Health Service Delivery Profile

Japan

2012

Compiled in collaboration between
WHO and Ministry of Health, Labour and Welfare, Japan

Japan health service delivery profile

Demographics and health situation

In 2012, the total Japanese population was 127 650 000; 13% were aged 0-14 years, 63.3% 15-64 years and 23.7% 65 years and over. Japan has a high proportion of older people, and a long life expectancy. In 2009, approximately 1.7% of the total population were foreigners, predominantly Korean, Chinese, and Brazilian.

Table 1. Key development indicators in Japan

Key development indicators	Measure	Year
Human development index	0.901	2011
Gini coefficient	0.39	2005
Gender Inequality Index	0.123	2011
GDP	PPP$ 32,418	2009
Total health expenditure	8.3% GDP	2009
Incidence of poverty	15.7%	2011
Literacy rate (male/female) (%)	99/99	2002
Life expectancy at birth	83.4 years	2011
Infant mortality rate	2.3 per 1,000 live births	2010
Maternal mortality rate	4.1 per 100,000 total births	2010

Sources: Statistics Bureau, Director-General for Policy Planning and Statistical Research and Training Institute – December 2011; UNDP - 2011; WHO - 2012

The top three of causes of death in 2010 were cancer (30%), heart disease (16%), and cerebrovascular disease (10%). Aspiration pneumonia is an emerging health issue due to the ageing population.

Health system strategies, objectives, and legislation

The *Medical Care Plan* is the national health strategy to establish a system to provide high quality and appropriate medical care. It promotes a division of roles and cooperation of medical functions in order to provide continued medical care in communities. Based on the national strategy, each prefectural government revises their Plan every 5 years. There are at least five Prefectural Health Care Plans based on the national plans; Health Promotion Plan, Medical Care Plan, Insured Long-term Care Service Plan, Basic Plan to Promote Cancer Control, and the Medical Expenditure Optimizing Plan.

The *Health Insurance Act (1922)* and The *National Health Insurance Act (1938)* established a health insurance system that covered the entire population by 1961. The *Medical Care Act 1948* and subsequent A*mendments* (1985 and 1992) form the basic law governing the Japanese health care delivery system. The 1948 Act sought to ensure adequate health care, including placement of medical facilities, personnel structure and management systems. The 1985 *Amendment* legislated for the creation of Prefectural Medical Care Plans, classified regional units for implementing the plans, and regulated the maximum number of beds for each zone. In 1992 the function of medical facilities was systematized and Special Functioning Hospitals and Regional Healthcare Support Hospitals were designated. The *Community Health Act (1997)* promoted regional health care. *Healthy Japan 21 (2000)* supported by a new *Health Promotion Law (2002)* established a national health promotion program to reduce non-communicable diseases. The law also stipulates the National Health and Nutritional Survey and encourages both central and local governments to monitor the prevalence of lifestyle related diseases for effective health promotion. A range of other legislation influences health services, including the *Mental Health Act, Maternal and Child Health Act, Child Welfare Act, Labor Standards Act, School Health Law,* and the *industrial Safety and Health Act*.

Traditional medicine is regulated in the same way as conventional medicine and relevant laws are applied; e.g. the *Pharmaceutical Affairs Law (1960)* regulates marketing approvals for all drugs including herbal medicines.

The Ministry of Health, Labour and Welfare (MHLW) is responsible for writing the policies and developing the structure of the National Health Care Plan, and provides national oversight. The Prefectural Departments of Health develop 5 yearly health delivery plans according to their prefectural health situation, deliver medical services, and report to the MHLW. Municipalities are primarily responsible for delivering public health services. The private sector owns over half of the total number of health institutions, and hospital care delivery in Japan has depended largely on the private sector. There are many non-profit organizations that provide health services such as medical interpretation for foreigners, HIV-AIDS prevention and health promotion, and a temperance society for alcoholic patients.

There are some models of community participation in health service delivery. For example, in one prefecture local citizens joined as members of the hospital and had a representative voice to the president of the hospital. These members also contributed to purchasing hospital equipment.

Service delivery model

The health care delivery system in Japan has three pillars that cover all people impartially; universal health insurance coverage, a framework for health care delivery cantered on the Medical Care Act, and public health administration and service.

"Free access" is a major characteristic in the health care delivery system in Japan; private facilities can open hospitals or clinics if they satisfy the criteria in the *Medical Care Act*, patients can choose their desired medical institution, and doctors can choose to work in the private or public systems. Both public and private sectors provide the same health care services at the same costs.

The Prefectural Health Care Plans document the service delivery model in each prefecture. In 2006, health care system reform required these to focus on four diseases (cancer, stroke, acute myocardial infarction and diabetes) and on providing five types of service (emergency health, perinatal health, paediatric health, rural health care and disaster-related health).

The provider network

Disease prevention and health promotion are primarily delivered by the government through prefectural and municipal health authorities. Public hospital facilities are managed by central government, local governments, the national university, local universities or special agencies such as the Japanese Red Cross. The private sector owns over half of the total number of health institutions, and includes individuals and medical corporations. Medical corporations are defined as hospitals, clinics with full-time doctors or dentists, or Long-term Health Care facilities. Private hospitals also provide services excluded under the Health Care Plans.

There are five areas of special health service delivery in Japan.

- Rural health care plans are being implemented to provide essential medical care in hard to reach places such as islands and mountains.
- The maternal health care delivery system.
- Child medical care.
- A 3-level emergency care system that ensures emergency services are available anywhere at any time, including holidays and night-time centres, in secondary emergency care hospitals, and tertiary level services accepting critically ill patients. There are also paediatric emergency care centres.
- A system of disaster relief medical teams and emergency-helicopters for medical care in natural disasters exists.

Kampo medicine, the Japanese traditional therapies, is based on oriental traditional ways of thinking such as Yin-Yan and the concept of "Qi". The mind-body unity is considered very important. Kampo medicine can be chosen as one option as well as Western medicine. In addition to Kampo therapies, herbal medicines, acupuncture, moxibustion, and others are also used in Japan. A 2005 study indicated that acupuncture is used by 32% of the population during their lives and by 6.1% of the population during a 12 month period. Another 2005 study, found that 45% of cancer patients used one or more traditional or alternative medicine or therapy to augment their treatment.

There is neither a national programme nor national expert committee related to traditional medicine in Japan. There is however the National Institute of Health Sciences, established in 1974, which conducts research on herbal medicines.

Table 2. Levels of service delivery and types of services in Japan

Facility	Characteristics
Schools	Health management of school children takes place under the *School Health Law* Includes nutrition education and a school lunch
Community Health centres	A municipal government function 2,710 centres provide: most primary care services, e.g. consultations; screening Cover approximately 100,000 people
Public health centres	A prefectural government function 510 centres provide: regional health statistics; environmental health; nutrition and food hygiene; housing and water and sanitation and waste disposal; dental health; mental health; and the prevention of diseases such as AIDS and tuberculosis Provides some primary care services, e.g. for the disabled Are expected to meet local health needs
Clinics	Provide primary health and disease prevention and health promotion services, for example maternal health and vaccinations
Hospitals	General Hospitals (some are Regional Healthcare Support Hospitals) Regional Healthcare Support Hospitals: they accept patient referrals, etc. Special Functioning Hospitals: provide advanced medical treatment, develop and evaluate advanced medical technologies, and train physicians for advanced treatment. Medical University Hospitals: there is at least one in each prefecture and they are accessible for rural populations. All have been accepted as Special Functioning Hospitals as well.
National Centres	6 semi-government national hospitals General, Cancer, Neurology and psychiatry, Child health and development, Cerebral and cardiovascular, Geriatrics and gerontology
Long-term care facilities	
Dental care	Provided at clinics and hospitals
Employers	Worker's health and safety is managed by the *Industrial Safety and Health Act* Provides annual general health examinations, mental health promotion, work environmental control, safety education
Infectious Disease Surveillance Centre	A surveillance system has been operational since 1981, as required under the *Infectious Disease Control Law*

Health financing

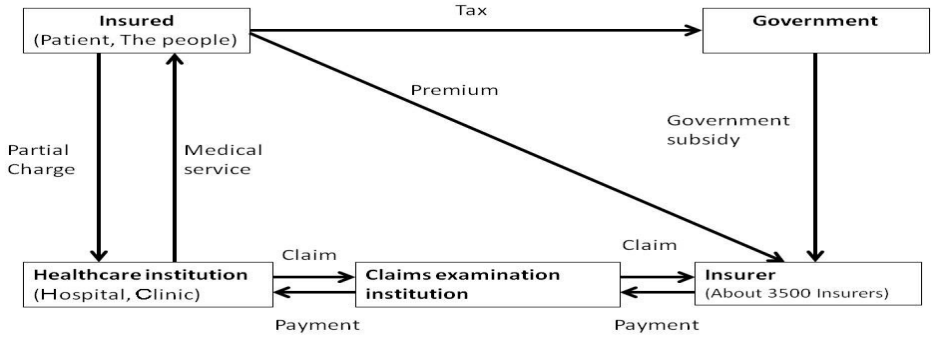
Expenditures on health services are predominantly paid for by the government, which funds them mainly from social health insurance contributions. Total health expenditure in 2009 was comprised of government health expenditure 37.5%, social health insurance 48.6%, and out-of-pocket payments 13.9%. Social health insurance is the main source of health financing, covering most curative services. Health promotion and preventive services are funded by general taxes.

Social insurance schemes are compulsory and approximately 3,500 insurers offer occupational schemes covering employees, or community schemes covering residents such as farmers and self-employed individuals, or schemes for the elderly. Individuals, and their dependents, are automatically enrolled with an insurer based on their occupation and age, and pay premiums according to income and rates from the insurer. The range of contribution rate as percentage of monthly wage is 3.12% to 9.62%.

Service users are required to make co-payments of 30% of the government-set price of the medical cost for curative services and 10% for long-term care services. This payment varies depending on the patient's age and circumstances: pre-school children, those aged 70-74 years, and the unemployed pay 20% of costs, and those over 75 years pay 10%. Insurers – via the claims examination institution – pay the remaining treatment costs directly to the health facility. Medical fees are revised by the government every two years, and this uniform reimbursement to providers is one reason for Japan's control of medical expenditure. Private providers must deliver services according to the fee schedule where they are covered by insurance, but may set prices for services not covered by insurance.

Very high medical care costs that exceed a certain amount are borne by the insurer. The insurance schemes also provide cash benefits while patients cannot work, during maternity leave, for childbirth, and for funeral expenses. Those with certain medical conditions, for example renal disease, also receive free treatment, and in some municipals there is financial aid, sometimes free, for healthcare costs of children. Individuals accepting social security are exempt from enrolling in insurance schemes and receive medical services for free.

Figure 1. System of health care insurance in Japan



Source: Annual Health, Labour and Welfare Report 2010-2011

Human Resources

Japan has fewer physicians per capita than most other OECD countries. Despite an overall increase of 3,500-4,500 physicians per year, there seems to be shortages of physicians, particularly obstetricians, gynaecologists and paediatricians. There is a relatively stable number of other health care professionals. The low number of health care workers per hospital bed, particularly physicians, is a considerable issue. The number of hospital beds has increased substantially with the aging population. The Medical Care Act sets staffing numbers for physicians and nurses for each type of hospital bed as a quality measure but there are not enough staff to meet the stated standards. In addition there is also debate whether the stated standards are adequate.

Table 3. The number of health institutions (by establisher) in Japan, 2010

Total	Central government	Public institution	Social health insurance	Medical corporation	Individual	Other
8,670 Hospitals	274	1,278	121	5,719	409	869
	3.2%	14.7%	1.4%	66%	4.7%	10%
99,824 Clinics	596	3,676	621	35,967	47,503	11,461
	0.6%	3.7%	0.6%	36%	47.6%	11.5%
68,384 Dental clinics	3	285	12	10,670	57,082	332
	0%	0.4%	0%	15.6%	83.5%	0.5%

Source: Ministry of Health, Labour and Welfare - 2010

Table 4: Health workers per 100 000 population in Japan

Category of health workers	**2008**	**2010**
Doctor	224.5	230.4
Dentist	77.9	79.3
Pharmacist	209.7	215.9
Public Health Nurse	34.0	35.2
Midwife	21.8	23.2
Nurse	687.0	744
Assistant Nurse	293.7	287.5
Dental hygienist	75.5	80.6
Dental technician	27.7	27.7
Massage and finger pressure practitioner	79.8	83.3
Judo heeling practitioner	34.4	40.1
Acupuncture practitioner	67.5	73.5
Moxibustion practitioner	66.3	40.1

Source: Ministry of Health, Labour and Welfare - 2010

Providers of traditional medicine

Specific regulation for acupuncture providers was issued in 1947. Medical doctors licensed under the Medical Practitioners Act (1948) can provide conventional and traditional therapies. Similarly, pharmacists licensed the Pharmacists Act (1950), (with updates and revisions in 1968 and 1997) can prepare and prescribe conventional medicines as well as Kampo and herbal medicines. Licenses are issued by the national government, and licensed practitioners can practise in both the public and private sectors.

Other providers for specific areas of traditional medicine, such as acupuncturist, moxacauterist, are shown in Table 5.

Table 5. The number of providers of traditional medicine, Japan 2006

Practitioner type	Number of practitioners
Medical doctors	277,927
Acupuncturists	81,361
Moxacauterists	79,932
Pharmacists	252,533

In 2001, the Ministry of Education, Culture, Sports, Science and Technology decided to incorporate education on Kampo medicines into the core curriculum of medical schools. Training in acupuncture is also available at undergraduate degree-level.

Medicines and therapeutic goods

The cost of pharmaceuticals is revised two yearly by the government. Conventionally, doctors have dispensed prescription drugs to patients, and may mark-up the cost of these to generate profit. The government is currently aiming to separate dispensing and prescribing functions, supported by the *Pharmaceutical Affairs Law (1960),* in order to ensure proper use of medicine, to increase the responsibility of pharmacy in community care, and to control costs. From 1989 to 2011, rate of separation rose from 11% to 63%. Subsequently, the role of pharmacists has expanded to include consultations with patients, and long waits at hospitals for prescriptions are now unnecessary.

Kampo medicines can be sold in pharmacies with prescription or as non-prescription over-the-counter medicines. In April 2000, the national health insurance reimbursement list included 149 prescription Kampo formulae and 188 herbal materials used in prescription of Kampo formulae. In 2010, 236 Kampo medicines were approved and permitted to be sold over-the-counter without a prescription. Acupuncture and moxibustion are partially covered by private health insurance.

In 2006 Kampo medicines made up 1.67% of total medicine production in Japan, with a total worth of ¥107,616 million (approximately US$1,376 million). Of this value, 83.2% relates to prescription medicines, 15.5% to proprietary medicines, and 1.3% to non-prescription household medicines. In 2008, total sales of Kampo medicine in Japan were ¥122,438 (approximately US$1,560 million), an increase of 3% on total sales in 2007.

Referrals and linkages through the system

People generally do not have a consistent primary health doctor, and there is no gate keeping to advanced medical treatment. Patients can freely choose their medical institution and can choose different facilities part-way through their care. If they pay a surcharge, patients can receive treatment at Special Functioning Hospitals or Regional Support Hospitals *without* a referral letter. In one Special Functioning Hospital, approximately 60% of patients visited the hospital without being referred (2006). The average length of stay in hospital is long (32.5 days), and large numbers of people seek outpatient care at hospitals instead of clinics.

Linkages between services are strongest where the Prefectural Health Care Plans include a Critical Pathway Plans and coordination for the four priority NCDs and the five types of services. These critical pathways support information sharing and the patient's smooth progression from acute phase to recovery phase hospitals and their early return home. In one prefecture, the use of these critical pathways over two years shortened the average stay in acute stroke care by 5.7 days.

The 1992 systematization of the advanced facilities was aimed to shorten patient waiting times and allow patients to receive more efficient and a more appropriate level of medical care. However, it's difficult to say whether patients understand this system or if it has achieved the desired impact

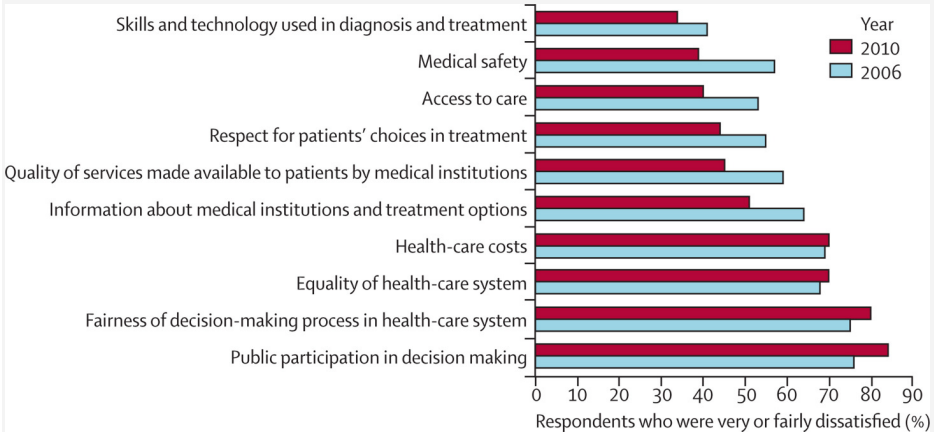
Quality

The quality of medical care and safety-related capacities of hospitals are assessed and certified, on a voluntary-basis. The Japan Council for Quality Health Care (JCQHC) was founded in 1995 to implement third party accreditation of hospitals. JCQHC sets indicators and a monitoring system for service delivery progress in hospitals. However, JCQHC is a Public Interest Incorporated Foundation and does not have the right to require hospitals to take part in the accreditation program. As of May 2011, 2965 (about 30% of all hospitals) hospitals had applied to the program and 2518 hospitals passed the JCQHC evaluation to be accredited.

In terms of patient safety and medical errors, a "no fault" system is used to ensure that clients are adequately and promptly compensated, and that the quality issues are dealt with in a problem-solving, continuous improvement approach. The *2006 Medical Care Act Amendment* emphasizes quality of care and patient safety and patient safety support centres was established in each prefecture to handle complaints and consultations concerning medical treatment and to provide advice and implement patient safety trainings to administrators and providers of medical institutions. The *Act on the Protection of Personal Information* (*2005)* legally obliges patients to be informed and medical records to be disclosed. This facilitates collaboration between patients and medical professionals over treatment. Advanced certification system for medical staff such as doctor and nurse is also current focus topic to improve patient safety and quality of care. Government aims to increase the number of advanced certification medical staff. For example, nurse specialist for cancer was started from 1994 when there were 4 nurses trained in this speciality area, but by 2012, the number of trained cancer specialist nurses reached 327.

A public opinion survey on health-care policy was done in January 2010, with an overall response rate of 62%. Figure 2 shows comparison with a similar survey in 2006 with the same set of questions. The 2010 results suggest that over recent years, public satisfaction with the decision-making process of the health-care system has decreased, while public satisfaction with the medical services and treatments has increased.

Figure 2. Reasons for dissatisfaction of Japanese population with the health-care system



Source: Shibuya et al, *The Lancet* - 1 October 2011

Equity

Universal health insurance coverage is a major pillar of the Japanese health care delivery system, and is an important tool to reduce health disparities. Despite the burden of premiums, (variable by

their health insurance plan, in turn variable by prefecture, occupation and age) the medical insurance system is considered to ensure equal access to medical treatment while reducing medical expenditure by offering the same medical services at the same prices to all citizens. There is some geographical inequity in access to health services between rural and urban areas. For example, 2010 annual report of MoH show the number of physician per 100,000 people in each prefecture. The lowest is 142.6 in Saitama prefecture and the highest is twice this - 286.2 in Kyoto prefecture. Regional disparity in quality of services and check-up rates of public health care centres is currently being addressed through improved policies. The first committee in Medical Action Plan for island and rural area was implemented in 2005. A 2004 survey showed that the percentage of households in which out-of-pocket health care expenditure exceeded 25% of total household expenditure excluding food was 1.68%.

Demands and constraints on the service delivery model

Sustainability of Japan's universal coverage is under threat from demographic, economic, and political changes. Related to this specific country context, there are three key factors influencing demands for service delivery in Japan:

1. Weak gate-keeping to advanced medicine - Several issues have been identified with the "free access" system. The lack of gate-keeping to advanced treatment results in high inpatient numbers and subsequent high burden for health care workers and reduced efficiency and quality of treatment. The lack of a consistent family general practitioner also means it is difficult to ensure an appropriate level of care is provided.
2. Financial sustainability - The health insurance system is coming under increasing pressure from an ageing society and relatively smaller workforce, resulting in a lack of growth in insurance premiums income compared to the increase in medical expenditure. Maintaining universal health insurance coverage together with the increase in national health expenditure is the biggest challenge currently facing the Japanese health care delivery. The introduction of the Long-term Care Insurance System was one response to the challenge of mitigating the burden to family care-givers and ensuring quality of life. As of 2011, 5 million older people were members of this scheme, and numbers are expected to increase. This is an ongoing political issue in Japan.
3. Information technology - Electronic medical records and sharing of patient medical information allows the lifelong management of individual's medical information, improves the quality of health care, and is also thought to lead to improved health care management by linking prevention and treatment and improving cost management. However, only 17.9% of hospitals with 400+ beds and 6.3% of general clinics had introduced electronic medical records in 2005. Incentive payments are offered to services that use electronic records; however these are considered too low and there is resistance from medical professionals. This is an area for further strengthening.

Indicators of progress

The Ministry of Health, Labour and Welfare publishes annual health reports on health status of the population collected routinely from health facilities. The government evaluates service delivery using financial criteria, number of hospital beds, and health outcomes.

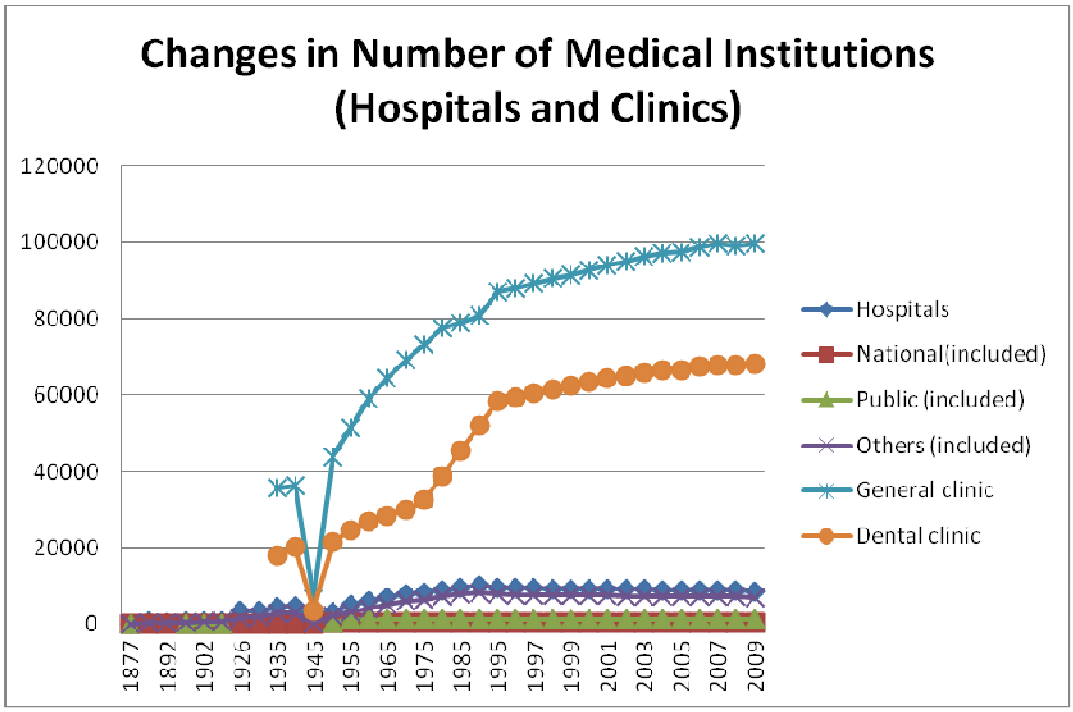
Prefectures evaluate and report on their activities, but do not yet have a systematic evaluation system for their performance in meeting their population needs, including for the aging population. The Japan Council for Quality of Health Care sets indicators and a monitoring system for service delivery progress in hospitals, however it currently only covers approximately 29% of all hospitals. In general, there is a lack of indicators for service delivery progress for all hospitals, clinics, public health care centres and health centres.

Table 6. Trends in Social Security Benefits in Japan, 1970 to 2010

	1970	1980	1990	2000	2010
National Income (¥trillion) A	61	203.9	346.9	371.8	351.1
Total Benefits (¥trillion) B	3.5 (100%)	24.8 (100%)	47.2 (100%)	78.1 (100%)	107.8 (100%)
(Breakdown) Pension	0.9 (24.3%)	10.5 (42.2%)	24.0 (50.9%)	41.2 (52.7%)	53.6 (49.7%)
Medical services	2.1 (58.9%)	10.7 (43.3%)	18.4 (38.9%)	26.0 (33.3%)	33.6 (31.2%)
Welfare, etc.	0.6 (16.8%)	3.6 (14.5%)	4.8 (10.2%)	10.9 (14.0%)	20.6 (19.1%)
B / A	5.77%	12.15%	13.61%	21.01%	30.70%

(¥10,000)

Source: MOHLW, 2012 http://www.mhlw.go.jp/english/wp/wp-hw5/dl/23010107e.pdf



Source: http://www.mhlw.go.jp/english/wp/wp-hw5/dl/23010207e.pdf

Table 7. Conforming Rate to the Statutory Number of Doctors and Nurses Designated in the Medical Care Act and Sufficiency Status (Results of FY2009 On-Site Inspection)

	Region								
	Nationwide	Hokkaido, Tohoku	Kanto	Hokuriku, Koshinetsu	Tokai	Kinki	Chugoku	Shikoku	Kyushu
Doctor	90	77.8	94.4	86.6	92.6	95.5	89.8	87.9	91.3
Nurse	99.2	99.5	98.4	99.2	99.3	99.2	99.4	99.3	99.8

Source: http://www.mhlw.go.jp/english/wp/wp-hw5/dl/23010210e.pdf

Table 8. Comparison of health indicators in Japan with OECD Averages

Indicator	Japan	Year	OECD average	Year
Total health spending as percentage of GDP	9.5%	2009	9.5%	2010
Total health spending per capita	USD 3035	2009	USD 3268	2010
Growth rate in health spending per capita	2.7%	2000-09	4.7%	2000-09
Total health spending funded by public sources	80.5%	2009	72.2%	2009
Practising physician per 1 000 population	2.2	2010	3.1	2010
Nurses per 1000 population	10.1	2010	8.7	2010
Acute care hospital beds per 1 000 population	8.1	2010	3.4	2010
MRI units per 1 000 000 population	43.1	2008	12.5	2008
CT scanners per 1 000 000 population	97.3	2008	22.6	2008
Life expectancy	83 years	2010	82 years	2010
Prevalence of obesity among adults	3.5%	2010	22.2%	2010
Proportion of adults smoking everyday	19.5%	2010	21.1%	2010

Source: OECD Health Data 2012 – Country Notes: How does Japan Compare

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