[2] Health and Medical Services

(1) Health Care Insurance

Health Care Insurance System

Overview

Outline of Health Care Insurance System

(As of June 2012)

System		Insurer (as of the end of March 2011)	Number of subscribers (March 2011) [Insured / Families] 1,000 persons	Insurance benefits: Medical care benefits: Co-payment	Insurance benefits: Medical care benefits: High-cost medical care benefit, Unitary high-cost medical/long-term care system	Insurance benefits: Medical care benefits: Hospital meal expenses	Insurance benefits: Medical care benefits: Hospital living expenses	Insurance benefits: Cash benefits	Financial resources: Premium rate	Financial resources: State subsidy
Health Insurance	General employees: JHIA-managed Health Insurance	Japan Health Insurance Association	34,845 [19,580 / 15,265]	After reaching compulsory education age until age 70: 30% Before reaching compulsory education age: 20% 70 or older but younger than 75: 20% (*) (30% for persons with more than a certain level of imcome) (*) For those aged 70 or older but younger than 75, co-payment remains 10% for the period between April 2008 and March 2013	(High-cost medical care benefit system) • Maximum co-payment (Persons younger than 70) (High income) ¥150,000 + (medical fee - ¥500,000) × 1% (General) ¥80,100 + (medical fee - ¥267,000) × 1% (Low income) ¥35,400 (Persons 70 or older but younger than 75) (More than a certain level of income) ¥80,100 + (medical fee - ¥267,000) × 1%, outpatient (per person) ¥44,400 (General (*)) ¥62,100, outpatient (per person) ¥24,600 (Low income) ¥24,600, outpatient (per person) ¥8,000 (Extremely low income) ¥15,000, outpatient (per person) ¥8,000 • Per-household standard amount 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 • Reduced payment for multiple high-cost medical care 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: (Persons younger than 70) (High income) ¥83,400 (General) ¥44,400 (Low income) ¥24,600 (Persons aged 70 or older with general or more than a certain level of income (*)) ¥44,400 • Reduced payment for persons receiving high-cost medical care for a long period Maximum co-payment for patients suffering from hemophilia or chronic renal failure requiring dialysis, etc.: ¥10,000 (high-income patients younger than 70 receiving dialysis: ¥20,000) (*) For persons with general income aged 70 to 74, maximum co-payment remains ¥44,400 (¥12,000 for outpatient medical care) for the period between April 2008 and March 2013, thus reduction for multiple high-cost medical care does not apply. (Unitary high cost medical/long-term care benefit system) Reduced payment for persons whose total co-payments of health care and long-term care insurances for a year (from August to June every year) is extremely high. Maximum co-payment is determined carefully according to their income and age.	(Co-payment for meal expenses) • General Per meal ¥260 • Low income Per meal first 90 days ¥210 Per meal after 90 days ¥160 • Expremely low income Per meal ¥100 Same as above	(Co-payment for living expenses) • General (I) Per meal ¥460 + Per day ¥320 • General (II) Per meal ¥420 + Per day ¥320 • Low income Per meal ¥210 + Per day ¥320 • Expremely low income Per meal ¥130 + Per day ¥320 * Applicable to those aged 65 or older in long-term care beds * For patients with intractable 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 • Lump-sum birth allowance, etc.	10.00% (national average)	16.4% of benefit expenses (16.4% for Support coverage for the late-stage elderly)
	General employees: Society-managed Health Insurance	Health Insurance Societies 1,458	29,609 [15,574 / 14,035]					Same as above (with additonal 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	18 [12 / 6]					• Sickness and injury allowance • Lump-sum birth allowance, etc.	Per day Class 1: ¥390 Class 11: ¥3,230	16.4% of benefit expenses (16.4% for Support coverage for the late-stage elderly)
Seamen's Insurance		Japan Health Insurance Association	136 [60 / 76] (March 2009)					Same as above	9.45% (sickness insurance premium rate)	Fixed amount
Mutual aid associations	National public employees	20 mutual aid associations	9,189 [4,523 / 4,665]					Same as above (with additonal 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 1,723	38,769 Municipalities 35,493 NHI associations 3,277					• Lump-sum birth allowance, • Funeral expenses	Calculated for each household according to the benefits received and ability to pay Levy calculation formulas differ among insurers	41% of benefit expenses, etc.
		NHI associations 165								47% of benefit expenses, etc.
	Retired persons under Employees' Health Insurance	Municipalities 1,723								None
Late-stage medical care system for the elderly		[Implementing bodies] Wide area unions for the late-stage medical care system for the elderly 47	14,341	10% (30% for persons with more than a certain level of imcome)	Maximum co-payment / Outpatient (per person) (Persons with more than a certain amount of income) ¥80,100 + (medical fee - ¥267,000) × 1% / ¥44,400 (Multiple high-cost medical care) ¥44,400 (General) ¥44,400 / ¥12,000 (Low income) ¥24,600 / ¥8,000 (Extremely low income) ¥15,000 / ¥8,000		Same as above except for • Recipients of old-age Welfare Pensions Per meal ¥100	• Funeral expenses, etc.	Calculated using the amount of the per capita rate and income ratio of insured persons provided by wide area unions	• Premium Approx. 10% • Support coverage Approx. 40% • Public funding Approx. 50% (Breakdown of public funding) National: Prefectural : Municipal 4 : 1 : 1

(Note) 1. Insured persons of the late-stage medical care system for the elderly includes 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, those in households of two or more elderly with a taxable income of ¥5.20 million, and those of a single elderly household with a taxable income of ¥3.83 million. Persons with a higher income are considered to be those with a monthly income of ¥530,000 or more (annual income of more than ¥6 million for NHI). Persons with a low income are considered to be those who belong to a municipal-tax exempt household. Persons with an extremely low income are 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 that newly subscribed to the National Health Insurance on and after September 1, 1997 and their families.

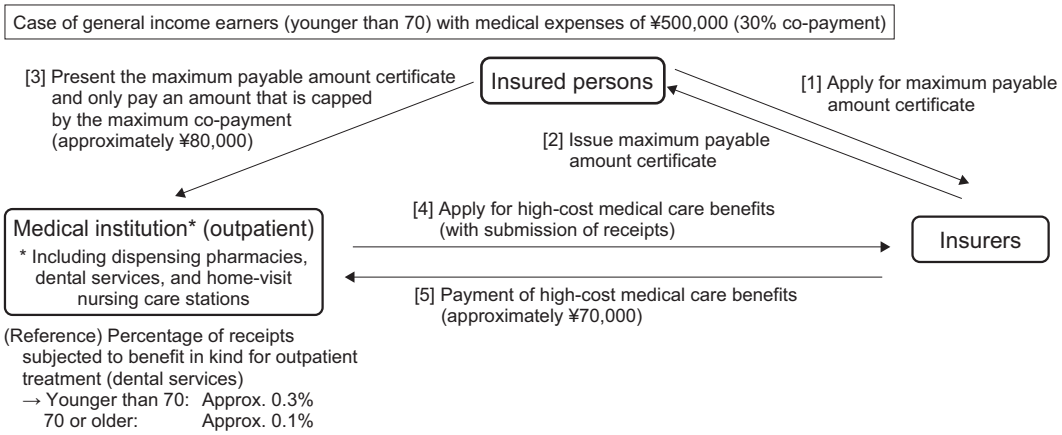
4. The numbers of Health Insurance subscribers are preliminary figures. The sums in the breakdown may not equal the total due to rounding.

5. National subsidy rate for the Japan Health Insurance Association (general insured persons and insured persons under item 2, Article 3 of the National Health Insurance Act) is 16.4% for the period between July 2010 and FY 2012.

6. 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 (0.35%).

Detailed Information 1 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.



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 2

Provision of Unitary High-Cost Medical/Long-Term Care Benefits

(Enforced in April 2008, provision commenced gradually from August 2009)

<Reduced co-payments for households receiving both medical and long-term care services>

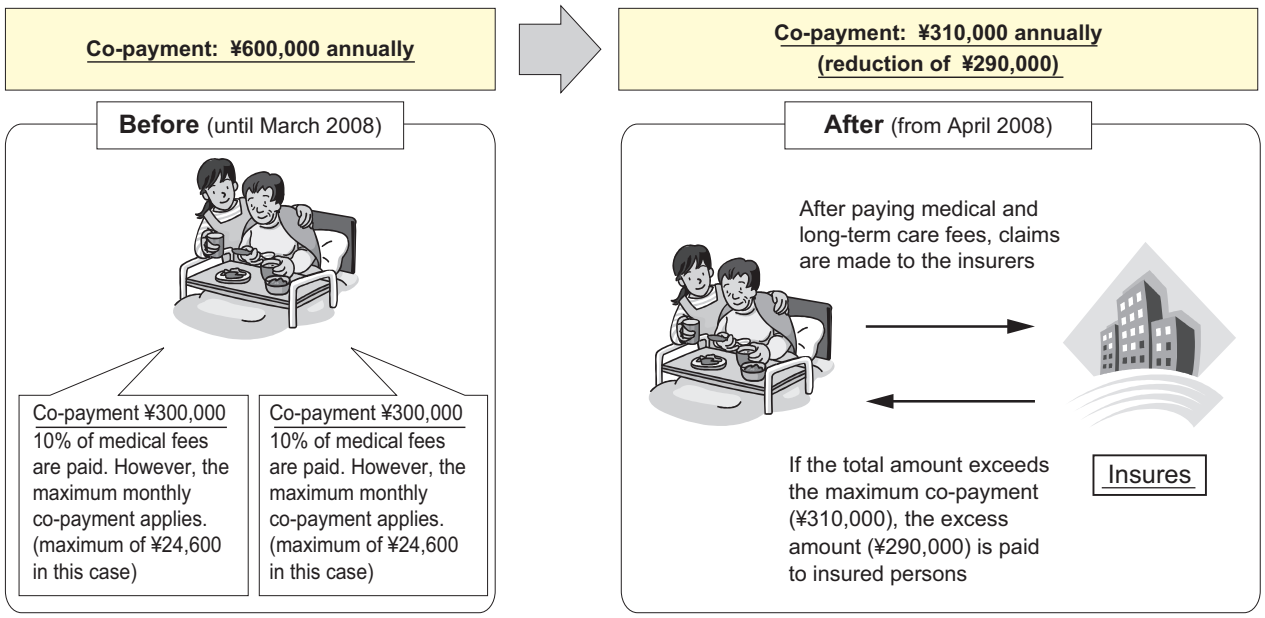
- Conventional maximum monthly co-payment is individually set for health care insurance and long-term care insurance systems
- In addition to these limits, new maximum co-payment is also set for the total annual co-payments for both systems

* Maximum co-payment is set carefully according to age and income levels.
* Diet/residence expenses need to be paid separately.

Reference case of the unitary high cost medical/long-term care system

❍Household with a husband receiving medical services and a wife receiving long-term care services, both 75 or older (exempted from residence tax)

(Medical care services) Being hospitalized (*)
(Long-term care services) Using multifunctional long-term care in a small group home
(Pension income) ¥2.11 million or less for a couple

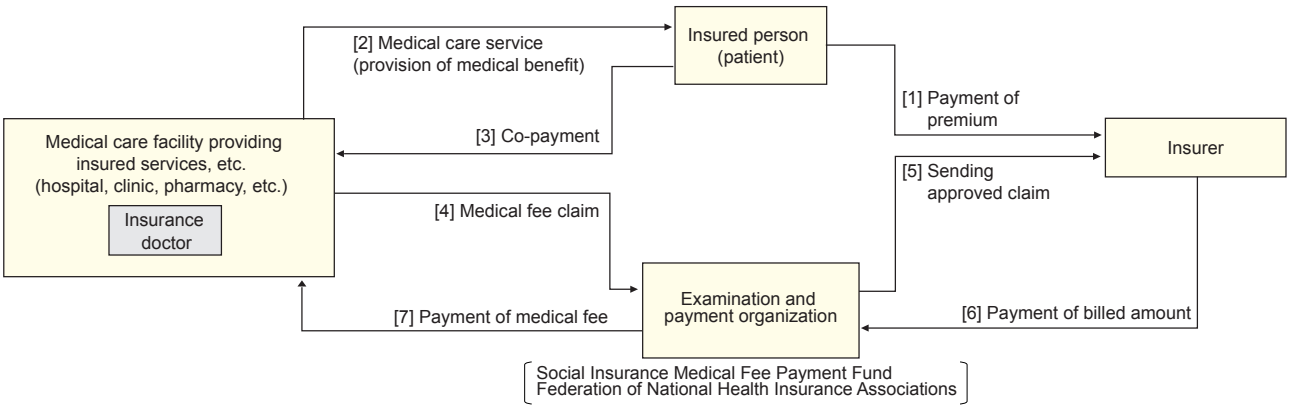


(*) In case of being hospitalized in long-term care beds, hospital meal/living expenses and bed surcharges, etc. need to be paid separately (same as the current high cost medical care system, etc.)

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 Revision of Reimbursement of Medical Fees of 2012**

Outline of the revision of reimbursement of medical fees of 2012 [1]

- The first step revision toward realizing the ideal medical care in anticipation of the image of 2025 given in the “Definite Plan for the Comprehensive Reform of Social Security and Tax”.
- Prioritized distribution in areas that are needed for the development of environments in which people/patients can receive safe, reliable, and high-quality medical care

Overall revision rate	+0.004%	
Medical fees (core)	+1.38%	(approx. ¥550 billion)
Medical services	+1.55%	(approx. ¥470 billion)
Dental services	+1.70%	(approx. ¥50 billion)
Dispensations	+0.46%	(approx. ¥30 billion)
Drug prices, etc.	-1.38%	(approx. ¥550 billion)

Outline of the revision of reimbursement of medical fees of 2012 [2]

Prioritized distribution via medical services (¥470 billion)

I Reducing the burden of medical professionals who have borne a significant burden

○ Reducing the burden of medical professionals, including hospital doctors, etc., in thereby enabling them to continue provide acute medical care, etc. in an appropriate manner. (¥120 billion)

II Division of functions and smooth cooperation between medical and long-term care, etc., and improved in-home medical care

○ Medical fee reimbursements were simultaneously revised alongside long-term care fees in 2012 in thereby ensuring the provision of seamless comprehensive services from acute medical care through to in-home/long-term care and in anticipation of the oncoming super aging society. (¥150 billion)

III Promotion and introduction of advanced medical technologies for cancer and dementia treatment, etc.

○ Efforts will be made to promote and introduce advanced medical technologies that enable everyone to receive the benefit of the endlessly advancing medical technologies. (¥200 billion)

Prioritized distribution via dental services (¥50 billion)

I Promotion of team medical care and improved in-home dental services, etc.

○ Reduced postoperative complications such as aspiration pneumonia, etc. through medical cooperation, and the promotion of in-home dental services to responding to a super aging society.

II Appropriate evaluation of dental services with consideration given to quality of life

○ Developing technologies that contribute to tooth retention in thereby improving treatment of dental diseases, including caries and periodontal diseases, etc.

Prioritized distribution via dispensations (¥30 billion)

I Promotion of in-home drug management and improved pharmaceutical management and guidance at pharmacies

○ In addition to promoting in-home drug management efforts will also be made to improve medication history management/guidance, including verification of leftover drugs and medication notebooks, etc.

II Promotion of generic drug usage

○ Promotion of information being provided on generic drugs, etc. by pharmacies

Outline of the revision of reimbursement of medical fees of 2012 [3]

Priority issue 1 Reducing the burden of hospital doctors, etc. and medical professionals who have borne the significant burden of providing appropriate acute medical care, etc.

[1] Promotion of emergency/perinatal care
[2] Efforts to improve the work systems of medical professionals at hospitals, etc.
[3] Division of functions of emergency outpatient and outpatient treatment
[4] Promotion of team medical care, and which will include hospital pharmacists and dentists, etc.

Priority issue 2 Clarification of division of roles and improved regional cooperation system between medical and long-term care, and improved in-home medical care, etc.

[1] Promotion of division of roles and cooperation between medical institutions providing in-home medical care
[2] Improved medical care until right up to end of life
[3] Improved in-home dental services/drug management
[4] Improved home-visit nursing, and smooth cooperation between medical and long-term care

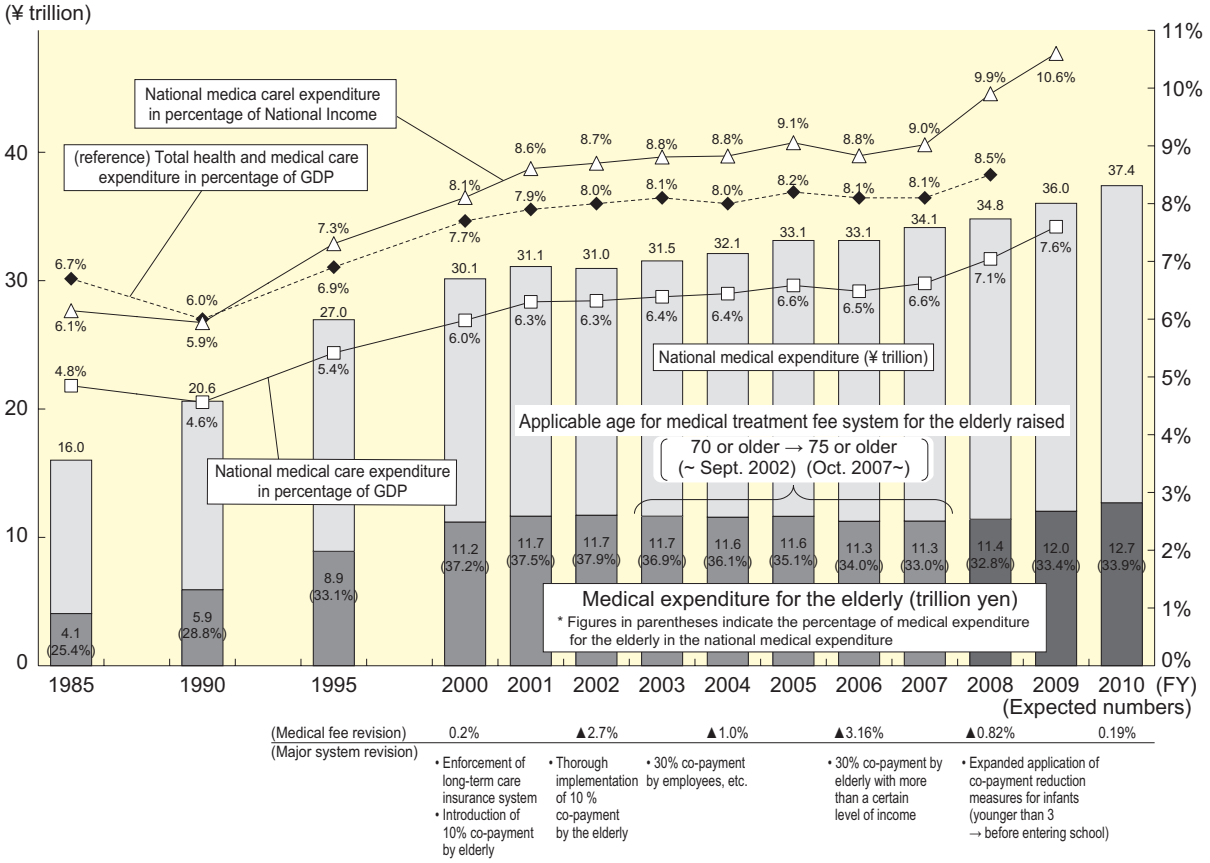
Promotion and introduction of advanced medical technologies, and other areas

[1] Appropriate evaluation of medical technologies, measures against cancer/lifestyle-related diseases, measures against mental disorders/dementia, improved rehabilitation, and dental services with consideration given to quality of life
[2] Medical safety measures, improved consultation support measures for patients
[3] Inpatient medical care according to the hospital functions, appropriate evaluation of chronic inpatient care, consideration for regions with insufficient resources, evaluations according to the clinical functions
[4] Promotion of generic drug usage, limited long-term hospitalization, appropriate evaluation of drugs, etc. and with consideration given to the actual market price

etc.

Medical Care Expenditure

Overview Changes in Medical Care Expenditure



<Year-on-year growth rate of National Health Expenditure>

(%)

	1985	1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
National medical care 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*
Medical expenditure for the 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	*5.5*
National income	7.2	8.1	▲0.3	2.0	▲2.8	▲1.5	0.7	1.6	0.5	2.6	0.9	▲7.1	▲3.6	-
GDP	7.2	8.6	1.7	0.9	▲2.1	▲0.8	0.8	1.0	0.9	1.5	1.0	▲4.6	▲3.7	-

(Note) 1. The national income and GDP are based on the national accounting announced by the Cabinet Office (December 2010). Total health and medical expenditure is the item used to compare the medical expenses among OEDC countries. It includes preventative services, etc. and has a wider range of coverage than national medical care expenditure. The average ratio of medical expenditure of OECD allies in 2009 was 9.5% of GDP.

2. The national health expenditure and health expenditure for elderly in their latter stage of life of FY2010 are estimated figures that were calculated by multiplying those of the previous fiscal year by the growth rate of approximate medical expenditure of FY2010. The figures in italics indicate the growth rate of approximate medical expenditure.

Detailed Data 1 National Medical Care Expenditure of OECD Countries (2009)

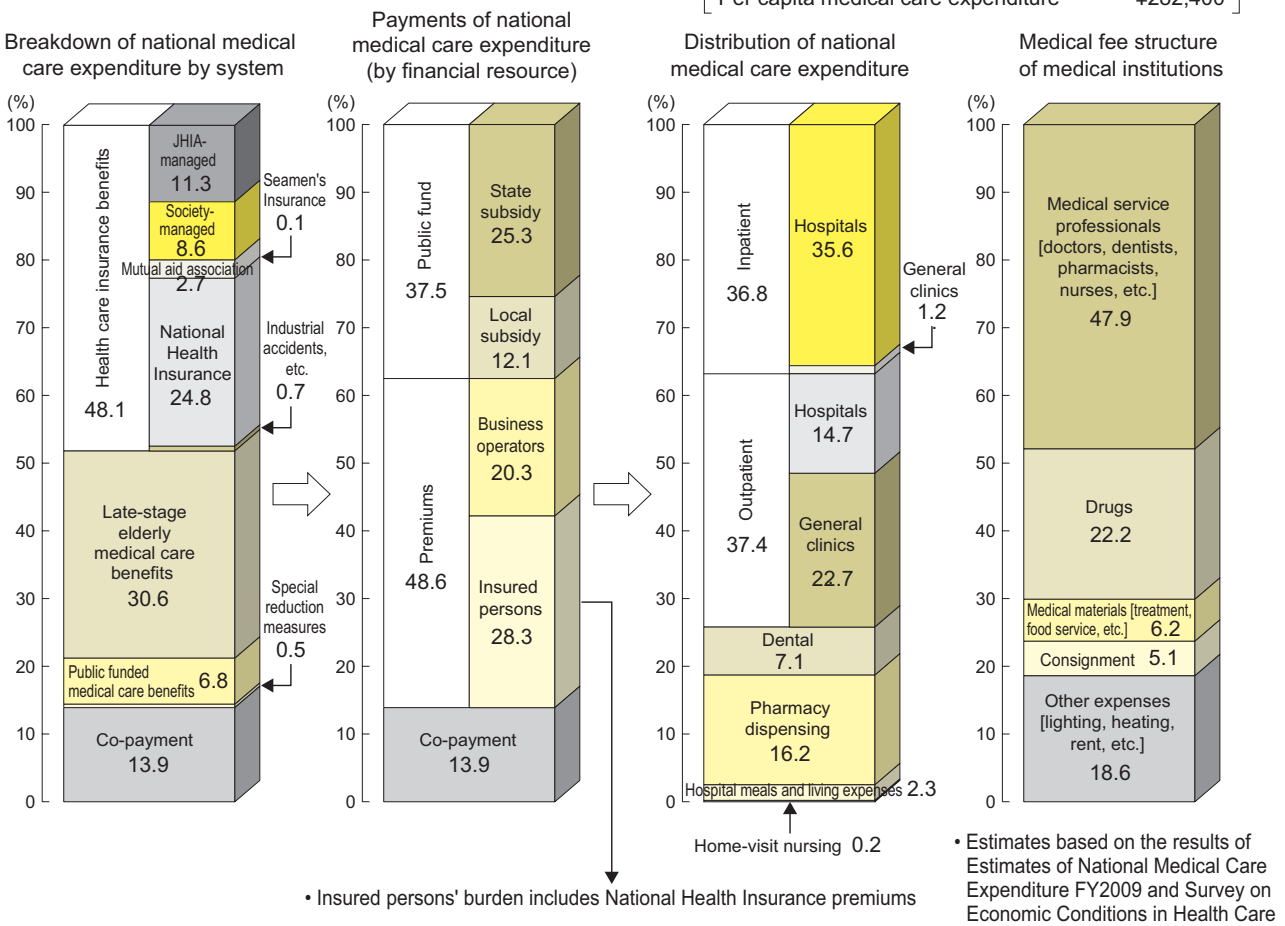
Country	Total medical care expenditure in GDP (%)	Rank	Per capita medical care expenditure ($)	Rank	Remarks
U.S.A.	17.4	1	7,960	1	
Netherlands	12.0	2	4,914	4	(*2)
France	11.8	3	3,978	10	
Germany	11.6	4	4,218	9	
Denmark	11.5	5	4,348	7	
Canada	11.4	6	4,363	6	
Switzerland	11.4	6	5,144	3	
Austria	11.0	8	4,289	8	
Belgium	10.9	9	3,946	11	
New Zealand	10.3	10	2,983	20	
Portugal	10.1	11	2,508	24	(*1)
Sweden	10.0	12	3,722	13	
U.K.	9.8	13	3,487	15	
Iceland	9.7	14	3,538	14	
Greece	9.6	15	2,724	22	(*1)
Norway	9.6	16	5,352	2	(*2)
Ireland	9.5	17	3,781	12	
Spain	9.5	17	3,067	19	

Country	Total medical care expenditure in GDP (%)	Rank	Per capita medical care expenditure ($)	Rank	Remarks
Italy	9.5	17	3,137	18	
Slovenia	9.3	20	2,579	23	
Finland	9.2	21	3,226	17	
Slovakia	9.1	22	2,084	27	
Australia	8.7	23	3,445	16	(*1)
Japan	8.5	24	2,878	21	(*1)
Chile	8.4	25	1,186	32	
Czech Republic	8.2	26	2,108	26	
Israel	7.9	27	2,164	25	
Hungary	7.4	28	1,511	29	
Poland	7.4	28	1,394	30	
Estonia	7.0	30	1,393	31	
Korea	6.9	31	1,879	28	
Luxembourg	6.8	32	4,451	5	(*1)
Mexico	6.4	33	918	33	
Turkey	6.1	34	902	34	(*1)
OECD average	9.5		3,223		

Source: "OECD HEALTH DATA 2011"
(Note) 1. The rank in this table indicates the rank among OECD member countries.
2. The figures marked with (*1) indicate the figures for 2008 (the figures for 2007 for Greece).
3. The figures marked with (*2) indicate estimates.

Detailed Data 2 Structure of National Medical Care Expenditure (FY2009)

National medical care expenditure ¥36,006.7 billion
Per capita medical care expenditure ¥282,400



• Insured persons' burden includes National Health Insurance premiums

• Estimates based on the results of Estimates of National Medical Care Expenditure FY2009 and Survey on Economic Conditions in Health Care (July 2009), etc.

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

Treatment type	FY1962	FY1965	FY1970	FY1975	FY1980	FY1985	FY1990	FY1995	FY2000	FY2006	FY2007	FY2008	FY2009
	Estimated amount (¥100 million)												
National medical care expenditure	6,132	11,224	24,962	64,779	119,805	160,159	206,074	269,577	301,418	331,276	341,360	348,084	360,067
General medical expenditure	5,372	10,082	22,513	59,102	105,349	140,287	179,764	218,683	237,960	250,468	256,418	259,595	267,425
Hospitals	2,948	5,499	12,121	32,996	62,970	92,091	123,256	148,543	161,670	168,943	173,102	174,801	181,411
General clinics	2,424	4,583	10,392	26,106	42,379	48,195	56,507	70,140	76,290	81,525	83,316	84,794	86,014
Impatient medical fee	2,344	4,104	8,799	25,427	48,341	70,833	85,553	99,229	113,019	122,543	126,132	128,248	132,602
Hospitals	2,072	3,635	7,801	22,640	43,334	65,054	80,470	94,545	108,642	117,885	121,349	123,822	128,348
General clinics	272	469	998	2,787	5,007	5,778	5,082	4,684	4,376	4,658	4,782	4,426	4,254
Outpatient medical fee	3,028	5,978	13,714	33,675	57,008	69,454	94,211	119,454	124,941	127,925	130,287	131,347	134,823
Hospitals	875	1,864	4,320	10,356	19,636	27,037	42,786	53,997	53,028	51,058	51,753	50,979	53,063
General clinics	2,153	4,113	9,394	23,319	37,372	42,417	51,425	65,456	71,913	76,867	78,534	80,368	81,760
Dental medical fees	759	1,143	2,448	5,677	12,807	16,778	20,354	23,837	25,569	25,039	24,996	25,777	25,587
Pharmacy dispensing medical fees 3)	…	…	…	…	1,649	3,094	5,290	12,662	27,605	47,061	51,222	53,955	58,228
Hospital meals and living expenses 4)	•	•	•	•	•	•	•	10,801	10,003	8,229	8,206	8,152	8,161
Medical care fees at health service facilities for the elderly 5)	•	•	•	•	•	•	666	3,385	•	•	•	•	•
Home-visit nursing medical fees	•	•	•	•	•	•	•	210	282	479	518	605	665
	Percentage distribution (%)												
National medical care expenditure	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General medical expenditure	87.6	89.8	90.2	91.2	87.9	87.6	87.2	81.1	78.9	75.6	75.1	74.6	74.3
Hospitals	48.1	49.0	48.6	50.9	52.6	57.5	59.8	55.1	53.6	51.0	50.7	50.2	50.4
General clinics	39.5	40.8	41.6	40.3	35.4	30.1	27.4	26.0	25.3	24.6	24.4	24.4	23.9
Impatient medical fee	38.2	36.6	35.2	39.3	40.3	44.2	41.5	36.8	37.5	37.0	36.9	36.8	36.8
Hospitals	33.8	32.4	31.3	34.9	36.2	40.6	39.0	35.1	36.0	35.6	35.5	35.6	35.6
General clinics	4.4	4.2	4.0	4.3	4.2	3.6	2.5	1.7	1.5	1.4	1.4	1.3	1.2
Outpatient medical fee	49.4	53.3	54.9	52.0	47.6	43.4	45.7	44.3	41.5	38.6	38.2	37.7	37.4
Hospitals	14.3	16.6	17.3	16.0	16.4	16.9	20.8	20.0	17.6	15.4	15.2	14.6	14.7
General clinics	35.1	36.6	37.6	36.0	31.2	26.5	25.0	24.3	23.9	23.2	23.0	23.1	22.7
Dental medical fees	12.4	10.2	9.8	8.8	10.7	10.5	9.9	8.8	8.5	7.6	7.3	7.4	7.1
Pharmacy dispensing medical fees 3)	…	…	…	…	1.4	1.9	2.6	4.7	9.2	14.2	15.0	15.5	16.2
Hospital meals and living expenses 4)	•	•	•	•	•	•	•	4.0	3.3	2.5	2.4	2.3	2.3
Medical care fees at health service facilities for the elderly 5)	•	•	•	•	•	•	0.3	1.3	•	•	•	•	•
Home-visit nursing medical fees	•	•	•	•	•	•	•	0.1	0.1	0.1	0.2	0.2	0.2

Source: “Estimates of National Medical Care Expenditure”, Statistics and Information Department, Minister's Secretariat, MHLW

(Note) 1. With the enforcement 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 FY2000.

2. Estimation of figures in this table has been made since FY1962.

3. Pharmacy dispensing was included in outpatient medical fees until they were newly classified as a separate item in FY1977.

4. The figures for FY2005 indicate “hospital meal expenses” (total amount of hospital meal expenses and standard co-payment) and figures for 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.

5. Medical care fees at health service facilities for the elderly are not included in national health expenditure on and after FY2000 because the these fees are those who are certified for long-term care need.

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

	FY	Total	Medical fees	Inpatient	Outpatient	Dental	Pharmacy dispensing	Hospital meals and living	Health service facilities for the elderly	Home-visit nursing	Medical fee allowance, etc.
Actual amount (¥100 million)	FY1984	36,098	34,645	19,725	14,025	895	689	.	.	.	764
	FY1985	40,673	38,986	22,519	15,433	1,034	785	.	.	.	902
	FY1986	44,377	42,445	24,343	16,924	1,178	902	.	.	.	1,030
	FY1987	48,309	46,104	26,247	18,605	1,252	1,037	.	.	.	1,168
	FY1988	51,593	49,138	27,798	19,975	1,365	1,133	.	.	.	1,296
	FY1989	55,578	52,573	29,400	21,743	1,430	1,312	.	26	.	1,441
	FY1990	59,269	55,669	30,724	23,315	1,630	1,457	.	253	.	1,523
	FY1991	64,095	59,804	32,325	25,705	1,773	1,689	.	619	.	1,633
	FY1992	69,372	64,307	35,009	27,249	2,049	1,992	.	970	5	1,626
	FY1993	74,511	68,530	36,766	29,536	2,228	2,529	.	1,442	29	1,535
	FY1994	81,596	72,501	38,235	31,790	2,476	3,133	1,855	1,888	86	1,439
	FY1995	89,152	75,910	38,883	34,319	2,708	3,909	4,678	2,582	174	1,224
	FY1996	97,232	82,181	42,314	36,789	3,078	4,620	4,816	3,259	323	1,094
	FY1997	102,786	85,475	44,205	37,965	3,305	5,606	4,869	4,198	479	1,073
	FY1998	108,932	88,881	46,787	38,584	3,511	6,900	4,967	5,285	657	1,101
	FY1999	118,040	94,653	49,558	41,181	3,915	8,809	5,115	6,426	858	1,169
	FY2000	111,997	94,640	48,568	41,871	4,200	10,569	4,612	7,436	235	1,271
	FY2001	116,560	97,954	50,296	43,243	4,416	12,462	4,677	670	191	1,277
	FY2002	117,300	97,155	51,198	41,434	4,522	13,913	4,689	-2	192	1,352
	FY2003	116,523	95,653	51,828	39,609	4,216	14,711	4,645	-1	174	1,342
	FY2004	115,763	94,429	52,048	38,371	4,010	15,143	4,654	-1	190	1,347
	FY2005	116,443	94,441	52,867	37,726	3,848	15,777	4,679	0	205	1,342
	FY2006	112,594	91,492	51,822	36,129	3,540	15,579	3,970	0	225	1,329
	FY2007	112,753	91,048	52,167	35,524	3,357	16,345	3,877	0	239	1,344
	FY2008	114,145	91,558	53,009	35,029	3,520	17,035	3,850	−	264	1,438
	FY2009	120,108	95,672	55,594	36,381	3,698	18,717	3,914	0	289	1,517
	FY2010	127,213	101,630	55,594	37,654	3,981	19,631	4,015	0	318	1,620

Source “Annual Report on Medical Care Service Programs for the Late-Stage Elderly”, Health Insurance Bureau, MHLW

(Note) 1. Terms are defined as follows.

a. Medical fees: Expenses paid for medical care services received at insurance medical care facilities providing insured services, etc. (excluding insurance pharmacies, etc.). (Benefit in kind)

b. Pharmacy dispensing: Expenses paid for drugs supplied at insurance pharmacies, etc. (Benefit in kind)

c. Meal and living: Meal and living expenses during hospitalization.(Benefit in kind)

d. Home-visit nursing: Expenses paid for home-visit nursing care services received that are provided by the offices of the specified service providers(Benefit in kind)

e. Medical treatment, etc.: Expenses paid for prosthetic devices supplied or treatment by judo therapists received in accordance with Articles 77 and 83 of the Act on Assurance of Medical Care for Elderly People (Benefit in cash)

f. Medical care fees at health service facilities for the elderly: Expenses paid for facility treatment at health service facilities for the elderly. (Benefit in kind) (Not applicable after March 2010)

g. Expenses include co-payment, standard co-payment for mail/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. Health expenditure for elderly in their latter stage of life before January 1983 was subjected to the former Medical expenditure payment system for the elderly while that of February 1983 and later was subjected to medical services that were provided for in the Health and Medical Services Act for the Aged. The increased number of subject persons due to the creation of the health services system for the elderly makes the figures between FY 1981 and 1982 and between FY 1982 and 1983 difficult to compare. In addition, that of April 2008 and later indicates expenditure for the health care system for elderly in their latter stage of life and thus the figures between FY2007 and 2008 are also difficult to compare due to the different systems used.

Financial Status of Health Insurance System

Overview **Finance Status of the Health Insurance System (FY2009 Settled Account)**

(Unit: ¥100 million)

		Government-managed Health Insurance/ JHIA-managed Health Insurance	Society-managed Health Insurance	National Health Insurance (municipalities)	Seamen's Insurance	Late-stage medical care system for the elderly
Operating revenue	Premium (tax) revenue	59,555	59,671	27,955	348	8,565
	State subsidy	9,678	39	29,246	30	35,842
	Late-stage elderly subsidy	-	-	-	-	47,235
	Early-stage elderly subsidy	-	-	26,690	-	-
	Others	501	2,007	30,024	-	19,837
	Total	69,735	61,718	113,914	378	111,480
Operating expenditure	Insurance benefit expenses	44,513	34,385	85,550	251	110,403
	Late-stage elderly support coverage	15,069	12,685	15,776	64	-
	Levies for early-stage elderly	10,961	11,094	45	47	-
	Contributions for retirees	2,742	2,851	-	12	-
	Others	1,343	5,938	18,633	0	571
	Total	74,628	66,952	120,005	374	110,974
	Balance of ordinary revenue and expenditure	▲4,893	▲5,234	▲6,090	3	505

		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.	-	198	
	Adjustment premium revenue	-	1,015	
	Subsidies to financial adjustment programs	-	1,365	
	Transfer from reserves, etc. and surplus carried forward	-	6,754	
	Others	-	54	
	Total	-	9,386	
Non-operating expenditure	Contribution to financial adjustment programs	-	1,007	
	Others	-	161	
	Total	-	1,168	
Balance of non-operating revenue and expenditure		-	8,218	(1,464)
Balance of total revenue and expenditure		▲4,893	2,984	(▲3,770)
Reserve fund, etc.		▲3,179		44,532

(Note) 1. The above figures indicate medical service revenue and expenditure.
2. The operating revenue of the National Health Insurance operated by municipalities includes an extra-legal transfer from the Municipal General Account of ¥315.3 billion for use in covering the deficit. The amounts of the national subsidy, etc. for National Health Insurance and the late-stage medical care system for the elderly were adjusted in the following FY.
3. The figures in parentheses for the Society-managed Health Insurance indicate the net balance of non-operating revenue and expenditure and the balance of total revenue and expenditure, but exclude transfers from reserves, etc. and surpluses carried forward).
4. Bed conversion support coverage is included in “support coverage for the late-stage elderly” of operating expenditure and contribution for health care services for the elderly is included in “others” of operating expenditure for each system.
5. Reserve fund, etc. indicates the operating stabilization fund for Government-managed Health Insurance. It includes reserves, a reserve fund (¥3,880.9 billion), and assets such as land and buildings, etc. of the Society-managed Health Insurance scheme.
6. The balance of total revenue and expenditure for the JHIA-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.
7. The figures may not equal the total due to rounding.

Detailed Data **Percentage of State Subsidy for Medical Care Expenditure in Genmenment Expenditure**

(Unit: ¥100 million, %)

Category	FY1980	FY1985	FY1990	FY1991	FY1992	FY1993	FY1994	FY1995	FY1996	FY1997	FY1998	FY1999
Amount	35,871	39,699	51,872	53,301	55,040	55,362	58,573	62,017	64,242	65,785	68,632	72,353
Percentage	11.7	12.2	14.7	14.4	14.2	13.9	14.3	14.7	14.9	15.0	15.4	15.4
Category	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Amount	67,956	72,083	74,782	77,772	81,445	80,862	81,586	84,285	85,644	90,252	94,594	99,250
Percentage	14.1	14.8	15.7	16.3	17.1	17.1	17.6	17.9	18.1	17.4	17.7	18.4

Source: Health Insurance Bureau, MHLW

(2) Medical Care Provision System

Medical Care Provision System

Overview **Outline of the Act to Amend the Part of Medical Care Act to Ensure the Establishment of a System to Provide Quality Medical Care (revised in 2006)**

In order to establish a system in which people's relief and trust in medical care is secured and quality medical care services are provided and in accordance with the ÅgGeneral Policies of Medical Care System ReformÅh compiled at a government-ruling party meeting on a medical care system reformation held on December 1, 2005, measures such as promotion of medical information provision to patients, promotion of a division of roles and cooperation through revision of the medical care plan system, and coping with the issue of the shortage of doctors in certain regions and clinical areas, etc. are implemented.

I Outline

1. Promotion of information provision on medical care to patients, etc.

Provide patients, etc. with support to obtain information on medical care and thus make the appropriate choice.

- ❍ Establish a system in which prefectures collect information on medical care institutions, etc., make that information available to the public in an understandable manner, and provide appropriate consultation to residents [Medical Care Act, Pharmaceutical Affairs Act]
- ❍ Provision of documented information on medical care, etc. at the beginning/end of hospitalization
- ❍ Expansion of matters that can be advertised with the revision of advertisement regulations [Medical care Act, for above]

2. Promotion of a division of roles and coordination of medical functions through medical care plan system revision, etc.

Revise the medical care plan system in promoting a division of roles and coordination through establishment of critical community coordination paths, etc. so as to provide continued medical care.
Improve in-home care to support returning home early.

- ❍ Establishment of a concrete medical coordination system for individual projects, including cerebral apoplexy, cancer, and pediatric emergency medical services, etc., within medical care plans
- ❍ Clear indication of understandable guidelines and numeric goals in medical care plans for enabling follow-up assessment [Medical Care Act, for above]
- ❍ Establishment of regulations for promoting in-home medical care, including adjustments made when leaving hospital [Medical Care Act, Pharmaceutical Affairs Act]

3. Responding to issues of the shortage of doctors in certain regions and clinical areas

Improve measures to secure doctors and other medical professionals to respond to the shortage of doctors in certain regions, including remote areas, and certain clinical areas such as pediatrics and obstetrics, etc.

- ❍ Establishment of prefectural “medical care councils” to promote measures through discussions held between relevant entities

m Provide cooperative support for medical professionals in securing regional medical care [Medical Care Act, for above]

4. Securing Medical Safety

- ❍ Establishment of medical safety support centers and obligation to establish a system for securing medical safety [Medical Care Act]
- ❍ Obligation of re-education for administratively punished doctors, dentists, pharmacists, and nurses and revision of the types of administrative punishments, etc. available [Medical Practitioners Act, Dental Practitioners Act, Pharmacists Act, Act on Public Health Nurses, Midwives and Nurses]

5. Quality improvement of medical professionals

- ❍ Obligation of re-education for administratively punished doctors (aforementioned)
- ❍ Establishment of a new provision for exclusive qualified name in addition to the existing provisions for exclusive qualified services with regard to nurse and midwife services, etc. [Act on Public Health Nurses, Midwives and Nurses]
- ❍ Inclusion of foreign national nurses and emergency life guards as subjects to the clinical training system [Act on Advanced Clinical Training of Foreign Medical Practitioners, etc.]

6. Reform of medical corporation system

Aim for improved transparency and efficiency in medical management.
Create a medical corporation system to take care of areas that were previously handled by public hospitals, etc.

- ❍ Improved non-profitability by limiting the ownership of residual assets in the event of dissolution
- ❍ Creation of a new type of medical corporation (“social medical corporation”) for providing medical services in remote areas and emergency medical services for children as stipulated in the medical care plans, etc [Medical Care Act, for above]

7. Others

- ❍ Revision of the purpose and structure of the entire current Medical Care Act, which has the characteristic of being more like a facility regulation law, so that it becomes more of a law for respecting patients' views
- ❍ Revision of the regulations on clinics with beds and other required revisions [Medical Care Act, as above]

II Date of Enforcement

- ● Basically on April 1, 2007
  * January 1, 2007 for revision on clinics with beds
  * April 1, 2008 for obligation of re-education for pharmacists and nurses, etc. and revision of the types of administrative punishments, etc.

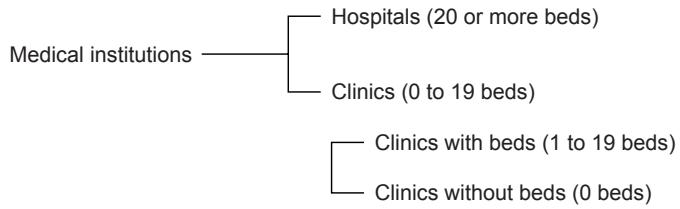
Types of Medical Institutions

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.



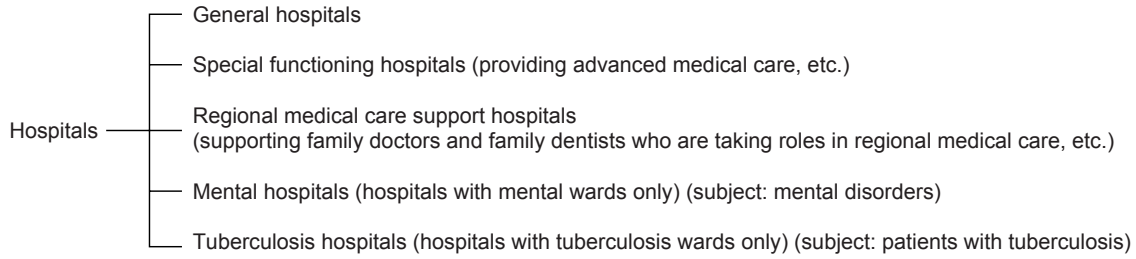
Hospitals are required to provide truly scientific and appropriate treatment to injured or sick people and are expected to have substantial facilities.

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) 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 mental disorders or tuberculosis).



Detailed Data 1 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 and clinics
- ❍ Number of beds ..... Must have 400 or more beds
- ❍ Staff deployment
  - • Doctors ..... Twice as many as ordinary hospitals, etc.
- ❍ Facilities ..... Must have intensive care units, sterile rooms, and drug information management rooms etc.

* The number of approved hospitals (as of Septeber 30, 2009) 83

Detailed Data 2 Regional Medical Care Support Hospitals (from 1997)

Purpose

Medical institutions that are approved by prefectural governors as being hospitals competent enough to secure regional medical care with the ability to support family doctors who are taking roles in providing regional medical care

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

[Administrative body]

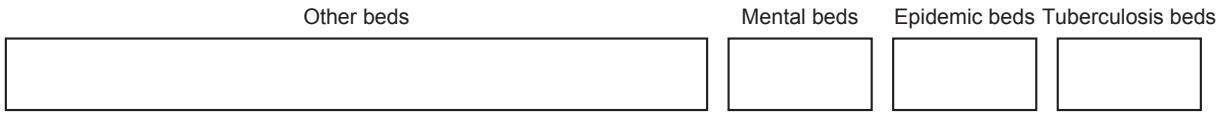
National government, prefectures, municipalities, special medical corporations, public medical institutions, medical corporations, etc., in principle

- ❍ Providing medical care mainly to patients on referral
  - • Percentage of patients on referral shall exceed 80%, etc.
- ❍ Being capable of providing emergency medical care
- ❍ Securing a system in which regional doctors, etc. can use buildings, facilities, and devices
- ❍ Providing education to regional medical professionals
- ❍ Having 200 or more beds, in principle, and facilities that are considered sufficient for a regional medical support hospital

* The number of approved hospitals (as of September 30, 2009) 267

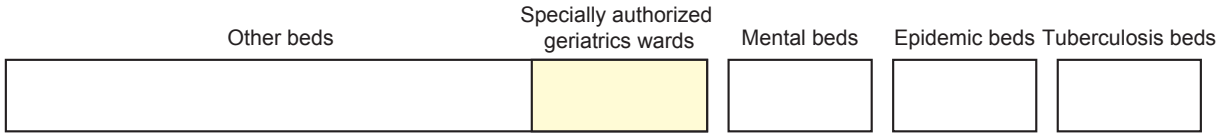
Detailed Data 3 Revision of Bed Classification

[An the beginning (from 1948)]



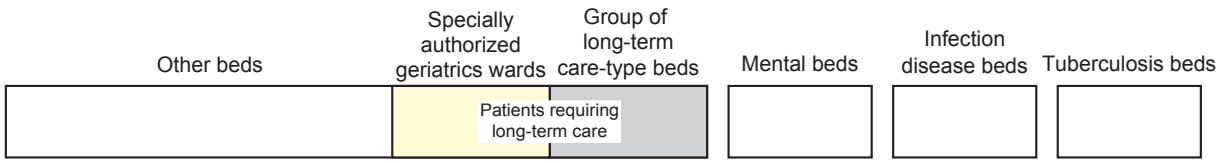
- Progress of aging
- Changes in disease structure

[Introduction of specially authorized geriatrics wards (1983)]



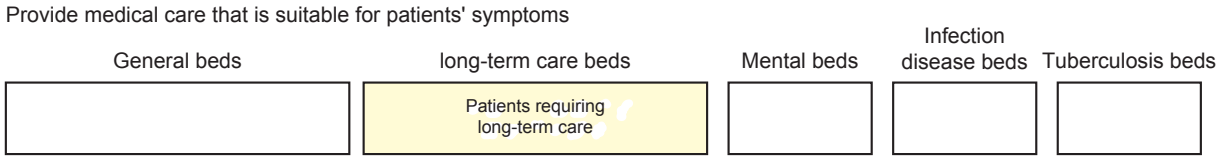
- In order to cope with the progress in aging and changes in disease structure, it was necessary to create facilities to provide medical care not only for elderly but for "patients requiring long-term care" in general.

[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)]



Trends with Medical Institutions

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

Year	Hospitals	National (included)	Public (included)	Others (included)	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

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 and on: "Survey of Medical Institutions" , Statistics and Information Department, Minister's Secretariat, MHLW
(Note) The figures in parentheses indicate the total number of public sector medical institutions.

Detailed Data 1 Changes in Number of Hospitals by Establisher and by Number of Beds

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	9,266	9,239	9,187	9,122	9,077	9,026	8,943	8,862	8,794	8,739	8,670
National	359	349	336	323	304	294	292	291	276	275	274
Public medical institutions	1,373	1,375	1,377	1,382	1,377	1,362	1,351	1,325	1,320	1,296	1,278
Social insurance organizations	131	130	130	129	129	129	125	123	122	122	121
Medical corporations	5,387	5,445	5,533	5,588	5,644	5,695	5,694	5,702	5,728	5,726	5,719
Private	1,173	1,085	954	838	760	677	604	533	476	448	409
Others	843	855	857	862	863	869	877	888	872	872	869
20-99 beds	3,811	3,781	3,726	3,667	3,616	3,558	3,482	3,391	3,339	3,296	3,232
100-299 beds	3,848	3,851	3,862	3,860	3,855	3,865	3,862	3,875	3,876	3,875	3,882
300-499 beds	1,111	1,111	1,110	1,110	1,125	1,118	1,120	1,123	1,111	1,106	1,096
500+ beds	496	496	489	485	481	485	479	473	468	462	460

Source: "Survey of Medical Institutions", Statistics and Information Department, Minister's Secretariat, MHLW

Detailed Data 2 Changes in Number of Hospitals by Hospital Type

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	9,266	9,239	9,187	9,122	9,077	9,026	8,943	8,862	8,794	8,739	8,670
Mental hospitals	1,058	1,065	1,069	1,073	1,076	1,073	1,072	1,076	1,079	1,083	1,082
Tuberculosis sanatorium	3	3	2	2	2	1	1	1	1	1	1
General hospitals	8,205	8,171	8,116	8,047	7,999	7,952	7,870	7,785	7,714	7,655	7,587

Source: “Survey of Medical Institutions”, Statistics and Information Department, Minister's Secretariat, MHLW

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

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	1,647,253	1,646,797	1,642,593	1,632,141	1,631,553	1,631,473	1,626,589	1,620,173	1,609,403	1,601,476	1,593,354
Mental beds	358,153	357,385	355,966	354,448	354,927	354,296	352,437	351,188	349,321	348,121	346,715
Infectious disease beds	2,396	2,033	1,854	1,773	1,690	1,799	1,779	1,809	1,785	1,757	1,788
Tuberculosis beds	22,631	20,847	17,558	14,507	13,293	11,949	11,129	10,542	9,502	8,924	8,244
Other beds, etc.	1,264,073	…	…	…	…	…	…	…	…	…	…
Beds for the elderly (included)	…	…	23,377	•	•	•	•	•	•	•	•
Long-term care beds	…	272,217	300,851	342,343	349,450	359,230	350,230	343,400	339,358	336,273	332,986
General beds	…	994,315	966,364	919,070	912,193	904,199	911,014	913,234	909,437	906,401	903,621
Number of beds per hospital	177.8	178.2	178.8	178.9	179.7	180.8	181.9	182.8	183.0	183.3	183.8

Source: “Survey of Medical Institutions”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) 1. "Other beds, etc." indicates those other than mental, infectious disease, and tuberculosis beds.
2. For 2001-2002, long-term care beds includes long-term care beds and transitional former groups of long term care beds.
3. For 2001-2002, general beds includes general beds and transitional former other beds (excluding transitional former groups of long term care beds).

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

	Bed utilization rate										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	85.2	85.3	85.0	84.9	84.9	84.8	83.5	82.2	81.7	81.6	82.3
Mental beds	93.1	93.2	93.1	92.9	92.3	91.7	91.1	90.2	90.0	89.9	89.6
Infectious disease beds	1.8	2.0	2.5	2.4	2.6	2.7	2.2	2.2	2.4	2.8	2.8
Tuberculosis beds	43.8	43.7	45.3	46.3	48.6	45.3	39.8	37.1	38.0	37.1	36.5
Other beds, etc.	83.8	…	…	…	…	…	…	…	…	…	…
Long-term care beds	…	94.1	94.1	93.4	93.5	93.4	91.9	90.7	90.6	91.2	91.7
General beds	…	81.1	80.1	79.7	79.4	79.4	78.0	76.6	75.9	75.4	76.6
Long-term care beds for nursing care	…	…	…	…	…	…	94.1	93.9	94.2	94.5	94.9

	Average length of stay										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total	39.1	38.7	37.5	36.4	36.3	35.7	34.7	34.1	33.8	33.2	32.5
Mental beds	376.5	373.9	363.7	348.7	338.0	327.2	320.3	317.9	312.9	307.4	301.0
Infectious disease beds	9.3	8.7	8.7	8.7	10.5	9.8	9.2	9.3	10.2	6.8	10.1
Tuberculosis beds	96.2	94.0	88.0	82.2	78.1	71.9	70.5	70.0	74.2	72.5	71.5
Other beds, etc.	30.4	…	…	…	…	…	…	…	…	…	…
Long-term care beds	…	183.7	179.1	172.3	172.6	172.8	171.4	177.1	176.6	179.5	176.4
General beds	…	23.5	22.2	20.7	20.2	19.8	19.2	19.0	18.8	18.5	18.2
Long-term care beds for nursing care	…	…	…	…	…	…	268.6	284.2	292.3	298.8	300.2

Source: “Hospital Report”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) 1. "Other beds, etc." indicates those other than mental, infectious disease, and tuberculosis beds.
2. For 2001-2003, long-term care beds includes long-term care beds and transitional former groups of long term care beds.
3. For 2001-2003, general beds includes general beds and transitional former other beds (excluding transitional former groups of long term care beds).

National Hansen's Disease Sanatoria, National Hospital Organization, and National Research Centers for Advanced and Specialized Medical Care

Overview

Outline of National Hansen' s Disease Sanatoria, National Hospital Organization, and National Research Centers for Advanced and Specialized Medical Care

[National Hansen's Disease Sanatoria]

(1) 2,134 persons are admitted in 13 national Hansen's disease sanatoria nationwide (as of May 1, 2012).

(2) National Hansen's disease sanatoria provide specialized medical care for Hansen's disease.

(Reference) Number of facilities (as of the end of 2011)

Classification	Number of facilities	Number of persons admitted
National Hansen's disease sanatoria	13	2,134

* The number of persons admitted is of May 1, 2012.

Classification	Number of facilities	Students quota (persons)
Training schools for nurses (national Hansen's disease sanatoria)	2	100

[National Hospital Organization]

(1) There are 144 National Hospital Organizations with 55,878 beds nationwide (as of October 1, 2011).

(2) National Hospital Organization provides medical services and conducts study/research and training on diseases with a great impact on people's health and intractable diseases through utilizing the policy medical treatment network of the Agency.

(Reference) Number of hospitals (as of October 1, 2011)

Classification	Number of facilities	Number of beds
National Hospital Organization	144	55,878

[National Research Center for Advanced and Specialized Medical Care]

(1) National Research Centers for Advanced and Specialized Medical Care comprise of 6 research-type independent administrative agencies established by shifting from National Centers for Advanced and Specialized Medical Care to non-public officer type independent administrative agencies under the "Act on Independent Administrative Agencies to Carry Out Research on Advanced Specialized Medical Services" (Act No. 93 of the 2008).

(2) National Research Centers for Advanced and Specialized Medical Care conduct development and dissemination of advanced and leading medical services, identification of causes and symptoms, research and development of new diagnostic and treatment methods, training for specialized medical professionals, and information provision on diseases with a great impact on people's health such as cancer, stroke, and cardiac diseases.

(3) There are 8 National Research Centers for Advanced and Specialized Medical Care with 4,435 beds nationwide (as of April, 2012).

(Reference) Number of facilities (as of April 1, 2012)

National Center		Specialized diseases, etc.	Number of hospitals	Number of beds
National Research Centers for Advanced and Specialized Medical Care	National Cancer Center	Cancer and other malignant neoplasm	2	1,025
	National Cerebral and Cardiovascular Center	Cardiovascular diseases, including heart diseases, cerebral apoplexy, hypertension	1	640
	National Center of Neurology and Psychiatry	Mental disorders, neurological diseases, muscular diseases, mental retardation and other developmental disorders	1	474
	National Center for Global Health and Medicine	International medical cooperation for developing countries, etc.	2	1,423
	National Center for Child Health and Development	Child health and development (pediatric, maternity, paternal medicine, etc.)	1	490
	National Center for Geriatrics and Gerontology	Longevity sciences (senile dementia, osteoporosis, etc.)	1	383
Total			8	4,435

Classification	Number of facilities	Students quota (persons)
National College of Nursing (National Center for Global Health and Medicine)	1	430

Medical Professionals

Overview Number of Doctors, etc.

The number of doctors and dentists are increasing every year. As of December 31, 2010, there are 295,049 doctors and 101,576 dentists.

Number of Medical Professionals

• Doctors	295,049 persons
• Dentists	101,576 persons
• Pharmacists	276,517 persons

Source: “Survey of Physicians, Dentists and Pharmacists 2010”, Statistics and Information Department, Minister's Secretariat, MHLW

• Public health nurses	54,289 persons
• Midwives	32,480 persons
• Nurses	994,639 persons
• Assistant nurses	389,013 persons

Source: Health Policy Bureau, MHLW (2010)

• Physical therapists (PT)	45,358.3 persons
• Occupational therapists (OT)	26,261.3 persons
• Orthoptists	5,603.4 persons
• Speech language hearing therapists	8,583.3 persons
• Orthotists	141.9 persons
• Dental hygienists	84,777.5 persons
• Dental technicians	11,651.3 persons
• Clinical radiologic technologists	46,115.8 persons
• Medical technicians	59,759.4 persons
• Clinical engineers	16,559.2 persons

Source: “Survey of Medical Institutions and Hospital Report 2008”, Statistics and Information Department, Minister's Secretariat, MHLW
* Full-time equivalent numbers

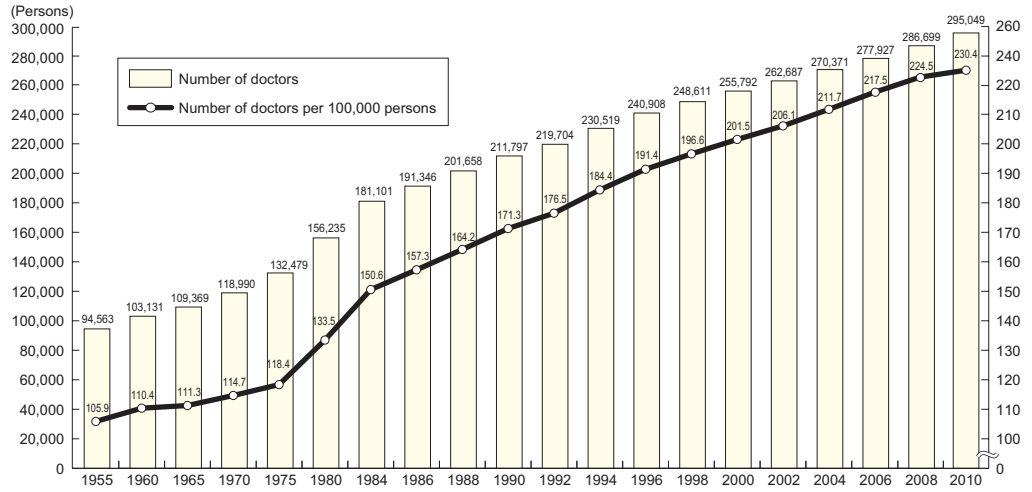
• Massage and finger pressure therapists	104,663 persons
• Acupuncture therapists	92,421 persons
• Moxibustion therapists	90,664 persons
• Judo therapists	50,428 persons

Source: “Report on Public Health Administration and Services 2010”, Statistics and Information Department, Minister's Secretariat, MHLW
* Figures were calculated with Miyagi Prefecture excluded due to the impact of the Great East Japan Earthquake

• Emergency medical technicians	37,567 persons

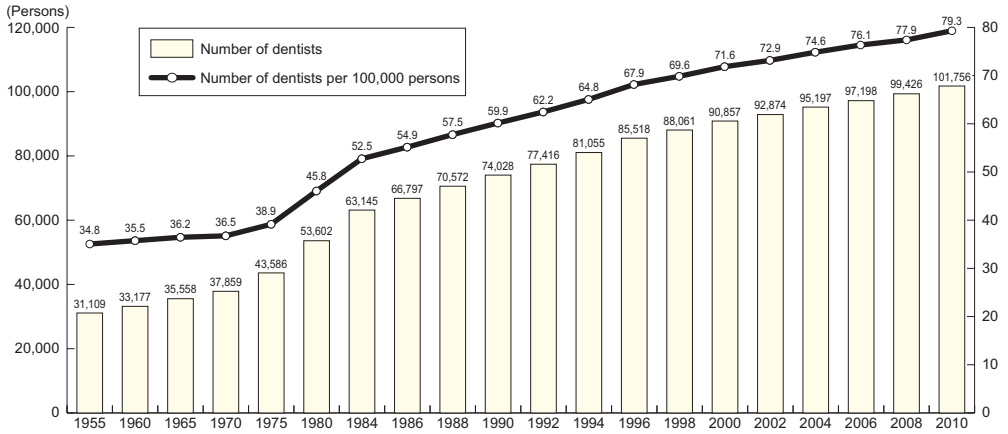
Source: Health Policy Bureau, MHLW (as of December 31, 2009)

Detailed Data 1 Changes in Number of Doctors



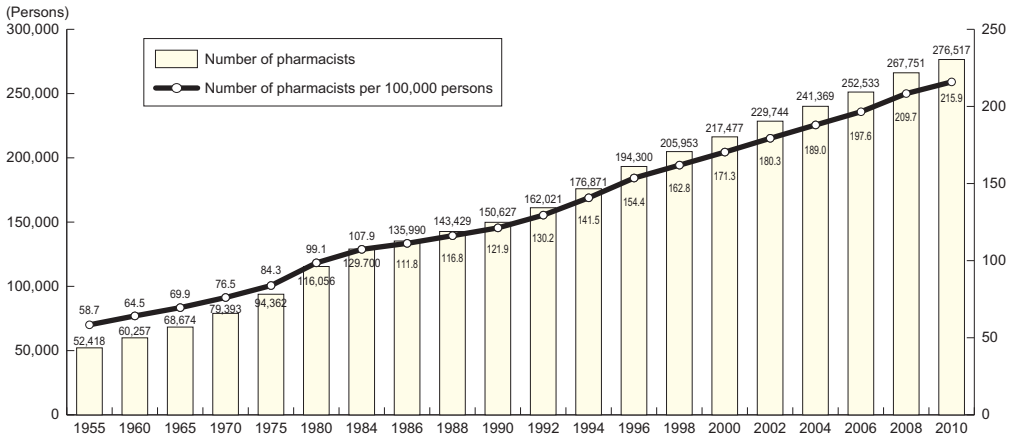
Source: "Survey of Physicians, Dentists and Pharmacists", Statistics and Information Department, Minister's Secretariat, MHLW

Detailed Data 2 Changes in Number of Dentists



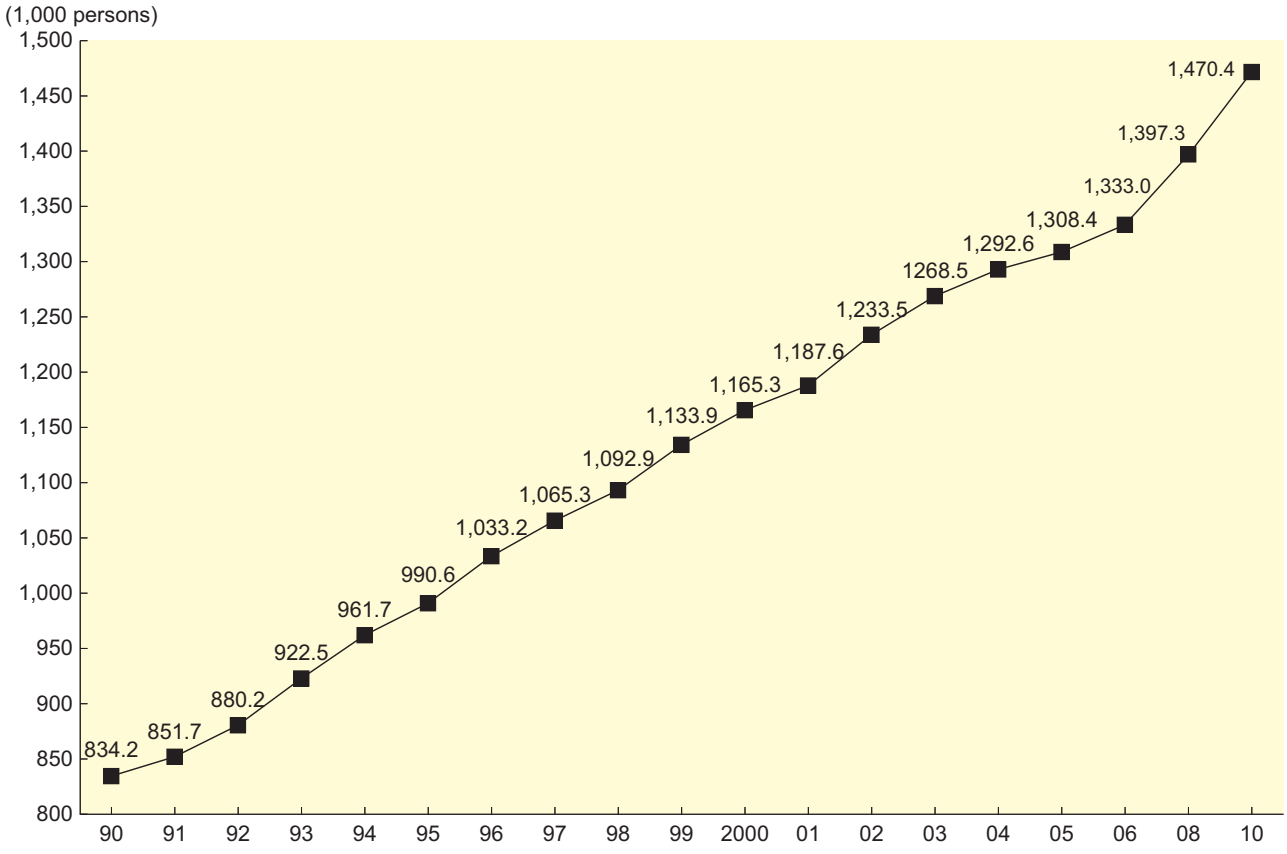
Source: "Survey of Physicians, Dentists and Pharmacists", Statistics and Information Department, Minister's Secretariat, MHLW

Detailed Data 3 Changes in Number of Pharmacists



Source: "Survey of Physicians, Dentists and Pharmacists", Statistics and Information Department, Minister's Secretariat, MHLW

Detailed Data 4 Changes in Number of Nursing personnel



Source: Health Policy Bureau, MHLW

Detailed Data 5 7th Projection of Estimated Supply and Demand for Nursing Personnel

The “7th Projection of Estimated Supply and Demand for Nursing Personnel” prepared in December 2010 estimated that demand for nursing personnel will reach approx. 1.501 million while supply will be approx. 1.486 million in 2015.

Based on the “Act on Assurance of Work Forces of Nurses and Other Medical Experts” enacted in 1992 and subsequent basic guidelines based on the said Act, comprehensive efforts have been made to improve quality, secure training capacity, promote reemployment, and prevent unemployment.

(Unit: person, regular employee-equivalent)

Category	2011	2012	2013	2014	2015
Demand prospects	1,404,300	1,430,900	1,454,800	1,477,700	1,500,900
[1] Hospitals	899,800	919,500	936,600	951,500	965,700
[2] Clinics	232,000	234,500	237,000	239,400	242,200
[3] Maternity clinics	2,300	2,300	2,400	2,400	2,400
[4] Home-visit nursing care stations	28,400	29,700	30,900	32,000	33,200
[5] Long-term care insurance facilities	153,300	155,100	157,300	160,900	164,700
[6] Social welfare facilities, in-home service facilities (excluding [5])	19,700	20,400	20,900	21,500	22,100
[6] Nursing schools, etc.	17,600	17,700	17,700	17,800	17,900
[8] Health centers and municipal facilities	37,500	37,600	37,800	38,000	38,200
[9] Offices, research institutions, etc.	13,800	14,000	14,100	14,300	14,500
Supply prospects	1,348,300	1,379,400	1,412,400	1,448,300	1,486,000
[1] Number of persons employed at the beginning of the year	1,320,500	1,348,300	1,379,400	1,412,400	1,448,300
[2] Number of persons newly graduated and employed	49,400	50,500	51,300	52,400	52,700
[3] Number of persons reemployed	123,000	126,400	129,600	133,400	137,100
[4] Reduction in number due to retirement, etc.	144,600	145,900	147,900	149,900	152,100
Difference between demand and supply prospects	56,000	51,500	42,400	29,500	14,900
(Demand prospects/supply prospects)	96.0%	96.4%	97.1%	98.0%	99.0%

(Note) The sums of breakdown items, etc. may not equal the total due to rounding.

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

Detailed Data 1 Regional Conforming Rates

(Unit: %)

Region / Classification	Nationwide	Hokkaido Tohoku	Kanto	Hokuriku Koshinetsu	Tokai	Kinki	Chugoku	Shikoku	Kyushu
Doctors	90.0	77.8	94.4	86.6	92.6	95.5	89.8	87.9	91.3
Nurses	99.2	99.5	98.4	99.2	99.3	99.2	99.4	99.3	99.8

Detailed Data 2 Nationwide Achievement Status

	Hospitals with sufficient number of doctors	Hospitals with insufficient number of doctors	Total
Hospitals with sufficient number of nurses	7,305 (88.9)	793 (9.7)	8.098 (98.6)
Hospitals with insufficient number of nurses	85 (1.1)	28 (0.3)	113 (1.4)
Total	7,390 (90.0)	821 (10.0)	8,211 (100.0)

(Note) Figures represent the number of hospitals (excluding dental hospitals). Figures in parentheses represent the percentage.

(Explanation of terms)

- **Numerical standards:** Number of doctors and nurses to be deployed at hospitals designated by the Medical Care Law.
- **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".

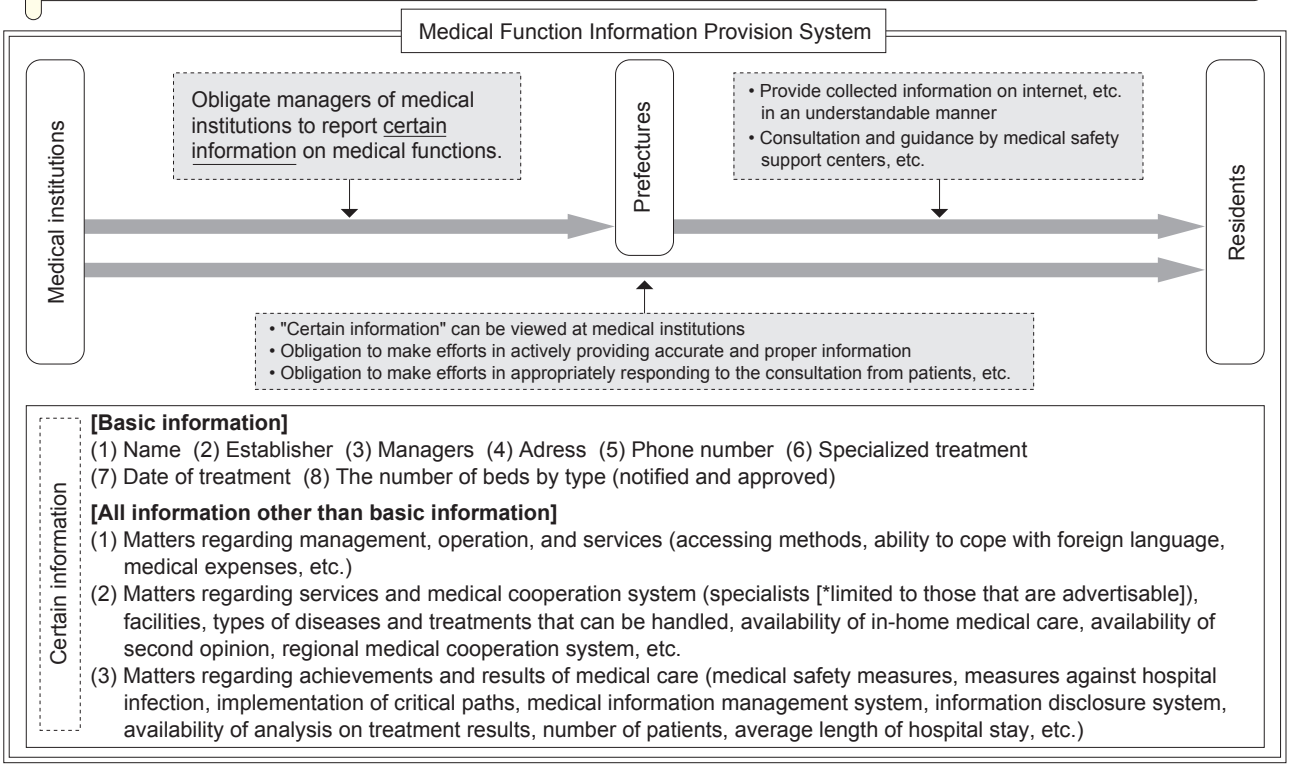
Provision of Medical Function Information

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 FY2006)

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

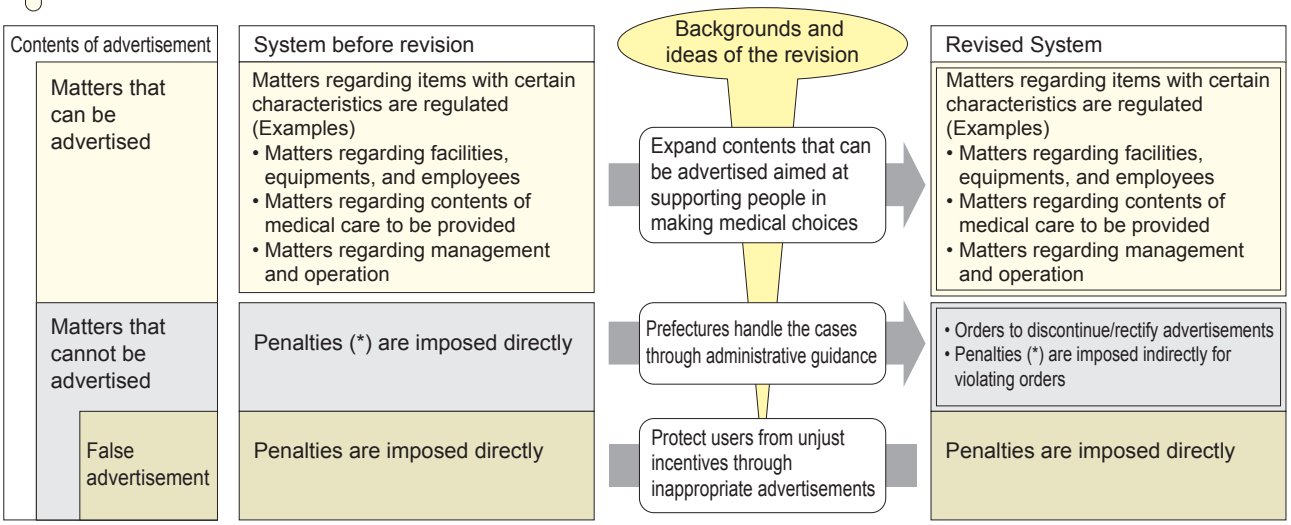
Obligation to make efforts in providing recuperation plans at the end of hospitalization

- 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.

Expansion of Matters that can be Advertised with the Revision of Advertisement Regulations (Medical Care Act)

- With regards to regulation of matters that can be advertised under advertisement regulation system, the system has been revised such that items with certain characteristics are grouped and regulated comprehensively as “matters regarding ...” instead of listing individual matters one by one as conventionally done.
  ➔Substantial relaxation of advertisement regulation
- Revision from direct penalties to indirect penalties in case matters that are not advertisable are advertised



* Imprisonment with work for a term not exceeding 6 months or a fine not exceeding ¥300,000.

[Example of relaxed advertisements]

- Specialities of medical professionals • Photographs and visual images of facilities and medical professionals • Treatment policies
- General name/development code of investigational drugs • Offerred treatments and its contents in understandable manner
- Matters regarding medical devices, etc.

(* These information, however, must be in accordance with laws, regulations, and guidelines)

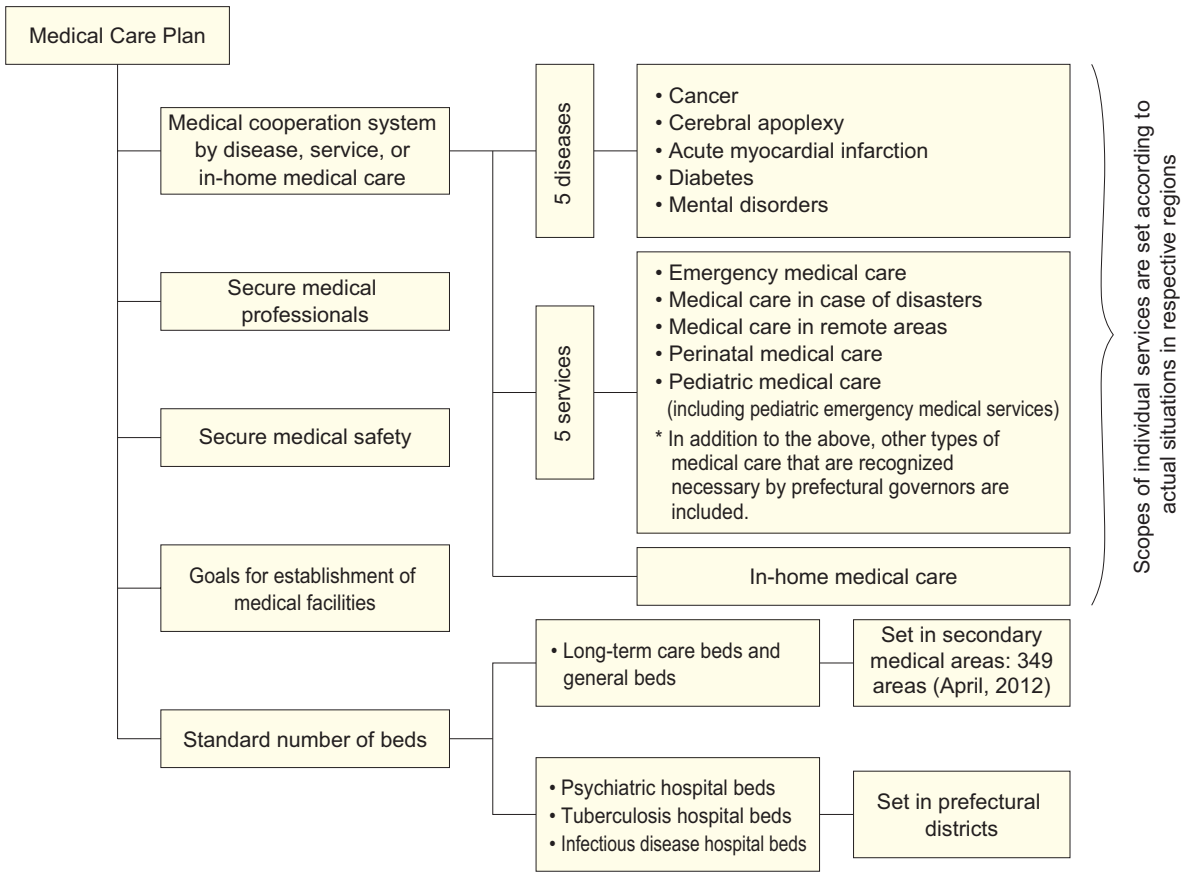
Medical Care Plan

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, 2012)

Classification	Standard number of beds	Number of existing beds
Long-term care beds and general beds	1,108,741	1,255,192
Psychiatric hospital beds	307,450	349,341
Tuberculosis hospital beds	6,256	9,867
Infectious disease hospital beds	1,889	1,725

Detailed Data **Standard Number of Beds in Prefectural Medical Care Plans and Number of Existing Beds**

No.	Classification	Public announcement date	General beds and long-term care beds			Psychiatic hospital beds		Tuberculosis hospital beds		Infectious disease hospital beds	
			Number of secondary medical areas	Standard number of beds	Number of existing beds	Standard number of beds	Number of existing beds	Standard number of beds	Number of existing beds	Standard number of beds	Number of existing beds
1	Hokkaido	Mar. 28, 2008	21	64,393	80,997	19,615	20,863	205	534	98	90
2	Aomori	Apr. 1, 2010	6	11,679	13,222	3,918	4,465	65	112	32	20
3	Iwate	Apr. 18, 2008	9	13,451	14,743	4,497	4,796	126	216	40	38
4	Miyagi	Apr. 1, 2008	7	18,402	19,635	4,627	6,495	100	140	28	28
5	Akita	Mar. 28, 2008	8	10,636	12,211	3,508	4,350	51	89	36	30
6	Yamagata	Mar. 18, 2008	4	11,551	11,678	3,003	4,090	59	50	22	18
7	Fukushima	Apr. 8, 2008	7	16,879	21,670	6,568	7,730	78	241	36	36
8	Ibaraki	Mar. 31, 2008	9	22,587	25,576	5,038	7,716	113	213	48	48
9	Tochigi	Mar. 31, 2008	5	15,418	16,774	4,669	5,315	65	134	28	26
10	Gunma	Mar. 30, 2010	10	16,998	19,114	4,419	5,255	66	69	48	46
11	Saitama	Apr. 1, 2010	10	46,033	48,699	11,343	14,474	203	273	58	44
12	Chiba	Apr. 26, 2011	9	48,482	45,659	12,949	12,911	114	218	59	58
13	Tokyo	Mar. 28, 2008	13	95,744	104,433	22,810	25,320	739	856	130	104
14	Kanagawa	Mar. 28, 2008	11	57,403	59,034	14,716	14,127	267	334	74	74
15	Niigata	Apr. 8, 2011	7	21,051	22,018	6,490	6,850	41	100	36	36
16	Toyama	Mar. 31, 2008	4	11,461	15,377	3,372	3,468	107	107	20	20
17	Ishikawa	Apr. 1, 2008	4	12,634	15,612	3,592	3,849	62	142	18	18
18	Fukui	Mar. 31, 2008	4	8,224	9,769	2,116	2,419	35	112	20	16
19	Yamanashi	Mar. 27, 2008	4	7,473	9,002	1,980	2,468	22	94	20	28
20	Nagano	Mar. 31, 2011	10	19,815	19,614	4,766	5,244	87	134	46	44
21	Gifu	Mar. 25, 2008	5	18,101	16,620	4,038	4,278	188	157	30	30
22	Shizuoka	Mar. 30, 2010	8	34,126	32,765	6,946	7,137	108	198	48	48
23	Aichi	Mar. 29, 2011	12	51,195	53,841	12,554	13,024	218	275	74	64
24	Mie	Oct. 17, 2008	4	14,320	16,254	3,727	4,818	96	80	24	20
25	Shiga	Apr. 1, 2008	7	11,150	12,304	2,398	2,403	102	132	32	32
26	Kyoto	Apr. 4, 2008	6	26,202	29,507	6,086	6,449	424	345	30	36
27	Osaka	Mar. 31, 2008	8	69,587	89,256	16,512	19,217	814	1,061	78	78
28	Hyogo	Apr. 1, 2011	10	54,082	51,825	10,938	11,434	178	343	58	54
29	Nara	Mar. 31, 2010	5	13,747	13,495	2,698	2,937	80	100	28	12
30	Wakayama	Mar. 14, 2008	7	9,267	11,832	1,475	2,369	46	166	32	24
31	Tottori	May 13, 2008	3	6,151	7,306	1,853	2,031	34	34	12	12
32	Shimane	Mar. 28, 2008	7	9,075	9,186	2,539	2,602	25	88	30	34
33	Okayama	Mar. 29, 2011	5	21,172	22,423	5,356	5,795	76	244	26	26
34	Hiroshima	Mar. 27, 2008	7	29,629	32,290	8,158	9,185	116	155	36	24
35	Yamaguchi	May 27, 2008	8	17,034	21,894	5,827	6,162	46	145	40	40
36	Tokushima	Apr. 22, 2008	6	7,354	12,136	3,032	4,071	47	103	21	14
37	Kagawa	Mar. 28, 2008	5	9,478	12,666	3,501	3,831	99	135	28	18
38	Ehime	Apr. 1, 2008	6	15,965	18,690	4,398	5,211	68	153	28	26
39	Kochi	Mar. 31, 2008	4	9,547	14,969	2,745	3,853	60	212	11	11
40	Fukuoka	Mar. 31, 2008	13	51,638	66,324	19,130	21,720	173	526	66	56
41	Saga	Apr. 1, 2008	5	9,652	11,390	3,661	4,347	58	80	24	22
42	Nagasaki	Apr. 19, 2011	8	16,872	19,224	6,492	8,043	70	150	38	38
43	Kumamoto	Mar. 23, 2010	11	19,716	26,223	7,126	9,013	137	246	48	48
44	Oita	Mar. 31, 2008	6	13,096	15,489	4,321	5,397	46	150	54	44
45	Miyazaki	Apr. 1, 2008	7	11,735	14,496	4,376	6,225	84	110	32	30
46	Kagoshima	Apr. 1, 2008	9	18,675	25,355	8,683	9,974	214	230	38	44
47	Okinawa	Apr. 1, 2008	5	9,861	12,595	4,884	5,610	44	81	26	18
	Total		349	1,108,741	1,255,192	307,450	349,341	6,256	9,867	1,889	1,725

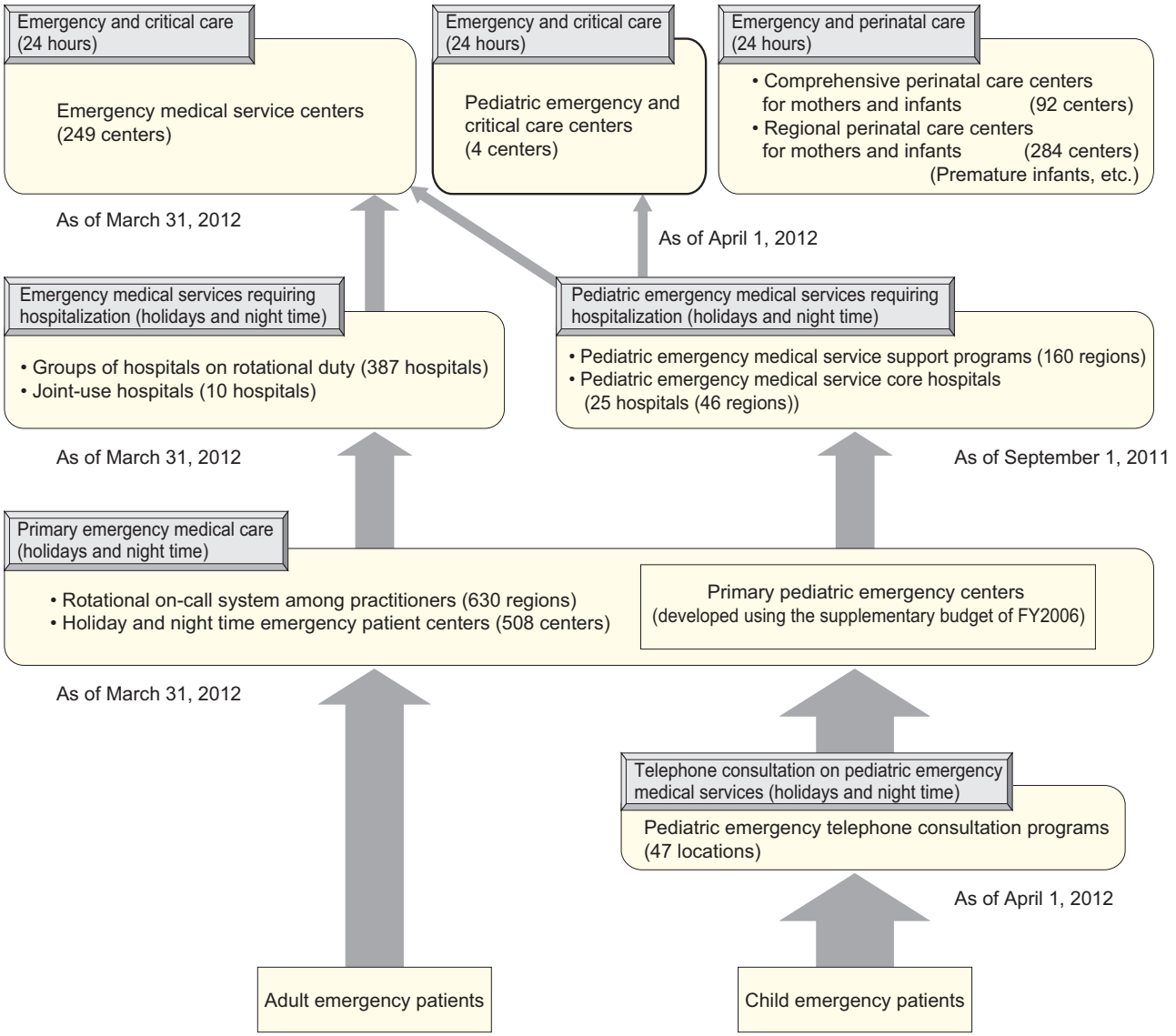
(Note) 1. Based on medical care plans as of April 2012.

2. The public announcement date differ depending on the date of reviewing medical care plans in respective prefectures.

Emergency Medical Service System

Overview

Structural Chart of Emergency Medical Service

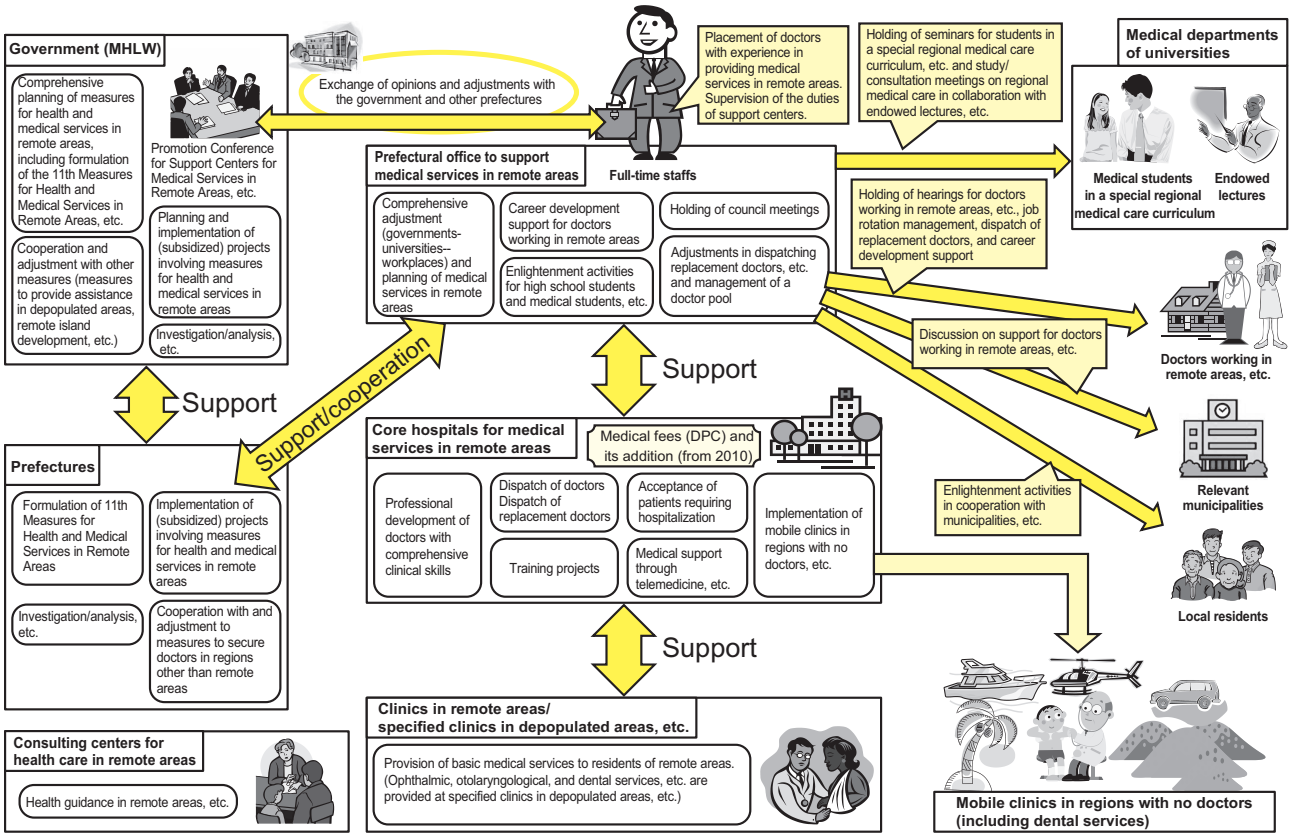


Medical Services in Remote Areas

Overview

Structural Chart of 11th Measures for Health and Medical Services in Remote Areas (FY2011-2015)

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 in plans for health and medical services in remote areas

As does the 10th plan, the new 11th plan for health and medical services in remote areas, which started in FY2011, provides that "prefectural office to support medical services in remote areas" are established in each prefecture to continue promoting broad-based measures for health and medical services in remote areas.

Year of investigation (once every 5 years)	Regions with no doctors	Subject population (10,000 persons)
1966	2,920	119
1973	2,088	77
1984	1,276	32
1999	914	20
2004	787	16.5
2009	705	13.6

* Regions with no doctors
Regions with no medical institutions in which population of 50 or more people live within a radius of approximately 4km from the major location of the region and it takes more than one hour one way to go to medical institutions using ordinary means of transportation.

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 39 prefectures as of January 1, 2012

(2) Core hospitals for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
281 hospitals are designated as of January 1, 2012

(3) Clinics for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
1,066 clinics (including National Health Insurance direct managed clinics) are established as of January 1, 2012

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

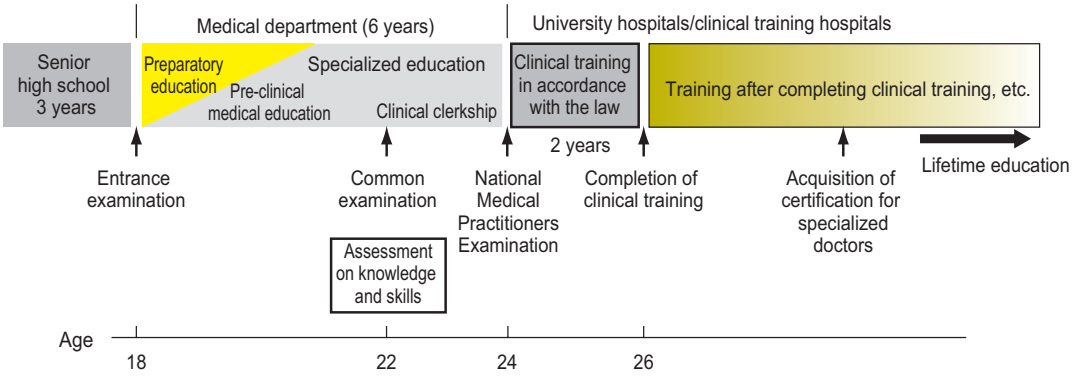
1. Training was voluntary
2. Training programs were not clearly defined
3. Mainly focused on straight training for specialized doctors
4. Remarkably large disparities existed among institutions
5. Insufficient guidance system
6. Insufficient evaluation of training achievements
7. Unstable status/work conditions → part-time jobs
8. Heavy concentration of trainees 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
○ 2007 Holding of Conference on Ideal Clinical Training System, etc. (September – February 2008)
○ 2008 Revision of the system (applied at the start of training in FY2010)

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 (FY2011)

Clinical resident training hospitals (core type)	924
Clinical resident training hospitals (cooperative type)	1,473
University hospitals (core type equivalent)	114
University hospitals (cooperative type equivalent)	20

[2] Enrollment status of residents

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%
3rd year of new system (FY2006)	44.7%	55.3%
4th year of new system (FY2007)	45.3%	54.7%
5th year of new system (FY2008)	46.4%	53.6%
6th year of new system (FY2009)	46.8%	53.2%
7th year of new system (FY2010)	47.2%	52.8%
8th year of new system (FY2011)	45.0%	55.0%

Outline of System Reform

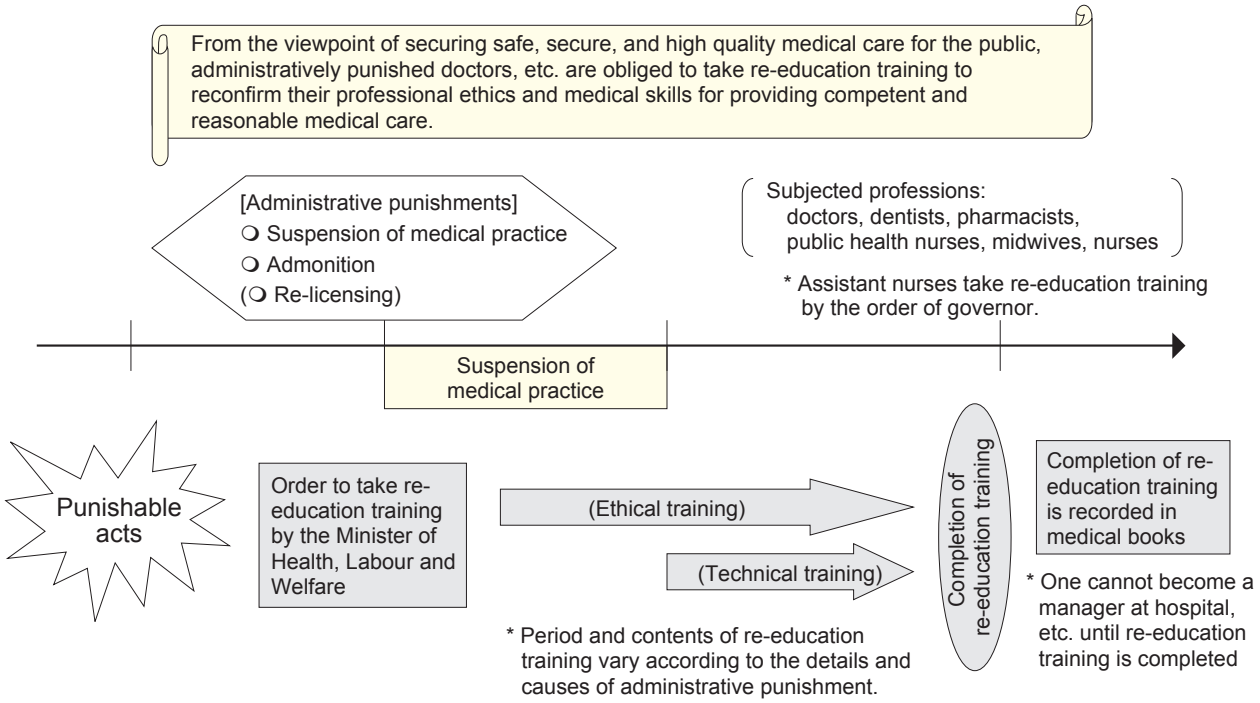
(1) Flexible Training Program
- Training program standards are revised to offer more flexibility while maintaining the basic ideas and achievement goals of clinical training.
- "Compulsory courses" comprise of internal, emergency, and community medicine. Surgery, anesthesiology, pediatrics, obstetrics and gynecology, and psychiatry are included in Âgelective compulsory coursesÀh, of which two courses are selected for training.
- Training periods are no less than 6 months for internal medicine, no less than 3 months for emergency medicine , and no less than 1 month for community medicine.
- Training programs are available for those who wish to become obstetricians or podiatrist (hospitals with 20 or more recruitment quotas for internship).

(2) Reinforcement of standards for designation of core clinical training hospitals
- Requirements for the annual number of inpatients being 3,000 or more, and placement of 1 or more preceptor for each 5 interns, etc. are included in standards for designation of core clinical training hospitals.

(3) Revision of recruitment quotas for internship
- Establishment of a limit on the total number of recruitment quotas that reflects the number of training applicants and the limit of recruitment quota in each prefecture for conducting appropriate regional arrangement of medical interns.
- A recruitment quota of each hospital is set after taking into consideration the actual results of accepting of interns in the past and dispatching doctors, etc. and making necessary adjustment with the prefectural limit.

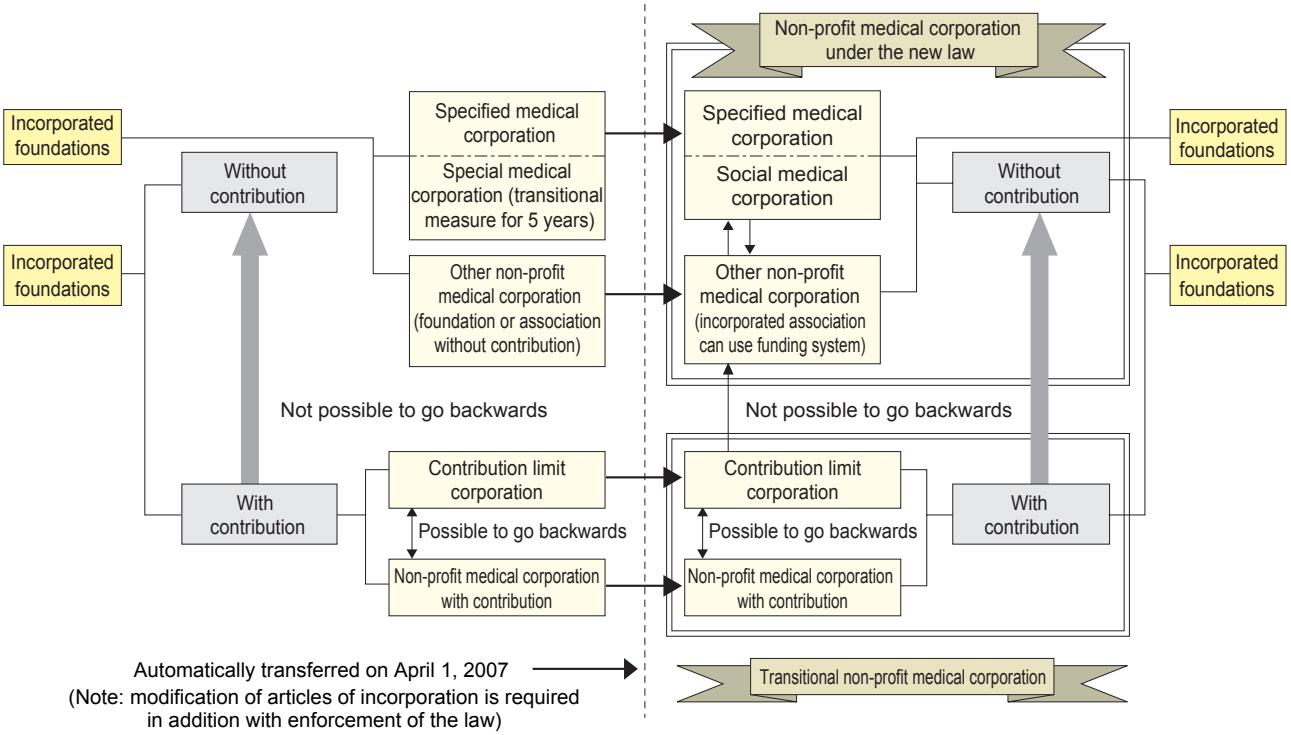
(4) Provision for the review
- Provisions of Ministerial Ordinance on Clinical Training shall be reviewed within 5 years from the enforcement of Ordinance, and necessary measures to be taken

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



Medical Corporation System

Overview **Transfer of Non-profit Medical Corporation System with the Revised Medical Care Law**



Only non-profit medical corporations under the new law can be established on and after April 1, 2007.

- Transitional non-profit medical corporation (non-profit medical corporation under the old law) cannot be established on and after April 1, 2007.
- Articles of incorporation can be modified from non-profit medical corporation with contribution to contribution limit corporation on and after April 1, 2007.

(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 372 locations in 47 prefectures, 100 locations in 69 designated cities, and 23 locations in 23 special wards under the Community Health Act (As of April 1, 2012).

<<Personal health service areas>>

<Measures against infectious diseases>

Health checkups, reporting emergence of patients, etc.
Non-regular health checkups of Tuberculosis, preventive vaccination, home-visit guidance, controlled medical examination, etc.
(Infectious Diseases Act)

<Measures against AIDS/intractable diseases>

AIDS individual counselling programs (including free anonymous examination), AIDS consultation
(AIDS guidelines)
Medical consultation of intractable diseases, etc.
(Outlines of infectious disease neasures)

<Measures for mental health>

Identification of current situation regarding mental health, mental health and welfare consultation, home-visit guidance of mental health, office works regarding medical care and protection, etc.
(Mental Health and Welfare Act)

<Measures for maternal and child health>

Home-visit guidance for premature infants, providing medical aid for premature infants, etc.
(Maternal and Child Health Act)

<<Objective health service areas>>

Health centre administration council
Directors of health centers (doctors)

<Food sanitation>

Providing business license for restaurants, supervising business facilities,guidance, etc.
(Food Sanitation Act)

<Environmental health>

Providing business license, notification, on-site investigation, etc.
(Act on Coordination and Improvement of Environmental Health Industry, Entertainment Places Act, Public Bath Houses Act, Inns and Hotels Act, Barbers Act, Cosmetologists Act, Laundries Act)

- Health risk management
- Technical support/advice for municipalities
- Adjustment between municipalities
- Formulation/promotion of regional health/medical care plans

495 health centers
373 in prefectures 99 in designated cities
23 in special wards

Doctors
Physical therapists
Dentists
Occupational therapists
Pharmacists
Public health nurses
Veterinarians
Midwives
Clinical radiologic technologists
Nurses
Medical social workers
Certified psychiatric social workers
Laboratory-medical technologists
Medical technologists
Food sanitation inspectors
Environmental sanitation inspectors
Registered dieticians
Dieticians
Dental hygienists
Abattoir inspectors, etc.

<Medical care inspection, etc.>

On-site investigation of hospitals, clinics, medical corporations, dental clinics, clinical laboratories, etc.
(Medical Care Act, Dental Technicians Act, Act on Clinical Laboratory Technicians, etc.)

<<Planning, adjustment, etc.>>

Publicity
Dissemination and enlightenment
Health statistics
Health consultation

* In addition to the activities above, health centers provide licenses for opening pharmacies (Pharmaceutical Affairs 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 Moxacauterization, etc.).

Changes in Number of Health Centers

FY	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total number of health centers	663	641	594	592	582	576	571	549	535	518	517	510	494	495	495
Prefectures	490	474	460	459	448	438	433	411	396	394	389	380	374	373	372
Cities	137	136	108	109	111	115	115	115	116	101	105	107	97	99	100
Special wards	36	31	26	24	23	23	23	23	23	23	23	23	23	23	23

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

Detailed Data 1 Number of Medical Personnel at Health Centers by Occupation

Occupation	Number of personnel
	Persons
Doctors	810
Dentists	82
Pharmacists	2,732
Veterinarians	2,179
Public health nurses	7,739
Midwives	54
Nurses	216
Assistant nurses	17
Radiology technicians, etc.	606
Medical technologists, etc.	853
Registered dietitians	1,057
Nutritionists	117
Dental hygienists	337
Physical/occupational therapists	78
Others	10,922
<Included in the upper column>	
Medical social workers	93
Mental health welfare counselors	1,335
Nutrition counselors	1,026
Total	27,799

Source: “Report on Regional Public Health Services and Health Promotion Services”, Statistics and Information Department, Minister's Secretariat, MHLW
(Modified by Health Service Bureau) (as of the end of FY2009)
(Note) Clinics in Miyagi Prefecture, apart from Sendai City, are not included due to the impact of the Great East Japan Earthquake.

Detailed Data 2 Changes in Number of Public Health Nurses

(Unit: person)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Municipalities	15,355	15,366	15,643	15,856	16,004	15,908	15,629	15,315	14,519	14,483	14,498	14,613	14,179
Designated cities/ special wards	4,167	4,450	4,584	4,696	4,907	5,047	5,281	5,524	5,563	5,604	5,964	6,094	6,081
Subtotal	19,522	19,816	20,227	20,552	20,911	20,955	20,910	20,839	20,082	20,087	20,462	20,707	20,260
Prefectures	4,620	4,535	4,481	4,439	4,311	4,242	4,178	4,014	3,935	3,889	3,800	3,737	3,640
Total	24,142	24,351	24,708	24,991	25,222	25,197	25,088	24,853	24,017	23,976	24,262	24,444	23,900

Source: Up to FY 1994: Health Service Bureau
FY 1995-1996: “Report on Statistics of Activities of Health Centers”, Statistics and Information Department, Minister's Secretariat, MHLW
FY1997-1998: “Report on Regional Public Health Services”, Statistics and Information Department, Minister's Secretariat, MHLW
FY 1999-2007: “Report on Regional Public Health Services and Health Services for the Aged”, Statistics and Information Department, Minister's Secretariat, MHLW
FY 2008 onward: “Report on Regional Public Health Services and Health Promotion Services”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) The figures up to FY1996 as of the end of December of each year and figures from FY1997 onward as of the end of March of the next year.
The figures of 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, Futaba Town, Iitate Town, and Aizuwakamatsu City) due to the impact of the Great East Japan Earthquake.

Measures against Hepatitis

Overview **Basic Act on Hepatitis Measures**

Basic Act on Hepatitis Measures (Act No.97 of 2009)

→ Comprehensive formulation/enforcement of measures against hepatitis

- To stipulate basic principles for measures against hepatitis;
- To clarify responsibilities of the government, local governments, medical insurers, citizens, and doctors, etc.;
- To formulate guidelines concerning promotion of measures against hepatitis; and
- To comprehensively promote measures against hepatitis by stipulating basic articles for them.

Basic measures

Promotion of prevention and early detection

- Prevention of hepatitis
- Quality improvement of hepatitis examinations, etc.

Research promotion

Promotion of equalization of medical services for hepatitis patients, etc.

- Training of doctors and other medical professionals to acquire the expertise
- Establishment and improvement of medical institutions
- Financial support for medical care expenses on hepatitis patients
- Securing opportunities for hepatitis care
- Establishment and improvement of systems for collecting and providing information on hepatitis care, etc.

Measures must be taken with careful consideration given to the human rights of patients and elimination of discrimination against them

Formulation of basic measures against hepatitis

The Council for Promotion of Hepatitis Measures

- Representatives of hepatitis patients, etc.
- The medical profession engaged in hepatitis care
- Persons with relevant knowledge and experience

Relevant administrative organizations

Establish / Advice

Request for documents, etc. / Discussion

Minister of Health, Labour and Welfare

Formulation

Basic measures against hepatitis

- Announcement
- Review at least every 5 years

→ Revise if necessary

Response to cirrhosis and liver cancer

- Creation of an environment for improved treatment level
- Review the patient support system as necessary taking into consideration the situation of medical treatments

Outline of Basic Guidelines on Hepatitis Measures (formulated on May 16, 2011)

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

- ○ Promoting measures in cooperation between the relevant parties, including hepatitis patients themselves, is important.
- ○ Developing a system for and promotion of receiving hepatitis virus examinations is necessary.
- ○ Promoting the development of a liver disease treatment cooperation system according to regional characteristics is necessary.
- ○ Making efforts via financial support for anti-virus treatment and evaluating the results is necessary.
- ○ Promoting comprehensive research, including hepatitis-related medical care, is necessary.
- ○ Disseminating/enlightening appropriate knowledge on hepatitis is necessary.
- ○ Providing consultation support and information for hepatitis patients and their families, etc. is necessary.

2 Matters concerning measures to take in preventing hepatitis

- ○ Disseminating appropriate knowledge in thereby preventing new infections and discussing ideal hepatitis B vaccinations is necessary.

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

- ○ Disseminating that everyone should have at least one hepatitis virus examination, developing a system that enables those who wish to have one to do so, and verifying their effectiveness is necessary.

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

- ○ Developing a system that enables all hepatitis patients to receive continued appropriate hepatitis-related medical care and encouraging people to have an examination is necessary.

5 Matters concerning development of human resources for the prevention of hepatitis and hepatitis-related medical care

- ○ Developing human resources that have knowledge on preventing hepatitis infections and those that can then lead them to the appropriate hepatitis-related medical care after an infection has been discovered is necessary.

6 Matters concerning surveys and research on hepatitis

- ○ Evaluating and verifying research achievements and conducting research that will be the basis for comprehensively promoting hepatitis measures is necessary.

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

- ○ Facilitating research and development of drugs, including those for hepatitis-related medical care, etc., promoting clinical trials and clinical research, and prompter evaluations, etc. is necessary

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

- ○ Dissemination/enlightenment on encouraging people to receive hepatitis virus examination consultations, preventing new infections, and preventing unjust discrimination against hepatitis patients, etc. is necessary.

9 Other important matters concerning the promotion of hepatitis measures

- ○ Enhanced support for hepatitis patients and their families, etc. is necessary.
- ○ Provision of further support for hepatic cirrhosis and liver cancer patients.
- ○ Establishment of a system for hepatitis measures to be taken according to the actual situation of the pertinent region is expected.
- ○ The effort to appropriately respond using the appropriate knowledge in thereby enabling all people to be aware of their own hepatitis infection status and preventing unfair discrimination against hepatitis patients, etc.
- ○ Regularly examining and evaluating the efforts of the respective implementing bodies in the future and reviewing the guidelines, if necessary. In addition, regularly reporting the status of efforts made to the Council for Promotion of Measures against Hepatitis.

Health Promotion Measures

Overview Changes in National Health Promotion Measures

1st National Health Promotion Measures (FY1978-1988)	2nd National Health Promotion Measures (from FY1988) (Active 80 Health Plan)	3rd National Health Promotion Measures (from FY2000) (National Health Promotion in the 21st Century (Health Japan 21))
(Basic idea) 1. Lifetime health promotion 〔Promotion of primary prevention of geriatric diseases〕 2. Promotion of health promotion projects through three major elements (diet, exercises, and rest) (special focus on diet)	(Basic idea) 1. Lifetime health promotion 2. Promotion of health promotion projects with the focus on exercise habits as they are lagging behind the other two of the three elements (diet, exercise, and rest)	(Basic idea) 1. Lifetime health promotion 〔Focusing on primary prevention, extended healthy life expectancy, and enhanced quality of life〕 2. Setting specific targets to serve as an index for national health/medical standards and promotion of health promotion projects based on assessments 3. Creation of social environments to support individuals' health promotion
(Outline of measures) (1) Lifetime health promotion • Establishment of health checkups and a complete health guidance system from infants and small children through to the elderly (2) Establishment of health promotion bases • Establishment of health promotion centers, municipal health centers, etc. • Securing sufficient human resources, including public health nurses and dieticians (3) Dissemination and enlightenment of health promotion • Establishment of municipal health promotion councils • Promoting the use of recommended dietary allowances • Nutritional content labelling for processed food • Conducting studies on health promotion, etc. etc.	(Outline of measures) (1) Lifetime health promotion • Enhanced health checkup and guidance system from infants and small children through to the elderly (2) Establishment of health promotion bases • Establishment of health science centers, municipal health centers, health promotion facilities, etc. • Securing sufficient manpower such as health fitness instructors, registered dieticians, and public health nurses (3) Dissemination and enlightenment of health promotion • Promoting the use of and revising recommended dietary allowances • Promoting recommended exercise allowance • Promoting the system to approve health promotion facilities • Action plan for tobacco control • Promoting a system of nutrition information labelling for meals eaten outside home • Promoting cities with health oriented cultures and health resorts • Conducting studies on health promotion, etc. etc.	(Outline of measures) (1) National health promotion campaign • Dissemination and enlightenment of effective programs and tools with regular revision • Dissemination and enlightenment of the acquisition of good exercise habits and improved dietary habits with a focus on metabolic syndrome (2) Implementation of effective medical examinations and health guidance • 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 FY 2008) (3) Cooperation with industry • Further cooperation in voluntary measures of industries (4) Human resource development (improving the quality of medical professionals) • Improved training for human resource development in cooperation between the government, prefectures, relevant medical organizations, and medical insurance organizations (5) Development of evidence-based measures • Revision of data identification methods to enable outcome assessments etc.
(Guidelines, etc.) • Dietary guidelines for health promotion (1985) • Report on nutritional content labelling for processed food (1986) • Announcement of a weight scale diagram and table (1986) • Report on smoking and health (1987)	(Guidelines, etc.) • Dietary guidelines for health promotion (by individual characteristics: 1990) • Guidelines for nutrition information labeling for meals eaten outside home (1990) • Report on smoking and health (revised) (1993) • Exercise and Physical Activity Guidelines for Health Promotion (1993) • Promoting guidelines on rest for health promotion (1994) • Committee report on action plan for tobacco control (1995) • Committee report on designated smoking areas in public spaces (1996) • Physical activity guidelines by age (1997)	(Guidelines, etc.) • Dietary guidelines (2000) • Committee report on relevance to designated smoking areas (2002) • Sleep guidelines for health promotion (2003) • Guidelines on implementation of health checkups (2004) • Japanese Dietary Reference Intake (2005 edition) (2004) • Guidelines for well-balanced diet (2005) • Manual for smoking cessation support (2006) • Exercise and Physical Activity Guidelines for Health Promotion 2006 (exercise guide 2006) (2006) • Exercise guidelines for health promotion 2006 (exercise guide 2006) (2006) • Japanese Dietary Reference Intake (2010 edition) (2009)

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 promoting people's health.

(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 (health promotion measure plans for 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 Japan, 2010

National Health and Nutrition Survey

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

Subjects: Households in 300 unit areas randomly selected from unit areas established in the Comprehensive Survey of Living Conditions 2009 (approximately 5,700 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.
* “Situation with cardiovascular diseases” is an item emphasized in 2010

Key points of the results of the survey

<Status with cardiovascular diseases>

- The percentage of those with a past history of major diseases of being diagnosed with “apoplexy” was 5.7% with males and 3.3% with females. The percentage rose from 2000 with both males and females. That diagnosed with a “myocardial infarction” was 2.7% with males and 0.9% with females. That diagnosed with “angina pectoris” was 3.8% with males and 2.8% with females. The percentage remained unchanged from 2000 with both males and females.
- The average systolic and diastolic blood pressure was 133.9mmHg and 82.4mmHg with males and 126.2mmHg and 77.0mmHg with females, respectively. These figures have remained unchanged from 2000 with both males and females. In contrast to this the percentage of those with hypertension was 60.0% with males and 44.6% with females. It rose from 2000 with males but remained unchanged with females.
- Risk factors in the onset of cardiovascular diseases that had improved from 2003 include a smaller percentage of smokers, less average salt intake, and the percentage of people that regularly exercised. In contrast to this the risk factors that had worsened include average potassium intake.
- The percentage of those making the effort to improve their lifestyles with the aim of preventing/improving lifestyle-related diseases was 50.4% with males and 57.6% with females.

<Status with tobacco use>

- The percentage of habitual smokers was 32.2% for males and 8.4% for females, and 19.5% for males and females. It had declined from the previous year with both males and females. The percentage of habitual smokers who wish to stop smoking was 35.9% for males and 43.6% for females. It rose from the previous year for males but had remained unchanged for females.
- The percentage of those who have been affected by passive smoking almost every day had declined from 2003 with all locations (home, workplace, restaurants, and amusement places).

<Status with income and lifestyle-related diseases, etc.>

- The percentage of obese females, who skip breakfast, do not regularly exercise, and habitual smokers was higher and the amount of vegetable intake lower with members of households with incomes of less than ¥2 million and those of ¥2 million to ¥6 million than those earning ¥6 million or more.

Detailed Data 1 Status of Formulating Health Promotion Plans in Prefectures/Municipalities

[Status of formulating health promotion plans in prefectures]
Already formulated in every prefecture (at the end of March 2002)

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

	Total	Formulated	Plan to formulate in FY2011	Plan to formulate in FY2012	Plan to formulate in FY2013 or later	No plan
Health center-designated cities	68	67	0	0	1	0
Special wards in Tokyo	23	23	0	0	0	0
Other municipalities	1,651	1,270	67	79	170	65

(As of Dec. 1, 2011)

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

Prefecture	No. of municipalities	Formulated	Formulation rate	FY2011	FY2012	FY2013 or later	No plan
Hokkaido	175	95	54.3%	2	15	56	7
Aomori	39	39	100.0%	0	0	0	0
Iwate	32	31	96.9%	0	1	0	0
Miyagi	34	33	97.1%	1	0	0	0
Akita	24	21	87.5%	0	1	2	0
Yamagata	35	35	100.0%	0	0	0	0
Fukushima	57	33	57.9%	4	3	17	0
Ibaraki	44	26	59.1%	7	7	4	0
Tochigi	25	25	100.0%	0	0	0	0
Gunma	33	31	93.9%	1	1	0	0
Saitama	61	38	62.3%	6	3	14	0
Chiba	51	24	47.1%	1	0	8	18
Tokyo	37	26	70.3%	1	2	8	0
Kanagawa	28	16	57.1%	3	3	3	3
Niigata	29	29	100.0%	0	0	0	0
Toyama	14	13	92.9%	1	0	0	0
Ishikawa	18	16	88.9%	1	1	0	0
Fukui	17	17	100.0%	0	0	0	0
Yamanashi	27	26	96.3%	1	0	0	0
Nagano	76	59	77.6%	1	6	7	3
Gifu	41	38	92.7%	0	1	2	0
Shizuoka	33	33	100.0%	0	0	0	0
Aichi	50	49	98.0%	1	0	0	0
Mie	28	16	57.1%	2	0	8	2
Shiga	18	17	94.4%	0	0	1	0
Kyoto	25	13	52.0%	5	1	2	4
Osaka	39	33	84.6%	1	1	3	1
Hyogo	37	37	100.0%	0	0	0	0
Nara	38	33	86.8%	1	1	1	2
Wakayama	29	18	62.1%	1	1	6	3
Tottori	19	18	94.7%	0	1	0	0
Shimane	19	19	100.0%	0	0	0	0
Okayama	25	25	100.0%	0	0	0	0
Hiroshima	20	20	100.0%	0	0	0	0
Yamaguchi	18	14	77.8%	2	2	0	0
Tokushima	24	19	78.3%	0	1	4	0
Kagawa	16	16	100.0%	0	0	0	0
Ehime	19	19	100.0%	0	0	0	0
Kochi	33	24	72.7%	7	1	1	0
Fukuoka	56	24	41.1%	2	1	13	16
Saga	20	14	70.0%	0	4	2	0
Nagasaki	19	19	100.0%	0	0	0	0
Kumamoto	44	28	63.6%	3	11	2	0
Oita	17	17	100.0%	0	0	0	0
Miyazaki	25	13	52.0%	8	2	2	0
Kagoshima	42	32	76.2%	2	3	0	5
Okinawa	41	29	70.7%	2	5	4	1
	1,651	1,270	76.8%	67	79	170	65

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

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

	Total number of patients (1,000 persons)	Number of deaths (Person)	Mortality rate (to the population of 100,000)
Malignant neoplasm	1,518	357,185	283.1
Diabetes	2,371	14,634	11.6
Hypertensive diseases	7,967	7,018	5.6
Heart diseases	1,542	194,761	154.4
Cerebrovascular diseases	1,339	123,784	98.1

Source:
<Total number of patients> "Patient Survey 2008", Statistics and Information Department, Minister's Secretariat, MHLW
<Number of death/moratlity rate> "Summary of Monthly Report of Vital Statistics", Statistics and Information Department, Minister's Secretariat, MHLW
(Note) The number of deaths and mortality rate were approximate figures in 2011.

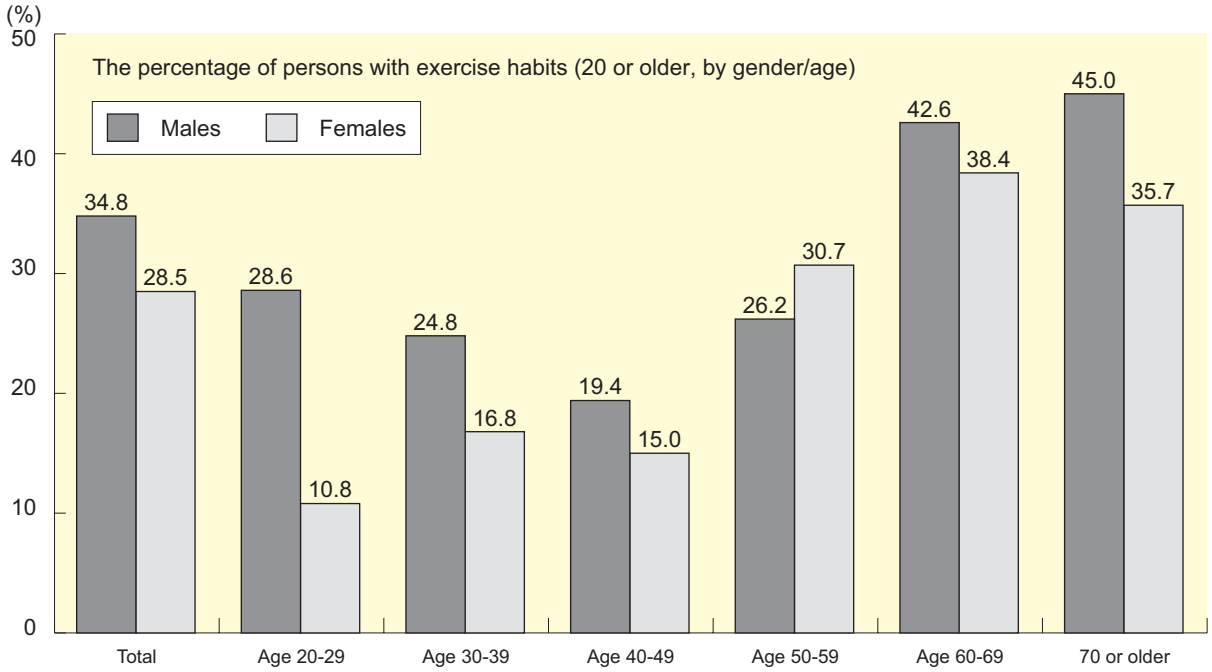
Detailed Data 3 Estimated Numbers on Diabetes

	Males (survey samples: 1,619)		Females (survey samples: 2,384)	
Age	Strongly suspected of having diabetes	With possibilities of having diabetes	Strongly suspected of having diabetes	With possibilities of having diabetes
20-29	1.1%	0%	0%	0.9%
30-39	3.0%	3.0%	0.5%	5.4%
40-49	7.6%	11.0%	2.9%	10.4%
50-59	12.1%	16.7%	5.6%	20.8%
60-69	22.1%	17.3%	14.1%	18.2%
70 or older	22.6%	18.4%	11.0%	23.8%

When the above figures are applied to the estimated population as of October 1, 2007, the estimated numbers nationwide are as follows:
• Those strongly suspected of having diabetes: approx. 8.9 million persons
• Those with possibilities of having diabetes: approx. 13.2 million persons

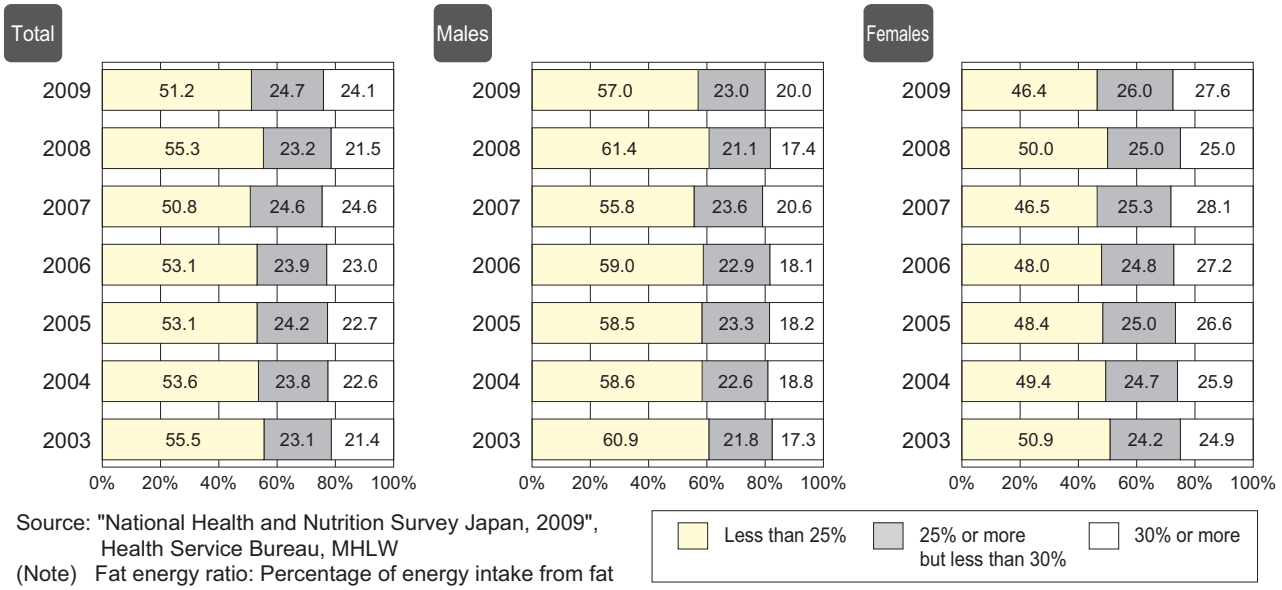
Source: "National Health and Nutrition Survey Japan, 2007", Health Service Bureau, MHLW

Detailed Data 4 Status of Exercise Habits



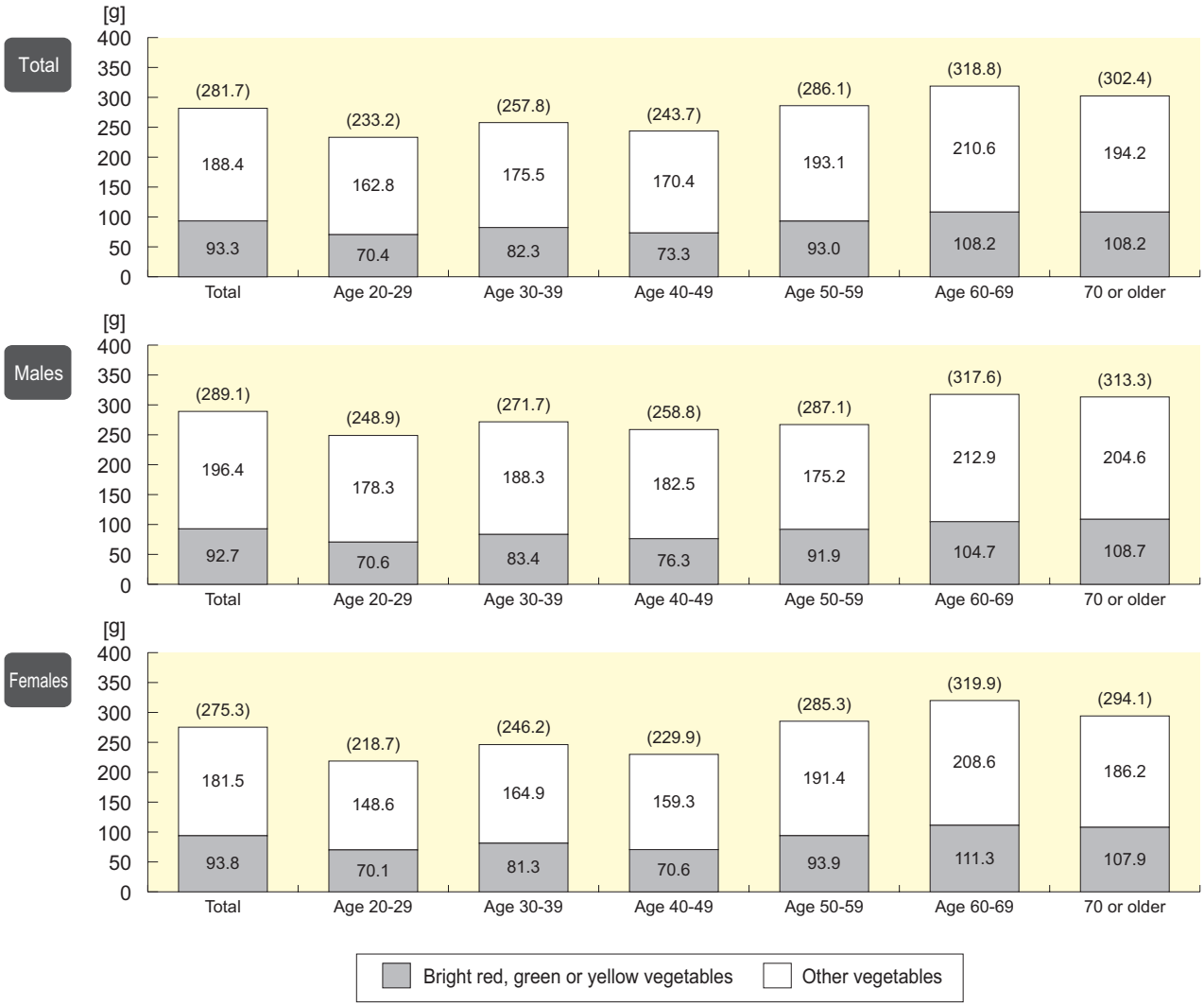
Source: “National Health and Nutrition Survey Japan, 2010”, Health Service Bureau, MHLW
(Note) Persons with exercise habits: Those who have been continuing daily exercise of 30 minutes or longer at least 2 days a week for at least a year.

Detailed Data 5 Changes in Distribution of Fat Energy Ratio (20 or Older)



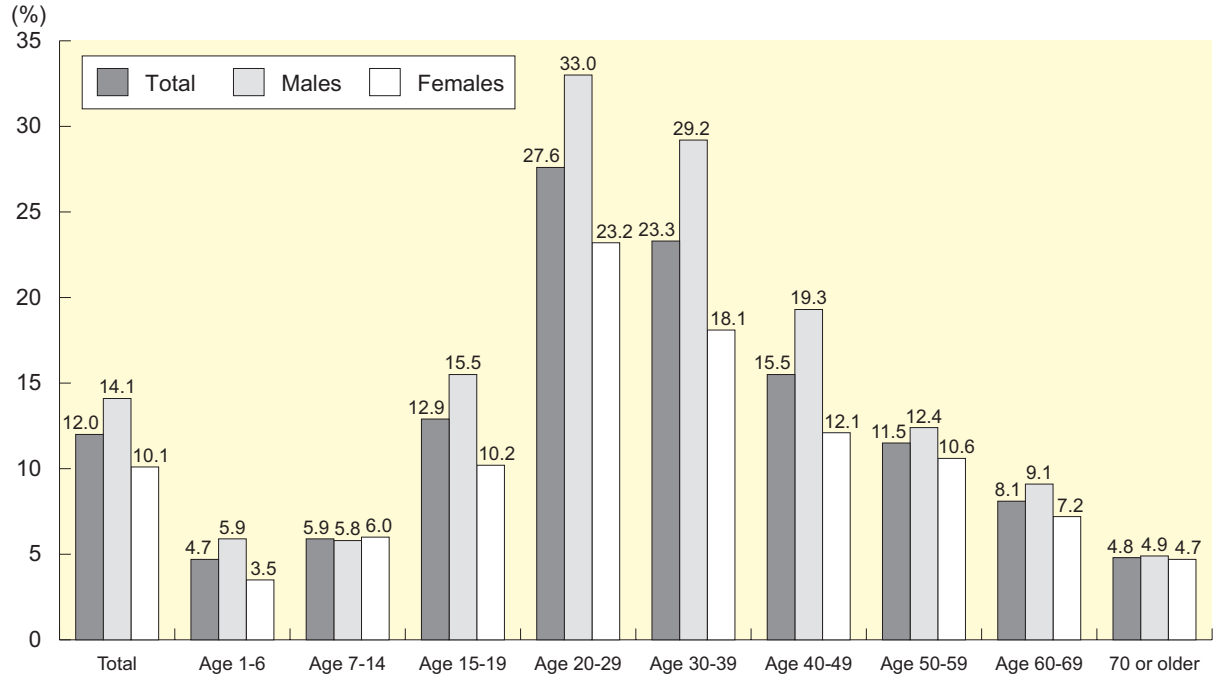
Source: "National Health and Nutrition Survey Japan, 2009", Health Service Bureau, MHLW
(Note) Fat energy ratio: Percentage of energy intake from fat

Detailed Data 6 Average Intake of Vegetables, etc. (20 or Older, by Gender/Age)



Source: "National Health and Nutrition Survey Japan, 2010", Health Service Bureau, MHLW
(Note) The figures in parentheses indicate the total intake of "bright red, green or yellow vegetables" and "other vegetables (excluding bright red, green or yellow vegetables)".

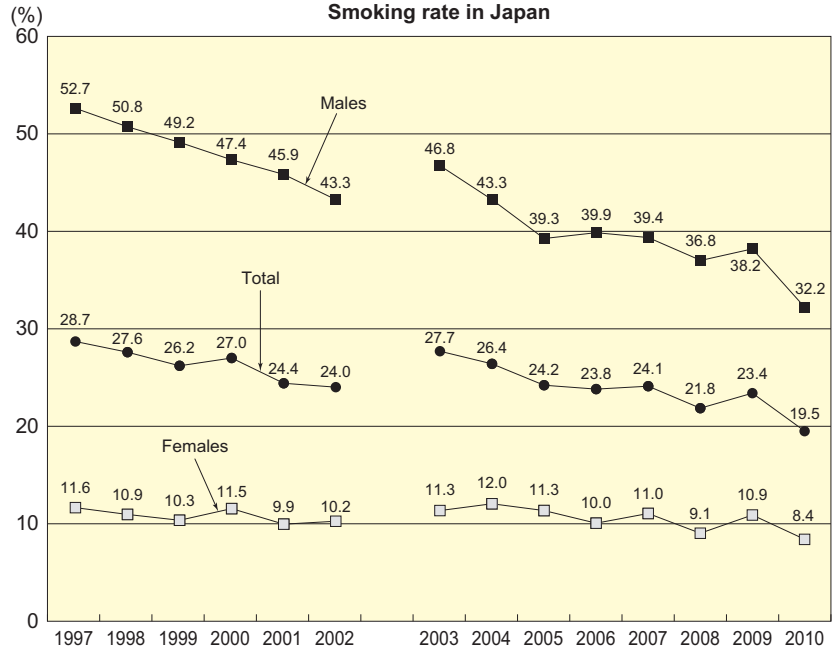
Detailed Data 7 Percentage of Persons Skipping Breakfast (1 or Older, by Gender/Age)



Source: "National Health and Nutrition Survey Japan, 2009", Health Service Bureau, MHLW

Detailed Data 8 Status with Smoking Rate

Smoking rate in Japan



Source: “National Nutrition Survey” up to 2002 and “National Health and Nutrition Survey Japan” from 2003 onward

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

Smoking rate in foreign countries (%)

Country	Males	Females
Japan	(36.8) 38.2	(9.1) 10.9
Germany	(37.3) 34.8	(28.0) 27.3
France	(30.0) 33.3	(21.2) 26.5
Netherlands	(35.8) 31.0	(28.4) 25.0
Italy	(31.3) 28.3	(17.2) 16.2
U.K.	(27.0) 22.0	(25.0) 20.0
Canada	(22.0) 19.9	(17.0) 15.5
U.S.A.	(24.1) 23.9	(19.2) 18.0
Australia	(18.6) 16.6	(16.3) 15.2
Sweden	(16.7) 16.5	(18.3) 18.8

Source: WHO Tobacco ATLAS (2009)
“National Health and Nutrition Survey Japan, 2009” for the figures for Japan

(Note) The figures in parentheses are from WHO Tobacco ATLAS (2006) and the National Health and Nutrition Survey Japan, 2008

Dental Health Promotion

Overview 8020 (Eighty-Twenty) Campaign

[History of 8020 (Eighty-Twenty) Campaign]

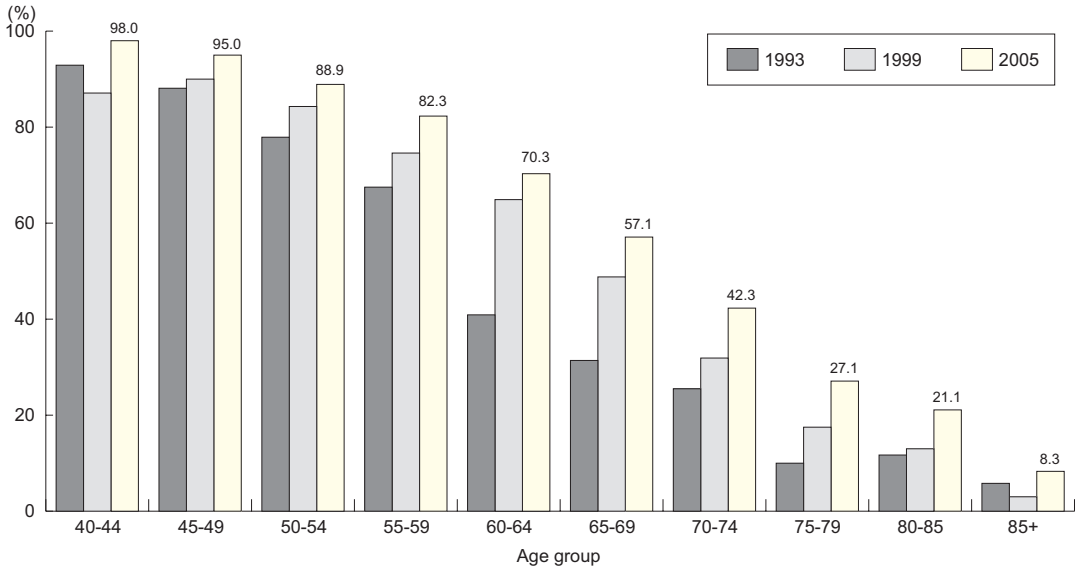
1989	A Study Group on the Dental Health Policy for Adults made public its interim reportin which the "8020 (Eighty-Twenty) Campaign" calling for the retention of 20 or more teeth even at age 80 was proposed.
1991	"Promotion of 8020 Campaign" was set to be the major objective for the Dental Hygiene Week (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).
1996	Study Group on the Future Dental Health and Medical Care pointed out in its written opinion that pointed out that the 8020 Campaign should be developed in a more practical and community-oriented manner.
1997	Municipal dental health promotion projects (menu projects) launched.
2000	Prefecture-led "8020 Campaign promotion special projects" launched.
2003	Dental health support model projects for operators of health promotion 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.
2008	8020 Campaign marked the 20th anniversary.
2011	The Act on Advancement of Dental and Oral Health was approved.

[Relationship between 8020 Campaign and Health Japan 21]

The "8020 Campaign" and "Health Japan 21" are complementary to each other and the projects to accomplish the goals of Health Japan 21 have been implemented within the framework of the 8020 Campaign. As dental health was explicitly stated as a key point in the Health Promotion Act, further promotion of lifelong dental health projects (8020 Campaign) is expected.

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+
1993	92.9%	88.1%	77.9%	67.5%	40.9%	31.4%	25.5%	10.0%	11.7%	5.6%
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

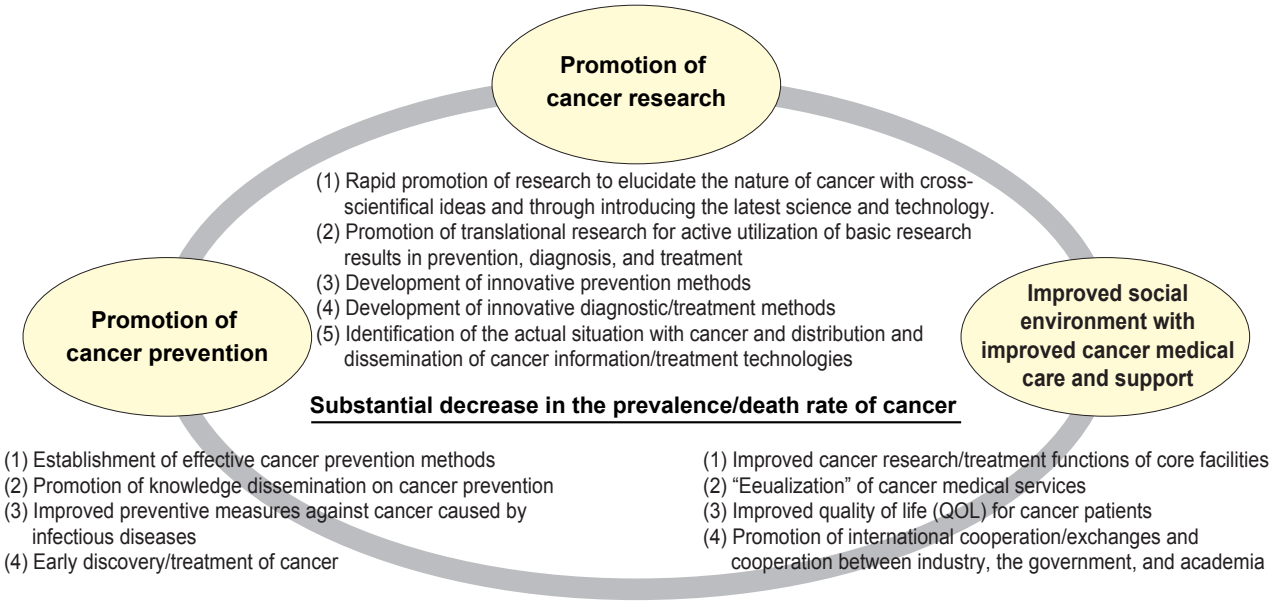


Source: "Survey of Dental Diseases", Health Policy Bureau, MHLW

Cancer Control Measures

Overview **Future Direction with the "3rd-Term Comprehensive 10-year Cancer Control Strategy"**

Goal of the strategy: Substantially decrease the prevalence and death rate of cancer, which is a major cause of death in Japan, through comprehensive promotion of research, prevention, and treatment.



Outline of the "Cancer Control Act"

Chapter I General Provisions

1. Purpose

- Although cancer control in Japan has made progress and gained certain achievements through conventional measures, cancer remains an important issue in people's lives and health. In order to further improve cancer control, therefore, the following matters are being provided in controlling cancer control in a comprehensive and systematic manner.

2. Basic Ideas

- In addition to promoting specialized, multidisciplinary, and comprehensive cancer research, dissemination/utilization and further expansion of the results of research with the aim of overcoming cancer
- Enable cancer patients to receive appropriate treatment based on scientific knowledge regardless of the region in which they reside.
- Establish a system that provides medical cancer care in which the treatment is selected according to the situation of the patient and respect paid to their own intentions.

3. Responsibilities of Relevant Parties

- Prescribe the responsibilities of the government, local governments, health care insurers, the public, and doctors

Chapter II The Basic Plan to Promote Cancer Control Programs, etc.

- In addition to consulting the directors of the relevant administrative organizations the Minister of Health, Labour and Welfare will hear the opinions of the Cancer Control Promotion Council, formulate the draft of a Basic Plan to Promote Cancer Control Programs , and then request for a Cabinet decision.
- The Minister of Health, Labour and Welfare may make the necessary requests for the Basic Plan to Promote Cancer Control Programs to be implemented to the directors of the relevant administrative organizations.
- Prefectures to formulate Prefectural Plans to Promote Cancer Control Programs .

Chapter III Basic Measures

1. Promotion of prevention and early discovery of cancer

- Implement required measures for promoting cancer prevention, and improved cancer screening and its promotion.

2. Promotion of equalization of cancer medical services

- Implement required measures for training cancer specialists, establishing core hospitals/cooperation system, maintenance and improved quality of the recuperation life of cancer patients, and establishing a system to collect/provide information on cancer medical care.

3. Promotion of cancer research

- Implement required measures for promoting cancer research and improving the environment for the early approval of drugs/medical devices that are highly needed in cancer treatment.

Chapter IV The Cancer Control Promotion Council

- Establish a Cancer Control Promotion Council within the Ministry of Health, Labour and Welfare as a council that will formulate the Basic Plan to Promote Cancer Control Programs.
- Members of the council will be appointed from representatives of cancer patients and their families or the bereaved, cancer medical care professions, and academic experts by the Minister of Health, Labour and Welfare, with the number of members not exceeding 20.

Chapter V Date of Enforcement

- The date of enforcement of this law shall be April 1, 2007.
- With regard to the establishment of the Cancer Control Promotion Council, the Act for Establishment of the Ministry of Health, Labour and Welfare shall be revised in establishing the required provisions.

Basic Plan to Promote Cancer Control Programs (Cabinet decision on June 2012)

Priority issues

- (1) Further improvement of radiotherapy, chemotherapy, and surgical therapy, and development of the specialist medical professionals
- (2) Promotion of palliative care from when first diagnosed with cancer
- (3) Promotion of cancer registry
- (New) (4) Improved cancer measures for the working generations and children

Overall goals [10 year goals from FY2007]

- (1) Decreasing the number of deaths from cancer (20% decline in the age-adjusted mortality rate of those younger than 75)
- (2) Reducing the pain of all cancer patients and their families, and maintaining or improving the quality of their recuperation
- (New) (3) Establishing a society in which people can live with a sense of security even though they have cancer

Measures by area and individual goals in measuring their achievements

1. Cancer medical care
[1] Further improved radiotherapy, chemotherapy, and surgical therapy, and promotion of team medical care
[2] Development of specialist medical cancer care professionals
[3] Promotion of palliative care from when first diagnosed with cancer
[4] Establishment of regional medical/long-term care service provision systems
(New) [5] Efforts to rapidly develop/approve drugs/medical devices, etc.
[6] Other (rare cancers, pathological diagnoses, and rehabilitation)

2. Cancer consultation support and information provision
Establishment of a consultation support system that alleviates the worries of patients and their families and is easier of use.

3. Cancer registry
Improving the accuracy of cancer registry through establishing an effective prognosis investigation system and increasing the number of medical institutions that implement hospital-based cancer registry, including discussing legal establishments.

4. Cancer prevention
The achievement of an adult smoking rate of 12%, underage smoking rate of 0%, passive smoking rates of 0% at administrative/medical institutions, 3% at home, 15% at eating/drinking places by FY2022, and with no passive smoking at workplaces by FY2020.

5. Early detection of cancer
Achieving a cancer screening rate of 50% within five years (40% with gastric, lung, and colon cancer for the time being).

6. Cancer research
Further promotion of research that contributes to anti-cancer measures. Formulation of new comprehensive cancer research strategies that specify the future direction of cancer research and concrete research items in the respective areas within two years in cooperation with the relevant ministries and agencies.

(New) 7. Childhood cancer
Establishment of core childhood cancer hospitals and commencement of the establishment of core institutions for childhood cancer within five years.

(New) 8. Education/dissemination/enlightenment on cancer
Discussions on the ideal cancer education for children and the promotion of cancer education within health education.

(New) 9. Social issues that include employment for cancer patients
The aim of establishing a society in which people can work and live with a sense of security, even though they have cancer, through facilitating understanding at workplaces and improving consultation support systems after clarifying their needs and issues with employment.

Outline of the Basic Plan to Promote Cancer Control Programs

Purpose

The Basic Plan to Promote Cancer Control Programs (hereinafter referred to as the "Basic Plan") was formulated by the government in accordance with the Cancer Control Act (Act No. 98 of 2006) of June 2007, with cancer measures then having been promoted in accordance with that Basic Plan. Five years have passed since the former Basic Plan was formulated and new issues identified. The Basic Plan has therefore been reviewed to clarify the basic direction that promoting cancer measures should take in order to comprehensively and systematically promote cancer measures over the new five year period of FY2012 through to 2016. The Basic Plan aims to create "a society in which all people, including cancer patients, understand cancer, and can face and withstand it" through these measures.

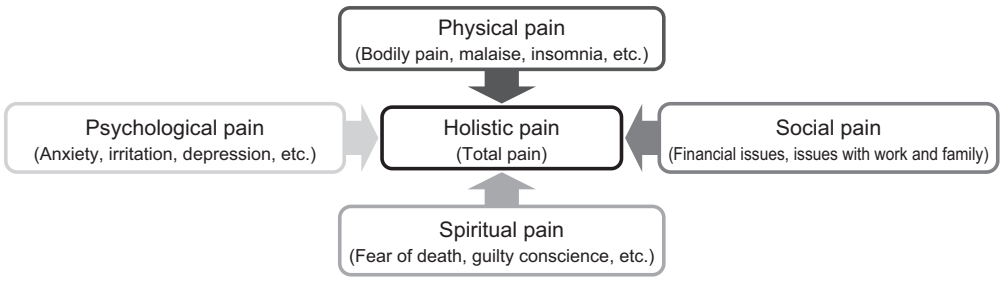
1 Basic policies

○ Implementing cancer measures from the viewpoint of the people, including cancer patients
○ Implementing comprehensive and systematic cancer measures that involve priority issues
○ Ideas involving the goals and achievement time

2 Priority issues

1. Further improvement of radiotherapy, chemotherapy, and surgical therapy, and the development of pertinent specialist medical professionals
   Development of medical professionals that have specialized in medical cancer care and the promotion of team medical care in thereby improving the quality of radiotherapy, chemotherapy, and surgical therapy, and multidisciplinary therapy that combines the aforementioned therapies.
2. Promotion of palliative care from when first diagnosed with cancer
   Further improving the palliative care system in thereby enabling patients and their families to receive holistic palliative care, including mental health care for psychological pain, when they are first diagnosed with cancer through training medical professionals who engage in medical cancer care and reinforcement of the functions of palliative care teams, etc.
3. Promotion of cancer registry
   The cancer registry involves a system to use in obtaining data that will be the basis of cancer measures through collecting and analyzing data on the number of patients with each type of cancer, the content of their treatment, and survival time, etc. Its development, however, is still lagging behind when compared to various foreign countries. Efforts will therefore be made to develop a system to use in smoothly promoting a cancer registry, including discussing its legal establishment.
4. (New) Improved cancer measures for the working generations and children
   Promoting measures for female cancer, which has a high mortality rate in Japan, responses to employment issues, raising the percentage of working generations receiving cancer screening, and measures for childhood cancer, etc.

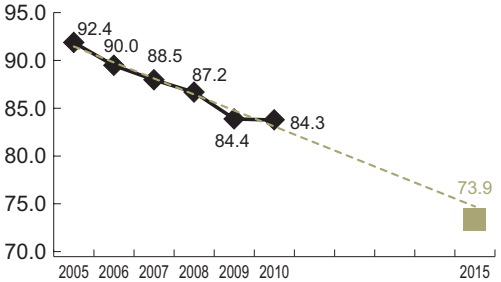
The various types of pain that cancer patients suffer



3 Overall goals (10 year goals from FY2007)

1. Decreasing the number of deaths from cancer (20% decrease in the age-adjusted mortality rate of those younger than 75)
2. Reducing the pain of all cancer patients and their families, and maintaining or improving the quality of their recuperation
3. (New) Establishing a society in which people can live with a sense of security, even though they have cancer

Changes in the age-adjusted mortality rate (younger than 75) (per population of 100,000)



4 Measures by area and individual goals

1. Cancer medical care
   (1) Further improvement of radiotherapy, chemotherapy, and surgical therapy, and promotion of team medical care
   Establishment of a system for team medical care at all core hospitals within three years.
   (2) Development of medical professionals who specialize in medical cancer care
   The aim of improving the quality of medical cancer care through developing specialized medical professionals to engage in medical cancer care.
   (3) Promotion of palliative care from when first diagnosed with cancer
   Ensuring all medical professionals that engage in cancer treatment understand basic palliative care and acquire the necessary knowledge and skills within five years. The effort to enhance palliative care teams and outpatient palliative care within three years, mainly at core hospitals.
   (4) Establishment of regional medical/long-term care service provision systems
   Discussing ideal core hospitals within three years and further enhancing their functionality within five years. The additional aim of establishing in-home medical/long-term care services provision systems.
   (5) (New) Efforts in the rapid development/approval of drugs/medical devices, etc.
   Consistent effort to rapidly provide the people with effective and safe drugs.
   (6) Other (rare cancers, pathological diagnoses, and rehabilitation)
2. Cancer consultation support and information provision
   Establishment of a consultation support system that alleviates the worries of patients and their families and can easily be used by them.
3. Cancer registry
   Improvement of the accuracy of cancer registry through establishing an effective prognosis investigation system and increasing the number of medical institutions that utilize the hospital-based cancer registry, including discussing its legal establishment.
4. Cancer prevention
   Achieving an adult smoking rate of 12%, underage smoking rate of 0%, passive smoking rate of 0% at administrative/medical institutions, 3% at home, and 15% at eating/drinking places by FY2022, and with no passive smoking at workplaces by FY2020.
5. Early detection of cancer
   Achieving a cancer screening rate of 50% within five years (40% with gastric, lung, and colon cancer for the time being).
   * The Health Promotion Act stipulates that all people subject to cancer screening be of a certain age or older but with no upper limit in terms of age having been established. With calculating the percentage of people receiving cancer screening, however, those aged 40-69 (20-69 for uterine cancer) are major subjects when compared with foreign countries.
   * Pertinent items and methods of cancer screening get separately discussed.
   * The target values will be reviewed if necessary after taking interim evaluations into account.
6. Cancer research
   Further promotion of research that contributes to cancer measures. Formulation of new comprehensive cancer research strategies that specify the future direction of cancer research and concrete research items in the respective areas within two years in cooperation with relevant ministries and agencies.
7. (New) Childhood cancer
   Establishment of core childhood cancer hospitals and commencement of the establishment of core institutions for childhood cancer within five years.
8. (New) Education/dissemination/enlightenment on cancer
   Discussions on ideal cancer education for children and promoting cancer education within health education.
9. (New) Social issues that include the employment of cancer patients
   Aim to establish a society in which people can work and live with a sense of security, even though they have cancer, through facilitating understanding at workplaces and improving consultation support systems after clarifying their employment needs and issues.

5 Matters required in the comprehensive and systematic promotion of cancer measures

1. Further enhancement of cooperation between the relevant parties, etc.
2. Formulation of prefectural plans by prefectures
3. Airing of opinions of relevant parties, etc.
4. Efforts made by the people, including cancer patients
5. Implementation of necessary financial measures and a more efficient/prioritized budget
6. Identification of the status of achievement of goals and formulation of indices for assessing cancer measures
7. Review of the Basic Plan

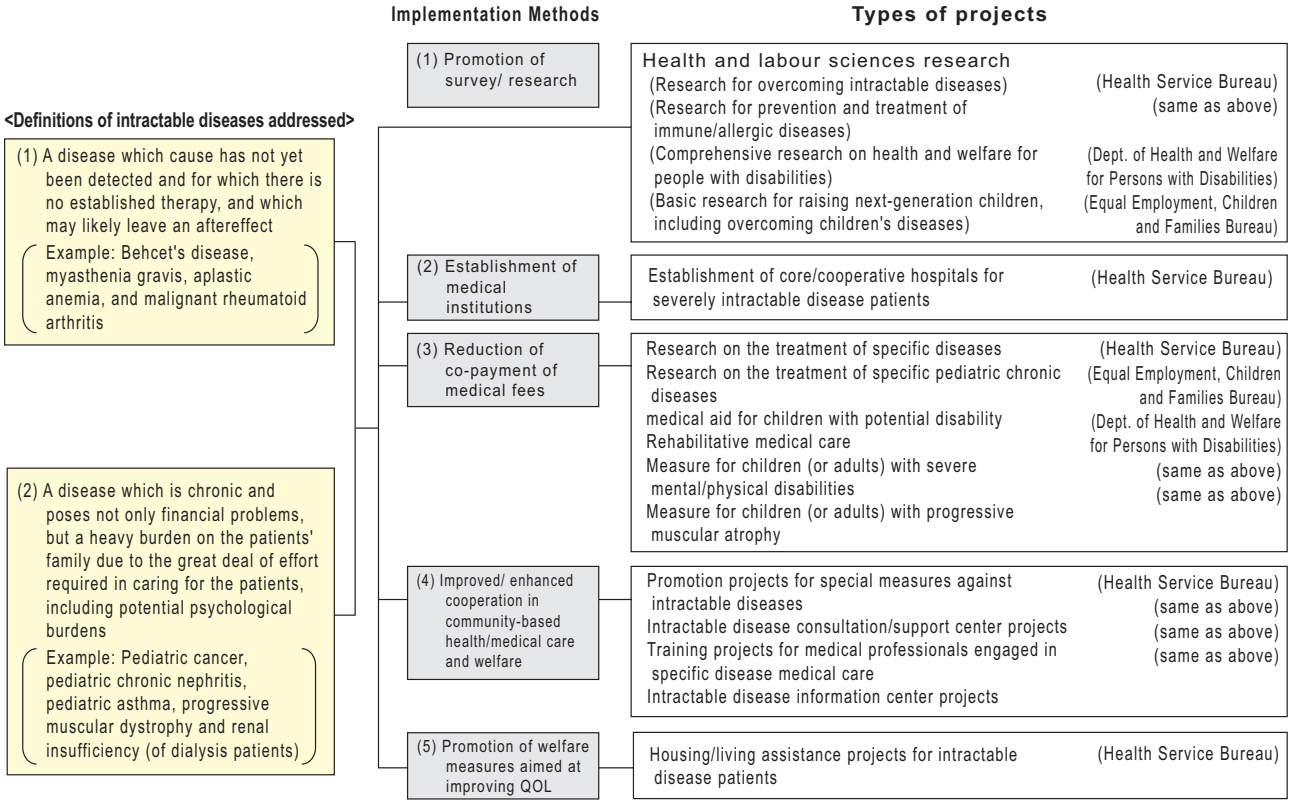
Detailed Data **Statistics on Cancer (as of March 1, 2012)**

Item	Current status	Source
Number of deaths	Total of 357,185 persons (28.5% of all causes of death) [213,109 males (32.5% of all causes of death)] [144,076 females (24.1% of all causes of death)] → "1 in every 3.5 Japanese die of cancer" * Risk of cancer increases with age → The gross number of deaths is increasing (effect of aging) * The age-adjusted mortality are (younger than 75) is on a declining trend since 1995 (108.4 in 1995 → 84.3 in 2010) * Types of cancers are changing	Vital Statistics of Japan (Annual total of monthly reports in 2011 (approximates)) (Recounted by the Center for Cancer Control and Information Services, National Cancer Center)
Incidence rate	743,664 persons [427,949 males] Major sites: stomach, large intestine, liver, and prostate gland, and liver [315,715 females] Major sites: breast, large intestine, stomach, lung, and uterine cervix * Including esophageal, colon, lung, skin, breast, uterine cervix, and carcinoma in situ bladder cancer	Estimates based on population-based cancer registry (2007)
Lifetime risk	Male 54%, Female 41% → "1 in every 2 persons will contract cancer in Japan"	Estimates by Center for Cancer Control and Information Services, National Cancer Center (2005)
Patients and persons receiving treatment	The number of persons requiring constant treatment was 1.52 million • The number of persons hospitalized at the time of the survey was 141,400 • The number of outpatients was 156,400 • 297,800 persons received treatment per day (3.6% of those receiving treatment)	Patient Survey (2008)
Medical care expenditure for cancer	¥2,957.7 billion * 11.1% of total general medical care expenditure	Estimates of National Medical Care Expenditure (2009)

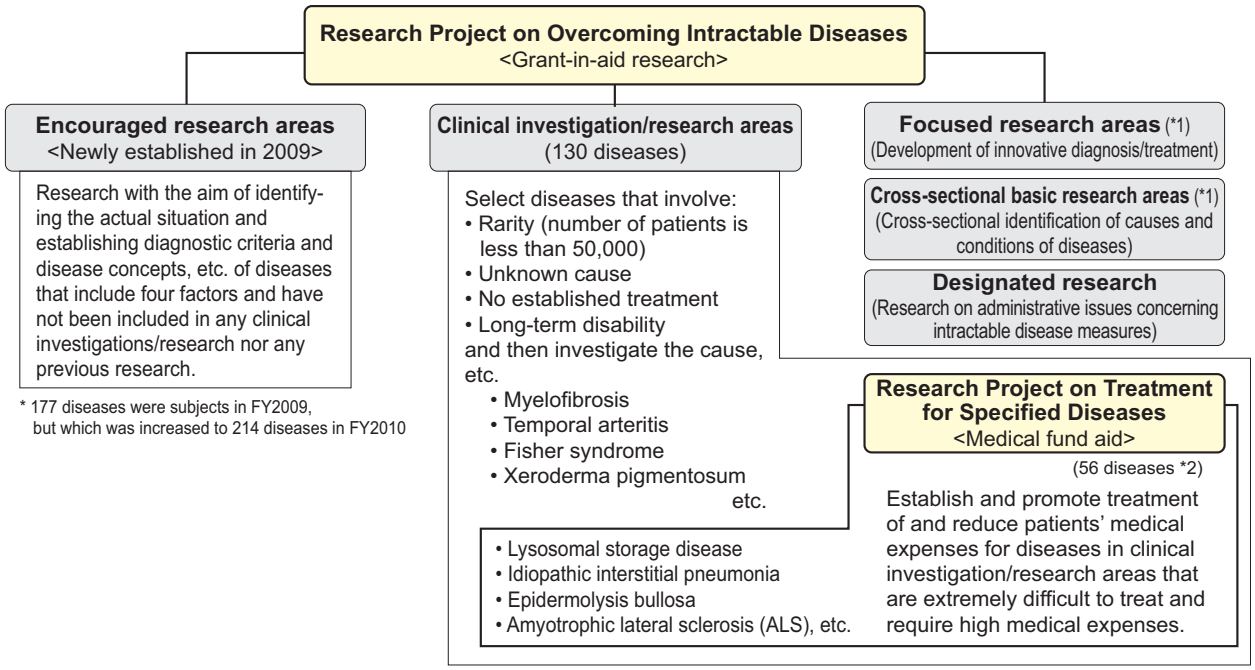
Intractable Disease Measures

Overview Outline of Intractable Disease Measures

Various projects have been implemented in accordance with the "Outline of Intractable Disease Measures" compiled in 1972.



Research Project on Overcoming Intractable Diseases



*1 Diseases subjected to focused research and cross-sectional basic research are the same as those subjected to clinical investigations/research.
*2 In addition to the 56 diseases the research project on the treatment of specified diseases includes the research project on hemophilia treatment, etc.

Detailed Data **Number of Intractable Disease Medical Treatment Recipient Certificates Issued**

Disease No.	Disease	Date of implementation	Number of certicifates issued
1	Behcet's disease	April , 1972	17,290
2	Multiple sclerosis (MS)	April ,1973	14,492
3	Myasthenia gravis	April ,1972	17,314
4	Systemic lupus erythematosus (SLE)	same as above	56,254
5	Subacute myelo-optico-neuropathy (SMON)	same as above	1,628
6	Aplastic anemia	April ,1973	9,417
7	Sarcoidosis	October, 1974	20,268
8	Amyotrophic lateral sclerosis (ALS)	same as above	8,406
9	Scleroderma, dermatomyositis, and polymyositis	same as above	42,233
10	Idiopathic thrombocytopenic purpura (ITP)	same as above	22,220
11	Polyarteritis nodosa	October ,1975	7,600
12	Ulcerative colitis	same as above	117,855
13	Aortitis syndrome	same as above	5,438
14	Buerger's disease	same as above	7,147
15	Pemphigus	same as above	4,648
16	Spinocerebellar ataxia	October, 1976	23,290
17	Crohn's disease	same as above	31,652
18	Fulminant hepatic failure	same as above	210
19	Malignant rheumatoid arthritis	October, 1977	5,891
20	Parkinsonian disorder		106,637
[1]	Progressive supranuclear palsy	October, 2003	
[2]	Corticobasal degeneration	October, 2003	
[3]	Parkinson's disease	October, 1978	
21	Amyloidosis	October, 1979	1,505
22	Ossification of posterior longitudinal ligament	December, 1980	29,647
23	Huntington's disease	October, 1981	798
24	Moyamoya disease (Occlusive disease in circle of Willis)	October, 1982	12,992
25	Wegener's granulomatosis	January, 1984	1,671
26	Idiopathic dilated (congestive) cardiomyopathy	January, 1985	22,123
27	Multiple system atrophy		11,096
[1]	Striatonigral degeneration	October, 2003	
[2]	Olivopontocerebellar atrophy	October, 1976	
[3]	Shy-Drager syndrome	January, 1986	
28	Epidermolysis bullosa (junctional or dystrophic)	January, 1987	315
29	Pustular psoriasis	January, 1988	1,679
30	Spinal stenosis	January, 1989	4,218
31	Primary biliary cirrhosis	January, 1990	17,298
32	Severe acute pancreatitis	January, 1991	1,132
33	Idiopathic necrosis in femur head	January, 1992	13,476
34	Mixed connective tissue disease	January, 1993	9,028
35	Primary immunodeficiency syndrome	January, 1994	1,147
36	Idiopathic interstitial pneumonia	January, 1995	5,896
37	Pigmentary degeneration of the retina	January, 1996	25,296
38	Prion disease	Unified in June, 2002	492
[1]	Creutzfeldt-Jakob disease	January, 1997	
[2]	Gerstmann-Straussler-Scheinker disease	June, 2002	
[3]	Fatal familial insomnia	June, 2002	
39	Primary pulmonary hypertension	January, 1998	1,560
40	Neurofibromatosis	May, 1998	3,112
41	Subacute sclerosing panencephalitis	December, 1998	87
42	Budd-Chiari syndrome	same as above	232
43	Idiopathic chronic pulmonary thromboembolism (pulmonary hypertensive)	same as above	1,288
44	Lysosomal storage disease	Unified in June, 2002	760
[1]	Fabry's disease	April, 1999	
[2]	Lysosomal storage disease	May, 2001	
45	Adrenoleukodystrophy	April, 2000	173
46	Familial hypercholesterolemia (homozygote)	October 2009	120
47	Spinal muscular atrophy	October 2009	514
48	Spinobulbar muscular atrophy	October 2009	686
49	Chronic inflammatory demyelinating polyradiculoneuropathy	October 2009	2,328
50	Hypertrophic cardiomyopathy	October 2009	2,239
51	Restrictive cardiomyopathy	October 2009	18
52	Mitochondrial disease	October 2009	764
53	Lymphangioleiomyomatosis (LAM)	October 2009	335
54	Severe erythema exudativum multiforme (acute phase)	October 2009	48
55	Ossification of ligamentum flavum	October 2009	993
56	Pituitary dysfunction (PRL secretion abnormality, gonadotropin secretion abnormality, ADH secretion abnormality, hypophyseal TSH secretion abnormality, Cushing's disease, acromegaly, hypopituitarism)	October 2009	11,764
	Total		706,720

(Note) Miyagi and Fukushima Prefectures are not included due to the impact of the Great East Japan Earthquake.
* Source: Report on Public Health Administration and Services
* Subjected diseases listed above are as of April 1, 2010.

Infectious Disease Measures

Overview

Outline of the Act on Prevention of Infectious Diseases and Medical Care for Patients Suffering 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, and measles (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 require comprehensive preventive measures in particular)

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 haemorrhagic 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), 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), West Nile fever, etc.)	Sterilization and other objective measures		
Hospitalization 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		
Novel influenza, 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 on its own responsibility shall provide 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 novel influenza from spreading
- Restricting entry to buildings to prevent Type 1 infectious diseases from spreading
- In the event of emergency, the government on its own responsibility shall provide 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 10 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

Vaccination (Individual)

Overview — Diseases and Persons Subjected to Regular Vaccination

Diseases	Persons subjected to vaccination
Diphtheria	1. Those aged 3 months or older but younger than 90 months 2. Those aged 11 years or older but younger than 13 years
Whooping cough	Those aged 3 months or older but younger than 90 months
Acute poliomyelitis	Those aged 3 months or older but younger than 90 months
Measles	1. Those aged 12 months or older but younger than 24 months 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 3. Those who are in the period between the first day of the fiscal year in which they turn 13 years old and the last day of the fiscal year 4. Those who are in the period between the first day of the fiscal year in which they turn 18 years old and the last day of the fiscal year
Rubella	1. Those aged 12 months or older but younger than 24 months 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 3. Those who are in the period between the first day of the fiscal year in which they turn 13 years old and the last day of the fiscal year 4. Those who are in the period between the first day of the fiscal year in which they turn 18 years old and the last day of the fiscal year
Japanese encephalitis	1. Those aged 6 months or older but younger than 90 months 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 2. Those aged 11 years or older but younger than 13 years
Tuberculosis	Those younger than 6 months old
Influenza	1. Those aged 65 years or older 2. Those aged 60 years or older but younger than 65 years suffering chronic severe cardiac/respiratory/renal insufficiencies, etc.

* Those born between June 1, 1995 and April 1, 2007 are subjected to regular vaccinations against Japanese encephalitis until turning 20.

Detailed Data — Type and Amount of Benefits of Relief System for Injury to Health with Vaccination

Type I disease			Type II disease (influenza)		
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 example 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 example of health insurance
Medical allowance	Same as above	Inpatient: 8 days or more per month: (month) ¥35,600 Inpatient: less than 8 days per month: (month) ¥33,600 Outpatient: 3 days or more per month: (month) ¥35,600 Outpatient: less than 3 days per month: (month) ¥33,600 Inpatient and outpatient treatment within the same month: (month) ¥35,600	Medical allowance	Same as above	Inpatient: 8 days or more per month: (month) ¥35,600 Inpatient: less than 8 days per month: (month) ¥33,600 Outpatient: 3 days or more per month: (month) ¥35,600 Outpatient: less than 3 days per month: (month) ¥33,600 Inpatient and outpatient treatment within the same month: (month) ¥35,600
Pension for rearing children with disabilities	Fosterers of children younger than 18 with certain disabilities caused by vaccination	Class 1: (annual) ¥1,520,400 (additional amount for long-term care): (annual) (¥834,200) Class 2: (annual) ¥1,215,600 (additional amount for long-term care): (annual) (¥556,200)	Disability Pension	Those aged 18 or older with certain disabilities caused by vaccination	Class 1: (annual) ¥2,700,000 Class 2: (annual) ¥2,160,000
Disability Pension	Those aged 18 or older with certain disabilities caused by vaccination	Class 1: (annual) ¥4,860,000 (additional amount for long-term care): (annual) (¥834,200) Class 2: (annual) ¥3,888,000 (additional amount for long-term care): (annual) (¥556,200) Class 3: (annual) ¥2,916,000	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) ¥2,361,600
			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	¥7,084,800
Lump-sum death benefit	The bereaved of the person who died of illness caused by vaccination	¥42,500,000			
Funeral allowance	Hosts of funerals for those who died of illness caused by vaccination	¥201,000	Funeral allowance	Hosts of funerals for those who died of illness caused by vaccination	¥201,000

* Term of claims for vaccination-related complications for Type II disease

(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 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, (high school) students, employees working at school and hospitals, and facility residents
- B. Regular preventive vaccination (BCG) — Infants younger than 6 months old
- C. Patient management
  - Notification — At the time of diagnosis, at the beginning/end of hospitalization
  - Registration — Tuberculosis registration cards, identification of the current situation of patients
  - Health guidance — Home-visit, public health education, etc.
  - Screening for proper disease management — Persons requiring follow-ups, patients who have suspended treatment, etc.
- D. Infection prevention
  - Work restriction, etc. — Restricting patients who may transmit diseases to others from working, recommendation/order for hospitalization
  - Sterilization, etc. — Sterilization of houses/buildings, sterilization and disposition of goods
  - On-site investigatio — Investigation of patients, etc.
- E. Medical care (public fund)
  - Hospitalization care — Medical care expenses for tuberculosis patients who have been given recommendation/order for hospitalization
  - Proper medical care — Medical fees for promoting proper medical care for tuberculosis

Detailed Data 1 Changes in Number of Newly Registered Tuberculosis Patients, Prevalence Rate, and the Number of Deaths

	Number of newly registered patients	Prevalence rate	Number of deaths	Rate of deaths
	(Person)	(To the population of 100,000)	(Person)	(To the population of 100,000)
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	2,162	1.7

Source: “Aggregate Result of the Annual Reports of Surveillance of Tuberculosis”, Health Service Bureau, MHLW
“Vital Statistics”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) 1. The figures for 1998 and later do not include those of atypical mycobacteria positive.
2. The number of deaths and the rate of deaths for 2011 are approximates.

Detailed Data 2 Tuberculosis Prevalence Rate by Prefecture (as of the end of 2011)

	Prefecture	Prevalence rate
5 prefectures with the lowest prevalence rate	Iwate	8.9
	Miyagi	9.8
	Nagano	10.1
	Gunma	11.2
	Yamagata	11.3
5 prefectures with the highest prevalence rate	Osaka	28.0
	Tokushima	23.6
	Wakayama	23.5
	Tokyo	22.9
	Gifu	21.0

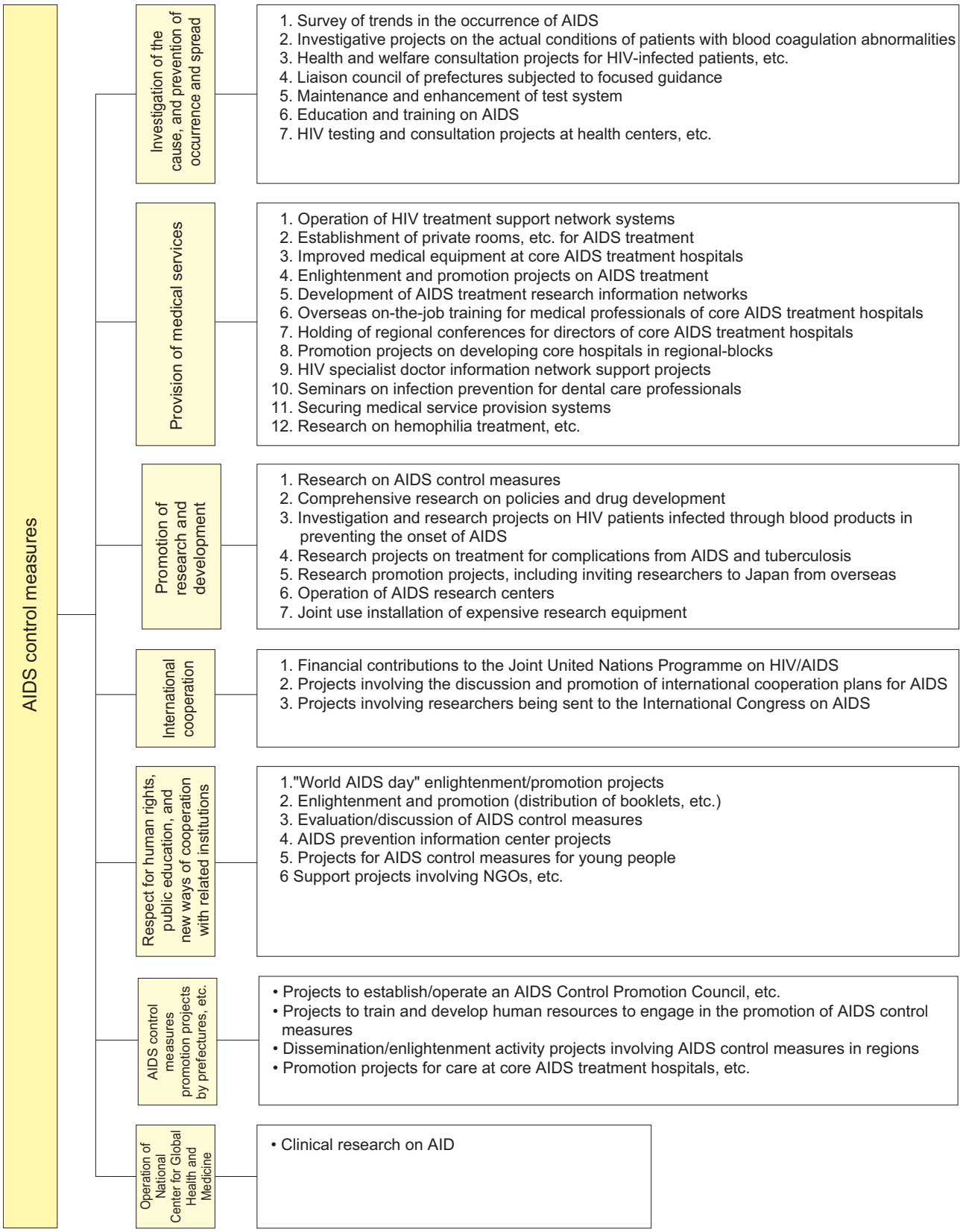
Detailed Data 3 International Comparison of Tuberculosis Prevalence Rate

Country	Prevalence rate	Year
U.S.A.	4.1	2010
Canada	4.7	2010
Sweden	6.8	2010
Australia	6.3	2010
Netherlands	7.3	2010
Germany	4.8	2010
Denmark	6.0	2010
Italy	4.9	2010
France	9.3	2010
U.K.	13.0	2010
Japan	17.7	2011

Source: Global Tuberculosis Control WHO Report 2011

AIDS Control Measures

Overview **Outline of AIDS Control Measures**



3 important areas on which measures should be focused

Dissemination, enlightenment, and education

<Measures mainly implemented by the government: general dissemination/enlightenment>
• Provision of basic information and correct knowledge on HIV/AIDS
• Development of and preparation of manuals on dissemination/enlightenment methods
<Measures mainly implemented by local governments: dissemination/enlightenment to vulnerable and at great risk populations>
• Measues for young people and homosexuals

Improvement of test/consultation system

<Measures mainly implemented by the government: provision of information on test/consultation>
• Establishment of HIV test promotion week (June 1 to 7 every year)
• Reformation of test/consultation information provision system
• Development of test methods, preparation of manuals on test/consultation methods
<Measures mainly implemented by local governments: improved/enhanced test/consultation system>
• Establishment of more accessible test system (night time on weekdays, holidays, quick test, etc.)

Reformation of medical care provision system (380 core hospitals)

<Measures mainly implemented by the government: development of new methods>
• Establishment of outpatient team medical care
• Discussion on hospital-clinic cooperation → creation of hospital-clinic cooperation model projects
<Measures mainly implemented by local governments: securing comprehensive treatment system within prefectures>
• Securing medical care system in prefectures, including establishment of core hospitals

New methods to support implementation of measures

○Enhanced cooperation with NGOs for implementing measures, including dissemination and enlightenment
○Promotion of comprehensive AIDS control measures through conducting regular conference among relevant ministries and agencies
○Focused support for prefectures, etc. with consideration given to policy evaluations
→ Focused cooperation with prefectures, etc. (17 local governments) with large number of infected persons/patients

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	Total	% of total
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	9,446	74.7
		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	735	5.8
		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	10,181	80.5
	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	1,124	8.9
		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	1,343	10.6
		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	2,467	19.5
	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	12,648	100
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	4,433	76.4
		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	290	5.0
		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	4,723	81.4
	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	731	12.6
		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	345	5.9
		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	1,076	18.6
	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	5,799	100

Source: “AIDS Surveillance Report 2010”, National AIDS Surveillance Committee, MHLW
(Note) The figures do not include the number of 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 2010, 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 that have died from AIDS (adults/children)
Sub-Sahara Africa	2010	22.90 million [21.60-24.10 million]	1.90 million [1.70-2.10 million]	5.0 [4.7-5.2]	1.20 million [1.10-1.40 million]
	2001	20.50 million [19.10-22.20 million]	2.20 million [2.10-2.40 million]	5.9 [5.6-6.4]	1.40 million [1.30-1.60 million]
Middle East, North Africa	2010	0.47 million [0.35-0.57 million]	59,000 [40,000-73,000]	0.2 [0.2-0.3]	35,000 [25,000-42,000]
	2001	0.32 million [0.19-0.45 million]	43,000 [31,000-57,000]	0.2 [0.1-0.3]	22,000 [9,700-38,000]
South Asia, Southeast Asia	2010	4.00 million [3.60-4.50 million]	0.27 million [0.23-0.34 million]	0.3 [0.3-0.3]	0.25 million [0.21-0.28 million]
	2001	3.80 million [3.40-4.20 million]	0.38 million [0.34-0.42 million]	0.3 [0.3-0.4]	0.23 million [0.20-0.28 million]
East Asia	2010	0.79 million [0.58-1.10 million]	88,000 [48,000-160,000]	0.1 [0.1-0.1]	56,000 [40,000-76,000]
	2001	0.38 million [0.28-0.53 million]	74,000 [54,000-100,000]	<0.1 [<0.1-0.1]	24,000 [16,000-45,000]
Oceania	2010	54,000 [48,000-62,000]	3,300 [2,400-4,200]	0.3 [0.2-0.3]	1,600 [1,200-2,000]
	2001	41,000 [34,000-50,000]	4,000 [3,300-4,600]	0.2 [0.2-0.3]	1,800 [1,300-2,900]
Latin America	2010	1.50 million [1.20-1.70 million]	0.10 million [73,000-140,000]	0.4 [0.3-0.5]	67,000 [45,000-92,000]
	2001	1.30 million [1.00-1.70 million]	99,000 [75,000-130,000]	0.4 [0.3-0.5]	83,000 [0.03-0.13 million]
Caribbean Coast	2010	0.20 million [0.17-0.22 million]	12,000 [9,400-17,000]	0.9 [0.8-1.0]	9,000 [6,900-12,000]
	2001	0.21 million [0.17-0.24 million]	19,000 [16,000-22,000]	1.0 [0.9-1.2]	18,000 [14,000-22,000]
Eastern Europe, Central Asia	2010	1.50 million [1.30-1.70 million]	0.16 million [0.11-0.20 million]	0.9 [0.8-1.1]	0.09 million [74,000-110,000]
	2001	0.41 million [0.34-0.49 million]	0.21 million [0.17-0.24 million]	0.3 [0.2-0.3]	7,800 [6,000-11,000]
Western Europe, Central Europe	2010	0.84 million [0.77-0.93 million]	0.03 million [22,000-39,000]	0.2 [0.2-0.2]	9,900 [8,900-11,000]
	2001	0.63 million [0.58-0.69 million]	0.03 million [26,000-34,000]	0.2 [0.2-0.2]	0.01 million [9,500-11,000]
North America	2010	1.30 million [1.00-1.90 million]	58,000 [24,000-130,000]	0.6 [0.5-0.9]	0.02 million [16,000-27,000]
	2001	0.98 million [0.78-1.20 million]	49,000 [34,000-70,000]	0.5 [0.4-0.7]	19,000 [15,000-24,000]
Total	2010	34.00 million [31.60-35.20 million]	2.70 million [2.40-2.90 million]	0.8 [0.8-0.8]	1.80 million [1.60-1.90 million]
	2001	28.60 million [26.70-30.90 million]	3.10 million [3.00-3.30 million]	0.8 [0.7-0.8]	1.90 million [1.70-2.20 million]

*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 REPORT ON THE GLOBAL AIDS EPIDEMIC 2011

Pandemic Influenza Preparedness

Overview Pandemic Influenza Preparedness

Pandemic Influenza

Pandemic Influenza refers to an influenza virus that has never caused human epidemics but has mutated into a form where humans can infect other humans. Differing to the seasonal influenza type that repeatedly causes epidemics every year, Pandemic Influenza virus, which most of the population have no immunity against, can allow humans to efficiently infect other humans and thus possible worldwide pandemics. In recent years a highly pathogenic avian influenza (H5N1) that can be transmitted from birds to humans has sporadically emerged, mainly in Asia, the Middle East, and Africa. If the virus mutates into a form spreading among humans, it could have a serious impact on people's lives and health, and thus people's daily lives and the national economy. The government is therefore taking the following measures.

(Assumptions made in the government action plans)

Number of patients consulting medical institutions	2,500,000 patients at maximum
Number of patients hospitalized	530,000-2,000,000 patients
Number of fatalities	170,000-640,000 deaths

Major events

Dec. 2005	Formulation of the "Action Plan of Measures against Pandemic Influenza" (Liaison Conference of the Relevant Ministries and Agencies on Avian Influenza, etc.)
May 2008	Revision of the infectious Diseases Act and the Quarantine Act (legislative development of assuming pandemic influenza to be the new category of infectious diseases as "a new or reemerging influenza strain, or a designated infectious disease", measures such as enforcement of hospitalization, and measures to prevent the virus from entering the country such as restricting activities. In addition, the H5N1-type influenza that birds can infect humans is categorized as the infectious disease category 2 "avian influenza (H5N1)" in the infectious Disease Control Law.)
Feb. 2009	Major revision of the "Action Plan for Pandemic Influenza Preparedness" (Liaison Conference of the Relevant Ministries and Agencies on Pandemic and Avian Influenza) in response to revision of the Infectious Diseases Control Law
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 Infectious Diseases Control Law as of March 31, and measures were switched to those for seasonal influenza
July 2011	Revision of the Preventive Vaccinations Law (providing new temporary vaccinations framework on the assumption of Pandemic influenza that had the same level of high infectivity as the influenza A(H1N1)pdm09 but is not highly pathogenic)
Sep. 2011	Revision of the "Action Plan for Pandemic Infectious Preparedness" (Ministerial Meeting on Countermeasures against Pandemic Influenza) with consideration also given to the experience gained from measures used against the influenza A(H1N1)pdm09, etc.
Apr. 2012	Approval of the "Act on Special Measures for Pandemic Influenza, etc. Preparedness and Response" (legislative development of measures, etc. to be taken specially at the emergence of pandemic influenza, etc.)

Major budgetary projects

Development of systems, including novel influenza medical institutions, etc.	Preparation of necessary beds capacity and medical resources/devices, etc. at medical institutions for hospitalizing pandemic influenza patients in each prefectures
Public communications of preparedness against pandemic influenza	Public communications for individuals, ordinary households, and issuance of mail magazines for directly providing information from the government to medical sites
Stockpile of anti-influenza virus drugs	Stockpiling for a total use of approximately 60 million people between the government and prefectures by FY2012
Manufacture/stockpile of pre-pandemic vaccines	Stockpiling for approximately 20 million people by FY2011, and an additional 10 million people using the FY2011 supplementary budget
Development of a system for manufacturing pandemic vaccines	Development of a system for manufacturing vaccines using cell culture technique in thereby enabling the manufacture of the volume required for all the people in approximately six months

Organ Transplantation and Hematopoietic Stem Cell Transplantation

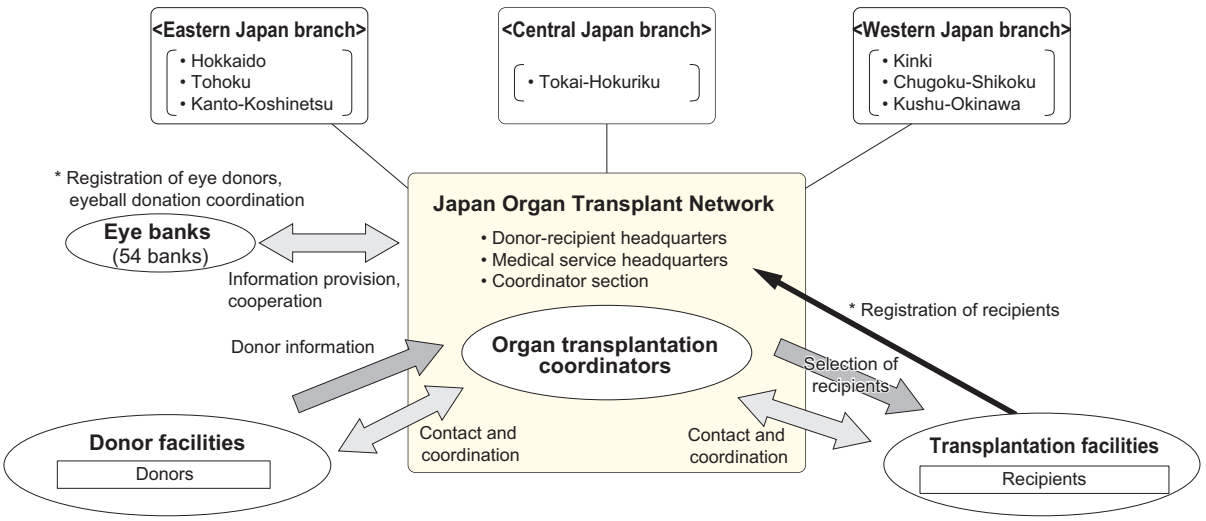
Overview　Organ Transplantation System

[Organ Transplantation System]

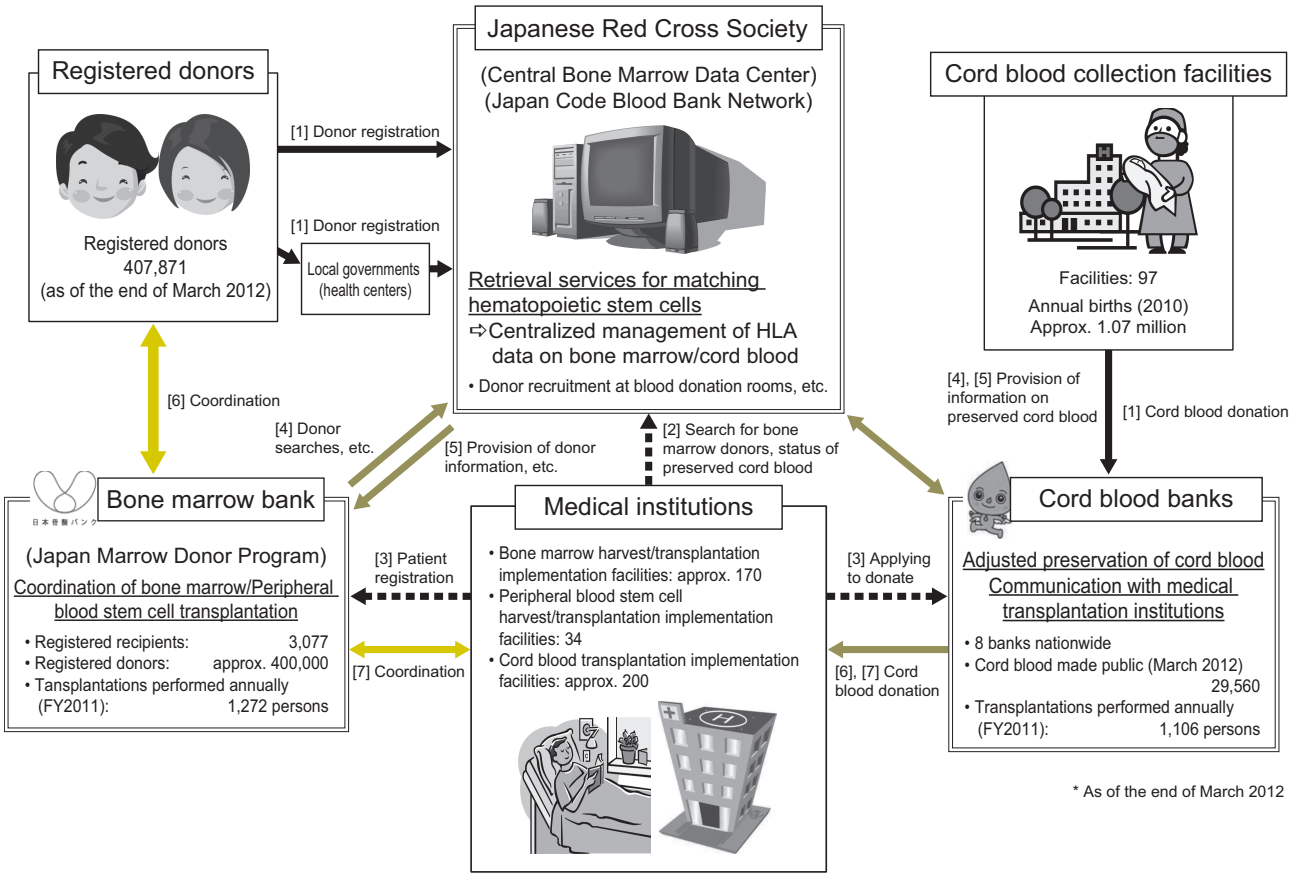
The traditional kidney transplantation system was reviewed and a new centralized nationwide kidney transplantation network established in FY1995. Enforcement of the “Act on Organ Transplantation” in October 1997 enabled multiple organ transplantations and the pertinent network.

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, etc.), mediation work, including enlightenment and promotion activities, is being carried out by eye banks at 54 locations nationwide.

Diagram of Organ Transplantation Network System



Hematopoietic Stem Cell Transplantation System



Detailed Data 1 Accumulated Number of Organ Transplantations

	Number of donors		Number of transplantations performed		Patients on waiting lists
		Under brain death		Under brain death	
Heart	126	126	126	126	207
Lung	109	109	134	134	181
Liver	137	137	145	145	404
Kidney	1,348	159	2,488	313	12,542
Pancreas	125	123	125	123	201
Small intestine	12	12	12	12	3
Eyeball (cornea)	14,006	66	22,659	127	2,365

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, 2012. The number of patients on waiting lists is as of March 31, 2012.

2. There have been 169 cases of brain death tests conducted nationwide under the Act on Organ Transplantation since the enforcement of the law until March 31, 2012. In the eighth case, 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 donors of pancreases and kidneys, the number of transplantations performed, and the number of patients on waiting lists include cases of simultaneous pancreas and kidney transplantations.

4. The number of donors of hearts and lungs, the number of transplantations performed, and the number of patients on waiting lists include cases of simultaneous heart and lung transplantations.

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

	Donors		Number of transplantations		
	Number of registered bone marrow donors	Number of cord blood made public	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	–	114
FY 2000	135,873	4,343	716	–	169
FY 2001	152,339	8,384	749	–	220
FY 2002	168,413	13,431	739	–	297
FY 2003	186,153	18,424	737	–	702
FY 2004	204,710	21,335	851	–	678
FY 2005	242,858	24,309	908	–	658
FY 2006	276,847	26,816	963	–	754
FY 2007	306,397	29,197	1,027	–	778
FY 2008	335,052	31,149	1,118	–	875
FY 2009	357,378	32,793	1,232	–	907
FY 2010	380,457	32,994	1,191	1	1,074
FY 2011	407,871	29,560	1,269	3	1,106
FY2012	412,908	28,887	320	3	313
Total	–	–	14,367	7	8,742

* The figures for cord blood stem from FY 1996 to FY 1998 indicate the number of transplantations coordinated by cord blood banks before the establishment of the Japanese Cord Blood Bank Network.
* The figures for FY 2012 indicate the numbers as of the end of June.
* The Miyagi Cord Blood Bank transferred its business to the Hokkaido Cord Blood Bank and the Kanto-Koshinetsu Cord Blood Bank of Japanese Red Cross Society, and the Chugoku-Shikoku Cord Blood Bank to the Kyushu Cord Blood Bank of the Japanese Red Cross Society in FY2012.
* Cord blood information formerly possessed by the Miyagi Cord Blood Bank and the Chugoku-Shikoku Cord Blood Bank is temporarily unavailable to the public due to the procedures of the transferred to institutions.
* Relaxation of the requirements for donor registrations:
  From Mar. 1, 2005: The minimum age for registration was lowered from 20 to 18 (minimum age for organ donations of 20), the condition of “family approval” in the registration deleted, and applicants are allowed to skip the video viewing when registering if they have read the booklet “Chance” and understood the details of bone marrow donations
  From Sep. 1, 2005: The maximum age for registration was raised from 50 to 54 (maximum age for organ donation of 55)

Drugs, etc.

Overview

Classification of Examinations for the Approval of Drugs, etc.

Drugs

- **Prescription drugs** (Used under doctors' prescription)
  - **New drugs** — Approved by MHLW based on reliability evaluation and examination for approval conducted by the Pharmaceuticals and Medical Devices Agency (Drugs for hypertension, antibiotics, antiulcer drugs, antineoplastic drugs, etc.)
  - **Generic drugs** — Approved by MHLW based on equivalency evaluation and examination for approval conducted by the Pharmaceuticals and Medical Devices Agency (Drugs equivalent to new drugs)
- **Over-the-counter drugs** (Available at pharmacies, etc. without prescription)
  - **Items meeting approved standards** — Approved by prefectural governors (14 items including cold medicine, antipyretic analgesics, etc. and those dispensed at pharmacies)
  - **Others** — Approved by MHLW based on equivalency evaluation and examination for approval conducted by the Pharmaceuticals and Medical Devices Agency

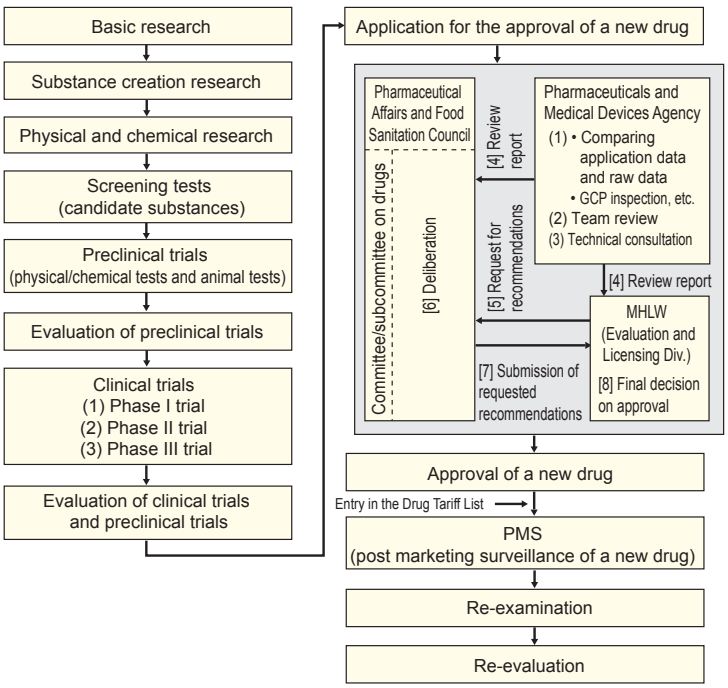
Quasi-drugs (Medicated toothpastes, hair dyes, bath products, mouth washes, etc.)

New quasi-drugs: Approved by MHLW based on equivalency evaluation and examination for approval conducted by the Pharmaceuticals and Medical Devices Agency
Items meeting approval standards: Approved by prefectural governors
Other items: Approved by MHLW based on equivalency evaluation and examination for approval conducted by the Pharmaceuticals and Medical Devices Agency

Cosmetics (Perfumes, lipsticks, shampoos, conditioners, etc.)

Items labeling all ingredients: Application for approval exempted, notification to prefectural governors required on individual items after acquiring manufacturing/marketing approval
Items containing ingredients not required for labeling: Approved by MHLW based on equivalency evaluation and examination for approval conducted by the Pharmaceuticals and Medical Devices Agency

Flow of Examination for the Approval of a New Drug



(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 anew 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 drugs, etc.]

The approval and licensing system for drugs, 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 compiles 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 drugs that require sophisticated manufacturing technology.

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

(As of the end of 2011)

Category	Drugs			Quasi-drugs	Cosmetics	Total
		Class 1 drugs	Class 2 drugs			
Marketing	1,212	253	959	1,331	3,404	5,947

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

Detailed Data 2 Number of Approvals for Manufacturing/Import/Marketing Drugs, etc. (2011)

		Prescription drugs	Over-the-counter drugs	Quasi-drugs	Cosmetics
Manufacturing	Approval	0	5	0	0
	Approval with partial revision	65	3	0	0
	Total	65	8	0	0
Import	Approval	0	2	0	0
	Approval with partial revision	8	0	0	0
	Total	8	2	0	0
Marketing	Approval	1,173	744	1,643	0
	Approval with partial revision	2,107	281	291	0
	Total	3,280	1,025	1,934	0

Source: Pharmaceutical and Food Safety Bureau, MHLW
(Note) Excluding in vitro diagnostics.

Detailed Data 3 Number of Approvals for Manufacturing Drugs, etc.

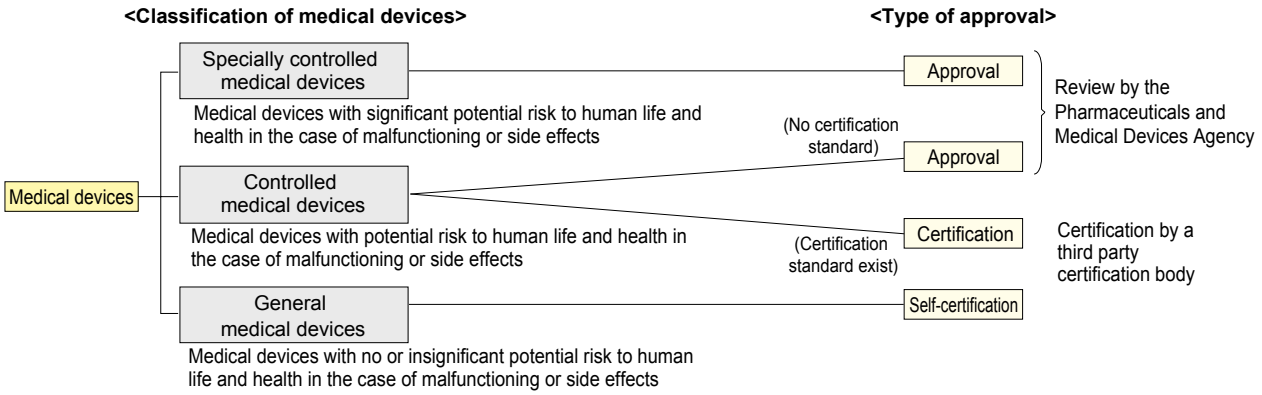
(As of the end of 2011)

Category	Drugs	Quasi-drugs	Cosmetics	Total
Manufacturing	2,414	1,641	3,374	7,429

Source: Pharmaceutical and Food Safety Bureau, MHLW
(Note) Licenses are granted by prefecturel governors from April 1, 1995 (excluding some drugs)

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 2011)

Category	Class 1 medical devices	Class 2 medical devices	Class 3 medical devices	Total
Marketing	616	925	927	2,468

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

Detailed Data 2 Number of Approvals for Manufacturing, Import, and Marketing Medical Devices (2011)

		Medical devices
Manufacturing	Approval	0
	Approval with partial change	10
	Total	10
Import	Approval	73
	Approval with partial change	21
	Total	94
Marketing	Approval	632
	Approval with partial change	536
	Total	1,168

Source: Pharmaceutical and Food Safety Bureau, MHLW

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

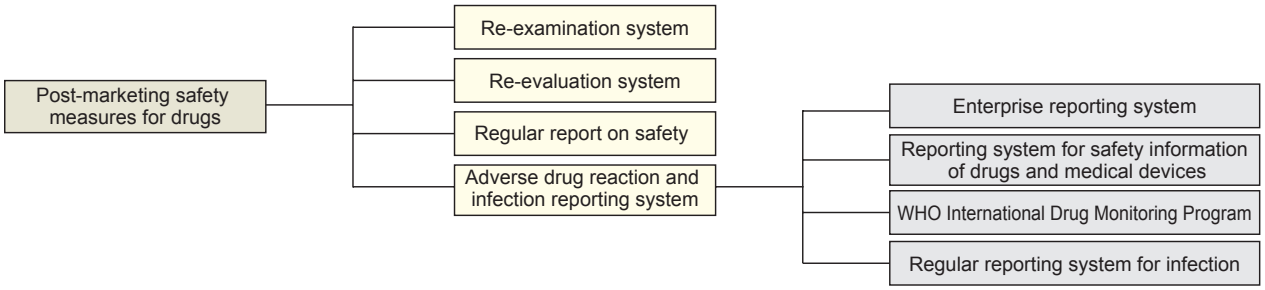
	Medical devices
Manufacturing	3,571
Repairs	6,268

Source: Pharmaceutical and Food Safety Bureau, MHLW (as of the end of 2011)
(Note) Licenses are granted by prefecturel governors from April 1997 (excluding some medical devices).

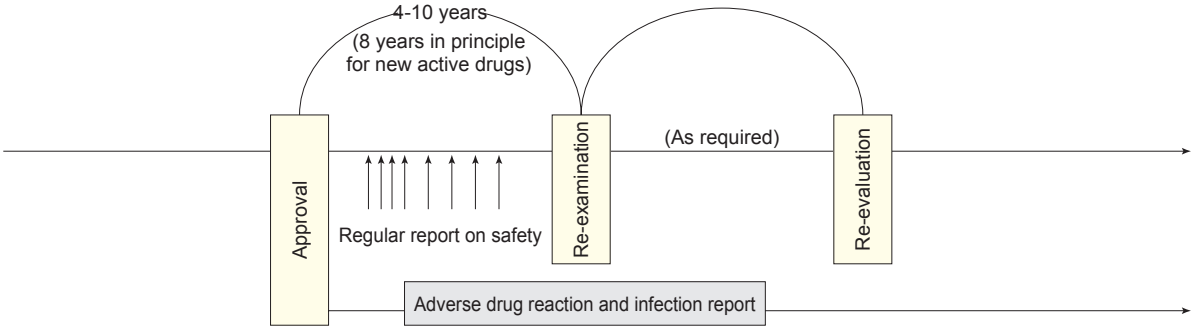
Post-Marketing Measures for Drugs/Medical Devices

Overview

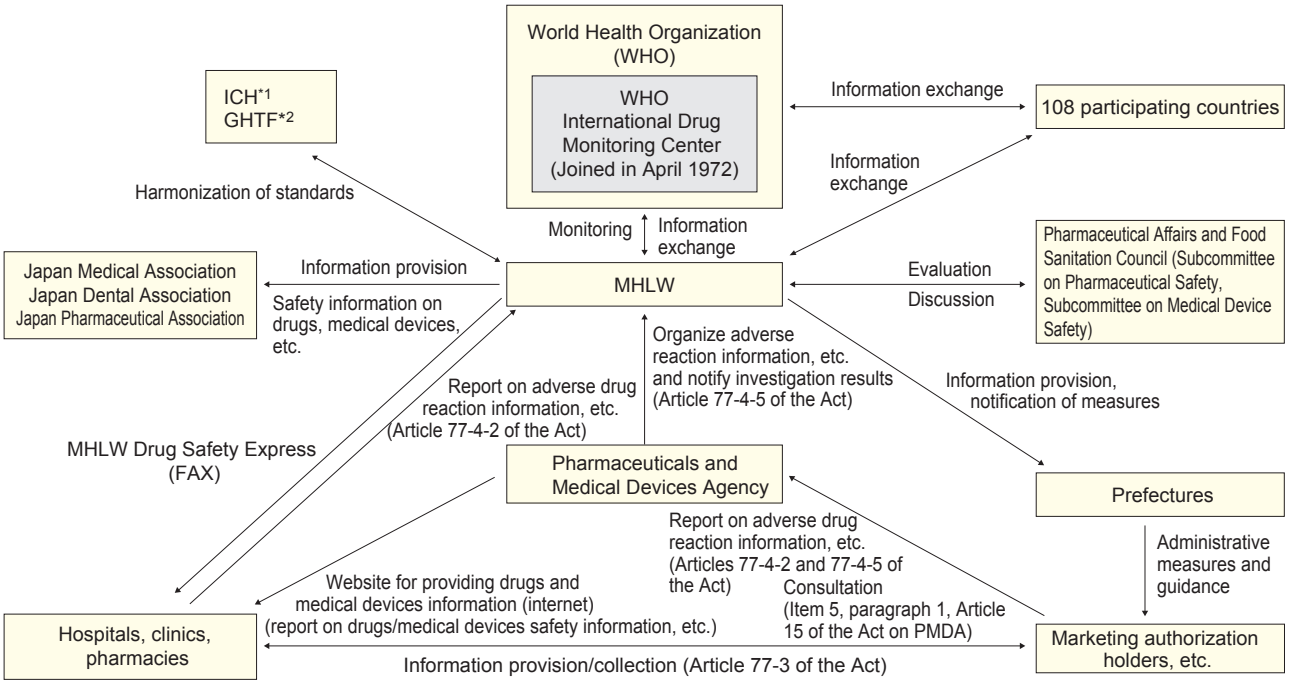
Post-Marketing Safety Measures for Drugs



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 forRegistration of Pharmaceuticals for Human Use
*2: Global Harmonization Task Force (transfer to IMDRF (International Medical Device Regulators Forum) planned for 2013)

Detailed Data 1 Results of Prescription Drug Re-examination

(As of the end of FY2011)

Drugs that are approved for effectiveness		Drugs that can be approved for effectiveness with partial revision of matters to be approved		Drugs that are not approved for effectiveness	
Number of ingredients	Number of items	Number of ingredients	Number of items	Number of ingredients	Number of items
1,107	3,058	50	142	0	0

Source: Pharmaceutical and Food Safety Bureau, MHLW

Detailed Data 2 Results of Prescription Drug Re-evaluation

(As of the end of FY2011)

	Comprehensive evaluation (number of items)				
	Drugs that are approved for effectiveness	Drugs that can be approved for effectiveness with partial revision of matters to be approved	Drugs that are not approved for effectiveness	Drugs that the applicants made adjustments on matters to be approved after filing re-evaluation application	Total
Phase 1 re-evaluation	11,098	7,330	1,116	305	19,849 (19,612)
Phase 2 re-evaluation	105	1,579	42	134	1,860
New re-evaluation	4,608	3,315	66	864	8,853

Source: Pharmaceutical and Food Safety Bureau, MHLW

(Note) 1. The figures in parentheses indicate those adjusted for cases where the same item was officially announced more than once.
2. Phase 1 re-evaluation: covers ingredients approved on or prior to September 30, 1967
3. Phase 2 re-evaluation: covers ingredients approved between October 1, 1967 and March 31, 1980
4. New re-evaluation: covers all ingredient

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				Reports on adverse drug reactions from medical professionals	
	Reports on adverse drug reactions	Reports on research results	Reports on overseas measures	Regular reports on infectious diseases		4 vaccines*
2007	28,231	858	695	1,092	3,891	
2008	31,455	855	869	1,074	3,839	
2009	30,814	933	930	1,108	3,721	2,460
2010	34,578	940	1,033	1,101	3,656	1,153
2011	36,641	841	1,347	1,089	3,388	1,843

*4 vaccines: Reports consolidated by MHLW on adverse reactions arising from voluntary inoculation of influenza vaccines (including novel type) or its inoculation with vaccination promotion project under the Preventive Vaccinations Act and those arising from emergency vaccination promotion projects involving cervical cancer prevention vaccines, Hib vaccines, pneumococcus vaccines for children.

Source: Pharmaceutical and Food Safety Bureau, MHLW

Detailed Data 4 Changes in Number of Reports on Adverse Event Related to Medical Devices, etc. in the Past 5 Years

(Unit: case)

FY	Reports from marketing authorization holders				Reports on adverse event from medical professionals
	Reports on adverse event	Reports on research results	Reports on overseas measures	Regular reports on infectious diseases	
2007	16,550	15	525	52	434
2008	6,351	10	748	64	410
2009	6,446	6	831	59	363
2010	14,811	27	978	58	374
2011	16,068	2	1,060	62	385

Source: Pharmaceutical and Food Safety 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.

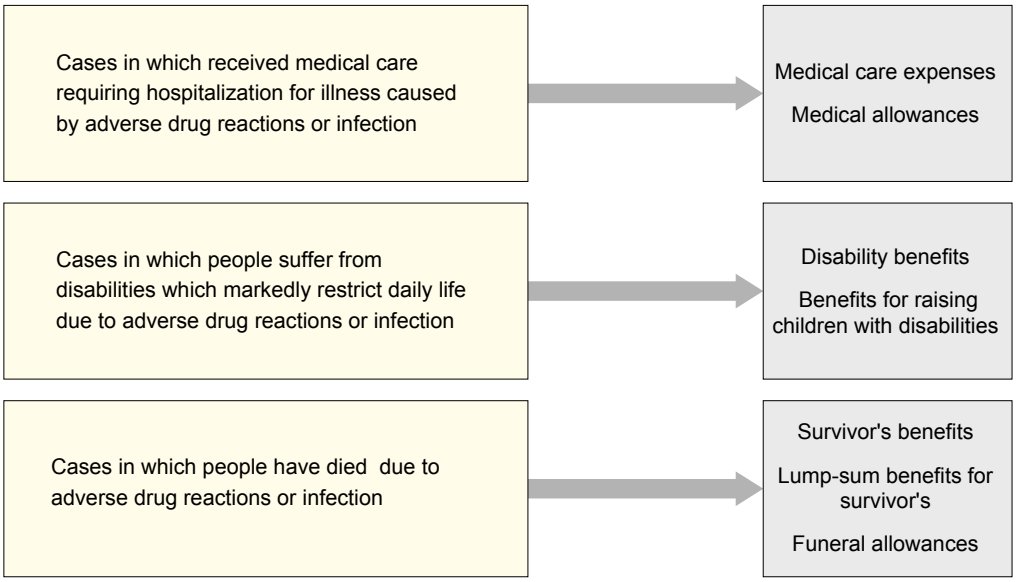
[Relief System for Infections Acquired through Biological Products]

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]

The Agency has been commissioned by pharmaceutical enterprises and the government to pay health management allowances, etc. to SMON (subacute myelo-optico-neuropathy) patients who have settled 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)

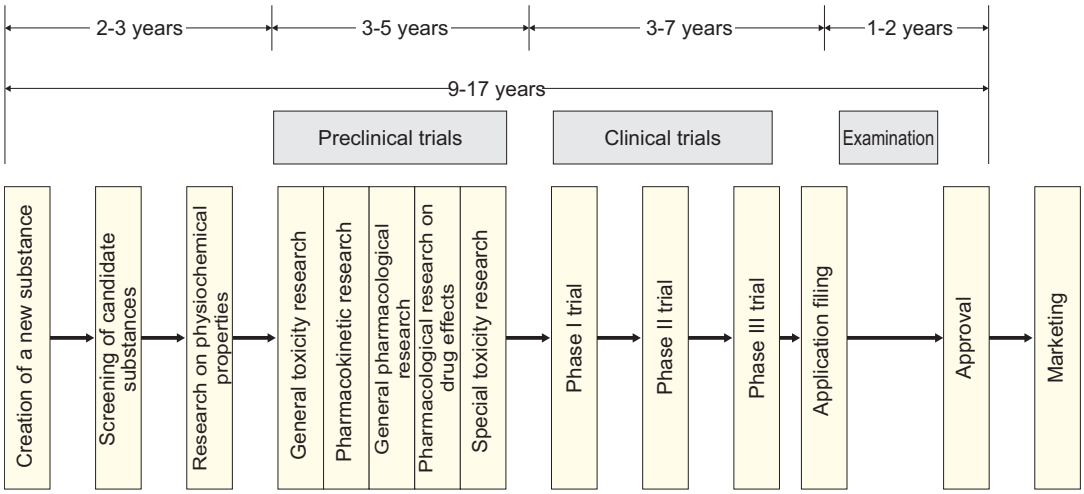
	FY1980 -1996	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Amount (¥1,000)	6,058,217	797,557	928,986	920,419	935,148	1,022,185	1,055,985	1,204,243	1,262,647	1,587,567	1,582,956	1,696,525	1,798,706	1,783,783	1,867,190	2,058,389
Number of claims (case)	2,665	399	361	389	480	483	629	793	769	760	788	908	926	1,052	1,018	1,075
Number of payments (case)	2,076	294	306	289	343	352	352	465	513	836	676	718	782	861	897	959

Source: Pharmaceutical and Medical Devices Agency

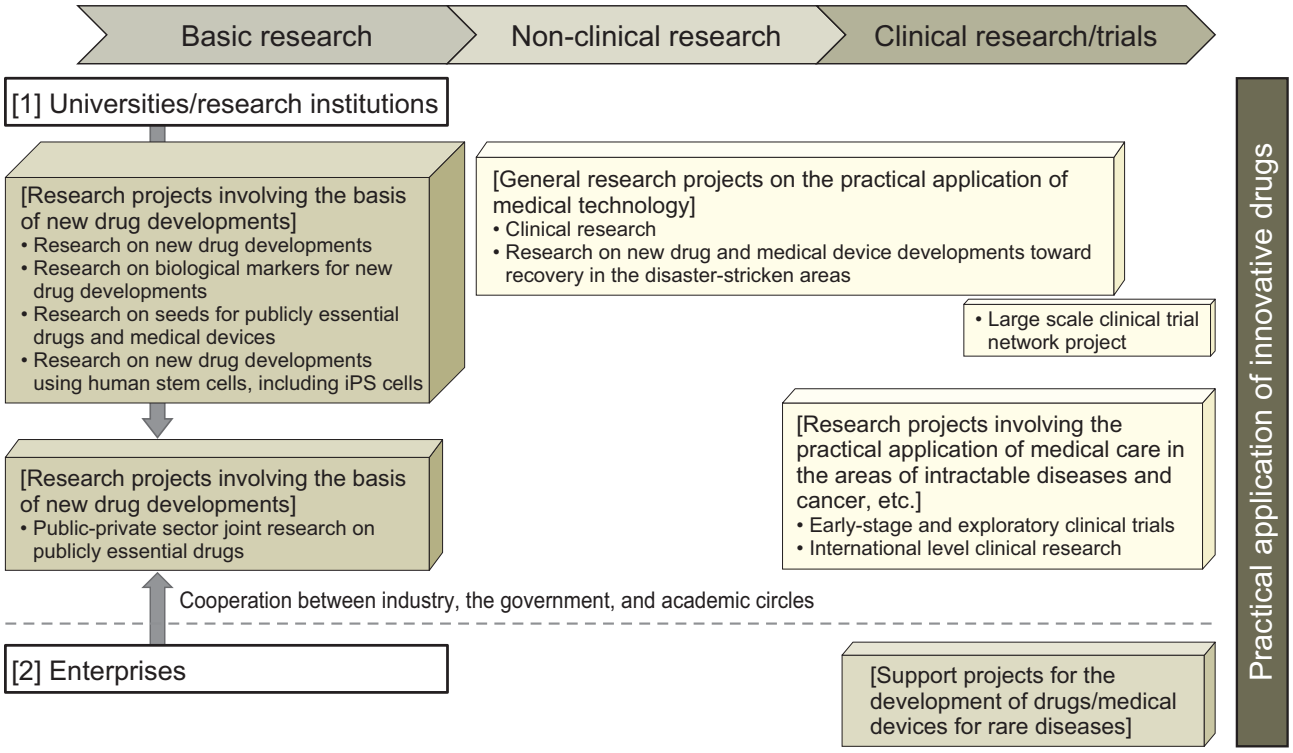
Research/Development of Drugs and Pharmaceutical Industry

Overview **Process and Period of New Drug Development**

Developing a new drug is considered to take 9-17 years and require ¥50 billion per product.



Support for research in the area of pharmaceuticals



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	188	50.0%	3,377	2.9%	1,839	2.0%
¥100 million - 5 billion	128	34.0%	30,382	25.8%	23,840	26.3%
¥5 billion or more	60	16.0%	83,934	71.3%	65,028	71.7%
Total	376	100.0%	117,693	100.0%	90,707	100.0%

Source: "Survey of the Prescription Pharmaceuticals Industry of Japan (FY2010)", Health Policy Bureau, MHLW
(Note) Survey targets were enterprises marketing drugs with approval of marketing authorization under the Pharmaceutical Affairs Act as of March 31, 2011 that were members of categorized organizations (14 organizations) of the Federation of harmaceutical Manufacturers' Association of Japan.

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
2002	15,035	-0.9	3,769	8,400	19,755
2003	14,989	-0.3	4,203	8,836	19,407
2004	15,344	2.4	4,301	9,553	21,102
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

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	Typical example
1. Devices for surgical procedures	4,277	25.0	Sterile tubes and catheters for vascular procedures, sterile blood transfusion sets
2. Diagnostic imaging system	2,743	16.0	Whole body X-ray CT units, general-purpose ultrasonic diagnostic imaging devices
3. Biological function assisting devices/substitutes	2,288	13.4	Stents, hip replacements
4. Bio-phenomena monitoring measuring/monitoring devices	2,091	12.2	Electronic endoscopes, sphygmomanometers
5. Dental materials	1,121	6.5	Gold silver palladium alloy for dental casting, dental ceramics
6. Medical specimen testers	1,035	6.0	Discrete automatic clinical chemical analyzers, luminescence immune measurement devices
7. Medical devices for home use	947	5.5	Electronic massaging devices for home use, in-ear hearing aids
8. Diagnostic imaging X-ray related units/instruments	786	4.6	Films for image recording and direct photography
9. Ophthalmologic devices and related products	588	3.4	Eyeglasses for sight correction, contact lenses
10. Others	1,258	7.3	
Total	17,134	100.0	

Source: “Annual Report on the Survey of Pharmaceutical Industry Productions 2010”, Health Policy Bureau, MHLW

Separation of Dispensing and Prescribing Functions

Overview — Separation of Dispensing and Prescribing Functions

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) Doctors and dentists can freely prescribe drugs necessary for patients even when the particular drugs are not stocked in their own hospitals or clinics.
2) Issuing prescriptions to patients allows them to know which drugs they are taking.
3) "Family pharmacies" can check for duplicate prescriptions, drugs interactions, etc. offered by multiple facilities through drug history management and thus improve efficacy and safety of drug therapies.
4) Reduced outpatient dispensing work of hospital pharmacists allows them to engage in hospital activities for inpatients which they should essentially perform.
5) 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.

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 of the rate of separation of dispensing and prescribing functions (%)
1989	36,670	13,542	95.2	11.3
1990	36,981	14,573	105.4	12.0
1991	36,979	15,957	111.7	12.8
1992	37,532	17,897	125.8	14.1
1993	38,077	20,149	140.6	15.8
1994	38,773	23,501	161.0	18.1
1995	39,433	26,508	182.5	20.3
1996	40,310	29,643	210.0	22.5
1997	42,412	33,782	238.1	26.0
1998	44,085	40,006	278.8	30.5
1999	45,171	45,537	307.3	34.8
2000	46,763	50,620	348.6	39.5
2001	48,252	55,960	393.7	44.5
2002	49,332	58,462	393.0	48.8
2003	49,956	59,812	418.8	51.6
2004	50,600	61,889	368.7	53.8
2005	51,233	64,508	425.2	54.1
2006	51,952	66,083	442.5	55.8
2007	52,539	68,375	481.0	57.2
2008	53,304	69,436	483.0	59.1
2009	53,642	70,222	494.1	60.7
2010	53,067*	72,939	486.6	63.1

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 Pharmaceutical and Food Safety Bureau, MHLW and number of prescriptions
The number of prescriptions and nationwide average rate of separation by Japan Pharmaceutical Association

(Note) The rate of separation of dispensing and prescribing functions is calculated as follows:

$$\text{Rate of separation of dispensing and prescribing functions (\%)} = \frac{\text{Number of prescriptions to pharmacies}}{\text{Number of prescriptions issued to outpatients (total)}} \times 100$$

* Miyagi Prefecture is not included due to the impact 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.

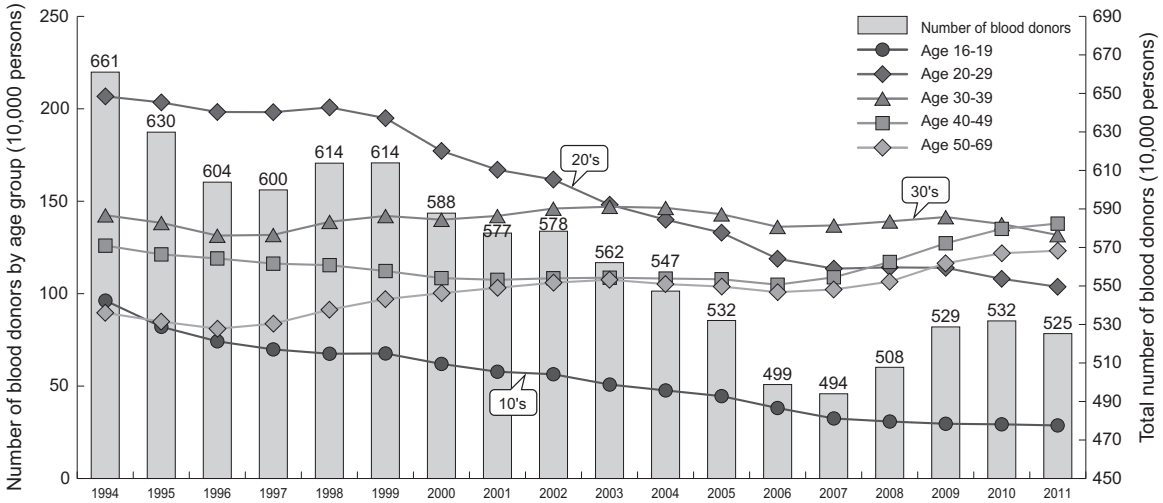
Of plasma derivatives, in contrast, while blood coagulation factor products are supplied domestically except for a few special products, a large part of other plasma derivatives, namely albumin preparations and hepatitis B immunoglobulin products, are still imported from overseas. This has been viewed as a problem, however, from the viewpoint of ethics and supply stability. Therefore efforts are being made in establishing a system for securing the domestic supply of all types of blood products including plasma derivatives.

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 diseases, etc.
Plasma derivatives	Albumin products	Hemorrhagic shock, nephrotic syndrome, hepatic cirrhosis accompanying intractable ascites, etc.
	Immunoglobulin products	Aglobulinemia or hypoglobulinemia, etc.
	Blood coagulation factor products	Supplementing blood coagulation factor to patients with blood coagulation factor deficiency

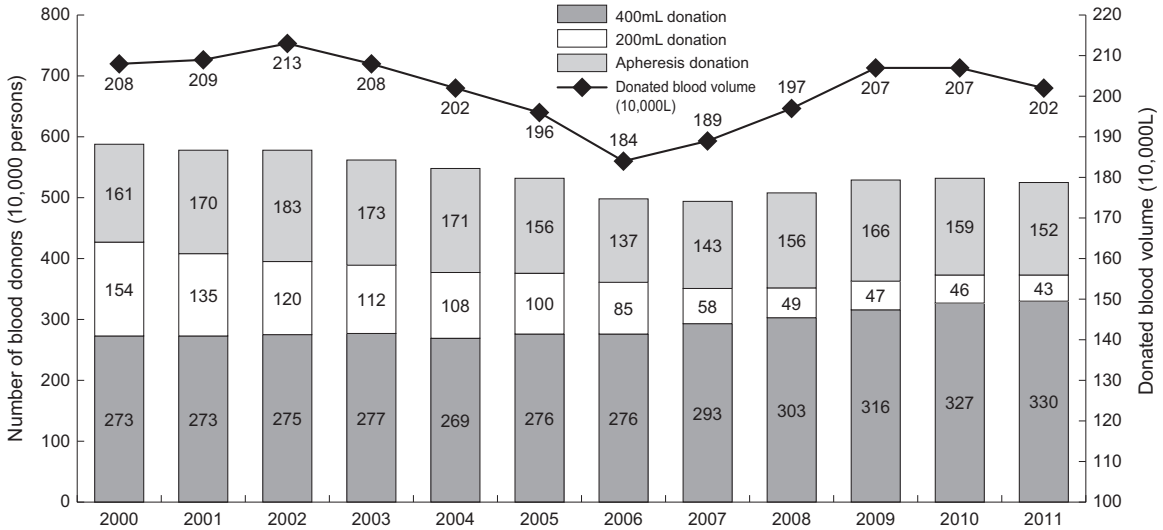
[Status of Blood Donation]

The number of blood donors increased in 2008, but the number of blood donors of younger populations aged 16-29 continues to remain on a decreasing trend. 400mL and apheresis donations have been introduced for some time in addition to the conventional 200mL donation. In recent years, 400mL and apheresis donations are becoming more popular.

Detailed Data 1 Change in Number of Blood Donors



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



(5) Health Risk Management System

Health Risk Management System

Overview

HMLW Health Risk Management System Diagram