# [2] Health and Medical Services

## (1) Health Care Insurance

### Health Care Insurance System

**Overview**

**Outline of Health Care Insurance System**

(As of April 2021)

| System | | | Insurer (as of the end of March 2020) | Number of subscribers (March 2020) Insured Families 1,000 persons | Insurance benefits | | | | | Financial resources | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Medical care benefits | | | | Cash benefits | Premium rate | State subsidy |
| | | | | | Co-payment | High-cost medical care benefit, Unitary high-cost medical/long-term care system | Hospital meal expenses | Hospital living expenses | | | |
| Health Insurance | General employees | JHIA-managed Health Insurance | Japan Health Insurance Association | 40,443 [24,793 / 15,650] | After reaching compulsory education age until age 70 30%<br>Before reaching compulsory education age 20%<br>70 or older but younger than 75 20% (30% for persons with more than a certain amount of income) | (High-cost medical care benefit system)<br>• Maximum co-payment<br>(Persons younger than 70)<br>(average annual income: over approximately 11.60 million yen) ¥252,600 + (medical expenses – ¥842,000) x1%<br>(average annual income: between about 7.70 million yen and about 11.60 million yen) ¥167,400 + (medical expenses – ¥558,000) x1%<br>(average annual income: between about 3.70 million yen and about 7.70 million yen) ¥80,100 + (medical expenses – ¥267,000) x 1%<br>(average annual income: under approximately 3.70 million yen) ¥57,600<br>(exempted from residence tax) ¥35,400<br>(Persons aged 70 or older but younger than 75)<br>(average annual income: over approximately 11.60 million yen) ¥252,600 + (medical expenses – ¥842,000) x1%<br>(average annual income: between about 7.70 million yen and about 11.60 million yen) ¥167,400 + (medical expenses – ¥558,000) x1%<br>(average annual income: between about 3.70 million yen and about 7.70 million yen) ¥80,100 + (medical expenses – ¥267,000) x 1%<br>(average annual income: under approximately 3.70 million yen) ¥57,600<br>outpatient (per person) ¥18,000(¥144,000/year)<br>(Household exempted from residence tax) ¥24,600, outpatient (per person) ¥8,000<br>(Especially household with lower income among household exempted from residence tax) ¥15,000, outpatient (per person) ¥8,000<br>• Per-household standard amount<br>If more than one person younger than 70 pay ¥21,000 or more in a single month, per-household standard amount is added to the benefits paid<br>• Reduced payment for multiple high-cost medical care<br>For persons who have received high-cost care three times within a twelve-month period, the maximum co-payment of the fourth time and up will be reduced to:<br>(Persons younger than 70)<br>(average annual income: over approximately 11.60 million yen) ¥140,100 (average annual income: between about 7.70 million yen and about 11.60 million yen) ¥93,000 (average annual income: between about 3.70 million yen and about 7.70 million yen) ¥44,000 (average annual income: under approximately 3.70 million yen) ¥44,000<br>(exempted from residence tax) ¥24,600<br>(Persons aged 70 or older but younger than 75)<br>(average annual income: over approximately 11.60 million yen) ¥140,100 (average annual income: between about 7.70 million yen and about 11.60 million yen) ¥93,000 (average annual income: between about 3.70 million yen and about 7.70 million yen) ¥44,000 (average annual income: under approximately 3.70 million yen) ¥44,000<br>• Reduced payment for persons receiving high-cost medical care for a long period<br>Maximum co-payment for patients suffering from hemophilia or chronic renal failure requiring dialysis, etc.: ¥10,000<br>(patient younger than 70 with over average annual income of 7.70 million yen, receiving dialysis: ¥20,000<br>(Unitary high cost medical/long-term care benefit system)<br>Reduced payment for persons whose total co-payments of health care and long-term care insurances for a year (every year from August to July of the next year) is extremely high. Maximum co-payment is determined carefully according to their income and age. | (Co-payment for meal expenses)<br>• Households with residential tax Per meal ¥460<br>• Household exempted from residence tax Per meal first 90 days ¥210<br>Per meal after 90 days ¥160<br>• Lower income household exempted from residence tax Per meal ¥100 | (Co-payment for living expenses)<br>• General (I) (II) (III) Per meal ¥460 + Per day ¥370<br>• Household exempted from residence tax Per meal ¥210 + Per day ¥370<br>• Lower income household exempted from residence tax Per meal ¥130<br>• Per day ¥370<br>• Applicable to those aged 65 or older in long-term care beds<br>• For patients with intractable/rare diseases, etc. and thus in high need for inpatient medical care, the amount of co-payment is the same as standard co-payment for meal expenses | • Sickness and injury allowance<br>• Lump-sum birth allowance, etc. | 10.00% (national average) | 16.4% of benefit expenses, etc. |
| | | Society-managed Health Insurance | Health Insurance Societies 1,388 | 28,837 [16,352 / 12,485] | | | | | Same as above (with additional benefits) | Different among health insurance associations | Fixed amount (subsidy from budget) |
| | The insured under Article 3-2 of the Health Insurance Act | | Japan Health Insurance Association | 17 [12 / 5] | | | | | • Sickness and injury allowance<br>• Lump-sum birth allowance, etc. | Per day Class 1: ¥390 Class 11: ¥3,230 | 16.4% of benefit expenses, etc. |
| Seamen's Insurance | | | Japan Health Insurance Association | 117 [58 / 59] | | | | | Same as above | 9.60% (sickness insurance premium rate) | Fixed amount |
| Mutual aid associations | National public employees | | 20 mutual aid associations | 8,545 [4,565 / 3,980] | | | | | Same as above (with additional benefits) | – | None |
| | Local public employees, etc. | | 64 mutual aid associations | | | | | | | – | |
| | Private school teachers/staffs | | 1 Corporation | | | | | | | – | |
| National Health Insurance (NHI) | Farmers, self-employed, etc. | | Municipalities 1,716 | 29,324 Municipalities 26,599 NHI associations 2,726 | | | | | • Lump-sum birth allowance,<br>• Funeral expenses | Calculated for each household according to the benefits received and ability to pay<br>Levy calculation formulas differ among insurers | 41% of benefit expenses, etc. |
| | | | NHI associations 162 | | | | | | | | 28.4～47.4% of benefit expenses, etc. |
| | Retired persons under Employees' Health Insurance | | Municipalities 1,716 | | | | | | | | None |

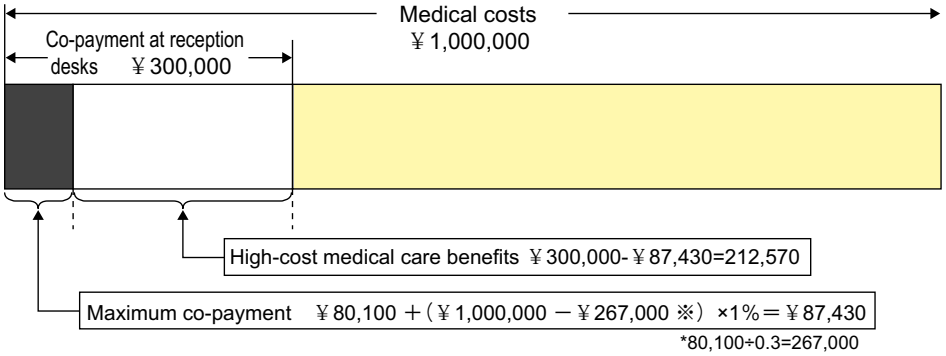
| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Medical care system for the elderly aged 75 and over | [Implementing bodies]<br><br>Wide area unions for medical care system for the elderly aged 75 and over<br><br>47 | 18,032 | 10%<br>(30% for persons with more than a certain amount of income) | (average annual income:<br>over approximately 11.60 million yen)<br>¥252,600 + (medical expenses – ¥842,000) x1%<br>(average annual income:<br>between about 7.70 million yen and about 11.60 million yen)<br>¥167,400 + (medical expenses – ¥558,000) x1%<br>(average annual income:<br>between about 3.70 million yen and about 7.70 million yen)<br>¥80,100 + (medical expenses – ¥267,000) x 1%<br>(average annual income:<br>under approximately 3.70 million yen) ¥57,600<br>outpatient (per person) ¥18,000(¥144,000/year)<br>(Household exempted from residence tax)<br>¥24,600, outpatient (per person) ¥8,000<br>(Especially household with lower income among household exempted from residence tax)<br>¥15,000, outpatient (per person) ¥8,000<br>• Reduced payment for multiple high-cost medical care<br>(average annual income:<br>over approximately 11.60 million yen) ¥140,100<br>(average annual income:<br>between about 7.70 million yen and about 11.60 million yen) ¥93,000<br>(average annual income:<br>between about 3.70 million yen and about 7.70 million yen) ¥44,000<br>(average annual income:<br>under approximately 3.70 million yen) ¥44,000 | Same as above | Same as above, except for<br>• Recipients of old-age Welfare Pensions<br>Per meal<br>¥100 | • Funeral expenses , etc. | Calculated using the amount of the per capita rate and income ratio of insured persons provided by wide area unions<br><br>About10% of benefits, expenses, etc. are borne as insurance premiums | • About10% of benefits, expenses, etc. are borne as insurance premiums (Breakdown of public funding)<br>National : Prefectures Municipalities<br>4 : 1 : 1<br><br>In addition, about 40% of the benefits will be borne by the working generation as support for the latter-stage elderly. |

(Note) 1. Insured persons of medical care system for the elderly aged 75 and over include those aged 75 or older or 65-75 certified as having a specific disability by a wide area union.
2. Persons with a certain amount of income include those with a taxable income of ¥1.45 million (monthly income of ¥280,000 or more) or persons whose total amount of gross income, etc. after deducting the basic amount of insured persons belonging to the 70-74 age group households is ¥2.10 million or more. However, those in households of two or more elderly with a taxable income of less than ¥5.20 million, and those of a elderly single-person household with a taxable income of 3.83 million and those with a total old income not more than ¥2.10 million are excluded. Lower income households exempted from residence tax is considered to be those with a pension income of ¥800,000 or less, etc.
3. Fixed-rate national subsidy for National Health Insurance shall be at the same level as that for the Japan Health Insurance Association-managed Health Insurance for those exempt from application of Health Insurance and those newly subscribed to the National Health Insurance on and after September 1, 1997.
4. The sums in the breakdown may not equal the total due to rounding.
5. The premium rate of Seamen's Insurance is the rate after the deduction resulting from the measure to reduce the burden of insurance premiums for insured persons (0.50).

## Detailed Information 1 Outline of High-Cost Medical Care Benefit System

○ The high-cost medical care benefit system is for use in avoiding co-payments made for medical costs becoming too expensive for family budgets. Under this system, households pay co-payments for medical costs at the reception desks of medical institutions but then get reimbursed by insurers for any amount exceeding the monthly maximum amount.
(*1) In case of hospitalization, a benefit in kind system has been introduced in which the monthly payment at the reception desks of medical institutions is limited to the maximum co-payment.
(*2) In case of outpatient treatment, a benefit in kind system was introduced in April 2012 for use when the monthly payment exceeds the maximum co-payment at the same medical institution.
○ The maximum co-payment is set up according to insured persons' income.

(For example) Below 70 years old/annual income: about ¥3.7 million—about ¥7.7 million (co-payment of 30%)

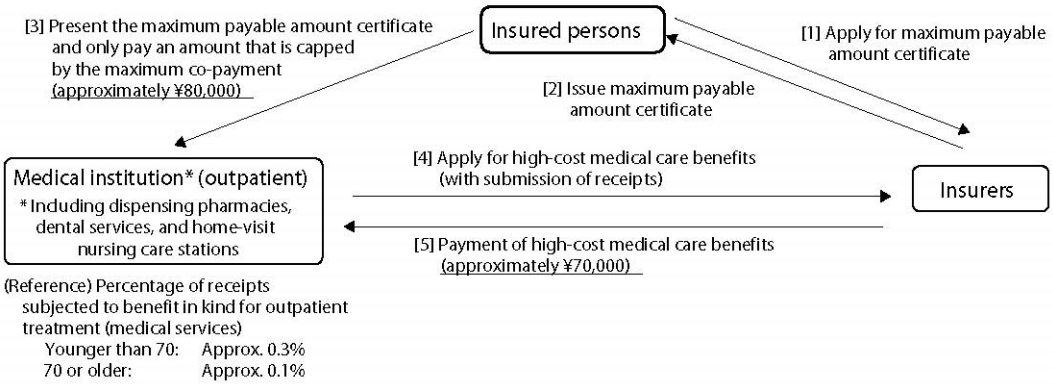



(Note) Per-household addition system
Even when partial co-payment does not exceed the maximum co-payment in the same medical institution, partial co-payments (those under 70 is ¥21,000) during the same month at multiple medical institutions can be added up. If the added-up sum exceeds the maximum, the high cost medical care system is applied.

## Detailed Information 2 Response to Benefit in Kind for Outpatient Treatment

○ A method (benefit in kind) of reducing the burden of patients paying high drug costs will be introduced for outpatient treatment in addition to conventional hospital treatment (enforced in April 2012). The method involves that when a patient receives outpatient treatment at the same medical institution and their monthly co-payment exceeds the maximum co-payment the insurer then makes the payment to the medical institution rather than the patient applying for the high-cost medical care benefits and receiving the benefits later, thus ensuring that the patient is only required to pay an amount which is capped at the maximum co-payment.

Medical expense ¥500,000 (co-payment of 30%) Annual income: about ¥3.7 million –about ¥7.70 million for persons below 70 years old




(Reference) Percentage of receipts subjected to benefit in kind for outpatient treatment (medical services)
Younger than 70: Approx. 0.3%
70 or older: Approx. 0.1%

Basic mechanism of benefit in kind

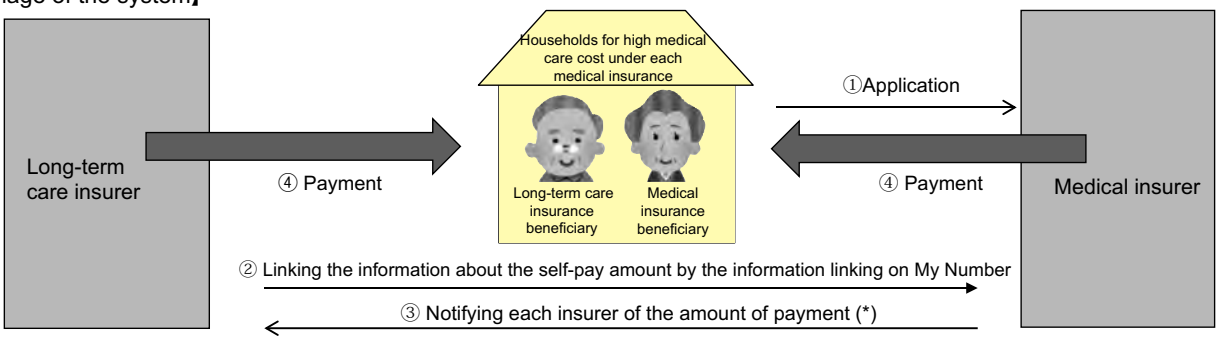
[1] Insured persons, etc. apply to insurers, etc. for a maximum payable amount certificate to be issued. (Same treatment as with inpatient treatment)
[2] Insurers issue insured persons with maximum payable amount certificates according to the income category of their household. (On an individual basis)
[3] Insured persons present the maximum payable amount certificates at the counters of medical institutions. Medical institutions calculate the amount of the co-payment of insured persons, etc. on an individual basis and do not collect the amount exceeding the maximum co-payment, etc.
* Co-payment for the 1% addition must be made even if the maximum co-payment has been exceeded.
[4] Medical institutions will require from insurers the amount of high-cost medical benefits in addition to receipts.

## Detailed Information 3 Outline of High Cost Long Term Care Total Medical Care Cost System

○ The High Cost Long Term Care Total Medical Care Cost System is where the upper limit amount for the total of medical and long-term care self-payment costs in addition to the upper limit amounts of th self-payment costs respective for the medical costs and long-term care costs one year (August 1st to July 31st of the following year) is set and the these two insurance programs jointly cover the costs exceeded such upper limit to mitigate the self-payment costs of the insured.
① Payment requirement: If the sum of self-payment of medical insurance and nursing care insurance exceeds the limit set for each income category in a household with medical insurance, an amount exceeding the limit is paid from the total amount.
② Limit amount: Set according to the income and age of the insured
③ Cost burden: Both of medical and long-term care insurers share the total burden according to the ratio of each self-payment amount.

*In long-term care, the same system is called the "High Cost Total Medical Care (Prevention) Service Cost".

【Image of the system】

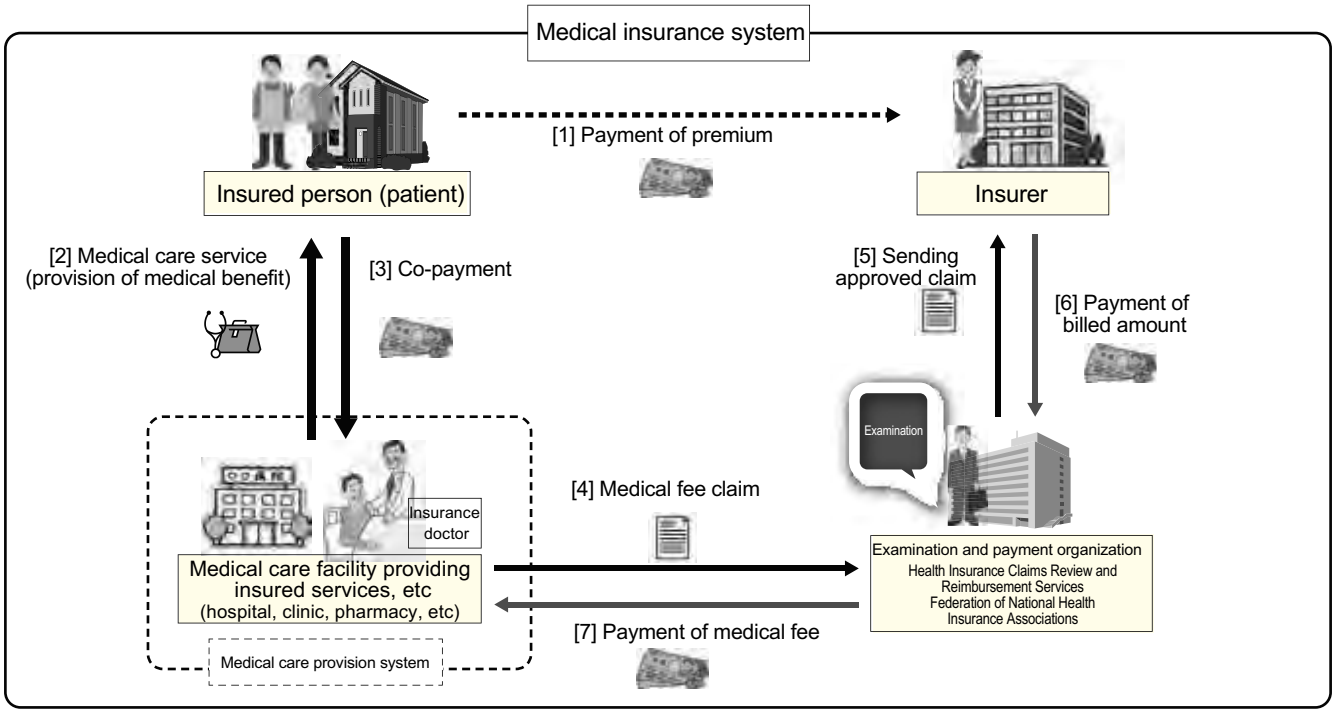



(*) Calculating the total amount of annual self-payment amount from the information on self-payment amount obtained in (2), to calculate the amount of High Cost Total Medical Care payment amount. This calculated amount of payment is apportioned among the insurers according to the ratio of the self-payment amount, and the amount to be paid by each insurer is notified.

# Insured Medical Treatment System

**Overview**

**Conceptual Chart of Insured Medical Treatment**




Medical fees are classified into three types: medical, dental, and dispensing fees.

The medical fee is calculated by adding stipulated numbers of points for the individual medical activities provided (so-called "fee-for-service system"). The unit price for one point is ¥10. For a typhlitis hospitalization case, for example, the first visit fee, the hospitalization fee multiplied by the length of stay (days), the typhlitis surgery fee, the test fee and the drug fee are added to one another and medical care facility providing insured services will receive the total amount less the patient's co-payment from the examination and payment organization.

**Detailed Information** **Outline of the FY 2020 Medical fees revision**

## The FY 2020 Medical fee revision

### Medical fee revision

**1. Medical fees ＋0.55%**

*1 Of which, revised portion except for * 2 +0.47%

Revision rate of each fee
- Medical services +0.53%
- Dental services +0.59%
- Dispensations +0.16%

*2 Of which, the special response to work style reforms of the employed doctors at emergency hospitals with utilizing consumption tax revenue + 0.08%

**2. Drug price**

[1] Drug price▲ 0.99%

*2 Of which, Revisions to the actual prices, etc. ▲ 0.43%,
Revisions to the recalculation of market expansion, etc. ▲ 0.01%

[2] Material price revision ▲ 0.02%

* Of which, revision to the actual price, etc. ▲ 0.01%

### Responding to work style reform for the employed doctors

**As the medical fee** **Public expenses about 12.6 billion yen**

**As the community medical care comprehensive securing fund** **Public expenses about 14.3 billion yen**

Regarding the response to work style reform for employed doctors, overtime work exceeding the upper limit will be resolved as soon as possible toward the application of the upper limit regulation for overtime work for doctors and the end of application of the provisional special level. In order to achieve above, the measures in medical fees and the measures of the Regional Medical Care Comprehensive Security Fund will be considered, in addition to the institutional measures to promote shortening of working hours by medical institutions.

**Detailed Information** **Outline of the FY 2020 Medical fees revision**

# Basic Understanding of the FY2020 Medical fee revision

## Basic recognition of the revision

- ▶Realization of the social security system for all generations towards extending a healthy life and coming of a 100-year-old life society
- ▶Realization of medical care accessible to patients and citizens
- ▶Realization of a society where people can receive appropriate medical care with confidence regardless of where they live, and promotion of reforms in the working styles of doctors and others
- ▶Securing the stability and sustainability of social security systems, and harmonization with the economy and finances

## Basic Perspectives and Specific Directions for Revision

**1 Reducing the burden on medical personnel and promoting reforms in the working styles of physicians, etc. [Priority Issues]**

[Examples of Specific Directions]

- Evaluation of efforts to improve the working environment for doctors, etc., such as long working hours
- Evaluation of emergency medical care systems requiring urgent action from the perspective of securing regional medical care
- Promotion of the use of ICT that contributes to the efficiency of operations

**2 Realization of high-quality medical care that is accessible, safe, and secure for patients and the public**

[Examples of Specific Directions]

- Evaluation of family doctors' functions
- Promotion of the provision of necessary information and consultation support for patients, efforts to prevent the progression of serious diseases and contribute to balancing medical treatment and work
- Promotion of evaluation that also focuses on outcomes
- Appropriate evaluation of areas that require prioritization
- Promotion of prevention of progression of oral diseases, enhancement of responses to the decline in oral functions, and promotion of dental care with consideration for quality of life
- Prioritization and optimization of necessary evaluations to promote a structural shift in pharmacies from physical to human services, and evaluation of in-hospital pharmacist services
- Utilization of ICT in medical care

**3 Differentiation and strengthening of medical functions, and promotion of cooperation and the Community-based Integrated Care System**

[Examples of Specific Directions]

- Evaluation of inpatient care based on medical functions and patients' conditions
- Functional separation of outpatient care
- Ensure high quality home medical care and home nursing care
- Efforts to promote a Community-based Integrated Care System

**4 Improving the stability and sustainability of the system through optimization and efficiency**

[Examples of Specific Directions]

- Promotion of the use of generic drugs and follow-on biologics
- Utilization of cost-effectiveness evaluation system
- Appropriate evaluation based on prevailing market prices, etc.
- Evaluation of inpatient care according to medical functions and patients' conditions (Re-listed)
- Functional differentiation of outpatient care and promotion of prevention of progression of serious diseases (Re-listed)
- Promotion of appropriate use of pharmaceuticals through collaborative efforts among physicians, in-house pharmacists, and pharmacy pharmacists

**Detailed Information** **Outline of the FY 2020 Medical fees revision**

# Outline of the FY 2020 Medical fee revision

### Ⅰ Reducing the burden on medical personnel and promoting reforms in the working styles of physicians, etc.

1.Evaluation of emergency medical care systems requiring urgent action from the perspective of securing regional medical care
2 Evaluation of efforts to improve the working environment for doctors, etc., such as long working hours
3 Promotion of team medicine, etc. for task shifting or task sharing
4 Promotion of the use of ICT that contributes to the efficiency of operations

### Ⅱ Realization of high-quality medical care that is accessible, safe, and secure for patients and the public

1.Evaluation of family doctors' functions
2 Promotion of information provision and consultation support necessary for patients
3 Enhancing multi-professional cooperation, including with local communities
4 Prevention of progression of diseases
5 Promotion of measures contributing to balancing medical treatment and work
6 Promotion of evaluation that also focuses on outcomes
7 Appropriate evaluation of areas that require prioritization
8 Appropriate evaluation and steady introduction of advanced medical technologies, including new technologies such as innovations in pharmaceuticals, medical equipment, and testing
9 Promotion of prevention of progression of oral diseases, enhancement of responses to the decline in oral functions, and promotion of dental care with consideration for quality of life
10 Evaluation of pharmacies according to their family doctor functions in the community, prioritization and optimization of necessary evaluations to promote structural transformation of pharmacies from physical to human services, and evaluation of in-hospital pharmaceutical services
11 Utilization of ICT in medical care

### Ⅲ Differentiation and strengthening of medical functions, and promotion of cooperation and the Community-based Integrated Care System

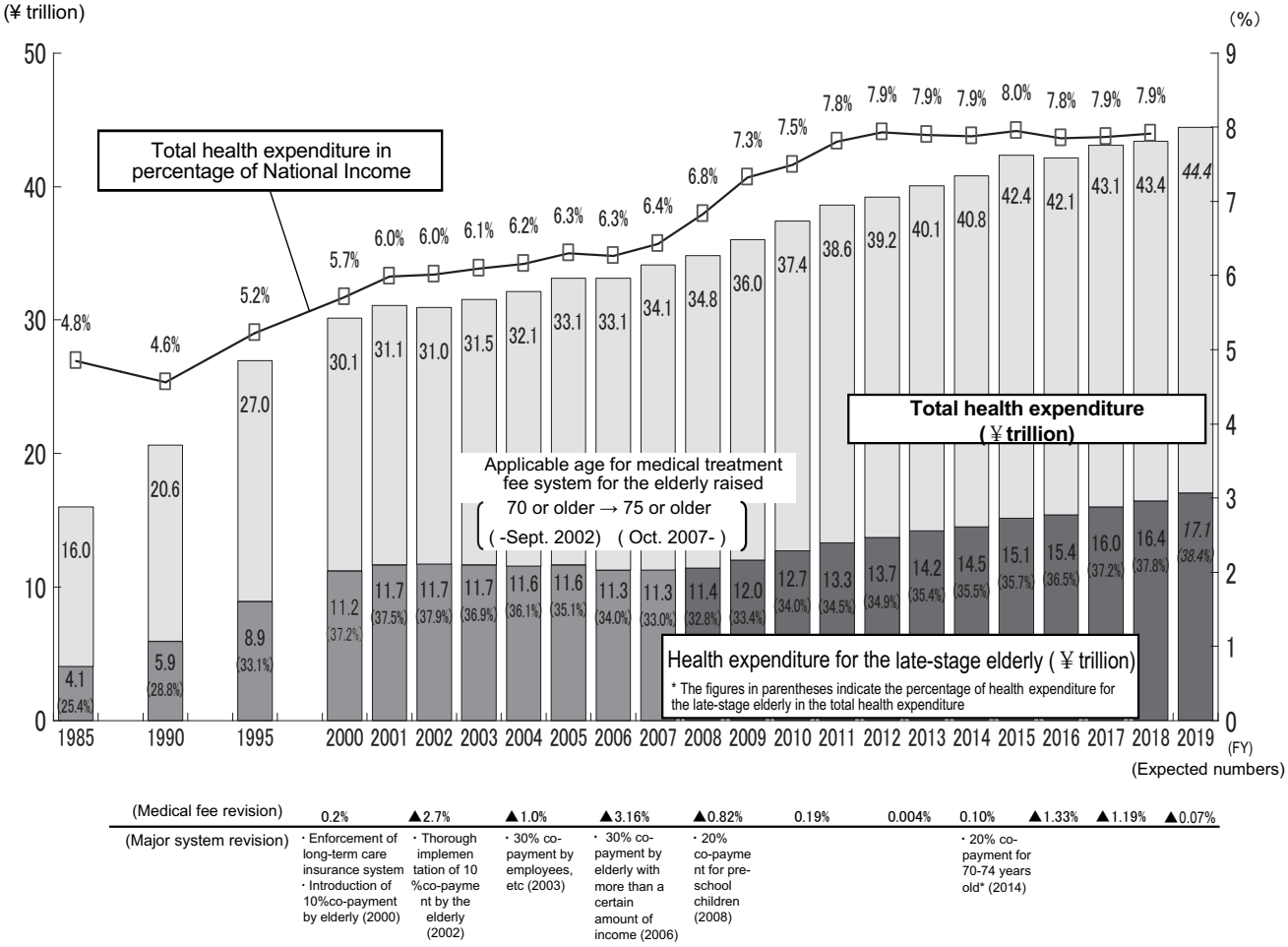
1.Evaluation of inpatient care based on medical functions and patients' conditions
2 Functional separation of outpatient care
3 Ensure high quality home medical care and home nursing care
4 Efforts to promote a Community-based Integrated Care System
5 Promotion of information sharing and cooperation among medical professionals and medical institutions

### Ⅳ I mproving the stability and sustainability of the system through optimization and efficiency

1.Promotion of the use of generic drugs and follow-on biologics
2 Utilization of cost-effectiveness evaluation system
3 Appropriate evaluation based on prevailing market prices, etc.
4 Evaluation of inpatient care according to medical functions and patients' conditions (Re-listed)
5 Functional differentiation of outpatient care and promotion of prevention of progression of serious diseases (Re-listed)
6 Promotion of appropriate use of pharmaceuticals through collaborative efforts among physicians, in-house pharmacists, and pharmacy pharmacists
7 Appropriate evaluation of pharmaceuticals, medical devices, testing, etc.

# Health Expenditure

## Overview Changes in Health Expenditure




**<Year-on-year growth rate of National Health Expenditure>** (%)

| | 1985 | 1990 | 1995 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total health expenditure | 6.1 | 4.5 | 4.5 | ▲1.8 | 3.2 | ▲0.5 | 1.9 | 1.8 | 3.2 | ▲0.0 | 3.0 | 2.0 | 3.4 | 3.9 | 3.1 | 1.6 | 2.2 | 1.9 | 3.8 | ▲0.5 | 2.2 | 0.8 | 2.4 |
| Health expenditure for the late-stage elderly | 12.7 | 6.6 | 9.3 | ▲5.1 | 4.1 | 0.6 | ▲0.7 | ▲0.7 | 0.6 | ▲3.3 | 0.1 | 1.2 | 5.2 | 5.9 | 4.5 | 3.0 | 3.6 | 2.1 | 4.4 | 1.6 | 4.2 | 2.5 | 3.9 |
| GDP | 7.2 | 8.6 | 2.7 | 1.2 | ▲1.8 | ▲0.8 | 0.6 | 0.7 | 0.8 | 0.6 | 0.4 | ▲4.0 | ▲3.4 | 1.5 | ▲1.1 | 0.1 | 2.6 | 2.2 | 2.8 | 0.7 | 2.0 | 0.1 | — |

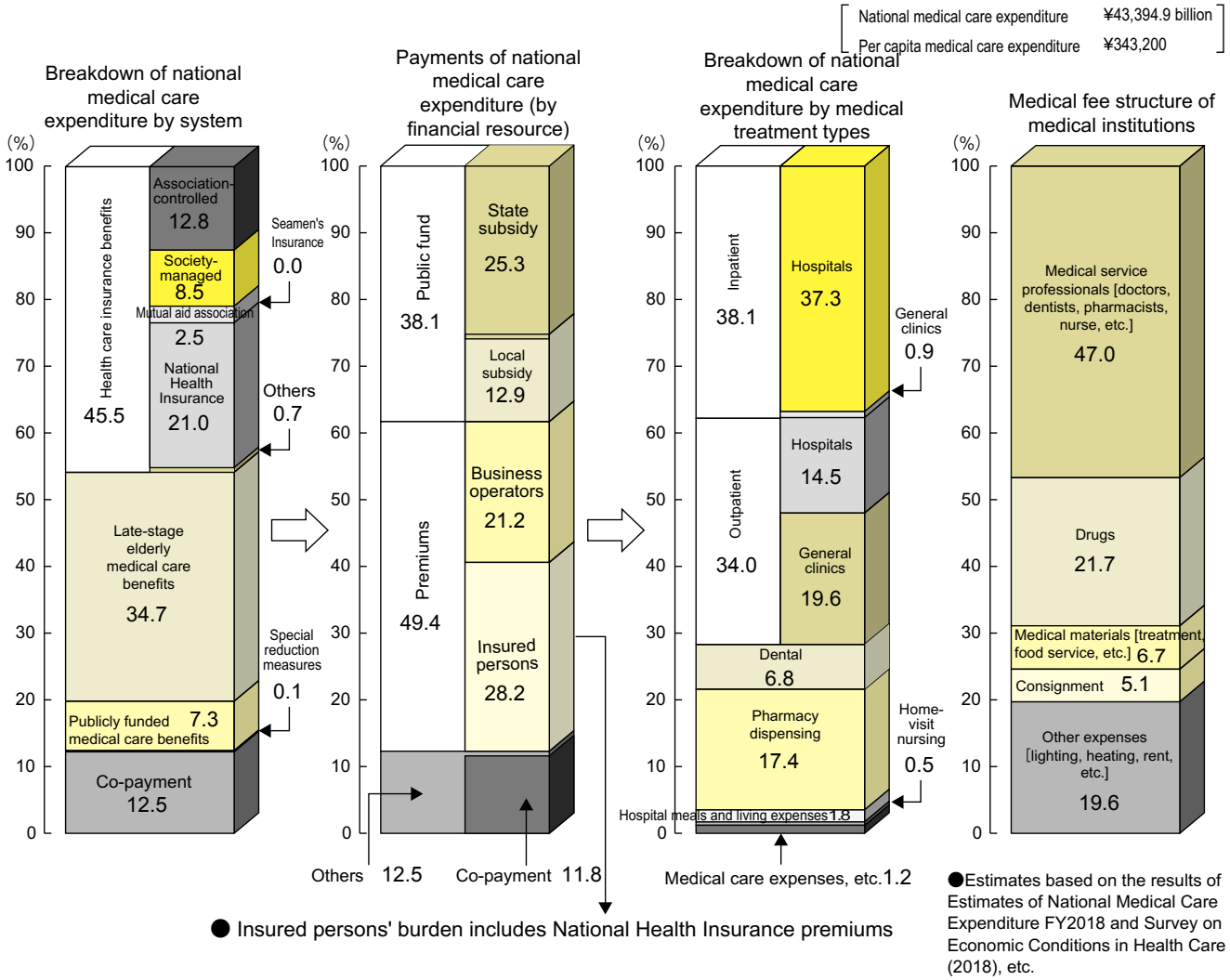
(Note) 1. The national income and GDP are based on the national accounting announced by the Cabinet Office.
2. National medical expenses (and those for advanced elderly. The same applies hereinafter) in FY2019 are estimates including the actual performance. The expenses for FY2019 are estimated by multiplying the national medical expenses for FY2018 by the rate of increase in approximate medical expenses in FY2019 (figures written in italics in the table above).
*The budget freezing measure for co-payment ratios of persons aged 70 to 74 was lifted (10%→20%). 20% is applied to persons who reached 70 years of age in April 2014 or after and the ratio of 10% is left unchanged for persons who reached 70 years of age in March 2014 or before.

## Detailed Data 1 National Medical Care Expenditure of OECD Countries (2019)

| Country | Total medical care expenditure in GDP (%) | Rank | Per capita medical care expenditure ($) | Rank | Remarks |
|---|---|---|---|---|---|
| United States | 17.0 | 1 | 11,071.7 | 1 | |
| Switzerland | 12.1 | 2 | 7,732.4 | 2 | |
| Germany | 11.7 | 3 | 6,645.8 | 4 | |
| France | 11.2 | 4 | 5,375.7 | 12 | |
| Japan | 11.1 | 5 | 4,822.8 | 15 | |
| Sweden | 10.9 | 6 | 5,782.3 | 6 | |
| Canada | 10.8 | 7 | 5,418.4 | 11 | |
| Norway | 10.5 | 8 | 6,646.7 | 3 | |
| Austria | 10.4 | 9 | 5,851.8 | 5 | |
| Belgium | 10.3 | 10 | 5,428.0 | 10 | |
| United Kingdom | 10.3 | 11 | 4,653.1 | 17 | |
| Denmark | 10.0 | 12 | 5,567.9 | 8 | |
| Netherlands | 10.0 | 13 | 5,765.1 | 7 | |
| Portugal | 9.6 | 14 | 3,378.6 | 24 | |
| Australia | 9.3 | 15 | 5,787.4 | 14 | |
| New Zealand | 9.3 | 16 | 4,204.0 | 19 | |
| Chile | 9.1 | 17 | 2,159.4 | 33 | |
| Finland | 9.1 | 18 | 4,578.4 | 18 | |
| Spain | 9.0 | 19 | 3,616.5 | 21 | |
| Iceland | 8.8 | 20 | 4,811.4 | 16 | |
| Italy | 8.7 | 21 | 3,649.2 | 20 | |
| Slovenia | 8.3 | 22 | 3,224.0 | 25 | |
| Korea | 8.0 | 23 | 3,384.2 | 23 | |
| Greece | 7.8 | 24 | 2,383.6 | 29 | |
| Czech Republic | 7.8 | 25 | 3,426.0 | 22 | |
| Israel | 7.5 | 26 | 2,932.5 | 26 | |
| Colombia | 7.3 | 27 | 1,212.6 | 36 | |
| Slovakia | 6.9 | 28 | 2,353.6 | 30 | |
| Ireland | 6.8 | 29 | 5,275.5 | 13 | |
| Lietuva | 6.8 | 30 | 2,638.1 | 27 | |
| Estonia | 6.8 | 31 | 2,578.8 | 28 | |
| Hungary | 6.4 | 32 | 2,222.4 | 32 | |
| Poland | 6.3 | 33 | 2,292.1 | 31 | |
| Latvia | 6.3 | 34 | 1,972.6 | 34 | |
| Mexico | 5.5 | 35 | 1,153.6 | 37 | |
| Luxembourg | 5.4 | 36 | 5,558.3 | 9 | |
| Turkey | 4.4 | 37 | 1,139.5 | 35 | |
| OECD average | 8.8 | | 4,224.1 | | |

Source: "OECD HEALTH DATA 2020"
(Note) 1. The rank in this table indicates the rank among OECD member countries.

## Detailed Data 2 Structure of National Medical Care Expenditure (FY 2018)




●Estimates based on the results of Estimates of National Medical Care Expenditure FY2018 and Survey on Economic Conditions in Health Care (2018), etc.

## Detailed Data 3 Changes in National Medical Care Expenditure and Percentage Distribution

| Year | National medical care expenditure | General medical fees | Impatient medical fees | | | Outpatient medical fees | | | Dental medical fees | Pharmacy dispensing medical fees 2) | Hospital meals and living expenses 3) | Medical treatment fees at health service facilities for the elderly 4) | Home-visit nursing medical fees |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Hospitals | General clinics | | Hospitals | General clinics | | Hospitals | General clinics | | | | | |
| | **Estimated amount (¥100 million)** | | | | | | | | | | | | | | |
| 1962 | 6,132 | 5,372 | 2,948 | 2,424 | 2,344 | 2,072 | 272 | 3,028 | 875 | 2,153 | 759 | … | · | · | · |
| 1965 | 11,224 | 10,082 | 5,499 | 4,583 | 4,104 | 3,635 | 469 | 5,978 | 1,864 | 4,113 | 1,143 | … | · | · | · |
| 1970 | 24,962 | 22,513 | 12,121 | 10,392 | 8,799 | 7,801 | 998 | 13,714 | 4,320 | 9,394 | 2,448 | … | · | · | · |
| 1975 | 64,779 | 59,102 | 32,996 | 26,106 | 25,427 | 22,640 | 2,787 | 33,675 | 10,356 | 23,319 | 5,677 | … | · | · | · |
| 1980 | 119,805 | 105,349 | 62,970 | 42,379 | 48,341 | 43,334 | 5,007 | 57,008 | 19,636 | 37,372 | 12,807 | 1,649 | · | · | · |
| 1985 | 160,159 | 140,287 | 92,091 | 48,195 | 70,833 | 65,054 | 5,778 | 69,454 | 27,037 | 42,417 | 16,778 | 3,094 | · | · | · |
| 1990 | 206,074 | 179,764 | 123,256 | 56,507 | 85,553 | 80,470 | 5,082 | 94,211 | 42,786 | 51,425 | 20,354 | 5,290 | · | 666 | · |
| 1995 | 269,577 | 218,683 | 148,543 | 70,140 | 99,229 | 94,545 | 4,684 | 119,454 | 53,997 | 65,456 | 23,837 | 12,662 | 10,801 | 3,385 | 210 |
| 2000 | 301,418 | 237,960 | 161,670 | 76,290 | 113,019 | 108,642 | 4,376 | 124,941 | 53,028 | 71,913 | 25,569 | 27,605 | 10,003 | · | 282 |
| 2001 | 310,998 | 242,494 | 164,536 | 77,958 | 115,219 | 110,841 | 4,378 | 127,275 | 53,695 | 73,580 | 26,041 | 32,140 | 9,999 | · | 324 |
| 2002 | 309,507 | 238,160 | 162,569 | 75,591 | 115,537 | 111,180 | 4,357 | 122,623 | 51,389 | 71,234 | 25,875 | 35,297 | 9,835 | · | 339 |
| 2003 | 315,375 | 240,931 | 164,077 | 76,854 | 117,231 | 112,942 | 4,289 | 123,700 | 51,135 | 72,565 | 25,375 | 38,907 | 9,815 | · | 348 |
| 2004 | 321,111 | 243,627 | 164,764 | 78,863 | 118,464 | 114,047 | 4,417 | 125,163 | 50,717 | 74,446 | 25,377 | 41,935 | 9,780 | · | 392 |
| 2005 | 331,289 | 249,677 | 167,955 | 81,722 | 121,178 | 116,624 | 4,555 | 128,499 | 51,331 | 77,167 | 25,766 | 45,608 | 9,807 | · | 431 |
| 2006 | 331,276 | 250,468 | 168,943 | 81,525 | 122,543 | 117,885 | 4,658 | 127,925 | 51,058 | 76,867 | 25,039 | 47,061 | 8,229 | · | 479 |
| 2007 | 341,360 | 256,418 | 173,102 | 83,316 | 126,132 | 121,349 | 4,782 | 130,287 | 51,753 | 78,534 | 24,996 | 51,222 | 8,206 | · | 518 |
| | **Percentage distribution (%)** | | | | | | | | | | | | | | |
| 1962 | 100.0 | 87.6 | 48.1 | 39.5 | 38.2 | 33.8 | 4.4 | 49.4 | 14.3 | 35.1 | 12.4 | … | · | · | · |
| 1965 | 100.0 | 89.8 | 49.0 | 40.8 | 36.6 | 32.4 | 4.2 | 53.3 | 16.6 | 36.6 | 10.2 | … | · | · | · |
| 1970 | 100.0 | 90.2 | 48.6 | 41.6 | 35.2 | 31.3 | 4.0 | 54.9 | 17.3 | 37.6 | 9.8 | … | · | · | · |
| 1975 | 100.0 | 91.2 | 50.9 | 40.3 | 39.3 | 34.9 | 4.3 | 52.0 | 16.0 | 36.0 | 8.8 | … | · | · | · |
| 1980 | 100.0 | 87.9 | 52.6 | 35.4 | 40.3 | 36.2 | 4.2 | 47.6 | 16.4 | 31.2 | 10.7 | 1.4 | · | · | · |
| 1985 | 100.0 | 87.6 | 57.5 | 30.1 | 44.2 | 40.6 | 3.6 | 43.4 | 16.9 | 26.5 | 10.5 | 1.9 | · | · | · |
| 1990 | 100.0 | 87.2 | 59.8 | 27.4 | 41.5 | 39.0 | 2.5 | 45.7 | 20.8 | 25.0 | 9.9 | 2.6 | · | 0.3 | · |
| 1995 | 100.0 | 81.1 | 55.1 | 26.0 | 36.8 | 35.1 | 1.7 | 44.3 | 20.0 | 24.3 | 8.8 | 4.7 | 4.0 | 1.3 | 0.1 |
| 2000 | 100.0 | 78.9 | 53.6 | 25.3 | 37.5 | 36.0 | 1.5 | 41.5 | 17.6 | 23.9 | 8.5 | 9.2 | 3.3 | · | 0.1 |
| 2001 | 100.0 | 78.0 | 52.9 | 25.1 | 37.0 | 35.6 | 1.4 | 40.9 | 17.3 | 23.7 | 8.4 | 10.3 | 3.2 | · | 0.1 |
| 2002 | 100.0 | 76.9 | 52.5 | 24.4 | 37.3 | 35.9 | 1.4 | 39.6 | 16.6 | 23.0 | 8.4 | 11.4 | 3.2 | · | 0.1 |
| 2003 | 100.0 | 76.4 | 52.0 | 24.4 | 37.2 | 35.8 | 1.4 | 39.2 | 16.2 | 23.0 | 8.0 | 12.3 | 3.1 | · | 0.1 |
| 2004 | 100.0 | 75.9 | 51.3 | 24.6 | 36.9 | 35.5 | 1.4 | 39.0 | 15.8 | 23.2 | 7.9 | 13.1 | 3.0 | · | 0.1 |
| 2005 | 100.0 | 75.4 | 50.7 | 24.7 | 36.6 | 35.2 | 1.4 | 38.8 | 15.5 | 23.3 | 7.8 | 13.8 | 3.0 | · | 0.1 |
| 2006 | 100.0 | 75.6 | 51.0 | 24.6 | 37.0 | 35.6 | 1.4 | 38.6 | 15.4 | 23.2 | 7.6 | 14.2 | 2.5 | · | 0.1 |
| 2007 | 100.0 | 75.1 | 50.7 | 24.4 | 36.9 | 35.5 | 1.4 | 38.2 | 15.2 | 23.0 | 7.3 | 15.0 | 2.4 | · | 0.2 |

| Year | National medical care expenditure | Medical fees of medical treatment 5) | Impatient medical fees | | | Outpatient medical fees | | | Dental medical fees | Pharmacy dispensing medical fees 2) | Hospital meals and living expenses 3) | Home-visit nursing medical fees | Medical care expenses, etc. 5) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Hospitals | General clinics | | Hospitals | General clinics | | Hospitals | General clinics | | | | | |
| | **Estimated amount (¥100 million)** | | | | | | | | | | | | | | |
| 2008 | 348,084 | 254,452 | 172,298 | 82,154 | 128,205 | 123,685 | 4,520 | 126,247 | 48,613 | 77,634 | 25,777 | 53,955 | 8,152 | 605 | 5,143 |
| 2009 | 360,067 | 262,041 | 178,848 | 83,193 | 132,559 | 128,266 | 4,293 | 129,482 | 50,582 | 78,900 | 25,587 | 58,228 | 8,161 | 665 | 5,384 |
| 2010 | 374,202 | 272,228 | 188,276 | 83,953 | 140,908 | 136,416 | 4,492 | 131,320 | 51,860 | 79,460 | 26,020 | 61,412 | 8,297 | 740 | 5,505 |
| 2011 | 385,850 | 278,129 | 192,816 | 85,314 | 143,754 | 139,394 | 4,359 | 134,376 | 53,421 | 80,954 | 26,757 | 66,288 | 8,231 | 808 | 5,637 |
| 2012 | 392,117 | 283,198 | 197,677 | 85,521 | 147,566 | 143,243 | 4,323 | 135,632 | 54,434 | 81,197 | 27,132 | 67,105 | 8,130 | 956 | 5,597 |
| 2013 | 400,610 | 287,447 | 201,417 | 86,030 | 149,667 | 145,523 | 4,144 | 137,780 | 55,894 | 81,886 | 27,368 | 71,118 | 8,082 | 1,086 | 5,509 |
| 2014 | 408,071 | 292,506 | 205,438 | 87,067 | 152,641 | 148,483 | 4,158 | 139,865 | 56,956 | 82,909 | 27,900 | 72,846 | 8,021 | 1,256 | 5,543 |
| 2015 | 423,644 | 300,461 | 211,860 | 88,601 | 155,752 | 151,772 | 3,980 | 144,709 | 60,088 | 84,622 | 28,294 | 79,831 | 8,014 | 1,485 | 5,558 |
| 2016 | 421,381 | 301,853 | 214,666 | 87,187 | 157,933 | 154,077 | 3,856 | 143,920 | 60,589 | 83,332 | 28,574 | 75,867 | 7,917 | 1,742 | 5,427 |
| 2017 | 430,710 | 308,335 | 219,675 | 88,660 | 162,116 | 158,228 | 3,888 | 146,219 | 61,447 | 84,772 | 29,003 | 78,108 | 7,954 | 2,023 | 5,287 |
| 2018 | 433,949 | 313,251 | 224,435 | 88,816 | 165,535 | 161,705 | 3,831 | 147,716 | 62,730 | 84,986 | 29,579 | 75,687 | 7,917 | 2,355 | 5,158 |
| | **Percentage distribution (%)** | | | | | | | | | | | | | | |
| 2008 | 100.0 | 73.1 | 49.5 | 23.6 | 36.8 | 35.5 | 1.3 | 36.3 | 14.0 | 22.3 | 7.4 | 15.5 | 2.3 | 0.2 | 1.5 |
| 2009 | 100.0 | 72.8 | 49.7 | 23.1 | 36.8 | 35.6 | 1.2 | 36.0 | 14.0 | 21.9 | 7.1 | 16.2 | 2.3 | 0.2 | 1.5 |
| 2010 | 100.0 | 72.7 | 50.3 | 22.4 | 37.7 | 36.5 | 1.2 | 35.1 | 13.9 | 21.2 | 7.0 | 16.4 | 2.2 | 0.2 | 1.5 |
| 2011 | 100.0 | 72.1 | 50.0 | 22.1 | 37.3 | 36.1 | 1.1 | 34.8 | 13.8 | 21.0 | 6.9 | 17.2 | 2.1 | 0.2 | 1.5 |
| 2012 | 100.0 | 72.2 | 50.4 | 21.8 | 37.6 | 36.5 | 1.1 | 34.6 | 13.9 | 20.7 | 6.9 | 17.1 | 2.1 | 0.2 | 1.4 |
| 2013 | 100.0 | 71.8 | 50.3 | 21.5 | 37.4 | 36.3 | 1.0 | 34.4 | 14.0 | 20.4 | 6.8 | 17.8 | 2.0 | 0.3 | 1.4 |
| 2014 | 100.0 | 71.7 | 50.3 | 21.3 | 37.4 | 36.4 | 1.0 | 34.3 | 14.0 | 20.3 | 6.8 | 17.9 | 2.0 | 0.3 | 1.4 |
| 2015 | 100.0 | 70.9 | 50.0 | 20.9 | 36.8 | 35.8 | 0.9 | 34.2 | 14.2 | 20.0 | 6.7 | 18.8 | 1.9 | 0.4 | 1.3 |
| 2016 | 100.0 | 71.6 | 50.9 | 20.7 | 37.5 | 36.6 | 0.9 | 34.2 | 14.4 | 19.8 | 6.8 | 18.0 | 1.9 | 0.4 | 1.3 |
| 2017 | 100.0 | 71.6 | 51.0 | 20.6 | 37.6 | 36.7 | 0.9 | 33.9 | 14.3 | 19.7 | 6.7 | 18.1 | 1.8 | 0.5 | 1.2 |
| 2018 | 100.0 | 72.2 | 51.7 | 20.5 | 38.1 | 37.3 | 0.9 | 34.0 | 14.5 | 19.6 | 6.8 | 17.4 | 1.8 | 0.5 | 1.2 |

Source: "Estimates of National Medical Care Expenditure", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

(Note)
1. With the launch of long-term care insurance system in April 2000, some of the expenses that were subjected to national medical care expenditure were transferred to long-term care insurance fees and are no longer included in national medical expenditure on and after FY 2000.
2. Pharmacy dispensing was included in outpatient medical fees until they were newly classified as a separate item in FY1977.
3. Figures until FY2005 indicate "hospital meal expenses" (total amount of hospital meal expenses and standard co-payment) and figures since FY2006 indicate the total amount of hospital meal expenses, standard co-payment for meal expenses, hospital living expenses, and standard co-payment for living expenses.
4. Medical treatment fees at health service facilities for the elderly are not included in national health expenditure on and after FY 2000 because these fees are those who are certified for long-term care need.
5. "Medical fees of medical treatment" and "medical care expenses, etc." were included in "general medical fees" until they were newly classified as a separate item in FY 2008.

## Detailed Data 4 Changes in Health Expenditure for the Elderly in the Later Stage of Life

| | FY | Total | Medical fees | | | | Dispensing | Hospital meals and living | Home-visit nursing | Medical treatment etc. | Health service facilities for the elderly |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Inpatient | Outpatient | Dental | | | | | |
| Actual amount (¥100 million) | FY 1983 | 33,185 | 31,966 | 17,785 | 13,405 | 776 | 640 | ・ | ・ | 579 | ・ |
| | FY 1984 | 36,098 | 34,645 | 19,725 | 14,025 | 895 | 689 | ・ | ・ | 764 | ・ |
| | FY 1985 | 40,673 | 38,986 | 22,519 | 15,433 | 1,034 | 785 | ・ | ・ | 902 | ・ |
| | FY 1986 | 44,377 | 42,445 | 24,343 | 16,924 | 1,178 | 902 | ・ | ・ | 1,030 | ・ |
| | FY 1987 | 48,309 | 46,104 | 26,247 | 18,605 | 1,252 | 1,037 | ・ | ・ | 1,168 | ・ |
| | FY 1988 | 51,593 | 49,138 | 27,798 | 19,975 | 1,365 | 1,133 | ・ | ・ | 1,296 | 26 |
| | FY 1989 | 55,578 | 52,573 | 29,400 | 21,743 | 1,430 | 1,312 | ・ | ・ | 1,441 | 253 |
| | FY 1990 | 59,269 | 55,669 | 30,724 | 23,315 | 1,630 | 1,457 | ・ | ・ | 1,523 | 619 |
| | FY 1991 | 64,095 | 59,804 | 32,325 | 25,705 | 1,773 | 1,689 | ・ | ・ | 1,633 | 970 |
| | FY 1992 | 69,372 | 64,307 | 35,009 | 27,249 | 2,049 | 1,992 | ・ | 5 | 1,626 | 1,442 |
| | FY 1993 | 74,511 | 68,530 | 36,766 | 29,536 | 2,228 | 2,529 | ・ | 29 | 1,535 | 1,888 |
| | FY 1994 | 81,596 | 72,501 | 38,235 | 31,790 | 2,476 | 3,133 | 1,855 | 86 | 1,439 | 2,582 |
| | FY 1995 | 89,152 | 75,910 | 38,883 | 34,319 | 2,708 | 3,909 | 4,678 | 174 | 1,224 | 3,259 |
| | FY 1996 | 97,232 | 82,181 | 42,314 | 36,789 | 3,078 | 4,620 | 4,816 | 323 | 1,094 | 4,198 |
| | FY 1997 | 102,786 | 85,475 | 44,205 | 37,965 | 3,305 | 5,606 | 4,869 | 479 | 1,073 | 5,285 |
| | FY 1998 | 108,932 | 88,881 | 46,787 | 38,584 | 3,511 | 6,900 | 4,967 | 657 | 1,101 | 6,426 |
| | FY 1999 | 118,040 | 94,653 | 49,558 | 41,181 | 3,915 | 8,809 | 5,115 | 858 | 1,169 | 7,436 |
| | FY 2000 | 111,997 | 94,640 | 48,568 | 41,871 | 4,200 | 10,569 | 4,612 | 235 | 1,271 | 670 |
| | FY 2001 | 116,560 | 97,954 | 50,296 | 43,243 | 4,416 | 12,462 | 4,677 | 191 | 1,277 | -2 |
| | FY 2002 | 117,300 | 97,155 | 51,198 | 41,434 | 4,522 | 13,913 | 4,689 | 192 | 1,352 | -1 |
| | FY 2003 | 116,524 | 95,653 | 51,828 | 39,609 | 4,216 | 14,711 | 4,645 | 174 | 1,342 | -1 |
| | FY 2004 | 115,764 | 94,429 | 52,048 | 38,371 | 4,010 | 15,143 | 4,654 | 190 | 1,348 | -0 |
| | FY 2005 | 116,444 | 94,441 | 52,867 | 37,726 | 3,848 | 15,777 | 4,679 | 205 | 1,342 | -0 |
| | FY 2006 | 112,594 | 91,492 | 51,822 | 36,129 | 3,540 | 15,579 | 3,970 | 225 | 1,329 | -0 |
| | FY 2007 | 112,753 | 91,048 | 52,167 | 35,524 | 3,357 | 16,245 | 3,877 | 239 | 1,345 | - |
| | FY 2008 | 114,146 | 91,558 | 53,009 | 35,029 | 3,520 | 17,035 | 3,850 | 264 | 1,439 | -0 |
| | FY 2009 | 120,108 | 95,672 | 55,594 | 36,381 | 3,698 | 18,717 | 3,914 | 289 | 1,517 | ・ |
| | FY 2010 | 127,213 | 101,630 | 59,994 | 37,654 | 3,981 | 19,631 | 4,015 | 318 | 1,620 | ・ |
| | FY 2011 | 132,991 | 105,409 | 62,170 | 38,980 | 4,260 | 21,489 | 4,029 | 341 | 1,725 | ・ |
| | FY 2012 | 137,044 | 108,751 | 64,094 | 40,139 | 4,518 | 22,111 | 4,012 | 404 | 1,767 | ・ |
| | FY 2013 | 141,912 | 111,837 | 65,599 | 41,484 | 4,753 | 23,798 | 1,028 | 461 | 1,788 | ・ |
| | FY 2014 | 144,927 | 114,063 | 67,121 | 41,978 | 4,963 | 24,488 | 4,024 | 529 | 1,823 | ・ |
| | FY 2015 | 151,323 | 118,083 | 69,219 | 43,643 | 5,221 | 26,698 | 4,063 | 616 | 1,862 | ・ |
| | FY 2016 | 153,806 | 121,143 | 71,393 | 44,259 | 5,491 | 26,017 | 4,058 | 723 | 1,865 | ・ |
| | FY 2017 | 160,229 | 126,372 | 74,905 | 45,695 | 5,772 | 26,996 | 4,155 | 839 | 1,867 | ・ |
| | FY 2018 | 164,246 | 130,712 | 77,685 | 46,921 | 6,106 | 26,490 | 4,207 | 983 | 1,854 | ・ |

(Note) 1. Terms are defined as follows.

a. Medical fees: Expenses paid for medical care services received at insurance medical care facilities. (excluding insurance pharmacies, etc.). (Benefit in kind)
b. Dispensing: Refers to the expenses paid when receiving medicine at an insurance-covered pharmacy (Benefit in kind)
c. Hospital Meals and living: Meal and living expenses during hospitalization. (Benefit in kind)
d. Home-visit nursing: Expenses paid for home-visit nursing care services by the specified service providers. (Benefit in kind)
e. Medical treatment, etc.: Expenses paid for prosthetic devices or treatment by judo therapists in accordance with Articles 77 and 83 of the Act on Assurance of Medical Care for Elderly People.(Benefit in cash)
f. Health services facilities for the elderly: Expenses paid for facility treatment at health service facilities for the elderly. (Benefit in kind)(Not applicable after March 2000)
g. Expenses include co-payment, standard co-payment for meal/living expenses, and basic fees of home-visit nursing.

2. The figures up to March 2008 are for those subjected to medical services that are provided in the Health and Medical Services Act for the Aged.
3. The figures for FY2008 include delayed requests for health expenditure for the elderly from April 2008 to February 2009.
4. The figures for FY2011 do not include the Great East Japan Earthquake related health expenditure, etc. (¥4.5 billion of the total of estimated payment requests and health expenditure of unknown insurers).
5. The figures for FY2016 do not include the medical expenses related to the 2016 Kumamoto Earthquake (¥50 million of the total estimated payment requests and health expenditure of unknown insurers).
6. The figures for FY2018 do not include the health expenditure, etc. related to the damage of Typhoon No. 7 and Heavy Rain Event of August 2018 associated with the rain front, the 2018 Hokkaido Eastern Iburi Earthquake and Typhoon No. 21 (¥0.4 billion of the total of estimated payment requests and health expenditure of unknown insurers).

Source "Annual report on the medical-care system for the latter-stage elderly", Health Insurance Bureau, MHLW

# Financial Status of Health Insurance System

## Overview Finance Status of the Health Insurance System (FY 2018 Settled Account)

(Unit: ¥100 million)

| | | Government-managed Health Insurance/ JHIA-managed Health Insurance | Society-managed Health Insurance | National Health Insurance (municipalities) | Seamen's Insurance | Medical care system for the elderly aged 75 and over |
|---|---|---|---|---|---|---|
| Operating revenue | Premium (tax) revenue | 91,429 | 82,730 | 24,526 | 310 | 12,365 |
| | National treasury contribution | 11,850 | 27 | 30,519 | 29 | 49,435 |
| | Prefectural contribution | — | ъ | 10,359 | ъ | 14,812 |
| | Municipal contribution | — | ъ | 6,455 | ъ | 13,013 |
| | Grants for late-stage elderly | — | ъ | ъ | ъ | 62,473 |
| | Grants for early-stage elderly | — | 2 | 36,403 | ъ | ъ |
| | Retirement grants | — | ъ | 599 | ъ | ъ |
| | Others | 164 | 1,147 | 126,371 | 1 | 281 |
| | Total | 103,443 | 83,905 | 235,234 | 340 | 152,381 |
| Operating expenditure | Insurance benefit expenses | 60,016 | 40,825 | 87,966 | 200 | 151,466 |
| | Late-stage elderly support coverage | 19,516 | 18,928 | 15,954 | 69 | ъ |
| | Levies for early-stage elderly | 15,268 | 15,396 | 68 | 31 | ъ |
| | Contributions for retirees | 208 | 211 | ъ | 1 | ъ |
| | Others | 2,505 | 5,494 | 129,569 | 7 | 925 |
| | Total | 97,513 | 80,854 | 233,557 | 307 | 152,391 |
| | Balance of ordinary revenue and expenditure | 5,930 | 3,052 | 1,677 | 33 | ъ10 |

| | | Government-managed Health Insurance/ JHIA-managed Health Insurance | Society-managed Health Insurance | |
|---|---|---|---|---|
| Non-operating revenue | Deferred repayment of state subsidy | - | - | |
| | Non-operating subsidy for benefits, etc. | - | 658 | |
| | Adjustment premium revenue | - | 1,209 | |
| | Subsidies to financial adjustment programs | - | 1,120 | |
| | Transfer from reserves, etc. and surplus carried forward | - | 2,876 | |
| | Others | 18 | 92 | |
| | Total | 18 | 5,840 | |
| Non-operating expenditure | Contribution to financial adjustment programs | - | 1,203 | |
| | Others | - | 83 | |
| | Total | - | 1,287 | |
| Balance of non-operating revenue and expenditure | | 18 | 4,553 | (1,676) |
| Balance of total revenue and expenditure | | 5,948 | 7,604 | (4,728) |
| Reserve fund, etc. | | 28,521 | | 51,002 |

(Note)
1. The above figures indicate medical service revenue and expenditure.
2. The operating revenue of the National Health Insurance (operated by municipalities) is the total amount of special account of the municipalities or prefectures. The current account includes an extra-legal transfer from the Municipal General Account of ¥125.8 billion for use in covering the settlement of accounts. The amounts of the national subsidy, etc. for National Health Insurance (operated by municipalities) and the late-stage medical care system for the elderly were adjusted in the following fiscal year.
3. The figures in parentheses for the Society-managed Health Insurance indicate the net balance between non-operating revenue and expenditure and the balance between total revenue and expenditure, but exclude transfers from reserves, etc. and surpluses carried forward).
4. Contribution to health care services for the elderly is included in “others” of operating expenditure for each system.
5. Reserve fund, etc. indicates reserves for the Japan Health Insurance Association-managed Health Insurance. It includes reserves, a reserve fund (¥4,733.6 billion), and assets such as land and buildings, etc. for the Society-managed Health Insurance.
6. In the non-operating revenue of the Japan Health Insurance Association-managed Health Insurance, operation account surplus at the end of FY2015 was added to FY2016 settlement of accounts.
7. The balance of total revenue and expenditure for the Japan Health Insurance Association-managed Health Insurance and Society-managed Health Insurance indicates the sum of the balance of operating revenue and expenditure and the balance of non-operating revenue and expenditure.
8. The figures may not equal the total, or balance of accounts may vary due to rounding.

Source: Health Insurance Bureau, MHLW

# Types of Medical Institutions

## Overview Types of Medical Institutions

**1. Hospitals, Clinics**

The Medical Care Act restricts the sites of medical practice to hospitals and clinics. Hospitals and clinics are classified as follows: hospitals are medical institutions with 20 or more beds and clinics are those with no beds or 19 or less beds.

- Medical institutions
  - Hospitals (20 or more beds)
  - Clinics (0 to 19 beds)
    - Clinics with beds (1 to 19 beds)
    - Clinics without beds (0 beds)

Hospitals are required to provide truly scientific and appropriate treatment to injured or sick people and are expected to have substantial facilities.

There is no strict regulation on facilities for clinics with 19 or less beds compared to hospitals.

**2. Types of Hospitals**

The Medical Care Act provides requirements (staff deployment standards, facility standards, responsibilities of managers, etc.) that are different from general hospitals for hospitals with special functions (special functioning hospitals, regional medical care support hospitals, clinical research core hospital) and accepts hospitals that satisfy requirements to use the name.

In addition, separate staff deployment standards and facility standards are provided for some beds in consideration of differences in subjects of patients (patients with psychiatric disorders or tuberculosis).

- Hospitals
  - General hospitals
  - Special functioning hospitals (providing advanced medical care, etc.)
  - Regional medical care support hospitals (supporting family doctors and family dentists who are taking roles in regional medical care, etc.)
  - Clinical research core hospital (A hospital that plays a core role in the implementation of clinical research)
  - Psychiatric hospitals (hospitals with psychiatric wards only) (subject: psychiatric disorders)
  - Tuberculosis hospitals (hospitals with tuberculosis wards only) (subject: patients with tuberculosis)

## Detailed Information 1 Outline of Special Functioning Hospitals

### Purpose

As part of efforts to systematize medical facility functions, the Minister of Health, Labour and Welfare approves individual hospitals having capabilities of providing advanced medical care, development of advanced medical technologies, and conducting advanced medical care training.

### Roles

- ❍ Provide advanced medical care
- ❍ Develop/evaluate advanced medical technologies
- ❍ Conduct advanced medical care training

### Requirements for Approval

- ❍ Having capabilities of providing, developing, evaluating, and conduct training of advanced medical care
- ❍ Providing medical care to patients who are referred to by other hospitals or clinics (maintaining the incoming referral rate of at least 50% and the outgoing referral rate of at least 40%)
- ❍ Number of beds .... Must have 400 or more beds.
- ❍ Staff deployment
  - Doctors ..... Twice as many as ordinary hospitals, etc. In addition, half the number of doctors specified by the staff
    More than half of the doctor's placement criteria must be from any of the 15 specialists.
  - Pharmacists ..... The minimum standard is 1/30 of the number of patients. (That for ordinary hospitals is 1/70 of the number of patients)
  - Nurses, etc. ..... The minimum standard is 1/2 of the number of patients. (That for ordinary hospitals is 1/3 of the number of patients)
  - Deployment of at least one registered dietitian.
- ❍ Facilities ..... Must have intensive care units, sterile rooms, and drug information management rooms.
- ❍ Improvement of medical safety management system
  - Placement of staff responsible for medical safety management
  - Placement of full-time doctors, pharmacists and nurses in the medical safety management department
  - Mandatory reporting of all death cases, etc.
  - Establishment of a department to decide the suitability of medical provision using high-difficulty new medical technology and unapproved new medicines
  - External audit by the Audit Committee
- ❍ Professing 16 specified clinical areas in principle.
- ❍ Having at least 70 papers written in English published annually in refereed journals, etc.
- ❍ Regarding specific function hospitals corresponding to specific areas such as cancer, separate approval requirements are set for the advocacy of clinical department, introduction rate, reverse introduction rate, etc.

* The numberofapproved hospitals (as of April 1,2021) .....87

## Detailed Information 2 Regional Medical Care Support Hospital System

### Purpose

Given the viewpoint that it is desirable to provide medical care to patients in their neighborhood area, a specific function hospital was founded subject to the 1997 revision of the Medical Care Act, as a hospital capable of supporting family doctors and dentists in charge of regional medical care, through medical care provision for referral patients and joint utilization of medical devices, etc., as well as a hospital ensuring regional medical care. The approval of the foundation is given by the concerned prefectural governor individually.

### Roles

- ❍ Provide medical care to patients on referral (including the reverse case in which patients are referred to family doctors)
- ❍ Implement shared use of medical devices
- ❍ Provide emergency medical care
- ❍ Conduct training for regional medical professionals

### Requirements for Approval

- ❍ Principal entity of foundation: Government, prefecture, municipality, social medical corporation, medical corporation, etc. in principle.
- ❍ Providing medical care mainly to referred patients (meeting one of the following)
  - [1] Incoming referred rate of at least 80%
  - [2] Incoming referred rate of at least 65% and outgoing referred rate of at least 40%
  - [3] Incoming referred rate of at least 50% and outgoing referred rate of at least 70%
- ❍ Having the ability to provide emergency medical care
- ❍ Securing a system to enable doctors, etc. in regions to use buildings, facilities, and devices, etc.
- ❍ Holding trainings for those engaged in regional medical care.
- ❍ Having at least 200 hospital beds in principle and facilities appropriate for being regional medical care support hospitals, etc.

* The number of approved hospitals (as of September, 2020) ..... 652 Hospitals

## Detailed Information 3 Outline of Clinical Research Core Hospital System

### Purpose

As part of efforts to systematize medical facility functions, the Minister of Health, Labour and Welfare approves individual hospitals having capabilities of playing a core role in the implementation of clinical research.

### Roles

○Design a plan for a specified clinical research and conduct it
○Play a leading role in the implementation of a specified clinical research in case where it is conducted in cooperation with another hospital or clinic
○Provide another hospital or clinic with consultations on the implementation of specified clinical researches and necessary information, advice or another type of assistance
○Provide trainings on specified clinical researches

### Requirements of Approval

○Number of specified clinical researches conducted (in the past three years)
- Number of specified clinical researches conducted by its own……8 or more clinical trials led by doctors or 4 or more clinical trials led by doctors and 40 or more specified clinical researches
- Number of specified clinical researches conducted jointly with different facilities……2 or more clinical trials led by doctors or 20 or more specified clinical researches

○Number of papers on specified clinical researches (in the past three years) …….45 cases or more
○Number of cases where assistance was provided for specified clinical researches conducted by other medical institutions (in the past year) ....15 cases or more
○Training on high-quality clinical researches
- Number of workshops held for persons who conduct specified clinical researches (in the past year) …….6 times or more
- Number of workshops held for persons who support specified clinical researches (in the past year) …….6 times or more
- Number of workshops held for members of Certified Review Board (in the past year) ..... 3 times or more

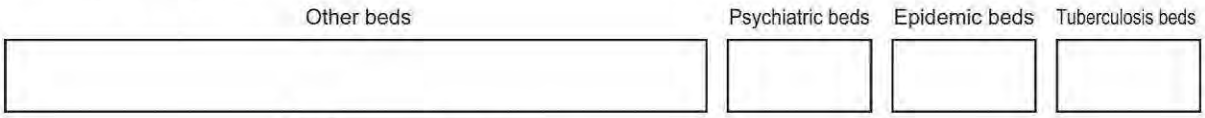
○Having 10 or more specified clinical departments
○Number of hospital beds: Having at least 400 hospital beds
○Staff deployment
- Doctors and dentists: 5 persons or more
- Pharmacists: 5 persons or more
- Nurses: 10 persons or more
- Clinical research coordinators, etc.: 24 persons or more
- Data managers: 3 persons or more
- Biological statisticians: 2 persons or more
- Persons who have experience in working in pharmaceutical affairs approval examination bodies: 1 person or more

○Facilities: Must have clinical research facilities with equipment to ensure accuracy of researches and intensive care units
○The requirements for approval concerning the number of new specified clinical researches conducted and the number of papers on specified clinical researches are separately set for clinical research core hospitals that deal with specific areas.

* The number of approved hospitals (as of April 1, 2021) ..... 13 Hospitals

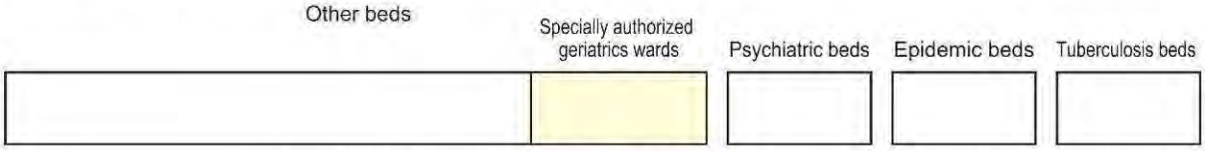
## Detailed Information 4 Revision of Bed Classification

**[At the beginning (from 1948)]**



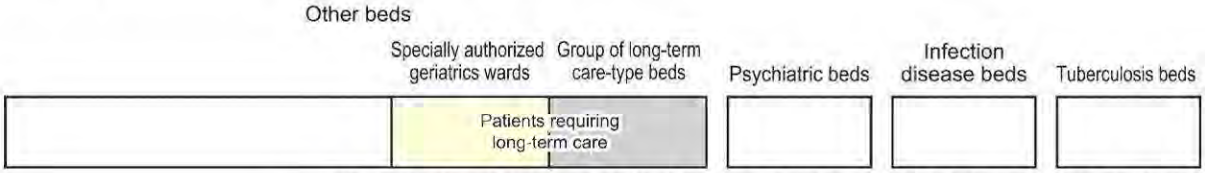

- Progress of aging
- Changes in disease structure

**[Introduction of specially authorized geriatrics wards (1983)]**



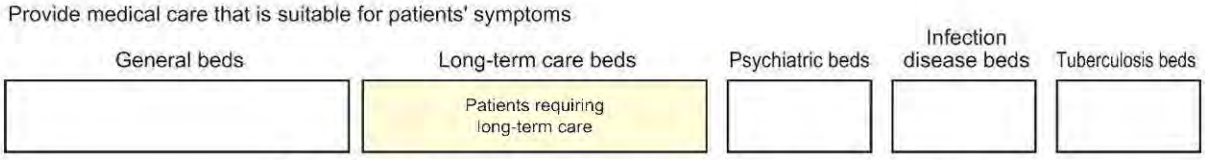

- In order to cope with the progress in aging and changes in disease structure, it was necessary to create facilities to provide medical care not only for elderly but for "patients requiring long-term care" in general.

**[Creation of long-term care-type bed group system (1992)]**



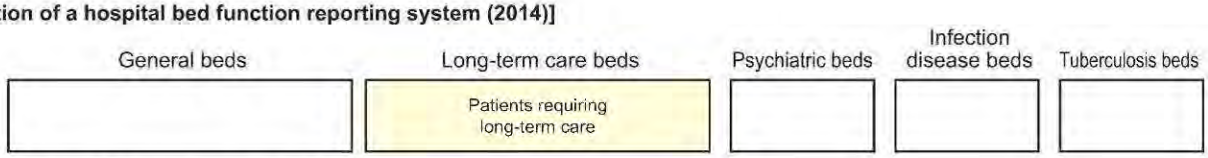

- The number of patients requiring long-term care increased due to changes in disease structure caused by the rapid progress in the birth rate decline and aging. Although various systems have been created, including long-term care-type bed group system, patients with various symptoms are still intermingled.

**[Creation of general beds and long-term care beds (2000)]**




- In order to promote division/cooperation of medical functions, identifying and analyzing information on medical functions implemented by the respective medical institutions in regions is important.

**[Creation of a hospital bed function reporting system (2014)]**




A system for selecting one of highly acute phase, acute phase, recovery phase, and chronic phase functions and reporting the function of general hospital beds and long-term care beds in each hospital ward was created.

# Trends with Medical Institutions

## Overview — Changes in Number of Medical Institutions (Hospitals and Clinics)

| Year | Hospitals | National (regrouped) | Public (regrouped) | Others (regrouped) | General clinics | Dental clinics |
|---|---|---|---|---|---|---|
| 1877 | 159 | 12 | 112 | 35 | | |
| 1882 | 626 | (330) | | 296 | | |
| 1892 | 576 | (198) | | 378 | | |
| 1897 | 624 | 3 | 156 | 465 | | |
| 1902 | 746 | 4 | 151 | 591 | | |
| 1907 | 807 | 5 | 101 | 691 | | |
| 1926 | 3,429 | (1,680) | | 1,749 | | |
| 1930 | 3,716 | (1,683) | | 2,033 | | |
| 1935 | 4,625 | (1,814) | | 2,811 | 35,772 | 18,066 |
| 1940 | 4,732 | (1,647) | | 3,085 | 36,416 | 20,290 |
| 1945 | 645 | (297) | | 348 | 6,607 | 3,660 |
| 1950 | 3,408 | 383 | 572 | 2,453 | 43,827 | 21,380 |
| 1955 | 5,119 | 425 | 1,337 | 3,357 | 51,349 | 24,773 |
| 1960 | 6,094 | 452 | 1,442 | 4,200 | 59,008 | 27,020 |
| 1965 | 7,047 | 448 | 1,466 | 5,133 | 64,524 | 28,602 |
| 1970 | 7,974 | 444 | 1,388 | 6,142 | 68,997 | 29,911 |
| 1975 | 8,294 | 439 | 1,366 | 6,489 | 73,114 | 32,565 |
| 1980 | 9,055 | 453 | 1,369 | 7,233 | 77,611 | 38,834 |
| 1985 | 9,608 | 411 | 1,369 | 7,828 | 78,927 | 45,540 |
| 1990 | 10,096 | 399 | 1,371 | 8,326 | 80,852 | 52,216 |
| 1995 | 9,606 | 388 | 1,372 | 7,846 | 87,069 | 58,407 |
| 1996 | 9,490 | 387 | 1,368 | 7,735 | 87,909 | 59,357 |
| 1997 | 9,413 | 380 | 1,369 | 7,664 | 89,292 | 60,579 |
| 1998 | 9,333 | 375 | 1,369 | 7,589 | 90,556 | 61,651 |
| 1999 | 9,286 | 370 | 1,368 | 7,548 | 91,500 | 62,484 |
| 2000 | 9,266 | 359 | 1,373 | 7,534 | 92,824 | 63,361 |
| 2001 | 9,239 | 349 | 1,375 | 7,515 | 94,019 | 64,297 |
| 2002 | 9,187 | 336 | 1,377 | 7,474 | 94,819 | 65,073 |
| 2003 | 9,122 | 323 | 1,382 | 7,417 | 96,050 | 65,828 |
| 2004 | 9,077 | 304 | 1,377 | 7,396 | 97,051 | 66,557 |
| 2005 | 9,026 | 294 | 1,362 | 7,370 | 97,442 | 66,732 |
| 2006 | 8,943 | 292 | 1,351 | 7,300 | 98,609 | 67,392 |
| 2007 | 8,862 | 291 | 1,325 | 7,246 | 99,532 | 67,798 |
| 2008 | 8,794 | 276 | 1,320 | 7,198 | 99,083 | 67,779 |
| 2009 | 8,739 | 275 | 1,296 | 7,168 | 99,635 | 68,097 |
| 2010 | 8,670 | 274 | 1,278 | 7,118 | 99,824 | 68,384 |
| 2011 | 8,605 | 274 | 1,258 | 7,073 | 99,547 | 68,156 |
| 2012 | 8,565 | 274 | 1,252 | 7,039 | 100,152 | 68,474 |
| 2013 | 8,540 | 273 | 1,242 | 7,025 | 100,528 | 68,701 |
| 2014 | 8,493 | 329 | 1,231 | 6,933 | 100,461 | 68,592 |
| 2015 | 8,480 | 329 | 1,227 | 6,924 | 100,995 | 68,737 |
| 2016 | 8,442 | 327 | 1,213 | 6,902 | 101,529 | 68,940 |
| 2017 | 8,412 | 327 | 1,211 | 6,874 | 101,471 | 68,609 |
| 2018 | 8,372 | 324 | 1,207 | 6,841 | 102,105 | 68,613 |
| 2019 | 8,300 | 322 | 1,202 | 6,776 | 102,616 | 68,500 |

Source: 1875-1937: "Annual Report of Public Health" , Ministry of Internal Affairs
1938-1952: "Annual Report of Public Health" , Ministry of Health and Welfare
From 1953 on: "Survey of Medical Institutions" , Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW
(Note) The figures in parentheses indicate the total number of public sector medical institutions.

## Detailed Data 1 — Changes in Number of Hospitals by Establishing Organization and Number of Beds

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 8,862 | 8,794 | 8,739 | 8,670 | 8,605 | 8,565 | 8,540 | 8,493 | 8,480 | 8,442 | 8,412 | 8,372 | 8,300 |
| National | 291 | 276 | 275 | 274 | 274 | 274 | 273 | 329 | 329 | 327 | 327 | 324 | 322 |
| Public medical institutions | 1,325 | 1,320 | 1,296 | 1,278 | 1,258 | 1,252 | 1,242 | 1,231 | 1,227 | 1,213 | 1,211 | 1,207 | 1,202 |
| Social insurance organizations | 123 | 122 | 122 | 121 | 121 | 118 | 115 | 57 | 55 | 53 | 52 | 52 | 51 |
| Medical corporations | 5,702 | 5,728 | 5,726 | 5,719 | 5,712 | 5,709 | 5,722 | 5,721 | 5,737 | 5,754 | 5,766 | 5,764 | 5,720 |
| Private | 533 | 476 | 448 | 409 | 373 | 348 | 320 | 289 | 266 | 240 | 210 | 187 | 174 |
| Others | 888 | 872 | 872 | 869 | 867 | 864 | 868 | 866 | 866 | 855 | 846 | 838 | 831 |
| 20-99 beds | 3,391 | 3,339 | 3,296 | 3,232 | 3,182 | 3,147 | 3,134 | 3,092 | 3,069 | 3,039 | 3,007 | 2,977 | 2,945 |
| 100-299 beds | 3,875 | 3,876 | 3,875 | 3,882 | 3,877 | 3,882 | 3,873 | 3,873 | 3,888 | 3,890 | 3,905 | 3,906 | 3,892 |
| 300-499 beds | 1,123 | 1,111 | 1,106 | 1,096 | 1,090 | 1,087 | 1,083 | 1,091 | 1,098 | 1,095 | 1,089 | 1,081 | 1,062 |
| 500+ beds | 473 | 468 | 462 | 460 | 456 | 449 | 450 | 437 | 425 | 418 | 411 | 408 | 401 |

Source: "Survey of Medical Institutions", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

## Detailed Data 2 Changes in Number of Hospitals by Hospital Type

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 8,862 | 8,794 | 8,739 | 8,670 | 8,605 | 8,565 | 8,540 | 8,493 | 8,480 | 8,442 | 8,412 | 8,372 | 8,300 |
| Psychiatric hospitals | 1,076 | 1,079 | 1,083 | 1,082 | 1,076 | 1,071 | 1,066 | 1,067 | 1,064 | 1,062 | 1,059 | 1,058 | 1,054 |
| Tuberculosis sanatorium | 1 | 1 | 1 | 1 | 1 | 1 | – | – | – | – | – | – | – |
| General hospitals | 7,785 | 7,714 | 7,655 | 7,587 | 7,528 | 7,493 | 7,474 | 7,426 | 7,416 | 7,380 | 7,353 | 7,314 | 7,246 |

Source: “Survey of Medical Institutions”, Health Statistics Office to to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

## Detailed Data 3 Changes in Number of Beds by Bed Type and Number of Beds per Hospital

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 1,620,173 | 1,609,403 | 1,601,476 | 1,593,354 | 1,583,073 | 1,578,254 | 1,573,772 | 1,568,261 | 1,565,968 | 1,561,005 | 1,554,879 | 1,546,554 | 1,529,215 |
| Psychiatric beds | 351,188 | 349,321 | 348,121 | 346,715 | 344,047 | 342,194 | 339,780 | 338,174 | 336,282 | 334,258 | 331,700 | 329,692 | 326,666 |
| Infectious disease beds | 1,809 | 1,785 | 1,757 | 1,788 | 1,793 | 1,798 | 1,815 | 1,778 | 1,814 | 1,841 | 1,876 | 1,882 | 1,888 |
| Tuberculosis beds | 10,542 | 9,502 | 8,924 | 8,244 | 7,681 | 7,208 | 6,602 | 5,949 | 5,496 | 5,347 | 5,210 | 4,762 | 4,370 |
| Long-term care beds | 343,400 | 339,358 | 336,273 | 332,986 | 330,167 | 328,888 | 328,195 | 328,144 | 328,406 | 328,161 | 325,228 | 319,506 | 308,444 |
| General beds | 913,234 | 909,437 | 906,401 | 903,621 | 899,385 | 898,166 | 897,380 | 894,216 | 893,970 | 891,398 | 890,865 | 890,712 | 887,847 |
| Number of beds per hospital | 182.8 | 183.0 | 183.3 | 183.8 | 184.0 | 184.3 | 184.3 | 184.7 | 184.7 | 184.9 | 184.8 | 184.7 | 184.2 |

Source: ”Survey of Medical Institutions”, Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

## Detailed Data 4 Changes in Bed Utilization Rate and Average Length of Stay by Bed Type

| | Bed utilization rate | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
| Total | 82.2 | 81.7 | 81.6 | 82.3 | 81.9 | 81.5 | 81.0 | 80.3 | 80.1 | 80.1 | 80.4 | 80.5 | 80.5 |
| Psychiatric beds | 90.2 | 90.0 | 89.9 | 89.6 | 89.1 | 88.7 | 88.1 | 87.3 | 86.5 | 86.2 | 86.1 | 86.1 | 85.9 |
| Infectious disease beds | 2.2 | 2.4 | 2.8 | 2.8 | 2.5 | 2.4 | 3.0 | 3.2 | 3.1 | 3.2 | 3.3 | 3.6 | 3.8 |
| Tuberculosis beds | 37.1 | 38.0 | 37.1 | 36.5 | 36.6 | 34.7 | 34.3 | 34.7 | 35.4 | 34.5 | 33.6 | 33.3 | 33.2 |
| Long-term care beds | 90.7 | 90.6 | 91.2 | 91.7 | 91.2 | 90.6 | 89.9 | 89.4 | 88.8 | 88.2 | 88.0 | 87.7 | 87.3 |
| General beds | 76.6 | 75.9 | 75.4 | 76.6 | 76.2 | 76.0 | 75.5 | 74.8 | 75.0 | 75.2 | 75.9 | 76.2 | 76.5 |
| Long-term care beds for nursing care | 93.9 | 94.2 | 94.5 | 94.9 | 94.6 | 93.9 | 93.1 | 92.9 | 92.1 | 91.4 | 90.9 | 91.3 | 90.7 |

| | Average length of stay | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
| Total | 34.1 | 33.8 | 33.2 | 32.5 | 32.0 | 31.2 | 30.6 | 29.9 | 29.1 | 28.5 | 28.2 | 27.8 | 27.3 |
| Psychiatric beds | 317.9 | 312.9 | 307.4 | 301.0 | 298.1 | 291.9 | 284.7 | 281.2 | 274.7 | 269.9 | 267.7 | 265.8 | 265.8 |
| Infectious disease beds | 9.3 | 10.2 | 6.8 | 10.1 | 10.0 | 8.5 | 9.6 | 8.9 | 8.2 | 7.8 | 8.0 | 8.3 | 8.5 |
| Tuberculosis beds | 70 | 74.2 | 72.5 | 71.5 | 71.0 | 70.7 | 68.8 | 66.7 | 67.3 | 66.3 | 66.5 | 65.6 | 64.6 |
| Long-term care beds | 177.1 | 176.6 | 179.5 | 176.4 | 175.1 | 171.8 | 168.3 | 164.6 | 158.2 | 152.2 | 146.3 | 141.5 | 135.9 |
| General beds | 19 | 18.8 | 18.5 | 18.2 | 17.9 | 17.5 | 17.2 | 16.8 | 16.5 | 16.2 | 16.2 | 16.1 | 16.0 |
| Long-term care beds for nursing care | 284.2 | 292.3 | 298.8 | 300.2 | 311.2 | 307.0 | 308.6 | 315.5 | 315.8 | 314.9 | 308.9 | 311.9 | 301.4 |

Source: ”Hospital Report”, Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

(Note) 1.The figures for March 2011 only include only the reported number of patients for 11 institutions (one in Kesen medical district, one in Miyako medical district of Iwate Prefecture, two in Ishinomaki medical district and two in Kesennuma medical district of Miyagi Prefecture, and five in Soso medical district of Fukushima Prefecture) due to the effect of the Great East Japan Earthquake.

2. The figures for April 2016 include the number of patients except for one institution in Kumamoto prefecture (Aso medical area) which didn't submit the report due to the impact of the 2016 Kumamoto earthquake.
3. The figures for July and August 2018 include the number of patients except for one institution in Hiroshima Prefecture (Osan Medical Area) which didn't submit the report due to the impact of the heavy rain in July 2018.

## Overview of National Hansen's Disease Sanatoriums and National Hospital Organization, etc.

**Overview** **Overview of National Hansen's Disease Sanatoriums and National Hospital Organization, etc.**

### [National Hansen's Disease Sanatoriums]

(1) 1,468 persons are admitted in 13 National Hansen's Disease Sanatoriums nationwide (as of May 1, 2020).
(2) National Hansen's Disease Sanatoriums provide mainly Hansen's disease aftereffects and medical care and health care related to lifestyle diseases for those as a result of aging.

(Reference) Number of facilities

| Classification | Number of facilities | Number of persons admitted |
|---|---|---|
| National Hansen's Disease Sanatoriums | 13 | 1,090 |

| Classification | Number of facilities | Students quota (persons) |
|---|---|---|
| Training schools for nurses (National Hansen's Disease Sanatoriums) | 2 | 80 |

**[National Hospital Organization]**

(1) National Hospital Organization is an independent administrative agency established and based on the "Act on the National Hospital Organization, Independent Administrative Agency" (Act No. 191 of 2002).
(2) National Hospital Organization utilizes nationwide hospital networks and provides examination, treatment, clinical study, education, and training in an integrated manner for medical care requiring risk management and active contribution by the government, medical care in the area of safety net that is not always implemented by other establishing entities, and medical care for 5 diseases and 5 businesses with regional needs taken into consideration.

(Reference) Number of hospitals (as of October 1, 2020)

| Institutions | Number of hospitals | Number of beds |
|---|---|---|
| National Hospital Organization | 143 | 53,029 |

**[National Research Center for Advanced and Specialized Medical Care]**

(1) National Research Centers for Advanced and Specialized Medical Care compose of 6 research-type national research and development agency established by shifting from National Centers for Advanced and Specialized Medical Care to non-public officer type independent administrative agencies under the "Act on National Research and Development Agency to Carry Out Research on Advanced Specialized Medical Services" (Act No. 93 of 2008)
(2) National Research Centers for Advanced and Specialized Medical Care conduct comprehensive and unitary surveys, research and development of technology as well as providing medical treatment associated with such diseases and training for specialized medical professionals on diseases with a great impact on people's health such as cancer, cerebral apoplexy, and cardiac diseases

(Reference) Number of hospitals (as of April 1, 2021)

| Institutions | Specialized diseases, etc. | Number of hospitals | Number of beds |
|---|---|---|---|
| National Cancer Center | Cancer and other malignant neoplasm | 2 | 1,003 |
| National Cerebral and Cardiovascular Center | Cardiovascular diseases, cardiac diseases, cerebral apoplexy, hypertension | 1 | 550 |
| National Center of Neurology and Psychiatry | Mental diseases, neurological diseases, muscular diseases, mental retardation and other developmental disorders | 1 | 486 |
| National Center for Global Health and Medicine | Infection diseases and other diseases, International medical cooperation for developing countries. | 2 | 1,166 |
| National Center for Child Health and Development | Child health and development (pediatric care, maternity, paternal medicine, etc.) | 1 | 490 |
| National Center for Geriatrics and Gerontology | Geriatrics and gerontology (senile dementia, osteoporosis, etc.) | 1 | 383 |

(Reference) Number of facilities (as of April 1, 2021)

| Classification | Number of facilities | Students quota (persons) |
|---|---|---|
| National College of Nursing (National Center for Global Health and Medicine) | 1 | 400 |

**[Japan Community Health care Organization]**

(1) Japan Community Health care Organization is an independent administrative agency established and based on "Act on the Japan Community Health care Organization, Independent Administrative Agency" (Act No. 71 of 2005).
(2) Japan Community Health care Organization has a wide variety of medical functions from emergency to rehabilitation. Also, one of the main traits of Japan Community Health care Organization is that about half of the hospitals under Japan Community Health care Organization have long-term care health facilities for the elderly. Through utilization of such facilities and collaboration with regional medical personnel, as an organization having nationwide facilities, it provides a wide variety of services seamlessly ranging from emergency to recovery rehabilitation to care for health and deals with securing regional medical and comprehensive care services. It especially specializes in 5 diseases, 5 businesses and rehabilitation, house care, etc. which are necessary in medicine and care in regional communities.

(Reference) Number of facilities (as of February 1, 2021)

| Classification | Number of facilities | Number of beds |
|---|---|---|
| Hospital | 57 | 15,240 |

| Classification | Number of facilities | [Admission capacity] |
|---|---|---|
| Long-term care health facilities | 26 | 2,479 |

| Classification | Number of facilities | [Student capacity] |
|---|---|---|
| Nursing School | 6 | 685 |

# Medical Professionals

## Overview Number of Physicians, etc.

The number of Physicians and dentists are increasing every year. As of December 31, 2018, there are 311,963 Physicians and 101,777 dentists.

### Number of Medical Professionals

| | |
|---|---|
| • Physicians | 311,963 persons |
| • Dentists | 101,777 persons |
| • Pharmacists | 240,371 persons |

Source: "Statistics of Physicians, Dentists and Pharmacists 2018", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

* Doctors and dentists are employees in medical facilities. Pharmacist are employees in pharmacies or medical facilities.

| | |
|---|---|
| • Public health nurses | 64,819 persons |
| • Midwives | 40,632 persons |
| • Nurses | 1,272,024 persons |
| • Assistant nurses | 305,820 persons |

Source: Health Policy Bureau, MHLW (2019)

| | |
|---|---|
| • Physical therapists (PT) | 91,694.8 persons |
| • Occupational therapists (OT) | 47,852.0 persons |
| • Orthoptists | 8,889.1 persons |
| • Speech language hearing therapists | 16,639.2 persons |
| • Orthotists | 105.3 persons |
| • Clinical radiologic technologists | 54,213.1 persons |
| • Medical technicians | 66,866.0 persons |
| • Clinical engineers | 28,043.4 persons |

Source: "Survey of Medical Institutions and Hospital Report 2017", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

* Full-time equivalent numbers

| | |
|---|---|
| • Dental hygienists | 132,629 persons |
| • Dental technicians | 34,468 persons |
| • Massage and shiatsu practitioners | 118,916 persons |
| • Acupuncturists | 121,757 persons |
| • Moxibustion practitioners | 119,796 persons |
| • Judo therapists | 73,017 persons |

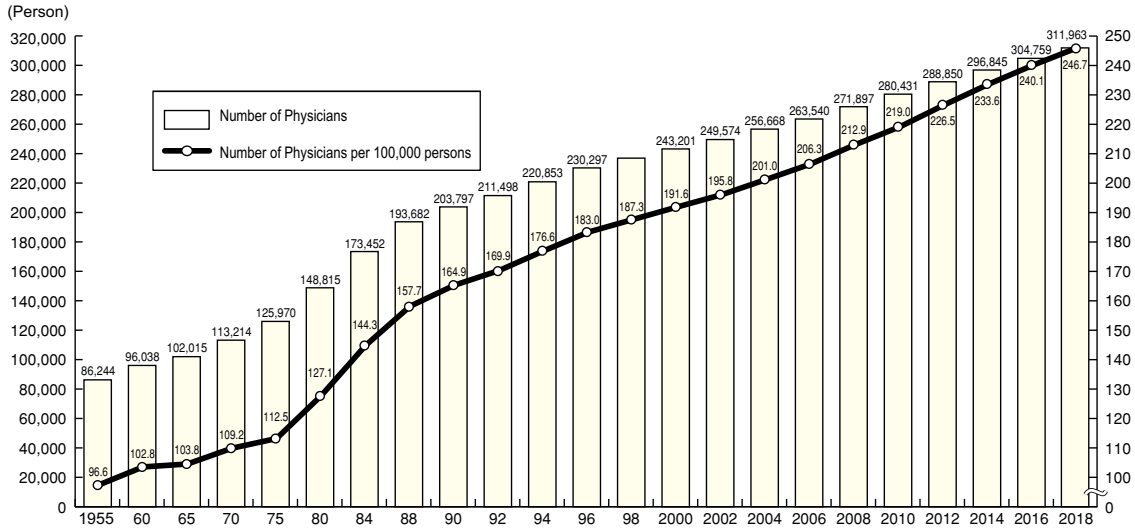
Source: "Report on Public Health Administration and Services 2018", Administrative Report Statistics Office to the Director-General for Statistics and Information Policy, MHLW

| | |
|---|---|
| • Emergency life-saving technicians | 61,771 persons |

Source: Health Policy Bureau, MHLW (as of March 31, 2020)

* Number of registered licensees

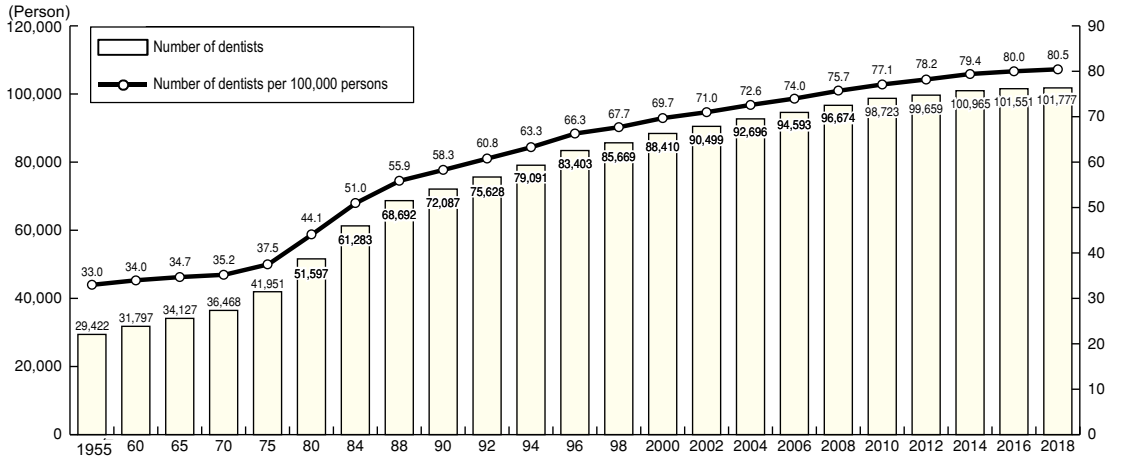
## Detailed Data 1 Changes in Number of Physicians




Source: "Statistics of Physicians, Dentists and Pharmacists", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

* Medical facility employees

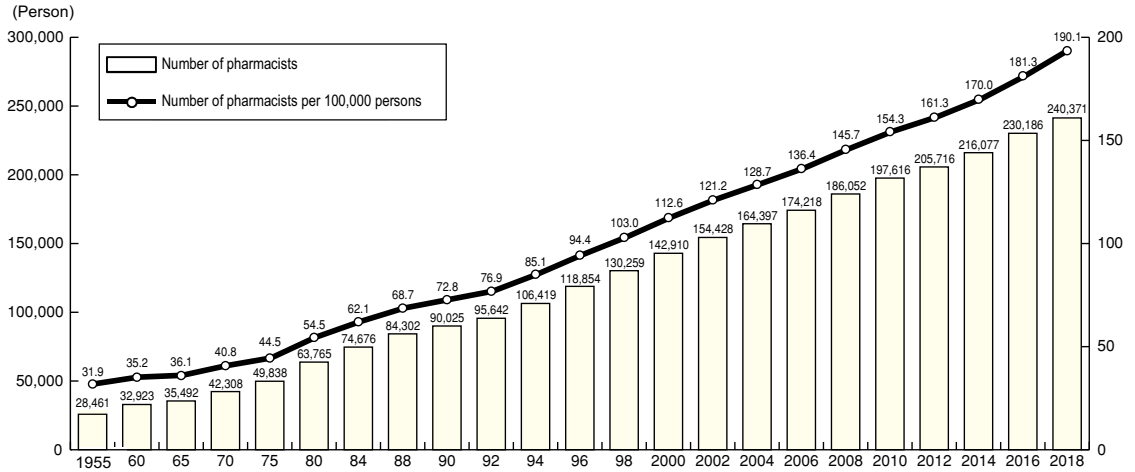
## Detailed Data 2 Changes in Number of Dentists




Source: "Statistics of Physicians, Dentists and Pharmacists", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

* Medical facility employees

## Detailed Data 3 Changes in Number of Pharmacists

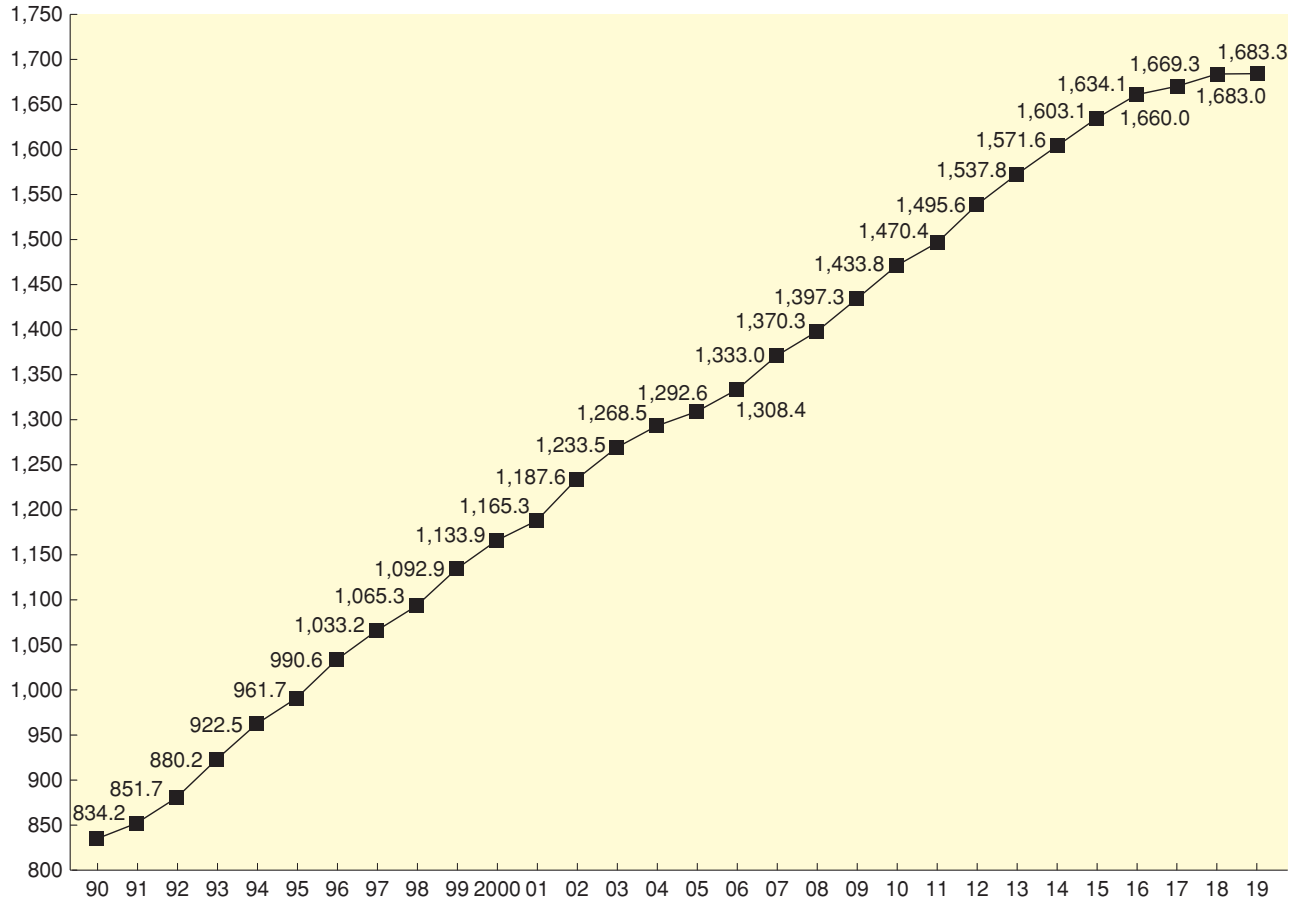



Source: "Statistics of Physicians, Dentists and Pharmacists", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

* Pharmacy or Medical facility employees

**Detailed Data 4** **Changes in Number of Nursing personnel**

(1,000 persons)




Source: Health Policy Bureau, MHLW

# Conforming Rate to the Statutory Number of Doctors and Nurses Designated in the Medical Care Act and Sufficiency Status (Results of FY2018 On-Site Inspection)

## Detailed Data 1 Regional Conforming Rates

(Unit: %)

| Classification \ Region | Nationwide | Hokkaido Tohoku | Kanto | Hokuriku Koshinetsu | Tokai | Kinki | Chugoku | Shikoku | Kyushu |
|---|---|---|---|---|---|---|---|---|---|
| Doctors | 97.0 | 92.7 | 98.6 | 96.2 | 98.8 | 99.3 | 96.3 | 95.1 | 97.2 |
| Nurses | 99.0 | 99.7 | 98.1 | 99.3 | 98.4 | 98.6 | 99.2 | 99.3 | 99.8 |

## Detailed Data 2 Nationwide Achievement Status

| | Hospitals with insufficient number of doctors | Hospitals with sufficient number of doctors | Total |
|---|---|---|---|
| Hospitals with sufficient number of nurses | 7,467（95.7） | 225（2.9） | 7,692（98.6） |
| Hospitals with insufficient number of nurses | 104（1.3） | 6（0.1） | 110（1.4） |
| Total | 7,571（97.0） | 231（3.0） | 7,802（100.0） |

(Note) The figures represent the number of hospitals (excluding dental hospitals) and the figures in parentheses represent the percentage.

**(Explanation of terms)**

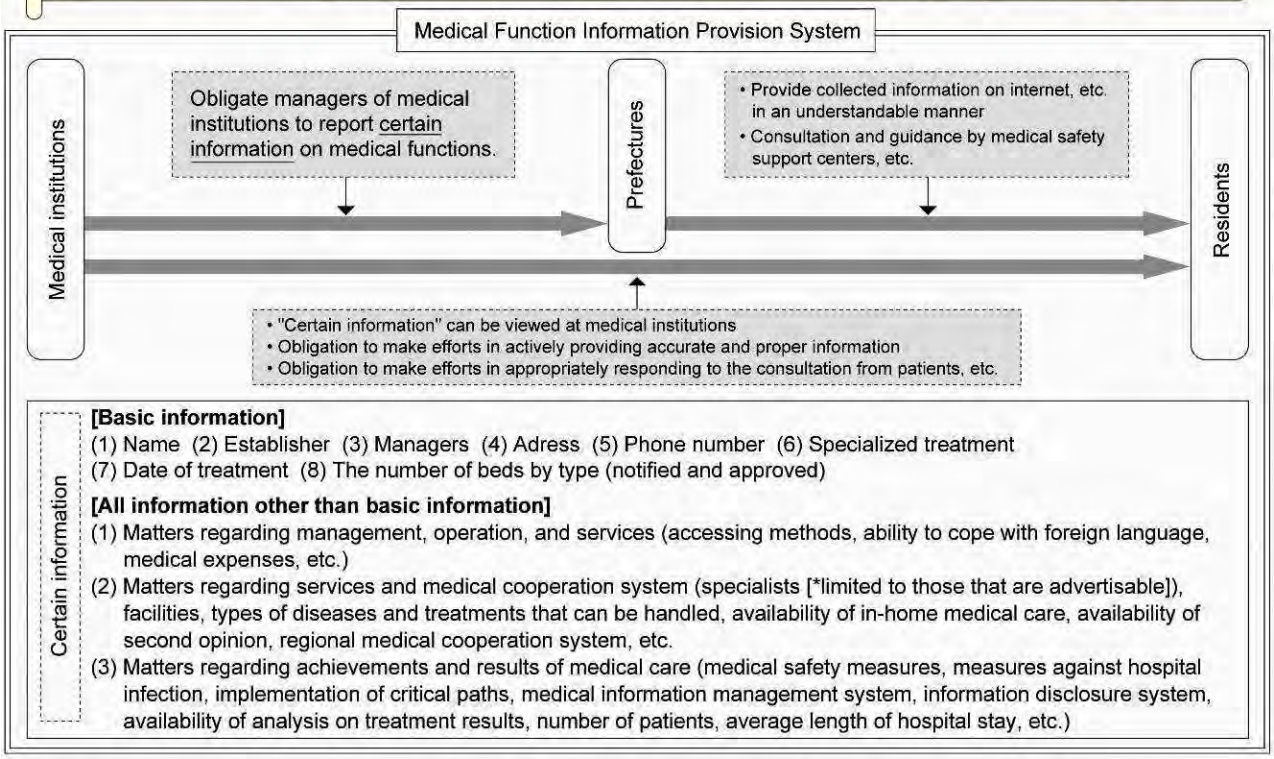
- **Numerical standards:** The statutory number of doctors, nurses and associate nurses to be placed in a hospital is prescribed by the Medical Care Act.
- **Conforming rate:** "Percentage of hospitals satisfying the designated number of doctors/nurses" in "hospitals for which on-site investigation are conducted".
- **Sufficient/insufficient:** Of hospitals for which on-site investigation are conducted, those satisfying the numerical standards are counted as "sufficient" and those not satisfying the numerical standards are counted as "insufficient".

# Provision of Medical Function Information

**Overview** **Creation of Medical Function Information Provision System**

Enforced April 1, 2007

Create a system to obligate medical institutions to report certain information on medical functions to prefectures and prefectures to collect the information and provide it to the public in an understandable manner (a similar system is created with pharmacies)




## Provision of documented explanation at the time hospitalization (Medical Care Act) (revised in 2006)

Legally establish in the Medical Care Act that managers of hospitals and clinics formulate, issue, and explain treatment plans at the beginning/end of hospitalization.

**[Overview of the revised system]**

Obligation to provide treatment plans at the beginning of hospitalization

- Managers of medical institutions are obliged to prepare, issue, and appropriately explain treatment plans describing treatments to be provided to patients during hospitalization.
- In so doing, managers are obliged to make efforts in reflecting knowledge of medical professionals of hospitals/clinics and facilitate organic cooperation with them.

(Items to be described in the treatment plan)
- ♦ Name, date of birth, and gender of the patient
- ♦ Name of a doctor or dentist who is in charge of providing treatment to the patient
- ♦ Specify disease or injury that caused hospitalization and main symptoms
- ♦ Plans for providing examinations, surgeries, medications, and other treatments during hospitalization
- ♦ Other items designated by the Ordinances of the Ministry of Health, Labour and Welfare

Obligation to make efforts in providing recuperation plans at the end of hospitalization

- Managers of medical institutions are obliged to make efforts in preparing, issuing, and appropriately explaining recuperation plans describing matters regarding required health care, medical care, and welfare services after discharge.
- In so doting, managers are obliged to make efforts in cooperating with health care, medical care, and welfare service providers.

**[Effects]** • Improved information provision to patients • Improved informed consent • Promotion of team medical care
• Enhanced cooperation with other medical institutions (so-called adjustment function for leaving hospital)
• Promotion of evidence-based medicine (EBM), etc.

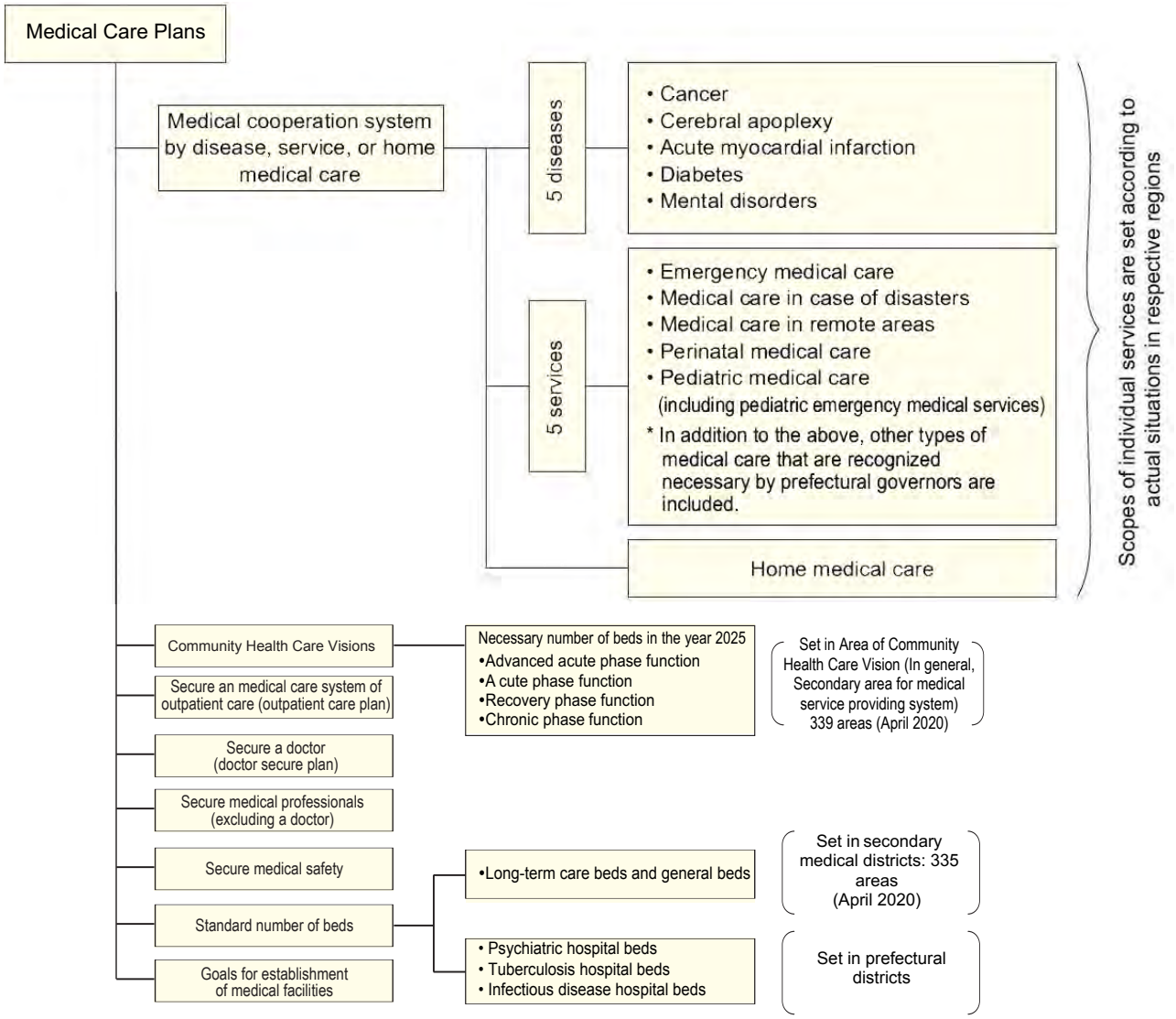
# Medical Care Plan

## Overview Overview of Medical Care Plan

**1. Purpose**

Establish a system for providing high quality and appropriate medical care efficiently by realizing continued medical care in communities through promoting a division of roles and cooperation of medical functions.

**2. Contents**




**3. Status of standard number of beds and number of existing beds**

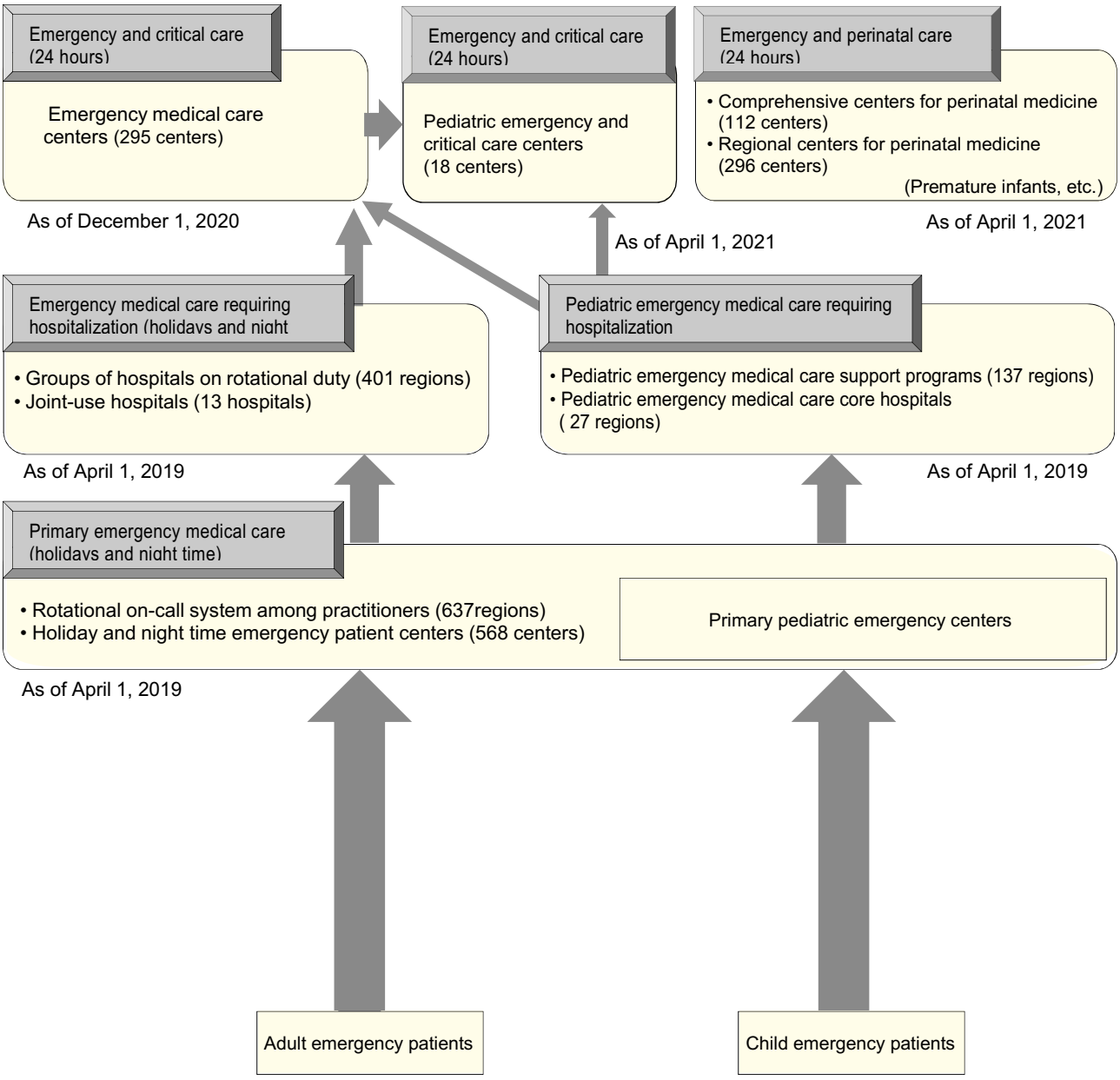
(As of April 2018)

| Classification | Standard number of beds | Number of existing beds |
|---|---|---|
| Long-term care beds and general beds | 1,017,066 | 1,228,598 |
| Psychiatric hospital beds | 282,104 | 330,405 |
| Tuberculosis hospital beds | 2,950 | 4,854 |
| Infectious disease hospital beds | 1,941 | 1,987 |

## Emergency Medical Service System

**Overview**

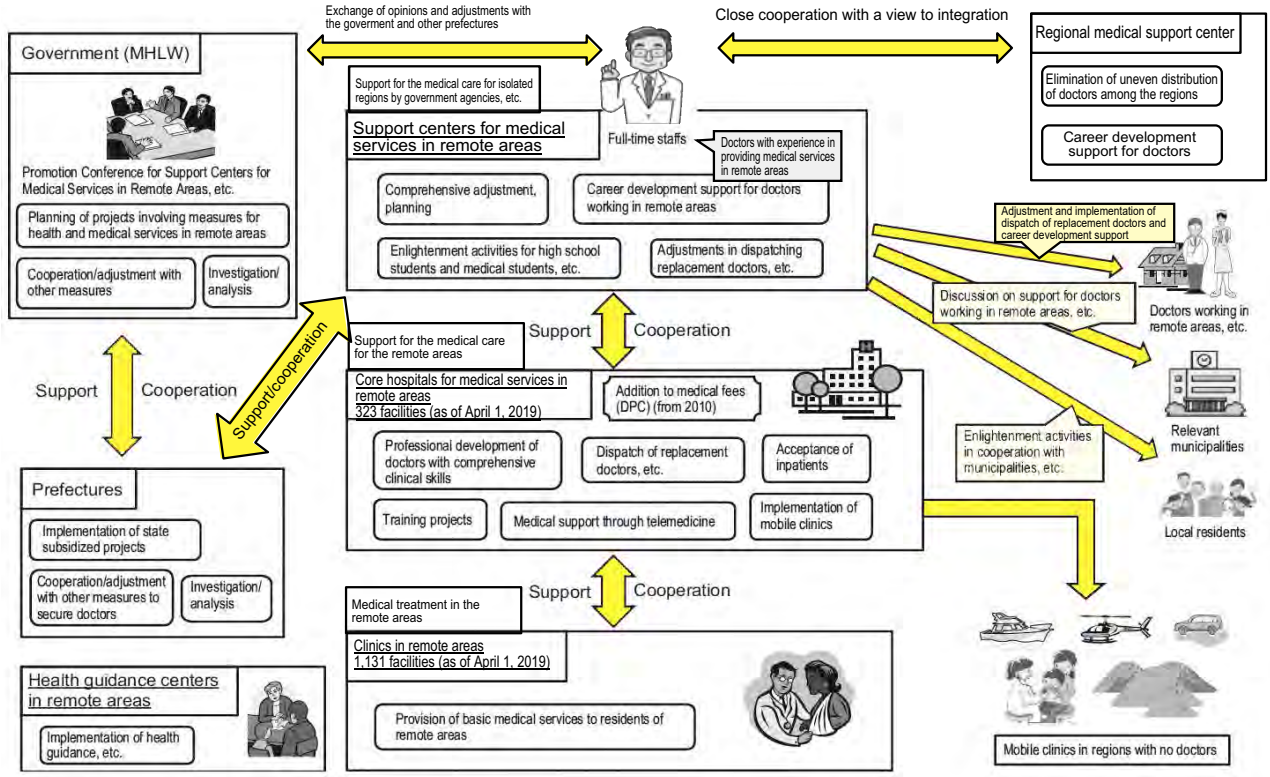
**Structural Chart of Emergency Medical Service**



# Medical Services in Remote Areas

**Overview** **Structural Chart of Measures for Health and Medical Services in Remote Area**

Establish an effective, efficient, and sustainable system that can provide medical services in remote areas mainly via prefectural support centers for medical services in remote areas in cooperation with governments, doctors working in remote areas, facilities and institutions engaged in medical services in remote areas, and residents of remote areas, and through studying advanced cases in other prefectures.




## Current Status of Measures for Health and Medical Services in Remote Areas

**1. Efforts to build the medical system in remote areas**

The medical system in remote areas, which has been taken measures in the remote area health care plan until 2017, shall be formulated integrally with the medical plan from 2018, and the medical system in remote areas shall be enhanced while further coordinating with other projects.

| Year of investigation (once every 5 years) | Regions with no doctors | Subject population (10,000 persons) |
|---|---|---|
| 1973 | 2,088 | 77 |
| 1984 | 1,276 | 32 |
| 1999 | 914 | 20 |
| 2004 | 787 | 16.5 |
| 2009 | 705 | 13.6 |
| 2014 | 637 | 12.4 |
| 2019 | 590 | 12.7 |

* Regions with no doctors Regions with no medical institutions in which population of 50 or more people live within a radius of approximately 4 km from the major location of the region and it is not easy to use a medical institution.

**2. Status of Establishment**

(1) Prefectural office to support medical services in remote areas (subject to assistance for operational expenses)
Scheduled to be established/operated in 40 prefectures as of April 1, 2019

(2) Core hospitals for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
323 hospitals are designated as of April 1, 2019

(3) Clinics for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
1,131 clinics (including National Health Insurance direct managed clinics) are established as of April 1, 2019

# Medical Safety Measures

**Overview**

## Medical Safety Measures

**[Basic idea]** Implement respective measures with great respect being paid to the viewpoint of medical safety and quality improvement taking into consideration report of the study group on medical safety measures (June 2005).

| <Key Suggestions> | <Measures> |
|---|---|
| **[Improved medical quality and safety]**<br>❍ Systematization of establishment of certain safety management system in clinics with no beds, dental clinics, maternity clinics, and pharmacies<br>([1]preparation of safety management guideline manual, [2] implementation of training on medical safety, and [3] internal report of accidents, etc.)<br>❍ Improved measures against hospital infection in medical institutions<br>([1] preparation of guidelines/manuals for preventing hospital infection, [2] implementation of training on hospital infection, [3] internal report on situation of infection, and [4] establishment of committee on hospital infection (only in hospitals and clinics with beds))<br>❍ Security of drug/medical device safety<br>([1] clarification of responsibilities regarding safety use, [2] establishment of work processes regarding safety use, and [3] regular maintenance check on medical devices)<br>❍ Improved quality of medical professionals<br>❍ Obligation for administratively punished medical professionals to take re-education training | ❍ Enhancement of medical safety management system (revision of law in 2006, etc.)<br>❍ Obligation of establishment of hospital infection control system (revision of Ministry Ordinance in 2006)<br>❍ Obligation of placement of responsible persons regarding safety use of drugs/medical devices, etc. (revision of Ministry Ordinance in 2006)<br>❍ Work guidelines for medical safety managers and guidelines for formulating training programs (March 2007)<br>❍ Obligation for punished medical professionals to take re-education training (revision of law in 2006, etc.) |
| **[Thorough implementation of preventive measures against recurrence through investigation/analysis of causes of medical accident cases, etc.]**<br>❍ Thorough implementation of preventive measures against recurrence through investigation/analysis of causes of accident cases<br>❍ Discussion on reporting system of medical related deaths, investigation system of cause of medical related deaths, and out-of-court dispute resolution system in medical areas | ❍Promotion of projects to collect information on medical accidents, etc. (from FY2004)<br>❍ Provision of "medical safety information" (from FY2005-FY2014)<br>❍ Model projects for investigation/analysis of deaths related to medical practices (from FY2005)<br>❍ Training projects for developing human resources to engage in coordination/mediation of medical disputes (FY2006)<br>❍ Discussion on investigation of causes and prevention of recurrences of deaths caused by medical accidents, etc. (from April 2007 to December)<br>❍ Japan Obstetric Compensation System for Cerebral Palsy (from January 2009)<br>❍ Liaison Conference of Alternative Medical Dispute Resolution Organizations (from March 2010)<br>❍ Discussion on utilization of autopsy imaging for determination of cause of death (from September 2010 to July 2011)<br>❍ Discussion on ideal no-fault compensation system that will contribute to the improvement of medical care quality (from August 2011 to June 2013)<br>❍ Enforcement of investigation system for medical accidents (October 2015~) |
| **[Promotion of information sharing with patients and the public and independent participation from patients and the public]**<br>❍ Promotion of information sharing with patients and the public and independent participation from patients and the public<br>❍ Systematization of medical safety support centers | ❍ Promotion of Patient Safety Action (PSA) (from FY2001)<br>❍ Obligation for medical institutions, etc. to make efforts in providing appropriate consultations to patients (revision of law in 2006)<br>❍ Systematization of medical safety support centers (revision of law in 2006, etc.)<br>❍ Work guidelines for medical communication promoters and guidelines for formulating their training programs (January 2013) |
| **[Roles of the government and local governments on medical safety]**<br>❍ Clarification of responsibilities of the government, prefectures, and medical institutions and roles of patients and the public, etc.<br>❍ Establishment of laws and regulations, promotion of research, and provision of financial support, etc. | ❍ Clarification of responsibilities of the government, local governments, and medical institutions (revision of law in 2006)<br>❍ Promotion of comprehensive support projects of medical safety support centers (from FY2003)<br>❍ Research for promoting medical safety management system (scientific research of health, labour and welfare)<br>❍ Guidelines for safety management in Intensive Care Unit (ICU) (March 2007)<br>❍ Model projects for making perinatal medical institutions open hospitals (FY2005-FY2007) |

# Improved Quality of Doctors

**Overview**

## History of Clinical Training System

○ **1948 1-Year internship system after graduation started** (1-year program necessary to be qualified for National Examination)
○ **1968 Creation of clinical training system** (effort obligation of more than 2 years after obtaining medical license)

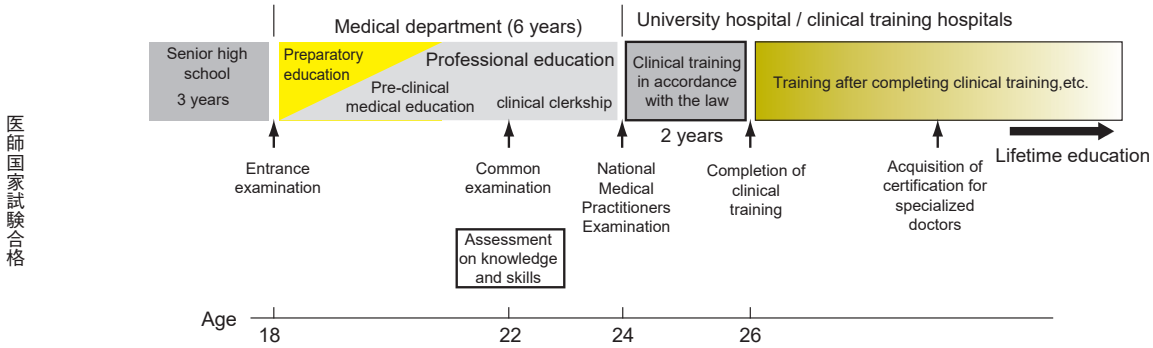
**[Issues of the conventional system]**
1. Training was voluntary
2. Training programs were not clearly defined
3. Mainly focused on straight training for specialized doctors
4. Remarkably large disparities existed among institutions
5. Insufficient guidance system
6. Insufficient evaluation of training achievements
7. Unstable status/work conditions " part-time jobs
8. Heavy concentration of interns in large hospitals in urban areas

○ **2000 Revision of the Medical Practitioners Act and the Medical Care Act** (obligating clinical training)
○ **2004 Enforcement of the new system**
○ **2010 Revision of the system**
○ **2015 Revision of the system**
○ **2020 Revision of the system**

## Overview of Clinical Training System

### 1. Medical Education and Clinical Training

○ Article 16-2 of the Medical Practitioners Act
Doctors to engage in clinical practice must take clinical training in hospitals attached to universities with medical training courses or hospitals designated by the Minister of Health, Labour and Welfare for no less than 2 years.




### 2. Basic Ideas of Clinical Training
**(Ministerial Ordinance on clinical training provided in paragraph 1, Article 16-2 of the Medical Practitioners Act)**

Clinical training must offer doctors the opportunity to cultivate the appropriate bedside manner and acquire basic diagnosis and treatment abilities while recognizing the social role to be fulfilled by medicine and medical services regardless of their future specialty so that they can provide appropriate treatment for injuries and diseases that frequently occur.

### 3. Status of Execution

[1] Clinical resident training facilities (FY2019)

| | |
|---|---|
| Clinical resident training hospitals (core type) | 913 |
| Clinical resident training hospitals (cooperative type) | 1,488 |
| University hospitals (core type equivalent) | 124 |
| University hospitals (cooperative type equivalent) | 16 |

[2] Changes in enrollment status of interns (by university hospitals and clinical training hospitals)

| Classification | University hospitals | Clinical resident training hospitals |
|---|---|---|
| Old system (FY2003) | 72.5% | 27.5% |
| 1st year of new system (FY2004) | 55.8% | 44.2% |
| 2nd year of new system (FY2005) | 49.2% | 50.8% |
| 6th year of new system (FY2009) | 46.8% | 53.2% |
| 7th year of new system (FY2010) | 47.2% | 52.8% |
| 10th year of new system (FY2013) | 42.9% | 57.1% |
| 11th year of new system (FY2014) | 42.8% | 57.2% |
| 12th year of new system (FY2015) | 41.7% | 58.3% |
| 13th year of new system (FY2016) | 40.5% | 59.5% |
| 14th year of new system (FY2017) | 40.4% | 59.6% |
| 15th year of new system (FY2018) | 38.9% | 61.1% |
| 16th year of new system (FY2019) | 38.1% | 61.9% |

[3] Changes in enrollment status of interns (by 6 prefectures with large cities (Tokyo, Kanagawa, Aichi, Kyoto, and Osaka) and other prefectures)

| Classification | 6 prefectures | Other prefectures |
|---|---|---|
| Old system (FY2003) | 51.3% | 48.7% |
| 1st year of new system (FY2004) | 47.8% | 52.2% |
| 6th year of new system (FY2009) | 48.6% | 51.4% |
| 7th year of new system (FY2010) | 47.8% | 52.2% |
| 10th year of new system (FY2013) | 45.5% | 54.5% |
| 11th year of new system (FY2014) | 44.4% | 55.6% |
| 12th yeay of new system (FY2015) | 43.6% | 56.4% |
| 13th yeay of new system (FY2016) | 42.6% | 57.4% |
| 14th yeay of new system (FY2017) | 41.8% | 58.2% |
| 15th yeay of new system (FY2018) | 41.7% | 58.3% |
| 16th yeay of new system (FY2019) | 41.7% | 58.3% |

## Outline of 2015 System Reform

**(1) Appropriate core clinical training hospitals**
- Appropriate core clinical training hospitals are clearly defined as those having an environment capable of training for most of the achievement goals and having overall management of, and responsibility for, interns and training programs.

**(2) Appropriate clinical training hospital groups**
- Groups consist of those capable of forming various abilities related to frequently occurring diseases, etc.
- The geographical coverage of a hospital group is basically within the same prefecture and secondary medical district.

**(3) Cases required for core clinical training hospitals**
- Newly applied hospitals with the annual number of inpatients being less than 3,000, but 2,700 or more that are deemed capable of providing high-quality training, are assessed through on-site evaluation for the time being.

**(4) Career development support**
- Smooth interruption/resumption of clinical training according to various career paths, including pregnancy, childbirth, research, and study abroad, etc.

**(5) Revision of recruitment quota setting**
- Reduction of the percentage of recruitment quotas for internship applicants (from approx. 1.23 times (FY2013) to 1.2 times for the time being (FY2015) and 1.1 times towards the next revision)
- Partial revision of the calculation formula for the upper limits of prefectures (the aging rate and the number of doctors per unit population are newly considered)
- The actual results of dispatching doctors of university hospitals, etc. is considered when setting a recruitment quota for each hospital.

**(6) Responses to regional limits and strengthening of roles of prefectures**
- Limits are included to enable a prefecture to adjust the quota for each hospital within the upper limit of the prefecture with consideration given to regional limits and the actual results of dispatching doctors, etc.
- Necessary reviews will be made within 5 years after the enforcement of this revised system.

## Outline of 2020 System Reform

**(1) Comprehensive Doctor training before and after graduation**
- Set up outcomes, measures and evaluation applicable for medical education model core curriculum.

**(2) Outcomes, measures and evaluation**
- As outcomes, set up 'basic value as a doctor (professionalism)', 'capabilities, abilities' and 'basic diagnosis task' and 'ensure basic medical examination for admission, out-patient, emergencies and regional medicines'.
- As measures, make surgery, pediatrics, gynecology and obstetrics and psychiatry compulsory in addition to internal medicine, emergency, regional medicine and add that it includes the training for out-patients.
- Standardize the evaluation considering the continuity with model core curriculum.

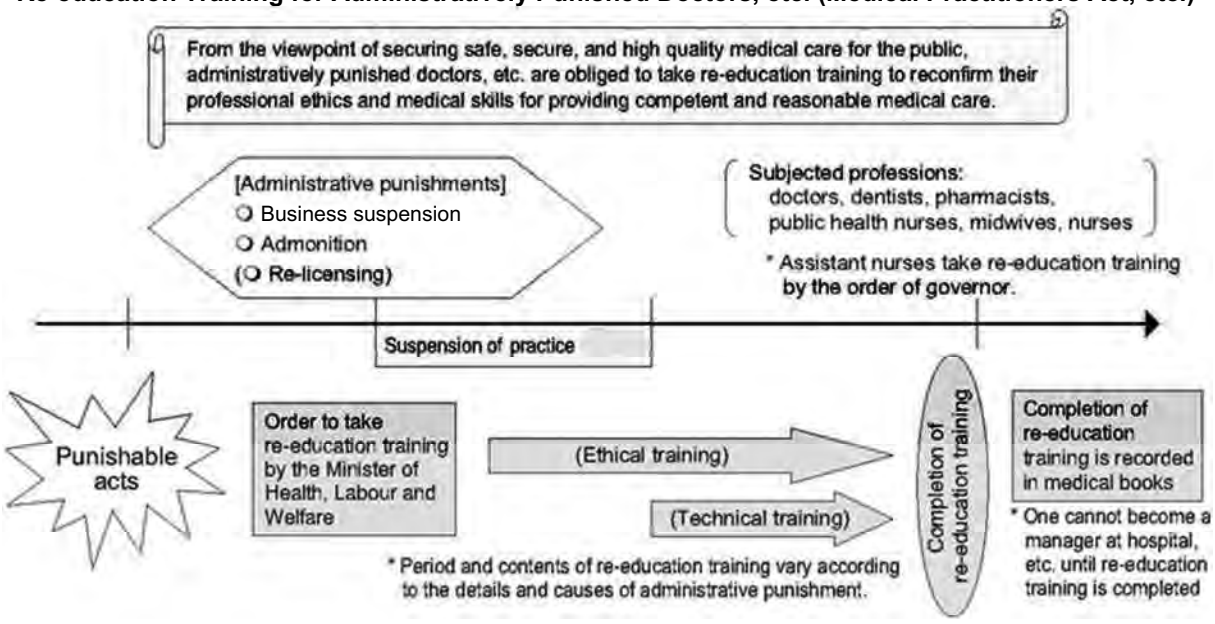
**(3) The modality of clinical training hospital**
- Make three-stage evaluation to four-stage for visiting survey of core hospitals which may have challenges and delete the designation from hospitals which do not show any improvement.
- Make the training for those who are in charge of program compulsory.
- Recommend strongly the third party evaluation.

**(4) Stable assurance of regional medical**
- Compress the recruiting ration up to 1.05 times and limit the maximum for calculating recruiting number of admission quota of medical department.
- As for the part of regional positions, etc., recruit differently from general matching.
- For setting up the designation and application number of clinical training hospital, prefectural governments will hear from regional medical measures committees, first.

**(5) Responses to diminishing international competitiveness on basic researches**
- Set up courses for capacity building and training for basic doctors in university hospitals which are basic clinical training hospitals. Separate applicants from general applications and separate selection from the general matching.

*Conduct required reviews within five years after the enforcement of this system review.

## Re-education Training for Administratively Punished Doctors, etc. (Medical Practitioners Act, etc.)



## Medical Corporation System

# Outline of Medical Corporation System

### 1. Purpose of the system

○ Corporate bodies based on the Medical Care Act. The system was created by the 1950 revision of the Medical Care Act.
○ Enabling administrative bodies of medical care service programs to become corporate bodies without losing the non-profit status of medical practices.

[Around the time of the system establishment]
Reducing the difficulties of administering medical institutions by private persons
(aiming to make fund collection easier)

→

Granting continuity of administration of medical institutions
→ Securing stability of regional medical care

### 2. Establishment

○ Associations or foundations based on the Medical Care Act.
○ Prefectural approval
(An organization opening a medical institute in more than 2 prefectures shall obtain approval from a governor at its main address.)

(Number of corporations)
- Medical corporations 55,674 (as of March 31, 2020)
  Of which 55,304 are associations (16,583 without contribution and 38,721 with contribution) and 370 are foundations.
  * Medical corporation without contribution
    - Medical corporation for which the ownership of residual assets in the event of dissolution is stipulated to be the government, local governments, or other medical corporations without contribution, etc. and exclude individuals (investors).
    - The revised Medical Care Act of 2006 limits newly established medical corporations to be those without contribution. The existing medical corporations, however, shall voluntarily transfer while applying the previous provisions.
- Social medical corporations 323 (as of April 1, 2020)

### 3. Operation

○A medical corporation may carry out operations associated with the health/hygiene and social welfare in addition to medical practice (operation of hospitals, clinics, long-term care health facilities)
○Medical corporations certified as social medical corporations may engage in profit-making practices for the purpose of appropriating the profits to the administration of hospitals, etc.
○Dividend of surplus is not allowed.
  * Social medical corporations
    - Established by the 2006 revision of the Medical Care Act as medical corporations with high public interest that take roles of providing emergency medical care and medical services in remote areas while utilizing high vitality of the private sector.
    - Must meet the requirements such that family corporation members are excluded from being officers, etc. and limiting the ownership of residual assets, in the event of dissolution, to the government and local governments, etc.
    - Exempt from corporation tax on medical and health practices. Exempt from fixed assets tax on hospitals/clinics that engage in practices for securing emergency medical care, etc.

# (3) Health Promotion/Disease Measures

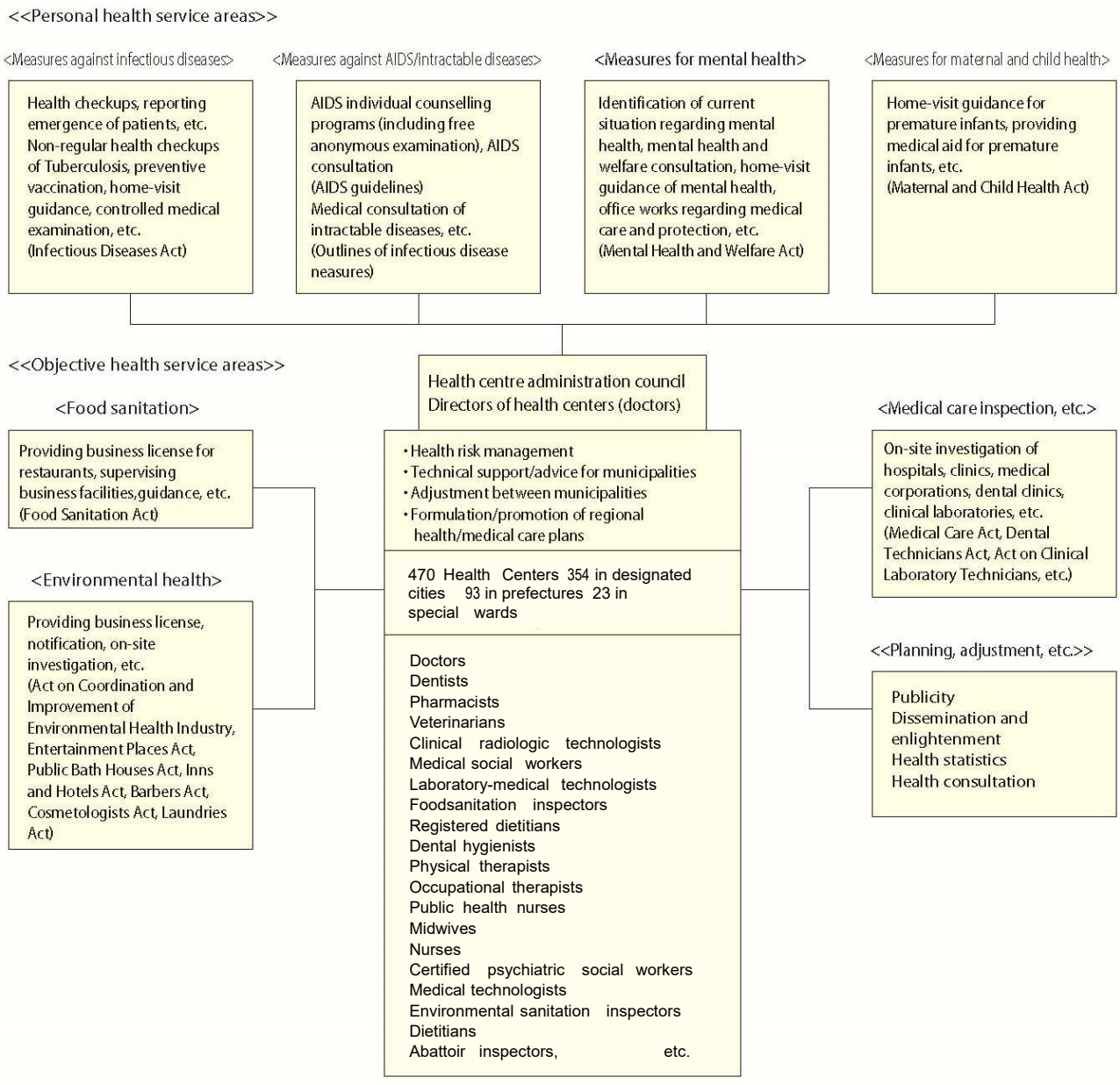
## Health Centers, etc.

**Overview**

### Activities of Health Centers

Health centers are front-line comprehensive public health administrative institutions that offer both personal and objective health services. Personal health services include broad-based services, services requiring specialized technologies, and services requiring team work of various health care professionals. In addition, health centers provide required technical assistance for health services provided by municipalities.

Health centers are established in 354 locations in 47 prefectures, 93 locations in 87 designated cities, and 23 locations in 23 special wards under the Community Health Act (As of April 1, 2021).




* In addition to the activities above, health centers provide licenses for opening pharmacies (Pharmaceuticals and Medical Devices Act), take custody of dogs to prevent the spread of rabies (Rabies Prevention Act), and accept applications for opening massage clinics, etc. (Act on Practitioners of Massage, Finger Pressure, Acupuncture and Moxa-cauterization, etc.).

### Changes in Number of Health Centers

| FY | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total number of health centers | 518 | 517 | 510 | 494 | 495 | 495 | 494 | 490 | 486 | 480 | 481 | 469 | 472 | 469 | 470 |
| Prefectures | 394 | 389 | 380 | 374 | 373 | 372 | 370 | 365 | 364 | 364 | 363 | 360 | 359 | 355 | 354 |
| Cities | 101 | 105 | 107 | 97 | 99 | 100 | 101 | 102 | 99 | 93 | 95 | 86 | 90 | 91 | 93 |
| Special wards | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 |

Source: Health Service Bureau, MHLW
(Note) The number of clinics is as of April 1 of each year.

## Detailed Data 1 Number of Full-time Medical Personnel at Health Centers by Occupation

| Occupation | Number of personnel |
|---|---|
| | Person |
| Doctors | 738 |
| Dentists | 73 |
| Pharmacists | 2,998 |
| Veterinarians | 2,189 |
| Public health nurses | 8,516 |
| Midwives | 52 |
| Nurses | 123 |
| Assistant nurses | 4 |
| Radiology technicians, etc. | 425 |
| Medical technologists, etc. | 708 |
| Registered dietitians | 1,234 |
| Dietitians | 42 |
| Dental hygienists | 308 |
| Physical/occupational therapists | 83 |
| Others | 10,393 |
| <Included in the upper column> | |
| Medical social workers | 38 |
| Mental health welfare counselors | 1,016 |
| Nutrition counselors | 980 |
| Total | 27,886 |

Source: “Report on Regional Public Health Services and Health Promotion Services”, Administrative Report Statistics Office to the Director-General for Statistics and Information Policy, MHLW
(Modified by Health Service Bureau) (as of the end of FY2018)

## Detailed Data 2 Changes in Number of Public Health Nurses

(Unit: person)

| | FY2007 | FY2008 | FY2009 | FY2010 | FY2011 | FY2012 | FY2013 | FY2014 | FY2015 | FY2016 | FY2017 | FY2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Municipalities | 14,483 | 14,498 | 14,613 | 14,179 | 15,015 | 14,753 | 14,920 | 14,850 | 14,935 | 15,035 | 15,227 | 15,193 |
| Designated cities / special wards | 5,604 | 5,964 | 6,094 | 6,081 | 6,280 | 6,256 | 6,564 | 6,586 | 6,829 | 6,928 | 7,107 | 7,512 |
| Subtotal | 20,087 | 20,462 | 20,707 | 20,260 | 21,295 | 21,009 | 21,484 | 21,436 | 21,764 | 21,963 | 22,334 | 22,705 |
| Prefectures | 3,889 | 3,800 | 3,737 | 3,640 | 3,689 | 3,659 | 3,603 | 3,607 | 3,613 | 3,661 | 3,659 | 3,637 |
| Total | 23,976 | 24,262 | 24,444 | 23,900 | 24,984 | 24,668 | 25,087 | 25,043 | 25,377 | 25,624 | 25,993 | 26,342 |

Source: FY2007: “Report on Regional Public Health Services and Health Services for the Aged”, Administrative Report Statistics Office to the Director-General for Statistics and Information Policy, MHLW

FY2008 onward: “Report on Regional Public Health Services and Health Promotion Services”, Administrative Report Statistics Office to the Director-General for Statistics and Information Policy, MHLW

(Note) The figures for FY2010 do not include some municipalities in Iwate Prefecture (Kamaishi City, Otsuchi Town, Miyako City, and Rikuzentakata City), clinics and municipalities in Miyagi Prefecture apart from Sendai City, and some municipalities in Fukushima Prefecture (Minamisoma City, Naraha Town, Tomioka Town, Kawauchi Village, Okuma Town, Futaba Town, Iitate Town, and Aizuwakamatsu City) due to the effect of the Great East Japan Earthquake.

# Health Promotion Measures

## Overview History of National Health Promotion Measures

| | | | |
|---|---|---|---|
| 1st National Health Promotion Measures (FY 1978-1988) | (Basic concept)<br>1. Lifetime health promotion<br>(Promotion of primary prevention of geriatric diseases)<br>2. Promotion of health promotion measures through three major elements (diet, exercises, and rest) (special focus on diet) | (Outline of measures)<br>(1) Lifetime health promotion<br>• Establishment of health checkups and a complete health guidance system from infants and small children through to the elderly<br>(2) Establishment of health promotion bases<br>• Establishment of health promotion centers, municipal health centers, etc.<br>• Securing sufficient human resources, including public health nurses and dietitians<br>(3) Dissemination and enlightenment of health promotion<br>• Establishment of municipal health promotion councils<br>• Promoting the use of recommended dietary allowances<br>• Nutritional content labelling for processed food<br>• Conducting studies on health promotion, etc.<br>etc. | (Guidelines, etc.)<br>• Dietary guidelines for health promotion (1985)<br>• Report on nutritional content labelling for processed food (1986)<br>• Announcement of a weight scale diagram and table (1986)<br>• Report on smoking and health (1987) |
| 2nd National Health Promotion Measures (FY 1988-1999) (Active 80 Health Plan) | (Basic concept)<br>1. Lifetime health promotion<br>2. Promotion of health promotion measures with the focus on exercise habits as they are lagging behind the other two of the three elements (diet, exercise, and rest) | (Outline of measures)<br>(1) Lifetime health promotion<br>• Enhanced health checkup and guidance system from infants and small children through to the elderly<br>(2) Establishment of health promotion bases<br>• Establishment of health science centers, municipal health centers, health promotion facilities, etc.<br>• Securing sufficient manpower such as health fitness instructors, registered dietitians, and public health nurses<br>(3) Dissemination and enlightenment of health promotion<br>• Promoting the use of and revising recommended dietary allowances • Promoting recommended exercise allowance • Promoting the system to approve health promotion facilities<br>• Action plan for tobacco control<br>• Promoting a system of nutrition information labelling for meals eaten outside home<br>• Promoting cities with health oriented cultures and health resorts<br>• Conducting studies on health promotion, etc. | (Guidelines, etc.)<br>• Dietary guidelines for health promotion (by individual characteristics: 1990)<br>• Guidelines for nutrition information labeling for meals eaten outside home (1990)<br>• Report on smoking and health (revised) (1993)<br>• Exercise and Physical Activity Guidelines for Health Promotion (1993)<br>• Promoting guidelines on rest for health promotion (1994)<br>• Committee report on action plan for tobacco control (1995)<br>• Committee report on designated smoking areas in public spaces (1996)<br>• Physical activity guidelines by age (1997) |
| 3rd National Health Promotion Measures (FY2000-2012) (National Health Promotion Movement in the 21st Century (Health Japan 21)) | (Basic concept)<br>1. Lifetime health promotion<br>(Focusing on primary prevention, extension of healthy life expectancy, and enhanced quality of life)<br>2. Setting specific targets to serve as an indicator for national health/medical standards and promotion of health promotion measures based on assessments<br>3. Creation of social environments to support individuals' health promotion | (Outline of measures)<br>(1) National health promotion campaign<br>• Dissemination and enlightenment of effective programs and tools with regular revision<br>• Dissemination and enlightenment of the acquisition of good exercise habits and improved dietary habits with a focus on metabolic syndrome<br>(2) Implementation of effective medical examinations and health guidance<br>• Steady implementation of health checkups and health guidance with a focus on metabolic syndrome for insured persons/dependents aged 40 or older by Health Care Insurers (from FY2008)<br>(3) Cooperation with industry<br>• Further cooperation in voluntary measures of industries<br>(4) Human resource development (improving the quality of medical professionals)<br>• Improved training for human resource development in cooperation between the government, prefectures, relevant medical organizations, and medical insurance organizations<br>(5) Development of evidence-based measures<br>• Revision of data identification methods to enable outcome assessments<br>etc. | (Guidelines, etc.)<br>• Dietary guidelines (2000)<br>• Committee report on relevance to designated smoking areas (2002)<br>• Sleep guidelines for health promotion (2003)<br>• Guidelines on implementation of health checkups (2004)<br>• Japanese Dietary Reference Intake (2005 edition) (2004)<br>• Guidelines for well-balanced diet (2005)<br>• Manual for smoking cessation support (2006)<br>• Exercise and Physical Activity Reference for Health Promotion 2006 (exercise guide 2006) (2006)<br>• Exercise guidelines for health promotion 2006 (Exercise Guide 2006) (2006)<br>• Japanese Dietary Reference Intake (2010 edition) (2009) |
| 4th National Health Promotion Measures (from FY 2013) (The second term of National Health Movement in the 21st Century (Health Japan 21 (the second term)) | [Basic Concept]<br>1. Extension of healthy life expectancy and reduction of health disparities<br>2. Lifetime health promotion [prevention of onset and progression of lifestyle-related diseases, maintenance and improvement of functions necessary, establishment of social environment]<br>3. Improvement of lifestyle and social environment<br>4. Setting specific targets to serve as an indicator for national health/medical standards and promotion of health promotion measures based on assessments. | [Outline of measures]<br>(1) Focusing on extension of healthy life expectancy and reduction of health disparity<br>• Comprehensive promotion for lifestyle diseases and promotion of efforts supporting areas such as medical and long-term care.<br>(2) Prevention of onset and progression of lifestyle diseases (Prevention of NCD (Non-Communicable Diseases))<br>• Promotion measures focused on primary prevention of cancer, cardiovascular disease, diabetes and COPD in addition to prevention of progression.<br>(3) Maintenance and improvement of necessary functions for healthy social life.<br>• Promotion of mental health programs for mind, and health of the next generation and the elderly.<br>(4) Development of social environment for supporting and protecting health.<br>• Providing information on the activities of companies working voluntarily on promoting health and evaluating these activities.<br>(5) Improvement of lifestyle and social environment relating to nutrition, dietary habits, physical activity/exercise, rest, alcohol, smoking, dental and oral health, etc.<br>• Promoting formulation and review of standards and guidelines relating to all areas of lifestyle habits, dissemination of correct awareness, and establishment of cooperation with private companies and organization. | [Guidelines, etc.]<br>• 2013 Physical activities for healthy life (2013)<br>• Active Guideline—Physical activities for healthy life (2013)<br>• Manual for supporting non-smoking (2nd edition) (2013)<br>• 2014 Sleeping guideline for healthy life (2014)<br>• Japanese Dietary Reference Intake (2015 edition) (2014)<br>• A report on effects of smoking on health by a study group (FY2016)<br>• Smoking Cessation Supporting Manual (Second Edition) (Supplemental Revision) (2018) |

## Outline of the Health Promotion Act

**Chapter 1. General Provisions**

(1) Purpose

Provide basic matters regarding comprehensive promotion of people's health and make the effort to improve public health through implementation of measures for health promotion.

(2) Responsibilities

1. People: Improved interest and understanding of the importance of healthy lifestyle habits in being aware of one's own health status and make the effort to stay healthy throughout life.
2. The government and local governments: Make efforts to disseminate the appropriate knowledge on health promotion, collect/organize/analyze/make available information, promote researches, develop and improve the quality of human resources, and provide the required technical support.
3. Health promotion service providers (insurers, business operators, municipalities, schools, etc.): Make an active effort to promote health promotion programs for people including health consultations.

(3) Cooperation between the government, local governments, health promotion service providers, and other related entities.

**Chapter 2. Basic Policies (legally establish "Health Japan 21")**

(1) Basic policies

Basic policies for comprehensive promotion of people's health are formulated by the Minister of Health, Labour and Welfare.

1. Basic direction with promoting people's health
2. Matters regarding goals in promoting people's health
3. Basic matters regarding formulation of health promotion plans of prefectures and municipalities
4. Basic matters regarding national health and nutrition surveys in Japan and other surveillance and researches
5. Basic matters regarding cooperation between health promotion service providers
6. Matters regarding dissemination of the appropriate knowledge on dietary habits, exercise, rest, smoking, alcohol drinking, dental health, and other lifestyle habits
7. Other important matters regarding promotion of people's health

(2) Formulation of health promotion plans for prefectures and municipalities (plans for health promotion measure to the people)

(3) Guidelines on implementation of health checkups

Guidelines on implementation of health checkups by health promotion service providers, notification of the results, a health handbook being issued, and other measures are formulated by the Minister of Health, Labour and Welfare in supporting people's lifelong self management of health.

# Outline of Results of National Health and Nutrition Survey 2019

## National Health and Nutrition Survey

Objective: Amassing basic information for comprehensive promotion of national health in accordance with the Health Promotion (Act No.103 of 2002)

Subjects: Household in 300 unit areas randomly selected from unit areas established in comprehensive Survey of Living Conditions 2019 （approximately 4,465 households）,and members of households aged 1 or older （approximately 15,000 persons）

Survey items: [Survey on physical condition] Height, weight, abdominal circumference, blood pressure, blood tests, number of steps taken when walking, interview (medication status, exercise)
[Survey on nutritional intake] Food intake, nutrient intake, etc., dietary situation (skipping meals, eating out, etc.)
[Survey on lifestyle] General lifestyle encompassing dietary habits, physical activities, exercise, rest (sleep), alcohol usage, smoking, dental health, etc.

## Key points of the results of the survey

The proportion of those who are not improve eating and excise habits is one fourth of the population.

- The proportion of those who are interested in but not improving eating habits is highest, 24.6% in men and 25.0% in women.
- The proportion of those who are interested in but not improving exercise habits is highest, 23.9% in men and 26.3% in women.
- By the willing of improvement, the proportion of those who responded ‘no time because they are busy at work (housework, rearing kids, etc.)’ as a reason for preventing from barriers to healthy eating habits and barriers to regular exercise habits is the highest.

The situation of smoking and passive smoking is under improving

- The proportion of those who are smoking regularly is 16.7%, 27.1% in men and 7.6% in women which has significantly decreased within these 10 years.
- The proportion of participants who were exposed to passive smoking are 29.6% in restaurants and 27.1% in streets and recreation halls which has significantly decreased since 2003.

There is a regional gap on the preparation for emergency stocks of food.

- The proportion of those households who prepared for emergency stocks of food for preparing for disasters is 53.8%. By regional blocks, the highest block is Kanto I block (*1), 72.3% and lowest block is South Kyushu block (*2), 33.1%.
(*1 Saitama, Chiba, Tokyo, Kanagawa, *2 Kumamoto, Miyazaki, Kagoshima and Okinawa)
- Among households who are storing emergency stocks of food, the proportion of households which store emergency stocks of food for at least three days was 69.9%.

## Detailed Data 1 Status of formulating health promotion plans in regional governments nationwide

**[Status of formulating health promotion plans in prefectures]**
Already formulated in every prefecture (at the end of March 2004)

**[Status of formulating health promotion plans in municipalities and special wards]**

| | Total | Formulated | Plan to formulate in FY 2019 | Plan to formulate in FY 2020 | Plan to formulate in FY 2021 | No plan |
|---|---|---|---|---|---|---|
| Health center-designated cities | 84 | 84 | 0 | 0 | 0 | 0 |
| Special wards in Tokyo | 23 | 23 | 0 | 0 | 0 | 0 |
| Other municipalities | 1,634 | 1,529 | 11 | 13 | 55 | 26 |

(As of January 1, 2020)

**[Status of formulating health promotion plans in municipalities by prefectures]**

| Prefecture | No. of municipalities | Formulated | Formulation rate | FY 2019 | FY 2020 | FY 2021or later | No plan |
|---|---|---|---|---|---|---|---|
| Hokkaido | 175 | 136 | 77.7% | 2 | 1 | 33 | 3 |
| Aomori | 38 | 38 | 100.0% | 0 | 0 | 0 | 0 |
| Iwate | 32 | 32 | 100.0% | 0 | 0 | 0 | 0 |
| Miyagi | 34 | 34 | 100.0% | 0 | 0 | 0 | 0 |
| Akita | 24 | 24 | 100.0% | 0 | 0 | 0 | 0 |
| Yamagata | 34 | 34 | 100.0% | 0 | 0 | 0 | 0 |
| Fukushima | 56 | 49 | 87.5% | 1 | 2 | 3 | 1 |
| Ibaraki | 44 | 44 | 100.0% | 0 | 0 | 0 | 0 |
| Tochigi | 24 | 24 | 100.0% | 0 | 0 | 0 | 0 |
| Gunma | 33 | 33 | 100.0% | 0 | 0 | 0 | 0 |
| Saitama | 59 | 55 | 93.2% | 2 | 1 | 1 | 0 |
| Chiba | 51 | 49 | 96.1% | 1 | 1 | 0 | 0 |
| Tokyo | 37 | 29 | 78.4% | 0 | 0 | 3 | 5 |
| Kanagawa | 27 | 26 | 96.3% | 0 | 0 | 0 | 1 |
| Niigata | 29 | 29 | 100.0% | 0 | 0 | 0 | 0 |
| Toyama | 14 | 14 | 100.0% | 0 | 0 | 0 | 0 |
| Ishikawa | 18 | 18 | 100.0% | 0 | 0 | 0 | 0 |
| Fukui | 16 | 16 | 100.0% | 0 | 0 | 0 | 0 |
| Yamanashi | 26 | 26 | 100.0% | 0 | 0 | 0 | 0 |
| Nagano | 76 | 67 | 88.2% | 1 | 2 | 5 | 1 |
| Gifu | 41 | 41 | 100.0% | 0 | 0 | 0 | 0 |
| Shizuoka | 33 | 33 | 100.0% | 0 | 0 | 0 | 0 |
| Aichi | 50 | 50 | 100.0% | 0 | 0 | 0 | 0 |
| Mie | 28 | 26 | 92.9% | 1 | 1 | 0 | 0 |
| Shiga | 18 | 18 | 100.0% | 0 | 0 | 0 | 0 |
| Kyoto | 25 | 19 | 76.0% | 0 | 0 | 1 | 5 |
| Osaka | 35 | 32 | 91.4% | 0 | 0 | 0 | 3 |
| Hyogo | 36 | 36 | 100.0% | 0 | 0 | 0 | 0 |
| Nara | 38 | 38 | 100.0% | 0 | 0 | 0 | 0 |
| Wakayama | 29 | 24 | 82.8% | 1 | 0 | 1 | 3 |
| Tottori | 18 | 18 | 100.0% | 0 | 0 | 0 | 0 |
| Shimane | 18 | 18 | 100.0% | 0 | 0 | 0 | 0 |
| Okayama | 25 | 24 | 96.0% | 1 | 0 | 0 | 0 |
| Hiroshima | 20 | 20 | 100.0% | 0 | 0 | 0 | 0 |
| Yamaguchi | 18 | 18 | 100.0% | 0 | 0 | 0 | 0 |
| Tokushima | 24 | 23 | 95.8% | 0 | 1 | 0 | 0 |
| Kagawa | 16 | 16 | 100.0% | 0 | 0 | 0 | 0 |
| Ehime | 19 | 19 | 100.0% | 0 | 0 | 0 | 0 |
| Kochi | 33 | 33 | 100.0% | 0 | 0 | 0 | 0 |
| Fukuoka | 56 | 51 | 91.1% | 1 | 3 | 1 | 0 |
| Saga | 20 | 17 | 85.0% | 0 | 0 | 2 | 1 |
| Nagasaki | 19 | 19 | 100.0% | 0 | 0 | 0 | 0 |
| Kumamoto | 44 | 39 | 88.6% | 0 | 1 | 4 | 0 |
| Oita | 17 | 17 | 100.0% | 0 | 0 | 0 | 0 |
| Miyazaki | 25 | 24 | 96.0% | 0 | 0 | 0 | 1 |
| Kagoshima | 42 | 42 | 100.0% | 0 | 0 | 0 | 0 |
| Okinawa | 40 | 37 | 92.5% | 0 | 0 | 1 | 2 |
| | 1,634 | 1,529 | 93.6% | 11 | 13 | 55 | 26 |

(Note) Excluding health center-designated cities and special wards.

## Detailed Data 2 Number of Patients and Deaths Related to Lifestyle Diseases

| | Estimated number of patients receiving medical treatment (1,000 persons) | Number of deaths (Person) | Death rate (Per 100,000 persons) |
|---|---|---|---|
| Malignant neoplasms | 1,782 | 378,356 | 307.0 |
| Diabetes mellitus | 3,289 | 13,891 | 11.3 |
| Hypertensive diseases | 9,937 | 9,997 | 8.1 |
| Heart diseases (excluding hypertensive) | 1,732 | 205,518 | 166.7 |
| Cerebrovascular diseases | 1,115 | 102,956 | 83.5 |

Source:

<The estimated number of patients receiving medical treatment> "Patient Survey 2017", Health Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW

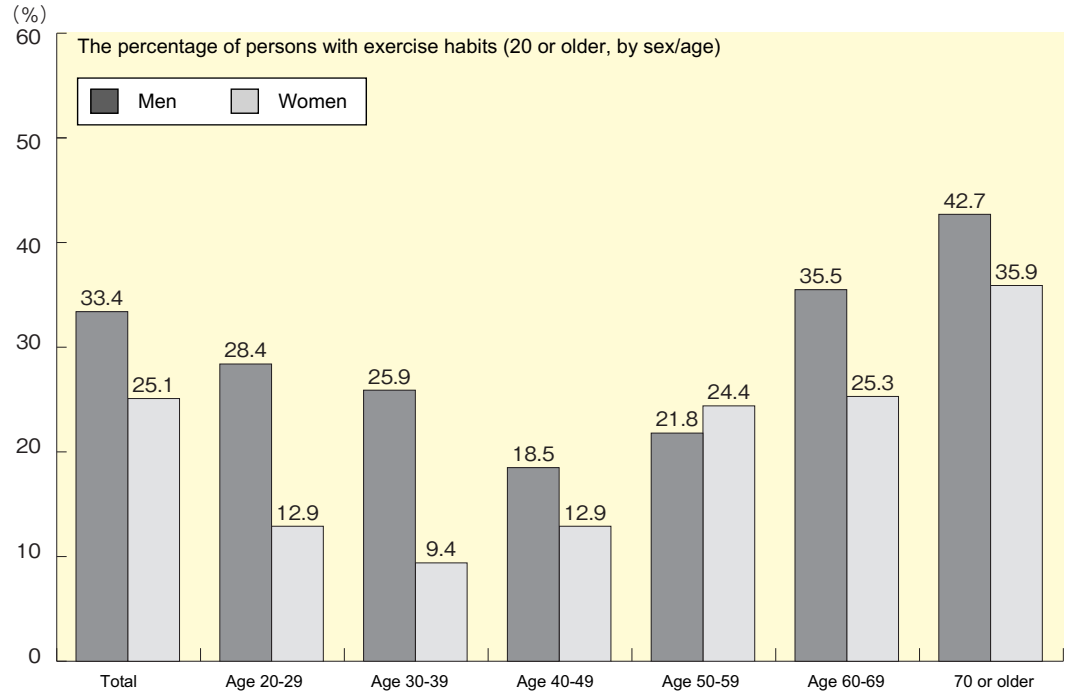
<Number of deaths, Death rate> "Vital Statistics", Vital, Health and Social Statistics Office to the Director-General for Statistics, Information Policy and Industrial Relations, MHLW
(2020 preliminary data)

## Detailed Data 3 Prevalence related to Diabetes

| | Males (survey samples: 1,013) | | Females (survey samples: 1,399) | |
|---|---|---|---|---|
| Age | Strongly suspected of having diabetes | With possibilities of having diabetes | Strongly suspected of having diabetes | With possibilities of having diabetes |
| 20-29 | 0.0% | 1.8% | 0.0% | 2.2% |
| 30-39 | 1.6% | 1.6% | 2.6% | 1.8% |
| 40-49 | 6.1% | 6.1% | 2.8% | 4.7% |
| 50-59 | 17.8% | 11.8% | 5.9% | 13.1% |
| 60-69 | 25.3% | 14.9% | 10.7% | 18.3% |
| 70 or older | 26.4% | 16.2% | 19.6% | 16.5% |

Source: "National Health and Nutrition Survey 2019", Health Service Bureau, MHLW

## Detailed Data 4 Status of Exercise Habits

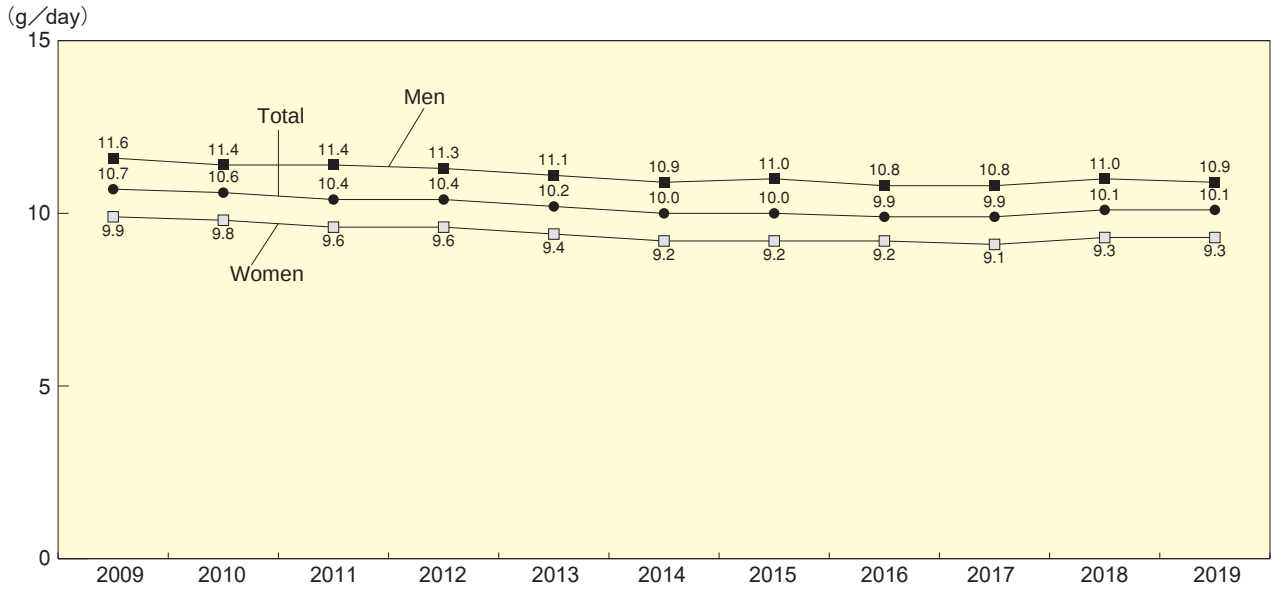



Source: "National Health and Nutrition Survey 2019", Health Service Bureau, MHLW
(Note) Persons with exercise habits: Those who have been continuing daily exercise of 30 minutes or longer at least 2 days a week for at least a year.

## Detailed Data 5 Average of salt intake (Aged 20 or Older, by Sex/Age)

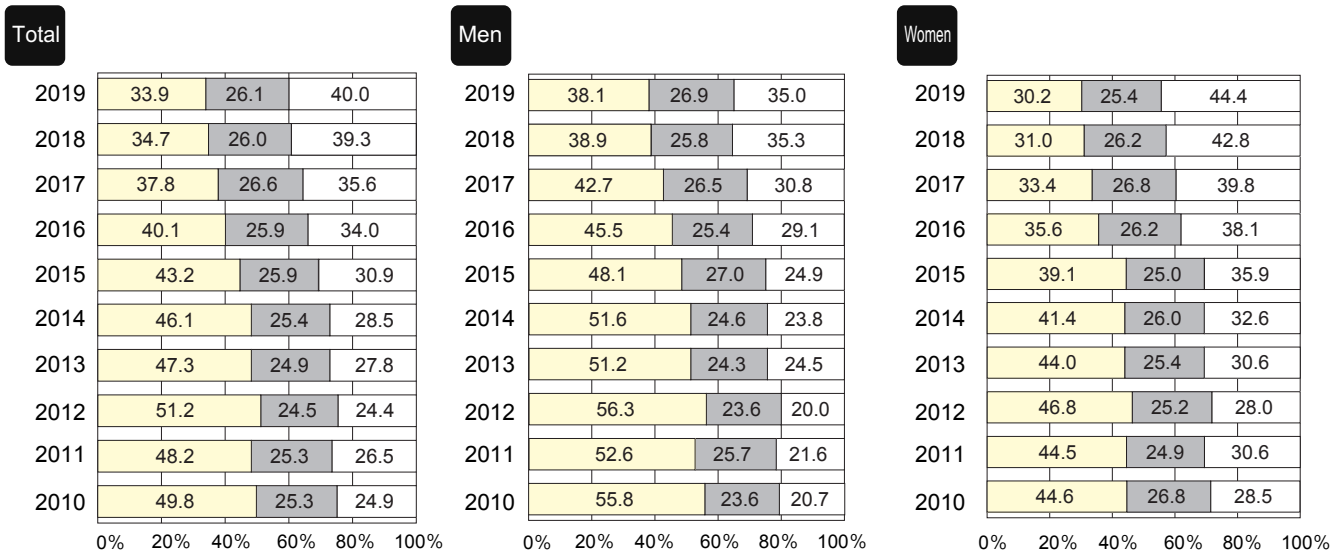
(g/day)

| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Men | 11.6 | 11.4 | 11.4 | 11.3 | 11.1 | 10.9 | 11.0 | 10.8 | 10.8 | 11.0 | 10.9 |
| Women | 9.9 | 9.8 | 9.6 | 9.6 | 9.4 | 9.2 | 9.2 | 9.2 | 9.1 | 9.3 | 9.3 |
| Total | 10.7 | 10.6 | 10.4 | 10.4 | 10.2 | 10.0 | 10.0 | 9.9 | 9.9 | 10.1 | 10.1 |



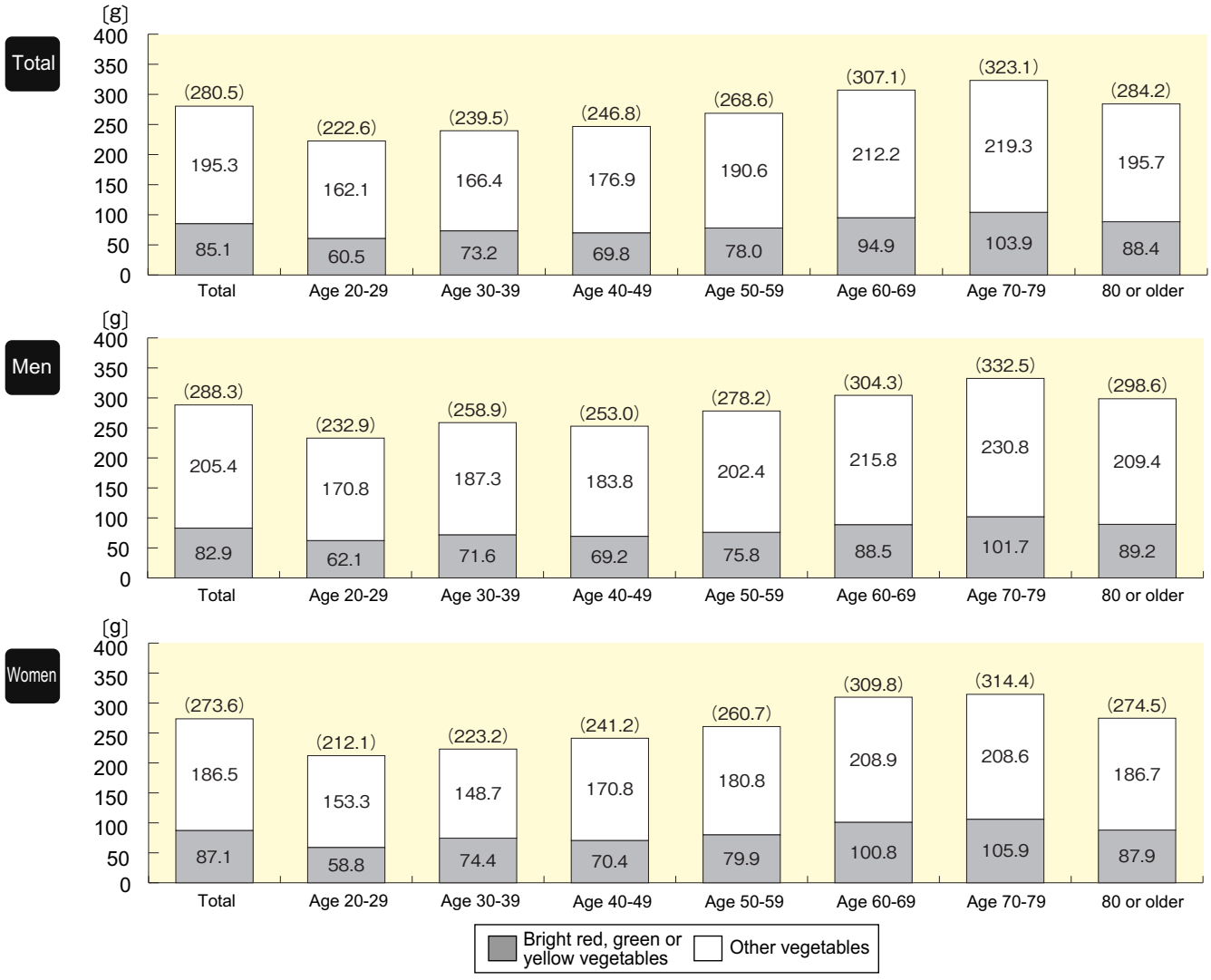

"National Health and Nutrition Survey", Health Service Bureau, MHLW

## Detailed Data 6 Secular Trend in Distribution of Fat Energy Ratio (Aged 20 or Older)



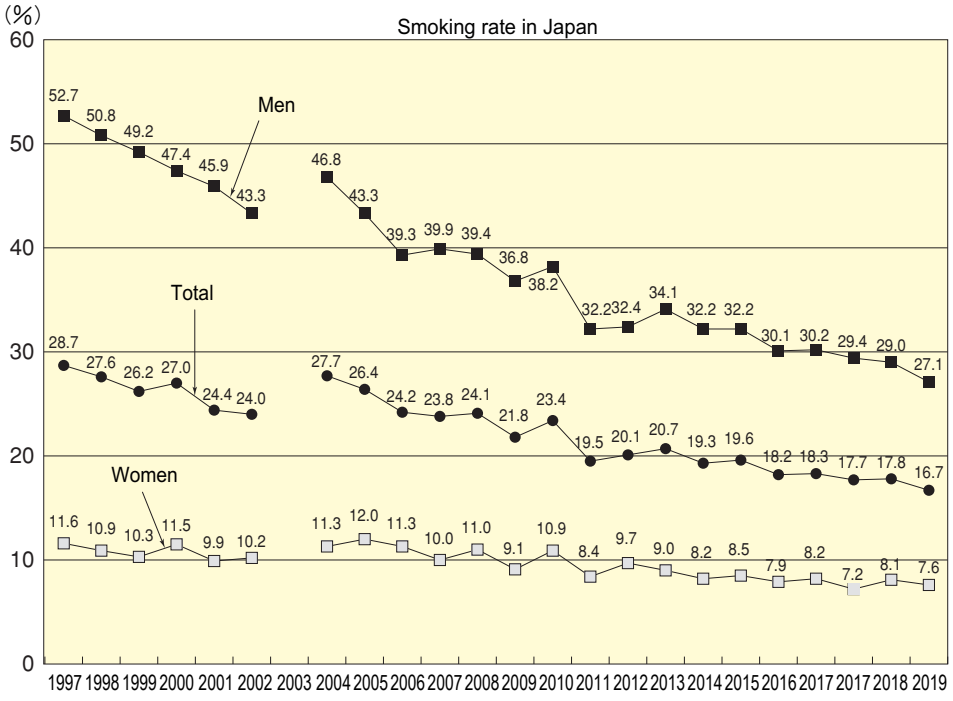

Source: "National Health and Nutrition Survey", Health Service Bureau, MHLW
(Note) Fat energy ratio: Percentage of energy intake from fat

## Detailed Data 7 Average Intake of Vegetables, etc. (Aged 20 or Older, by Sex/Age)




Source: "National Health and Nutrition Survey 2019", Health Service Bureau, MHLW
(Note) The figures in parentheses indicate the total intake of "bright red, green or yellow vegetables" and "other vegetables

## Detailed Data 8 Smoking Rate in Japan




Source: "National Nutrition Survey" up to 2002 and "National Health and Nutrition Survey" from 2003 onward

(Note) Definition of smoking and survey methods differ between the National Nutrition Survey and the National Health and Nutrition Survey hence figures cannot simply be compared.

Smoking rates in other countries (%)

| Country | Men | Women |
|---|---|---|
| Japan | 29.0 | 8.1 |
| Germany | 22.3 | 15.3 |
| France | 28.2 | 22.9 |
| Netherlands | 17.8 | 13.4 |
| Italy | 23.5 | 15.1 |
| United Kingdom | 17.0 | 16.2 |
| Canada | 12.8 | 9.7 |
| United States | 11.5 | 9.1 |
| Australia | 14.0 | 10.8 |
| Sweden | 11.0 | 9.2 |

Source: OECD Health Statics 2020

# Cardiovascular Measures

## Overview

The Basic Plan for Promoting Cardiovascular Measures

**Overall target**

**Promote cardiovascular measures comprehensively** and widely from prevention, medical to welfare services targeting an over three year **extension of healthy life-spans and a reduction of the age-adjusted death rate** by 2040 through taking the following measures: **1. Create awareness of cardiovascular prevention and accurate knowledge 2. Improve systems for health, medical, and welfare services 3. Promote research on cardiovascular issues**

For 3 years: 2020- 2022

<Characters and measures of cardiovascular measures>

Prevention (1st, 2nd and 3rd) → Acute Phase → Recovery and Chronic Phases → Prevention of palindromia, complications, and aggravations

*Cardiovascular diseases such as cerebral apoplexy, and hypertension

Extension of healthy life-spans and reduction of age-adjusted death rates

## Each Measure

**【Foundation】Collect treatment information on cardiovascular issues and establish a system of provision**

▸establish official framework to collect and utilize treatment information on cardiovascular issues

**1. Prevention of cardiovascular issues and creation of awareness and appropriate knowledge**

○ Prevention of illness and aggregation of cardiovascular issues and public awareness of cardiovascular issues (prevention and responses at early stage of pathogeny. etc) from childhood

**2.Fulfillment of a system for providing healthcare, medical and welfare services**

① Widespread medical checkups and promotions to tackle cardiovascular issues ▸ Popularize measures for special medical checkups and health instructions, etc. and promote measures to improve the execution rate

② Establish an emergency system ▸ Establish a transportable system more speedily and appropriately from emergency sites to medical institutions

③ Establish a medical service system for cardiovascular issues including securing emergency medical services ▸ Build a medical service system that can respond to problems

④ Support cardiovascular measures and patients based on social collaborations ▸ Promote regional comprehensive care systems providing medical, nursing care and welfare services in collaboration with various health professionals

⑤ Rehabilitation measures ▸ Promote services based on the status of the acute, recovery, mainten ance and living phases

⑥ Provide accurate information and consultation support on cardiovascular issues ▸ Comprehensive measures for providing accurate information and consultation for patients based on scientific grounds

⑦ Palliative care for cardiovascular issues ▸ Promote appropriate palliative care from the first stage of treatment in collaboration with various health professionals and regions

⑧ Support people experiencing delayed effects from cardiovascular issues ▸ Establish a support system for those experiencing delayed effects including torpor of hands and legs, alogia, epilepsy, higher brain dysfunctions, etc.

⑨ Support combining treatment with employment assistance for patients ▸ Promote measures for combining treatment with assisting work situations, etc.

⑩ Implement measures on cardiovascular issues that require early consideration from childhood and adolescence onwards ▸ Provide necessary medical systems continually from childhood to adulthood

**3.Promote research on cardiovascular issues**

○ Promote research on disease states, prevention, diagnosis, treatment, rehabilitation, etc. to prevent cardiovascular sickness

▸ Promote from basic study to actualized study for development of diagnosis and treatment methods, etc. in collaboration with industries and the medical industry

▸ Promote research on evidence based policy

**Comprehensive cardiovascular measures**

Strengthen collaboration and cooperation among relevant persons and design a prefectural plan and then evaluate and review basic plans

## Overview

**Basic Act on measures for treating cardiovascular diseases such as cerebral apoplexy, and hypertension to extend life expectancy**

### Purpose

Promulgation date: 14th Dec, 2018, Enforcement date: 1st Dec., 2019

Based on the current situation where cardiovascular diseases such as cerebral apoplexy, hypertension, etc. are major causes of death of citizens, take measures for the prevention, etc. of cardiovascular diseases, extend the life expectancy of citizens, and reduce the burden on healthcare.

### Overview

**Ⅰ Basic policy**

- Deepen citizens' understanding and interest in the importance of preventing cardiovascular issues and implement swift and appropriate responses for patients with suspected cardiovascular issues
- Provide continuous and comprehensive services for healthcare, medical (including rehabilitation), and welfare services for cardiovascular patients irrespective of where they live
- Promote research on cardiovascular issues, provide outcomes of researches, etc. of technical improvement, develop goods utilizing those outcomes and provide them

**Ⅱ Legal measures**

- The government will take legal, financial, and other actions required to implement cardiovascular measures

**Ⅲ Formation of a basic plan, etc. for the promotion of cardiovascular measures**

- The government will establish a promotion committee for cardiovascular measures and set up a basic plan for the promotion of cardiovascular measures. And after at least every six years, it shall be reviewed. The prefectural governments will establish a prefectural promotion committee for cardiovascular measures and set up a prefectural basic plan for the promotion of cardiovascular measures. And after at least every six years, it shall also be reviewed.

**Ⅳ Basic implementation**

- 1) Promote the prevention of cardiovascular issues 2) Establish systems for the transport and admittance of patients with suspected cardiovascular issues 3) Improve medical institutions 4) Maintain and improve the quality of life of patients with cardiovascular issues 5) Establish collaborative systems among related institutions that provide health, medical, and welfare services 6) Foster those working in health, medical, and welfare services 7) Establish the collection and provision of information systems 8) Promote research, etc.

# Dental Health Promotion

## Overview 8020 (Eighty-Twenty) Campaign

**[History of 8020 (Eighty-Twenty) Campaign]**

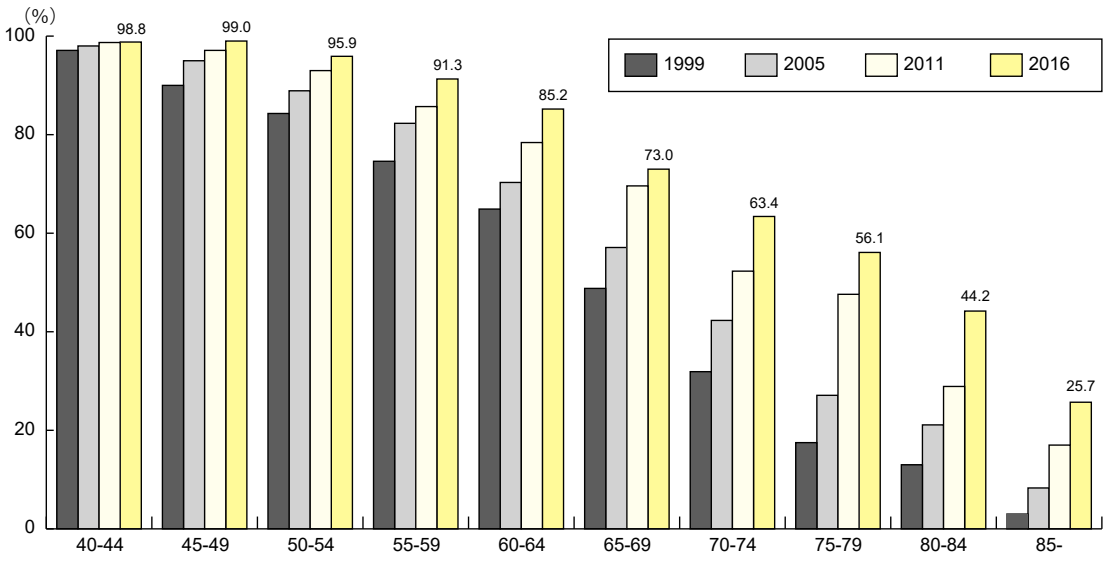
| | |
|---|---|
| 1989 | A Study Group on the Dental Health Policy for Adults made public its interim report in which the “8020 (Eighty-Twenty) Campaign” calling for the retention of 20 or more teeth even at age 80 was proposed. |
| 1991 | “Promotion of 8020 Campaign” was set to be the major objective for the Dental Hygiene Week (June 4-10). |
| 1992 | “8020 Campaign promotion measure projects” launched for dissemination and enlightenment of the 8020 Campaign (until 1996). |
| 1993 | 8020 Campaign promotion support projects launched for smooth implementation of 8020 Campaign promotion measure projects (until 1997). |
| 1997 | Municipal dental health promotion projects (menu projects) launched. |
| 2000 | Prefecture-led “8020 Campaign promotion special projects” launched. |
| 2006 | The results of the “Survey of Dental Diseases (2005)” was published to reveal that the percentage of persons achieving 8020 reached over 20% for the first time since the survey started. |
| 2011 | The Act on Advancement of Dental and Oral Health was approved. |
| 2012 | The “Basic Matters regarding the Advancement of Dental and Oral Health” was announced by the Minister in accordance with the “Act on Advancement of Dental and Oral Health”.<br>“Health Japan 21 (second campaign)”, which provides efforts for further advancing 8020 activities, was announced by the Minister.<br>The results of the “Survey of Dental Diseases (2011)” were published to reveal that the percentage of persons achieving 8020 reached over 40%. |
| 2013 | The title of “Dental Hygiene Week” was changed to “Dental and Oral Health Week” and the priority objective “advancement of dental and oral health that supports the power to live – new development of 8020 Campaign throughout life –” |
| 2017 | Released the "Survey Results of Dental Diseases in 2016 (Overview)". Those who achieved the 8020 Movement exceeded 50%. |
| 2018 | The interim evaluation of "Basic Matters regarding the Advancement of Dental and Oral Health" was compiled. |

**[8020 Campaign and the “Basic Matters regarding the Advancement of Dental and Oral Health”, “Health Japan 21 (second campaign)”]**

The “Basic Matters regarding the Advancement of Dental and Oral Health” and “Health Japan 21 (second campaign)”, announced in July 2012, mutually harmonized and provided further advancement of the “8020 Campaign”. Both set the goal of “raising the percentage of those retaining 20 or more teeth at age 80” and the FY2022 target value of 60%. Efforts for dental and oral health promotion through dental health measures (8020 Campaign) throughout life continue to be important.

## Detailed Data Changes in Percentage of Persons Having 20 or More Teeth by Age Group

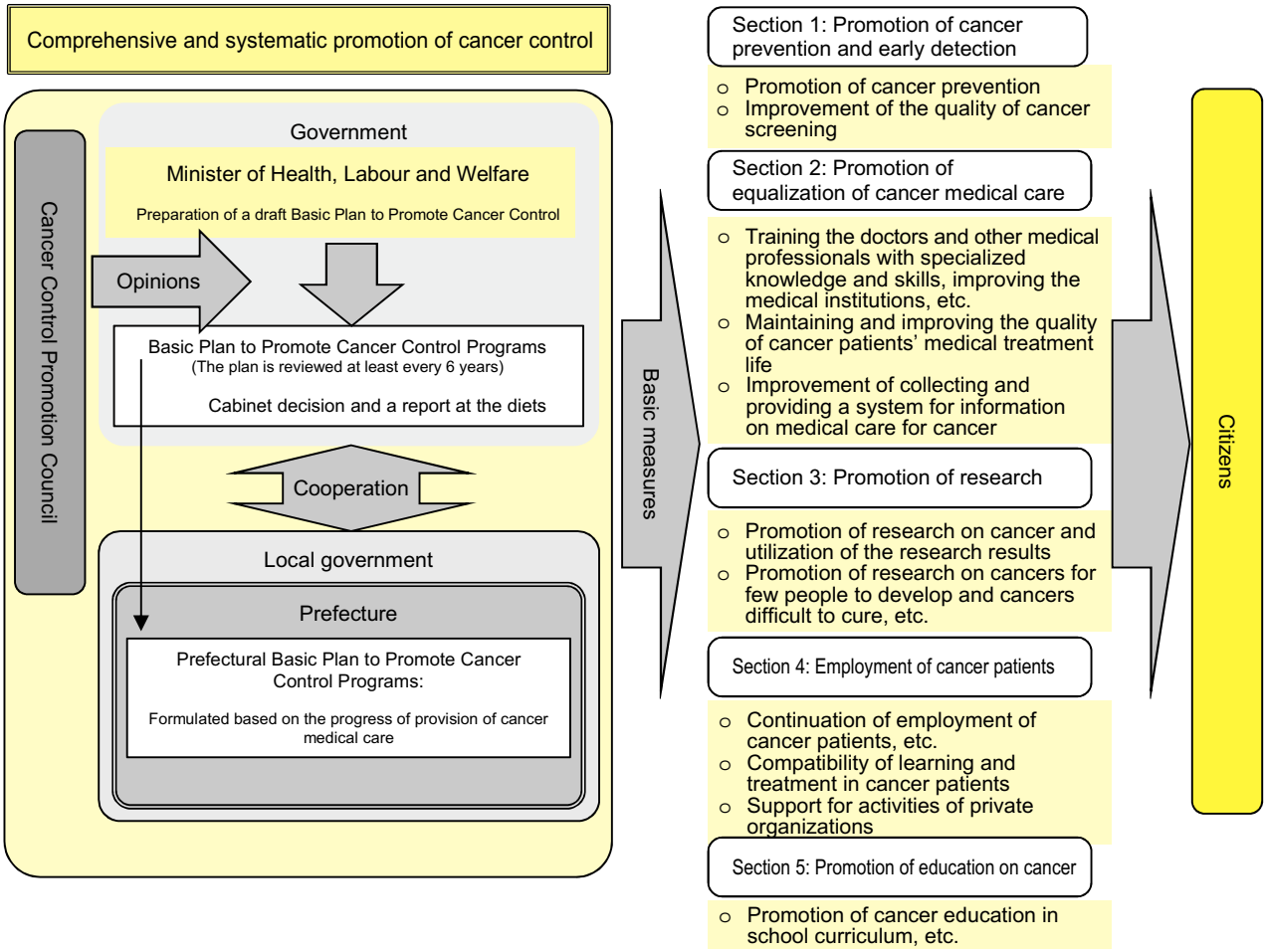
| Year \ Age | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75-79 | 80-85 | 85+ |
|---|---|---|---|---|---|---|---|---|---|---|
| 1999 | 97.1% | 90.0% | 84.3% | 74.6% | 64.9% | 48.8% | 31.9% | 17.5% | 13.0% | 3.0% |
| 2005 | 98.0 | 95.0 | 88.9 | 82.3 | 70.3 | 57.1 | 42.3 | 27.1 | 21.1 | 8.3 |
| 2011 | 98.7 | 97.1 | 93.0 | 85.7 | 78.4 | 69.6 | 52.3 | 47.6 | 28.9 | 17.0 |
| 2016 | 98.8 | 99.0 | 95.9 | 91.3 | 85.2 | 73.0 | 63.4 | 56.1 | 44.2 | 25.7 |




Source: “Survey of Dental Diseases”, Health Policy Bureau, MHLW

## Cancer Control Measures

**Overview** **Cancer control Act (Act No. 98 of 2006, enforced in April 2007, revised and enforced in December 2016)**



## The 3rd-term Basic Plan to Promote Cancer Control Programs
## (Cabinet decision on March 9, 2018) * (Outline)

### 1. Overall goal

**"People, including cancer patients, learn and overcome cancer."**

① Improvement of cancer prevention and screening based on scientific evidence ② Realization of patient-oriented cancer medicine
③ Establishment of a society where patients can live peacefully while maintaining dignity

### 2. Measures of each section

#### 1. Cancer prevention

(1) Primary cancer prevention
(2) Early detection and screening of cancer (Secondary prevention)

#### 2. Improvement of cancer care

(1) Cancer genome medicine
(2) Surgery, radiation therapy, drug therapy, and immunotherapy for cancer.
(3) Team medicine
(4) Cancer rehabilitation
(5) Supportive therapy
(6) Rare and refractory cancers (Measures according to cancer characteristics)
(7) Childhood cancers and cancers of AYA (*) generation and the elderly (*) Adolescent and Young Adult
(8) Pathological diagnosis
(9) Cancer registration
(10) Efforts towards early development and approval of pharmaceuticals and medical equipment

#### 3. Coexistence with cancer

(1) Palliative care after cancer diagnosis
(2) Consultation support and information provision
(3) Cancer measures and cancer patient support based on social cooperation
(4) Social problems, including employment statuses of cancer patients
(5) Cancer measures according to life stages

#### 4. Improvement of infrastructure to support the above

(1) Cancer research
(2) Human resource development
(3) Cancer education and awareness

### 3. Comprehensive and systematic promotion of cancer measures

1. Further cooperation among persons concerned
2. Planning by prefectural governments
3. Efforts of the people, including cancer patients
4. Cooperation with patient organizations
5. Necessary financial measures and efficient and prioritized budgets
6. Comprehension of goal achievements
7. Review of basic plans

# Outline of Cancer Registry Promotion Act

Cancer registration (Collection of information on cancer treatment by the national cancer registration or in-hospital cancer registration)

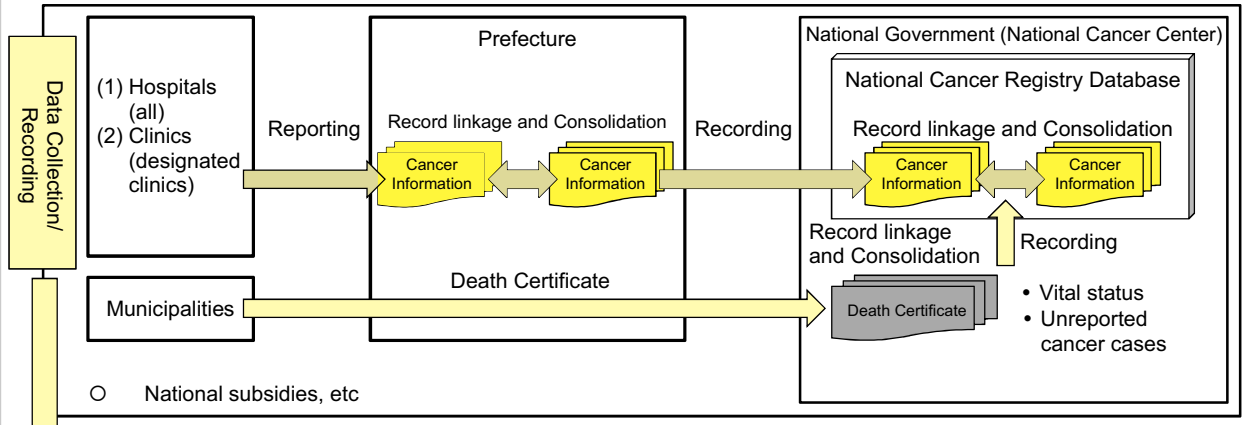
- ○ National cancer registry: The government records and preserves information on cancers, treatment and outcomes in Japan in a database so that it is used and provided for the government and prefectures.
- ○ Hospital-based cancer registry: Hospitals record and preserve detailed information on cancers, treatment and outcomes for the purpose of accurately grasping the status of cancer medical care.

⇨ The measures for improvement of the quality of cancer medical care (improvement of the quality of cancer medical care and cancer screening and promotion of cancer prevention) and for enhanced provision of information on cancers, cancer medical care and their prevention to citizens and other cancer control measures are implemented based on scientific knowledge.

## Basic principles

- ○ The national cancer registry grasps the status of cancers, treatment and outcomes as accurately as possible by means of broad information collection;
- ○ The Hospital-based cancer registry aims to collect necessary information without fail through the national cancer registry and to disseminate and enhance such information;
- ○ The Act aims to collect detailed information on cancer treatment with the aim of enhancing cancer control measures;
- ○ It aims to utilize cancer registries information for researches and studies on cancers including those conducted by the private sector and to use their results for the benefit of society; and
- ○ It aims to strictly protect individual information stored in cancer registries

## National Cancer Registry




Data use and protection

- ○ Information is used and provided for conducting researches and studies necessary for cancer control measures taken by the government and local governments
- ○ Information on confirmation of existence is provided to hospitals that submit a notification
- ○ Information is provided to persons who conduct researches and studies that contribute to the improvement of the quality of cancer medical care (there are additional requirements such as that non-anonymous information is provided to a researcher only when there is a consent of the person involved)

*The time limit of preservation of non-anonymous information is specified by a Cabinet Order

- ○ Establishment of prefectural cancer databases (integrated preservation of data of regional cancer registries)

Expert panel advice

Protection of information (Appropriate management of information. Prohibition of unintended use. Penalties for disclosure of secrets. No request for disclosure of information and etc.is permitted)

Promotion of the hospital-based cancer registry (Promotion of the hospital-based cancer registry and system improvement for collection of information on cancer treatment)

Human resource development (Provision of necessary trainings for securing human resources who engage in administrative affairs of the national cancer registry or hospital-based cancer registry)

## Utilization of cancer registries information

- ○ Government and prefectures⇒ Enhancement of cancer control measures, provision of information to medical institutions, disclosure of statistics and consultation services for patients
- ○ Medical institutions⇒Provision of appropriate information to patients, analysis and evaluation of cancer medical care, improvement of the quality of cancer medical care
- ○ Researchers who receive cancer registries information⇒Contribution to the improvement of the quality of cancer medical care

## Detailed Data Statistics on Cancer

| Item | Current status | Source |
|---|---|---|
| Number of deaths | Total of 378,356 persons (27.6% of all causes of death)<br>[220,965 males (31.3% of all causes of death)]<br>[157,391 females (23.6% of all causes of death)]<br>→ "1 in every 3 Japanese die of cancer" | Vital Statistics of Japan (2020 preliminary data) |
| Incidence rate | 977,393 persons (Not including carcinoma in situ)<br>[558,869 males]<br>Sites often affected: ① prostate, ② stomach, ③ large intestine, ④ lung, ④ liver<br>[418,510 females]<br>Sites often affected: ① breast, ② large intestine, ③ lung, ④ stomach, ⑤ uterus | National Cancer Registration patients number and incidence rate Report 2017 (2017) |
| Lifetime risk | Male: 65.5%, Female: 50.2%<br>→ "1 in every 2 persons will contract cancer in Japan" | Estimates by Center for Cancer Control and Information Services, National Cancer Center (2017) |
| Patients and persons receiving treatment | The estimated number of patients receiving medical treatment is 1,782,000<br>•The estimated number of inpatients on the dates of survey is 126,100<br>•The estimated number of outpatients on the dates of survey is 183,600 | Patient Survey (2017) |
| Medical care expenditure for cancer | ¥3,954.6 billion<br>* 12.6% of all medical care expenditures for general practice | Estimates of National Medical Care Expenditure (FY 2018) |

# Measures against allergic diseases

**Overview** **Basic Act on Allergic Diseases Measures (enacted on December 25, 2015)**

Diseases subject to this Act: Bronchial asthma, atopic dermatitis, allergic rhinitis, allergic conjunctivitis, pollinosis, food allergy

*Although the Act provides that any disease other than the six diseases mentioned above may be specified by a Cabinet Order where necessary, there is no plan at this moment to add any disease.

**Basic principles**

(1) Improving living conditions by taking comprehensive measures.
(2) Providing appropriate medical care for allergic diseases regardless of the location of residence.
(3) Establishing a system by which appropriate information can be obtained and a support system to maintain and improve the quality of life.
(4) Promoting researches on allergic diseases and disseminating, utilizing and evolving their achievements.

**Basic Guidelines for Promotion of Control Measures for Allergic Diseases**

○ The Minister of Health, Labour and Welfare shall formulate the Basic Guidelines for the purpose of comprehensively promoting measures against allergic diseases
- Basic matters concerning the promotion of measures against allergic diseases
- Matters concerning measures for raising awareness and disseminating knowledge about allergic diseases and for prevention thereof
- Matters concerning the securing of systems to provide medical care for allergic diseases
- Matters concerning researches and studies on allergic diseases
- Other important matters concerning the promotion of measures against allergic diseases

Ministry of Health, Labour and Welfare

**Allergic Disease Control Promotion Council**

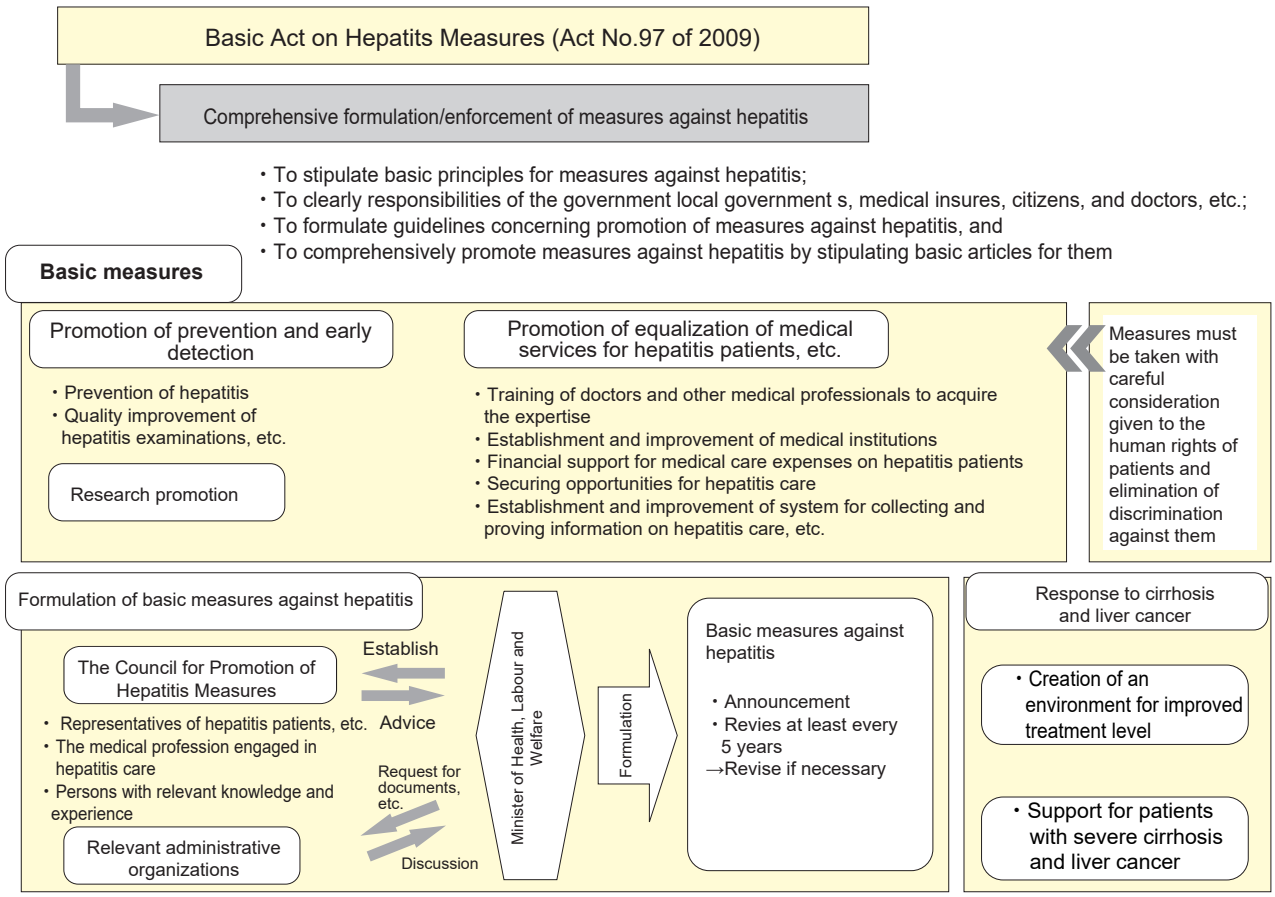
- The Council expresses its opinions when the Basic Guidelines for Measures against Allergic Diseases are formulated or changed
- Its members are appointed by the Minister of Health, Labour and Welfare

(Members)
- Patients and their representatives
- Persons who involve in medical care for allergic diseases
- Persons who have academic experience

*Matters necessary for the organization and operation of the Council are provided for by a Cabinet Order

# Measures against Hepatitis

**Overview** **Basic Act on Hepatitis Measures**



**Basic Guidelines for Hepatitis Measures in Brief (formulated on May 16, 2011, revised on June 30, 2016)**

1 The basic direction to take in promoting the prevention of hepatitis and hepatitis-related medical care

- To reduce liver cirrhosis and liver cancer, and set as much reduction as possible of the incidence of liver cancer

2 Matters concerning measures to take in preventing hepatitis

- Necessary to disseminate correct knowledge about hepatitis to prevent new infections,
- To promote preventive measures for infection of mother-to-child hepatitis B virus, and promote periodic hepatitis B vaccination.

3 Matters concerning improvement of a system to use implementing hepatitis examinations and their capabilities

- To inform all citizens that they need to receive hepatitis virus test at least once
- To continue to develop a system that allows for examination of the hepatitis virus tests with due consideration to the convenience of the examinee..
- To make such efforts that a hepatitis virus test can be carried out together with a medical examination, while making the concerned parties understand, such as medical insurers and employers.

4 Matters concerning securing of a system to use providing hepatitis-related medical care

- Necessary to further develop the regional hepatitis clinical care network so that all hepatitis patients can receive continuous and appropriate hepatitis medicine.
- To make further efforts for increase of hepatitis virus inspection and follow-up after the inspection
- Necessary to enlighten stakeholders such as business operators and get their understanding and cooperation so that the employees can receive medical treatment continuously while continuing to work

5 Matters concerning prevention of hepatitis and human resource development for hepatitis medical care

- Necessity to develop human resources with knowledge about the prevention of hepatitis infection and those capable of linking appropriate hepatitis care after infection is known, such as hepatitis medical coordinator.

6 Matters concerning surveys and research on hepatitis

- To evaluate and verify research achievements comprehensively, and promote hepatitis research as the basis for comprehensive promotion of measures against hepatitis so that the past achievements can be appropriately reflected on such measures

7 Matters concerning promotion of research and development of medicine to use hepatitis- related medical care

- Necessary to proceed with research and development of hepatitis medicine-related new medicines, including medicines related to treatment of hepatitis B and cirrhosis, and make a prompt review of clinical trials and research in light of recent trends concerning hepatitis medicine

8 Matters concerning public awareness and dissemination of information concerning hepatitis is and matters concerning respect for the human rights of hepatitis patients, etc.

- Necessary to disseminate information and enlighten people to promote receipt of hepatitis virus tests, prevent new infections, discontinue unfair discrimination against hepatitis patients, protect their human rights, and create an environment where people can live a secure social life

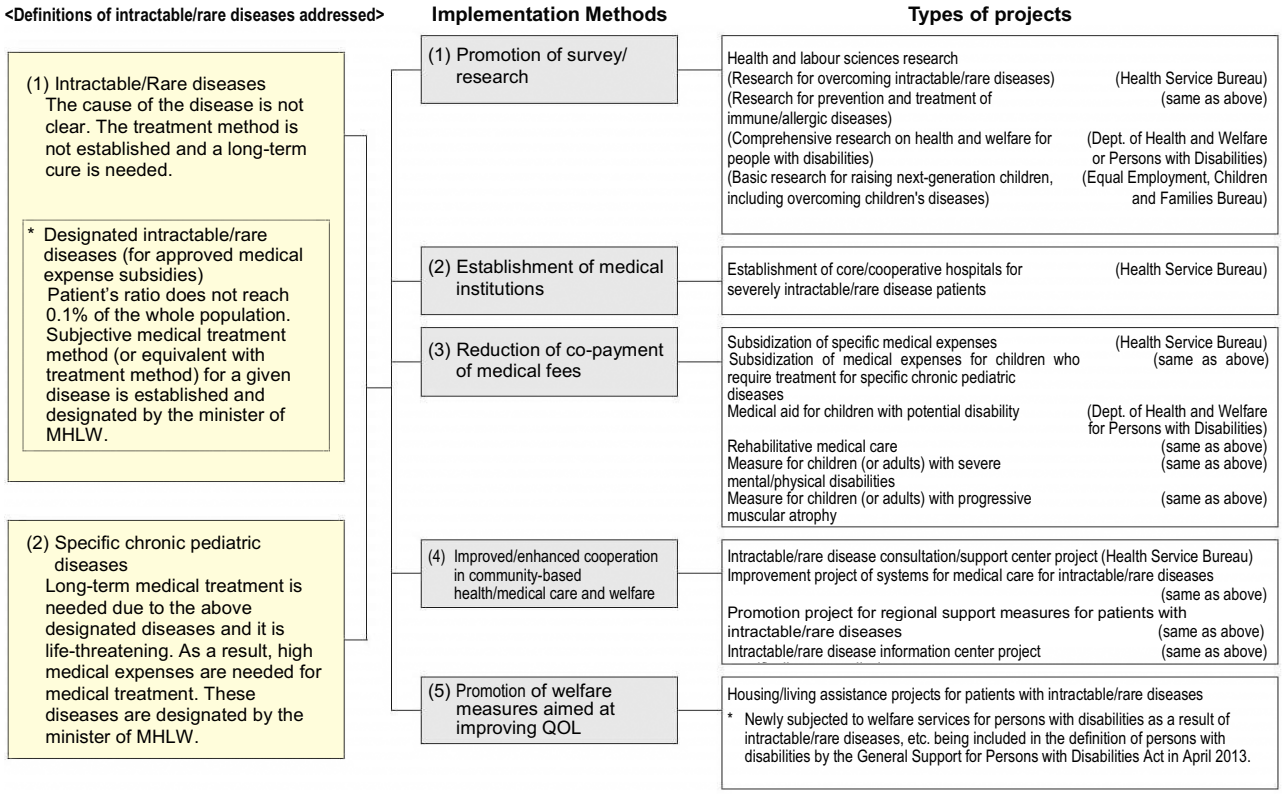
9 Other important matters concerning the promotion of hepatitis measures

- To strengthen and enhance support for hepatitis patients and their families, etc.
- To promote review of how to support cirrhosis and liver cancer patients.
- To require the national government to urge the local governments to make a plan and set a target concerning measures against hepatitis after consultation with the stakeholders based on the actual circumstances in the community
- To request each citizen to confirm his/her own hepatitis virus infection, have proper knowledge about the possibility of infection, act appropriately to prevent new infection, acquire correct knowledge and make efforts for responding appropriately not to cause discrimination against hepatitis patients, etc.

# Intractable/Rare Disease Measures

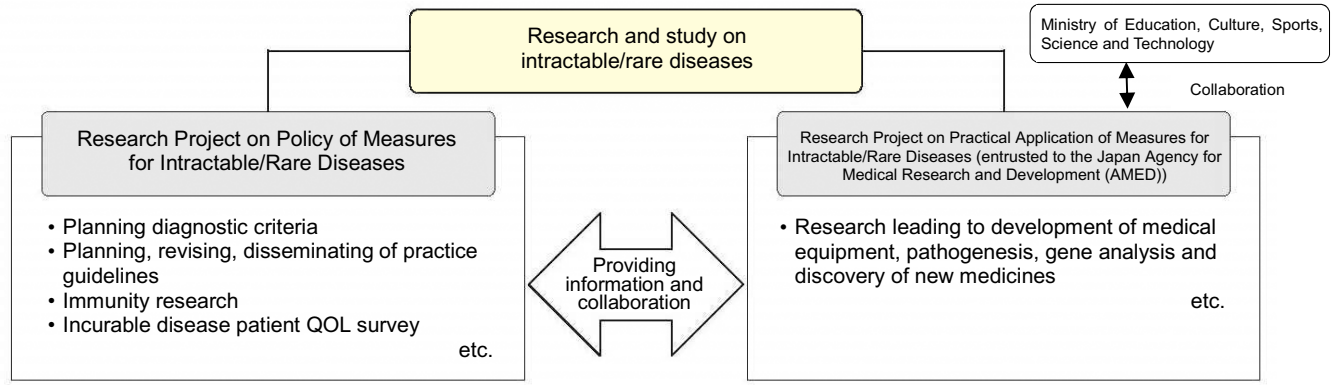
## Overview Outline of Intractable/Rare Disease Measures

Various projects have been implemented based on Act on Medical Care and Social Supports for Patients with Intractable/Rare Diseases




### Intractable Diseases Policy Research Program

In order to comprehensively and strategically conduct researches on intractable/rare diseases, the project makes use of the nationwide database to specify epidemiology and pathogenesis, develop new cure methods and conduct researches with the use of regenerative medical techniques as well as promotes researches and studies integrated with the policies for intractable/rare diseases.



## **Detailed Data** Designated intractable/rare diseases

| No. | Disease Name | No. | Disease Name | No. | Disease Name |
|---|---|---|---|---|---|
| 1 | Spinobulbar muscular atrophy | 103 | CFC syndrome | 205 | Fragile X syndrome related disease |
| 2 | Amyotrophic lateral sclerosis | 104 | Costello syndrome | 206 | Fragile X syndrome |
| 3 | Myelopathic muscular atrophy | 105 | Charge syndrome | 207 | Tmc/Art,: truncus arteriosus |
| 4 | Primary lateral sclerosis | 106 | Cryopyrin associated periodic fever syndrome | 208 | Corrected TGA |
| 5 | Progressive supranuclear palsy | 107 | Systemic-onset juvenile idiopathic arthritis | 209 | TGA |
| 6 | Parkinson's disease | 108 | TNF receptor associated periodic sydrome | 210 | Single ventricle |
| 7 | Corticobasal degeneration | 109 | Atypical hemolytic uremic syndrome | 211 | Hypoplastic left heart syndrome |
| 8 | Huntington disease | 110 | Blau syndrome | 212 | Tricuspid atresia |
| 9 | Neuroacanthocytosis | 111 | Congenital myopathy | 213 | Pulmonary atresia with intact ventricular septum |
| 10 | Charcot-Marie-Tooth disease | 112 | Marinesco – Sjogren's syndrome | 214 | Pulmonary atresia with ventricular septal defect |
| 11 | Myasthenia gravis | 113 | Muscular dystrophy | 215 | Tetralogy of Fallot |
| 12 | Congenital myasthenic syndrome | 114 | Non- dystrophic myotonia syndrome | 216 | Double outlet right ventricle (DORV) |
| 13 | Multiple sclerosis／Optic neuromyelitis | 115 | Hereditary periodic paralysis | 217 | Ebstein disease |
| 14 | Chronic inflammatory demyelinating polyradiculo neuropathy/Multifocal motor neuropathy | 116 | Atopic myelitis | 218 | Alport's syndrome |
| 15 | Inclusion body myositis | 117 | Syringomyelia | 219 | Galloway-Mowat syndrome |
| 16 | Crow-Fukase syndrome | 118 | Myelomeningocele | 220 | Rapidly progressive glomerulonephritis |
| 17 | Mutiple-system atrophy | 119 | Isaacs syndrome | 221 | Anti-glomerular basement membrane disease |
| 18 | Spinocerebellar degeneration (except multiple-system atrohpy) | 120 | Hereditary dystonia | 222 | Primary Nephrotic syndrome |
| 19 | Lysosomal storage disease | 121 | Nerve ferritin disease | 223 | Primary membranoproliferative glomerulonephritis |
| 20 | Adrenoleukodystrophy | 122 | Brain table hemosiderosis | 224 | Purpura nephritis |
| 21 | Mitochondrial diseases | 123 | Autosomal recessive leukoencephalopathy with baldness and degenerative spondylosis | 225 | Congenital nephrogenic diabetes insipidus |
| 22 | Moyamoya disease | 124 | Autosomal dominant cerebral artery disease with subcortical infarct and leukoencephalopathy | 226 | Interstitial cystitis |
| 23 | Prion disease | 125 | Autosomal dominant cerebral arteriopathy with subcortical infarction and leukoencephalopathy | 227 | Osler disease |
| 24 | Subacute sclerosing panencephalitis | 126 | Perry syndrome | 228 | Obliterating bronchiolitis |
| 25 | Progressive multifocal leukoencephalopathy | 127 | Frontotemporal lobar degeneration | 229 | Pulmonary proteinosis (autoimmunity/hereditary) |
| 26 | HTLV-1-associated myelopathy | 128 | Vickers staff brainstem encephalitis | 230 | Alveolar hypoventilation sysdrome |
| 27 | Idiopathic basal ganglia calcification diseases | 129 | Epilepticus type (biphasic) acute encephalopathy | 231 | α1-antitrypsin deficiency |
| 28 | Systemic amyloidosis | 130 | Congenital insensitivity to pain with anhidrosis | 232 | Camey complex |
| 29 | Ulrich disease | 131 | Alexander disease | 233 | Wolfram syndrome |
| 30 | Distal muscular dystrophy | 132 | Congenital supranuclear pasly | 234 | Peroxisomal disease （excluding adrenoleukodystrophy） |
| 31 | Beth Rem myopathy | 133 | Moebius syndrome | 235 | Accessory thyroid hypergasia disease |
| 32 | Autophagic vacuolar myopathy | 134 | Nervous system malformation/De Morsier sysdrome | 236 | Pseudohypoparathyroidism |
| 33 | Schwarz Yanperu syndrome | 135 | Aicardi syndrome | 237 | Adrenocorticotropic hormone insensitivity |
| 34 | Neurofibromatosis | 136 | Hemimegalencephaly | 238 | Vitamin D-resistant rickets/osteomalacia |
| 35 | Pemphigus | 137 | Focal cortical dysplasia | 239 | Vitamin D-dependent rickets/osteomalacia |
| 36 | Epidermolysis bullosa | 138 | Nerve cell migration disorder | 240 | Phenylketonuria |
| 37 | Pustular psoriasis （universal） | 139 | Congenital cerebral white matter asplasia | 241 | High tyrosinemia type 1 |
| 38 | Stevens-Jonson syndrome | 140 | Dorabe syndrome | 242 | High tyrosinemia type 2 |
| 39 | Toxic epidermal necrosis | 141 | Medial temporal lobe epilepsy with hippocampal sclerosis | 243 | High tyrosinemia type 3 |
| 40 | Takayasu's disease | 142 | Myoclonic epilepsy absences | 244 | Maple syrup urine disease (MSUD) |
| 41 | Giant cell artritis | 143 | Epilepsy with myoclonic cataplexy | 245 | Propionic acidemia |
| 42 | Polyateritis nodosa | 144 | Lennox-Gastaut syndrome | 246 | Methylmalonic acidemia |
| 43 | Microscopic polyangiitis | 145 | West syndrome | 247 | Isovaleric adidemia |
| 44 | Multiple vasculitis granulomatous disease | 146 | Otawara syndrome | 248 | Glucose transporter 1 deficiency |
| 45 | Esosinophilic multiple vasculitis granulomatous disease | 147 | Early myoclonic encephalopathy | 249 | Glutaric acidemia type 1 |
| 46 | Malignant rheumatoid arthritis | 148 | Infant epilepsy with migratory focus seizure | 250 | Glutaric acidemia type 2 |
| 47 | Buerger's disease | 149 | One side convulsions, hemiplegia – epilepsy syndrome | 251 | Urea cycle disorders |
| 48 | Primary antiphospholipid antibody sysdrome | 150 | Ring chromosome 20 syndrome | 252 | Lysinuric protein intolerance |
| 49 | Systemic lupus erythematosus | 151 | Rasmussen's encephalitis | 253 | Congenital malabsorption of falate |
| 50 | Dermatomyositis／polymyositis | 152 | PCDH19 related syndrome | 254 | Porphyria |
| 51 | Systemic scleroderma | 153 | Refractory frequent partial seizures intussusception acute encephalitis | 255 | Multiple carboxylase deficiency |
| 52 | Mixed connective tissue disease | 154 | Epilepsy with continuous spikes and waves during slow sleep (CSWD) | 256 | Muscle type glycogen storage disease |
| 53 | Sjogren's sndrome | 155 | Landau-Kleffner syndrome | 257 | Glycogen storage disease |
| 54 | Adult-onset Still's disease | 156 | Rett syndrome | 258 | Galactose- 1 – phosphate uridyltransferase deficiency |
| 55 | Relapsing polychondritis | 157 | Sturge-Weber syndrome | 259 | Lecithin-cholesterol acyltransferase deficiency |
| 56 | Bechet's disease | 158 | Tuberous sclerosis | 260 | Sitosterolemia |
| 57 | Idiopathic dilated cardiomyopathy | 159 | Xeroderma | 261 | Tangier disease |
| 58 | Hypertrophic cardiomyopathy | 160 | Congenital ichthyosis | 262 | Primary hyperlipidemia |
| 59 | Constrictive cardiomyopathy | 161 | Familial benign chronic pemphigus | 263 | Cerebrotendinous xanthomatosis |
| 60 | Aplastic anaemia | 162 | Pemphigoid (including acquired epidermolysis bullosa) | 264 | Abeta-lipoproteinemia |
| 61 | Autoimmune hemolytic anemia | 163 | Idiopathic acquired systemic anhidrosis | 265 | Lipodystrophy |
| 62 | Paroxysmal nocturnal | 164 | Oculocutaneous ablinism | 266 | Familial Mediterranean fever |
| 63 | Idiopathic thrombocytopenic purpura | 165 | Pachydermoperiostosis syndrome | 267 | Hyper-IgD syndrome |
| 64 | Thrombotic thrombocytopenic purpura | 166 | Pseudoxanthoma elasticum | 268 | Nakajo-nisimura syndrome |
| 65 | Primary immunodeficiency syndrome | 167 | Marfan syndrome | 269 | Purulent gonitis • pyoderma gangrenosum • hirsutism syndrome |
| 66 | IgA nephropathy | 168 | Ehlers-Danlos syndrome | 270 | Chronic nonbacterial osteomyelitis |
| 67 | Polycystic kidney | 169 | Menkes disease | 271 | Spondylarthritis ankylopoietica |
| 68 | Ossification of the ligamentum flavum | 170 | Okushipitaru horn syndrome | 272 | Fibrodysplasia ossificans progressive |
| 69 | Ossification of the posterior longitudinal ligament | 171 | Wilson's disease | 273 | Congenital scoliosis with rib anomaly |
| 70 | Extensive spinal canal stenosis | 172 | Hypophosphatasia | 274 | Osteogenesis imperfecta |
| 71 | Idiopathic femoral head necrosis | 173 | VATER syndrome | 275 | Thanatophoric dysplasia |
| 72 | Pituitary ADH secretion disorders | 174 | Nasu-Hakola disease | 276 | Achondroplasia |
| 73 | Pituitary TSH secretion hyperthyroidism | 175 | Weaver's syndrome | 277 | Lymphangiomatoris/gorham's disease |
| 74 | Pituitary PRL secretion hyperthyroidism | 176 | Coffin-Lowry syndrome | 278 | Huge lymphatic malformation (cervicofacial lesion) |
| 75 | Cushing's disease | 177 | Arima sydrome | 279 | Huge venouse malformation [neck oropharyngeal diffuse lesion] |
| 76 | Pituitary gonadotropin secretion hyperthyroidism | 178 | Mowat - Wilson syndrome | 280 | Huge arteriovenouse malformation (cervicofacial or limb lesion) |
| 77 | Pituitary growth hormone secretion hyperthyroidism | 179 | Williams' syndrome | 281 | Klippel-Trenauray-Weber sydrome |
| 78 | Anterior pituitary hypothyroidism | 180 | ATR-X syndrome | 282 | Congenital thropoietic anemia |
| 79 | Familial hypercholesterolemia (homozygous) | 181 | Crouzon syndrome | 283 | Acquired pure red cell aplasia |
| 80 | Thyroid hormone insensitivity syndrome | 182 | Apert syndrome | 284 | Diamond-blackfan anemia |
| 81 | Congenial adrenal cortex enzyme deficiency | 183 | Pheiffer syndrome | 285 | Fanconi anemia |
| 82 | Congenital adrenal hypoplasia | 184 | Anley-Bixler syndrome | 286 | Hereditary sideroblastic anemia |
| 83 | Addison's disease | 185 | Coffin Siris syndrome | 287 | Epstein-Barr virus |
| 84 | Sarcoidosis | 186 | Trothmund-Thomson syndrome | 288 | Autoimmune hemorrhaphilia XIII |
| 85 | Idiopathic interstitial pneumonia | 187 | Kabuki syndrome | 289 | Cronkhite-Canada syndrome |
| 86 | Pulmonary arterial hypertension | 188 | Polysplenia syndrome | 290 | Chronic nonspecific multiple ulcers of the small intestine |
| 87 | Pulmonary venous obstruction/pulmonary capillary hemangiomatosis | 189 | Asplenia sysndrome | 291 | Hirschsprung disease (entire colon type or small intestine type) |
| 88 | Chronic thromboembolic pulmonary hypertension | 190 | Branchio-oto-renal syndrome | 292 | Cloacal exstrophy |
| 89 | Lymphangioleiom yomatosis | 191 | Werner's syndrome | 293 | Persistent cloaca |
| 90 | Retinitis pigmentosa | 192 | Cockayne's syndrome | 294 | Congenial diaphragmatic hernia |
| 91 | Bad chiari sysdrome | 193 | Prader-Willi syndrome | 295 | Infant giant liver hemangioma |
| 92 | Idiopathic portal hypertension | 194 | Sotos' syndrome | 296 | Biliary atresia |
| 93 | Primary biliary cirrhosis | 195 | Noonan's syndrome | 297 | Alagille syndrome |
| 94 | Primary sclerosing cholangitis | 196 | Young Simpson's syndrome | 298 | Hereditary pancreatitis syndrome |
| 95 | Autoimmune hepatitis | 197 | 1p36 deletion syndrome | 299 | Cystic fibrosis |
| 96 | Crohn's disease | 198 | 4psyndrome | 300 | IgG4-related disease |
| 97 | Ulcerative colitis | 199 | 5psyndrome | 301 | Heredomacular dystrophy |
| 98 | Eosinophilic gastrointenstinal disease | 200 | No. 14 chromosome father disomy syndrom | 302 | Leber's hereditary optic neropathy |
| 99 | Chronic idiopathic pseudo-bowel obstruction | 201 | Angelman syndrome 303 | 303 | Ascher syndrome |
| 100 | Huge bladder short and small colon intestinal peristalsis deficiency | 202 | Smith-Magenis syndrome | 304 | Juvenile-onset bilateral sensorineural hearing loss |
| 101 | Intestinal ganglion cells insignificant disease | 203 | 22q11.2 deletion syndrome | 305 | Delayed endolymphatic hydrops |
| 102 | Rubinstein - Teibi syndrome | 204 | Emanuel syndrome | 306 | eosinophilic sinusitis |

**Detailed Data** Designated intractable/rare diseases

| No. | Disease Name |
|---|---|
| 307 | Canavan disease |
| 308 | Progressive leukoencephalopathy |
| 309 | Progressive myoclonic epilepsy |
| 310 | Congenital syndrome |
| 311 | Congenital tricuspid stenosis |
| 312 | Congenital mitral valve stenosis |
| 313 | Congenital pulmonary vein stenosis |
| 314 | Left pulmonary artery right pulmonary artery initiation |
| 315 | Nail Patera syndrome/LMX 1 B-related nephropathy |
| 316 | Carnitine circuit disorder |
| 317 | Triple enzyme deficiency |
| 318 | Citrin deficiency |
| 319 | Sepiapterin reductase (SR) deficiency |
| 320 | Congenital glycosylphosphatidylinositol (GPI) deficiency |
| 321 | Nonketotic hyperglycinemia |
| 322 | β-ketothiolase deficiency |
| 323 | Aromatic L-amino acid decarboxylase deficiency |
| 324 | Methyl glutamic nuria |
| 325 | Hereditary autoinflammatory disease |
| 326 | Marble bone disease |
| 327 | Idiopathic thrombosis (limited to those due to hereditary thrombophilia) |
| 328 | Anomalous anterior segment formation |
| 329 | Aniridia |
| 330 | Congenital tracheal stenosis／Congenital subglottic stenosis |
| 331 | Idiopathic multicentric Castleman disease |
| 332 | Gelatinous drop-like corneal dystrophy |
| 333 | Hutchinson - Gilford syndrome |

# Infectious Disease Measures

## Overview — Outline of the Act on Prevention of Infectious Diseases and Medical Care for Patients with Infectious Diseases

(Approved on September 28, 1998 and enforced on April 1, 1999)

### Preventive administrative measures against outbreak and spread of infectious diseases

- Development and establishment of the surveillance system for infectious diseases
- Promotion of comprehensive nationwide and prefectural measures
  (in order to facilitate cooperation of related parties, basic guidelines to prevent infectious diseases are formulated and announced by the government, and the prevention plans by the prefectural governments)

- Formulation of guidelines to prevent specific infectious diseases, including influenza, sexually transmitted diseases, AIDS, tuberculosis, measles rubella and mosquito-borne infectious diseases (the government formulates and announces guidelines to investigate causes, prevent outbreak and spread, provide medical care services, promote research and development, and obtain international cooperation for the diseases that particularly require comprehensive preventive measures)

### Types of infectious diseases and medical care system

| Type of infectious disease | Key measures | Medical care system | Medical fee payment |
|---|---|---|---|
| New infectious diseases | Hospitalization | Designated medical institutions for specific infectious disease (several in number nationwide designated by the government) | Publicly funded in full (no insurance applied) |
| Type 1 (Plague, Ebola hemorrhagic fever, South American hemorrhagic fever, etc.) | | Designated medical institutions for Type 1 infectious disease [1 hospital in each prefecture designated by prefectural governors] | Medical insurance applied with public funds (for hospitalization) |
| Type 2 (Avian influenza (H5N1, H7N9), Tuberculosis, SARS, etc) | | Designated medical institutions for Type 2 infectious disease [1 hospital in each secondary medical service area designated by prefectural governors] | |
| Type 3 (Cholera, Enterohemorrhagic Escherichia coli infection, etc.) | Work restriction in certain jobs | General medical institutions | Medical insurance applied (partial cost sharing) |
| Type 4 (Avian influenza (excluding H5N1, H7N9), Zika virus infection, etc.) | Sterilization and other objective measures | General medical institutions | Medical insurance applied (partial cost sharing) |
| Type 5 (Influenza (excluding avian influenza and novel influenza infection, etc.), AIDS, viral hepatitis (excluding hepatitis E and hepatitis A), etc.) | Identification of the situation with infection and information provision | General medical institutions | Medical insurance applied (partial cost sharing) |
| Novel influenza infection, etc. | Hospitalization | Designated medical institutions for specific/Type 1/Type 2 infectious disease | Medical insurance applied with public funds (for hospitalization) |

* Infectious diseases other than Type 1, 2, or 3 infectious diseases requiring emergency measures are designated as "designated infectious diseases" in Cabinet Order and are treated the same as Type 1, 2, and 3 infectious diseases for a limited period of 1 year in principle.

### Development of hospitalization procedures respecting patients' human rights

- Work restriction and hospitalization according to the type of infectious disease
- Introduction of a system to recommend hospitalization based on patients' decisions
- Hospitalization up to 72 hours by orders of prefectural governors (directors of health centers)
- Hospitalization for every 10 days (30 days for tuberculosis) with hearing opinions from the council for infectious disease examination established in health centers
- Reporting of complaints on conditions of hospitalization to prefectural governors
- Provision of special cases to make decisions within 5 days against the request for administrative appeal from the patients who are hospitalized for more than 30 days
- In the event of emergency, the government should be responsible for providing necessary guidance to prefectural governments on hospitalization of patients.

### Development of measures, including sufficient sterilization to prevent infectious diseases from spreading

- Sterilization to prevent Type 1, 2, 3, and 4 infectious diseases and pandemic influenza from spreading
- Restricting entry to buildings to prevent Type 1 infectious diseases from spreading
- In the event of emergency, the government should be responsible for providing necessary guidance to prefectural governments on sterilization and other measures.

**Development of countermeasures against zoonoses**

- Prohibition of the import of monkeys, masked palm civets, bats, African soft-furred rats, prairie dogs, etc.
- Establishment of the import quarantine system for monkeys from designated exporting countries
- Designation of 11 diseases, including Ebola hemorrhagic fever, etc., as subjects of notification obligation for veterinarians
- "Notification System for the Importation of Animals" to require importers of living mammals and birds, and carcasses of rodents and Lagomorpha to report necessary information to the Minister of Health, Labour and Welfare (quarantine station) along with a health certificate issued by government authorities of the exporting countries

**Development of regulation on possession of pathogens, etc.**

- Regulation through enforcement of standards of prohibition, permission, notification, and facilities according to the classification of Type 1, 2, 3, and 4 pathogens, etc.
- Establishment of standards on facilities according to the types of pathogens, etc.
- Development of regulations on prevention of infectious disease outbreaks, selection of persons in charge of handling pathogens, and obligation for the owners to notify the transportation of pathogens, etc.
- Supervision by the Minister of Health, Labour and Welfare on facilities handling pathogens, including on-site investigation of the facilities and orders of corrective measures for sterilization/transfer methods, etc.

**Development of measures against novel influenza**

- Implementation of measures, including hospitalization, etc. and enabling measures equivalent to those for Type 1 infectious diseases to be taken by Cabinet Order
- Request for persons possibly infected to report health status and abstain from going out
- Disclosure of information regarding outbreak and measures to be taken, etc.
- Report on progress from prefectural governors
- Enhancement of cooperation between prefectural governors and directors of Quarantine Stations

**Prepare countermeasures in COVID-19**

- Place COVID-19 as a ‘new influenza, etc. infection’ and enable to take measures for those infected
- Make compulsory on reporting health conditions for those who are expected to be infected
- Ensure viability on admission, accommodation treatment, home treatment and proactive epidemiological study
- Strengthen information collaboration among countries and local authorities
- Governmental or Prefectural request for collaboration from medical personnel (including medical institutes) and test institutes during emergencies
- Comprehensive arrangement by Prefectural Governors on admission, etc.

# Immunization

## Overview Diseases and Persons Subjected to Routine Vaccination

| Diseases | Persons subjected to vaccination |
|---|---|
| Diphtheria | 1. Those aged 3 months or older but younger than 90 months<br>2. Those aged 11 years or older but younger than 13 years |
| Pertussis | Those aged 3 months or older but younger than 90 months |
| Polio (acute myelitis) | Those aged 3 months or older but younger than 90 months |
| Measles | 1. Those aged 12 months or older but younger than 24 months<br>2. Those aged 5 years or older but younger than 7 years who are in the period between 1 year before entering elementary school and the date of entering school |
| Rubella | 1. Those aged 12 months or older but younger than 24 months<br>2. Those aged 5 years or older but younger than 7 years who are in the period between 1 year before entering elementary school and the date of entering school |
| Japanese encephalitis | 1. Those aged 6 months or older but younger than 90 months<br>2. Those aged 9 years or older but younger than 13 years |
| Tetanus | 1. Those aged 3 months or older but younger than 90 months<br>2. Those aged 11 years or older but younger than 13 years |
| Tuberculosis | Those younger than 1 year old |
| Hib infection (Haemophilus influenzae type B) | Those aged 2 months or older but younger than 60 months |
| Pneumococcal infectious disease (limited to one that is of infants) | Those aged 2 months or older but younger than 60 months |
| Varicella | Those aged 12 months or older but younger than 36 months |
| Hepatitis B | Those younger than 1 year old |
| Human papillomavirus infection | Females who are in the period between the first day of the fiscal year in which they turn 12 years old and the last day of the fiscal year in which they turn 16 years old |
| Rotavirus infection disease | 1 titer: From 6 weeks to 24 weeks after birth<br>5 titer: From 6 weeks to 32 weeks after birth |
| Influenza | 1. Those aged 65 years or older<br>2. Those aged 60 years or older but younger than 65 years suffering from cardiac, renal, or respiratory disorders, etc. |
| Pneumococcal infectious disease (limited to one that is of the elderly) | 1. Those aged 65 years<br>2. Those aged 60 years or older but younger than 65 years suffering from cardiac, renal, or respiratory disorders, etc. |

* Those born between April 2, 1995 and April 1, 2007, are subjected to routine vaccination with Japanese encephalitis before they reach the age of 20.

## Detailed Data Benefits type and Amount of Relief System for Injury to Health with Vaccination

**(As of April,1, 2021)**

| Category A diseases | | | Category B diseases | | |
|---|---|---|---|---|---|
| Benefit type | Qualification | Details and amount of benefit | Benefit type | Qualification | Details and amount of benefit |
| Subsidy for medical care expenses | Recipients of medical services due to illness caused by vaccination | Amount equivalent to co-payment calculated based on the case of health insurance | Subsidy for medical care expenses | Recipients of medical services due to illness caused by vaccination | Amount equivalent to co-payment calculated based on the case of health insurance |
| Medical allowance | Same as above | Inpatient: 8 days or more per month: (month) ¥37,000<br>Inpatient: less than 8 days per month: (month) ¥35,000<br>Outpatient: 3 days or more per month: (month) ¥37,000<br>Outpatient: less than 3 days per month: (month) ¥35,000<br>Inpatient and outpatient treatment within the same month: (month) ¥37,000 | Medical allowance | Same as above | Inpatient: 8 days or more per month: (month) ¥37,000<br>Inpatient: less than 8 days per month: (month) ¥35,000<br>Outpatient: 3 days or more per month: (month) ¥37,000<br>Outpatient: less than 3 days per month: (month) ¥35,000<br>Inpatient and outpatient treatment within the same month: (month) ¥37,000 |
| Pension for rearing children with disabilities | Fosterers of children younger than 18 with certain disabilities caused by vaccination | Class 1: (annual) ¥1,581,600<br>(additional amount for long-term care):(annual) (¥844,300)<br>Class 2: (annual) ¥1,266,000<br>(additional amount for long-term care):(annual) (¥562,900) | Disability Pension | Those aged 18 or older with certain disabilities caused by vaccination | Class 1: (annual) ¥2,809,200<br>Class 2: (annual) ¥2,247,600 |
| Disability Pension | Those aged 18 or older with certain disabilities caused by vaccination | Class 1: (annual) ¥5,056,800<br>(additional amount for long-term care):(annual) (¥844,300)<br>Class 2: (annual) ¥4,045,200<br>(additional amount for long-term care):(annual) (¥562,900)<br>Class 3: (annual) ¥3,034,800 | Survivors' Pension | The bereaved will be beneficiary in case the deceased who died from vaccination was the main wage earner of the family (Pension shall be paid up to 10 years) | (annual) ¥2,457,600 |
| | | | Lump-sum benefit for survivors | The bereaved will be beneficiary in case the deceased who died from vaccination was not the main wage earner of the family | ¥7,372,800 |
| Lump-sum death benefit | The bereaved of the person who died of diseases caused by vaccination | ¥44,200,000 | | | |
| Funeral allowance | Hosts of funerals for those who died of diseases caused by vaccination | ¥212,000 | Funeral allowance | Hosts of funerals for those who died of illness caused by vaccination | ¥209,000 |

* The medical care covered by the benefits of the medical expenses and medical allowances for Category B disease shall be the medical care required when it is deemed necessary to be admitted to a hospital or clinic.
* Deadline for claiming a health problem in category B diseases

(Note) 1. The term of claims for subsidy for medical care expenses and medical allowance shall be within 5 years after the payment of the expenses eligible for the benefits.

2. The deadline for claiming medical allowance shall be five years from the first day of the month following the month in which the medical treatment date for such claim belongs.
3. The term of claims for Survivors' Pension and lump-sum benefit for survivors shall be within 2 years from the death of the deceased who died from vaccination for the cases where the deceased was paid with subsidy for medical care expenses, medical allowance, or Disability Pension for his/her complications or disabilities while he/she was alive, or within 5 years from the death for other cases.

# Tuberculosis Measures

## Overview Outline of Tuberculosis Prevention Measures

- A. Regular physical checkups (tuberculin test, X-ray test, etc.) — Elderly (over 65), (high school) students, employees working at school and hospitals, and facility residents
- B. Regular preventive vaccination (BCG) — Infants younger than 1 year old
- C. Patient management
  - Notification — At the time of diagnosis and admission/discharge from hospital.
  - Registration — Tuberculosis registration cards, identification of the current situation of patients
  - Medication advice — Home-visit, health education, etc.
  - Screening for proper disease management — Persons requiring follow-ups, patients who have suspended treatment, etc.
- D. Infection prevention
  - Contact health examination — Health examination to contact person with tuberculosis patients
  - Work restriction, etc. — Work restrictions to tuberculosis patients
  - Admission recommendation — Admission recommendation to tuberculosis patients .
- E. Medical care (public fund)
  - Hospitalization care — Medical care expenses for tuberculosis patients who have been given recommendation/order for hospitalization
  - Hospital visit medical care — Medical fees for hospital visit medical care for tuberculosis patients

## Detailed Data 1 Changes in Number of Newly Notified Tuberculosis Patients, Incidence, and the Mortality

| Year | Number of newly notified patients | Incidence | Number of deaths | Mortality |
|---|---|---|---|---|
| | (Person) | (Per 100,000 persons) | (Person) | (Per 100,000 persons) |
| 1960 | 489,715 | 524.2 | 31,959 | 34.2 |
| 1965 | 304,556 | 309.9 | 22,366 | 22.8 |
| 1970 | 178,940 | 172.3 | 15,899 | 15.4 |
| 1975 | 108,088 | 96.6 | 10,567 | 9.5 |
| 1980 | 70,916 | 60.7 | 6,439 | 5.5 |
| 1985 | 58,567 | 48.4 | 4,692 | 3.9 |
| 1990 | 51,821 | 41.9 | 3,664 | 3.0 |
| 1995 | 43,078 | 34.3 | 3,178 | 2.6 |
| 1999 | 43,818 | 34.6 | 2,935 | 2.3 |
| 2000 | 39,384 | 31.0 | 2,656 | 2.1 |
| 2001 | 35,489 | 27.9 | 2,491 | 2.0 |
| 2002 | 32,828 | 25.8 | 2,317 | 1.8 |
| 2003 | 31,638 | 24.8 | 2,337 | 1.9 |
| 2004 | 29,736 | 23.3 | 2,330 | 1.8 |
| 2005 | 28,319 | 22.2 | 2,296 | 1.8 |
| 2006 | 26,384 | 20.6 | 2,269 | 1.8 |
| 2007 | 25,311 | 19.8 | 2,194 | 1.7 |
| 2008 | 24,760 | 19.4 | 2,220 | 1.8 |
| 2009 | 24,170 | 19.0 | 2,159 | 1.7 |
| 2010 | 23,261 | 18.2 | 2,129 | 1.7 |
| 2011 | 22,681 | 17.7 | 2,166 | 1.7 |
| 2012 | 21,283 | 16.7 | 2,110 | 1.7 |
| 2013 | 20,495 | 16.1 | 2,087 | 1.7 |
| 2014 | 19,615 | 15.4 | 2,100 | 1.7 |
| 2015 | 18,280 | 14.4 | 1,956 | 1.6 |
| 2016 | 17,625 | 13.9 | 1,893 | 1.5 |
| 2017 | 16,789 | 13.3 | 2,306 | 1.9 |
| 2018 | 15,590 | 12.3 | 2,204 | 1.8 |
| 2019 | 14,460 | 11.5 | 2,087 | 1.7 |
| 2020 | | | ＊1,909 | ＊1.5 |

Source: <Number of newly registered patients / prevalence rate>
"Aggregate Result of the Annual Reports of Surveillance of Tuberculosis", Health Service Bureau, MHLW
<Number of deaths / Death rates>
"Vital Statistics", Vital, Health and Social Statistics Office to the Director-General for Statistics and Information Policy, MHLW

(Note) 1. The figures for 1998 and later do not include those of atypical mycobacteria positive.
2. The increase in the number of deaths and the mortality rate after 2017 includes the impact of revisions to the cause of death classification, etc.
3. The figures indicated by "*" are preliminary data.

**Detailed Data 2** **Tuberculosis Incidence by Prefecture (as of the end of 2019)**

| | Prefecture or City | Incidence |
|---|---|---|
| Prefectures with the lowest incidence | Iwate | 6.8 |
| | Akita | 6.8 |
| | Fukushima | 6.9 |
| | Miyagi | 7.3 |
| | Hokkaidou | 7.4 |
| Prefectures with the highest incidence | Osaka | 18.4 |
| | Gifu | 14.6 |
| | Hyogo | 14.0 |
| | Nara | 14.0 |
| | Kyoto | 13.7 |

**Detailed Data 3** **International Comparison of Tuberculosis Incidence**

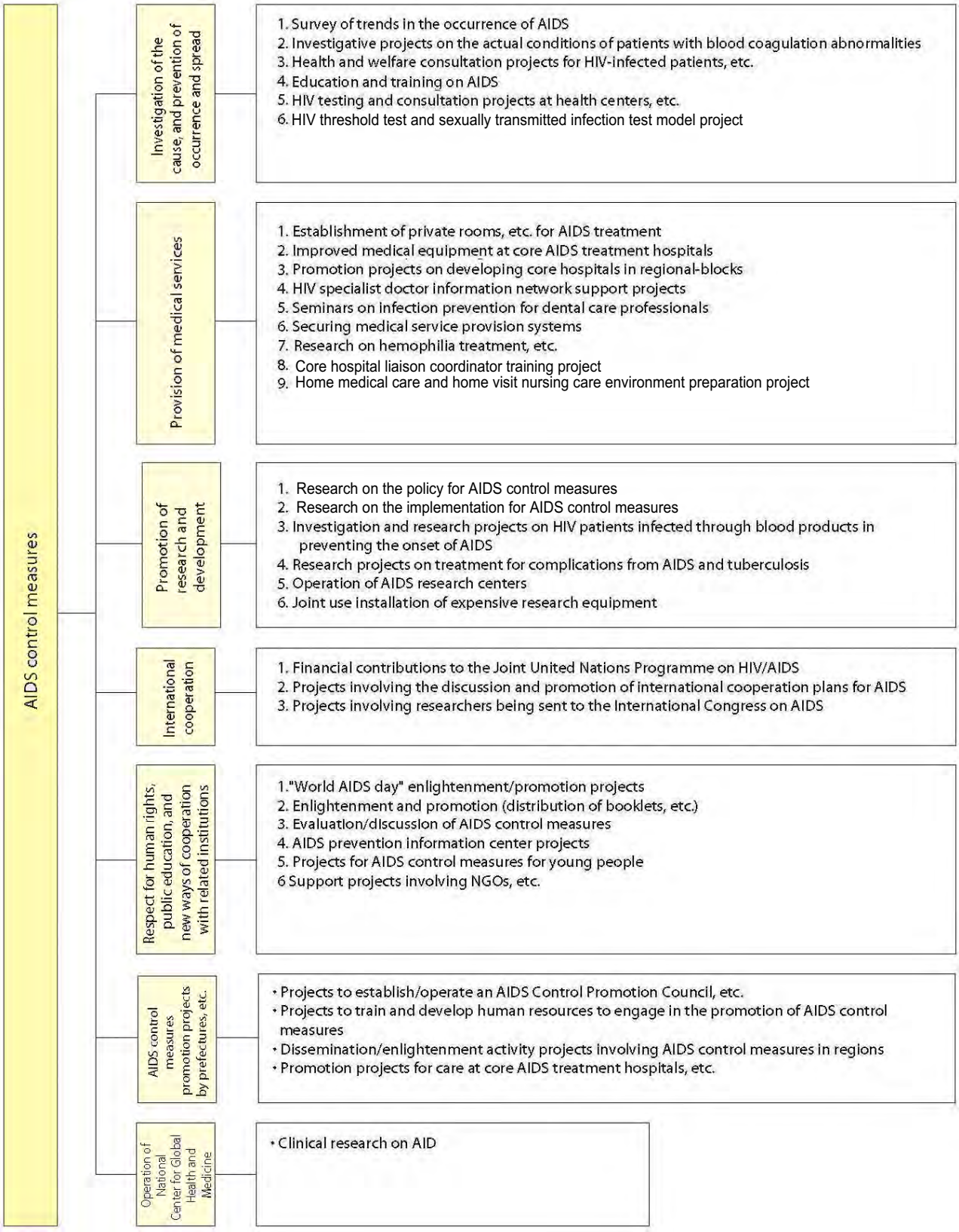
| Country | Incidence |
|---|---|
| United States | 3.0 |
| Canada | 5.6 |
| Sweden | 5.5 |
| Australia | 6.6 |
| Netherlands | 5.3 |
| Denmark | 5.4 |
| France | 8.9 |
| United Kingdom | 8.0 |
| Japan | 11.5 |

Source: WHO's global tuberculosis database

*Data is referred to one at 2018 except Japan.

# AIDS Control Measures

**Overview** **Outline of AIDS Control Measures**



## Detailed Data 1 Changes in Number of HIV Carriers and AIDS Patients by Nationality and Gender

| Category | Nationality | Gender | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | Total | Total % of |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIV | Japan | Male | 0 | 0 | 34 | 15 | 35 | 27 | 52 | 108 | 102 | 134 | 147 | 189 | 234 | 261 | 379 | 336 | 475 | 481 | 525 | 636 | 709 | 787 | 931 | 999 | 894 | 956 | 923 | 889 | 963 | 959 | 860 | 857 | 802 | 768 | 741 | 17,208 | 79.2 |
| | | Female | 0 | 0 | 11 | 4 | 18 | 10 | 17 | 16 | 22 | 32 | 19 | 41 | 34 | 36 | 45 | 32 | 50 | 40 | 32 | 44 | 32 | 49 | 38 | 34 | 38 | 41 | 42 | 31 | 33 | 35 | 38 | 28 | 22 | 32 | 29 | 1,025 | 4.7 |
| | | Total | 0 | 0 | 45 | 19 | 53 | 37 | 69 | 124 | 124 | 166 | 166 | 230 | 268 | 297 | 424 | 368 | 525 | 521 | 557 | 680 | 741 | 836 | 969 | 1,033 | 932 | 997 | 965 | 920 | 996 | 994 | 898 | 885 | 824 | 800 | 770 | 18,233 | 83.9 |
| | Foreign national | Male | 0 | 0 | 10 | 4 | 21 | 11 | 26 | 45 | 33 | 37 | 47 | 65 | 49 | 58 | 39 | 53 | 59 | 55 | 48 | 62 | 60 | 76 | 76 | 60 | 71 | 59 | 71 | 65 | 97 | 82 | 88 | 108 | 136 | 121 | 116 | 2,008 | 9.2 |
| | | Female | 0 | 0 | 0 | 0 | 6 | 18 | 105 | 273 | 120 | 95 | 64 | 81 | 80 | 67 | 67 | 41 | 37 | 38 | 35 | 38 | 31 | 40 | 37 | 33 | 18 | 19 | 20 | 17 | 13 | 15 | 20 | 18 | 16 | 19 | 17 | 1,498 | 6.9 |
| | | Total | 0 | 0 | 10 | 4 | 27 | 29 | 131 | 318 | 153 | 132 | 111 | 146 | 129 | 125 | 106 | 94 | 96 | 93 | 83 | 100 | 91 | 116 | 113 | 93 | 89 | 78 | 91 | 82 | 110 | 97 | 108 | 126 | 152 | 140 | 133 | 3,506 | 16.1 |
| | Total | | 0 | 0 | 55 | 23 | 80 | 66 | 200 | 442 | 277 | 298 | 277 | 376 | 397 | 422 | 530 | 462 | 621 | 614 | 640 | 780 | 832 | 952 | 1,082 | 1,126 | 1,021 | 1,075 | 1,056 | 1,002 | 1,106 | 1,091 | 1,006 | 1,011 | 976 | 940 | 903 | 21,739 | 100.0 |
| AIDS | Japan | Male | 5 | 3 | 6 | 9 | 15 | 18 | 24 | 36 | 53 | 91 | 108 | 156 | 170 | 158 | 212 | 239 | 221 | 232 | 252 | 290 | 291 | 335 | 343 | 359 | 386 | 421 | 419 | 387 | 438 | 409 | 379 | 376 | 348 | 328 | 281 | 7,798 | 80.8 |
| | | Female | 0 | 0 | 3 | 2 | 2 | 3 | 0 | 1 | 5 | 9 | 11 | 15 | 12 | 10 | 12 | 21 | 24 | 20 | 19 | 19 | 11 | 20 | 22 | 19 | 15 | 15 | 16 | 18 | 11 | 13 | 11 | 18 | 21 | 15 | 9 | 422 | 4.4 |
| | | Total | 5 | 3 | 9 | 11 | 17 | 21 | 24 | 37 | 58 | 100 | 119 | 171 | 182 | 168 | 224 | 260 | 245 | 252 | 271 | 309 | 302 | 355 | 365 | 378 | 401 | 436 | 435 | 405 | 449 | 422 | 390 | 394 | 369 | 343 | 290 | 8,220 | 85.2 |
| | Foreign national | Male | 1 | 2 | 3 | 3 | 4 | 10 | 14 | 13 | 19 | 28 | 33 | 45 | 39 | 42 | 46 | 41 | 61 | 36 | 39 | 54 | 49 | 33 | 34 | 32 | 21 | 29 | 21 | 31 | 28 | 26 | 30 | 39 | 27 | 25 | 37 | 995 | 10.3 |
| | | Female | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 9 | 8 | 17 | 18 | 29 | 21 | 31 | 28 | 26 | 20 | 26 | 22 | 16 | 18 | 19 | 21 | 9 | 4 | 17 | 11 | 7 | 7 | 8 | 4 | 17 | 9 | 6 | 431 | 4.5 |
| | | Total | 1 | 2 | 5 | 3 | 4 | 10 | 14 | 14 | 28 | 36 | 50 | 63 | 68 | 63 | 77 | 69 | 87 | 56 | 65 | 76 | 65 | 51 | 53 | 53 | 30 | 33 | 38 | 42 | 35 | 33 | 38 | 43 | 44 | 34 | 43 | 1,426 | 14.8 |
| | Total | | 6 | 5 | 14 | 14 | 21 | 31 | 38 | 51 | 86 | 136 | 169 | 234 | 250 | 231 | 301 | 329 | 332 | 308 | 336 | 385 | 367 | 406 | 418 | 431 | 431 | 469 | 473 | 447 | 484 | 455 | 428 | 437 | 413 | 377 | 333 | 9,646 | 100.0 |

Source: "AIDS Surveillance Report 2019", National AIDS Surveillance Committee, MHLW

(Note) The figures do not include HIV carriers and AIDS patients who have been infected through blood-coagulation-factor preparations.

## Detailed Data 2 Status of AIDS Patients in the World (as of the end of 2019, UNAIDS Report)

| Region | | Number of HIV infected patients (adults/children) | Number of newly infected HIV patients (adults/children) | Percentage of HIV-positive adults (%) | Number of persons died from AIDS (adults/children) |
|---|---|---|---|---|---|
| Asia Pacific | 2019 | 5.80 million [4,300,000-7,200,000] | 0.30 million [210,000-390,000] | 0.2 [0.1-0.3] | 0.16 million [94,000-240,000] |
| | 2010 | 4.90 million [3,900,000-6,400,000] | 0.32 million [240,000-450,000] | 0.2 [0.2-0.3] | 0.28 million [170,000-460,000] |
| East/South Africa | 2019 | 20.70 million [18,400,000-23,000,000] | 0.73 million [580,000-940,000] | 6.7 [5.7-7.6] | 0.30 million [230,000-390,000] |
| | 2010 | 16.80 million [15,000,000-18,900,000] | 1.20 million [940,000-1,400,000] | 7.5 [6.5-8.5] | 0.66 million [510,000-870,000] |
| Eastern Europe, Central Asia | 2019 | 1.70 million [1,400,000-1,900,000] | 0.17 million [140,000-190,000] | 0.9 [0.8-1.0] | 35,000 [26,000-45,000] |
| | 2010 | 0.89 million [810,000-970,000] | 0.10 million [94,000-110,000] | 0.5 [0.5-0.5] | 34,000 [25,000-41,000] |
| Latin America | 2019 | 2.10 million [1,400,000-2,800,000] | 0.12 million [73,000-180,000] | 0.4 [0.3-0.6] | 37,000 [23,000-56,000] |
| | 2010 | 1.50 million [1,100,000-1,800,000] | 0.10 million 78,000-130,000] | 0.4 [0.3-0.5] | 42,000 [29,000-58,000] |
| Caribbean Coast | 2019 | 0.33 million [270,000-400,000] | 13,000 [8,700-19,000] | 1.1 [0.9-1.4] | 6,900 [4,900-10,000] |
| | 2010 | 0.30 million [250,000-390,000] | 19,000 [14,000-31,000] | 1.2 [1.0-1.7] | 13,000 [9,300-22,000] |
| Middle East / North Africa | 2019 | 0.24 million [170,000-400,000] | 20,000 [11,000-38,000] | <0.1 [<0.1-0.1] | 8,000 [4,900-14,000] |
| | 2010 | 0.18 million [120,000-250,000] | 16,000 [9,000-27,000] | <0.1 [<0.1-0.1] | 8,800 [5,800-13,000] |
| Western/Central Africa | 2019 | 4.90 million [3,900,000-6,200,000] | 0.24 million [150,000-390,000] | 1.4 [1.0-1.7] | 0.14 million [100,000-210,000] |
| | 2010 | 6.00 million [4,400,000-8,000,000] | 0.41 million [240,000-620,000] | 2.4 [1.7-3.2] | 0.37 million [240,000-540,000] |
| Western Europe / Central Europe / North America | 2019 | 2.20 million [1,700,000-2,600,000] | 65,000 [49,000-87,000] | 0.2 [0.2-0.3] | 12,000 [8,700-19,000] |
| | 2010 | 1.80 million [1,600,000-2,000,000] | 75,000 [62,000-90,000] | 0.3 [0.3-0.3] | 21,000 [15,000-28,000] |
| Total | 2019 | 38.00 million [31,600,000-44,500,000] | 1.70 million [1,200,000-2,200,000] | 0.7 [0.6-0.9] | 0.69 million [500,000-970,000] |
| | 2010 | 32.40 million [27,400,000-38,500,000] | 2.20 million [1,700,000-2,900,000] | 0.7 [0.6-0.9] | 1.40 million [1,000,000-2,000,000] |

*Actual figures fall within the range of the figures in parentheses. The estimated numbers and ranges are calculated based on the best data available to date.

Source:UNAIDS 2020 estimates

# Pandemic Influenza Preparedness

## Overview Pandemic Influenza Preparedness

### Pandemic Influenza

Pandemic influenza occurs when a new type of influenza virus, which has never spread among humans, gains a new ability for human-to-human transmission. In contrast to seasonal influenza, which can cause outbreak annually, humans have little or no immunity to pandemic influenza. This allows pandemic influenza an ability to efficiently transmit from one human to another, possibly resulting in global pandemic. In recent years, a highly pathogenic avian influenza A(H5N1) that can be transmitted from birds to humans has sporadically emerged, mainly in Asia, the Middle East, and Africa. In addition, the infection to humans of bird flu (H7N9) have been reported in China. If the virus mutates into a form that can spread among humans, it could have a significant impact on people's well-being, health, lives and the national economy. The government is therefore implementing the following pandemic preparedness and response measures.

(Assumptions made in the National Action Plan)

| | |
|---|---|
| Number of patients consulting medical institutions | Approx. 13-25 million |
| Number of inpatients | Approx. 0.53-2 million |
| Number of deaths | Approx. 0.17 - 0.64 million |

### Major events

| | |
|---|---|
| Dec. 2005 | Formulation of the "National Action Plan for Pandemic Influenza" (Meeting of Relevant Ministries and Agencies on Countermeasures against Avian Influenza, etc.) |
| May 2008 | Amendment of the Act on Infectious Disease Control and the Act on Quarantine (Legislative preparation by categorizing a new or re-emerging influenza as "pandemic influenza" to legally conduct hospitalization and quarantine at the ports of entry. In addition, influenza H5N1 transmitted from birds to humans was categorized as the infectious disease category 2 "avian influenza (H5N1)" in the Act on Infectious Diseases Control) |
| Feb. 2009 | Amendment of the "National Action Plan for Pandemic Influenza" (Meeting of Relevant Ministries and Agencies on Countermeasures against Pandemic Influenza and New Infectious Diseases, Avian Influenza, etc.) followed by the amendment of the Act on Infectious Diseases Control |
| Apr. 2009 | Emergence of Influenza A(H1N1)pdm09 |
| Mar. 2011 | The announcement was made in March that it is no longer recognized as "a new or reemerging influenza strain, or a designated infectious disease" as stipulated in the Act on Infectious Disease Control as of March 31, and measures were switched to those for seasonal influenza |
| July 2011 | Amendment of the Act on Preventive Vaccinations (providing new temporary vaccinations framework based on the assumption of pandemic influenza that had the same level of high transmissibility as the influenza A(H1N1)pdm09 but not highly pathogenic) |
| Sep. 2011 | Revision of the "National Action Plan for Pandemic Influenza" (Ministerial Meeting on Countermeasures against Pandemic Influenza) followed by the experiences of influenza A(H1N1)pdm09 |
| Apr. 2012 | Approval of the "Act on Special Measures for Pandemic Influenza and New Infectious Diseases Preparedness and Response" (Legal countermeasures when a pandemic influenza and new infectious disease emerged) |
| Jun. 2013 | Formulation of the "National Action Plan for Pandemic Influenza" (Cabinet decision)<br>Formulation of the "Guideline for Pandemic Influenza" (Meeting of Relevant Ministries and Agencies on Countermeasures against Pandemic Influenza and New Infectious Diseases, Avian Influenza, etc.) |
| Mar. 2016 | Partial revision of the Guideline for Pandemic Influenza (Meeting of Relevant Ministries and Agencies on Countermeasures against Pandemic Influenza and New Infectious Diseases, Avian Influenza, etc.) in response to the review of the policies for stockpiles of antiviral drugs. |
| Sep. 2017 | "National Action Plan for Countermeasures against New Influenza" (Cabinet decision) was partially amended and "Guideline for Pandemic Influenza" was partially revised, due to the changes in the stock amount of anti-influenza virus drugs, etc. |
| Mar. 2019 | "Cell culture method vaccine actual production facility maintenance promotion project" completed. |

### Major budgetary projects

| | |
|---|---|
| Capacity development of medical institutions against pandemic influenza | Arrange and secure necessary number of beds and medical resources at medical institutions designated by local governments to accept pandemic influenza patients |
| Dissemination of countermeasures against pandemic influenza | Public communications for individuals, families and workplaces. Information sharing with medical institutions through e-mail magazines |
| Stockpiles of antiviral drugs | Stockpile targeting approximately 45 million people, including national, prefectural, and distribution |
| Stockpiles of H5N1 pre-pandemic vaccine | Priority is given to stockpiling of vaccine stocks with a high "importance in crisis management". Store Equip H7N9 type London stock for about 10 million by the end of 2020 |
| Promotion of technical development on Pandemic Influenza | Promotion of technical development by Cell culture method vaccine on Pandemic Influenza |

# Organ Transplantation and Hematopoietic Stem Cell Transplantation

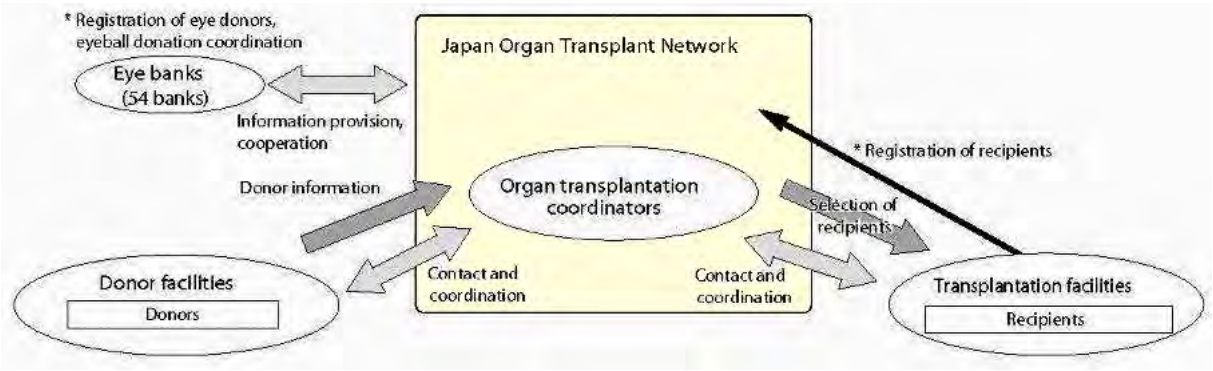
## Overview　Organ Transplantation System

**[Organ Transplantation System]**

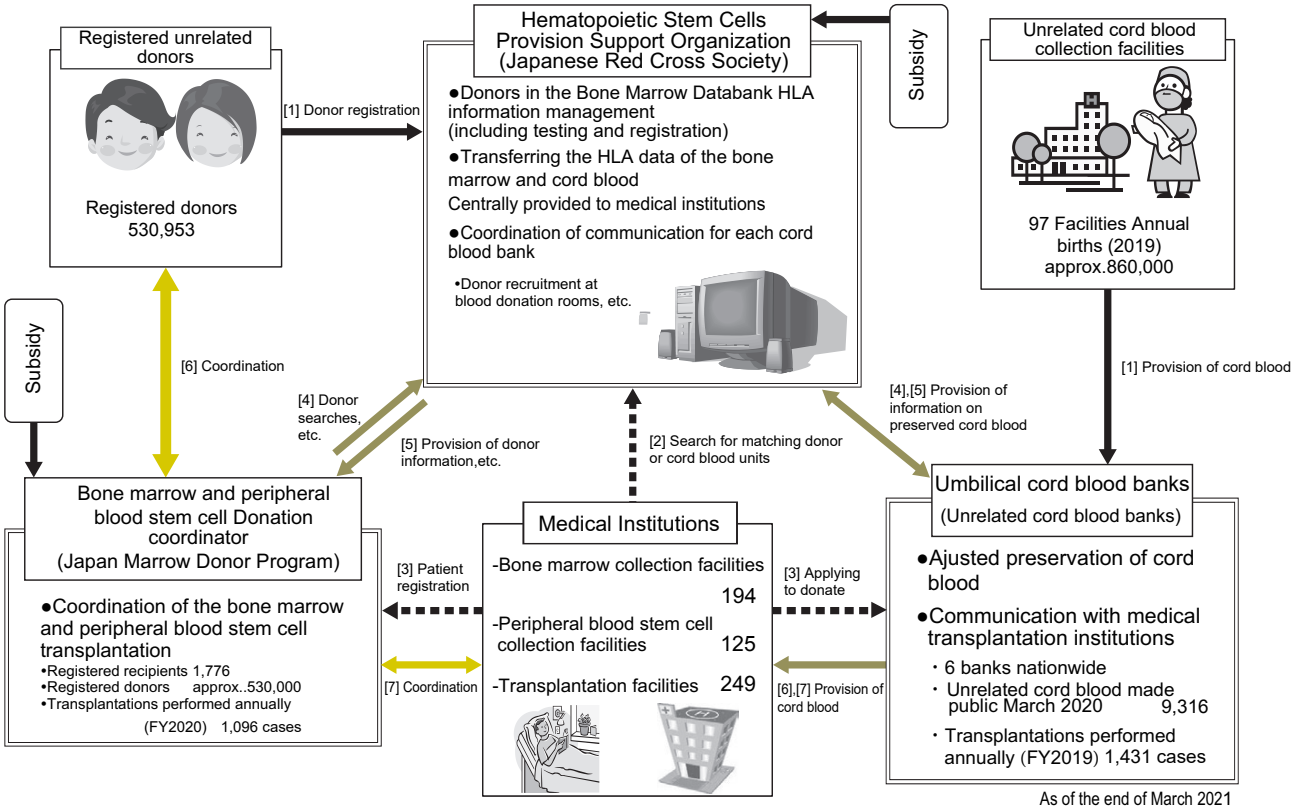
The traditional kidney transplantation system was reviewed and a new centralized nationwide kidney transplantation network established in FY1995. Enforcement of the “Act on Organ Transplantation” in October 1997 enabled multiple organ transplantations and the pertinent network.

At present fair and appropriate mediation of organ donations has been conducted mainly by the Japan Organ Transplant Network through recipients being selected using universal standards. With regard to the transplantation of eyeballs (corneas), mediation work, including enlightenment and promotion activities, is being carried out by eye banks at 54 locations nationwide.

### Diagram of Organ Transplantation Network System




### Unrelated Hematopoietic Stem Cell Transplantation System



## Detailed Data 1 Accumulated Number of Organ Transplantations

| | Number of donors | | Number of transplantations performed | | Registered transplant applicants |
|---|---|---|---|---|---|
| | | Under brain death | | Under brain death | |
| Heart | 580 persons | 580 persons | 579 cases | 579 cases | 918 persons |
| Lung | 493 persons | 493 persons | 601 cases | 601 cases | 478 persons |
| Liver | 621 persons | 621 persons | 666 cases | 666 cases | 337 persons |
| Kidney | 2,154 persons | 685 persons | 4,032 cases | 1,345 cases | 13,335 persons |
| Pancreas | 445 persons | 441 persons | 441 cases | 438 cases | 197 persons |
| Small intestine | 23 persons | 23 persons | 23 cases | 23 cases | 7 persons |
| Eyeball (cornea) | 21,160 persons | 312 persons | 34,389 cases | 591 cases | 1,716 persons |

Source: Japan Organ Transplant Network, Japan Eye Bank Association

(Note)
1. The number of donors and the number of transplantations performed indicate the cumulative total from October 16, 1997 (the day of the enforcement of the Act on Organ Transplantation) to March 31, 2021. The number of patients on waiting lists is as of March 31, 2021.
2. There have been 742 persons of brain death tests conducted nationwide under the Act on Organ Transplantation since the enforcement of the law until March 31, 2021. In the seven cases, the donor was determined legally brain dead, but the organ was not removed for medical reasons. The case is therefore not included in the number of donors.
3. The number of pancreas and kidneys includes the number of pancreatic kidney simultaneous transplants (371 cases) and the number of registered pancreatic kidney simultaneous transplant applicants (161 persons).
4. The number of heart and lung cases includes the number of the heart lung simultaneous transplants (3 cases) and the number of registered heart lung simultaneous transplant applicants (6 persons).
5. The number of liver and kidney cases includes the number of cases of liver kidney simultaneous transplants (30 cases) and the number of registered liver kidney simultaneous transplant applicants (41 persons).

## Detailed Data 2 Changes in Numbers of Hematopoietic Stem Cell Transplantations Performed

| | Unrelated donors | | Number of unrelated transplantations | | |
|---|---|---|---|---|---|
| | Number of registered donors | Number of registered cord blood | Bone marrow | Peripheral blood stem cell | Cord blood |
| FY 1991 | 3,176 | − | − | − | − |
| FY 1992 | 19,829 | − | 8 | − | − |
| FY 1993 | 46,224 | − | 112 | − | − |
| FY 1994 | 62,482 | − | 231 | − | − |
| FY 1995 | 71,174 | − | 358 | − | − |
| FY 1996 | 81,922 | − | 363 | − | 1 |
| FY 1997 | 94,822 | − | 405 | − | 19 |
| FY 1998 | 114,354 | − | 482 | − | 77 |
| FY 1999 | 127,556 | − | 588 | − | 117 |
| FY 2000 | 135,873 | 4,343 | 716 | − | 165 |
| FY 2001 | 152,339 | 8,384 | 749 | − | 221 |
| FY 2002 | 168,413 | 13,431 | 739 | − | 296 |
| FY 2003 | 186,153 | 18,424 | 737 | − | 697 |
| FY 2004 | 204,710 | 21,335 | 851 | − | 674 |
| FY 2005 | 242,858 | 24,309 | 908 | − | 658 |
| FY 2006 | 276,847 | 26,816 | 963 | − | 732 |
| FY 2007 | 306,397 | 29,197 | 1,027 | − | 762 |
| FY 2008 | 335,052 | 31,149 | 1,118 | − | 859 |
| FY 2009 | 357,378 | 32,793 | 1,232 | − | 895 |
| FY 2010 | 380,457 | 32,994 | 1,191 | 1 | 1,075 |
| FY 2011 | 407,871 | 29,560 | 1,269 | 3 | 1,107 |
| FY 2012 | 429,677 | 25,385 | 1,323 | 15 | 1,199 |
| FY 2013 | 444,143 | 13,281 | 1,324 | 19 | 1,134 |
| FY 2014 | 450,597 | 11,595 | 1,269 | 62 | 1,165 |
| FY 2015 | 458,352 | 11,185 | 1,176 | 58 | 1,311 |
| FY 2016 | 470,270 | 11,287 | 1,127 | 123 | 1,347 |
| FY 2017 | 483,879 | 9,991 | 1,059 | 182 | 1,334 |
| FY 2018 | 509,263 | 9,516 | 992 | 222 | 1,355 |
| FY 2019 | 529,965 | 9,162 | 992 | 240 | 1,430 |
| FY 2020 | 530,953 | 9,316 | 838 | 258 | 1,431 |
| Total | − | − | 24,147 | 1,183 | 20,061 |

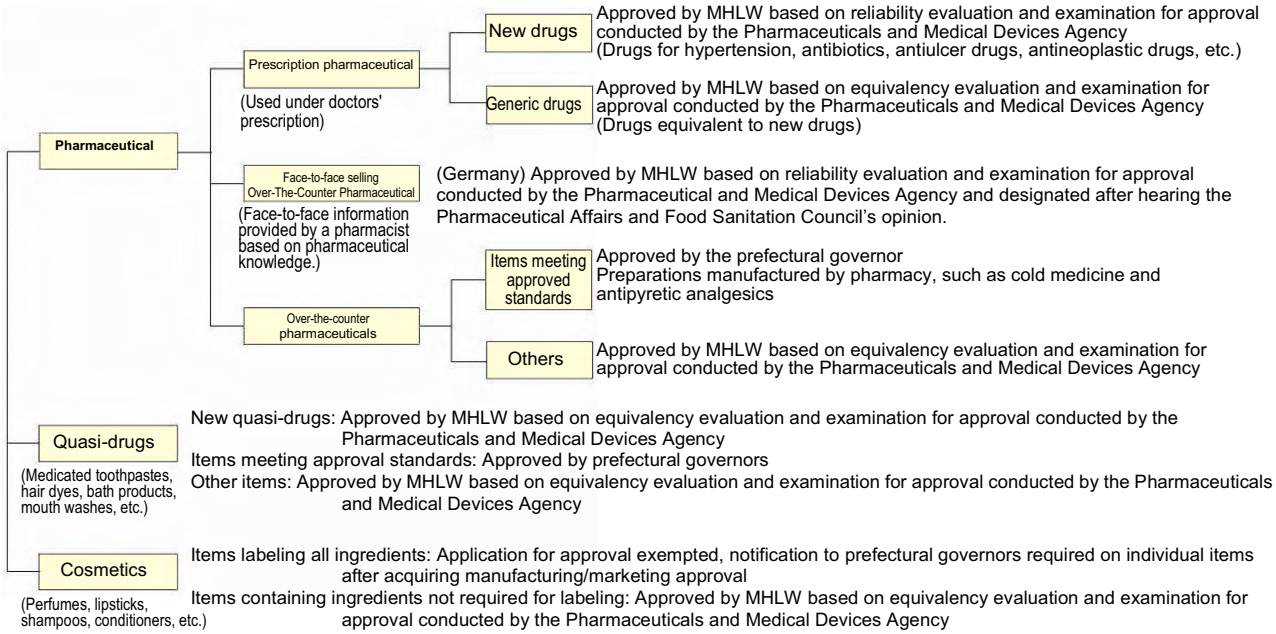
Source: Japan Marrow Donor Program, Japanese Red Cross Society

* The figures for cord blood stem from FY1996 to FY1998 indicate the number of transplantations coordinated by cord blood banks before the establishment of the Japan Cord Blood Bank Network.
* Number of donors is as of the end of the respective years.

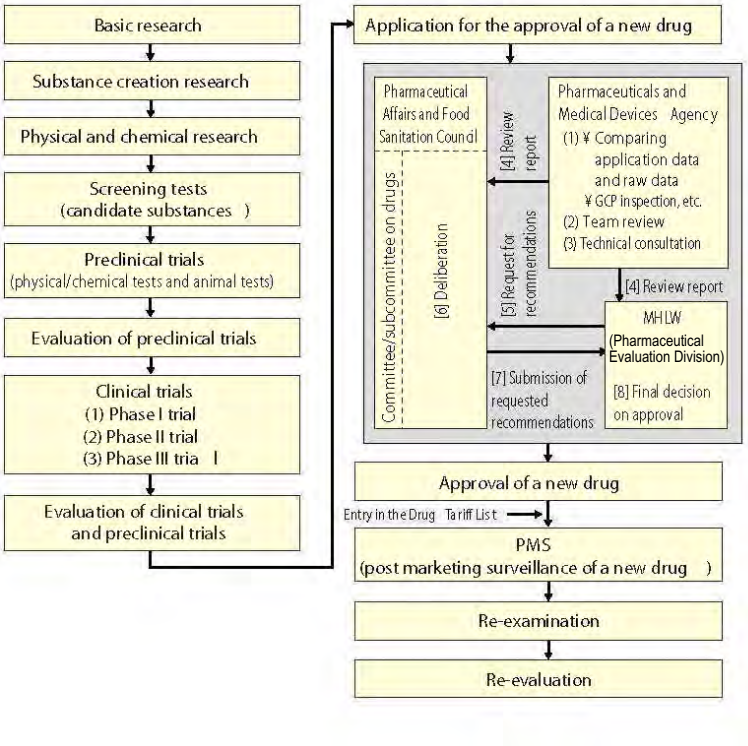
# (4) Pharmaceuticals, etc.

## Approval/Licensing System for Pharmaceuticals, Quasi-Drugs, and Cosmetics

**Overview** **Classification of Examinations for the Approval of Pharmaceuticals, etc.**




### Flow of Examination for the Approval of a New Pharmaceutical




(Note) The trials that are deemed necessary for application for the approval of a new drug can be roughly divided into two categories: preclinical (physical/chemical tests and animal tests) and clinical trials. Clinical trials are conducted on a phased basis from phase I trial (a small number of healthy volunteers), the phase II trial (a small number of patients), and the phase III trial (a large number of patients), as indicated in the chart above.

**[Examination for the approval of a new drug]**

The quality, efficacy, and safety of a new drugs require an especially careful review. Therefore, a mechanism is in place in which the Pharmaceutical Affairs and Food Sanitation Council (an advisory organ to the Minister of Health, Labour and Welfare) composed of experts in the fields of medical science, pharmaceutical science, veterinary science, and statistical science deliberates on these subjects based on a number of data derived from basic and clinical studies. This mechanism also includes the decision making process in which the Minister of Health, Labour and Welfare makes decisions on the approvals of a new drug based on the results of the deliberations of the Council.

Good Laboratory Practices (GLP) for the implementation of animal testing (against toxicity) among non-clinical tests and Good Clinical Practices (GCP) for the implementation of clinical tests are set forth by ministerial ordinances. Each test is regulated by GLP and GCP to assure appropriate testing.

**[License for marketing and manufacturing pharmaceuticals, etc.]**

The approval and licensing system for pharmaceuticals, etc. was revised. Since April 2005, the system has been applied separately to a marketing authorization holder that ships products to markets and to a manufacturer of the products.

To obtain a license, a marketing authorization holder will be reviewed whether it complies with the standards on quality control procedures, as well as post-marketing safety control procedures. A manufacturer will be reviewed whether it complies with the standards on structure and facilities of manufacturing sites and on quality control procedures.

Prefectural governors issue the license for marketing and that for manufacturing, except for manufacturing of some pharmaceuticals that require sophisticated manufacturing technology.

## Detailed Data 1 Number of Licenses for Marketing Authorization Holder of Drugs, etc.

(As of the end of 2020

| Category | Pharmaceuticals | Class 1 pharmaceuticals | Class 2 pharmaceuticals | Quasi-drugs | Cosmetics | Total |
|---|---|---|---|---|---|---|
| Marketing | 1,037 | 274 | 763 | 1,458 | 3,957 | 6,452 |

Source: Pharmaceutical Safety and Environmental Health Bureau, MHLW
(Note) Licenses are granted by prefectural governors (from April 1, 2005).

## Detailed Data 2 Number of Approvals for Manufacturing/Import/Marketing Drugs, etc. (2020)

| | | Prescription pharmaceuticals | Face-to-face selling / OTC pharmaceuticals | Quasi-drugs | Cosmetics |
|---|---|---|---|---|---|
| Manufacturing Marketing Approval | Approval | 964 | 463 | 1,893 | 0 |
| | Approval with partial revision | 2,249 | 162 | 225 | 0 |
| | Total | 3,213 | 625 | 2,118 | 0 |

Source: Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) The figures exclude in vitro diagnostics.

## Detailed Data 3 Number of Approvals for Manufacturing Pharmaceuticals , etc.

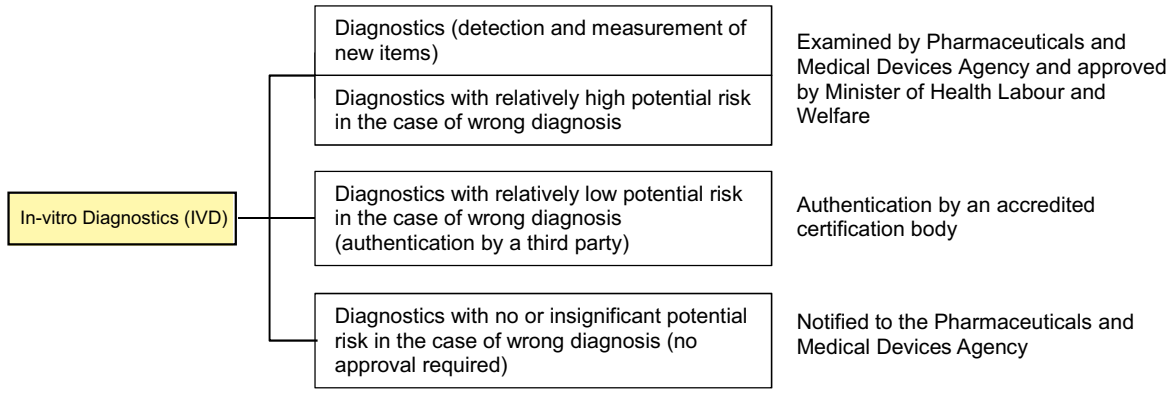
(As of the end of 2020)

| Category | Pharmaceuticals | Quasi-drugs | Cosmetics | Total |
|---|---|---|---|---|
| Manufacturing | 2,047 | 1,958 | 3,876 | 7,881 |

Source: Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) Licenses are granted by prefectural governors from April 1, 1995 (excluding some drugs).

# Review for the Approval of In-vitro Diagnostics (IVD)

## Overview Review for the Approval of IVD




## Detailed Data 1 Number of Licenses for Marketing IVD

(As of the end of 2020)

| | IVD |
|---|---|
| Marketing | 167 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) Licenses are granted by prefectural governors.

## Detailed Data 2 Number of Approvals for Marketing (2020)

| | Medicines for in-vitro diagnosis |
|---|---|
| Approval | 98 |
| Approval with partial change | 85 |
| Total | 183 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed Data 3 Number of Registrations for Manufacturing IVD

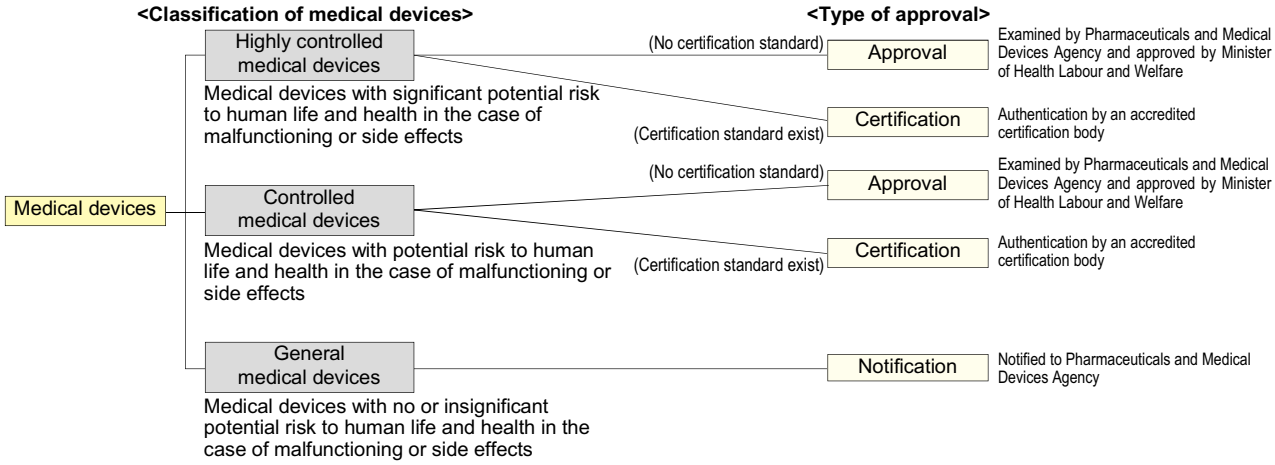
(as of the end of 2020)

| | IVD |
|---|---|
| Manufacturing | 216 |

Source: Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) Licenses are granted by prefectural governors.

# Medical Device Approval/Licensing System

## Overview Review for the Approval of Medical Devices




## Detailed Data 1 Number of Licenses for Marketing Authorization Holder of Medical Devices

(As of the end of 2020)

| Category | Class 1 medical devices | Class 2 medical devices | Class 3 medical devices | Total |
|---|---|---|---|---|
| Marketing | 756 | 1,122 | 921 | 2,799 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) Licenses are granted by prefectural governors (from April 1, 2005).

## Detailed Data 2 Number of Approvals for Manufacturing, Import, and Marketing Medical Devices (2020)

| | | Medical devices |
|---|---|---|
| Manufacturing | Approval | 0 |
| | Approval with partial change | 0 |
| | Total | 0 |
| Import | Approval | 0 |
| | Approval with partial change | 0 |
| | Total | 0 |
| Marketing | Approval | 536 |
| | Approval with partial change | 580 |
| | Total | 1,116 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

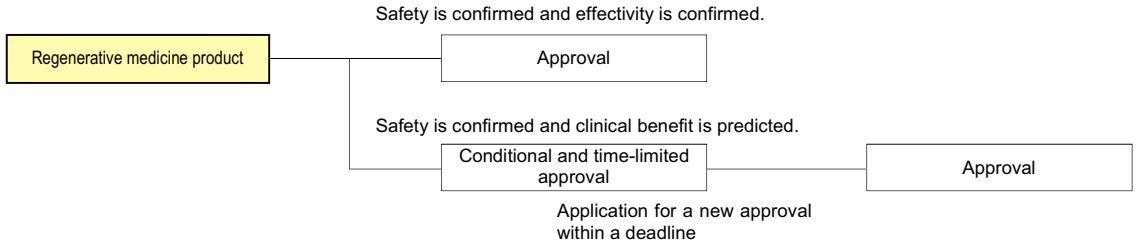
## Detailed Data 3 Number of Licenses and registrations for Manufacturing Medical Devices, etc.

(As of the end of 2020)

| | Medical devices |
|---|---|
| Manufacturing | 4,442 |
| Repairs | 6,526 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) Manufacturing licenses are granted by prefectural governors.
Repairing licenses are granted by prefectural governors.

## Overview Review for the Approval of Regenerative medicine product




## Detailed Data 1 Number of Licenses for Marketing Authorization Holder of Regenerative medicine Detailed Data 1 product (2020)

| | Regenerative medicine product |
|---|---|
| Marketing | 16 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) Licenses are granted by prefectural governors.

## Detailed Data 2 Number of Approvals for Marketing Regenerative medicine product (2020)

| | Regenerative medicine product |
|---|---|
| Approval | 2 |
| Approval with partial change regarding manufacture and sales | 3 |
| Total | 5 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed Data 3 Number of Licenses for Manufacturing Regenerative medicine product

(As of the end of 2020)

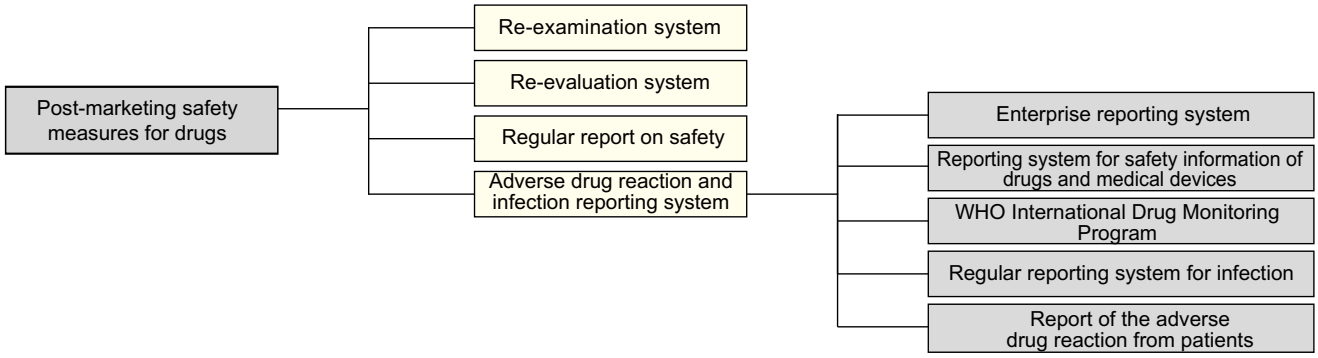
| | Regenerative medicine product |
|---|---|
| Manufacturing | 22 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW.

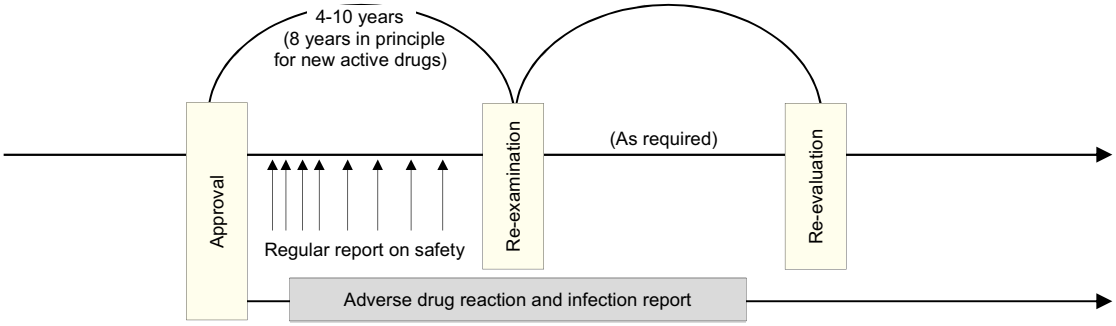
# Post-Marketing Measures for Drugs/Medical Devices

**Overview**

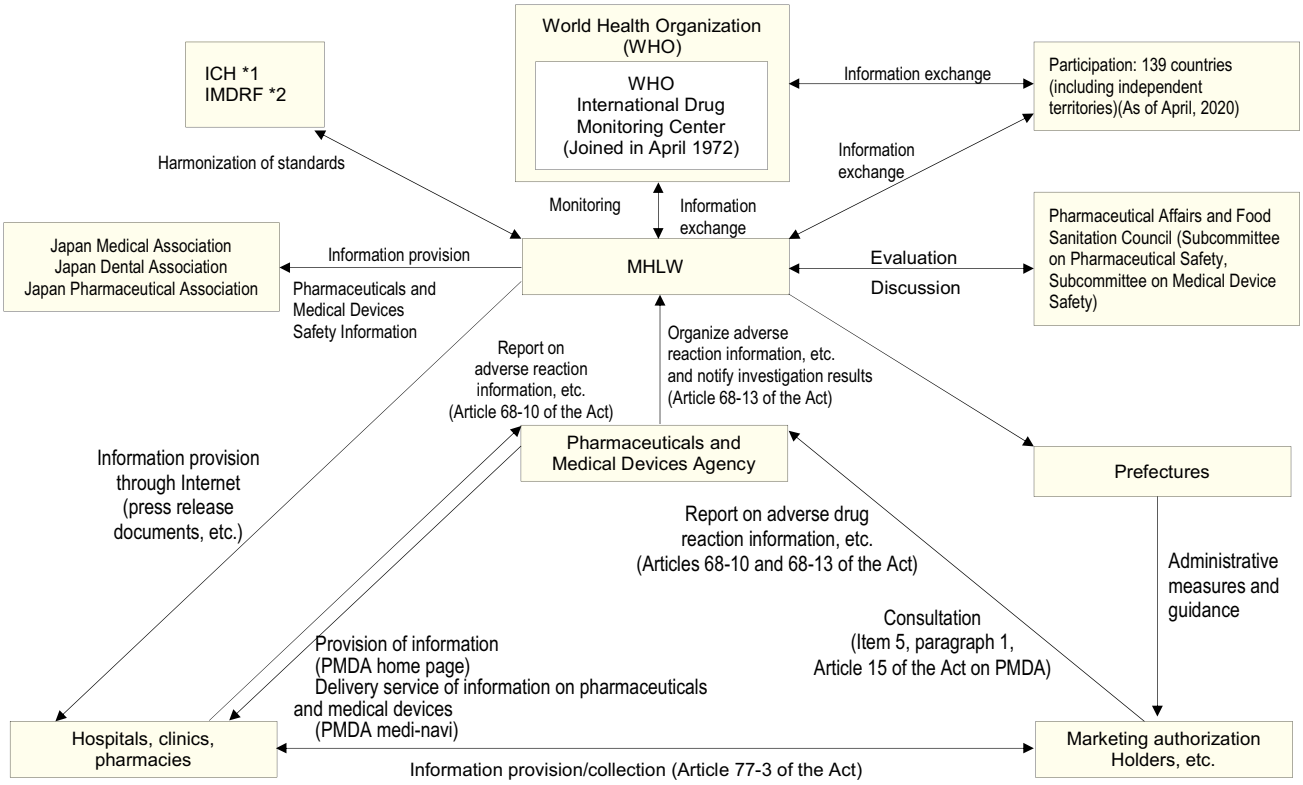
## Post-Marketing Safety Measures for Drugs




## Flow of Post-Marketing Surveillance and Re-examination/Re-evaluation of Drugs




## Outline of the Adverse Drug Reaction, etc. Reporting System




*1: International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use
2: International Medical Device Regulators Forum

## Detailed Data 1 Results of Prescription Drug Re-examination

(As of the end of FY2020)

| No. of reexamination results (no. of items) | | |
|---|---|---|
| Drugs that can be approved for effectiveness | Drugs that are approved for effectiveness with partial revision of matters to be approved | Drugs that are not approved for effectiveness |
| 4,216 | 142 | 0 |

* In case that the same items are reexamined more than once, calculated figures are based on actual reexamination.
Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed Data 2 Results of Prescription Drug Re-evaluation

(As of the end of FY2020)

(1) Phase 1 re-evaluation

| | No. of finished ingredients or no. of subscriptions | No. of finished items |
|---|---|---|
| Total | 1,819 | 19,612 |
| Only one ingredient contained in medicine | 1,159 | 18,169 |
| Mixed ingredients for medicine | 660 | 1,443 |

(2) Phase 2 re-evaluation

| | No. of finished ingredients or no. of subscriptions | No. of finished items |
|---|---|---|
| Total | 131 | 1,860 |
| Only one ingredient contained in medicine | 108 | 1,668 |
| Mixed ingredients for medicine | 23 | 192 |

(3) New reevaluation

| | No. of ingredients | No. of finished items |
|---|---|---|
| Total | 1,115 | 9,225 |
| Re-evaluation for medicine effect | 477 | 4,635 |
| Re-evaluation of quality | 638 | 4,590 |

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW
(Note) 1. Phase 1 re-evaluation (between November 1973 and September 1995): Ingredients approved before September 30, 1967)
2. Phase 2 re-evaluation: covers ingredients approved between January 1988 and March 1996) : covers ingredients approved between October 1, 1967 and March 31, 1980.
3. New re-evaluation (between December 1990 and March 2016): covers all the ingredients.

## Detailed Data 3 Changes in the Number of Reports on Adverse Drug Reaction, etc. in the Past 5 Years

(Unit: case)

| FY | Reports from marketing authorization holders Note 1) | | | | | Reports on adverse drug reactions from medical professionals Note 3) |
|---|---|---|---|---|---|---|
| | Reports on adverse drug reactions Note 2) | Reports on infectious diseases Note 2) | Reports on research results | Reports on overseas measures | Regular reports on infectious diseases | |
| FY 2015 | 50,977 | 88 | 1,219 | 1,273 | 1,102 | 6,129 |
| FY 2016 | 55,728 | 89 | 1,117 | 1,397 | 1,140 | 6,047 |
| FY 2017 | 60,872 | 100 | 1,206 | 1,492 | 1,052 | 7,624 |
| FY 2018 | 62,037 | 73 | 1,078 | 1,451 | 1,084 | 9,931 |
| FY 2019 | 60,405 | 72 | 983 | 1,579 | 1,061 | 9,537 |

Note 1) Including a report once accepted but withdrawn later by the manufacturer/seller (such as one found to have not taken the medicine after reporting, etc.), and a report accepted as a non-target report (such as one for which the causal relation was denied due to additional information after the reporting).
Note 2) Reports on domestic cases.
Note 2) The sum consists of the number of adverse reaction reports based on the safety information reporting system and the number of post-vaccination side reaction reports. Note, however, that the number of post-vaccination side reaction reports is equivalent to the total number of reports related to cervical cancer preventive vaccine, hib vaccine, pediatric pneumococcal vaccine and influenza vaccine alone for FY 2012, and the total number of all vaccines for FY2013 and the following years.

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed Data 4 Changes in the Number of Fault Reports on Combination Drugs (Note1) Medical Devices

| FY | Fault cases of combination(domestic) | Fault cases of combination drugs(Overseas) |
|---|---|---|
| 2015 | 38 | 60 |
| 2016 | 661 | 1,126 |
| 2017 | 1,120 | 2,951 |
| 2018 | 1,653 | 2,542 |
| 2019 | 1,395 | 2,634 |

Note 1) A medicinal combination product refers to a medicine that has been approved for sale as an integrated unit with mechanical device such as insulin pen injector. Subject to the enforcement of the Pharmaceuticals and Medical Devices Law on November 25, 2014, reporting was mandated from November 25, 2016 after the transitional measure period from November 25, 2014 to November 24, 2016.

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed data 5 Reported number of adverse reactions, etc. of quasi-drugs/cosmetics [Note 1)]

| FY | Quasi-drugs (domestic) | Cosmetics (domestic) |
|---|---|---|
| FY 2015 | 323 | 114 |
| FY 2016 | 146 | 71 |
| FY 2017 | 119 | 97 |
| FY 2018 | 163 | 83 |
| FY 2019 | 119 | 80 |

Note 1) A report after the enforcement of the ministerial ordinance that revises a part of the ministerial ordinance concerning the standards for post-marketing safety management of the pharmaceuticals, quasi-drugs, cosmetics and medical equipment on April 1, Heisei 20, and was mandated.

Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed Data 6 Changes in Number of Reports on Adverse Event Related to Medical Devices, etc. in the Past 5 Years

| FY | Reports from marketing authorization holders | | | | | Reports on adverse drug reactions from medical professionals (Unit: case) |
|---|---|---|---|---|---|---|
| | Reports on adverse event [Note 1)] | Reports on infectious diseases [Note 2)] | Reports on research results | Reports on overseas measures | Regular reports on infectious diseases | |
| FY 2015 | 43,997 | 0 | 598 | 1,742 | 68 | 406 |
| FY 2016 | 48,563 | 0 | 1,289 | 2,144 | 67 | 548 |
| FY 2017 | 50,887 | 0 | 2,701 | 2,437 | 56 | 441 |
| FY 2018 | 52,544 | 0 | 2,314 | 2,512 | 69 | 487 |
| FY 2019 | 76,053 | 0 | 3,147 | 1,201 | 66 | 498 |

Note 1) Reports on adverse event include overseas cases.
Note 2) Reports on domestic cases.
Source: Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

## Detailed Data 7 Changes in Number of Reports on adverse events including drugs produced by utilizing regenerative medicine

| FY | Reports from manufacturers (Unit: case) | | | | | Reports on adverse drug reactions from medical professionals (unit: case) |
|---|---|---|---|---|---|---|
| | Reports on adverse event [Note 1)] | Reports on infectious diseases [Note 2)] | Research reports | Reports on overseas measures | Regular reports on infectious diseases | |
| FY 2015 | 35 | 0 | 0 | 0 | 14 | 0 |
| FY 2016 | 88 | 0 | 0 | 0 | 34 | 0 |
| FY 2017 | 110 | 0 | 0 | 0 | 34 | 0 |
| FY 2018 | 163 | 0 | 0 | 0 | 34 | 0 |
| FY 2019 | 1,145 | 0 | 1 | 2 | 62 | 0 |

Note 1) Reports on adverse event of drugs produced by utilizing regenerative medicine, etc. including overseas cases.
Note 2) Reports on domestic cases
Source:Survey conducted by Pharmaceutical safety and Environmental Health Bureau, MHLW

# Relief Systems for Adverse Drug Reactions and Infections Acquired through Biological Products

## Overview

**[Relief System for Adverse Drug Reactions]**

The purpose of this system is to provide various relief benefits and prompt relief to patients and their families, apart from civil liability, in relation to injury caused by adverse reactions despite the proper use of drugs.

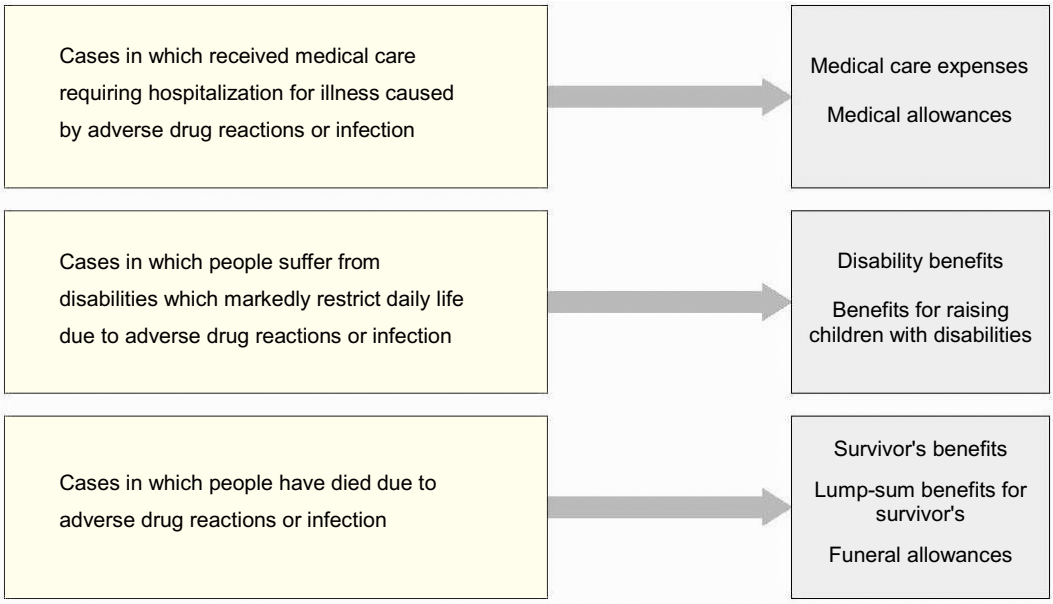
**[Relief System for Infections Acquired through Biological Products]**

The purpose of this system is to provide various relief benefits and prompt relief to patients and their families, apart from civil liability, in relation to injury caused by infections despite the proper use of biological products.

**[Responsible organization]**

Pharmaceuticals and Medical Devices Agency

**[Types of Relief Benefits]**




**[Activities on the Relief for Caused Damages]**

Since 1968, the Agency has been entrusted by the pharmaceutical enterprises and the government to pay health management allowances, etc. to patients who have been settled by SMON (subacute myelo-optico-neuropathy) of the lawsuit out of court.

**[Relief Program for AIDS patients, etc. caused by Blood Products]**

A survey and research project has been conducted since FY 1993 for helping HIV carriers infected through the use of contaminated blood products to prevent them from developing symptoms. For the prevention of the onset o AIDS and for health management in daily life, the government provides health management expenses and in turn requests the carriers report their health status.

Since FY 1996, assistance on health management expenses has been provided for the health management of those who developed AIDS and accepted the court settlement.

## Detailed Data Changes in Status of Adverse Drug Reaction Relief Payments (as of the end of each FY)

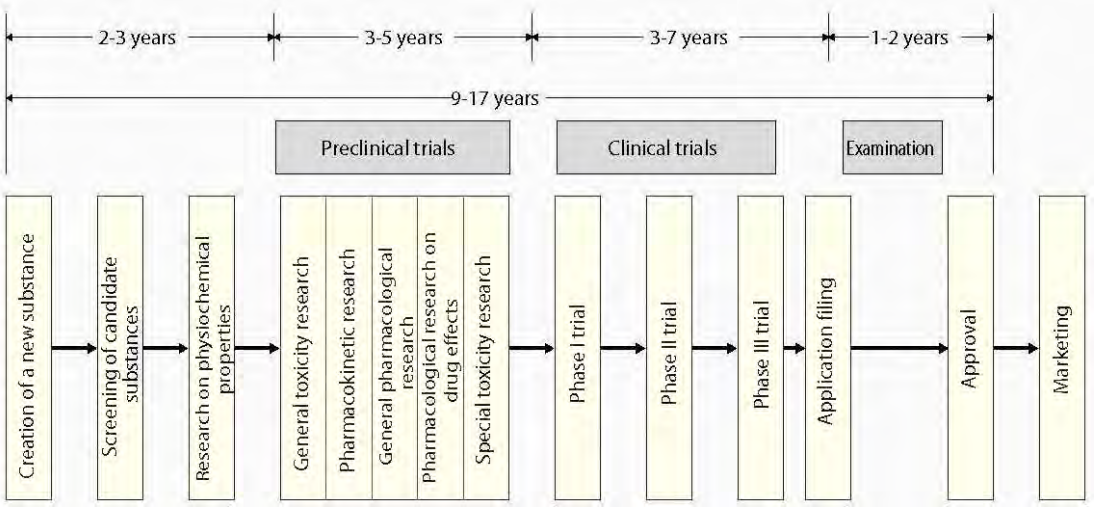
| | FY1980-FY1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Amount (¥1,000) | 8,705,179 | 935,148 | 1,022,185 | 1,055,985 | 1,204,243 | 1,262,647 | 1,587,567 | 1,582,956 | 1,696,525 | 1,798,706 | 1,783,783 | 1,867,190 | 2,058,389 | 1,920,771 | 1,959,184 | 2,113,286 | 2,086,902 | 2,267,542 | 2,351,545 | 2,353,225 | 2,461,090 | 2,420,942 |
| Number of claims (case) | 3,814 | 480 | 483 | 629 | 793 | 769 | 760 | 788 | 908 | 926 | 1,052 | 1,018 | 1,075 | 1,280 | 1,371 | 1,412 | 1,566 | 1,843 | 1,491 | 1,419 | 1,590 | 1,431 |
| Number of payments (case) | 2,965 | 343 | 352 | 352 | 465 | 513 | 836 | 676 | 718 | 782 | 861 | 897 | 959 | 997 | 1,007 | 1,204 | 1,279 | 1,340 | 1,305 | 1,263 | 1,285 | 1,342 |

Source: Pharmaceutical and Medical Devices Agency

# Research/Development of Drugs and Pharmaceutical Industry

## Overview Process and Period of New Drug Development

Developing a new drug is considered to take 9-17 years and require nearly ¥100 billion per product including the costs of abandoned cases.




## Detailed Data Breakdown of Marketing Authorization Holders of Drugs, etc. by Scale

| Category | Number of enterprises | Percentage | Drug sales (¥100 million) | Percentage | Prescription drug sales (included) (¥100 million) | Percentage |
|---|---|---|---|---|---|---|
| Capital of less than ¥100 million | 136 | 46.6% | 4,369 | 3.1% | 2,862 | 2.5% |
| ¥100 million - 5 billion | 99 | 33.9% | 26,155 | 18.2% | 20,387 | 17.8% |
| ¥5 billion or more | 57 | 19.9% | 112,927 | 78.7% | 91,076 | 79.7% |
| Total | 292 | 100.0% | 143,450 | 100.0% | 114,325 | 100.0% |

Source: "Survey of the Prescription Pharmaceuticals Industry of Japan (FY2015", Health Policy Bureau, MHLW

(Note 1) Survey targets were enterprises marketing drugs with approval of marketing authorization under the Law on Securing Quality, Efficacy and Safety of Products Including Pharmaceuticals and Medical devices as of March 31, 2020, that were members of categorized organizations (15 organizations) of the Federation of Pharmaceutical Manufacturers' Association of Japan.

(Note 2) As for the numerical values in the table, it may not agree with the total due to the rounding of figures.

# Medical Devices

## Overview Production of Medical Devices, etc.

(Unit: ¥100 million, %)

| Year | Production | Percent change from the previous year | Export | Import | Total domestic production |
|---|---|---|---|---|---|
| 1979 | 5,669 | 23.1 | — | — | — |
| 1989 | 12,195 | 9.9 | 2,266 | 2,972 | 12,819 |
| 1999 | 15,075 | -0.4 | 3,273 | 8,345 | 19,298 |
| 2005 | 15,724 | 2.5 | 4,739 | 10,120 | 20,695 |
| 2006 | 16,883 | 7.4 | 5,275 | 10,979 | 24,170 |
| 2007 | 16,845 | -0.2 | 5,750 | 10,220 | 21,727 |
| 2008 | 16,924 | 0.5 | 5,592 | 10,907 | 22,001 |
| 2009 | 15,762 | -6.9 | 4,752 | 10,750 | 21,829 |
| 2010 | 17,134 | 8.7 | 4,534 | 10,554 | 22,856 |
| 2011 | 18,085 | 5.5 | 4,809 | 10,584 | 23,525 |
| 2012 | 18,952 | 4.8 | 4,901 | 11,884 | 25,894 |
| 2013 | 19,055 | 0.5 | 5,305 | 13,008 | 26,722 |
| 2014 | 19,895 | 4.4 | 5,723 | 13,685 | 27,655 |
| 2015 | 19,456 | -2.2 | 6,226 | 14,249 | 27,173 |
| 2016 | 19,146 | -1.6 | 5,840 | 15,564 | 28,455 |
| 2017 | 19,904 | 4.0 | 6,190 | 16,492 | 29,314 |
| 2018 | 19,490 | -2.1 | 6,676 | 16,204 | 28,672 |
| 2019 | 25,678 | 31.8 | 10,091 | 27,230 | 39,864 |

Source: “Annual Report on the Survey of Pharmaceutical Industry Productions, Health Policy Bureau, MHLW

## Detailed Data Production by Medical Device Type

(Unit: ¥100 million, %)

| | Category | Production | Percentage |
|---|---|---|---|
| 1 | Visceral function substitute | 3,049 | 11.9 |
| 2 | Cannulae/catheters of assorted tip configurations | 2,824 | 11.0 |
| 3 | Medical mirror | 2,419 | 9.4 |
| 4 | Medical X-ray device and X-ray tube for medical X-ray device | 2,259 | 8.8 |
| 5 | Blood test device | 1,823 | 7.1 |
| 6 | Visceral function test device | 1,301 | 5.1 |
| 7 | Physiotherapy device | 1,299 | 5.1 |
| 8 | Orthopedic goods | 1,087 | 4.2 |
| 9 | Pump for drugs | 1,034 | 4.0 |
| 10 | Dental metals | 1,011 | 3.9 |
| 11 | Eyeglasses for sight correction | 885 | 3.4 |
| 12 | Vision tester | 562 | 2.2 |
| 13 | X‐ray film | 530 | 2.1 |
| 14 | Needles and puncture needle | 459 | 1.8 |
| 15 | Others | 445 | 1.7 |
| 16 | Blood collecting or transfusion device | 428 | 1.7 |
| 17 | Medical gap-filling adhesive | 337 | 1.3 |
| 18 | Medical materials generator | 225 | 0.9 |
| 19 | Dental unit | 213 | 0.8 |
| 20 | Orthopedic instruments and apparatus (note) | 205 | 0.8 |
| 21 | Syringe barrel | 178 | 0.7 |
| 22 | Respiratory equipment | 174 | 0.7 |
| 23 | Hearing aid | 162 | 0.6 |
| 24 | Medical puncture device and rotating instrument (note) | 148 | 0.6 |
| 25 | Blood pressure test or pulse wave velocity test device | 143 | 0.6 |
| 26 | Tooth crown materials | 138 | 0.5 |
| 27 | Electrical therapy apparatus for household use | 137 | 0.5 |
| 28 | Dental hand piece | 132 | 0.5 |
| 29 | Medical disinfection apparatus | 131 | 0.5 |
| 30 | Operating table and treatment table | 121 | 0.5 |
| 31 | Condom | 116 | 0.5 |
| 32 | Electrosurgical unit | 92 | 0.4 |
| 33 | Magnetic therapy apparatus | 89 | 0.3 |
| 34 | Ligation device and Suturing devices and | 85 | 0.3 |
| 35 | Acus or moxibustion device | 82 | 0.3 |
| 36 | Suture | 80 | 0.3 |
| 37 | Dental impression material | 76 | 0.3 |
| 38 | Medical cauter | 74 | 0.3 |
| 39 | Vibrator | 69 | 0.3 |

| | Category | Production | Percentage |
|---|---|---|---|
| 40 | Medical knife | 66 | 0.3 |
| 41 | Dental engine | 66 | 0.3 |
| 42 | Urine test or stercus test device | 58 | 0.2 |
| 43 | Medical evacuator | 56 | 0.2 |
| 44 | Medical microtome | 56 | 0.2 |
| 45 | Medical washer | 45 | 0.2 |
| 46 | Dental cutting machine | 42 | 0.2 |
| 47 | Dental ground materials | 39 | 0.2 |
| 48 | Accessories designated due to the MHLW Act | 37 | 0.1 |
| 49 | Incubator | 35 | 0.1 |
| 50 | Dental calcium sulfate and calcium sulfates’ goods | 34 | 0.1 |
| 51 | Tampon for menstruation treatment | 33 | 0.1 |
| 52 | Diagnosis program. | 32 | 0.1 |
| 53 | Plate materials | 31 | 0.1 |
| 54 | Medical light | 30 | 0.1 |
| 55 | Radiological material diagnosis device | 27 | 0.1 |
| 56 | Opening or stoma device | 26 | 0.1 |
| 57 | Dental steamer and polymerization vessel | 24 | 0.1 |
| 58 | Vision corrective glass | 22 | 0.1 |
| 59 | Dental casting apparatus | 21 | 0.1 |
| 60 | Dental materials for root canal filling | 21 | 0.1 |
| 61 | Visual acuity chart and color anomaly test table | 21 | 0.1 |
| 62 | Medical inhalant | 20 | 0.1 |
| 63 | Perception test or physical function test device | 19 | 0.1 |
| 64 | Medical forceps | 17 | 0.1 |
| 65 | Medical centrifugal separator | 17 | 0.1 |
| 66 | Hearing test device | 15 | 0.1 |
| 67 | Pneumothorax and pneumoperitoneum apparatus | 14 | 0.1 |
| 68 | Medical elevator | 12 | 0.0 |
| 69 | Anesthesia apparatus and Rebreathing bags for anesthesia apparatus and gas canister | 10 | 0.0 |
| 70 | Protection kit from radiation hazard | 9 | 0.0 |
| 71 | Medical pincette | 9 | 0.0 |
| 72 | Medical rolled cotton | 9 | 0.0 |
| 73 | Impression taking or maxillomandibular registration device | 6 | 0.0 |
| 74 | Medical scissors | 6 | 0.0 |
| 75 | Themomter | 6 | 0.0 |
| 76 | Splint | 6 | 0.0 |
| 77 | Medical incubator | 6 | 0.0 |
| 78 | Medical dilator | 5 | 0.0 |

| | Category | Production | Percentage |
|---|---|---|---|
| 79 | Dental wax | 5 | 0.0 |
| 80 | Medical sew | 4 | 0.0 |
| 81 | Biological fluid test device | 4 | 0.0 |
| 82 | Medical treatment program | 4 | 0.0 |
| 83 | Dental filling instruments | 4 | 0.0 |
| 84 | Medical uncal | 4 | 0.0 |
| 85 | Stethoscope | 4 | 0.0 |
| 86 | Dental filling instrument | 4 | 0.0 |
| 87 | Surgical gloves and finger cot | 3 | 0.0 |
| 88 | Dental desiccator | 2 | 0.0 |
| 89 | Dental probe | 2 | 0.0 |
| 90 | Hernia supporters (note) | 2 | 0.0 |
| 91 | Dental broach | 1 | 0.0 |
| 92 | Medical snare | 1 | 0.0 |

| | Category | Production | Percentage |
|---|---|---|---|
| 93 | Medical lever | 1 | 0.0 |
| 94 | Medical Water sterilizers | 1 | 0.0 |
| 95 | For medical use only | | 0.0 |
| 96 | Contact lenses (excluding for sight correction.) | 1 | 0.0 |
| 97 | Spatula | 1 | 0.0 |
| 98 | Medical spoon | 1 | 0.0 |
| 99 | Medical bougie | 0 | 0.0 |
| 100 | Contraceptive device | 0 | 0.0 |
| 101 | Medical hammer | 0 | 0.0 |
| 102 | Plexor | 0 | 0.0 |
| 103 | Smallpox vaccination device | 0 | 0.0 |
| 104 | Medical raspatory | 0 | 0.0 |
| 105 | Finger pressure substitute | 0 | 0.0 |
| | Total | 25,678 | 100.0 |

Source: "Annual Report on the Survey of Pharmaceutical Industry Productions 2019", Health Policy Bureau, MHLW

# Pharmacies

## Overview

Separation of dispensing and prescribing functions in improving the quality of national medical care by dividing the roles of doctors and pharmacists based on their specialized field in that doctors will issue prescriptions to patients and the pharmacists of pharmacies then dispense according to those prescriptions.

**[Advantages of separation of dispensing and prescribing functions]**

1) By centrally and continuously grasping the patient's condition and medications taken by the pharmacy pharmacist and checking the prescription contents, it is possible to confirm whether the multiple medications and interactions caused by visiting multiple clinical departments exist, and to inprove the effectiveness and safety of drug therapy.
2) Pharmacists, in cooperation with prescribing physicians and dentists, will explain effects, side effects, directions for use, etc. of drugs to patients (patient compliance instruction) so that patients improve their understanding on drugs and are expected to take dispensed drugs as directed leading to improved efficacy and safety of drug therapies.
3) Doctors and dentists can freely prescribe drugs necessary for patients even when the particular drugs are not stocked in their own hospitals or clinics.
4) Issuing prescriptions to patients allows them to know which drugs they are taking.
5) Reduced outpatient dispensing work of hospital pharmacists allows them to engage in hospital activities for inpatients which they should essentially perform.

## Detailed Data Changes in Number of Pharmacies and Prescriptions

| FY | Number of pharmacies | Number of prescriptions (10,000/year) | Number of prescriptions per 1,000 persons (per month) | Nationwide average rate of separation of dispensing and prescribing functions (%) |
|---|---|---|---|---|
| FY1989 | 36,670 | 13,542 | 95.2 | 11.3 |
| FY1990 | 36,981 | 14,573 | 105.4 | 12.0 |
| FY1991 | 36,979 | 15,957 | 111.7 | 12.8 |
| FY1992 | 37,532 | 17,897 | 125.8 | 14.1 |
| FY1993 | 38,077 | 20,149 | 140.6 | 15.8 |
| FY1994 | 38,773 | 23,501 | 161.0 | 18.1 |
| FY1995 | 39,433 | 26,508 | 182.5 | 20.3 |
| FY1996 | 40,310 | 29,643 | 210.0 | 22.5 |
| FY1997 | 42,412 | 33,782 | 238.1 | 26.0 |
| FY1998 | 44,085 | 40,006 | 278.8 | 30.5 |
| FY1999 | 45,171 | 45,537 | 307.3 | 34.8 |
| FY2000 | 46,763 | 50,620 | 348.6 | 39.5 |
| FY2001 | 48,252 | 55,960 | 393.7 | 44.5 |
| FY2002 | 49,332 | 58,462 | 393.0 | 48.8 |
| FY2003 | 49,956 | 59,812 | 418.8 | 51.6 |
| FY2004 | 50,600 | 61,889 | 368.7 | 53.8 |
| FY2005 | 51,233 | 64,508 | 425.2 | 54.1 |
| FY2006 | 51,952 | 66,083 | 442.5 | 55.8 |
| FY2007 | 52,539 | 68,375 | 481.0 | 57.2 |
| FY2008 | 53,304 | 69,436 | 483.0 | 59.1 |
| FY2009 | 53,642 | 70,222 | 494.1 | 60.7 |
| FY2010 | 53,067 * | 72,939 | 486.6 | 63.1 |
| FY2011 | 54,780 | 74,689 | 498.3 | 65.1 |
| FY2012 | 55,797 | 75,888 | 533.3 | 66.1 |
| FY2013 | 57,071 | 76,303 | 510.2 | 67.0 |
| FY2014 | 57,784 | 77,558 | 509.3 | 68.7 |
| FY2015 | 58,326 | 78,818 | 513.1 | 70.0 |
| FY2016 | 58,678 | 79,929 | 533.1 | 71.7 |
| FY2017 | 59,138 | 80,386 | 529.8 | 72.8 |
| FY2018 | 59,613 | 81,229 | 568.9 | 74.0 |
| FY2019 | 60,171 | 81,803 | 547.6 | 74.9 |

Source: The number of pharmacies as of December 31 of each year until 1996 and of the end of each fiscal year from 1997 on by the Pharmaceutical safety and Environmental Health Bureau, MHLW. The number of prescriptions for 1,000 persons, and prescription receiving rate investigation by Japan Pharmaceutical Association.

(Note) How to calculate the rate of prescription receipt are as follows:

$$\text{Prescription receipt rate (\%)} = \frac{\text{Number of prescriptions to pharmacies}}{\text{Number of prescriptions issued to outpatients (total)}} \times 100$$

* Miyagi Prefecture is not included due to the effect of the Great East Japan Earthquake.

# Blood Programme

## Overview

**[Blood Products]**

Blood products refer to all pharmaceutical products which are derived from human blood and are roughly classified into blood transfusion products and plasma derivatives. All of the blood transfusion products are supplied through blood donations in Japan.

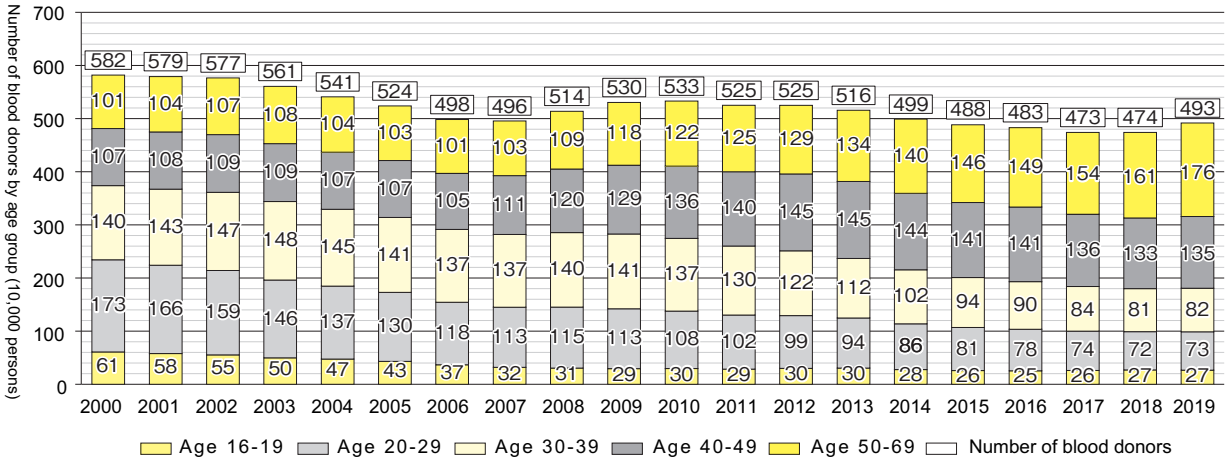
Regarding plasma derivatives, the domestic self-sufficiency has been achieved for blood coagulation factor products. On the other hand, for some albumin products and anti-HBs human immunoglobulin products, the products and raw materials are still imported from overseas. From the viewpoint of ethics and international fairness, efforts are being made to achieve domestic self-sufficiency for these plasma products.

| Category | Type | Application |
|---|---|---|
| Blood transfusion products | Red blood cell products | Anemia due to hematopoietic organ diseases and chronic bleeding, etc. |
| | Plasma products | Liver damage, disseminated intravascular coagulation (DIC), thrombotic thrombocytopenic purpura (TTP), hemolytic-uremic syndrome (HUS), etc. |
| | Platelet products | Active bleeding, preoperative conditions of surgical operation, large volume blood transfusion, disseminated intravascular coagulation (DIC), blood disorders, etc. |
| Plasma derivatives | Albumin products | Hemorrhagic shock, nephrotic syndrome, hepatic cirrhosis accompanying intractable ascites, etc. |
| | Immunoglobulin products | Aglobulinemia or hypoglobulinemia, severe infection, chronic inflammatory demyelinating polyneuropathy(CIDP), Kawasaki disease, etc |
| | Blood coagulation factor products | Supplementing blood coagulation factor to patients with blood coagulation factor deficiency |

**[Status of Blood Donation]**

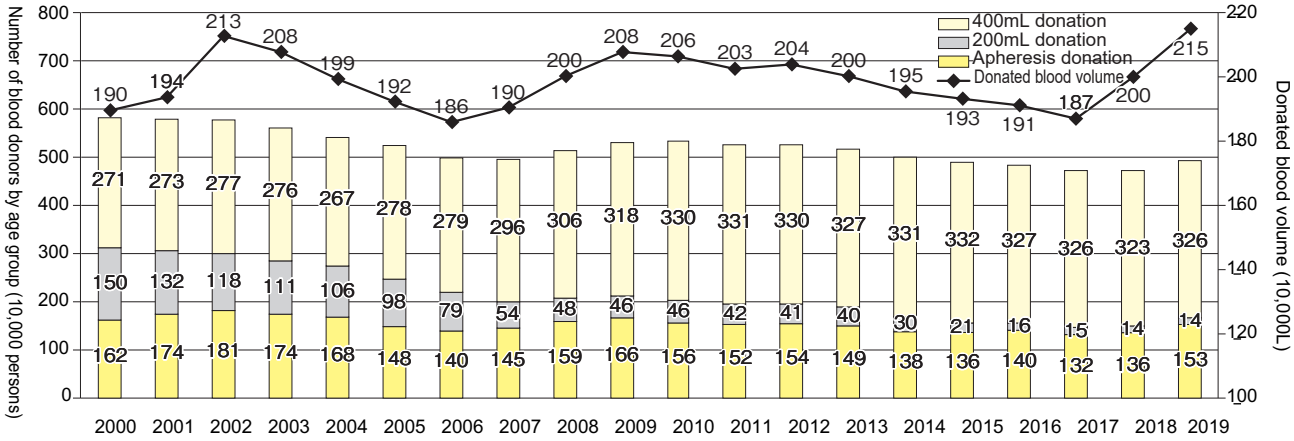
In recent years, due to an increase in the amount of blood donated per person, the required amount of blood can be secured with a smaller number of people than before, and the total number of blood donors is declining. On the other hand, looking at the number of blood donors by age group, the proportion of young people in the total blood population has decreased significantly compared to 10 years ago, but the number of teenagers has been improving since FY 2017. For the numbers of 20s and 30s, they turned to increase in the FY 2019.

## Detailed Data 1 Change in Number of Blood Donors




Source:Survey by Japanese Red Cross Society, and created by Pharmaceutical Safety and Environmental Health Bureau, Ministry of Health, Labor and Welfare

## Detailed Data 2 Changes in Number of Blood Donors by Donation Type and Donated Blood Volume




※**From 2018, the amount of blood donated by component blood donation is calculated based on the total volume at the manufacturing stage (including the amount of blood storage solution).**

# (5) Health Risk Management System

## Health Risk Management System

**Overview** **MHLW Health Risk Management System Diagram**