[2] Health and Medical Services

(1) Health Care Insurance

Health Care Insurance System

Overview

Outline of Health Care Insurance System

(As of May 2014)

System		Insurer (as of the end of March 2013)	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	35,103 [19,871 / 15,232]	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) (*) 20% for those turning 70 years old in April 2014 and later, and 10% for those already turned 70 years old by the end of March 2014	(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 aged 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 (*)) ¥44,400, outpatient (per person) ¥12,000 (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 • 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) (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 (every year from August to July of the next year) is extremely high. Maximum co-payment is determined carefully according to their income and age.	(Co-payment for meal expenses) • General Per meal ¥260 • Low income Per meal first 90 days ¥210 Per meal after 90 days ¥160 • Expremely low income Per meal ¥100	(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, etc.
	Society-managed Health Insurance	Health Insurance Societies 1,431	29,353 [15,537 / 13,816]					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	19 [58 / 71]					• Sickness and injury allowance • Lump-sum birth allowance, etc.	Per day Class 1: ¥390 Class 11: ¥3,230	16.4% of benefit expenses, etc.
Seamen's Insurance		Japan Health Insurance Association	129 [58 / 71]					Same as above	9.60% (sickness insurance premium rate)	Fixed amount
Mutual aid associations	National public employees	20 mutual aid associations	9,000 [4,501 / 4,499]					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 1,717 NHI associations 164	37,678 Municipalities 34,658 NHI associations 3,020					• 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. 47% of benefit expenses, etc.
	Retired persons under Employees' Health Insurance	Municipalities 1,717								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	15,168	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	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 sums in the breakdown may not equal the total due to rounding.

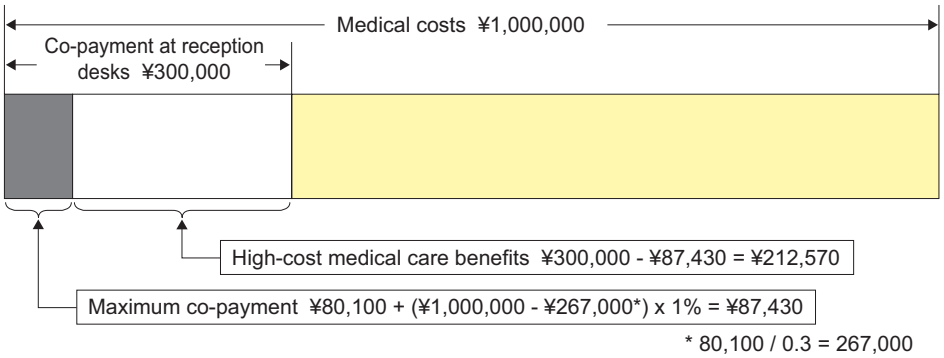
5. National subsidy rate for the Japan Health Insurance Association (general insured persons and insured persons under item 2, Article 3 of the National Health Insurance Act) is 16.4% for the period between July 2010 and FY2014.

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 (0.50%).

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

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

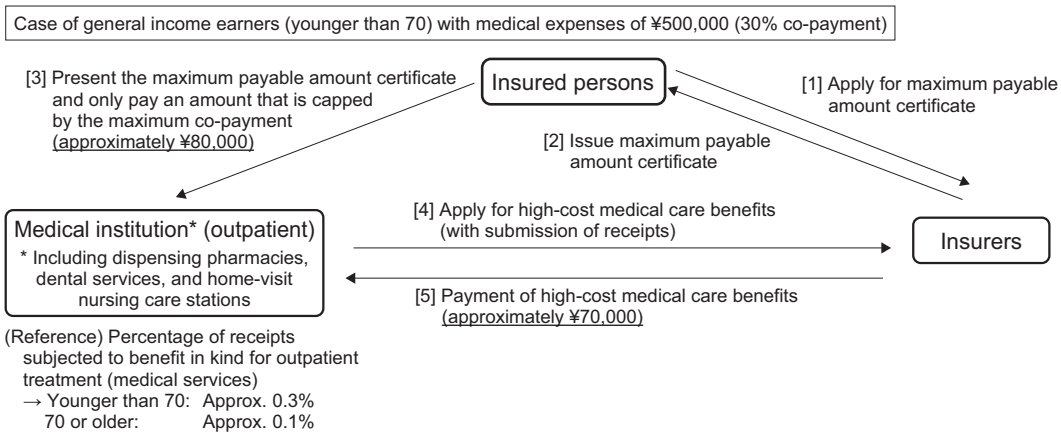
<General case (co-payment of 30%)>



(Note) Per-household addition system
For cases where co-payments are paid multiple times in the same month by the same household (for example, a insured person receives medical treatment at medical institutions A and B and one of their dependents at medical institution C), co-payments are added for the individual household (for those younger than 70, co-payments paid at medical institutions A, B, and C must respectively be ¥21,000 or more: per-household standard amount) and if the amount exceeds the maximum co-payment, it will be the subject of high-cost medical care benefits.

Detailed Information 2 Response to Benefit in Kind for Outpatient Treatment

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



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

Basic mechanism of benefit in kind

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

Detailed Information 3

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>

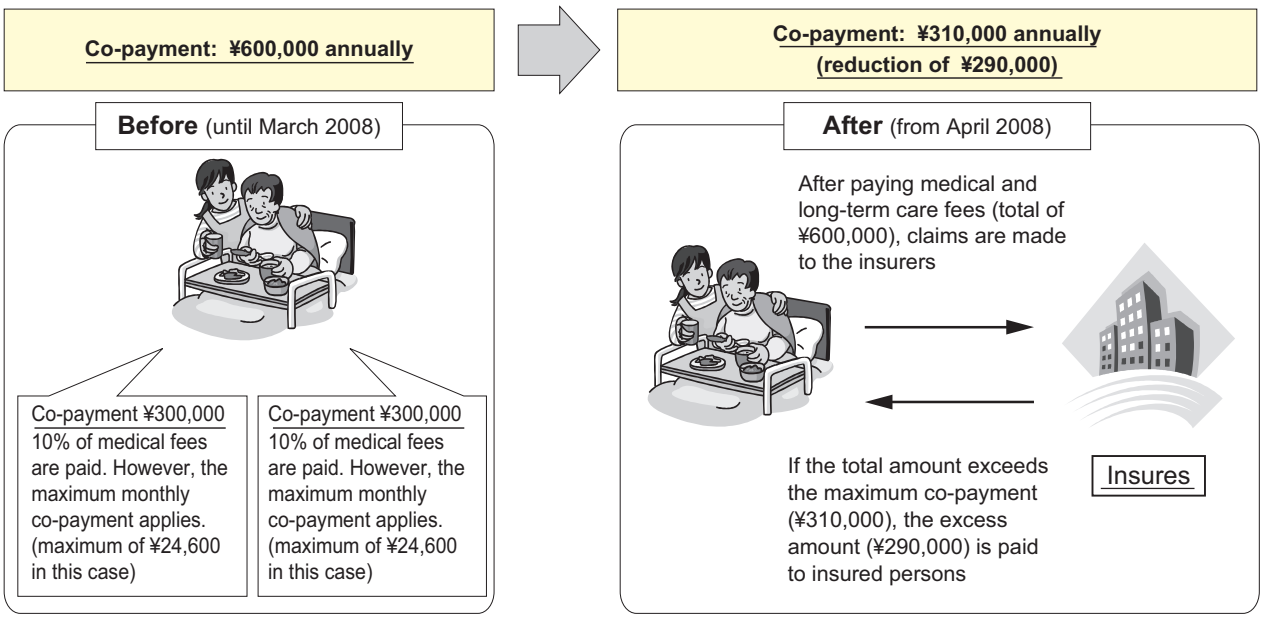
- Conventional maximum monthly co-payment is individually set for health care insurance and long-term care insurance systems
- In addition to these limits, new maximum co-payment is also set for the total annual co-payments for both systems

* 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) Care level 4 and using multifunctional long-term care in a small group home
(Pension income) ¥2.11 million or less for a couple

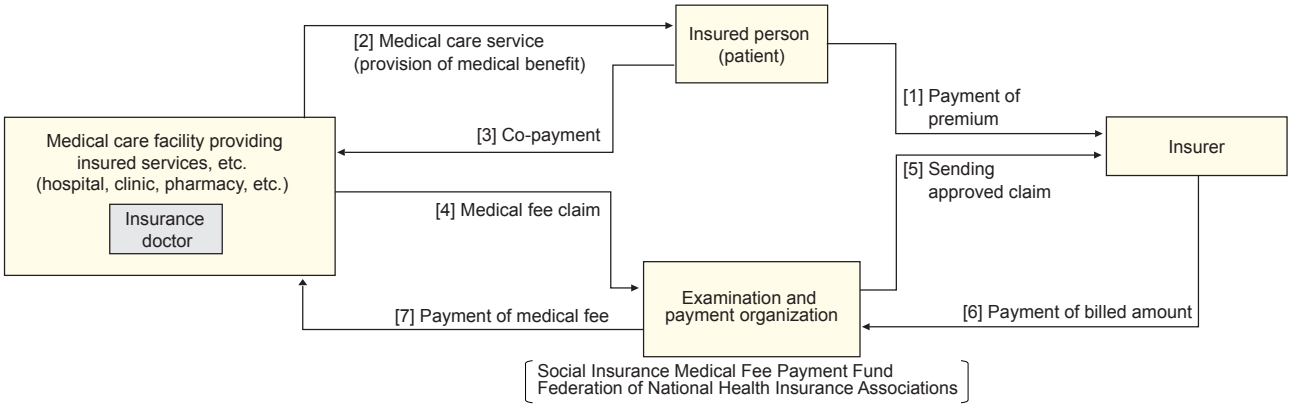


(*) In case of being hospitalized in long-term care beds, hospital meal/living expenses and bed surcharges, etc. need to be paid separately (same as the current high cost medical care system, etc.)

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 FY2014 Revision of Reimbursement of Medical Fees**

Outline of the FY2014 Revision of Reimbursement of Medical Fees

- Rebuilding the medical care system and building the integrated community care system towards 2025
- Efforts will be made in distribution/reinforcement and cooperation of medical institution functions, including inpatient/outpatient medical care, and enhancement of in-home medical care, etc.

Overall revision rate	+0.10%	* The figures in parentheses indicate the portion for responding to the increased costs for taxable purchases of medical care institutions, etc. due to the increased consumption tax rate
Medical fees (core)	+0.73% (+0.63%)	[approx. ¥300 billion (approx. ¥260 billion)]
Medical services	+0.82% (+0.71%)	[approx. ¥260 billion (approx. ¥220 billion)]
Dental services	+0.99% (+0.87%)	[approx. ¥30 billion (approx. ¥20 billion)]
Dispensations	+0.22% (+0.18%)	[approx. ¥20 billion (approx. ¥10 billion)]
Drug price revision	-0.58% (+0.64%)	[approx. -¥240 billion (approx. ¥260 billion)]
Material price revision	-0.05% (+0.09%)	[approx. -¥20 billion (approx. ¥40 billion)]

* The prices of generic drugs will be reviewed separately and only measures such as exclusion from insurance application to the prescription of mouthwash will be taken.

Main Points of the Basic Policies of the FY2014 Revision of Reimbursement of Medical Fees

December 6, 2013
Health Care Insurance Subcommittee, Medical Social Security Council
Medical Care Subcommittee, Medical Social Security Council

Basic understanding

○ Aiming to rebuild the medical care system and establish an integrated community care system through distribution/reinforcement and cooperation of medical institution functions, including inpatient/outpatient medical care, and enhancement of in-home medical care, etc.

Priority issues

○ Functional division/strengthening and cooperation of medical institutions and enhancement of in-home medical care, etc.
Functional division/strengthening and cooperation of medical institutions, including inpatient/outpatient medical care, and enhancement of in-home medical care, etc.

Perspectives of the revision

- Perspective to appropriately assess the areas requiring enhancement
  Promotion of cancer medical care and promotion of medical care for mental disabilities, etc.
- Perspective to realize safe, reliable, and high quality medical care that is understandable and convincing to patients, etc.
  Promotion of medical safety measures and provision of patient data, etc.
- Perspective to reduce burden of medical professionals
  Efforts to reduce burden of medical professionals and promotion of functional division of emergency outpatient treatment, etc.
- Perspective to improve the areas that can be made more efficient
  Promotion of generic drug usage, etc.

Issues for the future

Rebuilding the medical care system according to the medical needs of a super aged society with a declining birthrate and building an integrated community care system cannot immediately be completed, and requires continued efforts in distribution/reinforcement and cooperation of medical institution functions, including inpatient/outpatient medical care, and enhancement of in-home medical care, etc., including discussion of an appropriate medical fee system for providing high-quality medical care, after the FY2014 revision of reimbursement of medical fees towards 2025.

Priority Issues of and Responses to the FY2014 Revision of Reimbursement of Medical Fees

Priority issues

"Basic policies" of the Social Security Council
• Functional division/strengthening and cooperation of medical institutions and enhancement of in-home medical care, etc.

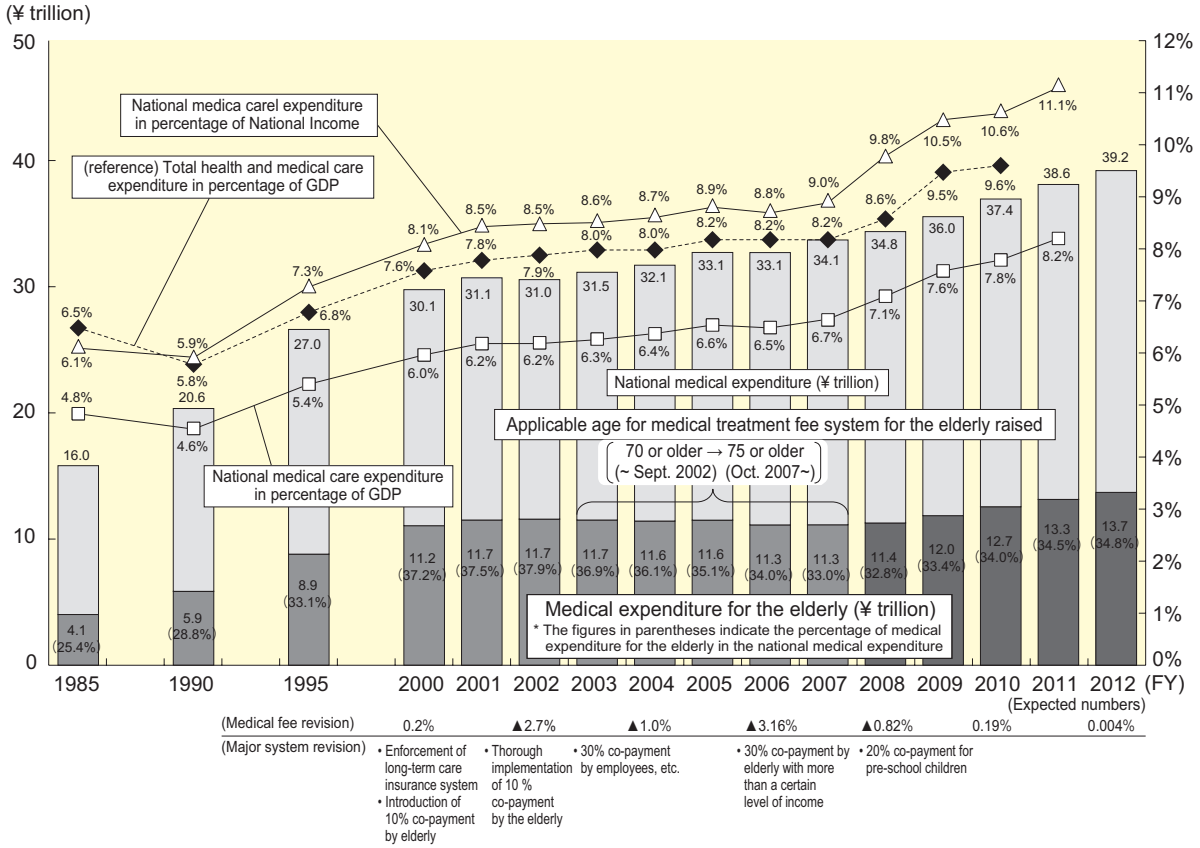
Responses to priority issues

Priority issue: Functional division/strengthening and cooperation of medical institutions and enhancement of in-home medical care, etc.

1. Inpatient medical care
   [1] Clarification of functions of hospital beds for the highly acute phase and general acute phase and assessment according to their functions
   [2] Securing service providers for patients requiring long-term medical treatment and functional division of hospital beds for the acute phase and long-term recuperation
   [3] Enhancement of hospital beds for the post-acute phase and recovery phase and assessment according to their functions
   [4] Assessment with consideration given to the actual situations of the regions
   [5] Assessment of inpatient medical care at clinics with beds
2. Promotion of division/cooperation of outpatient medical care functions
   [1] Assessment of family doctor functions
   [2] Appropriate prescription fees, etc. at large hospitals with low incoming/outgoing referral rate
3. Ensuring that there are medical institutions that take the role of providing in-home medical care, and promotion of high-quality in-home medical care
4. Assessment of mutual cooperation between medical institutions and medical/long-term care cooperation

Medical Care Expenditure

Overview **Changes in Medical Care Expenditure**



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

(%)

	1985	1990	1995	2000	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
National medical care expenditure	6.1	4.5	4.5	▲1.8	▲0.5	1.9	1.8	3.2	▲0.0	3.0	2.0	3.4	3.9	3.1	*1.7*
Medical expenditure for the elderly	12.7	6.6	9.3	▲5.1	0.6	▲0.7	▲0.7	0.6	▲3.3	0.1	1.2	5.2	5.9	4.5	*2.8*
National Income	7.2	8.1	▲0.3	2.0	▲0.8	1.2	0.5	1.1	1.1	0.8	▲6.9	▲3.0	2.3	▲1.6	—
GDP	7.2	8.6	1.7	0.9	▲0.7	0.8	0.2	0.5	0.7	0.8	▲4.6	▲3.2	1.3	▲1.4	—

(Note) 1. The national income and GDP are based on the national accounting announced by the Cabinet Office. 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 2011 was 9.3% of GDP.

2. The national health expenditure (and health expenditure for the elderly in their latter stage of life; hereinafter the same) of FY2012 are estimated figures. The FY2012 figures were calculated by multiplying the FY2011 figures by the growth rate of approximate medical expenditure of FY2012 (the figures in italics in the above table).

Detailed Data 1 National Medical Care Expenditure of OECD Countries (2011)

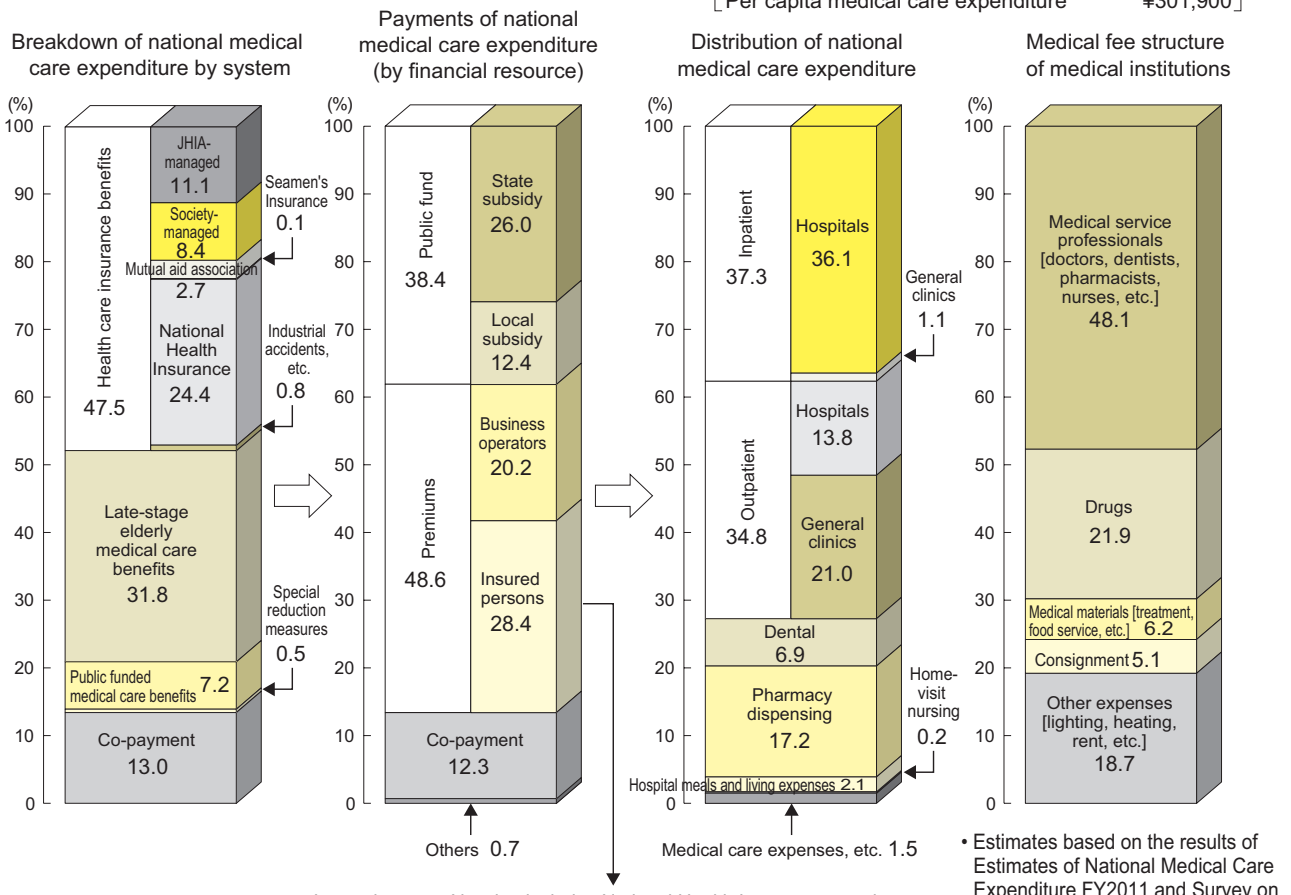
Country	Total medical care expenditure in GDP (%)	Rank	Per capita medical care expenditure ($)	Rank	Remarks
U.S.A.	17.7	1	8,508	1	
Netherlands	11.9	2	5,099	4	
France	11.6	3	4,118	10	
Germany	11.3	4	4,495	7	
Canada	11.2	5	4,522	6	
Switzerland	11.0	6	5,643	3	
Denmark	10.9	7	4,448	8	
Austria	10.8	8	4,546	5	
Belgium	10.5	9	4,061	11	
New Zealand	10.3	10	3,182	19	
Portugal	10.2	11	2,619	22	
Japan	9.6	12	3,213	18	*
Sweden	9.5	13	3,925	12	
U.K.	9.4	14	3,406	15	
Norway	9.3	15	5,669	2	
Spain	9.3	15	3,072	20	
Italy	9.2	17	3,012	21	
Greece	9.1	18	2,361	24	

Country	Total medical care expenditure in GDP (%)	Rank	Per capita medical care expenditure ($)	Rank	Remarks
Finland	9.0	19	3,374	16	
Iceland	9.0	19	3,305	17	
Australia	8.9	21	3,800	13	*
Ireland	8.9	21	3,700	14	
Slovenia	8.9	21	2,421	23	
Slovakia	7.9	24	1,915	28	
Hungary	7.9	24	1,689	29	
Israel	7.7	26	2,239	25	
Czech Republic	7.5	27	1,966	27	
Chile	7.5	27	1,568	30	
Korea	7.4	29	2,199	26	
Poland	6.9	30	1,452	31	
Luxembourg	6.6	31	4,246	9	
Mexico	6.2	32	977	33	*
Turkey	6.1	33	906	34	*
Estonia	5.9	34	1,303	32	
OECD average	9.3		3,322		

Source: "OECD HEALTH DATA 2013"
(Note) 1. The rank in this table indicates the rank among OECD member countries.
2. The figures marked with "*" indicate the figures for 2010 (the figures for 2008 for Turkey).

Detailed Data 2 Structure of National Medical Care Expenditure (FY2011)

National medical care expenditure ¥38,585.0 billion
Per capita medical care expenditure ¥301,900



• Insured persons' burden includes National Health Insurance premiums

• Estimates based on the results of Estimates of National Medical Care Expenditure FY2011 and Survey on Economic Conditions in Health Care (June 2011), etc.

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

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

Year	National medical care expenditure	Medical fees of medical treatment 6)	Hospitals	General clinics	Impatient medical fees	Hospitals	General clinics	Outpatient medical fees	Hospitals	General clinics	Dental medical fees	Pharmacy dispensing medical fees 3)	Hospital meals and living expenses 4)	Home-visit nursing medical fees	Medical care expenses, etc. 6)
	Estimated amount (¥100 million)														
2008	348,084	254,452	172,298	82,154	128,205	123,685	4,520	126,247	48,613	77,634	25,777	53,955	8,152	605	5,143
2009	360,067	262,041	178,848	83,193	132,559	128,266	4,293	129,482	50,582	78,900	25,587	58,228	8,161	665	5,384
2010	374,202	272,228	188,276	83,953	140,908	136,416	4,492	131,320	51,860	79,460	26,020	61,412	8,297	740	5,505
2011	385,850	278,129	192,816	85,314	143,754	139,394	4,359	134,376	53,421	80,954	26,757	66,288	8,231	808	5,637
	Percentage distribution (%)														
2008	100.0	73.1	49.5	23.6	36.8	35.5	1.3	36.3	14.0	22.3	7.4	15.5	2.3	0.2	1.5
2009	100.0	72.8	49.7	23.1	36.8	35.6	1.2	36.0	14.0	21.9	7.1	16.2	2.3	0.2	1.5
2010	100.0	72.7	50.3	22.4	37.7	36.5	1.2	35.1	13.9	21.2	7.0	16.4	2.2	0.2	1.5
2011	100.0	72.1	50.0	22.1	37.3	36.1	1.1	34.8	13.8	21.0	6.9	17.2	2.1	0.2	1.5

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

(Note) 1. With the launch of long-term care insurance system in April 2000, some of the expenses that were subjected to national medical care expenditure were transferred to long-term care insurance fees and are no longer included in national medical expenditure on and after 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. Figures until FY2005 indicate “hospital meal expenses” (total amount of hospital meal expenses and standard co-payment) and figures since FY2006 indicate the total amount of hospital meal expenses, standard co-payment for meal expenses, hospital living expenses, and standard co-payment for living expenses.
5. Medical treatment 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.
6. “Medical fees of medical treatment” and “medical care expenses, etc.” were included in “general medical fees” until they were newly classified as a separate item in FY2008.

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	Home-visit nursing	Medical care expenses, etc.	Health service facilities for the elderly
Actual amount (¥100 million)	FY1983	33,185	31,966	17,785	13,405	776	640	·	·	579	·
	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	26
	FY1989	55,578	52,573	29,400	21,743	1,430	1,312	·	·	1,441	253
	FY1990	59,269	55,669	30,724	23,315	1,630	1,457	·	·	1,523	619
	FY1991	64,095	59,804	32,325	25,705	1,773	1,689	·	·	1,633	970
	FY1992	69,372	64,307	35,009	27,249	2,049	1,992	·	5	1,626	1,442
	FY1993	74,511	68,530	36,766	29,536	2,228	2,529	·	29	1,535	1,888
	FY1994	81,596	72,501	38,235	31,790	2,476	3,133	1,855	86	1,439	2,582
	FY1995	89,152	75,910	38,883	34,319	2,708	3,909	4,678	174	1,224	3,259
	FY1996	97,232	82,181	42,314	36,789	3,078	4,620	4,816	323	1,094	4,198
	FY1997	102,786	85,475	44,205	37,965	3,305	5,606	4,869	479	1,073	5,285
	FY1998	108,932	88,881	46,787	38,584	3,511	6,900	4,967	657	1,101	6,426
	FY1999	118,040	94,653	49,558	41,181	3,915	8,809	5,115	858	1,169	7,436
	FY2000	111,997	94,640	48,568	41,871	4,200	10,569	4,612	235	1,271	670
	FY2001	116,560	97,954	50,296	43,243	4,416	12,462	4,677	191	1,277	-2
	FY2002	117,300	97,155	51,198	41,434	4,522	13,913	4,689	192	1,352	-1
	FY2003	116,524	95,653	51,828	39,609	4,216	14,711	4,645	174	1,342	-1
	FY2004	115,764	94,429	52,048	38,371	4,010	15,143	4,654	190	1,348	-0
	FY2005	116,444	94,441	52,867	37,726	3,848	15,777	4,679	205	1,342	-0
	FY2006	112,594	91,492	51,822	36,129	3,540	15,579	3,970	225	1,329	-0
	FY2007	112,753	91,048	52,167	35,524	3,357	16,245	3,877	239	1,345	—
	FY2008	114,146	91,558	53,009	35,029	3,520	17,035	3,850	264	1,439	-0
	FY2009	120,108	95,672	55,594	36,381	3,698	18,717	3,914	289	1,517	·
	FY2010	127,213	101,630	59,994	37,654	3,981	19,631	4,015	318	1,620	·
	FY2011	132,991	105,409	62,170	38,980	4,260	21,489	4,029	341	1,725	·
	FY2012	137,044	108,751	64,094	40,139	4,518	22,111	4,012	404	1,767	·

(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. Health services facilities for the elderly: Expenses paid for facility treatment at health service facilities for the elderly. (Benefit in kind) (Not applicable after March 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. The figures for FY2008 include delayed requests for health expenditure for the elderly from April 2008 to February 2009.

4. The figures for FY2011 do not include the Great East Japan Earthquake related health expenditure, etc. (¥4.5 billion of the total of estimated payment requests and health expenditure of unknown insurers).

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

Financial Status of Health Insurance System

Overview **Finance Status of the Health Insurance System (FY2011 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	68,855	65,150	27,755	279	9,073
	State subsidy	11,539	36	30,944	35	39,806
	Prefectural contribution	−	−	8,292	−	11,809
	Municipal contribution	−	−	8,093	−	10,458
	Grants for late-stage elderly	−	−	−	−	51,917
	Grants for early-stage elderly	−	2	29,569	−	−
	Retirement grants	−	−	7,058	−	−
	Others	176	1,297	15,184	1	169
	Total	80,571	66,484	126,894	316	123,233
Operating expenditure	Insurance benefit expenses	46,997	36,181	90,820	203	122,948
	Late-stage elderly support coverage	14,652	14,079	15,915	56	−
	Levies for early-stage elderly	12,425	11,779	47	40	−
	Contributions for retirees	2,675	2,855	−	12	−
	Others	1,243	5,088	19,132	6	692
	Total	77,992	69,981	125,915	317	123,640
	Balance of ordinary revenue and expenditure	2,579	▲3,497	979	▲1	▲407

		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.	−		385
	Adjustment premium revenue	−		1,096
	Subsidies to financial adjustment programs	−		1,021
	Transfer from reserves, etc. and surplus carried forward	−		5,798
	Others	10		139
	Total	10		8,439
Non-operating expenditure	Contribution to financial adjustment programs	−		1,088
	Others	−		151
	Total	−		1,239
Balance of non-operating revenue and expenditure		10	7,200	(1,401)
Balance of total revenue and expenditure		2,589	3,606	(▲2,096)
Reserve fund, etc.		1,951		38,867

(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 ¥250.9 billion for use in covering the settlement of accounts. The amounts of the national subsidy, etc. for National Health Insurance (operated by municipalities) and the late-stage medical care system for the elderly were adjusted in the following fiscal year.
3. The figures in parentheses for the Society-managed Health Insurance indicate the net balance between non-operating revenue and expenditure and the balance between total revenue and expenditure, but exclude transfers from reserves, etc. and surpluses carried forward).
4. Contribution to health care services for the elderly is included in “others” of operating expenditure for each system.
5. Reserve fund, etc. indicates reserves for the Japan Health Insurance Association-managed Health Insurance. It includes reserves, a reserve fund (¥3,374.2 billion), and assets such as land and buildings, etc. for the Society-managed Health Insurance.
6. In the non-operating revenue of the Japan Health Insurance Association-managed Health Insurance, operation account surplus at the end of FY2010 was added to FY2011 settlement of accounts.
7. The balance of total revenue and expenditure for the Japan Health Insurance Association-managed Health Insurance and Society-managed Health Insurance indicates the sum of the balance of operating revenue and expenditure and the balance of non-operating revenue and expenditure.
8. The figures may not equal the total, or balance of accounts may vary due to rounding.

(2) Medical Care Provision System

Medical Care Provision System

Overview

Outline of the Draft Act on Arrangement of Relevant Acts on Advancement of Comprehensive Measures for Securing Regional Medical and Long-Term Care, etc. (scheduled to be revised in 2014)

As measures based on the Act on Promotion of Reform for the Establishment of a Sustainable Social Security System, an efficient and high-quality medical care system will be established, and necessary improvements, etc. will be made for relevant laws, including the Medical Care Act and the Long-Term Care Insurance Act, etc., to secure regional medical and long-term care in an integrated manner.

I Outline

1. Creation of new funds and stronger cooperation of medical and long-term care (related to the Act on Promotion of Development of Regional Long-Term Care Facilities, etc.)
   - [1] Establishment of new funds in prefectures through utilization of the increased consumption tax revenue for medical/long-term care businesses listed in the business plans of prefectures (functional division/cooperation of hospital beds, promotion of in-home medical/long-term care, etc.)
   - [2] Formulation of basic policies by the Minister of Health, Labour and Welfare for stronger cooperation of medical and long-term care

2. Securing an efficient and effective medical care system in regions (related to the Medical Care Act)
   - [1] Reporting on medical functions of hospital beds (highly acute phase, acute phase, recovery phase, and chronic phase), etc. to prefectural governors by medical institutions, and formulation of regional medical care vision (appropriate future regional medical care system) based on the reports in medical care plans by prefectures
   - [2] Legally establishing functions of regional medical support centers that provide support for securing doctors

3. Establishment of integrated community care system and fair balance of cost sharing (related to the Long-Term Care Insurance Act)
   - [1] Enhancement of community support programs, including promotion of in-home medical/long-term care, etc., with transfer of prevention benefits (home-visit long-term care and day care services) to community support programs to make them more diverse
     * Community support programs: Programs implemented by municipalities using the financial resources of long-term care insurance
   - [2] Focusing the functions of special nursing homes for the elderly on support for persons with medium to severe long-term care needs who have difficulty living at home
   - [3] Enhancement of reduction of insurance premiums for persons with low-income
   - [4] Raising the co-payment of users with income above a certain level to 20% (however, the maximum monthly amount of general households will remain unchanged)
   - [5] Including the assets to the requirements for “supplementary benefits” to compensate for meal and living expenses of facility users with low-income

4. Others
   - [1] Clarification of specific acts of medical care aid and creation of a new training system for nurses that engage in these acts using procedure manuals
   - [2] Establishment of a system for investigating medical accidents
   - [3] Merger of medical corporation associations and medical corporation foundations, and measures to promote transfer to medical corporations without contribution
   - [4] Discussion of measures to secure long-term care personnel (implementation period of the revised qualification system of certified care workers will be postponed from FY2015 to FY2016)

II Enforcement Date

The promulgation date. However, measures related to the Long-Term Care Insurance Act will be gradually enforced in October 2014 or later, and those related to the Long-Term Care Insurance Act in April 2015 or later.

Types of Medical Institutions

Overview

Types of Medical Institutions

1. Hospitals, Clinics

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

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

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

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

2. Types of Hospitals

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

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

- Hospitals
  - General hospitals
  - Special functioning hospitals (providing advanced medical care, etc.)
  - Regional medical care support hospitals (supporting family doctors and family dentists who are taking roles in regional medical care, etc.)
  - Psychiatric hospitals (hospitals with psychiatric wards only) (subject: psychiatric disorders)
  - Tuberculosis hospitals (hospitals with tuberculosis wards only) (subject: patients with tuberculosis)

Detailed Information 1 Outline of Special Functioning Hospitals

Purpose

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

Roles

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

Requirements for Approval

- ❍ Having capabilities of providing, developing, evaluating, and conduct training of advanced medical care
- ❍ Providing medical care to patients who are referred to by other hospitals or clinics (maintaining the incoming referral rate of at least 50% and the outgoing referral rate of at least 40%)
- ❍ Number of beds .... Must have 400 or more beds.
- ❍ Staff deployment
  - Doctors ..... Twice as many as ordinary hospitals, etc. In addition, half the number of doctors specified by the staff deployment standards must be specialized doctors of one of the 15 types.
  - Pharmacists ..... The minimum standard is 1/30 of the number of patients. (That for ordinary hospitals is 1/70 of the number of patients)
  - Nurses, etc. ..... The minimum standard is 1/2 of the number of patients. (That for ordinary hospitals is 1/3 of the number of patients) [The minimum standard of outpatients is 1/30 of the number of patients, the same as that for ordinary hospitals]
  - Deployment of at least one registered dietitian.
- ❍ Facilities ..... Must have intensive care units, sterile rooms, and drug information management rooms.
- ❍ Professing 16 specified clinical areas in principle.
- ❍ Having at least 70 papers written in English published annually in refereed journals, etc.
- ❍ For special functioning hospitals in the specified areas, requirements for approval regarding the profession of clinical areas and the incoming/outgoing referral rate, etc. are separately established.

* The number of approved hospitals (as of April 1, 2014) 86

Detailed Information 2 Regional Medical Care Support Hospital System

Purpose

Medical institutions that are individually approved by prefectural governors as being hospitals with the ability to support family doctors and dentists, etc. who are taking roles in providing regional medical care at the medical front and facilities competent enough to secure regional medical care, etc. by providing medical care to referred patients and joint use of medical devices, etc. from the point of view of provision of medical care to patients in their neighborhoods as part of systematized medical institution functions being desirable.

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

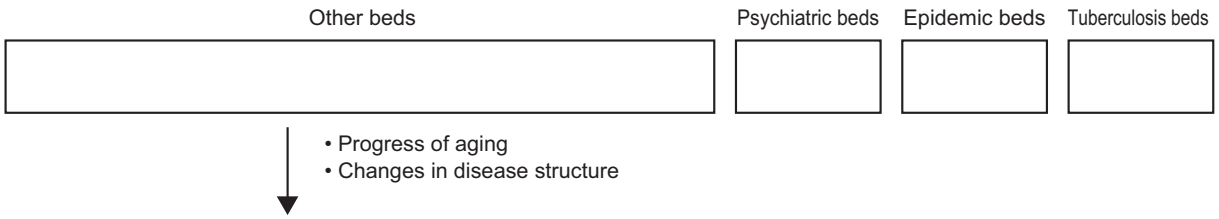
Requirements for Approval

- ❍ Providing medical care mainly to referred patients (meeting one of the following)
  - [1] Incoming referred rate of at least 80%
  - [2] Incoming referred rate of at least 65% and outgoing referred rate of at least 40%
  - [3] Incoming referred rate of at least 50% and outgoing referred rate of at least 70%
- ❍ Having the ability to provide emergency medical care (meeting one of the following in principle)
  1. Annual number of emergency patients received / population of the emergency medical district * 1,000 ≥ 2
  2. Annual number of emergency patients received >= 1,000
- ❍ Securing a system to enable doctors, etc. in regions to use buildings, facilities, and devices, etc.
- ❍ Holding trainings for those engaged in regional medical care at least 12 times annually
- ❍ Having at least 200 hospital beds in principle and facilities appropriate for being regional medical care support hospitals, etc.

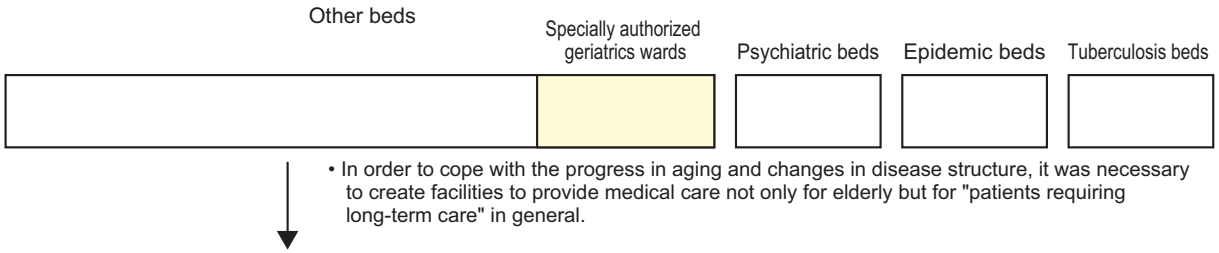
* The number of approved hospitals (as of the end of October, 2012) 439

Detailed Information 3 Revision of Bed Classification

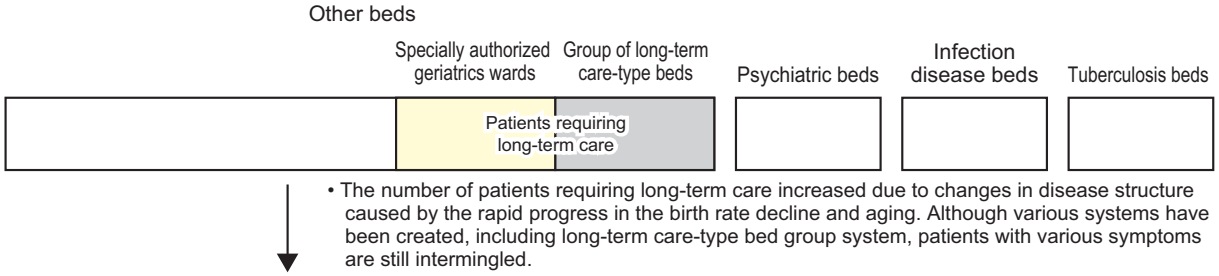
[At the beginning (from 1948)]



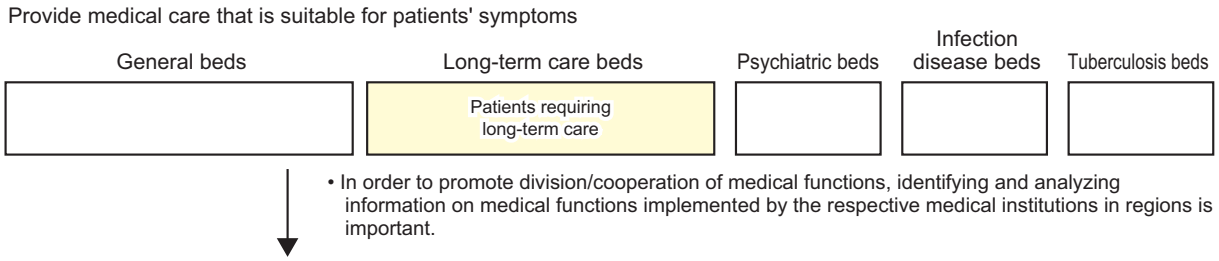
[Introduction of specially authorized geriatrics wards (1983)]



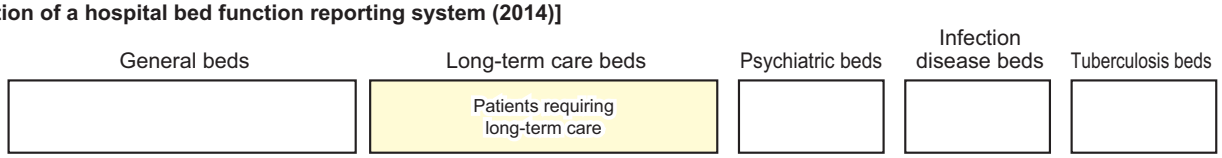
[Creation of long-term care-type bed group system (1992)]



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



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



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

Trends with Medical Institutions

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

Year	Hospitals	National (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
2011	8,605	274	1,258	7,073	99,547	68,156
2012	8,565	274	1,252	7,039	100,152	68,474

Source: 1875-1937: "Annual Report of Public Health" , Ministry of Internal Affairs
1938-1952: "Annual Report of Public Health" , Ministry of Health and Welfare
From 1953 on: "Survey of Medical Institutions" , 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

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	9,239	9,187	9,122	9,077	9,026	8,943	8,862	8,794	8,739	8,670	8,605	8,565
National	349	336	323	304	294	292	291	276	275	274	274	274
Public medical institutions	1,375	1,377	1,382	1,377	1,362	1,351	1,325	1,320	1,296	1,278	1,258	1,252
Social insurance organizations	130	130	129	129	129	125	123	122	122	121	121	118
Medical corporations	5,445	5,533	5,588	5,644	5,695	5,694	5,702	5,728	5,726	5,719	5,712	5,709
Private	1,085	954	838	760	677	604	533	476	448	409	373	348
Others	855	857	862	863	869	877	888	872	872	869	867	864
20-99 beds	3,781	3,726	3,667	3,616	3,558	3,482	3,391	3,339	3,296	3,232	3,182	3,147
100-299 beds	3,851	3,862	3,860	3,855	3,865	3,862	3,875	3,876	3,875	3,882	3,877	3,882
300-499 beds	1,111	1,110	1,110	1,125	1,118	1,120	1,123	1,111	1,106	1,096	1,090	1,087
500+ beds	496	489	485	481	485	479	473	468	462	460	456	449

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

Detailed Data 2 Changes in Number of Hospitals by Hospital Type

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	9,239	9,187	9,122	9,077	9,026	8,943	8,862	8,794	8,739	8,670	8,605	8,565
Psychiatric hospitals	1,065	1,069	1,073	1,076	1,073	1,072	1,076	1,079	1,083	1,082	1,076	1,071
Tuberculosis sanatorium	3	2	2	2	1	1	1	1	1	1	1	1
General hospitals	8,171	8,116	8,047	7,999	7,952	7,870	7,785	7,714	7,655	7,587	7,528	7,493

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

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	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	1,583,073	1,578,254
Psychiatric beds	357,385	355,966	354,448	354,927	354,296	352,437	351,188	349,321	348,121	346,715	344,047	342,194
Infectious disease beds	2,033	1,854	1,773	1,690	1,799	1,779	1,809	1,785	1,757	1,788	1,793	1,798
Tuberculosis beds	20,847	17,558	14,507	13,293	11,949	11,129	10,542	9,502	8,924	8,244	7,681	7,208
Long-term care beds	272,217	300,851	342,343	349,450	359,230	350,230	343,400	339,358	336,273	332,986	330,167	328,888
General beds	994,315	966,364	919,070	912,193	904,199	911,014	913,234	909,437	906,401	903,621	899,385	898,166
Number of beds per hospital	178.2	178.8	178.9	179.7	180.8	181.9	182.8	183.0	183.3	183.8	184.0	184.3

Source: “Survey of Medical Institutions”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) 1. For 2001-2002, long-term care beds includes long-term care beds and transitional former groups of long term care beds.
2. 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											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	85.3	85	84.9	84.9	84.8	83.5	82.2	81.7	81.6	82.3	81.9	81.5
Psychiatric beds	93.2	93.1	92.9	92.3	91.7	91.1	90.2	90.0	89.9	89.6	89.1	88.7
Infectious disease beds	2	2.5	2.4	2.6	2.7	2.2	2.2	2.4	2.8	2.8	2.5	2.4
Tuberculosis beds	43.7	45.3	46.3	48.6	45.3	39.8	37.1	38.0	37.1	36.5	36.6	34.7
Long-term care beds	94.1	94.1	93.4	93.5	93.4	91.9	90.7	90.6	91.2	91.7	91.2	90.6
General beds	81.1	80.1	79.7	79.4	79.4	78	76.6	75.9	75.4	76.6	76.2	76.0
Long-term care beds for nursing care	…	…	…	…	…	94.1	93.9	94.2	94.5	94.9	94.6	93.9

	Average length of stay											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	38.7	37.5	36.4	36.3	35.7	34.7	34.1	33.8	33.2	32.5	32.0	31.2
Psychiatric beds	373.9	363.7	348.7	338.0	327.2	320.3	317.9	312.9	307.4	301.0	298.1	291.9
Infectious disease beds	8.7	8.7	8.7	10.5	9.8	9.2	9.3	10.2	6.8	10.1	10.0	8.5
Tuberculosis beds	94	88	82.2	78.1	71.9	70.5	70	74.2	72.5	71.5	71.0	70.7
Long-term care beds	183.7	179.1	172.3	172.6	172.8	171.4	177.1	176.6	179.5	176.4	175.1	171.8
General beds	23.5	22.2	20.7	20.2	19.8	19.2	19	18.8	18.5	18.2	17.9	17.5
Long-term care beds for nursing care	…	…	…	…	…	268.6	284.2	292.3	298.8	300.2	311.2	307.0

Source: “Hospital Report”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) 1. For 2001-2003, long-term care beds includes long-term care beds and transitional former groups of long term care beds.
2. For 2001-2003, general beds includes general beds and transitional former other beds (excluding transitional former groups of long term care beds).
3. The figures for 2011 only include the reported number of patients in March 2011 for 11 institutions (one in Kesen medical district and one in Miyako medical district of Iwate Prefecture, two in Ishinomaki medical district and two in Kesennuma medical district of Miyagi Prefecture, and five in Soso medical district of Fukushima Prefecture) due to the effect of the Great East Japan Earthquake.

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) 1,840 persons are admitted in 13 National Hansen's Disease Sanatoria nationwide (as of May 1, 2014).

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

(Reference) Number of facilities (as of the end of May 2014)

Classification	Number of facilities	Number of persons admitted
National Hansen's Disease Sanatoria	13	1,840

* The number of persons admitted is of May 1, 2014.

Classification	Number of facilities	Students quota (persons)
Training schools for nurses (National Hansen's Disease Sanatoria)	2	100

[National Hospital Organization]

(1) National Hospital Organization is an independent administrative agency established based on the "Act on the National Hospital Organization, Independent Administrative Agency" (Act No. 191 of 2002).

(2) National Hospital Organization utilizes nationwide hospital networks and provides examination, treatment, clinical study, education, and training in an integrated manner for medical care requiring risk management and active contribution by the government, medical care in the area of safety net that is not always implemented by other establishing entities, and medical care for 5 diseases and 5 businesses with regional needs taken into consideration.

(Reference) Number of hospitals (as of October 1, 2013)

Classification	Number of hospitals	Number of beds
National Hospital Organization	143	55,159

[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.

(Reference) Number of hospitals (as of January 1, 2014)

National Center	Specialized diseases, etc.	Number of hospitals	Number of beds
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	612
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	1,373
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

(Reference) Number of facilities (as of January 1, 2014)

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, 2012, there are 303,268 doctors and 102,551 dentists.

Number of Medical Professionals

• Doctors	303,268 persons
• Dentists	102,551 persons
• Pharmacists	280,052 persons

Source: “Survey of Physicians, Dentists and Pharmacists 2012”, Statistics and Information Department, Minister's Secretariat, MHLW

• Public health nurses	57,112 persons
• Midwives	35,185 persons
• Nurses	1,067,760 persons
• Assistant nurses	377,756 persons

Source: Health Policy Bureau, MHLW (2012)

• Physical therapists (PT)	61,620.8 persons
• Occupational therapists (OT)	35,427.3 persons
• Orthoptists	6,818.7 persons
• Speech language hearing therapists	11,456.2 persons
• Orthotists	138.0 persons
• Clinical radiologic technologists	49,105.9 persons
• Medical technicians	62,458.5 persons
• Clinical engineers	20,001.0 persons

Source: “Survey of Medical Institutions and Hospital Report 2011”, Statistics and Information Department, Minister's Secretariat, MHLW
* Full-time equivalent numbers

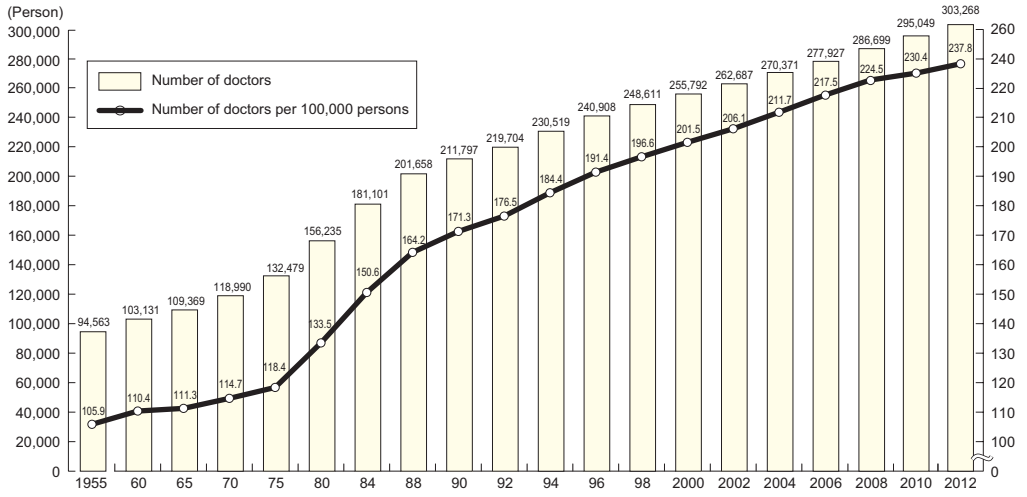
• Dental hygienists	108,123 persons
• Dental technicians	34,613 persons
• Massage and finger pressure therapists	109,309 persons
• Acupuncture therapists	100,881 persons
• Moxibustion therapists	99,118 persons
• Judo therapists	58,573 persons

Source: “Report on Public Health Administration and Services 2012”, Statistics and Information Department, Minister's Secretariat, MHLW

• Emergency medical technicians	37,567 persons

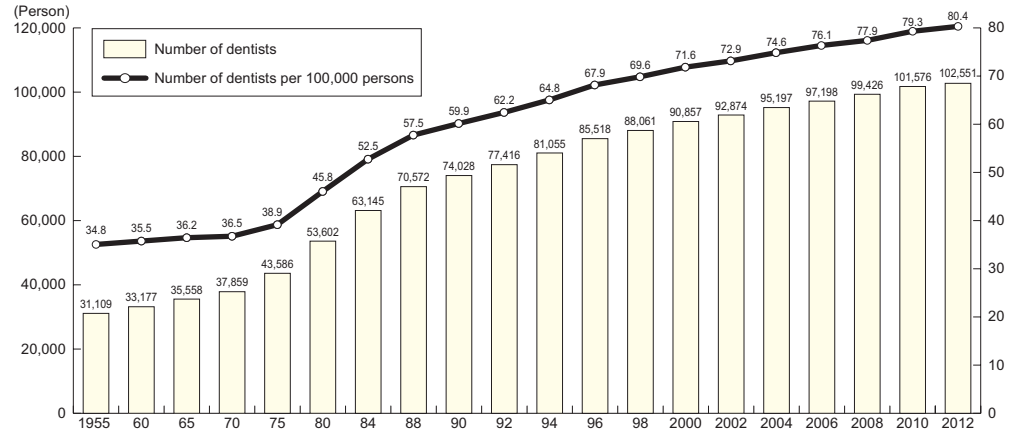
Source: Health Policy Bureau, MHLW (as of December 31, 2009)

Detailed Data 1 Changes in Number of Doctors



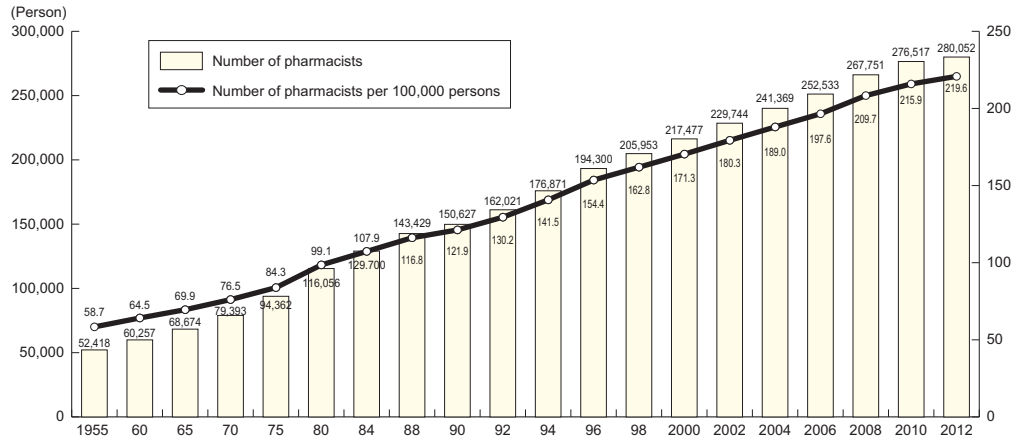
Source: "Survey of Physicians, Dentists and Pharmacists", Statistics and Information Department, Minister's Secretariat, MHLW

Detailed Data 2 Changes in Number of Dentists



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

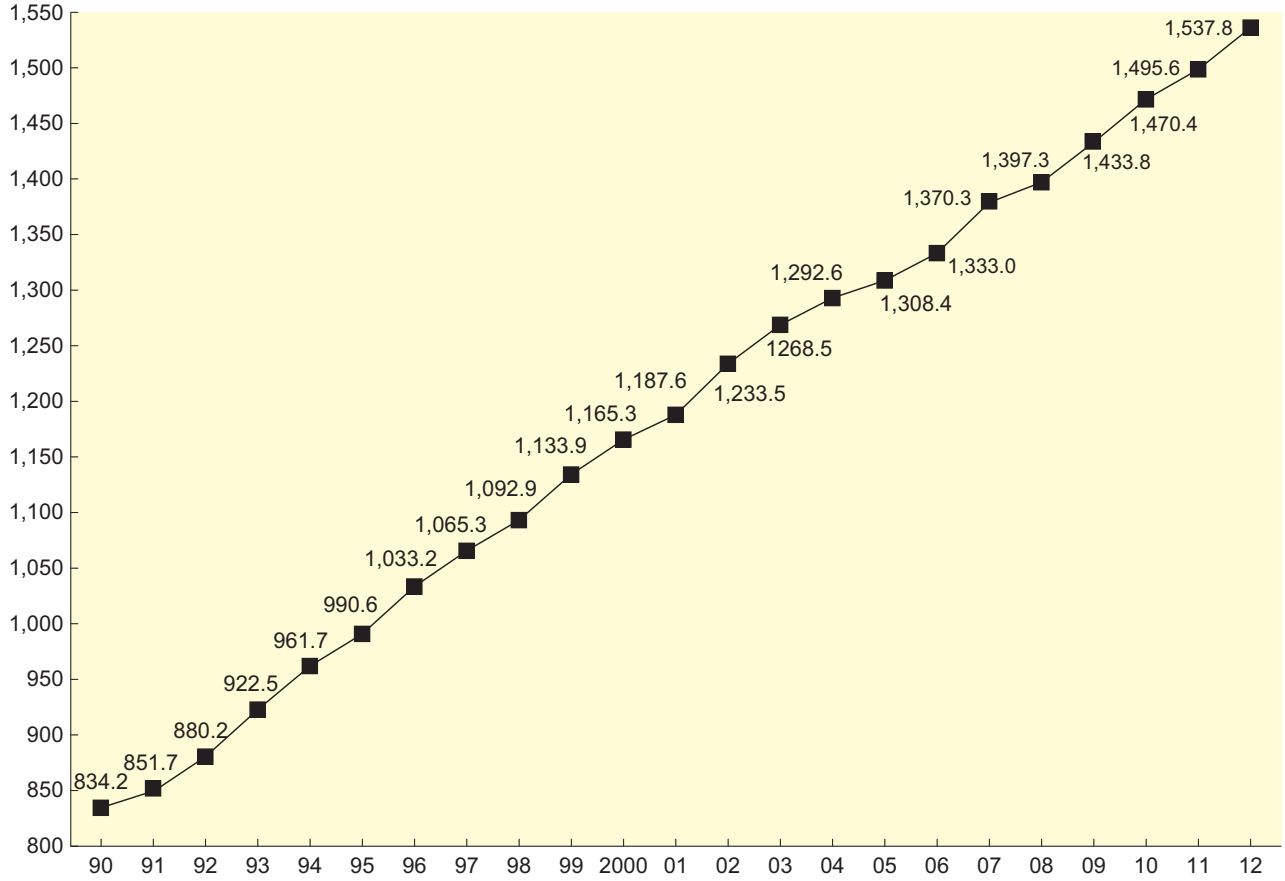
Detailed Data 3 Changes in Number of Pharmacists



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

Detailed Data 4 Changes in Number of Nursing personnel

(1,000 persons)



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 FY2010 On-Site Inspection)

Detailed Data 1 Regional Conforming Rates

(Unit: %)

Classification \ Region	Nationwide	Hokkaido Tohoku	Kanto	Hokuriku Koshinetsu	Tokai	Kinki	Chugoku	Shikoku	Kyushu
Doctors	92.5	83.3	96.4	87.7	94.7	96.8	92.4	90.1	93.3
Nurses	99.4	99.4	98.8	99.2	99.9	99.3	99.7	99.6	99.9

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	7,466 (91.5)	597 (7.3)	8,063 (98.8)
Hospitals with insufficient number of nurses	80 (1.0)	15 (0.2)	95 (1.2)
Total	7,546 (92.5)	612 (7.5)	8,158 (100.0)

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

(Explanation of terms)

- **Numerical standards:** 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".

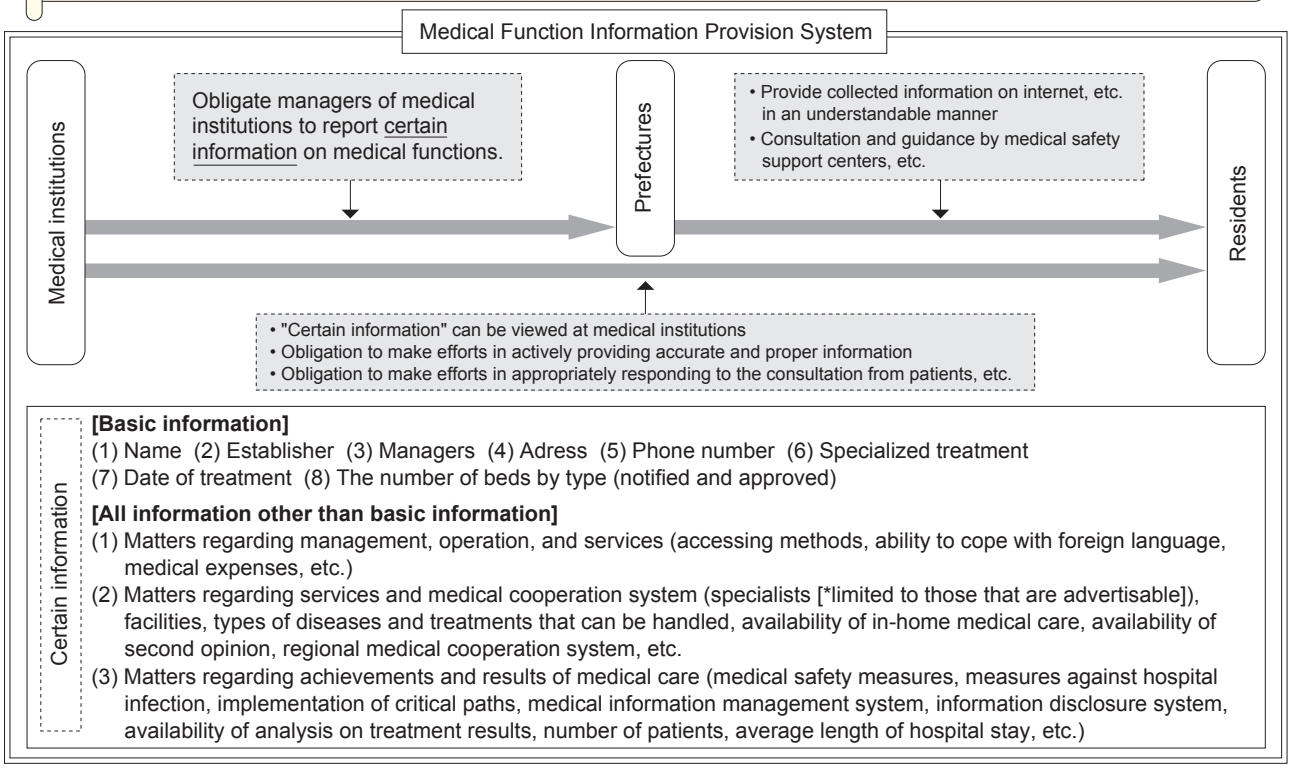
Provision of Medical Function Information

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 2006)

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

[Overview of the revised system]

Obligation to provide treatment plans at the beginning of hospitalization

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

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

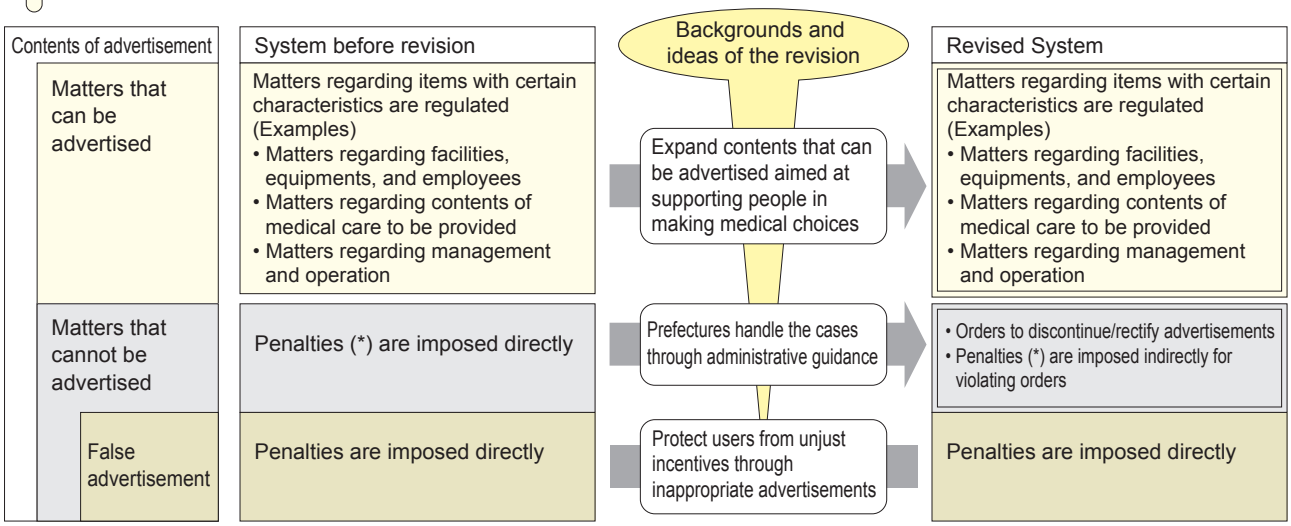
Obligation to make efforts in providing recuperation plans at the end of hospitalization

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

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

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)

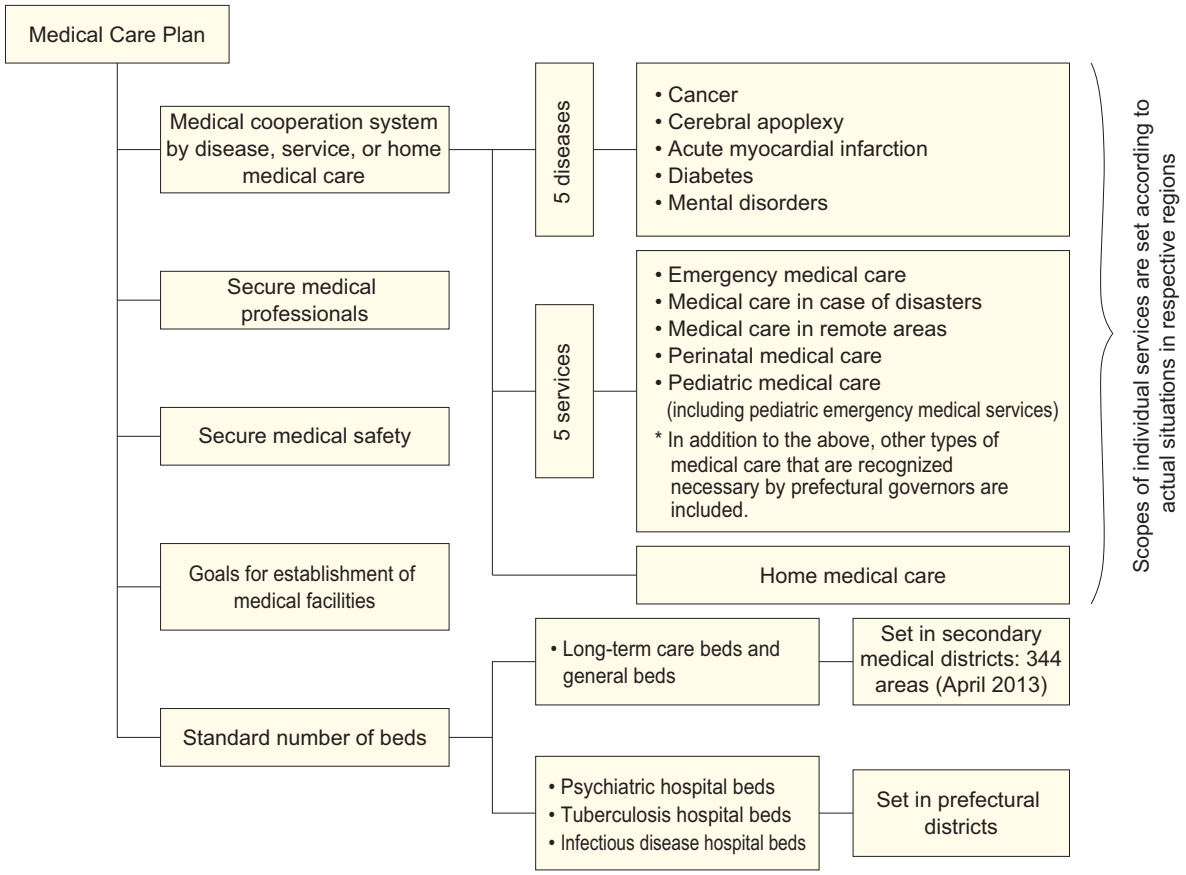
Medical Care Plan

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 2013)

Classification	Standard number of beds	Number of existing beds
Long-term care beds and general beds	1,052,631	1,237,464
Psychiatric hospital beds	310,510	340,470
Tuberculosis hospital beds	4,377	6,777
Infectious disease hospital beds	1,899	1,776

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

(As of April 1, 2013)

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. 29, 2013	21	59,648	77,373	18,967	20,108	143	359	98	94
2	Aomori	Apr. 30, 2013	6	11,320	13,041	3,870	4,511	60	66	32	20
3	Iwate	Mar. 29, 2013	9	11,157	13,889	4,220	4,454	30	137	40	40
4	Miyagi	Apr. 1, 2013	4	17,174	18,576	5,021	6,388	62	62	28	28
5	Akita	Mar. 29, 2013	8	8,791	11,580	3,839	4,152	38	58	36	30
6	Yamagata	Mar. 29, 2013	4	10,150	11,338	3,373	3,817	34	30	20	18
7	Fukushima	Apr. 5, 2013	7	15,351	20,386	6,478	7,236	60	134	36	36
8	Ibaraki	Apr. 2, 2013	9	17,890	25,216	5,770	7,444	60	128	48	48
9	Tochigi	Mar. 29, 2013	6	12,140	16,195	4,779	5,224	65	115	32	26
10	Gunma	Mar. 29, 2013	10	16,998	18,841	4,419	5,207	66	69	48	48
11	Saitama	Mar. 29, 2013	10	42,707	47,910	13,345	14,495	137	191	85	40
12	Chiba	May 5, 2013	9	48,482	48,325	12,949	12,936	114	218	59	58
13	Tokyo	Apr. 1, 2013	13	95,627	104,140	21,956	23,221	398	563	130	124
14	Kanagawa	Mar. 29, 2013	11	59,985	60,572	12,958	13,889	166	166	74	74
15	Niigata	Apr. 5, 2013	7	21,051	21,863	6,490	6,850	41	100	36	36
16	Toyama	Mar. 29, 2013	4	10,235	14,339	3,080	3,365	82	86	20	20
17	Ishikawa	Apr. 1, 2013	4	9,910	14,608	3,656	3,816	62	92	18	18
18	Fukui	Mar. 29, 2013	4	6,471	9,001	2,116	2,342	22	48	20	20
19	Yamanashi	Mar. 28, 2013	4	6,144	8,449	2,345	2,468	20	50	20	28
20	Nagano	Mar. 28, 2013	10	17,801	19,067	4,861	4,977	42	74	46	46
21	Gifu	Mar. 29, 2013	5	14,552	17,094	3,294	4,118	95	137	30	30
22	Shizuoka	Mar. 29, 2013	8	34,126	31,939	6,946	7,021	108	178	48	48
23	Aichi	Mar. 29, 2013	12	51,195	54,809	12,554	13,031	218	256	74	70
24	Mie	Mar. 29, 2013	4	13,612	15,756	4,120	4,786	60	54	24	24
25	Shiga	Apr. 1, 2013	7	10,279	12,706	2,345	2,373	73	77	34	32
26	Kyoto	Apr. 2, 2013	6	24,786	28,796	5,728	6,376	300	300	38	38
27	Osaka	Apr. 3, 2013	8	67,263	88,397	18,318	19,025	514	577	78	78
28	Hyogo	Apr. 1, 2013	10	54,082	53,523	10,938	11,411	178	211	58	54
29	Nara	Mar. 29, 2013	5	13,747	13,890	2,800	2,863	50	60	28	13
30	Wakayama	Apr. 16, 2013	7	8,496	11,484	1,850	2,336	27	73	32	32
31	Tottori	Apr. 1, 2013	3	5,665	6,813	1,729	1,966	21	34	12	12
32	Shimane	Mar. 29, 2013	7	7,885	8,443	2,369	2,376	16	33	30	30
33	Okayama	Mar. 29, 2013	5	21,172	21,991	5,356	5,674	76	216	26	26
34	Hiroshima	Apr. 1, 2013	7	26,284	31,512	8,174	8,984	85	155	36	24
35	Yamaguchi	May 31, 2013	8	16,585	21,035	5,848	6,068	37	60	40	40
36	Tokushima	Apr. 9, 2013	3	7,025	11,240	2,772	3,928	37	49	16	16
37	Kagawa	Mar. 29, 2013	5	8,886	11,984	2,943	3,459	35	123	24	18
38	Ehime	Apr. 5, 2013	6	15,165	18,311	4,569	5,160	54	153	28	26
39	Kochi	Mar. 29, 2013	4	8,403	14,896	2,493	3,721	60	170	11	11
40	Fukuoka	Mar. 29, 2013	13	49,713	65,704	18,469	21,436	191	312	66	56
41	Saga	Apr. 1, 2013	5	9,187	10,961	4,090	4,239	30	30	24	22
42	Nagasaki	Apr. 9, 2013	8	16,185	19,501	6,844	7,955	70	143	38	38
43	Kumamoto	Apr. 2, 2013	11	19,053	25,476	7,522	8,931	54	231	48	48
44	Oita	Mar. 31, 2013	6	11,720	15,183	4,693	5,247	38	50	28	40
45	Miyazaki	Apr. 1, 2013	7	11,762	13,847	5,370	5,844	26	97	32	30
46	Kagoshima	Mar. 29, 2013	9	16,769	25,046	8,683	9,812	183	181	44	44
47	Okinawa	Mar. 29, 2013	5	10,002	12,418	5,201	5,430	39	71	26	24
	Total		344	1,052,631	1,237,464	310,510	340,470	4,377	6,777	1,899	1,776

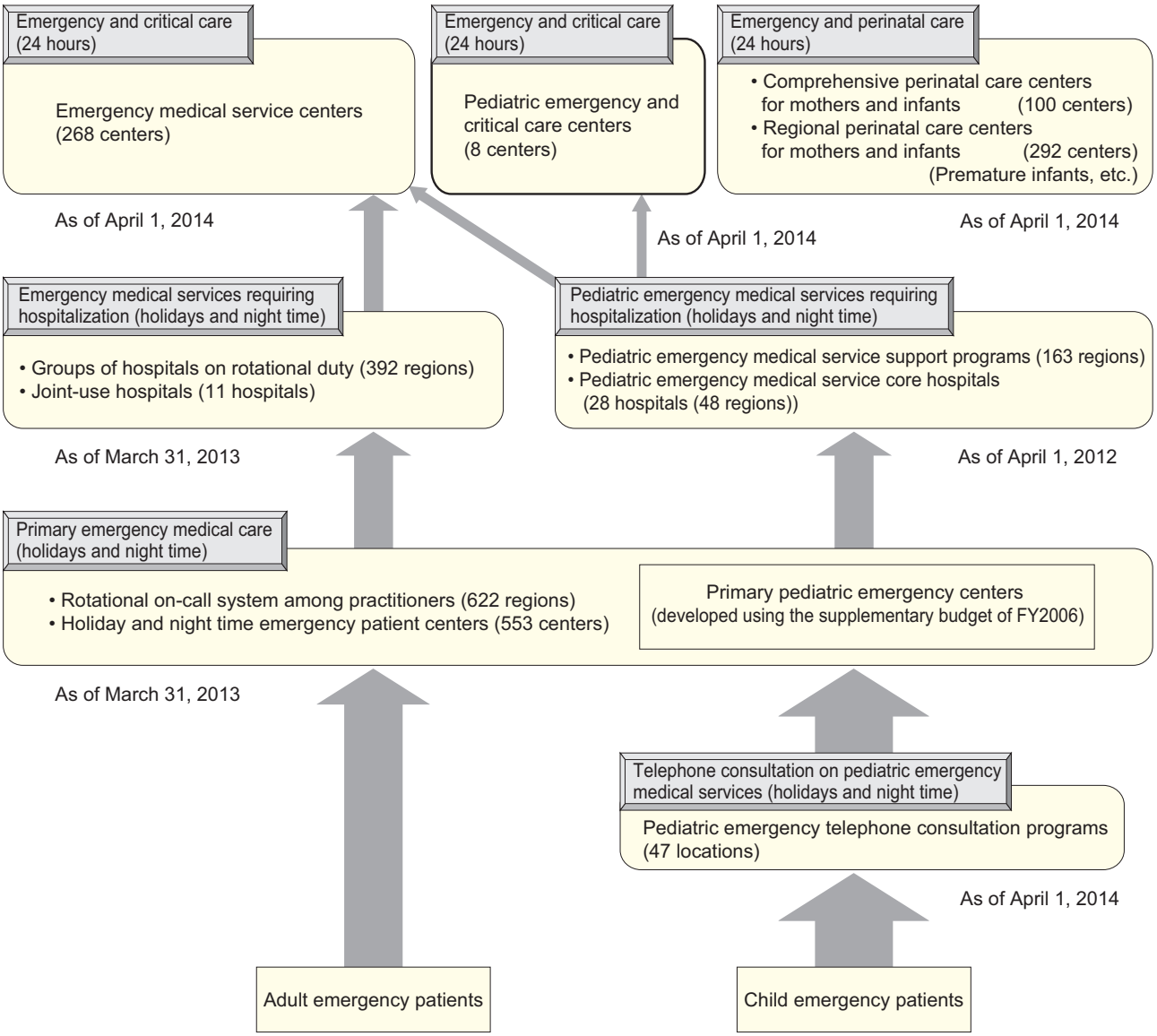
(Note) 1. The standard number of beds is as of the public announcement date of each prefecture.

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

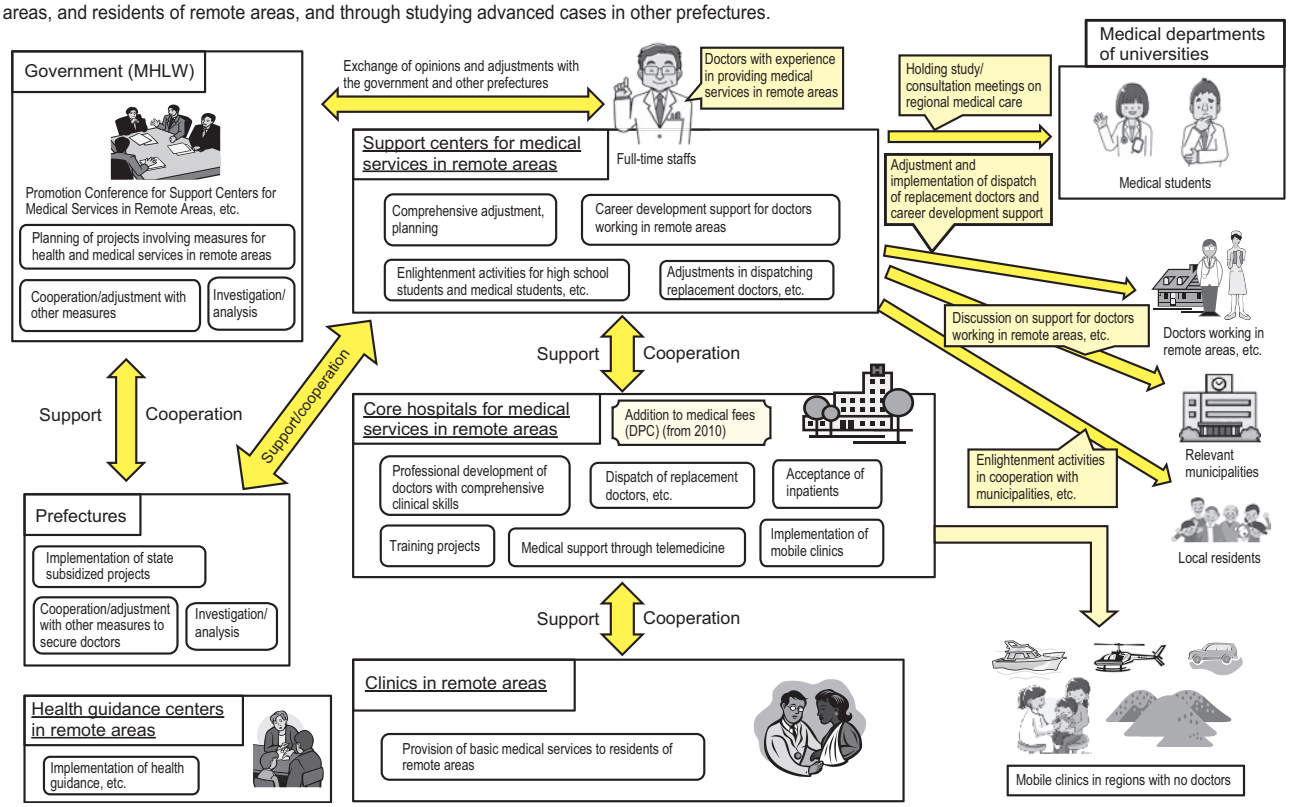


Medical Services in Remote Areas

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 4 km 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 40 prefectures as of January 1, 2014

(2) Core hospitals for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
296 hospitals are designated as of January 1, 2014

(3) Clinics for medical services in remote areas (subject to assistance of operational expenses, facility establishment expenses, and equipment installment expenses)
1,038 clinics (including National Health Insurance direct managed clinics) are established as of January 1, 2014

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 (from 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 to June 2013)
[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.) ❍ Work guidelines for medical communication promoters and guidelines for formulating their training programs (January 2013)
[Roles of the government and local governments on medical safety] ❍ 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 (FY2005-FY2007)

Improved Quality of Doctors

Overview

History of Clinical Training System

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

[Issues of the conventional system]

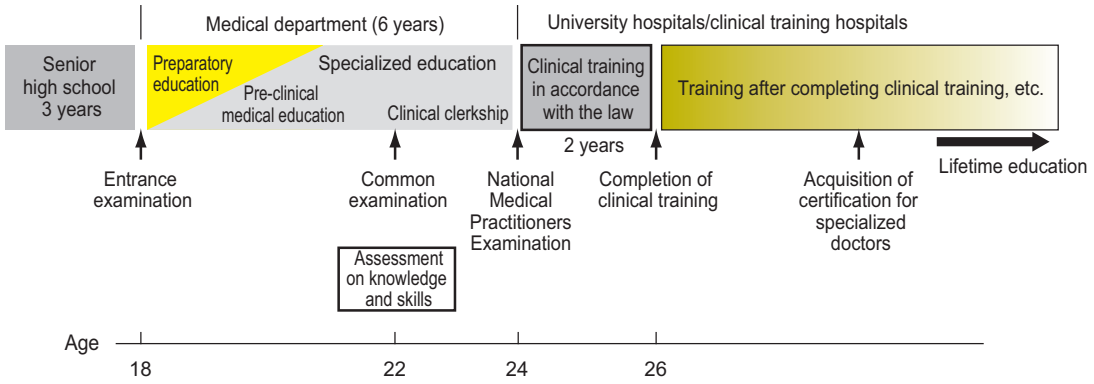
1. Training was voluntary
2. Training programs were not clearly defined
3. Mainly focused on straight training for specialized doctors
4. Remarkably large disparities existed among institutions
5. Insufficient guidance system
6. Insufficient evaluation of training achievements
7. Unstable status/work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

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

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 (FY2013)

Clinical resident training hospitals (core type)	903
Clinical resident training hospitals (cooperative type)	1,514
University hospitals (core type equivalent)	116
University hospitals (cooperative type equivalent)	19

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

Classification	University hospitals	Clinical resident training hospitals
Old system (FY2003)	72.5%	27.5%
1st year of new system (FY2004)	55.8%	44.2%
2nd year of new system (FY2005)	49.2%	50.8%
6th year of new system (FY2009)	46.8%	53.2%
7th year of new system (FY2010)	47.2%	52.8%
10th year of new system (FY2013)	45.0%	55.0%

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

Classification	6 prefectures	Other prefectures
Old system (FY2003)	51.3%	48.7%
1st year of new system (FY2004)	47.8%	52.2%
6th year of new system (FY2009)	48.6%	51.4%
7th year of new system (FY2010)	47.8%	52.2%
10th year of new system (FY2013)	45.5%	54.5%

Outline of 2010 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 "elective compulsory courses", 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 designation of core clinical training hospitals includes the annual number of inpatients being 3,000 or more and placement of 1 or more preceptors for each of 5 interns, etc.

(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.

Outline of 2015 System Reform

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

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

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

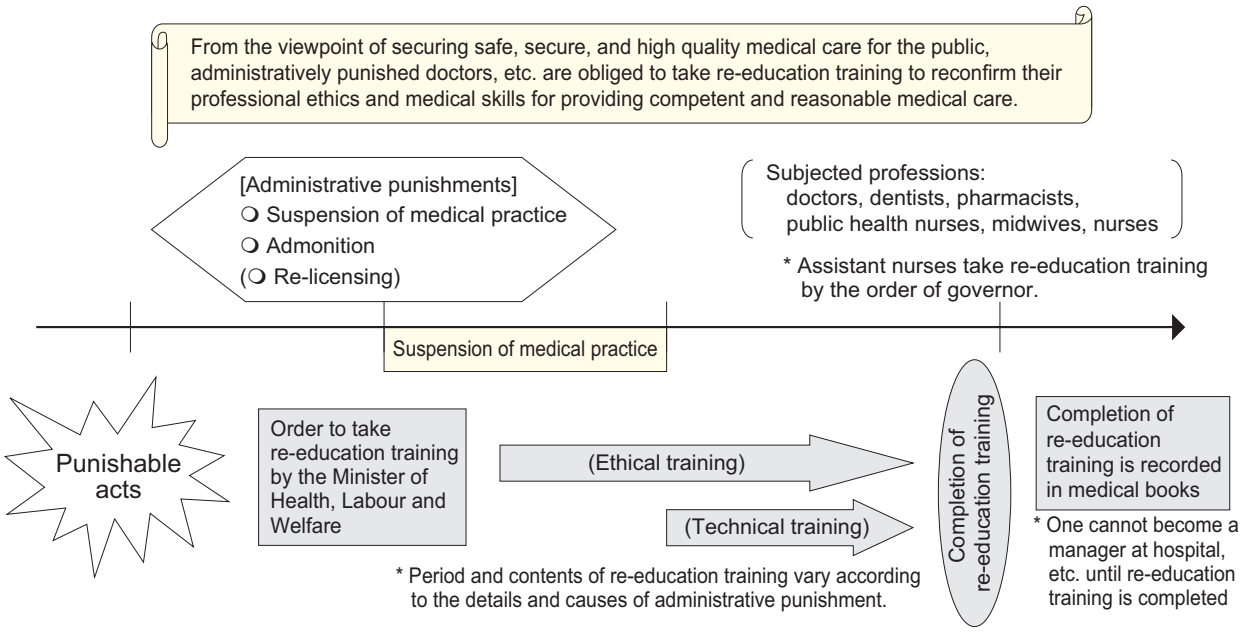
(4) Career development support
- Smooth interruption/resumption of clinical training according to various career paths, including pregnancy, childbirth, research, and study abroad, etc.

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

(6) Responses to regional limits and strengthening of roles of prefectures
- Limits are included to enable a prefecture to adjust the quota for each hospital within the upper limit of the prefecture with consideration given to regional limits and the actual results of dispatching doctors, etc.

* Necessary reviews will be made within 5 years after the enforcement of this revised system.

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 Act**

Outline of Medical Corporation System

1. Purpose of the system

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

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

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

2. Establishment

○ Associations or foundations based on the Medical Care Act.
○ Approved by prefectural governors. However, those establishing medical institutions in 2 or more prefectures are approved by the Minister of Health, Labour and Welfare.

(Number of corporations)
• Medical corporations 49,889 (as of March 31, 2014)
Of which 49,498 are associations (8,022 without contribution and 41,476 with contribution) and 391 are foundations.
* Medical corporation without contribution
• Medical corporation for which the ownership of residual assets in the event of dissolution is stipulated to be the government, local governments, or other medical corporations without contribution, etc. and exclude individuals (investors).
• The revised Medical Care Act of 2006 limits newly established medical corporations to be those without contribution. The existing medical corporations, however, shall voluntarily transfer while applying the previous provisions.
• Social medical corporations 225 (as of April 1, 2014)

3. Operation

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

(3) Health Promotion/Disease Measures

Health Centers, etc.

Overview

Activities of Health Centers

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

Health centers are established in 370 locations in 47 prefectures, 101 locations in 70 designated cities, and 23 locations in 23 special wards under the Community Health Act (As of April 1, 2013).

<<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>>

<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 centre administration council
Directors of health centers (doctors)

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

494 health centers
370 in prefectures 101 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 dietitians
Dietitians
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	2013
Total number of health centers	663	641	594	592	582	576	571	549	535	518	517	510	494	495	495	494
Prefectures	490	474	460	459	448	438	433	411	396	394	389	380	374	373	372	370
Cities	137	136	108	109	111	115	115	115	116	101	105	107	97	99	100	101
Special wards	36	31	26	24	23	23	23	23	23	23	23	23	23	23	23	23

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

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

Occupation	Number of personnel
	Person
Doctors	794
Dentists	95
Pharmacists	2,823
Veterinarians	2,236
Public health nurses	7,781
Midwives	66
Nurses	405
Assistant nurses	13
Radiology technicians, etc.	546
Medical technologists, etc.	826
Registered dietitians	1,119
Dietitians	171
Dental hygienists	314
Physical/occupational therapists	99
Others	11,267
<Included in the upper column>	
Medical social workers	41
Mental health welfare counselors	1,065
Nutrition counselors	1,026
Total	28,555

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 FY2012)

Detailed Data 2 Changes in Number of Public Health Nurses

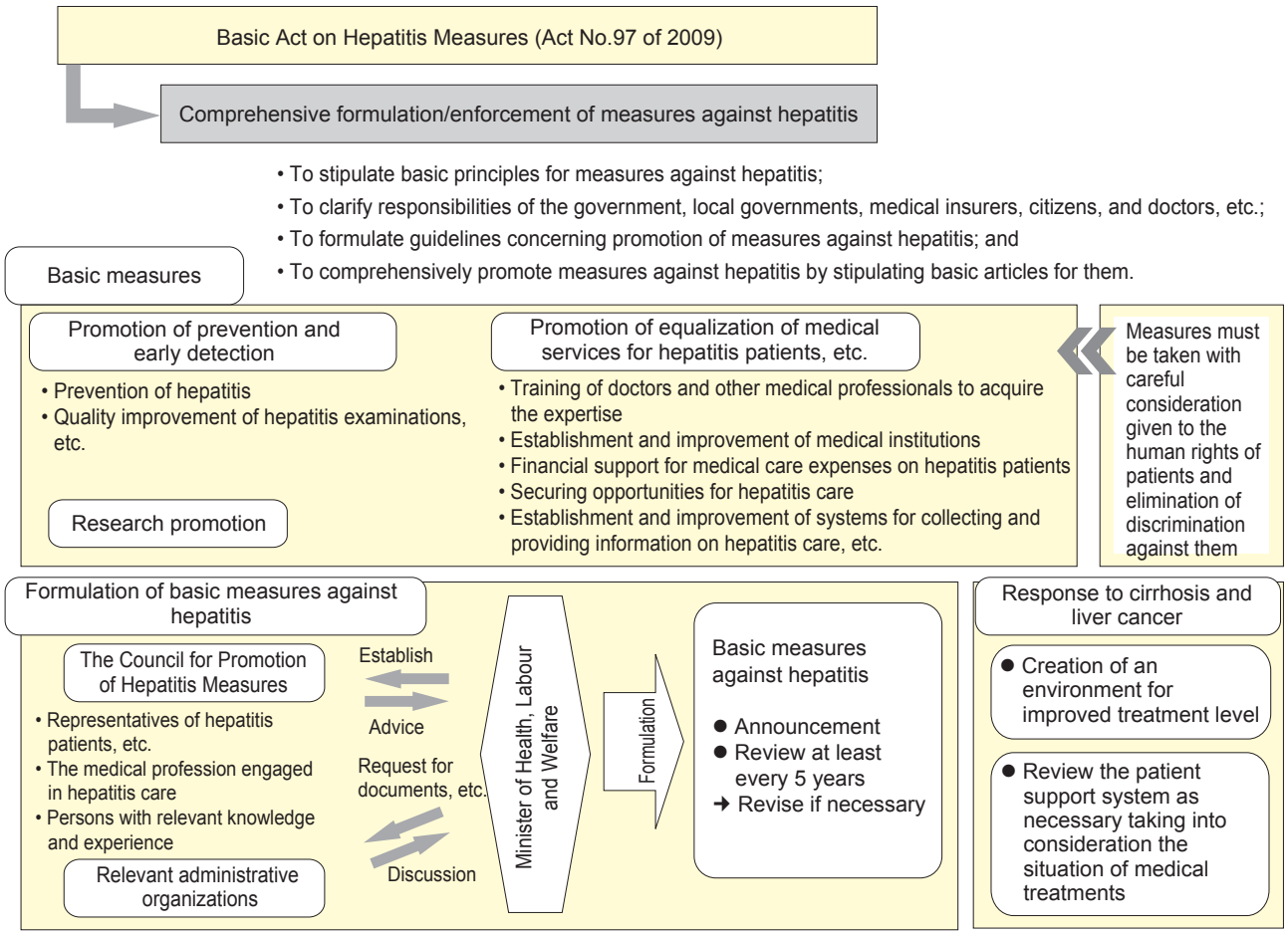
(Unit: person)

	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
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	15,015	14,753
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	6,280	6,256
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	21,295	21,009
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	3,689	3,659
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	24,984	24,668

Source: FY1998: “Report on Regional Public Health Services”, Statistics and Information Department, Minister's Secretariat, MHLW
FY1999-2007: “Report on Regional Public Health Services and Health Services for the Aged”, Statistics and Information Department, Minister's Secretariat, MHLW
FY2008 onward: “Report on Regional Public Health Services and Health Promotion Services”, Statistics and Information Department, Minister's Secretariat, MHLW
(Note) The figures from FY1998 onward as of the end of March of the next year.
The figures for FY2010 do not include some municipalities in Iwate Prefecture (Kamaishi City, Otsuchi Town, Miyako City, and Rikuzentakata City), clinics and municipalities in Miyagi Prefecture apart from Sendai City, and some municipalities in Fukushima Prefecture (Minamisoma City, Naraha Town, Tomioka Town, Kawauchi Village, Futaba Town, Iitate Town, and Aizuwakamatsu City) due to the effect of the Great East Japan Earthquake.

Measures against Hepatitis

Overview **Basic Act on Hepatitis Measures**



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 History of National Health Promotion Measures

1st National Health Promotion Measures (FY1978-1988)	2nd National Health Promotion Measures (FY1988-1999) (Active 80 Health Plan)	3rd National Health Promotion Measures (FY2000-2012) (National Health Promotion in the 21st Century (Health Japan 21))
(Basic concept) 1. Lifetime health promotion 〔Promotion of primary prevention of geriatric diseases〕 2. Promotion of health promotion measures through three major elements (diet, exercises, and rest) (special focus on diet)	(Basic concept) 1. Lifetime health promotion 2. Promotion of health promotion measures with the focus on exercise habits as they are lagging behind the other two of the three elements (diet, exercise, and rest)	(Basic concept) 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 indicator for national health/medical standards and promotion of health promotion measures 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 dietitians (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 dietitians, 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 FY2008) (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 Reference 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) • Physical Activity Reference for Health Promotion 2013 (2013)

Outline of the Health Promotion Act

Chapter 1. General Provisions

(1) Purpose

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

(2) Responsibilities

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

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

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

(1) Basic policies

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

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

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

(3) Guidelines on implementation of health checkups

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

Outline of Results of National Health and Nutrition Survey 2011

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 2011 (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.

Key points of the results of the survey

<Status with dietary habits>

- When compared to 2001, and with regard to the status of fresh food consumption, the amount of intake of vegetables, fruits, fish, and shellfish decreased while that of meat increased. By age group, the amount of intake of vegetables, fruits, fish, and shellfish is small with those aged 20-49.
- Of those that usually acquire fresh food, the percentage, the reason for refraining from acquiring or not being able to acquire fresh food over the last year was the highest in percentage with “too expensive” at 30.4% (over 40% for those aged 20-49).
- The amount of intake by annual household income reveals that the amount of intake of vegetables was small with males and that of fruits and meat was small with both males and females in households with income of less than ¥2 million income when compared to households with income of ¥6 million or more.
- The percentage of households that had stocked a supply of emergency food was 47.4%. By regional block, the percentage was the highest with Tokai block at 65.9% and the lowest with Kyushu block at 24.6%.

<Status with tobacco use>

- The percentage of habitual smokers was 20.1% (32.4% of males and 9.7% of females).
- The percentage of those whose smoking status was affected by the rise in price of cigarettes in October 2010 was 29.2%. Of them, the percentage of those that answered “stopped smoking” due to the impact of the increase in the price of cigarettes was 15.0% and “continued smoking but reduced the amount” was 39.0%.

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 FY2012	Plan to formulate in FY2013	Plan to formulate in FY2014 or later	No plan
Health center-designated cities	69	68	0	1	0	0
Special wards in Tokyo	23	23	0	0	0	0
Other municipalities	1,651	1,335	56	86	130	48

(As of January 1, 2013)

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

Prefecture	No. of municipalities	Formulated	Formulation rate	FY2012	FY2013	FY2014 or later	No plan
Hokkaido	175	102	58.3%	15	15	44	3
Aomori	39	39	100.0%	0	0	0	0
Iwate	32	31	96.9%	0	1	0	0
Miyagi	34	34	100.0%	0	0	0	0
Akita	24	22	91.7%	0	1	2	0
Yamagata	35	35	100.0%	0	0	0	0
Fukushima	57	35	61.4%	4	2	16	0
Ibaraki	44	33	75.0%	5	4	2	0
Tochigi	25	25	100.0%	0	0	0	0
Gunma	33	32	97.0%	0	0	1	0
Saitama	61	42	68.9%	1	6	12	0
Chiba	51	25	49.0%	0	2	6	18
Tokyo	37	27	73.0%	0	0	9	1
Kanagawa	28	20	71.4%	2	2	2	1
Niigata	29	29	100.0%	0	0	0	0
Toyama	14	14	100.0%	0	0	0	0
Ishikawa	18	17	94.4%	0	1	0	0
Fukui	17	17	100.0%	0	0	0	0
Yamanashi	27	27	100.0%	0	0	0	0
Nagano	76	58	76.3%	5	5	5	3
Gifu	41	38	92.7%	0	3	0	0
Shizuoka	33	33	100.0%	0	0	0	0
Aichi	50	49	98.0%	1	0	0	0
Mie	28	18	64.3%	0	7	3	0
Shiga	18	17	94.4%	0	0	1	0
Kyoto	26	19	73.1%	1	0	2	4
Osaka	38	33	86.8%	1	1	2	1
Hyogo	37	37	100.0%	0	0	0	0
Nara	38	34	89.5%	0	1	1	2
Wakayama	29	19	65.5%	0	1	5	4
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	16	88.9%	2	0	0	0
Tokushima	24	19	79.2%	2	3	0	0
Kagawa	16	16	100.0%	0	0	0	0
Ehime	19	19	100.0%	0	0	0	0
Kochi	33	30	90.9%	2	1	0	0
Fukuoka	56	24	42.9%	2	9	10	11
Saga	20	15	75.0%	2	1	2	0
Nagasaki	19	19	100.0%	0	0	0	0
Kumamoto	44	31	70.5%	3	9	1	0
Oita	17	17	100.0%	0	0	0	0
Miyazaki	25	21	84.0%	2	2	0	0
Kagoshima	42	34	81.0%	0	6	2	0
Okinawa	41	31	75.6%	6	2	2	0
	1,651	1,335	80.9%	56	86	130	48

(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 (Per 100,000 persons)
Malignant neoplasms	1,526	364,721	290.1
Diabetes mellitus	2,700	13,783	11.0
Hypertensive diseases	9,067	7,161	5.7
Heart diseases (excluding hypertensive)	1,612	196,547	156.4
Cerebrovascular diseases	1,235	118,286	94.1

Source:
<Total number of patients> "Patient Survey 2011", Statistics and Information Department, Minister's Secretariat, MHLW
<Number of death/moratlity rate> "Vital Statistics", Statistics and Information Department, Minister's Secretariat, MHLW (2013 approximate figures)
(Note) Total number of patients excludes Ishinomaki and Kesennuma medical districts of Miyagi Prefecture and Fukushima Prefecture due to the effect of the Great East Japan Earthquake.

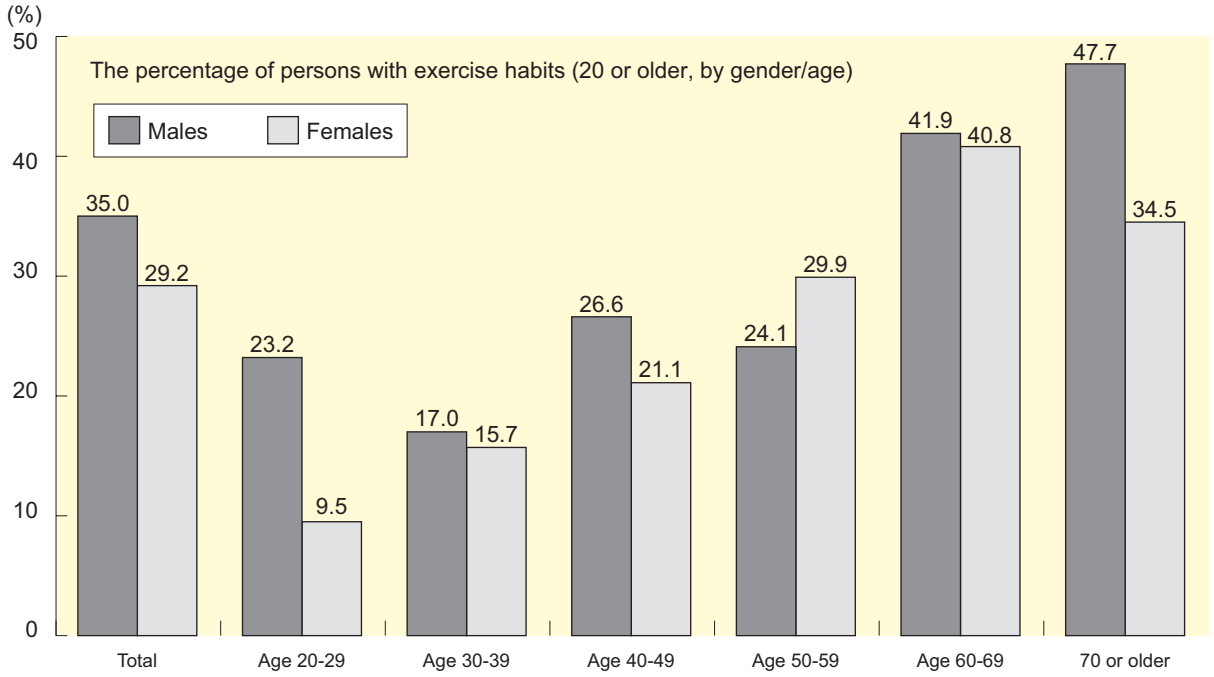
Detailed Data 3 Prevalence related to Diabetes

	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

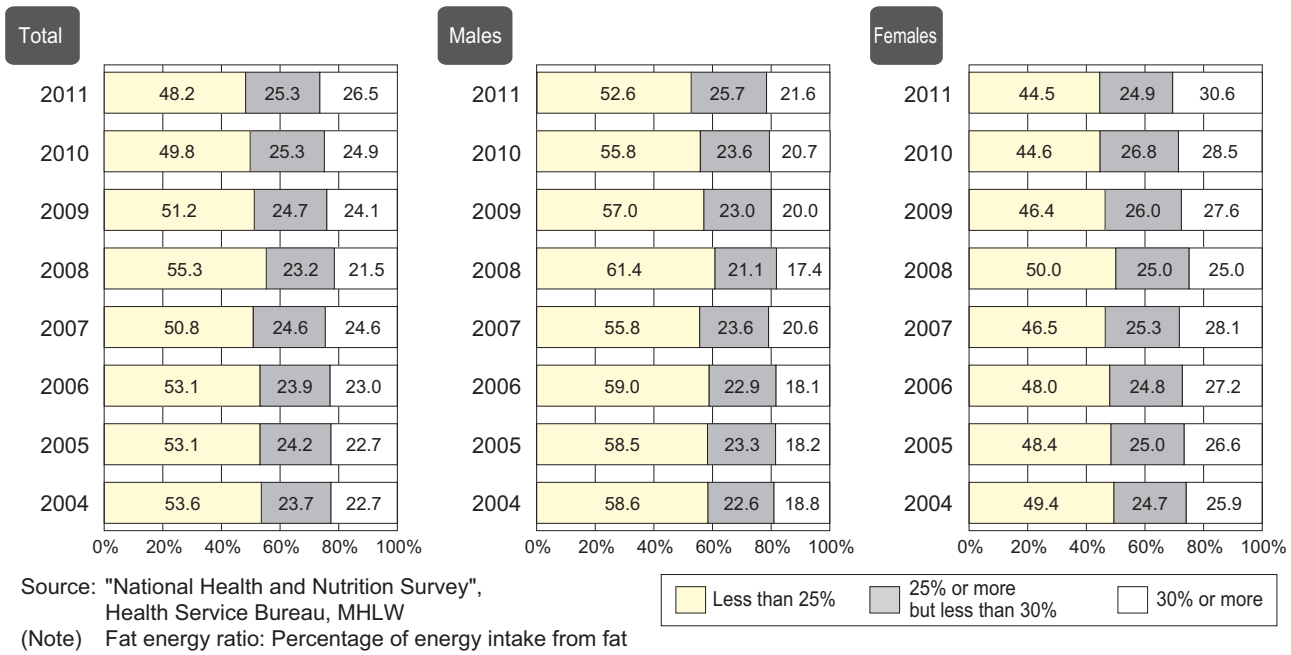
Source: "National Health and Nutrition Survey 2007", Health Service Bureau, MHLW

Detailed Data 4 Status of Exercise Habits



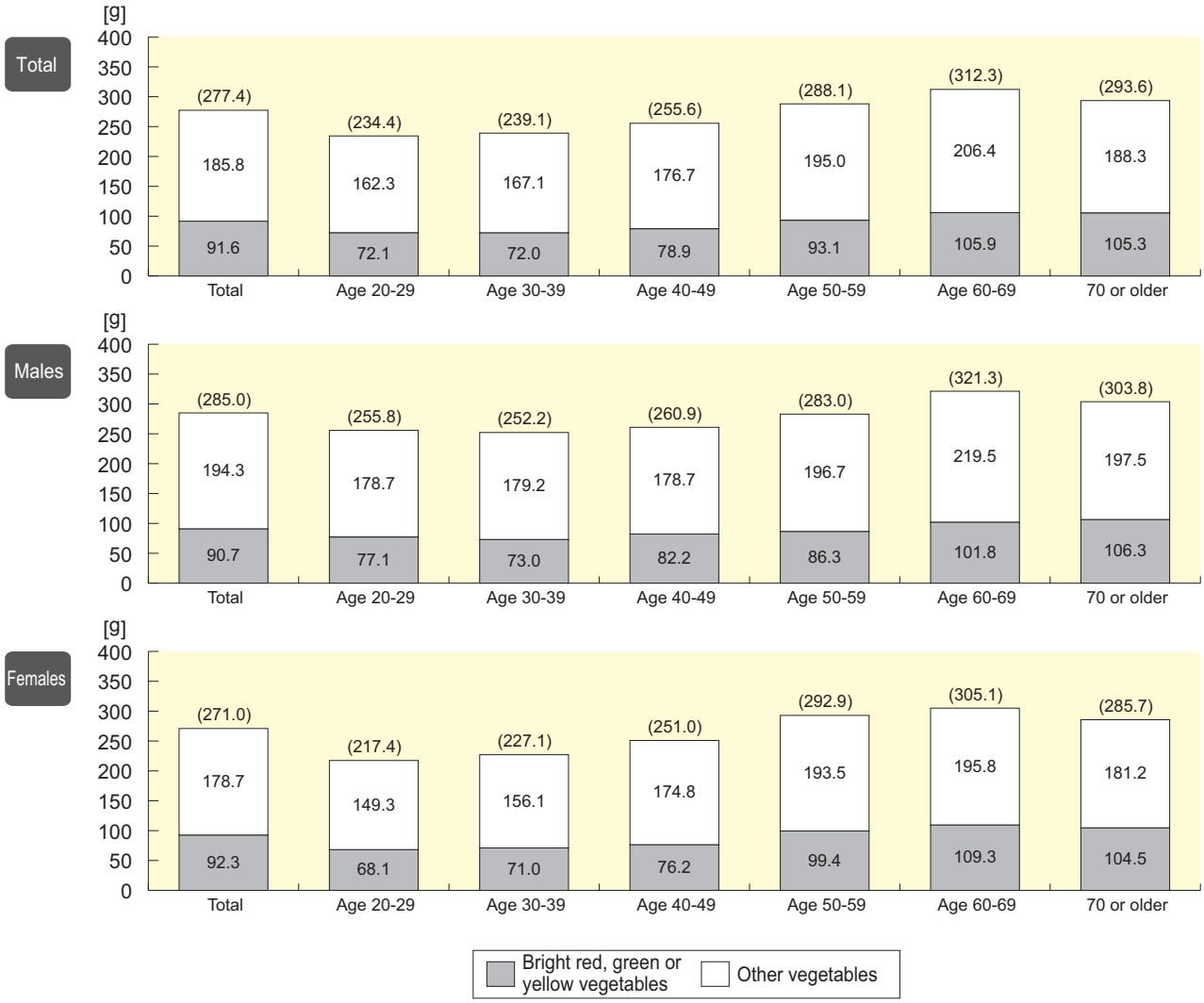
Source: “National Health and Nutrition Survey 2011”, Health Service Bureau, MHLW
(Note) Persons with exercise habits: Those who have been continuing daily exercise of 30 minutes or longer at least 2 days a week for at least a year.

Detailed Data 5 Secular Trend in Distribution of Fat Energy Ratio (Aged 20 or Older)



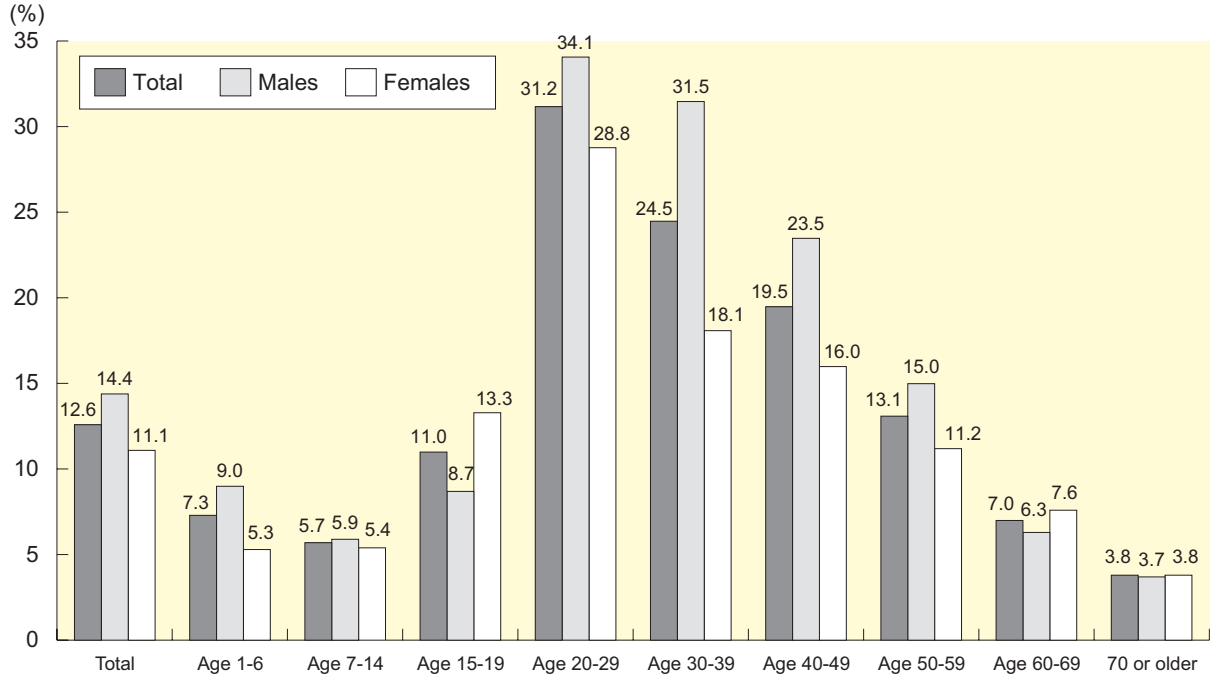
Source: "National Health and Nutrition Survey", Health Service Bureau, MHLW
(Note) Fat energy ratio: Percentage of energy intake from fat

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



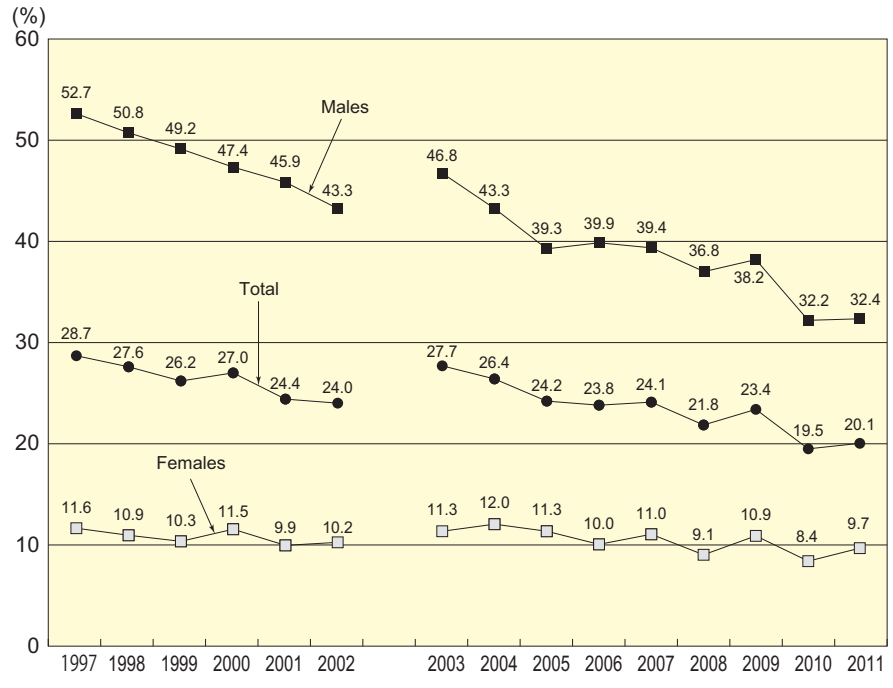
Source: "National Health and Nutrition Survey 2011", Health Service Bureau, MHLW
(Note) The figures in parentheses indicate the total intake of "bright red, green or yellow vegetables" and "other vegetables (excluding bright red, green or yellow vegetables)".

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



Source: "National Health and Nutrition Survey 2011", Health Service Bureau, MHLW

Detailed Data 8 Smoking Rate in Japan



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

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

Smoking rate in foreign countries (%)

Country	Males	Females
Japan	(32.2) 32.4	(8.4) 9.7
Germany	(34.8) 34.8	(27.3) 27.3
France	(33.3) 35.6	(26.5) 27.4
Netherlands	(31.0) 28.1	(25.0) 22.1
Italy	(28.3) 32.8	(16.2) 19.2
U.K.	(22.0) 22.0	(20.0) 21.0
Canada	(19.9) 19.1	(15.5) 15.8
U.S.A.	(23.9) 21.6	(18.0) 17.4
Australia	(16.6) 19.9	(15.2) 16.3
Sweden	(16.5) 12.8	(18.8) 15.7

Source: WHO Tobacco ATLAS (2012) "National Health and Nutrition Survey 2011" for the figures for Japan

(Note) The figures in parentheses are from WHO Tobacco ATLAS (2009) and the National Health and Nutrition Survey 2010

Dental Health Promotion

Overview 8020 (Eighty-Twenty) Campaign

[History of 8020 (Eighty-Twenty) Campaign]

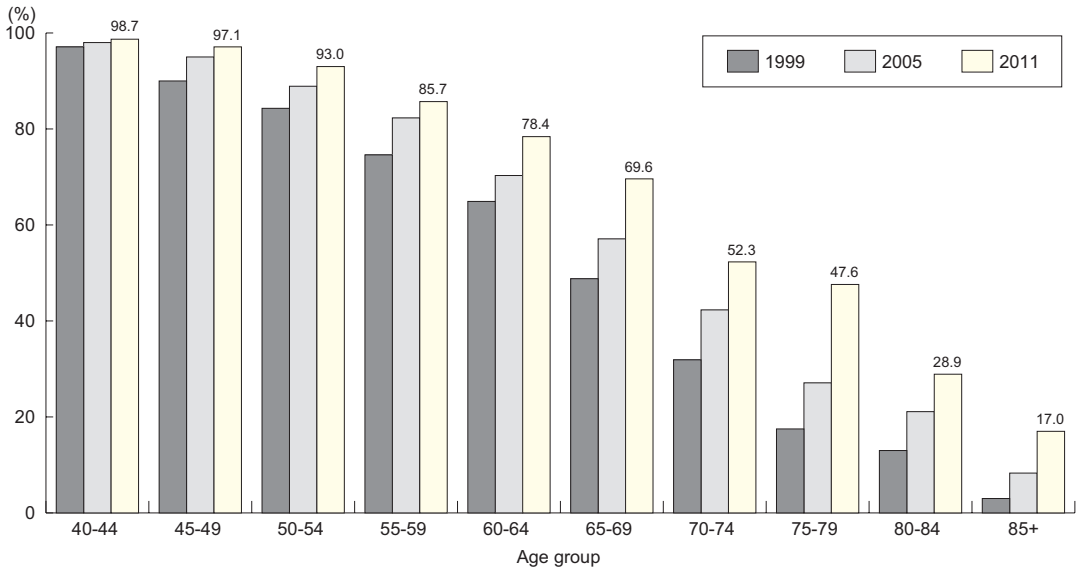
1989	A Study Group on the Dental Health Policy for Adults made public its interim reportin which the "8020 (Eighty-Twenty) Campaign" calling for the retention of 20 or more teeth even at age 80 was proposed.
1991	"Promotion of 8020 Campaign" was set to be the major objective for the Dental Hygiene Week (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).
1997	Municipal dental health promotion projects (menu projects) launched.
2000	Prefecture-led "8020 Campaign promotion special projects" launched.
2006	The results of the "Survey of Dental Diseases (2005)" was published to reveal that the percentage of persons achieving 8020 reached over 20% for the first time since the survey started.
2011	The Act on Advancement of Dental and Oral Health was approved.
2012	The "Basic Matters regarding the Advancement of Dental and Oral Health" was announced by the Minister in accordance with the "Act on Advancement of Dental and Oral Health". "Health Japan 21 (second campaign)", which provides efforts for further advancing 8020 activities, was announced by the Minister. The results of the "Survey of Dental Diseases (2011)" were published to reveal that the percentage of persons achieving 8020 reached over 40%.
2013	The title of "Dental Hygiene Week" was changed to "Dental and Oral Health Week" and the priority objective "advancement of dental and oral health that supports the power to live – new development of 8020 Campaign throughout life –"

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

The "Basic Matters regarding the Advancement of Dental and Oral Health" and "Health Japan 21 (second campaign)", announced in July 2012, mutually harmonized and provided further advancement of the "8020 Campaign". Both set the goal of "raising the percentage of those retaining 20 or more teeth at age 80" and the FY2022 target value of 50%. Efforts for dental and oral health promotion through dental health measures (8020 Campaign) throughout life continue to be important.

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

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

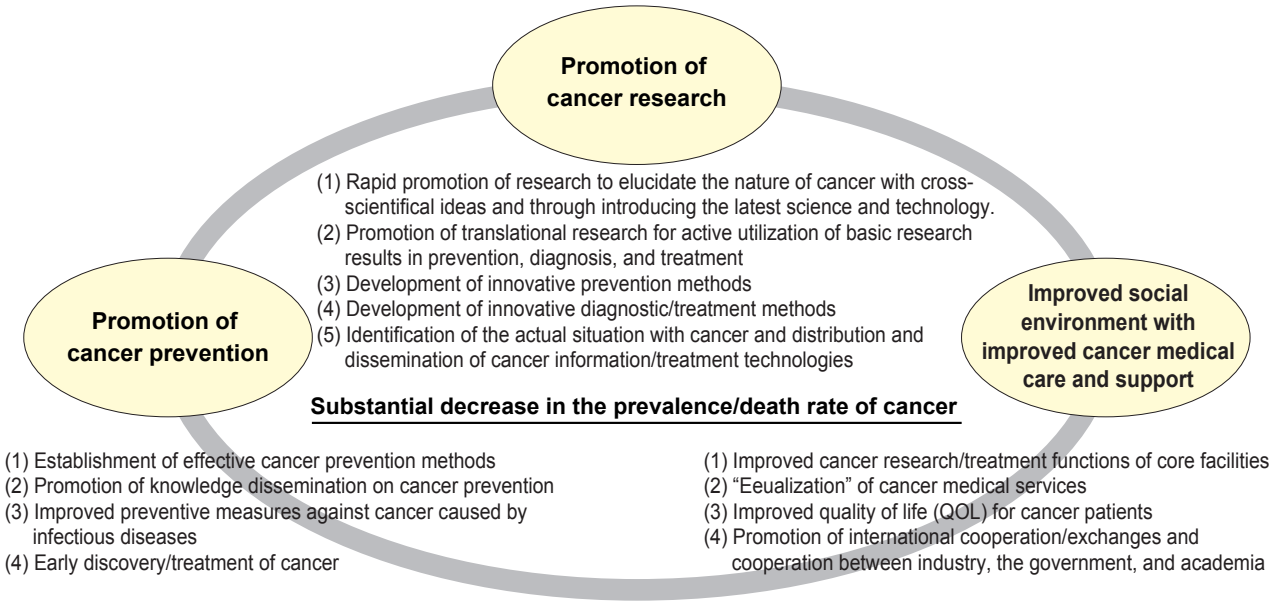


Source: "Survey of Dental Diseases", Health Policy Bureau, MHLW

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.

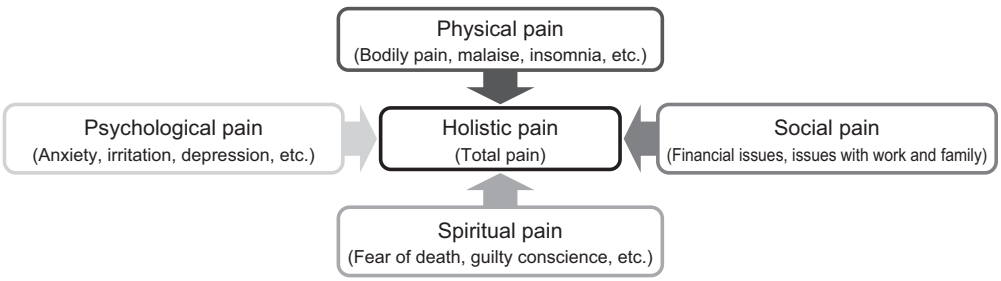
1 Basic policies

○ 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.

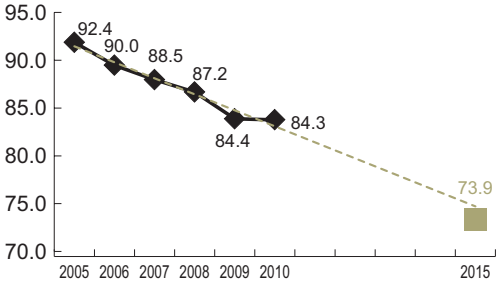
The various types of pain that cancer patients suffer



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)**

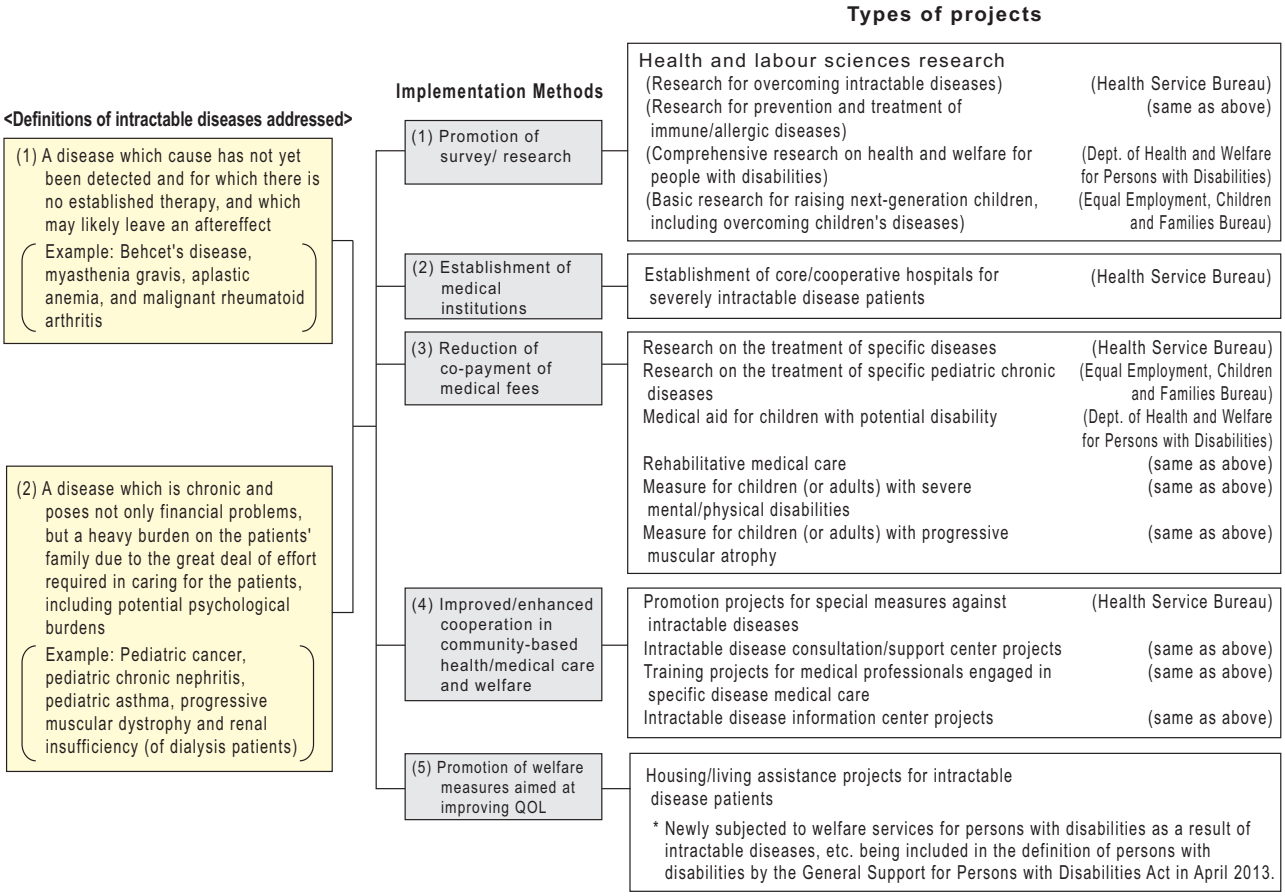
Item	Current status	Source
Number of deaths	Total of 364,721 persons (28.8% of all causes of death) [216,883 males (32.9% of all causes of death)] [147,838 females (24.2% of all causes of death)] → "1 in every 3.5 Japanese die of cancer" * Risk of cancer increases with age → The gross number of deaths is increasing (effect of aging) * The age-adjusted mortality (younger than 75) has been on a declining trend since 1995 (108.4 in 1995 → 84.3 in 2010) * Types of cancers are changing	Vital Statistics of Japan (2013 approximates) (Recounted by the Center for Cancer Control and Information Services, National Cancer Center)
Incidence rate	743,664 persons [427,949 males] Major sites: [1] stomach, [2] large intestine, [3] lung, [4] prostate gland, [5] liver [315,715 females] Major sites: [1] breast, [2] large intestine, [3] stomach, [4] lung, [5] 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 1.53 million • The number of persons hospitalized at the time of the survey was 134,800 • The number of outpatients was 163,500 • 298,300 persons received treatment per day (3.5% of those receiving treatment)	Patient Survey (2011)
Medical care expenditure for cancer	¥3,183.1 billion * 11.4% of total medical fees of medical treatment	Estimates of National Medical Care Expenditure (FY2011)

(Note) The figures of Patient Survey exclude Ishinomaki and Kesennuma medical districts of Miyagi Prefecture and Fukushima Prefecture due to the effect of the Great East Japan Earthquake.

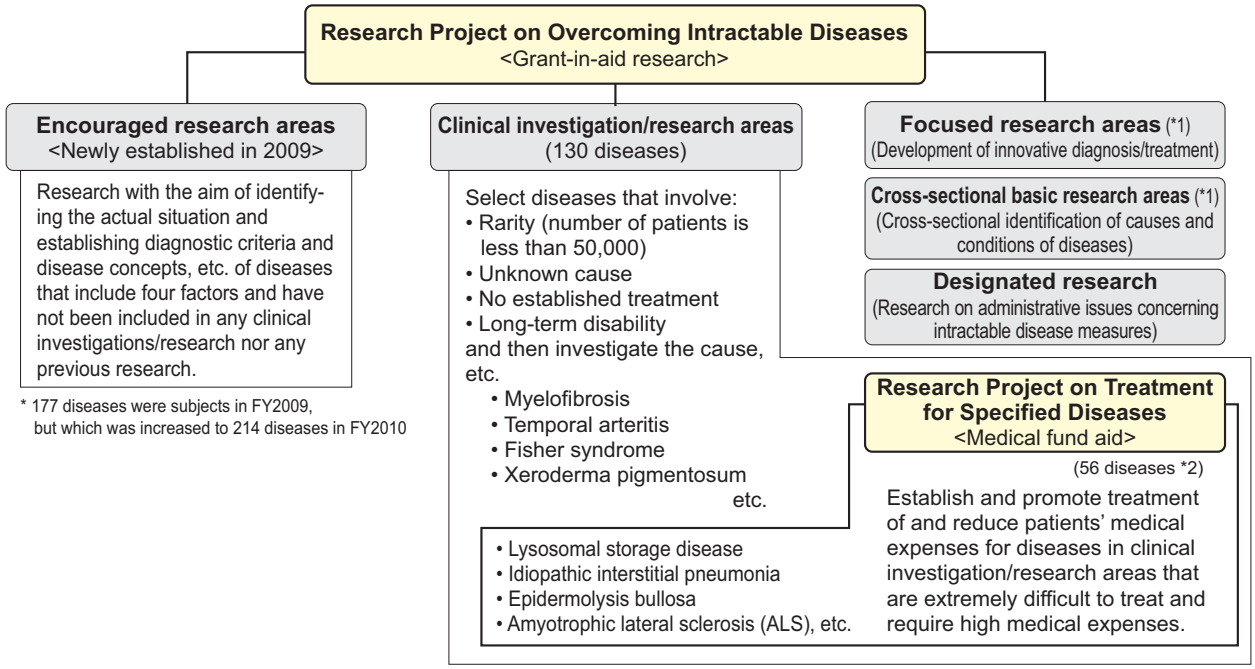
Intractable Disease Measures

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 certificates issued
1	Behcet's disease	April , 1972	18,636
2	Multiple sclerosis (MS)	April ,1973	17,073
3	Myasthenia gravis	April ,1972	19,670
4	Systemic lupus erythematosus (SLE)	same as above	60,122
5	Subacute myelo-optico-neuropathy (SMON)	same as above	1,524
6	Aplastic anemia	April ,1973	10,287
7	Sarcoidosis	October, 1974	23,088
8	Amyotrophic lateral sclerosis (ALS)	same as above	9,096
9	Scleroderma, dermatomyositis, and polymyositis	same as above	47,310
10	Idiopathic thrombocytopenic purpura (ITP)	same as above	24,100
11	Polyarteritis nodosa	October ,1975	9,610
12	Ulcerative colitis	same as above	143,733
13	Aortitis syndrome	same as above	5,881
14	Buerger's disease	same as above	7,109
15	Pemphigus	same as above	5,279
16	Spinocerebellar ataxia	October, 1976	25,447
17	Crohn's disease	same as above	36,418
18	Fulminant hepatic failure	same as above	266
19	Malignant rheumatoid arthritis	October, 1977	6,255
20	Parkinsonian disorder		120,406
[1]	Progressive supranuclear palsy	October, 2003	
[2]	Corticobasal degeneration	same as above	
[3]	Parkinson's disease	October, 1978	
21	Amyloidosis	October, 1979	1,802
22	Ossification of posterior longitudinal ligament	December, 1980	33,346
23	Huntington's disease	October, 1981	851
24	Moyamoya disease (Occlusive disease in circle of Willis)	October, 1982	15,177
25	Wegener's granulomatosis	January, 1984	1,942
26	Idiopathic dilated (congestive) cardiomyopathy	January, 1985	25,233
27	Multiple system atrophy		11,733
[1]	Striatonigral degeneration	October, 2003	
[2]	Olivopontocerebellar atrophy	October, 1976	
[3]	Shy-Drager syndrome	January, 1986	
28	Epidermolysis bullosa (junctional or dystrophic)	January, 1987	347
29	Pustular psoriasis	January, 1988	1,843
30	Spinal stenosis	January, 1989	5,147
31	Primary biliary cirrhosis	January, 1990	19,701
32	Severe acute pancreatitis	January, 1991	1,664
33	Idiopathic necrosis in femur head	January, 1992	15,388
34	Mixed connective tissue disease	January, 1993	10,146
35	Primary immunodeficiency syndrome	January, 1994	1,383
36	Idiopathic interstitial pneumonia	January, 1995	7,367
37	Pigmentary degeneration of the retina	January, 1996	27,158
38	Prion disease	Unified in June, 2002	475
[1]	Creutzfeldt-Jakob disease	January, 1997	
[2]	Gerstmann-Straussler-Scheinker disease	June, 2002	
[3]	Fatal familial insomnia	same as above	
39	Primary pulmonary hypertension	January, 1998	2,299
40	Neurofibromatosis	May, 1998	3,588
41	Subacute sclerosing panencephalitis	December, 1998	83
42	Budd-Chiari syndrome	same as above	252
43	Idiopathic chronic pulmonary thromboembolism (pulmonary hypertensive)	same as above	1,810
44	Lysosomal storage disease	Unified in June, 2002	911
[1]	Fabry's disease	April, 1999	
[2]	Lysosomal storage disease	May, 2001	
45	Adrenoleukodystrophy	April, 2000	193
46	Familial hypercholesterolemia (homozygote)	October 2009	140
47	Spinal muscular atrophy	same as above	712
48	Spinobulbar muscular atrophy	same as above	960
49	Chronic inflammatory demyelinating polyradiculoneuropathy	same as above	3,423
50	Hypertrophic cardiomyopathy	same as above	3,144
51	Restrictive cardiomyopathy	same as above	24
52	Mitochondrial disease	same as above	1,087
53	Lymphangioleiomyomatosis (LAM)	same as above	526
54	Severe erythema exudativum multiforme (acute phase)	same as above	59
55	Ossification of ligamentum flavum	same as above	2,360
56	Pituitary dysfunction (PRL secretion abnormality, gonadotropin secretion abnormality, ADH secretion abnormality, hypophyseal TSH secretion abnormality, Cushing's disease, acromegaly, hypopituitarism)	same as above	17,069
	Total		810,653

As of the end of FY2012

Source: Report on Public Health Administration and Services

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

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
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
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
Hib infection	Those aged 2 months or older but younger than 60 months
Streptococcus pneumoniae infection (limited to that in children)	same as above
Human papillomavirus infection	Females who are in the period between the first day of the fiscal year in which they turn 12 years old and the last day of the fiscal year in which they turn 16 years old
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 April 2, 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)	(Per 100,000 persons)	(Person)	(Per 100,000 persons)
1960	489,715	524.2	31,959	34.2
1965	304,556	309.9	22,366	22.8
1970	178,940	172.3	15,899	15.4
1975	108,088	96.6	10,567	9.5
1980	70,916	60.7	6,439	5.5
1985	58,567	48.4	4,692	3.9
1990	51,821	41.9	3,664	3.0
1995	43,078	34.3	3,178	2.6
1999	43,818	34.6	2,935	2.3
2000	39,384	31.0	2,656	2.1
2001	35,489	27.9	2,491	2.0
2002	32,828	25.8	2,317	1.8
2003	31,638	24.8	2,337	1.9
2004	29,736	23.3	2,330	1.8
2005	28,319	22.2	2,296	1.8
2006	26,384	20.6	2,269	1.8
2007	25,311	19.8	2,194	1.7
2008	24,760	19.4	2,220	1.8
2009	24,170	19.0	2,159	1.7
2010	23,261	18.2	2,129	1.7
2011	22,681	17.7	2,166	1.7
2012			2,110	1.7
2013			* 2,084	* 1.7

Source: <Number of newly registered patients / prevalence rate>
"Aggregate Result of the Annual Reports of Surveillance of Tuberculosis", Health Service Bureau, MHLW
<Number of deaths / rate of deaths>
"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 figures indicated by "*" 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

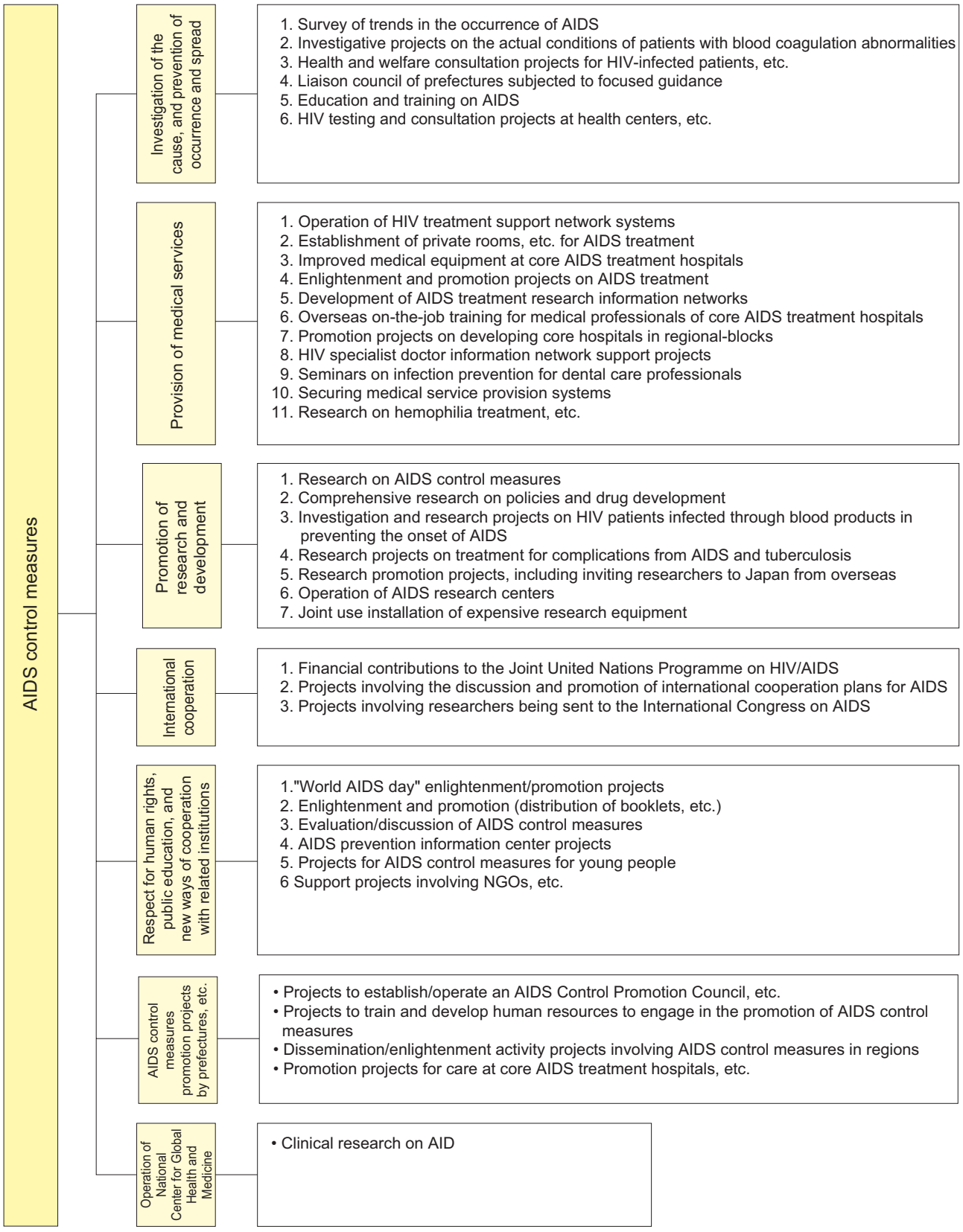
Detailed Data 3 International Comparison of Tuberculosis Prevalence Rate

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)
- 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.)
- Formulation of annual test plans and implementation of consultations regarding tests

Provision of medical care services

<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
- Support for cooperation between respective hospitals through establishing conferences, etc.

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 cooperation with prefectures, etc. with large numbers 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	2011	2012	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	923	889	11,258	76.6
		Female	0	0	11	4	18	10	17	16	22	32	19	41	34	36	45	32	50	40	32	44	32	49	38	34	38	41	42	31	808	5.5
		Total	0	0	45	19	53	37	69	124	124	166	166	230	268	297	424	368	525	521	557	680	741	836	969	1,033	932	997	965	920	12,066	82.0
	Foreign national	Male	0	0	10	4	21	11	26	45	33	37	47	65	49	58	39	53	59	55	48	62	60	76	76	60	71	59	71	65	1,260	8.6
		Female	0	0	0	0	6	18	105	273	120	95	64	81	80	67	67	41	37	38	35	38	31	40	37	33	18	19	20	17	1,380	9.4
		Total	0	0	10	4	27	29	131	318	153	132	111	146	129	125	106	94	96	93	83	100	91	116	113	93	89	78	91	82	2,640	18.0
	Total		0	0	55	23	80	66	200	442	277	298	277	376	397	422	530	462	621	614	640	780	832	952	1,082	1,126	1,021	1,075	1,056	1,002	14,706	100.0
AIDS	Japan	Male	5	3	6	9	15	18	24	36	53	91	108	156	170	158	212	239	221	232	252	290	291	335	343	359	386	421	419	387	5,239	78.0
		Female	0	0	3	2	2	3	0	1	5	9	11	15	12	10	12	21	24	20	19	19	11	20	22	19	15	15	16	18	324	4.8
		Total	5	3	9	11	17	21	24	37	58	100	119	171	182	168	224	260	245	252	271	309	302	355	365	378	401	436	435	405	5,563	82.8
	Foreign national	Male	1	2	3	3	4	10	14	13	19	28	33	45	39	42	46	41	61	36	39	54	49	33	34	32	21	29	21	31	783	11.7
		Female	0	0	2	0	0	0	0	1	9	8	17	18	29	21	31	28	26	20	26	22	16	18	19	21	9	4	17	11	373	5.6
		Total	1	2	5	3	4	10	14	14	28	36	50	63	68	63	77	69	87	56	65	76	65	51	53	53	30	33	38	42	1,156	17.2
	Total		6	5	14	14	21	31	38	51	86	136	169	234	250	231	301	329	332	308	336	385	367	406	418	431	431	469	473	447	6,719	100.0

Source: “AIDS Surveillance Report 2012”, National AIDS Surveillance Committee, MHLW
(Note) The figures do not include HIV carriers and AIDS patients who have been infected through blood-coagulation-factor preparations.

Detailed Data 2 Status of AIDS Patients in the World (as of the end of 2011, UNAIDS Report)

Region		Number of HIV infected patients (adults/children)	Number of newly infected HIV patients (adults/children)	Percentage of HIV-positive adults (%)		Number of persons died from AIDS (adults/children)
Sub-Sahara Africa	2011	23.50 million [22,100,000 - 24,800,000]	1.80 million [1,600,000 - 2,000,000]	4.9 [4.6 - 5.1]	2011	1.20 million [1,100,000 - 1,300,000]
	2001	20.90 million [19,300,000 - 22,500,000]	2.40 million [2,200,000 - 2,500,000]	5.9 [5.4 - 6.2]	2005	1.80 million [1,600,000 - 1,900,000]
Middle East, North Africa	2011	0.30 million [250,000 - 360,000]	37,000 [29,000 - 46,000]	0.2 [0.1 - 0.2]	2011	23,000 [18,000 - 29,000]
	2001	0.21 million [170,000 - 270,000]	27,000 [22,000 - 34,000]	0.1 [0.1 - 0.2]	2005	20,000 [15,000 - 25,000]
South Asia, Southeast Asia	2011	4.00 million [3,100,000 - 4,600,000]	0.28 million [170,000 - 370,000]	0.3 [0.2 - 0.3]	2011	0.25 million [190,000 - 330,000]
	2001	3.70 million [3,200,000 - 5,100,000]	0.37 million [250,000 - 450,000]	0.3 [0.3 - 0.5]	2005	0.29 million [270,000 - 310,000]
East Asia	2011	0.83 million [590,000 - 1,200,000]	89,000 [44,000 - 170,000]	0.1 [<0.1 - 0.1]	2011	59,000 [41,000 - 82,000]
	2001	0.39 million [280,000 - 530,000]	75,000 [55,000 - 100,000]	<0.1 [<0.1 - <0.1]	2005	39,000 [27,000 - 56,000]
Oceania	2011	53,000 [47,000 - 60,000]	2,900 [2,200 - 3,800]	0.3 [0.2 - 0.3]	2011	1,300 [<1.000 - 1,800]
	2001	38,000 [32,000 - 46,000]	3,700 [3,100 - 4,300]	0.2 [0.2 - 0.3]	2005	2,300 [1,700 - 3,000]
Latin America	2011	1.40 million [1,100,000 - 1,700,000]	83,000 [51,000 - 140,000]	0.4 [0.3 - 0.5]	2011	54,000 [32,000 - 81,000]
	2001	1.20 million [970,000 - 1,500,000]	93,000 [67,000 - 120,000]	0.4 [0.3 - 0.5]	2005	60,000 [36,000 - 93,000]
Caribbean Coast	2011	0.23 million [200,000 - 250,000]	13,000 [9,600 - 16,000]	1.0 [0.9 - 1.1]	2011	10,000 [8,200 - 12,000]
	2001	0.24 million [200,000 - 270,000]	22,000 [20,000 - 25,000]	1.2 [1.0 - 1.3]	2005	20,000 [16,000 - 23,000]
Eastern Europe, Central Asia	2011	1.40 million [1,100,000 - 1,800,000]	0.14 million [91,000 - 210,000]	1.0 [0.6 - 1.0]	2011	92,000 [63,000 - 120,000]
	2001	0.97 million [760,000 - 1,200,000]	0.13 million [99,000 - 170,000]	0.3 [0.4 - 0.7]	2005	76,000 [58,000 - 100,000]
Western Europe, Central Europe	2011	0.90 million [830,000 - 1,000,000]	30,000 [21,000 - 40,000]	0.2 [0.2 - 0.3]	2011	7,000 [6,100 - 7,500]
	2001	0.64 million [590,000 - 710,000]	29,000 [26,000 - 34,000]	0.2 [0.2 - 0.2]	2005	7,800 [7,600 - 9,000]
North America	2011	1.40 million [1,100,000 - 2,000,000]	51,000 [19,000 - 120,000]	0.6 [0.5 - 1.0]	2011	21,000 [17,000 - 28,000]
	2001	1.10 million [850,000 - 1,300,000]	50,000 [35,000 - 71,000]	0.6 [0.5 - 0.7]	2005	20,000 [16,000 - 26,000]
Total	2011	34.00 million [31,400,000 - 35,900,000]	2.50 million [2,200,000 - 2,800,000]	0.8 [0.7 - 0.8]	2011	1.70 million [1,500,000 - 1,900,000]
	2001	29.40 million [27,200,000 - 32,100,000]	3.20 million [2,900,000 - 3,400,000]	0.8 [0.7 - 0.9]	2005	2.30 million [2,100,000 - 2,600,000]

*Actual figures fall within the range of the figures in parentheses.
The estimated numbers and ranges are calculated based on the best data available to date.
Source: “UNAIDS report on the global AIDS epidemic 2012”

Pandemic Influenza Preparedness

Overview Pandemic Influenza Preparedness

Pandemic Influenza

A pandemic influenza occurs when a new type of influenza virus emerges for which humans have little or no immunity, which allows the virus to easily spread person to person worldwide and cause a global outbreak as it differs from an annual influenza epidemic. In recent year, a highly pathogenic avian influenza A(H5N1) that can be transmitted from birds to humans has sporadically emerged, mainly in Asia, the Middle East, and Africa. 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 pandemic preparedness and response measures.

(Assumptions made in the national action plan)

Number of patients consulting medical institutions	Approx. 13-25 million
Number of hospitalized patients	Approx. 0.53-2 million
Number of fatalities	Approx. 0.17 - 0.64 million

Major events

Dec. 2005	Formulation of the "National Action Plan for Pandemic Influenza" (Liaison Conference of the Relevant Ministries and Agencies on Avian Influenza, etc.)
May 2008	Amendment of the Act on Infectious Disease Control and the Act on Quarantine (Legislative preparation by categorizing a new or re-emerging influenza as "pandemic influenza" to legally conduct hospitalization and quarantine at the ports of entry. In addition, influenza H5N1 transmitted from birds to humans was categorized as the infectious disease category 2 "avian influenza (H5N1)" in the Act on Infectious Diseases Control)
Feb. 2009	Amendment of the "National Action Plan for Pandemic Influenza" (Liaison Conference of the Relevant Ministries and Agencies on Pandemic and Avian Influenza) followed by the amendment of the Act on Infectious Diseases Control
Apr. 2009	Emergence of Influenza A(H1N1)pdm09
Mar. 2011	The announcement was made in March that it is no longer recognized as "a new or reemerging influenza strain, or a designated infectious disease" as stipulated in the Act on Infectious Disease Control as of March 31, and measures were switched to those for seasonal influenza
July 2011	Amendment of the Act on Preventive Vaccinations (providing new temporary vaccinations framework based on the assumption of Pandemic influenza that had the same level of high transmissibility as the influenza A(H1N1)pdm09 but not highly pathogenic)
Sep. 2011	Revision of the "National Action Plan for Pandemic Influenza" (Ministerial Meeting on Countermeasures against Pandemic Influenza) followed by the experiences of influenza A(H1N1)pdm09, etc.
Apr. 2012	Approval of the "Act on Special Measures for Pandemic Influenza and New Infectious Diseases Preparedness and Response" (Legal countermeasures when a pandemic influenza and new infectious disease emerged)

Major budgetary projects

Capacity development in medical institutions of novel infleunza	Capacity building in necessary beds and medical resources at medical institutions designated by local governments to accept pandemic influenza patients
Public communications of preparedness against pandemic influenza	Public communications for individuals, families and workplaces. Information sharing with medical institutions through mail magazines
Stockpiles of antiviral drugs	National and local stockpiles for a total use of approx. 60 million people by FY2012
Stockpiles of H5N1 pre-pandemic vaccine	As of the end of FY2012, Vietnam and Indonesia strains (produced in FY2010) for approx.10 million people and Qinghai strain (produced in FY2012) for approx.10 million people had been stockpiled
Capacity development for pandemic influenza vaccine	Development of capacity to develop pandemic influenza vaccine by cell culture technology for the whole population within 6 months

Organ Transplantation and Hematopoietic Stem Cell Transplantation

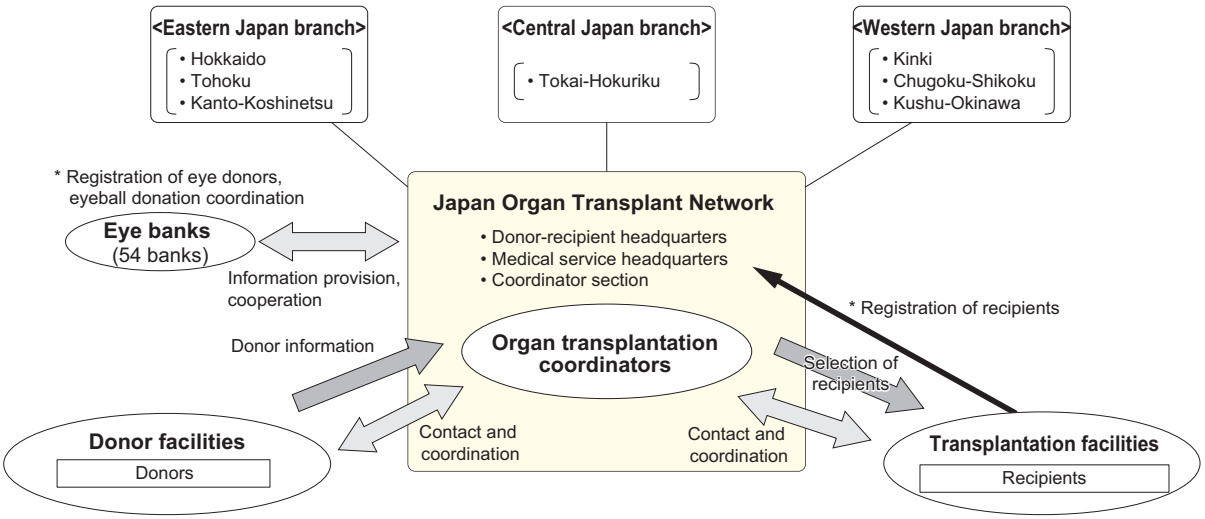
Overview　Organ Transplantation System

[Organ Transplantation System]

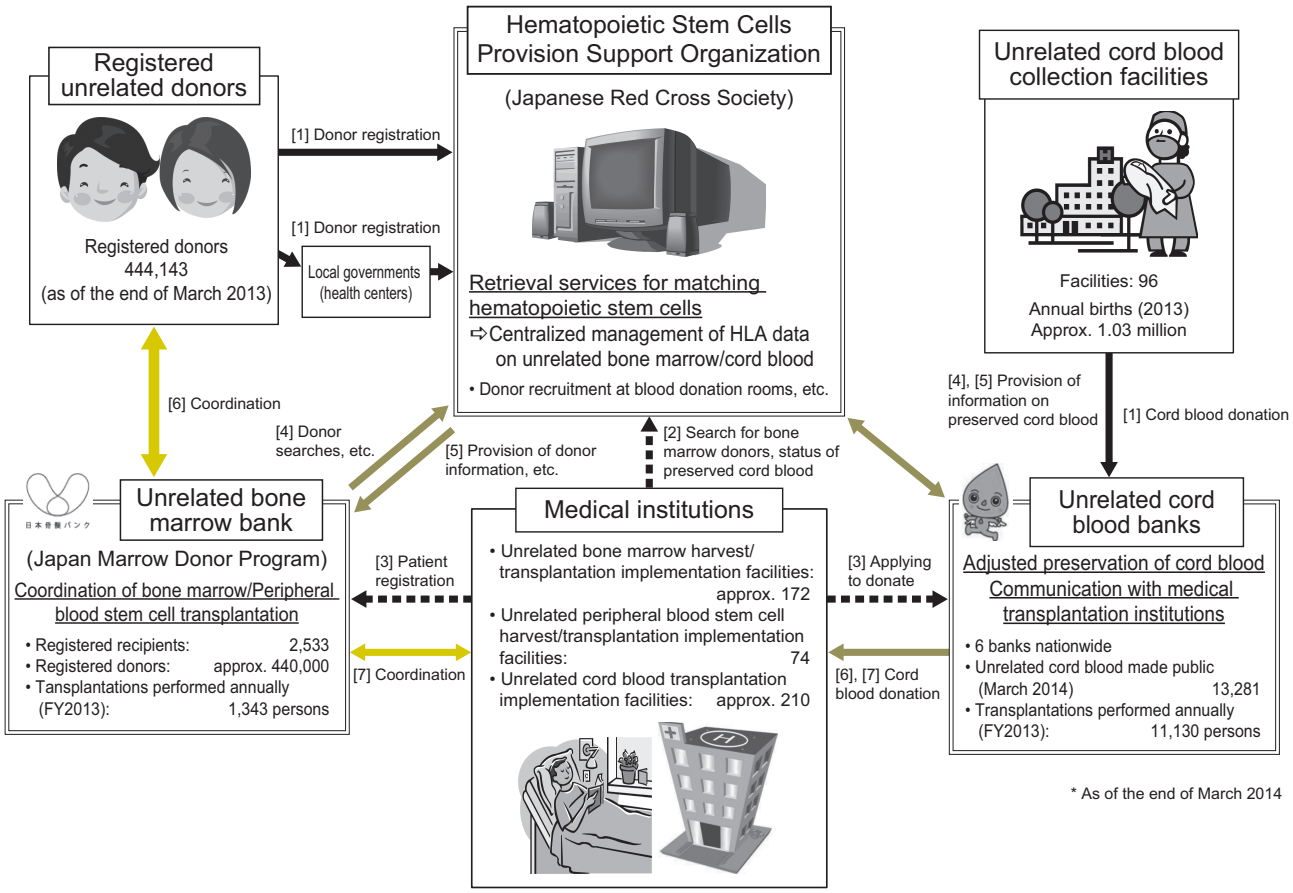
The traditional kidney transplantation system was reviewed and a new centralized nationwide kidney transplantation network established in FY1995. Enforcement of the "Act on Organ Transplantation" in October 1997 enabled multiple organ transplantations and the pertinent network.

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



Unrelated 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	201 persons	201 persons	201 cases	201 cases	316 persons
Lung	177 persons	177 persons	217 cases	217 cases	235 persons
Liver	216 persons	216 persons	231 cases	231 cases	408 persons
Kidney	1,524 persons	247 persons	2,822 cases	486 cases	12,697 persons
Pancreas	193 persons	190 persons	192 cases	190 cases	187 persons
Small intestine	13 persons	13 persons	13 cases	13 cases	3 persons
Eyeball (cornea)	15,873 persons	107 persons	25,591 cases	196 cases	2,217 persons

Source: Japan Organ Transplant Network, Japan Eye Bank Association

(Note) 1. The number of donors and the number of transplantations performed indicate the cumulative total from October 16, 1997 (the day of the enforcement of the Act on Organ Transplantation) to April 30, 2014. The number of patients on waiting lists is as of April 30, 2014.

2. There have been 268 cases of brain death tests conducted nationwide under the Act on Organ Transplantation since the enforcement of the law until April 30, 2014. 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

	Unrelated donors		Number of unrelated transplantations		
	Number of registered donors	Number of registered cord blood	Bone marrow	Peripheral blood stem cell	Cord blood
FY1991	3,176	—	—	—	—
FY1992	19,829	—	8	—	—
FY1993	46,224	—	112	—	—
FY1994	62,482	—	231	—	—
FY1995	71,174	—	358	—	—
FY1996	81,922	—	363	—	1
FY1997	94,822	—	405	—	19
FY1998	114,354	—	482	—	77
FY1999	127,556	—	588	—	114
FY2000	135,873	4,343	716	—	169
FY2001	152,339	8,384	749	—	220
FY2002	168,413	13,431	739	—	297
FY2003	186,153	18,424	737	—	702
FY2004	204,710	21,335	851	—	678
FY2005	242,858	24,309	908	—	658
FY2006	276,847	26,816	963	—	754
FY2007	306,397	29,197	1,027	—	778
FY2008	335,052	31,149	1,118	—	875
FY2009	357,378	32,793	1,232	—	907
FY2010	380,457	32,994	1,191	1	1,074
FY2011	407,871	29,560	1,269	3	1,106
FY2012	429,677	25,385	1,323	15	1,199
FY2013	444,143	13,281	1,324	19	1,130
Total	—	—	16,694	38	10,758

Source: Japan Marrow Donor Program, Japan Cord Blood Bank Network

* The figures for cord blood stem from FY1996 to FY1998 indicate the number of transplantations coordinated by cord blood banks before the establishment of the Japanese Cord Blood Bank Network.

* Number of donors is as of the end of the respective years.

(4) Drugs, etc.

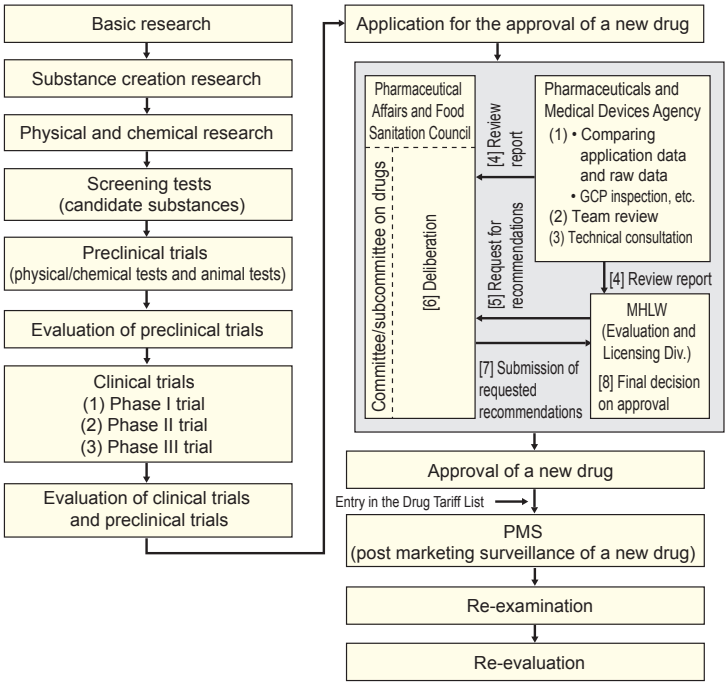
Approval/Licensing System for Drugs, Quasi-Drugs, and Cosmetics

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 2013)

Category	Drugs			Quasi-drugs	Cosmetics	Total
		Class 1 drugs	Class 2 drugs			
Marketing	1,206	266	940	1,406	3,608	6,220

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. (2013)

		Prescription drugs	Over-the-counter drugs	Quasi-drugs	Cosmetics
Manufacturing	Approval	1	0	0	0
	Approval with partial revision	2	0	0	0
	Total	3	0	0	0
Import	Approval	0	0	0	0
	Approval with partial revision	5	0	0	0
	Total	5	0	0	0
Marketing	Approval	1,929	628	1,680	0
	Approval with partial revision	2,585	265	290	0
	Total	4,514	893	1,970	0

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

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

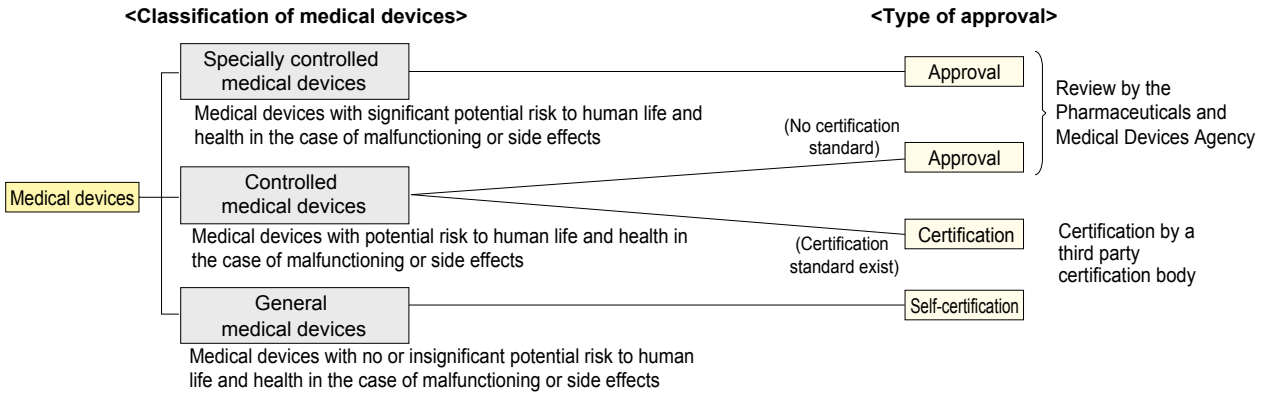
(As of the end of 2013)

Category	Drugs	Quasi-drugs	Cosmetics	Total
Manufacturing	2,349	1,707	3,530	7,586

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 2013)

Category	Class 1 medical devices	Class 2 medical devices	Class 3 medical devices	Total
Marketing	644	973	904	2,521

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 (2012)

		Medical devices
Manufacturing	Approval	8
	Approval with partial change	0
	Total	0
Import	Approval	0
	Approval with partial change	0
	Total	0
Marketing	Approval	609
	Approval with partial change	885
	Total	1,494

Source: Pharmaceutical and Food Safety Bureau, MHLW

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

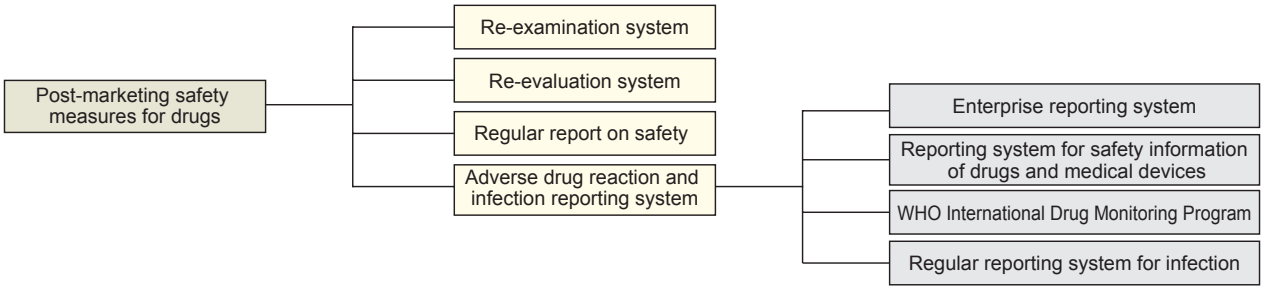
	Medical devices
Manufacturing	3,569
Repairs	6,389

Source: Pharmaceutical and Food Safety Bureau, MHLW (as of the end of 2012)
(Note) Licenses are granted by prefecturel governors from April 1997 (excluding some medical devices).

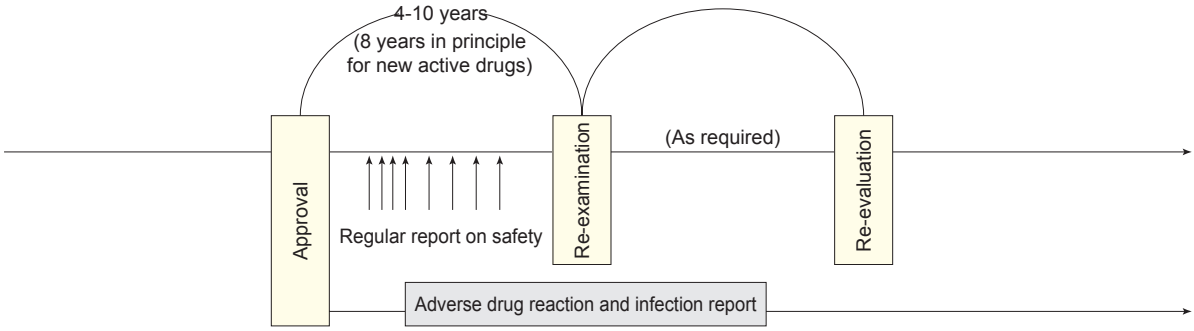
Post-Marketing Measures for Drugs/Medical Devices

Overview

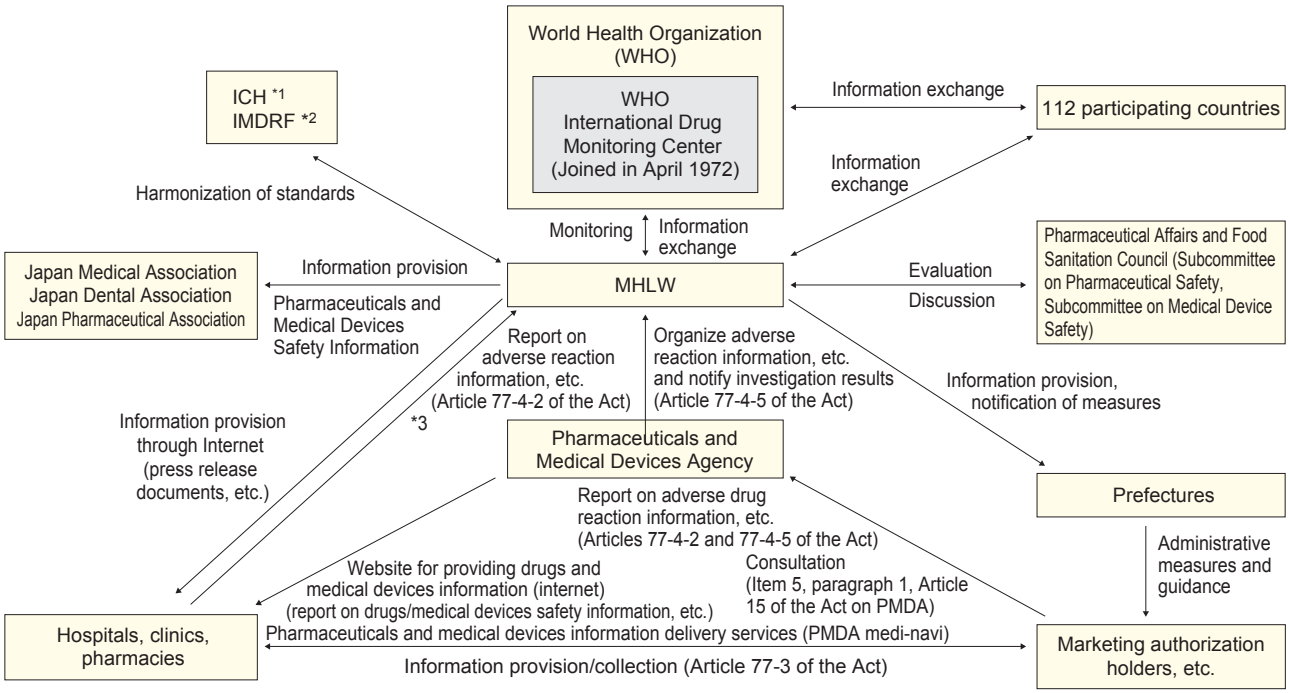
Post-Marketing Safety Measures for Drugs



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: International Medical Device Regulators Forum
*3: From November 25, 2014, medical institutions, etc. will report to the Pharmaceuticals and Medical Devices Agency.
Note: Other than the above, collection of adverse drug reaction information from patients has commenced as an original service of the Pharmaceuticals and Medical Devices Agency on a trial basis since March 26, 2012.

Detailed Data 1 Results of Prescription Drug Re-examination

(As of the end of FY2013)

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
1,179	3,228	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 FY2013)

	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 infectious diseases	Reports on research results	Reports on overseas measures	Regular reports on infectious diseases	
FY2009	30,814	114	933	930	1,108	6,181
FY2010	34,578	99	940	1,033	1,101	4,809
FY2011	36,641	100	841	1,347	1,089	5,231
FY2012	41,254	159	884	1,134	1,117	4,147
FY2013	38,329	98	962	1,317	1,138	5,420

* The figures for FY2009 to FY2012 include 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, and pneumococcus vaccines for children. From FY2013, reports on adverse drug reaction after taking preventive vaccination are included in “reports from medical institutions”.

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 infectious diseases	Reports on research results	Reports on overseas measures	Regular reports on infectious diseases	
FY2009	6,446	0	6	831	59	363
FY2010	14,811	0	27	978	58	374
FY2011	16,068	0	2	1,060	62	385
FY2012	22,234	0	3	1,337	69	522
FY2013	25,554	0	5	1,669	75	489

* Reports on adverse event include overseas cases.

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.

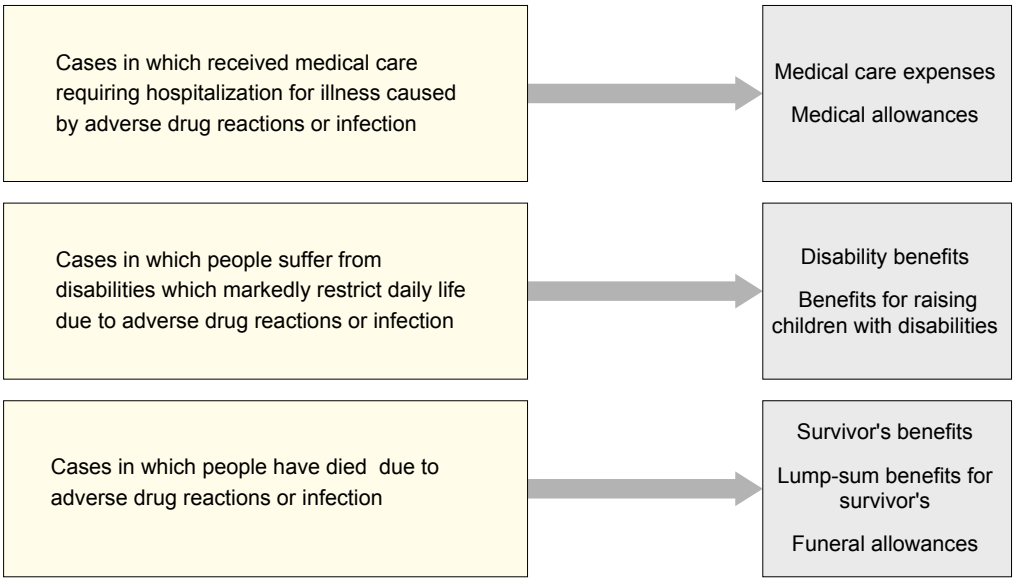
[Relief System for Infections Acquired through Biological Products]

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)

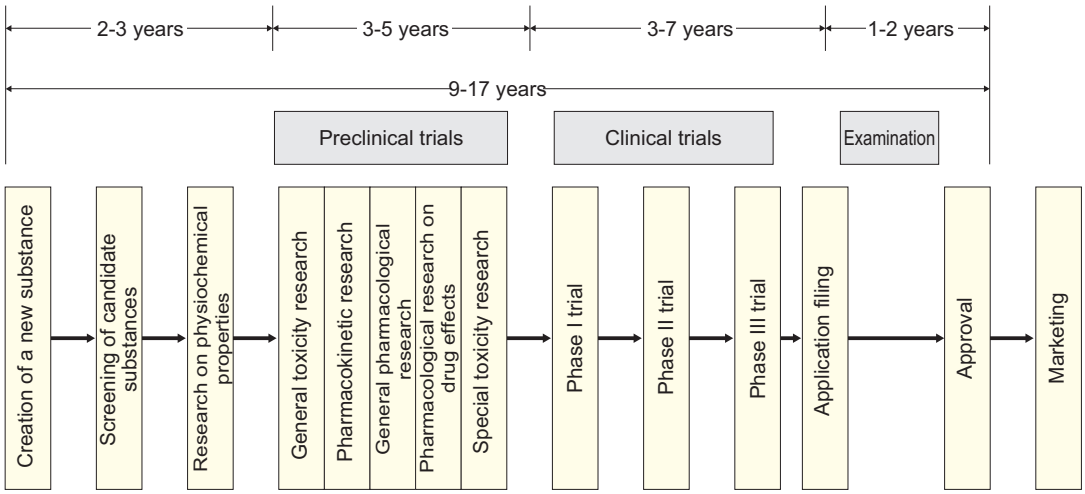
	FY1980-FY1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Amount (¥1,000)	6,058,217	797,557	928,986	920,419	935,148	1,022,185	1,055,985	1,204,243	1,262,647	1,587,567	1,582,956	1,696,525	1,798,706	1,783,783	1,867,190	2,058,389	1,920,771	1,959,184
Number of claims (case)	2,665	399	361	389	480	483	629	793	769	760	788	908	926	1,052	1,018	1,075	1,280	1,371
Number of payments (case)	2,076	294	306	289	343	352	352	465	513	836	676	718	782	861	897	959	997	1,007

Source: Pharmaceutical and Medical Devices Agency

Research/Development of Drugs and Pharmaceutical Industry

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

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



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

Category	Number of enterprises	Percentage	Drug sales (¥100 million)	Percentage	Prescription drug sales (included) (¥100 million)	Percentage
Capital of less than ¥100 million	172	48.6%	3,262	2.6%	1,918	1.9%
¥100 million - 5 billion	119	33.6%	31,454	24.7%	25,385	24.9%
¥5 billion or more	63	17.8%	92,592	72.7%	74,553	73.2%
Total	354	100.0%	127,308	100.0%	101,856	100.0%

Source: “Survey of the Prescription Pharmaceuticals Industry of Japan (FY2012)”, 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, 2013 that were members of categorized organizations (14 organizations) of the Federation of Pharmaceutical 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
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
2011	18,085	5.5	4,809	10,584	23,525
2012	18,952	4.8	4,901	11,884	25,894

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	4,682	24.7	Sterile tubes and catheters for vascular procedures, sterile blood transfusion sets
2. Diagnostic imaging system	2,925	15.4	Whole body X-ray CT units, general-purpose ultrasonic diagnostic imaging devices
3. Biological function assisting devices/substitutes	2,883	15.2	Stents, hip replacements
4. Bio-phenomena monitoring measuring/monitoring devices	2,433	12.8	Electronic endoscopes, sphygmomanometers
5. Medical specimen testers	1,587	8.4	Discrete automatic clinical chemical analyzers, luminescence immune measurement devices
6. Dental materials	1,131	6.0	Gold silver palladium alloy for dental casting, dental ceramics
7. Medical devices for home use	807	4.3	Electronic massaging devices for home use, in-ear hearing aids
8. Diagnostic imaging X-ray related units/instruments	615	3.2	Films for image recording and direct photography
9. Ophthalmologic devices and related products	564	3.0	Eyeglasses for sight correction, contact lenses
10. Others	1,325	7.0	
Total	18,952	100.0	

Source: “Annual Report on the Survey of Pharmaceutical Industry Productions 2012”, 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 rate of separation of dispensing and prescribing functions (%)
FY1989	36,670	13,542	95.2	11.3
FY1990	36,981	14,573	105.4	12.0
FY1991	36,979	15,957	111.7	12.8
FY1992	37,532	17,897	125.8	14.1
FY1993	38,077	20,149	140.6	15.8
FY1994	38,773	23,501	161.0	18.1
FY1995	39,433	26,508	182.5	20.3
FY1996	40,310	29,643	210.0	22.5
FY1997	42,412	33,782	238.1	26.0
FY1998	44,085	40,006	278.8	30.5
FY1999	45,171	45,537	307.3	34.8
FY2000	46,763	50,620	348.6	39.5
FY2001	48,252	55,960	393.7	44.5
FY2002	49,332	58,462	393.0	48.8
FY2003	49,956	59,812	418.8	51.6
FY2004	50,600	61,889	368.7	53.8
FY2005	51,233	64,508	425.2	54.1
FY2006	51,952	66,083	442.5	55.8
FY2007	52,539	68,375	481.0	57.2
FY2008	53,304	69,436	483.0	59.1
FY2009	53,642	70,222	494.1	60.7
FY2010	53,067 *	72,939	486.6	63.1
FY2011	54,780	74,396	498.3	65.1
FY2012	55,797	75,888	533.3	66.1

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. The number of prescriptions, that per 1,000 persons, 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 effect of the Great East Japan Earthquake.

Blood Programme

Overview

[Blood Products]

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

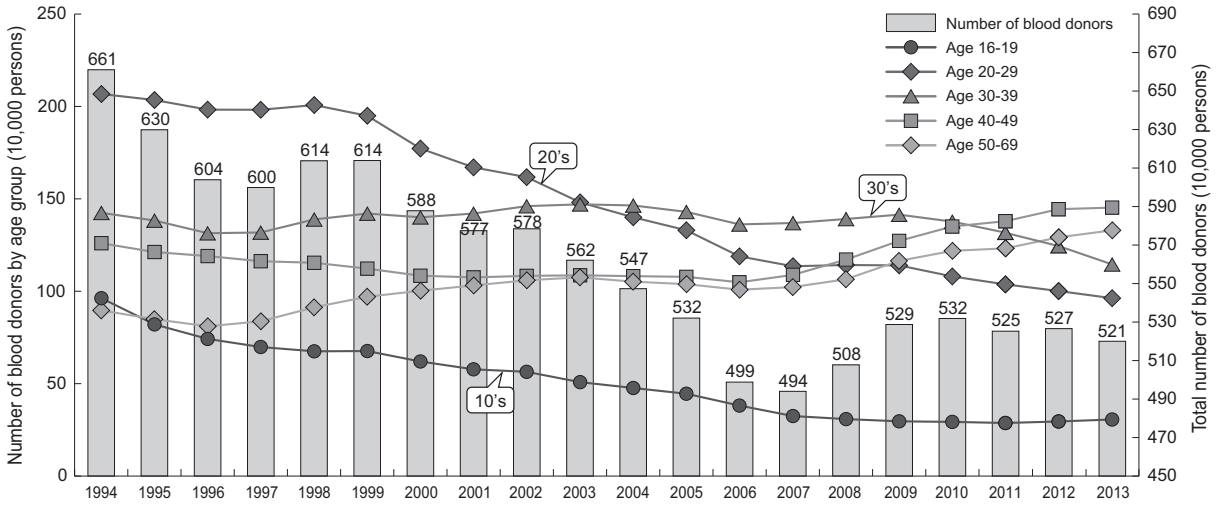
Regarding plasma derivatives, blood coagulation factor products are supplied domestically except for a few special products. Some kinds of plasma derivatives, such as albumin preparations and hepatitis B immunoglobulin products, are still imported from overseas. From the viewpoint of “self sufficiency” and “securing stable supply”, efforts are being made to establish 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 disorders, 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

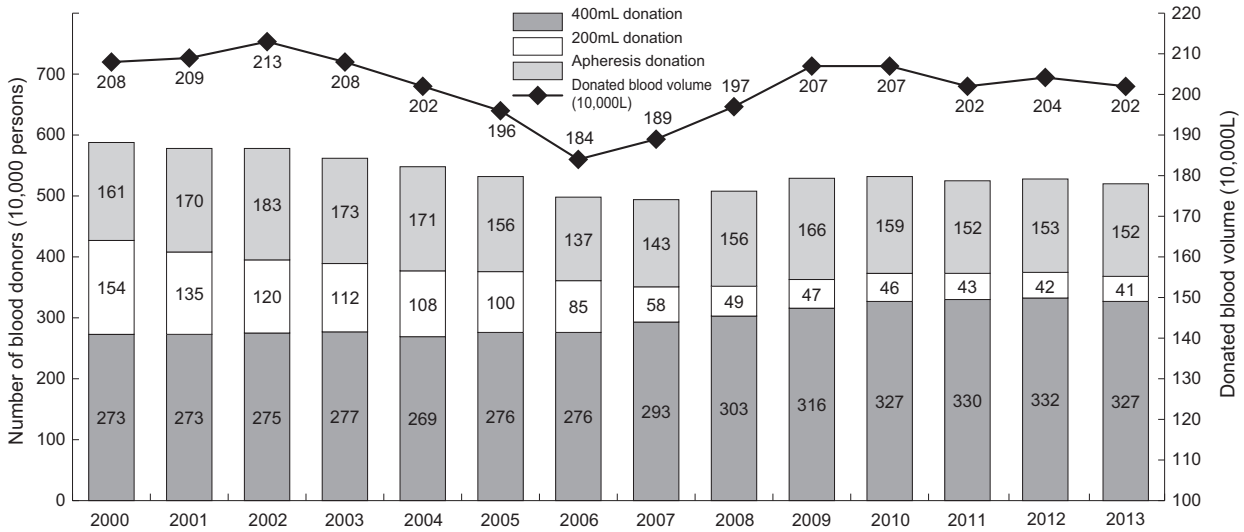
[Status of Blood Donation]

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