Social expenditure in Japan and the US

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Abstract

As the Japanese total population shrinks, the social safety net becomes more vulnerable in Japan. We did a Japan-US macro comparison on social expenditure, and found these features of the Japanese system: the pension system does not prevent the elderly from poverty; use of medical resources by the elderly, especially by super-old age groups, is intensive; and those who need help are still left behind. In order to remedy the weakened safety net in Japan, social expenditure resources should be increased, and the benefits/funding structure should also be properly corrected.

Key words: income security, health expenditure, social expenditure, social protection, safety net

Introduction

Pension benefits are among the main sources of income after retirement. The public pension is ran by the government through a "pay-as-you-go system" in Japan and the US. Enrollment in the public pension plan is mandatory for every regular worker in both countries. Private pensions consist of corporate pensions and individual pensions. Corporate pension plans are plans workers can contribute to monetarily via their employers. Individual pension plans are established through insurance organizations and banks, and the government promotes these plans through tax incentives. Despite these pension plans, those who work in low-earning jobs are at risk of facing poverty after retirement.

Japan has been gradually expanding pension coverage for part-time workers. Under the 2016 reform, coverage for mandatory earnings-related pensions was extended to those working at least 20 hours a week per month at large companies, rather than the 30 required hours previously (OECD, 2021a). The 2016 reform only covered part-time workers in companies with more than 500 fulltime-employees and earning 88,000 Yen or more per month. In 2020, this was extended to companies with more than 100 fulltime-employees in 2022 and more than 50 in 2024 (OECD, 2021a).

Both inpatient and outpatient services are provided in Japanese hospitals, which causes severe competition for outpatient services between hospitals and physicians. In order to correct excessive competition and use healthcare resources effectively, it has been proposed that hospitals in Japan be classified by function, and patient flow streamlined (Fukawa, 2007). The Japanese reimbursement system is basically fee-for-service, with partial price bundling mainly for chronic diseases common among the elderly, and the same nationwide fee schedule is applied to physicians and hospitals (Fukawa, 2007).

Japanese public long-term-care (LTC) insurance has been implemented since April 2000. One of the main reasons for the introduction of LTC Insurance in Japan was to reduce the number of so-called socially induced hospitalization cases especially among elderly patients (Note 1). There had been frequent use of hospitals instead of LTC facilities because accessibility to the latter is limited, and medically oriented services are readily accessible to the elderly in Japan (Fukawa, 2018). There had been a large increase in the demand for institutional beds

following the implementation of LTC Insurance, but the Japanese government was unwilling to increase the supply of this higher cost care option by building new nursing homes, resulting in long waiting lists for LTC institutions (Tamiya et al, 2011). Taking the rapid aging of the population into consideration, limiting the costs of LTC Insurance is a big issue for the Japanese government.

This paper is structured as follows. Income security of the elderly in Japan and the US is reviewed in Section 1, using the OECD Income Distribution Database. Health expenditures (medical expenditure and LTC expenditure) in Japan and the US are compared in Section 2, using OECD Health Statistics as well as national sources. After briefly reviewing social protection in Japan and the US in Section 3, we discuss implications, based on a Japan-US comparison on social expenditure in Section 4.

1 Income security of the elderly in Japan and the US

Table 1 compares income security of the elderly aged 65 or over relative to the working age population (18-64) in Japan and the US. The mean disposable income of elderly in Japan was 77% of that of the working age population, which was lower than the US figure (89%). Income sources for the elderly are quite different between Japan and the US. Japanese elderly rely more on social security benefits and earnings, but income sources for US elderly are distributed more evenly between social security benefits, earnings, and capital income. Income inequality is larger among the elderly compared to the working age population in both Japan and the US, implying that pension systems do not eliminate poverty in old age in both countries.

Table 1 Income security of the elderly compared to the working age population in Japan and the US

	Japan (2018)		US (2021)	
	18-64	65+	18-64	65+
Mean disposable income (1,000Yen, $)	3,171	2,431	60,505	53,781
Proportion to mean disposable income (%)				
Earnings	109.1	42.8	98.9	33.6
Capital income	3.0	8.2	9.2	27.1
Income from self-employment	6.1	5.8	5.0	3.9
Social security benefits	11.0	60.3	12.4	46.1
Employment-related benefits	0.5	2.5	1.0	6.4
Taxes & social security contributions	28.7	19.3	27.3	17.2
Gini coefficient	0.324	0.339	0.372	0.409
Poverty rate (50% of median) %	13.0	20.0	13.7	22.8

Source: OECD Income Distribution Database. (accessed in July 2023)

Based on the OECD Social Expenditure Database, Table 2 compares the Social Expenditure by branch in Japan and the US in 2020. Japanese social expenditure (Public + Private) was 28.0% of GDP in 2020, which was lower than that of 36.7% in the US. Compared to the US, Japanese social expenditure (Public + Private) is higher in Survivors and Family, but lower in all the other areas. From this Database, we calculated public and private pension expenditures in both countries. As a percentage of GDP, public pension benefits amounted 10.0% in Japan, and 8.1% in the US. Similarly, private pension benefits amounted to 2.6% of GDP in Japan, and 6.1% in

the US. Therefore, total pension benefits were larger in the US (14.2% of GDP, compared to 12.6% in Japan) due to large private pension benefits.

Table 2 Social Expenditure in Japan and the US: 2020

	Japan (100 billion Yen)			US (billion $)		
	Public	Private		Public	Private	
Old Age	469.4	144.4		1,448.6	1,274.6	
Pension	454.9	138.7		1,437.9	1,274.6	
Other cash	2.7	5.8		6.1		SSI
Benefits in kind	11.9			4.6		
Survivors	64.2			130.7		
Pension	62.8			130.4		
Incapacity-related	65.8			206.9	35.5	
Pension	21.8			143.5		
Benefits in kind	29.8					
Health	559.0	19.2		2,181.0	1,386.9	
Family	107.5			140.1		
Active Labour Policy	40.2			546.7		
Unemployment	12.7			172.1		
Housing	6.0			51.8		
Other Social Policy	19.7			153.2	0.6	
	10.5		Pablic assistance	57.6		EITC
	5.4		Sicial welfare	6.2		Refugee assist.
				85.6		Food stanps
				3.8		LIHEAP
Total	1,344.6	165.2		5,031.1	2,697.6	
(% of GDP)	24.9	3.1		23.9	12.8	
Pention	539.5	138.7		1,711.8	1,274.6	
(% of GDP)	10.0	2.6		8.1	6.1	

Note : EITC = Earned income tax credit, LIHEAP = Low income housing energy assistance programme.
Source: OECD Social Expenditure Database accessed in July 2023.

2 Health expenditure in Japan and the US

2.1 Health expenditure

Based on OECD Health Statistics, Table 3 shows health expenditure by function as well as by financing scheme in Japan and the US. Health expenditure includes not only medical expenditure but also LTC (Health) as seen in Table 3 (Note 2).

The US spends 17.4% of GDP on health compared to 11.0% of GDP in Japan, and the distribution by function differs between the two countries. Inpatient care and Outpatient care together share over 60% of total health expenditure in the US, but this share is about 52% in Japan. LTC (Health) is a growing aspect and makes up 20% of total health expenditure in Japan, but its share in the US is less than 10%. Health expenditure by financing scheme, however, is rather similar for the two countries.

According to national sources, medical expenditure was 8.2% of GDP and LTC expenditure was 2.0% of GDP in FY2021 in Japan, and health expenditure (including LTC expenditure) in the US was 4,048 billion $, or 17.4% of GDP in 2021.

Table 3 Health Expenditure in Japan and the US

(Amount in 100 billion Yen in Japan and billion $ in the US)

	Japan (2020)			US (2021)		
	Amount	% of GDP	Share (%)	Amount	% of GDP	Share (%)
Health Expenditure by function						
Total	593.3	11.0	100.0	4,048.1	17.4	100.0
Inpatient	158.6	2.9	26.7	1,323.9	5.7	32.7
Outpatient	152.1	2.8	25.6	1,165.2	5.0	28.8
LTC (Health)	117.6	2.2	19.8	306.5	1.3	7.6
Medical goods	112.9	2.1	19.0	542.5	2.3	13.4
Others	52.1	1.0	8.8	710.0	3.1	17.5
Health Expenditure by financing scheme						
Total	593.3	11.0	100.0	4,048.1	17.4	100.0
Government / compulsory scheme	503.4	9.3	84.8	3,385.8	14.5	83.6
Voluntary scheme	19.0	0.4	3.2	229.2	1.0	5.7
Household out-of-pocket payments	70.8	1.3	11.9	433.2	1.9	10.7

Note: US Inpatient was blank originally, and underlined value came from Hospital Care in Table 4.
Source: OECD Health Statistics 2023. (accessed in July 2023)

Table 4 shows the relationship between National Health Expenditure and Personal Health Care Expenditure in the US in 2021. Health Consumption Expenditure in Table 4 is reported as Health Expenditure shown in Table 3. The breakdown of Personal Health Care Expenditure by type of expenditure and program is also shown in Table 4. Among the Personal Health Care Expenditure, Medicare shared 23.6% of the total, followed by Medicaid (18.1%) and Out-of-pocket (12.2%). Personal Health Care Expenditure can be compared to the Japanese medical expenditure plus LTC expenditure, as shown in Section 2.3.

Table 4 Personal Heralth Care by Type of Expenditure and Program in the US: 2021

(in billion $)

National Heralth Expenditure	4,255.1
Investment	207.0
Health Consumption Expenditure	4,048.1
Government Administration and Net Cost of Health Insurance	494.7
Personal Health Care	3,553.4

(in billion $)

Personal Health Care	Total	Medicare	Medicaid	Other Public Health Ins.	Private Health Ins.	Other Third Party	Out of pocket
Total	3,553.4	839.9	644.8	163.6	1,091.0	380.9	433.2
Hospital Care	1,323.9	350.7	245.3	91.7	448.8	153.3	34.1
Physician Serv.	864.6	222.1	99.3	43.6	328.1	105.9	65.6
Other Profess.	130.7	36.2	9.5	0.5	37.5	17.5	29.5
Dental Serv.	161.7	4.7	15.3	4.7	64.9	8.7	63.4
Residential S.	223.5	4.3	129.6	2.9	14.8	64.9	7.0
Home Health	125.2	46.6	42.8	0.8	15.9	6.2	12.9
Nursing Care &	181.4	40.6	54.3	6.8	16.3	19.0	44.4
Medical Goods	542.4	134.7	48.7	12.6	164.7	5.4	176.3

Source: CMS (2022).

2.2 Long-term care (LTC) recipients and expenditure

Table 5 shows LTC recipients among the elderly aged 65 or over as well as elderly aged 80 or over in 5 countries in 2021. From this table, the following two points can be ascertained:

- Among the elderly aged 65 or over, 14.6% received LTC services in institutions or at home in Japan, but recipient rates for LTC services are not high enough, taking the high Japanese aging rate into consideration; and

-LTC services are not widespread in the US, and only 1.7% of those aged 65 or over received LTC services in institutions.

Table 5 LTC recipients in 5 countries: 2021

(Number in thousand)

	65+					80+			
	France	Germany	Japan	Sweden	USA	Germany	Japan	Sweden	USA
LTC recipients in institutions (other than hospitals)					(2020)				(2020)
Number	535.8	721.6	1,438.9	82.1	926.8	552.1	1,196.2	59.7	527.4
%	3.8	3.9	4.0	3.9	1.7	9.3	10.0	11.0	4.3
LTC recipients at home					(2017)				(2017)
Number	789.8	3,039.9	3,864.4	246.8	4,083.0	2,027.7	2,956.5	155.3	1,986.6
%	5.6	16.6	10.6	11.8	8.0	34.2	24.7	28.6	16.0

Note 1: % shows the proportion of recipients among the population concerned.
Note 2: Japanese data are based on Fukawa (2023).
Source: OECD Health ststistics 2023. (accessed in August 2023)

Table 6 compares recipients and expenditure of LTC services in Japan and the US, using national sources. The percentage of those who received LTC services was 4.2% of the total population, and total LTC expenditure was 2.0% of GDP in FY2021, most of which was covered by Public LTC Insurance in Japan. On the other hand, only 2.4% of the total population received LTC services, and total LTC expenditure was 1.4% of GDP in 2020 in the US.

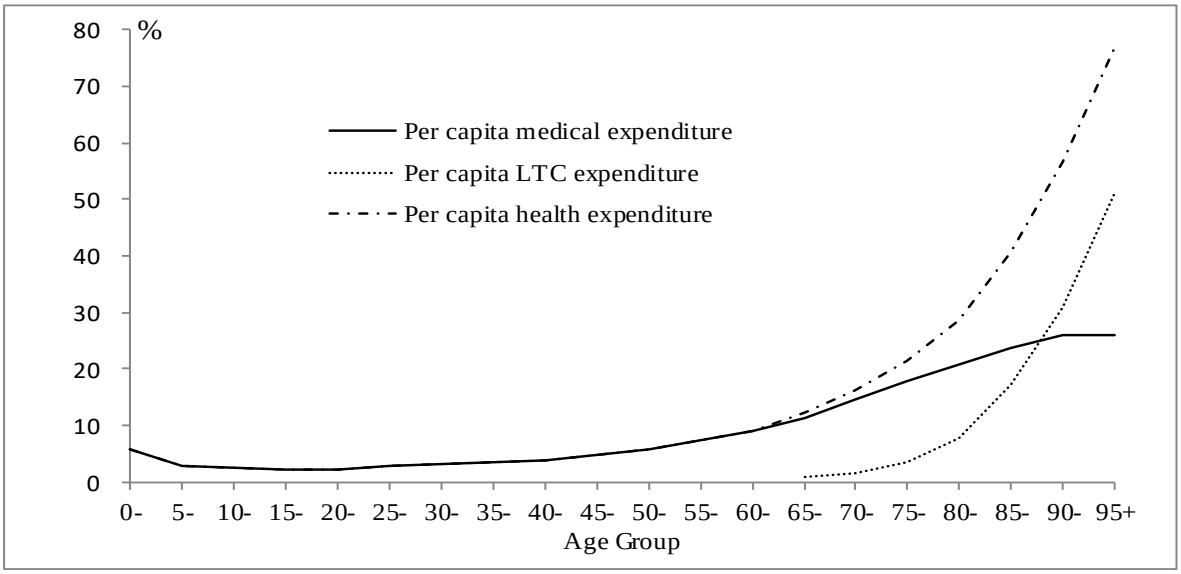
Table 6 LTC recipients and expenditure in Japan and the US

	Japan FY2021		US 2020			
	LTC Insurance		Medicaid	Other Payers	Total	
LTC recipients	In millions	%	In millions			%
Total	5.3	4.2	5.8	2.0	7.8	2.4
Institutions	1.4	1.1	0.9	1.0	1.9	0.6
Community	3.9	3.1	4.9	1.0	5.9	1.8
LTC expenditure	In 100 billion Yen	% of GDP	In billions of dollars			% of GDP
Total	108.3	2.0	173	128	302	1.4
Institutions			68	76	144	0.7
Community			105	52	158	0.8

Note: % at LTC recipients shows the proportion of recipients among total population.
Source: Fukawa (2023) for Japan and CBO (2020) for the US.

2.3 Age profile of health expenditure

Figure 1 shows per capita health expenditure by age group as percentage of per capita GDP in FY2021 in Japan. It can be clearly seen from this figure that the shape of per capita health expenditure in advanced age groups is determined by LTC expenditure, and that LTC expenditure is greater than medical expenditure for those aged 90 years or over.

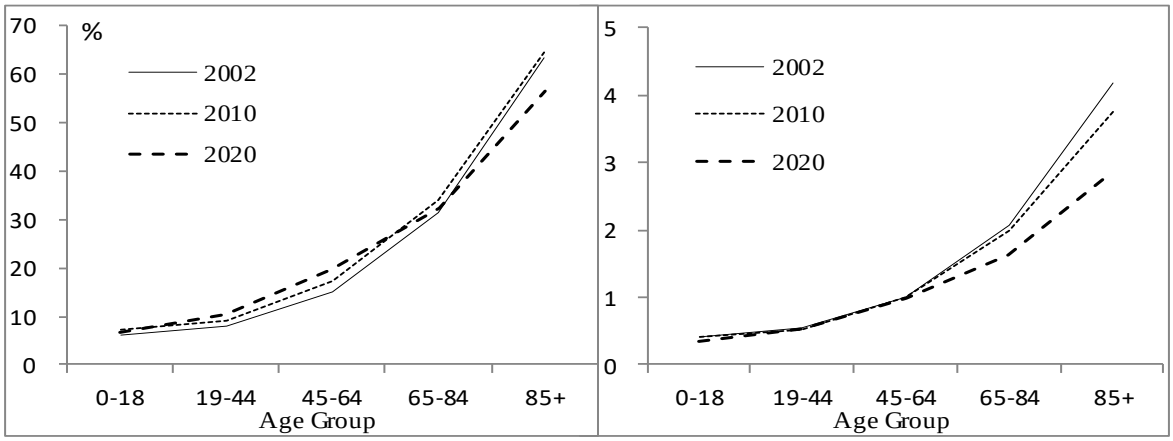


Source: Prepared by the author based on MHLW (2023) and MHLW (2022).

Figure 1 Per capita medical expenditure and LTC expenditure for the elderly as percent of per capita GDP in FY2021 in Japan

Figure 2 shows per capita health expenditure by age group in the US in 2002, 2010, and 2020, as a percentage of per capita GDP (Figure 2a) as well as relative to age group 45-64 (Figure 2b). Per capita health expenditure increases with age, but we can observe that the rate of increase is declining recently.

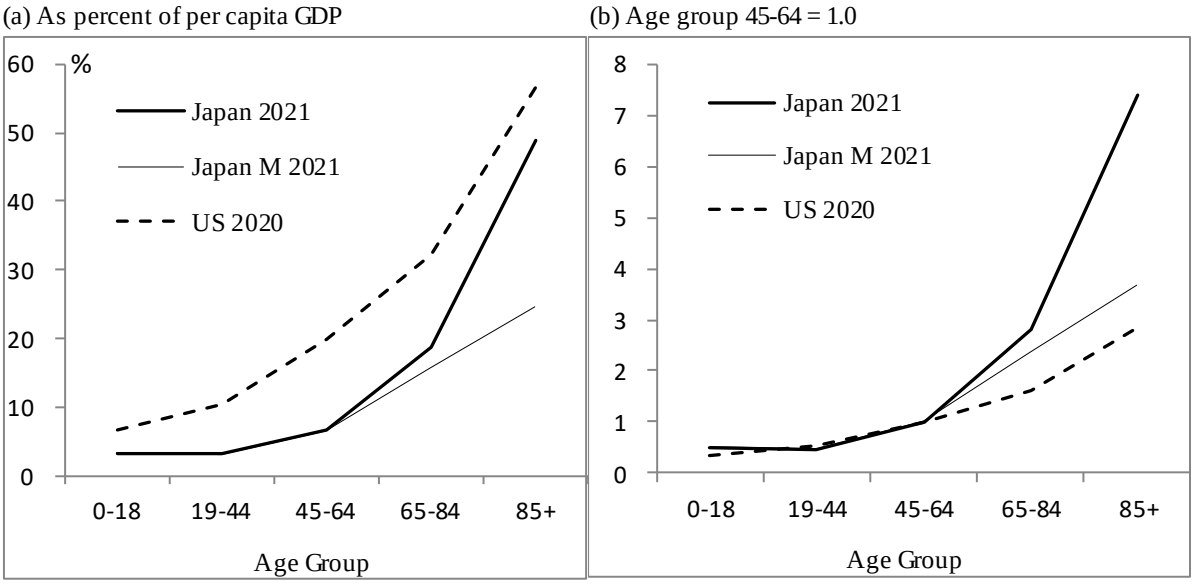
(a) As percent of per capita GDP (b) Age group 45-64 = 1.0



Source: Prepared by the author based on CMS (2022).

Figure 2 Per capita health care spending by age group in the US: 2002, 2010, and 2020

Figure 3 compares per capita health expenditure in Japan and the US. When we look at per capita health expenditure as a percentage of per capita GDP, US data is higher than Japanese data for all age groups (Figure 3a). However, if we look at per capita health expenditure relative to age group 45-65, then figures in the data for the Japanese elderly are quite high compared to their US counterparts (Figure 3b).



Note: Japan M containes medical expenditure only.
Source: Prepared by the author based on MHLW (2023) and MHLW (2022) for Japan and CMS (2022) for the US.
Figure 3 Per capita health expenditure by age group in Japan (2021) and the US (2020)

3 Social protection in Japan and the US

Social assistance in Japan includes Public Assistance and various welfare programs for socially disadvantaged people (Note 3). The Public Assistance Law stipulates a principle that every citizen has a right to claim public assistance without discrimination, regardless of their reasons for falling into hardship. Japanese Public Assistance is regarded as the last resort for those who have exhausted all other means to live by themselves. However, Public Assistance is provided depending on a fairly strict means-test, which might be a reason for the low percentage of the population (1.6% of the total population) receiving Public Assistance. This low take-up rate symbolizes the weakness of the Japanese safety net.

Public assistance in the US refers to assistance programs that provide either cash assistance or in-kind benefits to individuals and families from any governmental entity through social welfare programs and social insurance programs. Benefits received from social welfare programs are usually based on a low income means-tested eligibility criterion. Table 7 shows ten social safety net programs and their estimated number of beneficiaries in the US. Among the beneficiaries, many participate in multiple programs, and the most common program combinations include either Medicaid (17% of the population in 2019), earned income tax credit (14%), or the Supplemental Nutrition Assistance Program (11%). Participation levels among eligible individuals vary across programs, and the entitlement benefits available to anyone eligible (Medicaid/CHIP, EITC, SNAP, child support

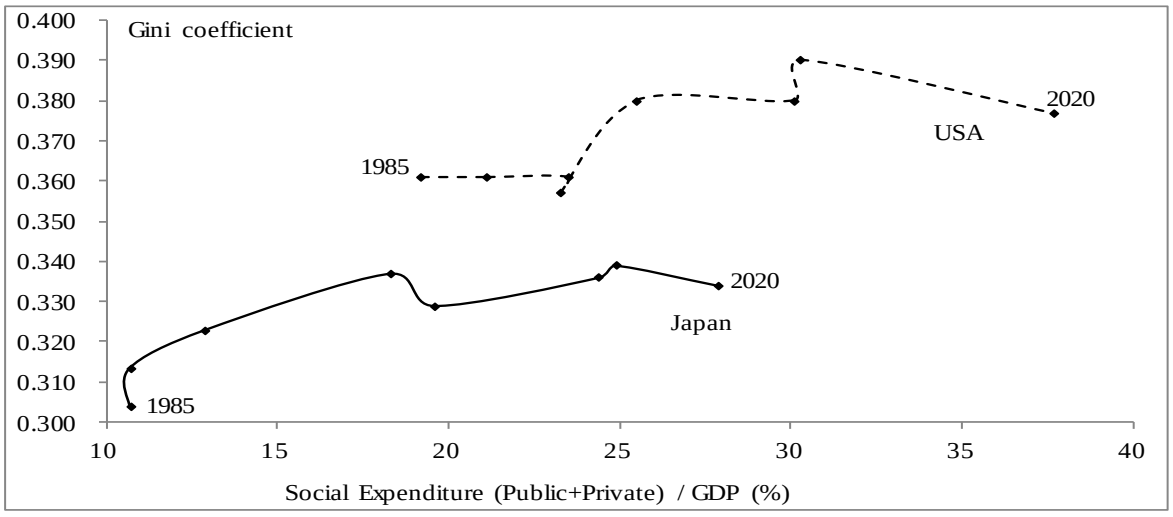
services, SSI, and WIC) had participation rates above 50 percent, whereas the four non-entitlement programs limited by federal appropriations (LIHEAP, Housing assistance, TANF, and CCDF) had rates below 30 percent in 2018.

Table 7 Ten social safety net programs and number of beneficiaries in the US

Program	2019	2018	
	Beneficiaries (in millions)	Beneficiaries (in millions)	Participation rate (%)
Medicaid / Children's Health Insurance Program (CHIP)	56.3	57.8	75
Earned Income Tax Credit (EITC)	47.0	37.8	78
Supplemental Nutrition Assistance Program (SNAP)	37.5	40.9	63
Child support services	23.1	10.2	70
Low-Income Home Energy Assistance Program (LIHEAP)	13.3	14.5	20
Housing assistance	9.6	11.0	22
Supplemental Security Income (SSI)	6.9	6.9	59
WIC	4.7	5.1	53
Temporary Assistance for Needy Families (TANF)	2.4	2.8	28
Child Care and Development Fund (CCDF)	2.3	2.2	15

Note: WIC = Special Supplemental Nutrition Program for Women, Infants, and Children
Source: ASPE (2023) for 2019 and ASPE (2021) for 2018.

Figure 4 plots social expenditure (Public + Private) as percentage of GDP on the X-axis and Gini coefficient of equivalized disposable income of the total population on the Y-axis for Japan and the US from 1985 to 2020 (5-year interval). Social expenditure/GDP increased rapidly during this period in both Japan and the US, and the Gini coefficient has moved rather similarly for both countries, although income distribution is much worse in the US than in Japan.



Source: OECD Social Expenditure Database and Income Distribution Database. (accessed in August 2023)
Figure 4 Social expenditure/GDP (X axis) and Gini coefficient of the total population (Y axis) in Japan and the US: 1985-2020

4 Discussions

We did a Japan-US macro comparison on social expenditure, with the following as major findings:

-Mean disposable income of the Japanese elderly was 77% of that of the working age population, which is lower than that of the US counterpart (89%), and Japanese elderly rely more on social security benefits and earnings, but income sources of the US elderly are distributed more evenly among social security benefits, earnings, and capital income;

-Public pension benefits amounted 10.0% of GDP in Japan, and 8.1% in the US. Similarly, private pension benefits amounted to 2.6% of GDP in Japan, and 6.1% in the US;

-Medical expenditure was 8.2% of GDP and LTC expenditure was 2.0% of GDP in FY2021 in Japan, but health expenditure (including LTC expenditure) in the US was much higher (17.4% of GDP in 2021);

-Among the elderly aged 65 or over, 14.6% received LTC services in institutions or at home in Japan, but LTC services are not widespread in the US, and only 1.7% of those who are 65 years old or over received LTC services in institutions;

-Health expenditure by age profile revealed that the US per capita health expenditure as a percentage of per capita GDP was higher than Japanese for all age groups, but Japanese elderly, in comparison with other age groups, used health resources much more intensively than their US counterparts;

-Public Assistance in Japan covers only 1.6% of the total population, but participation rates for various social safety net programs in the US can be above 50% if they are entitlement benefits; and

-Japanese Social Expenditure (Public + Private) was 28% of GDP in 2020, which is much lower than that in the US (38%), although income distribution is much worse in the US than in Japan.

There is a large difference between the average pension received by men and women in Japan. About one-third of women work part-time, compared to the OECD average of one-fifth, and women aged 65+ receive pension benefits that are on average 47% lower than men's, compared to the OECD average of 26% (OECD, 2021a). Many part-time workers will not be covered by mandatory earnings-related pensions even after 2024, as more than 90% of companies in Japan have fewer than 50 full-time employees (OECD, 2021a). Restrictions on combining work and pensions might act as a disincentive to continue working or at least as an incentive to reduce work after age 60 (Note 4), yet Japan has the highest employment rate of older workers in the OECD countries (OECD, 2021a).

Japan introduced "macroeconomic indexation" in 2004, an automatic adjustment mechanism meant to improve pension financial sustainability given rapid population ageing, through a reduced adjustment of pension benefits. The mechanism applies a correction both to the price indexation of mandatory earnings-related pensions in payment and, for new pensions, to the uprating of past wages (OECD, 2021a). Both are adjusted by the sum, if negative, of the growth rate in the total number of contributors to public pensions, minus a factor that is in principle a proxy for life expectancy gains at 65 (OECD, 2021a). By fixing the factor at 0.3% since its introduction in 2004, this no longer accounts for uncertainties in changes in life expectancy. Indeed, 0.3% was about half of the actual gains in life expectancy since 2004 (OECD, 2021a). Moreover, negative price inflation or negative wage

growth limit the full application of the mechanism. The same indexation mechanism also applies to the Basic Pension, which endangers low pension elderly at risk of poverty.

Kitao S and Mikoshiba M (2022) showed that eliminating spousal tax deductions, social insurance premium exemptions and survivors' pension benefits for low-income spouses would significantly raise the labor supply of women and their earnings. More women would opt for regular jobs rather than contingent jobs, accumulate more human capital, and enjoy higher income growth. Eliminating these barriers that act as a disincentive to work and for the skill accumulation of women will also contribute to further tax revenues for the government as well as mitigation of labor shortages expected over the coming decades in Japan.

For the US mandatory pension (OASDI), the self-employed pay the total contributions, both the employee part and employer part, and receive exactly the same pension in retirement as dependent employees with the same taxable income. Therefore, unification of the public pension system is already complete in the US. Income redistribution is clearly intended in the US public pension, which is not the case in Japan, although the Basic Pension does work as a de facto income distribution mechanism.

Private pensions play an important role in providing old-age income in the US and represent 43% of total pension spending (OECD, 2021b). The country has one of the longest traditions of complementing public pensions with voluntary private pensions, and over half of the working-age population (15-64 years) are covered by voluntary private pension schemes: 48% participate in occupational pension schemes and 20% in personal plans, with some having both (OECD, 2021b).

Based on the 2018 Survey of Income and Program Participation (SIPP), the Census Bureau (2022) showed that in 2017, lower-income households relied on Social Security to a large degree, while higher-income households received a larger share of their income from private retirement savings and earnings. Further, the highest decile of the income distribution received the largest share of its income from earnings.

Japan’s healthcare delivery system has raised many questions during the COVID-19 pandemic. Although Japanese universality concerning healthcare delivery and pricing of the services provided may have some significant effects in terms of preventing the occurrence of moral hazard on both service provider sides and service user sides, miscoordination among hospitals and between administration and service providers caused many unnecessary sacrifices of COVID-19 patients (Fukawa, 2023). As implied from Figure 1, it is safe to say that there is some room to reduce medical expenditure for Japanese elderly. As medical resources are limited, the age profile of medical expenditure suggests that there exists a severe question about the equitable distribution of medical resources among age groups even if there is reason to believe that lives at advanced ages could be saved if maximum medical treatment applied to everybody irrespective of age (Fukawa, 2023).

Prevalence rate of LTC services among the Japanese elderly is lower than that of Germany as seen in Table 5, although the rate of aging is much higher in Japan. It is not feasible to shift the costs of care to individuals and their relatives as well as to other programs that provide income and housing assistance to elderly in need in order to increase the sustainability of LTC Insurance. By investing in prevention and in community resources, Japan is creating supportive communities that seek to maintain wellness and reduce social isolation in order to prevent or delay the need for state-funded services (Curry et al., 2018).

The United States spends much more on health than other high-income countries, both on a per capita basis and as a share of GDP, and prices in the health sector tend to be high in the US, which helps to explain high health spending, although the use of certain health goods and services may also be high (OECD, 2022). Among high-income countries, the US is the only country that does not have universal health coverage, and the US system rarely provides better health outcomes despite high health expenditure (The Commonwealth Fund, 2023):

-The U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates; and

-The U.S. has the highest rate of people with multiple chronic conditions and an obesity rate of nearly twice the OECD average.

While containing the growth in healthcare costs is important to the nation's long-term fiscal future, US federal programs exist to achieve certain policy objectives. The federal government is the largest payer of healthcare expenditures, and the federal government provides direct subsidies to help moderate-income people purchase insurance and uses the tax code to subsidize employment-based health insurance (Peterson Foundation, 2023). Consequently, policymakers cannot simply clamp down on federal costs without the risk of shifting costs to other parts of the healthcare system and potentially disrupting access to good care for intended beneficiaries, but careful federal action can address fiscal concerns while protecting program beneficiaries (Peterson Foundation, 2023).

Since the Japanese social security system has traditionally been built around full-time employees and the residual functions are left to local governments, a rapid aging of the population, changes in the labor market structure and an increase in poverty conspire to make the pieces of safety nets operate separately, leaving those in need caught in the holes without help (Hayashi, 2010). Japan's relative poverty rate among the working-age population is one of the higher examples among OECD countries, although Japan's unemployment rate remains relatively low compared to other OECD countries. As Public Assistance in Japan does not provide adequate income support for the working poor and creates inherent work disincentives, Zhiyong and Asao (2023) advocates to introduce an Earned Income Tax Credit (EITC) in order to strengthen the social safety net and relieve poverty of the working poor in Japan. Japan has suffered from a low fertility rate for many years, but actual expenditure on Family is still quite low from the international standard.

In 2019, 99.1 million people participated in one of the 10 programs, representing 30 percent of the U.S. population, and more than one in four working-age adults (27 percent) and nearly one of every two children (49 percent) participated in a safety net program (ASPE, 2023):

-One in six people (16 percent) and one in three children (33 percent) participated in multiple safety net programs;

-Among the beneficiaries, 54 percent of people participated in multiple programs including two out of three children (67 percent); and

-Among people in the United States who received benefits from two or more programs, most were children or older adults (56 percent).

As seen in Figure 4, Japan has not caught up with the US in terms of the level of social expenditure. Retirement income in Japan is heavily dependent on the public pension which is vulnerable to population aging and population decline. The pension system does not prevent the elderly from poverty in both countries, but the

economic position of the Japanese elderly is weaker than the US elderly in terms of mean disposable income and diversity of income sources. Medical expenditure of the elderly is structurally high in Japan, but the prevalence rate of LTC services among the Japanese elderly is not in harmony with the high aging rate. The Japanese social safety net is already quite weak, and not reaching enough to those who need help. In order to remedy the weakened safety net in Japan, social expenditure resources should be increased, and the benefits/funding structure should also be properly corrected. A solidarity contribution (namely national subsidy) is required to finance solidarity benefits in social expenditure, and the prerequisite for this is that the social expenditure system is consistent, fair, and supported by the general public (Fukawa, 2023). Proper policy requires proper recognition of the issue, which is only possible through well consolidated statistics.

(Note 1) Cases of elderly individuals who stay in hospitals much longer than medically appropriate are referred to as "social hospitalization," an induced stay in hospital due to social reasons.

(Note 2) A System of Health Accounts 2011 defines total long-term care expenditure as the sum of long-term care (health) and long-term care (social) expenditure (OECD, 2017): LTC (health) includes medical or nursing care and personal care services which provide help with activities of daily living (ADL); LTC (social) consists of assistance services that enable a person to live independently, relating to help with instrumental activities of daily living (IADL) as well as subsidies to residential services in assisted living facilities.

(Note 3) Until Long-Term Care (LTC) Insurance was introduced in 2000, services for the elderly were termed as "Welfare for the Elderly". However, many services for the elderly are now covered by LTC Insurance.

(Note 4) In 2020, Japan decided to raise the total income threshold that reduces pension benefits from 280 thousand Yen to 470 thousand Yen (109% of average monthly earnings) starting in 2022, but only for those aged 60 to 64, and no change for those aged 65 and over is planned.

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