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Health, Illness, and Health Policy in Japan

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Health Care and Socio-Behavioral Factors in Health and Illness in Japan

In this chapter, we will deal with the sociocultural factors of health and illness in contemporary Japan and the historical view of health care policies in financing and delivery of services in Japan.

The Ten Components of a Nation's Health Care

First of all, we would like to present our model describing a nation's health and health care delivery system (Anesaki 1977). Our model is comprised of ten components. Health care starts with a physician's response to a person's needs for care or treatment. The consumers or recipients of health care are not only sick, injured, or disabled, but also include healthy people who ask for preventive care and health promotion. Sometimes people who are in need of care refuse the necessary care because of mental illness or other reasons. In modern society, health care is provided by a team of health personnel who have the necessary educational qualifications to use modern technology in well- equipped health care institutions like clinics or hospitals. This type of health care produces health-related and other industries, while governments, insurers, and individuals pay for the costs. The health economy has become a large sector of any national economy. Laws and ethics regulate health care because it directly intervenes with people's lives and is a basic human right. As the protection of the population's health is a major governmental responsibility, health care is an important aspect

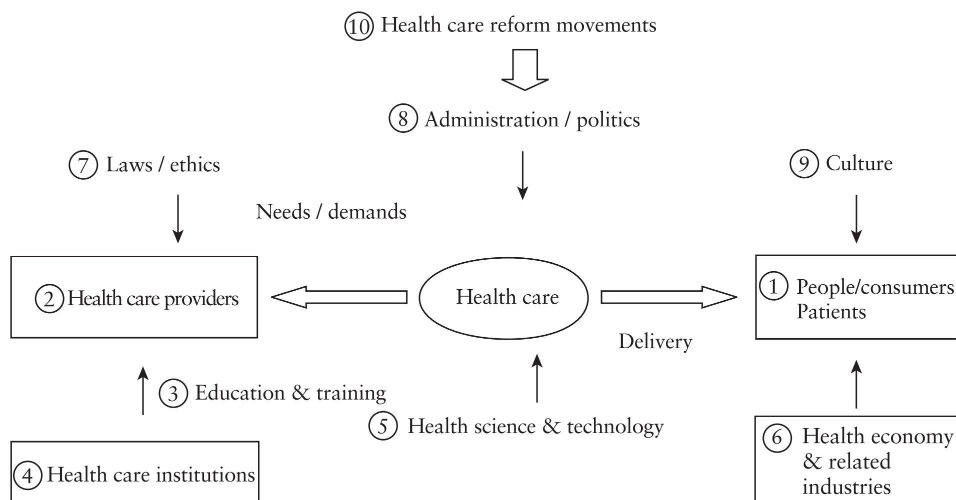

Figure 25.1 The structure of nation's health care

of civic administration and politics. People's health and health care has universal as well as cultural features. Any nation is faced often with health care reform movements, whether radical or minor.

The ten components of a nation's health care are shown in figure 25.1: (1) people/consumers, (2) health care providers, (3) health care education and training, (4) health care institutions, (5) health science and technology, (6) the health economy, (7) health-related laws and ethics, (8) health administration and politics, (9) health-related culture, and (10) reform movements. These components and the whole of health care are determined by a nation's history, economy, technology, culture, and traditions.

HEALTH AND ILLNESS IN JAPAN

In 1996, the average life expectancy in Japan was 77.01 years for men and 83.59 for women. The death rate adjusted for age was 7.4 per 1,000 for men and 4.0 per 1,000 for women. The infant mortality rate was 3.8 per 1,000 births. In each case, the Japanese figures are the best in the world. These figures reflect the high standard of living and favorable sanitation conditions in Japan. In addition, the speed at which Japan's population structure is aging is among the fastest in the world, so is the speed at which the birth rate is decreasing. These trends will force Japan to face enormous challenges in the future, as the country copes with a rapidly increasing aged population and a low birth rate.

To identify today's health problems, let us first look at the principal diseases that make up the total patient population of Japan. Hypertension, diabetes, stroke, cancer, and other diseases related to daily living habits are the principal afflictions

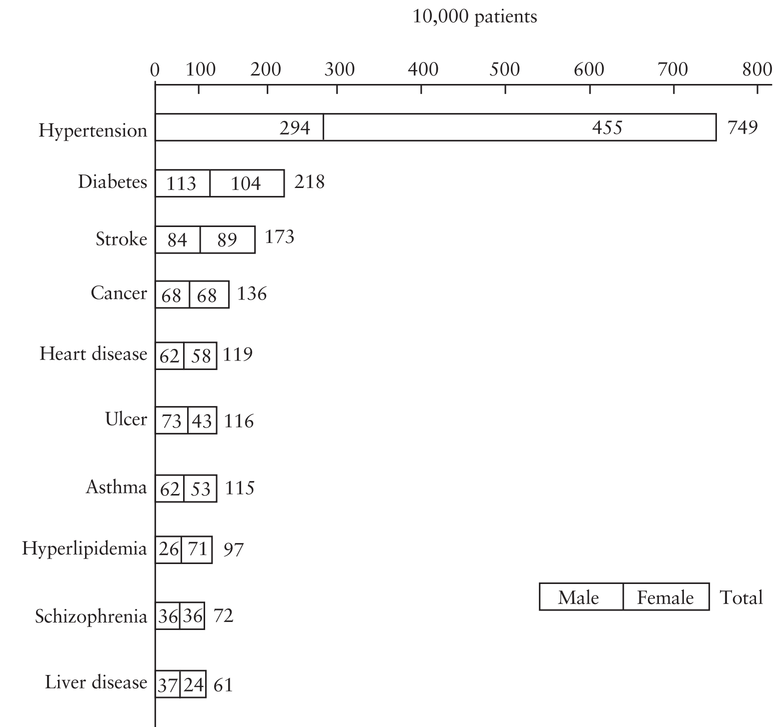

Figure 25.2 Total patient (inpatient and outpatient) population by principal disease diagnoses

Source: Ministry of Health and Welfare, 1998.

of the Japanese (Japan Ministry of Health and Welfare 1999). On one hand, Japan has created a highly managed society with excellent sanitation that enable the Japanese to live on average longer than in any other country in the world. On the other hand, it is today beset with an aging population, with more and more Japanese suffering from diseases caused by living in a highly managed, stressful society.

SOCIO-ENVIRONMENTAL FACTORS CAUSING LIFESTYLE DISEASES AND JAPANESE BEHAVIORAL CHARACTERISTICS

Diseases related to daily living habits are by nature preventable, treatable, or controllable, provided healthy habits and behaviors are followed. Thus, it is important that we know what habits are health-inducing and learn how to change any daily habits that are detrimental to health. But in reality it is difficult to develop healthy habits and behaviors even if we have sound knowledge of what is good and what is bad for us.

Why? One reason is that the environment we live in is such that it is hard to develop healthy daily behaviors. For example, in a 1991 survey, we found that, while people in most cities of the world can get to work in 30 minutes

(Munakata 1990), more than 30 percent of commuters in the greater Tokyo area have to travel over an hour to get to work (Munakata et al. 1991). A study of the neurotic tendencies of Japanese people using the General Health Questionnaire Scale (GHQ, the Japanese edition) of 60 items reveals that among those commuting 60 minutes or less, 26–28 percent had a neurotic tendency, as opposed to 33 percent for those commuting more than 60 minutes. In the case of white-collar workers in the greater Tokyo area, we found that the longer their commuting time, the more likely they are to experience daily hassles, have irregular eating habits, eat unbalanced meals, suffer from lack of sleep, drink more per week, and habitually smoke more.

Another reason has to do with the fact that the difficulty of developing healthy habits and the unhealthy daily environment people live in are correlated. That is, Japanese workers react to the source of stress at work or home that they cannot control by engaging in escapist or compensatory behaviors such as overeating, overdrinking, and watching television excessively. Consequently, to change our unhealthy daily habits we need to reconstruct the environment we live in to make it more conducive to healthy living. Also, individually the Japanese should develop effective stress-management skills. However, the Japanese personality until now has been characterized by a strong tendency to adopt self-repressive behavior traits in which they repress their feelings hoping to be well-regarded by those around them. This kind of personality is reflected in such statements as "I try hard to meet the expectations of other people," "I have a hard time expressing what's on my mind," and "I'm the type that endures hardships."

These behavior patterns make it easier for stress to accumulate, are apt to lead to neurotic tendencies, and cause people to develop unhealthy living habits to compensate for their stress. In our survey we found that, while it is true that the Japanese people's self-repressive behavior is correlated to Japanese Type-A behavior, it is precisely these behavioral patterns that have enabled the Japanese to build an industrialized society at a speed unprecedented in the world. In the United States, people with Type-A personality make all-out efforts to succeed in society by asserting themselves freely as individuals and competing openly with others and aggressively airing their views. By contrast, in Japan, Type-A people "work hard" while trying to maintain "amicable relationships" with those around them. This is reflected in such statements as "I feel like I'm betraying my colleagues if I take too many days off" or "I feel like I'm cheating the company if I don't work late." People with such attitudes become workaholics, keep irregular hours, and develop various stress-related diseases caused by daily habits including ischemic cardiac disorders.

HEALING NEGATIVE FEEDBACK OF DISEASES AND BEING ONESELF

By the beginning of the 1980s, there was so much material wealth and such positive sanitary conditions that life expectancy in Japan was, as noted, the longest in the world. But also around that time, people began to place

more importance on quality than quantity, that is, on life-satisfaction. In response to this change in consumer preference, businesses came to value workers good at empathizing with the feelings of others, for such workers would be able to creatively determine what sort of goods or services would satisfy their customers. Instead of refraining from self-assertion for the sake of group harmony and devoting themselves to work, as has been the norm up to now, workers are currently expected to openly express their feelings and ideas, assert their own individuality, and demonstrate a creativity high in added value.

However, the vast majority of people in urban areas, formerly the base from which industrialization was achieved, are citizens who still strongly tend to be self-repressive. These citizens, as noted earlier, tend to live in stressful environments and continue showing stress-generating behavioral characteristics (Munakata 1991). Consequently, their neurotic condition gets worse, which compels them to take compensatory, habitual behavior against stress. If change is not forthcoming, it will be impossible to prevent the spread of diseases caused by stress-induced daily habits.

Illness is deeply related to how people live, but it is also filled with potential for changing our environment. Illness is also the subconscious expression of the demands of those who have repressed their desire for self-satisfaction in their daily lives governed by a strong social order. For example, as we found in our survey, with the exception of those who worked less than four hours a day, the more hours people worked, the shorter their sleeping hours, and fewer the number of days off per month, the more likely they were to show neurotic tendencies. People who work long hours without taking a rest tend to isolate themselves from their surroundings. To compensate, they try to meet the expectations of those around them by repressing their feelings, thus aggravating their neurotic symptoms. These symptoms in turn push them into unhealthy habits, paving the way for the onslaught of diseases related to daily living habits.

What then are the demands those who are afflicted with such diseases repress? The answer: these people live constantly worried about how they are viewed by others and repress their wish to live their own lives based on their own self-evaluation. The medical establishment continues to treat only the symptoms of such diseases. Stress that causes diseases related to daily living habit has become a real problem, for it increases workplace bullying, karoshi (death from overwork), depression, suicide, and the like.

The more serious the problem becomes, the greater the demand for a labor environment where workers would have more time for recreation and healing, including reduction in working hours, flexible working hours, working at home, working at satellite offices, and workplace amenities. It is also true that a shift in orientation has begun to take place through mental examinations, stress-management training, self-awareness seminars, and counseling services, just to name a few. The change is from a “nice guy” orientation which force people to be cooperative and self-repressive to “being oneself” orientation where people express themselves more openly without worrying about what others may think.

HISTORICAL VIEW OF HEALTH POLICIES IN JAPAN

Primitive Medicine Earlier than the Sixth Century

One of the major historical features of health care and medicine in Japan, particularly after the middle of the sixth century, is that Japan has modeled itself after a certain country during each major time period (Powell and Anesaki 1990). In ancient times the Japanese developed their own primitive medical beliefs and practices including anatomical dissections, autopsies, and an awareness of how cleanliness can prevent the spread of disease. This awareness about cleanliness, in turn, led to the development of purification rituals.

Adoption of Chinese Medicine

From earliest times, knowledge about Chinese medicine came to Japan largely through Koreans. However, direct communication between China and Japan grew from the middle of the sixth century, and Buddhism and other components of Chinese culture came into Japan. Especially during the periods of the Sui (AD 589–617) and Tang (AD 618–959) dynasties when China enjoyed remarkable prosperity and prestige, Japan's political and intellectual leaders were so eager to adopt and copy all things Chinese that priests, scholars, and artisans were sent from Japan to study in China. Buddhist medico-priests were among the many visitors from the mainland. Chinese medicine at that time was closely connected with Buddhism; charity institutions were established in the precincts of Buddhist temples and medico-priests and nurse-priests were produced in great numbers. Chinese medicine became the national medicine in Japan, and remained so until the end of the feudalistic era in 1868.

During the long dominance of Chinese medicine in Japan, there was some modification and development. Some schools, for example, emphasized the importance of observation and experiment, thereby establishing the positivist foundation of medical practice in Japan. Toward the end of the seventeenth century, scientists carried out the dissection of animals when human dissection was prohibited, and began using an anaesthetic preparation during surgical procedures at the beginning of the nineteenth century – one century earlier than the United States pioneered the use of anesthesia in the West.

Jesuit Missionary Medicine and Dutch Medicine

Before modern times, Japan had direct contact with western medicine three times: (1) Christian missionary medicine in the middle of the sixteenth century, (2) Dutch medicine through Dutch medical officers stationed at the Dutch trading house in Dejima, Nagasaki, and (3) Japanese interpreters from 1641 to 1858 under Japan's isolation policy. Even after Christian missionary activities were strictly prohibited and foreign missionaries were expelled, missionary medicine survived as "southern barbarian surgery," thanks to the usefulness of the surgical techniques. This "southern barbarian surgery"

was combined with Dutch medicine that was up-to-date European medicine. This combination of western medicine and the positivistic and experimental Chinese (or Japanized Chinese) medicine paved the way for the adoption of modern western medical practice in Japan (Powell and Anesaki 1990).

German Medicine as a Model for Modern Japan until World War II

As soon as the isolation policy under the feudalistic Tokugawa Shogunate ended in 1868, Japan decided to adopt German medicine as the model for modernization, along with the German model for the constitution and military system. This decision was based upon Germany's method of modernization in which the country strengthened industry and the military. The Japanese government invited two instructors from a German army medical school to be a part of the institution that was the forerunner of the University of Tokyo Medical School. The two instructors were empowered with full authority to establish a new medical education system at Tokyo University that would disseminate western medicine all over Japan.

The Golden Age for Private Medical Practitioners

Beginning in 1876, a license to practice medicine was granted only to those trained in western medical science. This excluded practitioners of Chinese medicine who were still the majority. Their fight for inclusion in the new system was in vain against a background of officially endorsed modernism. Successful candidates for a medical practitioner's license were educated at national, municipal, and private medical schools, with the University of Tokyo School of Medicine at the top of a pyramidal structure.

The popular demand for western medical care services grew so rapidly that the demand for services exceeded the supply of medical practitioners. Those practitioners who possessed the knowledge and skills of western medicine and were protected by license enjoyed economic advantages under the free market principle.

From Public to Private Dominance of Hospitals

At the Meiji Restoration in 1868, when Japan's modernization began, there were no hospitals in Japan. The only exception was a hospital built toward the end of the feudalistic era on the advice of a Dutch doctor named Pompe van Meerdervont who had been invited by the Shogunate to help with the preparation for modernization. After the Meiji Restoration the central and local governments built public hospitals, including military hospitals for soldiers injured in the civil wars, which were mostly attached to medical schools. However, after 1887 an ordinance banned support for medical schools from prefectural taxes, and many prefectural hospitals were closed. Private hospitals then began to outnumber public hospitals. Private practitioners in particular began to convert their clinics into hospitals. This type of private practitioner-owned hospital became the majority of hospitals in Japan. By 1898, there were 136 government hospitals

in Japan and 518 private ones. Except for military hospitals and leading national university hospitals (or imperial university hospitals), Japan's private sector-dominated pattern of medical care delivery was established toward the end of the nineteenth century.

Charity, Discount Clinics, and Health Insurance

Japan experienced industrial revolutions in light and then heavy industry during the Sino–Japanese War of 1894–5, the Russo– Japanese War of 1904–5, the World War of 1914–18. Under the development of a free market economy, medical fees were not regulated and doctors could charge their patients any amount they wished. The economic benefits of industrialization did not trickle down to the majority of the population while living conditions in the rapidly expanding urban centers were poor and rural remote areas were isolated from the benefits of modern medicine. High medical fees became a concern for the country.

Economic and social conditions were favorable to the growth of the labor and socialist movements. In 1910, a group of socialists was arrested on suspicion of regicide and the "conspirators" were executed. In 1911 the Emperor issued an imperial proclamation on charity medical care that looked like compensation for this dubious "high treason" case. He donated initial money to the state, and with further donations collected by public subscription, the government set up an Imperial charitable foundation to own and operate charity clinics and welfare institutions. By 1936 the foundation ran fifteen hospitals, three sanatoria, one maternity hospital, one nursery, ten visiting medical units, 12 mobile nurses units, and 61 clinics in various parts of the country.

Also in 1911, a dedicated physician, ex-businessman, and parliamentarian set up a chain of discount and low profit clinics. The clinics had such strong support, especially among the working class, that this phenomenon became a national movement in the provision of medical care. The local medical associations were afraid and thus opposed to the further development of such clinics, but the clinics had been highly successful and paved the way for the organization of medical co-ops. They also established the foundation for the introduction of health insurance. Mutual aid associations began to be organized toward the end of the nineteenth century as the predecessors of health insurance societies. The associations were set up at mines, textile companies, and government agencies such as railways, printing offices, mints, postal and telecommunications offices, and army and navy bases.

Japan's first health insurance law was passed by the Diet in 1922 and came into force in 1927; about 40 years later than the world's first health insurance law passed by the German Reichstag. It is said that the Health Insurance Bill sneaked through the Diet, overshadowed by the contentious debates that attended the passing of the Anti-Socialist Bill of 1925. This was similar to the Anti-Socialist Law of 1878 in connection with the Health Insurance Law of 1882 in Germany. Japan's first health insurance law was a provision of medical treatment for disease, injuries, and death, with some cash allowances for only 2 million employees out of an estimated 4.7 million employed workers to a maximum 180-day period.

The Road to War and its Impact on Health Care: 1930–45

Japan benefited from World War I economically. Soon, however, it suffered from the postwar trade depression, a banking crisis in 1927, and the World Depression in 1929. These economic crises affected certain sectors of society: mainly workers and small business owners in urban centers and poor tenant farmers in rural areas. Under these conditions, the health status of the people was deteriorating. The incidence of tuberculosis was high and growing, and the infant mortality-rate was also high. Many areas were without doctors, clinics, or hospitals. Even if a doctor was available, the number of insured people was so limited that most of the population could not afford to have medical care.

The early 1930s saw two notable attempts to remedy these situations. One was the movement for the development of cooperative medical care facilities led by Christian intellectuals. The other was the socialist or communist movement for medical facilities for poor workers. The first group, the cooperative movement, in association with other groups such as the agricultural cooperative association, was taken over during the war by the Japan Medical Corporation, the official body in charge of wartime medical services. However, the Corporation was dissolved after the war by the Occupation Forces. The second group, sponsored by the Communists, was found unacceptable by the authorities and their facilities were closed under pressure of the Japanese police force.

In the 1930s fanatic ultra-nationalistic ideas about how to rebuild Japan prevailed and especially inspired the younger army officers, some of whom assassinated political and business leaders whom they blamed for lack of policy and leadership. Extremists in the military took advantage of this political tension and upheaval to take Japan the way of militarism. They exerted control over the nation and invaded China and neighboring countries. Japan started the "Fifteen-years war" with China and proceeded toward involvement in the World War II.

With war underway, Japan's military forces demanded radical changes in health policy. The military force was worried about the worsening health examination records of its soldiers upon conscription, and demanded the establishment of an independent Ministry of Health and Welfare that would be responsible for the nation's health and social welfare, to make "healthy and strong soldiers." It was established in 1938. At the same time, community public health centers were starting to offer preventive health services, health education, and guidance. Also in 1938, the National Health Insurance Act, which covered self-employed people such as farmers and fishermen and their families, was enacted.

With the beginning of the Pacific War on December 8, 1941 (December 7 in the US and Europe) the country came under total wartime conditions. The National Medical Service Act of 1942 regulated all matters relating to the medical and health professions, and it set up the Japan Medical Corporation to organize and control a nationwide network of all medical facilities. The Japan Medical Corporation Plan called for two central hospitals with 500 beds each, one for the northeastern half of the country and another for the southwestern half; 47 prefectural hospitals (one for each prefecture) with 250 beds each; 588 district hospitals with 50 beds each; new clinics for communities without doctors

so far; and 100,000 new beds in tuberculosis sanatoria. Since the Japan Medical Corporation was dissolved after the war ended, this effort to establish a nationwide pyramidal medical care delivery system was never fully realized.

The war years saw some expansion of the health insurance system. By the end of the war in 1945 approximately one-third of the population was covered by some insurance. Ironically, however, the war had severely limited the availability of medical care because bombing had destroyed many facilities, production of drugs and supplies was interrupted, and male physicians had been drafted by the military. As many medical students were trained in shorter courses to meet the wartime need for medical personnel, problems of over-supply and the quality of doctors became serious after the war when doctors returned from military service.

From the War-Devastated Ruins to Universal Health Insurance: 1945–61

Japan accepted the unconditional surrender demanded in the Potsdam Proclamation by the Allies, and the war ended on August 15, 1945. General Douglas MacArthur and his American staff led the Occupation by the Allied Powers after the war ended. Their main purpose was to democratize Japan after demilitarization, so the General Headquarters (GHQ) of the Occupation Forces drafted a new constitution for Japan. It passed the Japanese Diet, was promulgated on November 3, 1946, and enforced on May 3, 1947. This new Constitution has been called the Constitution of Pacifism and Democracy. Article 25 of the Constitution is as famous as Article 1 about the emperor as the national symbol and Article 9 about the renouncement of the armed forces. Article 25 states: “All people shall have the right to maintain the minimum standards of wholesome and cultural living. In all spheres of life the state shall use its endeavors for the promotion and extension of social welfare and security and of public health.” It was a revolution in Japan that the new Constitution guaranteed the people’s right to life and established state responsibility to promote and improve welfare, social security, and public health (in contrast to the old Constitution). This article of the Constitution became a foundation of social and health policy as well as the legal ground for future social and health judgments (Powell and Anesaki 1990).

During the war, 40 percent of the built-up area of more than 60 cities and towns was destroyed, including atomic-bombed Hiroshima and Nagasaki. Many medical facilities were also destroyed. When the war ended the total number of hospital beds was reduced to 31,756 or 15 percent of the number available in 1941 when the war started. The clinics decreased from 45,808 in 1940 to 6,607 in 1945, a mere 15 percent of their previous number. The number of physicians went from 67,600 in 1941 to 12,800 in 1945. Health care delivery was almost paralyzed. The extremely short supply of medical care in addition to postwar hyperinflation also paralyzed health insurance that had at one time covered approximately one-third of the population.

Some Japanese intellectuals were idealistic seekers of Beveridge’s plan in Britain for a welfare state in Japan. During the early period of the occupation, government committees on social security, or social insurance, were set up one after another on the recommendation from American advisors and the staff of

the GHQ. Those committees and councils presented an idealistic blueprint for the future social security system based upon social insurance.

During the cold war, the Chinese Revolution, the Korean War, and Japan's Peace Treaty with free bloc countries among the Allies accompanied by the Security Treaty with the USA, the Japanese government's policies, including social policies, leaned toward the political right. Britain and other European welfare states were experiencing at the same time the controversial choice between "Butter or Cannons" (social security or armament). Japan also struggled with this issue. However, when the Korean war broke out across the Japan Sea the pacifist Constitution prohibited Japan from participating in the war directly, and Japan reaped the economic benefit of the Korean War. Japan's economy not only recovered but began booming. Universal health insurance was achieved finally in 1961, but unfortunately it still left some problems unsolved. This universal health insurance was comprised of too many kinds of employer-based health insurance societies along with many municipality-based health insurance societies. Copayment varied between the insured and their dependents as well as among the diverse societies. The same fee-schedule was applied to both privately invested medical facilities and publicly subsidized public medical facilities.

On the side of health care delivery the number of medical facilities climbed so steadily that the number of hospitals in 1947 exceeded that of 1941. At first, the government adopted a policy of focusing their restoration efforts on public hospitals because private sources could not afford to invest in building hospitals. As military forces began dwindling, army/navy hospitals and facilities for invalids were transferred to the Ministry of Health and Welfare. The Japan Medical Corporation, set up by the wartime government, was dissolved. The 688 medical facilities under the Corporation were transferred to the Ministry of Health and Welfare or returned to the local governments.

The Japanese government next nullified the major wartime medical provision, entitled "The National Medical Service Act." Instead, the government legislated a group of more specific laws such as the Medical Service Act, the Medical Practitioners Act, the Dental Practitioners Act, and the Nurses Act in 1948 to secure and improve the quality of medical facilities, physicians, dentists, and nurses. Legislation for other allied medical professions soon followed: the Dental Hygienists Act of 1948, the Clinical X-ray Technologists Act of 1951, the Dental Engineers Act of 1955, and the Clinical Laboratory Technicians Act of 1958. Considering the aging population, the Japanese government also instated legislation to regulate rehabilitation personnel, as in the Physical and Occupational Therapists Act of 1965, the Orthopedists Act of 1971, the Artificial Limb Fitters Act of 1987, and the Clinical Engineers Act of 1987.

Private Sector Dominance in the Development of Health Care Delivery

In order to address the overflow of physicians after the war, the government restricted the training of new physicians for some time after the war ended. However, because experts predicted a sharp increase in the demand for medical care after the introduction of universal health insurance, the government

planned to increase the intake of medical students and even allowed the establishment of new medical schools from 1970. The "one medical school at one prefecture" policy was instituted in 1973. The government's target was to reach 150 physicians per 10,000 population by 1985, but instead it achieved this goal two years earlier than expected, in 1983.

Private sector dominance in the field of medical facilities was soon restored under Japan's high growth economy and strengthened under heavy political pressure from the Japanese Medical Association, which represented the interest of private practitioners and physician-owned private hospitals. Moreover, since 1950 private hospitals have been given the privilege of tax exemption with only a few requirements. In 1960 the new Medical Finance Corporation began to provide private hospitals with long-term and low interest loans, and in 1962 the government introduced laws to limit the increase in public hospital beds. Because of this series of policies and circumstances, private hospitals came into a favorable position in Japan.

An Epoch-Making Progress in Health Insurance Benefits followed by the 1973 "Oil Crisis"

Because the postwar development in hospitals often involved the reduction of hospital workers, strikes broke out in hospitals throughout Japan from 1960 to 1961. Sometimes physicians, led by the Japanese Medical Association (JMA), and hospital workers, led by hospital labor unions, fought with the government over their working conditions. After universal health insurance was achieved, it became a source of political contention between the Japanese Medical Association and the Japanese government. The JMA fought for conditions favorable to physicians, while the government wanted to protect health insurance finances. Eventually, high economic growth in the health care field seemed to make it possible for the government to accept the demands of the JMA.

The year 1973 was a turning point for Japan's social security. The government instituted free medical care for the aged, decreased the percentage of copayment required of dependents to 30 percent, and introduced a ceiling on the total amount of copayment. Japan also enjoyed a new universal pension scheme, one of the fruits of its high economic growth. Tragically, all of these benefits originating in Japan's high economic growth came to a halt in October of the same year, when the Fourth Arab–Israeli War began. The Organization of Arabic Oil Exporting Countries (OPEC) took advantage of oil supplies as a diplomatic weapon and restricted the oil export to the countries supporting Israel. Most western countries as well as Japan were affected, and oil prices increased by 30 to 70 percent. Japan's high economic growth, which relied upon almost all imported oil as its energy source, slowed down beginning in 1973. Eventually, the government had to take cost-containment actions in all areas, including health service fields.

The Beginning of Cost-Containment Policies

In 1980 the conservative-led government set up the Administrative Reform Council. The Council consisted of a number of specialized subcommittees and

study groups. In the long-term, its objective was to privatize the public sector as much as possible to make a small government sector. This was similar to the policy of restraint that was being instituted by the Reagan administration in the United States and the Thatcher administration in the United Kingdom. The Administrative Reform Council issued specific recommendations about health and social welfare to guide the Ministry of Health and Welfare in policy formation. The Administrative Reform Council's first report on July 10, 1981, included recommendations to restrict government expenditure and to slash government subsidies by 10 percent. On the issue of medical care the report stated: "Medical care costs should be borne by the beneficiary where possible. Raise the maximum amount to be paid by beneficiaries of expensive medical treatment. Require elderly beneficiaries to bear part their medical expenses." Similarly, the third report on July 30, 1982 included a specific recommendation related to health care that Japan "rationalize medical costs to curb total medical expenditures." Finally, the fifth report of March 14, 1983 notes that the country should "transfer one-tenth of government controlled activities to local authorities over the next two years."

The government's concerns and subsequent policies tended to concentrate on health and medical expenditures and on health care financing mechanisms while ignoring problems concerning health and medical care delivery. Problems remained with the shortage and misdistribution of medical care resources (i.e. medical care personnel and facilities). Official concern grew concerning both the dramatic rise in the cost of medical care for elderly people and the ratio of medical care costs for the elderly to total national medical costs. The Health and Medical Services for the Elderly Act of 1982 (enacted in 1983) introduced a flat rate co-payment by elderly people for medical care that would restrict excessive medical care for elderly people. In addition to illness-specific medical care for the elderly this Act provided prevention health services for them like health check-ups and health education. The provision of preventative health care was based upon the principle that "prevention is cheaper than cure."

Cost Containment through Health Insurance to Health Care Delivery

Socialization, or systematization, of health care financing and of health care delivery should go together in a good balance. In Japan, however, health care financing was socialized under a universal health insurance scheme, while health care delivery remained dominated by the private sector in a "laissez- faire" way. Misdistribution of health care resources rendered areas in which there were no medical care services available even when the residents paid premiums. Any patient could have free access to any medical facility with the same health insurance book, and there was no official distinction between medical facilities. Ambulatory care patients could go either to individual doctors' clinics or directly to the outpatient department (OPD) of large hospitals without any referral by family physicians. In urban areas, therefore, people often preferred large hospital outpatient departments to small clinics, which meant that the OPDs were so crowded that patients had to wait "three hours for three minutes' consultation."

Among inpatients acute and chronic patients were mixed, and the average length of stay was more than 30 days.

The increase of enrollment in medical schools continued until 1979 when the 80th and last medical school opened in Okinawa. Concern over the future potential for an excessive supply of physicians had already started. A series of amendments to the Medical Service Act began in 1985. The amendments were meant to effect cost-containment and to solve accumulated problems caused by the mainly "laissez-faire" system of health care delivery. The First Amendment to Medical Service Act asked each prefecture to demarcate secondary medical care or hospital care service zones along with the estimation of the needed number of hospital beds for each zone. In zones where the number of hospital beds exceeded the estimated number, new increases in hospital beds were not allowed. The Second Amendment in 1992 classified hospitals' function according to two opposite purposes. It designated two national medical centers and 80 university hospitals as highly advanced hospitals and specified on the other hand long-term nursing care units in hospitals. The Third Amendment in 1997 instituted informed consent to treatments in order to protect patients' rights. The Fourth Amendment is still forthcoming. Topics that will possibly be included are: clearer distinction between beds for acute patients and for chronic patients, broader disclosure of medical information, deregulation of restriction of advertisements concerning medical facilities, two-year compulsory postgraduate medical training.

Along with this series of policies regulating medical care delivery, a 1986 government committee on future supply and demand of physicians disclosed its recommendation that the intake of medical students should decrease by 10 percent before 1995. The Japanese counterpart to the Joint Commission on Accreditation of Health Care Organizations (JCAHO) in the USA, the Japan Council for Quality Health Care (JCQHC), was set up in 1995 to assess the quality of hospitals. As of May 1999, 220 hospitals were accredited. Also, care by private nurses or relatives for inpatients, which is a Japanese traditional custom, was abolished in September 1998 after a few years' preparation.

Policies on Care Delivery and Financing for the Aging Population

In 1989 the "Ten-Year Strategy to Promote Health and Welfare for the Elderly in the Twenty-first Century" (the Gold Plan) was adopted. This plan included numerical targets to be completed by the end of the twentieth century for health and welfare personnel and for domiciliary and institutional care facilities for the elderly. In 1995 those targets were revised (the New Gold Plan). To finance the care for the elderly in the twenty-first century, as prepared by the Gold Plan, the Japanese government prepared the Long-Term Nursing Care Insurance Plan of 1997. This social insurance will be enacted on April 1, 2000 when the fiscal as well as the academic year starts in Japan at the first year of the new millennium.

Conclusion

The national health policy and its outcome are a combined product of the ten components (noted at the beginning of this chapter) and the country's natural and sociocultural histories. The main principle of Japan's health policy after World War II has been equal access to health care for everyone, mainly through health insurance (Campbell and Ikegami 1998; Maruyama, Shimizu, and Tsurumaki 1998). This fundamental egalitarian principle has been successful, but it has sacrificed or ignored efficiency and amenity in health care delivery. Japan's health care service is at a turning point. Rationalization and competition are being introduced. In this situation, it is becoming important how equity and patients' rights should be protected.

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