

# PROTECTION AND PROMOTION OF HUMAN HEALTH IN JAPAN

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## Summary

Recent administrative reform and decentralization of governmental power have been worthwhile though leaving some problems to be solved. To cope with our aging society and reduce the decline in child population, the Ministry of Health and Welfare has presented several concrete plans.

As for communicable diseases, tuberculosis, influenza, salmonella, HIV and AIDS are emerging/ re-emerging infectious diseases, while measles, diphtheria and poliomyelitis are controlled by regular vaccination.

People with disabilities are surveyed concerning their residence, education and employment. The government Action Plan for Persons with Disabilities has concrete numerical goals. The first priority should be given to the establishment of a new organization and the realization of normalization in the community.

The figures concerning child abuse show rapid and sharp growth. One of the problems is that many citizens do not know about Children's Welfare Law Article 25, which makes it a citizen's duty to report child abuse cases. Suggestions to prevent such cases include a toll-free, 24-hour-working hotline for children supported by the Ministry of Health and Welfare and intervention by the CGC or other public authorities.

Current topics in occupational safety and health include “karoshi” (death from overwork), suicides and occupational accidents and diseases. The Industrial Safety and Health Law was revised in 1996 in response to the changes of industrial health status, obliging companies to undertake general health examinations for all workers.

With changes of the living environment, both assessment and management of environmental risk are necessary. After the occurrence of pollution-related diseases, the Basic Environment Plan was established in 1994 for environmental conservation.

## **1. Introduction**

After World War II, Japan industrialized, modernized and urbanized in a rather short period. With the improvements of the living environment and medical care, average life expectancy improved significantly and now it is the country enjoying the longest life expectancy. Since the 1970s, the aging of society and the decline in the child population have been moving forward with full speed. With this trend and with rapid shifts in lifestyle and living environment, various aspects of human health have changed dramatically in recent years. This report introduces current administrative plans to deal with these problems.

In postwar Japan, massive outbreaks of acute communicable diseases such as cholera were experienced. For this reason, measures to prevent the spread of communicable diseases became an urgent task. Japan now promotes measures to deal with contagious disease based on the Communicable Disease Prevention Law and the Preventive Vaccination Law. With advances in medicine in recent years, it appeared that many infectious diseases had been defeated. Since the emergence of AIDS in the 1980s and against a background of increased international relations, however, infectious diseases, some of them new, have been crossing national borders and have once again become an issue. There is thus a demand for increased international health and medical care cooperation in the infectious diseases field.

As to vulnerable groups, we focused on persons with disabilities and children. As regards the disability issues, more than 60% of such persons are 60 years or older and the number is growing. To further self-reliance among persons with disabilities and to enhance their participation in society, the Government is promoting extensive measures to guarantee them healthy and cultural living standards. The number of child abuse cases reported to

local Children's Guidance Centers has been rapidly increasing. Children are victims of adults' mental disorders induced by a stressful society. As child abuse is an emergency, intervention by CGCs or other public authorities is expected.

The urbanization that Japan underwent after the 1950s created a multitude of problems, including lack of proper housing, atmospheric, water, and noise pollution, and an increase in traffic congestion and accidents. The occupational environment for urban workers in Japan is getting worse. The Japanese government has not yet ratified any of the ILO Conventions concerning working hours. As a result, excessive working hours and overtime work have become prevalent in Japan. In fact, the inquiry of the Legal Defense Team for “Karoshi” (death from overwork) has reported that more than 10,000 people die of Karoshi every year.

From the 1950s to the 1970s, the Japanese economy boomed and living standards rose with a background of increasing population and affluent manpower. However, this economic growth and material prosperity also generated a number of social, cultural and mental strains. Disorders induced by environmental pollution, industrial chemicals or medical drugs have been major social and medical problems since the 1960s, and include Minamata disease, Itai-Itai disease, SMON disease, etc. Although the situation with regard to environmental pollution has been remarkably improved compared to earlier periods, some serious environmental problems still remain.

## **2. General Issues**

### **2.1. Health and Welfare Administration**

#### **2.1.1. Administrative Reform**

A major event in the national administration in Japan is an administrative reform by which the current 22 ministries and agencies will be restructured into 11 organizations according to the Prime Minister's proposal. The Ministry of Health and Welfare and the Ministry of Labor then will be merged into the Ministry of Labor and Welfare, possibly in 2001.

#### **2.1.2. Decentralization of Government Power**

Administrative authority has long been centered in the national government. However, the health and welfare administration system, whereby the current Ministry of Health and Welfare had been dominant over municipalities, has recently been changed. The Community Health Act was enacted in 1994 with the intent to create a new health-maintenance promotion system for community residents by transferring greater authority and responsibility to local governments so that municipalities can implement specific health and welfare policies and provide health services for their community residents.

Municipalities are direct health service-providers, closer to the service-consumer than the national government is. Therefore, the decentralization of government power may be a matter of course. However, there are some problems to be solved in the matter of

autonomy such as of fiscal resources, the need for community health specialists among local government administrators, the low potentials of small municipalities and consequently a need for the central government's cooperation.

### **2.1.3. Changes in Roles of Public Health Centers**

Public health centers were established in accord with the Public Health Center Law. In 1994, the law was revised into the Community Health Law, and the roles of public health centers have been changed in many respects. In terms of community health, public health centers have conventionally played leading roles for disease-protection, health promotion and environmental health. After the implementation of the Community Health Law, some of their services were transferred to the municipalities. These include vaccination, health checkup, maternal and child health services etc., while special subjects such as mental health, intractable diseases, and AIDS still belong to public health centers. Public health centers are to be located in prefectures and public health ordinance cities, and the number of the centers totaled 582 in 2001. They cover specific areas and undertake planning, arrangements, guidance, investigation, research and management for community health. The legislation allows the municipalities to establish municipal health centers for the purpose of implementation of their basic health services. Though responsibility and authority were transferred to local governments, some municipalities are not ready to take on new administrative tasks because of lack of manpower, for example.

### **2.1.4. Other Issues in Health and Welfare Administration**

Administrative reform and decentralization of governmental power are worth taking into consideration. Another issue is the vertical structure of every level of national and local administration. It has always been an obstructive factor against quick, qualified and efficient performance of administrative services.

What is required for the present and future health and welfare administration is cooperation. Cooperation among health, medicine and social welfare providers is a key word for further promotion of health for the people.

## **2.2. Medical System**

### **2.2.1. Medical Personnel and Care Facilities**

The Ministry of Health and Welfare set a policy target of 150 doctors per 100 000 population and the target was attained in 1983. An age of excess doctors began after that. The number of doctors in Japan was 255 792 as of 2000, with 90 857 dentists, 217 477 pharmacists, 36 781 public health nurses, 24 511 midwives, 1 042 468 nurses.

The total number of medical facilities was 165 451 as of 2000, including 9 266 hospitals (7.3 per 100 000 population), 92 824 medical clinics (73.1) and 63 361 dental clinics (49.9).

### **2.2.2. Health Insurance System and Medical Expenditures**

In 1961, the national health insurance system was started and all people were required to have some type of medical insurance. The total number of persons covered by medical insurance as of 2000 was 126.78 million: 36.8% are covered by national health insurance, 29.5% by government-managed health insurance, 25.3% by union-managed health insurance, 8% by mutual aid associations, and 0.4% by others.

National medical expenditures are continually increasing. In 2000 the amount totaled 30 358 300 million yen. More than 50% was borne by insured persons, 33.7% by the insurance system for the elderly, 14.8% by patients and 4.7% by public funds. The growth of the cost for the elderly persons' medical expenditures is remarkable. The cut of medical expenditures is an important nation-based issue.

### 2.3. Aging Society

The population of Japan was 126 926 000 in 2000. The average life expectancy of males at birth in 2000 was 77.72, and that of females, 84.60. As for principal causes of death in 2000, the main cause was cancer with a death rate of 235.2 per 100 000 persons, the second cause was heart disease with a death rate of 116.8 and the third, cerebral stroke, with a death rate of 105.5. The death rate in 2000 was 7.7, the birth rate 9.5 and the infant mortality 3.2 (unit: per 1 000 people). This provides a brief explanation of Japan's current demography. Figure 1 shows the trends in average life expectancy and in birth rate.

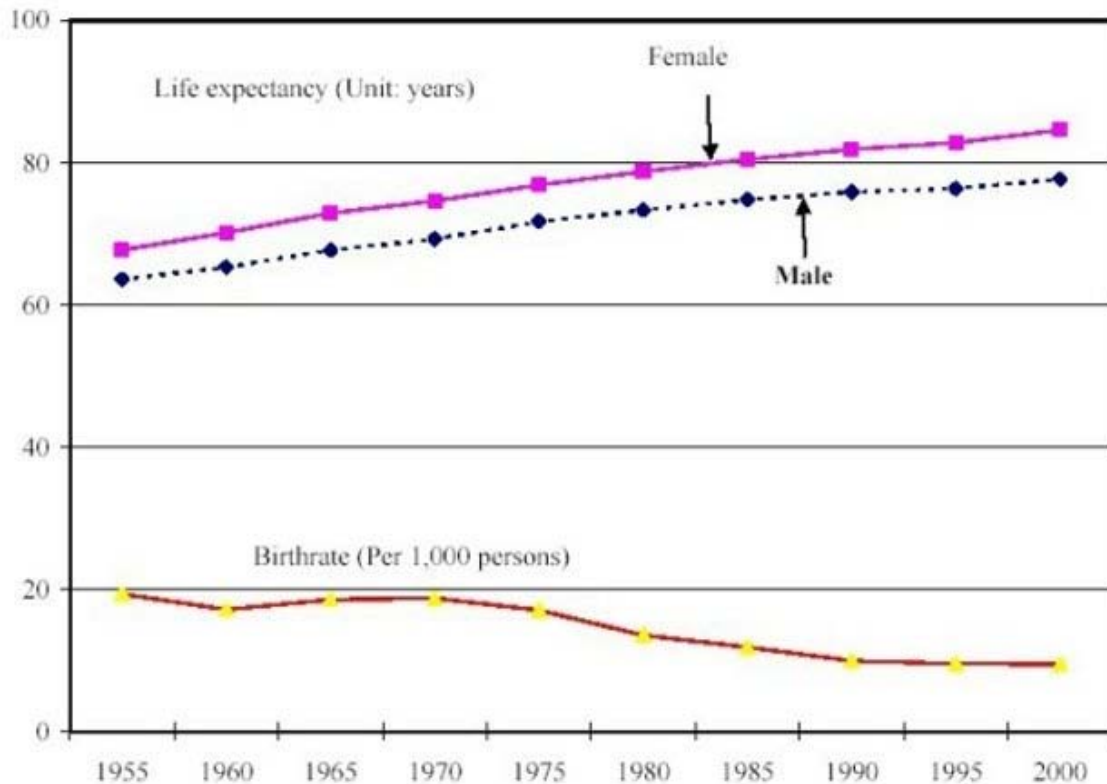


Figure 1. Life Expectancy and Birthrate

As is clear from Figure 1, society is aging and the population of children is declining in

today’s Japan. In 2000 the aging index was 119.1 and the elderly population accounted for 17.34% of the population, which is estimated to increase to 35.7% by 2050. On the other hand, the 0-14 age group accounted for 14.6% of population in April 2000, lower than in other countries (except for the 14.7% of Italy). Both the aging and the population drop have become controversial and are serious political issues now.

The Japanese government has presented several concrete plans. As a policy for the aging society, in 1989, a “10-year strategy for promotion of health and welfare for the aged” (the so-called “Gold Plan”) was published by the Ministries of Finance, Health and Welfare, and Home Affairs. Along with the Gold Plan, all prefectures and municipalities (cities, towns and villages) became responsible for their own program of health and welfare services for the aged. The Gold Plan was revised in 1995 into the “New Gold Plan” based on a policy of 1) user-based services and support for self-care, 2) universality, 3) integrated services, and 4) autonomy. Furthermore, the New Gold Plan sets a higher goal to upgrade the social infrastructure and capital such as manpower. As a legislative measure for the aged who need nursing care, the “Public Long-term Care Insurance Program” of 1998 is to go into operation on and after April 1, 2000. The number of aged people who suffer from infirmity, dementia and/or are bedridden and need care is around 2 million at present and is expected to increase up to 5.2 million by 2025. (See Figure 2) Nursing care for the elderly has long been a serious household issue. Most carers are family members, mainly women (85%). This has been an obstructive factor for women trying to manage both their occupation and care-taking together. Carers are aging, too, and suffer from fatigue. Thus, household nursing care has reached its limit. The “Care Insurance Program” is expected to play a role as an administrative intervention into this household problem.

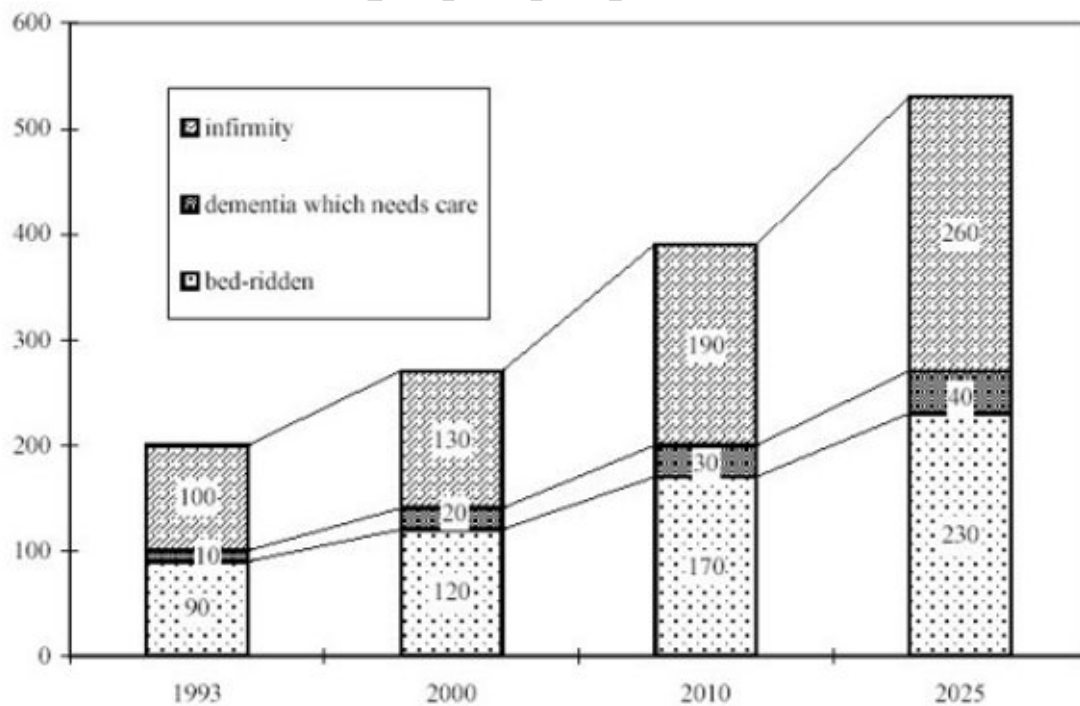


Figure 2. The Number of Aged Suffering from Infirmity, Dementia and/or Bedridden

### 2.3.1. Public Long-Term Care Insurance Program

A brief summary of the program is as follows:

1. Insurer: the municipalities
2. Beneficiary:
  - (a) Over 65-year-old person who needs care for activities of daily living
  - (b) 40 to 64 year-old person who has medical insurance and needs care because of diseases of old age such as senility and cerebrovascular accident
3. Benefits:
  - (a) Home care services such as: bathing, rehabilitation, day-care, short-stay, group-home, rental welfare tools and support for barrier-free house repair.
  - (b) Care services at facilities
4. Individual payment: 10% of the bill
5. Contribution: monthly average 2 000 yen (estimated)
6. Fiscal resources: national government 25%, prefectures 12.5%, municipalities 12.5% and contributions 50%
7. Conditions: health conditions assessed by a “Care Manager”, a licensed health professional; beneficiary needs to be approved by a screening committee that will determine if he or she genuinely needs nursing care.

There have already been several difficulties: imbalance in potentials among the municipalities, prospective fiscal crises, anxiety in cases in which an applicant for care service is not approved as a beneficiary, and so on.

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