is calculated by multiplying that person’s income such as wages and salaries which are the basis for the calculation of insurance premiums (beitragspflichtiges Einkommen = premium contribution-liable income) with the insurance premium rate. Half of the insurance premium thus calculated is paid by the insuree him- or herself, while the other half is borne by his/her employer.\(^4\)

As a result of this arrangement, the insurance premium amount that each insuree has to shoulder is calculated depending not on that person’s health risk but his/her wage or salary. Moreover, the medical care received through the health insurance does not depend on the amount of insurance premium contributions but basically is determined by the necessity of medical treatment. Through this framework, the public health insurance has a redistributive effect among the healthy and the

\(^4\) In the case of those receiving a public pension, it is the pension income that is the basis for the calculation of insurance premium contributions and the insuree and the pension insurer each pay half of the insurance premium.
sick, the young and the old, and high-income and low-income earners. The adoption of this kind of solidarity financing (*solidarische Finanzierung*) is a key characteristic of the public health insurance system. Thus, in practice, insurance contributions by pensioner households, for instance, cover no more than 40 percent of the medical care required by such households, and the difference is made up for by the premium contributions paid by worker households. The reason for this redistribution is that while the aged, such as pensioners, typically require more health care, pension income on a net basis is no more than 70 percent of the wage and salary level of the working age generation.

In Germany’s health insurance system, financial responsibility rests with the Krankenkassen ("health insurance funds"), which each year set insurance premium rates at levels designed to ensure that premium revenues cover expenditures. However, there are large differences in Krankenkassen’s risk structure in terms of the age structure of insurees that have joined and their level of wages and salaries, and there are therefore differences in the premiums the various Krankenkassen charge. For example, Krankenkassen with a greater number of elderly insurees and low-income insurees generally have to set higher insurance premiums than other Krankenkassen.

This situation leads to the following problems. One is that even though two insurees may earn the same wage or salary, if they have joined different Krankenkassen, they have to pay different insurance premiums, even though the medical care they receive does not differ. Another problem is related to competition among the Krankenkassen. In Germany, insurees have extensive rights to choose which Krankenkasse they join. For that reason, the Krankenkassen compete with each other to attract insurees. However, an important factor in insurees’ choice of Krankenkasse is the premium they charge. Assuming that there were no intervention in this type of competition, Krankenkassen with fewer elderly insurees or with insurees with higher wages would enjoy an advantage through this very fact alone, which would be completely unrelated to any efforts to lower

---

6 According to official data by the Federal Ministry of Health, public health insurance payments per insuree in 2004 were €3,937 in the case of pensioners and their families compared with €1,294 for other insurees and their families. Before the implementation of the adjustment for risk structures (explained shortly), the average insurance premium for all Krankenkassen was 13.22 percent. However, by type of Krankenkasse, they ranged from 11.83 percent for the Betriebskrankenkassen (BKK; company health insurance funds) to 13.80 percent for the Allgemeine Ortskrankenkassen (AOK; regional health insurance funds).
premiums through improved management, which is the key objective of having competition. There would thus be the danger of a tendency toward risk selection by the Krankenkassen by attracting young high-income insurees.

To resolve this problem, and hence to ensure fairness in premium contributions and maintain the basis for competition between the Krankenkassen, a mechanism of adjusting for risk structures (Risikostrukturausgleich) was put into place that takes differences between the Krankenkassen in terms of the factors that influence their expenditure and income – such as insurees’ sex and age structure, the share of insured family members (in Germany’s public health insurance system, dependent family members are automatically covered), the level of insurees’ gross income liable to premium contributions – into account. Under this mechanism, each Krankenkasse pays funds corresponding to its financial strength (Finanzkraft) determined on the basis of its insuree base, and receives funds corresponding to its required premium contributions (Beitragsbedarf). The financial strength of each Krankenkasse is calculated by multiplying the total amount of insurees’ premium contribution-liable gross income by an adjustment requirement rate (Ausgleichsbedarfssatz). The adjustment requirement rate is calculated by dividing the required premium contributions of all Krankenkassen (i.e., the total medical care expenses of all Krankenkassen) by the total amount of insurees’ premium contribution-liable gross income of all Krankenkassen and is equivalent to the calculated average premium contribution rate. On the other hand, the required premium contributions of each Krankenkasse are obtained by using the average per-person medical care expenses across all Krankenkassen for each group of insurees classified by sex, age, whether there are disability payments, etc., and multiplying this by the number of insurees belonging to each group at a particular Krankenkasse.

Through the implementation of the risk structure adjustment mechanism, it is on the basis of restraining the level of medical care expenses and not by attracting young high-income insurees that Krankenkassen can lower premium contribution rates and compete with other Krankenkassen in attracting insurees. Thus, the type of competition that results is one that forces each Krankenkasse

---

8 In practice, it is only the difference between their actual financial strength and the required premium contributions that the Krankenkassen pay and receive through the mechanism.
to make efforts to raise the efficiency of the provision of benefit and restrain medical care expenses.

2.2.2 Problems with regard to the current financing structure

One of the problems of the current financing arrangements is related to the solidarity principle. As outlined above, the public health insurance contains a redistributive element. The problem is that in Germany, where unlike in Japan, a “universal insurance” system has not been adopted, there are people who are not included in the redistribution. A representative example is high-income employees.

While wage earning employees, generally speaking, are obliged to join the public health insurance scheme, those earning wages beyond a certain threshold are exempted from this obligation and have the choice of joining a private health insurance instead of the public health insurance.\(^9\) The background to this exemption is the philosophical tradition underlying German social insurance based on the motto “social insurance to those who require social protection.” However, from the viewpoint of the fairness of burden sharing, the fact that high-income earners do not participate in the redistribution brought about by the public health insurance system and join a private health insurance, which provides cover on more advantageous terms, is problematic.

Another problem is that because premium contributions are calculated on the basis of wages and salaries, those who derive part of their income from assets will, for the same level of total income, pay lower premium contributions. Yet another problem is that the obligation to join the public health insurance and the calculation of premium contributions are closely related to work. For this reason, the premium contribution revenues of the health insurance system are influenced by employment trends and fluctuations in wages. Looking at the situation in recent years, given large-scale unemployment and the low rate of wage increases, the growth in premium contribution revenues has been lower than the growth in disbursements, which is a major reason for the increase in the premium contribution rate. Furthermore, the increase in non-wage labor costs as a result of the rise in contribution rates has further lowered Germany’s attractiveness as a place to do business, leading to fears that this lowers domestic employment.

\(^9\) In 2007, this threshold was an annual salary of €47,700.
2.2.3 Proposals to address the problems with regard to the financing structure

In order to resolve the problems just mentioned, the coalition parties made the following proposals. The SPD, which stresses social solidarity, proposed the introduction of a “Citizens’ Insurance” (*Bürgerversicherung*), important pillars of which would have been that it covers all citizens, including high-income earners, and bases premium contributions on broadly-defined incomes that include asset income and the like. On the other hand, the CDU/CSU, which emphasizes the expansion of employment through a reduction in non-wage labor costs, proposed the introduction of a fixed “Health Insurance Premium” (*Gesundheitsprämie*), which would have imposed the same premium on all insurees. The two proposals thus went in opposing directions with regard to the redistributive function of the health insurance, which relies on medical care being provided based on medical necessity funded by premium contributions imposed on the income of each insuree. Given the fundamental differences, the debate between the coalition parties surrounding the two proposals remained unresolved, resulting in neither of them being adopted. Instead, what was eventually adopted was the Law for the Strengthening of Competition in the Public Health Insurance, which introduces a radical reform of the financing structure that has as its central element the establishment of a “Health Fund” (*Gesundheitsfond*).

2.2.4 Contents of the reform

Following the reform, public health insurance premium contributions will be paid through the *Krankenversicherungen* into the Health Fund. Moreover, federal subsidies for the public health insurance will also be paid into the Health Fund. Premium contributions, as before, will be calculated on the basis of wages and salaries, and will be shouldered by insurees and employers. However, in contrast with before, the contribution rate will be set by the federal government at the end of each year and then applied by all *Krankenkassen* in a unified manner in the following year. The contribution rate will be set to cover, from the revenues of the Health Fund, all care

---

10 The Health Fund will be created by the Federal Insurance Authority (*Bundesversicherungsamt*), which until now has been in charge of the risk structure adjustment mechanism.
11 Federal subsidies in 2007 and 2008 will be €2.5 billion and from 2009 onward will be raised in annual steps of €1.5 billion until they reach €14 billion.
expenditure and total administrative expenses of all Krankenkassen. If it is anticipated that the revenues of the Health Fund will exceed 100 percent of total care expenditure and administrative expenses or fall below 95 percent, contribution rates will be lowered or raised.

Each Krankenkasse will be allotted funds from the Health Fund, taking into account how differences in their risk structures affect expenditures. That is, the amount that each Krankenkasse will be allotted is calculated based on a fixed basic lump sum (Grundpauschale) for each insuree which is adjusted upward or downward depending on the insuree’s age, sex, and morbidity,12 and the medical fees due for all insurees are then totaled up. While this way of allotting funds basically is a replacement of the risk structure adjustment mechanism, an important difference is that it takes morbidity into account.

In the risk structure adjustment mechanism, the same amount of care expenditure was assumed for insurees of the same sex and age, no matter what their health condition may be. For this reason, Krankenkassen could gain an advantage over their rivals by attracting healthier insurees, thus leaving room for risk selection by the Krankenkassen. To address this problem and achieve a more level playing field, the morbidity component is now also considered in the allotment of funds from the Health Fund. In addition, through the establishment of the Health Fund, the need for an adjustment mechanism to offset the impact of insurees’ wage and income levels on the revenues of each Krankenkasse disappears.

Should a Krankenkasse find that the funds allotted from the Health Fund are insufficient to cover its expenditure, it can charge insurees supplementary premium contributions; conversely, in the opposite case, it can refund premium contributions. Regarding the amount of supplementary contributions, the Krankenkasse can determine this as a fixed proportion of insurees’ wages and salaries or as a fixed amount that is independent of wages and salaries. In practice, it is likely that most Krankenkassen will adopt fixed-amount supplementary contributions in order to prevent insurees with high wages and salaries to migrate to their rivals. Moreover, in order to avoid that

---

12 That is, in the case of young and healthy insurees, a certain amount will be subtracted, while in the case of old and sick insurees a certain amount will be added.
supplementary contributions become too great a burden for insurees, they are set at a maximum of 1 percent of an insuree’s wage or salary if it is in excess of €8 a month.

2.2.5 Assessment of the reform and lessons for Japan

Assessment

One of the most important aspects of the health care reforms in Germany in recent years is that although the public health insurance system is based on the solidarity principle, it provides incentives for Krankenkassen to improve their performance by promoting competition through the expansion of insurees’ choice of Krankenkasse and the introduction of the risk structure adjustment mechanism. The reform of the financing structure outlined above also points in this direction and is likely to further intensify competition among Krankenkassen. The reason is that the framework that has been put in place means that it is now clearly observable to insurees whether Krankenkassen that are part of this set-up have been successful in restraining medical care expenditures by increasing the efficiency of the delivery of medical care. Although under the current system the extent to which Krankenkassen have been successful in restraining costs is also reflected in premium contribution rates, insurees in many cases have shown little interest in the premium contributions deducted directly from their wages and salaries. Under the new system, however, those insured with a Krankenkasse with above-average success in restraining costs will receive a refund of their contributions, while those insured with less successful Krankenkassen will have to pay supplementary contributions. Furthermore, when a Krankenkasse starts to charge supplementary contributions or raises the level of supplementary contributions, insurees are allowed to move to another Krankenkasse before being charged the supplementary contributions.13

Moreover, the fact that in the allotment of funds from the Health Fund to each Krankenkasse not only insurees’ age and sex but also their morbidity is taken into account is likely to further stimulate efforts by the Krankenkassen to lower costs and raise the quality of medical care provided. Thus, the reform of the financing structure itself is not something that will directly ensure that the

---

13 However, insurees are typically bound to their choice of Krankenkasse for 18 months and cannot move to another one before this period is up.
financial resources to cover future health care costs, which are only bound to rise as a result of population aging, etc., are secured in a stable and equitable manner; rather, its special characteristic is that it aims at securing the financial future of the health care system by strengthening incentives to raise the effectiveness and efficiency of the provision of medical care.

Nevertheless, the following problem with regard to the new system needs to be highlighted. As mentioned above, it is possible that the ratio of medical care and administrative expenses covered by the revenues of the Health Fund falls to 95 percent. In this case, it becomes necessary to charge supplementary premium contributions which, averaged out over all Krankenkassen, work out at €12.50 per month per insuree (which would be equivalent to 0.8 percentage points in terms of the premium rate). This means that a Krankenkasse which already had to charge supplementary premium contributions because it was not sufficiently successful in controlling the efficiency of medical care provisions, will have to charge even higher supplementary premium contributions, which in the case of low-income insurees may exceed the fixed threshold. If this happens, the Krankenkasse will have to make up the shortfall in supplementary premium contributions of low-income insurees by raising those of high-income insurees. As a result, high-income insurees may migrate to other Krankenkassen. Ultimately, such a Krankenkasse may be left with many low-income insurees and unable to cover shortfalls through supplementary premium contributions and may therefore collapse.

Lessons for Japan

In 2006, Japan also undertook reforms of its health care system, as part of which, for example, a new health care system for the “old old” (those aged 75 and over) was established, replacing the health care system for the elderly in force until then, and the financing mechanism for medical expenses for the elderly was reformed. However, in contrast with the German case, these reforms do not in any way deal with the role of competition. Rather, the health care system for the old old contains elements that aim at mitigating the burden of population aging on the young, such as an increase in co-payments by the elderly, an expansion of the scope of the elderly liable to premium

---

14 The figures are based on calculations by the AOK Bundesverband (Federal Association of the AOK).
contributions, an increase in the share of expenses borne by the elderly in response to the increase in the ratio of the elderly to the young, etc. However, the changes in the financing mechanism did not introduce any elements which promote efforts by insurers to raise the efficiency of medical care provisions through competition.

In Germany, even before insurees’ right to choose their Krankenkasse was expanded, there was a certain degree of competition among the Krankenkassen. Moreover, as the Krankenkassen are party to the negotiations on medical fees, etc., there was already scope for them to optimize medical care through their own efforts. Furthermore, unlike in Japan, there is no separation of the system into employee insurance and national health insurance. Circumstances differ greatly in Japan and it is difficult to imagine that competition between insurers will be introduced in the near future. For this reason, measures to restrain increases in health care insurance expenditure in Japan have concentrated on increases in the level of co-payments through legal revisions and reform of the criteria for payment of medical services by the Ministry of Health, Labour and Welfare. Moreover, looking ahead, it seems likely that public interventions by the national government, etc., will continue to play a large role in attempts to raise the quality and cost-effectiveness of medical care supply.

As for financial adjustment in Japan’s health insurance, the sole aim – in contrast with the German case – is to achieve an equitable burden sharing of the expenses required for caring for the elderly. Nevertheless, there are large differences between insurers in terms of the age structure and wage and salary level of their insurees other than the old. For this reason, even though an adjustment through government subsidies takes place, differences in insurance premium rates between insurers can be found. Moreover, in Japan, insurees are not allowed to choose which insurer to join, so even if premium rates are high, they cannot move to another insurer. Looking at this situation from the viewpoint of equitable burden share to provide health care for all insurees, the way financial adjustments are made would need to be reexamined to resolve this problem.
2.3 Reform of the fee system for outpatient medical services

2.3.1 The present fee system for medical services

In Germany, payment for outpatient treatment by a health insurance physician (Vertragsarzt) by the Krankenkassen is made through the associations of health insurance physicians (kassenärztliche Vereinigungen), of which there is one for each of the 17 regions of Germany. The reason why medical fees to health insurance physicians are paid through the health insurance physician associations is that these associations are legally obliged to ensure the adequacy of outpatient treatment by health insurance physicians. Because of this, contracts relating to medical care by health insurance physicians are concluded not with individual physicians but between the health insurance physician associations and Krankenkassen associations.

Each Krankenkasse pays the relevant health insurance physician association a total amount for medical fees that is obtained by multiplying a per capita amount for member insurees (excluding family dependents) that was agreed beforehand between the state associations of the Krankenkassen with jurisdiction for that particular region and the health insurance physician association, with the number of member insurees (again without family dependents) living in that region, irrespective of whether they received outpatient treatment or not. Because the number of member insurees on the record date is used, any change in the morbidity after the agreement (for example, because of an outbreak of influenza) will not affect the total amount of medical fees. Rather, changes in morbidity will be reflected in future revisions of total medical fees paid. However, in that case, too, because the “principle of stable contribution rates” (Grundsatz der Beitragsstabilität) is applied, the extent to which the amount of medical fees is raised is basically restricted to be within the increase in the average premium contribution-liable income per insuree.

The health insurance physician associations then distribute this amount of medical fees among all the health insurance physicians under their umbrella based on a fixed allotment criterion. This allotment criterion is decided by the health insurance physician associations on the basis of

---

15 Health insurance physician associations are basically organized by Land (state). However, North Rhine-Westphalia is divided into two regions with a physician association with jurisdiction over each region.
unified valuation standards (einheitlicher Bewertungsmaßstab) and the agreement with the Krankenkassen associations. The unified valuation standards are expressed as a score for treatments that physicians can claim and their value (number of points), and are decided by the valuation committee (Bewertungsausschuss), a committee at the federal level consisting of representatives of the health insurance physicians and the Krankenkassen.\(^\text{16}\) The amount of medical fees allotted to each physician, similar to the Japanese case, is obtained by first calculating the points corresponding to the individual medical services (medical examinations and treatments) provided by each health insurance physician. The total number of points is then multiplied by the point value. However, because the total amount of medical fees that can be allotted to physicians is determined in advance, if physicians under the umbrella of the health insurance physician association provide more services, the point value decreases to the extent that the total number of remuneration points increases. Therefore, in contrast with Japan, where the point value is fixed at ¥10, in Germany, a quantitative increase in services provided does not result in an increase in expenditure because of the decrease in the point value. This is a crucial difference between the systems of the two countries.

2.3.2 Problems with the present fee system

Under this system, where the total amount of medical fees paid by the Krankenkassen to the health insurance physician associations is tethered to the total premium contribution-liable income and is not affected by a quantitative expansion in the medical services provided by each health insurance physician, increases in expenditure on outpatient treatment in the public health insurance have been slower than increases in expenditure on hospital treatments and medication. However, there is mounting criticism that the present system lacks in fairness, transparency and efficiency.\(^\text{17}\) Moreover, dissatisfaction with regard to these issues in outpatient treatment is also increasing.

A key aspect in this respect is that the level of compensation per insuree, on which the calculation of the total amount of payments for medical services is based, differs greatly by Krankenkasse. For

\(^\text{16}\) The valuation committee consists of seven members designated by the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung) and the federal associations of Krankenkassen (Bundesverbände der Krankenkassen).

\(^\text{17}\) Orlowski U. and Wasem J., Gesundheitsreform 2007 (GKV-WSG), C.F. Müller, Frankfurt am Main 2007, p.51.
example, in 2004, the compensation per member insuree by Barmer, Germany’s largest Krankenkasse, was €134.40, while that by the Berlin AOK (Berlin regional Krankenkasse) was only €106.80. Yet, it is difficult to discover a logical reason behind such a gap for instance differences in the age structure of insurees or the share of family members covered through the insurees of these Krankenkassen. The only explanation therefore are historical reasons. As a result, the current system has been criticized in particular by the Krankenkassen that pay relatively high levels of total compensation. On the other hand, physicians have leveled the following criticisms:18

- because the point value changes, the compensation for medical services actually provided cannot be predicted in advance;
- even if the volume of necessary medical services increases, the medical fees physicians receive do not necessarily correspond;
- for example, if there is an outbreak of influenza or the like, the risk of increases in expenses caused by changes in morbidity have to be borne by physicians;
- because the extent of increase in the amount of payments for medical services is limited to fall within the rise in premium contribution-liable incomes, the effects of changes in demographic structure and medical progress are not sufficiently taken into account;
- because the allotment criteria are influenced by the opinions of the type of physicians that make up the majority in the health insurance physician associations, the allotment of compensation becomes arbitrary.

Moreover, many patients have been complaining that although they are charged large amounts of money for outpatient treatment, in practice they still have to wait many days to see a doctor, especially in the case of specialized physicians.19

2.3.3 Content of the reform

In order to resolve these issues, the “Public Health Insurance Modernization Law” (GKV-Modernisierungsgesetz) enacted in 2003 introduced a system that calculates compensation

18 Ibid., pp. 52-53.
19 According to a sample survey conducted by the research institute of the AOK, one in four insurees with acute medical problems had to wait more than two weeks to be seen by a physicians.
amounts using a fixed point value. However, because the Krankenkassen and physician associations have not reached the necessary agreement to implement this, the old method continues to be used. For this reason, the Law for the Strengthening of Competition in the Public Health Insurance contains a further revision to advance the reform of the payment system for outpatient medical services. The aim of this revision is to increase the transparency of the system by switching to a system that calculates the remuneration for outpatient medical services performed by physicians using a fixed point value and at the same time to shift the cost risks resulting from changes in morbidity from physicians to the Krankenkassen. In addition, the revision also aims at eliminating the arbitrary allotment of payments for medical services through the physician associations. This revision will be implemented in two steps, with the switch to the revised unified valuation standards (see below) to take place in 2008 and that to the compensation system based on a fixed point value to commence from 2009.

**Revision to the unified valuation standards**

From 2009, physicians’ compensation will be calculated on the basis of a fixed point value that will not change regardless of the volume of medical services provided (total points). However, because it is feared that this would relax the controls on the quantity of medical care provided and hence result in a large increase in health insurance expenditures for outpatient treatment, the unified valuation standards were revised by the valuation committee in line with the regulations of the Law for the Strengthening of Competition in the Public Health Insurance with the aim of putting in place the necessary framework for the introduction of the new system. The principal aim of the revision of the valuation standard is to advance the use of lump sum payments for most medical fees paid to family and specialist physicians.

In Germany’s health insurance system, outpatient services by physicians by law are separated into family physician medical care (*hausärztliche Versorgung*) and specialist physician medical care (*fachärztlicher Versorgung*). Medical services by the family physician principally consist of medical care provided in the diagnosis and treatment of patients based on knowledge of patients’ individual and family circumstances, the coordination of diagnostic, therapeutic, and nursing
measures, the documentation of important medical diagnoses and treatments, and the initiation or implementation of preventative or rehabilitative measures. The family physician acts as a general practitioner, pediatrician, or non-specialist internist and is expected to coordinate medical care that straddles various fields. However, in Germany, patients can choose their family physician themselves and there is no obligation to consult their family doctor first when medical care is necessary.

Based on the most recent reforms, family physicians will now be compensated by being paid each quarter a per insuree lump sum (Versichertenpauschale) for every insuree that they treated. Included in this lump sum compensation are all medical services that family physicians commonly perform in outpatient treatments. Because the amount of work involved in treating different types of patients varies substantially, the points for the lump sum compensation per insuree will by law be set taking differences in patients’ age, sex and contracted disease (e.g., diabetes mellitus) into account. Under the new unified valuation standards, the basic points for the lump sum per insuree are assigned by patient age bracket and are 1000 points for those up to 4 years of age, 900 points for those aged between 5 and 58, and 1020 points for those aged 59 and over. Moreover, if a patient suffers from a severe chronic disease, a further 495 points are added to the lump sum points.20

As a general rule, family physicians cannot make claims for compensation for individual treatments apart from this lump sum. However, there are a number of individual treatments that are considered worthy of being encouraged and physicians are therefore allowed to claim compensation that is separate from the lump sum per insuree.21 Furthermore, the arrangement also allows for a “quality supplement” (Qualitätszuschlag) to take into account high-quality treatments for specific diseases.22

Turning to the compensation of specialist physicians, this is now essentially composed of a basic lump sum allowance (Grundpauschale) and a supplementary lump sum allowance

20 In this case, the definition of a “severe chronic disease” follows the guidelines determined by the Federal Joint Committee (Gemeinsamer Bundesausschuss) based on the provisions of Article 62, Paragraph 1, of Book 5 of the Social Security Code.
21 The present reform provides for ten types of individual treatments that should be especially encouraged, such as computer-aided evaluation of continuously recorded long-term cardiograms (260 points) and testing procedures in the case of suspected dementia (55 points).
22 In the current reforms, 20 points may be added in cases where physicians are required to possess a qualification to perform psychosomatic treatments.
The lump sum allowances are determined for each type of specialist physician, such as internists, urologists, psychiatrists, etc. Compensation for individual treatments that fall outside the lump sum allowances is limited to especially necessary treatments included in the unified valuation standards.

Treatments covered by the basic lump sum allowance are those included in the unified valuation standards and typically offered in all treatments by a particular type of specialist physician. Moreover, the supplementary lump sum allowance takes into consideration cases in which the treatment requires special qualifications, equipments, or therapies. Under the new unified valuation standards, the number of points for the basic lump sum allowance that internists, who play an important role in the treatment of heart disease, can claim depends on the age of the patient and is set at 405 points for those up to four years of age, 585 for those between five and fifty-eight, and 605 points for those aged fifty-nine and over. In addition, the supplementary lump sum allowance for duplex echocardiographic diagnosis and concomitant treatment (1920 points) and the like are also set.

Turning to concerns that have been raised with regard to the use of lump sum payments, it has been suggested that a system in which a fixed lump sum compensation is paid that does not depend on the type and quantity of treatment actually performed provides an incentive for physicians to economize on treatment. For this reason, physicians potentially may not always provide the treatment that would be necessary from a medical point of view and could refer time-consuming patients to other health insurance physicians or hospitals. To address this problem, the present reforms contain regulations stipulating that the valuation committee must set rules that contain inspection standards in order to ensure that physicians provide the necessary treatment and maintain the necessary quality levels.

The change over of the compensation system

Based on the reform of the unified valuation standards, there will be a gradual changeover, from 2009 onward, to the system in which compensation will be calculated on the basis of fixed point
values. Issues with regard to this concern the setting of the point values and the control of the volume of treatments.

Regarding point values, the valuation committee will set every year the commonly applied “national unified standard values of points” (hereafter, “national standard values” for short). Compensation for medical services provided by physicians will basically be determined by multiplying the number of points for applicable medical services according to the unified valuation standard with the national standard values. In addition, from 2011 onward, the valuation committee will set national standard values that reflect the excess or shortage of supply in each year. That is, in areas where physician demand planning suggests there is a shortage of supply,23 a higher national standard value will be set in order to make it more attractive for physicians to open a practice. Conversely, in areas where there is excess supply, a lower than usual national standard value will be set. For example, if in a particular planning area there is an excess of supply of internists, a national standard value will be applied that is lowered to the extent that it will influence physicians’ practice opening behaviour.

The point value applied in a particular area will be negotiated and agreed upon by the state associations of the Krankenkassen and physician associations based on the national standard values decided by the valuation committee. However, because the national standard values will be binding in these negotiations and agreements, they can decide on point values that differ from the national standard values only in specific instances laid down by the law.

Specifically, they can agree on a supplement (Zuschlag) or deduction (Abschlag) only if there are special regional characteristics in cost or supply structures that warrant such a diversion from the national standard values. The assessment of whether such special regional characteristics in cost or supply structures exist occurs on the basis of indicators determined by the valuation committee. An example of an indicator used to assess special regional characteristics in cost structures is the degree

---

23 Physician demand planning is determined by each physician association in order to redress regional maldistributions of physicians. In the physician demand planning, one or several planning areas are designated. If, in a particular planning area, the ratio of physicians in a specific medical field relative to the population of that planning area exceeds the “demand-compatible supply ratio” by more than 10 percent and, hence, there is judged to be “excess supply,” the approval of health insurance physicians will be restricted. Based on the situation at the end of 1990, the “demand-compatible supply ratio” in each medical field, expressed as the ratio of the number of physicians per population, is obtained for each area taking regional characteristics such as population density into account.
to which labor costs related to medical treatments by physicians diverge from the national average. Similarly, with regard to indicators to assess special regional characteristics in supply structure, an example is the degree to which the rate of increase in the number of treatments diverges from the national average rate.

In sum, the unified valuation standards determine the medical services physicians can claim as well as the number of points for those services. Moreover, the point value is determined by the national standard values and the supplement or deduction agreed in each of the 17 regions. Based on this, the medical fee schedule for claimable medical services and the respective value of medical fees expressed in euro for each region (the regionale Euro-Gebührenordnung) is determined.

Turning to controls on the volume of medical supply, following the introduction of the medical fee system based on fixed point values, the total amount of medical fees to be allotted will continue to be set. However, in contrast with before, this total amount will no longer be restricted to fall within increases of premium contribution-liable income per insuree, but will be revised to respond to changes in medical care needs. Moreover, in addition to the total amount of medical fees, the standard volume with regard to the medical services provided by each physician will also be set.

The state associations of the Krankenkassen and each physician association will, until the end of October of each year, jointly and in a unified manner decide the total amount of medical fees to be paid the following year by each Krankenkasse to the physician associations. In order to set the total amount of fee payments, medical care needs (Behandlungsbedarf), determined on the basis of the number of insurees living in the relevant area, their morbidity, etc., will be established as a total number of points based on the unified valuation standard. The total amount of medical fees that the Krankenkassen should pay expressed in euros is then obtained by multiplying the total number of points with the point value applied in that region.

Medical care needs will be adjusted taking into account the effect on the volume of medical care of changes in the number of insurees and morbidity, changes in the type and extent of outpatient

\[24\] In order to grasp changes in morbidity, the valuation committee, based on data on patients’ diagnosis category and the quantity of supply of respective outpatient treatment, groups together insurees with equivalent medical care needs corresponding to the diagnosis category. Moreover, a comparative grading taking into account the medical care needs of insurees belonging to each group is conducted.

According to the National Association of Statutory Health Insurance Physicians (Kassenärztliche Bundesvereinigung), the relative grading for a 67 year-old male, for example, is 0.1, that if a person falls into the
treatments as a result of legal revisions, and changes in the relative weight of outpatient and hospital treatments as well as increases in cost effectiveness of outpatient treatments. With regard to the total medical fees, the “principle of stable contribution rates” no longer applies. Therefore, the increase in the total amount of medical fees paid as a result of a change in medical needs in a region may now exceed the increase in premium contribution-liable income per insuree.

Within the extent of total medical fees agreed, each Krankenkasse then pays the physician association the amount of compensation which is obtained by multiplying the number of points for medical services actually delivered with the point value applied in the region. If the amount thus obtained exceeds the total amount of medical fees agreed, the fees for medical services that would be equivalent to the excess amount, as a general rule, are not paid. However, if the reason that the amount obtained exceeds the total medical fees agreed is an increase in medical care needs caused by a change in morbidity that could not be anticipated at the time the agreement was made, then the fees for treatments corresponding to the excess part will also be paid, using the point value applied to that region.25 In other words, it is now the Krankenkassen rather than the physicians that will bear the risk of unanticipated changes in morbidity.

Another element to control the volume of medical supply are the so-called “standard benefits volumes per physician” (arztbezogene Regelleistungsvolumina). These are basically the number of points for medical services delivered that are allotted to individual physicians from the total number of points (=total volume of medical services delivered) after a certain number of points has been set aside to provide for anticipated medical services volumes for insurees residing outside the jurisdiction of the concerned physician association, for services exceeding the standard benefits volumes, for anticipated service volumes not included in the standard benefits volumes, and for provisions for the compensation of fluctuations, for example in an increase in the number of physicians. The standard benefits volumes (=number of points), which is determined by the state diagnosis category “hypertensive heart disease” is 0.3, that if he falls into the diagnosis classification “kidney diseases caused by diabetes mellitus” is 1.1, and that in the case of “pancreatic disease” 0.2, which will be added to the grade. In the case that all of these categories apply, the relative grade of the person’s medical care needs will be 1.7 (=0.1+0.3+1.1+0.2) (Source: D. Stillfried, Gesundheitsreform 2007, manuscript for a speech held in Berlin, November 27, 2007).

25 The procedure to assess whether a change in morbidity could have been anticipated is determined by the valuation committee.
associations of Krankenkassen and the physician associations, is basically set by type of physician (i.e., family physician, cardiologist, urologist, gynecologist, etc.) taking insurees’ morbidity into account. However, in cases where there are special circumstances in the number and age of insurees that receive treatment by individual physicians, exceptions for individual physicians with regard to the setting of the “standard benefits” volume are permissible. The standard benefits volumes are set at a level that allows physicians to provide the medical service necessary to fulfill his/her outpatient medical care responsibility.

With regard to the services provided by each physician within the range of the standard benefits volume, the amount of compensation is calculated by the fixed point value applied to that region. On the other hand, with regard to the part of benefits that exceeds the standard benefits volume, the fee amount is calculated using a reduced point value. However, this reduction does not apply with regard to excess services resulting from an extremely large increase in the number of insurees receiving medical services. In addition, if, after the standard benefits volumes have been agreed, the total amount of medical fees rises as a consequence of a large change in morbidity that could not be anticipated (e.g., as a result of an outbreak of influenza), the standard service volume will be raised correspondingly.

2.3.4 Assessment of the reforms and lessons for Japan

Transparency and fairness

The reform of the medical fee system described above is thought to have the following effects. For insurance physicians, the introduction of the fixed point value system means that they now know in advance the compensation they will receive when providing a service. In addition, because point values are based on the national standard values, physicians are paid the same compensation for the same treatment no matter in which region the treatment is performed. Furthermore, an

26 Possible cases, for example, are those where a family physician has opened a practice in an area with a shortage of supply and needs to treat a large number of patients, or where the elderly account for a large proportion of patients because there is a senior citizens’ home in the vicinity.
27 It is also permissible to gradually increase the rate of this reduction depending on the extent to which the standard treatment volume is exceeded. This rate, in accordance with the standard decided by the valuation committee, is agreed upon between the state associations of the Krankenkassen and the physician associations.
increase in expenses through a change in insurees’ morbidity is no longer shouldered by physicians but is now borne by the Krankenkassen through a corresponding increase in the total amount of fee payments. On the other hand, the amount of medical fees each Krankenkasse now pays out is rationally calculated based on the morbidity of its insurees. For these reasons, it can be said that the reform raises the transparency of the medical fee system for outpatient treatment and greatly helps to ensure fairness in the financial burden shouldered by each Krankenkasse and in the allotment of compensation to physicians.

Turning to the case of Japan, the aforementioned issues do not arise because Japan has adopted a system in which insurers directly pay medical institutions for the treatments their insurees received based on a fixed point value. It would be useful for Japan to examine the pros and cons of taking regional characteristics into account by introducing supplements or deductions to the point value to take regional cost and supply structures into account like in Germany.

**Control of medical service volumes**

The use of a fixed point value system in the calculation of medical fees means that both in Germany and Japan, appropriate measures need to be put in place to keep the quantitative expansion of medical care supply in check. In this context, an issue that deserves special attention in the case of the recent reforms in Germany is the comprehensive use of lump sum payments of medical fees, not only in the case of the elderly but all insurees. Thus, the basic approach is that, in principle, lump sum payments of medical fees cover all services and that the payment of medical fees on a per-service basis is limited to exceptional cases where there is a special reason to warrant an exception. In addition, the system puts a brake on increases in health care insurance expenditure resulting from increases in service supply by linking the total amount of payable medical fees to medical needs and introducing “standard benefits volumes.” The reforms thus establish a framework that now also in the field of outpatient treatment imposes rationally determined checks on increases in medical fees by stipulating the volume and cost of medical care that is considered to be necessary in a standard treatment for a patient’s particular condition.
In contrast, in Japan, medical fees not only for outpatient but also for hospital treatment are calculated using a fixed point value, while lump sum payments and medical fee payments that diminish with the volume of medical care provided are applied only for very specific treatments by medical institutions. Thus, ways to affect treatment volumes are confined to modifications of medical fee points and a review of the medical appropriateness of the content of individual treatments. Yet, there are naturally limits to the extent to which the content of treatments and the rapidly growing number of claims by the great number of medical institutions that exist throughout the country can be individually inspected. Therefore, in order to resolve the problems associated with the fixed point value fee system and control the volume of treatments, Japan should also examine the comprehensive use of lump sum payments and set standards for the volume of treatments that is necessary for a particular type of ailment not only in the case of the elderly and special hospitals. It goes without saying that in implementing the use of lump sum payments, etc., it would be necessary to put measures in place to ensure that this does not lead to a deterioration in the quality of medical care.

**Redressing the regional maldistribution of physicians**

In Germany, medical demand planning at the regional level is conducted not only for hospitals but also with regard to the opening of practices by insurance physicians and supply is controlled to correspond to demand. However, in the past, the consultations and recommendations with regard to the opening of practices and the approval of insurance physicians through the physician associations based on this planning has failed to correct the regional maldistribution of physicians. Against this background, the most recent reform aims to resolve this problem through the introduction of a system that applies increased or decreased point values relative to the regular point values in areas with an excess or shortage of physicians, thus providing economic incentives to influence the behavior of physicians with regard to the opening of practices.

Yet, there are also problems with the present demand planning process itself. For example, within large cities such as Berlin, there are districts with high-income earners, with low-income earners, and with many foreigners, and large differences can be found in the ratio of physicians to
inhabitants in each district. However, because in the present planning process, Berlin is treated as one planning area, it does nothing to redress these types of differences. Therefore, the introduction of the system in which medical fee point values are adjusted depending on the demand for physicians is unlikely to sufficiently redress the maldistribution of physicians unless it is accompanied by a revision of the demand planning process.

In Japan, in contrast, the designation of health insurance physicians is unrelated to demand conditions in the region and physicians can decide to provide treatment as a health insurance physician in any area they like. This situation reflects the fact that in Japan the decision to set up as an insurance physician is assumed to be an issue related to the freedom of business guaranteed in the constitution. Moreover, the point value for medical fees is unified and independent of demand conditions. Nevertheless, providing appropriate economic incentives through the medical fee system, potentially represents a realistic and effective means of redressing the maldistribution of insurance physicians.

2.4 The expansion of choice

2.4.1 The nature of competition among the Krankenkassen

As already mentioned, the fact that insurees have the right to choose their Krankenkasse means that the Krankenkassen are put in a position where they compete with each other in attracting insurees. However, until now, efforts by the Krankenkassen to attract insurees have concentrated on keeping premium contributions low rather than, say, the quality of medical care supplied. The reason is that the medical services that each Krankenkasse was allowed to offer were set in a unified manner. As a result, there was no room for individual Krankenkassen to differentiate themselves, for example by making efforts to provide high-quality medical care by cooperating with medical care suppliers.

In order to change this, the recent health care reforms contain various measures to allow the Krankenkassen to compete not only on the basis of premium contribution rates but also the content and quality of medical services supplied. That is, the reforms provide a systematic framework by which it is now possible for the Krankenkassen, by cooperating with medical care providers such as
physician practices and hospitals, and by developing and implementing new medical examination and treatment processes and new forms of medical care provision, to compete on the basis of medical services that better meet insurees’ needs.

For example, by concluding contracts with medical institutions, each Krankenkasse can, in addition to the family physician-centered medical care (hausarztzentrierte Versorgung), introduce systems of “integrated care” (integrierte Versorgung) and “disease management programs” that aim at building an organizational structure in the region that provides patients with the different types of medical care (i.e., outpatient, hospital, rehabilitation, etc.) from the right supplier at the right time. Specific measures based on this system are already fairly widespread, and are showing results such as the shortening of treatment periods and cost savings.

2.4.2 Content of the reforms

Already prior to the most recent reforms, the Krankenkassen, rather than providing a standardized level of medical care at a standardized premium, were able to offer different levels of medical care at different premium rates. The aim of the current reform is to systemize and expand the choice of tariffs (Wahltarif) for insurees.

As a result, each Krankenkasse can now offer insurees the different types of tariff choice listed below. The aim of the reform is to promote the offering of attractive tariff choices, which allow insurees to choose from among a range of options the one that is most suitable for their individual situation.

Types of tariff choice

(a) Participation in a family physician-focused medical care scheme

Since April 2007, all Krankenkassen are obliged to put into practice a system of “medical care supply focused on the family physician.” It is optional for insurees to participate in this scheme, but in order to ensure family physician-focused medical care, participating insurees are obliged to choose a family physician and to not go to a specialist physician unless referred by the family
physician. This obligation for insurees is restricted to one year. On the other hand, the Krankenkassen can offer insurees that participate in this scheme a financial bonus or a reduction in co-payments.

(b) Participation in an integrated care scheme or a disease management program

The Krankenkassen can implement integrated care schemes and disease management programs that aim at strengthening the cooperation and appropriate division of roles between the different fields of medical care and at the efficient provision of high-quality care that responds to patients’ particular situation. It is optional for insurees to participate in these schemes, but if they do, they are oblied to submit to standardized therapies. On the other hand, the Krankenkassen can again offer insurees that participate in these schemes a financial bonus or a reduction in co-payments.

(c) Deductible (Selbstbehalt)

The Krankenkassen can offer a tariff option that includes a deductible. Insurees that have chosen this option, in addition to the normal co-payments, agree to pay out of their own pocket up to the deductible what essentially the Krankenkasse would otherwise have to pay, but in return can receive a financial bonus from the Krankenkasse. The application of this scheme previously had been limited to those who were voluntarily insured but is now expanded to all insurees.

(d) Refund of premium contributions

Another tariff option the Krankenkassen can offer is one that includes a refund of premium contributions. Insurees that chose this option can receive a financial bonus from the Krankenkasse if they or their family dependents (minors under age 18 excluded) did not require medical treatment in a calendar year. However, the amount of this financial bonus cannot exceed the average monthly

---

28 However, insurees will be allowed to see an ophthalmologist or gynecologist without referral from the family physician.
29 The reason why the effective reduction in insurance premiums takes the form of a bonus is that, through the introduction of the Health Fund, premium contributions are collected in a unified manner.
30 It is possible, under certain circumstances, to join a statutory Krankenkasse voluntarily, for example, if a person ceased to be subject to the obligation to join a statutory health insurance and was insured for at least 24 months during the five years prior to ceasing to be insured.
value of premium contributions in the applicable calendar year. The application of this scheme, too, had previously been limited to those voluntarily insured and has now been expanded to all insurees.

(e) Reimbursements (Kostenerstattung)

Yet another tariff option that the Krankenkassen can offer is one that includes reimbursements. Insurees that choose this option are reimbursed by their Krankenkasse for physician invoices billed on the basis of the higher medical fee schedule (privatärztliche Gebührenordnung) applied in the case of private medical insurance. This entitles insurees to receive benefits equivalent to those in a private insurance scheme, but requires them to pay supplemental insurance premiums.

(f) Special drug therapies

The Krankenkassen can offer a tariff option that includes reimbursements for treatments with drugs that are usually not covered by the public health insurance. This applies, for example, to drugs used in homeopathic therapy. Insurees choosing this option have to pay a supplementary premium.

Rules concerning tariff options

The Law for the Strengthening of Competition in the Public Health Insurance stipulates the following rules with regard to the offering of the above tariff options. First, the financial bonuses offered in the different tariff options must now be covered by the cost savings resulting from the relevant tariff option. Similarly, the supplementary costs must be covered by the supplementary premium contributions resulting from the tariff option. Taking the tariff option with a deductible and the offer of a bonus as an example, what this means is that if the cost savings on medical fees from this option are not as expected, it is not permissible to make up the shortfall by raising the regular insurance premiums for insurees that have chosen other tariff options.

Moreover, with the exception of options (a) and (b) listed above, insurees, as a general rule, are bound by their choice of option for a period of three years. This prevents, for example that people who chose the option with a deductible because they had been healthy, but who then became ill,
immediately change back to a regular insurance premium without a deductible. In addition, insurees are also not permitted to switch to another Krankenkasse during this period. However, exceptions with regard to the three year restriction are allowed in the case of “hardship cases,” which are decided by the Krankenkassen. Furthermore, the amount of the financial bonus is restricted to less than €600 per year or 20 percent of an insuree’s premium payments in a calendar year.

2.4.3 Assessment of the reforms and lessons for Japan

Assessment

As competition among the Krankenkassen intensifies, it is likely that they will expand the range of tariff options they offer in order to attract insurees. For the Krankenkassen, offering tariff options with a deductible or a refund of premiums, which so far had only been available to voluntary insurees but can now be offered to all insurees, provides an effective means to attract, and bind, insurees (because insurees will be tied to their tariff choices for three years). But at least for healthy insurees, there are also likely to be attractive options that will allow them to save on premium contributions.

However, with regard to the solidarity principle that underlies the public health insurance, the following issues need to be highlighted. First, although according to the new law, the Krankenkassen are not allowed to cover any shortfalls in, say, tariff options with a deductible through the contributions of insurees on other tariffs, if such tariff options did not exist in the first place, part of the premium contributions shouldered by the healthy insurees that are likely to choose such tariffs would go toward paying the treatment costs of sickly insurees. However, now such contributions will go toward paying for the financial bonus to healthy insurees on a tariff with a deductible. Moreover, sickly insurees have nothing to gain from this option. The only ones that will be interested in this option are young and healthy insurees, and although some expect that the effect of this will be limited,\footnote{See, e.g., Wille M. and Koch E., Gesundheitsreform 2007, C.H. Beck, Munich 2007, pp.165-166.} the expansion of this type of choice carries the danger of weakening the
solidarity between insurees, on which the public health insurance system is based, and of giving rise to differences and segregation between insurees. Moreover, concerns have been voiced that some patients may not get medically necessary treatments because of the deductible or because they want to receive a refund of premium contributions. It is thus feared that the health of such insurees may become even worse and as a result even more medical treatment will be necessary.

In contrast, “integrated care” schemes, “disease management programs” and the like are based on the premise that these will be joined by insurees with chronic diseases. By joining these, insurees can receive appropriate medical treatment for chronic diseases and at the same time enjoy an economic advantage by receiving a financial bonus or a partial reduction of their co-payments. In this sense, this type of tariff choice goes in a different direction than the tariff choices that include a deductible or a refund of premium contributions.

**Lessons for Japan**

In Japan, the revision of co-payments has become an important pillar in the reform of the health care system in recent years. However, the aim of the reform has been to restrain excessive visits to physicians by raising insurees’ cost consciousness by increasing co-payments and to reduce medical insurance expenditures by raising the share of costs borne by insurees. Although there are now differences in the co-payment share by age group, there are basically no differences between insurees belonging to the same age group. Moreover, a reduction in insurance premiums in the national health insurance is allowed only in cases where there are special circumstances such as a disaster.

It is difficult to imagine that Japan in the foreseeable future would follow the German example and introduce tariff options that include a deductible or premium contribution refunds. The reason for this is that with regard to these tariff options, in addition to the issues outlined above, the Japanese public health insurance system places far greater emphasis on equal treatment and solidarity of insurees than the German one.

Moreover, in respect to guaranteeing an appropriate system of medical care supply for the chronically ill, in Germany it is expected that the Krankenkassen play the central role through the
implementation of disease management programs, integrated medical care schemes, etc. In contrast, in Japan, according to the 2006 reform of the health care system, it is the prefectures that play the leading role by working out “Medical Expenditure Optimization Plans.” Yet, while the role of the prefectures, by working out such plans, is simply to form a consensus among concerned parties with regard to the shape that the medical care supply in the region should take and to make efforts achieve this, they themselves are not directly involved in the supply of medical care in specific cases. Consequently, providing incentives for insurees to join programs delivering the appropriate medical care by reducing co-payments or premium contributions could be an effective means to raise the quality and cost efficiency of medical care in Japan as well.

2.5 Summary

The establishment of a Health Fund and other parts of the 2007 health care reforms in Germany have further intensified competition between the Krankenkassen by allowing them to compete not only in terms of the level of premium contributions, but also on the basis of tariff options and the content and quality of benefits they offer. Thus, the reforms, like previous reforms in recent years, go in the direction of further developing the competitive framework in the public health insurance produced by expanding insurees’ right of choice of their Krankenkasse. An important aspect of the competitive framework which allows Krankenkassen to compete on the basis of the content and quality of benefits offered is that it produces a system in which each Krankenkasse can provide insurees with the appropriate medical care by working out cooperative agreements with medical care suppliers.

Already in the past, competition has led some Krankenkassen to merge with the aim of raising their competitive strength and, as a result, a drastic decline in the number of Krankenkassen. Looking ahead, it is like that this consolidation will continue as the Krankenkassen seek to improve their bargaining position vis-à-vis medical care suppliers and build an effective and efficient medical care supply system. It is therefore expected that in future, there will only be a relatively small number of Krankenkassen that will have various tariff choices on offer for each insuree.
Given these considerations, it seems fair to say that the 2007 health care reforms will continue to shape changes in the sector for the next 10 or 15 years. But the crucial question is whether, as this process unfolds, the greater competition and choice will be able to guarantee high-quality medical care that does not depend on people’s age or income, or whether, instead, it will lead to segregation and differences between people with regard to the medical care they receive.
References for Chapter 2


Chapter 3

The Japanese Pension System in an Intergenerational Context

3.1 Introduction

Today, Japan has the oldest population in the world. It has also built a generous social security pension programme, but since 2002, the income statement of the principal pension programme has shown a deficit. Consequently, public distrust in the government’s commitment towards pensions has been growing steadily in recent years.

The current pay-as-you-go public pension system has been working not as a pure insurance system but rather as a tax-and-transfer system involving huge income transfers between generations. In such a pay-as-you-go (PAYG) system, pension benefits for the aged are financed mainly by contributions from the working generation.

However, the nature of such an intergenerational contract is difficult for many people to understand. Maintaining a fixed rate of replacement in gross income terms for the elderly is by no means a contract. In fact, increasing costs stemming from larger numbers of retirees can only to a limited degree be shouldered by the actively working generation or future generations, because an increasing contribution burden will ultimately inhibit their work incentives. Instead, benefits and contributions in PAYG defined-benefit plans should be changed flexibly to respond to changing circumstances. This is necessary also because planning for different possible outcomes in the future can never be complete. Consequently we have found that the replacement rate embedded in the law is not a promise in a strict sense, but is just the starting point for an ongoing process of adaptation to a changing and unpredictable world. Continual adjustments will be required to keep the system viable.

This chapter addresses pension issues in the context of intergenerational equity. Special attention is paid to the following two problems: first, how to find an intergenerationally equitable remedy for the mistakes made in the past; second, what pension schemes will be preferable for a nation to avoid

---

32 This chapter is a slightly revised version of Takayama (2008).
any inequities between generations arising from uncertainties in the future.

The chapter is structured as follows. The next two sections 3.2 and 3.3 will give a brief overview of the Japanese social security pension programme and its financing perspectives. This is followed by a discussion of the key problems of the public pension system in section 3.4 and an analysis of the most important reform measures of the last pension reform in section 3.5. Sections 3.6 and 3.7 deal with intergenerational equity issues in Japan’s social security pensions and the future policy options to secure equity between generations. The chapter closes with some concluding remarks.

3.2 Pension provisions before the 2004 reform

Since 1980, Japan has carried out piecemeal pension reforms every five years, mainly due to great pressure caused by anticipated demographic and economic changes. Since then, overly generous pension benefits have been reduced step by step with an increase of the normal pensionable age from 60 to 65. The pension contribution rate has been lifted gradually as well. Yet, existing pension provisions still remain generous, and face serious financial difficulties in the future.

Japan currently has a two-tier benefit system. The first tier with a flat-rate basic benefit covers all sectors of the population and the second tier, earnings-related benefits, applies only to employees. The system operates largely like a pay-as-you-go defined-benefit programme.

The flat-rate basic pension covers all residents aged 20 to 60. The full old-age pension is payable after 40 years of contributions, provided the contributions were made before 60 years of age. The maximum monthly pension of 66,000 yen at 2008 prices (with the maximum number of years of coverage) per person is payable from age 65. The benefit is indexed automatically each fiscal year (from 1 April) to reflect changes in the consumer price index (CPI) from the previous calendar year. The pension may be claimed at any age between 60 and 70 years. It is subject to actuarial reduction if claimed before age 65, or actuarial increase if claimed after 65 years.

Earnings-related benefits are given to all employees. The accrual rate for the earnings-related

---

33 A detailed explanation of the Japanese social security pension system is given by Takayama (1998, 2003).
component of old-age benefits is 0.5481 per cent per year; 40 years’ contributions will thus earn 28.5 per cent of career average monthly real earnings.\textsuperscript{34}

The career-average monthly earnings are calculated over the employee’s entire period of coverage, adjusted by a net-wage index factor, and converted to the current earnings level. The full earnings-related pension is normally payable from age 65 to an employee who is fully retired.\textsuperscript{35} An earnings test is applied to those who are not fully retired. The current replacement rate (including basic benefits) for take-home pay or net income is about 60 per cent for a model male retiree (with an average salary earned during 40 years of coverage) and his dependent wife. The monthly benefit in this case is about 233,000 yen in 2008.

Equal percentage contributions are required of employees and their employers. The contributions are based on the annual standard earnings including bonuses. The total percentage in effect before October 2004 was 13.58 per cent for the principal programme for private-sector employees, the Employees’ Pension Insurance (Kōsei Nenkin Hoken), hereafter referred to as KNH. Non-employed persons between age 20 and 60 pay flat-rate individual contributions, which was 13,300 yen per month in 2004. For those who cannot pay for financial reasons, exemptions are permitted. The flat-rate basic benefits for the period of exemption is one-third of the normal amount.

Under the current system, if the husband has the pension contribution for social security deducted from his salary, his dependent wife is automatically entitled to the flat-rate basic benefits without making any individual payments to the public pension system.

The government pays administrative expenses and subsidizes one-third of the total cost of the flat-rate basic benefits. There is no subsidy for the earnings-related part.

The aggregate amount of social security pension benefits was around 46 billion yen in 2004, which is equivalent to about 9 per cent of Japan’s GDP of the same year.

\textsuperscript{34} A semi-annual bonus equivalent to 3.6 months’ salary is typically assumed.

\textsuperscript{35} The normal pensionable age of the KNH is 65, although Japan has special arrangements for a transition period between 2000 and 2025. See Takayama (2003) for more details.
3.3 Demography and its impact on financing social security

In January 2002, the Japanese National Institute of Population and Social Security Research (NIPSSR) released population projections according to which the total population would peak at 128 million around 2006 and then begin to fall steadily, decreasing to about 50 per cent of the current number by 2100.

The total fertility rate (TFR) was 1.32 in 2006. There is still little sign that the TFR will stabilize or return to a higher level. However, the 2002 medium variant projections assume that it will record a historical low of 1.31 in 2006 and will gradually rise to 1.39 around 2050, progressing slowly to 2.07 by 2150. The number of births, currently about 1.06 million in 2005, will continue to decrease to less than 1.0 million by 2014, falling further to 0.67 million in 2050.

Because it has the longest life expectancy in the world, Japan is now experiencing a very rapid ageing of its population. The number of elderly people (65 years and over) was 26.4 million in 2006 and will increase sharply to reach 34 million by 2018, remaining around 34–36 million thereafter until around 2060. Consequently the proportion of the elderly will grow very rapidly, from 20.7 per cent in 2006 to 25.3 per cent by 2014, rising further to more than 30 per cent by 2033.

In Japan, nearly 70 per cent of social security benefits are currently distributed to the elderly. Along with the ailing domestic economy, rapid ageing will certainly put more and more pressure on financing social security.

In May 2006, the Japanese Ministry of Health, Labour and Welfare published the latest estimates of the cost of social security, using the 2002 population projections of the NIPSSR. According to these latest estimates, the aggregate cost of social security in terms of GDP was 17.5 per cent in 2006. It will increase steadily to 19.0 per cent by 2025.

Of the various costs, that of pensions is quite predominant, amounting to 9.2 per cent of GDP in 2006, with an expected slight decrease to 8.7 per cent by 2025 (after the 2004 reform). The cost for health care was 5.4 per cent in 2006, but will rise steadily to 6.4 per cent by 2025.
3.4 Current problems of Japan’s public pension system

The public pension system in Japan currently faces several difficulties. Among these, the following five problems are especially crucial.

1. Persistent deficit in the income statement: since 2002, the KNH has been facing an income statement deficit. It recorded a deficit of 1.3 billion yen in 2002, and the deficit was expected to be 4.8 billion yen in 2005. It is estimated that the deficit will persist for a long time, unless radical improvements are made in the KNH financing.

2. Huge excess liabilities in the balance sheet: the KNH balance sheet is shown in Figure 3. In calculating the balance sheet, we assumed that:
   a) annual increases in wages and CPI are 2.1 per cent and 1.0 per cent respectively in nominal terms, while the discount rate is 3.2 per cent annually,
   b) the current contribution rate of the KNH, 13.58 percentage points, will remain unchanged in the future, and
   c) the period up to 2100 is taken into account.

Figure 3.1 indicates that, as of 31 March 2005, there were excess liabilities of 550 billion yen, which is a quarter of the total liabilities.36

Part One of Figure 3.1 is assets and liabilities accrued from past contributions and Part Two is those accrued from future contributions. Figure 3.1 implies that, as far as Part Two is concerned, the balance sheet of the KNH has been almost cleaned up. The funding sources of the current provisions will be sufficient to finance future benefits, and the only task left is to slim down future benefits by 4.5 per cent.

But if we look at Part One of Figure 3.1, things look quite different. The remaining pension liabilities are estimated to be 800 billion yen, while pension assets are only 300 billion yen (a

---

36 Excess liabilities of all social security pension programmes in Japan as of March 2005 amounted to around 650 billion yen, which is equivalent to 1.3 times the fiscal year 2004 GDP of Japan.
funded reserve of 170 billion yen plus transfers from general revenue of 130 billion yen). The difference is quite large – about 500 billion yen— which accounts for the major part of excess liabilities in the KNH.

500 billion yen is more than 60 per cent of Part One liabilities, equivalent to about 100 per cent of GDP of Japan in 2004. In the past, too many promises on pension benefits were made, while sufficient funding sources have not been arranged. The Japanese have enjoyed a long history of generous social security pensions. However, contributions made in the past were relatively small, resulting in a fairly small funded reserve. Consequently, the locus of the true crisis in Japanese social security pensions is how to handle the excess liabilities of 500 billion yen to which people are entitled on the basis of their past contributions.

3. Heavy pension contribution burden: in Japanese public debates, one of the principal issues has been how to cut down personal and corporate income tax. But recently the situation has changed drastically. Social security contributions (for pensions, health care, unemployment, work injury and long-term care) are 55.6 billion yen (15.2 per cent of national income) for FY 2003. This is more than all tax revenues (43.9 billion yen) of the government for the same year. Since 1998, the government has acquired more from social security contributions than from tax incomes. Looking in more detail, we can see that revenue from personal income tax is 13.8 billion yen and corporate income tax is 9.1 billion yen, while revenue from social security pension contributions stands out at 29.0 billion yen. Needless to say, the last places a most heavy burden on the public. The Japanese now feel that social security pension contributions are too heavy; they operate as the most significant factor in determining the take-home pay from the gross salary. On the other hand, businesses have begun to show serious concerns about further increases in social security contributions.

4. Overshooting in income transfer between generations: currently, in terms of per-capita income after redistribution, the elderly in Japan are better off than those aged 30 to 44 (see Figure 3.2). This

---

37 The amount of excess liabilities (EL) will vary depending on alternative discount rates. For example, a 2.1 per cent discount rate produces EL of 650 billion yen, while another 4.0 per cent discount rate produces EL of 420 billion yen. Part One excess liabilities can be termed as “accrued-to-date net liabilities” or “net termination liabilities”. See Franco (1995) and Holzmann et al. (2004).
indicates that there must still be room for reductions in benefits provided to the current retired population.

5. Increasing drop-out: in the past 20 years, the Japanese government has made repeated changes to the pension programme, increasing social security pension contributions and reducing benefits by raising the normal pensionable age while reducing the accrual rate. Further such piecemeal reforms are very likely to follow in the future.

Many Japanese feel that the government is breaking its promise. As distrust against government commitment builds up, concern about such ‘lack of credibility’ problem is also growing.

In 2005, nearly 33 per cent of non-salaried workers and the unemployed dropped out from the basic level of old-age income protection, due to exemption, delinquency in paying contributions or non-application (see Figure 3.3 for increasing delinquency).

Also, employers are discreetly trying to find ways to avoid paying social security pension contributions. The Ministry of Internal Affairs and Communications has estimated that nearly 30 per cent of the relevant business establishments did not participate in the KNH in 2004. Any further escalation in the social security contribution rate is likely to induce a higher drop-out rate.38

3.5 The 2004 pension reform: Main reform measures and remaining difficulties39

The administration of former Prime Minister Koizumi Jun’ichirō submitted a set of pension reform bills to the National Diet on 10 February 2004, and these were enacted on June 5. This section will describe the gist of the approved reforms and explore issues that remain to be addressed.

Salaried workers are, as a rule, enrolled in the KNH, which is part of the public pension system. Contributions under this plan had since October 1996 been set at 13.58 per cent of annual income,

38 Contributions to social security pensions operate as “penalties on employment.” Further increases in the contribution rate will severely hit domestic companies, which have been facing mega-competition on a global scale, thereby exerting negative effects on the economy, leading to a higher unemployment rate, lower economic growth, lower saving rates and so on. Further increases in the contribution rate will be sure to decrease the take-home pay of actively working people in real terms, producing lower consumption and lower effective demand.

39 This section draws heavily on Takayama (2004).
paid half by the worker and half by the employer, but the newly enacted reform has raised this rate by 0.354 percentage point per year starting in October 2004. The rate will rise every September thereafter until 2017, after which it will remain fixed at 18.30 per cent. The portion paid by workers will accordingly rise from 6.79 per cent of annual income in 2003 to 9.15 per cent in 2017.

For an average male company employee earning 360,000 yen a month plus annual bonuses equivalent to 3.6 months’ pay, contributions will increase by nearly 20,000 yen a year starting in October 2004. By the time they stop rising in September 2017, they will have reached just under 1.03 million yen a year, and the share paid by the worker will be just over 514,000 yen. This amounts to a 35 per cent increase from current contribution levels.

Those who are not enrolled in the KNH or other public pension schemes for civil servants are required to participate in the National Pension Insurance (Kokumin Nenkin), which provides only the basic pension (the basic pension also forms the first tier of benefits under the KNH and other public pension systems for civil servants). Contributions under this plan will rise by 280 yen each April from the current 13,300 yen per month until they plateau at 16,900 yen (at 2004 prices) in April 2017. The actual rise in National Pension contributions will be adjusted according to increases in general wage levels.

In addition, the government will increase its subsidies for the basic pension. One-third of the cost of basic pension benefits is paid from the national treasury; this share is to be raised in stages until it reaches one-half in 2009.

Benefits under the KNH consist of two tiers: the flat-rate basic pension, which is paid to all public pension plan participants, and a separate earnings-related component. The latter is calculated on the basis of the worker’s average pre-retirement income, converted to current values. Until now, the index used to convert past income to current values was the rate of increase in take-home pay. Under the 2004 reform, though, this index will be subject to a negative adjustment over the course of an “exceptional period” based on changes in two demographic factors, namely, the decline in the number of participants and the increase in life expectancy. This period of adjustment is expected to last through 2023.

The application of the first demographic factor will mean that benefit levels will be cut to reflect
the fact that fewer people are supporting the pension system. The actual number of people enrolled in all public pension schemes will be ascertained each year, and the rate of decline will be calculated based on this figure. The average annual decline is projected to be around 0.6 point.

Introducing the second demographic factor, meanwhile, will adjust for the fact that people are living longer and thus collecting their pensions for more years; the aim is to slow the pace of increase in the total amount of benefits paid as a result of increased longevity. This factor will not be calculated by tracking future movements in life expectancy; instead, it has been set at an annual rate of about 0.3 percentage point on the basis of current demographic projections for the period through 2025. Together, the two demographic factors are thus expected to mean a negative adjustment of about 0.9 point a year during the period in question.

How will these changes affect people’s benefits in concrete terms? Let us consider the case of a pair of model KNH beneficiaries as defined by the Ministry of Health, Labour, and Welfare: a 65-year-old man who earned the average wage throughout his 40-year career, and his 65-year-old wife, who was a full-time homemaker for 40 years from her twentieth birthday. In fiscal 2004 (April 2004 to March 2005), this model couple would receive 233,000 yen a month.

How does this amount compare to what employees are currently taking home? The average monthly income of a salaried worker in 2004 was around 360,000 yen, before taxes and social insurance deductions. Assuming that this is supplemented by bonuses totalling an equivalent of 3.6 months’ pay, the average annual income is roughly 5.6 million yen. Deducting 16 per cent of this figure for taxes and social insurance payments leaves a figure for annual take-home pay of about 4.7 million yen, or 393,000 yen a month.

The 233,000 yen provided to the model pensioners is 59.3 per cent of 393,000 yen. But this percentage, which pension specialists call the “income replacement ratio,” will gradually decline to an estimated figure of 50.2 per cent as of fiscal 2023 (assuming that consumer prices and nominal wages rise according to government projections by 1.0 per cent and 2.1 per cent a year respectively). Over the next two decades, then, benefit levels will decline by roughly 15 per cent in comparison with wage levels.

The revised pension legislation stipulates that the income replacement ratio is not to fall below 50
per cent for the model case described above, and so the exceptional period of negative adjustment will come to an end once the ratio declines to 50 per cent. This provision was included to alleviate fears that benefits would continue to shrink without limit.

How will the reforms affect those who are already receiving their pensions? Until now, benefits for those 65 years old and over have been adjusted for fluctuations in the consumer price index. This ensured that pensioners’ real purchasing power remained unchanged and helped ease postretirement worries. But this cost-of-living link will effectively be severed during the exceptional period, since the application of the demographic factors will pull down real benefits by around 0.9 point a year. In principle, however, nominal benefits are not to be cut unless there has also been a drop in consumer prices. Once the exceptional period is over, the link to the consumer price index is to be restored.

Social insurance contributions in Japan already exceed the amount collected in national taxes, and contributions to the pension system are by far the biggest social insurance item. If this already huge sum is increased by more than 1 billion yen a year as the government plans, both individuals and companies are bound to change their behaviour. Government projections of revenues and expenditures, however, completely ignore the prospect of such changes. Companies are likely to revamp their hiring plans and wage scales to sidestep the higher social insurance burden. They will cut back on recruitment of new graduates and become more selective about mid-career hiring as well. Many young people will be stripped of employment opportunities and driven out of the labour market, instead of being enlisted to support the pension system with a percentage of their income. And most of the employment options for middle-aged women who wish to re-enter the work force will be low-paying ones. Only a few older workers will be able to continue to command high wages; there is likely to be a dramatic rise in the number of ageing workers who will be forced to choose between remaining on the payroll with a cut in pay or settling for retirement. Many more companies will either choose or be forced to leave the KNH, causing the number of subscribers to fall far below the government’s projections and pushing the system closer to bankruptcy.

The jobless rate overall will rise. The Japanese Ministry of Economy, Trade, and Industry has estimated that higher pension contributions will lead to the loss of one million jobs and raise the
unemployment rate by 1.3 points. The government plan to increase pension contributions annually for the next 13 years will exert ongoing deflationary pressure on the Japanese economy. For the worker, a rise in contribution levels means less take-home pay; as a result, consumer spending is likely to fall, and this will certainly hinder prospects for a self-sustaining recovery and return to steady growth.

Another problem with increasing pension contributions is that they are regressive, since there is a ceiling for the earnings on which payment calculations are based and unearned income is not included in the calculations at all.

One major objective of the reforms is to eventually eliminate the huge excess liabilities in the balance sheet of the KNH. The plan is to generate a surplus by (1) raising contributions, (2) increasing payments from the national treasury, and (3) reducing benefits. The policy measures adopted in the 2004 pension reform bill will induce huge excess assets of 420 billion yen in Part Two of the balance sheet whereby offsetting excess liabilities of the same amount in Part One of the balance sheet, as shown in Figure 4. Huge excess assets of Part Two of the balance sheet imply that future generations will be forced to pay more than the anticipated benefits they will receive. Their benefits will be around 80 percent of their contributions, on the whole.

It is like using a sledgehammer to crack a nut. Younger generations are most likely to intensify their distrust of the government. The incentive-compatibility problem or the drop-out problem will become graver. Businesses (represented by the Japan Business Federation Nippon Keidanren) and trade unions (represented by the Japanese Trade Union Confederation Rengo) both oppose any further increases of more than 15 percentage points in the KNH contribution rate.

As noted above, those who are already receiving their pensions will see their benefits decline in real terms by an average 0.9 per cent per year. The government scenario sees consumer prices eventually rising by 1.0 per cent a year and take-home pay by 2.1 per cent a year. This means that the model beneficiary who begins receiving 233,000 yen a month at age 65 in 2004 will get roughly 240,000 yen at age 84 in 2023; nominal benefits, in other words, will remain virtually unchanged for two decades, despite the fact that the average take-home pay of the working population will have risen by over 40 per cent. The income replacement rate, which stood at nearly 60 per cent at
age 65, will dwindle to 43 per cent by the time the model recipient turns 84. The promise of benefits in excess of 50 per cent of take-home pay does not apply, therefore, to those who are already on old-age pensions.

The so-called demographic factors are likely to continue changing for the foreseeable future. The government itself foresees the number of participants in public pension plans declining over the coming century: the estimated figure of 69.4 million participants as of 2005 is expected to fall to 61.0 million in 2025, 45.3 million in 2050, and 29.2 million in 2100. This corresponds to an average annual decline of 0.6 per cent through 2025, 1.2 per cent of the quarter-century from 2025, and 0.9 per cent for the half-century from 2050. In other words, the decline in the number of workers who are financially supporting the public pension system is not likely to stop after just two decades.

However, the 2004 reform adjusts benefit levels in keeping with the decline in the contribution-paying population for the next 20 years only; the government’s standard case does not foresee any further downward revisions, even if the number of participants continues to fall. If the government really anticipates an ongoing decline, there is no good reason to abruptly stop adjusting benefit levels after a certain period of time. Sweden and Germany, for instance, have adopted permanent mechanisms whereby benefit levels are automatically adjusted for fluctuations in demographic factors.

The decision to keep the model income replacement rate at 50 per cent at the point when pension payments commence represents, in effect, the adoption of a defined-benefit formula. Maintaining both fixed contributions on the one hand and defined benefit levels on the other is not an easy task, for there is no room to deal flexibly with unforeseen developments. The government will be confronted with a fiscal emergency should its projections for growth in contributions and a reversal in the falling birth rate be wide off the mark.

The government bases its population figures on the January 2002 projections of the National Institute of Population and Social Security Research. According to these projections, the medium variant for the total fertility rate (the average number of childbirths per woman) will fall to 1.31 in 2007, after which it will begin climbing, reaching 1.39 in 2050 and 1.73 in 2100. Actual figures since the projections were released have been slightly lower than this variant, and there are no signs
whatsoever that the fertility rate will stop declining in 2007.

If the government is to keep its promise on an upper limit for contributions and a lower limit for benefits, the only policy option it will have in the event of a financial shortfall will be to raise the age at which people begin receiving benefits. The reform package makes no mention of such a possibility; the drafters of the bills no doubt chose simply to put this task off for a future date.40

By fiscal 2009, the share of the basic pension benefits funded by the national treasury will be raised from one-third to one-half. This means that more taxes will be used to cover the cost of benefits. Taxes are by nature different from contributions paid by participants in specific pension plans, and there is a need to reconsider the benefits that are to be funded by tax revenues.

The leaders of Japanese industries tend to be quite advanced in years. For the most part, they are over the age of 65, which means that they are qualified to receive the flat-rate basic pension. Even though they are among the wealthiest people in the country, they are entitled to the same basic pension as other older people hovering around the poverty line. Using tax revenues to finance a bigger share of the basic pension essentially means asking taxpayers to foot a bigger bill for the benefits of wealthy households as well. For an elderly couple, the tax-financed portion of the basic pension will rise from 530,000 yen a year to 800,000 yen. If a need arises to raise taxes at a future date, who will then actually agree to pay more? Few people will be willing to tolerate such a wasteful use of tax money.

3.6 Intergenerational equity issues in Japan’s social security pensions

Huge excess liabilities of 500 billion yen appearing in Part One of Figure 3.1 partly reflect mistakes made in the past.41 It is true that any social security scheme for pensions faces great uncertainties for its future long-term scenarios: uncertainties about the number of participants, the number of pensioners, the rate of increases in wages or the consumer price index, and the rate of

40 Later retirement would be preferable for the country to achieve active ageing, provided that this has little substitution effects on employment for young people.
41 The excess liabilities arise partly from windfall gains given to the first generation in a pay-as-you-go pension system. This part should not simply be interpreted as “the mistakes made in the past.”
return from investment. No one has precise information on these variables beforehand. Nevertheless, the system planners need some fixed figures on the system’s future scenario when designing (or re-designing) the pension system. It is often the case, however, that the assumed figures differ to a greater or lesser extent from the actual ones. What really matters is whether or not the system planners adjust their system to correspond to the changing circumstances in a timely and proper way.

Japanese experience in the past 30 years shows that the adjustments were too slow and insufficient; the consequence of which is the huge excess liabilities amounting to 500 billion yen. It is evident that pension projections always turned out to be too optimistic, and that politicians were always reluctant to introduce painful remedies for current pensioners and current contributors, leaving the pension system financially unsustainable and inequitable between generations.

The 2004 reform in Japan looks very drastic, since the introduction of the demographic factors will significantly reduce the level of pension benefits in real terms. These reductions are regarded as an inevitable reaction to make up for the mistakes or omissions made in the past, for which the current pensioners and the baby-boomers were responsible. Nevertheless, the 2004 reform still suffers from an incentive-compatibility problem, leaving the pension system inequitable from the younger generations’ point of view.42

3.7 Future policy options for securing equity between generations

Are there any policy measures that could avoid the incentive-compatibility problem in Japan? This section tries to answer this question.

To begin with, how about separating the “legacy pension” problem from the problem of re-building a sustainable pension system for the future? The two problems are quite different in

---

42 Richard Musgrave once examined the credibility and long-run political viability of alternative contracts between generations, demonstrating that a “Fixed Relative Position (FRP)” approach is most preferable (Musgrave 1981). Following his suggestion, Germany and Japan had introduced a net indexation method in adjusting their social security pension benefits since the early 1990s. The FRP approach faces some difficulties, however. For example, this approach could be acceptable only if participation in the social security pension system pays for the younger generations.
nature, and accordingly they require separate treatment.

The legacy pension problem of Japan looks like *sunk costs* from an economic perspective. It can be eased, not by increasing the KNH contribution rate, but by introducing a new 2.0 per cent earmarked consumption tax and intensive interjection of the increased transfers from general revenue (see Figure 3.5). Needless to say, the current generous benefits have to be reduced more or less by the same percentage in the aggregate level as implemented in the 2004 pension reform.

All these measures are considered on the understanding that current pensioners and baby-boomers are mainly responsible for Part One excess liabilities, and that they are therefore first in line in diminishing the existing excess liabilities. Note that any increases in the contribution rate for social security pensions will be paid by current younger and future generations. Current pensioners no longer pay them and baby boomers will pay them only to a small extent. They are not an appropriate measure for diminishing Part One excess liabilities. By contrast, an increase in the consumption-based tax will be shared by all the existing and future generations, including current pensioners and baby-boomers. Increased transfers from general revenue can be financed by increases in inheritance tax and income tax on pension benefits as well.

When it comes to Part Two of the balance sheet, which relates to future contributions and promised pension benefits to which people are entitled through future contributions, a switch to an NDC (notional defined contribution) system is possible and preferable. An NDC system follows the philosophy of a funded system of individual accounts, but with a pay-as-you-go financing structure. The main difference from a defined-benefit model is that NDC benefits are defined, not by a formula based on wages and years of service, but by a worker’s accumulated account balance

43 The payroll tax and the consumption-based tax might be indifferent in a steady-state economy, although they will induce different economic impacts in a transition period.

44 A 2 per cent earmarked consumption tax could be all right, since the remaining excess liabilities of 90 billion yen might be acceptable as a “hidden” national debt. Even if all the alternative measures above stated are implemented, current young and future generations will still have to pay a substantial part of Part One excess liabilities. However, the current pensioners and baby boomers should still make the best effort to diminish the excess liabilities before any further increases in the contribution rate are considered.

45 A funded plan might be another alternative. However, it cannot escape the so-called “double burden” problem in the transition period, while the NDC is free from it.
at retirement. Benefits are thus closely linked to contributions. With an NDC system in place, the KNH contribution rate can be kept unchanged at the current level, around 15 percentage points.

With an NDC plan, the incentive-compatibility problem can be avoided. Indeed, in an NDC system, every penny counts, and this would be the most important element, because it would demonstrate to the public that everybody gets a pension equivalent to his or her own contribution payments (see Könberg 2002; Palmer 2003).

In an NDC, the notional rate of return should be endogenous. It could be periodically adjusted by an automatic balance mechanism, such as those introduced in Sweden (see Settergren 2001). Alternatively, in 2004, Germany introduced a sustainability factor, whereas Japan implemented the demographic factors in the same year. Both factors operate more or less as an automatic balance mechanism. The automatic balance mechanism aims to avoid any political difficulties by flexibly adapting the pension system to a changing and unpredictable world.

We could also introduce a guaranteed pension (GP) to add to the NDC pensions in order to provide an adequate income in old age. However, this should be financed by sources other than contributions (payroll tax), since the policy objectives for a guaranteed pension and an NDC are quite different (see Figure 3.6).

Needless to say, more efficient use of the funded reserve will mitigate the financial difficulties of social security pensions in Japan.

3.8 Concluding Remarks

Regarding pensions, the Japanese are increasingly concerned with the “taste of the pie” rather than the “size of the pie” or the “distribution of the pie.” When it comes to social security pensions, the most important question is whether or not they are worth buying. How big or how fair they are has become a secondary concern. The basic design of the pension programme should be incentive-compatible. Contributions should be much more directly linked with old-age pension benefits, while an element of social adequacy should be incorporated in a separate tier of pension benefits financed by sources other than contributions.
Japan faces the problem of seeking to meet more targets than possible through the single policy instrument of pensions. This contradicts the standard theory of policy assignment, which suggests that each policy objective can be best attained only if it is matched with a different policy instrument of comparative advantage. A diversified multi-tier system is thus most preferable.

Also important is the separation of the legacy pension problem from the problem of rebuilding a sustainable and intergenerationally equitable pension system.

Social security pensions are consumption-allocation mechanisms, transferring resources from workers to pensioners when pensions are paid. Under a pay-as-you-go system, the transfer is direct, through contributions or taxes paid by workers. Under a funded system, pensioners liquidate their accumulated assets by selling them to the current working generation. In both cases, workers’ disposable income is reduced by the amount of resources transferred to retirees. Supporting an increasing number of retired people is possible if output grows. Economic output depends crucially on the supply of workers, and thus increasing labour force participation on the part of young retirees, women and young generations will be required.

No one can claim to see clearly all the changes that lie ahead in the decades to come. Nevertheless, the challenge cannot be ignored. What is missing is a more explicit consideration of an automatic balancing mechanism to compensate for possible mistakes in the projections towards the future.
References for Chapter 3


Pensions and a Weakened Economy. Tokyo: Maruzen CO., Ltd.


Figures for Chapter 3

Figure 3.1: KNH Balance Sheet: Before Reform

Excess Li: 50 Tr. Yen

\[
\begin{array}{c|c|c|c|c|c}
\text{Part One (PAST)} & \text{Part Two (FUTURE)} \\
\hline
\text{Assets} & \text{Liabilities} & \text{Assets} & \text{Liabilities} \\
\hline
\text{Excess Li: 500 Tr. Yen} & \text{Transfers 130} & \text{Pension Liabilities 1100} \\
\text{Basic Liabilities 800} & \text{Contribution 920} & \text{Endowment 170} \\
\hline
\end{array}
\]

Source: Calculations by the author

Figure 3.2: Per capita income by age-group in Japan

Figure 3.3: Drop-out rate in the National Pension Insurance (non-employees)
(Percentage of those not paying pension contributions)

Source: Social Insurance Agency, Japan

Figure 3.4: KNH Balance Sheet: After Reform

Excess L: 420 Tr. Yen

Part One (PAST)

Source: Calculations by the author
Figure 3.5: KNH Balance Sheet: Alternative

Excess I: 90 Tr. Yen

Excess A: 0 Tr. Yen

Part One (PAST)
Source: Calculations by the author

Part Two (FUTURE)

Figure 3.6: Notional Defined Contribution plus Guarantee Pension

Benefits

Source: By the author