Outlook for Regional Health Care

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Introduction

Regional health care is an expression that is currently used without any incongruity; however, its meaning differs according to the person who uses it and it can signify anything from simply regional health care to a complete health care system in a particular region supported by clinics and hospitals.

The health care system is approaching a major turning point and a renewed reconsideration of how community health care is going to change, how it should change, is a task that I consider to be of significance to the health care of the nation.

Current Condition of Regional Health Care and Related Issues

1. The origins of regional health care

Beginning in 1965, social development was set forth as a national policy. To coincide with this, Dr. Taro Takemi, the former president of the Japan Medical Association (JMA) asserted that the aim of social development was the realization of improved social welfare for Japanese citizens in harmony with socioeconomic development, on the basis of the concept that health care is the application of medical science to society. To which end, and in recognition of the fundamental importance of adapting the philosophy that the main constituent of economic activities is the respect for humanity in regional settings, he convincingly elucidated the concept of regional health care as follows. “Development of the regional population from a health perspective is a field of the utmost importance and it is physicians and the activities of medical associations which are primarily responsible for conducting such developmental activities. Based on this line of thought, local medical associations instituted a regional health delivery system that was tailored to meet the particular characteristics of the regions. On the basis of these efforts and via the provision of appropriate health care, it would be possible to improve health in the regions. In other words, the maintenance and promotion of the health of the regional population is the desired aim of the system. This constitutes the ideology of so-called ‘regional health care’.”

At the heart of this concept of community health care lie transitions in the concept of health care itself. Formerly, it was normal practice for physicians to devote themselves to the care of patients, predominantly within health care
care facilities. However, the concept of health care has expanded in conjunction with advances in medical science and technology, leading to a common recognition by physicians and medical associations that comprehensive health care that includes convalescence after a failure in health, disease prevention and health promotion would contribute to improving health standards in the regions. This broadened the sphere of physicians’ activities and simultaneously amplified their social mission.

In 1965, the establishment of organic links among hospitals and between hospitals and clinics was thought to be necessary to streamline and provide appropriate medical care. The opening of hospitals, the establishment and operation of medical association hospitals and the provision of clinical laboratory test facilities, were also considered desirable as a means of developing regional health care. Provision of appropriate medical care needed to be effectively implemented to develop various specialty hospitals, promote group activities, and the shared-use of facilities among hospitals and clinics in line with social objectives.

In the sphere of health care and public health activities, the medical associations advocated the appropriate utilization of a comprehensive health care system for regional health care and social welfare that encompassed medical care, disease prevention, rehabilitation, health education, mental health, maternal and child health, industrial health, health management (educational, occupational, among the general population). The medical associations postulated the need for consolidated activities since the inconsistent application of the various health care activities would be ineffective, and the need for guidance on and promotion of systematic activities by an independent body, i.e. medical associations.

As a matter of fact, the concept of comprehensive health care as proposed by JMA was finally guaranteed under law in a revision of the Medical Services Law enacted in 1992. Article 2.1 included the following statement on the philosophy of providing health care: “Health care upholds the principles of the respect for human life and the protection of dignity. It is implemented on the basis of relationships of trust between medical physicians, dental practitioners, pharmacists, nurses and other medical professionals responsible for providing health care, and the individuals receiving such care, and in response to the physical conditions of the individuals receiving such care. The content of health care should not merely comprise treatment but should also include high-quality and appropriate provisions to prevent the occurrence of disease and rehabilitation.”

2. Current condition of regional health care

Based on this idea, local medical associations have continued to conduct various activities at medical association-operated hospitals, including the provision of medical care, vaccination, public health, maternal and child health, school health care, industrial health care, sports health care, and emergency/disaster medicine, centering on the shared-use of facilities, and additionally, to operate nursing training facilities, to the present day. However, not all facets have developed smoothly, and there is the perception that some of the activities in the sphere of regional health care have begun to deteriorate in quality.

The following is a survey of the present status of the various regional health care activities.

(1) Industrial health care activities

With the aim of improving the nature of industrial health physicians and furthering their activities as one link in the provision of regional health care, JMA inaugurated a program to certify industrial health physicians in April 1990. According to the latest statistics, the number of industrial physicians certified by JMA has steadily increased and currently stands at 52,165. There are 347 regional industrial health centers nationwide, which aim to promote occupational health among the personnel of offices employing less than 50 staff that is not legally required to assign an industrial health physi-
cian. Prefectural and municipal authorities have established 42 industrial health care promotion centers to support the activities of industrial health physicians and the institutions involved in the provision of industrial health care, and local health association activities in this field are positively vigorous.

The ideology of applying industrial medicine to society advocated by former JMA President Takemi, which aims to promote overall health standards within the industrial system via the development of a system for industrial medicine and thereby to promote occupational health, formed the foundations of the current industrial health care system.

(2) Medical association shared-use facilities

Among medical association shared-use facilities, which originated with medical association hospitals and clinical laboratory test centers, there are currently 81 medical association hospitals, 42 medical examination centers, 86 compound medical examination/testing facilities, 527 facilities that include satellite home-visit stations, 99 home care support centers and 48 helper stations.

[Medical association operated hospitals]

In line with the legislation of medical-care programs enacted under the revision of the Medical Services Law in 1985, and in the same way as general hospitals, the majority of medical association operated hospitals in regions with a surplus of hospital beds were precluded from increasing the number of hospital beds or establishing new hospital facilities. At one point, there was even a decreasing trend in connection with the medical fee schedule. However, under the Medical Service Law, hospital beds at shared-use facilities were recognized as exceptional cases, and a tendency toward recovery in the number of hospital beds available became apparent as a result of the newly established regional medical care support hospital system enacted under the third revision to the Medical Services Law in 1997. In addition, the consolidation of national hospitals, together with the delegation of hospitals and entrusted hospital management has generated further increases in the number of hospital beds. Medical association operated hospitals epitomize the concept of shared-use and should be considered the origin of cooperative disease diagnosis, in that primary care physicians refer patients requiring in-patient treatment for admission, such patients subsequently undergo collaborative treatment provided by both their primary care physician and hospital physicians and are then returned to the supervision of their primary care physicians upon discharge. It is necessary to protect and cultivate medical association operated hospitals, which may form the base for regional health care.

[Regional medical care support hospitals]

Regional medical care support hospitals were systemized under the third revision of the Medical Services Law in 1997. These hospitals accept patients who are referred by their primary care physicians or by small and medium-size hospitals in the regions, and are designed to support regional health care. Accordingly, the most characteristic specifications (conditions) for the hospitals in question are as follows: the requirement to handle more than 80 percent patient referrals and the positioning of a steering committee with a representative from the local medical association in order to guarantee the support of primary care physicians in the region.

As of the present, August 2001, 33 hospitals have become regional medical care support hospitals, a figure which breakdowns into 26 association operated hospitals, 2 prefectural and municipal operated hospitals, 2 local authority operated hospitals, and 3 medical corporation operated hospitals. (Note: There were 35 regional medical support care hospitals as of October 1, 2001.)

Regional medical care support hospitals require public health care institution participation, and it is considered necessary for such hospitals to expand into all regions in order to promote health care delivery in local communities.

The previous health care delivery system
centered on public hospitals, however, private-sector hospitals and clinics are currently the main constituents of this delivery system in the regions. It is necessary to be cognizant of the fact that the mission/raison d’être of public health care facilities is to support the private-sector health care institutions that are the main providers of health care in the regions, and effect a change in mentality to reflect the transition to an era of private, as opposed to public, significance in the health care arena.

[Home visit stations]
The objective of the home visit stations established by JMA, is to provide home treatment to local residents (the patients) mainly by regional medical associations, and as such they differ from the stations attached to specific hospitals. Home visit stations epitomize the shared-use of facilities by physicians in the regions.

Long-term care insurance is applicable to home visit stations as medical association operated shared-use facilities, however, since the entry of profit-making enterprises has been authorized, it will be necessary to pay particular attention to how this affects such facilities in the future. Moreover, home visit stations are not independent entities, but are operated as part of a tripartite body including home care support centers and helper stations, and accordingly it is considered necessary to continue to provide support to those individuals in need of nursing care.

[Clinical laboratory test centers/Medical examination centers]
Medical association operated clinical laboratory test centers have a long and illustrious history and have accumulated results over the years. However, since such centers are now in competition with the laboratory test centers run by profit-making companies and member physicians are selecting the low-priced facilities of the latter, medical association operated clinical laboratory test centers are facing an increasingly hard fight. In terms of attaching significance to the provision of a service to people, it is necessary to make efforts to streamline management by, for example, substantiating health management operations at centers for regional populations in line with the implementation of medical examination operations in order to improve health standards in the regions; target collaborative operation of clinical laboratory test centers; and to facilitate cooperation among neighboring centers so that they can be managed according to the characteristics of their individual fields.

Clinical laboratory test centers and medical examination centers are both regional health management centers and simultaneously, bases for providing information on health to local populations. In other words, it is necessary to confer the new function of health information centers. In addition, the use of medical association operated laboratory test centers is one link in the provision of regional health care and it is also necessary to alter the mentality of association members to this effect.

(3) Training centers for nurses, etc.
Of those nursing training center facilities established and managed by medical associations, JMA is heavily involved in the management of 26 three-year curriculum nursing training centers, 117 two-year curriculum facilities and 292 assistant nurse training centers.

The assistant nursing system was established in 1951, and medical associations have been particularly central to this type of training since the outset. The uniform cuts in financial assistance imposed under the so-called Fiscal Structural Reform Law of 1997, the decline in the population of young people under 18 years caused by the falling birth rate, the changes to be made in the curriculum for assistant nurses in 2002, under which the hours of training will be increased from 1,500 to 1,890 hours with the aim of improving the skills of such nurses, and the minimum requirement for full-time teachers to be increased from two to three, there has been a steady increase in the number of medical associations suspending such training. A total of 22 vocational nursing training centers suspended student recruiting in 2001.
The review of financial aid administration means that there can be no expectation of an increase in government subsidies in the foreseeable future. Although the sums involved were minimal, JMA was able to provide a fixed amount of financial assistance to assistant nurse training centers last year (2000), an expression of JMA’s intention to improve the aptitude of assistant nurses and to promote the continued existence of this kind of system.

Nonetheless, the Shodoshima assistant nurse training center, which has a student quota of 15, is continuing to work hard despite difficult management conditions, due to the realization of the necessity for assistant nurses in regional communities. Given the need for assistant nurses in the provision of regional health care, the sustained promotion of their continued existence is necessary, even in the face of difficult managerial circumstances.

Against a background of a declining birthrate and an aging population, it is necessary to promote awareness of the importance of nursing and nursing care and the active participation in its provision whether it is among one or many people. In recent years, there has been an increase in the number of students enrolling in assistant nurse training courses not only among junior and high school graduates but also from among working members of society, which is evidence of the emergence of a new perspective on the assistant nurse system.

Recent Trends in Regional Health Care

The surge in the declining birthrate and the aging population has hastened the need for reforms of the social security system including the health care system, and it is currently difficult to forecast the recent trends surrounding regional health care.

With the aim of breaking the tight financial conditions and activating the economy, the government’s Council on Economic and Fiscal Policy and the Council for Comprehensive Regulatory Reform, have made respective public announcements of “fundamental policies relating to economic and fiscal management and the structural reform of the economy and society,” so-called muscular indicators, and “interim reports pertaining to six important fields.”

These policies and the contents of the interim report are highly significant in the field of social security, and especially, in the field of health care.

The fundamental policies of the Council on Economic and Fiscal Policy were reported to the Prime Minister on June 21, 2001, and a cabinet decision was made on June 26th. Furthermore, the Council for Comprehensive Regulatory Reform released its interim report on July 24th.

One of the objectives of the Council on Economic and Fiscal Policy is to control the increases in total medical costs, while the Council for Comprehensive Regulatory Reform is striving for institutional reform. The content of the interim report released by the Council for Comprehensive Regulatory Reform contained the following specific policies in the field of health care; broadly, (1) public disclosure of health care information and the promotion of IT, (2) a review of the medical fee reimbursement system, (3) the reinforcement of the functions of insurers, and (4) the introduction of competition in the medical field while upholding efficiency. Dates have been set for the implementation of each of these measures.

In response to these measures, JMA has issued statements on both the fundamental policies of the Council on Economic and Fiscal Policy and the interim report of the Council for Comprehensive Regulatory Reform. It has also compiled a booklet for relevant parties and a pamphlet for the general public concerning its Structural Health Reform Plan. These have been widely distributed in a bid to gain understanding for the reforms being proposed by JMA.

JMA is strongly opposed to authorizing the
The entry of private companies, which will induce the collapse of regional health care, and to authorizing hybrid health care, i.e. differences in the content of health care based on the gap between the rich and the poor.

If the entry of profit-making enterprises to the field of health care is permitted, quite naturally, medical corporations, which currently come under various regulations, will also have to be systematically revised and incorporated as joint-stock corporations or limited liability corporations. This will in turn result in the entry of large capital, and additionally, of foreign capital, bringing about the interlocking of medical facilities under the auspices of such capital, so that health care will become nothing more than one step in the profit-making activities of corporations. The result will be the culling of unprofitable departments, for example, health care in remote areas, emergency health care and pediatric health care. As might be expected, this will result in the disintegration of community health care, inclusive of school health activities and public hygiene activities.

The review and reform of the organizational structure of society as a whole must be instituted without exception; this is an essential task at the dawning of the 21st century. Should regional health care collapse, this will destroy the foundations of Japan’s outstanding health care and will be a great misfortune to the people of this nation.

In Conclusion—the Future of Regional Health Care

In such ways, regional health care, which is on the verge of potential collapse due to internal factors such as the dimming awareness of health care in regional communities among members of the medical associations, and external factors such as the reforms from a financial standpoint, is approaching a crucial period in its history.

At this point and by way of conclusion, I would like to give some consideration to those areas that will need to be focused on if regional health is to be further developed.

In the first instance, in order for physicians and medical associations to protect the health of the population, a substantial reassessment of regional health care from its very beginnings is necessary to renew awareness of the significance of this branch of medicine.

Currently, health care is at a critical turning point; is it to be maintained for the common good or handed over to market mechanisms? If the principle of adhering to health care for common welfare is selected, then there is a need for reforms in perceptions and awareness. As physicians, each and every one of us needs to recall our reasons for choosing this profession and to once again consider how to conceive of and how to act in order to maintain and further develop regional health care for the population of this country.

I also consider that the revolutionary development in IT (information technology) will have a major impact on regional health care. While IT does connect to issues of the protection of personal information, in terms of the provision of health information to regional populations it can also be expected to produce new expansions in regional health care, by utilizing medical information on local communities accumulated and analyzed by medical associations, which has the potential to contribute to maintaining and improving health in the regions. JMA believes in the need to actively promote the provision of information on health care and medical practice and is accordingly in the process of setting up a website on the Internet to offer information on medical institutions to the Japanese public. Although digital patient records and medical fee receipts will rapidly gain popularity, I would like to request local medical associations to dedicate their activities to improving health standards for local communities in the regions by actively analyzing and providing information on regional health care.

In addition, declining birth rates and the
aging of the population are progressing ever more rapidly. However, while measures to address the aging population have been formulated within the field of regional health care, the formulation of countermeasures against falling birth rates has become an urgent task. In addressing this issue, it is not merely a question of enumerating individual measures on prenatal visits and emergency treatment for pediatric patients, or increasing child care facilities for convalescent pediatric patients or day-care centers. The construction of a child care support system to facilitate support from within society is important, as is elucidating the role to be played by local medical associations within such a system and the nature of the involvement of medical institutions. The prompt construction of this kind of child care support system will be a major pillar in regional health care, and is an important issue for this branch of health care in the future.

The construction of a child care support system and the socialization of child care are urgent tasks if we are to target the creation of a gender-free society in which both men and women can participate fully and a brighter future for the 21st century.