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have been indicated in the foregoing analysis. There are no simple or painless solutions to many of these problems, but there is experience in the practices of the more successful health insurance societies which points the way toward improvements. These practices include:

1. Direct locally negotiated arrangements with participating doctors and medical facilities regarding terms and conditions of service to the insured members. Although the unit fee schedules are beyond the control of the individual societies, other inducements and considerations can be brought into play in these arrangements, especially with hospitals.

2. Making use of the most economical and efficient methods locally available for furnishing medical and hospital care. An incentive to economical operation is provided by the fact that contribution rates are permitted to vary, within limits, among the individual societies; thus it is to the advantage of the insured group to obtain service at low cost which will be reflected in lower contribution rates.

3. Educational activities among the insured group, furnishing assistance in selection of competent and cooperative doctors and institutions, explaining the rights and operating procedures of health insurance, and acting on behalf of the patient in cases of excessive charges or other grievances.

4. Participation of the insured group, through elected representatives, in the management of the society, and hence in the administration of the program. Such participation is essential if the advantages stated under (2) and (3) above are to be realized. It provides an important safeguard against economy being practices to an extent detrimental to the quality of service, and makes educational activities meaningful to the membership of the society.

2. Protection for Industrial, Commercial and Government Employees.

Japanese law nowprotects industrial, commercial, and government employees generally (in establishments with five or more employees) and their dependents against having to meet the full costs of medical care. All such employees are required to participate in one or another of the systems of Health Insurance, Seamen's Insurance, and of the government Mutual Aid Associations. The first and largest of these has been operating for over twenty years.

These systems would be integrated, so far as this is possible without destroying the advantages of the decentralization offered by society management. Individual societies would continue much as at present, with the mutual aid plans assuming the character and form of health insurance societies. Effort should be directed toward developing the administration of society managed plans along the lines found useful by the more successful societies; it is believed that increased employee participation should be encouraged. Most important is the improvement of government managed health insurance. If, as suggested elsewhere, it is deemed feasible to extend health insurance to employees in plants of less than five, the number of persons covered in the

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advantages and limitations. Each practitioner who wishes to participate in insurance practice agrees to abide by the regulations and his name is placed on the list for the information of the public. Each insured patient selects a practitioner and his name is placed on the list of the doctor of his choice. Every insurance doctor thus becomes responsible for the care of a specified number of insured persons, and he is paid a fixed amount per year (the "capitation fee") per person on his list.

This method of payment is simple from the doctor's standpoint, since there is no billing procedure and, since patients change doctors rather infrequently, the doctor's income is relatively stable and predictable. The total expense to the insurance fund bears an exact relationship to the number of insured persons and hence is closely related also to the total premium income. Once the capitation payment is fixed for a given period, the expense to the insurance fund can change only if the number of insured persons changes, since it is not dependent on the number of services rendered. There is no incentive on the part of the doctor to give an unnecessarily large number of treatments, for his payment is based only on the number of persons for whom he assumes responsibility. On the other hand, the patient isprotected against refusal of the doctor to treat him by his privilege to change doctors, since the doctor will lose his insurance income if his patients change to other doctors. Thus this system tends to police itself, so far as safeguarding funds and satisfaction of patients are concerned.

Two major problems would be encountered in applying this method of payment to the health insurance systems in Japan. The first difficulty would be in the payment of specialists, to whom patients are referred by general practitioners. Since specialists see patients only for particular types of illness, they cannot readily be paid on a capitation basis. It would be possible to pay specialists on the basis of a fee schedule, but this would require criteria for designation of specialists who would be entitled to receive such fees. Where specialist are attached to hospital staffs, as would be desirable when an adequate hospital system is developed, this problem would be simplified by making payment for specialist service through the hospital. Group practice of specialists in clinics and hospitals might be encouraged by health insurance plans making contracts with groups for services to their beneficiaries.

The second obvious difficulty would be arrival at a satisfactory method for payment for drugs and medicines. In countries such as the United States and England, where drugs are generally furnished by pharmacists on prescription of the doctor, payments might be made directly to the pharmacist. In Japan, however, drugs are customarily dispensed by the doctor, and their cost makes up a substantial portion of the total charges for medical care. Theoretically, a suitable addition to the capitation fee could be made to allow for the average yearly cost of drugs per person. If payment were made to the doctor for each medicine furnished, there would be danger of the same type of abuse as occurs under the fee-for-service system of payment for professional services.

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government managed portion will be substantially increased, and this phase will be even more important.

It will not be simple to achieve a genuinely decentralized administration sensitive to the local needs and problems of the insured group and of the persons and institutions furnishing service. Nevertheless, it is believed that the effort will be worth while and must be made if a satisfactory program is to be achieved. Specifically, it is suggested that the government managed portion be broken up into prefectural or even sub-prefectural units, with its funds and contribution rates as distinct, within the statutory limits, as are the separate health insurance societies at present. Each unit would have an advisory council including representatives of employers, employees, and the professional groups furnishing services in the area. This council would be in a position to advise the administrators regarding the local needs of the groups concerned.

As at present, national law would impose on employers and employees minimum, and on employees maximum limits on contribution rates. The law would put the basic responsibility on the national government for assuring that adequate arrangements are made to provide the medical care for which individuals are paying by their insurance contributions.

(a). Features of operation. Features of operation of societies and government managed health insurance would be the following:

(1). Each society or government plan would make its own arrangements for the provision of medical care through approved public and private facilities and by doctors in private practice. These facilities and doctors should be free to participate or not participate in an insurance plan. Complete reliance must be placed on the efficacy of these arrangements. As has been pointed out, perhaps the greatest cause of the present unsatisfactory conditions of the health insurances is the failure of doctors to be content with the scale of payments for service and their succumbing to the temptation to charge fees higher than those officially allowed under the health insurances. In a period of inflation, these temptations will continue and adjustments will have to be made. However, the health insurance systems will only function if the agreed-upon rates of payment for services are strictly observed. We believe that the greatest possibility for achieving that essential condition is to have the arrangements made locally, between representatives of local interests who realize fully what the insured people can pay, who recognize the value to the insured group of prepaid medical care, who have a sense of responsibility to the insured group, and who can, on a day-to-day basis, enforce an observance of the agreements.

(a). Negotiating bodies. Given an administrative organization with a broad viewpoint, the first need will be for effective representative bodies of the medical profession both centrally and locally. It is to be hoped that the reconstituted Japan Medical Association and its constituent local societies will form the basis for such representative bodies. However, if but a relatively small proportion of doctors participate in the health

insurance program, as may happen in some localities, it is important that the negotiating group be really representative of the doctors concerned. Since non-participating doctors are potentially insurance doctors and may come into the system if the inducements are sufficient, they should also be represented but not to an undue extent. It is essential that the groups carr ing on negotiations on behalf of the insurance doctors have their full confidence if the conditions of service and the rates of remuneration are to be accepted wholeheartedly. Only under these circumstances can satisfactory cooperation be hoped for from the doctors.

(b). Terms of service. As has been suggested above, participation in the insurance system must be made voluntary on the part of the doctors, and the terms of service made sufficiently attractive so that an adequate number of doctors will wish to take part in the program. A draft of basic terms of service should be agreed upon between the Ministry of Welfare and the central medical negotiating body. These terms of service would be designed to safeguard the interests of the doctors, the insured patients, and the funds of the insurance system, and would include such matters as: definition of the eligible insured whom the doctor agrees to treat; the responsibility of the doctor to treat emergencies and, in non-emergency cases, to treat or to refer the patient elsewhere for treatment; prohibition of acceptance of fees directly from insured patients; protection of the doctor against objectionable patients; kinds of medical service included (e.g., some services might be limited to recognized specialists or institutions); obligation of the doctor to specify and keep regular office hours and to arrange for substitute service when not available himself; protection against unnecessary or unreasonalby distant home calls; obligation to keep minimum records; conditions under which medical certificates will be issued; and the doctor's rights and obligations in disciplinary procedures.

These drafts terms of service would be the basis of participation of individual doctors and would be subject to variations in detail, but not of basic principle, at the local level. Doctors wishing to participate in the program would sign individual contracts with the local insurance agency in which they would agree to abide by the terms of service and the rates of remuneration as determined in detail by local negotiation.

(c). Method and rate of remuneration. As indicated above, the present method of paying doctors on a fee-for-service basis has serious drawbacks. Effort should be direct to experiment with other methods of payment; suggestions are given below. The determination of rates, whatever method is used, must be subject to re-negotiation at intervals as frequent as may be necessary in an unstable economy. There should be limits set by national agreement between which local rates may be established.

The method of capitation payment which has been used for many years in a number of other countries should be given serious study; it has both

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The simplest method of payment is, of course, the use of a salary. The chief theoretical difficulty with this method is the problem of determining, first, a salary scale which makes proper allowances for differences in experience, ability, and skill, and second, applying criteria to individual doctors in order to place them at proper salary levels. Another important difficulty is that of developing adequate incentives to do good work; this should not be impossible in hospital or other organized practice where doctors work together in groups, but it would be difficult to prevent abuses if doctors practicing individually were paid on a salary basis. There appears to be, too, a feeling in Japan, as in some other countries, that a doctor receiving a salary under a government program is a government official and may not have the interests of hispatients at heart. However, this feeling does not appear to exist in the case of doctors employed in clinics operated and paid for by National Health Insurance Associations or Health Insurence Societies; nor does it appear to be a serious problem in goveramental hospitals in Japan.

It is believed that one of the most important problems to be solved in making the present health insurances in Japan work satisfactorily, and one which must be solved before any major extensions of coverage are attempted, is that of finding a satisfactory method of payment of practitioners for their services to insured patients and of developing effective administration of whatever method of payment is used. The following criteria may be stated for a satisfactory system of payment:

a) Payment must be adequate to satisfy the doctors that they are getting reasonable remuneration, having regard to their training and experience, and to the amount of income which they might expect to derive from the class of patients treated under the insurance system.

b) Payment in the aggregate must be within the ran e of the insurance funds available.

c) The system should be administratively simple, having regard to the minimization of paper work, promptness of payment, and controls against abuses. The last should be internal or automatic as far as possible.

d) The system should provide reasonable incentives to the doctors to furnish service of high professional quality.

The particular and complex problems of the Japanese social security systems and of the professional practices and facilities make it impossible to apply any system of payment now in use elsewhere without careful study and appropriate modification. It is believed, however, that the fee-for-service system offers least promise of fulfilling the criteria stated above, and that study and experimentation should be given to other methods with a view to thier application and extension as rapidly as experimentation proves their feasibility. Such experimentation might well start with a trial of the capitation method in one or more areas where conditions are most favorable, especially with respect to cooperation from the local doctor.

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Whatever the basis for payment, it should be made promptly and directly to the doctor or hospital furnishing service. Although it is hoped that under the conditions specified above there will be few abuses, provision must be made for both administrative and professional review of bills for accuracy and reasonableness. To the extent that review by medical persons is found necessary, this should be done by doctors in the employ of the insurance system. These should be men with actual experience in individual and hospital practice; their duties should include not only review of bills, but the making of personal contacts with insurance doctors as necessary to explain the proper workings of the insurance system and to investigate abuses. Delay in payment need not result from review of bills, since this can equally well be done after payment and appropriate adjustments later made to correct over- or under-charges.

The present practice of permitting patients to pay the doctor directly, obtain a receipted statement, and subsequently obtain reimbursement from the insurance fund should be discontinued. This practice greatly increases the administrative work of the insurance agency and lends itself to abuse by over-charges on the part of the doctor. If bills are paid promptly by the insurance plan, there is no justification for this practice. The only exceptions which should be permitted are in case of emergency when the patient has to be treated by a non-insurance doctor of if the patient has lost his identification card and the doctor is in doubt as to his insured status. Such exceptions should be kept to a minimum.

d. Agreements with hospitals. These should be subject to similar safeguards and conditions. In the absence of national and local hospital associations there should be consultation with, and participation by, representatives of public, semi-public, and private hospitals. In order to protect insured patients, service should be given them only in hospitals and clinics which meet definite standards established by the Ministry of Welfare in consultation with expert bodies.

d. Functions of medical organizations. It will be noted that the above recommendations would place on responsible medical organizations the opportunity and duty of safeguarding the interests of doctors, and, from the standpoint of quality of care rendered, of patients, in the determination of standards of care and methods and amounts of payment. Nominally, this has been a function of the Japan Medical Association in the past, but becuase this agency has been undemocratic and its viewpoint entirely unlike that of the medical associations of Western democracies, it has not been effective. It is assumed that the new Japanese medical organization, which is being set up on democratic lines primarily for scientific purposes and which will participate in health insurance only as one of many functions, will be in a position to carry out this duty in the public interst. It will be noted also that these recommendations would remove administrative functions from the hands of the medical organizations and place them in the agencies which are set up to administer the plan, which will operate under policies determined after consultation and negotiation with the professional groups concerned.

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2. The existing structure for financing Health Insurance, permitting variations in rates between societies reflecting differences in costs of medical care, would be substantially unchanged except for the adoption of a plan to permit some equalization of income to the plans. Theneed for a degree of equalization arises from the fact that the cost of medical care for individuals or groups of individuals will not be proportionate to their income, whereas contributions are based on wages. Two societies with exactly the same number of members will have differing premium incomeif the memberships are at different wage levels.

This problem can be met by having a portion of all premium income, say one-half percent of the taxable wage, paid into a national pool from which payment will be made to societies in proportion to the degree to which their per capita annual wage is less than the national average wage of workers protected by the system.

An alternative approach to financing the equalization fund would be to add to the total tax required for all forms of social insurance an amount which would permit some equalization of the costs of medical care and, together with receipts from public revenue, would finance the construction and some of the cost of operation of hospitals or other public facilities. Such use of a portion of the total tax is justifiable because the availability of public medical care facilities may be expected to reduce the cost of medical care and, to the extent that the facilities are placed and financially aided in areas of low incomes, will also tend to lessen the disadvantage of the low income areas.

3. With health insurance strengthened financially, professionally, and administratively by these changes, the groundwork will be laid for such extension of coverage as the Japanese people may subsequently find to be disirable and feasible. It is believed that it would be possible, and unquestionably desirable, to:

a) Prepay the full cost, rather than only one-half as at present, of medical care for dependents of insured persons;

b) Apply protection also to those working in establishments employing less than five persons. This would be a natural consequence of the extension, recommended elsewhere in this report, of other forms of social insurance to the whole employed industrial population.

3. <u>Protection for other segments of the Population.</u>

The National Health Insurance was set up in 1938 to provide health insurance to groups other than those covered by the Health Insurance system, the mutual aid associations, or the Seamen's system. Of all the existing social insurance programs it is the one which has suffered most directly and most severly in the post-war period. Not only has it suffered from the difficulties detailed above common to all the health insurances, but

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it has had additional problems arising from certain of its special characteristics, notably that its membership is elf-employed and largely rural, that participation is voluntary and many of the associations are small and that there is no statutory minimum contribution rate. However, many National Health Insurance Associations are so operating as to make medical care available to individuals who would not have it without the plan operated by the association. It is, therefore, desirable to give at this time some place in the total health insurance structure to those units which are operating on a reasonably adequate basis.

(a). Features of Operation.

The job of rebuilding these associations has to be done carefully and thoroughly, from the ground up. The general recommendations made regarding protection for industrial, commercial and government employees are to a large extent applicable also to National Health Insurance, but in view of their special character certain additional standards will have to be laid down. If communities are sufficiently interested in prepayment medical coverage to set up a plan complying with these standards, they will have reasonable expectation of having a successful program; if these standards are not met, the present unsatisfactory situation will continue.

1). The local health insurance plan should be adopted by election by a community - prefecture, city, town or village - as applicable to all in the community not covered by other health insurance plans. Such adoption by election would make the plan a primary responsibility of the community and, by making it applicable to all in the community, would do two things: (a) give the plan stability in its support, and (b) make the plan a public function of such a character as to justify tying it in with the performance of other public functions in the health field.

2). The plan would have to cover a certain minimum number of people in order to permit the operation of the insurance principle.

3). The plan should provide for paying the full costs of medical care, insofar as those costs would otherwise have to be met by insured people as individuals.

4). The plan must provide for its financing by an income from all sources sufficient to pay benefits. Such income would include that from any source, including that which may be received from prefectural, national, or other governmental units. Contributions from insured people could be collected through any taxing device the community desires to use; presumably there would be a strong tendency to follow the methods now being used to collect premiums under National Health Insurance.

The community medical care prepayment plan could be operated directly

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as a department of local government or could be run as an association of the membership. That form of organization should be adopted which will best assure participation by the membership and maintenance under public control.

In making arrangements for the provision of medical care to the insured group, the same general principles and practices, as outlined above for health insurance plans, would be followed. The same objectives would be sought.

B. Financing.

Since communities will come into the National Health Insurance program on a voluntary basis, it would not be feasible to set up a central equalization fund to assist the poorer communities, as is proposed under Health Insurance. To do so would discourage the wealthier communities from entering the program, since they would thus voluntarily undergo payment of contributions, a portion of which would leave the community. However, if the poorer communities, which will need prepayment care the most, are to benefit from the program, they will need assistance, and it seems reasonable to provide this to a limited extent from the national level by grants-in-aid out of general revenues. These grants in aid would be available only to associations meeting the standards set forth above, including participation of all persons in the community, and setting of contribution rates at a substantial level. Grants would be related to the amount which the community proposed to raise itself but would be larger in communities with lower per capita income. They would take the form, so far as would be consistent with the master plan for a network of facilities, of assistance in the form of construction rehabilitation, andoperation funds for clinics or hospitals. On the other hand, where national funds were already being put into a community to finance public institutions, this would be regarded as part of the total grant-in-aid to that community, since availability of the public facility would be of substantial aid to the association.

A special justification for the use of national funds for assisting National Health Insurance arises from the following considerations. Those communities which adopt a health insurance plan will thereby, by promising full medical care to all in the community, assume responsibility for some medical care which would otherwise be provided by the Daily Life Security Law, which is financed wholly from national tax revenue. Therefore, such communities are assuming, through the adoption of a health insurance plan, some of the financial responsibilities now borne by the national government.

Of course it is true generally that the more extensive and effective insurance programs become the more general assistance programs are relieved. However, in view of the strong probability that the health insurances will not be of universal application for some time, it seems wise to recognize this transfer of responsibility as it occurs and to provide for granting revenue which represent the degree of responsibility assumed by the

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community health insurance plan. It is not proposed that such grants be computed on a precise cost basis. They might be determined on the basis of national estimates of the ratio of number of individuals entitled to medical care on a needs basis to the total number of individuals in communities comparable to those to which grants are made for this purpose.

An additional justification for grants-in-aid is based on a comparison of the health insurance plans applicable to industrial, commercial, and government workers generally and the community health insurance plans. In the case of the former, only a part of the cost is borne directly by the insured person. At least an equal part is borne by the employer. To the extent that the latter share becomes a cost of production and is incorporated in the selling price of goods and services produced, it is passed on to the whole consuming public. This shifting of cost by those participating in community health insurance plans is not so obvious. Therefore, it may be considered appropriate to equalize this difference between the two types of plans by a system of grants to meet part of the actual costs incurred for medical care.

C. Incentives for Adoption of Community Plans.

It is recognized that the requirements proposed for the setting up of community health insurance plans are much more rigorous than those prevailing at present under the National Health Insurance Law. To qualify for grants-in-aid these standards would have to be complied with. There will be existing associations which for one reason or another are functioning reasonably well at present but may not wish to meet the standards; they will be permitted to continue in operation under their present arrangements if they wish to do so. On the other hand, there will be strong incentives to communities to adopt community-wide plans, which may be summarized as follows:

(1) The advantage of a prepayment plan in equalizing the burden of the existing costs of medical care in the community and in improving the health of the community by making medical care available to those who could not afford it except on a prepayment basis, should itself constitute a strong incentive to any community to which this advantage has fully been explained.

(2) Theexistence of a prepayment plan will provide an inducement to the establishment of a public medical care facility, hospital or clinic, and thus redound to the benefit to the community.

(3) Where such clinics exist, national assistance will be afforded by the payment ofpart of the costs of operation of the facility, in order that the total costs of operation of the prepayment plan will be decreased

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in the interests of making medical care more generally available. Furthermore, any community operating a hospital or clinic will have that medical care facility considered a part of the nation-wide system of medical care facilities. This means that for such a community public health activities sponsored and supported by the prefectural or national government would also be a part of the program of the medical facility and would strengthen and support the prepayment plan itself.

(4) For the communities with relatively low resources, the offer of additional grants-in-aid would be an additional inducement.

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4. ORGANIZATION OF THE PROGRAM

A. Advantages of an Integrated Program.

An integrated program and administration is recommended for the social security system in Japan. For the current variety of programs and divided administration there should be substituted a unified system with coordinated administration decentralized in operation but under the leadership of a single, efficient ministry. This end is important from several points of view - from those of the insured persons, the employers subject to the system, service groups dealing with the program, and from the standpoint of effective government planning and administration.

1. Advantages to insured persons.

From the position of the insured, there are several advantages in a combined system. In the first place, a worker who makes contributions to a social insurance system is entitled to the assurance, particularly in connection with protection against long term risks, of continued coverage for his working life. He should be entitled to qualify for benefits on the basis of the aggregate time he has spent in covered employment. With separate systems of social insurance for similar risks, the worker may be subject to two or more systems during his working life. As a result, he may find that when retired for age or invalidity he is not qualified for benefits under any system. This problem is particularly serious for the lower paid, temporary type of worker attached to particular jobs of short duration. Such workers characteristically most need the protection against social security risks. Contributions collected from such persons under separate systems frequently yield no advantage to them, although that do help finance the protection of the more permanent and higher paid workers. This is an unfortunate kind of discrimination, very much contrary to the spirit and intent of a sound social security program. In theory it is true that a system of transfer of credits can be worked out; however, where an attempt has been made to do this for separate systems in other countries, the maze of procedures which is required has led to abandonment of the attempt.

The confidence of workers that comes from assurance of coverage and understanding of the program is vital in a social security program. It is important that the provisions of the program be uniform for all groups and that there be a consistency in their administration. This can be achieved best under a unified program and administration. For persons subject to the system it is confusing and frustrating to be obliged to deal with separate agencies for different kinds of risks. For example, when the administration of cash benefits for wage loss due to unemployment and sickness are separated, two separate agencies must be consulted by the worker if he becomes ill while in receipt of unemployment compensation payments and is thus unavailable for work. He must be dropped from the unemployment compensation roll and transferred to the disability roll. At the end of his disability he must be transferred back if he is still qualified

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for unemployment compensation. This process, which would tend to become complicated with separate systems, could be quite simply handled with administrative integration. Questions of qualification, benefit amount, and number of qualified dependents would be determined only once, and the shift from one type of benefit to the other would be a quite simple matter of internal accounting. Similar complications for the insured arise in the case of injury or disease where one agency is responsible for occupationally caused disability and another for non-occupationally caused. In borderline cases where the cause of the disability is in doubt there is danger that the worker will fall between the systems, being held ineligible because neither system will accept the liability. This might result in delay in provision of the necessary medical care and such a delay is very probable in the case of cash benefits due.

Representatives of the major labor groups in Japan, which were consulted were, with the exception of the representatives of the seamen's union, unanimous in emphasising their desire for a unification of the social insurances.

2. Advantages to the employer.

Employer representatives also expressed their desire for a unification of the social insurances. While not satisfied with the quality of present administration by the Ministry of Welfare and the prefectures, they expressed a view that the proper solution is in improving that administration rather than breaking up the social security program among several government agencies. The employer group emphasizes the desirability of reducing the number of agencies with which an employer must deal. It is important that there be consistency in the rulings as to what workers are covered for a given risk and contribution, that required reports be as simple and uniform as possible, and that exceptions to employer actions and audit of those actions be similarly handled for different insurance purposes. Moreover, the employer has a genuine concern in making the system simple for his employees, since it is traditional in Japan for the worker to depend upon his employer for his assistance in securing the benefits to which he is entitled.

3. Advantage to service groups.

From the standpoint of groups providing service under the system, such as doctors and dentists, midwives, and hospitals, a unified system is desirable. Negotiations for the provision of service are difficult and frequently lengthy. The problems encountered are similar for medical care whether an injury or illness is due to occupational or non-occupational causes. The doctor or hospital should be in a position to give the necessary care without question as to the basis upon which payment will be made. The appropriate program to be charged can be determined administratively with the professional advice of the doctor, but neither care nor payment should wait on such a determination. Discussions with representatives of the Japanese Medical Association and the Council on Medical Care have revealed considerable dissatisfaction with the

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complexity and variety of the reports required. This dissatisfaction tends to become a barrier to the immediate provision of medical care for insured persons. Simplification of administration is imperative from the viewpoint of the service groups; their job is to be experts in medical care and they should not be required to be experts in social insurance.

4. Advantage to Government.

From the view of government and public interest in the systematic development of social security in Japan, unification of the system is essential. First and most important, from the standpoint of basic social security planning and policy, responsibility should be centered in one administrative department which can be held responsible for this function. While it is important that the responsible agency be responsive to the needs and interests of special interest groups in the population, it is clearly important that these should be seen and weighed in the light of the public interest generally. To assure the protection of all groups and to keep the developing program in proper balance, the broad planning responsibility should be centralized in a single agency.

Government contributions on a significant but varied basis have been made to several social security programs. In good fiscal planning, it is important that the total resources to be expended from general revenues be carefully appraised and that their distribution be according to an integrated, fiscal plan.

With respect to the establishment or management of reserve funds, a consistent policy and administration is desirable. At present the funding policies vary according to programs. Whether it is decided to adopt a policy of full funding of programs, partial funding, or a pay-as-you-go basis, such as is recommended in this report, the same policy should apply throughout in the handling of similar types of risk.

In administration, integration provides the opportunity for simplification and economy. For example, with respect to coverage, rulings as to covered employment and wages should be consistent among the several programs. Experience in other countries has shown that separation in administration leads to disparity in interpretation and resulting confusion to employers and employees, and, in any case, there is no justification for having several groups of officials working on the same problem with a resulting duplication of public rules and regulations. Similar duplication of staff and regulations would occur with respect to qualification or disqualification for benefits, qualification for medical care and dependents. Such duplications add up to unwarranted administrative costs.

With respect to reports and records, unifor mity where possible is the first requisite in the interests of government efficiency and understanding by employers and employees. With unification, moreover, the same reports and records can be made to serve at the same time the purposes of several programs. Necessary actuarial staff and educational staff and channels can be minimized under a unified system. The development of more adequate data for social security planning and operation is important. Some broad estimates of probable costs for the coverage of specific risks have been made by the staff of the Ministry of Welfare, but many of these

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estimates are shown upon examination to be invalid. Likewise, the reporting of operating statistics and the analysis of these statistics is superficial and inadequate. To remedy this situation it is essential that basic estimates be developed from the best data now available and that operating, statistical reports be developed for use in connection with planning, administration and proper evaluation of the program. As noted in the discussion on medical care and hospital facilities, the initiation and conduct of the program should be preceded by basic surveys as to facilities now available and as to needs for and cost of medical care. These activities should be established as an essential tool for social security planning and policy. They can best be carried on through a combined staff serving an integrated administration.

In the field of medical care there has been a lack of coordination in the provision of hospital and clinical facilities. In the recommendations on medical care it is proposed that a master plan for hospital development be formulated and that such government funds as are made available for hospitals be provided in a manner consistent with the plan. This approach calls for unification in planning and top-level administration and requires close coordination of their insurance systems which defray the costs of medical care.

Where insurance benefits are inadequate for subsistence and must be supplemented by welfare allowances under the Daily Life Security Law, the existence of separate insurance programs will complicate the administrative process. It is necessary that the welfare staff be thoroughly acquainted with the rights of insured persons in order that full benefits are obtained before any supplementation is given from assistance funds. The procedures for coordinating the work under the welfare agency with insurance agencies should be as simple and uniform as possible. With separate programs, the welfare staff is required to be expert in a multiplicity of rules and regulations, and the process of supplementation is unnecessarily complicated. The duplication of effort in establishing relationships with numerous agencies is both costly and delaying.

B. Special Problem Areas.

1. Seamen's Insurance.

Interest in maintaining a separate program is strongest for seamen's insurance. There is active support not only for the separate system but also for the transfer of administration from the Ministry of Welfare to the Ministry of Transportation. In this case there appears to be unanimity among union representatives, employer representatives, and the Ministry of Transportation. The argument for separation is premised in part upon the unique character of the seamen's occupation. It is represented that traditionally there has been little movement in and out of this occupation and that, accordingly, it can safely be provided for in a separate system without seriously complicating administration or detracting from the protection given to employed persons. However, during the war years there

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was an extensive movement in and out of the occupation. It is to be anticipated that, as the merchant marine of Japan is rehabilitated and expanded from its present very low level, additional persons now in other employment will be recruited.

It is argued also that the present administration of seamen's insurance is inefficient and inadequate and that a transfer of the operation of the system to the Ministry of Transportation would result in more responsive and efficient management. Whatever the merit of this view may be, the administrative inefficiency of a government department is never in itself a good reason for transferring functions to another department. The obvious and proper remedy for this problem is to improve the efficiency of the agency presently responsible.

A more persuasive argument is that, in the case of seamen, the prefectural welfare offices are not located to meet the convenience of seamen, whereas the maritime offices are located in the port cities and are, in general, in close contact with the employers and employees of the industry. Availability of service offices is a prime requisite for efficient social insurance operation. There is no good reason why the Ministry of Welfare should not work out a cooperative arrangement with the Ministry of Transportation for the use of the maritime offices, where necessary, as administrative outposts. This could be done on an agency basis and would be an economical and profitable arrangement for both ministries. Arrangements of this type are common in the social insurance systems of other countries throughout the world.

2. Unemployment Insurance and Workmen's Compensation.

The new Unemployment and Workmen's Compensation laws are to be administered by the Ministry of Labor. One argument used for the separation of the systems from the other social insurances is that the new Labor Standards Law includes provisions relating to social insurance aspects of employer liability. This is very true and it emphasizes a serious weakness in the Labor Standards Law. The proper remedy in this case is to revise the Labor Standards Law to confine its terms to provisions appropriate to such a law, leaving the social insurance aspects to be provided for in the appropriate Workmen's Compensation legislation. Another argument for this separation is the need to strengthen the activities of the new Ministry of Labor. Strategic considerations of this character are beyond the scope of this report; however, it would be unfortunate to have desirable unification of the social insurances forestalled for this reason. The long-time interest of labor in a well planned and orderly social insurance operation is such that the wisdom of sacrificing this interest to a short-time, strategic advantage is very doubtful. Again it should be noted that representatives of the two principal labor unions, the Japanese Federation of Labor and the Congress of Industrial Unions, have indicated that they would prefer to see unification in the program. These groups are also not satisfied with the present administration, but believe that the proper remedy is to strengthen and improve that administration.

The most serious problem in the administrative integration of

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the social insurances lies in the sheer size of the operation. Unquestionably the administrative [redacted] required to do an efficient job is a large and difficult one. The current virtues of parcelling out the total job, however, are illusory in the face of the confusion and the administrative waste which must follow such a course. The long-time advantages of unification are so important and so apparent that there should be no hesitancy as to which course to follow.

It is recommended that the government take steps to plan and effect a unified social security system. The Ministry of Welfare now has the responsibility for operation of the programs for Health Insurance, National Health Insurance, public health, the Daily Life Security Law, and Seamen's Insurance. The unemployment compensation and the workmen's compensation systems should be made responsibilities of the same Ministry.

6. Specific Suggestions on Organization.

Japan is a small area compactly populated by genetically similar people with a high degree of literacy who have had considerable experience with social insurance. Such factors appear to present an ideal setting for effective and economical admini tration within a legal framework that permits such operations. On the supposition that the legal changes will be made, the following specific organization steps are recommended:

1. The establishment of a representative Advisory Council on the level of the Cabinet to advise the Diet and responsible administrative agency on planning, policy, and legislation with regard to Social Security.

2. The delegation by the Diet of full authority and responsibility for the administration of the social security program in Japan to a single ministry, for which the Welfare Ministry would seem the most appropriate choice. The assignment should direct that administration function be diffused on a decentralized local basis to accord with democratic principles and that full utilization be made of local advisory councils. Further, there should be complete coordination of social security activities within the Ministry.

3. An independent appeal structure of quasi-judicial nature should be established to give a fair hearing to all interested parties on any determination of a social insurance nature, with the right of subsequent appeal to courts of law.

1. Advisory Council

The social security program affects so many people and is the concern of so many interested groups that it is desirable to have, for some years to come, the assurance of representation and participation at a high level of all those interested. It is evident that there has been insufficient consultation between the various ministries with respect to common problems. In a broad social security program it is a primary essential that the Ministry of Labor be fully heard where the interests of labor are involved and that the Ministry of Transportation be similarly consulted with respect to problems and interests of seamen. A Council

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representing employers, industrial, [illegible] and governmental workers, the professions, agriculture and representatives selected for their interest and knowledge of economic and social problems, could perform this advisory function. Such an advisory group would be invaluable to the ministries and to the Diet. It would bring to the government the consensus of national opinion with reference to socialsecurity matters and constitute a channel to secure communication between the public groups and their government.

The Council must feel that it has independent character which permits freedom of expression,and research if desired, and be answerable only to the Diet. It should be given separate offices, secretarial and administrative personnel, and a small staff of qualified technical consultants. Major dependence should be placed on the staff and facilities of the Ministry of Welfare for data and technical advice. A yearly report should be required and minimum number of meetings prescribed. The membership should be appointed by the Prime Minister and confirmed by the Diet with overlapping 4 to 6 year terms.

2. Delegation of Responsibility and Authority to One Ministry.

The integration and coordination of the administration of all social security activities, including welfare, social insurance, public health and medical care, by designation of final responsibility and authority in one ministry is a most vital step for attaining the maximum protection possible within the limited resources available to the Japanese people. With such delegation and the requirements that full utilization be made of local facilities and agencies, there can be widespread availability of facilities, decentralized administration to permit adjustment to local conditions and effective application of democratic processes, and the most economical use of the limited funds for sustaining the welfare of the nation.

a. Indicated organizational changes.

To conform with such designation and assuming that the Ministry of Welfare would be chosen as the responsible agency, the following organization changes are indicated:

(1) The transfer of responsibility for the administration of mutual aid activities, workmen's compensation, unemployment compensation and government pensions to the jurisdiction of the Ministry of Welfare for integration with the other social security programs. It is expected that many of the functions would be delegated to other government departments for coordination with activities of mutual concern but subject to supervision and direction of the responsible Ministry.

(2) The assumption by the Ministry of Welfare of the administrative functions relating to social security which are now performed by the medical profession, employer organizations, and private and semi-private federations and foundations.

(3) The reorganization of the Ministry of Welfare to the fullest extent necessary to adequately meet its total responsibilities.

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The transfer of responsibility for administration of the various social security programs to the Ministry of Welfare should not be too difficult. The functions to be transferred are identical to those already performed by the Ministry of Welfare and can be readily integrated with the present activities.

The principal problem areas are the functions which should be performed on a cooperative basis by more than one ministry, because of mutual concern and interest and to achieve economical operations. The resources and facilities of all the ministries should be available where such utilization would permit more effective administration. Policies and procedures to facilitate such working relationships should emanate from and be enforced by the Diet through a responsible Cabinet. A major responsibility of the Ministry of Welfare should be the adoption of such methods in administering the social security program. Its actions should conform with the concept that the interdependence of ministries in serving the nation as a whole has supplanted the independent, categorical, and special- interest attitude of the past and of which vestiges remain.

The working relationship must be particularly developed with reference to workmen's compensation and unemployment insurance. Effective and economical operations dictate that the Labor Standards and Employment Service technicians coordinate their operation and facilities with the Insurance officials in the administration of these two social insurance programs. They should submit recommendations with supporting factual information relative to any particular claim to the Insurance office. That office will consider such material in conjunction with insurance and medical material, experts in arriving at the initial determination. The responsibility of the decision should rest with the insurance program subject to appeal and review by the regular appeal mechanism. Such degree of coordination has been reached and is effective in the various employment security programs of the United States.

Further, the application of medical care should not be conditioned or delayed by decisions of liability under the workman's compensation program. Such care is to be given in case of need regardless of whether the cause was attributable to occupational or non-occupational reasons. The Insurance official with medical facilities readily available can give priority to such considerations. Any statistics or medical knowledge pertinent to industrial hygiene should be transmitted by the Insurance officials to the Labor Standards offices.

3. Appeal Structure.

At the instigation of SCAP, the concept of appeals and fair hearing, with supporting administration, has been incorporated into all of the present social insurance laws with compulsory coverage provisions except those pertaining to government workers. To avoid duplication and to permit maximum utilization of established facilities, one structure and procedure should be formulated that has application to all social insurances including the voluntary coverage aspects provided by the community health societies.

With integrated administration of appeals, the volume should warrant local referees responsible for a regional area within a prefecture, an appeal board for each prefecture, and a final appeal board on the national level to assume jurisdiction at its own initiative only on major issues. Where special knowledge with reference to medical implications, employment practices, or industrial hygiene is required, the regular appeals facilities should be implemented with such assistance.

The details of the transition of appeals from the quasi-judicial to the legal machinery must necessarily be formulated by persons more familiar with suchprocedures than those formulating this report. It is suggested that consideration be given to providing an appeal from the prefecture appeal board to the highest legal court in the prefecture and following the regular legal procedure from that point.

The local referees and prefecture appeal boards should consist of qualified people on a full-time salary basis. Funds should be provided to hire consultants on a per diem basis and to pay transportation and fee costs of witnesses. The National Appeal Board need not have full-time salaried members t[redacted] secretariat should be provided. The membership should be representative.

4. Internal Organization.

In meeting the new responsibilities, it is advised that the Ministry of Welfare establish an internal organization to perform the following functions:

a. Conduct an extensive informational and educational program of the rights, obligations and available protection of all interested parties under the social security system and the administrative procedures provided to serve the people.

b. Plan and coordinate within the given legal framework all social security activities of the government.

c. Formulate and prescribe policies, standards and procedures for implementing the social security legislation.

d. Provide an inspection and supervisory staff to enforce the legal provisions, policies and standards.

e. Conduct on a continuous basis, a research and statistical reporting program to gather, compile and interpret the factual information required for intelligent planning and effective management.

f. Establish one set of wage records properly coordinated for the entire nation with due regard for the necessity of paying "long-term benefits", e.g., old age pensions, on a timely and accurate basis, and to give valuable economic data for national planning.

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g. Prescribe simplified and uniform procedures and forms for collecting contributions, claims taking and determinations with full information on rights of appeal, and benefit payments.

h. Because of the vital nature of social security protection to the basic livelihood of the individual claimant, obtain and train a staff for operations at all levels of administration that will be both capable and sympathetic to the basic intent of the social security program.

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5. FINANCING THE SOCIAL INSURANCE SYSTEM

The previous discussion has presented the recommended scope and general pattern of an integrated and somewhat enlarged social insurance system for Japan. The amount of protection for each risk which can be provided under present circumstances will be limited by the fiscal capacity of the country and, in particular, by the tax burden decided upon for that portion of the population proposed to be insured. In the appendix to this report alternative cost estimates under various assumptions as to eligibility requirements and benefit formulae are presented in detail. According to the specific decisions made with respect to each of the variables, the costs of protecting the individual risks and for the system as a whole will vary greatly. At this point, for purposes of indicating the general magnitude of the probable costs and for discussing basic problems and principles of financing, summary estimates are presented based on the assumptions set forth below.

A. Social Insurances for General Workers in Commerce, Industry, and Government: Eligibility and Benefit Formulae.

Three of the assumptions made throughout the subsequent discussion of the compulsory program may be summed up conveniently before stating the special features of each benefit scheme.

Firstly, concerning the relationship between the tax base and the benefit base, it is assumed that all kinds of pay, including wages, bonuses and regular allowances, especially family allowances shall be subject to contributions. The cut-off should be high enough to include virtually all salaries in their entirety, leaving untaxed only exceptionally high rewards paid for top managerial responsibilities. On the other hand, benefits both for the primary insured and his dependents shall be computed as percentage of wages proper, that is, total regular pay minus family allowances. If at a future date family allowances should cease to be paid, which seems not unlikely, benefit rates would not be affected by that change. Of course, the percentage rate of contributions might have to be increased. It is suggested that the cut-off in regard to the basis on which benefits are computed should be well below the cut-off for purposes of contributions. In the estimates following below, account has not been taken of the savings thus to be effectuated.

Secondly, dependents' benefits will be paid at a flat rate to all those qualifying as dependents. However, the absolute limit on total benefits payable under anyone scheme shall be 80 percent of the total pay (including family allowances) of the insured. Thus benefits will not reach total take-home pay but will exceed in many cases the working wage proper of the insured.

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Thirdly, as to eligibility requirements, the assumptions stated under the various schemes represent a compromise between two opposing considerations. One is the necessity to establish an insured person bona fide attachment to the labor market. The other is the desirability of granting each insured person an equity in the insurance system as soon as possible after he has become a contributor. Obviously, both considerations must be weighed in the light of financial considerations and of the nature of the right to be protected.

1. Old age benefits. Retired workers will be eligible for life-time pensions on the basis of ten years of covered employment at age sixty for males and fifty-five for females. Benefits would be forty percent of average earnings. Dependents' benefits would be included equal to fifty percent of the primary benefit for each dependent.

2. Survivors' benefits. Survivors qualify for life-time pensions with the usual restrictions on the basis of minimum previous employment of the deceased. It is assumed that the minimum would be a total of five years of covered employment including 18 months of the preceding 36 months, or ten years of covered employment altogether. The benefit would be fifty percent of the amount which the deceased received or would have received as old age benefit had he qualified for one. In the case of a surviving wife and/or one or more children qualifying as dependents, such benefits should be paid cumulatively rather than being paid to only one person at a time as has been the practice heretofore.

3. Invalidity benefits. In instances of non-occupational cases only total invalidity and incapacity for remunerative work of any kind would be compensable. The qualifying conditions in regard to minimum covered employment will be the same as for survivors' benefits. Benefit rates and duration would be identical with those under the old age scheme, both in regard to the primary insured and his dependents.

Occupational invalidity is not here dealt with. It is understood that the assumptions concerning qualifying period and non-compensability of partial invalidity do not apply. Also, the benefit rate might be higher.

4. Temporary disability benefits. Cash benefits would be payable for the full duration of temporary non-occupational disability after qualifying employment of six months out of the preceding twelve and a three-day waiting period. Primary benefits would be sixty percent of earnings, dependents' benefits one-half of the primary benefit.

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Temporary disability due to occupational causes is not here considered and its probable costs as well as the costs of occupational invalidity have not been included in the estimates. It is understood that in cases of occupational disability of insured persons the qualifying conditions are waived and benefits are paid at a higher percentage rate.

5. Unemployment compensation. Jobless workers have had six months covered employment in the preceding twelve months would be eligible after a brief waiting period for benefits at a rate of sixty percent of earnings payable for 26 weeks. Dependents' benefits would be paid at one-half of the primary benefit.

6. Medical care. Complete medical care and hospitalization would be provided to workers and their dependents for the full duration of sickness. Workers with six months of employment out of the previous twelve months would be eligible for such care for themselves and their dependents. This eligibility requirement would not apply to primary insured patients suffering from occupational causes.

B. Estimated costs of the Compulsory System.1/

On the basis of these assumptions, estimated costs are presented below. The various components of the system would mature over a period of years; therefore, the costs are indicated for the immediate future, for the sixth year of the system's operation, and as ultimate costs at maturity.

1/ Columns marked A show the costs of benefits paid on the basis of wages proper, exeluding family allowances, while contributions are paid on total pay, including family allowances. Columns marked B show the costs of benefits as percentages computed on the same base on which contributions were collected, as might be the case, e.g., if the family allowance were to disappear.

Estimated Cost of the Social Insurances in 1/ Percent of Payrolls

Benefits	First Year of Operation (Assumed 1948)						Sixth Year After Start of Operation (Assumed 1954)						At Maturity of the System (Maturity well over 90% assumed 1978)					
	Primary Insured		Dependents		Total		Primary Insured		Dependents		Total		Primary Insured		Dependents		Total	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B
Old Age	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.4	12.0	1.8	2.5	10.2	14.5
Transfers2/	1.3	1.8	0.3	0.4	1.6	2.2	2.7	3.2	0.5	0.6	3.2	3.8	0.0	0.0	0.0	0.0	0.0	0.0
Total	1.3	1.8	0.3	0.4	1.6	2.2	2.7	3.2	0.5	0.6	3.2	3.8	8.4	12.0	1.8	2.5	10.2	14.5
Survivors'	-	-	0.0	0.0	0.0	0.0	-	-	0.6	0.9	0.6	0.9	-	-	5.6	8.0	5.6	8.0
Transfers2/	-	-	1.3	1.8	1.3	1.8	-	-	2.9	4.1	2.9	4.1	-	-	0.0	0.0	0.0	0.0
Total	-	-	1.3	1.8	1.3	1.8	-	-	3.5	5.0	3.5	5.0	-	-	5.6	8.0	5.6	8.0
Invalidity	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.1	0.7	1.0	0.4	0.5	1.1	1.5
Transfers2/	0.2	0.2	0.1	0.1	0.3	0.3	0.5	0.7	0.2	0.3	0.7	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.2	0.2	0.1	0.1	0.3	0.3	0.6	0.8	0.2	0.3	0.8	1.1	0.7	1.0	0.4	0.5	1.1	1.5
Temp. Disblty	0.6	0.8	0.3	0.5	0.9	1.3	1.2	1.7	0.6	0.9	1.8	2.6	1.2	1.7	0.6	0.9	1.8	2.6
Transfers2/	0.4	0.6	0.2	0.3	0.6	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	1.0	1.4	0.5	0.8	1.5	2.2	1.2	1.7	0.6	0.9	1.8	2.6	1.2	1.7	0.6	0.9	1.8	2.6
Medl. Care	0.7	0.9	1.6	2.3	2.3	3.2	1.3	1.8	3.3	4.7	4.6	6.5	1.3	1.8	3.3	4.7	4.6	6.5
Transfers2/	0.6	0.7	1.4	1.9	2.0	2.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	1.3	1.6	3.0	4.2	4.3	5.8	1.3	1.8	3.3	4.7	4.6	6.5	1.3	1.8	3.3	4.7	4.6	6.5
Hospital	0.7	0.9	0.4	0.5	1.1	1.4	1.1	1.5	0.6	0.9	1.7	2.4	1.1	1.5	0.6	0.9	1.7	2.4
Transfers2/	0.3	0.5	0.2	0.3	0.5	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	1.0	1.4	0.6	0.8	1.6	2.2	1.1	1.5	0.6	0.9	1.7	2.4	1.1	1.5	0.6	0.9	1.7	2.4
Grand Total	4.6	6.4	5.8	8.1	10.6	14.5	6.9	9.0	8.7	12.4	15.6	21.4	12.7	18.0	12.3	17.5	25.0	35.5

1/ - (See foregoing page)

2/ - Estimate of cost to be taken over by the new scheme in view of rights acquired by contributors to schemes now in existence who would qualify under the new system.

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The figures shown in the above table do not aspire to be anything but very rough estimates. They purport to give an idea of the order of magnitude of the costs of the compulsory part of the insurances proposed in this report as well as of the probable load of beneficiaries to be taken over from the old systems. Regardless of the differences between the existing and the proposed benefit provisions it is proposed to transfer all those claimants and potential claimants, under any of the insurances now in existence provided they can meet the eligibility provisions of the new scheme. Likewise it is suggested that differences in the rate of contributions required in the old schemes as compared with those to be charged under the several parts of the new integrated system be disregarded too, to facilitate such transfers and minimize the loss of accumulated wage credits and insurance protection.

It appears that the program outlined for the protection of workers and employees in commerce, industry and government will cost 10.6 percent of total payrolls (including family allowances) at the outset, 15.6 percent in the sixth year and 25 percent at maturity. If family allowances were not included in the tax-base, these percentages would change to 14.5, 21.4 and 35.5, respectively.

These higher percentages are due, of course, to the narrowing of the tax-base. In the case of medical care costs, which are not computed on a percentage basis but at assumed prices of drugs and services provided, it may have been unrealistic to apply the 6.5 percent rate, computed on the basis of an average taxable wage not lower than ¥1800 per month (see Appendix), to the smaller of the two tax bases shown. Some upward adjustment of this item might have to be made, therefore, unless it is possible on the basis of prevailing wages to reach agreement with the insurance physicians on the basis of the lower payroll fraction indicated.

The initial cost of 10.6 percent of total payrolls compares with close to seven percent in the fiscal year 1946-47, allowing less than two percent for unemployment compensation or, if government subsidies are counted in, as they should be, a rate of about 8.5 percent.

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Total contributions to the Compulsory Insurances in Fiscal 1946-47 1/

	Membership Contributions	National Subsidies	Total
Health Insurance - Society Management	¥376,668,000	¥3,401,000	
Health Insurance - Govt. Management	253,551,000	14,222,000	
Seamen's Insurance	57,642,000		
Welfare Pensions Insurance	1,543,730,000		
Government Pension Insurance	20,000,000 2/	160,000,000	
Mutual Aid Societies	107,165,000	104,000,000	
Total	¥2,338,776,000	¥281,623,000	¥2620399000

Total employment in covered industry regardless of exclusions on 31 July 1946.

	No. of male workers (millions)	Ave Wage (thousands of yen)	Total annual payroll M.
Manufacturing	3.8	6.7	25,400,000
Mining	0.5	6.1	3,050,000
Transport & Com.	1.1	6.5	7,150,000
Commerce,	2.1	6.0 2/	12,600,000
	7.5		

	No. of Female workers (millions)	Ave. Wage (thousands of ¥)	Total Annual payroll F	M & F Payroll
Manufacturing	1.4	3.0	4,200,000	29,600,000
Mining	0.1	3.3	330,000	3,380,000
Transport & Com.	0.2	3.2	640,000	7,790,000
Commerce,	0.9	3.0 2/	270,000	12,870,000
	2.6			53,640,000

1/ Sources: Insurance Bureau of the Ministry of Welfare, Cabinet Bureau of Statistics and Allowance Bureau of the Finance Ministry

2/ Estimate

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Deducting those employed in enterprises of less than 5, excepting only government, or 20% of 8,000,000 paid presumably less than the average wage - say ¥4,500 instead of 5,300 leaves a total payroll of 46 billion yen.

Total contributions for compulsory social insurances expressed in percent of total payrolls: 5%;

Contributions plus national subsidies as percent of total payroll: 6,7%;

Add in either case the costs of unemployment compensation not provided in 1946.

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At this rate neither the extent of coverage nor the liberality of benefits now envisaged were provided. On the other hand, a sizable reserve was being accumulated. At the end of the fiscal year 1946-47 this reserve amounted to a round 4.2 billion yen or, in terms of total benefit payments in that fiscal year which aggregated 857 million yen, roughly five times that amount.

It is understood that along with the accumulated obligations of the several systems now in existence, these reserves too will be taken over under the new program. While their use will be earmarked for social insurance purposes they should not be restricted to financing the compulsory part thereof. Rather their use should be decided on the principles of allocation set forth below (Sections D-G of this chapter).

C. Principles of Financing

With the above assumptions and estimates as to the magnitude of the compulsory part of the proposed social insurance system, we have to consider the general problems and principles of financing it. Traditionally, three sources of revenue have been drawn upon: contributions from employees or insured persons, and appropriations by the government from general revenues. Each of these sources has a proper place in an established social system and it is suggested to utilize all three.

For the insured, the contributory principle has several advantages which justify its use. In the first place, there are good grounds for imposing a substantial share of the initial cost burden on the persons who will receive the benefits of the insurance protection. For this group, the effect of the insurance program is to provide a cooperative financing of costs which would otherwise be borne individually by those in the insured group with no assurance of reasonable uniformity of minimum protection.

There is also a psychological value in the contributory principle. Making a regular contribution to the cost of insurance gives the insured man a sense of participation in and responsibility for the system and for its costs. A wholesome check is provided against groups pressuring for extension of benefits at the expense of others in the population. With respect to employer contributions, the rationale is that the economic risks incident to the occupations covered are a proper charge, in part at least, against the particular industry exposing its workers to these risks. Also, it is commonly argued that industry has in its power to reduce in some degree, varying with the nature of the hazard, both volume and severity of its incidence. Since in the case of industrial (occupational) injury and disease this argument is particularly strong, the entire cost of the type of insurance has traditionally been charged to the employer, both for reasons of equity and to provide an incentive to industry to initiate effective safety and

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prevention measures. For other risks it has been customary to assess the employer only a share of the cost. Also it should be remembered that the employer gains advantages from the social insurance system, through improved morale and efficiency when his employees have the assurance of protection against adversity.

As a taxing device, moreover, the payroll tax, despite its possible liabilities as to incidence and effect, does offer practical advantages which make it administratively an expedient tool. Under normal economic conditions payrolls constitute a reliable index of the size and income of the compulsorily insured population, as well as changes therein from month to month. A tax thereon -- certainly in the short-run and, given reasonable economic stability, in the long-run as well -- provides a self-adjusting mechanism of gauging revenue to the volume of the risk to be financed. Moreover, collection of payroll taxes is comparatively easy, prompt, and cheap.

Government or public contributions are justifiable on several grounds. In the first place, the government has a responsibility for assuring a minimum of health and well-being to all persons in the population. Therefore, a substantial government participation in a comprehensive social security program is clearly warranted. In the second place, the risks of those insured are, in a large measure, social risks inherent in the total economy. While there is merit in holding industry responsible within limits, there is equal reason for considering them as broad social hazards to the extent that the individual employer or employee is subject to conditions beyond his control. To this extent, it is, therefore, reasonable to make the costs of bearing such risks a social cost.

The argument in favor of a government contribution is strongest where coverage is most comprehensive. Even in a limited coverage system, however, such as is herein proposed for Japan, a government contribution is justified. To the extent that specific areas in the population can be insured, there is that much progress toward the goal of providing protection for all; and there is, also, a very real saving to the public fisc in that so much less money is needed for public assistance in the form of direct relief or public works which would otherwise be required to bear the burden of dependency or inability to pay for medical care in cases of need. Apart from the justification of government contributions on grounds of public interest, there is another consideration which argues for its use. To a considerable measure, the incidence of payroll taxes is not limited to the persons who make the initial payments. These taxes, or at least and most likely the employer portion, tend to be reflected in higher costs and ultimately in prices of things purchased by the entire population. To the extent that this happens, cost is borne by all, and it should be pointed out that the incidence of such a cost is not in accordance with ability to pay. Under such circumstances a government contribution derived from the population at large on the basis of an individual's ability to pay, provides a more desirable way of financing.

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D. The Question of Reserves

Serious differences of opinion exist among economists concerning the advisability of operating a social insurance system on a fully funded actuarial basis under any circumstances. In Japan today, under present inflationary conditions, the main argument in favor of full liability reserves loses whatever force it may have elsewhere under stable economic conditions. For collection of contributions in excess or advance of current needs, merely to build such reserves, cannot provide significant protection to the social insurance system of Japan as long as present inflationary conditions persist. In the present situation, social insurance contributions collected for the alleged purpose of storing up "security" are not likely to serve any purpose except to provide the Treasury with excess cash readily available to be absorbed by new issues of government bonds. In this way there are apt to turn into a concealed tax for the partial financing of the government deficit.

E. Government Subsidies: Timing and Allocation

With the adoption of the pay-as-you-go principle, advantage may be taken of the fact that the system matures slowly to defer to later years the government's share in the benefit financing of the compulsory social insurances. This is particularly advantageous in view of the present financial stringency and doubt as to immediate prospects for substantial contributions from government revenues, in view of other essential needs competing for government funds. Social insurance cost in the initial years can be financed by employer and employee contributions, equally divided. Gradually, combined benefit costs will reach proportions requiring the levy of contributions upon employers and employees at the maximum rate compatible with labor's and industry's capacity to pay. Once this point is reached, the use of payroll taxes to raise additional funds, clearly, is no longer indicated. It remains for the Japanese Government to judge when this point is reached -- giving due consideration to the undesirable indirect effects of a heavy payroll tax -- and to determine when subsidies to the system should begin. However, it is recommended that employers and employees bear the entire cost of the non-occupational risks until the total burden reaches approximately two-thirds of the percentage amount estimated to be required under a mature system. At this point, government subsidies would begin in the amounts necessary to cover the deficit. Starting on a small scale, these government subsidies would reach eventually one-third of the total benefit amount required, thus equalling the respective contributions of employers and employees. If this method is adopted no subsidies from general revenues ought to be required for a long time to come, certainly not during the first six years after the start of operations, herein envisaged for 1948.

This is not to say that government subsidies for the broader purposes of social security can be dispensed with during this initial period. On the contrary, such subsidies are essential for the implementation of proposals hereafter presented which are an integral part

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of the recommendations in this report. Reference is made to that part of the report advising that the government develop a master plan for hospitals and clinics, and that a first priority for funds be given to the construction and improvement of facilities. With the pattern of financing proposed, whatever funds can be provided from general revenues should be devoted to this purpose. To the extent that facilities can and must be planned and completed in the early years of the insurance system, government funds would be available later for the compulsory social insurances as the maturing of the system requires.

F. Ways and Means for a Program of Capital Outlay on Medical Care Facilities

The expansion and improvement of hospital and clinical facilities is an integral part of the recommendations in this report. Unfortunately, it is not feasible to make even a rough estimate of the probable cost of the required expansion. As noted elsewhere, there are now no reliable data on the quality of existing facilities; even the data on number and general classification of such facilities appear not to be sufficiently reliable. With respect to both the total need and the extent of the deficiency of facilities in the light of that need, no proper judgments or estimates can be made until there is available a comprehensive survey of medical care and facilities now in existence.

A capital outlay program based on national fact-finding, planning and financial incentive should be undertaken without delay. Its main characteristics should be the joint effort of national, local and civic authorities. To insure its success, it is essential, however, that this continue beyond the construction phase and be applied, on a reduced scale, to the operating phase as well. In this fashion a three-fold national effort appears to be called for:

1. Capital Outlay

The required new construction as well as the rehabilitation of existing but inadequate facilities should to a far-reaching extent be provided by funds either granted or loaned by the government. Funds should be made available, not only for the development of government owned hospitals but for the rehabilitation of hospitals operated by non-profit organizations where these agree to operate facilities in accordance with the prescribed national standards. The choice between direct grants and loans is one on which it is difficult to advise in view of the scanty information available. It is suggested that pending the development of a sound system of variable grants-in-aid a loan basis could be used for both direct government construction and for assistance to non-profit organizations, with provision for debt service as suggested in (2) below.

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2. Capital charges

An annual grant should be provided by the national government for the purpose of paying interest on indebtedness and for debt retirement, according to a reasonable key, geared to the local fiscal effort and limitations. Such a device would spread costs over a period of years and would give assurance of debt retirement. With respect to the hospitals in question, a condition incidental to the annual grant could properly be the continuance of conformity with minimum national standards and cooperation with publicly sponsored social insurance systems. Similar provision could be made for the retirement of rehabilitation costs.

3. Costs of Operation

As contemplated in the medical care section of this report, it is proposed that provision be made for grants covering in part the costs of hospitals in, or cooperating with, the national hospital system. Aside from being desirable as a means of aiding in the financing of medical care costs, such assistance may prove, for some time, an essential corollary to make some of the existing as well as the newly established hospitals and clinics going concerns.

g. From National Health Insurance to a Nation-wide Community Pre-payment Plan

The best hope for a rehabilitation and eventual consolidation of National Health Insurance as it exists now appears intimately connected with the early launching of an effective program along the lines discussed in the preceding section of this report. This is the only social insurance recommended at this time for groups other than those in commerce, industry, and government. It is hoped that will provide health insurance through community pre-payment plans to a substantial portion of the population not otherwise covered. No detailed estimates have been prepared on the cost to these groups of medical care comparable to that available to the compulsorily insured groups. On the assumption, on the average, of roughly comparable family incomes, somewhat larger families and probably somewhat slighter demand for medical care, the percentage of earnings required might be assumed to be the same. However, in view of the uncertainty concerning these assumptions, especially the first one, this at best is a tentative working hypothesis.

As in the case of the compulsory schemes, here too a distribution of costs is recommended between the membership and the government, within the framework of the plan outlined above (f). There is justification for government financing for several reasons, namely, the public interest in adequate medical care, the community responsibility for social insurance risks, and the fact that the entire population, including those insured only under the community pre-payment plans are

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subject indirectly to the incidence of the social insurance taxes wherever levied and thus are entitled to a quid pro quo in similar protection.

Certain conditions would be imposed in connection with payment of the government aid. These conditions are described in more detail in the health insurance section of this report. Briefly, it would be conditioned on a minimum contribution paid by the insured members of the community plans; upon their including all members of the administrative area not covered by other insurance, and upon compliance with the minimum organization and operating standards prescribed by the national government through the Ministry of Welfare. As a part of the operating standards, associations meeting these conditions should be required to submit a plan showing the specific facilities which are available or intended to be made available for the provision of care. Its plans in this respect should be consistent with the master plan for hospitals and clinics developed by the national government. Where additional facilities are required, these would preferably be provided as a part of the new facilities program of the national government. Prompt accounting for the funds received is essential. This should be both in terms of the amounts spent and accomplishments wrought.

The total aid provided to associations operating on the community plan would be of one, two or all three of the types outlined above (F). It is probable that in order to make feasible any extensive development of these associations, a substantial share of the total cost would be required from the government. To the extent capital outlay grants are provided, the government contribution toward operating expenses would be reduced.

With respect to assistance given for current operating costs, it is recommended that these be made upon a variable basis, taking into consideration the per capita income of the associations on the basis of the comparative tax efforts of their membership. Thus less prosperous communities would receive a higher percentage grant than would be given to wealthier communities.

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B. PUBLIC HEALTH: GENERAL COMMENTS AND RECOMMENDATIONS

1. Child Hygiene.

At present the Children's Bureau is operating on limited funds which accompanied the transfer of contituent units from other bureaus in the Ministry of Welfare. Its limited funds make possible only the maintenance of a skeleton staff and the issuance of a few bulletins and pamphlets. Obviously, effective maternal and child health programs cannot develop on such a circumscribed base. On the other hand, proposals are being entertained that involve the setting up of complete and independent health programs for mothers and children. Such extreme measures are not justifiable under ordinary circumstances and especially in Japan with its limited resources and fairly logical scheme of health administration. The better plan would be to provide a reasonable budget and staff to promote the peculiar health interests of mothers and children and to require that these services operate through the general framework of health organization at national, prefectural, and local levels.

The problem of integrating school health services with the general health programspresents additional difficulties since it is administered by the Ministry of Education through the public school system. Aside from the teaching function proper, these services should be more closely integrated with the health centers and with health insurance or other means for assuring needed medical or surgical corrective work.

2. Sanitary Engineering.

In the bureaus and divisions of the Ministry of Welfare the several public health interests and professions seem to be reasonably well represented with one notable exception, sanitary engineering. Of all the public health problems that confront Japan, that of sanitation is, without doubt, the most important. Until this defect in the organization is remedied at the top level, sanitation is not likely to receive the sympathetic and sustained attention that it merits throughout the whole public health structure of Japan. Steps already taken in this regard by SCAP should receive favorable response.

3. Public Health Nursing and Midwifery.

While public health agencies employ a considerable, but inadequate, number of individuals classed as public health nurses, one has great difficulty ascertaining precisely what these people are qualified to do and what they are expected to undertake beyond assisting in health center clinics. It would appear that any person of nursing background employed in a public health agency, regardless of her actual duties, may be carried as a public health nurse. Actually many of them do clinic work only. These points should be cleared up for the nurses themselves, the people they are expected to assist, and the employing authorities. This is basic to planning training courses and later in the administration of actual service programs. The need

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for well qualified nursing supervision isapparent throughout the whole public health organization.

As stated earlier, practically all women in labor are attended by unsupervised midwives, the great majority of whom have had very little or no systematic training. To remedy this situation, two steps are recommended: 1) assignment of responsibility for field training and supervision of all midwives to public health agencies; and 2) the gradual development of a publicly supported home delivery service by well-qualified midwives under the auspices of public health agencies.

4. Laboratory Service.

A great contributory factor to the lack of precision in the public health program is the present inadequate laboratory service. A strong system of central and branch diagnosits laboratories, is therefore, recommended. Where feasible, traditional sanitary and public health laboratory procedures should be augmented by the inclusion of blood chemistry determinations, serology, blood cultures and tissue work. By these additions the public laboratories will be improving the quality of medical service and, at the same time, meeting part of the cost.

5. Personnel

War and political changes that followed have pretty well disrupted former public health agencies. It has become necessary to set up practically an entirely new organization in consonance with the principle of decentralized authority and responsibility. People still need to be recruited, trained, and fitted into staffs at central, prefectural, and local levels of operation. Positions in such a far-flung and complex organization as that required for modern public health service for Japan should represent a variety of professional backgrounds with varying degrees of technical skill and administrative competence. Obviously, suitable applicants in sufficient numbers cannot be attracted without adequate inducements in the way of salary, security of tenure, and opportunity for advancement. Even though these requirements are satisfied, only a small proportion of those otherwise acceptable will be fully qualified on entering the jobs they are to pursue; hence the necessity for a comprehensive training program. In the array of training opportunities provision needs to be made for post-graduate courses of professional level, shorter orientation courses, supervised experience, and continuing staff improvement. Only a few students need be sent abroad, and these should be carefully selected in advance for key positions. The great bulk of training can be provided in Japan, and for the time being a good part of it must be done on the job. Courses already resumed at the Institute of Public Health, while commendable, can meet only part of the need. Selected universities should be induced to develop the necessary additional opportunities.

6. Physical Facilities

A modern health department cannot be expected to function properly unless it is housed adequately in a building arranged and equipped for the

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functions that are to be performed. In other words, an integrated system of health centers is indicated for Japan. The Health Center Law passed in 1937 authorizes grants-in-aid from the national treasury for construction and operation, but it has been implemented only in small part. The Health Center Act as amended in 1947, together with the proposal made elsewhere in this report for hospital construction, should be coordinated into an integrated functional scheme. Whenever possible, health centers should be located so as to permit easy access to hospitals, sanatoria, or clinical facilities of other types. This arrangement facilitates joint utilization of staff and equipment and adds to the convenience of clientele.

7. Coordination of Resources

Quite essential to effective and amicable administration is the clarification of relationship between central, prefectural and local governments. The public health program can neither be lodged wholly in the central government nor left entirely to the initiative and resources of cities, towns, and villages. This applies to finance, authority, responsibility, and operating procedures. Especially, the present scheme of support should be made more uniform in its general provisions but should still contain differentials in favor of communities relatively less able to assume their share of the financial burden. Account also should be taken of the public health character inherent in some of the benefits commonly afforded by health insurance organizations. Moreover, it may be found both feasible and desirable to utilize, under appropriate arrangement, the framework ofhealth insurance for carrying out selected parts of the public health program. Insofar as practicable, public health services should be financed out of taxes, thus removing the financial barrier that otherwise might tend to separate service and recipient.

8. Definition and Evaluation of Program

One is impressed by the scope of the public health program as conceived by the Japanese health authorities but ruther disappointed by lack of detailed plans and stated objectives. It often seems that limited excursions have been made into new fields at the expense of old jobs which, by being done better, would offer greater possibilities for improvement of the public health. More numbers of superficial contacts seem to carry greater weight than securing measurable results. Such characteristics are not altogether peculiar to Japan. To remedy this basic defect, studies and demonstrations have been developed in other places. There are numerous problems, both administrative and technical, where this approach might be applied in Japan. The following are illustrative:

1. Statistical analysis of causes of morbidity and mortality in relation to possible causative factors.

2. Procedures for training sub-professional personnel and utilizing them in operating programs.

3. Record and report requirements.

4. Collection and utilization of night soil.

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5. Effectiveness and feasibility of mass immunization by B.C.G. and typhoid fever vaccines.

6. Effectiveness and cost of specific supplements to diets of representative families and other population groups.

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G. GENERAL HOSPITAL AND CLINIC FACILITIES

1. Major Consideration.

A method of paying for medical services, no matter how well organized, does not of itself guarantee provision of the desired services. Hospitals are the focal point for modern medical practice, and an adequate system of hospitals (including clinics and out-patient departments for the care of ambulatory patients) is necessary for proper medical care of the population whatever be the system of payment. Such a system requires a sufficient number of hospitals of suitable size and character, located in relation to the needs of the population. These institutions must be staffed with trained professional and sub-professional personnel. They must not only be geographically accessible but must also have admission policies which permit all members of the public to obtain needed care without barriers related to economic status or place of residence.

At the present time in Japan a considerable portion of the population is entitled to hospital care among other medical benefits at the expense of one or another of the insurance systems. To the extent that insurance payments meet the cost of hospitalization, they remove the economic barrier, but many hospitals find that during the present inflation, insurance payments do not meet the cost of care. Hospitals serving chiefly insured patients therefore frequently find themselves operating at a deficit. For those segments of the population which are not insured, some means of paying for the cost of hospital care must be provided ff care is to be made available in relation to need rather than economic status.

Judged by American standards, the number of general hospital beds in Japan is very low. There are, however, many beds not ordinarily counted in hospital statistics but which are used by private practitioners to accomodate sick patients in their own offices. These "clinics", as they are often called by definition do not have more than 9 beds, since facilities for the care of the sick containing 10 or more beds are classed as hospitals and are subject to building code regulations. The significance of these "clincs" in relation to thehospital staffing system and to quality of care is discussed elsewhere in this report. Although the number of such beds is not accurately known, they undoubtedly constitute a substantial proportion of the facilities in which sick patients are treated, but they are not to be regarded as hospitals in the present discussion.

A. Factors in low utilization rates. Despite the relatively small number of general hospital beds per unit of population, occupancy rates show that hospitals generally are not being used to capacity. The most important factors in these low utilization rates seem to be the following:

(1) Direct cost to the patient or his family. In nearly all hospitals, even when the cost is nominally paid out of insurance funds, the family is required to provide part or all of the food, and a family member (or servant) has to devote full time to preparing food and giving general care to the patient.

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(2) Lack of service. Since a family member has to move into the hospital to care for the patient, it isoften easier for the family to keep the patient at home unless he cannot possibly be treated there; for example, in cases requiring major surgery.

(3) Lack of confidence. Many people regard hospitals merely as a place where sick persons go to die, and they wish to avoid hospitalization even when seriously ill.

(4) Closed staff system. Doctors often prefer to treat patients at home or in their own "alinics" because a hospitalized patient comes under the care of the doctors on the hospital staff.

(5) Geographic inaccessibility. Many hospitals - notably the former military hospitals now operated by the National Government - are not in locations convenient to the general public.

b. Service and Staffing. Evaluation of the quality of medical care furnished in Japanese hospitals is beyond the scope of this report, but is evident even to casual observation by a physician familiar with hospital practice in the United States that space, cleanliness, equipment, nursing care, therapeutic techniques, and laboratory facilities are generally inferior. The general clutter in hospital rooms and wards resulting from the family belongings, cooking equipment, etc., and the continuous presence of untrained family members are hardly compatible with modern treatment of acutely ill patients.

It is also evident that there are inherent disadvantages in the existing hospital staffing system. Nearly all hospitals are staffed exclusively with full-time doctors, so that the majority of doctors, including many specialists, are excluded from practice in properly equipped hospitals. This leads to perpetuation of the "clinic" of 9 beds or less operated by the individual practitioner (often with an assistant) in which it is uneconomical and frequently impossible to provide the facilities necessary for the proper care of patients with serious illness. This system is further aggravated by the fact that remuneration to hospital staff doctors is generally lower, especially during the current inflation, than well qualified practitioners can earn in private practice. There is thus an economic pressure tending to drive doctors out of hospitals into private practice as soon as they have gained sufficient experience to feel capable of practicing individually.

c. Advantages of hospital service. Despite the defects in the hospitals of Japan, it is apparent from the opinions of nearly every group consulted that insured patients generally find care more satisfactory from hospitals than from private practitioners. Officials concerned with the administration of the health insurances find that costs to the insurance funds are much lower when patients are treated in hospitals - either as out- patients or as bed cases than when treated by private practitioners. Patients complain that when they present themselves to private doctors as insured patients, they are given second-rate attention, or are asked to pay additional fees; hospitals which accept them do so at the agreed insurance rates. These advantages of hospital

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service appear to result from these considerations:

(1) Hospital staff doctors are generally paid on a basis independent of the number of services rendered to patients, andof the rates actually paid by or on behalf of individual patients.

(2) Hospitals realize substantial economies in overhead costs, and especially inpurchase of drugs and supplies under present conditions of short supply.

(3) Individual practitioners cannot provide the expensive equipment and technical staff necessary for modern diagnosis and treatment of many types of disease, without undue overhead costs and hence excessive charges to patients.

(4) Hospitals frequently have sources of income other than payments by patients; e.g. tax funds available to national and prefectural institutions.

It is characteristic of Japanese hospitals that they have relatively large and active out-patients departments, which make available to ambulatory patients the advantages of hospital service. Similar advantages are provided by clinics operated by employers, Health insurance or mutual aid associations. Such clinics may or may not be associated with hospitals.

Against this background it becomes evident that attention must be directed to improvements, both structural and functional, in the hospitals of Japan, if the system of social security is to give adequate protection against the risk of sickness. The following recommendations have this end in view.

2. Recommendations:

a. Recognition of the public service character of hospitals. There is ample evidence that hospitals and related facilities are ferquently regarded as commercial undertakings which are expected to show an operating surplus. This attitude exists in relation to public as well as private institutions. Even the National Hospitals, which are financed largely out of public funds, are placed on such a limited budget that the hospital officials are under pressure to realize as large an income as possible from patients' fees. This attitude results in unsatisfactory service in the following respects:

(1) There tends to be discrimination, in the admission policy of the hospital, against patients unable to pay full hospital charges. In many instances this discrimination applies to insured patients, since the amounts payable under the insurance systems are less than the charges many hospitals make to private patients.

(2) Undue economy is practiced in hospital operation, to the detriment of adequacy of care. Under present conditions of supply inadequacies, this

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factor is difficult to evaluate, since the obvious deficiencies in food, clean linen, and medical supplies and equipment are generally blamed on inability to procure the needed articles at any cost. The relatively low pay scales of professional and sub-professional hospital personnel is undoubtedly a factor in failure of many institutions to attract and retain personnel of high caliber.

(3) Since payment for hospital care is made on the basis of unit charges for each service rendered, rather than on a flat per day rate, there is a tendency to multiply services and treatments unnecessarily, especially in the case of insured patients, where payment is guaranteed by the insurance fund.

The public officials concerned with operating hospitals and with reviewing their budgets must realize that hospitals are not commercial enterprises, that good hospital care is expensive, and that a large proportion of patients cannot be expected to pay the full cost of care at the time they are hospitalized. The principle should be accepted that hospital care should be available to everyone in accordance with his need, at a cost consistent with his ability to pay. To the extent that this principle cannot be implemented by private and charitable institutuions and funds, it should be regarded as a public responsibility to provide the necessary institutions and the funds for payment for care of persons of low income.

b. Development of a hospital system according to a master plan. Existing hospitals and related facilities have developed with little relation to the over-all needs of the public. If good hospital care is to be made available to everyone, the best possible use must be made of existing institutions and new construction must be placed in relation to need. The first step in such program is a detailed survey of existing facilities - hospitals, clinics, health centers, and laboratories. Such a survey must include not merely the number of hospital beds, but such information as the character of the buildings - modern or obsolescent - the adequacy of equipment, the type of professional care available, the facilities for the care of ambulatory patients. Careful study must be made of present utilization of existing facilities, andof the economic, social, andprofessional factors relating to the low utilization rates found in many Japanese hospitals at the present time.

On the basisof this physical and functional survey, a long-range master plan for development of hospitals andrelated facilities can be constructed. An important feature of this plan will be assignemtn of priorities in relation to the most urgent needs, since the speed with which new construction can proceed will be limited by the general economic picture and the availability of materials and equipment. The plan should include not only new construction, but rehabilitation, alternation, or adaptation of existing hospitals or other structures for more efficient use.

c. A publicly supported construction program. The capital cost of the hospital program should be borne from public funds, primarily from the national level. It would be desirable for a substantial proportion, varying with the wealth of the prefecture, to be borne by the prefecture.

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Whether the national contribution should be regarded as an outright grant or as a loan to be repaid out of operating revenue is a matter of fiscal policy to be determined, but this question must be related to the operational subsidies discussed below.

National standards for hospital construction should be developed, to safeguard the use of public funds, but subject to these standards as much local autonomy as possible should be permitted to encourage the development of institutions suited to local needs.

d. Assistance in operating costs. If hospital care is to be made available to those unable to pay the full cost themselves, a substantial portion of the operating expenses of hospitals will have to be met from public funds. National funds will be needed to equalize the burden between areas of relatively high and low income. These funds should be made available on a basis of grants related to the cost of hospital care, the percentage of cost varying with the wealth of the area. The objective would be to bring the charges by the hospital to the patient down to a level which he is able to pay, either directly or through prepayment or insurance funds.

It is evident that the amount of deficit in hospital operation to be made up from public funds will be greatly decreased if a substantial proportion of the population in a given area is covered by some form of health insurance, since this device enables persons in relatively low income brackets to prepay the cost of care which they could not possibly meet out of pocket at the time of hospitalization. On the other hand, if, as at present, the population is not universally covered by health insurance, the device of hospital operation grants could be used to assist both the insured and the uninsured segments of the population by lowering the charges made by hospitals for both categories of patients. By making the charges to insurance funds lower than would be possible without operating grants, these would in effect constitute a form of subsidy to the insurance programs. (An example of such a subsidy may be seen in the Transportation Ministry Hospital) which receives a large operating grant from the government and is thereby enabled to furnish care on an insurance basis to members of the Mutual Aid Society at a very low premium cost). If subsidies are to be made out of general tax funds to the health insurance programs, this form of subsidy would seem more equitable than the direct grants made at present, since it would benefit the whole population rather than only the insured groups.

Grants to hospitals should be offered not merely to public institutions, but to other hospitals meeting minimum standards of service, provided they operate on a non-profit bais. It may be necessary to make grants to non-public hospitals in the form on reimbursement on a per day basis, to avoid the constitutional limitation on subsidy to private organizations.

Direction of hospital staff policy toward improving professional service. Greater flexibility is needed in scales or remuneration to permit

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financial recognition of experience and special skill, and to encourage properly qualified doctors to engage in hospital practice on a part-time basis. Unless full-time doctors are paid on a basis which is in reasonalbe relation to earning of private practitioners it will not be possible to build up hospital staffs of high caliber. Due weight should of course be given to inducements to hospital service such as living quarters, food, absence of overhead costs, etc., in determining appropriate salary scales.

It is believed that the question of open- vs. closed-staff policy is not one that can be settled on and all-or-none bais. The present system, as has been indicated above, does not give sufficient access to hospitals to many practitioners and forces them to set up their own, usually inadequate, facilities for the care of bed patients. On the other hand it would not be practicalbe to open all hospitals to all licensed practitioners, because there is too much variation in the qualifications and experience of individual practitioners. It is suggested that a system be developed along the lines of the courtesy and visiting staff arrangements common in many American hospitals. Qualifications of practitioners desiring hospital staff privileges would be reviewed by a professional staff committee of each hospital or group of hospitals, and a number of general practitioners and or specialists consistent with the size and character of the hospital would be admitted to perform general or specialist services according to theindividual's qualifications. It isunderstood that a start in this direction has already been made in some of the National Hospitals. It is recognized that knotty problems will arise in connection with selection of part-time and courtesy staff members and in working out satisfactory methods ofpayment, but these difficulties should not be insuperable. The benefit to the quality of medical practice, by bringing a degree of professional competition into hospitals and discouraging the care of bed patients in inadequate facilities would far outweight the difficulties.

f. Enforcement of hospitals by a licensing system. If hospitals are generally aided by government grants, these grants may be made contingent on compliance with standards by the hospital. However, to safeguard the public against institutions which do not wish to qualify for grants, minimum standards should be enforced by a licensure law applicable to all institutions for the care of the sick. Such licensure laws are in effect in a number of the United States. The standards to be set by regulation under such a law would have to be low initially to be raised as rapidly as realistically possible under present conditionsof short supply and limited funds. Onthe other hand, if coupled with government funds available for rehabilitation and new construction, promulgation of standards would act as an important stimulustoimprovements.

g. Adequate allocations of food. The present inadequacy of food supply to hospitals results not only in inadequate diets to sick patients, but in lowered standards of hospital care because of the necessity of having cooking facilities and family members in hospital rooms. Furthermore,the cost of hospitalization is greatly increased,so far as the patinet and his family are concerned. Since only about one-fourth ofoneper cent of the population is hospitalized at any one time, the fraction of total food supplies required by adequate allocations to hospitals seems small indeed.

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REPRESENTATIVE GROUPS CONSULTED BY SOCIAL SECURITY MISSION

1. Government Mutual Aid Societies
(Attachment 1.)

2. Labor Unions

All Japan Government Workers Union	-	S. Hida K. Imai S. Onagi
Congress Industrial Unions	-	M. Kan J. Wada T. Akiyama
Japanese Federations of Labor	-	A. Uchimura S. Yamada T. Hara
Teachers Union	-	T. Uotani S. Kitahama K. Iwasaki

3. Employers and Employees Associations

Y. Morita	-	Federation of Japanese Industries
K. Yoneda	-	Kanto Employers' Association
T. Miyaoka	-	Tokyo Factory Association
H. Hayeda	-	Coal Production Association
A. Yamamoto	-	Tokyo Industries Federation
B. Chtsuka	-	Japan Special Steel & Pipe Co., Ltd.
T. Aso	-	Aso Mining Co.
T. Sukureda	-	Missin Cotton Spinning Col. Ltd.
H. Otsuka	-	Otsuka Factory
T. Shiobara	-	Sankyo Pharmaceutical Co.
O. Isomura	-	Hodogaya Chemical Manufacturing Co., Ltd.
J. Akagi		
S. Yokose		

4. Professional Associations
S. Kato, President, Dental Association
I. Takenaka, Director, Pharmaceutical Association
K. Takai, Director, Pharmaceutical Association
J. Tobe, Secretary, Pharmaceutical Association

Japanese Medical Association:
M. Nakayama, President
N. Takahibara, Director
S. Fujita
K. Takeda
C. Ota
S. Watanabe

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5. Council on Medical Treatment
(see Attachment 2)

6. Health Insurance Federation
(see attachment 3)

7. National Health Insurance Federations

Kondo - National Health Insurance Federation, Aichi Prefecture
Ebi - National Health Insurance Federation, Saitama Prefecture
Tangi - National Health Insurance Federation, Tokyo-To
Morimoto - National Health Insurance Federation, Ehime Prefecture
Fukushima - National Health Insurance Federation, Niigata Prefecture
Morimoto - Welfare Ministry
Honda - Nikon Socialist Party

8. Social Insurance Investigating Committee

Mr. Hara, Chairman of Social Insurance Investigating Committee
Dr. Minamizaki
Prof. Sustaka
Miyao
Shimizu
Horioka, Ministry of Welfare

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REPRESENTATIVES FOR CONFERENCE ON COOPERATIVE MUTUAL AID SOCIETIES

Cabinet Bureau - E. Ogawa

Communication - G. Shinozaki

Education (Teachers' Association). - R. Suzuki

Finance Ministry - S. Horigome
Watanabe

Home Ministry - M. Nakamura
Arai

Home Ministry (Police Association) - F. Nakamura

Transportation Ministry - R. Yamaguchi

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Acting Vice Director of Medical Bureau of Ministry of Welfare.	KUGE Katsuji
Chief of Medical Section of Ministry of Welfare.	TAKADA Hiroyuki

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HEALTH INSURANCE FEDERATION CONFERENCE

16 October 1947

Mr. Tomono - Welfare Ministry

Mr. M. Tasaka - Nippon Diesel Co., Health Insurance Association director.

Mr. Miyao - Vice Chairman, Union of Health Insurance Associations.

Mr. Kanda - Chief of General Affairs Bureau, Dai Nippon Oil Co.

Mr. Ishigaki - Employer (Movies).

Mr. Watanabe - Employer (Printing Factory).

Mr. Miura - Social Insurance Society, director.

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JAPANESE SOCIAL INSURANCE INVESTIGATING COMMITTEE

Re: Epitome for Social Security scheme
(Plan prepared by the First Committee of
Committeemen for Investigation of Social
Insurance Scheme)

Oct. 8, 1947

I. Basic Theory

1. Security for the minimum standard of living.

Present social insurance schemes and the daily allowance scheme for the hard livings are not sufficient to secure the national minimum standard of livings in healthy and cultural way which are read in the Constitution article 25. Therefore, it must be positively necessary to establish a new scheme of social security. To establish the said scheme is the fundamental condition for the reconstruction of the economical situation.

2. Comprehensive scheme for the whole nation:

The scheme, being not only amending and unifying of the present various social insurance schemes but intended to inhale the Daily Allowance Scheme for the hard livings, is a revolutional and comprehensive Social Security Scheme for the whole nation. As being the scheme secures the minimum standard of national livings, it shall be emphasized that every sort of voluntary insurances and mutual aid systems shall be available in any way, for the maintain of the higher living.

3. Having a regard for the reference of every social policy.

Closed reference to the social policy and facilities concerning employment wages, dwellings, sanitary medical care, education and public welfare etc., be held in this scheme, and the scheme aims to secure the national livings with the cooperation of strengthening these social policy.

II. Construction of the Social Security program.

1. Risks covered.

Among those risks of the needs, the scheme mainly secures the following risks:

Sickness and injury
Invalidity
Death
Childbirth
Breeding
Old age
Unemployment

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2. Classification of the nation.

For the purpose of the classification of the benefit and the Contribution the nation has divided into the following classes:

Employee.....person employed under the employment

Self-substainer.....person living on work and on undertaking

Person without occupation.....person other than above mentioned

3. Kind of the benefits.

Kinds of the benefit shall be read as follows:

Risks covered	Benefits
Sickness and injury	Medical benefit sickness allowance
Invalidity	Invalidity Pension
Death	Burial expense Widow pension Orphan pension
Childbirth	Maternity benefit Delivery Allowance
Breeding	Children Allowance
Old-age	Old-age Pension
Unemployment	Unemployment Allowance.

As the purpose of the scheme based on the maintaining of the minimum standard of livings, every benefit are granted at the flat rate, irrespective of the former income of the beneficiaries.

A separated scheme shall be established for the sickness or injury due to the occupation, after considering it's nature.

4. Bearing of the expense.

(1) The whole nation shall have the obligation of the contribution for the scheme.

(2) Rate of the contribution shall be proportionated to the income of the beneficiaries.

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(3) So far as the contribution of the employee concerned, a definite rate shall be burdened by the employer.

(4) The State shares the burden of a portion of the expenditure for the benefit and the whole amount for the expense on office running.

5. Unification of the responsibility of administrations

The schemem shall be undertaken by a unified authority in a unitary way.

III. Details of the benefits.

1. Sickness and injury.

(1) Medical benefit.

Medical benefit shall be granted up to the recovery of health continuously, as a rule in kind.

(2) Sickness allowance.

The sickness allowance shall be granted to employee and self-substence. The term of the benefit shall coincide with that of the medical benefit. However, awaiting period shall be introduced to the self-substainer and as for the employee no allowance shall be due to the term on which the full wages are paid.

An allowance for the beneficiary whose wife has no occupation shall be increased appropriately.

2. Invalidity

Invalidity pension shall be granted to the invalide according to the grade of the invalidity. However, the pension for the beneficiary whose wife has no occupation, shall be increased appropriately.

3. Death.

(1) Burial expense.

The burial expense shall be granted to the person who holds a funeral.

(2) Widow Pension.

The widow pension shall be granted to such a widow as after the death of the consort, nursing her depending child and has no occupation or as over the age of 50 and had spent at least 1 year prior the death of the consort and has no occupation. To other widows than that of above mentioned and has no occupation the benefit shall be due 1 year only after the death of her consort.

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(3) Orphanage pension.

To orphan shall be granted the orphanage pension which shall be larger sum than the children's allowance.

4. Childbirth.

(1) Maternity benefit.

As for the maternity benefit a benefit in kind and the definite sum in cash shall be granted.

(2) Childbirth allowance.

The said allowance shall be granted to employee and self-substainer. The term of the benefits are as follows:

That is to say every 6 week before and 2 weeks after the delivery for the self-substainer. However, the benefit shall not due to the term in which employee receives the full salary.

5. Breeding.

Children's allowance.

The children's allowance shall be due to the children, who does not reach to the age of graduating the obligational education.

6. Old-age.

Old-Age pension.

The old-age pension shall be due at the following month of the full age of 60 for male and 55 for female. However, some consideration shall be made for that beginning of the benefit according to the kind of occupation, and some deduction shall be made for man and wife both old-aged, and appropriate increase shall be made in case he has a old-aged wife without occupations.

7. Unemployment.

Unemployment allowance.

The unemployment allowance shall be granted to a person, who has a Capability for work and has a good will to exercise the work and yet cannot find any chance for the employment, up to the date of his employment.

The amount of the allowance coincides with that of sickness allowance, however, allowance for the beneficiary, whose wife has no occupation, shall be increased appropriately.

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8. Other benefit for security.

Appropriate benefits for security shall be granted according to the situation in case of a person who is in special needs.

IV. Considerations to be made as to the time of operation.

As to the time of the operation of the scheme, following programs in due order shall be adequate after considering the present situation of the national economy, the long term economic plans and the burden on finance. Special consideration must be paid to the method of the contribute for the expense, holding of a closed connection to the existing allied schemes and arrangement for the benefits. Further more, it must be positively emphasized of the enforcement of such social policies as employment, wages, and medical care which held a deep reference with the operation of this scheme. And in the first step, program, prompt enforcement of the family allowance insurance scheme for the employee shall be necessitated too.

First step program.

Benefit of medical care

Sickness Allowance (for employee only)

Invalidity pension (for employee only)

Burial expense

Widows' pension

Opphan's pension

Maternity benefit

Childbirth allowance (for employee only)

Unemployment allowance (for employee only; term of benefit shall be for 6 months)

Children allowance (shall due after the means test)

Old-Age pension (shall due after the means test)

Second step program

Sickness allowance (for self-substainer)

Invalidity pension (for self-substainer)

Childbirth allowance (for self-substainer)

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Third step program

Unemployment allowance (for self-substainer; definite limitation shall be made for the granting period)

Fourth step program

Other benefits for theperson without occupation

Unemployment allowance (no limitation shall be made as to the term of granting the benefit)

Fifth step program

Old-age pension (shall due without the means test)

Sixth step program

Children allowance (shall due without the means test

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Attached Table

Classification	Employee		Self-substainer		Person without Occupation	
Benefits	Male	Female	Male	Female	Male	Female
Medical care	1	1	1	1	1	1
Sickness allowance	1	1	1	1		
Invalidity pension	1	1	1	1	1	1
Burial expense	1	1	1	1	1	1
Widows' pension						1
Opphange pension					1	1
Maternity benefit		1		1		
Child-birth allowance		1		1		
Childrens'. allowance					1	1
Old-age pension	1	1	1	1	1	1
Unemployment	1	1	1	1	1	1

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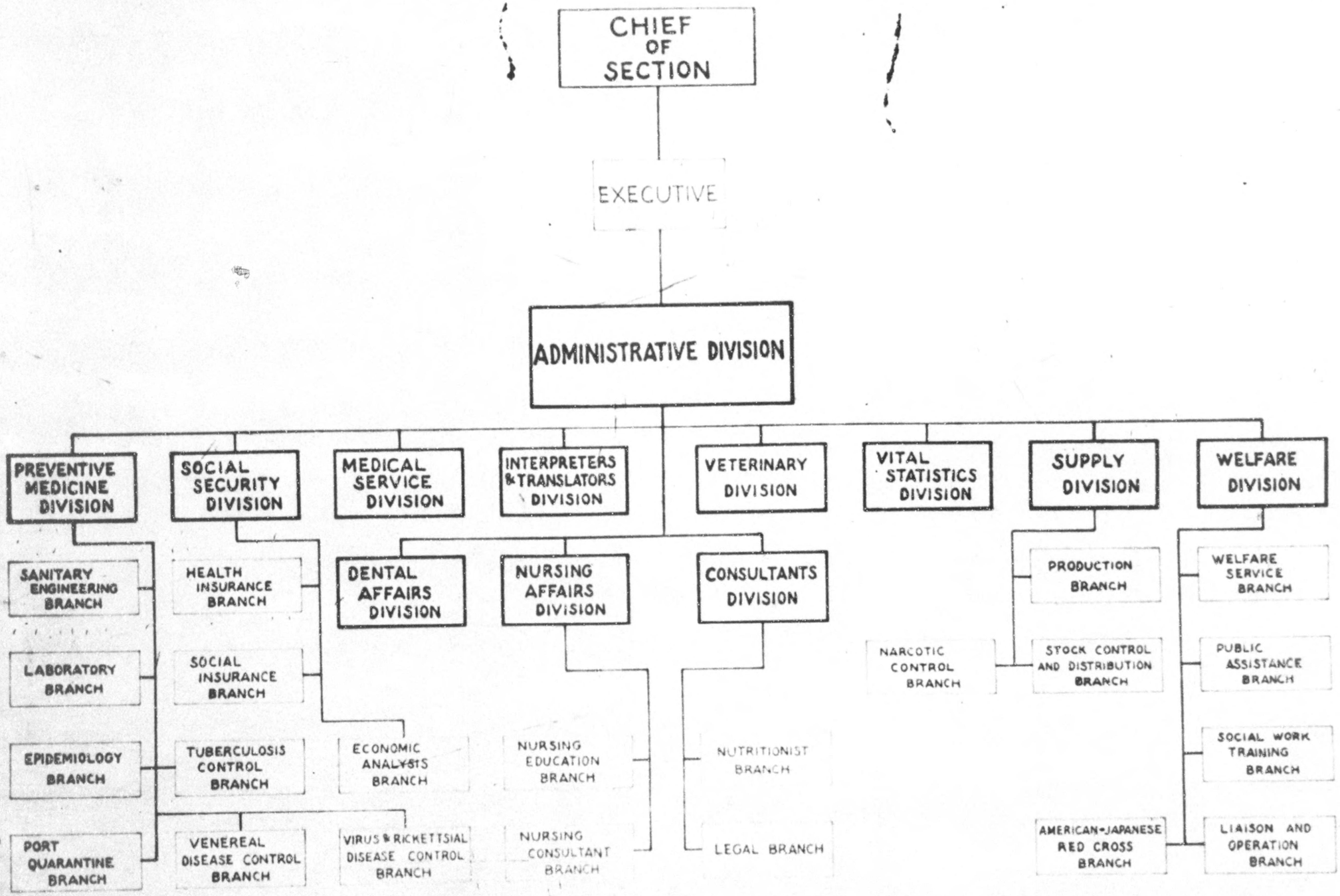
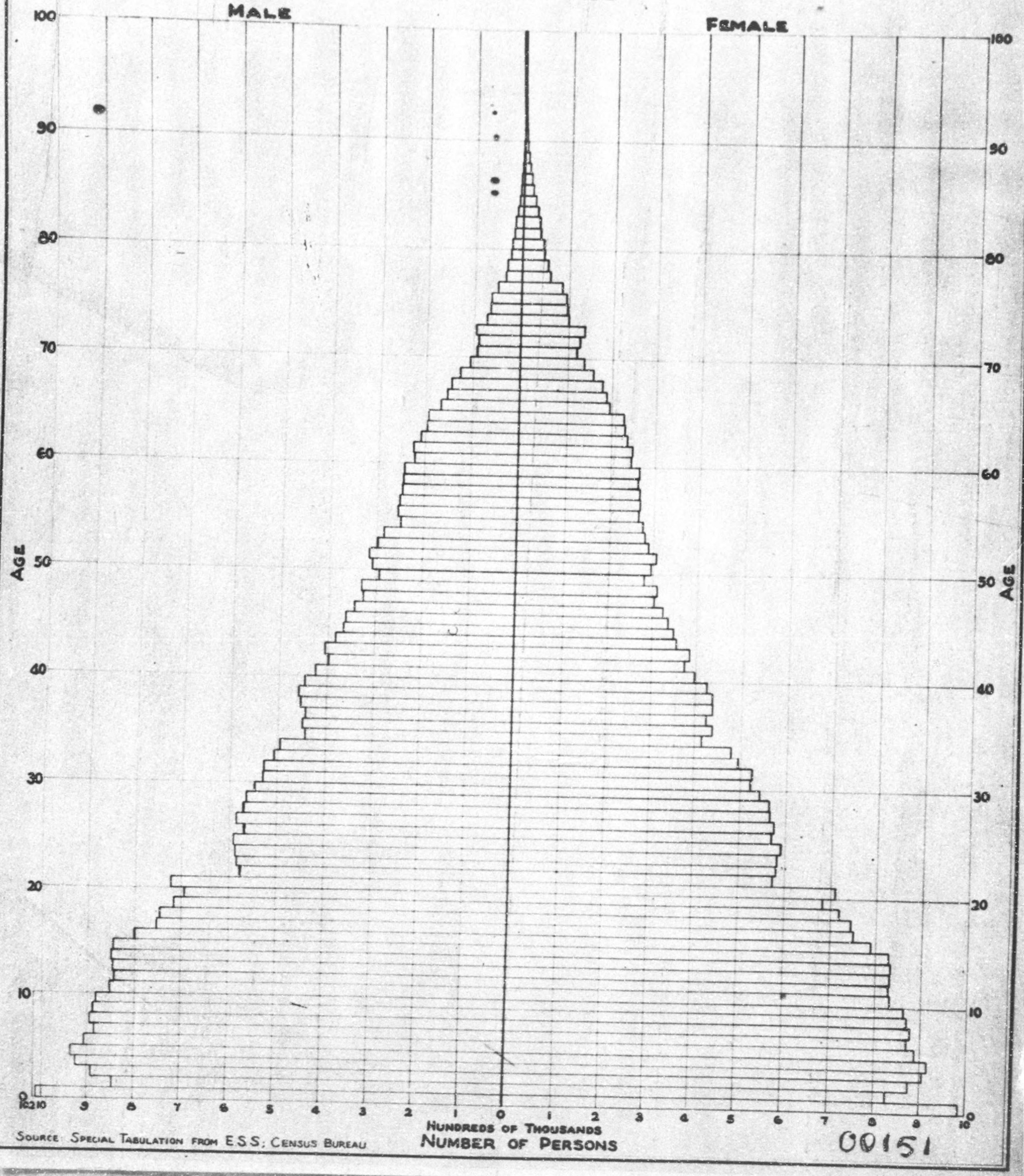
PUBLIC HEALTH AND WELFARE SECTION GHQ. SCAP.



AGE DISTRIBUTION OF THE POPULATION: JAPAN, 1940

EUROPEAN AGE

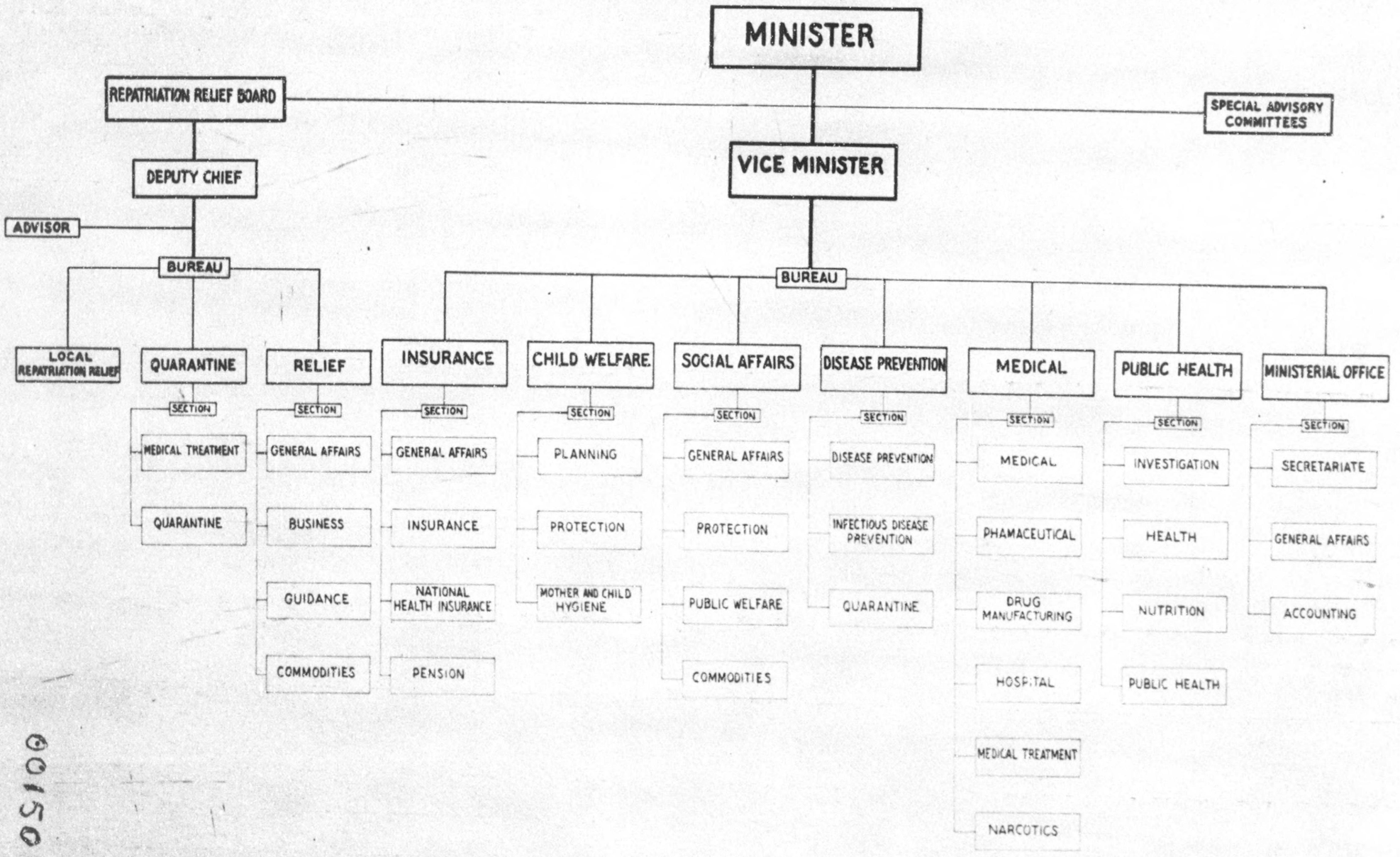


SOURCE: SPECIAL TABULATION FROM E.S.S.; CENSUS BUREAU

00151

MINISTRY OF WELFARE

JAPANESE GOVERNMENT



00150

CLASSES

	SICKNESS AND INJURY		
	Cash	Medical Care	C
INDUSTRIAL WAGE EARNERS	HI-Temporary cash disability benefits (non-occupational). WCI-Temporary cash disability benefits and invalidity pension and allowance (occupational). WPI-Invalidity pension and allowance.	HI-Hospitalization, doctor, and drugs (non-occupational). WCI-Hospitalization, doctor and drugs (occupational). NHI-Hospitalization, doctor and drugs.	HI-Confinem delivery gr allowance.
AGRICULTURAL WAGE EARNERS	-	NHI-Hospitalization, doctor, and drugs	
SEAMEN	SI-Temporary cash disability benefits and invalidity pension and allowance.	SI-Hospitalization, doctor, and drugs.	
GOVERNMENT EMPLOYEES Ministry Employees	GPMAS-Temporary cash disability (non-occupational). WCGE-Sickness allowance and disability allowance (occupational). GPS-Invalidity pension (occupational).	GPMAS-Hospitalization,doctor, and drugs (non-occupational). WCGE-Hospitalization, doctor, and drugs (occupational).	GPMAS-Confi and nursing
Enterprise Employees	GEMAS-Sickness Allowance.	GEMAS-Hospitalization, doctor, and drugs.	GEMAS-Confi and nursin
SELF-EMPLOYED	-	NHI-Hospitalization, doctor, and drugs.	
UNEMPLOYED	-	-	
AGED	-	-	
DEPENDENTS	-	HI-Half cost of hospitalization, doctor, and drugs. NHI-Partial cost of hospitalization, doctor, and drugs. GPMAS-Half cost of hospitalization, doctor, and drugs. GEMAS-Half cost of hospitalization, doctor, and drugs.	GPMAS-Conf and nursin GEMAS-Conf and nursin HI-Nursing delivery g

HI - Health Insurance
WCI - Workmens' Compensation Insurance
WPI - Welfare Pension Insurance
NHI - National Health Insurance

UI - Unempl
SI - Seamen
GPMAS - Gov
GEMAS - Gov

Japanese Social Insurances

CLASSES OF POPULATION AND APPLICABLE PROGRAMS

	MATERNITY		OLD AGE	UNEMPLOYM
Care	Cash	Medical Care		
on, doctor, occupational). ion, doctor ational). ion, doctor	HI-Confinement allowance, delivery grant, and nursing allowance.	HI-Obstetrical care. NHI-Obstetrical care.	WPI-Pension and retirement allowance.	UI-Cash benefit days. (Pending
ion, doctor,	-	NHI-Obstetrical care.	-	-
n, doctor,	-	-	SI-Pension and retirement allowance	SI-Cash benefit days. (Proposed
tion,doctor, cupational). ion, doctor, tional).	GPMAS-Confinement allowance and nursing allowance.	GPMAS-Delivery grant or care in Ministry hospital.	GPS-Pension	SA-Separation a
tion,	GEMAS-Confinement allowance and nursing allowance.	GEMAS-Delivery grant or care in Ministry hospital.	GEMAS-Pension	SA-Separation a
n, doctor,	-	NHI-Obstetrical care.	-	-
	-	-	-	-
	-	-	-	-
spitaliza- drugs. f hospita- nd drugs. hospitali- drugs. hospitali- drugs.	GPMAS-Confinement allowance and nursing allowance. GEMAS-Confinement allowance and nursing allowance. HI-Nursing allowance and delivery grant.	NHI-Partial cost of obstetrical care.	-	-

UI - Unemployment Insurance
SI - Seamens' Insurance
GPMAS - Government Personnel Mutual Aid Society
GEMAS - Government Enterprise Mutual Aid Society

GPS - Government P
WCGE - Workmen's C
SA - Separation A

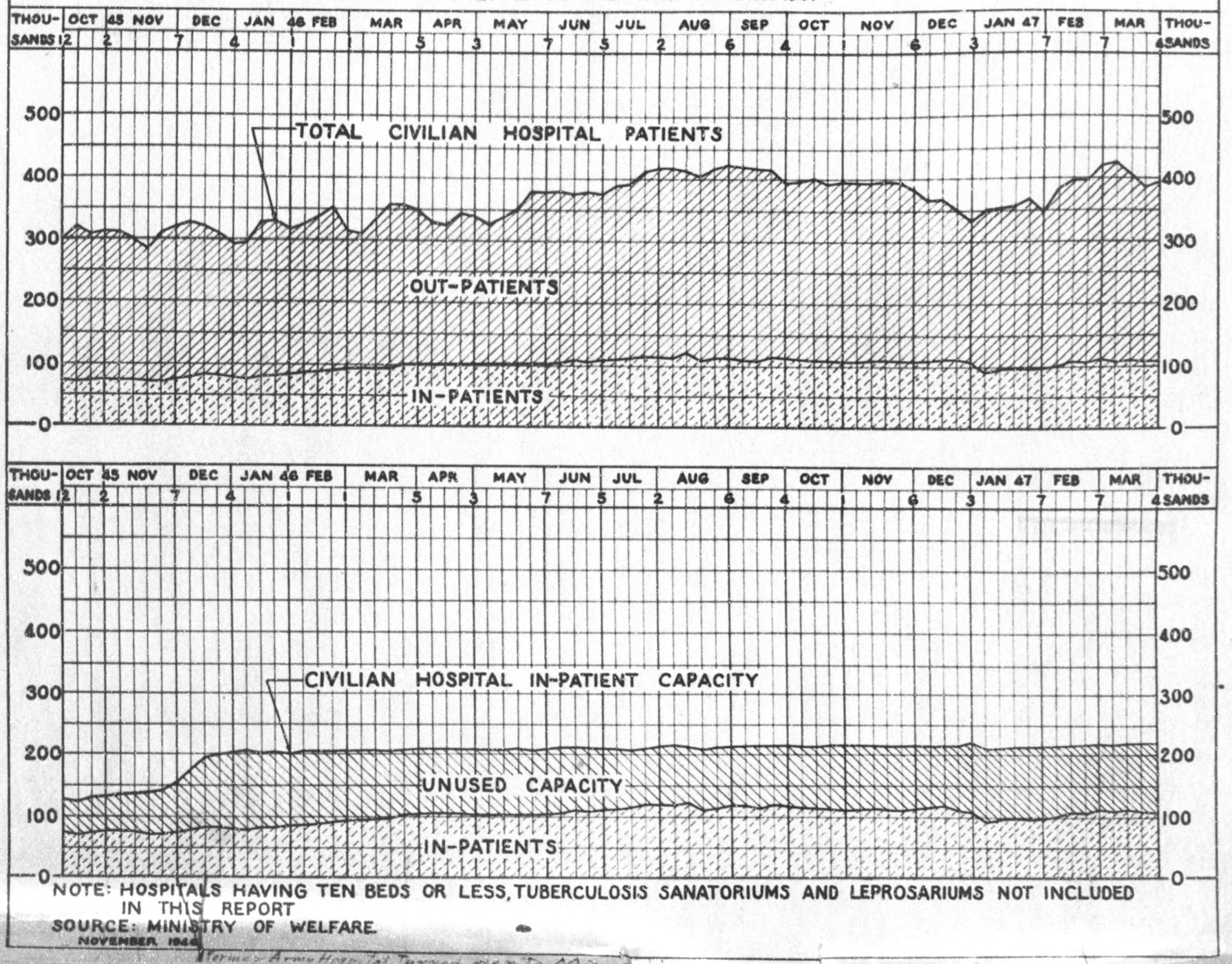
OLD AGE	UNEMPLOYMENT	DEATH	
		Funeral	Survivors
PI-Pension and retire-ent allowance.	UI-Cash benefits for 180 days. (Pending legislation)	HI-Cash. NHI-Cash and infrequently in kind.	WPI-Pension and lump-sum. WCI-Pension and lump-sum.
-	-	NHI-Cash and infrequently in kind.	-
I-Pension and retire-nt allowance	SI-Cash benefits for 180 days. (Proposed amendment)	SI-Cash.	SI-Pension and lump-sum,
S-Pension	SA-Separation allowance.	WCGE-Cash. GPMAS-Cash.	GPS-Pension and lump-sum. WCGE-Lump-sum. SA-Lump-sum.
AS-Pension	SA-Separation allowance.	GEMAS-Cash.	GEMAS-Pension and lump-sum. SA-Lump-sum.
-	-	NHI-Cash and infrequently in kind.	-
-	-	-	-
-	-	-	-
-	-	HI-Cash NHI-Cash and infrequently in kind.	-

GPS - Government Pension System
WCGE - Workmen's Compensation for Government Employees
SA - Separation Allowance

Social Security Division
PH&W, GHQ, SCAP
1 November 1947

CIVILIAN HOSPITAL PATIENTS

JAPAN-WEEKLY 12 OCTOBER 1945-4 MARCH 1947



NOTE: HOSPITALS HAVING TEN BEDS OR LESS, TUBERCULOSIS SANATORIUMS AND LEPROSARIUMS NOT INCLUDED IN THIS REPORT

SOURCE: MINISTRY OF WELFARE.

NOVEMBER 1946

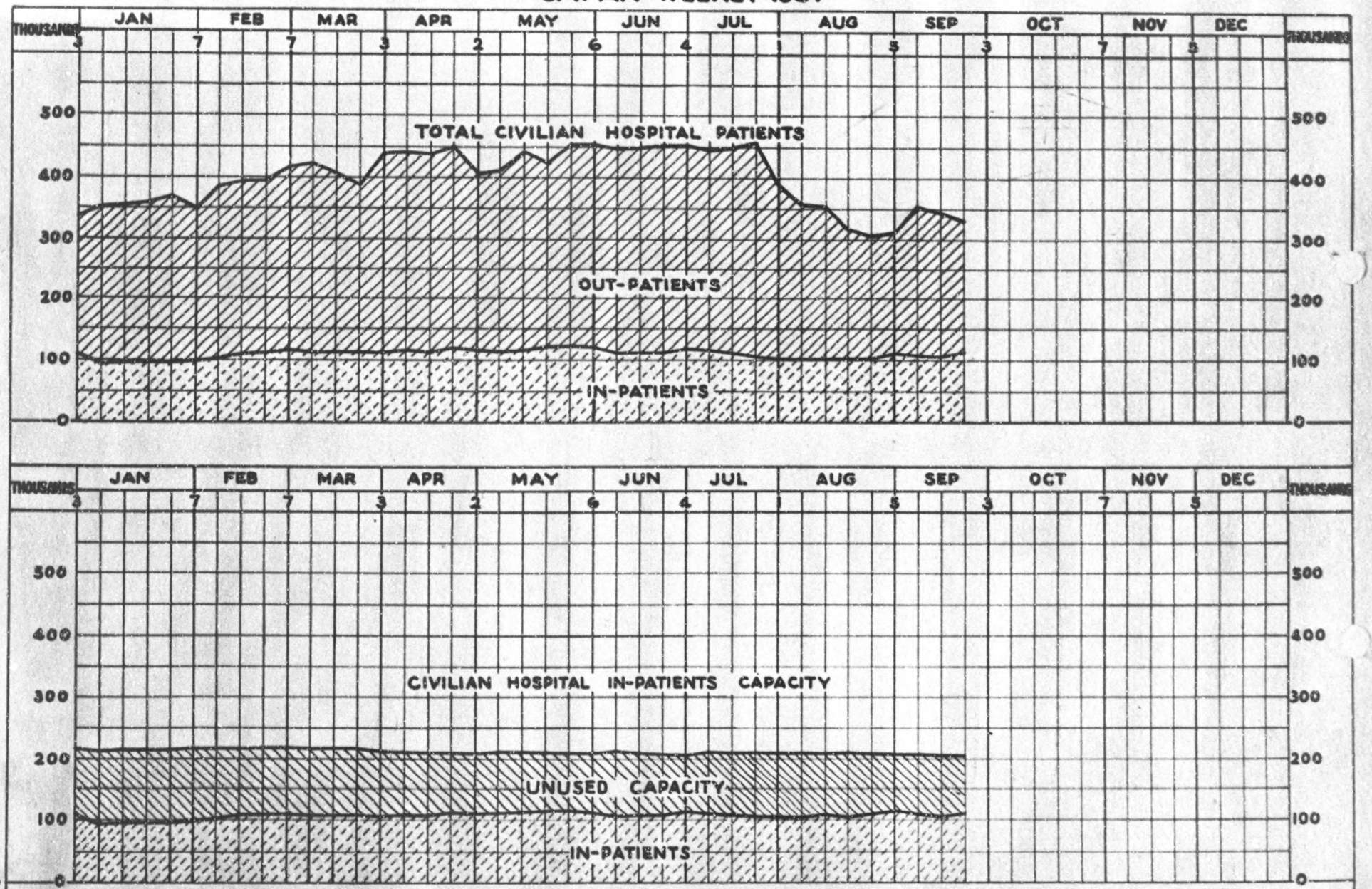
63100

Former Army Hospital Turned over to Mi...

REPRO BY 64TH ...

CIVILIAN HOSPITAL PATIENTS

JAPAN WEEKLY 1947



NOTE: HOSPITALS HAVING TEN BEDS OR LESS, TUBERCULOSIS SANATORIUMS AND LEPROSARIUMS NOT INCLUDED IN THIS REPORT

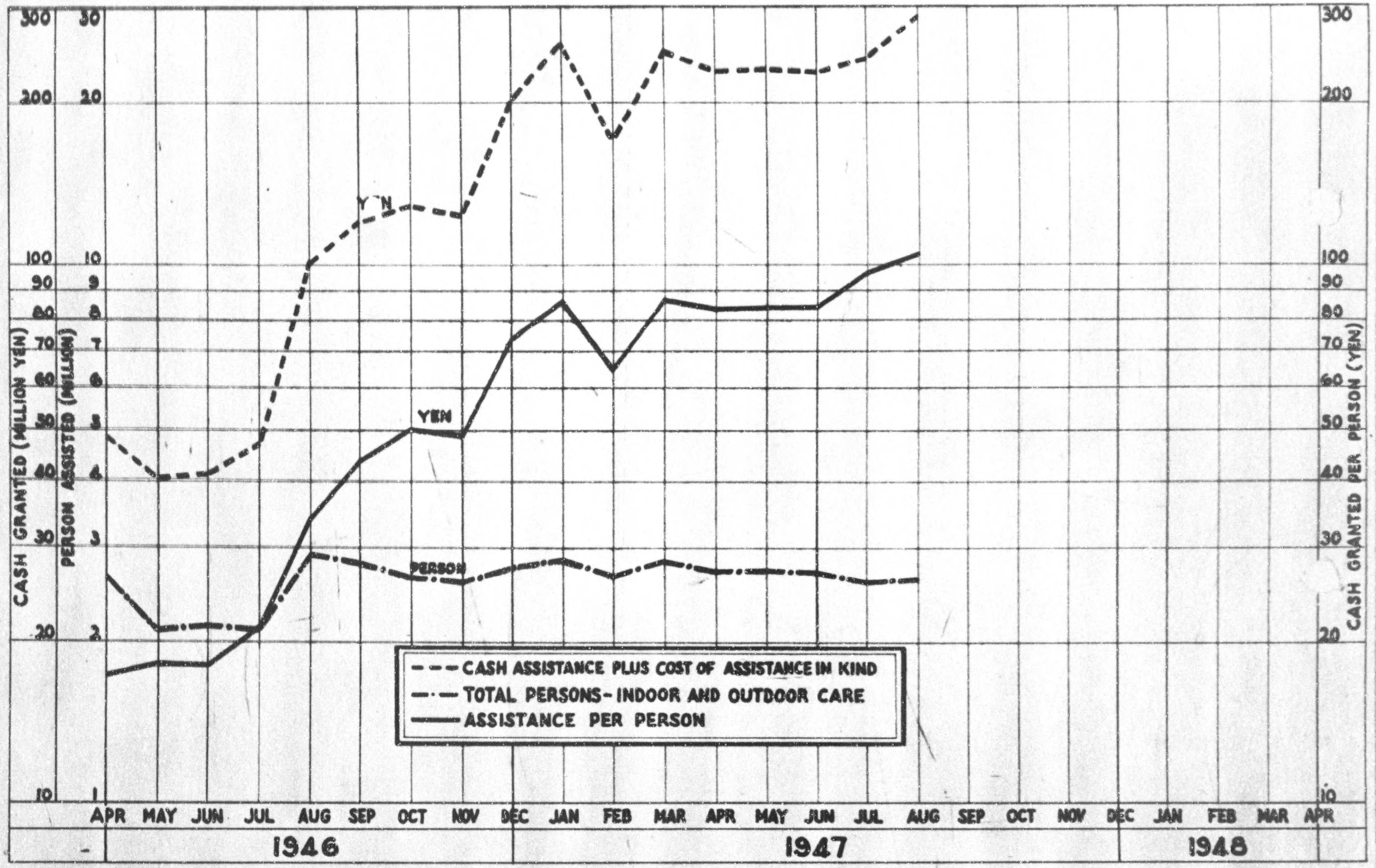
SOURCE: MINISTRY OF WELFARE

25100

REPRO BY 64TH ENGR TOPO BN

PUBLIC ASSISTANCE

APRIL 1946 THROUGH MARCH 1948



09/60

Program	Population*	WAGES		INDUSTRIAL WAGE EARNERS
		Amount	Definition	
HEALTH INSURANCE	4,300,000 plus 9,900,000 dependents	First ¥2000 of monthly wage.	Basic wage plus such allowances or bonuses as are paid regularly and not less frequently than every 3 months, exclusive of family allowances, commuting expenses, travel expenses and rental or lodging allowances which do not result in proportionate deduction from basic wage.	Compulsory for workers in concerns employin and specifically included in the following i manufacturing,packing,repairing,mining,produ distribution of electricity and motive power passenger transportation,freight handling,ma and insurance,incineration,cleaning,slaughte and leasing,brokerage and middleman services ing,advertising,information service,and offi legal persons and corporations except religi tions. Excluded are persons covered by Seam or Government Enterprise Mutual Aid,national officials and government administrative empl of undertakings without fixed addresses or d for less than 6 months, persons employed tem contract is less than 2 months or who are da seasonal workers employed less than 4 months of less than 6 months who work outside for li companies. Members of National Health Insur tions are exempt upon request.
NATIONAL HEALTH INSURANCE	41,000,000 31,000,000**	Contributions are based on a flat rate plus amounts related to total income and number of dependents.		Excluded if covered by Health Insurance but tarily insure dependents.
WELFARE PENSION INSURANCE	4,300,000	First ¥600 of monthly wage.	(Same as Health Insurance).	(Same as Health Insurance except as to exempt members of National Health Insurance Associat
WORKMEN'S COMPENSATION INSURANCE	6,000,000 (Estimated number brought in 1 Sept 1947)	Total wages	Total amount of wages,salaries allowances and all other payment by employer to employee for work regardless of what it is called (including family allowances) excluding only bonuses paid less frequently than every 3 months.	Industries for which coverage is compulsory a those specified in Welfare Pension Insurance variations: voluntary for office workers and marketing,finance and insurance,incineration, slaughtering,storage and leasing,brokerage an services,bill collecting,advertising and info service. Compulsory for workers in industries or more steadily or a total of 300 man hours engaged in freight handling or,if included an prises specifically designated by cabinet ord ous,in industries employing 1 or more and eng facturing,packing,repairing,mining,production bution of electricity and motive power,freigh ger transportation. In addition to industries Welfare Pension Insurance,industries employin steadily or a total of 300 man hours in a yea in engineering,construction,demolition,lumber coal production. Excluded are persons covered Insurance,employees of the government, and un that employ only members of family living in Workers are not excluded because of being tem employees or day laborers.

Japanese Social Insurances

COVERAGE PROVISIONS

	INDUSTRIAL WAGE EARNERS	AGRICULTURAL WAGE EARNERS	SEAMEN	
allowances id regul- equently exclusive , commu- l expenses g allow- esult in ion from	Compulsory for workers in concerns employing 5 or more and specifically included in the following industries: manufacturing,packing,repairing,mining,production and distribution of electricity and motive power,freight and passenger transportation,freight handling,marketing,finance and insurance,incineration,cleaning,slaughtering,storage and leasing,brokerage and middleman services,bill collecting,advertising,information service,and office workers of legal persons and corporations except religious organizations. Excluded are persons covered by Seamen's Insurance or Government Enterprise Mutual Aid,national and local officials and government administrative employees,employees of undertakings without fixed addresses or doing business for less than 6 months, persons employed temporarily whose contract is less than 2 months or who are day laborers, seasonal workers employed less than 4 months,and employees of less than 6 months who work outside for life insurance companies. Members of National Health Insurance Associations are exempt upon request.	-	Excluded if covered by Seamen's Insurance.	
t al income	Excluded if covered by Health Insurance but may voluntarily insure dependents.	Voluntary unless resident of community wherein over half are members of association and prefectural governor has declared membership for balance of community is compulsory.	Excluded if covered by Seamen's Insurance but families may insure themselves in their own right with spouse or eldest child acting as head of the household and taking out membership.	Exclud depend
rance).	(Same as Health Insurance except as to exemption of members of National Health Insurance Association).	-	Excluded if covered by Seamen's Insurance.	Exclud
,salaries her pay- mployee f what ng cluding s fre- months.	Industries for which coverage is compulsory are same as those specified in Welfare Pension Insurance with following variations: voluntary for office workers and workers in marketing,finance and insurance,incineration,cleaning, slaughtering,storage and leasing,brokerage and middle-man services,bill collecting,advertising and information service. Compulsory for workers in industries employing 1 or more steadily or a total of 300 man hours in a year and engaged in freight handling or,if included among enterprises specifically designated by cabinet order as dangercus,in industries employing 1 or more and engaged in manufacturing,packing,repairing,mining,production and distribution of electricity and motive power,freight and passenger transportation. In addition to industries covered by Welfare Pension Insurance,industries employing 1 or more steadily or a total of 300 man hours in a year,and engaged in engineering,construction,demolition,lumbering and charcoal production. Excluded are persons covered by Seamen's Insurance,employees of the government, and undertakings that employ only members of family living in same household Workers are not excluded because of being temporary employees or day laborers.	-	Excluded if covered by Seamen's Insurance.	

SEAMEN	GOVERNMENT EMPLOYEES		SELF-EMPLOYED	UNEMPLOYED	AGED
	MINISTRY	ENTERPRISE			
luded if covered by men's Insurance.	Excluded.	Excluded if covered by Mutual Aid.			
ded if covered by Sea- Insurance but families nsure themselves in their ight with spouse or t child acting as head e household and taking embership.	Excluded if covered by Mutual Aid but may voluntarily insure dependents.		Voluntary unless resident of community wherein over half are members of association and prefectural governor has declared membership for balance of community is compulsory.	-	-
ed if covered by Sea- Insurance.	Excluded.	Excluded if covered by Mutual Aid.	-	-	-
ed if covered by Sea- Insurance.	Excluded.		-	-	-

				that employ only members of family living in same ho Workers are not excluded because of being temporary employees or day laborers.
SEAMEN'S INSURANCE	215,000(Estimated number under new limitation to vessels over 5 tons;93,000 under old limitation to vessels over 20 tons).	First ¥8000 of monthly wage (¥750 prior to 1 Nov 1947)	Basic wage plus all allowances except family allowances and allowances paid for overtime work and for pilots.	
UNEMPLOYMENT INSURANCE (Pending)	6,500,000 (Estimated number to be covered).	First ¥5000 of monthly wage.	Basic wage plus each allowances or bonuses as are paid regularly and not less frequently than every 3 months, including family allowances.	Industries compulsorily covered are same as those sp cally listed in Welfare Pension Insurance National a local government employees are included unless entit equivalent benefits under other laws. Excluded are e ees of undertakings without fixed addresses,persons ed by Seamen's Insurance, day laborers unless employ continously for more than 1 month by the same employ persons employed under contract for less than 2 mont those employed in seasonal enterprises with a term l than 4 months unless in either case they are continu employed by same employer for a longer period,and wo probationally employed for less than 14 days.
GOVERNMENT PENSION INSURANCE	950,000	Total wages	Basic wage under wage schedule prior to 1 July 1946 and exclusive of all allowances.	-
GOVERNMENT MUTUAL AID SOCIETIES. Government Personnel (10 Ass'ns)	383,000 plus 920,000 dependents	¥1200 of monthly wage (wages in excess exclude employees from coverage).	Basic wage under 1 July 1946 wage schedule and exclusive of all allowances except that for purposes of computing benefits the wage schedule prior to 1 July 1946 is used.	-
Government Enterprise (11 Ass'ns).	1,538,000 plus 3,650,000 dependents.	(Same as for Ministry employees).	Basic wage under 1 July 1946 wage schedule and exclusive of all allowances except that for purposes of computing benefits other than for occupational injuries the wage schedule prior to 1 July 1946 is used.	-
WORKMENS' COMPENSATION FOR GOVERNMENT EMPLOYEES ***	1,357,000	Total wages	Basic Wage under 1 July 1946 wage schedule and exclusive of all allowances.	-
SEPARATION ALLOWANCES ****	1,927,000	Total wages	Basic wage under 1 July 1946 wage schedule and exclusive of all allowances.	-

* As of 1 April 1947 except where otherwise stated.
. Dependents estimated on basis of ratios reported.

** Larger figure pertains to those covered if all associations in existence were active.

	that employ only members of family living in same household Workers are not excluded because of being temporary employees or day laborers.			
ances and ime	-	-	All seamen, including masters, serving aboard a fishing vessel of over 30 tons or other vessels of over 5 tons, except that those who serve aboard vessels which operate exclusively in lakes, rivers orwithin barbors, government employees entitled to mutual aid benefits equal to Seamen's Insurance benefits, and government officials, are excluded.	Government to Seamen's excluded.
ow-paid re-ths. ces.	Industries compulsorily covered are same as those specifically listed in Welfare Pension Insurance National and local government employees are included unless entitled to equivalent benefits under other laws. Excluded are employees of undertakings without fixed addresses, persons covered by Seamen's Insurance, day laborers unless employed continously for more than 1 month by the same employer, persons employed under contract for less than 2 months and those employed in seasonal enterprises with a term less than 4 months unless in either case they are continuously employed by same employer for a longer period, and workers probationally employed for less than 14 days.	-	Excluded if covered by Seamens Insurance.	Excluded i
hedule ex-s.	-	-	-	All nations (including
1946 sive that g le used.	-	-	-	All nations ployees, in covered by Mutual Aid.
1946 sive that g occu-ge 1946	-	-	-	
1946 ive	-	-	-	All nation ployees, i covered by Mutual Aid
1946 sive	-	-	-	All nation employed b

** Larger figure pertains to those covered if all associations in existence were active.

*** Provided through 3 separate cabinet orders:
1. Medical Allowance for Officials, Cabinet Order N
2. Grant-in-Aid for Auxiliary Workers (Tradesmen), C
3. Grant-in-Aid for Junior Clerks, Cabinet Order No

All seamen, including masters, serving aboard a fishing vessel of over 30 tons or other vessels of over 5 tons, except that those who serve aboard vessels which operate exclusively in lakes, rivers or within harbors government employees entitled to mutual aid benefit equal to Seamen's Insurance benefits, and government officials, are excluded.	Government employees entitled to Mutual Aid benefits equal to Seamen's Insurance benefits, and government officials are excluded.		-	-	-
Excluded if covered by Seamens Insurance.	Excluded if entitled to equivalent benefits under other laws.		-	-	-
-	All national and prefectural officials in a career status (including policemen and teachers).		-	-	-
-	All national and prefectural employees, including officials, not covered by Government Enterprise Mutual Aid.	-	-	-	-
-	-	All government employees, excluding officials, working in government enterprises.	-	-	-
-	All national and prefectural employees, including officials, not covered by Government Enterprise Mutual Aid.	-	-	-	-
-	All national and prefectural employees except those (214,351) employed by the occupation forces.		-	-	-

...gh 3 separate cabinet orders:
...Allowance for Officials, Cabinet Order No. 80, 1890.
...-Aid for Auxiliary Workers (Tradesmen), Cabinet Order No. 382, 1918.
...-Aid for Junior Clerks, Cabinet Order No. 109, 1928.

**** Cabinet Decision, No. 29, March 1947.

Social Security Division
PH&W, GHQ, SCAP
1 November 1947

Sickness and Injury		MATERNITY		
Cash	Medical Care	Cash	Medical Care	
Industrial wage earners - Sickness allowance, beginning on 4th day of illness, amounting to 60% of daily wage (40% if without dependents and admitted to insurance hospital) paid monthly while medical treatment is necessary, up to maximum of 6 months except for tuberculosis for which maximum is 18 months. Any salary paid by employer is deducted. No qualifying term of coverage required for any benefits under this law and no benefits paid if disability or death due to insured's intentional injury, intentional criminal act, fighting, intoxication, or marked profligacy.	Industrial wage earners-80% of standard costs unless full care provided by insurance hospital or clinic. Maximum treatment limited to 2 years ubless beneficiary leaves covered employment while under treatment,in which case care continues not longer than 1 year after he left employment. Dependents provided 50% of cost of medical care.	Industrial wage earners - Confinement allowance is 60% of daily wage. Paid monthly for 42 days before and after delivery, provided that (this also applies to delivery grant and nursing allowance), if insured has left covered employment,delivery takes place with in 6 months of discontinuing employment.Allowance reduced to 40% if beneficiary admitted to insurance hospital and has no dependents. Delivery grant is lump-sum amounting to 50% of monthly wage but not less than ¥300(reduced 50% if admitted to insurance hospital). Spouse entitled to 25% of insured's monthly wage but not less than ¥150. Nursing Allowance is ¥30 per month for 6 months following delivery.Spouse entitled to same allowance.	Industrial wage earners-Obstetrical care in insurance hospital.	
	Agricultural workers,self-employed,and workers in minor industries- General medical care in kind or cash but ordinarily to the extent of 50% of standard costs and ranging from 20% to 80% depending upon finances of individual association.All members of insured family equally eligible provided, dependents of worker insured under Health Insurance are protected to extent combined benefits do not exceed standard costs.		Agricultural workers,self-employed,and workers in minor industries - Provided on same basis as general medical care.	
Industrial wage earners - Invalidity Pension or Allowance (lump-sum) payable from date of determination of continuing disability (date of termination of medical care under Workmen's Compensation Insurance or,for non-occupational disability - for which care is provided by law for a maximum of 2 years,Health Insurance)for worker insured over 6 months, except that no allowance paid on claim compensable under Workmen's Compensation Insurance or Labor Standards Act and no pension paid in such cases until 7th year of disability, 6 years being maximum duration of invalidity benefits under that law. Annual pension is 4 or 5 times (depending on degree of incapacity)average standard monthly remuneration plus 4 times average standard daily remuneration for each year of covered employment in excess of 20. Lump-sum, for lesser incapacity, is 10 times average standard monthly remuneration. Average standard monthly remuneration used in computing invalidity allowance and basic amount of invalidity pension is that of 3 months immediately preceding month of onset of disability (or less, if continuous covered employment preceding such month was less) or entire period of covered employment, which ever is greater. Invalidity pension and allowance not granted for disability resulting from insured's wilfull injury, wilfull criminal act, or grave fault.				Industrial wage ear ing at age 55 (50 i not currently engag computation,if favo red employment)and 20 yrs, (15 for min quarterly installm dard monthly remune covered employment ard daily remunerat employment in exces paid as lump-sum i employment,on appli in covered employme receiving other ben allowance)under thi number of years ins steps from 15 to 51 daily remuneration. allowance is given tive date of this I If recovery termina payment of total am Allowance,balance m Allowance. Period ance was based will towards Old Age Pen
Industrial wage earners - Regardless of length of service,beginning with 8th day of disability, sickness allowance amounting to 60% of average daily wage is paid as long as medical treatment is necessary unless,indiscretion of prefectural governor.at end of 3 years treatment settlement is paid as a lump-sum in amount of 1,200 times average daily wage or a 6 year pension in annual amount of 215 times average daily wage,form of payment being at discretion of prefectural governor. Upon determination of permanent disability at conclusion of medical treatment and in absence of foregoing settlement,compensation for injury may be invalidity pension or lump-sum, form being in discretion of prefectural governor as to first 10 of 14 stated degrees of incapacity. Lump-sums for 14 grades vary from 50 to 1,340 times average daily wage. Six year annual pensions for first 6 grades run from 120 to 240 times average daily wage,4 year pension for 7th grade is 146 times average daily wage, 3 year pension for 8th grade is 155 times average daily wage,and 2 year pensions for 9th and 10th grades are 178 and 137 times average daily wage. Average daily wage used in computing all benefits under this program is that of 3 months immediately preceding month of onset of disability (or less,if covered employment preceding such month was less).No benefits granted under this law if injury or death due to wilful injury or grievous fault of insured.	Industrial wage earners - All expenses in excess of ¥100 unless full care provided in insurance hospital or clinic. Medical care may be terminated in discretion of prefectural governor in 3 years upon payment of settlement in form of pension or lump-sum as described under cash benefits.			
...sickness allowance for off duty disability paid to seamen in ... amounts to 60% of daily wage	Seamen - All expenses of medical treatment computed on standard rates with ...			Seamen-Pension pay

Industrial wage earners - Regardless of length of service, beginning with 8th day of disability, sickness allowance amounting to 60% of average daily wage is paid as long as medical treatment is necessary unless, indiscretion of prefectural governor, at end of 3 years treatment settlement is paid as a lump-sum in amount of 1,200 times average daily wage or a 6 year pension in annual amount of 215 times average daily wage, form of payment being at discretion of prefectural governor. Upon determination of permanent disability at conclusion of medical treatment and in absence of foregoing settlement, compensation for injury may be invalidity pension or lump-sum, form being in discretion of prefectural governor as to first 10 of 14 stated degrees of incapacity. Lump-sums for 14 grades vary from 50 to 1,340 times average daily wage. Six year annual pensions for first 6 grades run from 120 to 240 times average daily wage, 4 year pension for 7th grade is 146 times average daily wage, 3 year pension for 8th grade is 155 times average daily wage, and 2 year pensions for 9th and 10th grades are 178 and 137 times average daily wage. Average daily wage used in computing all benefits under this program is that of 3 months immediately preceding month of onset of disability (or less, if covered employment preceding such month was less). No benefits granted under this law if injury or death due to wilful injury or grievous fault of insured.	Industrial wage earners - All expenses in excess of ¥100 unless full care provided in insurance hospital or clinic. Medical care may be terminated in discretion of prefectural governor in 3 years upon payment of settlement in form of pension or lump-sum as described under cash benefits.			
Seamen - Sickness allowance for off duty disability paid to seamen in covered employment for at least 6 months amounts to 60% of daily wage while receiving medical treatment and continues for maximum of 2 yrs. Illness or injury from occupational cause requires no qualifying term of coverage and amounts to 100% of wages for first 4 months of disability and 60% thereafter as long as medical treatment necessary or until invalidity pension or allowance awarded. Benefits payable from first day of disability. Invalidity Pension or Allowance (lump-sum) - payable from date of determination of continuing disability or upon expiration of 2 years after medical treatment was begun. Seamen afflicted with non-occupational disability must have 6 months covered employment but no qualifying period required for occupational disabilities. Average standard monthly wage used in computing invalidity allowance and basic amount of invalidity pension is that of 3 months immediately preceding month of onset of disability (or less, if continuous covered employment preceding such month was less) or entire period of covered employment, which ever is greater. Annual pension for occupational disability is 5 to 8 times (depending on degree of incapacity) average monthly wage and 4 times for non-occupational disability. An additional amount of 6 times average daily wage is granted for each year of covered employment in excess of 15 but total pension cannot exceed 12 times average monthly wage. Lump-sum for lesser incapacity is 2 to 25 times (depending on degree of incapacity) average monthly wage for occupational disability and 10 times for non-occupational. Invalidity allowance may be awarded to old-age pension or invalidity pension recipient for occupational disability. Benefits not granted under this law if injury or death due to wilfull self-injury, wilfull criminal act, wilfull quarrel, marked dissipation, or wilfull disobedience of safety inspector or physician.	Seamen - All expenses of medical treatment computed on standard rates with care to be provided by insurance doctors and facilities but actual expenses may be paid for care provided by other doctors and institutions. Maximum treatment for non-occupational injury or illness limited to 2 years.			Seamen-Pension paye seamen while not cu employment (recompu again leaving cover been insured over l times average stand period of covered e age standard daily ed employment in ex wance paid as lump covered employment, engaged in covered and not receiving idity Allowance) u with number of year 14 steps from 1/2 monthly wage. Cre ance is given for date of this law i recovery terminates payment of total em Allowance, balance Allowance. Period ance was based will wards Old Age Pensi

Japanese Social Insurances

BENEFITS FOR WORKERS IN PRIVATE EMPLOYMENT

OLD AGE	UNEMPLOYMENT	DEATH	
		Funeral	Survivors
		Industrial wage earners-One months pay but not less than ¥600 if death occurred within 3 months of termination of medical benefits. Dependents entitled to 50% of insured's monthly wage but not less than ¥300.	
		Agricultural workers,self-employed and workers in minor industries - Irregularly given, rarely in kind and cash allowance ordinarily not in excess of 5% of actual costs. All members of insured family eligible as for medical care.	
Industrial wage earners-Pension payable beginning at age 55 (50 for miners) for persons while not currently engaged in covered employment(recomputation,if favorable,on again leaving covered employment)and who have been insured over 20 yrs, (15 for miners),Annual pension paid in quarterly installments,is 4 times average standard monthly remuneration over entire period of covered employment plus 4 times average standard daily remuneration for each year of covered employment in excess of 20. Retirement Allowance paid as lump-sum immediately on leaving covered employment,on application of worker,if engaged in covered employment at least 6 months and not receiving other benefits (except invalidity allowance)under this law. Amount varies with number of years insured and is scaled in 20 steps from 15 to 510 times average standard daily remuneration. Credit towards retirement allowance is given for service prior to effective date of this law in employment now covered. If recovery terminates Invalidity Pension before payment of total amount equal to Retirement Allowance,balance may be paid as Retirement Allowance. Period upon which Retirement Allowance was based will not count thereafter towards Old Age Pension.			Industrial wage earners - Pension paid dependent surviving spouse, children, parents, grandchildren, or grandparents (in that priority)of worker insured over 20 years at death. Annual pension is half Old Age Pension due worker plus 10 times average standard daily remuneration for each child. Payments terminated and pension transferred to survivors in next priority: on death of survivor; if child or grandchild, at age 16 unless incapacitated and unable to be self-supporting; if spouse, on remarriage; and if widower, parent, or grandparent and under 60,on becoming able to be self-supporting. In absence of survivor meeting appropriate requirement as to relationship,dependency,age,or inability to be self-supporting,lump-sum is paid to survivors in same order as for pension,followed in priority by others supported by insured worker at his death,unless one of such latter persons had been designated beneficiary by deceased's will or notice to Welfare Minister. No lump sum paid on claim compensable under Workmen's Compensation Insurance and no pension paid in such cases until expiration of 6 year pension under that law.Lump sum paid on wage record of worker engaged in covered employment 20 years or more amounts to 6 times annual Old Age Pension; unless worker had been eligible for Invalidity Pension not covered by Workmen's Compensation Insurance, in which case lump sum is 10 times average standard monthly remuneration or 6 times annual Old Age Pension,whichever is greater.Lump-sum on termination of Survivor's Pension is computed in same manner.All pension payments are deducted from lump sum.If deceased worker had less than 20 years coverage but entitled to Invalidity Pension,lump sum equals Retirement Allowance less total Invalidity Pension payments,unless deceased entitled to Invalidity Pension not covered by Workmen's Compensation Insurance,in which case Retirement Allowance includes additional amount equal to 10 times average standard monthly remuneration on which Invalidity Pension was based but not in excess of 22 times average standard monthly remuneration for term of coverage unless that is less than 10 times remuneration on which Invalidity Pension was based. Survivors benefits not granted for death resulting from wilfull injury or wilfull criminal act of insured.
		Industrial wage earners - 60 times average daily wage.	Industrial wage earners - Benefits paid dependent surviving spouse,children, parents, grandchildren, or grandparents (in that priority) of workers regardless of term of coverage, are in form of lump sum or pension in discretion of prefectural governor. Lump sum equals 1,000 times average daily wage and pension is for 6 years in annual amount of 180 times average daily wage. In absence of dependent standing in relationship prescribed, benefits are paid to any person supported by worker at death unless he has designated a beneficiary in his will or by notice to his employer.

payment of total amount equal to Retirement Allowance, balance may be paid as Retirement Allowance. Period upon which Retirement Allowance was based will not count thereafter towards Old Age Pension.			Industrial wage earners - Benefits not granted for death resulting from willful injury or criminal act of victim.
		Industrial wage earners - 60 times average daily wage.	Industrial wage earners - Benefits paid dependent surviving spouse, children, parents, grandchildren, or grandparents (in that priority) of workers regardless of term of coverage, are in form of lump sum or pension in discretion of prefectural governor. Lump sum equals 1,000 times average daily wage and pension is for 6 years in annual amount of 180 times average daily wage. In absence of dependent standing in relationship prescribed, benefits are paid to any person supported by worker at death unless he has designated a beneficiary in his will or by notice to his employer.
Seamen-Pension payable beginning at age 50 for seamen while not currently engaged in covered employment (recomputation, if favorable, on again leaving covered employment) and who have been insured over 15 years. Annual pension is 4 times average standard monthly wage over entire period of covered employment plus 6 times average standard daily wage for each year of covered employment in excess of 15. Retirement Allowance paid as lump sum immediately on leaving covered employment, on application of seaman, if engaged in covered employment at least 6 months and not receiving other benefits (except Invalidity Allowance) under this law. Amount varies with number of years insured and is scaled in 14 steps from 1/2 to 18 times average standard monthly wage. Credit toward Retirement Allowance is given for service prior to effective date of this law in employment now covered. If recovery terminates Invalidity Pension before payment of total amount equal to Retirement Allowance, balance may be paid as Retirement Allowance. Period upon which Retirement Allowance was based will not count thereafter towards Old Age Pension.	Seaman - (Proposed amendment to include unemployment insurance). Seamen insured over 6 months during 12 months preceding unemployment is eligible for weekly benefits following waiting period of 7 days after demonstrating ability and willingness to accept suitable work as either seamen or ashore by applying to employment office. Waiting period may be extended additional 1 to 2 months if seaman discharged due to own misconduct or resigned without good cause. Benefits may continue for maximum of 180 days in 1 year and amount to 60% of standard daily remuneration.	Seamen-Two month's wage if seamen died while insured or, if no longer in covered employment, he died while receiving medical care or within 3 months of leaving employment or within 3 months of termination of medical care.	Seamen-Pension paid dependent surviving spouse, children, parents, grandchildren, or grandparents (in that priority) of seaman insured over 15 years, or whose death occurred from occupational cause within 2 years of leaving covered employment, or who was receiving occupational invalidity pension and died from non-occupational cause. Annual pension is half old age pension due seaman insured over 15 years who died from non-occupational cause, or 2.5 times last (3 months prior to month of onset of disability) average monthly wage for seaman receiving occupational invalidity pension who died from non-occupational cause, or 5 times "last" average monthly wage for seaman whose death occurred from occupational cause with 2 years of leaving covered employment. When seaman died from occupational cause, or was receiving occupational disability pension and died from non-occupational cause, and had been insured over 15 years, 3 times average daily wage for each year in excess of 15 is added to pension. For each qualified child survivor, except one of those receiving survivors pension, 10 times average daily wage is added to survivors pension (10 times "last" average daily wage when seaman died from occupational cause or was receiving occupational disability pension and died from non-occupational cause). Payments terminated and pension transferred to survivors next in priority: on death of survivor; if child or grandchild, at age 16 unless incapacitated and unable to be self-supporting; if spouse, on remarriage; and if widower, parent, or grandparent and under 60, on becoming able to be self-supporting. In absence of survivor meeting appropriate requirements as to relationship, dependency, age, or inability to be self-supporting, lump sum is paid to survivors in same order as for pension, followed in priority by others supported by insured seaman at his death, unless one of such latter persons had been designated beneficiary by deceased's will or notice to Welfare Minister. All pension payments to seaman (and prior survivor, if any) are deducted from lump sum If seaman died from non-occupational cause and had been insured more than 6 months but less than 15 yrs. lump sum varies from 1 to 23 times average monthly wage, depending on term insured. If death due to non-occupational cause, term of coverage exceeded 15 years, and no survivor entitled to pension, lump sum equals 6 times Old Age Pension less pension payments made. Lump sum on termination of survivors pension is terminated in same manner. If death due to occupational cause within 2 years of leaving covered employment and no survivor entitled to pension, lump sum equals 36 times "last" average monthly wage plus (if over 15 yrs coverage) 36 times average daily wage for each yr. of coverage over 15; provided, if seaman had received occupational invalidity pension and total payments were less than 6 times the invalidity pension, lump sum equals balance of pension payments. Lump sum on termination of survivors pension is computed in same manner. If death due to non-occupational cause, seaman had received occupational invalidity pension, and no survivor entitled to pension, lump sum equals 6 times invalidity pension less pension payments made. Lump sum on termination of survivors pension is computed in same manner. If death due to non-occupational cause, seaman had received non-occupational invalidity pension, term of coverage exceeded 15 yrs. and no survivor entitled to pension, lump sum equals 6 times Old Age Pension or 10 times "last" average monthly wage, whichever is greater, less pension payments made. Lump sum on termination of survivors pension equals 6 times Old Age Pension less pension payments made. If death due to non-occupational cause, seaman had received non-occupational invalidity pension, and term of coverage was less than 15 years, lump sum is difference between pension payments made and amount equal to Retirement Allowance and 10 times "last" average monthly wage (total of such combination not to exceed 22 times average monthly wage to be not less than 10 times "last" average monthly wage).
	Industrial wage earners - Worker insured over 6 months during 12 months preceding unemployment is eligible for weekly benefits following waiting period of 7 days after demonstrating ability and willingness to accept suitable work by applying to employment office. Waiting period may be extended additional 1 to 2 months if worker discharged due to own misconduct or resigned without good cause. Benefits may continue for maximum of 180 days in 1 yr. and generally amount to 60% of standard daily remuneration, with variations from 40% to 80% for exceptionally high and low wages.		

	SICKNESS AND INJURY		
	Cash	Medical Care	Cash
GOVERNMENT PENSION SYSTEM	Officials-If occupationally disabled, regardless of length of service, invalidity pension equal to old age pension plus an additional sum related to degree of disability and pay grade ranging from ¥644 to ¥8,400 for severe disability or from ¥420 to ¥1,218 for less serious disability		
MUTUAL AID SOCIETIES Government Personnel	Ministry employees-For non-occupational disability allowance of 50% basic wage for 6 months from 4th day of disability. Tubercular receives regular pay for 1 year and disability allowance of 50% basic wage for second year.	Ministry employees -80% of cost at standard rate unless full care provided in Ministry hospital. Dependents receive 50% of cost.	Ministry employee ment allowance of wage for 28 days b 42 days after deli nursing allowance month for 6 months spouse, confinemen ance of ¥50 and nu lowance of ¥10 per 6 months.
Government Enterprise	Enterprise employees-Same as ministry employees except disability allowance is 60% of basic wage and is for both occupational and non-occupational disability.	Enterprise employees-Same as ministry employees.	Enterprise employee ministry employees confinement allowan 60% of basic wage.
WORKMEN'S COMPENSATION FOR GOVERNMENT	Junior clerks-Disability allowance amounting to 2 to 30 months base pay depending on degree of disability at termination of	Government officials, junior clerks, and Maintenance workers -	

Japanese Social Insurances

BENEFITS FOR GOVERNMENT WORKERS

	MATERNITY		OLD AGE	
re	Cash	Medical Care		
			Officials-Pension paid quarterly for minimum of 17 years (12 years for police) service amounting annually to 1/3 basic wage at retirement plus 1/150 basic wage for each additional year under 40. Lump-sum for service of 3 years but less than 17 amounting to 1 month's basic wage for each year of service.	
yees -80% ndard rate e pro- try endents cost.	Ministry employees-Confinement allowance of 50% basic wage for 28 days before and 42 days after delivery and nursing allowance of ¥10 per month for 6 months. For spouse, confinement allowance of ¥50 and nursing allowance of ¥10 per month for 6 months.	Ministry employees - Delivery grant of 1 month basic wage or minimum of ¥100 unless full care provided in Ministry hospital.		
oyees- y	Enterprise employees-Same as ministry employees except confinement allowances is 60% of basic wage.	Enterprise employees - Same as ministry employees.	Enterprise employees-Varies with individual societies but average is pension for minimum of 20 years service amounting to 3 to 4 times 5 days base pay plus 3 to 4 times 1/6 days pay for each additional year over 20. Lump-sum for service of 1 year but less than 20 amounting to 4 days basic wage for each year of service.	
cials, and kers -				

	UNEMPLOYMENT	DEATH	
		Funeral	Survivors
imum e re- int- r of			Officials-Widow (or widower if incapacitated) children under age 20, parents, or grandparents in that order of priority, receive pension equal to 1/2 old age pension if insured had 17 years service or his death was due to occupational cause, otherwise receive amount equal to old age lump sum.
		Ministry employees-1 month basic wage or minimum of ¥30.	
ual i- o 4 1/6 0. than ch		Enterprise employees-Same as Ministry employees.	Enterprise employees-Widow (or widower if incapacitated) children under age 20, parents, grandparents or grandchildren under age 20, in that order of priority, receive pension equal to 1/2 old age pension if insured had 20 years service or equal to 5 times monthly wage if his death was due to occupational cause, otherwise receive amount equal to old age lump-sum.
		Junior clerks-2 months basic wage.	Junior clerks-Dependents receive 15 to 20 months basic wage depending on cause of death.
		Maintenance workers-	Maintenance workers-Dependents receive 400 to

WORKMEN'S COMPENSATION FOR GOVERNMENT EMPLOYEES (Occupational disability of Ministry Employees).	Junior clerks-Disability allowance amounting to 2 to 30 months base pay depending on degree of disability at termination of medical treatment within 3 years. Cash settlement amounting to 16 to 30 months base pay depending on degree of disability if treatment continues beyond 3 years. Maintenance Workers-Sickness allowance of 60% basic wages during medical treatment but not to exceed 3 years. Disability allowance amounting to 40 to 700 days base pay depending on degree of disability at termination of medical treatment within 3 years. Cash settlement amounting to 540 to 700 days base pay depending on degree of disability if treatment continues beyond 3 years.	Government officials, junior clerks, and Maintenance workers - 100% of cost.	
SEPARATION ALLOWANCE			

				Junior cl basic wag Maintenan 30 to 40 wage.
			Government employees-For ordinary separation after 10 years service the following portions of 1 months base pay are paid for each year of service as a separation allowance in a lump-sum; 1-5,50%; 6-10, 55%; 11-15,60%; 16-25, 65%; over 25, 60%. For ordinary separation after 10 years or less service, the portions are reduced to half. For separation due to non-occupational injury, 1 1/2 times the portions are paid. For separation due to occupational injury or reduction in force, 2 times the portions are paid. Minimum in cases of any injury or reduction in force is 1 1/2 times monthly basic wage.	

				Junior cl basic wag Maintenan 30 to 40 wage.
			Government employees-For ordinary separation after 10 years service the following portions of 1 months base pay are paid for each year of service as a separation allowance in a lump-sum; 1-5,50%; 6-10, 55%; 11-15,60%; 16-25, 65%; over 25, 60%. For ordinary separation after 10 years or less service, the portions are reduced to half. For separation due to non-occupational injury, 1 1/2 times the portions are paid. For separation due to occupational injury or reduction in force, 2 times the portions are paid. Minimum in cases of any injury or reduction in force is 1 1/2 times monthly basic wage.	

	Junior clerks-2 months basic wage. Maintenance workers-30 to 40 days basic wage.	Junior clerks-Dependents receive 15 to 20 months basic wage depending on cause of death. Maintenance workers-Dependents receive 400 to 600 days basic wage depending on cause of death.
Government employees-For ordinary separation after 10 years service the following portions of 1 month base pay are paid for each year of service as a separation allowance in a lump sum; 1-5, 50%; 6-10, 55%; 11-15, 60%; 16-25, 65%; over 25, 60%. For ordinary separation after 10 years or less service, the portions are reduced to half. For separation due to non-occupational injury, 1 1/2 times the portions are paid. For separation due to occupational injury or reduction in force, 2 times the portions are paid. Minimum in cases of any injury or reduction in force is 1 1/2 times monthly basic wage.		Government employees-When death is due to non-occupational cause dependents receive 1 1/2 times the portions upon which separation allowance is computed and 2 times such portions when death is due to occupational cause. Minimum in either case is 1 1/2 times monthly basic wage.

Social Security Division
PH&W, GHQ, SCAP
1 November 1947

FINANCING

Program	BENEFIT COST	
	Rate of Contributions	Distribution of burdens
HEALTH INSURANCE Government-managed	3.6% of taxable salaries and wages.	(1) 1/2 employer, 1/2 employee, with the exception of those voluntary insured who pay the total themselves. The law provides for increase in the employer's share and concomitant decrease of employee's share in hazardous or low paid industries. However none of these modifications is in operation at present. (2) National subsidies-see Administration.
Society-managed	Varying from 2-8% of taxable salaries and wages depending on the nature of the enterprise.	(1) The respective shares of employers and employees vary from equal proportions to complete employer financing with a higher than 50% employer contribution as the rule. In the last completed fiscal year (1946-47) the distribution of burdens in the 627 societies then operating was as follows: Employers paid 50 - 59 percent of contributions in 299 " " 60 - 69 " " " " 239 " " 70 - 79 " " " " 69 " " 80 - 89 " " " " 18 " " 90 -100 " " " " 2 (2) National subsidies - see Administration.
NATIONAL HEALTH INSURANCE	The average rate of contributions is determined annually by each Association, by estimating the probable cost of services to be rendered, reserve requirements and administrative costs. Members are rated on the basis of their resident tax in one of thirty contribution classes. In addition, contribution rates are modified on the basis of number of dependents. In the last completed fiscal year (1946-47) actual contributions ranged from ¥10-600 with the average close to ¥ 110. During the current fiscal yr. the average is reported to have risen considerably and some contributions are expected to reach ¥2000.	National, prefectural and local subsidies are paid to the Associations and for federations thereof and to the administrative offices. (1) National subsidies: a. To the National Health Insurance Associations: 1. one-half of office and clerical expenses 2. one-third of the salaries of doctors employed by the National Health Insurance Association on a contract basis, 3. one-third of the health nurses' salaries, 4. one-third of the construction costs of new hospitals and clinics built and administered by the National Health Insurance Association, 5. one-third of the travelling cost of the National Health Insurance Association's staff, 6. Total of promotional and publicity expenses. b. To the federations of National Health Insurance Associations: one-half of the officials' and clerical salaries (inspection costs). c. To the Prefectures: one-half of the salaries of insurance officials and clerks working in the prefectural offices.

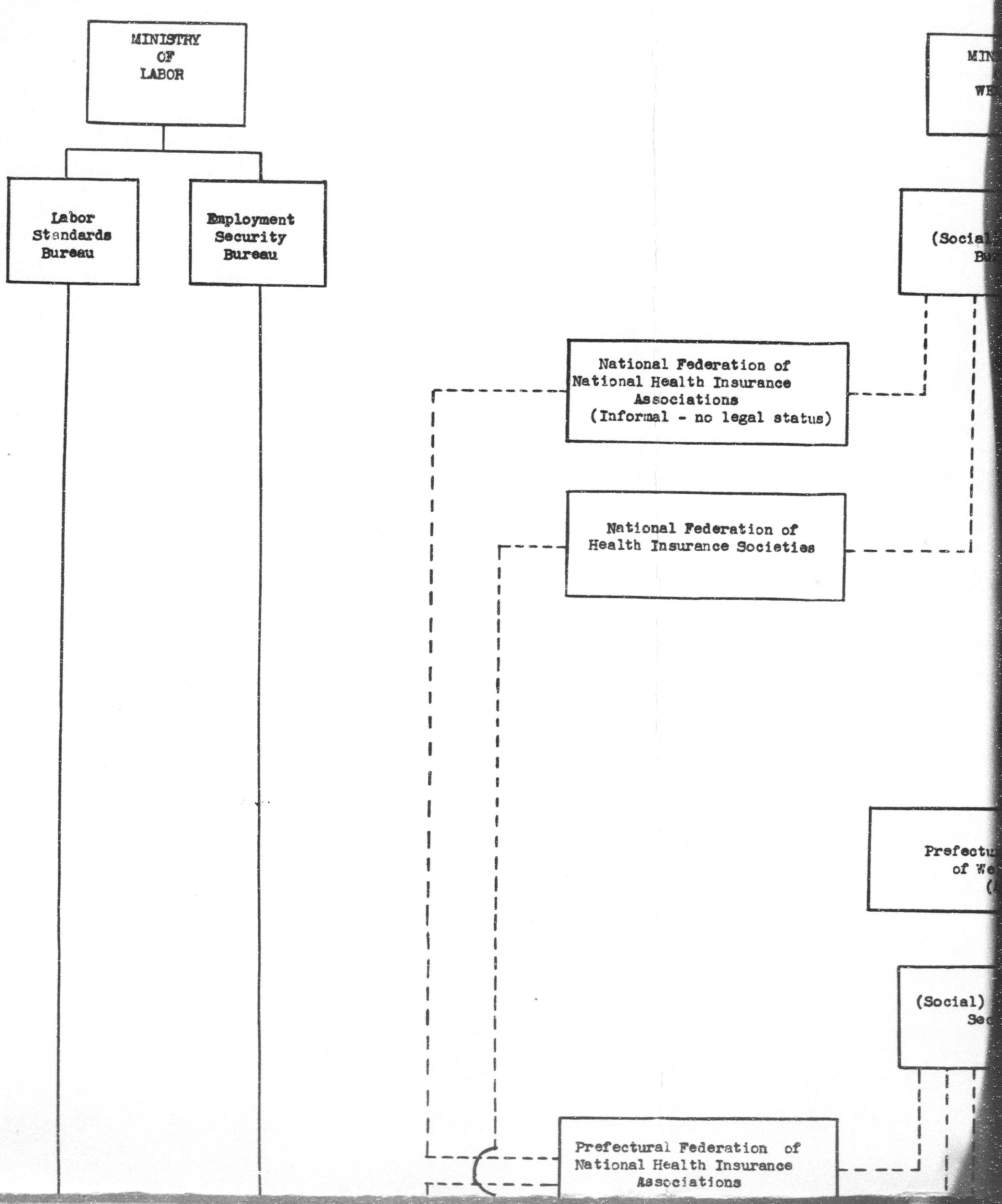
Japanese Social Insurances

FINANCING

BENEFIT COST	ADMINISTRATIVE COST
Distribution of burdens	
1/2 employer, 1/2 employee, with the exception of e voluntary insured who pay the total themselves. The provides for increase in the employer's share and con- tant decrease of employee's share in hazardous or low- industries. However none of these modifications is peration at present. (2) National subsidies-see nistration.	National subsidies are provided in the annual budget and are based on the estimated cost of administration in that fiscal year. By law these subsidies are not limited per cap. of insured. Actually national subsidies have kept well below the requirements and administrative expenses had to be defrayed in part from contributions collected.
The respective shares of employers and employees vary equal proportions to complete employer financing with gher than 50% employer contribution as the rule. In last completed fiscal year (1946-47) the distribution urdens in the 627 societies then operating was as ows: ployers paid 50 - 59 percent of contributions in 299 " " 60 - 69 " " " " 239 " " 70 - 79 " " " " 69 " " 80 - 89 " " " " 18 " " 90 -100 " " " " 2 National subsidies - see Administration.	National subsidies are provided in the annual budget and are based supposedly on the estimated cost of administration, although not earmarked for that purpose. By law these subsidies must not exceed three yen per insured. In the past few years, national subsidies have kept well below the statutory ceiling and administrative costs had to be defrayed in part from contributions, not infrequently they were borne entirely by the employer.
onal, prefectural and local subsidies are paid to the ciations and for federations thereof and to the ad- trative offices. (1) National subsidies: a. To the National Health Insurance Associations: 1. one-half of office and clerical expenses 2. one-third of the salaries of doctors employed by the National Health Insurance Association on a contract basis, 3. one-third of the health nurses' salaries, 4. one-third of the construction costs of new hospitals and clinics built and administered by the National Health Insurance Association, 5. one-third of the travelling cost of the National Health Insurance Association's staff, 6. Total of promotional and publicity expenses. b. To the federations of National Health Insurance iations: one-half of the officials' and clerical ies (inspection costs). c. To the Prefectures: one-half of the salaries of ance officials and clerks working in the prefectural es.	Apart from that part of the national subsidies which are earmarked for administrative purposes (see above preceding column), the individual National Health Insurance Associations are expected to bear the costs of administration.

		(2) Prefectural and local subsidies: these appear t be uneven, varying with the fiscal capacity of the juris diction. Formulas used, if any, are not known. Total amounts of local subsidies are considerably below those the national subsidies.
WELFARE PENSION INSURANCE	9.395% of taxable salaries and wages for all male workers except underground miners; 6.795% for female workers; 12.582% for underground miners.	(1) 1/2 employer, 1/2 employee, except those voluntary i sured after termination of their covered employment who pay the total contribution. (2) National subsidies: one tenth of the costs of benefits payable to all but miner and two-tenths of the benefit cost of miners. (During war years this provision was not enforced).
WORKMEN'S COMPENSATION SCHEMES (General, Seamen's, Government Workers)	Varies according to scheme and individual enterprise.	Entirely financed by the employers.
SEAMEN'S INSURANCE	17% of taxable wages for all but those voluntarily insured who pay 12.2% in view of their limited coverage.	(1) Employer (shipowner) pays 10.2%, employees 6.8%, w the exception of those voluntarily insured who pay th tal contributions themselves. (2) National subsidies vide one-fifth of the cost of "long-term" benefits.
GOVERNMENT PENSION INSURANCE	1/2% of taxable salaries.	The national government pays annually the difference b contributions collected and benefits paid out. While is no statutory ratio, the government's share, in the ten years has amounted to roughly 97% of the total cos
GOVERNMENT MUTUAL AID SOCIETIES	(1) Government Personnel: 1.4% of taxable salaries and wages of employees, 1.0% of taxable salaries of officials (2) Government Enterprise: Varying among the several associations from 1.98-3.3% for employees and from 0.94-1.3% for officials.	The national government pays one-half of the benefit c by matching contributions of all except the voluntaril insured members of the Mutual Aid Societies. Those vo tarily insured pay all of their benefit cost. Concern those government workers technically employed by the p fectures, contributions are made by the prefectural go ments; these amount to roughly 10% of national contri
SEPARATION ALLOWANCES (for government workers)	Non-contributory.	Government pays 100% of cost.
UNEMPLOYMENT INSURANCE (pending legislation)	2.2% of taxable salaries and wages.	(1) 1/2 employer, 1/2 employee. (2) National subsidi pay one-third of benefits disbursed during the year.

) Prefectural and local subsidies: these appear to en,varying with the fiscal capacity of the juris- . Formulas used, if any, are not known. Total of local subsidies are considerably below those of ional subsidies.	
employer, 1/2 employee,except those voluntary in- fter termination of their covered employment who total contribution. (2) National subsidies: one- f the costs of benefits payable to all but miners -tenths of the benefit cost of miners. (During the rs this provision was not enforced).	National subsidies provide for the cost of administration in toto.
y financed by the employers.	The total administrative bill is footed by the employers.
loyer (shipowner) pays 10.2%,employees 6.8%, with ception of those voluntarily insured who pay the to- ntributions themselves. (2) National subsidies pro- ne-fifth of the cost of "long-term" benefits.	Paid in toto from national subsidies deter- mined and appropriated each year as part of the national budget.
onal government pays annually the difference betwee tions collected and benefits paid out. While there statutory ratio, the government's share, in the past s has amounted to roughly 97% of the total cost.	Borne entirely by the national government.
onal government pays one-half of the benefit costs ing contributions of all except the voluntarily members of the Mutual Aid Societies. Those volun- insured pay all of their benefit cost. Concerning overnment workers technically employed by the pre- , contributions are made by the prefectural govern- hese amount to roughly 10% of national contributions.	The national government pays the salaries of the entire administrative personnel as well as a share of the other administra- tive cost (originally all of it). The pre- fectural governments likewise contribute to the financing of cost of administration. The remaining costs are financed from the Society's other income.
nt pays 100% of cost.	Paid by the government in full.
employer, 1/2 employee. (2) National subsidies to -third of benefits disbursed during the year.	Borne entirely by the national government.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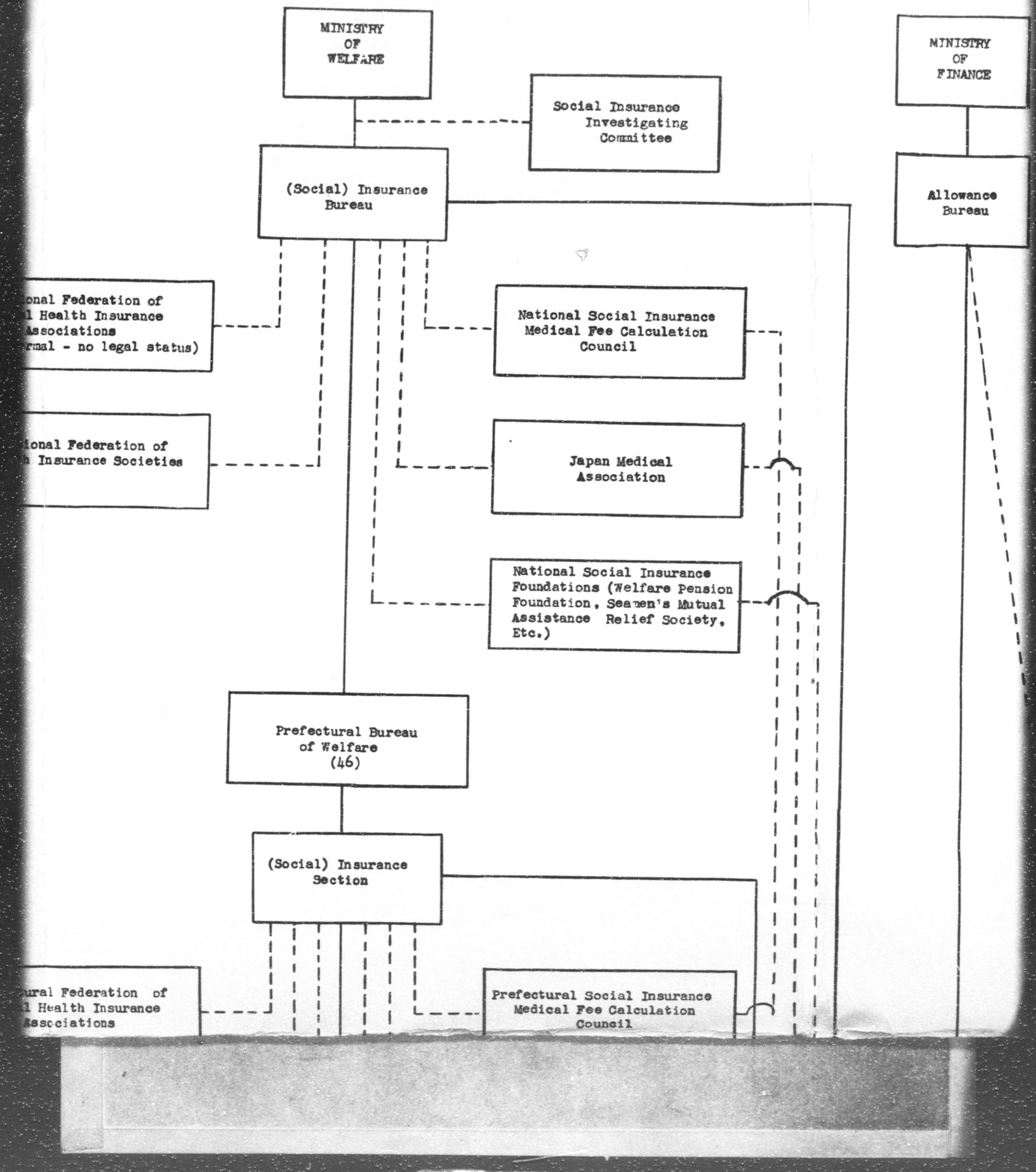
Japanese Social Insurances

ADMINISTRATION



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Investigating
Committee

Social Insurance
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Council

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Social Insurance
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Social Insurance
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MINISTRY
OF
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Allowance
Bureau

ALL
MINISTRIES
(10)

(Appropriate
Bureaus)

PRIME
MINISTER'S
OFFICE

Bureau of
Pensions

National Federation
of Mutual Aid
Associations

Prefectural Federation of Health Insurance Societies

Prefectural District Office (55)

National Health Insurance Association (10,000-1/3 of which are inactive)

Labor Standards Office (334)

Employment Security Office (650)

Bran
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Health Insurance Society (627)

Workmen's Compensation Insurance

Unemployment Insurance

National Health Insurance

Health Insurance

Functional Responsibility

Functional Affiliation

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Prefectural Medical
Association

Prefectural Social Insurance
Foundations (Welfare Pension
Foundation, Seamen's Mutual
Assistance Relief Society,
Etc.)

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Office
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Health
Insurance
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(627)

Health
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Welfare
Pension
Insurance

Seamen's
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Workmen's
Compensation
Insurance for
Government
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Seamen's Insurance

Workmen's Compensation Insurance for Government Employees

Government Enterprise Mutual Aid Societies

Government Personnel Mutual Aid Societies

Separation Allowance for Government Employees

Government Pension System

Social Security Division
PH&W, GHQ, SCAP
1 November 1947