Section 5

Enhancing a Safe, Reliable, and High Quality Medical Care System, including Securing Doctors and Providing Emergency Medical Care

1 Stable provision of high quality services

(1) Promotion of securing doctors and medical professionals

1) Increase in the number of doctors to be trained

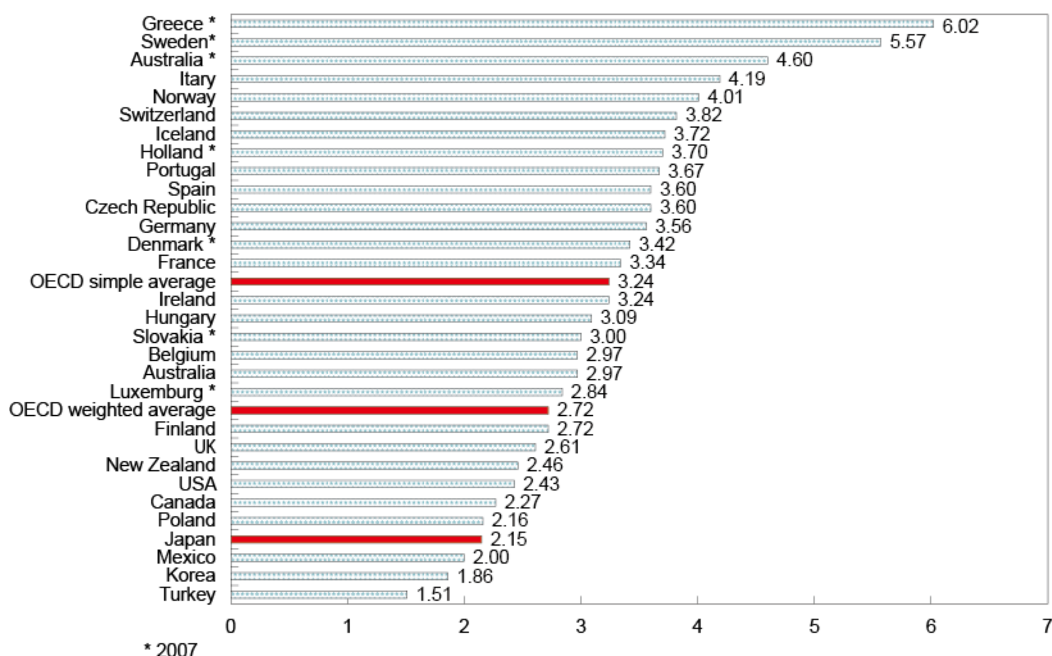
In Japan, the number of medical doctors per population is lower than the average of the OECD, and shortage of the absolute number of doctors has been pointed out. Accordingly, in FY 2007, the quota of medical students was emergently and temporary increased to train doctors working in the doctor shortage areas. In FY 2008, the quota of medical students reached 7,793, an increase of 168 students.

To be in line with the“2008 Basic Policies (Honebuto)”, the quota of medical students was increased to a record high of 8,486 in FY 2009. Furthermore, in FY 2010, an emergent and temporal increase of 360 students was accepted with the aim of securing doctors for regional placement, and 8,846 students were enrolled in the medical department.

2) Disparities in the number of doctors among the departments and regions

In Japan, there is a regional disparity in the number of doctors with extremely small number of doctors in mountainous and remote areas compared with the urban areas, and also a disparity among the departments with serious shortage of doctors mainly obstetrics and pediatrics. Accordingly, in the FY 2009 first supplementary budget, the “Local Health Care Revitalization Foundation” was established in each prefecture to support the efforts to secure regional doctors in accordance with the “Local Health Care Revitalization Plan” formulated by prefectures, aiming at solving the medical issues in regions.

Chart 2-5-1 International Comparison of Clinician Density per 1000 Population (2008)



(Note) 1) Simple average refers to the total number of physicians per population of each country divided by the number of countries.

2) Weighted average refers to the total number of physicians divided by the entire population.

3) The figures for Canada, France, Greece, Italy and Turkey indicate the number of professionally active physicians, and those for Ireland, Holland, Portugal and Sweden shows the total number of physicians.

Source: OECD Health DATA2010

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In addition to financial support in FY 2009 for paying the allowances provided to the doctors in charge of emergency medical care in the nighttime and on holidays and delivery, similar financial support was launched in the FY 2010 budget for the hospital doctors in charge of neonatal medical care as the measures against disparity in the number of doctors among the departments.

Moreover, through the FY 2010 Medical Fee Revision, the rate was revised positively at +1.55% for medical fee aiming at rebuilding medical care such as in emergency medical services, obstetrics, pediatrics and surgery and reducing the burdens on hospital doctors in these departments.

Furthermore, the fact・finding survey on the necessary number doctors is currently conducted in prefectures to clarify the goal for securing doctors in each region, and the survey results are scheduled to be announced after summer.

3) Measures to prevent female doctors from leaving their jobs and support for their returning to work

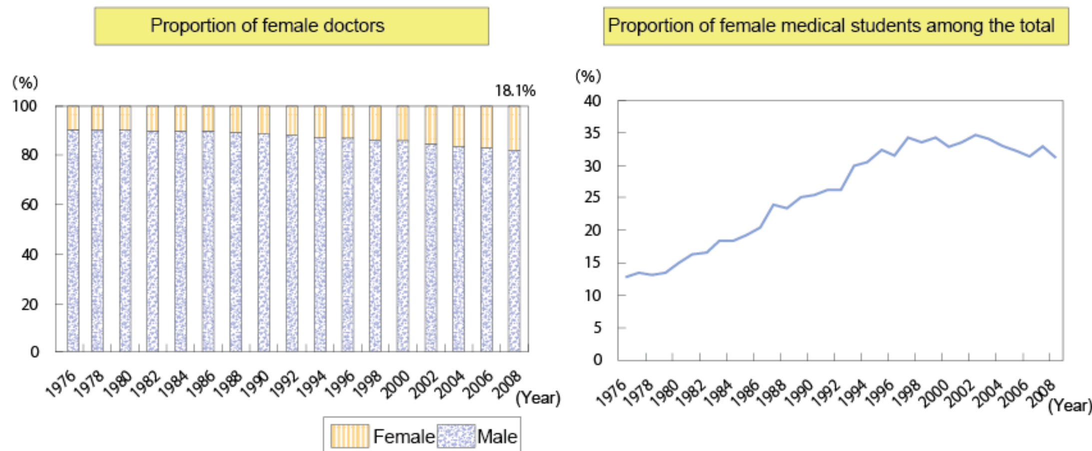
In recent years, female doctors are on the increase at medical practice sites as illustrated by the fact that one third of examinees of national examination for medical practitioners are

females. Therefore, it is important to create an environment that responds to the various life cycle stages such as childbirth and child rearing and enables female doctors to engage in their work without anxiety.

More specifically, in the FY 2010 budget, the financial support for example for operating day care centers at hospitals was expanded. The budget also incorporates the measures to help female doctors who are leaving their jobs to return to work for instance through the establishment of reception and consultation desk in each prefecture, referral service to the medical institutions that offer training programs, and implementation of training programs in accordance with their work situation after returning to work. The implementation of these measures together with the ones to improve working environment of hospital doctors aims to establish an environment that enables female doctors to continue to work or return to work without anxiety.

Chart 2-5-2 Change in the Number of Female Doctors

○The share of female doctors among the total number of doctors has been on the increase, with 18.1% in 2008.
○In recent years, young female doctors are on the steep increase as illustrated by the fact that one third of examinees of the national examination for medical practitioners are female.



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

Source: "School Basic Survey" Ministry of Education, Culture, Sports, Science and Technology

4) Promotion of team medical care

In order to realize high quality medical care with patients and their families, it is important to offer medical service that respond exactly to the patients' situation through enhancing expertise of each medical professional, expanding their duties and roles and making cooperation among each medical staff. Based on this viewpoint, the "Study Group on the Promotion of Team Medical Care" consisting of experts in various fields such as doctors,

nurses, patients and jurists, had discussed the specific measures to promote team medical care since August 2009 through conducting hearings with the persons related to the medical practice sites. At the end of March, 2010, the study group compiled a report. The Ministry of Health, Labour and Welfare will take specific measures to promote team medical in accordance with the said report.

Column

Roles of office workers in medical fields ~Ex. “medical clerk” In Saiseikai Kurihashi Hospital~

While workloads has been increasing accompanied by sophisticating/complicating medical care in Japan’s medical fields, requirements from patients/their families for high quality and safe/secure medical service has been rising up. It is said that how medical care should be is questioned fundamentally since exhaustion of medical related occupation engaging in field works is pointed out. In such a situation, “team medical care” where various kinds of medical personnel cooperate to/complement each other as excising their specialty is focused on as a keyword which has a possibility to bring reform upon medical care in Japan. In the Ministry of Health, Labour and Welfare, “Investigation Commission on Promotion of Team Medical Care” was established in August 2009, and we discussed how consultation/cooperation of medical personnel should be according to the actual conditions of our country and organized reports in March 2010.

On this report, it is advanced that we must promote service improvement for patients/their family while positively introducing highly skilled office workers (medical clerks) in medical related office works and striving to ease burdens of doctors and others since burdens of doctors/nurses has been increasing due to increase of workloads on paper chases such as medical certificates, reports and letter of introduction. As for medical fee, “Revision of the Medical Fee Scheme and the Approval of 'Additional Fees for the Assistance of Medical Office Work” was established for hospitals which fulfill the requirement such as disposition of full・time assistants for medical office work according to the revision in 2008, and expansion of the points has just been conducted according to the 2010 revision.

In the run・up to policy movement, the hospital which has been advancing original efforts like introduction of “medical clerk” and has been yielding results is Saitama prefecture Saiseikai Kurihashi Hospital. In this hospital too, paper works and workloads related with other office procedures had been increased before. Medical clerk was introduced to solve problems such as rising complaints and exhaustion of regular doctors up due to the actual

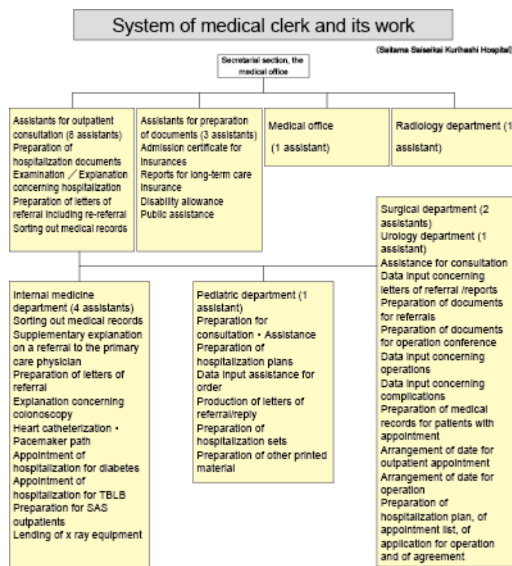
condition where they dealt with various kinds of documents like proof of hospitalization after their regular working hours and on their day・off. After disposing one clerk on that post tentatively in June 2005, they have been disposing more clerks on the department of surgery, internal medicine and pediatrics for outpatients, and they put them together in April 2008 and established the system where they positioned 11 clerks of "Medical Assistance Department" under the general practice department. As for the latest update, 16 clerks (including 3 part・time clerks) have been disposed as of April 1, 2010.

Observing the results from introduction of medical clerk, most of doctors made responses like "my working hour is reduced" and "I feel less tired because I do not need to do complicated outpatients work" in the anonymous survey conducted to 45 regular・doctors in October 2007 in that hospital.

We see by observing transition of actual overtime work as well that overtime work decreased by 14% in 2006 compared with the previous year, and it has been still reducing since then.

As for medical clerk, it is essential to implement maintenance/improvement of abilities of actual workers. This hospital has original educational training program for medical clerks where they can acquire required systematic knowledge/skills of medical clerks through taking orientation for one or two months, acquiring basic office skills, taking education on personal information protection and compliance, training to understand treatment contents and in knowledge on medical record and medical related law between 3th month to 4th month, and then grasping actual work in medical treatment department in 5th month and 6th month after confirming their achievement level of knowledge/skills.

Although those kinds of efforts in medical fields are important from perspective of securing medical quality, we also think that the efforts must be taken from the viewpoint of a new employment creation. We, the Ministry of Health, Labour and Welfare, in charge of promotion of such measures, will continue to work on our policies.



5) The Local Health Care Revitalization Foundation

In order to solve the regional medical issues, the “Local Health Care Revitalization Foundation” was established in each prefecture in the FY 2009 first supplementary budget for the purpose of supporting the efforts to secure regional doctors and strengthen emergency medical care for five years until FY 2013 based on the “Local Health Care Revitalization Plan.”

Column

Actual condition of regional medical recovery plan ~efforts in Hiroshima prefecture~

Regional medical recover foundation established in 2009 with the first supplementary budget is not the traditional support for hospital individually but it is the support for a whole target area on the basis of “regional medical recover plan” formulated by prefectures by establishing foundation in prefectures in order to solve regional medical issues such as securing doctors in regions and stabilizing emergency medical care.

Although various plans were formulated like changing a hospital to a base hospital for emergency and high・risk childbirth and doctor pool system together with prefectures and universities, we will show the plan in Hiroshima prefecture.

Hiroshima is composed of 14 cities and 9 towns, and all kinds of statistics are close to the average in Japan, and it has characteristic physiognomy of Japan like mountains, seas, rivers, valleys, plains, basins and isolated islands and it has variety population distribution

from a city designated by government ordinance to remote places. Therefore, we can say it's like an epitome of Japan.

The present status of regional medicine in Hiroshima is that doctors in remote places medical base hospitals of intermediate and mountainous area owing vast underpopulated area has been dramatically decreasing and they have serious problems like progressing of reduction of medical treatment department, while medical resource of hospitals are enough furnished in urban cities but the fact that patients have been coming in urban areas from the periphery of them and patients in need of emergency treatment have been increasing exhausts regular doctors.

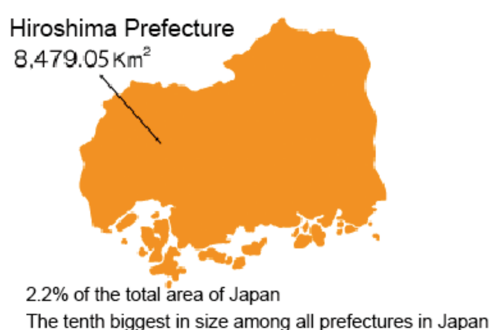
The framed plan on the basis of such the situation is to promote coordination between medical facilities in a body so as to improve efforts for shortage of doctors and main medical function, and to meet deepened/varied high medical needs.

The main plan among of them is to establish "Promotion Organization for Regional Medicine in Hiroshima Prefecture (tentative name) " composed of the prefecture, municipalities, Hiroshima University, prefectural medical association and so on. The pillar of this organization is, to arrange dispatch/disposition of doctors with will for regional medicine to medical institutes in the prefecture, "Measures Securing Enough Pysicians" to support for return・to・work of female doctors, and "Promoting Regional Clinical Cooperative System" adjusting reform/cooperation of medical organizations starting with coordination of base hospitals in Hiroshima prefecture and intermediate and mountainous area. By conducting those two measures together, the organization aims to formulate the foundation of General Policy Planning for Recruitment and to raise a whole medical environment in Hiroshima prefecture.

Relating with reform plan, it will put its efforts into enriching "Regional Health Care Council of Hiroshima Prefecture" (established in 1969) where administration (Hiroshima prefecture and Hiroshima city) , prefectural medical association and Hiroshima University discusses together on emergency medical measure and so on. Regional Health Care Council of Hiroshima Prefecture is the remarkable organization nationally which has implemented various efforts such as utilizing Doctor・Heli Business In Hiroshima's way covering a whole prefecture with low cost by unifying two Helitacks and telephone consultation on sudden illness of children "#8000", and it has been producing cooperation between parties by building activities through 40 years and intends to support for realization of the plan.

Hiroshima prefecture has conducted "Urgent Appeal of 'Let's Preserve Medicine in Hiroshima All Together'" to inhabitants together with administration, medicine and educationists in February 2008, and it asks people for cooperation as not just being a taker of medicine but a part of props for medical treatment, Besides, it wrestles to medical

problems with all public officers and it urges efforts for securing medical system required in the region by that municipality itself distributes “Municipality Subsidy to Support Urgent Medicine” for costs consumed to invite doctors and to maintain environment. Moreover, In order to improve weak system to shortage of doctors because medical organization (a fixed number of faculties of medicine) is little against the size of population, it has just developed unique policies positively such as expanding limit for provincials for faculty of medicine in Hiroshima University and formulating Scholarship to Grow Doctors in Hiroshima. Hiroshima prefecture aims to reform medical system with regional medicine reform plan by utilizing experience it has got through the efforts.



(2) Establishment of a high quality and efficient health care system

As a result of upgrade within the universal health care insurance and free access system to allow people to receive the necessary health care, the Japanese health service system has become an important foundation for securing people’s health.

On the other hand, it is necessary to take measures against the imminent issues, including serious shortage of doctors in obstetrics and pediatrics and in remote areas, as well as the issues related to acceptance of critical・care patients. At the same, time, the environment surrounding the health care has been undergone changes because of a rapid progress of the aging of society, and changes in the way people think. Under these circumstances, it is also necessary to cope with the mid・ to long・term challenges regarding how to build a medical service system with an eye toward the future.

1) Promotion of a Division of Roles and Cooperation between Regional Medical Institutions within the Medical Care Plan System

In order to realize efficient and high quality medical care by effectively using the limited medical resources, it is important to divide roles and make cooperation among regional medical institutions and to establish a system to provide continuous medical care from the

acute to the maintenance stage via the recovery stage in the entire region. Based on the medical care plan in prefectures, medical cooperation system in each region will be established by specifying necessary medical functions for each of four specific diseases (i.e. cancer, cerebral apoplexy, acute myocardial infarction and diabetes) and five services (i.e. emergency medical care, medical care in disasters, medical care in remote areas, maternal and perinatal service and medical care for children including emergency child medical services) and by clarifying the medical institutions to serve each medical function.

Chart 2-5-3 Division of Roles and Cooperation among Medical Institutions

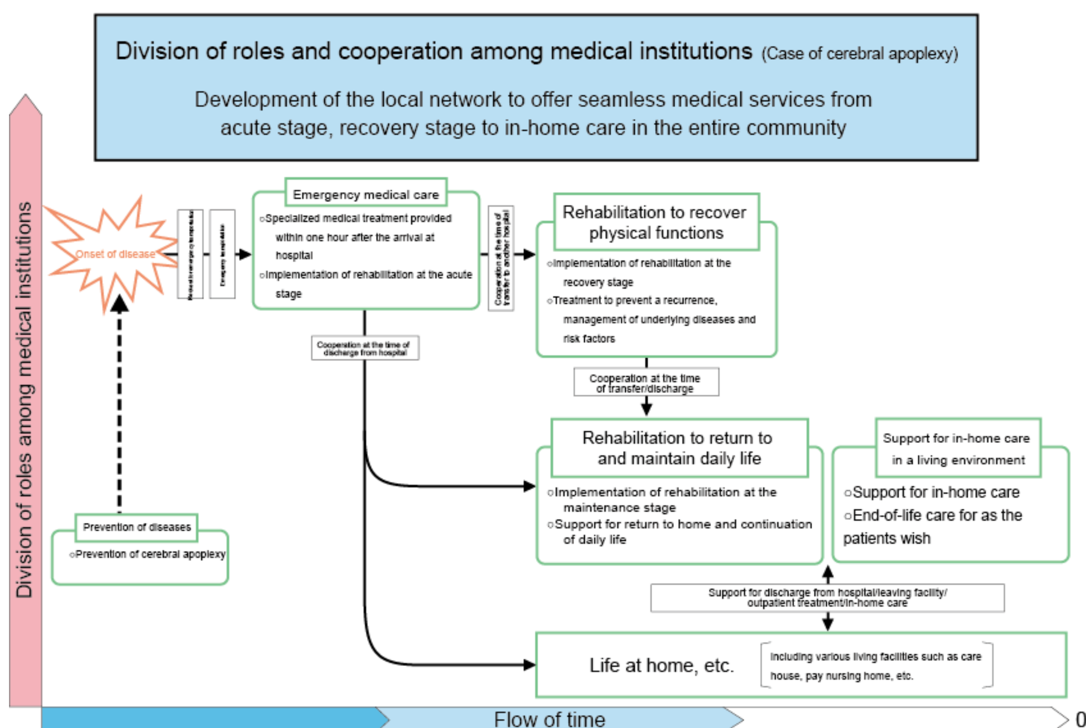
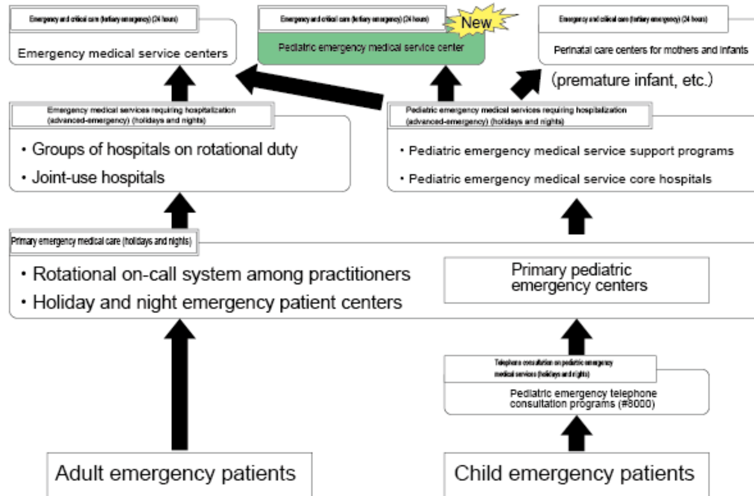


Chart 2-5-4 Structural Chart of Emergency Medical Service



2) Securing a System to Provide Emergency Medical Care, Perinatal Care, and Other Medical Services in All the Regions

❶ Emergency Medical Care

Emergency medical care is indispensable for s people's daily lives without undue anxiety. Hence, since FY 1977, the system for emergency medical care, consisting of early stage emergencies, emergencies requiring hospitalization (second stage emergencies) , and lifesaving emergencies (third stage emergencies) , has been systematically established (Chart 2-5-4) .

The system for emergency medical care, however, cannot respond to the increasing number of patients who use emergency medical services, which makes it hard to accept critical・care patients smoothly.

In order to improve such situations, efforts are being made in the FY 2010 budget to giving ① support for the emergency and critical care centers that accept critical care patients in a serious condition around the clock; ② support for the doctors at clinic who offer medical services at medical institutions for the second stage emergencies in the nighttime and on holidays; ③ support for the medical institutions that accept patients who are hard to be accepted, including patients with acute alcohol intoxication or with mental illness, without fail; ④ support for the allowance to the doctors in charge of emergency medical care in the nighttime and on holidays; and ⑤ support for allocating coordinators who serve the patients recovered from acute stage to smoothly change hospitals or hospital rooms.

Furthermore, with the aim of strengthening cooperation between the fire department and medical institutions and also facilitating transportation and acceptance of critical・care patients, partial revision of Fire and Disaster Management Act was implemented at the

171th ordinary Diet session (The revised act was enforced on October 30, 2009) . Prefectures are currently establishing implementation standards for transporting and accepting critical・care patients in cooperation with the fire department and medical institutions.

Aiming at deploying medical helicopters nationwide in accordance with the actual situation in regions, the subsidized projects to introduce medical helicopters have been implemented. As of July 1, 2010, 23 medical helicopters are in operation in a total of 19 prefectures.

The medical fee revision in FY 2010 also ① improved assessment of emergency hospitalization care; and ② improved assessment of emergency department allied with local communities.

Column

Promotion of AED ~Effort of Tokyo Disaster prevention & Emergency medical service Association~

Automated External Defibrillator (AED) is medical equipment used to recover heart function by giving electric shock (Defibrillator) when so・called ventricular fibrillation which is a kind of arrhythmia occurred to your heart. Although usage of this equipment was only limited to doctors and nurses/emergency life guards instructed by doctors, AED is available to everyone since July, 2004 on the basis of the fact a survival rate can be risen up by that people at a scene use AED as soon as possible because allegedly a survival rate is getting lower by 7 to 10% per a minute in proportion to latency of defibrillator after arrest cardiac, and that its safety and credibility has been established in Europe and the United States where it is already popularized to general people. Since then, it has been equipped at various places such as public facilities like stations, airports and schools, business establishments and apartments so we see it more often than before. As estimated number of equipped AED is 200,000 and more as of December 2008.

Tokyo Disaster prevention & Emergency medical service Association (Public Interest Incorporated Association) (hereafter the Association) established in 1994 for promotion of first aid is the association that has included usage of AED in all kind of life saving program since January 2005 and is in effort to promote usage of AED. It has good reputation so far like it is very understandable since most of teachers are those who have large experience on medical fields like lifesaving guards and they lecture with talking their actual experience.

In 2009, lifesaving program was held about 10,000 times in a year. It was so popular that every lecture had almost as many students as it almost reached the fixed number for those courses. Although lecture is held in fire stations and welfare facilities in Tokyo, if there are requests, it can be held in business establishments. A number of students in 2008 are about 230,000.

First, we learn about cardiopulmonary resuscitation in programs for AED because when to use AED we should not only do so but we need to also conduct it with cardiac compression and artificial respiration.

Although how to use AED is a little bit depending on a sort of AED, its system is designed to announce instructions so that even beginners can manage it easily. However, if time has come that you have to use AED, whether or not you can deal with it calmly is much different if you have used it before in programs and so on. The Association says that we'd like to put our much effort into promoting life saving program with our wish that a number of people take programs on and on, and as many life as possible will be saved thanks to it.

(Refer to)

○ Website of Tokyo Disaster prevention & Emergency medical service Association
http://www.teate.jp/

❷ Children's medical care

It is important to establish a system for children's medical care in consideration of protecting lives of children as well as ensuring a guardians' sense of security about child・rearing. The infant mortality rate of Japan is lower than that of other developed countries.

The rate for the children aged 1・4, however, is higher, and the necessity to establish medical institutions to provide emergency medical care for children has been pointed out. Accordingly, the FY 2010 budget was allocated for ① support for emergency and critical care center for children that offer emergency medical care for children; and ② support for intensive care units for children that provide children in acute stage with intensive and specialized medical care.

Besides, child・oriented emergency medical telephone services (#8000) provided by professionals such as pediatricians for the guardians of children have been in service to ease the anxiety of the guardians whose children are in acute stage.

When guardians are not sure how to treat their children who suddenly become ill during evenings and holidays or where they should bring their children to a hospital to receive medical treatment, they can call a telephone consulting desk by dialing #8000 from anywhere in Japan to receive proper advice on how to treat their children in accordance with their conditions and an appropriate hospital to visit.

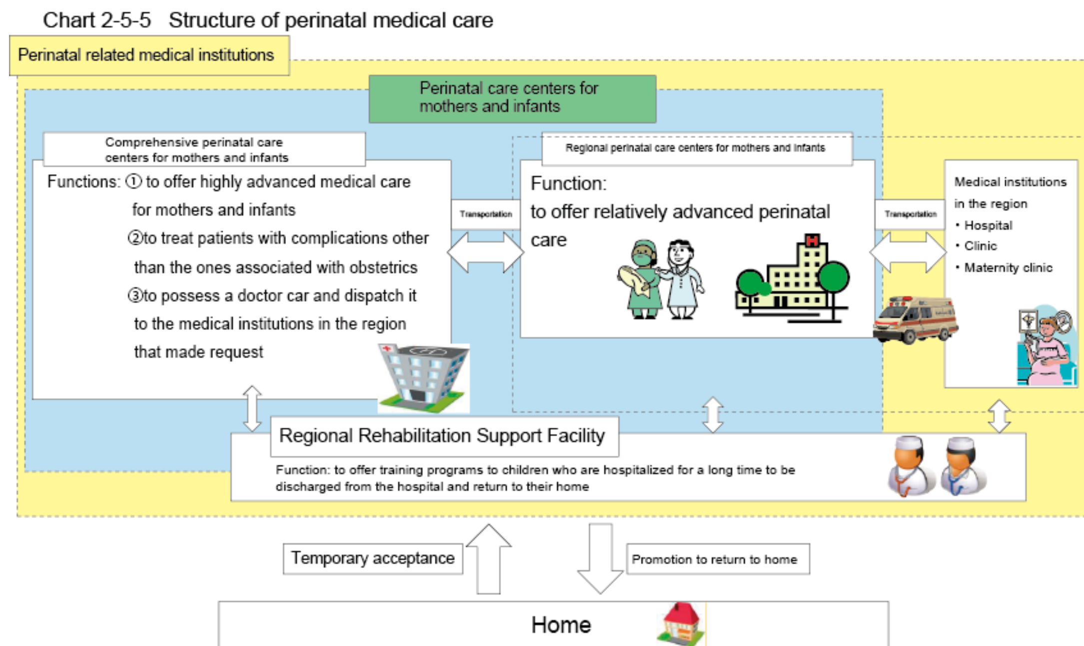
Telephone Consulting Desk for Emergency Child Medical Services (#8000)

❸ Perinatal Services

Aiming at properly providing high level medical care to high・risk pregnant/parturient women and newborns, efforts are being made to improve the mortality rates of pregnant/parturient women and infants through establishing Maternal and Perinatal Care Centers, which lies at the core of perinatal services, and Regional Maternal and Perinatal Care Centers that support the former centers and also through securing cooperation with regional labour/delivery facilities. However, there was a case relating to emergency transportation which occurred in Tokyo in 2008 that many referrals had to be made before a pregnant woman was finally received at the hospital. In consideration of this case, Maternal and Perinatal Care Centers has been positioned as institutions that treat patients with complications other than the ones associated with obstetrics at their own centers or in cooperation with the related department of other institutions. In addition, according to the" Vision on Children and Child・rearing" (adopted by the Cabinet on January 29, 2010) , the number of beds Neonatal Intensive Care Unit (ＮＩＣＵ*1) will be increased to 25・30 beds per 10,000 birth.

*1 NICU stands for “Neonatal Intensive Care Unit.”

Chart 2-5-5 Structure of perinatal medical care



Furthermore, the FY 2010 budget was allocated to ① support for Mather・Fetus Intensive Care Unit (MFICU) and NICU of Maternal and Perinatal Care Centers; ② support for allowance for obstetrician in charge of delivery and the doctors in charge of NICU; ③ support for the medical institutions which has the “Regional Rehabilitation Support Facility” that offers training programs to promote children who are hospitalized at NICU for a long time to be discharged from the hospital and return to their home; and ④ support for the medical institutions that always temporarily accept children who have returned to home (Chart 2-5-5) .

Moreover, the medical fee revision in FY 2010 ① enhanced assessment of handling delivery of high・risk pregnant/parturient women with complications; and ② enhanced assessment of accepting pregnant/parturient women who are emergently transported to the hospital; ③ enhanced assessment of NICU; and ④ created assessment of the Treatment and Recovery Rooms for Infants, which receive infants with high risk from NICU.

❹ edical care in disasters

Utilizing the experience brought about by the great Hanshin・Awaji earthquake, efforts are being made to establish the core disaster hospitals (a total of 588 locations as of July 2009)

and to provide training for Disaster Medical Assistance Teams (DMAT) as measures for securing medical care in disasters.

※ DMAT, consisting of five doctors/nurses at a core disaster hospital, is sent to a disaster area immediately after the attack, conducts triage or provides emergency lifesaving at the sites and assists a medical care at hospital in the disaster area (by the end of March 2010, 703 teams completed the training) .

In addition, with regard to making medical institutions resistant to earthquakes, subsidized project have been carried out to make hospitals more earthquake resistant. Additionally, in the FY 2009 budget, the fund for enhancing hospitals' earthquake safety was established in each prefecture through the Extraordinary Special Grant for Making Earthquake・Resistant Medical Institutions for the purpose of supporting core disaster hospitals to make buildings resistant to earthquakes.

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*2 MFICU stands for "Maternal Fetal Intensive Care Unit."

❺ Medical care for remote areas and islands

It is difficult to secure medical services in remote areas and on islands because of small population and inconvenient transportations. In consideration to this, the "10th medical care plans for remote areas" (for the period of 2006 to 2010) was formulated. Since then, efforts have been made according to the plans, including support for clinics in remote areas, support for mobile clinics (see picture) , securing transportation means for providing first aid, and introduction of remote medical care.

Mobile clinics in no・doctor area in Kochi Prefecture
(Medical team and a vehicle for mobile clinic)

❻ Social medical corporation system for emergency medical care

Social medical corporations are medical corporations to provide medical care particularly needed in region (emergency medical care, medical care in disasters, medical care in remote areas, perinatal cares, medical care for children including emergency medical care for children) based on the medical care plan. They are certified by prefectural governors and the Minister of Health. To secure their stable management, social medical corporations are granted tax exempt for corporate income tax related to medical and healthcare business, and property tax imposed on fixed assets used for business for instance to secure direct emergency medical care. As of June 1, 2010, 99 social medical corporations have been certified.

3) Securing and improving the quality of human resources to support medical services

❶ Obligating reeducation of administratively punished doctors, nurses, etc.

In accordance with the reform of the medical care system in 2006, punished doctors, dentists, public health nurses, midwives, and nurses have been obliged to undergo reeducation in reconfirming their professional ethics and medical skills and to confirm if they are competent enough to resume medical practice.

At present, the government offers reeducation for doctors, dentists, pharmacists, public health nurses and midwives, while each prefecture implements reeducation training for assistant nurses.

❷ Review on clinical training system

Since April 2004, doctors engaged in medical examinations and treatments have been obliged to take clinical training, which had previously been voluntary, for 2 years after acquiring a doctor's license with the basic idea of offering 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.

Some say that this system has had a certain effect for instance through considerably improving the status and working conditions of medical interns, creating an environment where medical interns can devote themselves to clinical training and enhancing diagnosis and treatment abilities. On the other hand, the issues have been pointed out, including uneven number of doctors in each region, lowering function of dispatching doctors by university hospitals and other medical institutions, and improvement of clinical training programs, and hence, review on clinical training system has been called for.

Accordingly, the Ministry of Health, Labour and Welfare and the Ministry of Education, Culture, Sports, Science and Technology jointly had held a study group to review the clinical training system since September 2008, and compiled a written report in February 2009. Based on the report, the Ordinance of the Ministry of Health, Labour and Welfare concerning clinical training system was revised in April 2009. The specific contents of revision include flexible clinical training system, tightening designation criteria for hospitals to offer clinical training and setting caps on the quota for medical interns in each prefecture. The revised system is applied to the medical interns who start clinical training from FY 2010. The effects of revision and impacts will be assessed, and the new system will be reviewed in five years.

❸ Review of clinical training system for dentists and improvement of dental practices

The environment surrounding dental practices in Japan has undergone a drastic change due to epidemiological transition and the diversification of people's needs related to the aging of society and changes in the manner in which patients and dentists communicate in respecting the rights of patients. Dental skills are also increasingly becoming more advancing and specialized, and as a result all dentists need to fully understand and acquire the basic attitudes that are necessary in being a medical professional as well as the skills and knowledge that ensure safe, reliable, and high quality dental health care. In consideration of that clinical training for dentists was made compulsory in April 2006 to enhance the quality of dentists. In order to respond to further improve quality of dentist and respond to the recent needs for dental practice, the Ordinance of the Ministry of Health, Labour and Welfare concerning clinical training system was revised in June 2010.

In recent years, there is a growing demand on safe, reliable and high quality dental practices. To cope with this demand, the project has been implemented since April 2008 to promote safety management system for dental practices in accordance with the actual situation in each region.

Furthermore, despite a strong demand on dental practices for the elderly and the bedridden people at home, there are not many dental institutions providing at・home dental practices yet. In consideration of this situation, efforts have been made since April 2008 to meet the public demands on dental health care through providing training to develop dentists and dental hygienists who are involved in promoting at・home dental practices and oral care for the elderly and the bedridden people at home, and implementing a subsidy system for devices used for at・home dental practices provided by dental institutions where the dentists who completed the training work.

The Revision of the Long・Term Care Rate aimed at improving oral care for the elderly through ① enhancing and reviewing the scope of assessment of "oral and cavity function improvement addition"; ② creating "oral cavity function maintenance addition" at insured long・term care service facilities. In addition, in order to further promote at・home dental practice,

The medical fee revision in FY 2010 ① created assessment for fine・tuned management of oral illness for patients requiring at・home dental practice; and ② enhanced assessment of at・home dental health guidance provided by dental hygienists.

❹ Improving quality of human resources in nursing

The environment surrounding nursing in Japan has undergone drastic changes due to the rapid decrease in the number of children and the aging of society as well as through the advancement of medical technologies. The roles of nurses such as in supporting the safety

and security of medical practice sites and in providing nursing care that is in accordance with patients' needs are expected to become increasingly important. And therefore improving the quality of nursing human resources is considered necessary.

Under such circumstances, the curriculum of basic nursing education was revised in order to focus on practical training, and the new curriculum has been implemented since FY 2009.

In July 2009, the Act for Partial Revision of the Public Health Nurses, Midwives and Nurses Act(Act No.78 of 2009) was enacted, and revision made it mandatory for new nursing professionals to take clinical and other training program. The revised act came into effect on April 1, 2010. In accordance with this, the "Guideline for Training for New Nursing Professionals" was established, and support for hospitals that implement training program for new nursing professionals was incorporated in the FY 2010 budget. With stable implementation of these measurers, the Ministry of Health, Labour and Welfare aims to establish a system to improve training programs for new nursing professionals after graduating from nursing school.

Column

Widened roles of visiting care ~Ex. "White Cross visiting nursing station" in Shinjuku ward~

Visiting care which provides nursing care for those who need care or are recuperating in their home was positioned officially in 1983, and "Elderly Visiting Nursing Station" was established where nurses have responsibility as administrators according to the Revised Health and Medical Service Law for the Aged / Elderly in October 1991 (5,434 stations as of October 1, 2008) . Since October 1, 1994, even people with obstinate diseases and disability can take this service, and according to the Revised Nursing・Care Benefits, new type service, "Outpatient Day Long・Term Care" where patients can go to visiting nursing station, was formulated as facilities for outpatient day・long・term care for patients with terminal center or obstinate diseases who had no alternative before except for hospitalization.

(1) What is visiting care

Visiting care is services offered according to the physician in charge such as ① "nutritional management" including meals, nutrition, excrement and management/support of terminal care, ②"medical assistant" for pressure・ulcer (bedsore) management when equipping medical implements (catheter) , ③rehabilitation, ④"Support for patients' family"

like instruction/consultation on care for their families and health management of them and ⑤Support for procedures as switching to homecare, and those services are for patients in need of both medicine and nursing treatment.

Because visiting care is conducted within life of patients/families, they occasionally instruct on methods for the case that nurses are not around them and family has to manage, for example, aspiration of phlegm and PEG as offering services in addition to providing their skills as a nurse.

Besides, not only providing techniques but it has various roles such as observation of house environment/life environment, instruction on how to face patients on the basis of medical knowledge and experience, consultation on varied anxiousness and questions occurred through life with taking treatment, advice on regional social resources related to welfare services except other than visiting care and management of health of patients' family. Even if they, who take homecare, are patients with same disease of hospitalized patients, their medical condition, for instance conflict with their family and worry about their condition, is different from patients in hospital since they have daily life with their family. Moreover, since it is not like nursing patients in medical institutes, nurses have to judge many things for patients who have different life depending to a person, and nurses are required of high specialty knowledge and a broad view so as to receive coordination/cooperation with people with different occupations like physicians in charge and welfare workers.

(2) Efforts in "White Cross visiting nursing station"

"White Cross visiting nursing station" in Shinjuku, Tokyo is one of stations where nurses offer visiting care in above ways. It offers those services to children with disability and patients with obstinate diseases in home in addition to elderly persons who can take Long・Term Care Insurance.

In the case of a child with congenital disease who went back home through experience of hospitalization for few years since birth and who have visiting care from "White Cross" once a week, parents have been learning viewpoints in daily life and how to care through observing work of care from nurses, taking instructions and talking to them. Or in another case, a patient with an obstinate disease who has been together with the disease for long takes visiting care from "White Cross" three times per week. Although that patient cannot move a whole muscle and has taken tracheotomy, by supporting for bath while wearing artificial respirator, safety as taking bath is secured and the life quality of the patient/family has been much improved.

In the case of children, various problems come up according to changes like

physical/mental development and starting school for handicapped children. Besides, burdens of families are significant such as progress of obstinate disease's condition, usage of various medical equipment in their home, administration of medicine and necessity to nurse them for 24 hours. Even in such the case, it is possible to offer concrete solutions for each case by that medical specialists visit patients regularly, and also by doing so, their questions and anxiousness can be solved often. Visiting care is the service having very important meaning not to just apparent medical care but also to parts which cannot be realized easily from the surface.

3) Securing medical safety

Securing medical safety is one of the most important medical care policy issues in Japan. Accordingly, the following measures have been promoted in complying with the "Comprehensive Measures for Promotion of Safety Measures for Medical Care" compiled in April 2002, the "Emergency Appeal for Measures against Medical Accidents", announced by the Minister of Health, Labour and Welfare in December 2003, and the "Regarding Safety Measures for Medical Care in the Future" (report) in June 2005.

❶ The Japan Obstetric Compensation System for Cerebral Palsy

As part of measures to provide safe obstetric medical care, discussions were held on establishing the Japan Obstetric Compensation System for Cerebral Palsy. A preparatory committee operating the Japan Obstetric Compensation System for Cerebral Palsy, organized within the Japan Council for Quality Health Care, compiled a framework for the said system in January 2008. Accordingly, the Japan Obstetric Compensation System *3 was launched in January 2009.

One of the objectives of the system is to promptly compensate people for the economic burden of children that suffer from cerebral palsy as a result of medical accidents (including those due to both medical malpractice and non・medical malpractice) which occurred during delivery to prevent and promptly settle disputes. An additional objective is to improve the quality of obstetric medical care by analyzing the causes of accidents and then provide that information for use in preventing similar accidents from occurring in the future.

Although the system utilizes private sector insurance, the Ministry of Health, Labour and Welfare also gives support for this system being introduced at childbirth institutions and helps smooth operation of the system given that this system will contribute to measures against the shortage of obstetricians and improve the quality of obstetric medical care through preventing repeated medical childbirth accidents from taking place.

❷ Securing medical safety at medical safety support centers

In order to promptly cope with claims and consultations from patients regarding medical care, medical safety support centers were established in total 47 prefectures. At present establishing those centers in their respective cities and wards with health centers and secondary medical areas is being promoted.

In June 2006, medical safety support centers were legally established within an organization under the Medical Care Law. And efforts have been made through activities that include a) responding to claims and consultations from patients or their families regarding medical care and offering advice to the managers of medical institutions, b) providing information to the aforementioned managers, patients, and families, and c) providing training on medical safety for the managers and employees of medical institutions.

As a comprehensive support project *4 for counselors working at medical safety support centers and in order that they can respond appropriately to difficult consultations, the Ministry of Health, Labour and Welfare has been conducting activities which include supporting training courses for acquiring specialized knowledge and improving their abilities and the collection, analysis and making available of information on the consulted matters.

❸ Obligations of medical institutions managers to secure medical safety

Managers of hospitals and clinics with beds are obliged to establish guidelines for safety management related to medical care and establish safety management systems that include providing training for employees. In the medical care system reform of FY 2006 the

subject institutions were expanded to include clinics without beds and birth centers. In addition, measures such as establishing a system for the safe use and maintenance of pharmaceuticals and medical devices was also included in securing medical safety.

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*3 Information on the Japan Obstetric Compensation System for Cerebral Palsy can be found on the following website: The administration department of the Japan Council for Quality Health Care
http://www.sanka・hp.jcqhc.or.jp/index.html
*4 Information on the comprehensive support project for the Medical Safety Support Center can be found on the following website:
http://www.anzen・shien.jp/

❹ Medical accident report system

In order to prevent medical accidents and their recurrence it is necessary to collect a wide range of high quality information from medical practice sites, have it analyzed by experts, and provide improvement measures back to the relevant sites. Since October 2004, the third party organization, Japan Council for Quality Health Care (JCQHC) has been collecting information on medial accidents*5 based on reports from the National Centers for Advanced and Specialized Medical Care, National Nursing Homes for Hansen's Disease Patients, hospitals run by the National Hospital Organization (NHO) , university hospitals (main hospitals) and special function hospitals. The collected information is analyzed with written reports being published every three months.

In the written reports、particular accident cases are analyzed and examined in addition to being numerically analyzed. From the reported information, the cases that require particular attention are then made available to all medical institutions through related organizations and prefectures.

Column

Efforts at improve medical safety ~Pharmacy Hiyari/Collecting Hatto Cases/Analyzing Business~

It is evenly expected from those who offer medicine and who take medicine to take appropriate and high quality medical treatment at ease. Japan Council for Quality Health Care (Incorporated Foundation) was established in 1995 as the third party organization

which fairly evaluates functions of medical organizations from academic perspective and support to improve disclosed problems thanks to the evaluation in order to strengthen people's reliance upon medical treatment and improve the quality more.

Japan Council for Quality Health Care wrestles with businesses like "Pharmacy Hiyari/Collecting Hatto Cases/Analyzing Business" besides Japan Council for Quality Hospital, Patient Safety Promotion, Subsidy System for Obstetrics, Medical Information Network Distribution Service (Minds) and Project to Collect Medical Near・Miss/Adverse Event Information.

Along with the Medical Care Act revised in 2006, community pharmacy was defined as facility that provides healthcare services, therefore, systems to secure medical safety, such as "disposition of a person in charge" and "preparation of textbook", have been obliged. As for cases that you got "scared" or "gasped" in hospitals and medical clinics, those cases had been collected and disclosed by Project to Collect Medical Near・Miss/Adverse Event Information, however, "Pharmacy Hiyari/Collecting Hatto Cases/Analyzing Business" was launched anew in order to promote medical safety programs, and it has been encouraging all pharmacies to register since April 2009. Its purpose is to prevent fatal medical near・miss and to produce safety culture in pharmacies through collecting detected/occurred cases which you got scared or gasped at in pharmacies, analyzing them and publicizing them as greatly useful information for medical safety programs.

Results of them, including annual report, statistics report twice a year and individual cases reported by each pharmacy, are publicized to related parties and you through the Homepage of "Pharmacy Hiyari/Collecting Hatto Cases/Analyzing Business" on Japan Council for Quality Health Care.

*5 Information on the project to collect information on medical accidents can be found on the following website:
http://www.med・safe.jp/

5) Promotion of information contributing to support patients and public to make a choice

In order to support patients and people to obtain sufficient information on medical care and thus make an appropriate choice, the following efforts have been made:
① Creating a system on a prefectural level to collect, summarize, and provide residents with easy・to・understand information including the one on medical institutions (System to Provide Information on Medical Functions Overview)
② Substantial relaxation of the issues, which can be used in advertising by medical institutions ③ Increasing the number of department names that can be used in advertising.

(3) The move to make the National Centers for Advanced and Specialized Medical Care as an independent administrative agency

The National Centers for Advanced and Specialized Medical Care (hereinafter referred to as "National Centers") analyzes the causes, develops and conducts research on treatment, offers the state・of・the・art medical care, and offers training programs for technicians concerning diseases that seriously affect the people's health such as cancer, cerebral apoplexy and heart disease. The National Centers consist of 6 main centers (National Cancer Center, National Cardiovascular Center, National center of Neurology and Psychiatry, International Medical Center of Japan, National center for Child Health and Development, and National Center for Geriatrics and Gerontology) , and plays a leading role in Japan in medical research concerning these fields.

The National Centers became six independent administrative agencies in April 2010, aiming at further exerting the Centers' functions for investigation/research and developing technologies. This move enables the Centers to cooperate with universities and private companies, to exchange personnel and to use private fund. The Centers are expected to lead medical care in Japan and serve to improve health and medical care in the world.

To make the National Centers an independent administrative agency, strengthening of financial base was required to allow each center to fully exert its own aims and functions and to continue stable operation. Accordingly, in the FY 2010 budget, the liabilities of the National Centers were reduced by transferring part of its liabilities to the national government. In addition, necessary grant for operational costs was secured for the National Center after becoming an independent administrative agency.

(4) Promoting dissemination of generic medicine

Generic medicine is a medical substance that contains the same amount of the same active ingredients with the same administration route and basically has the same therapeutic effect, the same dosage and administration and the same clinical effect with an original pharmaceutical product.

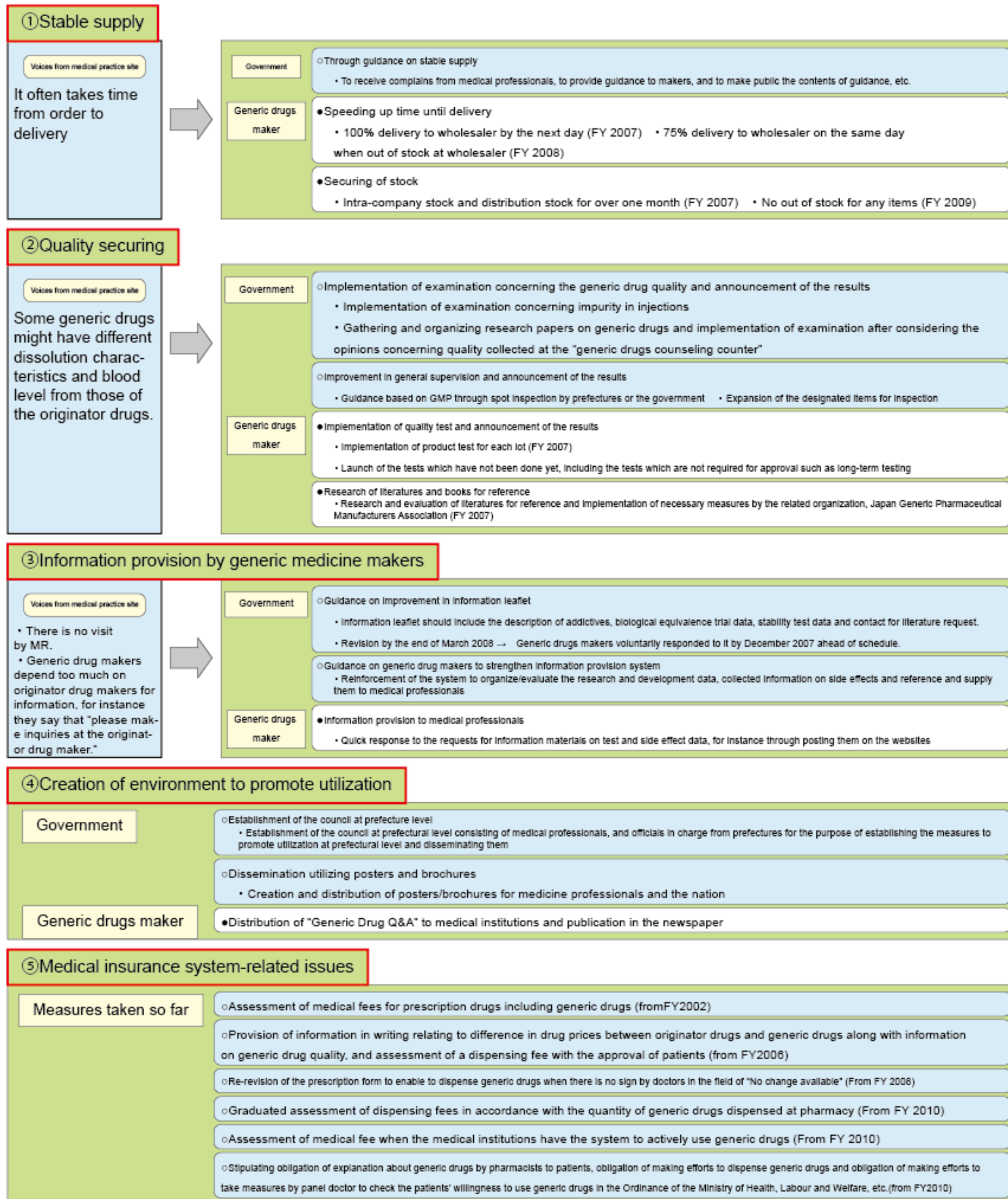
As the dissemination of generic medicine contributes to reducing the burden on patients and improves medical insurance finances, the numerical target was set to raise the share of generic medicine per unit to 30% by FY2012. Base on the "Action Programs for Promoting Safe Use of Generic Medicine"(formulated in October 2007) , which summarized the efforts that should be made by the parties concerned such as the national government and pharmaceutical companies of generic medicine to achieve the target, efforts have been made to secure stable supply of generic medicine, to ensure quality, to strengthen a system to offer information and to gain the trust of patients and medical professionals with regard to generic medicine. (As of September 2009, the share of generic medicine per unit among all prescription medicines is 20.2 %.)

With regard to the health insurance system, prescription forms and the healthcare management regulations were revised in the medical fee revision in FY 2008. In the medical fee revision in FY 2010, various measures were proposed to promote generic medicine utilization, for instance through revising assessment of dispensing fees to further promote dispensing generic medicine at pharmacies and creating assessment of medical fee for the medical institutions that actively utilize general medicine.

In addition, each prefecture established the "Council for Promoting Safe Use of Generic Medicine" to create the environments including dissemination and enlightenment on the use of generic medicine in accordance with the actual situation in each region.

Chart 2-5-6 Action Program for the Promotion and Safe Use of Generics (Overview)

To attain the goal set by the government to "achieve over 30% market share by volume for generic drugs by 2012 (more than double from the current status)" , the action program aims to clarify the measures that should be taken by the government and the parties concerned on a) stable supply, b) quality securing, c) information provision by generic medicine makers, d) creation of an environment to promote utilization, and e) medical insurance system-related issues, in order to enable the patients and medical professionals to safely use generic drugs.



Source: Ministry of Health, Labour and Welfare（http://www.mhlw.go.jp/houdou/2007/10/h1015-1.html）

Column

Cooperation between health care providers and patients ~20・year・history of NPO Consumer Organization for Medicine & Law (COML) ~

“NPO Consumer Organization for Medicine & Law (COML) ” located near Temmabashi Bridge in Umeda Osaka, aims to realize open patient・oriented medicine and is working on various efforts in order to establish relationship that patients and health care providers can realize each other and come closer to each other through interchange. In the beginning with publication of zero volume of News Letter and commencement of telephone consultation for free in 1990, its activities has been getting wider to Civic Forum with various themes, “KANJYA・JYUKU” for patients to learn about medicine, “Simulated Patient Activity”, “Exploration in Hospitals” where they visit hospital to improve hospital and offer their suggestions to health care providers, and training school for volunteers who plays active parts in various medical field.

What COML always focus on is balance between health care providers and patients. Although “C” of COML stands for “Consumer”, why they adopted “Consumer” is to promote “realization” to patients that medicine cannot be composed without patients taking part in it since the view of “Paternalism”, where while considering about patients who had not been on as good position as they are now, health care providers intervened against the will in 1990, was spread much wider. It has been 20 years since then, and now there are sometimes too much demands and claims from patients by contraries so it may deal with patients in different way from that time. Because of such the style, it seems that COML gets criticism now and then such as “too much inclining to health care providers” and “too much inclining to patients”, however, thanks to the consistent effort for 20 years, it obtains reliance from both health care providers and patients.

The chart at the right side shows transition of a number of free telephone consultations within the year from all over the country in COML. It has been increasing since the inauguration and it reached the peak due to especially dramatic increase of consultation on distrust of medicine through Great Hanshin earthquake in 1995, and then it had calmed down so the number of it could get to a half of that peak in 2009. In COML opinion, a number of consultations tend to be subject to frequency of report and contents by mass media.

Also, the following chart shows change in the ratio of consultation contents comparing 2005 with 2009. Although consultation of Top 3, “distrust of doctors”, “distrust of medical treatment” and “insignificant explanation from doctors” is exactly the same, the ratio of consultation on “something relating with medicine” and “medical fee” risen up. COML analyzes that this result indicates that patients’ awareness of medical cost has improved against the background of the depression.

Especially as for “medical costs”, most of inquiries are about costs of difference of hospitalization and costs relating to hospitalization, and as for medical service fee, inquiries

such as “Why is a cost depending on a hospital even though I make use of those hospitals due to the same disease” and “What is the cost for that we have to pay in pharmacies besides medicine cost” come up often. As for the fact that the rank of “legal solution and composition” fell down but its ratio is not changed, COML assumes that “obscure distrust” and “inflamed distrust” decreased according to the fact that a total number of consultation decreased, however, people who specify whose responsibility it is and try to make an action for it have not decreased at all.

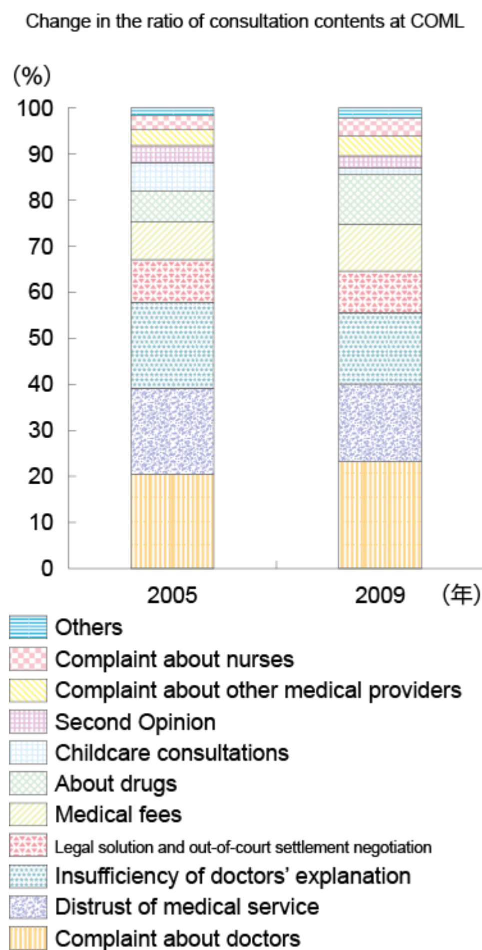
As this chart shows, while complaints on doctors are on the top list, COML realizes that doctors’ way to face patients has been improved. When we visit hospitals in opportunities of “Exploration in Hospitals”, we feel that a kind of their “Protector of Hearts” has been dissolving. They assume this is because even doctors, depending on hospitals, though, has taken a lecture on customer service in some hospitals, or doctors in young generation who can take a proper communication beginning with greetings thanks to the result of OSCE2 have been increasing.

Moreover, COML always suggests “Be wise patient” to people. Medicine is personal matter considering about meaning which always relates with yourself and your family. However, if considering about the facts such as, that medical resource is limited, and that health care providers have as much personality as you have and that your/their actions affect medicine at another side, you may understand medicine is actually a part of matter in the social. Or, the facts, such as understanding to that only we can do in a term of medicine is “to improve it better than present situation” and medical treatment always accompany uncertain results, must be known widely in the society in the future in order to be “wise patient”.

Satisfaction at medical treatment which patients take can be better by that health care providers understand pain and conflict in physical/mental of patients and their pain of families, and putting their best effort into treatment after explaining to patients sincerely, and for patients, by cooperating with health care providers while endeavoring to carry the ball for understanding the limit of medical treatment and illness/disease, therefore, it helps health care providers’ satisfaction and pride for special knowledge/skills improved. The Ministry of Health, Labour and Welfare has supports to familiarize activities more widely such as subsidy for businesses which are striving for both providers and patients to know more of mutual understanding through town meetings held by municipalities and are in effort to get medical treatment better.

1 “Simulated Patient” is as it sounds, and it indicates volunteers who play a patient in order for students that aim to be a health care provider to learn how to communicate with patients.

2 It stands for Objective Structured Clinical Examination. In Japanese, it can be called as "OSCE", pronounced in Japanese as "OSUKEE". It was established to evaluate clinical ability (clinical practice) objectively, and it is conducted to medical students at 4th and 5th grade in each medical colleges in order to confirm if required education has been going on properly.



2 Promotion of Measures against Infectious/specific Diseases

(1) Measures against intractable diseases

Measures against what they call intractable diseases have centered on the five principles of "promoting investigations and research", "providing medical care facilities", "reducing the co・payment for medical costs", "improving and coordinating community・based health care, medical care, and welfare services", and "promoting welfare measures aimed at improving

people's quality of life (QOL) ". Based on these principles, provision for health, medical and welfare services for patients have been promoted.

With regard to the intractable disease research program, carried out as part of the health and labour sciences research, 10 billion yen was secured as the budget as same as last year in order to promote research on the intractable diseases, whose research is difficult to be conducted due to small number of patients, selected among the diseases whose cause has not yet been detected and for which there is no established therapy, and which may likely leave an aftereffect. More specifically, efforts will be made to improve the research on the diseases which have not been sufficiently researched in addition to the subject diseases (130 diseases) focusing on the encouraged areas for research with the aim of establishing diagnosis and understand the current situation.

Concerning specific intractable disease research program to ease the burden of medical expenses on intractable disease patients, 56 diseases are designated as the subject diseases for medical fee subsidies, including 11 diseases which were newly added in the FY 2009 first supplementary budget.

Further efforts will be continuously made to promote community・based program to support the lives of patients with intractable diseases through the establishment of an intractable disease consultation and support center in each prefecture.

In February 2005 the first case of vCJD (variant Creutfeldt・Jakob disease) was discovered in Japan. In response, efforts are being made to enhance the CJD surveillance system.

(2) Measures against rheumatism and allergic diseases

In order to implement comprehensive and systematic measures against rheumatism and allergic diseases in the future, the "Direction of Measures against Rheumatism" and "Direction of Measures against Allergic Diseases" were formulated, and disseminated to prefectures and related organizations in promoting the three principles of "securing a system to provide medical care", "securing a system to provide information and consultations", and "promoting research and development."

Concerning "securing a system to provide medical care", "Zero Asthma Death Operation" has been implemented since FY 2006 with the aim of decreasing the number of deaths caused by asthma. In addition, asthma used to be the only subject disease, but since FY 2010, the the special counter plan for rheumatism and allergic diseases was launched in prefectures with the aim of decreasing the number of new patients of rheumatism and allergic diseases. With regard to "securing a system to provide information and consultations", in addition to improving training for nurturing consultants, dissemination and

enlightenment efforts have been made, which includes holding symposiums, and establishing allergy consultation centers. Regarding “promoting research and development”, as part of the health and labour sciences research, efforts are being made to promote research on clarifying the cause and symptoms of the disease and developing treatment methods (See Section 5 4 (1) 1)(P235)

(3) Promotion of measures against AIDS (Acquired Immune Deficiency Syndrome)

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated the number of people infected with the Human Immunodeficiency Virus (HIV) to be 33.4 million worldwide at the end of 2008. The region in which HIV is the most rapidly spreading is sub・Saharan Africa but is also rapidly increasing in Eastern Europe, Central Asia, and East Asia. The infection has the trend of increasing in East Asia, which includes Japan.

The total number of reported HIV infected/AIDS patients in 2008 in Japan was 1,557 and was the highest ever with the total reported number of HIV infected persons being 10,552 and total number of AIDS patients 4,899 (1,439 cases due to blood coagulation factor products are excluded from each number) . The characteristics of the trend with the infection is that the rate of increase of newly infected persons continues to grow, has an increasing trend in local cities, the percentage of people in their twenties and thirties is high, and 90 percent of the cause of infection is through sexual contact, with homosexual contact between men increasing in particular. Further improvements and enhancement of measures are needed therefore to cope with the situation

In consideration to that and with respect to the “Report of the Study Group on Revision of Specific Infectious Disease Prevention Guidelines Regarding Acquired Immune Deficiency Syndrome” that was compiled in June 2005, the revised “Specific Infectious Disease Prevention Guidelines Regarding Acquired Immune Deficiency Syndrome” (so・called AIDS prevention guidelines) was enforced on April 1, 2006.

This guideline requests that comprehensive measures related to prevention and medical care be taken with respect being paid to the human rights of HIV infected, and AIDS patients in cooperation between the government, local governments, and NGOs which includes medical professionals and patients groups. These measures shall mainly focus on 3 important areas (① dissemination, enlightenment, and education, ② improved examination and consultation systems, ③ reconstruction of the medical care system,) and include such measures as establishing a core hospital system to promote the establishment of a comprehensive medical care system within prefectures.

(4) Solving Hansen’s disease issues

1) History of Hansen's disease

The "Act on Repealing the Leprosy Prevention Act" was enforced in April 1996 and support for the former residents of Hansen's disease sanatoria with the necessary recuperation and rehabilitation. Subsequently, patients and former patients sued the national government in Kumamoto and other cities. The Kumamoto District Court handed down a juridical judgment that the plaintiffs had won a favorable verdict in May 2001. The government decided not to lodge an intermediate appeal with the court, and instead announced a "Colloquy by the Prime Minister on the Early and Full・Scale Solution of Hansen's Disease Problems" on May 25, 2001. Furthermore, the "Act on Payment of Compensation, etc. to Inmates of Hansen's Disease Sanatoria, etc." (hereinafter referred to as the Indemnity Law) was promulgated and enforced on June 22, 2001, under which compensation is being made to former residents of Hansen's disease sanatoria. In February 2006, the "Act on Payment of Compensation, etc. to Inmates of Hansen's Disease Sanatoria, etc." was revised to include people who used to be in Hansen's disease sanatoria established abroad

The Ministry of Health, Labour and Welfare and representatives of patients and former patients has also held the "Conference on Measures for Hansen's disease Problems" and had discussions on restoration of honor of patients as well as former patients and promotion of their welfare.

In addition to reconciliation effected before the court, compensation has been made that includes "Benefits for People Who Were in the National Hansen's Disease Sanatoria" program in establishing a living base for them and the "Reburial Cost for the Diseased in the National Hansen's Disease Sanatoria" program for use in returning the honor of the dead since FY 2002; and the "Gratuity for People Who Were Not in National Hansen's Disease Sanatoria" program for patients and former patients who had never actually been in sanatoria, for their stable, comfortable and normal social lives since FY 2005. *6

2) The "Act on Promotion of the Resolution of Hansen's Disease Issues"

These efforts helped those who used to be the patients of Hansen disease to some degree to recover the damage, but promotion of their welfare and restoration of their honor remain unsolved. In consideration of these circumstances, the "Act on Promotion of the Resolution of Hansen's Disease Issues" (hereinafter referred to as the Act on Promotion") was approved at the Diet session in June 2008 and enforced on April 1, 2009 to promote resolution of the Hansen's disease Issues.

In line with this, the "Act on Repealing the Leprosy Prevention" was abolished, and in accordance with the Act on promotion, following measures have been continuously taken:

① securing of care and life at the National Hansen's Disease Sanatorium, etc.; ② support for rehabilitation and assistance for social life; ③ restoration of honor and mourning to the dead; and ④ support for families.

To disseminate and enlighten knowledge about the history of Hansen disease and its countermeasures, brochures for junior high school students have been published and distributed to junior high school across the country, and the Ministry of Health, Labour and Welfare has held the “Symposium on the Hansen Disease Issue” since FY 2002. Since FY 2009, June 22, the date when the “Indemnity Law” was enforced, has been designated as the “Day of Honor Restoration and Mourning for the Victims by the Act on Repealing the Leprosy Prevention Act”, and the Ministry of Health, Labour and Welfare holds the event for mourning, memorial service and honor restoration.

Since its reopening in April 2007, the “National Hansen's Disease Museum” has been positioned as the ① base for dissemination and enlightenment; ② base for information; and ③ base for exchange, and efforts have been made to further disseminate and enlighten the history of Hansen disease and its countermeasures.

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*6 With the enforcement of the “Act on Promotion of the Resolution of Hansen’s Disease Issues” in April 1, 2009, the names were changed from “Benefits for People Who Were in the National Hansen’s Disease Sanatoria” to “Benefits for People Who Were in the Hansen’s Disease Sanatoria”; from “Reburial Cost for the Diseased in the National Hansen’s Disease Sanatoria” to “Reburial Cost for the Diseased in the Reburial Cost for the Diseased in the Kokuritsu (National) Hansen’s Disease Sanatoria”; and from “Gratuity for People Who Were Not in National Hansen’s Disease Sanatoria” to “Gratuity for People Who Were Not in Hansen’s Disease Sanatoria.”

(5) Appropriate implementation of organ transplantations

1) Implementation status of organ transplantations

The Act on Organ Transplantations (hereinafter referred to as the Organ Transplantation Law) was enforced in October 1997. The law permits transplantation of organs such as eyeballs (corneas) , hearts, lungs, livers and kidneys from brain・dead donors.

From enforcement of the law to the end of March 2010, 87 people had been judged as brain・dead in compliance with the Organ Transplantation Law. In FY 2009, 5 cases of heart transplantations from 5 donors, 8 cases of lung transplantations from 5 donors (of heart and lung transplantations, no case had heart and lung transplanted at the same

time) , 4 cases of liver transplantations from 4 donors, 146 cases of kidney transplantations from 83 donors, 5 cases of pancreas transplantations from 5 donors (of kidney and pancreas transplantations, 5 cases had kidneys and pancreases transplanted at the same time) and 1,627 cases of cornea transplantations from 962 donors had occurred, including transplantations from both brain・ and heart・dead donors.

As of the end of March 2010, patients waiting for organ transplantations consisted of those needing hearts (166) , lungs (142) , livers (277) , kidneys (12,010) , pancreases (175) , small intestines (3) and corneas (2,604) .

In the meantime, the Minister of Health, Labour and Welfare has held “Examination Meetings on Organ Transplantation Cases from Brain・Dead Donors” and invited both learned and experienced people to them. At the meetings, the situation with lifesaving treatments of donors, legal brain death judgments, and intermediary work conducted by the Japan Organ Transplant Network are being examined.

2) Recent movements towards the promotion of organ transplantations

The “Act for Partial Revision of the Act on Organ Transplantation (hereinafter referred to as the “Revision Act” was introduced by members of the Diet and approved at the ordinary Diet session in 2009. The Revision Act allows donors to indicate their willingness to donate organs preferentially to their families; and allows donations of organs from a brain・dead person if family members agree in writing, even if the will of the donor is not confirmed. The provisions concerning preferential donation to families was to come into effect on January 17, 2010, and other provisions were to be enforced on July 17.

The Revision Act stipulates that the national government and local governments take measures, for instance through allowing to people to indicate the willingness of organ donation in their driver’s licenses and the insurance cards of health insurance. In response to this, it was decided to add a column to indicate the willingness to the back of a driver’s license and to an insurance cards issued by National Health Insurance Societies and National Health Insurance scheme. In addition, the form for Organ Donation Decision Card issued and distributed by the Japan Organ Transplant Network was revised based on the intension of the Revision Act.

Since March 2007, the Japan Organ Transplant Network started has launched an online registration system for organ donation willingness and made efforts to enhance its awareness.

Organ Donation Decision Card (front side)

《 1. 2. 3. いずれかの番号を◯で囲んでください。》

1. 私は、脳死後及び心臓が停止した死後のいずれでも、移植の為に臓器を提供します。
2. 私は、心臓が停止した死後に限り、移植の為に臓器を提供します。
3. 私は、臓器を提供しません。

《 1 又は 2 を選んだ方で、提供したくない臓器があれば、×をつけてください。》
【 心臓 ・ 肺 ・ 肝臓 ・ 腎臓 ・ 膵臓 ・ 小腸 ・ 眼球 】

〔特記欄： 〕

署名年月日： 年 月 日

本人署名(自筆)：

家族署名(自筆)：

Organ Donation Decision Card (back side)

臓器移植に関するQ&A

Q1 臓器は誰でも提供できますか？ 年齢の上限はありますか？

A 意思を表示することには、年齢の上限はありません。高齢の方でも病気で薬を飲んでいる場合でもどなたでも記入していただけます。
ただし、がんや全身性の感染症で亡くなられた場合に臓器提供できない場合があり、実際の臓器提供時に医学的検査をして判断します。これまで0～70歳代の方からの臓器提供が行われています。

Q2 提供後のからだはどうなりますか？

A 入院している病院で、数時間（3～5時間）の摘出手術をした後にご家族の元に戻ります。臓器を摘出するための傷ができますが、きれいに縫い合わせて、清潔なガーゼで覆い、外から見ても傷がわからないようにします。
また眼球提供の際は、義眼を入れますので顔はほとんど変わりません。

Q3 提供する時に費用の負担や謝礼はありますか？

A あくまでも善意に基づく無償の提供ですので、臓器提供者の方には提供に関する費用は一切かかりません。
また、葬儀の費用や謝礼が支払われることもありません。

Q4 現在意思表示カードを所持していますが....

A 平成22年7月17日より新しい制度に変わり、意思表示カードの内容も変わりました。今お持ちのカードも有効ですが、この機会になるべく書き直して、家族にも自分の意思を伝えておきましょう。

Q5 インターネットでの意思表示（登録）も必要ですか？

A 本人の意思をより確実に確認するためにも特に親族優先提供を希望する方、臓器を提供しない意思の方は、インターネットでの登録をおすすめします。意思を登録すると、ID入り登録カードが郵送されます。変更や削除は、いつでも可能です。

その他のQ&Aについては、ホームページでご覧になれます。

臓器移植 検索 あなたの意思を登録しましょう。

ホームページ http://www.jotnw.or.jp
モバイルサイト http://www.jotnw.or.jp/m

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〒105-0001 東京都港区虎ノ門1-5-16 晩翠ビル3階
(社)日本臓器移植ネットワーク 0120-78-1069
(携帯電話からは) TEL：03-3502-2071 FAX：03-3502-2072

Leaflet attached to the distributed card (back side) , containing brief Q&A about organ transplants

3) Transplantation of hematopoietic stem cells

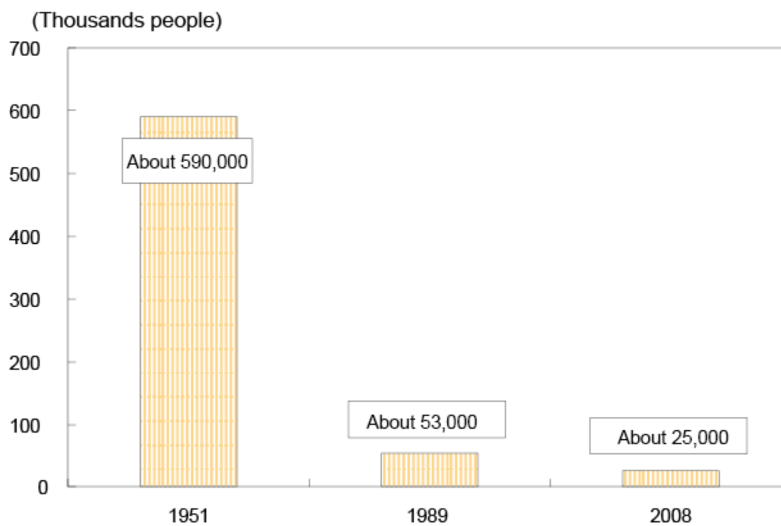
Transplantations of hematopoietic stem cells, such as from bone marrow and umbilical cord blood, have been implemented as a treatment method for leukemia, aplastic anemia or the like. With such transplantations, it is essential that the type of leucocyte (HLA type) of the patient matches that of the donor, or that of stored umbilical cord blood, which means that a larger number of donors must be secured for transplanting hematopoietic stem cells to all the patients that are in need of them.

In light of this, a public bone marrow bank project has been implemented since FY 1991, with a public umbilical cord blood bank project having been in operation since FY 1999 for transplanting hematopoietic stem cells between non・biologically related patients and donors. As of March 2010, the number of registered donors at the public bone marrow bank had reached the objective of 357,378 and the number of stored umbilical cord blood was 32,793. Further efforts are being made to promote donor registrations for patients in need of bone marrow transplantations. In addition, the Committee on Hematopoietic Cell Transplantations within the Subcommittee on Measures against Diseases, Health Sciences Council are discussing measures that will need to be taken in the future with hematopoietic stem cell transplantations

(6) Promotion of measures against tuberculosis

Tuberculosis, which was once called as the “National Disease” and the top cause of death, was feared by the nation as the largest infectious disease that threatened the people’s lives and health. In 1951, the Tuberculosis Prevention Act was established. Thanks to the efforts by the country, the situation around tuberculosis was significantly improved with considerable decline in the number of tuberculosis patients. In 2007, the Tuberculosis Prevention Act was integrated to the legislations concerning prevention and patients of infectious diseases, and the comprehensive measure against tuberculosis have been promoted together with other infectious diseases.

Chart 2-5-7 Changes in the Number of Newly Registered Tuberculosis Patients



Source: Prepared by the Health Service Bureau, MHLW based on the "Statistics of Tuberculosis" 2009"

With the sharp decline in the number of the tuberculosis patients, the nation has become less aware of tuberculosis, which is now considered as the "disease in the past." Nevertheless, tuberculosis is still one of the major infectious diseases in Japan with about 250,000 newly registered patients annually (Chart 2-5-7) .

Especially in recent years, the outbreak of MDR TB (multi・drug・resistant tuberculosis) , infection of people without fixed address and foreigners and recurrence of the elderly have become major issues calling for strengthening of tuberculosis measures against these issues.

Declining use rate of beds at sanatoriums due to a decrease in the number of tuberculosis patients has forced the medical institutions to close sanatoriums, causing concerns for the shortage of beds for tuberculosis patients.

In consideration of these circumstances, comprehensive measures against tuberculosis have been promoted including the measures using Directly Observed Treatment (DOTS) , which treats patients by thoroughly implementing health examination, medical care bearing public expenses, vaccination and management of patient's taking medicine based on the legislations concerning prevention and patients of infectious diseases. In addition, the Committee on Tuberculosis within Infectious Diseases Section of the Health Sciences Council has been discussing the future medical treatment of tuberculosis.

(7) Promotion of measures for vaccination

Based on the Preventive Vaccinations Law, municipalities are implementing vaccination

on a regular basis for certain diseases for the purpose of preventing outbreak and spread of infectious diseases. The subject diseases include nine diseases: diphtheria, whooping cough, tetanus, measles, rubella, polio, Japanese encephalitis, tuberculosis and influenza. The government and ministerial ordinances stipulate age, number of times and period between shots and types of vaccine for vaccination.

While vaccination has great effect on preventing spread of infectious diseases, it has an incidence of adverse effects on a very rare occasion due to its nature. People who receive vaccination or their guardians should be fully aware of effects, safety, adverse effects and relief system for sufferers from adverse drug reaction. The Ministry of Health, Labour and Welfare and local governments are making efforts to provide proper information through various media such as the web sites and brochures.

Regarding regular vaccination, the subject people of vaccination are obliged to make efforts to receive vaccination, and their guardians are obliged to make efforts to have the subject people of vaccination to receive vaccination (what is called “obligation to make effort”) . Regular vaccination has been carried out under the understanding and agreement concerning vaccination, and high rate of vaccination has been maintained.

On the other hand, there may be a sign of new prevalence of infectious diseases caused by the change in immunity maintenance. For example, in recent years, there was the prevalence of measles among young people in the spring of 2007.

The Ministry of Health, Labour and Welfare has been promoting the measures against measles thorough aiming at reducing the number of outbreak of measles in Japan to as close as to zero by FY 2012; positioning measles as a infectious diseases whose preventive measures should be promoted; and establishing the “Guidelines for the Specific Infectious Disease Concerning Measles” (Notice No. 442 from the Ministry of Health, Labour and Welfare, Japan, issued on 2007・12・28) . Based on the guidelines, regular vaccination of measles has launched on April 2010 as part of the concrete measure to promote vaccination, targeting those aged 13 years old (in the first grade of junior high school) and aged 18 years old (in the third grade of high school) as a measure of specified duration for five years.

○ Year・on・year changes in the number of measles patients (total number report)
The number of reported patients (total number report) in 2008: 11,008
The number of reported patients (total number report) in 2009: 731

○ Year・on・year changes in the number of measles patients before 2007 (fixed point report)

FY	1999	2000	2001	2002	2003	2004	2005	2006	2007
The number of reported patients (persons)	5,875	22,552	33,812	12,473	8,285	1,547	537	516	3,133

※ Since total number report has been used to count the number of patients after 2008, it is hard to compare these numbers with those before 2008.

Triggered by the outbreak of novel influenza (A /H1N1) and its measures, the interest in reviewing the system for vaccination has grown among the nation. In response to this, the Committee on Vaccination within Infectious Diseases Section of the Health Sciences Council was launched in December 2009. Particularly as the urgent measures, the subcommittee compiled the proposal on the measures against the novel influenza this time in February 2010 and presented the bill to revise the Preventive Vaccinations Law. Furthermore, the "Subcommittee on Japanese Encephalitis" was established was established within the Committee on Vaccination to discuss the procedures for the future regular vaccination for Japanese encephalitis. In March 2010, the Subcommittee compiled an interim report, which stated that it is appropriate to actively encourage the first・stage of the regular vaccination for Japanese encephalitis. To be in line with this report, the Ministry of Health, Labour and Welfare has been actively encouraging the people subject to the first stage of standard vaccination period since April 1, 2010. (In FY 2010, the Ministry encouraged the children aged 3 to have the first vaccination.)

The Committee on Vaccination is reviewing the purpose, the basic ideas and sharing of roles among the persons concerned of vaccination aiming toward the fundamental review of the vaccination system (see Chapter 1, Section 5・ 5) .

(8) Promotion of measures against sexually transmitted disease （ＳＴＤ）

Genital Chlamydia infections, genital herpes infection, condyloma acuminate, syphilis gonococcal infection (hereinafter referred to as STD) are the infectious diseases that anyone can be infected through sexual contact and are one of the major health issues particularly among males and females of reproductive age.

STD patients tend not to visit a hospital to receive examination even if they are aware of the symptom, which makes it difficult to understand the actual situation of infection and might lead to underestimation. In addition, special attentions should be paid to the

protection of personal information because patients are infected through sexual contact. Accordingly, STD is a disease which requires special attention from the viewpoint of public health.

Moreover, regarding the recent circumstances around STD, since people in the age group from the mid・teens to their 20's take a larger share of the infected patients, it is important to take measures against STD in consideration of these situations.

To prevent STD, correct information and careful action based on it are important. Additionally, early detection and early treatment enable healing, prevention of aggravation and prevention of spreading infection. Therefore, dissemination and enlightenment of correct information and establishment of an environment that supports STD prevention are important as the prevention measures.

The Ministry of Health, Labour and Welfare established the special guidelines for STD prevention based on the legislations concerning the prevention and medical care for the patients of infectious diseases. In accordance with the guidelines, the Ministry subsidizes prefectures, ordinance・designated cities and special wards for STD examination and counseling on STD carried out at health centers.

Furthermore, the period between November 25 and December 1 is designated as the "Health Week for Sex", and dissemination and enlightenment activities are intensively implemented especially during this week every year.

Column

Measures to prevent hospital infection ~efforts in NTT Medical Center~

NTT Medical Center is the hospital with 606 beds for mainly acute treatment administered by private sectors. As reinforcement of medical system for severe acute respiratory syndrome (hereafter "SARS") , Tokyo Metropolitan Government specified "Cooperated Medical Facility for Out・Patient Clinic with SARS" in 2003 for primary care of potential out・patients for SARS except for infectious diseases and designated medical institutions, and this hospital is also one of them since 2003. In 2008, it started service of out・patient clinic for other infectious diseases including new type flu besides SARS as "Cooperated Medical Organization for Infection Diseases".

(1) Effort at the organization

As the concrete efforts at hospital infection, although infection control team had been established and working, the infection prevention office with the authority under the direct

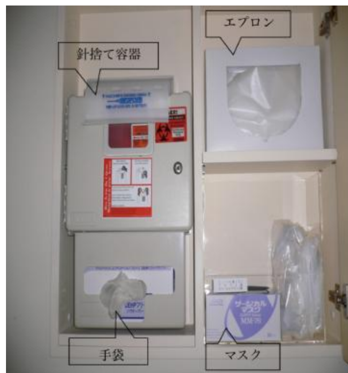
control of a director of hospital was formulated in 2005 so as to reinforce infection prevention activities. 8 health care providers such as doctors, nurses, pharmacists and inspecting engineers with authorized qualification for infection management concurrently (one of them is full・time authorized nurse for infection management) , are disposed in the infection prevention office, and they work as the infection prevention team.

Since this infection prevention office is under the direct control of the director of a hospital, it receives instructions from the directors on infection management and also it has function to advance to the directors. Besides, the infection prevention committee composed of 22 members such as the director of the hospital and the head nurse, members from the general manager, clinical laboratory department, each medical department and pharmaceutical department inside the hospital, and it fulfills its role as consultative organization for infection management in the hospital. Moreover, 25 nurses who have a leadership with enthusiasm on infections are positioned in each hospital ward, the out・patient department and the operation department as a link nurse under the infection prevention office, and it implements infection management as well as instruction and gathering information.

One of main activities of the infection prevention team is to patrol the hospital. They patrol hospital wards especially where resistant bacteria, which are tolerant to antimicrobials (antibiotics) , have been detected, and then investigate into medical condition, usage of antimicrobials and implementation condition of infection prevention, and give advices if necessary. Needless to say, as for detection condition of antimicrobials and usage condition of antibiotics, clinical laboratory department, pharmaceutical department and each hospital ward report conditions with internal fax and so on, and those information are analyzed. Moreover, that team is in effort to improve awareness of infection prevention of hospital stuffs by preparing manual of hospital infection prevention and publicizing team news of infection prevention as well as enlightenment.

(2) Efforts at equipment

As efforts at equipment, equipment such as hospital rooms with negative/isobaric pressure function (with one bed) that is changeable to negative pressure in order not to spread like viruses over other hospital wards are equipped in each hospital wards except for special wards like hematology wards and maternity wards, and the emergency center for out・patient care at night/holidays has the same rooms as well.



Equipped box for used needles and clothing to prevent infection

In order to let patients anytime make a use of gloves, masks and aprons to prevent infection which nurses usually have with like a cart as they come to a room for diagnosis, those items are in the box attached on a wall of each room, and also in order for patients not to touch something sharp, there is the box on walls in rooms used to throw away items with possibility to cause accidentally infection by getting a cut with a needle. Besides, since exclusive path is set up in hospital wards, nurses can dispose ordure and infective waste there, therefore, it is the system that those procedures cannot be seen by patients and also an elevator, of course, used only to dispose waste is set up.

(3) Efforts at swine flu

For swine flu A (H1N1) spread last year, the NTT Medical Center revised the manual produced in November 2008 in assumption of highly・virulent avian influenza A (H5N1) to use it for provision. As for the efforts at reminder posters in order to prevent for visitors to bring influenza virus into hospitals, those posters for seasonal influenza used to be put on during only flu season, however now, those posters are always on the place we can see.

It has a system that hospital employees can get information on novel influenza provided from Tokyo Metropolitan Government and health centers through internal mail so that they can share this kind of information. For local residents, it holds annual "Communication Festival (with purpose to communicate with regional residents) ” on May 23 which was the day when each region forbore any meetings due to novel influenza, and offers the opportunity that people can learn infection measure through watching video against novel influenza, and letting people practice wearing a mask and washing their hands according to educational material.

(4) Conclusion

As for efforts at hospital infection measure in this hospital, we think that their ideas at

construction and equipment are admirable, and we could know of them striving for it in a body with the infection prevention team.
Besides, we got a request from person in charge to help appropriate infection prevention measure well known in this kind of occasions such as following “Cough Etiquette” when meeting those who have possibility having flu. Please learn something like that masks are not something for preventing to get infected but also useful for preventing to infect others because there were apparently some people wearing a mask for only preventing to get infected.

(9) Promotion of measures for Atomic bomb survivors

Comprehensive health/medical care and welfare measures to support the atomic bomb survivors, who obtained A・bomb Survivors' Certificate, are being promoted in accordance with the Law Concerning Atomic Bomb Survivors Relief *7. The measures include a) health checkups; b) a public・funded medical care system; c) supply of various allowances; and d) welfare services such as counseling.

To help the Minister of Health, Labour and Welfare to certify atomic bomb disease suffers, the”Subcommittee on Atomic Bomb Survivors Medical Care of the Examination Committee for Certification of Sickness and Disability”, established for the purpose of asking technical questions to the scientific and medical point of view, have carried out the assessment based on the “New Certification Guidelines”, the revised ones, since April, 2008. As of the end of 2010, about 5,800 cases were certified.

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*7 The Law Concerning Atomic Bomb Survivors Relief

Regarding the A・bomb Disease Recognition Class Action, in consideration of the “special situation” of the plaintiffs, who had been engaged in lawsuit for a long time and were getting old, the “the Letter of Confirmation on the Basic Policy in Closing the A・bomb Disease Recognition” was signed on August 6, 2009 with the aim of early settlement of the class action and early rescue of plaintiffs. In line with this Letter of Confirmation, the “Act on Subsidy to the Fund for Settlement of the Issues Concerning the Class・action Plaintiffs” (hereinafter referred to as the Act on Fund”) was introduced by members of the Diet and unanimously approved on December 1, 2009. The act stipulates the establishment of the fund to support the settlement of the issues concerning the plaintiffs, and came into effect on April 1, 2010. In consideration of the supplementary regulations of the Act on Fund

stipulated that discussion should be made on the certification system for A･bomb survivors, comprehensive discussion has been carried out from a broad spectrum.

Improvement has been made to the various support projects for the atomic bomb survivors living abroad. In consideration of the supplementary regulations of the amended Atomic Bomb Survivors' Assistance Act, which stipulated that “the government would have discussions on the application procedure of A・bomb Survivors Certification for the survivors living abroad taking into account of enforcement status of this Act”, discussions were made including on the measure for paperwork, enabling application for A・bomb Survivors Certification in foreign countries. In addition, application for a certificate of the A・bomb survivors who received medical examination has become available since April 1, 2010.

(10) Comprehensive promotion of measures against hepatitis

Hepatitis B and hepatitis C are the major chronic infectious diseases in Japan, and their measures are the national issue. (The total number of patients of both types of hepatitis in Japan is estimated to be over 3 million.)

Hepatitis patients rarely notice the symptom, and thus, often develop severer diseases such as cirrhosis of liver and liver cancer without being aware of infection.

Proper treatment at an early stage can heal hepatitis or delay the development of liver cancer. Therefore, it is extremely important to detect infection of hepatitis B or hepatitis C virus at an early stage and to promote prompt and appropriate medical treatment from the nation’s health maintenance point of view.

Since 2008, the Ministry of Health, Labour and Welfare has strengthened the comprehensive measures against hepatitis, including:

・Free examination at medical institutions consigned by prefectures; and

・Launch of medical fee subsidies for interferon treatment for hepatitis.

(Chart 2-5-8, 2-5-9)

Chart 2-5-8　5 pillars of Comprehensive Measures for Hepatitis

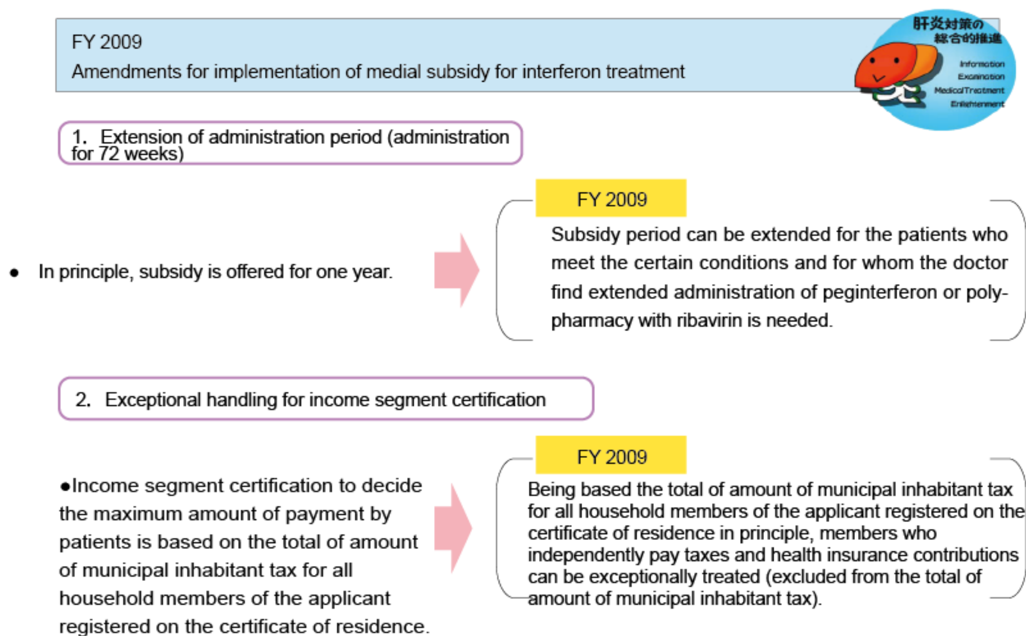
1. Creating an environment for promoting hepatitis treatment (medical fee subsidies)
2. Promotion of hepatitis virus examinations
3. Improvement in the medical treatment system for the patients with hepatitis, training for doctors, support for patients such as through establishing the consultation system, etc.
4. Dissemination of correct knowledge and understanding among the nation
5. Promotion of research

Chart 2-5-9 Medical subsidy for hepatitis treatment (FY 2009)

If the interferon treatment is successfully provided, hepatitis B and hepatitis C, which are the largest infectious diseases in Japan, can be completely cured, and serious diseases such as liver cirrhosis and hepatoma can be prevented. Nevertheless, large medical expense for interferon treatment interferes with early treatment. In consideration of this, subsidy is provided to the interferon treatment.

Implementation entity	Prefectures
Eligible patients	Patients with hepatitis B and hepatitis C
Treatment subject to subsidy	Interferon treatment aiming at complete recovery from hepatitis B and hepatitis C
Maximum amount of monthly payment by patient	Upper- income patients (20%) 50,000 yen Middle- income patients (30%) 30,000 yen Others (50%) 10,000 yen
Ratio of revenue source	National government to Local government= 1: 1

Chart 2-5-10 Amendments for implementation of medial subsidy for interferon treatment in FY 2009



Furthermore, in FY 2009, taking into account new medical knowledge, efforts were made to further promote early treatment through operational changes such as extension of the period for medical fee subsidies for interferon treatment (Chart 2-5-10) .

Moreover, with the aim of comprehensively promoting the measures against hepatitis, the Hepatitis Control Act, proposed by the lead director of the Lower House's Health, Labor and Welfare Committee, was approved in November 2009 and came into effect in January 2010. (For further information on the Hepatitis Control Act, please refer to Part1 Chapter 2

Section 2・3.)

In consideration of the aim of this Act, efforts are made in FY 2010 to further promote the comprehensive measures against hepatitis by improving the subsidy for hepatitis treatment so that as many hepatitis patients as possible can receive early and proper medical treatment without anxiety. (For further information on medical fee subsidies for hepatitis patients, please refer to Part 1, Chapter 2, Section2・31) ❶) *8

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*8 Detailed information on the comprehensive measures against hepatitis can be found on the banner of the MHLW website: (http://www.mhlw.go.jp/)

3 Measures against lifestyle related diseases such as cancer and diabetes

(1) Comprehensive and well・planned promotion of cancer control

1) Promotion of cancer control

Cancer has been the leading cause of death since 1981 in Japan with currently more than 300,000 people dying from it every year. It is estimated that the number of people who will develop cancer in their life time is 1 out of every 2 men and 1 out of every 3 women. Furthermore, the number of deaths from cancer is expected to increase as the aging of society progresses.

Therefore, the Japanese government implemented measures such as “Comprehensive 10・year Strategy for Cancer Control” since FY 1984, the “New 10・year Strategy to Overcome Cancer” since FY 1994, and the “3rd・term Comprehensive 10・year Strategy for Cancer Control" since 2004 to tackle cancer focusing on research. As a result, skills and technologies for cancer diagnosis and treatment have been advanced. In accordance with the “Cancer Control Act” that was introduced by members of the Diet and approved in June 2006, the “Basic Plan to Promote Cancer Control Programs” (hereinafter referred to as the “Basic Plan”) was approved in June 2007, with efforts against cancer being made in a comprehensive and systematic manner.

Mr. Akira Nagatsuma, Minister of Health, Labour and Welfare receiving the proposal from Mr. Kakizoe, the Head of The Cancer Control Promotion Council (at the office of the Minister of Health, Labour and Welfare on April 9)

2) Promotion of radiotherapy and chemotherapy

Among the cancer treatments available in Japan, the use of radiotherapy and chemotherapy has been pointed out as inadequate. Hence the "promotion of radiotherapy and chemotherapy" is being positioned as a priority issue and the goal of establishing a system wherein radiotherapy and outpatient chemotherapy is available at all designated cancer hospitals (the medical institutions designated by the Minister of Health, Labour and Welfare to provide high quality cancer treatment anywhere in Japan, which offer specialized cancer treatment, establish a cooperation system for regional cancer treatment and offer counseling support as well as information provision for cancer patients) , and provides cooperation) by FY 2011 has been set.

Accordingly, the Ministry of Health, Labour and Welfare revised the "Guidelines for Establishing Designated Cancer Hospitals" (hereinafter referred to as the "Guideline") in March 2008, and implements the training programs for doctors engaged in radiotherapy and chemotherapy aiming at qualitative improvement in radiotherapy and chemotherapy.

3) Implementation of palliative care from the early phase of treatment

Many cancer patients suffer physical pain and psychological distress while their families also suffer various pains from when they are first diagnosed cancer. Hence "palliative care from the early phase of treatment" is being positioned as a priority issue and the goal set of ensuring that all doctors engaged in cancer treatment have acquired basic knowledge on palliative care through training within ten years.

Therefore, the Ministry of Health, Labour and Welfare formulated the guidelines for training for doctors who are involved in palliative care in April 2008 aiming at achieving this target by FY 2011, and the Ministry has been providing a) training for doctors who are involved in palliative care mainly at designated cancer hospitals so that they can offer guidance on palliative care training in respective regions; and b) training for doctors in

respective regions who are engaged in the practice of cancer treatment. In addition, the Guidelines request a system in which the appropriate palliative care that c) palliative care teams consisting of doctors and nurses with specialized knowledge and skills in palliative care be established; and d) palliative care for outpatients can be made available.

Further efforts are being made to promote public awareness of palliative care, and the appropriate use of medical narcotics needed in palliative medical care through holding workshops for medical professionals.

4) Promotion of cancer registry

The cancer registry is a system to understand and analyze incidences, such as cancer occurrence and development after treatment, consisting of "hospital・based cancer registry" and "regional cancer registry", both of which are necessary in providing appropriate cancer treatment based on scientific knowledge. In the Basic Plan, the cancer registry has been positioned as a priority issue and the goals of providing the necessary training for people in charge of actual cancer registry work at all designated cancer hospitals set by FY 2011.

"Hospital・based cancer registry" refers to collecting and compiling information on patients who visit the hospital, including their diagnosis, treatments and prognosis with the aim of improving cancer treatment at hospitals and offering support to cancer patients.

The requisites to implement the system for cancer registry (hospital・based cancer registry) at designated cancer hospitals include:

① to implement cancer registry based on the "standard registry format" designated by the head of General Affairs Division, Health Service Bureau;

② to actively cooperate with regional cancer registry conducted by the prefecture concerned by utilizing hospital・based registry;

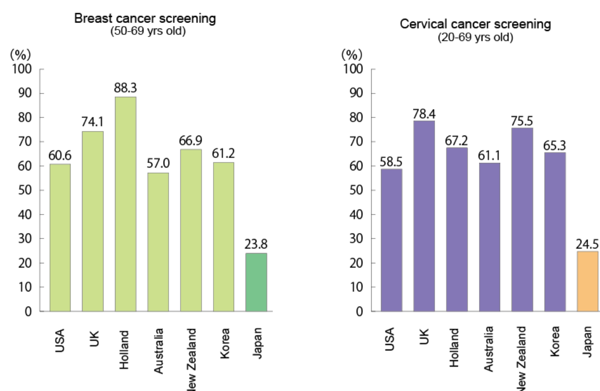
③ to place more than one full・time staff in charge of the actual cancer registry who have been trained at the National Cancer Center; and

④ to supply the results of hospital・based registry to the National Cancer Center every year.

On the other hand, "regional cancer registry" is to capture the trend of cancer occurrence in a certain region. In other words, it refers to collecting and organizing on information on the patients who have cancer (residents who are diagnosed with cancer) to use it as basic data for effective cancer screening and prevention in the region. So far, 37 prefectures have carried out cancer registry, and other prefectures are also requested to positively consider the implementation of cancer registry.

5) Promotion of cancer screening and research

Chart 2-5-11 Cancer screening rates: International comparison



(USA) data for survey in 2008, (UK) breast cancer: data for the project in 2007, cervical cancer: data for the project in 2008, (Holland) data for survey in 2007, (Australia) breast cancer: data for the project in 2006, cervical cancer: data for the project in 2007,
(New Zealand) data for survey in 2009, (Korea) data for survey in 2009, (Japan) data for survey in 2007

OECD Health Data 2010 – Version : June 2010

With regard to the percentage of people receiving cancer screening, it remains as low as 20 – 30%, which is low compared with the international standard (Chart 2-5-11). Accordingly, the Basic Plan set the goal to raise the ratio to at least 50% by FY 2011. Based on the Basic Plan, efforts are being made to support modeling measures for raising the percentage of people receiving cancer screening as well as through dissemination and enlightenment activities. At the same time, since October 2008, “Discussion Group on Dissemination and Enlightenment of Cancer” was held to implement dissemination and enlightenment programs effectively and properly. Through these activities, advanced cases are being collected regarding dissemination and enlightenment for correct understanding of symptoms, importance of cancer screening, cancer registry, and palliative care, and exchange of views are being conducted among experts. Furthermore, in July 2009, the “Task force for 50 % Cancer Screening Rate” was developed with the Minister of Health, Labour and Welfare as a chief for the purpose of multidisciplinary promoting the improvement of screening rate. At the first headquarters meeting, decision was made, including logos aiming at achieving 50% screening rate (see below) .

Furthermore, since 2009, every October has been designated as the “Intensive Campaign Month Aiming at 50 % Cancer Screening Rate”. During the campaign month, various measures such as “National Convention for 50 % Cancer Screening Rate” are carried out to raise awareness of the necessity of cancer prevention among the nation and encourage people to receive cancer screening.

Moreover, the “Center for Corporate Alliance to Promote Cancer Screening (or the Corporate Action Office for Cancer Screening) ” was launched in FY 2009, which was

established to solicit promotional partner companies with the aim of enhancing the cancer screening rate at workplace and asking cooperation from the companies in the cancer screening promotion projects. Efforts are being made in each prefecture to ask for cooperation in cancer screening promotion project in partnership with the Corporate Action Office for Cancer Screening.

Additionally, with regard to consultation and information provision concerning cancer medical care, “Cancer care support centers” have also been set up at designated cancer hospitals to respond to the anxieties and questions of patients and their families through the telephone, facsimile, and interviews.

With regard to cancer research, which is positioned to be the overall basis for controlling cancer, the Ministry of Health, Labour and Welfare has been working on research to discover the nature of cancer and promotion of translational research to apply the results to wide areas; establishment of effective cancer treatment aiming at equalization of medical level; research on maintenance and improvement of the quality of life under medical treatment such as palliative care; research on understanding the facts about cancer and disseminating information on cancer; and research on the political issues such as the establishment of a system to promote equalization of medical level.

がん検診 愛する家族への贈りもの

(tag line) (image character) (logo)

6) Control for women・specific cancers

Since 1981, cancer has been the leading cause of death in Japan, with more than 300,000 people died from cancer annually. Progress in diagnosis and treatment technology has enabled early detection and treatment.

Under such circumstances, it is extremely important to enhance cancer screening rate and to detect and treat cancer at an early stage in order to decrease the number of people died from cancer. In particular the screening rate remains low for women・specific cancers (i.e. cervical cancer, breast cancer) . Accordingly, as part of childrearing support as an investment for future, coupons of free screening for women・specific cancers (cervical cancer and breast cancer) and “Handbook for Screening” were distributed to women above a certain age in the FY 2009 supplementary budget.

This project has been continuously implemented in FY 2010 for the purpose of promoting control for women・specific cancers.

(2) Control of lifestyle related diseases such as diabetes and cerebral apoplexy

1) Survey on the nation's health conditions and trend in the survey results

National Health and Nutrition Survey has been carried out every November based on the Health Promotion Law in order to use the survey results as basic data to comprehensively promote the nation's health promotion. According to the "National Health and Nutrition Survey 2008", the most noteworthy result is the current status of diabetes and smoking rate.

Since 2000 when the "Health Japan 21"was launched, the upward trend in the ratio of obesity among males aged between 20's and 60's has slowed down compared with the rate for the previous five years, and the ratio among females aged between 40's and 60's has declined.

Regarding smoking rate, the ratio of those who smoke on a regular basis is 36.8% among males and 9.1% among females.

2) Promotion of measures against lifestyle・related diseases through national campaign

The Ministry of Health, Labour and Welfare has been promoting the "National Health Promotion Movement in the 21st Century (Health Japan 21) " as the third health promotion measure for citizens since 2000. "Health Japan 21" aims to reduce the number of deaths of people in the prime of their life, prolong healthy years of life, and improve people's quality of life (QOL) in order to become a vigorous society in which all citizens can live in good health both physically and mentally. To this end, the Ministry of Health, Labour and Welfare set goals within the 9 areas including "nutrition and dietary habits" and "rest and mental health development."

The Health Promotion Law was enforced in May 2003 to establish legal foundations for facilitating greater health promotion efforts by citizens made in accordance with "Health Japan 21".

Furthermore, to be in line with a written report of the "Health Japan 21 middle evaluation report" published in April 2007, the development of new effective methods has been going on since 2008 for the purpose of carrying out the "National Campaign for Healthy Lifestyle" in partnership with industry as a new national movement focusing on "appropriate exercise", "appropriate dietary habits" and "no smoking" aiming at preventing lifestyle・related diseases by feeling a sense of freshness of "healthy lifestyle" in daily lives and encouraging individuals to change their lifestyle. In addition, as part of the reform of the medical care

system, measures against lifestyle・related diseases are being promoted through providing specific health checkup and specific counseling guidance focused on metabolic syndrome (visceral fat syndrome) .

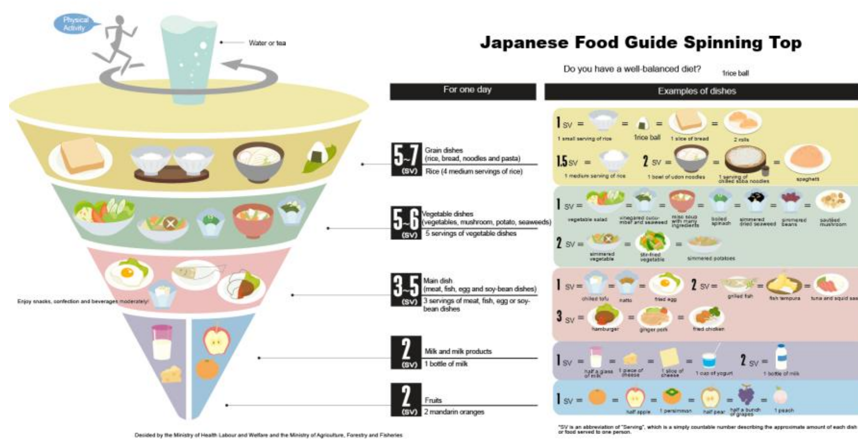
"Health Japan 21"
Logo

❶ Nutrition and dietary habits

Nutrition and dietary habits are closely related to most lifestyle・related diseases and people's quality of life. To improve people's nutrition and dietary habits, it is necessary to encourage individuals to change their lifestyle as well as develop the necessary underlying environment.

Accordingly, "Dietary Reference Intakes for Japanese (2010) " was compiled to be used as scientific data as a basis for dietary counseling and school lunch supply over the period of 5 years from FY 2010 to 2014, aiming at the nation's health promotion and disease prevention. For the purpose of deepening understanding of the reference, lectures were held in six blocks nationwide. Furthermore, in FY 2009, discussions were made on proper usage of reference for dietary improvement school and lunch management. To promote better dietary patterns as a measure in promoting "Shokuiku (Food and Nutrition education) ", the Ministry of Health, Labour and Welfare, and the Ministry of Agriculture, Forestry and Fisheries jointly compiled "Japanese Food Guide Spinning Top" in June 2005. Efforts are being made to disseminate and utilize the guide through measures that include promotion of the services available from registered dietitians, dissemination and enlightenment via community volunteers such as promoters of healthier dietary habits, and measures in cooperation with the food industry (Chart 2-5-12) .

Chart 2-5-12 Japanese Food Guide Spinning Top



In addition, nurturing health instructors such as registered dietitians have been trained to cope with the specific health checkup and specific counseling guidance. Furthermore, strategic services to prevent metabolic syndrome with a focus on the promotion of exercise and dietary rhythm adjustments have been promoted that include a clear understanding of the current situation, seminars, and measures in cooperation with private industry.

❷ Physical activities and exercise

Physical activities and exercise effectively prevent lifestyle・related diseases and are an important factor in health promotion, and therefore it is necessary is implement measures such as for raising public awareness on physical activities and exercise, increasing the percentage of individuals involved in daily exercise activities and habits, and creating environments where those activities can take place.

Accordingly, the “Recommended Exercise for Health Promotion” was revised as the “Exercise and Physical Activity Reference for Health Promotion 2006 –Physical activity, exercise and fitness” in July 2006 to be in line with the latest scientific knowledge of Rest and Mental Health Development. Standard values for physical activities, exercise, and physical strength for preventing lifestyle・related diseases based on the results of a variety of research are given in the revised edition. In addition, “Exercise and Physical Activity Guide for Health Promotion 2006” was compiled to make widely available the content of the standards in an understandable manner. Ongoing efforts are being made to disseminate and utilize the guideline (Chart 2-5-13) .

❸ Rest and mental health development

Mental health is a decisive factor in determining quality of life. Three major factors for maintaining health both physically and mentally are said to be appropriate “exercise”, well balanced “nutrition and dietary habits”, and “rest” to ensure physical and mental refreshment and thus comfortable lifestyle. In addition, getting sufficient rest and handling stress are both essential to good mental health.

Accordingly, the “Sleep Guidelines for Health Promotion” were established in 2003 and dissemination and enlightenment of information on sleep has been promoted in cooperation with related organizations and the mass media

❹ Tobacco

Tobacco smoking has been pointed out as being related to the cause of many types of cancer such as lung cancer as well as cardiovascular diseases. It has also been pointed out that the negative impact on people’s health is not limited to the smoker himself/herself, but extends to the people surrounding them via “passive smoking”, which is accidentally inhaling the smoke when someone else is smoking.

Accordingly, based on the “World Health Organization Framework Convention on Tobacco Control”, the “Health Promotion Law” and “the “Health Japan 21”, efforts have been made to disseminate information on the impact of smoking on the health and to promote comprehensive measures against tobacco, for example concerning prohibition of minors’ smoking. (For promotion of measures against tobacco, please refer to Section 5・3・(3) .)

❺ Alcohol

The effect of alcohol on health includes acute alcohol intoxication when a large amount of alcohol is consumed over a short time, liver disease from chronic drinking, and a relationship to illnesses such as cancer. Underage drinking is considered to affect both young people’s physical and mental development, while alcohol being consumed by pregnant woman is considered to affect the fetus.

The following goals were set in “Health Japan 21”, ① reducing the number of heavy drinkers, ② prohibiting minors from drinking, and ③disseminating information on appropriate alcohol intake. In accordance with these goals measures such as disclosing information at seminars and holding symposiums on underage drinking are being implemented.

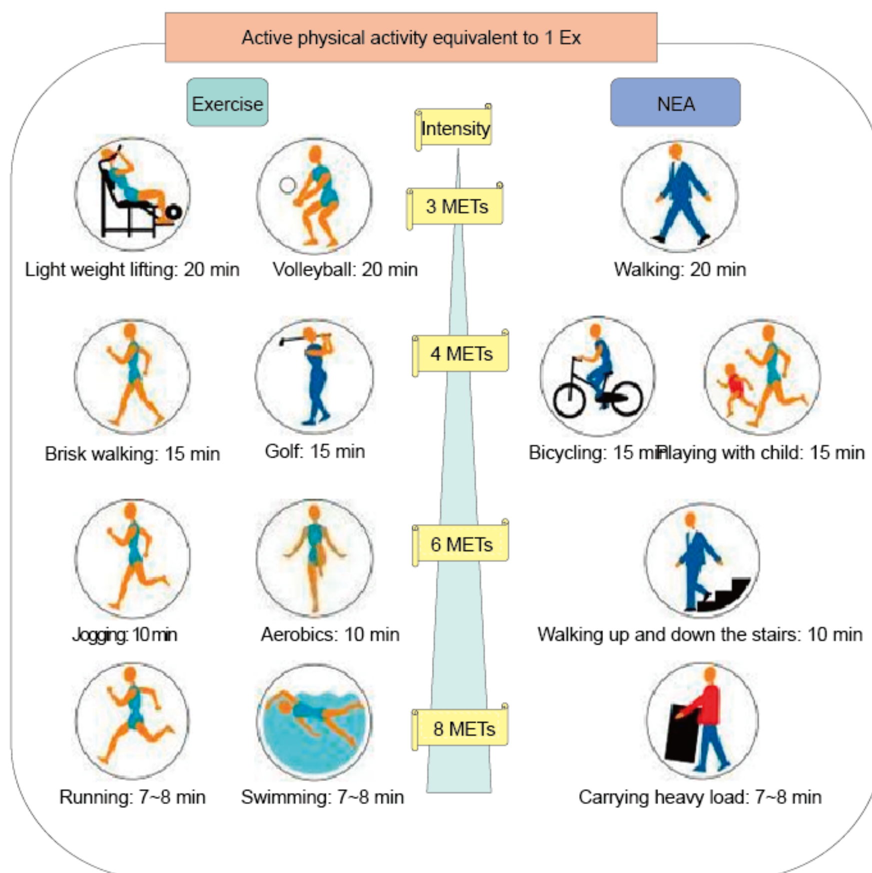
Chart 2-5-13　Exercise and Physical Activity Guide for Health Promotion 2006 (Exercise Guide 2006)

> Let’ s target 23 Ex (METs•hour) per week by physical activity, of which 4 Ex by active exercise!

The goal of quantity of physical activity for health promotion was set at 23 Ex or more per week by active physical activity (including both exercise and NEA (non-exercise activity)), of which 4 Ex or more by active exercise.

Based on the results of a systematic review of domestic and foreign literature on the association between physical activity/exercise and lifestyle-related diseases, this goal was set by calculating the mean of quantity of physical activity and exercise necessary for prevention of lifestyle-related diseases.

The “active physical activity” is defined as those with intensity of 3 METs or more. The MET of sitting/resting is 1, and the physical activity with less than 3 METs are not included in this goal.



A “public・health problems caused by harmful use of alcohol” resolution was adopted at a World Health Assembly in May 2005, and Member States were requested to formulate, implement, and evaluate effective strategies and programs to reduce the negative impact on health and society caused by harmful use of alcohol. In accordance with the resolution, discussions were held at a WHO Regional Committee, and “Strategies to reduce the harmful use of alcohol” was approved. At the World Health Assembly in May 2010, the “Global Strategy to Reduce Harmful Use of Alcohol” was adopted. Countermeasures

against alcohol abuse have become an important global issue.

In consideration of these situations, the Ministry of Health, Labour and Welfare, in cooperation with related ministries and agencies including the National Tax Agency, has implemented measures stipulated in “Health Japan 21”aiming at: ① reducing the number of heavy drinkers; ② prohibiting minors from drinking; and ③disseminating information on appropriate alcohol intake. In accordance with these goals measures such as disclosing information at seminars and holding symposiums on underage drinking are being implemented.

Column

Alcohol Symposium on “Alcoholic issues” in 2009

In Japan, we have drink on many occasions such as having celebration or dinner since long time ago so alcohol drink has been around us as a part of our life/culture. However, it is sometimes a cause of traffic accidents caused by dim consciousness due to alcohol and also it may be cause of death due to acute alcohol intoxication caused by drinking too much amount of alcohol for a short period.

Also we have received reports that some diseases, such as hepatic disease, cerebral apoplexy and some cancers, have to do with uncontrolled consumption of alcohol. Besides, long・term uncontrolled consumption of alcohol makes us addict to alcohol, and pare down our social ability besides causing damage on his/her mental/physical health so it affects badly on people around his/her family and so on. Those characteristics are unique characteristics that other general food doesn’t have. Recently, along with producing various kinds of alcoholic drink and increasing opportunities to have drink, various issues like above caused by alcohol have become social problem.

Considering about those facts, Alcohol Symposium was held with purposes, to prompt efforts toward prevention of alcohol・related issues by offering their opinions from each of different perspective while showing actual conditions of alcohol・related issues to administrations, people related with health care and educational institutes in addition to citizens.

On this Symposium, lectures and reports on actual conditions of underage drinking and drinking prevention were conducted.

In the lecture with a theme “About drinking age of minors” produced by Mr. Susumu Higuchi in Kurihama Alcoholism Center, he showed us various research findings and controversy on the possibility to get drinking age down in the discussion on lowering legal

age in Japan from 20 to 18. He proved that damages on health and social due to underage drinking is more obvious than legal age drinking and there is no proof that 18 or 19・year・old person are unlikely to be affected comparing with persons with lower age in the research on humans and animals.

Also he picked up some cases of America, some states of Canada, Australia and New Zealand which already have experienced that a number of alcohol consumption and that of traffic accidents due to alcohol increase because of lowering drinking age, and on the other hand, by raising the age up, the number of them decreases. With consideration on those facts, since amount of alcohol consumption of young females at 18 to 20 years old has been increasing, there has a possibility that amount of alcohol consumption increase more by lowering drinking age. Therefore, he said "We must be careful to lower drinking age."

In the lecture from Mr. Hagiwara in Brewers Association of Japan, he introduced efforts of alcohol business to prevent underage drinking. Those efforts include voluntary standards for advertisement/publicity and enlightenment activities to consumers.

The Ministry of Health, Labour and Welfare shows its concrete goals in 9 fields including alcohol prevention as a provision for health promotion, and promotes "21th Health Promotion (Healthy Japan 21) ". As you may know by seeing the fact that WHO adopted "Global Information System on Alcohol and Health", alcohol prevention has been getting the worldwide issue. On the basis of those situations, the Ministry of Health, Labour and Welfare promotes alcohol prevention while cooperating with related administrations.

(Refer to)

○ Materials of Alcohol Symposium in 2009
http://www.mhlw.go.jp/topics/bukyoku/kenkou/alcohol/sympo/sympo09.html

❻ Oral health development and promotion of "Shokuiku (food and nutrition education) "

Proper measures for oral health development are being taken for each life stage including fetus, infants, school children, adults and the elderly.

The measures for fetus include oral health management for pregnant and parturient women through providing oral health guidance and dissemination of knowledge about cutting of fetus teeth. With regards to the measures for infants, since dental caries (to create tooth decay) most commonly occur in this period, dental checkup for children aged 18・month old and 3 years have been provided together with dental health guidance in order to help them develop the function to "eat". For school children, in addition to the conventional measures to prevent dental caries, efforts are being made to help them establish oral functions in relation to the growth of permanent teeth to replace baby teeth,

and the development of jawbone. Concerning adults, group health education and health consultation focusing on checkup for periodontal diseases have been offered in each municipality to prevent loss of teeth so that they can maintain good health and enjoy meals at a later stage. Regarding the measures for the elderly, “improvement of oral functions” has been introduced as the preventive measures for nursing care need in order to support the elderly to fulfill their lives through enjoying delicious and safe dietary habits.

As part of the "8020 campaign" with the goal of retaining more than 20 teeth at the age of 80 in order that all the people can lead a healthy and enriching life, instructions to maintain oral functions to support dietary habits, etc. have been promoted. The result of the survey on dental diseases shows that the ratio of people aged 80 or older who retain more than 20 teeth jumped to 21.1% in 2005 from 7.0% in 1987.

In recent years, the relationship between the health of oral cavity and that of whole body has attracted attentions, and it is important to promote “Shokuiku (food and nutrition education) ” as the basis for such health from childhood. Moreover, year 2080 marked the 20th anniversary of the “8020 campaign”. Accordingly, in addition to the oral health measures that have been taken so far, new approaches to oral health measures should be taken such as involvement in “Shokuiku” and measures for the elderly. In December 2008, the “Study Group on Oral Health and Shokuiku” was held to discuss the method to promote “Shokuiku” from various perspectives including the viewpoint including oral health, and the written report was compiled in July 2009. Regarding the future efforts toward the promotion of “Shokuiku”, the report made proposals on promotion of “Shokuiku” in each life stage. The proposals include the methods of promotion by related organization (job categories) for oral health and “Shokuiku” and promotion of oral health measures in consideration of new perspective.

❼ Diabetes

Diabetes can often occur before the patient is aware of its development. And without appropriate treatment, it can result in serious complications such as retinopathy, nephropathy, and neuropathy. In the terminal stage, it can lead to blindness or require dialysis treatment. Diabetes is also known to facilitate the onset or development of strokes and cardiovascular diseases, such as ischemic heart disease, resulting in lowering people’s quality of life (QOL) . Countermeasures such as preventing the onset, early discovery, and prevention of complications are important with this disease.

The number of diabetes patients in Japan has been on the increase as a result of the changes in people’s lifestyles and social environments. According to an “Outline of National Health and Nutrition Survey, Japan 2007” announced in 2008 by Health Service Bureau,

Ministry of Health, Labour and Welfare, approximately 8.9 million people are strongly suspected of having diabetes, and the total number of patients is expected to reach nearly 22.1 million when those who definitely have it are included.

In “Health Japan 21”, specific goals were set for improving lifestyle, early discovery, and continued treatment in promoting the primary prevention of diabetes. In FY 2007, in consideration of the interim evaluations of the reform of the medical care system and “Health Japan 21”, the goals were added, including: “reducing the number of patients and those that have a high risk of contracting metabolic syndrome (visceral fat syndrome) ”; and “increasing the number of visits for specific health checkup specifically programmed against metabolic syndrome (visceral fat syndrome) followed by specific counseling”.

In addition, subsidies for health science research expenses have been spent on “Japan Diabetes Outcome Intervention Trial” since FY 2005 to examine such intervention measures as ① halving the rate of transition from the pre・diabetes stage to actual diabetes, ② halving the discontinuation rate of treatment by diabetes patients, ③ reducing diabetic complications by thirty percent.

In addition, the “Study Group toward Further Improvement in Chronic Diseases” pointed out that it would be continuously important to further promote efficient and effective enlightenment and dissemination activities concerning chronic diseases such as diabetes; to enhance the ratio of people who received health checkup; and to further promote alliance among related medical institutions, etc. In FY 2010, the guidelines for diabetes patients will be formulated taking into account the results of this study group.

❽ Cardiovascular diseases such as cerebral apoplexy

The second leading cause of death in Japan is heart disease and the third cerebro・vascular disease, while the number of deaths caused by cardiovascular disease accounts for approximately 30 percent of the total. Reducing the prevalence rate and death rate of cardiovascular disease has become an important issue as the aftereffects of cardiovascular disease are important factors in lowering patients’ quality of life (QOL) .

In “Health Japan 21”, specific goals were set to improve lifestyles and the early discovery of cardiovascular disease through the primary prevention. Therefore, in addition to early discovery through health checkup and prevention from becoming chronic, primary prevention through dissemination and enlightenment of nutrition and dietary habit information as well as physical activities and exercise is important.

Furthermore, research on the prevention, diagnosis, and treatment of cardiovascular disease has been promoted in “Comprehensive Research on Cardiovascular and Lifestyle・Related Diseases”.

❾ Cancer

Cancer has been the leading cause of death since 1981 in Japan with currently more than 300 thousand people dying from it every year. In consideration of this preventive measures such as improving people's lifestyles are very important. Accordingly, in accordance with the "Cancer Control Act" that was introduced by members of the Diet and approved in June 2006, the "Basic Plan to Promote Cancer Control Programs" was approved in June 2007, and efforts against cancer have been made in a comprehensive and systematic manner. (For more details on the comprehensive and systematic promotion of countermeasures against cancer, please refer to Chapter 1 Section 3) .

(3) Promotion of tobacco control

The fact that tobacco smoking has negative impact on smokers' health has been scientifically proven. It also causes various negative impacts extend to the people around smokers and fetus, including cancers such as lung cancer, ischemic heart disease and other cardiovascular diseases, premature delivery, stillbirth and declining birth weight.

Tobacco control is important to prevent these negative impacts on heath, and the Ministry of Health, Labour and Welfare has been promoting measures focusing on the "World Health Organization Framework Convention on Tobacco Control", the "Health Promotion Law" and the "Health Japan 21."

1) "World Health Organization Framework Convention on Tobacco Control"

In February 2005, the "World Health Organization Framework Convention on Tobacco Control", which is the first international treaty in the field of public health, was established. Japan is promoting the establishment of a system to enhance tobacco control in accordance with the basic principle "to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke."

As the concrete measures, the Ministry of Health, Labour and Welfare designated one week starting from World No Tobacco Day, which was designated by the WHO on May 31 every year, as a no tobacco week, bans smoking inside the ministry building and suspends the operation of vending machines of tobacco. The MHLW also holds various events titled Symposium Commemorating World No Tobacco Day.

In addition, for the people hoping to stop smoking, smoking cessation treatments have been covered by health insurance since April 2006, and smoking cessations has been covered by the medical fee payment system since June 2006. An environment to facilitate

no smoking is being created.

Furthermore, the Large Package of Tax Revisions for Fiscal 2010" (approved by the Cabinet on December 22) suggested the basic idea that "from the viewpoint of the nation's health, tobacco tax needs to be raised for the future to control tobacco consumption." In accordance with this, it was decided to raise the tobacco tax by 3.5 yen per cigarette (starting October 2010) , and related legislations, including tobacco tax hike, were promulgated on March 31, 2010.

2) The "Health Promotion Law" and the "Health Japan 21"

Article 25 of the Health Promotion Law stipulates that managers of facilities with heavy human traffic are required to take relevant measures to prevent passive smoking. In response to this, the Ministry of Health, Labour and Welfare is making efforts to prevent passive smoking.

"Health Japan 21" is promoting measures with specific goals to achieve ① dissemination of the necessary information on the impact of smoking on the health, ② prohibiting minors from smoking, ③ complete separation of smoking areas in public areas and workplaces and promoting awareness on it, and ④ dissemination of programs to support people giving up smoking.

Regarding the measures against passive smoking, the "Study Group on Preventive Measures against Passive Smoking" was held in March 2008, and discussion was made for nearly one a year. In March 2009, the written report was prepared incorporating the basic policies such as total smoking ban basically in public spaces with heavy human traffic.

In consideration of these situations, the Director Notice "Concerning Measures for Passive Smoking Prevention" was issued by the Director General of the Health Service Bureau dated February 25, 2010, and each municipality was made known about total smoking ban basically in public spaces with heavy human traffic as the basic policies concerning passive smoking control.

It is important to positively promote measures to prevent negative impacts of smoking on health, including preventive measures against passive smoking and support for smoking cessation.

(4) Women's health promotion

Cervical cancer screening and breast cancer screening have been implemented as conventional measures for women's health promotion, but most of which did not pay much attention to gender differences. In recent years, however, it has gradually become clear

that there exist gender differences in incidence rates and progress of patients' conditions depending on a kind of disease. Additionally, such issues have been point out that "Many young women are striving to lose their weight though they are skinny" and "Along with women's social advancement, increasing number of women are becoming ill because lifestyle events such as promotion at work site, marriage, pregnancy, childbirth, child rearing, nursing care for families, may take place at the same time ." Thus, it has become more important than ever to take measures for women's health promotion.

In order that women independently lead their healthy, lively, and enriched life, a whole society needs to provide support for women's various health problems in a comprehensive manner. To enable women to control themselves in accordance with their health conditions, the Ministry of Health, Labour and Welfare establishes the system for health education and counseling. In addition, the MHLW has been making efforts for women's health maintenance and promotion throughout their lives through diffusing the effective methods and case studies as the women's health promotion measures corresponding to women's each life stage, including adolescence, pregnancy, child delivery, climacterium and the elderly stage.

Additionally, with the aim of enhancing the knowledge about women's health and raise awareness of health issues surrounding women, "Women's Health Week" was designated for March 1 to March 8 every year. A whole society including the national government, local authorities, and related organizations, is united together to develop a variety of enlightenment programs and events.

4 Promotion of science and technology to prolong healthy years of life

Research and development of life science are positioned as a priority area under the Science and Technology Basic Program based on Science and Technology Basic Act. Under the overall coordination by Council for Science Technology Policy, the Ministry of Health, Labour and Welfare is also forcefully promoting research and development in this field in cooperation with related ministries including the Ministry of Education, Culture, Sports, Science and Technology.

(1) Promotion of Science and Technology Research in FY 2009

In consideration of the discussions made by the Subcommittee of Science and Technology within the Health Sciences Council, the Ministry of Health, Labour and Welfare set three principles in FY 2006 that includes: "promotion of health and security"; "realization of advanced medical care" ; and "securing health and safety", and since then has been

promoting science and technology.

1) “Promotion of Health and Security”

Development of prevention, diagnosis and treatment methods for diseases has been promoted along with the research and development aiming at prolongation of healthy years of life and quality improvement of medical care.

<Main fields and contents of the research>

Fields of research	Contents of research
Lifestyle diseases:	Research to promote systematic and strategic countermeasures against lifestyle diseases including cardiovascular diseases such as myocardial infarction and diabetes, from their primary prevention to diagnosis and treatment of lifestyle diseases, are being carried out. In addition, the research is being conducted on creating scientific evidence on metabolic syndrome (visceral fat syndrome) , which is a risk factor in heart disease and cerebral apoplexy.
Promotion of mental health	Mental illnesses that include schizophrenia, depression, neurosis, stress disorder, and developmental disorder are causing a wide range of serious problems. As countermeasures against these illnesses, the development of prevention, diagnosis, and treatment methods for them along with a support system and epidemiology studies are being conducted.
Development of prevention, diagnosis, and treatment methods for cancer	Researches are being carried out, including: research to discover the nature of cancer: translational research to apply the results to wide areas; and research on the political issues such as the establishment of a system to promote equalization of medical

	level. < Examples of research aiming at equalization of medical level of cancer treatment> ・Research on understanding the facts about cancer and disseminating information on cancer; ・Establishment of effective cancer treatment; ・Research on maintenance and improvement of the quality of life under medical treatment such as palliative care; and ・ Research on the political issues such as the establishment of a system to promote equalization of medical level.
Promotion of the preventing the need for nursing care	Research on prevention, diagnosis, treatment, and rehabilitation of locomotorium disorders and dementia is being conducted, in order to prevent the elderly from requiring long・term care and to supporting self・sufficiency,
Overcoming of immune diseases and allergic diseases	Research is being promoted on prevention, diagnosis and treatment method relating to immune and allergic diseases such as rheumatism, bronchial asthma, atopic dermatitis, pollinosis and food allergy aiming at preventing aggravation and proper self control.
Improvement of the quality of life (QOL) of people with disabilities and intractable diseases	With regard to the intractable disease research program, efforts are being made to improve the research on the diseases which have not been sufficiently researched in addition to the subject diseases (130

	diseases) focusing on the encouraged areas for research with the aim of understand the current situation, establishing diagnosis criteria and establishing the concept of diseases. In addition, research on comprehensive health and welfare measures for people with disabilities is being promoted that includes support for social participation of the people with disabilities; evaluation of welfare equipment; and support for people with developmental disorders and higher brain dysfunctions.

2) Realization of advanced medical care

Efforts are being made to promote development of basic technology to realize advanced medical care utilizing regenerative medicine technology, genomics, nanotechnology, and bio resources and to establish a clinical trial/research infrastructure

❶ Development of basic technology for realizing advanced medical care

Aiming at the realization of innovative medical care according to the characteristics of individuals based on the outcome of genomics and the realization of regenerative medicine, research on ensuring its safety and the utilization of bio resources is being promoted.

In addition, research is being promoted to develop low・invasive medical devices through utilizing nanotechnology in medical science are being promoted in cooperation with industry to provide safer and more secure medical technology for use with patients.

In addition to that, research to promote clinical applications is being conducted in cooperation with industry to utilize the outcome of basic studies such as gene therapy, and cell therapy and research on developing new medical devices.

❷ Promotion of the establishment of a clinical trial/research infrastructure

In order to achieve a further improved clinical research environment in Japan, the “New 5・Year Clinical Trial Activation Plan” was established in April 2007, and since then, efforts have been made aiming at the establishment of a system for medical institutions, securing and development of human resources, diffusion and enlightenment and effectively

implementation.

Furthermore, in order to respond to the changing environments surrounding clinical research and to further enhance research ethics and protection of trial subjects, the "Ethical Guideline for Clinical Research" was totally reviewed and has been enforced since April 2009.

(2) Third Science and Technology Basic Program

The Japanese government has formulated a "3rd Science and Technology Basic Program" plan for the period of FY 2006 to FY 2010, which is currently being implemented. In consideration of providing complete accountability to society and citizens as well as passing on the outcome of science technology, this basic program sets political goals for contributing to "overcoming diseases that distress people" and "creating a society where all people can enjoy healthy lives" based on the idea of "securing health and safety."

As with the 2nd planning period (from FY 2001 to FY 2005) , life sciences, information and communication, the environment, and nanotechnology and materials were defined as the "4 priority areas" and a budget and human resources are being allocated for them as a high priority.

5 Promotion of Creating Innovative Pharmaceuticals and Medical Devices

With the aim of being the top management industry, the government, and academics are sharing ideas on the direction of various measures should take in creating innovations and enhanced international competitiveness for industry in the area of pharmaceuticals in Japan with the "government and private sector discussion on innovative drug development" being held since 2008 and run by the Minister of Health, Labour and Welfare and participated in by the Minister of Education, Culture, Sports, Science and Technology, the Minister of Economy, Trade and Industry, and participants from the pharmaceutical industry as well as education and research institutions. Discussions between the government and the private sector will continue to be held, and efforts will be made to support the entire process from research through to practice, including intensive infusion of research fund, establishment of an environment to promote clinical research and clinical trials, acceleration and quality improvement of medical devices review and proper assessment of innovation.

Furthermore, the Ministry of Health, Labour and Welfare formulated the "New Vision for the Medicine Industry" on August 30, 2007 aiming at developing the pharmaceutical industry as an internationally competitive industry to make innovation. The MHLW also

established the "New Vision for Medical devices and the Medical Technology Industry" on September 19, which gives consideration to characteristics of medical devices, and indicated the direction of the whole process from research and development to disposal/recycle, and also described measures to be taken by the government in the future in the form of an action plan. Hereafter, the Ministry will implement the action plan ahead of schedule, while monitoring the progress situation.

In addition, to provide support from the research and developmental side, a "New 5・Year Clinical Trial Activation Plan" was formulated in conjunction with the Ministry of Education, Culture, Sports, Science and Technology in March 2007 for the purpose of establishing an environment to promote clinical research and clinical trials. Additional efforts are also being made by the independent administrative organization of the National Institute of Biomedical Innovation in supporting venture enterprises to create pharmaceuticals that are difficult to achieve by private enterprises alone.

Besides, to overcome the factors that hinder the development of innovative technologies, exchanging views and consultations were implemented on a trial base with the organizations in charge of integrated and efficient operation of research funds, or regulations from the development stage. The related ministries and agencies are working together through the establishment of "Special zones for advanced medical care development" in FY 2008 to promote the development and practical applications of state・of・the・art regenerative medicine, pharmaceuticals, and medical devices.

In June 2010, the "New Growth Strategies" were adopted by the Cabinet, which incorporated the concrete measures for seven strategic fields. The strategies aim at promoting research and development of highly safe, excellent and innovative pharmaceuticals from Japan and medical/nursing technologies, the industry・government・academia projects, cutting・edge medical technologies such as for new pharmaceuticals and regenerative medicine, solving drug lag and devise lag; establishing an environment for clinical trials; and accelerating procedure for approval review . (Please refer to Chapter 2 Section 1・3(4) .)

Through these efforts, the necessary measures will be taken to achieve a further improved health care level by providing high quality, safe and secure pharmaceuticals and medical devices.

Since the establishment of the universal healthcare system in 1961, Japan has attained the longest average life span and high standard healthcare by developing the system that allows the public to receive necessary medical services at a certain amount of self・pay burden. On the other hand, after 50 years have passed since establishment of the

universal healthcare system, Japan now faces continuous difficulty in health insurance finance partly due to a significant change in circumstances around medical care, such as rapid progress in aging, and is required to establish the sustainable system that can respond to demographic changes while ensuring medical care in need.

(1) Reform of National Health Insurance Law

Regarding the Health Insurance System in Japan, Due to the drop in income of the insured persons because of the recent economic slump and increased medical care costs partly due to aging, insurance premiums for the National Health Insurance and health insurance administered by the Japan Health Insurance Association (Kyokai Kenpo) , and the late・stage medical care system for the elderly are scheduled to be significantly increased in fiscal 2010, which will be applied to each entity. In view of this, to suppress increases in the premiums for each individual insurance system, the “Draft Legislation to Amend National Health Insurance Law to Promote Stable Management of Health Insurance System”, which aimed at taking financial support measures to hold down a rise in premium of each insurer, was presented at the FY 2010 ordinary session of the Diet, passed and enacted on May 12. The main contents are as follows.

First, regarding municipal national health insurance, it was decided to extend the period of financial support measure, which had been taken until FY 2009, for four years also after FY 2010. This measure helps to curb the premium hike of 12,000 yen per household for about 20 million households with the total of about 36 million subscribers. In addition, the units of National Health Insurance include small municipalities, and financial stability led by promotion of management in wider・area has become an issue. Thus, prefectures are endowed with the privilege to establish support policy for municipalities in order to promote management in wider・area and financial stability (support policy for wider・area management, etc.) . Furthermore, even if a head of household falls behind in pension premium payment obligations, limited・time insurance cards, valid for six month, has been issued to the children at middle school age and under since April 2009. The eligibility of the care, however, has expanded to the children at high school age and under.

Second, with regard to the Japan Health Insurance Association (Kyokai Kenpo) for workers of small and medium・sized firms, a significant premium hike for the next fiscal year from the current 8.2% to 9.9% was expected due to tight financial conditions unless the system was changed. Therefore, for three years through FY 2012, ① The share of the state subsidy has been increased from 13% to 16.4%; ② As a special treatment for equilibrium in balance of settled account in a fiscal year, the deficit after FY 2009 can be redeemed by FY 2012; and ③ One third of the amount of support coverage of medical

care system for elderly in the latter stage of life, paid by insurers such as employee insurance, is decided in accordance with the standard remuneration of insurers including employee insurance.

Third, concerning the late・stage medical care system for the elderly, unless no measures had been taken, the premium in FY 2010 and FY 2011 would have been increased by 13.2% on a national level (an increase of about 6,000 yen annually on average) . Accordingly, decision was made so that the fiscal stability fund established in each prefecture could be used to curb premium hike. Thanks to this measure, the national average of the increase rate of premium for FY 2010 and FY remained as low as 2.1% on a national average (an increase of 1,300 yen annually on average) . In addition, the measure to reduce 90% of the premium for the elder dependents of the employee insurance expired for many insurants at the end of FY 2009, and has been extended for the time being.

(2) Reform of medical care system for the elderly

Abolishment of the late・stage medical care system for the elderly and investigation of new substitute system

Regarding the late・stage medical care system for the elderly, the abolishment of the system has been determined, after consideration of opinions from the public on the system. In November 2009, the meeting for reform of medical care system for the elderly, consisting of representatives from interested organizations and elder persons and academic experts, was held under the presidency of the minister of Health and Welfare and Labor to investigate a specific scheme for a new substitute system. In this meeting, six principles were presented as the basic concepts: “abolish the late・stage medical care system for the elderly”; “develop a new system for the elderly, as the first step for integrated management as regional insurance presented in the manifesto”; “design a new system that allows elimination of categorization by age”; “one of the defects in the late・stage medical care system for the elderly”; “provide adequate attention to prevent a greater burden associated with municipal national health insurance, prevent a sudden increase in insurance fees applied to the elderly or unfair burdens”; and “work on a review seeking wider coverage of municipal national health insurance.” The discussion is proceeding based on these principles.

Through processes of building consensus among a broad range of interested persons, such as the elderly, local governments, and the insurers, the meeting continues discussion, aiming (i) to complete an interim report outlining the basic orientation of a new system by the summer of 2010, (ii) to come up with the definitive report by the end of 2010, (iii) to submit a bill at the ordinary parliamentary session in 2011, and (iv) to implement a new

system in April 2013. Concurrently the discussion in the meeting, an attitude survey targeting a wide range of the public including the elderly is to be meticulously executed, together with public hearing in local regions in order to carefully listen to opinions from the public.

(3) The FY 2010 Medical Fee Revision

1) Development of the FY 2010 Medical Fee Revision

To make decisions on the medical fee revision, discussions are conducted at the Central Social Insurance Medical Council (Chuikyo) , consisting of the payment member, the medical professional member and the public member, based on (i) “Basic Guidelines” decided at the Social Security Council; and (ii) revision rate decided during the process of budget compilation by the Cabinet.

Regarding the FY 2010 Medical Fee Revision, discussions were made on individual items at the Central Social Insurance Medical Council based on:

(i) “Basic Guidelines for the FY 2010 Medical Fee Revision” compiled at the Social Security Council on December 8, 2009; and

(ii) Revised rate (an increase of 1, 55 % for medical fee (itself) , a decline of 1.36% for drug prices, etc. and an increase of 0.19% for overall rate.

In consideration of these discussions, the reform plan for the medical fee points was submitted by the Central Social Insurance Medical Council (Chuikyo) on February 12, 2010. In March in 2010, the medical fee points were revised and have been enforced since April 2010.

2) Overview of revision of the remuneration for medical service fee in fiscal 2010

Under the perception of the provision of secure medical services to the public,

・remuneration for medical services has been revised with a net increase of 0.19% for the first time in 10 years; and

・for the medical service providers' portion, the increase is more than four times compared with that in the previous revision, i.e., from plus 0.38% to plus 1.55%.

Overall revision rate　+0.19%　About 70 billion yen

→A net increase for the first time in a decade

Medical fee (itself)　+1.55%　About 570 billion yen

Medical department　+1.74%　(About 480 billion yen)

Inpatient treatment　+3.03%　(About 440 billion yen)

Outpatient treatment　+0.31%　(About 40 billion yen)

About 400 billion yen was allocated to acute inpatient medical care.

Dental medicine +2.09% (About 60 billion yen)

Dispensation fee +0.52% (About 30 billion yen)

Drug fee, etc. ▲1.36% (About 500 billion yen)

Under this circumstances, reconstruction of medical services provided by emergency, obstetrics, pediatrics, and surgery and a reduction of the burden for hospital doctors have been primarily addressed as the top priority issues in the “Basic Principle for the Revision of the Remuneration for Medical Service Fee in FY 2010”, together with various approaches to challenges in medical practice setting.

More concretely, following measures were taken along with these priority issues:

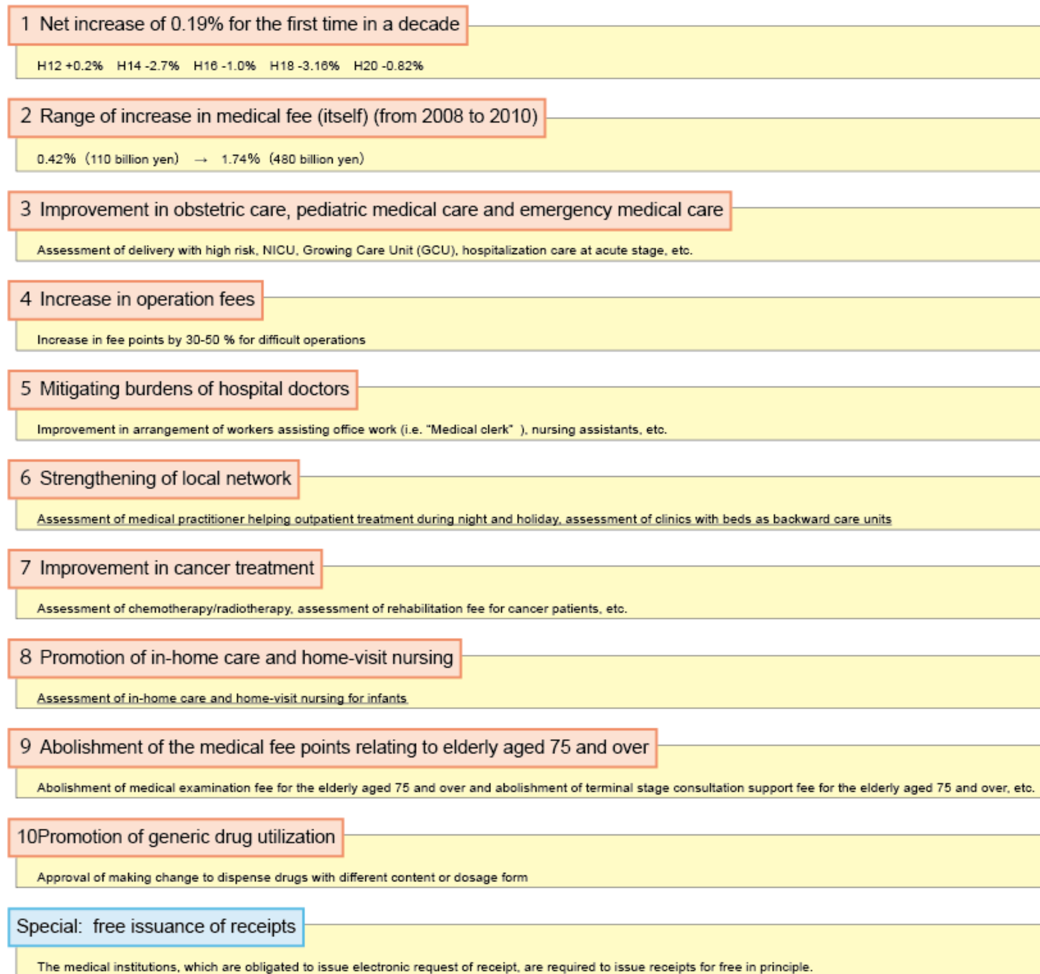
- As a measure to improve assessments of emergency medical care, enhancement of hospitalization fee at emergency and critical care centers which have excellent system to receive patients, creation of new medical service fee which is paid when doctors at clinics cooperate in providing emergency outpatient service at the hospital during night and holidays;
- As a measure to improve assessments of obstetric and pediatric medical care, enhancement of hospitalization fee associated with high・risk delivery such as premature delivery and enhancement of hospitalization fee of neonatal intensive・care unit (NICU) that provides treatment for premature infants;
- As a measure to improve assessment for surgery, significant enhancement of technical fee focusing on extremely difficult operations (an increase of 30・50%) ; and
- As a measure to reduce the burden for hospital doctors, improvement of assessment of hospitals that place medical clerk who assist doctors’ office work, and creation of medical service fee of the hospitals for acute・stage patients which place nursing assistants.

Additionally, a new medical service fee has been put into practice for hospitals and clinics if they work to provide treatment of diseases such as cancer or dementia, which particularly requires reinforcement of medicine in Japan.

Moreover, a written description showing medical service fees in detail has been issued for free at medical institutions and pharmacies in principle, from the viewpoint of promoting transparency in medicine and provision of information for patients.

Furthermore, remuneration for medical services applied to the elderly over 75 years (including remuneration for consultation services for the elderly in the terminal phase) is abolished prior to removal of the late・stage medical care system for the elderly.

Chart 2-5-14 Overview of FY 2010 Revision of Medical Fee



(4) Other actions

1) Creation of a new scheme for lowering insurance premiums for unemployed persons

The Local Tax Act was revised so that unemployed persons who lost their jobs due to bankruptcy, etc. can receive medical care without anxiety. Since April 2010, the scheme of municipal national health insurance has been launched for the persons who left their jobs due to bankruptcy or dismissal (specified recipients eligible for employment insurance benefits) and the unemployed persons who were refused to renew their employment contract (the employment insurance beneficiaries who are unemployed due to the specified reasons) . The new scheme lowers tax (contribution) for the National Health Insurance for these unemployed persons from when they have lost their jobs until the end of next fiscal

year by calculating (contribution) the premium based on 30/100 of the income previous year.

2) Promotion of approach to moderation in healthcare cost

The national medical expenditures reached reaching 34.1 trillion yen (267 thousand yen per capita) in FY 2007. With progress in medical technologies and aging, the medical expenditures are expected to continue to increase. In order to maintain universal medical care insurance, it is important to enhance efficiency where possible while focusing on the structural factors behind the growth of medical expenditures and securing necessary medical care. It is also important to promote efficient medical care through prevention of lifestyle・related diseases and appropriate medical services in accordance with the mental and physical conditions of patients.

For these ends, the health expenditure regulation plans (from FY 2008 through FY 2012) , which have the specific numerical targets concerning prevention of lifestyle diseases and shortening average lengths of stay at hospital, were established in the national government and prefectures. In FY 2010, the middle year of the plan, the assessment of progress was to be made, and necessary revision was to be carried out. The goal relating to the number of beds of long・term care beds is put on hold for a while, and the number of bed will not be mechanically reduced. Investigation will be implemented to understand the real situation for bed conversions/facility transition at each facility and conditions of patients; and based on the results, discussions will be made on revision of the plan.

3) Electronic receipt

Aiming at making the office work involved in health care insurance more efficient, and enhancing the quality of medical services, it was planned to have all the receipts to be submitted in principle online by medical institutions to examination and payment organizations from the beginning of FY 2011. However, according to the ministerial ordinance, which was revised in November 2009, the following exceptional measures were taken:

i) Progress in the electronic receipt system helps to achieve efficient office work involved in health care insurance and high quality of medical services, even if the receipts are not submitted online. Accordingly, medical institutions are allowed to submit receipts also via electronic media; and

ii) To avoid the collapse of regional medical care, the medical institutions, which face difficulty in exercising online receipt request on their own due to handwritten receipts issued at the institutions or their older staff, are exceptionally permitted to

submit paper receipts.

As of June 2010, the share of electronic receipts was 81.2% (and 61.4% was requested online) , showing a significant growth from 61.9% at the end of June of previous year.

Column

Health insurance reform in the USA

On March 30 2010, the legislative process for a health insurance reform bill, whose content was to increase insurance participation rate to 94% in the USA, was completed after US President, Obama signed it into law. This was fruition of his eager appeal for establishment of a health insurance system with universal coverage as a top priority of the domestic administration since January 1 2009.

On the other hand, the White House gave up establishing a new public health insurance plan, and supported the bill for utilization of private insurance plans after passing the Upper House, requiring repeated arrangement and negotiation to pass the Congress. Protesting activities of US citizens against the system were repeatedly broadcasted, resulting that the US people's allergic reaction to improvement of the public health system with universal health insurance has become well・known in Japan.

(1) Background to the reform

According to the latest data of the American Statistical Association, as of 2008, it is assumed that those who join in health insurance reach to 46.34 million people which accounts for 15.4% out of citizens. This indicates that 1 out of 6.5 persons are not covered by any health insurance.

Looking into those who hold a health insurance plan, they join in one of three types of public insurance ・ Medicare for the elderly (14.3%) , Medicaid for people with low income (14.1%) or the insurance for military personnel (3.8%) , or either of two types of private insurance, ・ an insurance plan provided from employers (58.5%) or an insurance plan people can purchase by themselves (8.9%) .

Also, Japan has a unified system for medical fee range covered by public insurance without differences among types of insurance. However, the USA has a system that service is changeable depending on a type of insurance. Besides, disadvantage, for instance, the insurance premium is higher due to anamnesis if they change the insurance plan, was

corrected, but issues, such as disadvantage for the self・employed and small business operators to join in an insurance plan and the high management cost, are not yet solved The background against that the President has moved health care reform forward with his initiative is because of such situation in addition to the fact that medical cost was rather high standard (16.0%) to GDP.

(2) History of the insurance system of USA

In the USA, the Social Security Act was enacted in 1935. There were opinions that medical insurance must be added to the Act, but it also met opposition from the American Medical Association. At that time, since establishment of unemployment insurance and that of public pension program were urged under the severe economic situation of the USA in 1930s, the medical insurance system, which was difficult to reach a consensus, was not included in the Act. Although some movements were occurred toward the universal coverage and a certain level of improvement, such as establishment of Medicare/Medicaid (refer to the above) , was seen, citizens' support to universal coverage was not enough due to the growth of private insurance plans which were useful to apply as fringe benefits profiting the labour・management relationship.

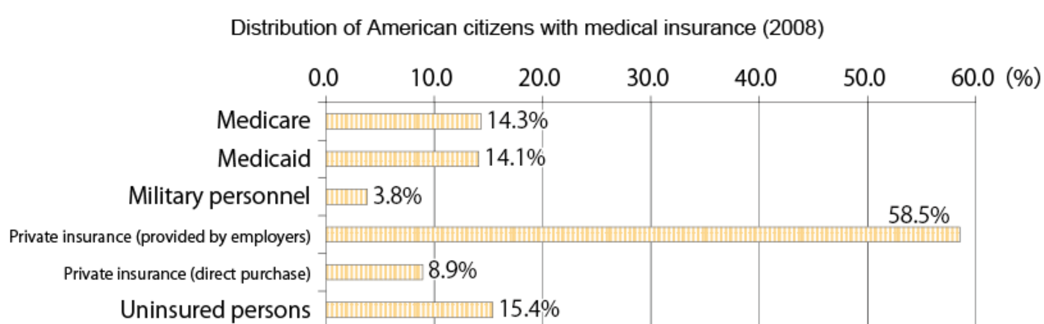
(3) Remained issues

As you may know by looking into the fact that many medical scientists including the Japanese go to the USA to study, the medical standard of the USA is at the top level of the world. Thanks to massive investment into medical researches by the government, progressive medical products and medical equipment have been developed and all countries over the world are blessed with them. According to the latest data of OECD, medical cost per person is 7,290 dollars a year which is as expensive as about 2.5 times compared to the average of OECD countries and also is about 2.8 times compared to Japan. Although above issue is expected to be improved due to the enacted bill, there is another issue that the level of medical service people can receive depends on if they join in a health insurance plan or what type of insurance they are in.

Patients without insurance or those with insurance that does not cover the treatment are not provided with necessary medical service, or medical institutions have to bear the burdens of medical service under the said situation. Even after the bill was enacted to improve such situation, opposition to introduction of universal coverage is rooted deeply, and it does not reach a consensus among the people. Citizens' concern over the intensification of the state regulations for medical service is allegedly deep・rooted, and this shows the nature of America that values independency and self・help.

(4) Importance of national consensus building

A medical system in every country has been formed under the mutual influence between finance and supply in their history, and the culture of each country has had a great impact upon its medical history as it is observed in the example of the USA. Comprehensive understanding including the social background besides finance and supply is indispensable to understand the medical system of each country. Besides, a medical insurance system involves many interested parties, such as persons who bear costs and who offer services, in addition to insured patients and their families. Service can be implemented smoothly by only establishing a system on the basis of agreement among such parties. Through a series of controversy, it has been recognized that the importance of national consensus building for the medical insurance system and continuation of health insurance for about 50 years since its establishment are not something taken for granted but it is the result of efforts made by concerned parties for a long time.



Note: Observing it in a year range, there may be cases that one person has more than two medical insurances
Reference; Produced by Policy Evaluation Division referring to US Census Bureau, Current Pooulation Survey, 2008 and 2009 Anneal Social and Economic Supplements