universal health coverage system are made.

C. 研究成績及び考察

C-1 Capital Stock and investments

In October 2011, the total number of active medical facilities was 196 308, including 8 605 hospitals, 99 547 general clinics, and 68 156 dental clinics. There were 7 528 general hospitals, one tuberculosis hospital, and 1 076 psychiatric hospitals. Of the general clinics, 9 934 (10.0%) had hospital beds, and 89 613 (90.0%) did not. Two thirds (67.0%, 6 651) of the general clinics with beds had 10–19 of them. There were 3 182 facilities with 20–99 beds (37.0%), 2 769 with 100–199 (32.2%), 2 198 (12.7%) with 200–499, and 426 with 500 beds or more (0.7%).

The licensing of health facilities is undertaken by local governments. Prefectural governors and city mayors or heads of special wards with a health care centre can request reports from the founders or managers of hospitals, clinics, and birth centres, or send staff to inspect the facilities. According to the 2011 report of spot inspections for medical facilities, the observance rate for compliance with the requirements of the Medical Care Act and related laws, including human resources and equipment, was 96.4% in medical workers, 98.0% in management, 98.3% in ledger sheets/records, 98.9% in subcontracting, 98.2% in fire/disaster prevention systems and 99.7% in radiation management (MHLW, 2013a).

The Japan Council for Quality Health Care (JCQHC) was founded in 1995 and started an official accreditation programme for hospitals in 1997. Accreditation is voluntary and hospitals wishing to achieve it must apply and pay the necessary fees. By March 2015, 2 270 hospitals (approximately 26.7%) were accredited and met the required standards. The JCQHC emphasizes that accreditation is intended to help hospitals improve their quality on a voluntary basis, not to close them. Hospitals that fail to meet the standards are encouraged to make the necessary improvements and then reapply (JCQHC 2014). The main

source of funding for private hospitals is borrowing from banks or the Welfare and Medical Service Agency (WAM). The WAM provides low-interest long-term loans for construction, maintenance and operation of facilities to private social welfare institutions such as intensive care homes for older people and support facilities for disabled people, and to private medical institutions, including hospitals, clinics, and long-term care facilities. At the end of 2013, WAM's balance of loan receivables was 1.635 trillion yen (including construction funds, funds for purchasing equipment, and funds for long-term operation) and 173.5 billion yen was provided in loans that year (WAM 2014).

As a way of raising money more directly, the issue of medical institute bonds (known as local medical promotion bonds) commenced in February 2004, subject to guidelines announced by the Ministry of Health, Labour and Welfare in October 2004. In June 2006, the Medical Care Act was revised to allow social medical corporations to issue securities called social medical corporation bonds, via the Financial Instruments and Exchange Act. According to a survey of the Ministry of Health, Labour, and Welfare, by 2013, 18 medical corporations had issued a total of 41 medical institute bonds, with a total monetary value of 4.309 billion yen (MHLW 2013b).

C-2 Infrastructure

Japanese hospitals and clinics are predominantly privately owned. In 2011, of the 8 605 hospitals, 274 had been established by national agencies, 1 258 by public organizations (such as prefectures or municipal governments), and 121 by social insurance groups. Private ownership accounted for more than 6 000, with 5 712 owned by non-profit medical corporations, 373 sole proprietorships owned by individual doctors, and 867 by others, including non-profit public corporations, non-profit school corporations and private

medical schools. Because national and public hospitals tend to be larger, however, the public sector accounts for approximately 45% of hospital beds.

Non-profit medical corporations incorporated under the Medical Care Act are similar to profit-making corporations in that they are established by direct investment from private shareholders, but are different from profit-making corporations in that they are prohibited from disbursing their profits to shareholders in the form of dividends. There are two kinds of medical corporations: associations and foundations. For many association-type medical corporations, the corporate assets of the corporations are the property of the shareholders, who are entitled to sell them at market value when certain conditions are met (such as inheritance). To emphasize the non-profit principle of Japan's health care system, such association-type medical corporations are no longer established and the government encourages the present association-type medical corporations to change to foundations by donating the assets owned by share holders. The government even advertises the financial advantages of such a transfer, such as waiver of inheritance tax when the current owners die (MHLW 2015). Non-profit medical corporations are subject to regulation and supervision by prefectural governments. Profit-making corporations are generally assumed to be prohibited from owning and operating hospitals and clinics under the Medical Care Act, although this prohibition is not explicit in the Act. The government has, however, championed the non-profit principle based on this presumption.

In 2014, there were a total of 49,889 medical corporations, of which 391 were foundations and 49,448 were associations.

The number of hospitals across all categories has declined steadily by more than 1 500 since a peak of 10 096 in 1990, reflecting mergers and acquisitions in recent years, and has been less than 10 000 since 1992. In 2011, there were 99 547 clinics, of which 9 934 had beds, and the number of dental clinics was 68 156, of which 38 had beds.

In 2011, the total number of inpatient

beds in all facilities was 1 712 539, of which 1 583 073 were in hospitals. A total of 899 385 hospital beds were general, 330 167 were for long-term care, 344 047 were for psychiatric disorders, 1 793 were for infectious diseases and 7 681 were specifically for tuberculosis. The total number of beds in clinics was 129 366 and of these, 14 150 were for long-term care. Like the number of hospitals, the number of beds within them has decreased gradually since its 1992 peak of 1 686 696 (MHLW 2011). Inpatient care in Japan is generally characterized by longer hospital stays than in other OECD countries. The average length of stay was 17.5 days for all hospital beds in 2012. The average across OECD countries for which data were available was 7.4 days. The average length of stay in Japan has, however, been steadily declining because of the rise of care in healthcare or welfare homes for older people covered by long-term care insurance (Figure 1) (OECD, 2014). Compared with other OECD countries, Japan also has more inpatient beds per head of population, although the number has declined somewhat from a peak of 1.95 million in 1990. This is chiefly as a result of controls on hospital beds, which were promoted in the area health planning enforced by the Medical Care Act. In 2012, Japan had 7.9 acute hospital beds per 1 000 population, compared with the OECD average of 3.3 for countries with available data (Figure 2) (OECD, 2014).

C-3 Medical equipment

Japanese hospitals are in general well equipped with high-technology devices (Matsumoto 2004). Available equipment is summarized in Table 1. Two out of every three hospitals, including psychiatric and tuberculosis hospitals, have whole-body CT scanners. The number of CT scanners per 1 000 people is 0.101, compared with a mean of 0.024 in other OECD countries, 0.051 in Australia, and 0.041 in the United States and Iceland. The number of MRI scanners per 1,000 population is 0.047 in Japan, significantly higher than the OECD's average of 0.014, 0.035 in the United States, 0.025 in Italy and 0.024 in Korea. The proportion of hospitals having MRI, CT and positron emission

tomography (PET) scanners in Japan is 70.5%, 59.4% and 74.2% (OECD 2014). So much high-technology equipment may be beneficial to patients in terms of easy access, but may not be efficient. An important challenge facing health policymakers is how to ensure that distribution of high-technology equipment is cost-effective but still provides easy access for patients.

Clinics fulfil a general diagnosis function and are usually very well equipped with apparatus for X-rays, electrocardiography and blood and urine tests. Clinics with inpatient beds function effectively as small-sized hospitals, and their beds constituted 9.9% of the total beds in 2004. This comprehensive function of clinics is an important basis for primary healthcare in Japan. People can access very convenient services at affordable prices almost anywhere in the country, and receive treatment at a comparatively early stage in any illness.

C-4 Information technology

The rate of Internet use in Japan is estimated to be 82.8%, with 100.4 million people using the internet in 2013. The rate of use in companies is 99.9%. The most common methods of access are personal computers at home (58.4%), followed by smartphones (42.4%), and personal computers elsewhere (27.9%). Access from smartphones has recently increased. Broadband is used by 97.4% of family units to access the Internet at home, with 59.3% of families using optical communication lines. Mobile phone lines are used in 50.2% of households (MIC 2014).

In healthcare, the Ministry of Health, Labour and Welfare has drawn up two documents to encourage IT use. These are *Grand design for informatization of the healthcare field* (2001) and *Grand design for information utilization in medical care, health care, long-term care, and welfare sectors* (2007). These were designed to promote online claim systems, development of databases of medical information, and exploration of other ways to make use of information and communication technology (ICT) through various demonstration businesses. Based on a "*Declaration* to be the World's Most Advanced *IT* Nation" from the cabinet in June 2013, the

Ministry of Health, Labour and Welfare has encouraged sharing of information among medical and long-term care institutions.

Surveys about ICT in healthcare by the Ministry of Health, Labour and Welfare in March 2014 found that electronic health records were used in 1 729 facilities (20.4% of the 8 460 respondents). Ordering systems and picture archiving and communication systems were used in 3 147 (37.2%) and 4 590 (54.2%).

C-5 Health workforce trends

Table 2 shows the trends in the number of doctors, dentists, pharmacists and nurses in Japan between 1980 and 2012. In December 2012, there were 303 268 doctors (2.38 per 1 000 population), 102 551 dentists (0.80 per 1 000 population), 280 052 pharmacists (2.20 per 1 000 population), 47 279 public health nurses (0.37 per 1 000 population), 31 835 midwives (0.25 per 1 000 population), 1 015 744 nurses (7.97 per 1 000 population) and 357 777 assistant nurses (2.81 per 1 000 population).

Of the 303 268 licensed physicians in 2012, 288 850 (95.2%) were working in medical facilities, with 188 306 (62.1%) in hospitals and 100 544 (33.2%) in clinics. A total of 3 549 (1.2%) were in offices for public health, 3 189 (1.0%) in healthcare homes for older people, 8 625 (2.8%) in institutions for education and research, and 2 602 (0.9%) elsewhere.

There were 50 medical schools in Japan in 1970 and 80 by 1981. The enrolment capacity for medical students per year reached a peak of 8 280 in 1981. In 1986, a special committee of the then Ministry of Health and Welfare recommended that the number of new doctors should be reduced by 10% before 1995, in anticipation of a large increase in the number of graduates. As a result, student enrolment dropped to 7 625 in the 2003 financial year. By 2008, the numbers had been increased again, to address concerns about insufficient numbers of physicians, to 1 509 more students than in the previous year. In the 2015 financial year, there are 9 069 new students. Student enrolment has increased in universities providing scholarships for those engaging in community healthcare or setting

selection criteria, co-operating with other universities to provide bases for training research physicians, and decreasing the number of dental students.

The number of female doctors was 15 659 (10.0% of the total) in 1980 and 59 641 (19.7%) in 2012. Of those aged under 29 years, 9 406 (35.5%) were female. Compared with other OECD countries, Japan has a relatively low supply of doctors (Figure 3), with an estimated two per 1 000 population in 2012, or the latest available year, compared with an OECD average of 3.2.

There were 248 165 practicing nurses in Japan in 1980 (2.12 per 1 000 population), which had risen to 1 015 744 (7.97 per 1 000 population) by 2012, a four-fold increase in 30 years. The number of public health nurses in total and per 1 000 population was 17 957 and 0.15 in 1980 and 47 279 and 0.37 in 2012. For midwives, the figures were 25 867 and 0.22 in 1980 and 31 835 and 0.25 in 2012. Japan has a similar number of nurses to other OECD countries (Figure 4).

The number of dentists in total and per 1 000 population was 53 602 and 0.46 in 1980, 60 857 and 0.72 in 2000, and 102 551 and 0.80 in 2012. The number of female dentists was 6 590 (12.3 %) in 1980 but up to 22 295 (21.7%) in 2012. Of those under 29 years old, 3 202 (42.1 %) were female. Compared with other OECD countries, Japan has a high number of dentists (Figure 5).

The number of pharmacists in total and per 1 000 population was 116 056 and 0.99 in 1980, 217 477 and 1.71 in 2000, and 280 052 and 2.20 in 2012. There were 170 788 (61.0%) female pharmacists in 2012. In 2006, the Ministry of Education and Science introduced a 6-year course for pharmacists, which includes compulsory practical training in pharmacies or hospitals. Compared with other OECD countries, Japan has a high number of pharmacists (Figure 6).

C-6 Professional mobility and training of health workers

Professional mobility, measured as the proportion of medical professionals trained abroad and practising domestically, is quite limited in Japan. Anyone graduating from medical

schools or obtaining a medical license outside Japan is required to take documentary examinations and demonstrate their ability to provide suitable medical care in Japanese if they want to take the national examinations for medical practitioners. They may then be permitted to sit for the national examination, or be required to take a pre-examination and undergo practical training for 1 year or more beforehand.

Based on formal agreements between countries, medical licenses may be given to foreign physicians who have passed the national examinations for medical practitioners in English, provided certain conditions are met. They must be undertaking medical practice at medical facilities approved by the Japanese government and not use Japanese public medical insurance. This agreement is so far limited to doctors from the United Kingdom, the United States, France, and Singapore (MHLW 2013c).

There is also a special system for foreign healthcare professionals coming to Japan to undertake medical training, and who aim to contribute to the development of international interaction with physicians and nurses in medical fields and to improve medical standards in developing countries, in which they are allowed to conduct medical and nursing services. However, there are certain conditions such as within 2 years for physicians or 1 year for nurses. The system is currently being expanded.

Through a new "Indonesia–Japan collaboration on the enhancement of nursing competency through in-service training" (Siyam 2013), established through the Economic Partnership Agreement, foreign applicants working towards acquiring the national license from Indonesia, Philippines, and Vietnam engage in training at receiving facilities with a view to passing the national examination. Some 2 377 foreign potential nurses and long-term care workers had entered Japan under this scheme by June 2014. The Ministry of Health, Labour and Welfare stated that this scheme was not designed to address the nursing shortages, but had been implemented following strong requests from the other countries, and to reinforce economic cooperation

(MHLW 2014).

Medical training in Japan involves 6 years at medical school after graduating from senior high school. Those who pass the national examination then go on to 2 years of clinical training, after which they are included in the medical register. In 2015, 8 258 students passed the national examinations. Decisions about where to provide clinical training are made by matching physicians and venues using an algorithm.

The quota on the number of students entering medical schools in the 1960s was about 3 000–4 000, but in 1973, the Cabinet endorsed a vision of every prefecture having a medical school. Since then, a number of new medical schools have been established. The peak of 8 280 new students was reached between 1981 and 1984. Cabinet decisions made in 1982 and 1997 resulted in a reduction in the quota of new students entering medical schools to 7 625, although this has since increased again to cope with shortages of medical personnel.

Postgraduate clinical training after medical school became mandatory in 2004 and training facilities for doctors in the initial stages have changed greatly. In 2003, 72.5% were trained at university hospitals and about 40% were trained in a single specialist department affiliated to a university. Only a few trainees received more general training from a broader rotation. Since then, the number of clinical training hospitals other than university hospitals has grown to provide more than half of the total training places.

In 2015, the quota for initial clinical training is 11 004 in 1 015 hospitals (1 396 training programmes), and the number of new registered physicians is 8 767, of whom 8 399 will be matched to the training programme (95.8%). The number of training slots is far more than the number of applicants, and the trainee physicians are likely to be concentrated in urban areas. Therefore, adjustments such as setting the upper limit of the numbers recruited in individual prefectures have been in operation since 2010.

Dentists follow a 6-year course at dental school after graduating from senior high school. Although most of these schools were private before the Second World War, dental schools were established at

three national universities in 1965. The quota on the number of students in 2014 was 2 720, at 29 schools in 27 universities. At least 1 year's clinical postgraduate training has been mandatory since 2006. In 2014, there were 2 428 clinical training facilities and 3 603 trainees. The number passing the national examination for dental practitioners in 2015 was 2 003.

The career path for pharmacists used to be a 4-year degree course provided by the pharmaceutical department of a university, followed by a national examination. In case of going on to graduate school, two-year master's courses and three-year doctoral courses were available. However, with increased social concern about pharmaceutical education due to recent advances in medical technologies and the separation of dispensary from medical practice, the course term was extended to 6 years and doctoral courses to 4 years. There are still some 4-year pharmaceutical courses for those planning to work in research and development at pharmaceutical companies and universities, or wanting to gain a basic knowledge of pharmacy but not wanting to work as a pharmacist. In 2015, 9 044 students passed the national pharmacists' examination.

There are a variety of different routes leading to a nursing qualification, including both short and longer college courses, some with associated clinical experience. Of the 47 340 who passed the national examination in 2008, 23.6% (11 170) had graduated from universities or colleges (MEXT 2009).

In 2012, of the 303 288 licenced physicians, 288 850 were practicing, 137 902 worked in "hospitals not attached to medical educational institutions," 50 404 in "hospitals attached to medical educational institutions" and 100 544 in clinics. There have been more physicians working in "hospitals not attached to medical educational institutions" than in clinics since 1986. The largest age group in each setting was those aged 30–39 in hospitals, and those aged 50–59 in clinics. The mean age was 45.6 years in "hospitals not attached to medical educational institutions," 38.5 years in "hospitals attached to medical educational institutions," and 58.7 years in clinics.

The career path for physicians is in transition because of the introduction of mandatory postgraduate clinical training in 2004 and the introduction of a new specialty board certification system starting in 2017.

Before 2004, physicians were trained at universities and reported to the medical office of the universities, from which they obtained a graduation diploma. They then acquired experience working at multiple hospitals, with the work managed by the clinical department (*ikyoku*) of the medical school (Otaki 1998). After the introduction of mandatory post-graduate clinical training, young physicians shifted to hospitals not attached to medical educational institutions and their future career path is expected to be affected. Specialty board certification has been introduced because of past problems in the evaluation or approval of specialists, which was previously conducted by academic societies. This independent accreditation process caused some problems, including a lack of uniform standards and gap in understanding about the abilities required for specialists between physicians and citizens. The Ministry of Health, Labour and Welfare has established a commission to investigate medical specialties and propose revisions. It has recommended establishment of a uniform system for approval of specialists, evaluation/approval of training programs, and a possible two-step system in which physicians acquire qualifications in more basic fields, and then acquire further qualifications in sub-specialties. The commission has also proposed adding general practice/family medicine as an area for general certification, because these physicians provide appropriate primary care and continuous medical care for a wide range of common diseases. (MHLW 2013d) The introduction of general practice/family medicine does not signify the introduction of "gate keeper" or "capitation" reimbursement because such reform will contradict the national principle of "free access". However, some advocate a "weak gate keeper" role for this new specialty.

The majority of midwives, nurses, and assistant nurses were working in hospitals: 20 784 (65.3%), 747 528

(73.6%), and 158 315 (44.2%), respectively. More than half (56.1%) of all public health nurses, 26 538, were working for local authorities. The number of universities providing nursing education has increased greatly from 11 universities recruiting 558 students in 1991 to 188 universities recruiting 15 394 students in 2010. In 2010, there were 127 graduate schools providing master's courses to 2 067 students per year, and 61 providing doctoral courses to 511 students. The Japanese Nursing Association also has systems for certified nurse specialists, certified nurses, and certified nurse administrators. In April 2012, certified nurses were working in 21 fields and certified nurse specialists in 11.

D 結論

Japan's health system has physical resources that are broadly consistent with levels across the OECD, and although the number of physicians is below the OECD average Japan continues to maintain levels of health outcomes that exceed OECD standards. Although historically the training of new doctors has not been consistent with estimated future needs, there is little evidence of a severe future shortage. However, medical training and certification processes need to be updated to better prepare medical staff for the challenges of a more interconnected health and social welfare system and to prepare them for the new caring systems that will be required in an aging population with high prevalence of NCDs.

E. 健康危険情報

なし

F. 研究発表

1.論文発表

1. Okamoto E. Farewell to free access: Japan's universal health coverage. East Asia Forum. 22nd February 2014.

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　Number of items of functioning diagnostic imaging technologies (MRI units, CT scanners, PET) per 1 000 population in latest available year (2011)

	Unit			Per 1 000
	Hospital	Clinic	Total	population
MRI	3 461	515	3 461	0.047
≥ 1.5 T	2 946	515	3 461	
< 1.5 T	1 293	1 236	2 529	
CT	7 877	5 066	12 943	0.101
Multi-detector CT	6 048	2 298	8 346	
Other CT	1 829	2 768	4 597	
PET	93	24	117	0.001
PET-CT	253	96	349	0.003

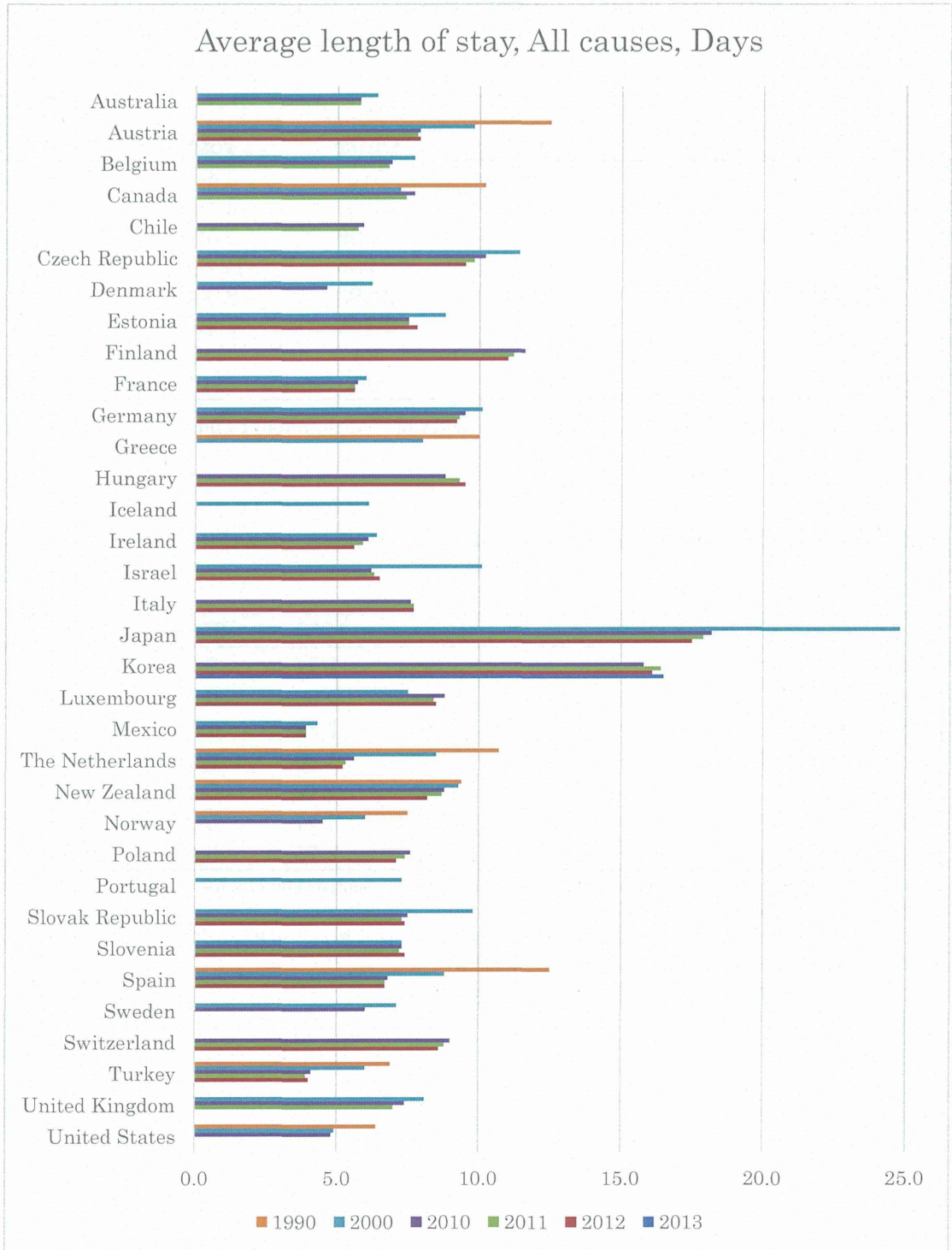
Source: 2011 Survey of Medical Institutions, Ministry of Health, Labour and Welfare, Japan.

表2　Healthcare workers per 1 000 population, 1995 to 2012 (latest available year)

	1980	1990	2000	2010	2012
Physicians	1.33	1.71	2.02	2.30	2.38
Dentists	0.46	0.60	0.72	0.79	0.80
Pharmacists	0.99	1.22	1.71	2.16	2.20
Public Health Nurses	0.15	0.20	0.29	0.35	0.37
Midwives	0.22	0.19	0.19	0.23	0.25
Nurses	2.12	3.27	5.15	7.44	7.97
Assistant Nurses	2.04	2.75	3.06	2.93	2.81

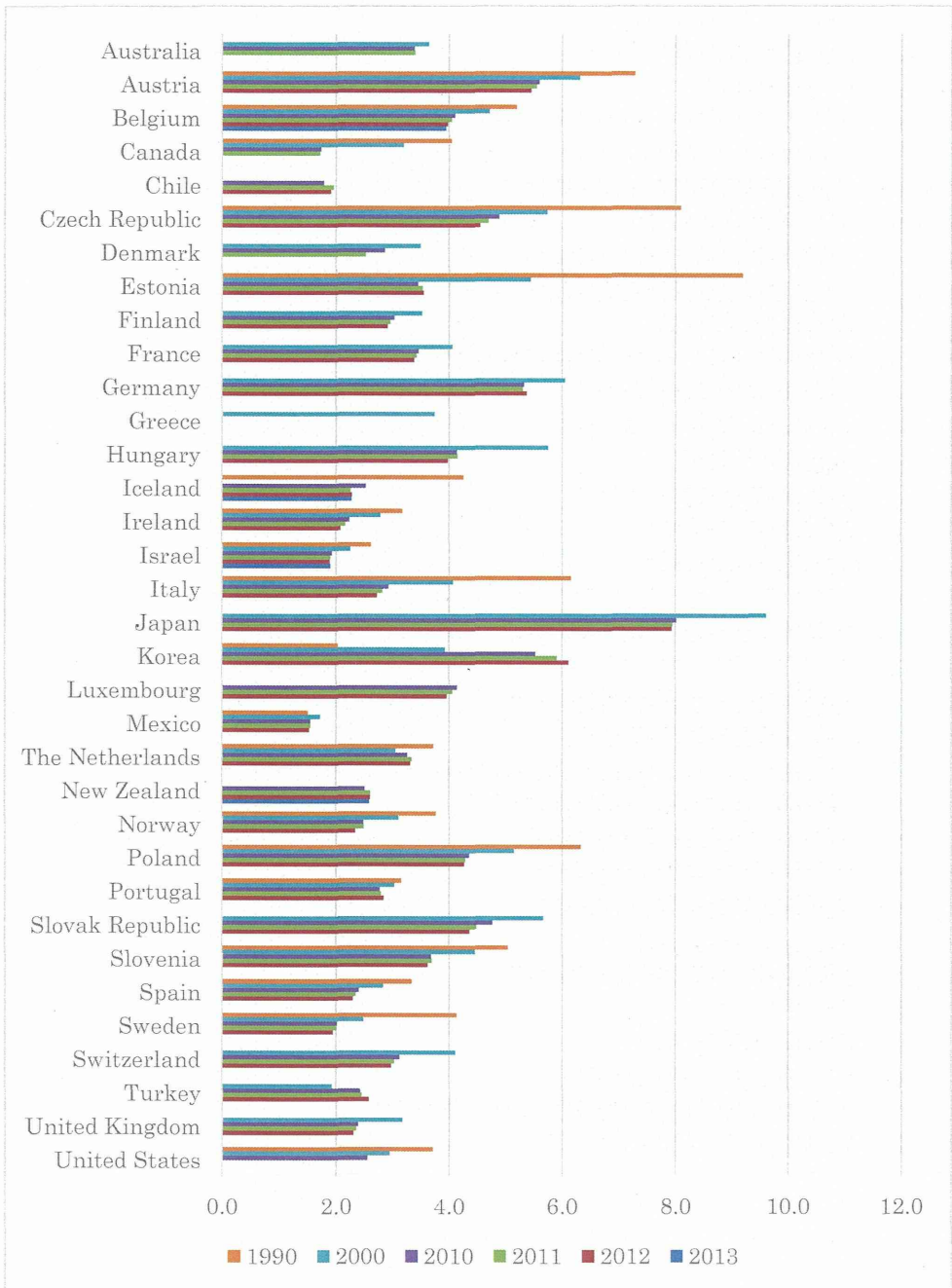
Sources: Physicians, Dentists, Pharmacists: Survey of Physicians, Dentists and Pharmacists, Ministry of Health, Labour and Welfare
Public Health Nurses, Midwives, Nurses, Assistant Nurses: Report on Public Health Administration and Services, Ministry of Health, Labour and Welfare

図 1　Average length of stay, all causes, 1990 to latest available year



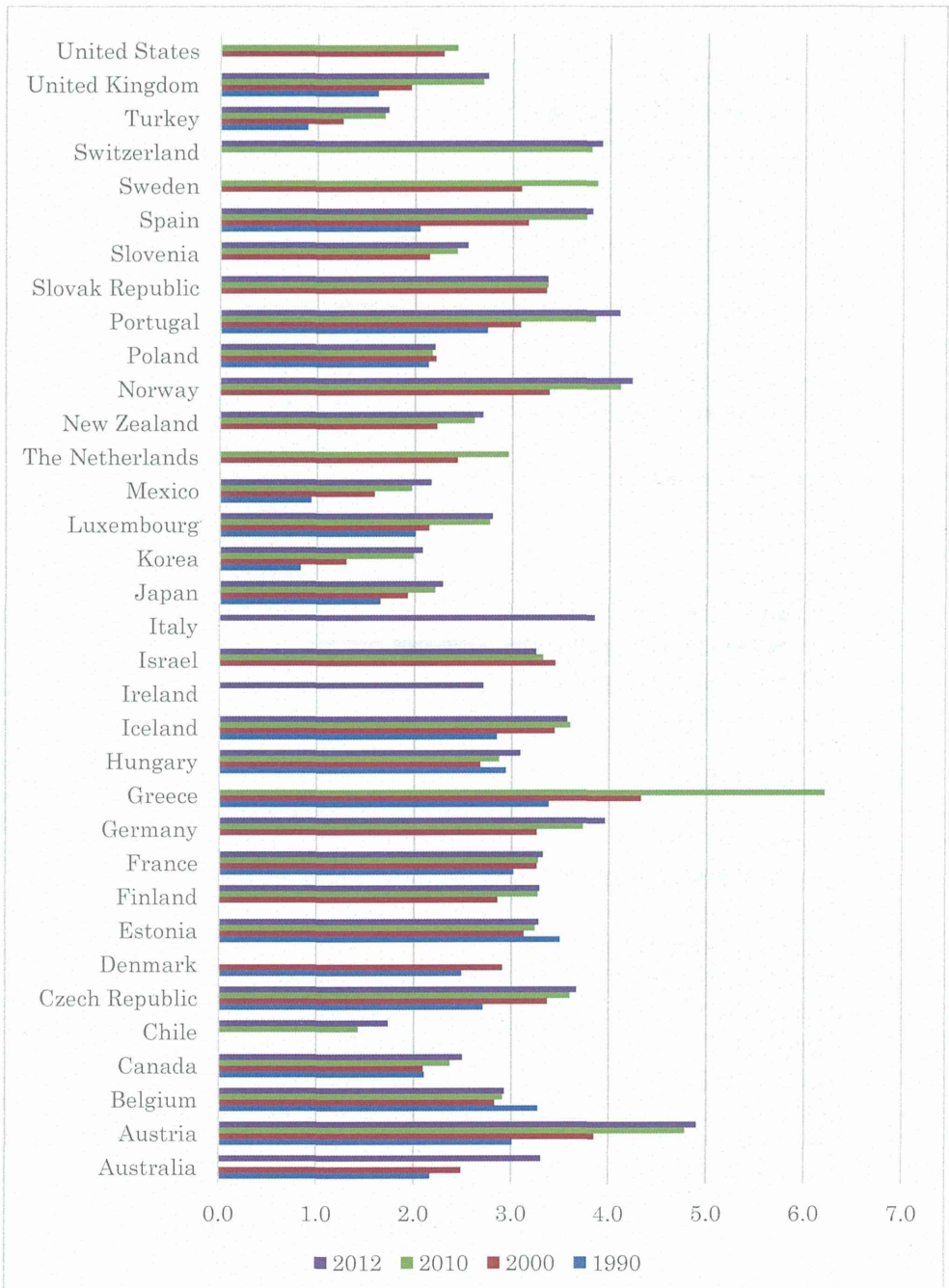
Japan: Data refer to average length of stay for acute care (excluding long-term care beds in hospitals). *Source*: OECD Health Statistics 2014

図 2 Beds in acute hospitals per 1 000 population in selected countries, 1990 to latest available year



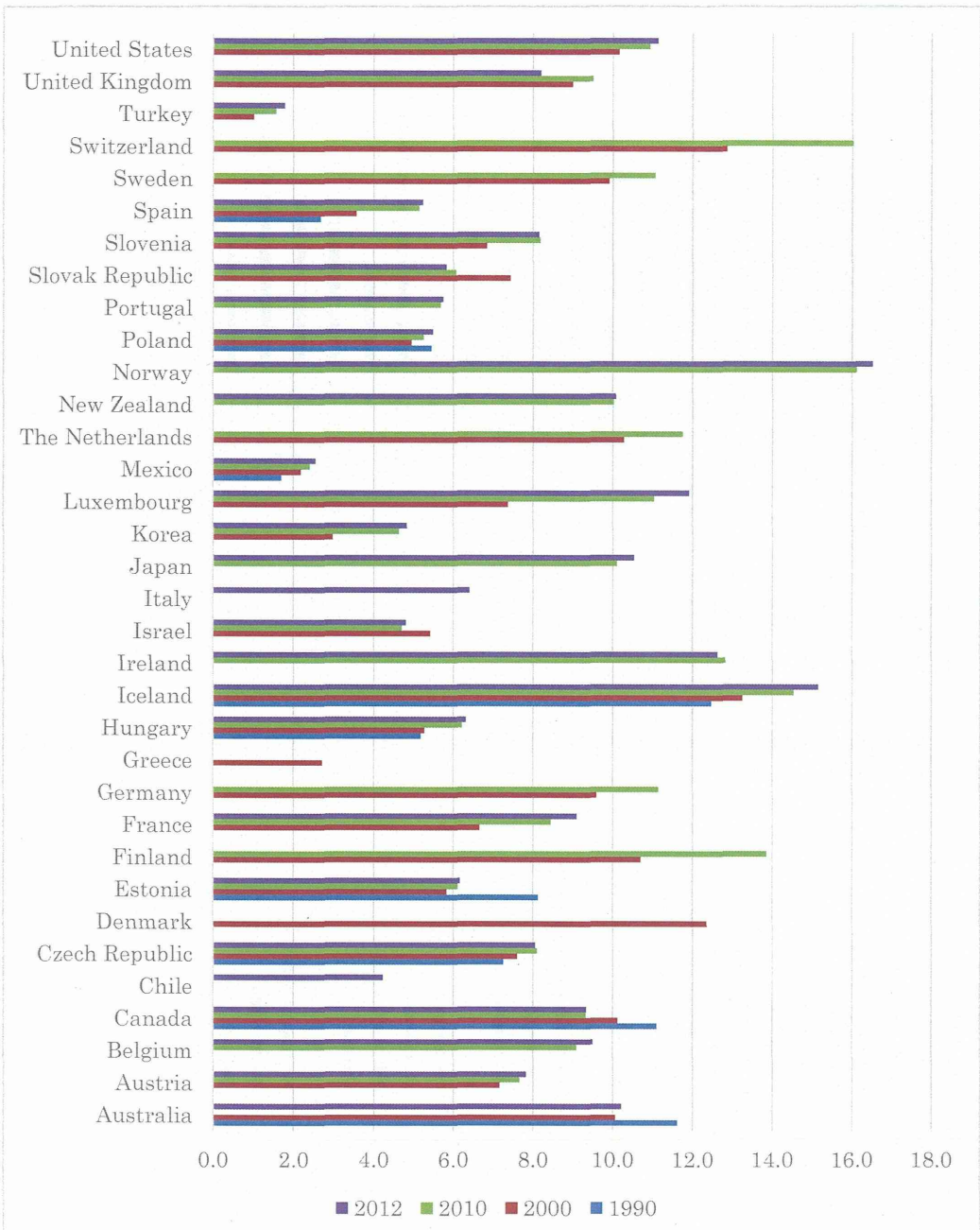
Source: OECD Health Statistics 2014

図 3　Number of physicians per 1 000 population in different countries, by year



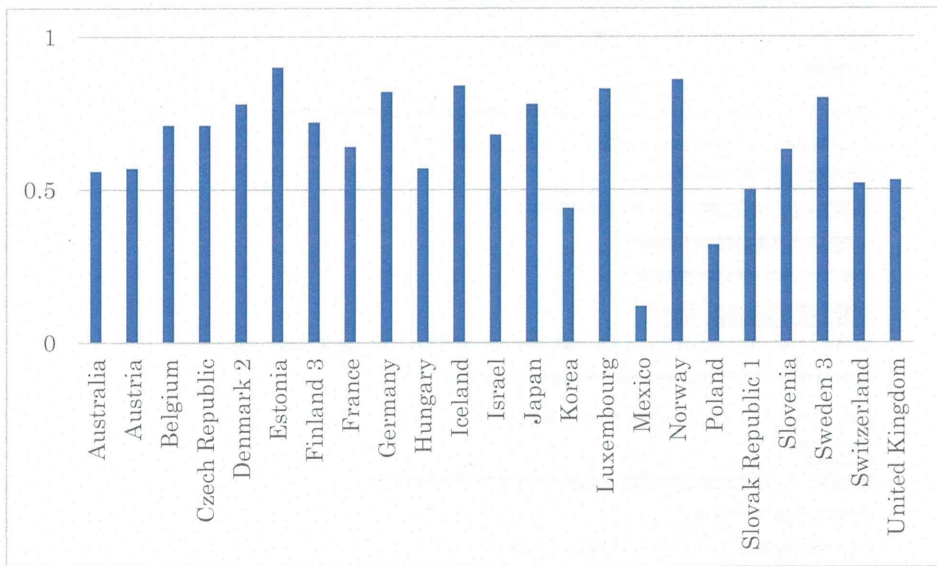
Source: OECD Health Statistics 2014

図 4　Number of nurses per 1 000 population in various countries, by year



Source: OECD Health Statistics 2014

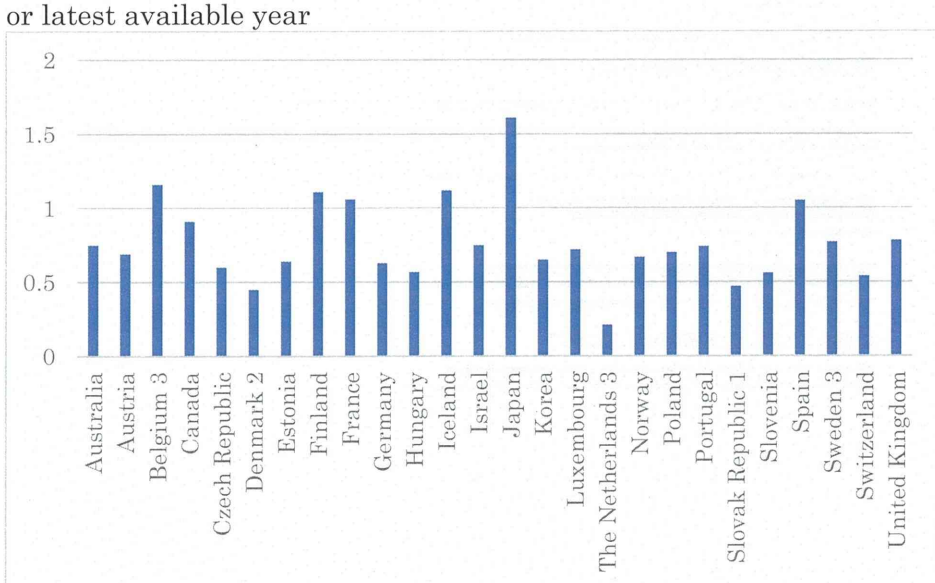
図 5 Number of dentists per 1 000 population in selected countries in 2012 (or latest available year)



1: 2007 data; 2: 2009 data; 3: 2011 data

Source: OECD Health Statistics 2014

図 6 Number of pharmacists per 1 000 population in selected countries, in 2012 or latest available year



1: 2007 data; 2: 2009 data; 3: 2011 data

Source: OECD Health Statistics 2014