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Abstract

Japan was the first Asian country to introduce social insurance measures and it has expanded them during the last few decades. The first social insurance law was passed in 1922, dealing with worker's health insurance, and it was followed by the National Health Insurance in 1938, Seamen's Insurance in 1939, and Employees' Pension Insurance in 1921. However, these were seldom widely available in actual practice because of the characteristics of public assistance which limited them to the poor.

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A CRITICAL REVIEW OF HEALTH SERVICES IN JAPAN

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Japan was the first Asian country to introduce social insurance measures and it has expanded them during the last few decades. The first social insurance law was passed in 1922, dealing with worker's health insurance, and it was followed by the National Health Insurance in 1938, Seamen's Insurance in 1939, and Employees' Pension Insurance in 1921. However, these were seldom widely available in actual practice because of the characteristics of public assistance which limited them to the poor.

At the end of World War II, the new Constitution was promulgated. It stated the principle that comprehensive social insurance was a fundamental right of the people. Therefore, many types of social insurance were established as a response to the growing demand:

Name of Social Insurance	*Year Instituted*
Workmen's Compensation Insurance	1947
Unemployment Insurance	1947
National Public Service Mutual Aid Association	1948
Health Insurance for Daily Workers	1953
Private School Teachers and Employees Mutual Aid Association	1953
City, Town and Village Employees Mutual Aid Association	1954
Public Corporation Employees Mutual Aid Association	1956
Agricultural, Forestry, and Fishery Institution Employees Mutual Aid Association	1956
National Pension	1959
Local Public Service Mutual Aid Association	1967

At present nearly the entire population is covered by one or more of these social insurance schemes.

It should be noted, however, that there are many differences in the amounts of the benefits granted or the pension received from insurance schemes which protect people from the same kind of insurance risks. For

example, the benefits from the National Health Insurance and Daily Workers Health Insurance are less than those from Seamen's Insurance for Employees. Although the former usually covers lower income persons who have higher risks from diseases, the development of social insurance has resulted in enlarging the gap between the poor and the rich due to the unequal coverage and distribution of benefits.

Auxiliary organs have been established as prescribed by law to aid in the administration of the social insurance schemes. These organs include the Social Security Advisory Council, Social Insurance Council, National Pension Council, Social Insurance Medical Councils (both Central and Local), Social Insurance Referees, Social Insurance Appeal Committee and Social Insurance Medical Fee Payment Fund.

I. *An Outline of the Organization of Health Services in Japan*:

Historically, two fields of health services have developed seperately in Japan; preventive medicine or public health and curative or therapeutic care. The former has always been located in the public sector, while the latter has remained in the private sector. These two sectors have usually been independent of one another, and it is very difficult to integrate them or even co-ordinate them.

As a result of traditional compartmentalization of the Japenese bureaucracy, there have been three independent fields of public health activity. These are the community, occupational and school health activities, which have been respectively supervised by the Ministry of Health and Welfare, Ministry of Labor, and Ministry of Education (Fig. 1).

Unfortunately, there is a shortage of physicians among these fields.

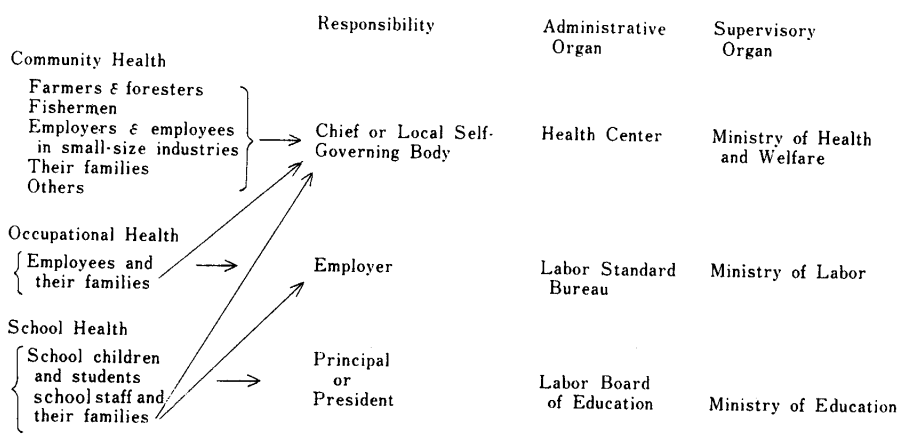

Fig. 1 Organization of Public Health Programs

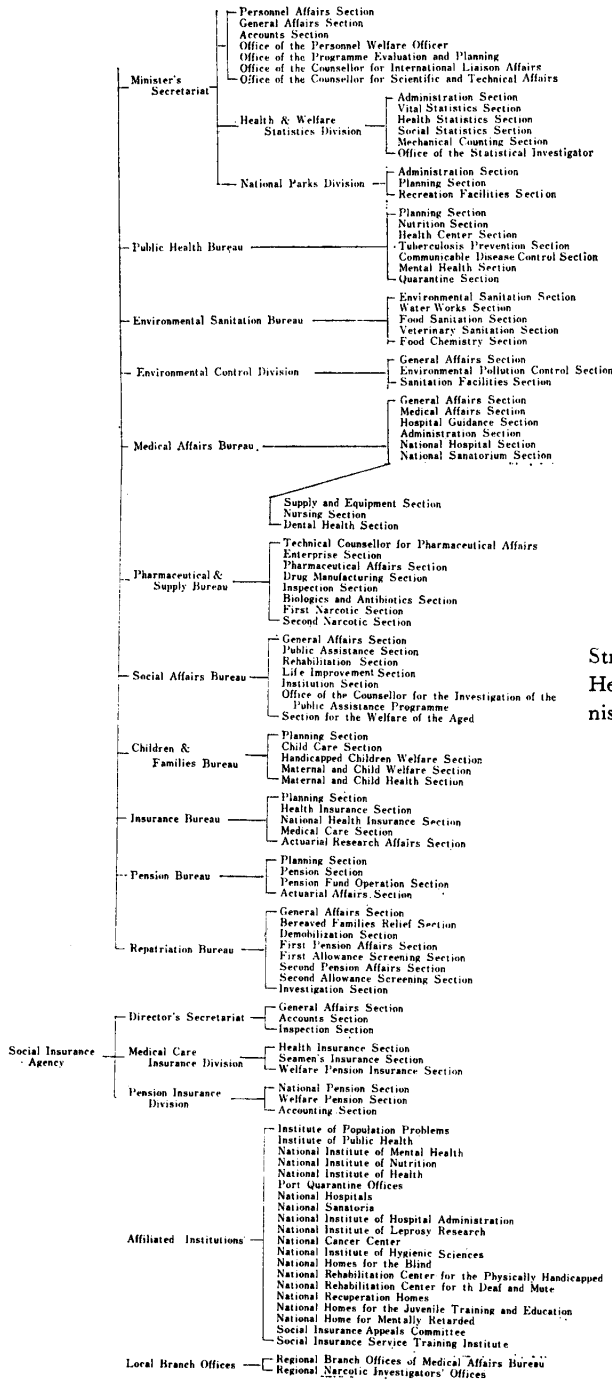

Fig. 2 Organizational Structure of the National Health and Welfare Administration (August 1, 1968)

There is an extreme scarcity of physicians in the administrative and supervisory organs of industry and schools, and consequently both have very little power to carry out their roles.

A. Organization of Public Health Administration

Fig. 2 shows the organizational structure of the national health and welfare administration in Japan as of August 1, 1968. These Bureaus, Divisions, Sections direct the health program by giving orders to 46 Prefectural Governments and 29 larger Municipal Governments.

The administrative and supervisory functions of each one of those divisions are set forth by law.

Most public health programs at the community level are supported by national, prefectural, and city, town or village funds each responsible for one-third of the funds. Consequently, the city, town or village government cannot independently institute programs without the approval of the higher authorities.

The lack of communication among Bureaus, Divisions, and Sections is one of the important disadvantages of Bureaucracy. Each Prefectural Government has its own Health Department in order to carry out its health programs in compliance with the national policies and programs as directed by the Bureaus, Divisions, and Sections.

The Prefectural and Municipal Governments divide their administrative boundaries into several health center districts each covering a section of cities, towns, and villages. A Health Center is established in each one of those districts.

The role and function of a Health Center is defined by law (The Health Center Law-1947, *etc.*) as a community health service and a health administration agency authorized by the Governor or Mayor. Consequently, all community health programs have been integrated only theoretically into the Health Center activities. The Health Center are not empowered to provide any curative services or even refer patients to a hospital because these functions are considered infringements on private medicine.

B. The Organization of Medical Care Services

In contrast to public health activities, which are regulated by many laws, medical care services are controlled mainly by the Medical Service Law (1948) and the Medical Practitioner Law (1948). Medical care services are provided mainly by private doctors and in private facilities (Tables 1 and 2). However, there is no difference in the functions provided by public medical care facilities from those by private facilities.

The medical care services are regulated by the law of socialized medicine, because nearly the entire population is covered by Government

TABLE 1. NUMBER OF HOSPITALS CFASSIFIED BY TYPE-1965 AND 1966

	Total		Mental Hospitals		Tuberculosis Sanatoria		Leprosaria		Communicable Disease Hospitals		General Hospitals	
	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966	1965	1966
National	448 (268)	446 (266)	3 (3)	3 (3)	97 (86)	76 (65)	11 (11)	11 (11)	—	—	337 1(68)	356 (187)
Prefectural and municipal	1,154	1,154	39	41	50	43	—	—	45	41	1,020	1,029
Semi-public	312	312	1	1	4	4	—	—	—	—	307	307
Social insurance	162	163	—	—	13	12	—	—	—	—	149	151
Private	4,971	5,233	682	724	176	148	3	3	1	—	4,109	4,358
Grand total	6,047	7,308	725	769	340	283	14	14	46	41	5,922	6,201

Note: 1) Those figures in the brackets are those directly under the jurisdiction of the Ministry of Health and Welfare.
2) Those semi-public facilities include hospitals operated by the Japan Red Cross Society, etc.

TABLE 2. NUMBER OF PHYSICIANS AND DENTISTS BY TYPE OF WORK (END OF DECEMBER 1965 AND 1966)

No. of Physicians & Dentists / Type of Work	Physician Number		Dentist Number	
	1965	1966	1965	1966
Owner of hospital or clinic	55,217	56,552	26,918	27,167
Employed in hospital or clinic	37,049	36,874	6,263	6,309
Teacher and research worker of clinical medicine	9,749	10,530	946	1,071
Teacher and research worker of medicine other than clinical medicine	2,165	1,966	183	184
Engaged in other public health	2,260	2,368	163	133
Others	2,929	2,469	1,085	1,158
Total	109,369	110,759	35,558	36,022

TABLE 3. THE NUMBER OF PERSONS COVERED BY MAIN HEALTH INSURANCE SCHEMES (March, 1967)

Kinds of Scheme	Insurance Carrier	Insured Persons ×1,000	Their Dependants ×1,000
National Health Insurance	156	43,200	
Health Insurance Society-managed	1,339	7,326	9,128
Government-managed	1	11,702	12,038
Seamen's Insurance	1	252	483
Daily Worker's Insurance	1	957	1,148
Mutual Aid Association	86	4,012	6,782

Others—Public Assistance=Daily Life Security Law

The coverage rate 15.9/1000

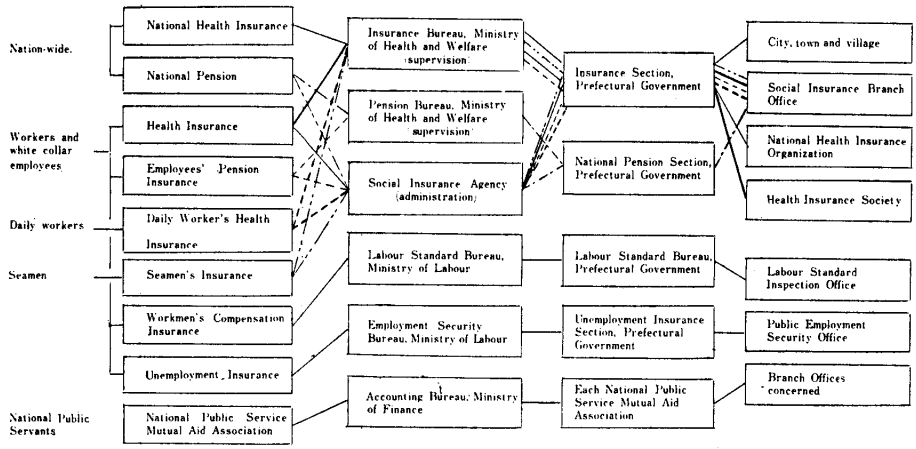

Fig. 3 Main Social Insurance Programs and Administrative and Supervisory Organs

regulated social insurance schemes (Fig. 3 and Table 3).

Although medical care services under social insurance lays are usually called "Health Insurance", these schemes do not furnish routine care health services because such health services are provided by public sector supported by tax but not by premium. This paper will cover only some social insurance schemes directly related to medical care services. Pension insurance, unemployment insurance, puplic assistance, etc. will not be discussed because it would be too lengthy to thoroughly cover these topics.

C. National Health Insurance

In 1956, the Government announced the policy to provide "medical care for the entire nation". The National Health Insurance Law was enacted in 1958, coming into force in April, 1959. According to this Law, every local self-governing body had to provide a National Health Insurance Scheme by April in 1961, regardless of their differing financial and administrative ability to do this. Therefore, a variety of benefits are available as a result of the different financial abilities to provide them. The new law has played a very important role in the nation-wide spread of medical care services. However, there has developed an unfortunate gap between the people who profited from this law and those who did not because of the different geographical, economical and social characteristics between the wealthy prefectures and the poor local prefectures.

Historically, the former National Health Insurance Law was enacted on July 1, 1938, to alleviate the difficulties of the nation-wide economic depression of the 1930's. It provided medical care services for people who were not covered under the Health Insurance Scheme (1927), farmers,

fishermen, middle and lower class businessmen, and blue collar workers.

The scheme was operated by the National Health Insurance Organization established in a city, town, or village. The scheme was non-profit and voluntary, and the Government contributed to encourage the scheme for reasons of economic policy. In 1942, the Law was revised giving the Prefectural Governor the power to appoint the members of the organizational committee, and affiliation with the Organization was made compulsory for all in 1945.

As previously mentioned these schemes were seldom available or accepted by the public because of the stigma and shame attached to public assistance, similar to that of the English Poor Laws.

Due to the social insecurity and the economic inflation after World War II, most of these organizations ran into financial difficulty and were obligated to suspend operations, thus bringing the scheme on the brink of ruin.

The Law was revised in 1948. Local public government (city, town, or village) became the insurer and the households and their dependents became affiliated with the local insurance association.

According to the current Law, insurance carriers consist of two types of organizations: local self-governing bodies, cities, towns, or villages (including special wards in large cities and federations of cities, towns or villages): and National Health Insurance Organizations.

Cities, towns, and villages are the insurance carriers by the law. In order to establish the organization, the law states that at least 15 promoters shall draw up the article. If at least 300 persons eligible for membership are willing to participate in the scheme, it is presented for the approval of the Prefectural Governor.

As a result of such measures in 1967 there were 3,495 insurance carriers (3,339 cities, towns and villages and 156 National Health Insurance Organizations); 12 million households and 43 million insured persons (41 million having city, town or village coverage and 2 million having National Health Insurance Organization coverage) (Table 4).

Persons who are already insured under other health insurance schemes and the Daily Life Security Law (1950), are excluded from coverage under National Health Insurance.

As for benefits, medical care services, midwife services, and funeral services or cash benefits are provided in case of sickness, injury, confinement or death of the insured persons.

It should be noticed that there are remarkable differences between Health Insurance and National Health Insurance, especially in connec-

TABLE 4. COVERAGE OF NATIONAL HEALTH INSURANCE (March 31)

	1967	1966	1965	1964
Insurance Carrier	3,495	3,541	3,563	3,570
City, Town or Village	3,339	3,385	3,407	3,413
N. H. I. organization	156	156	156	157
Household	11,793,060	11,590,802	11,434,136	11,401,932
City, Town or Village	11,172,209	10,988,266	11,828,938	10,749,399
N. H. I. organization	620,851	602,536	605,198	652,533
Insured Person	42,798,682	43,244,666	34,605,021	54,154,817
City, Town or Village	41,119,890	41,604,846	41,959,877	43,404,892
N. H. I. organization	1,698,792	1,639,820	1,645,144	1,749,925

tion with the "partial liability" borne by the beneficiary of the medical care benefits.

Medical care facilities and personnel have to be approved by the Prefectural Covernor if they want to provide medical care services to insured persons.

There are some medical facilities directly administered by the schemes. However, most of them, especially small hospitals and clinics, have run into difficulty as a result of the shortage of physicians, financial weakness of self-governing body, geographical, social and cultural disadvantages, *etc.*

To cover necessary operation costs of the scheme, a premium (National Health Insurance tax) shall be paid by the household of the insured person. The amount of the premium and the method of collection are regulated by Law. The rates are set to meet individual financial ability considering income, property, capital and so on. The maximum amount is 50, 000 yen per year a household.

D. Health Insurance

Although the National Health Insurance scheme has a difficult situation especially because of financial reasons, Health Insurance schemes seem to be active in general. This situation is inevitable partly because a person belongs to Health Insurance when he can work and therefore has a higher income, but he belongs to National Health Insurance after retirement. Also the Health Insurance schemes are found in the larger industries which pay higher wages to employees, while the middle and smaller industries where wages are lower cannot establish a Health Insurance Organization.

Historically, Health Insurance was established earlier than National

Health Insurance. The rapid growth at the beginning of the century of the capitalistic system of production, the industrial revolution, has caused a remarkable increase in the number of Japanese workers. Mutual aid associations were establish in many factories to deal with oppressive working conditions.

The development of the labor movement after World War I attracted Governmental interest in the success of the social insurance system in European countries. Consequently, Japan enacted the Health Insurance Law in 1922, the enforcement of which started in 1927. This scheme covered all workers who are employees in work places under the application of the Factory Law or the Mining Law, which was a famous law against oppression of the labor movement.

In 1943, the Law was revised to cover white-collar workers.

After the termination of World War I, benefits of the Health Insurance Law gradually improved accompanied by the rapid expansion of its scope.

There are two types of insurance carriers in the scheme: the government (compulsory government managed Health Insurance), and the Health Insurance Society (voluntary).

The former applies to all persons employed in industries which usually employ 5 or more persons, and the latter may be established by an employer or by a group of employers, who employ more than 300 employees, with the consent of more than half of the employees and the approval of the Minister of Health and Welfare. The Minister of Health and Welfare may order any employer who employs usually more than 500 employees to establish a Health Insurance Society.

TABLE 5. INSURED PERSONS PER WORK PLACE (GOVERNMENT MANAGED) (March 31)

1967	21.57
1966	21.44
1965	22.26
1964	22.76

TABLE 6. SOCIETIES CLASSIFIED ACCORDING TO THEIR SCALE (March 31)

Insured person	H. I. Society
less than 500	18
500 and over	76
1,000	353
2,000	233
3,000	129
4,000	115
5,000	74
6,000	59
7,000	32
8,000	29
9,000	27
10,000	90
15,000	43
20,000	27
30,000	15
50,000	9
100,000	2
	1,331

Accordingly, the Schemes are also compulsory or semi-compulsory, Governmental Insurance as well as National Health Insurance. The difference between the two types is due only to industry-size (Table 5 and 6).

As previously mentioned with the exception of persons engaged in agriculture, forestry, fishing, restaurants and hotels, almost every kind of employee is covered by the Scheme. Coverage of the Schemes is shown in Tables 7 and 8.

TABLE 7. HEALTH INSURANCE COVERAGE (GOVERNMENT MANAGED) (March 31)

	1967	1966	1965	1964
Workplace	565,145	537,103	513,381	477,239
Compulsory	459,458	440,589	513,547	403,480
Voluntary	106,111	96,965	85,217	69,173
Insured person				
Total	12,203,333	11,702,370	11,425,874	10,864,129
Male	7,864,837	7,580,808	7,449,754	7,138,824
Female	4,338,496	4,121,602	3,976,120	3,725,305
Compulsory	11,428,294	11,009,922	10,806,777	10,369,896
Male	7,436,663	7,197,036	7,103,436	6,856,004
Female	3,991,631	3,812,836	3,703,341	3,513,892
Voluntary	755,933	673,689	602,742	479,722
Male	418,687	373,463	337,388	273,949
Female	337,246	300,226	265,354	205,773
Continuously	19,016	18,759	16,355	14,511
Male	9,487	10,219	8,930	8,871
Female	9,617	8,540	7,425	5,640

TABLE 8. HEALTH INSURANCE COVERAGE (SOCIETY MANAGED) (March 31)

	1967	1965	1964	1963
Society	1,331	1,339	1,320	1,279
Workplace	73,970	71,692	67,170	60,233
Compulsory	66,727	65,049	61,324	54,362
Voluntary	7,243	6,643	6,386	5,871
Insured person				
Total	7,592,004	7,326,155	7,098,033	6,565,172
Male	5,420,445	5,242,798	5,080,772	4,703,023
Female	2,171,559	2,083,357	2,071,261	1,862,149
Compulsory	7,560,361	7,297,045	7,068,718	6,540,972
Voluntary	31,527	28,957	29,219	24,058
Continuously	116	153	96	132

Insurance benefits provide actual medical care services, sickness and injury allowances, maternity allowances, delivery expenses, nursing allowances, and funeral expenses for the insured person and his dependents, defined as spouse and children supported by the insured person.

Medical care benefits are provided for non-occupational caused injury or sickness. They include medical consultation, medicines and other therapeutical materials, medical examinations and treatment, hospitalization and clinical services, and transportation. Partial liability is borne by the insured person; such as, 200 yen for the first consultation, 60 yen per day for 1 month in hospitalization, 15 yen per dose a day for the medicine in out-patient clinics, and so on.

Medical Care Organs and Pharmacies which provide medical care benefits under Health Insurance Scheme are called Insurance Medical Care Organs and Insurance Pharmacies, and they have to be approved by the Prefectural Governor.

Doctors, dentist and pharmacists who want to engage in medical care services under the Scheme must also apply to the Prefectural Governor for registration.

In 1967, 180,853 Medical Care Organs, 184,000 pharmacies, 122,029 doctors, 38,555 dentists and 28,109 pharmacists were registered.

The Schemes are financed by employer and employee premium, a national subsidy, and a loan (since 1966).

The amount of the premium is obtained by multiplying insurance premium in rate by the standard monthly wage of the insured person, and the premium is shared in equal proportion by the employer and the insured person. The employer is responsible for the payment of the contributions and is authorized to deduct an amount equal to the employee's premium from his salary. The premium rate under Government-managed Health Insurance is 7%. The premium rate for Society-managed Health Insurance is determined by the provisions of the Societies Articles within the range of 3% to 8% and it must be approved by

TABLE 9. SOCIETIES CLASSIFIED ACCORDING TO CONTRIBUTION RATES
(March 31)

Contribution Rate	Society
4.5 %	0
4.6~4.9	1
5.0	3
5.1~5.4	8
5.5	11
5.6~5.9	19
6.0	89
6.1~6.4	106
6.5	317
6.6~6.9	173
7.0	237
7.1~7.4	84
7.5	96
7.6~7.9	60
8.0	127
	1,331

the Ministry of Health and Welfare. However, the rate for the insured person must not exceed 3.5% of his wages (Table 9).

As to the National Subsidy, the administrative expenses of the Scheme are borne by the Government and benefit expenses are subsidized from National Treasury, the amount of which is fixed by the national budget.

Financing of the Health Insurance Scheme is carried out within the Health and Business Sub-Account of the Welfare Insurance Special Account, being independent from the General Account of the Government. The 1967 budget is shown in Table 10.

TABLE 10. HEALTH INSURANCE BUDHET (GOVERNMENT MANAGED) (March 31)

Fical Year	1967	1966	1965	1964
Total insurance	374,257,719	274,810,785	203,486,603	168,815,626
Contribution	273,303,107	221,022,934	192,221,107	164,534,319
National subsidy	18,672,158	6,253,649	3,303,254	2,979,594
Loan	80,687,432	46,252,116	—	—
Transfered from reserve fund	—	—	7,000,000	—
Miscellaneous	1,595,023	1,282,086	957,242	1,301,722
Total expenditure	373,114,139	273,698,969	214,261,337	177,541,667
Insurance benefit	315,997,481	266,529,403	207,823,255	171,780,604
Management expense	4,809,277	4,194,400	3,819,202	3,167,884
Redemption for loan	51,103,905	1,558,023	—	—
Health facility	288,521	293,591	380,328	334,862
Welfare facility	858,970	1,025,726	2,176,273	2,213,929
Miscellaneous	55,983	97,826	62,329	44,389
Ballance	1,143,580	1,111,816	△10,774,784	△ 8,726,031
Transfer to following year	—	6,754	8,418	15,925
Transfer to reserve fund	1,143,580	1,105,062	△)10,783,202	△ 8,741,956
Reserve fund	2,228,647	1,123,585	11,906,787	27,648,742

(in 1,000 yen)

Recently, the Government decided to revise the schemes entirely because of financial crisis in the Government-managed Health Insurance.

The Law concerning provisional exception to Health Insurance Law and Seamen's Insurance Law was enacted in August, 1967 with a period limitation of two years.

Some of the main targets of the Law are an increase of premium rates and partial liability on medical care benefits, a payment system for the provider of medical care services, and so on.

E. Other Health Insurance Schemes

As one of social policies of a nation which is surrounded by sea,

Seamen's Insurance Scheme was established by the Seamen's Law in 1939. Since then there have been many revisions of the basic law concerning both the extent of coverage and the insurance benefits.

As the result of these amendments, the Seamen's Insurance Scheme has a comprehensive social insurance program which provides insurance benefits for occupationally related accidents and disorders as well as non-occupational causes. This scheme includes not only all sorts of benefits which are provided under Health Insurance Schemes and National Health Insurance Schemes, but also unemployment benefits, a pension plan and some preventive measures such as periodic health examinations. The insurance carrier of this scheme is the Goverment and the insurance benefits are almost the same as that of Health Insurance Scheme so far as its medical care benefits in kind are concerned.

Daily Workers' Health Insurance is another kind of Insurance Scheme which was enacted as a social policy. The scheme was established by Basic Law No. 207, in 1953.

"Daily Worker" is defined by the Law as a person who is employed provisionally by the day or for less than 2 months, seasonal workers employed for less than 4 months, and persons employed at work of a provisional nature for less than 6 months.

This Scheme has features of its premium; "level premium paid by the stamp" and "requirement of a certain number of stamps for entitlement to benefits". The premium is calculated on the basis of daily earnings and is divided into two classes; first class and second class. First class is composed of daily workers whose daily wages are more than 480 yen. The worker pays a premium of 13 yen per day and an equal amount is remitted by his employer. The premium for the second class workers, daily wages less than 480 yen, is 10 yen. For each day of employment the employer offers a "Health Insurance Stamp" (13 yen or 10 yen) purchased at the Post Office on the "Insurance Card" carried by each daily worker. The Post Office pays the money to the Government which is the carrier of the Scheme.

To be eligible for insurance benefits, the insured person must have paid premiums for at least 28 days within the 2 months immediately preceding the application for benefits.

The insurance benefits under this scheme are generally poorer than other health insurance schemes and the medical care benefits are limited to a period of 2 years from the first day of treatment.

The National Treasury is responible for administrative expenses within the limit of the budget and 35% of the benefit expenses.

Several kinds of mutual aid associations also provide medical benefits. These schemes provide similar pensions and medical care benefits as are characteristic of those provided under the Health Insurance Scheme.

Government employees are covered by National Public Service Mutual Aid Associations under the jurisdiction of the Ministry of Finance (1948), Local Public Service Mutual Aid Association under the jurisdiction of the Ministry of Autonomy (1962), Public Coroperation Employee Mutual Aid Association under the jurisdiction of the Ministries of Transportation, Finance and Postal Service (1956), Private School Teachers and Employees Mutual Aid Association under the jurisdiction of the Ministry of Education (1953), and Staffs of Forestry and Fishing Institutions Mutual Aid Association under the jurisdiction of the Ministry of Agriculture and Forestry (1958).

It should be noted that the premium rates are determined by each Mutual Aid Association and written in its articles. The cost of the benefits is borne by the member and the Government in equal portion; approximately 4.4% of the member's average monthly salary for short term benefits, and approximately 6.1% for long term benefits. In addition to the premium, administrative expenses of the association are entirely supported by a National Subsidy.

As mentioned above, there are many different health insurance schemes in Japan and each has its own history and laws although the same fee-tariff of medical care services is used. Accordingly the schemes offer different services for the insured persons and financial conditions for insurance carriers. Therefore, the Schemes have contributed in large to the gap between the middle class and the poor.

It is also necessary to discuss Workmens Accident Compensation Insurance (1947) because it provides medical care services for occupational-genetic disorders, and recently it has become more and more difficult to distinguish occupational disorders from non-occupational disorders. The Insurance carrier of the scheme is the Government, however, it is under the jurisdiction of the Ministry of Labor. The Workmen's Accident Compensation Division, Labor Standards Bureau, Ministry of Labor administers its scheme at the national level and the Labor Standard Office in each prefecture and the 384 Labor Standards Inspection Offices situated in the main cities throughout the country are responsible for the field work. The financial management is carried out within the scope of the Workmen's Accident Compensation Special Account apart from the General Account.

As a rule coverage is compulsory for industries which usually employ

5 or more workers. Exceptions to this are government offices, seamen and others because of the reasons previously mentioned.

Insurance benefits include medical care compensation, compensation for the temporary disabled, survivors, invalids and the long-term disabled.

Funeral expense benefits and some welfare services such as artificial limbs, optical appliances, hand-operated bicycles, etc. are also provided.

It should be noted that its financial resources are supported only by the employers, calculated by the amount of wages paid to all the workers during the fiscal year and by the rate which is fixed for each class of industries in proportion to the rate of accidents during the past 3 years. The National Treasury within the limits of the national budget subsidizes annually part of the expenditure required for the insurance benefits.

II. The Outlook for Comprehensive Health Care:

As previously explained, there are many difficult problems which the Japanese public health doctors are faced with at present. Since the term "comprehensive health care system" has been introduced to our field, many health professionals have concentrated their efforts on establishing comprehensive health care in Japan.

In order to discuss the outlook of the comprehensive health care system, first it is necessary to define the conception of "comprehensive health care", and then to discuss the way it can be established in the near future in Japan.

A. The Definition of Comprehensive Health Care

There are many viewpoints and definitions of the term "comprehensive health care". However, the various definitions have something in common with each other; namely, the clear recognition of dissatisfaction with the delivery of medical care in relation to the technological developments in the field of medical care. The dissatisfaction has come mainly from the gap between a stable medical care system and the rapid development of technology in the field of medical science. At the same time, the expansion of the gap between the system and the rapid changes of society cannot be disregarded.

Accordingly, these changes should be discussed in order to formulate a reasonable definition. A possible definition would be a medical care system which can satisfactorily meet today's health needs.

B. The Need for Comprehensive Health Care

The rapid development of medical technology has increased the complexity of medical practice with a corresponding increase in the number of specialists. This has, in turn, required the integration of

medical services and the continuity of care; "specialization" must be accompanied with "integration" and team work of various kinds of medical and health professionals is one possible measure to meet the need for comprehensive health care.

The coordination between the public health sector and curative sector is an urgent problem. In connection with the problem, it should never be disregarded that medical and health professionals other than physicians may have their own responsibilities as members of medical and health teams, because their specialities have traditionally never been recognized as independent functions from physicians.

Moreover, the technological developments of medical science have changed our concepts of health and disease.

As the acute communicable diseases have been brought under control, there has been a corresponding increase in the importance of the chronic degenerative diseases. These latter diseases usually develop during many symptomless years and require long periods of continued care. Because of this, early detection and rehabilitation have become much more important, and health promotion and maintainance is changing from a slogan to a clearly attainable aim in the field of public health. Persons who are provided medical care should not only be patients with sickness or disorders but also those without any trouble in their mental, physical and social conditions. The public must now be motivated to make use of medical services. Instead of "waiting" for people to come when they are sick, these services must develop techniques of "reaching out" to the public.

In addition to the changes in health needs resulting from the technological development of medical science, we have to pay much more attention to the impacts of our rapidly changing society.

Health is being recognized as a basic human right rather than a privilege by the public. The public is taking a more active part in the

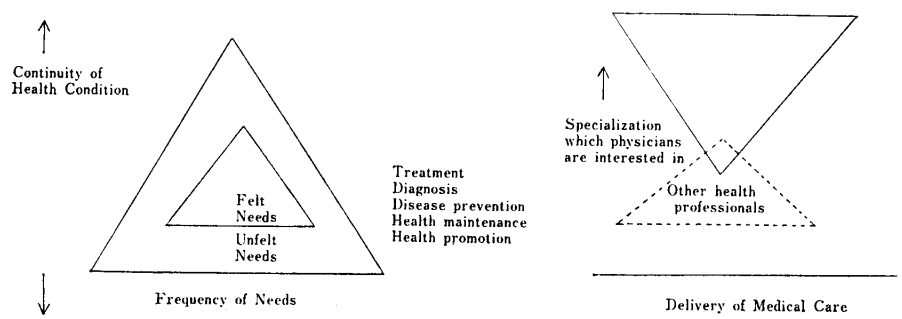

Fig. 4 Needs and Organization of Medical Care

determination of public health and welfare policy as a result of the adoption of a prepaid system into the health insurance scheme budget.

Moreover, the high cost of medical care has led to a rapid expansion of this tendency. Medical and health care services are being recognized as one of the most important governmental services by the public.

Finally, the most important problem of the current medical and health care system is one that has not met a continuous need like the spectrum from health to disease. It is necessary to establish a medical care system for healthy persons; the majority of the public (Fig. 4).

In order to meet these health needs, we should establish a speciality of medical care for healthy individuals.

This might mean an expansion of the applicability of medical sciences to the overall life of human beings (Fig. 5).

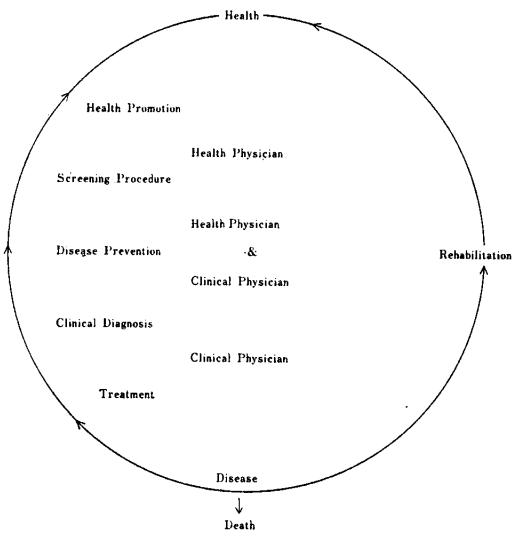

Fig. 5 Scope of Medical Care Services

III. Specialty of Medical Care for Health :

A specialty consists of academic techniques and knowledge which are acquired through education. Specialists are required to make judgements, and provide treatments based on judgements in their field of speciality. For example, a physician, as one of the specialists in medical care, plays his role through diagnosis and treatment. Diagnosis might be considered the process by which it increases true information and reduces false information.

Assuming that there might be an analogy of medical care for health

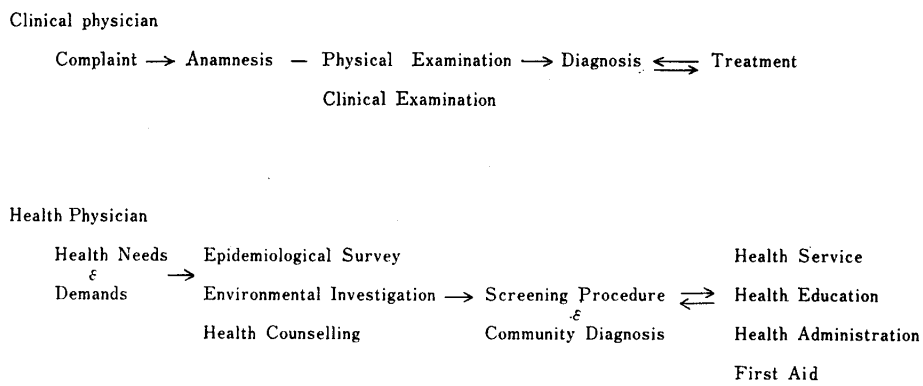

Fig. 6 Functions of Specialists

to clinical medicine, we would consider its methodology as shown in Fig. 6.

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