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9. ABSTRACT
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 Japanese developments in rural medical care may have relevance for developing countries, since the basic problem for developing countries is manpower whether a developing country has the resources to fulfill that requirement. When the universal health insurance program was instituted in Japan and the demand for medical services rose, a shortage of doctors became a significant issue. Sufficient manpower for medical care was an important prerequisite to the spread of the clinical approach in rural health services. After World War II, occupational authorities upgraded the role of Japanese public health centers and community nurses. Wide-ranging programs included educational campaigns directed toward modernization of rural life-styles, improvement of public hygiene and disease prevention activities, and promotion of high standards of pediatric and obstetric care. The Japanese experience shows that developing nations can wisely concentrate on training public health nurses, since this takes much less time and money than training doctors, and nurses can fulfill a significant role in medical care. Public health efforts also need to be combined with social and economic development. Developing countries need to decide whether to develop a system of free medical care, or follow the pattern of Japan and move toward major reliance on the private sector. In a system of free medical care, with government responsibility for all facilities and programs, the rewards must be enough to induce doctors to stay with the program. This has not been a serious problem in Japan because of the difficulties Japanese faced in language when they tried to study or practice in other countries, although Japan did experience an unbalancing flow of doctors from country to city. It is most desirable that governments bear the entire cost of training their own doctors and medical personnel.

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A STUDY OF
THE JAPANESE RURAL HEALTH DELIVERY SYSTEM

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RURAL MEDICAL CARE IN JAPAN

September 9, 1974

CHAPTER I THE PREWAR SITUATION

1. The Japanese have made vast improvements since World War II in the quality and organization of rural medical care and public hygiene and disease prevention programs, and they have established a health insurance system to finance universal medical care and secure adequate funds. In spite of the fact that tremendous changes have taken place in Japanese society in the last thirty years, the present system owes much to the efforts that were made and the experiments conducted during and before the war. Public medical institutions and systems--expanded and developed in post-World War II Japan--had their origin in the prewar period. For example, the practice of sending doctors to rural areas where there were none, opening health centers, and providing community nurses, originated in prewar medical policies, as did anti-tuberculosis programs and a national health insurance plan designed to procure funds for rural medical care. Public efforts toward improving rural medical care show a great deal of continuity between the prewar and postwar periods.

2. Japan's modern medical system dates back to the Meiji Restoration (1868), when Western medical science was given official sanction by the new leadership. In 1873 a medical bureau was established within the Ministry of Education; in 1874 a medical service system was instituted, and in 1876 a medical practice examination law was promulgated. There were at that time seven national hospitals, 64 public hospitals, and 35 private hospitals, making a total of 106. Doctors numbered 30,000, including practitioners of Chinese medicine.

3. Medical services in Japan are based on an open-practice system, in which the private sector dominates in supplying medical care, but public facilities are operated in much the same way as profit-oriented private facilities. That tendency is partly the result of policy made during the early Meiji period when the government tried to modernize medical services by utilizing a large number of doctors in private practice, many of whom had been trained in Chinese medical techniques. The government not only encouraged these doctors to practice Western methodology, but placed them under bureaucratic control in order to establish a uniform system of medical services.

4. From the beginning of the Meiji period (1868-1912) the government concentrated its efforts on developing the national and public hospitals. Like

their counterparts in the West, these hospitals were designed to function as the major source of medical care; they were, in addition, expected to serve as welfare hospitals, shouldering responsibility for social medical care. In actuality, however, they were used mainly by the upper classes who had the ability to pay. As the number of private doctors increased, conflicting interests emerged between the private practitioners and the national and public hospitals. The situation intensified when financial difficulties beset the national and public hospitals, prompting their management to become more and more profit-oriented. The pervasiveness of this profit orientation and the competitive relationship between the public and private sectors have consistently marked Japanese medical services from the Meiji period until the present. This is one important historical factor that explains why our health insurance programs have treated public medical institutions and private doctors exactly alike, contracting them both on identical terms.

5. Japanese capitalism developed rapidly from the time of the Sino-Japanese War (1894-95) through the Russo-Japanese War (1904-05) and World War I, during which time a modern working class emerged. While it was growing rapidly, however, the Japanese economy was beset with increasingly serious labor and social problems, fluctuations in business, and the aggravation of agricultural problems. During this period the training of doctors proceeded apace, but a rapid increase in population caused a decline in the relative number of doctors. At the beginning of the Meiji period there were 10 doctors for every 10,000 people. At the end of Meiji this number declined to 7 for every 10,000. It climbed to 8 per 10,000 during the Taisho period (1912-26), but declined again to 7 per 10,000 at the end of this period.

6. In a country faced with serious social problems, the exceedingly profit-oriented behavior of both the private and public medical sectors meant that the poor were left without adequate health protection. The need for some kind of socialized medicine was obvious. During the end of Meiji and the beginning of Taisho, there was an increase in the number of infirmary facilities and philanthropical medical care centers designed for this purpose. In 1911, the Imperial Endowment Foundation Welfare Society (Saisei-kai) was established; this was an important breakthrough in the effort to expand facilities and provide medicine and medical care for impoverished people. According to statistics on social work facilities, there was only one medical welfare

establishment in 1868, but the number of such facilities grew to 67 by 1907 and to 408 by 1928. In 1868 there were 8 medical care facilities, 107 in 1907 and in 1928 there were 438. In addition to these there were also public dispensaries established for the lower classes. (These were not, in fact, purely philanthropical, but were geared to accommodate the needs of average citizens, in order to prevent them from becoming déclassé because of illness.)

7. Prewar rural Japan was notoriously poor, because of fragmented, small landownership and the preponderance of tenant farming, under which land taxes and tenancy fees were very high. There is disagreement among economic historians over the interpretation of the high rent-in-kind system, but it is generally agreed that the rural areas provided the labor force for the development of a capitalistic economy in the urban areas and also functioned to absorb surplus labor during times of recession. Consequently, the burden of economic growth and its attendant problems was borne in large part by the rural areas. Tenancy disputes gradually proliferated, and rural problems became more and more the focus of serious social concern.

Population statistics for that period, according to the 1930 national census, show that the number of people living in Japan proper was 64,450,000. By industrial sector, 47.4 percent of the total labor force was engaged in agriculture; the number of agricultural households was 5,599,000. The Great Depression, which began in the fall of 1929, combined with a worldwide agricultural crash to cause a sharp drop in farm prices. Hard hit by these developments, Japan's rural population was driven further into economic impoverishment. The miserable plight of village life became a major political issue of the time: it was, in fact, a direct cause of rightwing terrorist activities directed against government and business leaders that took place in 1932 and later.

8. Rural impoverishment further stimulated the growing concentration of doctors and medical facilities in urban areas. The net effect was to keep the level of health care in the rural areas extremely low. Although it is impossible to compare exactly urban and rural mortality rates because of differences in age structure, we know that in the mid-1920s the rural mortality rate was higher than the urban by two or three per thousand. A comparison of the infant mortality rate shows a gradual decline in urban area. The urban rate continued to decline until the 1928-29 period when it dropped below the rural rate. There is also evidence that tuberculosis was widespread in rural areas in prewar Japan.

In 1937 the Medical Bureau of the War Ministry stated, "Records of the physical examinations for conscription show that in our country approximately 250 out of 1,000 youths were rated C or D (unsatisfactory) in the period from 1922 to 1926. From 1927 to 1932 this average rose to 350, and in 1936 it reached 400... there has been a striking increase in the numbers suffering from tuberculosis. During 1928 and 1929 two out of 1,000 youths just reaching adulthood had such respiratory diseases, and this has increased yearly so that the number is now more than 20 per 1,000."

9. In the late thirties the militarist government began to promote an active rural reconstruction program, hoping to consolidate the home base for the war effort. Prior to that, it had been generally recognized that medical care in Japan faced three, closely intertwined and serious problems: The first was a vast increase in the number of rural communities without doctors, one result of the concentration of medical personnel in the cities. Second, distressed economic conditions made it very difficult for farmers to pay for medical care. The third problem was the spread of tuberculosis from urban into rural areas.

If one examines the concentration of doctors in urban areas, he finds that at the beginning of the Meiji period all doctors were either traditional medical men or practitioners of Chinese medicine. At that time scattered throughout the country, there were more than 10 doctors for every 10,000 people. These old-time practitioners were not concentrated in any particular area, but as Western-style doctors, whose training and equipment required considerable financing, gradually replaced traditional doctors, there emerged a growing tendency for doctors to concentrate in the cities. This tendency grew even more pronounced during the Showa period (1926-). In eight years, from 1928 to 1936, the number of practicing doctors increased from 43,273 to 53,376. At the same time the total number of doctors in towns decreased by 2,000; the number of doctors in villages also decreased by 2,000. In 1936, there were 13.62 doctors per 10,000 people in the cities, 7.72 in towns, and 3.59 in villages, with an average of 4.83 per 10,000 in counties (towns and villages together). In proportion to population, rural areas had only one-third of the number of doctors that urban areas had.

10. The figures above are average of the number of doctors per total population. From this information it becomes apparent that there was a vast

increase in the number of villages and towns that had no doctors at all. The number of such villages and towns in fact increased from 1,960 in 1923, to 2,909 in 1927, 3,231 in 1930, and to 3,427 in 1934. The size of villages and towns in prewar Japan was much smaller than after the war, but there were three to four times as many municipalities at that time than there are today. Although it is hard to evaluate previous conditions by contemporary standards--since these conditions have changed qualitatively since prewar times--we know that by the end of May 1936, the effort to provide all villages with doctors was proving to be somewhat successful. In that month records show that out of the 3,243 villages without doctors, the distance from the village or town office to the nearest doctor was more than four kilometers in 1,419 villages. Of these, 344 were located more than eight kilometers from the nearest doctor.

11. Precise figures are not available to give direct evidence of the inability of farmers to pay for medical care. However, according to a survey made from 1931 to 1934 by the Ministry of Agriculture and Forestry, 4.9 percent of the household expenses of the wealthiest independent farmers went for medical care. Semi-independent farmers (those owning their land and simultaneously farming tenant land) paid 4.3 percent. The average for the poorest tenant farmers was 3.9 percent. It is clear that the poorer the farmer, the more he had to hold back on medical expenses, instead relying more and more on patent medicines. Patent medicines accounted for 22 percent of total medical expenditures by the tenant farmers, 19 percent for semi-independent farmers, and 14 percent for independent farmers.

A Cabinet Statistics Bureau survey on urban middle-class household spendings for the same period show that medical expenditures for the lowest income group (under ¥60 per month) made up 2.4 percent of their household budget. Medical expenditures for the highest income group (over ¥100 per month) were 4.3 percent. In absolute figures the annual medical expenditures for the lowest income group was ¥4.22 per person. In contrast, tenant farmers spent an average of ¥2.90 per person, 30 percent less than the lowest urban income group. The farmer had to hold down his medical expenses more than the city dweller, but even so, he spent a higher proportion of his income on medical care than did his urban counterpart.

12. Difficulty in paying for medical expenses and the dearth of doctors in certain villages is revealed tragically in a survey conducted at that time by the Police Department of Shimane prefecture.

"There are 486 doctors practicing in Shimane prefecture. However, there are 66 villages without doctors and the regional distribution of doctors shows an extreme imbalance. In the mountain and fishing villages, the majority of illnesses must be treated by patent medicines. There are many instances when the only time the people call a doctor is when they want him to fill out a death certificate. There is evidence that farm people die, unable to receive treatment for illnesses that could have been treated by a doctor. Five percent of deaths occur under such miserable conditions. (January 1933 - September 1935)

13. Tuberculosis was the third most critical problem in the prewar rural medical situation. This disease was originally most prevalent in urban areas. According to a 1906 survey, in cities with a population of over 100,000, out of every 10,000 population 37 died of tuberculosis. This rate was twice as high as in communities with under 100,000 people, where only 17.5 out of 10,000 died of the disease. But tuberculosis at that time most often struck young people and if we adjust the figures according to age structure, the distinction between urban and rural areas diminishes.

After this period the death rate from tuberculosis declined in the urban areas, though the rate in rural areas remained more or less constant. In both, the crude death rate (disregarding differences in age structure) was almost the same. When rural inhabitants who had left their villages for work in the city came home, particularly women from the spinning mills, they brought back tuberculosis bacteria that found virgin territory in the rural areas. The crude death rate from pulmonary tuberculosis in urban areas in 1920 was 25.07 per 10,000, and this decreased to 18.12 by 1935. During the same period the rate in villages and towns declined only slightly, from 14.30 to 12.95. Substantial research has been conducted that shows that the spread of tuberculosis, particularly in distressed farm, mountain and fishing villages in the Tohoku and Hokuriku districts, was largely caused by the return of girls who had gone to work in the cities.

14. To cope with these problems in rural medical care, the prewar government took the following countermeasures, highly effective even by today's standards: a) an active campaign, joint project of the government and the

industrial association (the present Agricultural Cooperatives), to eliminate the problem of villages without doctors; b) establishment of a national health insurance plan; c) establishment of public health centers and assignment of community nurses; and d) promotion of an anti-tuberculosis campaign.

In its earlier stages, the drive to eliminate the problem of doctorless villages was, like the industrial workers' health insurance legislation, part of the government's overall "social policy" program; it was also helped by private movements of a spontaneous or idealistic nature. All these measures were, nevertheless, eventually undertaken as part of the wartime policy of relieving farm villages in extraordinary times and promoting national health ("Healthy soldiers, healthy citizens!"). The motivating considerations behind these programs were military, spelled out in the 1936 War Ministry statement, part of which was quoted earlier. After the war, what were military motivations became primarily social security concerns, and with the help of the Occupation authorities the programs got off to a new start. Postwar recovery was rapid, but of course the programs had been started, and the administrative experience accumulated, during the wartime period.

15. The government's efforts to provide doctors for all rural areas gained in vigor after the extraordinary 1932 session of the Diet took up the issue for discussion. A contribution from the Mitsubishi zaibatsu to aid rural medical care was one factor that greatly facilitated these efforts. The government slated this fund to go into a project to build 700 clinics in three years, in locations where such facilities were immediately necessary. This project was completed in 1936, at which time 666 clinics had been built. Meanwhile, the village, town, city or prefectural government set up a system of public subsidies to go to rural doctors to keep them where they were. In 666 villages and towns, a total of 824 doctors received this subsidy. About 400 clinics were set up by the publicly managed health care system (in which the prefectural government provided doctors for villages where there were none; the budget for this system was approved by the 70th Diet session, 1937). The public health care system also included a program of mobile examination (visiting 1,156 villages in 1937).

In the Taisho period, central to which was World War I, a movement for health facilities and equipment burgeoned among the farmers. By the beginning of Showa it grew into a movement to establish general hospitals. It expanded considerably and after 1935 the Agriculture and Forestry Ministry steered the

farmers' efforts toward setting up medical facilities under the auspices of each prefectural federation of industrial associations. These facilities were taken over after the war by the Agricultural Cooperatives' Welfare Federation.

16. In 1922 the Health Insurance Law was established, principally for the urban laboring class, and insurance benefits began in January 1927. It was not until almost ten years later that the burden of paying for rural medical care was eased through the establishment of the National Health Insurance. More details will be given in Chapter III as to how this developed, but the salient points will be given here. It became a live issue around 1933 in connection with the movement for rural relief to cope with the depression in agriculture. The aim of that program was to "Make it easier for the average citizen to bear the expenses of medical care, and through coordinated planning to deal with the situation of the rural populace, to encourage the formation of the national health insurance unions" (report to the Home Minister from the Social Works Research Council). The National Health Insurance, by alleviating pressures of heavy medical costs in farming, fishing and mountain villages hard-hit by the agricultural depression, made an important contribution to improving the level of rural medical care and health protection. It also provided the base for the universal sickness insurance available to the entire nation (a compulsory system of universal health insurance was completed in 1961).

17. Public health centers in Japan grew out of efforts made during the Taisho period to set up public health counselling offices, mainly for expectant and nursing mothers and for pediatrics. In the early Showa period there were moves throughout the country to set up public counselling offices for tuberculosis prevention. Thus, the Public Health Center Law was enacted in 1937 with these efforts in the background, to support health counselling with public funds. These centers were to become institutions to help guide the public in health protection and sanitation, and they were patterned after health centers in the United States. In the regional prefectures a health center was provided for every 200,000 people. As deemed necessary, branch offices were set up, and in 1937, a ten-year plan was formed that projected 550 centers and 1,100 branches throughout the country.

Personnel for the centers was planned around a standard of two doctors, one pharmacist, one clerk, three counsellors, three community nurses.

and one caretaker--a total of 11 people. Each center would have a floor space of about 500 square meters and would be equipped with an X-ray apparatus and other examination instruments. It would offer health counselling services and guidance in nutrition for residents of areas under its jurisdiction. The public health centers were thus created primarily as a health counselling and guidance institution, particularly for infants and mothers and for pediatric care. However, many administrative duties were later accumulated to create a dualistic administrative-educational role. The ambiguity of the exact nature of the health centers as institutions continues to this date, thirty years after the war.

18. The modern system of community nurses was established much later than the nursing system (regulations governing the nursing profession were established by Home Ministry ordinance in 1915). The regulations governing community nurses were set forth by Health and Welfare Ministry ordinance in 1941, giving official recognition to their status after a long period--from around the mid- or late twenties--during which they had been active in urban social work. Their activities gradually spread to the rural areas; Tohoku (northeast Japan) was the first to benefit from the services of community nurses. Throughout the country the industrial associations (today's agricultural cooperatives) pushed for assignment of community nurses in cities, towns and villages, part of their movement for a better rural health program.

With the enactment of the 1937 Public Health Center Law, the appellation "community nurse" was used for the first time in official document that named the persons on the center staff (regulations for the execution of the Public Health Center Law). The role of community nurses was thought to be particularly significant for rural health in view of the growing concentration of doctors in the cities. Furthermore, the establishment of the National Health Insurance Law in 1938 meant that the community nurse was regarded as an important element supporting programs to be carried out within the framework of the new law. Consequently, the number of community nurses rapidly increased.

19. The anti-tuberculosis campaign in Japan began in the Taisho period and it was focused mainly on urban areas. There were more than 80,000 deaths per year from TB during the middle of the Taisho period, and the number of patients was estimated at more than 500,000. Furthermore, the number of cases was believed to be rising year by year. The Tuberculosis Prevention Law, enacted

in 1919, provided for germicidal measures to take care of areas contaminated by TB, as well as other preventive measures; it made health examinations for workers in certain occupations mandatory, it prohibited persons with the disease from working, and it stipulated the establishment of sanatoriums and other facilities. The law also devised ways for the patient to enter hospital on public monies and to receive funds for living expenses while recuperating. These programs were very successful. With the development of heavy industry during the Showa period, however, tuberculosis, which had begun to decline somewhat, started to spread once more. Because of the threat of more serious incidence, attempts were made several times to strengthen countermeasures.

We have already seen how many of the rural population had begun to work in urban factories and how, when ill, they returned to their rural farm or village. Public attention was focused mainly on the threat of tuberculosis spreading to the rural regions and the government started a new anti-tuberculosis campaign in 1939. This included TB examinations for those who had come back to their hometowns, guidance in how to treat a patient in the family and the remodeling of homes. This program was implemented first in Hokkaido, Ishikawa and five other prefectures, and was expanded to cover the entire country in 1940. Ishikawa prefecture at that time had the highest death rate from TB in Japan, but it fell to eleventh place by the end of the war after the prevention plan was put into motion. The mortality rate among young people and children fell to one-fifth of the 1939 level.

Some of the most successful aspects of treatment in Japan were the tuberculin reaction test and the use of chest X ray examinations. Group examinations also proved highly successful, along with extensive inoculations with BCG vaccine.

CHAPTER II RURAL MEDICAL CARE IN THE POSTWAR PERIOD

1. Postwar Change in Rural Areas

Underlying and affecting every aspect of improvement in rural medical care during the postwar period has been the drastic rise in the standard of living for farm families. Three factors in particular are responsible for this change: first, the effects of the land reform; second, the steady rise in income from the rice crop under the staple food control system, and third, a rapid increase in non-farm income accruing to farm family members during the period of high economic growth.

Thus, for those three reasons, the income and standard of living of farm households showed remarkable overall improvement, even though small-scale farming based on ownership of small plots showed no basic change. The farm family's standard of living in the prewar period was low, but it hit its nadir in 1931 with the agricultural panic of that year, and the average family budget in rural areas was only 543 yen per household. After 1931 income gradually rose. In the postwar period, particularly in the first half of the 1960s (when the economy began its period of high growth and universal health insurance was realized in the form of the National Health Insurance system), farm households' expenditures rose considerably. Data show that the average farm family budget was steadily rising. In 1951 it totalled ¥213,000; ¥319,000 in 1956; ¥414,000 in 1961; ¥725,000 in 1966; and ¥1,363,000 in 1971. Looking at the breakdown of farm income, (including gross earnings and value of products in kind), we can see that the proportion of non-farm income in the whole farm household income rose each year. It was 28.7 percent in 1956; 44.4 percent in 1961; 45.9 percent in 1966; and 60.4 percent in 1971. These figures are the best indication of how important non-farm income, especially wage earnings, became.

When we look at levels of consumption, ignoring for the time being price fluctuations and change in household composition, consumption in farming households doubled in the decade between 1960 and 1970, and in the same interval, the average for urban workers increased only 60 percent. In comparison, the rural rate of consumption rose much more quickly. We could also apply Engels' coefficient to gauge change by measuring expenses for food as a proportion of the entire farm budget (including home-produced goods and kind). The farm food budget took up 47.5 percent in 1956, 39.4 percent in 1961, and in 1966 it was 35.1 percent;

in 1971 it was 27.7 percent. Another index of rising living standards is the rate of vehicle ownership--indicating accessibility to medical facilities. In 1966 the rate of privately-owned cars or light vans among the farm population was 7 percent, and 51.8 percent for scooters and motorbikes. In 1971, car ownership was 42.7 percent, 18.6 percent owned light vans, and 46.9 percent had motorbikes or scooters. These rates are higher than the national average for the non-farm population. (Non-farm vehicle ownership in 1971 was cars, 35.4 percent; light vans, 9.6 percent; motorbikes/scooters, 16.8 percent.)

2. Public Health Centers and Community Nurses

We have seen how rapidly and with what wide ranging effects the standard of living rose after the war among the farming population, but the farm villages retained, nonetheless, at least during the first part of the postwar period, many of the characteristics of prewar rural society. Let us take radio and TV, which, as they spread from city to country, is one way to measure "urbanization" of life-style. In 1963 TV ownership rose for the first time above 50 percent in farm families and the following year, 1964, the rate of TV distribution overtook radio. (TV ownership was 81.7 percent, while radio was only 68.0 percent.)

Thus, there was not only a clear need, but also wide margin for more emphasis on public hygiene and preventive medicine in rural health care in the first half of the postwar period. The surge of growth was definitely influenced by the strong and active interest in rural health care displayed by the American Occupation, in their efforts to expand facilities and raise standards of public health. That was the dawn of the era of advanced public health and hygiene for Japan.

One of the chief concerns of the Occupation authorities was to expand and improve the level of health and hygiene in the rural villages. To democratize the rural management of health programs, and guided by the [William H.] Wandell report, they pushed a system of health insurance that would be based on self-governing regional and local administrations. Further, they stressed the need to integrate the universal health insurance system with public health and hygiene activities (which leaned heavily on public health centers and community nurses). The Occupation authorities also stressed training, both of regular and community nurses. The facts speak for themselves--the number of trained nurses today

attests to the efforts that the Occupation invested in rural health.

As we shall see in greater detail in Chapter III, the National Health Insurance system provided a method to finance rural health programs and a mechanism to channel payments. It was instituted just after the end of the war when the large number of rural medical insurance associations, suspended from functioning during the war, were just beginning to resume their activities. The financial condition was precarious--a situation that continued for the first postwar decade. To overcome extremely limited finances, a great deal of effort was put into making the most effective use of existing resources to carry out preventive medical care programs. Those responsible for planning believed that deliberate efforts should be made to combine the public health and hygiene activities of health-center types of organizations with the placement and activities of community nurses.

For example, in 1949 a directive was issued to prefectural governors jointly by the Director of the Insurance Bureau and the Director of Public Hygiene in the Ministry of Health and Welfare, concerning the "Expansion and Improvement of Facilities under the National Health Insurance Program." In that directive it was stated that, 1) The insurer will provide counselling doctors who will be responsible for programming and carrying out the work of health service under the guidance of the local public health centers; 2) If possible, at least one community nurse will be placed for every 3,000 population in the cities, and for every 2,000 population in towns and villages to execute the work of health service facilities under the guidance of counselling doctors; 3) Clinics (and hospitals) under the direct management of the insurer will supply medical care and carry out active guidance activities in health and hygiene. In cases when such facilities are not directly managed by the insurer, the insurer should make all necessary efforts to secure a location for medical consultation and treatment, such as the office of the insurer, a public hall, or other suitable building and guidance should be carried out under the leadership of counselling doctors and community nurses.

In accordance with the Wandell report, the policy formulated at that time was aimed at developing public health by bringing local public health centers and the national health insurance facilities together into an efficient, well-coordinated system.

The most important of the preventive health activities at that time were tuberculosis prevention programs, immunization against contagious disease.

of various kinds, and infant health care. Many community nurses devoted themselves to their duties out of a sense of social activism, and, as far as their work went, it had significant effect.

There has been considerable change in the assignment of community nurses between the prewar and postwar years. According to a survey carried out in September 1940 by the Ministry of Health and Welfare, of 18,447 nurses with thirty or more different employment designations, who were engaged in guidance and counselling in public health, including social nurses, visiting nurses, and so on, 1,148 were working for city, town or village administrations. Thereafter, starting in about 1943, with the rapid spread of local National Health Associations, the number of community nurses, one of the main supports of public health program, grew very quickly. In 1943 there were 3,275; in 1944, there were 7,172; in 1945 that figure rose to 9,641 and to a peak of 9,777 in 1946.

Beginning in fiscal 1947, community nurses working for city, town or village governments transferred to positions with the local National Health Insurance Association. That was made possible partly by a government subsidy arranged the previous year. In fiscal 1946, the National Treasury began to provide funds that would cover one-third the finances necessary for the costs of the National Health Insurance nurses. This system of subsidizing National Health Insurance community nurses has been retained to this day, with virtually no change.

The total number of certified community nurses who have the required qualifications rose abruptly from 17,030 in 1946 to 30,497 in 1952 when the American Occupation came to a close, but not all of them, of course, were actually working in public health programs. Those employed as bona fide public health nurses came to about 12,000 or 13,000, and about half that number were employed by local public health centers, while half worked for city, town or village associations of the National Health Insurance. A few probably found employment in some private institution. There was not, then, any great change in the actual number of community nurses working in the field of public health.

3. The Clinical Approach

Rising standards of living among farm families, reorganization of the national health insurance as a pooling and settlement mechanism of funds for medical care, the realization of a universal medical insurance system, and advances in medical science and technology (in particular the development of

rapid spread of methods of treating bacterial diseases based on chemotherapy and antibiotics), all these factors brought new trends in rural medical care, shifting from an overall program centered on public hygiene and preventive medicine to the clinical approach.

During and just after the war there was a very high incidence of infectious disease in Japan, including smallpox, cholera, typhoid fever and others. With the return of social stability, however, and the gradual rise in standards of living, along with a much more effective program of quarantine and epidemic prevention measures, epidemics almost completely disappeared. Antibiotics offered an effective means to cure the highly contagious disease, dysentery, causing the mortality rate to drop sharply. One concrete sign of the dramatic advance for the clinical approach was the revision of the Tuberculosis Prevention Law of 1951. The way had been prepared by the successful TB prevention treatment given to youths since the wartime years. Japan ranked high in the incidence of tuberculosis, with a high mortality rate among youth in particular, but since the beginning of organized treatment, the disease ceased to be a major cause of death and steadily declined in its incidence as postwar developments in chemotherapy and antibiotics continued to produce startlingly effective results in medical treatment.

The postwar approach to tuberculosis underwent a complete changeover from prewar stress on halting the spread of the disease to a more comprehensive policy of early detection, optimum treatment and prevention of the disease itself. The old law was revised along this new postwar line. The system of providing public monies for optimum medical treatment is one of the most advanced forms of the clinical approach. The revised law made such a system a reality in Japan. Another move that made the shift to the clinical approach even more decisive was the allocation of public funds to hospital facilities so that they could accommodate more tuberculosis patients. Starting with about 100,000 hospital beds as of the end of 1950, a goal was set at 260,000 beds to be furnished by 1958. (The original figure was far lower than this, but in 1954 it was upgraded considerably.)

There is no question that the monumental change involved in moving to the clinical approach affected attitudes toward the importance of preventive medicine and public hygiene. It was at least partly responsible for a growing neglect of such programs and a tendency to undervalue the public sector in medical care. Some have explained those trends in terms of the Occupation's influence.

When the San Francisco peace treaty ended the American Occupation, it also took away the people who had attached so much importance to public health and hygiene, and their energetic support of activities in these fields. There is certainly a kernel of truth to this argument. There was, in fact, a time when people began to talk about the "twilight of public hygiene."

4. Rural Medical Care through Universal Insurance

The really epochal advance based on the clinical approach in rural medical care was made with the completion of planning for a universal health insurance system at the end of 1960. The guiding idea behind it was to make everyone--not just urban workers but rural residents as well--eligible to receive insurance benefits for medical care whenever they became ill. It was an attempt to bring to fruition the efforts made during the war years toward socialized medicine, but this time it was made compulsory by law for every citizen to become a beneficiary of one health insurance program or another. It might not have been possible but for the high economic growth beginning in the late fifties, which stimulated public demand for greater social security benefits as well as a rise in the financial capacity of the citizenry to bear the costs of insurance. A further important factor was the steady growth of financial strength of the National Treasury.

We will discuss in detail how compulsory insurance evolved as a system in Chapter III, but at the time when legislation for universal insurance was acted upon in 1958, the number of people who were not receiving insurance benefits was estimated at 18 million, throughout the nation. It is impressive to consider that by 1961, one year after the compulsory insurance system went into effect, the number of insurees in the National Health Insurance program increased by about 10 million, while those insured by the category of employee insurance rose by 3.5 million. The number of dependents covered by either program increased by about 3 million, making a total increase of 16.5 million. Health insurance coverage became virtually universal with only two years needed for the transition. This is an extraordinary achievement in itself, but one must not forget how much it owes to the administrative efforts that went into the wartime program and the experience gained thereby.

As Chapter III will explain in further detail, after the initial period of transition the total benefits from National Health Insurance continued to

increase, while at the same time the proportion of assistance given in the form of subsidies by the National Treasury steadily rose. Thus, the clinical approach to medical care became firmly established among the rural population, a process we can imagine better by looking at some figures: In 1955, the average annual benefit accruing to each subscriber to National Health Insurance was ¥1,330; in 1960 it was ¥2,570; in 1965, ¥7,455; 1970, ¥17,652. These figures embody a rise of about 20 percent a year. The amount each insuree paid in annual fees also rose. For the same years, the corresponding annual fees were ¥515, ¥884, ¥2,226, and ¥5,146, respectively. A close look at the comparative benefits and fees clearly indicates the extraordinarily high level of subsidy by the National Treasury to finance a large portion of the National Health Insurance.

As a general rule, if we take 100 as a base index of medical costs, the insured patient bears 30 percent of the cost which he pays to the medical facility or the doctor. The National Treasury bears 45 percent, and the remaining 25 percent is covered by the regular dues paid by each insuree. It is the significantly high rate of funding by the National Treasury that provides the unsung key to support for medical care in rural Japan. National Treasury support for National Health Insurance was ¥500 billion in fiscal 1973; that amount is expected to rise to ¥1,000 billion in the 1975 budget.

The high level of National Treasury subsidy can be justified on the grounds that it covers for the rural population what the firm itself pays on behalf of its employees. There are, however, several other--political--factors at work. One is the fact that the rural village or town mayor is simultaneously the head of the local National Health Insurance Association, and he is almost always conservative. Second, National Health Insurance is directed chiefly at providing medical care for the rural population, the most important source of conservative votes. Japan Medical Association, a powerful pressure group composed of predominantly conservative, practicing doctors, gives strong support to National Health Insurance; the very fact that the clinical approach has become dominant throughout the system benefits the doctors themselves and provides a way to channel adequate public funds into the system.

5. The Public Sector -- Its Role and Future

We have already discussed how the Japanese system of medical care, since before the war, has been highly dependent upon private medical facilities.

For a time after the war efforts were made to expand the public sector in response to the encouragement by the Occupation, but interest in and the importance of the public sector have gradually diminished since that time. One reason for the declining importance of public facilities is that the Japan Medical Association pressed for a law to regulate the number of beds in publicly managed medical facilities.

If we can take 1955 as a base year, for example, with 100 as the index, the number of hospitals rose to 155.8 by 1970 and beds increased to 207.3 in the same year. (In real numbers, hospitals increased from 5,119 to 7,974, while the number of beds rose from 512,688 to 1,062,553.) Thus, facilities and beds expanded considerably, but the proportion in the total held by public hospitals declined from 28.3 percent to 19.1 percent during the same interval, and the proportion of beds for "public" patients fell from 48.3 percent to 41.6 percent of all beds. Furthermore, to repeat my earlier statement, there is almost no difference between the public and private sectors in the manner in which they operate, mainly because public facilities are compelled to be self-sustaining, financially.

The number of clinics, exclusive of dental clinics, rose in the same period to 134.4, or from 51,349 to 68,997. Dental clinics increased from 24,773 to 29,911, but most are privately run. In 1970, 87.1 percent of clinics were private, and 98.8 percent of dentists were private.

Finally, I would like to discuss the future of the public sector in rural medical care. We live in an age when the clinical approach is far and away the dominant trend, making it more difficult to formulate a clear perspective on what positive role the public sector can play in the future.

Very practically, what was once a highly systematic approach to rural health services, involving public health centers, community nurses, National Health Insurance clinics and nurses directly employed by the National Health Insurance, has degenerated to the point where it can no longer function effectively. Doctors have been moving out of public health centers, and clinics under direct management of the National Health Insurance have decreased. Community nurses no longer represent the important figures that they once did, and, as a result of fewer applicants, their ages are now relatively much higher. With the exception of community nurses in very remote areas, their role has diminished until many of them now function as hardly more than administrative workers.

Is there any future at all for the old approach centered around public hygiene programs and preventive medicine? Will the importance of the public sector return to its previous level? The following points are intended to indicate some of the problems involved in the issue of public facilities vs. the dominant position of the clinical approach.

a) The current overemphasis on the clinical approach and overdependence on the private sector will continue to amplify the imbalances in rural medical care and intensify the abuse of the nation's medical resources. Preventive and rehabilitative medical services will lag further behind clinical medicine in their penetration into rural communities. To redress this imbalance, and develop what we might call "comprehensive" medical care or a program of "positive health," we will have to redefine the role of public health centers and community nurses, thereby restructuring the network of local health services. To finance such a well-balanced, comprehensive approach to rural medical care, the present system of medical fee payments will also have to be revised and adequate funds channeled into public health services.

b) Another problem at present is the difficulty of providing medical care to remote or sparsely populated areas that are without doctors or facilities. Increased motorization and better public transportation have certainly helped raise the accessibility of medical facilities in rural areas, and a computerized system of medical information is being developed, but the concrete problem of redistributing National Health Insurance clinics and community nurses within the system of regional medical care will grow more acute, especially as the population continues to decline in rural areas. The proposal to create "community nurse stations," an idea that is being advanced along with the computerized system of medical information, may indeed be feasible, suggesting a new course for the public sector centered around effective placement of community nurses.

c) Pre-natal guidance and health measures and post-partum medical care for both mother and child are areas whose importance in overall health care programs remains constant. New illnesses, on the other hand, demand new countermeasures and treatment; the need for guidance and care for such "modern" adult ailments as high blood pressure, cancer and so on, as opposed to the traditional contagious diseases has increased very rapidly. The necessity of providing care for the elderly, particularly in the form of home visits to those who are confined (and possibly alone), has grown in recent years, demanding more medical attention.

The prevalence of pollution-related diseases has also grown tremendously, creating a demand for new kinds of treatment.

A balanced, effective medical program should be able to provide adequate care and facilities to handle the problems and kinds of illnesses mentioned above, but the system as it now stands must become broader--the comprehensive or "positive health" approach constitutes a framework that could encompass the various health needs of the populace.

CHAPTER III HISTORY OF THE NATIONAL HEALTH INSURANCE SYSTEM

1. Establishment of the System

The overall plan for establishing national health insurance was completed in 1933, and in September of the following year the Social Affairs Bureau of the Home Ministry published a draft outline of the National Health Insurance system in order to elicit public opinion on the projected plan. The government chose to use as the base local medical care associations, which had been operating mutual-aid health care programs prior to this time, and set up an experimental national health insurance system in twelve places throughout the nation.

The salient points of the system were:

1) Two types of voluntary associations fell under management by the National Health Insurance system: ordinary and special associations.

2) The household head became a member, on a voluntary basis, of the ordinary association in his city, town, or village. Those who worked in the same place or who were engaged in the same trade became members of the special association, also on a voluntary basis.

3) Both the member and his household gained insurance protection through membership in either type of association.

4) Insurance benefits could be collected for health care, obstetrics and funerals. Benefits for obstetrics and funerals were paid at the discretion of the local association. In certain cases the associations gave cash to members for health care, births and funerals instead of paying in kind or service.

5) The association could require the insured patient to bear a portion of the total medical expenses.

6) Medical care was conducted on a contract basis between the association and the doctor or pharmacist. A nonprofit organization with its own medical facilities had to obtain permission from the prefectural governor in order to carry out the equivalent functions of a national health insurance association.

7) If the family of a member received no benefits from insurance over a certain period, part of the membership dues paid for that period could revert to the payee.

8) The associations were to be managed by their trustees, who were in turn responsible to the general assembly of the given association. The regulations of the association were to stipulate type of insurance; extent and period of coverage and amount of insurance benefits, as well as amount and method of collection

of membership dues; provisions for reduction in dues; exemption, and other matters pertinent to benefits and dues.

9) Associations could form a federation.

The above points were presented to the 70th session of the Imperial Diet in March 1937. However, the House of Representatives was dissolved before a vote could be taken on the bill. It came up again at the 73rd session in January 1938. The March 15 plenary session of the House of Representatives approved the bill, along with three supplementary resolutions that:

1) the government take on an increasing share of the cost through greater subsidies in the future, so as to encourage the establishment of more associations to cover more areas;

2) the government take special care to ascertain that the standards of medical care not decline as a result of the legislation;

3) each association establish regulations under which insurance benefits could not be extended to cover patent medicines or other medication not specifically prescribed by a certified physician after examination of the beneficiary or his family.

The bill was passed unanimously by a plenary session of the House of Peers on March 27, 1938.

The parliamentary debate on the bill focused on three points: contract with the medical association for treatment; use of rural industrial associations in lieu of legal National Health Insurance associations, and protection of pharmaceutical interests. The industrial and medical associations clashed bitterly over the use of agricultural cooperatives. After both sides were vehemently argued in the Diet, Article 9 of the National Health Insurance law, which stipulated the legitimacy of another organization acting in the capacity of an association, was rescinded. That provision was instead shifted to the supplement to the law, making clear that only in exceptional cases would a local industrial association be allowed to carry out the functions of the National Health Insurance association.

2. Wartime Expansion and Revision of the National Health Insurance System

a. Expansion during the years immediately after enactment.

At the time it was passed, most Japanese did not completely understand the National Health Insurance system, largely because they had very little conception of the nature of social security. It was expected to be particularly

difficult to explain the new system to the populations in farm, mountain and fishing villages in order to expand the scope of national health insurance.

Under these somewhat adverse circumstances, the Ministry of Health and Welfare drew up a plan for expanding the associations and broadening the framework of national health insurance. The Health and Welfare authorities were able to enlist the cooperation of all groups concerned.

First Plan for Expanding National Health Insurance

Year	Projected Number of NHI Associations (Cumulative totals in parentheses)	Number of Insured (in thousands)
1938	120	500
1939	240 (total 360)	1,000 (total 1,500)
1940	360 (720)	1,500 (3,000)
1941	480 (1,200)	2,000 (5,000)
1942	600 (1,800)	2,500 (7,500)
1943	720 (2,520)	3,000 (10,500)
1944	840 (3,360)	3,500 (14,000)
1945	960 (4,320)	4,000 (18,000)
1946	960 (5,280)	4,000 (22,000)
1947	860 (6,140)	3,600 (25,000)

The goal of the first plan was to insure 25 million people, or 60 percent of the population in the first ten years. Aided by the diligent efforts of the ministry staff and others, achievements in the first year outstripped the projected goals. At the first NHI convention, held in Tokyo in October 1940 to commemorate the third anniversary of the establishment of the system, a recommendation was made to the government "that this system be extended to every village, town and city in the nation within the next five years."

In 1941 it was decided, in accordance with the law concerning the national health commissions provided for in articles 48 and 51 of the National Health Insurance law, that the commissions would become part of the regional social insurance councils. This was the first revision of the National Health Insurance law.

b. Efforts toward universal health insurance.

The health insurance program began its development in an orderly fashion, but a period of national emergency quickly followed the beginning of the war in China; the prospect of peace was a long way off. The situation deteriorated

considerably at the start of the Pacific War in December 1941. As part of the war effort, the "healthy citizens, healthy soldiers" program symbolized an important national goal. The army surgeon general, Chikahiko Koizumi, was appointed minister of health and welfare in October 1941. In December he announced that national health insurance associations were to be established in every city, village and town within the next three years. This expansion policy led to the second revision of the National Health Insurance law. The revision was extensive, providing for stronger measures to facilitate the procedures of setting up an association, compulsory membership in the association, and a system of recruiting physicians to serve within the health insurance system. The main points of the revision were as follows:

1) Whereas the establishment of an association of the National Health Insurance had been left as an optional choice for each local community, the revised law gave the prefectural governor the power to demand that a local association be set up if he deemed it necessary.

2) In order to strengthen the associations, membership was made mandatory.

3) Whereas doctors and dentists providing medical services and medication under the NHI had formerly been under contract with the association, the revised law authorized the prefectural governor to appoint the physicians, dentists and pharmacists who would serve under the system. The law stipulated that the appointee be given no option to refuse appointment unless he had reasonable justification.

4) Physicians and pharmacists thus appointed would receive remuneration for their services in accordance with the decision of the competent minister in consultation with the medical association and other appropriate agencies.

5) The competent minister and the prefectural governor were empowered to order the insuring association or federation thereof to operate health care facilities and/or to supply the necessary funds for such facilities.

6) Whereas previously only those nonprofit organizations operating their own medical facilities were eligible to carry out functions equivalent to the functions of the National Health Insurance association, the revision made it possible for other nonprofit organizations to operate in lieu of the NHI association even if they did not have facilities of their own.

7) The competent minister or prefectural governor was authorized to send officials to inspect the records of medical treatment, accounting books and

other pertinent documents of the doctors and facilities operating under the system.

The revised law was promulgated on February 21, 1942 and went into effect on May 1 (though some of the provisions were not enforced until January 1, 1943). In fiscal 1942, approximately 15,900,000 people became members of the plan, and an additional 14,700,000 became members in fiscal 1943. By the end of fiscal 1943, insurance coverage extended to 95 percent of all villages, towns and cities; except in the large urban centers, the goal of universal health insurance had been virtually achieved.

c. Spread into the cities and the end of the war.

There had been a plan to expand the program in the cities after fiscal 1944, but the heavy bombing and increasing severity of the war prevented satisfactory progress. Only 50 percent of the plan was realized in fiscal 1944, and in 1945 only 12 new associations were formed.

At the end of the war, 78 cities and 306 villages were without associations.

By fiscal 1945 the total number of associations was 10,349, with a membership of 40,750,000.

3. The Immediate Postwar Situation

When the end of the war drew near, there was a shortage of doctors, other medical personnel, and medicines and pharmaceutical products. Government leadership was no longer very strong by that time and it was impossible for many of the associations to provide proper medical care in any smooth fashion. The National Health Insurance system had been greatly damaged by the disruption in social and economic conditions that came in the wake of the defeat. Prices soared after the war, including the cost of medication, health equipment, and treatment by doctors. The Ministry of Health and Welfare announced higher unit prices of medical care; from ¥0.35 in October 1945, the per unit standard fee was raised in April 1946 to ¥1.50 in the six largest cities, to ¥1.30 in other cities and to ¥1.00 in villages and towns. The per capita insurance benefits in 1946 had increased a startling 351 percent over the previous year in rural areas, and 406 percent in cities. As medical fees went up, insurance fees also rose, but it was very difficult to collect the higher insurance fees because of the mounting pressure of inflation on the people's livelihood. Escalating problems in their

management forced a number of associations to discontinue operations. Those that did not close down had to decrease the level of benefits by raising the percentage of the medical costs that the patient was required to bear.

Conditions	June, 1947	
	Number of Associations	Percentage
Active Operation	1,675	16
Normal Operation	4,654	45
Conditions Poor	2,576	25
Operation Ceased	1,438	14
Total	20,342	100

December, 1947		
Active Operation	1,611	15.7
Normal Operation	4,190	41.0
Conditions Poor	2,576	27.1
Operation Ceased	1,654	16.2
Total	10,224	100.0

On top of all other problems, many doctors were refusing to treat patients who were insured under the system; indeed, the system itself seemed to be on the brink of collapse.

4. Reconstructing the System

a. Reconstruction

On the 24th of December 1946, the Ministry of Health and Welfare requested the Council on the Social Insurance System to devise plans for a system that would meet future needs. The NHI was then re-examined in context of the entire framework of a social insurance system.

The Council on the Social Insurance System urged the unification of National Health Insurance with other health insurance programs. The proposed reorganization of social insurance was based on the following principles:

1) The government-managed health insurance and the national health insurance would be merged into a single program to be operated through the regional associations, whose establishment and membership would be compulsory.

2) Corporate health insurance associations would continue as before.

but benefits to family members would be taken over by the regional associations.

3) Separate workmen's compensation insurance would be established to cover workers' occupational accidents and illnesses.

In addition to the above changes, the report suggested ways to reorganize social insurance around national health insurance; this touched upon such issues as insurance benefits, the medical care system and the patient's share of the costs. All that actually materialized was the separate establishment of the workmen's compensation insurance system in May 1947. In that month, the Health and Welfare Ministry held a national conference of all secretary-generals of the health insurance federations. An immediate-action plan was adopted to seek greater subsidies from the National Treasury. The National Council of Federations of NHI Associations was formed to provide the motivating force behind this program. The council later became the League for Reform of the National Health Insurance System. The league actively campaigned for increased National Treasury funding, and as a result, 105 million yen was approved in September 1947 in additional government subsidies for national health insurance. The increase was more than double the amount in the original budget, but higher medical fees tended to cancel out much of the effectiveness of the larger subsidies.

Occupation headquarters announced at its regular press conference on June 14, 1947 that the economic security of the Japanese people demanded an even stronger system of national health insurance. The announcement stressed the need for an overall increase in National Treasury subsidy. It also recommended that since the national insurance system was suffering from the many weakness inherent in a voluntary program, it should be placed on the same footing as other social insurance programs, and that all health insurance plans should be integrated into a single National Health Insurance system.

b. Transfer to City, Town and Village Management

On October 8, 1947, the Council on Social Insurance Systems gave its findings to the health and welfare minister in a report entitled "Outline of the Social Security System." It stated that

in the spirit of Article 25 of the Constitution which says that, "All people shall have the right to maintain the minimum standards of wholesome and cultured living," the present system of social insurance and welfare is inadequate. Consequently, it is necessary to set up a new social security system.

The report contained a broad, basic plan to handle the problems of social security and stability, drawing on the Beveridge (William Henry) Plan in England. It

attracted a great deal of public attention, but there was little likelihood that its recommendations could be put into effect immediately.

Nevertheless, the Ministry of Health and Welfare took steps to prepare for the third revision of the National Health Insurance Law itself. Reconstruction of the NHI system had become urgent; in the first place, the new Constitution provided for a national social security system, and second, some kind of national mutual-aid system was imperative to stabilize the people's livelihood in the immediate postwar years. The revised law sought to solve the following problems, which had so far prevented successful working of the national health insurance plan: 1) inadequate public knowledge and understanding of the purposes of the system; 2) failure to efficiently carry out medical care provided under the health insurance system; 3) precarious insurance financing.

The revised law was promulgated June 30, 1948, and went into effect July 1. Its main points were:

1) National Health Insurance would be administered by the village, town or city (including special ward) governments.

2) When the health insurance was not managed by the city, town or village, the National Health Insurance association or nonprofit organization could assume management with the permission of the governor of the prefecture in which the area was located.

3) In those cases where the NHI was administered by the association or nonprofit body, important matters would require the approval of the related city, town or village assembly.

4) The period of extinctive prescription would be extended from one to two years.

5) Physicians who provide medical care under the insurance system would be contracted, rather than designated by the insurer.

6) Medical fees would be decided by mutual agreement between the person who administers medical treatment and consultation and the insurer.

7) When no decision could be reached either on the appointment of insurance doctors or the unit price of medical fees, the matter was then referred to the National Health Insurance Review Commission for mediation.

8) The composition and competence of the Council for Establishing Social Insurance Medical Fees would be determined by law.

9) The insurer was to provide maternity facilities in addition to those already required by law; provisions were remanded that concerned the authority of

the minister of health and welfare and the prefectural government to enforce establishment of facilities and payment of their operating costs.

10) The system of reimbursing insurance dues when insufficiently used was to be ended.

11) Regulations governing compulsory establishment of associations would be rescinded.

12) When the ordinary associations were established all those who were qualified could become members. The membership of a given association would correspond to the registered population of the city, town or village.

13) Regulations were made governing the election of the association council chairman from among council members, as well as the qualifications for council membership, their numbers, terms of office, and membership of the board of directors.

14) The composition of the general assembly of the federation, the number of board members, their method of selection and term of office were stipulated by law.

15) If a nonprofit organization was no longer qualified to function as an NHI agent, permission granted under (2) could be revoked.

16) As determined by law, National Treasury subsidies could comprise funds necessary to the NHI program.

17) Provisions were made for a system of application for and review of medical fees under the NHI consistent with provisions in other social insurance laws.

The revised law greatly facilitated the reconstruction of the national health insurance system. Although there were many problems in determining the unit price of medical care and collecting insurance payments, with the efforts of the Ministry of Health and Welfare the prefectures and the federations of local NHI associations, as well as community nurses and other zealous individuals, NHI became revitalized as a system available to the entire populace.

c. Establishment of the National Health Insurance Tax and NHI Medical Fees Review Board

The rebuilding of the insurance system and the general economic stagnation of farm and mountain villages resulted in greater numbers of people receiving medical treatment. The total amount collected in insurance fees, however, steadily falling, until the NHI went into a crisis period beginning in about

(receipts from fees were 81% in 1949, 77% in 1950 and 80% in 1951).

To solve the difficulties of financing insurance, cities, towns and villages were authorized to collect insurance fees as taxes. It seemed easier to collect the fees in the form of taxes since the population generally responds obediently to authority. It was also argued that the tax collection method would give the local government a clearer picture of its financial resources for health insurance programs. Partial revision of the local tax laws made a national health insurance tax possible. The revisions were effective April 1, 1951.

On that day the fifth revision of the NHI Law also went into effect.

The major points of the revision were:

- 1) establishment of a commission to review medical fees under the insurance system;
- 2) in programs managed by the local government, a city could be divided into several zones and NHI operated in each zone; and
- 3) the portion of medical fees to be borne by the patient could be paid directly to the doctor or hospital cashier.

Under the old law it was possible to entrust administrative work involving review and payment of medical fees to the Social Insurance Medical Fees Review Board, though it was rather difficult to do this with the national health insurance. Through administrative directives, a National Health Insurance Medical Fees Review Board had been set up in each prefecture.

The 1951 revision gave this NHI board a legal basis. The second point in the revision reflected the amalgamation of cities, villages and towns, and the expansion of the program into urban areas. The third change gave ipso facto recognition to the actual practise of paying the patient's portion of medical fees directly to the doctor or hospital cashier, although the pre-revision law had stipulated that in principle the insurer would collect those fees later from the insured.

d. Loans for reconstruction of the NHI and incentive subsidies

Despite all the measures that were taken to alleviate the financial difficulties of local NHI programs, their total deficit was estimated at Y2,600 million as of the end of fiscal 1951. To handle the situation, loans for the reconstruction of National Health Insurance and a system of incentive grants were set up that would help stabilize insurance financing.

Long-term, low-interest loans were made available to help wipe out past deficits. It was promulgated May 20, 1952 and went into effect the same day as

the Law for Reconstruction Loans. The incentive subsidies were budgeted in large part to encourage higher rate of collection of insurance premiums.

e. National Treasury subsidies for benefits payments

The National Health Insurance gradually spread, but because of soaring costs of medical benefits, insurance financing was not stable. Most cities, towns and villages were assisting NHI operations with money transferred from their general accounts, but the additional expenditures required for the new, extended system of compulsory education made local public financing extremely difficult.

The October 1947 "Outline of the Social Security System," compiled by the Social Insurance System Research Commission, discussed the need for National Treasury subsidies for insurance benefits payments. In addition to this report, the same ideas had been propounded in recommendations by the Occupation authorities, as well as two separate reports by the Council on the Social Security System. Further, in the Diet a resolution was passed calling on the government to give such subsidies to local governments.

Based on these recommendations and resolutions, and in response to the movement by insurers and other interested groups for increased subsidies, the Ministry of Health and Welfare began in fiscal 1951 to request appropriations to cover 20 percent of the funds needed for insurance benefits. The same year, the ministry began the loan system mentioned above and took other measures to place local financing of insurance on a more stable footing. In the 16th session of the Diet in July 1953 the budget was passed that would provide 20 percent of the needed funds out of the National Treasury (National Health Insurance Promotion Subsidy) to help in the payment of medical care benefits. The subsidy was not intended to cover 20 percent of all medical care benefits uniformly; it was designed to strengthen and develop the NHI by emphasizing assistance to certain specific aspects of the program.

Promotion subsidies were given until 1955, but in that year another revision (the seventh) of the NHI Law, made and supported by both opposition and government parties, legally sanctioned treasury support of the costs of health benefits.

The essential features of the revision were as follows:

- 1) The National Treasury would provide funds for all administrative costs, one-third the expenses for community nurses, and part of medical care benefits.

2) National Treasury subsidies for medical care benefits would not go below 20 percent of total costs.

3) The National Treasury would make loans and provide subsidies within the limits of the budget.

4) The prefectures and municipalities would also be empowered to make loans and provide subsidies.

Through partial revision of the Local Financing Law, in accordance with the supplementary provisions in the revised National Health Insurance Law, National Treasury subsidies for expenses specified in (1) above were clearly defined as the national government's share in local financing.

f. Impact of town and village amalgamation

The Municipalities Amalgamation Promotion Law of 1953 and the New Municipalities Construction Promotion Law of 1956 pushed towns and villages to merge; between September 1953 and September 1956, a total of 6,154 towns and villages were amalgamated under these laws, helping to strengthen the foundation of the NHI system.

Amalgamation, however, caused a great deal of trouble for officials in charge of NHI programs because of lack of uniformity between the towns and villages involved in the merger, in types of benefits and shares borne by patients in medical care costs. Standardizing these and amalgamation itself helped to give the NHI system a sturdier foundation.

5. Movement Toward Universal Insurance

a. Reports by the Medical Security Committee and advisory opinions by the Council on the Social Security System

In 1956 the drive to universalize health insurance became very active. In order to respond to various defects in the medical security system, the government was compelled to review the evolution of the entire system itself and to map out a comprehensive, as well as basic, policy on the issue. In July 1956, the Ministry of Health and Welfare issued the "Ministerial ordinance concerning the establishment of the medical security committee," and appointed Hiroki Nagai and three other persons to examine the problems. The committee first took up their attitudes toward the fiscal 1957 budget. On August 24, 1956, they released an interim report on the subject of universal health insurance, in which they indicated that priority should go to encouraging the expansion of sickness

insurance programs centered on National Health Insurance. They also urged the revision of relevant laws to make insurance universal. Their report represented the first official opinion on the universalization of health insurance ever to be made public.

On November 8, 1956, the "Advisory Opinion concerning the Medical Security System" was issued by the Council on the Social Security System, which had been deliberating the issue since July 1955. The council advised that present medical and living conditions necessitated immediate improvement in the medical security system as well as establishment of a universal health insurance system. The council emphasized the need to make the national health insurance compulsory by stages, and to enforce its implementation by the municipalities that were not operating such a program. The advisory opinions were given in the knowledge that over 20,000,000 people were unable to join the national health insurance because it had not yet been introduced to their towns and villages. The council felt strongly that these people must all be guaranteed medical care.

The medical security committee responded in its second report submitted on January 7, 1957. The committee report pointed out the urgent need for additional financial measures, such as the increase in the National Treasury subsidies for medical care benefits and administrative expenses. The following other points were also made:

- 1) All cities, towns and villages should participate in National Health Insurance, to achieve the goal of nationwide coverage by fiscal 1960.
- 2) Coverage and period of insurance should be equivalent to those applied to dependents (family members) in government-administered or corporate health insurance programs. Benefits should eventually be increased to cover more than 50 percent of the medical fees.
- 3) Standards of assessment of insurance fees should be drastically changed. In particular, a maximum limit should be imposed on insurance charges borne by those in the lower income brackets.
- 4) The government should not only subsidize the NHI but should also be prepared to assume overall responsibility for the system. Cities, towns and villages should collect insurance charges in amounts appropriate to the benefits distributed, but the aforementioned maximum limit on charges borne by those with low incomes would require stabilization of insurance finances through additional funding, such as equalizing subsidies from the National Treasury.

5) The operational network should be expanded and developed, both on the national and local government levels.

This second report became an administrative guideline in the development of a universal health insurance system; it had a strong impact upon NHI administration and finance.

In addition to the recommendations of the medical security committee and the advisory opinions of the social security council, universal insurance was strongly urged by the Central Association of NHI Organizations (predecessor of the present National Health Insurance Central Association), and the issue received considerable notice in newspapers and other mass media. Thus, the movement toward universal insurance gradually gained, in both scope and momentum.

b. Planning for Universal Insurance

In view of the increasing popular demand for such a system, the government decided to move toward the establishment of universal insurance in 1957. In April the Ministry of Health and Welfare adopted plans for universal insurance, and set a yearly target, beginning in fiscal 1957, to increase the number insured by 5 or 6 million; by fiscal 1960, universal insurance would be virtually achieved when as many as 20 million uninsured people would have been covered by one program or another.

In order to achieve their aim, the ministry established headquarters for universal insurance and appointed the vice minister to be the highest responsible official. The ministry also began to prepare for the overall revision of the National Health Insurance law. In October 1957, they proposed the following guidelines to form the basis of the revision:

1) Operation of National Health Insurance to be made compulsory for every city, town and village.

2) The scope of benefits to be the same as for government and corporate health insurance programs, and the period and rate of benefits received to be established by law.

3) The total cost of insurance administration and 25 percent of medical care benefits to be borne by the National Treasury.

4) A system of equalizing subsidies to be created to adjust the differences in the financial capacity of insurers.

5) To remove outstanding deficits before fiscal 1956, funds for financial reconstruction to be loaned to cities, towns and villages where such deficits have accrued.

6) This law to be effective April 1, 1958.

The Ministry of Health and Welfare discussed these points of revision with government officials, party leaders, and other concerned ministries, as well as with various interest groups, and in the process each item was sorted out according to its feasibility. A new National Health Insurance bill gradually took shape.

6. Enactment of the New National Health Insurance Law

a. Deliberation and opinion of the Council on the Social Security System

The Ministry of Health and Welfare negotiated further with other authorities the various points contained in the overall revision of NHI, and in February 1958 they submitted the results in the form of a draft bill to the Council on the Social Security System for deliberation. The main points of the draft can be summarized as follows:

1) National Health Insurance was to be instituted in all cities, towns and villages by the end of fiscal 1960.

The old law held that the NHI program was the province of each city, town or village; whether to actually carry out all the activities or not was left to the discretion of each local administration. However, NHI comprises activities basic to the welfare of the people, and therefore it was thought that it should be compulsory for all cities, towns and villages to carry out all activities related to the program.

2) The central government was to be responsible for the establishment of a universal health insurance system.

Since NHI activities were entrusted to the local authorities of cities, towns and villages, it was thought that the financial responsibility of the central government should be increased. The old law stipulated that the government subsidize less than 20 percent of medical care benefits, but under the new law that proportion was to be taken by the National Treasury which would provide the full 20 percent. In addition, the equalizing subsidy system was to provide a way for the National Treasury to cover an additional 5 percent of medical care benefits. In accordance with the revision, responsibility for subsidies administration

expenses based on the old law would be shifted onto the National Treasury as their share.

- 3) The quality of benefits received was to undergo improvement. Under the old law, detailed provisions for medical care benefits were to be spelled out in the local ordinances or regulations. The new law was to stipulate that the patient would bear 50 percent of medical care costs. In this way, the minimum level of benefits could be guaranteed and the wide discrepancies in the level of benefits between NHI and other health insurance programs could be narrowed.

- 4) The system of free contract with insurance for doctors would be converted into the "dual designation" system. The remuneration to doctors for treatment would be raised to the same level as that stipulated in other health insurance programs.

"Dual designation" indicates that all medical facilities designated for government and corporate health insurance would automatically be designated facilities for NHI programs within the particular prefecture. The dual designation system would not only put an end to duality in the role of insurance physicians under the old law, but would provide for handling public medical facilities and private medical facilities in the same legal terms.

- 5) The new law was to go into effect October 1, 1958.

After deliberating these points, the Council on the Social Security System reported in March 1958 that, "This Council approves compulsory implementation of National Health Insurance in the form that it is presented in the proposed outline of the National Health Insurance bill." In the preamble, however, the council also pointed out that the outline fell short of a workable plan for a universal health insurance system; its proposals were not sufficient, even though they provided for increased benefits, greater contribution from the National Treasury, improvements in medical facilities, a new formula to calculate doctors' fees, payment procedures for medical services, and expansion of the anti-tuberculosis campaign.

b. The 28th Diet

The Ministry of Health and Welfare proposed its National Health Insurance bill to the 28th Diet in March 1958 and presented an accompanying bill to execute it.

NHI to the April 1958 session. The bill was an attempt to embody the revisions suggested in the Council on the Social Security System's "Advisory Opinion Concerning the Medical Security System," and also to lay the legal foundation for universal coverage, putting the whole program on solid financial ground.

In spite of the government's determination, however, the 28th Diet session seemed too preoccupied with the prospect of Lower House dissolution; it was anticipated from the beginning that it would be hard to get this bill passed. Moreover, the suggestion that the bill be put into effect from October 1, 1958 created the possibility that deliberation would be postponed until an extraordinary session to be held immediately after the approaching general election. Furthermore, members of the House of Representatives' Social-Labor Committee, who were to discuss the bill, were already concentrating on another important bill on minimum wages that had been presented earlier. Thus, the NHI bill could not receive full attention. Prime Minister Nobusuke Kishi stated at the plenary session of the Lower House in the 28th session, "Since this bill [NHI] is a very important one, the government will make every possible effort to ensure its passage." Nevertheless, the bill was discussed only one day in the Social-Labor Commission of the Lower House before the Diet was finally dissolved. It was consequently dropped.

The 29th extraordinary session was very brief; the bill could not possibly be passed in such a limited time.

c. The 30th Diet

At the 30th session of the Diet the government brought up the National Health Insurance bill along with a bill for its execution, for consideration by the Lower House. The National Health Insurance bill was identical with that introduced to the 28th session, only the effective date (and the transitional provision that went with it) had been changed. On November 1, 1958, Masami Tanaka and 24 other members of the Lower House Social-Labor Committee presented amendments to the NHI and execution bills. The bill was amended and supplementary resolutions were adopted by the committee and by the plenary session on the same day. The amendments, pushed by the Liberal-Democratic party, strongly reflected the position of the Japan Medical Association.

One of the greatest differences between the revised bill and the original proposal concerned insurance doctors. Whereas the government proposed that "medical care benefits shall be given by the designated medical facilities,"

revised bill stated, "Medical care benefits shall be given by doctors (institutions) in charge of the medical services, but medical treatment, medicines and medications shall be given by insurance doctors and pharmacists," and, "Insurance doctors shall not be limited to institutions. A separate registration shall be established for NHI doctors and pharmacists."

Second, whereas the government proposal said, "The hospitals, clinics and pharmacies that are entrusted with providing medical services shall be designated medical institutions after applying for and being granted such designation by the prefectural governors"; the revised bill said, "The appellation 'medical institutions' shall be replaced by 'institutions responsible for medical care' and anyone qualified who applies shall be approved as such." Third, whereas the government proposal said, "Those facilities that function under both government or corporate health insurance and NHI shall be acknowledged as National Health Insurance institutions only insofar as they remain designated as government or corporate health insurance facilities. Once an institution is disqualified by the latter program, its designation as an NHI facility will have to be reconsidered"; the amendment read, "Revocation of the status accorded by the Health Insurance Law (government or corporate) shall not affect status accorded by the National Health Insurance Law." Both bills passed in the Lower House, but temporary closure of deliberation meant that they were shelved in the Upper House and eventually dropped.

d. The 31st Diet

The 31st Diet session was held in December 1958. At the very beginning of the session the new National Health Insurance bill was introduced, together with the accompanying bill for its execution. The wording had been revised somewhat, combining the amendments by the House of Representatives in the previous session and the results of substantive discussions among some members of the House of Councillors Social-Labor Committee since the 30th session. This NHI bill was approved with supplementary resolutions at the plenary session of the House of Representatives, December 19, 1958. On the 23rd of the same month, the bill and supplementary resolutions were approved at the plenary session of the House of Councillors. Passage of that bill brought into force the National Health Insurance law currently in force. The bill concerning the execution of national health insurance was passed, and became effective the same day.

7. Realization of Universal Health Insurance

Today's National Health Insurance finally became law, but only after a

long, painstaking process. It was promulgated on December 27, 1958 as Law No. 192 and put into effect January 1, 1959. This law played an important role in promoting the four-year program of expanding the National Health Insurance throughout the country, starting in 1957.

The law stipulated in its supplementary provisions that cities, towns and villages that had not been operating National Health Insurance as of January 1, 1959 should start the insurance project at the latest by the final year of the four-year program for expanding National Health Insurance. By April 1, 1961 NHI coverage would be universal.

The Ministry of Health and Welfare made every possible effort to expand the new National Health Insurance through established measures as well as by issuing by-laws of the NHI ordinance and appropriating funds for equalizing subsidies.

A number of obstacles were anticipated in expanding the NHI programs in urban areas. The government made particular efforts to have these obstacles removed. For example, there was some disagreement between the Tokyo Metropolitan government and the Tokyo Medical Association on how the NHI program might be implemented in the twenty-three wards of Tokyo. Negotiations proved difficult. The medical associations in other large cities, such as Fukuoka, Osaka, Kobe, Kyoto, Nagoya and Yokohama, went along with the Tokyo group, and hopes of carrying out the National Health Insurance program in urban areas grew dim. The Ministry of Health and Welfare responded by measures such as revising part of the execution law through government ordinance No. 277. The partial revision, for example, authorized the metropolitan government to issue its own ordinances by which to coordinate NHI programs operated in the various wards of Tokyo.

Subsequent negotiations between the metropolitan government and the Tokyo Medical Association resulted in agreement and the National Health Insurance began to operate December 1, 1959. Medical care benefits were 70 percent of the total fee for a household head (the insuree) and 50 percent for other family members. Maternity benefits were ¥1,500, and funerals, ¥2,500.

The insurance program steadily developed in other large cities; it began in Fukuoka, for example, on April 1, 1961. The chart below shows the change during the four-years devoted to expanding NHI.

As a result of the new law, each Federation of National Health Insurance Organizations was allowed to take over the functions of the NHI Medical Fees view

Board in its prefecture. Entrusted by the insurers with the task of checking bills for medical charges, the prefectural federations began to expand and strengthen their internal organization, especially after April 1, 1959.

	Number of cities, towns and villages operating NHI program	Number of insured	Number of prefectures which achieved universal insurance
Fiscal 1956	2,810 (60)	30,582,065	2
End of fiscal 1957 (first year of the four-year program)	2,853 (88)	33,575,724	3
End of fiscal 1958	3,020 (147)	37,238,964	7
End of fiscal 1959	3,194 (171)	43,244,081	12
As of April 1, 1961	3,508 (162)	49,019,000	45

- Note: 1. Figures in () show number of NHI associations.
 2. In Kagoshima prefecture, one town and five villages had not implemented an NHI program as of April 1, 1961.

8. Improvements following Universalization

- a. Seventy percent insurance benefits for a household head with tuberculosis or mental disease

Even after the new National Health Insurance law was enacted and health insurance became universal, benefits still covered only 50 percent of the costs; moreover, there were restrictions on the insurance benefit system. The insurance program was far from perfect. Efforts to increase medical benefits continued after the attainment of universal insurance coverage on April 1, 1961.

The National Health Insurance law stipulated that the insured person had to bear 50 percent of the total medical fees for treatment of illness. This percentage could be decreased to accord with the financial capability of the insurer. As of April 1, 1961, however, 93.48 percent of all insurers in cities, towns and villages, and 18.75 percent of the national health insurance associations stipulated that the household head and insured family members should pay 50 percent of their medical fees. Of all the insurers in the nation, 90.21 percent paid benefits that covered only 50 percent of total medical costs.

Medical benefits for the insured were quite low, compared to the government-managed or corporate health insurance programs for employed persons.

From the outset demands had been made on insurers and government to increase benefits to the level of the employee's health insurance.

The government responded to these demands by increasing the percentage of benefits paid to those suffering from tuberculosis or mental illness. This was largely because at that time the government was actively promoting a campaign against tuberculosis and mental illness in a strong effort to raise the standard of public hygiene.

Consequently, if a household head suffered from tuberculosis or mental illness, the percentage of the medical cost that he paid himself was reduced from 50 to 30 percent. The government either paid the remaining amount or subsidized the insurer to pay higher benefits. This revision was promulgated as Law No. 143 on June 17, 1961 and was put into effect October 1. It was especially important to cut down the cost of medical treatment when a household head suffered from tuberculosis or mental illness--diseases which take a long time to treat--because medical expenses fall more heavily on a family without a breadwinner. In the past it usually meant that the household head could not afford adequate treatment.

An outline of a partial amendment of the National Health Insurance law had been submitted to the Council on the Social Security System before it went to the Diet. The council recommended that "measures taken for a household head must also be applied to other family members if they have long-term illnesses, such as tuberculosis or mental disease." This recommendation was incorporated in a later revision.

b. Increased rate of National Treasury subsidy

Considerable discussion took place over the need to improve NHI financing during the Diet deliberation of the 70 percent benefits to a household head with tuberculosis or mental illness. In the 1962 budget the government decided to increase the ratio of National Treasury subsidies to and share in handling medical care benefits from 20 to 25 percent, thereby bolstering insurance finances. To legalize the increase in subsidies, a partial amendment of the National Health Insurance law was brought up in the 44th Diet session in 1962, and was approved. The revision was promulgated and went into effect as Law No. 57 on April 1, 1962.

The amendment served to offset possible difficulties caused by a large number of insured by NHI who, because their incomes were too low, could not afford to pay high insurance premiums and made insurers' finances very shaky. High

fees and the increasing numbers of people having medical examinations made it necessary for the government to take firm financial measures to strengthen insurance finances.

c. Seventy-percent benefits for the household head

In July 1962, the Council on the Social Security System reported on a basic policy that would coordinate the overall social security system and advised on ways to make improvement. The report recommended that "insurance benefits should be increased to cover 90 percent of medical expenses for all insured heads of households and their families. For the present, the rate should be raised to cover at least 70 percent." Increased insurance coverage means, however, that the insurance premiums and taxes borne by the insured will also increase. Therefore, taking into account the ability of the insured to pay and the capacity of the National Treasury to lend its support, it was apparent that it would be impossible to actually increase insurance benefits over 70 percent at that stage. If 70 percent of the medical fees were covered, however, it would be possible to redress the balance between the medical care received by high income families and care received by low income families. Seventy percent coverage payments would mark significant improvement; the government considered this goal realistic and strove to attain it.

But it was impossible to immediately raise insurance benefits to cover 70 percent of all costs of illnesses for all insured people because the ability of the insured to pay increased insurance premiums and taxes was limited, and the financial resources of the National Treasury also had a ceiling. A five-year program to reach the 70 percent goal was therefore set up in fiscal 1963.

Seventy percent benefits were paid in the first stage of the five-year program, starting October 1, 1963, for all illnesses suffered by insured heads of households. As of April 1 that year, 18 percent of all insurers in cities, towns and villages, and 81 percent of all NHI associations were providing benefits to cover more than 70 percent of the costs of all illnesses of insured heads of households. This was achieved by a total of 21 percent of all insurers. In terms of financial resources, 15 percent out of the total 20 percent increase was borne by the National Treasury, with the funds appropriated as equalizing subsidies

d. Removal of restrictions on insurance benefits

Higher benefits marked a significant step forward, but since the n

National Health Insurance law was enacted, better coverage was urgently needed. Restrictions included a three-year limit on the period during which benefits would be paid, and no benefits could be claimed for physicians' house calls, dental prosthesis, hospitalization, or bedding equipment.

Ever since the enactment of the new law, it was clear that ultimately these restrictions would have to be removed, but the financial condition of the insurers did not permit unlimited coverage immediately. Nevertheless, the law permitted the insurer to ease any restrictions at his discretion, and under the administrative guidance of the Ministry of Health and Welfare, continuous efforts were made to remove them.

The number of insurers who paid benefits covering the whole period of sickness increased to 48 percent of all insurers as of March 31, 1962. By April 1 the following year, 97 percent of all insurers had no coverage restrictions on their insurance benefit programs. Time limits were removed completely after April 1, 1963, allowing payment of benefits until the insured person recovered. Restrictions on the coverage of insurance programs have been illegal since April 1, 1965.

e. Separating insurance and welfare

Until April 1, 1963, if a participant in the National Health Insurance program was covered also by eligibility to receive welfare, which is administered according to the provisions of the Welfare Law, he could receive benefits from both for three months. The system was changed as of April 1, 1963, when it was decided that the medical expenses of a welfare recipient should be handled by the welfare system. The day a person receives welfare coverage, she or he loses eligibility for National Health Insurance.

1. Reduction of insurance premiums and taxes and increased subsidies from the National Treasury

In 1963 NHI taxes and premiums were reduced for those with low incomes. This decision was part of a larger effort to help those in lower income brackets. The cabinet decision on July 2, 1962 to raise the consumer price of rice by 12 percent, compelled the government to come up with some concrete measures by which to alleviate the pressure on the less privileged segment of the population. Funds were appropriated from the 1963 national budget to allow an average premium reduction of ¥500 for 20 percent of the total number of people insured as of April 1963. If the family of the insured was in a lower income bracket, he

receive a 40 - 60 percent reduction on his monthly premiums. Since then the rate of reduction has been gradually increasing.

Besides covering expenses to cover the reduction in taxes and premiums, the 1963 budget paid for the 15 percent increase in insurance benefits given to the head of a household, who was then able to claim benefits to cover 70 percent, instead of the earlier 50 percent, of medical costs for any illness. Abolition of regional differences in medical fees raised the total cost of insurance and the 1963 budget covered the increase. Funds to cover the three new expenses were distributed to local governments through equalizing subsidies added to the 5 percent of total estimated expenses already received by local governments for medical care benefits. Altogether, local governments received, on an annual average, 10 percent of their total expenses for medical care benefits in the form of equalizing subsidies. The increase in funds received by local governments led to revision of the National Health Insurance law by Law No. 62, on March 31, 1963. Apart from the subsidy increase, the revision concerned the following four changes, which we discussed earlier:

- 1) When the head of a household was given medical treatment, the portion he had to pay was reduced from 50 to 30 percent of the total cost;
- 2) Time limits on eligibility to receive medical care were abolished;
- 3) If a person under NHI received welfare benefits, he would instantly lose his insurance;
- 4) Public ordinances could specify details of reduction in insurance fees.

g. Seventy percent benefits for dependents and increased share by the National Treasury

In the budget for fiscal 1964, the second year of the five-year plan to achieve 70 percent coverage of all medical expenses, several important financial measures were taken, including appropriation of a special subsidy to improve medical care benefits, a sum equivalent to three-quarters of the total amount the government was paying to increase coverage from 50 to 70 percent. The special subsidy was intended to launch a four-year program, starting in fiscal 1964, to pay benefits covering 70 percent of the medical expenses of insured persons other than household heads. The four-year plan began by immediately extending 70 percent coverage to one-fourth the total number of insured in January 1965.

In spite of the fiscal measures, however, the financial condition of the National Health Insurance in 1963-64 seemed to be deteriorating as a result of the rapid improvements in the scope and quality of benefits it offered. The insurers, the LDP, the National Association of City Mayors, and others pressed the government to increase its share of the financial burden, while some local governments began to express a desire to discontinue their National Health Insurance programs because of financial difficulties.

The circumstances pushed the Ministry of Health and Welfare to make a budget request in 1966 and it succeeded in raising national assistance to local medical programs from 25 percent to a fixed rate of 40 percent. In addition, a five percent equalizing subsidy now became part of the national government's fixed share of the financial burden. The previous 10 percent equalizing subsidies included a fixed sum equivalent to three-quarters of the total 20 percent increase in benefits given to heads of households. By transferring this portion to become part of the National Treasury's fixed share, the previous 10 percent was reduced to five percent.

Budgetary measures that increased the National Treasury's fixed share and equalizing funds resulted in partial revision of the National Health Insurance law by Law No. 79 on June 6, 1966. It provided for: 1) an increase from 50 to 70 percent in medical benefits for insured persons other than heads of households; 2) an increase from 25 to 40 percent in the National Treasury's fixed share of medical benefits provided by local governments; and 3) a reduction in the total amount of equalizing funds, from 10 to 5 percent of the estimated expenses needed by local governments for medical care benefits and fees. Provisions for the first item listed above became effective January 1, 1968, and the other two provisions became effective retroactive to April 1, 1966.

9. Public Support for Medical Care for the Aged and National Health Insurance

All those insured under the National Health Insurance system must pay 30 percent of the cost of services to the institution that provides medical care, as his share of the insurance benefits. Naturally, those who find it difficult to pay the charges avoid treatment when they become ill. This has been true not only of those insured by the National Health Insurance, but to some extent, of family members covered by an employee insurance program.

The NHI law provides that the insurer can, at his discretion, decrease the charges borne by the patient and increase the benefits in certain cases, such as the elderly. As of April 1, 1972, 67 municipalities operated NHI programs which allowed those over 70 to pay only 10 percent--receiving up to 90 percent in benefits. Such programs, however, were run on a partially voluntary basis, and since many old people could not carry the full medical fees, their access to medical care was limited even under a universal insurance program.

To provide the necessary medical care for the aged in a way that made it accessible to them, a bill was introduced in the 68th session of the Diet in 1972. It proposed partial revision of the Welfare for the Aged Law to permit full payment by the insurer of medical fees and costs for treatment of senior citizens. The bill was approved and enacted the same year. The new arrangement was based on the existing insurance system, but it shifted the burden of medical payments from the shoulders of elderly individuals who could not afford them to the public. Provisions for these aged citizens were regarded as complementary to the present medical care insurance system.

One anticipated result was an increased financial load on the insurer, as the number of elderly people receiving medical care would rise after the proposal was put into effect. To avoid too rapid an increase, a temporary subsidy of ¥3,400 million for medical care for the aged was entered in the budget for fiscal 1973.

10. Moves for Reform of the NHI System

Since 1965 the National Health Insurance system has become a major link in the overall reform of the medical insurance system. Efforts to improve the NHI system itself have continued to this date, more conspicuously so since the Liberal Democratic party announced the "Outline Policy for National Medical Care" in June 1969.

The Ministry of Health and Welfare reviewed the whole system of medical care insurance on the basis of the thinking specified in the LDP "Outline" and opinions expressed in its supplements. Then, in August 1969, the ministry submitted a provisional plan to both the Social Insurance Council and the Council for the Social Security System for drastic revision of the present medical care system.

One of the provisional plans concerned reform in the National Health Insurance system, especially as it related to the definition of eligible recipients.

the question of who should manage the program, ways to increase benefits, cost sharing, financial adjustments, and, finally, what to do with the large deficits that have accumulated over the years for every NHI program.

The two councils submitted their reports to the government in the fall of 1971. They were both negative about the idea of separating the insured and his dependents (family members) in the employee health insurance and covering the latter by the National Health Insurance. The report by the Council on the Social Security System stated,

Although a large number of families covered by NHI programs are presumably in the lower income bracket, a thorough investigation seems necessary to gain an accurate picture of their real incomes so that fair insurance taxes may be computed. The family composition of the NHI insurees must also be accurately grasped. A uniform approach is necessary to deal with those who do not qualify as dependents (family members) in an employee insurance program. More specifically, the last question involves the pseudo-families--whether or not it is desirable to bring out their existence in the realm of public policy. Furthermore, the distinct lack of uniformity in the assessment methods of insurance premiums is a situation that needs to be rectified.

Upon receipt of these reports, the government (the Ministry of Health and Welfare) began work on formulating concrete proposals, in consultation with the Liberal-Democratic party. These efforts resulted in an outline of plans for revising various medical care insurance laws, including the National Health Insurance. The outline was submitted for deliberation to the Council on the Social Security System, and based on the report of that deliberation, the government introduced a bill for partial revision of health insurance laws in the 68th Diet session of May 1972. It was designed to make a rather drastic revision of the medical care insurance system, but the circumstances did not permit the Diet to finish its business on the bill before the close of the session.

With regard to the National Health Insurance, the bill touched on the following three points, in addition to separation of clinical treatment and medication, and matters relating to the issuance of receipts for medical fees.

1) Improved benefits

When fees required for medical treatment are extraordinarily high, pursuant to a government ordinance the insurance will cover a certain proportion of the charges that the patient would ordinarily be expected to cover himself.

2) Equalization of insurance finance

To ensure a fair system of cost-sharing in operating NHI programs,

the National Treasury will provide cities, towns and villages with equalizing subsidies.

3) Expansion of area in which NHI benefits may be claimed

When a medical institution offers its services under the NHI program to the governor of that prefecture, it becomes, thereupon, a facility available to all the insurers and insured within the boundaries of that prefecture.

Prior to the drafting of this bill in June 1970, the Ministry of Health and Welfare organized a "Discussion Group on the National Health Insurance System." The group was composed of five experts on NHI. The subject of discussion was the ideal form the system of standard insurance premiums should take. The results of their study were released in a report in September 1971.

The report assumed that the National Treasury's share would rise to 45 percent of the total insurance costs and that the equalizing subsidies would increase through imposing a higher fixed rate of share on the National Treasury. Premised on these assumptions, the report recommended the following:

1) The rate of insurance taxes levied on the insured would be determined by a unified standard established by the government;

2) The levy would be made by unifying the standard rate charge and income-rated charge, each accounting for 50 percent of the total levy;

3) The income-rated charge will be computed on the basis of one's net taxable income--the amount left after basic deductions, deduction for dependents, social insurance fees, life insurance premiums, medical care expenses and miscellaneous losses have all been subtracted. (Currently, in many municipalities, "total income minus basic deductions" is used as a basic guide in calculating the income-rated charge.)

4) The National Treasury will provide full compensation for deficits to those municipalities where the standard insurance premiums and the fixed rate or amount of National Treasury assistance together do not reach the legally prescribed level of medical care benefits (70 percent of the total cost).

The report suggested that the government (i.e. the minister of health and welfare) should determine the insurance tax rates so that local differences that exist today could be ironed out to make possible a more balanced system of levies. That formula had its virtues, but it contained several problems that seemed to preclude its ultimate usefulness:

a - Calculating the income-rated charge solely on the basis

of net taxable income would compound the problems because of fluctuations in the individual's net income--and hence in his insurance taxes--from year to year.

- b - The standard per capita charge would rise disproportionately, imposing a heavy burden on those in lower income brackets.
- c - Tax autonomy of the city, town or village government would be severely curtailed.
- d - It would be not only difficult, but also very impractical to try and adjust the standard amount of insurance payments and the National Treasury subsidy after calculating the actual total amount paid out in medical care benefits. That procedure would not work unless "standard estimates of medical care benefits," or similar, comprehensive guidelines were provided.
- e - Most groups and individuals involved in the management of NHI programs are strongly opposed to any reduction of the fixed rate in the share of the National Treasury. To them, it is crucially important that the fixed 40 percent share made "70-percent benefits" possible in the first place, as well as helping to stabilize local NHI finances.

The Ministry of Health and Welfare took into consideration such criticism and observations when they decided to maintain the present system of levying the insurance tax and the 40 percent fixed share of the National Treasury. The ministry did, however, accept the suggestion in the report that the standard insurance tax rates be used as the main criterion in determining the amount of equalizing subsidies from the National Treasury. By equalizing the financial burden on the municipal governments, it was hoped that a better balance would be achieved for the individual's insurance tax burdens. The bill presented to the 68th session of the Diet in May 1972 contained a proposal for financial adjustments based upon this kind of thinking.

The 68th session of the Diet failed to take a vote on the bill for partial revision of the health insurance and other related laws, and so the Ministry of Health and Welfare undertook further study of its proposed reform, and in January 1973 it submitted to the Council on the Social Security System a new set of proposals for reform of the health insurance laws.

While it incorporated the recommendations in the council report of September 1971, the proposed plan was basically an attempt at gradual improvement of the type and coverage of insurance benefits, and thus it centered on those suggestions that could actually be implemented in the immediate future. For National Health Insurance, the new proposal dealt only with the question of improved benefits, not taking up the four other items contained in the earlier bill.

Specifically, the Ministry of Health and Welfare wanted to revise the National Health Insurance law to provide insurance coverage of the amount in excess when the 30 percent portion of the medical costs borne by the patient exceeded a predetermined level. That provision would allow the insured to receive high cost treatment necessary in certain illnesses. The ministry planned to carry out the measure by stages in three years, beginning October 1, 1973.

The Council on the Social Security System responded in February 1973 with the following commentary:

Support for especially costly medical treatment is commendable, but it should not become simply another means by which to shift the burden off the local insurers onto the National Treasury. The ministry plan to implement the measure by stages in three years will disappoint the public; if possible, the time should be shortened. More research and further improvements are necessary to simplify the payments procedure for those patients covered by National Health Insurance.

The government presented a new bill for partial revision of the health insurance laws to the 71st session of the Diet on February 17, 1973. The revision that affected the National Health Insurance law was exactly the same as that submitted earlier to the Council on the Social Security System.

Diet debate on the proposed revision of NHI benefits centered on the methods and timing of implementing the new subsidy for highly specialized, costly medical treatment. Feeling was strong among Diet members that the plan should be implemented at once on a nationwide scale, especially in view of the fact that the employee health insurance programs all give 100 percent coverage to the insured. The government defense argued that the financial capabilities of the local insurers (city, town or village governments) varied so widely that they could not possibly provide the new benefit simultaneously. The government pledged, nevertheless, to reduce the period before implementation as much as possible and to ascertain that all insurers were providing the new benefit by the end of fiscal 1974.

The 71st Diet postponed conclusion of the session twice, but the bill for partial revision of the health insurance laws was approved in the 18th,

some amendments to the original government version. It was promulgated on September 26th.

The provisions for high cost treatment coverage under National Health Insurance will officially go into effect on October 1, 1975. In the interim they can be implemented on a voluntary basis by local government ordinance or by-laws. Some insurers began providing the new benefit in the fall of 1973, and it is expected that all of them will have begun by the end of fiscal 1974.

CHAPTER IV SUMMARY, EVALUATION AND APPLICABILITY

1. Summary

We have discussed some of the ways in which both concepts and system of rural medical care have maintained strong continuity between the prewar and postwar periods in Japan. Motivations have changed, however. Before the war, national efforts were directed toward the military need to build a "Healthy nation and healthy soldiers." After the war this energy was redirected into programs based on the guarantee of the right to life, embodied in the new Constitution. Vast changes in the economy and society after the war, moreover, meant new and stronger emphasis on the clinical approach in rural medical care, except in extremely remote areas, distant islands and mountain villages.

It is a fact that the level of medical care in the rural areas remained qualitatively below that in the urban, but the rural population was given, nevertheless, increasing access to and opportunities to use medical facilities as one result of a remarkable rise in standard of living, financial leeway to pay medical fees, greater willingness to seek proper medical treatment and accessibility of medical facilities. Improved transportation and more widespread ownership of motor vehicles brought medical facilities within reach of more people than ever before. Medical facilities became accessible to farmers not only physically, but psychologically, socially and economically, as well. This change was largely the product of better education and economic improvement in the rural areas, the nationwide spread of the National Health Insurance system, free medical service for the old and public assistance to tuberculosis patients. The level of Japan's compulsory education has been comparatively very high since before the war. That factor, with the remarkable expansion of the mass media, had considerable influence in urbanizing the life-styles of ordinary farmers, and a tendency toward pragmatic rationalism soon dominated most rural communities.

Those changes are significant, but they took place over a period of thirty years of postwar rural medical care. In the first fifteen years after the war, however, the rural standard of living was still low, and traditional attitudes remained substantially unaffected. Although it is impossible to do more than generalize about these changes, it is worth noting that public hygiene and disease prevention programs were most effective in the first fifteen years. Because rural conditions were receptive to the medical programs and the Occupation strongly

encouraged them, the activities of health centers and community nurses expanded in scope, causing a remarkable decrease in the incidence of tuberculosis, and improvement in pre- and postnatal care of infants and mothers. Health care in the decade right after the war was brilliantly successful. During this period a large number of field workers were assigned to promote the government policy of agricultural reform and modernization. The farmers themselves volunteered their time and energy to work for the welfare movement of the agricultural cooperative society.

Except in remote areas, isolated islands and mountain villages, where the basic programs are still considered useful, health care has come increasingly under the influence of clinical approach. Consequently, public health organizations and personnel are both confronted with a need to redefine their goals. Reorganization and reassignment will directly affect the status and working conditions of health service personnel, and for that reason it will take a long time to work out a solution.

The future is certainly not bright, because the clinical approach has become so widespread that a large number of doctors have left the public health centers altogether and other agencies concerned with disease prevention services. Individual medical treatment and counselling have, for the most part, been entrusted to private doctors. The only areas unaffected by the intrusion of private practitioners are extremely remote places, isolated islands and mountain villages; environmental pollution and the plight of the old and the bedridden are outside the concerns of the private sector.

2. Evaluation

Any evaluation of rural medical care in Japan will of course differ according to one's viewpoint. The following premises constitute the basis of my own evaluation.

1) Medical care in Japan now lies in the hands of the private sector. The public sector is weak, and because it has been compelled to become economically self-supporting in ordinary expenditures, and sometimes even in capital outlay, it closely resembles the private sector in the mode of operation.

2) Throughout the pre- and post-World War II periods, the clinical approach has been central to medical care. The preventive approach played a large part in tuberculosis prevention and rural medical care in the first half

the postwar period, but today it is considered important only in special regions and in regard to exceptional problems. It should be recognized that the preventive approach was enormously effective in the fight against tuberculosis and the high infant mortality rate.

3) There has, in the past, been a sufficient amount of medical manpower, enough to meet the demands of the people. The high incomes of doctors made the profession attractive so that the number of doctors in proportion to population steadily increased, especially since the mid-1920s. In the prewar buyers' market there was never any shortage of nurses. With the completion of the universal health insurance system after the war, however, demand for medical care increased rapidly, bringing about an acute shortage of medical manpower in the 1960s.

4) High standards of compulsory education since the Meiji period and traditionally open attitudes toward change enabled the Japanese people to adapt very quickly to the new medical treatment and new medicines. The only major obstacles that blocked easy access to medical care were lack of information and inability to pay for treatment. Of course, irrational attitudes persisted particularly among those in the low-income brackets, but when rural income increased after the war, that problem disappeared.

5) The National Health Insurance system, together with the steadily rising economy and new mass media, were able to solve a majority of the rural medical care problems.

Since most postwar statistics make no clear distinction between urban and rural areas, we must infer the changing levels of rural health conditions from the nationwide totals. For example, the average yearly death rate of infants less than twelve months old was 164.0 out of 1,000 during the period from 1920 to 1924. This mortality rate decreased by half to 86.5 during the period from 1940 to 1943, when prewar rural medical care was at its peak. From 1955 to 1959, immediately before the establishment of a universal health insurance system, the rate decreased again by half to 37.7; in 1965 it had decreased to 18.5. In 1972 it was only 11.7, the lowest infant mortality rate in the world. Average life expectancy for male babies born in 1935-36 was 46.92 years; it rose to 50.06 years in 1947, 63.38 in 1955, 67.73 in 1965, and 70.51 by 1972-73. For baby girls, life expectancy figures for the same years were 49.63, 53.96, 72.95, and 75.94, respectively.

The number of deaths from tuberculosis was 190.8 out of every 100,000 deaths in 1935; 235.3 in 1943, and 146.4 in 1950. The tuberculosis mortality rate decreased to 66.4 in 1953, to 34.2 in 1960, and to 16.8 in 1968. In 1972, the mortality rate was 11.9.

Rural medical care in Japan has developed negative, as well as positive aspects. A system of medical care that relies overwhelmingly on the private sector suffers from several serious defects. Private practitioners have formed a powerful pressure group, exerting influence over the whole system of medical treatment, but ultimately moved by the profit motive. Consequently, medical care is most willingly provided to the regions and social groups whose members can pay more for various services. Any attempt to redistribute medical resources to needy areas has met with tenacious political opposition from the doctors.

The average number of doctors in Japan in 1962 was 110.8 per 100,000 people; regional distribution was 160.7 doctors per 100,000 people in the seven largest cities, 123.7 in other cities, and 66.3 in the rural areas (mostly agricultural, mountain, and fishing villages). In 1972, ten years later, the average for the whole country was 116.7; 166.1 in the seven largest cities; 121.0 in other cities, and 64.9 in rural areas (towns and villages). During this time the number of doctors per 100,000 people decreased, except in the seven largest cities. The availability of doctors in many rural areas probably decreased much more than these figures indicate, because of the population drain in some agricultural, mountain and fishing communities. Moreover, in this period much of the rural area was administratively incorporated into cities, making the statistics even more deceptive. On the other hand, there was drastic population increase in the areas around the big cities, and naturally the number of doctors did not increase as rapidly as the population.

The official definition of a doctorless area, adopted after the war, is a circular area at least eight kilometers in diameter in which at least fifty people are living without medical facilities and no easy access to a doctor or medical facilities. In May 1973 Japan had 2,044 such areas not including Okinawa.

Many problems have arisen as a direct result of the quest for higher income and profits from medical care. They are common to all advanced countries whose system of medical care is not socialized; they are basic problems whose solutions must be weighted against the possible disadvantages of socialized medical care. Profit-motivated doctors in Japan tend to abuse medicines, a tendency

which has come under strong criticism. Another problem brought about by over-dependence on the private sector is the neglect of rehabilitation and preventive diagnosis and care. Doctors favor more profitable clinical treatment through abundant use of patent medicines. All these issues are now being re-examined, giving rise to much discussion and dispute over the problem of regional medical care and involving the government in efforts to find solutions. The general direction seems to be toward finding ways to implement "comprehensive" medical care but there has been very little progress to date in mapping out a concrete plan.

3. Applicability of Japanese Experience

Finally, let us consider the extent to which the development of Japanese rural medical care has any relevance to developing countries.

The most basic question here is that of manpower. From the very beginning of the Meiji period, the traditional practitioners of Chinese medicine in Japan--once found in virtually every rural village--gradually gave way to Western medicine and Western-trained doctors. In the decades before the war the number of doctors and medical personnel was adequate to meet the demand, and efforts were made during the war to train more. It was not until the universal health insurance was instituted and the demand for medical services started to rise that a shortage of doctors became a significant issue. At any rate, sufficient manpower for medical care was an important prerequisite to the spread of the clinical approach in rural health services. The resources necessary to fulfill that requirement might prove difficult for the developing countries to provide.

The second factor in successful clinical services in rural Japan was the rising economic and educational standards, as well as the ability of the National Treasury to support a universal health insurance system. To do all of this may pose insurmountable obstacles in a developing country.

Perhaps more immediately applicable to the developing countries will be the Japanese experience with the public health centers and community nurses. Beginning with their wartime activities, these centers and nurses made significant contributions to the nation's public health. The Occupation authorities were instrumental in upgrading their role after the war, but their wide-ranging programs included educational campaigns toward modernization of rural life-styles, and public hygiene and disease prevention activities to combat tuberculosis and promote

high standards in pediatric and obstetric care. In all of these areas, the developing countries have the resources to develop significant programs.

The fourth consideration in a national health policy is that it takes less time and money to train public health nurses than doctors. Nurses can nevertheless fulfill a significant role in medical care, often substituting the doctor's functions. The developing countries should train a large number of such nurses in a relatively short period of time. They can then be assigned to medical facilities or government offices concerned to become an important link in a broad network of public health services.

Fifth, since it is impossible to build a successful rural medical care program among poor and ignorant people living under a premodern system of landownership, it is necessary to combine social and economic development with the establishment of a rural health policy in an integrated approach to the problem as a whole.

Sixth, an organized program of rural medical care will mature when the number of doctors increases and more people are able to pay the medical fees necessary to sustain them. Free medical care is already available in many developing countries, although it is on a very small scale. These countries will have to carefully consider whether to maintain and develop the system of free medical care, or whether they wish to follow the pattern of Japan and move toward overwhelming reliance on the private sector. My personal inclination would be to encourage expansion of free medical care.

Free medical care for the whole population, however, presupposes government responsibility for all facilities and programs, and the rewards must be enough to induce doctors to stay with the program. In other words, all possible measures must be taken to prevent a "brain-drain" from occurring in the medical profession. This has not been a serious problem in the Japanese experience because of the severe difficulties Japanese faced in language when they tried to study or practise in other countries, although Japan did experience an unbalancing flow of doctors from country to city. The language barrier is perhaps not as strong in the developing countries, but for whatever reason, it is most desirable that the respective governments bear the entire cost of training their own doctors and medical personnel.

JAPANESE RURAL HEALTH SYSTEM DATA

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CHANGES IN NUMBER OF DOCTORS PER 100,000 PERSONS BY PREFECTURES

(Unit: Number of doctors / 100,000 persons)

Area	1925	1930	1935	1938	1940	1947	1950	1955	1960	1965	1970	1971	1972
Total	75.9	77.8	83.9	87.1	90.1	90.4	91.9	105.9	110.4	111.3	114.7	117.3	116.7
Urban	---	(123.8)	(127.8)	(117.7)	(121.6)	145.0	.....	138.1	.....	132.8	134.5	135.4	---
Rural	---	(54.7)	(49.3)	(46.1)	(45.6)	63.5	---	64.4	---	65.4	63.5	65.4	---
<u>High-density prefectures</u>													
Tokyo	140.9	140.8	168.2	186.5	181.8	175.0	161.2	170.7	157.8	135.5	133.0	145.5	144.3
Kanagawa	69.3	85.4	84.5	93.9	89.7	95.2	102.7	116.5	113.6	96.8	87.6	94.6	94.0
Kyoto	115.8	133.6	152.7	161.9	180.9	171.1	172.0	167.7	168.4	170.4	171.5	177.7	174.7
Osaka	86.7	93.3	103.9	100.5	103.2	138.1	111.6	145.9	144.3	135.3	135.1	135.9	134.9
<u>Agricultural prefectures</u>													
Hokkaido	59.6	67.6	63.4	60.3	65.1	64.8	63.0	78.4	84.7	89.4	99.0	100.3	101.8
Iwate	47.2	48.1	47.3	50.8	55.2	66.1	71.2	80.2	90.7	100.6	112.0	117.0	116.9
Shimane	25.6	23.6	23.4	28.6	31.9	36.9	33.8	39.0	44.6	102.8	106.1	108.9	109.5
Yamaguchi	89.8	65.3	72.1	76.0	81.6	86.0	74.2	103.0	109.6	121.8	134.9	140.2	140.9

Source: "Jis-i Nenro" (Hygiene Annual Report) for periods prior to 1950. "Survey on Doctors, Dentists & Pharmacists" for periods after 1955.

Note: "High-density prefectures" mean prefectures with high population density with consideration of agricultural population ratio.

Population density (1973, per km²): Tokyo - 5287, Osaka - 4347, Kanagawa - 2546, Saitama - 1177, Aichi - 1121, Fukuoka - 939, Chiba - 755, Hyogo - 593, Kyoto - 509.

Agricultural population ratio against prefectural population (1973): Tokyo - 0.4%, Osaka - 1.0%, Chiba - 1.0%, Kanagawa - 1.7%, Kyoto - 1.1%.

YEARLY CHANGES IN MORTALITY RATE & INFANT MORTALITY RATE BY URBAN & RURAL AREAS
 年間死亡率(%)・乳児死亡率(%)の年次推移

3

	1925	1930	1935	1938	1940	1947	1950	1955	1960	1965	1970	1971	1972	1973
<u>National</u>														
No. of death	1,710,706	1,170,867	1,161,736	1,259,805	1,185,575	1,138,238	704,876	693,523	704,599	700,438	712,962	684,521	683,751	709,416
No. of infant death	297,008	258,703	233,706	220,695	190,509	205,360	140,515	68,801	49,293	33,742	25,412	24,805	23,773	23,623
<u>Urban area</u>														
No. of death	242,206	254,171	322,630	392,664	384,562	352,075	298,126	344,732	405,097	420,984	454,829	446,126	...	...
No. of infant death	35,458	30,941	40,416	41,174	...	59,782	40,225	30,513	22,195	21,437	18,067	18,221	17,923	17,912
<u>Rural area</u>														
No. of death	962,500	916,696	828,306	862,141	802,033	786,163	606,750	346,619	299,330	277,652	255,986	236,319	...	...
No. of infant death	261,550	227,762	208,346	179,521	...	146,078	100,290	38,275	22,085	12,750	7,299	6,543	5,825	5,729
<u>Mortality rate</u>														
<u>National</u>														
per 1,000 persons	20.5	18.3	16.9	17.4	16.4	14.6	10.9	7.8	7.6	7.1	6.9	6.5	6.4	6.5
per 1,000 birth	142.4	124.1	106.7	114.5	90.0	76.7	60.1	39.8	30.7	18.5	13.1	12.4	11.7	11.3
<u>Urban area</u>														
per 1,000 persons	19.7	16.5	14.8	15.4	14.2	13.6	9.6	6.9	6.7	6.3	6.1	...	...	...
per 1,000 birth	150.9	116.9	91.4	98.4	...	70.4	50.6	34.5	26.8	16.4	12.2	11.7	11.1	10.8
<u>Rural area</u>														
per 1,000 persons	20.8	18.9	18.0	18.6	17.4	15.1	11.7	8.9	9.2	8.9	8.9	...	...	...
per 1,000 birth	141.3	125.1	119.2	118.9	...	79.5	65.0	45.2	37.3	24.0	15.9	14.8	13.8	13.3

注) 大正14年より昭和15年までの乳児死亡率の市部は人口10万人以上の市部を以て、郡部はそれ以外のものである。

資料: 厚生省「人口動態統計」、総理府「国勢調査」

Note: Infant mortality rates for 1925-46 indicate an average of cities with population more than 1,000,000 for "urban area" and remaining areas "rural".
 Source: "Jiryo Sotai Tokei" (Population Movement Statistics) by Welfare Ministry, "The Census" by Prime Minister's Office.

YEARLY CHANGE IN POPULATION RATE & INFANT MORTALITY BY HIGH-DENSITY PREFECTURES
 人口死亡率及人口動態統計表(高人口密度都府)

	1975	1980	1985	1989	1990	1997	1999	1999	1999	2000	2005	2010	2011	2012	2013
<u>High-density prefectures</u>															
Tokyo - Mortality (per 1,000)	17.6	14.2	12.9	13.5	12.2	11.7	8.3	5.6	5.2	4.8	5.0	4.8	4.7	4.8	4.8
Infant mortality (per 1,000 birth)	133.0	97.5	79.4	84.7	59.5	62.4	42.9	26.7	20.4	13.5	11.5	11.0	10.2	9.8	9.8
Kanagawa - Mortality (")	19.2	15.8	15.2	15.6	13.9	12.1	8.9	6.4	6.0	5.1	4.7	4.6	4.4	4.5	4.5
Infant mortality (")	134.9	106.2	95.8	94.3	66.9	60.3	40.9	20.1	23.3	14.2	11.0	10.4	10.7	9.7	9.7
Kyoto - Mortality (")	19.9	17.6	15.4	15.9	15.2	14.8	9.7	7.1	7.7	7.2	7.0	6.9	6.7	6.9	6.9
Infant mortality (")	155.9	131.6	98.0	112.8	99.9	68.8	50.4	32.5	25.6	16.0	11.7	11.6	10.5	10.6	10.6
Osaka - Mortality (")	19.5	16.2	14.8	13.9	13.4	14.5	9.3	6.6	6.4	5.5	5.4	5.1	5.2	5.2	5.2
Infant mortality (")	179.6	131.5	111.8	106.8	82.9	79.9	54.5	34.4	23.4	15.5	11.4	11.2	11.1	10.2	10.2
<u>Agricultural prefectures</u>															
Hokkaido - Mortality (")	19.2	17.4	15.9	16.1	15.7	13.4	10.0	6.9	6.3	6.1	6.2	5.9	5.9	6.0	6.0
Infant mortality (")	145.3	123.9	105.3	106.2	95.6	82.8	55.6	38.5	30.2	19.5	13.1	13.2	12.9	13.1	13.1
Iwate - Mortality (")	22.6	20.7	18.4	19.6	20.1	15.5	13.1	8.7	8.0	7.7	7.7	7.5	7.2	7.7	7.7
Infant mortality (")	160.5	142.8	133.6	147.3	132.9	98.2	89.9	64.7	48.4	28.7	18.4	16.5	14.9	15.8	15.8
Shimane - Mortality (")	22.3	23.2	19.9	21.9	19.9	16.5	12.8	9.0	9.5	10.0	10.1	9.6	9.5	8.2	8.2
Infant mortality (")	139.0	143.4	112.2	126.1	104.5	76.0	62.9	41.2	35.1	22.8	14.1	14.0	10.6	9.0	9.0
Hamamoto - Mortality (")	18.8	18.7	17.1	18.2	16.3	15.0	11.5	8.3	8.6	8.6	8.8	8.2	8.3	8.6	8.6
Infant mortality (")	103.1	98.8	87.6	96.2	74.8	70.0	54.5	34.5	25.4	23.4	16.2	13.4	13.5	14.1	14.1

資料：厚生省「人口動態統計」

Source: "Population Movement Statistics" by the Welfare Ministry

CHANGES IN NUMBER OF PERSONS INSURED WITH NATIONAL HEALTH INSURANCE & AVERAGE MEDICAL EXPENSES per PERSON COVERED BY INSURANCE

国民健康保険被保険者数及び被保険者一人当り給付額の推移

Year	Number of persons insured	Average medical expenses per person	Year	Number of persons insured	Average medical expenses per person
年度	被保険者数	一人当り給付額	年度	被保険者数	一人当り給付額
1933	523,223人	0.38 Yen	1956	3,058,206人	1,500 Yen
1939	1,313,484	1.89	1957	3,357,572	1,651
1940	3,045,046	---	1958	3,723,964	1,823
1941	6,704,992	---	1959	4,343,883	2,118
1942	22,661,192	---	1960	4,617,092	2,563
1943	37,959,663	---	1961	4,680,625	3,389
1944	41,161,301	5.33	1962	4,578,710	4,044
1945	40,925,424	---	1963	4,478,780	4,981
1946	* 41,820,949	17.41	1964	4,360,021	6,276
1947	* 32,123,642	63.20 (予定)	1965	4,314,877	7,540
1948	* 25,826,890	146.45 (予定)	1966	4,279,682	8,801
1949	24,057,301	(547)	1967	4,265,586	10,553
1950	24,353,974	(580)	1968	4,254,023	13,007
1951	24,596,213	(559)	1969	4,241,624	15,095
1952	23,088,674	(771)	1970	4,336,252	17,714
1953	24,965,541	961	1971	4,372,344	20,098
1954	26,633,438	1,189	1972	4,436,580	25,109
1955	28,711,436	1,319	1973	4,412,866	30,186

Notes: 1) Insured numbers are figures as of each fiscal year-end (March) (* figures are as of December).
 2) Average medical expenses are obtained by dividing a total compensation from Insurance (including patient's own payment) by insured persons number.
 3) Sources: "Twenty Years' History of National Health Insurance" - insured persons number up to 1953 & total compensation figures for 1953.
 "A Short History of National Health Insurance" - Total compensation for 1933, 39, 40, 47 and 49.
 "National Health Insurance Activity Report" - Number of insured persons & total compensation for 1954-61.
 "National Health Insurance Annual Report" - Number of insured persons & total compensation for 1962-72.
 "National Health Insurance Monthly Report" - Figures for 1973.
 Statistics from the Welfare Ministry - Total compensation figures for 1949-52 are on a basis of payments made by insured persons of N.H.I. and also taking into consideration the compensation rate.

CHANGES IN NUMBER OF RESIDING COMMUNITY NURSES (QUALIFIED)

(Unit: person)

保健婦就業員数(有資格者)の推移

(単位: 人)

Year	Total	Community nurses for Public Health Centers	Community nurses	Others	Year	Total	Community nurses for Public Health Centers	N.H.I. community nurses	Others
年次	総数	保健所保健婦	国保保健婦	その他	年次	総数	保健所保健婦	国保保健婦	その他
13 1937	---	147	---	---	31 1952	12,156	5,245	4,264	2,647
14 38	---	234	---	---	32 57	11,821	5,232	4,553	2,036
15 43	---	324	---	---	33 58	12,201	5,323	4,692	2,186
16 48	2,720	402	344	6,974	34 59	12,519	5,465	4,963	2,091
17 53	5,805	561	---	---	35 60	13,010	5,542	5,220	2,248
18 58	6,874	817	2,632	3,425	36 61	13,248	5,580	5,445	2,223
19 63	9,244	1,805	5,604	1,835	37 62	13,606	5,715	5,567	2,324
20 68	13,071	4,423	7,811	837	38 63	13,910	5,818	5,653	2,439
21 73	12,010	2,187	7,586	2,237	39 64	13,957	5,916	5,624	2,417
22 78	12,675	2,770	6,532	3,373	40 65	13,959	5,926	5,629	2,404
23 83	13,614	2,574	4,467	6,573	41 66	14,175	6,012	5,590	2,573
24 88	11,214	3,473	3,842	3,899	42 67	13,606	5,994	5,559	2,053
25 93	14,691	4,287	3,863	6,541	43 68	13,560	6,025	5,494	2,041
26 98	15,494	4,661	4,360	6,473	44 69	13,759	6,104	5,490	2,165
27 1951	12,147	5,121	(5,334)	(1,692)	45 70	14,007	6,354	5,507	2,146
28 52	12,339	5,414	(5,334)	(1,591)	46 71	14,276	6,471	5,531	2,274
29 57	12,186	5,430	4,259	2,497	47 72	14,735	6,698	5,656	2,381
30 58	12,369	5,403	4,192	2,774	48 73				

Note: 1) "Public Health Center Law" was established in 1937 and "Community Nurse Regulations" in 1941.

2) Sources: "Nurse Annual Report" - Total & community nurse figures up to 1951, & NHI nurse for 1946-51.

3) "A Short History of National Health Insurance" - NHI nurse figures up to 1945.

"National Health Insurance Activity Report" - Figures for 1954-61.

"National Health Insurance Annual Report" - Figures for 1962-72.

3) Figures are as of each calendar year-end except for a period of 1954-61, figures of NHI nurses are as of fiscal year-end (March). National Health Insurance community nurse figures for a period 1946-51 are nurses provided by the government subsidiary funds, and figures for 1952-53 are budgeted numbers in the government subsidiary funds.

CHANGES IN NATIONAL MEDICAL EXPENSE

Years	Unit: In 100 million yen					Percentage				
	(1) Total medical expenses	(2) Insurance coverage	(3) National Health Insurance	(4) Public funds	(5) Patients' share	(1)	(2)	(3)	(4)	(5)
24 1949	9.61	3.36	.68	.61	5.63	100.0	35.0	7.1	6.4	58.5
25 1950	9.84	4.22	.73	.98	4.64	100.0	42.9	7.4	10.0	47.2
26 1951	9.43	4.84	.71	.80	3.79	100.0	51.3	7.5	8.5	46.7
27 1952	1.285	6.33	.92	1.64	4.88	100.0	49.3	7.2	12.8	38.7
28 1953	1.730	8.07	1.24	2.00	7.23	100.0	41.7	7.2	11.6	41.8
29 1954	2.152	1.066	1.58	2.64	8.22	100.0	49.5	7.3	12.3	38.2
30 1955	2.388	1.185	1.88	2.79	9.23	100.0	49.6	7.9	11.7	38.7
31 1956	2.584	1.317	2.28	2.92	9.75	100.0	51.0	8.6	11.3	37.7
32 1957	2.897	1.489	2.75	3.23	11.55	100.0	51.7	9.5	12.5	37
33 1958	3.231	1.686	3.39	3.43	12.02	100.0	52.2	10.5	12.6	37.2
34 1959	3.625	2.065	4.61	4.00	11.60	100.0	57.0	12.7	11.0	32.0
35 1960	4.095	2.415	5.98	4.51	12.29	100.0	69.0	14.6	11.0	31.7
36 1961	5.130	3.121	8.24	5.9	14.10	100.0	68.5	15.1	11.7	29.7
37 1962	6.132	3.790	9.75	8.06	15.86	100.0	67.8	15.9	13.1	27.7
38 1963	7.541	4.823	12.40	10.30	16.88	100.0	64.0	16.4	13.7	22.7
39 1964	9.389	6.133	16.11	12.20	20.36	100.0	65.3	17.2	13.0	21.7
40 1965	11.224	7.442	20.15	14.71	23.72	100.0	61.3	18.0	13.1	20.6
41 1966	13.002	8.749	24.25	16.93	26.20	100.0	67.3	18.7	12.6	20.2
42 1967	15.116	10.214	30.34	19.26	30.74	100.0	67.6	20.1	12.1	20.3
43 1968	18.016	12.281	38.60	20.39	33.45	100.0	68.2	21.4	11.6	20.2
44 1969	20.780	14.307	44.64	23.21	36.52	100.0	68.8	21.5	11.2	20.0
45 1970	24.962	17.320	53.57	25.22	43.20	100.0	69.4	21.5	11.3	19.7
46 1971	27.250	19.372	61.35	3.209	51.19	100.0	69.3	22.5	11.8	19.5
47 1972	32.994	22.401	72.17	4.157	59.86	100.0	68.7	23.0	13.6	17.7