Seeking the Most Appropriate Healthcare System for the People in Japan

—A way to avoid weakening of community healthcare—

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Healthcare That Values the Regional Characteristics of Individual Communities

The rapid progression of declining birth rate and aging is a serious problem in Japan. Considering the current social security system of this country, we need to have a perspective different from that seen in the development of the economy and industry. The keywords in this context may include "safety" and "security," as well as "ensuring reliability," "overcoming of solitude," "mutual support," and "coexistence."

The serious issue of regional disparity is currently observed in Japan. While urban areas are seeing population growth with a larger ratio of the young generation and more opportunities for having and rearing children, rural areas are facing a decrease in population with dwindling support for elderly people.

Another social concern is the employment problem of non-regular workers. This single problem alone may trigger more and more problems in a chain reaction.

The medical profession should closely observe local problems in the communities and find out what underlies, when finding a policy for its solution. I believe this is the way to meet the people's expectations. In shaping these policies, we also need to take the geographical characteristics of Japan fully into account, that Japan extends vertically from Okinawa to Hokkaido.

Supporting Community Healthcare

Japan has long been the world's second-largest economic power with a gross national product of 400 to 500 trillion yen (US$4,211 to 5,263 billion).*2 Although the economy faltered somewhat after the bursting of the bubble, it recovered, and national wealth is now estimated to be 1,500 trillion yen (US$15,790 billion). Despite this enrichment, many people in Japan do not feel the affluence of the country because problems in the nation remain to be resolved such as a sense of anxiety in daily and future life, feeling of isolation because of self-support inability, and leading a lonely life.

Dilution of human relationships, which may cause fear of lack of support from others, increases solitariness among the people causing various problems. As Mr. Kunio Yanagida, a Japanese journalist, pointed out, the collapse of family relationships may be a significant factor underlying current social problems. During the era of high economic growth, many young people moved from rural to urban areas to make money, leaving elderly people behind. Although elderly people try to live independently as much as they can, they are being isolated with waning support from the community and are likely to become victims of disasters. Solitary deaths of elderly people are often reported in the media.

The production technology and economy in local communities have close relationships with

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those in the country as a whole. Without these relationships, enterprises and intensive industrial activities would stand still. However, individual people are often neglected in the expanding gap between the individuality of local communities and the general position related to the whole nation.

We must base our society on the concept of social common capital proposed by the economist Hirofumi Uzawa, who stated that individuals should be supported by society, their sense of values esteemed, and their pursuit of happiness advocated.

Health personnel should try their best to have the people better understand health insurance and pension systems as part of the social common capital. We should also recognize the increasing roles of community healthcare as a means to support families and help people return to communities for their livings. With respect to return to communities, I focus heavily on the behavior of baby-boomers born in the period around 1947–49, who have been making significant contributions to re-building and developing the economy of post-war Japan through their hard work.

Healthcare of Japan in Crisis

Community healthcare in such fields as pediatrics, obstetrics, and emergency medicine is now in a critical crisis. Medical institutions with childbirth facilities are closing down one after another, those offering pediatric care are going out of business, and the number of beds is decreasing. The increase rate of the number of physicians has been declining. These changes are having serious consequences across the country. Healthcare system reform in this situation must not follow traditional cost containment policies. Greater emphasis should be placed on the improvement of community healthcare and the healthcare delivery system. This recognition is shared by the National Council on Social Security, which was concluded recently. However, improvement of healthcare will require tremendous fund sources. The decision of the National Council on Social Security to strengthen community healthcare may be progress, albeit belated.

The Japan Medical Association (JMA) recognizes that we have come to an important turning point in the process of reforming the social security system of Japan.

The time when shortage and maldistribution of physicians became a substantial problem coincides with the beginning of the new clinical training program for physicians in Japan. The 2-year clinical training was introduced because young physicians were considered to need wide-ranging experience for 2 years after graduation rather than directly working in a specialty area. However, the maldistribution of physicians became manifested starting from this time. The program requesting non-compulsory 2-year training was implemented in 1968, the year of my graduation. I think that this was the source of many problems currently discussed.

Implications of the new clinical training program in the long history of the program have been a focus of discussion. Although I am not going to say that the period of clinical training should be shortened or elongated, I think that this program may be a cause of the present shortage and maldistribution of physicians.

Another important cause of the shortage physicians is the increase in medical lawsuits, exemplified by the case of Oono Hospital in Fukushima Prefecture in northern Japan. In this case, the police arrested an ob-gyn physician accused of the criminal offense of medical accident despite his earnest clinical practice. This arrest occurred not shortly after the incident but after a period of more than a year, and the possibility of such intervention in clinical practice greatly dispirited specialist physicians engaged in high-risk, difficult treatment and in supporting the central core of the healthcare delivery system. Many physicians lost motivation to continue working with high-risk cases in the face of shortage of physicians.

Lastly, the largest cause lies in government policy to curtail health expenditure. The need for vigorous investment in the healthcare section has been understood by neither the government nor the citizens. The universal health insurance system of Japan ensuring the provision of care to everyone at reasonable prices has come to be taken for granted, like water and electricity supplied indefinitely at the turn of a faucet or flip of a switch.

I saw the hard work of obstetricians during my internship long time ago. In the face of the present shortage of physicians, hospital-employed physicians are working long hours with frequent

night duties. Working for a day after a night duty with little sleep, they are expected to succeed in difficult treatment or surgery with no reinforcements coming to their assistance. Physicians fight alone and often burn out. Because this fact is not sufficiently known to the public, it is physicians, nurses, and midwives who are blamed once an incident has occurred. We need to urge the public to understand this situation. To do this, the JMA is ready to take further action in cooperation with specialist societies.

The percentage of female physicians is increasing year by year. The lack of sufficient measures to support the healthcare activities of female physicians has been causing a major loss to our society. We should address this problem more seriously in the years to come.

Cutback in the Number of Long-term Care Beds

The aging of the population in communities and the isolation and solitary deaths of elderly people are important problems as discussed above. Although there were approximately 380,000 beds for long-term care including those under long-term care insurance and those under medical insurance in 2005, the healthcare cost-saving measure in the bill related to healthcare system reform proposes to abolish those under long-term care insurance and reduce the number of long-term care beds under medical insurance to 150,000.

The total number of long-term care beds has already dropped by 13,000 from 367,000 as of 2007. People who should be staying in long-term care facilities and hospitals are living at home, because they have nowhere else to go, and this accelerates the solitude of these people. The number of long-term care beds will be curtailed to a much smaller number by the time baby-boomers reach the age of 75.

Terms such as "healthcare refugees" and "long-term care refugees" have been coined to describe this situation. The consequences can be disastrous in many regions unless prompt measures are taken.

The need for healthcare arises in various settings, including the acute phase in pediatrics and obstetrics, emergency medicine, chronic diseases mainly of elderly patients, and long-term care recipients who sometimes need medical treatment due to infection, swallowing difficulty, malnutrition, dehydration, and pressure sores. Therefore, we need to have a comprehensive healthcare system that can broadly provide diversified support to community people covering from children to the elderly.

Healthcare at Hospitals and Clinics

Current healthcare can be broadly divided into outpatient care, hospitalized care, home care, etc. Recent technological innovations have blessed us with most advanced medical technology in ambulatory care as well. Some procedures that previously needed hospitalization for a week need only 1 day, called 1-day surgery. We see less invasive operations performed in medical facilities these days. There is a wide range of cutting-edge technologies developed that are both less invasive and less bleeding, such as endoscopic surgery, microscopic surgery, and the use of robots and other equipment.

Ambulatory care is provided both at hospitals and clinics in Japan. The number of hospitals and clinics providing ambulatory care reversed around 1990. As more patients have come to choose hospital outpatient departments, hospitals have come to need more physicians to meet this demand. We need to know correctly what is happening and estimate the number of physicians and other health professionals who will be needed in the future to avoid the confusion that may otherwise arise in healthcare settings.

Aside from hospitals, hospitalized care is provided at clinics with beds that support community healthcare. In fact, childbirth services are mostly provided at clinics with beds in Japan. These are operated by the clinics with beds in many forms, including those specialized in particular clinical areas and those dedicated to long-term care. We need to take these resources into account to discuss future healthcare in our country. It becomes all the more important to consider how we should support both specialization of medicine that is increasingly sophisticated and primary care that is closely linked to the healthcare of community inhabitants.

A new system for providing healthcare based on collaboration between hospitals and clinics cannot be developed solely depending on administrative regulations. The medical profession itself needs to work toward the establishment of a

community healthcare delivery system. This is the task of local medical associations, specialist associations, and societies. These organizations must provide information to their respective members and citizens, and construct a solid foundation for a healthcare delivery system that comprehensively supports the life of local inhabitants.

The types of healthcare services provided by medical institutions are changing, as is the disease structure. Looking at infections alone, we have viral and other types of hepatitis, AIDS, new influenza posing another threat, and conventional influenzas A and B. We have entered the age when antibiotics are not necessarily the best option.

Response to Shortage of Physicians

There is a plan of the government in Japan to increase the number of medical school students, but it requires 8 to 10 years for a medical graduate to become a fully trained medical profession. As urgent measures to ensure healthcare, we need first and foremost to raise medical fees. Demand to raise medical fees is often responded by the media as if the JMA were the leader of greedy physicians. In this respect, it is necessary to explain to the citizens why this demand is imperative to support healthcare in Japan from a broad perspective.

The importance of the roles played by female physicians is expected to expand increasingly in the future. There is a need to develop a system to provide support in medical areas where female physicians may take leadership. They usually undergo the period of marriage, pregnancy, childbirth, and child rearing, and may have difficulty in returning to work after these phases. If they need to find a job in a different specialty area from their previous one when they return, they cannot benefit from their previous career. We need a system that ensures their consistent work in an area throughout their career.

"Family Doctors" and Their Roles

Clinic physicians in Japan are close to patients and their families in that they see the patient from his/her childhood to older age together with his/her other family members. They have a lot of information about not only the health of the patient but also his/her lifestyle and how and in what environment he/she was raised because clinic physicians ordinarily have their office near their patients, which means that they share the living area. In this sense, they are called "family doctor" or "clinic physician."

However, I am strongly against the position of accepting the system in which community-based physicians are systematically and mandatory registered in the community and become registered physicians mainly working as referral services. I also object to the creation of "general physicians" and "general departments" predicated on per-capita payment. Family doctors or clinic physicians in Japan do not fit well in such systems. The "general departments" and "general physicians" proposed by the government would not provide healthcare based on the full knowledge of medical and health information covering patients and their family members, but would mainly refer registered patients to somewhere else. Although they would have medical knowledge sufficient for making referrals, they are not likely to provide healthcare at their own facilities. If a patient developing a fever, stomach ache, or sudden wasting asked, "What should I do?", they would say, "Go to such-and-such hospital next week, next month, or in a few months." This is what happened in the U.K. as a result of health cost containment policy. After the Blair administration came to power and increased the social security budget, this situation is now changing for the better. In the worst of times, hundreds of thousands of patients were reportedly on the waiting list for hospitalization or examination at hospitals. Because patients have free access that enables all citizens to directly receive appropriate healthcare with reasonable fees in hospitals in Japan, they are entitled to visit any medical institution they choose. Family doctors and clinic physicians are there to help patients in this process. In this system, the clinic physician can refer a patient to an appropriate medical institution if the condition is beyond the capacity of the physician. When a patient complains of a fever, it is the clinic physician who makes the decision on whether to treat the patient by him/herself or to make a referral for detailed examination.

In this sense, it is valuable for family doctors or clinic physicians to work closely with patients, giving advice on various health problems and providing proper primary care. The most appropriate and reliable healthcare services for all

people available at any place are delivered at the community level in the current system of Japan. We should continue to maintain this excellent system to the future.

Maintenance and Further Development of the Universal Health Insurance System

The universal health insurance system created in 1961 is now facing a serious crisis. Despite its long history, I think that the system is still in the process of development. Each different insurer is operated independently, and the costs and benefits to the insured also vary. It is absolutely necessary to develop the system to achieve equality in cost sharing and benefits so that everybody can receive a reasonable level of health services with uniform cost sharing.

A safe and compassionate healthcare system is what the nation needs. This system should allow us to maintain a high standard of healthcare in accordance with the current advanced medical technology. We should strive to establish such a system. I heard that a parliament member visiting the U.S. received hospitalized care for 2 days and was charged 1,800,000 yen (US$18,947). This is impossible in Japan. If it happened in Japan, a nation with a lower health expense ratio to GDP among the OECD nations, it would become a focus of serious public concern.

Medical institutions are nowadays providing healthcare services in very difficult financial conditions as they are supporting the current insurance system. The break-even percentage, an important index in hospital management describing income and expenditure, is exceeding 90%, 95%, or even 98% in most hospitals and is higher

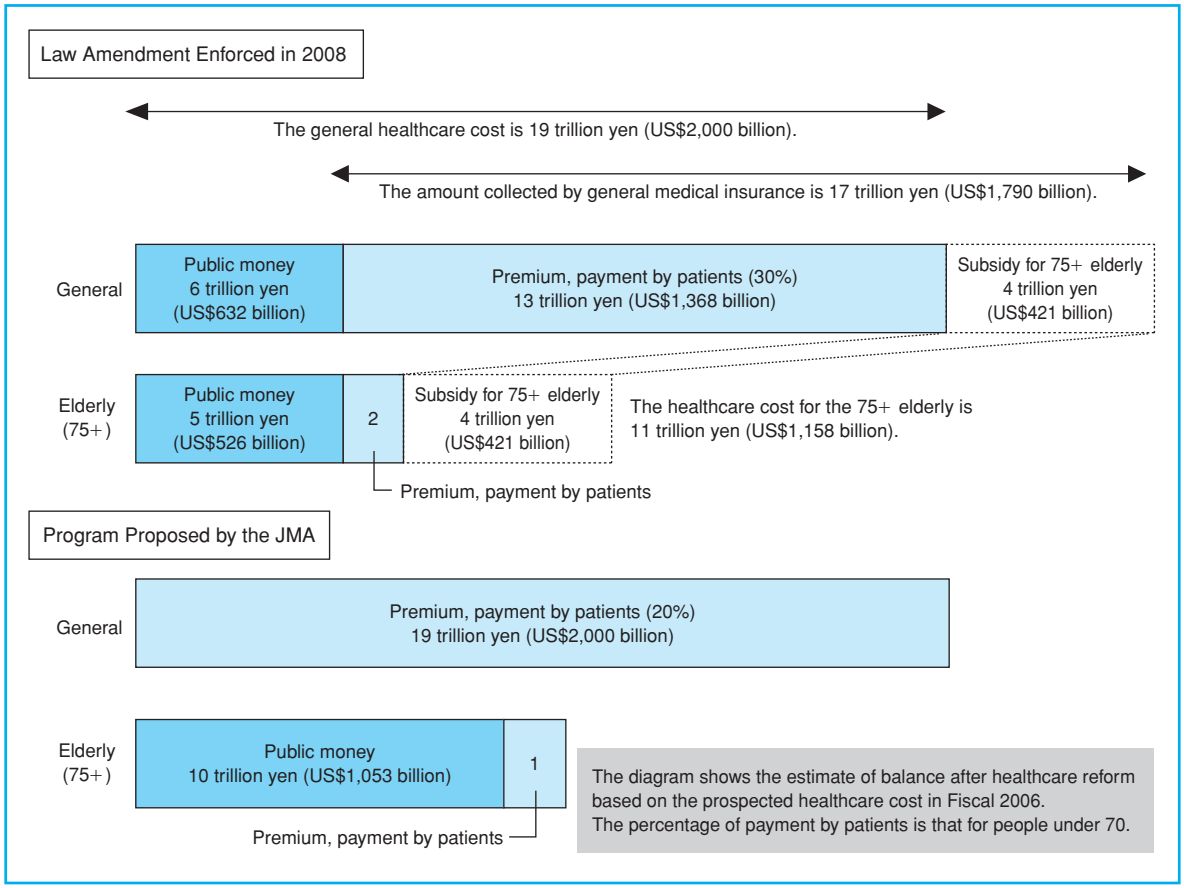

Fig. 1 Healthcare program for the elderly aged 75 and over

"Public money" such as livelihood protection has been excluded from the diagram. Subsidies for the office cost of employees' health insurance have also been excluded. The scale is not proportional.

than 100% in not a few. A rate above 100% means bankruptcy of a business enterprise, and such an enterprise would be transferred to a different owner, replace all executives, or go out of business. Medical professionals should raise their voices to make people understand that they are working hard in such conditions. They should also tell people the fact that the number of medical institutions exceeding 90% in break-even percentage increased dramatically after 2000. This is an important message, because cutback in social security cost leads to the collapse of security of life and health, which are the most precious for the nation.

After the Meiji Restoration in the latter half of the 19th century, Japan endeavored to expand its armaments and build a country with economic wealth and military strength. As we look at the situations in the world, particularly international and regional conflicts, we find that nations giving priority to social security achieve the trust of their people and receive respect from other countries. This is one of the reasons that modern Japan has always developed policies based on the Constitution. The path that Japan should follow in the future is to strengthen social security systems and build a country where people can enjoy daily life with peace of mind. The book "Human Security Now," authored by Sadako Ogata and Amartya Sen and published by the United Nations, states that countries should strive to achieve human security. That is the primary policy to promote world peace controlling wars and conflicts.

Financial Resources for Healthcare Costs

The special healthcare program for the elderly aged 75 and over, which started in 2008, is poorly accepted by the people in Japan. As an alternative, the JMA has proposed the healthcare program for the elderly illustrated in **Fig. 1**. This system, designed for people over the age of 75 presenting elevated risk of morbidity and constant need for healthcare and long-term care, provides support when healthcare becomes necessary, both in the case of people who have no income and in the case of those who have no income but have property. This ideal system, I believe, would be accepted by elderly people with gratitude. I believe that this alternative program will ensure that the people are thankful for having been born in this country and having lived a long life. It will also take strong measures to help increase the childbirth rate.

The problem here is how to create the necessary funds. The national budget exceeds 500 trillion yen (US$52,632 billion) in total, including over 80 trillion yen (US$8,421 billion) in the general account and over 400 trillion yen (US$42,105 billion) in special accounts. Excluding duplications, the real amount is considered to fall somewhere between 200 and 300 trillion yen (US$21,053 and 31,579 billion). While the general account is closed at the end of each fiscal year, special accounts are carried over to the next year. Because there is a surplus of over 40 trillion yen (US$4,211 billion) in special accounts, I hope measures may be devised to return a part of this amount to the general account.

The fund sources for public medical insurance and long-term care insurance include not only public money but also the insurance premiums paid by the people insured. It is probable that much of this money from the people is used to cover administrative costs and management costs, and this should be returned in a rational way so that equality of insurance premiums may be achieved.

The insurance premium is 82/1,000 for the Japan Health Insurance Association. For employees' health insurance, it ranges from about 53/1,000 at the lowest to 76/1,000 at the highest. Even if the premium is 76/1,000, this load is not shared evenly between the person insured and the employer. The person insured bears less than 50% and the employer bears more than 50%. On the other hand, mutual aid association insurance for national public servants and that for local public servants are partly supported by tax revenues. The fact that employers are bearing more than 50% indicates the need for improvement from the standpoint of unification or equalization of insurance. Looking at the situation of small enterprises participating in the Japan Health Insurance Association, I want to emphasize the need to correct things like this before discussing social inequity and economic disparities in society.

The debate around consumption tax has become active recently. Uses of the consumption tax are earmarked by the General Provisions of the Budget. While a part is returned to the general account, most of it is fed to basic pension, elderly

care, and long-term care insurance. Therefore, a rise in the consumption tax rate would not directly lead to an increase in the money allocated to healthcare under the current laws. Simply raising consumption tax without revising regulations does not solve the problem.

Furthermore, because consumption tax is not covered by medical insurance, this tax generates a loss on the part of health institutions or payers of consumption tax. Finding a way to correct this problem is essential for the stable management of health institutions.

Conclusion

Healthcare in the past has been promoted for the single purpose of treating diseases. Nowadays, emphasis should be placed more on prevention, and we need to focus on how to live long without developing diseases and how to quickly recover from a disease once it develops. It will become increasingly important in the future for the medical professionals to consider how to build measures for health maintenance or disease prevention.

The medical profession should help shape a society in which people can enjoy wellbeing even in their older age. For this sake, we need to provide quality, compassionate healthcare services, which deliver a high standard of healthcare at reasonable prices.

There is an approach called narrative-based medicine (NBM), which is the practice of healthcare that starts from listening to and respecting to the narrative of patients about their "experience." The JMA also wants to hear the opinions of people from various fields and reflect them in healthcare policies.