History of Japanese Medicine

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It's impossible to understand the development and organization of medicine in Japan today without first briefly looking at the history of the country. Most health service in the world have evolved because of historical , social and political factors has been performed and Japan is no exception as well.

Japan, which lies at the edge of Asian Continent. It consists of a group of four big islands and lots of small ones that stretch over a total are of '377.435 kilometer square'. Being situated on the border of East and West, Japan has developed a medical care system which suits for themselves by modifying and referring other countries. In this report two major paradigmatic shifts marked the evolution of Japanese medical first was 'traditional medicine' influenced mainly from India, China in the sixth century A.D. Almost one thousand and two hundred years later. Western influences on Japanese medical care accelerated after the 'Meiji Restoration' (3,6).

From Nineteen forty-five at the end of World War II, the plan of health insurance is still continuous. In fact the first Health Planning Law was enacted in 1927. After that ,the United States of America occupied Japan from 1945 to 1952. It is that I believe the health planning or provision of comprehensive medical care system for the whole Japanese people just started to be established at that time.

Recently Japan's economical and physical environment have been changed greatly over major reorganization and investment in its health service adopting the best medical system, which is suitable to themselves.

In Japan, the Ministry of the health and welfare was set up in 1938. From that time it has been enlarged and become a top-heavy bureaucratic administration. The organization of the Ministry exacted health programs to the six hundred thirty and four Prefecture Governments and fifty three Designated Cites (total one thousand one hundred and six health centers) (14). Each Prefecture Government and Designated City Government has their own Health department which organizes and carries out health programs and policy at a national consistency under the supervision of the Ministry of heal and welfare.

With respect to the function of health administration, Japanese national health administration are divided into four main categories as follow:

1. ENVIROMENT PROTECTION
2. INDUSTRIAL HEALTH ADMINISTRATION
3. SCHOOL HEALTH ADMINSTRATION
4. GENERAL HEALTH ADMINISTRATION, they are strongly connected to each other.

Health status in recently Japan

The rapidly economical growth in Japan from the Second World War has been accompanied by improving health standards of the Japanese people. The average life expectancies of men and women in Japan are the highest in the world (75.9 years for men, 81.8 years for women, 1990 data) (1,14); with the result that 11.6% of the population of Japan is over 65. Owing to the continuous migration of younger people from the country to the cities, rural area over a quarter of the population is over 65.

There are many complex factors that determine the health status of Japanese, for example. Japan's low-fat diet is considered as a principle ingredient in maintaining the health of its people . Thought this kind of low-fat diet is not absolutely useful, and Japanese conventional salty food has led to a high prevalence of stroke occurred. Japanese always has a stable and low incidence of Hodgkin's disease (4,5 and 6).

Some reports showed that the high rate (6.3%) smoking population of Japanese men has suffered a great risk against well-being. Other socio-cultural factors may affect Japanese well-being include its strong commitment to cleanliness and resistance to invasive medical procedures. Japanese prefer bed rest and prescription drugs than surgery. As a consequence, Japan spends more on prescription drugs than any other Western counties. However, its surgical rates are lower than those in the United States. The rapid promotion to develop countries resulted on dramatic improvements in living standards, but it s narrow minded on economical growth and material pursuit has also generated new1960s. Lacking of proper housing (inadequate sewage and garbage-disposal systems), increasing traffic congestion and accidents can indicate on Japanese general population health status. Industrialization has led to some degree of occupational diseases much like those faced by workers in Europe and North America. It's just pattern change of disease in Japan (4,5,6 and 12).

Health insurance and primary health service in Japan

Japan has a compulsive nation health service system that is financial supported by employer contributions, individual contributions and taxes though non-profit insurance funds. Since April 1961 the system has been operated to guarantee the coverage by some form of medical care insurance to everyone. Each of these insurance plans have its own insurer level, different premium and cost sharing rates. Currently insurance system has some problems occurred. For example, the heavy use of pharmaceutical products and long stay in hospital both are the problems for this system.

The insurance plans can roughly divided into two categories. First one is the insurance system for employees and their dependents, in which the premiums are generally paid by an equal basis between employer and employee. Nearly 8.2% of the monthly wage of an employer by automatically deducted from their payment for the purpose of social security.

However, contributions are not far less than the biannual bonus, which typically total a third of the employee's annual income, premiums amount to only 2.7 percent of the average employer's total income under all the employee health insurance plans, an insured person musts in addition to contributing to the premium, pay 10 percent of the cost of the medical care he or she used. An employee's dependents fact a cost-sharing which are usually of 20 percent for in-patient care and 30 percent for outpatient care (10, 12 and 13).

Second one is the insurance system for the self-employed, pensioners and their dependents. The unemployed elderly should be covered in this system or their low income makes them eligible for coverage by their dependents. Premiums are calculated on this basis of income, the number of individuals in the insured household, and assets. This category can be divided into the community based ordinary National Health Insurance (NHI) in which the municipal government acts as insure and the NHI associations which insure members in the same occupation, such as carpenters or barges. Under this system, the co-payment rate is 30 percent for both in-patient and out patient care (10, 12 and 13).

Primary medical care and physician's services

The basic organization and structure of this aspect of health service is differences in meaning between Japan and Taiwan. The differences are described as following:

1. Clinic: in Japan generally a qualified clinic can be without or with beds. The qualified hospital needs to own 20 beds at least.
2. Health center: it's a building owned by the Prefecture or Designated City Government in which first care and guidance in health, sanitation, health education and prevention medicine is available.

Usually, Japanese first time contact with a doctor is carried out in three different ways: (3, 7)

- Private clinics with or without beds run by a doctor with some specialist training, most commonly are physicians or pediatricians. There are a few government owned clinics.
- Out-patient department of a hospital
- Health centers staff who can be a public health doctor or a part-time clinic doctor.

In addition, the private practitioners are always important in Japan medical system. Private doctors are significantly effective in this system even though Japan's network of health insurance plans have led to a form of socialized medical care. The most part of care in Japan is provided both private clinics and hospital. There are some 9400 hospitals in Japan and about 27,000 clinics with fewer than 19 beds. Any facility with 20 or more beds is considered a hospital.

Japanese practicing physicians are paid a fee-for-service basis, with all prices fixed by nationally uniform, itemized and minutely different schedule, known as the point-fee system. Each medical service is assigned a certain number of points, and each point is worth 10 yen. The assigned points are based on the degree of technical skill required to provide a particular service or consultation and the cost of material, such as drugs, laboratory tests and injections.

The fees established for particular service or procedure are common throughout the system. No matter how skilled a physician is at rendering a particular service or how prestigious the hospital in which it is performed, the same fee is paid to all providers for the same service.

Physicians must accept as payment in full the fees that are allowed by the ministry's schedule. But there is another important dimension to physician remuneration that

is largely unknown is the United States and other Western countries. Physicians often receive small or large sums of money and other gifts from patients as expressions of gratitude. This is a long standing and acceptable practice. However, there is no documentation of how much these presumably tax-free gifts add to physicians' incomes. No one includes them in estimates of Japan medical expenditures.

The problems of Japanese Health system

According to medical reports, Japan health care system seems to have achieved success. The gross health index is the best in the world, for example, the infant mortality rate is 0.46% of live births and the life expectancy at birth is 75.9 for males and 81.8 for females (1,5). There is universal coverage with virtually unlimited access to all health care facilities by any single citizen. Moreover, because Japanese per capita rates of computer-aided topography (CAT) scans and patients undergoing renal dialysis are among the highest of all nations, they can be seen that might be no overt signs of rationing (7). What makes this record even more impressive is that the ratio of the gross domestic product (GDP) devoted to health care is 6.8%, little more than half the ratio of the United States (2, 7). But no health care system is perfect because infinite demands must always be met with finite resource. Moreover, budget arrangement problems of Japan health system also can be seen by:

Firstly, some problems exist in the average life expectancy is the longest of the world, also 12 percent of the population in Japan is over 65 years. In addition to the question of who should bear the rapidly increasing usage of medical care for elderly people is that who should provide long term care for disable members of the group. The lack of sufficient facilities providing excellent care and severity of disability of many elderly people have weak relationship between older and younger generations. The excessive family burden has led to crises in many families, resulting increased public awareness of the problem.

Secondly, there are limitation to the fee scheduling approach, especially in the areas of prescribing drugs. These areas are a major problem in Japan because most physicians in clinics do their own dispensing and hospital based doctors prescribe from the institution's pharmacy. Although periodic surveys of the market price are made by the government and insurance prices are adjusted accordingly providers continue to make a profit because competition leads to new round of price cutting. The providers have maintained that they need this margin to offset the deficit coming

from low hospitalization fees, this competition has not necessary led to greater efficiency. However, despite the downward trend in price, most pharmaceutical companies have managed to survive successfully by continuously introducing the reason that Japan use of third generation antibiotics is more expensive than anywhere else.

Thirdly, the price is uniform for all providers based on the assumption that their quality is the same. However, patients attempt to go to the university and large public hospitals because of their perceived higher quality of care. As a result there are long queues for ambulatory visits and waiting lists for hospitalization. This situation is difficult to reverse because freedom of choice has been regarded as the principle in the delivery care in Japan. Also clinics and hospitals has basically regarded each other as competitor rather than partners. Therefore, for the system to perform effectively, both of them have to evaluate their function again and cooperate to promote health service.

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