

expending as a share of GDP has grown in all countries except Denmark, Finland, and Italy since 1995. In 2013 healthcare expenditure in most European countries accounted for 9-11% of GDP and only a handful of OECD countries like Canada, Germany, and Mexico exceeded 11%. A steady increase in health care expenditure was also noticeable in Japan from 7% of the GDP in 1995 to 9% in 2013.

Given the rapidly aging population, the burden of health care expenditure is expected to grow fast in Japan. Per capita health expenditures in Japan have increased from \$1762.9 in 2000 to \$2356.6 in 2013 (Table 4). Recent per capita health expenditure is below the median OECD countries per capita of \$34045.2. In contrast, in the United Kingdom and the United States of America, per capita expenditure shows decreasing trends from 2010 to 2013. In 2013, the per capita expenditures in these two countries were \$1061.1 and \$1677.6, below Japan's. Among European countries, the per capita health expenditures increased very rapidly in Turkey from \$3810.3 in 1995 to \$9145.8 in 2013. The other OECD

countries, which saw an increase in per capita health expenditures more than \$6000 were Israel, Iceland, and Denmark.

C2 Patterns of health care expenditure

National health care expenditure by types of medical care from 1995 to 2011 is presented in Table 5. Hospital expenditure was substantially higher in inpatient care; however, general clinic expenditure was higher for outpatient health services. The proportion of medical, outpatient, and dental care expenditure has been slightly decreasing since 1995, while pharmaceutical expenditure rapidly increased. In 2011, pharmaceutical expenditure increased more than four times compared to 1995. In recent times, home visit health expenditure also increased substantially compared to 1995-2005.

Age-specific health care expenditure by type of health service is presented in Table 6. Overall, per capita expenditure on health was 278129 million yen, and little difference was observed between inpatient (143754 million yen) and outpatient care

(134376 million yen). Per capita medical expenditure increased rapidly with increased age. The highest medical expenditure for individuals was observed in those aged 65 years or over (159738 million yen) and the lowest in the age of 14 years or less (17544 million yen).

Disease-specific medical care expenditure by major types of health services is shown in Table 7. The three main categories of expenditure were the circulatory system (57926 million yen), neoplasms (36381 million yen), and respiratory system (21707 million yen). Inpatient expenditure was substantially higher compared to outpatient care.

The proportion of people covered by types of risk of pooling mechanisms from 1980 to 2011 is presented in Table 8. The health insurance coverage rate was 100% in Japan. The largest proportion (58%) of the population was covered by employee health insurance, including government-managed health insurance, society-managed health insurance and mutual aid societies. Government-managed health insurance covered a larger proportion of the

population (27%), followed by society-managed health insurance (23%), and mutual Aid Societies (7%). National health insurance covered 30% of the total population.

The trend in national health expenditure by financing sources since 1985 is shown in Table 9. The total proportion of national health expenditure drawn from taxation increased from 32% in 1995 to 38% in 2011; however, insurance premium contributions declined rapidly in this period, from 56% in 1995 to 48% in 2011. The proportion of payment drawn from patient cost sharing fluctuated during this period. The patient cost sharing amount was almost stable from 1985 (12.3%) to 1995 (11.9%), and increased from 2000 (13.4%) to 2005 (14.4%) before returning to levels similar to those seen in 1985. In developing and developed countries where public funding for health services is inadequate and risk pooling mechanisms in health financing are limited or unavailable, unexpected out-of-pocket (OOP) payments and illness-related production or income loss can trigger asset depletion, indebtedness

and reductions in essential consumption, leading sometimes to financial catastrophe. (Chuma et al. 2007; Ezeoke et al. 2012; Huffman et al. 2011; Kabir et al. 2000; Leive and Xu 2008; McIntyre et al. 2006; Russell 2004; Steinhardt et al. 2009) On average 14% of health spending is paid directly by patients in Japan in 2011. The burden of OOP payments across OECD countries is presented in Figure 2. The burden of out-of-pocket health spending can be measured either by as a share of total consumption expenditure or in total household income. On average in OECD countries, the OOP payment as a proportion of total household consumption was around 3%. The average share varied substantially across OECD countries in 2011, from its lowest value in France, the UK, Turkey, and the Netherlands (1.5%) to its highest in Chile, Mexico and Korea (4.6%). In Japan, 2.2% of consumption was spent on OOP health services, slightly lower than the OECD average. The low burden of OOP payments in Japan is due to sustainable health insurance policies with low co-payments and caps on maximum OOP

payment size. (Ministry of Health 2013, 2014)

The share of OOP spending on different health-related goods and services across selected OECD countries is presented in Figure 3. In most OECD countries, curative care and pharmaceutical goods or services are the two most important spending items for OOP payments and account for more than 70% of total health care expenditure. In Japan, Hungary, Iceland, Poland, Estonia, Canada and the Czech Republic, more than 40% of OOP payments are for pharmaceuticals. However, in Belgium, Switzerland, New Zealand, Korea, household payments for curative care account for about 50% or more of total household medical expenditure. OOP payments for pharmaceutical goods or services are substantially higher than curative care in Japan and many other OECDs countries including Hungary, France, Australia, Finland, Iceland, Netherlands, Poland, Estonia, Canada and the Czech Republic. Health expenditure related to dental care also contributes a larger share in household medical spending. On average, OECD countries spend around 19% of OOP

payments on dental care. The highest OOP payments related to dental care were in Spain (30%) and the lowest in Belgium, Hungary, and the Slovak Republic (8%) 2011. Around 12% of OOP payments went to therapy in OECD countries in 2011. In Japan this figure was only 8%

C-3: Payment mechanisms

Reimbursement under Japan's national health insurance (NHI) system uses a contract-based purchaser/provider system. Under this system, providers contract with the government to follow NHI directives on billing and provision of services, in return for payment from the national insurance pool. Practitioners agree to follow best practice rules set by the government in order to be paid under this system, and as a result very few practitioners operate independently from the national scheme. Selective contracting between insurers and providers is strictly regulated and therefore remains uncommon, though legislation was relaxed in May 2003.

All claims made by providers are vetted

and monitored by the government. In instances of fraud or abuse of the system, contracts with medical facilities are voided and individual practitioners may have their licenses revoked. For instance, in 2004 a total of 27 hospitals and clinics, 19 dental clinics and 2 pharmacies had their contracts terminated. (Pinilla et al. 2015)

By enabling the vetting of providers and setting of standardized fees, this contract allows the central government to exert great influence over the entire healthcare system: controlling costs, distributing human resources more evenly across the country, and maintaining equality in health outcomes at levels higher than many other OECD countries.

In 2003 a new system of reimbursement was introduced: Diagnosis Procedure Combination (DPC). In contrast with the traditional fee-for-service system, DPC introduced a scaled per diem payment dependent diagnosis and procedures given. Hospitalization is divided into three stages, with the first being reimbursed at a 15% higher rate which then decreases as length of stay increases up until a cutoff point after

which hospitals may revert to pay-for-service. Another unique feature of DPC is that pricing can vary according to hospital, partly in order to maintain historic levels of reimbursement.

However, the system is limited to hospital charges alone (e.g. accommodation charges, nursing and laboratory costs) whilst doctors' fees, including surgery, consultation, and rehabilitation, are reimbursed under the old retrospective payment model. In recent years the expansion and operation of the system has been limited by shortcomings in hospital information systems.

Despite these issues the DPC system has grown over the years. 360 hospitals were using the system in 2006, whilst in 2005 over 974, 163 inpatients were billed using DPC. Furthermore, hospitals using DPC have shown reductions in average length of stay amongst patients. Okamoto (2005)(WHO) reports that in the three months after the initiation of DPC, 80 out of 82 hospitals experienced shorter average lengths of stay, with reductions increasing the longer the initial pre-DPC average length of stay was.

Reimbursement for medical staff and services is revised every two years through negotiations between state administrators, professional and hospital organizations, insurers, pharmaceutical companies, consumer rights groups, and other related parties. This regular review allows the government to control costs as well as promote specific health policy through the price incentivization of certain treatments. The next review is due to be held in 2016.

To facilitate this process the Central Social Insurance Medical Care Committee conducts economic surveys to provide data for the revision of fees. Findings from June 2005 showed that out of 550 privately owned clinics (run by a practicing doctor as dictated by law) the average turnover in the survey month was 2.27 million yen (approximately US\$20 000 at that time). Dentists were relatively less well reimbursed, with the average monthly salary of 642 dentists being 1.35 million yen.

Payment of staff is set at a uniform rate across Japan, with no distinction made as to whether someone works in a

hospital or a clinic. The incorporation of some hospitals means that many doctors and other staff are paid a salary (and bonus) rather than the direct rate set by the government. Combined with the aforementioned uniform payment systems, there is often a disparity in pay between workers at clinics and hospitals due to higher overheads at the latter.

According to figures for April 2004 from the National Personnel Authority the average monthly salary for hospital doctors was 910,558 yen (derived from 2175 doctors, average age 37.9 years), 338 859 yen for nurses (9813 nurses, average age 34.3 years, and 1.56 million yen for hospital presidents (124 doctors, average age 58.4 years). The difference between nurses' and doctors' pay however is to an extent lessened by end of year bonuses which nurses, but not always doctors, receive.

D 結論

Total expenditure on health accounted for 10% of GDP in Japan in 2013, one percentage point above the OECD average of 9%. In nearly all OECD countries including Japan, the public

sector is the main source of health funding. In 2013, 82% of health spending came from public sources, well above the average of 76% in OECD countries. Direct OOP payments contribute only 12% of total health financing. 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%). Despite this success, the key challenges in Japan are population ageing and rapid increases in chronic illness, which see Japan facing a future of contracting public revenues, pressures on the healthcare workforce, and an increasing burden of social care and long-term treatment payments. Reforms to the financing system and greater efficiencies will be necessary to maintain a low-cost, equitable health system in the future.

E. 健康危険情報

なし

F. 研究発表

1.論文発表

2.学会発表

なし

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 health care expenditure in Japan, 1995-2013

Expenditure	1995	2000	2001	2005	2010	2013
Total health expenditure (% GDP)	7	8	8	8	10	10
Public expenditure on health as % of THE	82	81	81	82	82	82
Private expenditure on health (% of THE)	18	19	19	18	18	18
Government expenditure on health (% of GTE)	15	16	17	18	19	20
OOP payments (% of PHE)	79	80	81	84	81	80
OOP payments (% of THE)	14	15	15	15	14	14

Sources: WHO, 2014(WHO)

Note: GDP, Gross domestic product; THE, total health care expenditure; GTE, Government total expenditure; PHE, private health expenditure

表 2 Government health expenditure as a percentage of total national health expenditure, OECD countries, selected years

Countries	1995	1996	2000	2005	2010	2013
Australia	71	71	70	70	71	70
Austria	33	32	36	38	47	47
Belgium	42	41	47	45	49	52
Canada	45	45	43	44	47	47
Chile	74	73	76	75	75	76
Czech Republic	77	78	75	74	75	76
Denmark	91	91	90	87	84	83
Estonia	83	82	84	84	85	85
Finland	90	88	77	77	79	78
France	72	72	71	74	74	75
Germany	80	80	79	78	78	78
Greece	81	82	80	77	77	77
Hungary	52	53	60	60	67	70
Iceland	84	82	71	70	65	64
Ireland	84	83	81	81	80	80
Israel	73	72	74	76	70	68
Italy	67	69	NA	NA	NA	NA
Japan	73	73	74	78	79	78
Luxembourg	92	93	85	85	86	84
Mexico	71	66	63	65	79	80
Netherlands	84	84	82	84	85	85
New Zealand	73	73	70	69	71	70
Norway	63	65	67	68	69	65
Poland	89	89	89	74	68	70
Portugal	78	76	74	73	74	72
Republic of Korea	72	72	72	71	74	70
Slovakia	87	87	85	81	82	81
Slovenia	54	54	55	59	65	66
Spain	70	69	63	68	79	77
Sweden	84	83	79	81	84	84
Switzerland	66	65	67	67	68	67
Turkey	82	82	81	82	82	82
United Kingdom	77	77	78	80	83	83
United States of America	38	40	49	53	57	53
OECD median	73.5	73	74	74	75	76

Source: WHO, 2014(WHO)

表 3 Health expenditure as a percentage of GDP, OECD countries, selected years

Countries	1995	2000	2005	2010	2013
Australia	9	9	10	11	11
Austria	6	7	7	7	8
Belgium	5	5	6	6	6
Canada	13	13	15	17	17
Chile	10	10	10	11	11
Czech Republic	8	8	10	11	11
Denmark	7	6	7	7	7
Estonia	8	9	10	11	11
Finland	6	5	5	6	6
France	8	7	8	9	9
Germany	10	10	11	12	12
Greece	10	10	11	12	11
Hungary	10	8	10	9	10
Iceland	7	7	8	8	8
Ireland	8	9	9	9	9
Israel	7	6	8	9	9
Italy	7	7	7	7	7
Japan	7	8	9	9	9
Luxembourg	6	7	8	8	7
Mexico	8	8	11	12	13
Netherlands	8	8	9	9	10
New Zealand	5	6	6	7	7
Norway	8	9	10	11	10
Poland	6	5	7	9	8
Portugal	7	8	8	9	9
Republic of Korea	7	7	8	10	9
Slovakia	8	8	9	9	10
Slovenia	9	10	11	11	11
Spain	3	5	5	6	6
Sweden	7	7	8	9	9
Switzerland	7	8	8	9	9
Turkey	7	8	8	10	10
United Kingdom	7	8	8	10	10
United States of America	4	4	6	7	7
OECD median	7	8	8	9	9

Sources: WHO, 2014(WHO)

表 4 National health expenditure per capita (US\$ PPP), OECD countries, selected years

Countries	1995	2000	2005	2010	2013
Australia	492.9	765.1	1288.7	2069.0	2398.4
Austria	1251.1	1613.9	2134.7	3033.6	3405.2
Belgium	1625.3	2255.3	2961.3	3761.3	4191.1
Canada	30.5	28.9	45.8	73.7	95.3
Chile	1347.1	1832.6	2710.7	3223.5	3310.7
Czech Republic	174.2	436.5	594.4	903.8	1053.5
Denmark	2567.8	3233.9	4027.3	5319.1	6186.7
Estonia	1741.7	2291.9	2969.5	3762.0	4243.8
Finland	1190.4	1547.6	2275.7	3025.5	2845.7
France	970.4	1453.9	1997.9	2452.3	2595.2
Germany	504.2	604.9	1142.7	2039.2	2146.6
Greece	1015.4	1652.4	2224.1	2810.4	2507.8
Hungary	406.1	584.1	856.3	1432.2	1550.7
Iceland	1861.1	3055.1	4317.0	5475.4	6307.8
Ireland	1796.9	2351.9	3823.6	5063.1	5601.1
Israel	2184.6	4046.9	5475.1	6520.6	6518.2
Italy	1495.9	2031.0	2504.0	3161.6	3126.0
Japan	NA	1762.9	1822.7	2078.0	2356.6
Luxembourg	1190.3	1800.1	2974.2	3796.2	3867.1
Mexico	1913.1	2764.6	3336.5	3415.2	3645.8
Netherlands	657.3	852.9	1432.2	1700.8	1839.0
New Zealand	1264.1	1454.4	2359.1	2685.0	2512.7
Norway	2275.8	2682.2	3361.9	4426.1	4811.8
Poland	2098.3	2556.5	3240.7	4039.5	4333.6
Portugal	1477.2	1857.2	2593.5	3296.8	3604.1
Republic of Korea	396.2	511.4	823.9	1300.2	1452.6
Slovakia	1871.5	2514.4	3248.0	4545.3	4552.4
Slovenia	895.8	982.2	1479.9	1930.1	1981.8
Spain	1710.3	2250.7	3115.4	4057.8	4526.1
Sweden	2070.0	2534.1	3469.0	4468.0	4759.3
Switzerland	2253.3	2904.4	3514.9	4516.8	4884.6
Turkey	3810.3	4817.9	6775.9	8298.5	9145.8
United Kingdom	387.9	509.2	731.6	1002.6	1061.1
United States of America	460.4	688.2	855.7	1308.9	1677.6
OECD median	1412.2	1832.6	2504.0	3223.5	3405.2

Sources: WHO, 2014(WHO)

表 5 National medical care expenditure and percentage distribution by type of medical care, by year

Type of medical care	Million yen (%)			
	1995	2000	2005	2011
National health expenditure	269577 (100)	301418 (100)	331289 (100)	385850 (100)
Medical expenditure	218683 (81.1)	237960 (78.9)	249677 (75.4)	278129 (72.1)
Hospitals	148543 (55.1)	161670 (53.6)	167955 (50.7)	192816 (50.0)
General clinics	70140 (26.0)	76290 (25.3)	81722 (24.7)	85314 (22.1)
Inpatient expenditure	99229 (36.8)	113019 (37.5)	121178 (36.6)	143754 (37.3)
Hospitals	94545 (35.1)	108642 (36.0)	116624 (35.2)	139394 (36.1)
General clinics	4684 (1.7)	4376 (1.5)	4555 (1.4)	4359 (1.1)
Outpatient expenditure	119454 (44.3)	124941 (41.5)	128499 (38.8)	134376 (34.8)
Hospitals	53997 (20.0)	53028 (17.6)	51331 (15.5)	53421 (13.8)
General clinics	65456 (24.3)	71913 (23.9)	77167 (23.3)	80954 (21.0)
Dental expenditure	23837 (8.8)	25569 (8.5)	25766 (7.8)	26757 (6.9)
Pharmacy expenditure	12662 (4.7)	27605 (9.2)	45608 (13.8)	66288 (17.2)
Hospital meals and living expenses	10801 (4.0)	10003 (3.3)	9807 (3.0)	8231 (2.1)
Medical treatment fee at health service facilities for the elderly	3385 (1.3)	NA	NA	808 (0.2)
Expenditure for home-visit nursing care	210 (0.1)	282 (0.1)	431 (0.1)	5637 (1.5)

Source: MHLW, 2014(Ministry of Health 2013, 2014)

表 6 Medical care expenditure of medical care by inpatient – outpatient, age group, 2011

	Medical expenditure (hundred million yen)		
	Overall	Inpatient	Outpatient
All ages	278129	143754	134376
0-14 years	17544	6294	11251
15-44	33788	13739	20049
45-64	67059	31292	35767
65 years or more	159738	92429	67309

Sources: MLHW, 2014(Ministry of Health 2013, 2014)

表7 Medical care expenditure of medical care by inpatient – outpatient and category of disease, 2011

Category of disease (ICD-10)	Medical expenditure (Hundred million yen)		
	Overall	Inpatient	Outpatient
Infectious and parasitic diseases	6 518	2 575	3 944
Neoplasms	36 381	24 359	12 023
Malignant neoplasms	31 831	21 708	10 124
Mental and behavioral disorders	19 050	13 943	5 108
Diseases of the nervous system	11 973	8 208	3 765
Alzheimer disease	2 196	1 548	648
Diseases of the circulatory system	57 926	32 481	25 445
Hypertensive diseases	19 082	2 327	16 755
Heart diseases ¹	17 020	12 409	4 611
Ischemic heart diseases	7 553	5 273	2 279
Cerebrovascular diseases	17 894	14 825	3 068
Diseases of the respiratory system	21 707	9 000	12 707
Pneumonia	3 506	3 301	205
Chronic obstructive pulmonary disease	1 441	725	715
Asthma	3 557	586	2 971
Diseases of the digestive system	16 505	8 725	7 780
Diseases of stomach and duodenum	4 784	1 018	3 766
Liver diseases	1 810	865	946
Complications of pregnancy, childbirth and postpartum	2 122	1 867	255
Perinatal conditions	1 876	1 595	281
Injury, poisoning and other external impacts	18 898	13 544	5 354

Sources: MHLW, 2014(Ministry of Health 2013)

¹excluding hypertensive diseases

表 8 Number of persons covered by health care insurance by type of insurance system

System category	1980	1990	2000	2005	2011
Number (thousands)					
Population	117060	124533	126926	127768	127799
Total insured population	117037	124260	126351	127176	126678
Employee's health insurance					
GMHI	31807	36821	36805	35675	34895
SMHI	27502	32009	31677	30119	29504
MAS	12520	11952	10017	9587	9101
Seamen	672	409	228	168	132
National Health Insurance	44536	43069	47628	51627	38313
Proportion (%)					
Proportion	100.0	100.0	100.0	100.0	100.0
Employee's health insurance	61.9	65.2	62.0	59.1	57.6
GMHI	27.2	29.6	29.0	27.9	27.3
SMHI	23.5	25.7	25.0	23.6	23.1
MAS	10.7	9.6	7.9	7.5	7.1
Seamen	0.6	0.3	0.2	0.1	0.1
National Health insurance	38.0	34.6	37.5	40.4	30.0

Source: MHLW, 2014(Ministry of Health 2013)

Notes: GMHI: Government-managed Health Insurance; SMHI: Society-managed Health

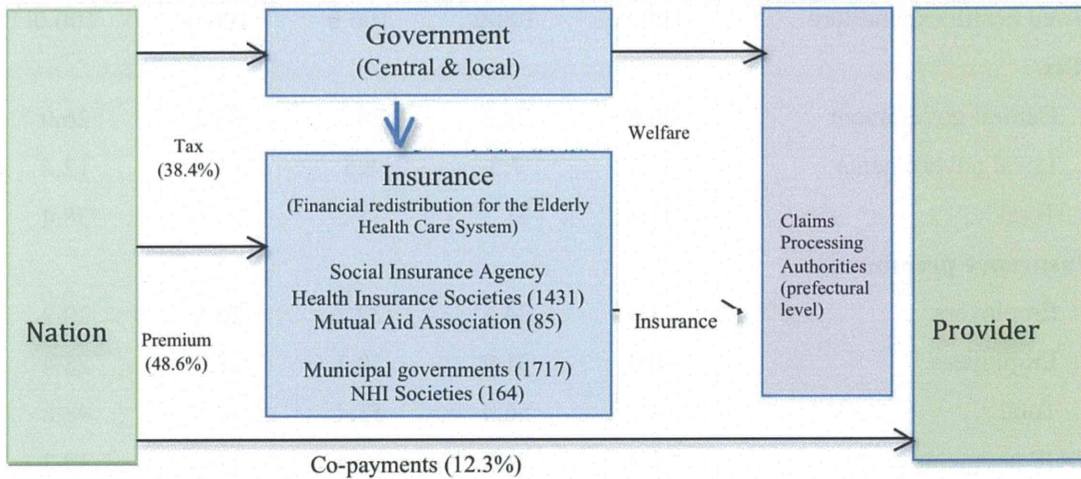
Insurance; MAS: Mutual Aid Societies

表 9 National health expenditure by financial sources, 1985 - 2011

	1985	1995	2000	2005	2011
Total health expenditure	100.0	100.0	100.0	100.0	100.0
Tax					
Central government	26.6	24.2	24.7	25.2	26.0
Local governments	6.8	7.5	8.5	11.4	12.4
Total	33.4	31.7	33.2	36.6	38.4
Insurance premiums					
Employers	23.4	24.5	22.7	20.3	20.2
Employees	30.9	31.9	30.7	28.7	28.4
Total	54.3	56.4	53.4	49.0	48.6
OOP payments	12.3	11.9	13.4	14.4	12.3

Sources: MHLW, 2006, 2014 (Ministry of Health 2013, 2014)

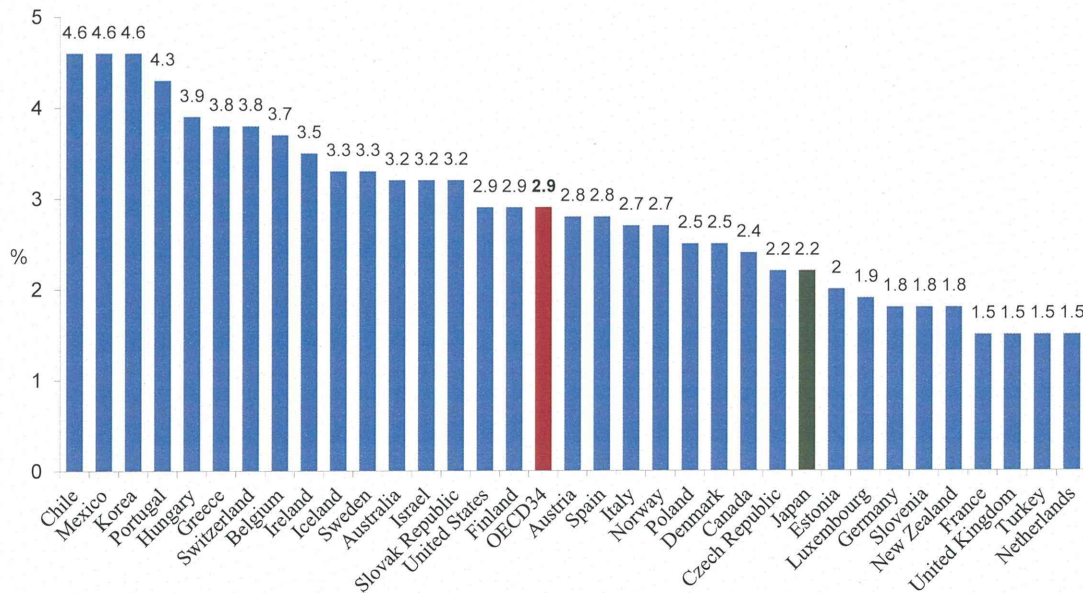
図1 Health financing framework



Sources: MHLW, 2014(Ministry of Health 2013, 2014)

Note: Tax and premium, co-payments based on 2011, and insurance number based on 2013

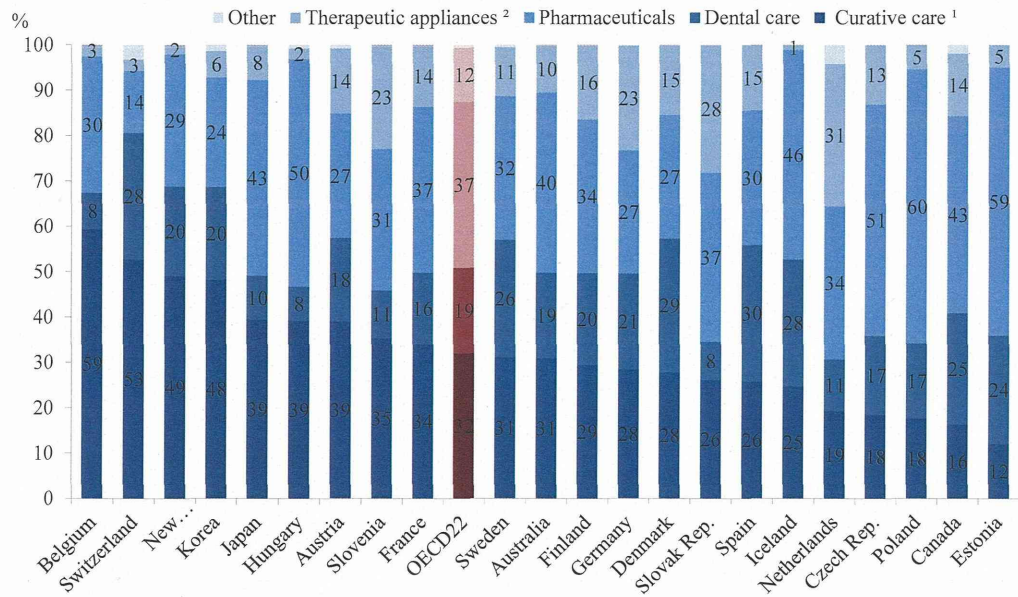
図2 Out-of-pocket medical spending as a share of final household consumption, OECD, 2011



Note: This indicator relates to current health spending excluding long-term care (health) expenditure.

Source: OECD Health Statistics 2013(OECD 2013)

☒ 3 Share of out-of-pocket medical spending by service type, OECD, 2011



Note: This indicator relates to current health spending excluding long-term care (health) expenditure.

¹Including rehabilitative and ancillary services.

²Including eye care products, hearing aids, wheelchairs, etc.

Source: OECD Health Statistics 2013(OECD 2013)

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Physical and human resources of the Japanese health system

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研究要旨

Understanding health system resources is essential to understand the factors affecting quality and equity of care and the challenges that the health system faces in implementing reform. This report describes the current state of physical and human resources in the Japanese health system, and trends in these resources.

In Japan, there are about 8 500 hospitals, 100 000 clinics and 70 000 dental clinics. Compared with other OECD countries, inpatient care in Japan is characterized by longer average hospital stays, with a greater number of inpatient beds per head of population. Japanese hospitals are in general well equipped with high-technology devices such as computed tomography (CT) and magnetic resonance imaging (MRI) scanners.

Japan has a relatively low number of doctors and an average number of nurses per head of population compared with other OECD countries. Japan is in a transitional period of healthcare human resource supply and education policy. The quota on the number of students entering medical schools has increased by roughly 20% over the last eight years. In 2004, mandatory postgraduate clinical training for medical doctors and dentists was introduced. These changes are likely to influence career path and staffing levels of relevant sections of the health care workforce in the future.

A. 研究目的

Understanding the physical and human resources available to a health system is essential to understand the factors affecting quality and equity of care, and also the challenges that the health system faces in implementing reform to meet new challenges and implement programs to reform current levels of care.

In Japan, hospital structure and the available resources for provision of healthcare is defined by the Medical Care Act. The Medical Care Act defines hospitals and clinics as places where physicians or dentists conduct a medical or dental practice serving either the general public or a particular group of people. Hospitals have facilities in which at least 20 patients can be hospitalized, and clinics have fewer than 20 hospital beds, but may have none. Because Japan does not maintain a system of family doctors or a gatekeeper system based on general practice, as is the case in many developed nations, understanding the way that the hospital system is established, and the resources available to it, is essential to understanding what

reform processes are necessary and what challenges exist to the provision of high quality care.

This report assesses the structure of the Japanese health system and describes the physical and human resources available to it, as well as the future reforms and policy changes necessary to reconfigure the health system to face the changing landscape of healthcare in Japan, and the challenges posed by the ageing society.

B. 研究方法

This report uses information from publicly available reports and datasets to summarize the capital stock, physical resources and personnel situation for the Japanese health system.

Available data is summarized and published literature reviewed to obtain information about how these resources are expected to change. Where policy reforms have been discussed in either Japanese government documents or published academic literature, these policy discussions are summarized in this report. Finally, recommendations for key changes to the physical and human resources of the Japanese