consumption among the Japanese adult population (Joossens and Raw 2006; Schumann et al. 2006).

The prevalence of smoking dropped almost 50% in Japan since 1980. Around 21% of adults in Japan now smoke daily, down from over 42% in 1980. Japanese men smoke more than four times as much daily compared to women. Effective policies for tobacco control are needed in Japan in the light of tobacco control ordinances consistent with the Framework Convention on Tobacco Control (Shibuya et al. 2003).

There were approximately 1,000,000 births in Japan in 2010. Of these 9.6% were low birth weight, a trend which has been increasing over the past decades. Since the 1970s Japan has enjoyed low mortality rates for both mothers and their children. Infant mortality reached a new low in 2013 with 2.1 deaths per 1000 live births. This decrease was mirrored in all measures, including neonatal, perinatal, and under-five mortality rates. Likewise the maternal mortality ratio (risk associated with each pregnancy) more than halved between 1990 and 2013.

Table 10 summarizes maternal, child and adolescent health indicators in Japan. Adolescent fertility rates have risen slowly over recent decades and have increased from four births per 1000 women to 5.4 per 1000, which is very low globally. Immunization rates in Japan are high and comprehensive coverage has been achieved for some years now, with the exception of measles where coverage fell to 73% in the 1990s due to fears surrounding the MMR vaccine. This drop proved to be temporary and as of 2013, 95% of children aged 12 to 23 months were immunized.

D 結論

In the past five decades, Japan has achieved many noticeable successes including the full implementation of sustainable universal health coverage, gaining the highest healthy life expectancy in the world and the eradication or control of common infectious diseases. In addition, tobacco and alcohol consumption and transport accident deaths decreased substantially in the past 50 years. Because of these achievements, the country is facing

many challenges including negative population growth with low fertility rate, an ageing population, shrinking economy, increasing unemployment rate, and increasing NCD-related disease burden. Many NCDs are preventable, since they are linked to modifiable lifestyles and dietary patterns. It is clear from the literature that people who do not smoke, abstain from or are moderate alcohol drinkers, are physically active, eat a healthy diet, and who are not overweight or obese are less likely to die or encounter disability in early life compared to those who have unhealthy habits. Therefore, further attention to implementing effective policies on the health agenda is needed in order to reduce the disease burden and prevent or reverse a declining population growth rate. To prepare for a future of low birth rates, population ageing and slow economic growth, Japan also needs to reform its universal health coverage system and reorient its health system towards managing the health problems that have arisen from its demographic transition.

E. 健康危険情報

なし

F. 研究発表

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G. 知的所有権の取得状況の出願・登録状況

　1.特許取得
　　なし
　2.実用新案登録
　　なし
　3.その他

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表 1　　Trends in population/demographic indicators, selected years

Indicators	1980	1990	2000	2010	2013
Population (in thousands) [a]	117060	123611	126926	128057	127298
Female (% of total) [a]	50.8	50.9	51.1	51.3	51.4
Population (% of total) [a,b]					
0–14 years	23.5	18.2	14.6	13.2	12.9
65 years and older	9.1	12.1	17.4	23.0	25.1
80 years and older	0.5	0.9	1.7	3.0	3.6
Annual population growth rate (%) [a]	0.90	0.42	0.21	0.05	-0.17
Population density (per sq. km) [a]	314	332	340	343	341
Mean age at first child [a]	26.4	27.0	28.0	29.9	30.4
Mean age at first marriage [a]					
Male	27.8	28.4	28.8	30.5	30.9
Female	25.5	25.9	27.0	28.8	29.3
Total fertility rate (per woman) [a]	1.75	1.54	1.36	1.39	1.43
Crude birth rate (per 1000 population) [a]	13.6	10.0	9.5	8.5	8.2
Crude death rate (per 1000 population) [a]	6.2	6.7	7.7	9.5	10.1
Age dependency ratio*	48.4	43.5	46.9	56.8	61.1
Rural population (%) [b]	23.8	22.7	21.3	9.5	7.5

Sources:　[a]MHLW(Ministry of Health 2015b), [b]World Bank(The World Bank)

*Age-dependency ratio is the ratio of population (0-14 and 65+)/15-64

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表 2 Macroeconomic indicators, selected years

Total population	1980	1990	2000	2010	2013
GDP (¥B)[a]	246465	449392	509860	482384	480128
GDP (2005, US$)[a]	2448	3851	4308	4648	4785
GDP per capita (¥)[a]	2110467	3637713	4018759	3784878	3770482
GDP per capita, PPP (US$)[a]	-	19249	25931	33916	36449
GDP average annual growth rate (%)[a]	2.8	5.6	2.3	4.6	1.6
Health expenditure, total (% of GDP)[b]	-	-	7.6	9.6	10.1
Value added in industry (% of GDP)[a]	39.1	38.0	31.1	27.5	-
Value added in agriculture (% of GDP)[a]	3.1	2.1	1.6	1.2	-
Value added in services (% of GDP)[a]	57.9	59.8	67.3	71.3	-
Labour force (total)[a]	-	63776260	67589249	66420609	65545688
Unemployment, total (% of labour force)[a]	2.0	2.1	4.8	5.0	-
Real interest rate[a]	2.8	4.5	3.4	3.8	1.9
Gini coefficient[c*]	0.315	0.358	0.379	0.377	-

Source: [a]World Bank,(The World Bank) [b]WHO,(World Health Organization (WHO) 2015) [c]OECD(OECD 2014)

Note: *The Gini coefficient is a measure of income inequality, higher figures indicate greater inequality among the population (estimated based on gross income).

¥, yen;   ¥B, billion ¥; ppp, purchasing per capita

表3　Life expectancy at birth and health indicators by gender, selected years

Indicators	1980	1990	2000	2010	2012
Life expectancy at birth[a]					
Male	73.3	75.9	77.7	79.5	79.9
Female	78.8	81.9	84.6	86.3	86.4
Healthy life expectancy at birth[b,c]					
Male	-	66.6	71.0	68.8	72.0
Female	-	70.0	76.0	71.7	77.0
Total death rate[a]					
Male	6.8	7.4	8.6	10.3	10.7
Female	5.6	6.0	6.8	8.7	9.3
Age-adjusted death rate[a]					
Male	9.2	7.5	6.3	5.4	5.2
Female	5.8	4.2	3.2	2.7	2.7

Sources: [a]MHLW,(Ministry of Health 2015a) [b]Salomon *et al.* 2012,(Salomon et al. 2012) [c]WHO(World Health Organization

(WHO) 2014). Note: Both death rates presented as per 1000 population

表4　Life expectancy (years), selected OECD countries, selected years

Life expectancy (years)	Year				
	1980	1990	2000	2010	2012
Selected OECD countries					
Canada	75.3	77.6	81.7	83.4	-
Finland	73.6	75	81.2	83.5	83.7
France	74.3	76.9	83	85.3	85.4
Germany	72.9	75.3	81.2	83.0	83.3
Greece	74.5	77.1	80.9	83.3	83.4
Italy	74.0	77.1	82.8	84.7	84.8
Japan	**76.1**	**78.9**	**84.6**	**86.3**	**86.4**
Korea	65.9	71.4	79.6	84.1	84.6
Mexico	-	-	76.1	77.0	77.3
United Kingdom	73.2	75.7	80.3	82.6	82.8
United States	73.7	75.3	79.3	81.0	-

Source: OECD(OECD 2014)

表5　　Main causes of death, selected years

Causes of death (ICD-10 classification)	Number (rate per 100 000 population)				
	1980	1990	2000	2010	2012
Communicable diseases	-	85902 (69.9)	120085 (95.7)	161162 (128.1)	
Tuberculosis	6439 (5.5)	3664 (3.0)	2656 (2.1)	2129 (1.7)	2714 (2.2)
HIV/AIDS	-	367 (0.3)	167 (0.1)	170 (0.1)	-
Non-communicable diseases	-	674492 (549.2)	811944 (647.1)	1024850 (814.5)	-
Circulatory diseases	308462 (265.2)	303061 (246.9)	298338 (237.5)	341882 (270.5)	350912 (278.6)
Malignant neoplasms	161764 (139.1)	217413 (177.2)	295484 (235.2)	353499 (279.7)	360963 (286.6)
Colon cancer	7932 (6.8)	15509 (12.6)	23637 (18.8)	30040 (23.8)	32177 (25.5)
Cancer of larynx, trachea, bronchus and lung	21294 (18.3)	36486 (29.7)	54770 (43.6)	70815 (56.0)	72471 (57.6)
Breast cancer	4141 (7.0)	5848 (9.4)	9171 (14.3)	12455 (19.2)	12529 (19.4)
Cervical cancer	1745 (3.0)	1875 (3.0)	2393 (3.7)	2664 (4.1)	2712 (4.2)
Diabetes	8504 (7.3)	9470 (7.7)	12303 (9.8)	14422 (11.4)	14486 (11.5)
Mental and behavioural disorders	3017 (2.6)	3068 (2.5)	3920 (3.1)	8049 (6.4)	10768 (8.5)
Ischaemic heart diseases	48347 (41.6)	48804 (41.9)	70183 (55.8)	77217 (61.1)	77579 (61.6)
Cerebrovascular diseases	162317 (139.5)	121944 (99.4)	132529 (105.5)	123461 (97.7)	121602 (96.5)
Chronic respiratory diseases	48466 (41.6)	84910 (69.3)	134501 (107.1)	187609 (148.4)	201798 (160.2)
Digestive diseases	29606 (25.5)	27264 (22.3)	38268 (30.5)	45503 (36.0)	47255 (37.5)
Transport accidents	13302 (11.4)	15828 (12.9)	12857 (10.2)	7222 (5.7)	6414 (5.1)
Suicide	20542 (17.7)	20088 (16.4)	30251 (24.1)	29554 (23.4)	26433 (21.0)

Sources: MHLW(Ministry of Health 2015a) and GBD database

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表 6 Disability adjusted life years (DALYs) by major diseases categories during 1990 to 2010

Characteristics	All ages DALYs	DALYs per 100,000	% of total DALYs
All diseases or injuries			**100**
1990	27812800	22647.1	100
2000	29990700	23900.2	100
2010	31231200	24821.3	100
Non-communicable diseases			
1990	22867400	18620.2	82.2
2000	24732800	19710.1	82.5
2010	26071600	20720.8	83.5
Communicable, maternal, neonatal, and nutritional disorders			
1990	2006120	1633.5	7.2
2000	2110450	1681.9	7.0
2010	2143830	1703.8	6.9
Injuries			
1990	2939220	2393.3	10.6
2000	3144150	2505.6	10.5
2010	3015670	2396.7	9.7

Sources: GBD database

表 7 Prevalence of diabetes and hypertension in adults, Japan, selected years

Health conditions	Percentage			
	1980	1990	2000	2010
Standardized diabetes (ages ≥ 20 years)				
Male	3.8	9.3	9.5	9.7
Female	3.3	6.6	6.3	6.1
Both sexes	-	7.9	7.8	7.9
Hypertension (ages ≥ 35-84 years)				
Male	50.1	51.7	41.4	57.6
Female	43.3	46.8	31.9	42.2
Age-standardized (both sexes)	48.2	45.5	39.7	48.5

Sources: Diabetes: Danaei *et al.* 2011(Danaei et al. 2011), Charvat *et al.* 2015(Charvat et al. 2015) and hypertension:

Ikeda *et al.* 2014, Kearney *et al.* 2004, Miura *et al.* 2013,(Miura et al. 2013b) Martiniuk *et al.* 2007(Martiniuk et al.

2007)   Note: Author's estimated prevalence of hypertension for 1990 using meta-analysis from Miura et al.

2013(Miura et al. 2013b) data

表 8　　　Body mass index in adult ages 20 years and older, Japan, selected years

High body mass index	Percentage				
	1980	1990	2000	2010	2013
Overweight or obesity					
Male	18.0	21.5	26.1	29.3	28.9
Female	19.4	18.5	18.0	20.7	17.6
Obesity					
Male	1.5	1.8	3.0	3.6	4.5
Female	2.5	2.4	3.1	3.2	3.3

Sources: Ng *et al*. 2014(Ng et al. 2014).　Note: Cut-off point for overweight or obesity≥25 kg/m^2 and obesity≥30 kg/m^2.

表 9　　　Proportion of Japanese adults who are daily smokers, 1980-2010

| Risk factors	Percentage			
	1980	1990	2000	2010
Smoking (ages ≥ 15 who are daily smokers)				
Male	70.2	53.1	47.4	32.2
Female	14.3	9.7	11.5	8.4
Both sexes	42.3	28.5	27.0	21.5

Sources: OECD(OECD/WHO and DOI: 2014)

表１０　Maternal, child and adolescent health indicators, selected years

Selected health indicator	1980	1990	2000	2010	2012	2013
Adolescent fertility rate	4.0	4.0	5.2	5.3	5.4	-
Perinatal mortality[b]	11.7	5.7	3.8	2.9	2.7	-
Neonatal mortality rate[b]	-	2.5	1.7	1.2	1.1	1.0
Infant mortality rate[c]	7.5	4.6	3.2	2.3	2.2	2.1
Under-five mortality rate[b]	9.9	6.3	4.5	3.2	3.0	2.9
Maternal mortality ratio[bd]	-	14.2	10.0	6.0	-	6.1
Measles immunization[b]	69.0	73.0	96.0	94.0	96.0	95.0
Low-birth weight babies (% of live births)	5.2	6.3	8.6	9.6	-	-

Sources:　[b]World Bank; [b,c]MHLW(Ministry of Health 2015a, b); [d]Kassebaum *et al.* 2014; [e]OECD(OECD/WHO and DOI: 2014)
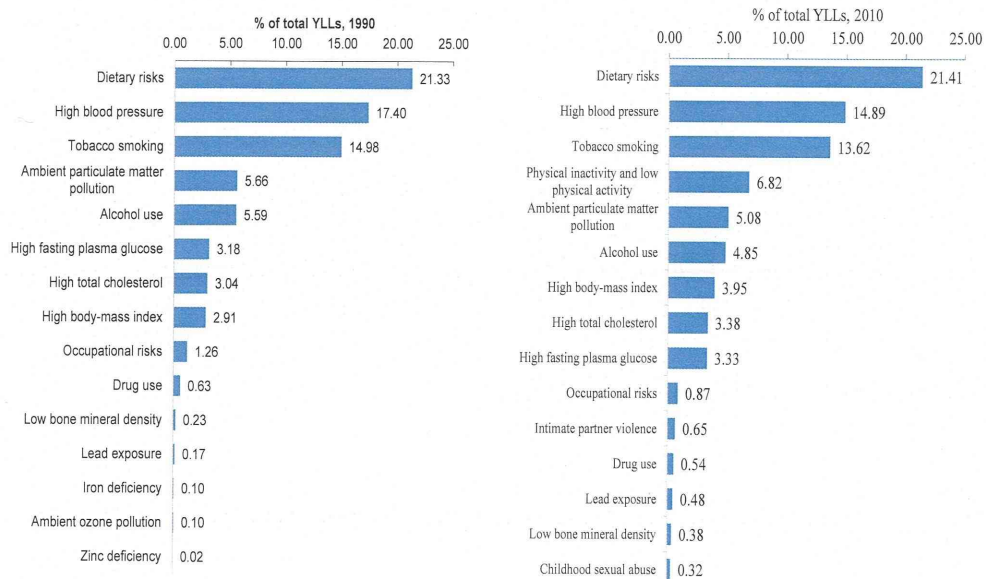
Note: Adolescent fertility rate birth per 1000 women ages 15-19; mortality represents per 1000 live births; measles immunization

for % of children ages 12-23 months
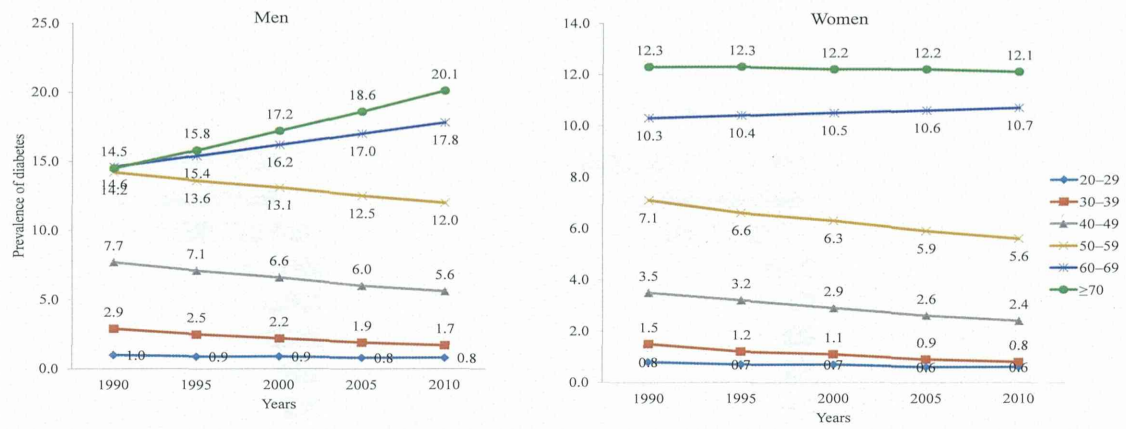
図 1   Population pyramid in Japan
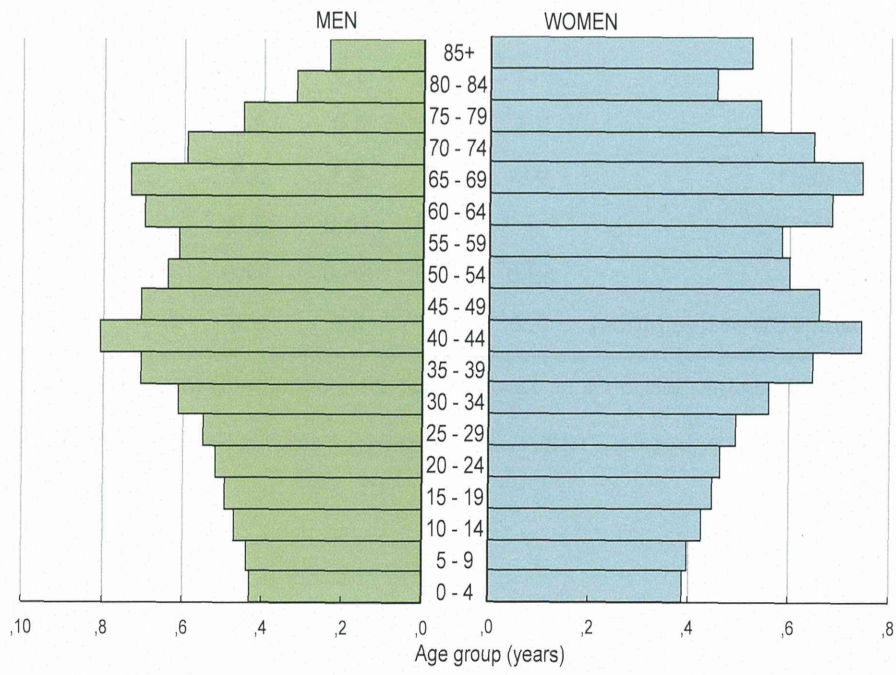
Sources: Ministry of Health, Labour and Welfare(MHLW) (Ministry of Health 2015b)

図 2　　　Top 15 leading risks for years of life lost (YLLs) in Japan

% of total YLLs, 1990

Risk	%
Dietary risks	21.33
High blood pressure	17.40
Tobacco smoking	14.98
Ambient particulate matter pollution	5.66
Alcohol use	5.59
High fasting plasma glucose	3.18
High total cholesterol	3.04
High body-mass index	2.91
Occupational risks	1.26
Drug use	0.63
Low bone mineral density	0.23
Lead exposure	0.17
Iron deficiency	0.10
Ambient ozone pollution	0.10
Zinc deficiency	0.02

% of total YLLs, 2010

Risk	%
Dietary risks	21.41
High blood pressure	14.89
Tobacco smoking	13.62
Physical inactivity and low physical activity	6.82
Ambient particulate matter pollution	5.08
Alcohol use	4.85
High body-mass index	3.95
High total cholesterol	3.38
High fasting plasma glucose	3.33
Occupational risks	0.87
Intimate partner violence	0.65
Drug use	0.54
Lead exposure	0.48
Low bone mineral density	0.38
Childhood sexual abuse	0.32

Sources: GBD database

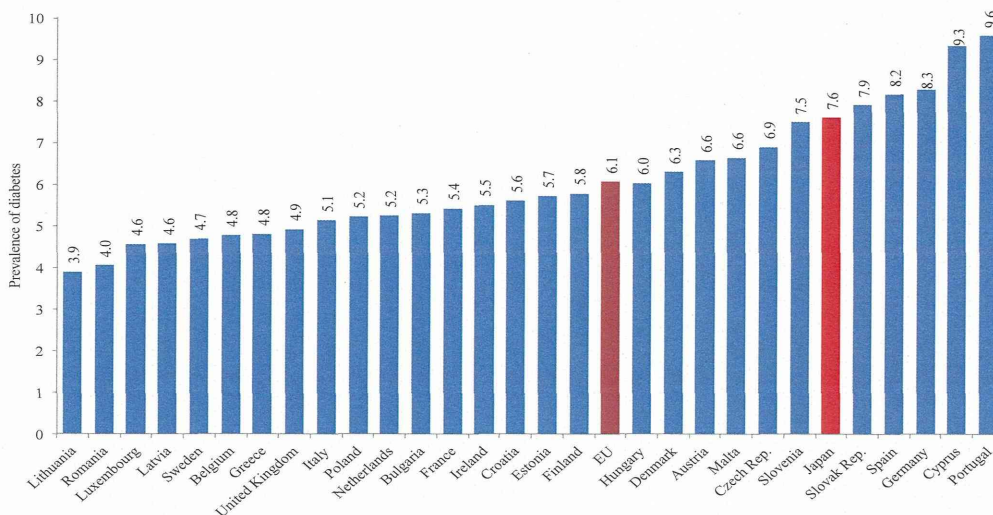図 3   Age and sex-specific prevalence of diabetes in Japan during 1990-2010

Sources: Charvat *et al.* 2015(Charvat et al. 2015)

図 4   Age and sex-specific prevalence of hypertension in Japan during 1980-2010
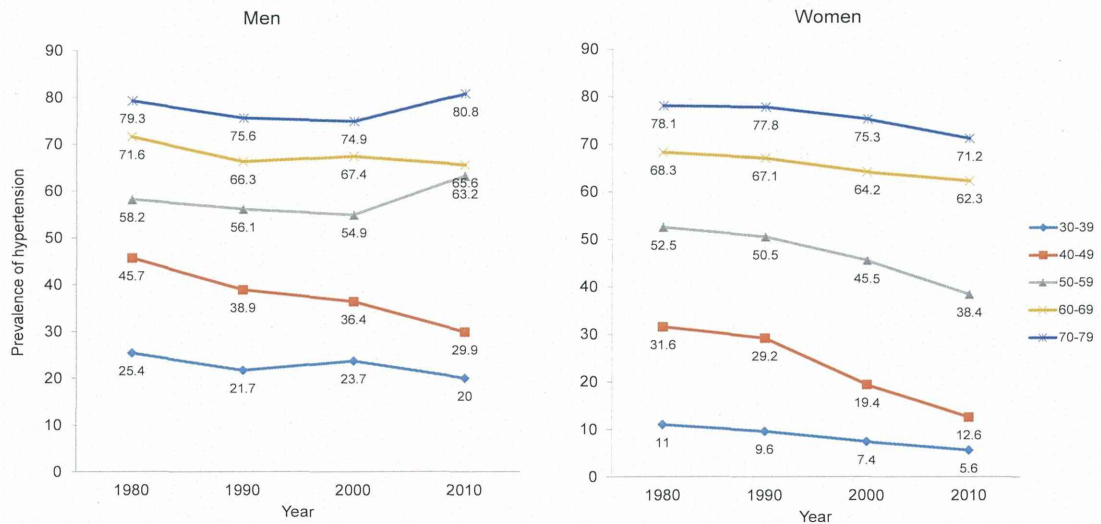
Sources: Miura *et al.* 2013(Miura et al. 2013b)

図 5   Prevalence estimates of diabetes, adults aged 20-79 years, 2013

Sources: OECD 2014(OECD/WHO and DOI: 2014); IDF 2014; Note: Used diabetes prevalence for Japan in 2014

平成 26 年度厚生労働科学研究費補助金（地球規模保健課題推進研究事業）

「エビデンスに基づく日本の保健医療制度の実証的分析」（H26-地球規模-一般-001）

平成２６年度分担研究報告書

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Japan health system financing: a systematic assessment

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研究要旨
Health financing is a core component of health system function and can have significant effects on health care utilization decisions. Understanding the effect of health financing and the different kinds of financing system available during the implementation of health system reforms is essential to effective and sustainable UHC. Total expenditure on health accounted for 10% of GDP in Japan in 2013, one percentage point above the OECD average of 9%. The health insurance coverage rate was nearly 100% in Japan, and the share of household consumption spent on OOP payments was only 2%, which is less than the OECD average (3%). Reforms to the financing system and greater efficiencies will be necessary to maintain a low-cost, equitable health system in the future.

A. 研究目的

Health financing is a core component of health system function and can have significant effects on health care utilization decisions. As national health systems move to universal health coverage (UHC), decisions about financing mechanisms can exert considerable influence on the structure of the overall health system and its ability to ensure UHC goals such as equity, access, coverage and quality. Understanding the effect of health financing and the different kinds of financing system available during the implementation of health system reforms is essential to effective and sustainable UHC. This report describes Japan's health financing system, how it has changed over time, and the future challenges it faces.

B. 研究方法

We used published national and international data sources to assess health financing in Japan. The available literature includes published papers, health financing-related reports and databases published by the Ministry of Health, Labour and Welfare (MHLW). International data sources mainly include World Health Organization (WHO) and OECD libraries. Using this data we conducted a short analysis of health expenditure patterns since 1995 and then presented sources of health care expenditure. We also describe how decisions are made on the allocation of resources between types of health care, the relationship between purchasing and purchaser and payment mechanisms.

C. 研究成績及び考察

C-1   Sources of financing

The Japanese health care system is primarily funded through taxes (Figure 1). Both the central government and municipalities levy proportional income taxes on their respective population. The key sources of financing are an insurance premium (20.2% business operators and 28.4% insured persons), followed by public funds (26% state subsidies and 12.4% local subsidies), co-payments (12%) and others (0.7%). The national subsidy rate for the Japan Health Insurance Association was 16.4% from July 2010 to fiscal year

2014.(Ministry of Health 2014) National medical expenditure was distributed as follows: 37% on inpatient care, 35% outpatient, 7% dental, 17% pharmacy dispensing, 2% hospital meals and living expenses, and 1.5% medical care expenses and others.(Ministry of Health 2013, 2014) Health care expenditure in Japan was almost stable over the last two decades. Table 1 presents the trend of health care expenditure in Japan.

Total expenditure on health as a proportion of GDP slightly increased from 8% in 2005 to 10% in 2013. However, health spending was stable from 1995 to 2005 and 2010 to 2013. In 2013, around 82% of expenditure was from public services and 18% from private services. A similar proportion was observed in the United Kingdom.(Boyle) Public and private expenditure on health as a proportion of total health expenditure have been almost stable since 1995. Government expenditure on health as a proportion of total expenditure increased from 15% in 1995 to 20% in 2013 with a 1% increase in the rate every year. When risk pooling mechanisms are not well designed, direct out-of-pocket (OOP) payments may incur financial catastrophe or push non-poor households into poverty. Many developing and developed countries are facing financial hardship due to high OOP payments. However, the share of OOP payments in total health expenditure in Japan declined from 15% in 2000 to 14% in 2013.

Government spending on health as a percentage of total national health expenditure across OECD countries since 1995 is shown in Table 3.2. The proportion of health expenditure paid by the public sector in Japan in 2013 was comparatively higher than many other high-income countries. Government expenditure as a percentage of total national expenditure ranged from 47% (Canada and Austria) to 85% (Estonia and Netherlands) in 2013. The 2013 OECD median was 76%, relatively lower than Japan.

Table 3 shows healthcare expenditure as a proportion of GDP in selected OECD countries. The 2013 median healthcare expenditure in selected OECD countries as a percentage of GDP was 9%. The total healthcare