

Session 1

## Power of Community Health in Implementing the Universal Health Insurance System in Japan<sup>\*1</sup>

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(Takemi Fellow 2001-02)

I was in Boston as a Takemi Fellow from 2001 to 2002. Before that, I worked in the Gaza Strip and West Bank for two years and Nepal for five years during the maoist conflict, and so I expected that I would finally be able to do some solid studying in a safe place. However, the 9.11 attack occurred a week after I arrived in Boston. Although danger seems to follow me, I was able to spend a very meaningful year there.

The topic of my talk today is universal health coverage. These days it is one of the hottest topics in global health and it is sometimes abbreviated UHC. The out-of-pocket (OOP) expenditure for health care is considered as a key indicator for UHC and it is extremely high in many developing countries. Reportedly, 150 million people suffer from financial catastrophes and 100 million are pushed into poverty due to OOP payments every year. In some of the South and South East Asian countries, on average, patients were required to pay 35% of the total health care expenditure in 2010. They are currently aiming to reduce this to 15 to 20%. Health care and poverty are closely related and UHC is an extremely important measure to fight poverty.

High healthcare costs can indeed lead to poverty, and this was also a major issue in Japan about 50 years ago. According to the Ministry of Health and Welfare's annual health report, 1.77 million people were on welfare in 1956 and disease or injury was its cause in 64.5% of those welfare cases. In those days, medical care was



also considered an extremely expensive luxury.

Globally, UHC is defined as follows: All people receiving quality health services that meet their needs without exposing them to financial hardship. This is a movement aiming at covering all people in every country with UHC systems and ensuring that paying health costs does not cause economic catastrophes.

Although UHC has been in the spotlight recently, its concept is by no means a new development. Let's look at WHO's movements since the WHO charter of 1948. Notably, the "Health for All" slogan advocated after the Declaration of Alma-Ata in 1978 has continued since then and come into the spotlight now as the realization of UHC. In Japan, a universal health insurance system was already established in 1961, and its successful outcomes, such as equity and reduction of medical costs, have been taken up in different professional journals.

Japan's universal health insurance system was even taken up in a 2011 edition of the Lancet as one of successful UHC cases in the world. Looking back at the chronology of UHC in Japan from 1922 to 1961, however, progress has been made by trials and errors than a series of

<sup>\*1</sup> This article is a revised transcript of the presentation delivered by the author at the Takemi Program 30th Anniversary Symposium, which was held at the JMA Auditorium, Tokyo, on November 23, 2013.


Due to space limitations, not all of the slides shown in the original presentation appear in this article.

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(Slide 1)

**In Japan**

### Challenges after UHC was started



- ◆ **No medical doctor area was not reduced**
  - Enlarged under-population areas
  - Doctors favored to go to urban area
  - People must pay for insurance but cannot find doctors
- ◆ **Tail chasing of emergency patients**
  - Specialists were not enough
  - 34,000 such cases in 1975

Shinmura T, The era of UHC in Japan, Hosei Univ Press, 2011

(Slide 2)

**From community**

### Now its time for community health

(Sugiyama A Japan Welfare Univ. Paper 114, Mar 2006)

- ◆ 1957: National Health Insurance System Revised
  - Levying of the health care cost at the time of the visit at the facilities.
- ◆ Until 1957
  - the municipal offices of Yachiho Village paid the health care facilities the incurred cost of health care until the patients paid back when they had sufficient income to do so.
  - Villagers were able to take advantage of available health care and protect their own finances.
  - The new system may decrease the number of visits by the patients, possibly resulting in delaying of diagnosis and worsening of symptoms.

**Go against the new system ! ( 1year lasted )  
Yachiho Village in Nagano (Now Sakuho v)**

evidence-based policies. Interestingly, when we focus this period of approximately 40 years from 1922, we can see that the phrase “global health” hardly appears in the scientific literature. It was not completely absent, but it certainly was not used very frequently. Also, it was not the case that Japan was initially thinking about its contribution to the rest of world when UHC was developed in Japan; it worked single-mindedly to create the system for the Japanese citizens. Yet today it is attracting attention as having global significance. Yesterday it was suggested that community health and global health are two sides of the same coin. The tireless journey taken locally for the Japanese people is globally applicable now, and the prime example is Japan’s universal health insurance system.

As UHC began to spread within Japan, there were some undesirable findings. For example, some areas continued to have no medical doctor available, and tail chasing of emergency patients took place where specialist doctors were not available (Slide 1). This was because invisible problems became visible as the nationwide system was put into practice. Problems lurking in every corner came into sight as the system was developed and then put into practice. How should we tackle this? The introduction of the UHC was highly appreciated, but it was no easy matter to make it work. This situation is similar to the Takemi Program, which faced a variety of trials after it had started, and the same went for Japan’s UHC.

To overcome such undesirable findings, the roles of community health should be more

emphasized. Let me show you an example of community actions which took place during the process of establishing the UHC in rural Japan. In 1957, the UHC was still incomplete and a new system was about to start to increase fund for its implementation. The aim of this system was to make a national policy to collect the medical expense at the time of a visit to a medical facility.

However, Yachiho Village (now Sakuho Village) in Nagano Prefecture in central Japan strongly opposed this new policy. Before, the municipal office of the village used to pay medical cost to a medical facility on behalf of patients, who would then pay back the costs when they had sufficient cash to do so. This enabled villagers to go to medical institutions when necessary without worry. But, if the medical expense were to be collected at the time of visit, the municipal office would not be able to pay expenses on patients’ behalf. In that case, villagers might not go to medical institutions unless they had an irreversibly serious illness. By having anxiety about such a possibility, Yachiho Village waged a yearlong opposition campaign (Slide 2).


However, resistance was not kept up long, and they were obliged to change their thinking (Slide 3). If the villagers thought, the collection of the medical expense was too difficult at the time of a visit, then they would try to avoid people getting sick. Thus they launched a health promotion campaign. First of all, they introduced health handbooks and health registers. The idea of using health register was used based on their

(Slide 3)

**From community**

**New way of thinking!**

- ◆ **Let's not make patients !**
  - Health promotion·disease
  - Prevention/early detection
  - Knowledge and awareness raising by performance
- ◆ **Health notebook·health handbook**
  - It used to be used for animals, but now for humans!



**1983 : This idea was introduced to a Japan's ageing health law**

(Slide 4)

**In Japan**

**Psychological tasks of the universal health insurance system of Japan**

- ◆ **Lowering of volition for self-management of health**
  - Mental disposition to easily visit hospitals/clinics, leaving his/her own health in the hand of specialists
  - Steep rise in the national healthcare expenditure  
(Shimamura T. The era of UHC in Japan, Hosei Univ Press, 2011: p.55)
- ◆ **Patients are too accustomed to convenience**
  - Sudden increase in the number of emergency patient transports
  - All residents: 3.24 million (1996) → 4.89 million (2006)
  - 65 ≥ years of age: 1.06 million (1996) → 2.20 million (2006)  
(Yamaoka J The UHC is in Danger, Heibonsha, 2011: p. 35)

**UHC Crisis**

experience of using livestock registers. At that time the village had many livestock, and a good system had been developed for checking the health of livestock, since the death of farm animals meant financial problems. And so the idea was to apply these registers for people to avoid people getting sick. This concept is not limited to Japan. When I met a specialist fighting polio in western Africa I heard that there are ethnic minorities who were hesitant to receive vaccination; however, similar to Yachiho Village, the ethnic minorities were vaccinating and managing the health of their livestock. With this information in hand, the medical personnel could say, "If you vaccinate your animals, you should also vaccinate your children." With this argument, the vaccination program went well.

After these health promotion activities, Yachiho Village could drastically reduce its healthcare costs. Data show that the village saved 200,000 yen per senior citizen in healthcare costs, or 200 million yen for a population of 1,000, as the outcome of 50 years of effort. Their community health programs also had a major impact on national policy.

It was Saku Central Hospital that supported these efforts. I am sure that most of you know about Saku Central Hospital, I would like to emphasize the efforts they made through theater and movies. Such art-based approaches created a rapport with the people and were extremely beneficial in practicing community health activities. The inspiration for these efforts came from the ideas of Kenji Miyazawa, an early twentieth-century poet and modernist. Accord-


ing to Miyazawa, one of keys to successful cultural activities in a rural community is to perform drama as an actor. Inspired by these words, Dr. Shunichi Wakatsuki, director of Saku Central Hospital, started theatrical activities and movies. Such activities are not limited to Japan; similar efforts have been made in other countries such as the UK, Australia, and South Africa. The importance of the arts in community health is suggested in a book entitled *Arts Development in Community Health: A Social Tonic*. In this way, the efforts undertaken by Dr. Wakatsuki have been similarly implemented in the world, not just in Japan.

Now let's turn our attention to the present. Japan's UHC has been maintained comparatively well thus far. Nevertheless, there are problems, such as the aging of the population. Figuring out how to resolve these problems has become a major issue. Several researchers have pointed out the psychological challenges brought about by this system. They wonder whether the spread of this system has caused a decline in awareness of the need to manage one's own health by oneself. People have come to perceive that they can leave their health issues to specialists, since health services are easily accessible. And the researchers question whether such an attitude has caused the rapid rise in the national healthcare expenditure. For example, ambulance transport has increased enormously as more and more patients become too accustomed to convenience. The number of patients who used an ambulance increased from 3.24 million in 1996 to 4.89 million in 2006. Meanwhile, patients

(Slide 5)

From community to the world

## Finally: UHC by All



◆ Who are players to achieve UHC?

- Not only health finance specialists
- Community people, local government, doctors, nurses, public health nurses, health volunteers...

Old pictures are taken from 'Health volunteer stories' [http://www.sakuhp.or.jp/yachiho/sidouin\\_back/sidouin100/sidouin16.htm](http://www.sakuhp.or.jp/yachiho/sidouin_back/sidouin100/sidouin16.htm)

aged 65 and older more than doubled, from 1.06 million to 2.20 million. Thus, the reasoning goes, soaring healthcare costs are associated with the patients who are overly accustomed to convenience. And so the challenge now is to figure out what can be done in community health to counter this trend (Slide 4).

Put another way: a community research specialist, John L. Mcknight, said this. "As the power of a system, such as Japan's UHC, grows, the power of community declines. As control magnifies, consent fades. As standardization is implemented, creativity disappears. As consumers and clients multiply, citizens lose power. To build a healthy society, we need two tools: a system and a community." It is important to strengthen systems. But, unless communities

become just as strong, a balanced society will not be created. A book has come out in Japan that addresses those kinds of questions. An English translation of the title would be something like *Toward a Society with Community Health*. It is a very useful book, and it introduces many examples of community health activities in Japan.

For example, in Kochi Prefecture there is something called "lively 100-year-old exercise." The other day I went to Ghana, where people were doing *yosakoi dance*, an energetic form of traditional Japanese dancing. Perhaps people will start doing lively 100-year-old exercise in Ghana, Thailand, and other places to get healthy. It really is a great community health action. This is something worth disseminating to the rest of the world. In that sense, it is becoming increasingly certain that community health and global health are two sides of the same coin nowadays.

Systems are important. But, it is the power of everyone together that brings a system into fruition. At the beginning of my talk, I mentioned the phrase "Health for All." Now, the important message is not "Universal Health Coverage for All" but rather "Universal Health Coverage by All" (Slide 5). Community health has a very big role to play toward that end. The members of prefectural medical associations involved in the realization of community health will make a big mark in the future. I hope that you will all do your best with the thought that someday what you are doing now will be accepted throughout the world.

### Comment



Akira AKAGAMI<sup>2</sup>

Dr. Jimba's talk noted the need for both top-down and bottom-up policy approaches when

establishing a community health and medical system in developing countries. He used the example of initiatives by Yachiho Village in Nagano Prefecture during the creation of Japan's universal health insurance system to highlight the importance of the role of bottom-up approaches. I felt that the talk was very instructive, considering the various problems faced by the current universal health insurance system.

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Within the social milieu in Japan, which has a rapidly graying population with a declining birth rate, an important role of community health will be to establish comprehensive community-care systems appropriate to the special characteristics of each community.

I would like to take this opportunity to introduce initiatives of local medical associations in regards to 1) emergency geriatric care and 2) 24-hour at-home care systems.

1) Emergency geriatric care: I live in the Hachioji City in Tokyo. Emergency transport of elderly patients has been increasing with the aging of the population. Dr. Jimba mentioned that patients are sometimes refused because of lack of space at medical institutions, and it is becoming increasingly difficult to find hospitals to transport patients to. In Hachioji, the Hachioji Geriatric Emergency Medical System Network was launched and an Emergency Medical Information Form (Fig. 1) created as a measure to establish a reliable and safe emergency transport system to handle the emergency requests of senior citizens. The participating institutions are emergency hospitals, psychiatric hospitals, geriatric facilities, nursing care companies, the fire department, Hachioji City, and the medical association. The special feature of this Emergency Medical Information Form is that it includes, in addition to the general medical information, check boxes for items that the patient would like to communicate to the doctor just in case, such as: "I want lifesaving and life-support measures taken as much as possible," "I want measures taken if they will ease pain," and "I want to be watched over in as natural a condition as possible." This form is for senior citizens aged 65 and older, and I think that it is important for older persons to talk in advance with their families about the kind of end-of-life care they would like to have.

2) 24-hour at-home care systems: Last year the Tokyo Metropolitan Government commissioned the Tokyo Medical Association to create an at-home mutual assistance system. The Hachioji Medical Association took over this project and is studying the establishment of an at-home care

system to assist member physicians.

With respect to at-home care, many physicians tend to be hesitant about home visit care for reasons such as they are too busy with outpatients to do home visit care or that it is difficult to respond on weekends, at night, or while traveling. So, we are considering three-way cooperation among primary care physicians, visiting nursing stations, and enhanced at-home assistance clinics.

The first step is to set up visits from a 24-hour visiting nursing station to the patient who will receive at-home care. This puts medical information such as visit instructions and visit nursing records in the station. The second step (Fig. 3) is to have a system for handling emergency house call requests at times when the patient's primary care doctor is not working, such as on days off, at night, or while traveling. As the first call, the visiting nursing station contacts the primary care doctor. If the primary care doctor cannot respond, a second call is made, this time to an enhanced at-home assistance clinic (on a rotating system), and the assistance clinic on duty will respond. The progress is then reported to the primary care doctor the following day. Future challenges will be to deepen cooperation between the government and logistical support hospitals, to develop safe IT for sharing information, and to conduct publicity so that more doctors can participate in at-home care.

Lastly, Figure 4 shows the medical association perspective for establishing comprehensive community-care systems. President Nonaka of the Tokyo Medical Association prepared this figure. The Tokyo Medical Association has expressed its active support for the creation of a medical provision system and comprehensive community care through the cooperation of local medical associations and multi-occupation organizations, for the benefit of people who live in the community. The elevation of bottom-up policies is critical for medical initiatives from the perspective of residents, from local medical associations to the Tokyo Medical Association and then up to the Japan Medical Association: the local medical associations can play such important roles.