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「我が国の世界保健総会等における効果的なプレゼンスの確立に関する研究」

（H29-地球規模-一般-002）

研究代表者・渋谷健司

分担研究報告書

Context and challenges of Japan’s health system

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研究要旨

UHC（すべての人に基本的な保健サービスを支払い可能な価格で普及させること）が大きな政策目標となったグローバルヘルス分野において、我が国の知見がアジア諸国を中心とした発展途上国から求められている。また、低成長と少子高齢化の中で多くの課題が噴出し、我が国がどのように対応していくかが世界の注目を集めている。UHC は WHO 総会をはじめとして各種国際会議にて必出の議題となっており、また 2019 年には UHC に関する国連ハイレベル会合の開催も予定されており、UHC に関する議論は今後も盛り上がることが予想される。本研究は、WHO 総会等の主要会合における日本のプレゼンス向上を大目標に掲げるものであるが、とりわけ、G7 伊勢志摩サミット以降日本が牽引し、また今後国際的にも議論が盛り上がるであろう UHC に焦点を当て、UHC を推進する上で我が国の比較優位性を抽出するものである。主な研究目的は WHO Asia-Pacific Health Observatory（APO）の枠組みを活用し、我が国の保健医療制度の現状と課題及び将来像を、実証的かつ包括的に分析することで、UHC 達成に必要不可欠な疾病構造と人口動態の変化がもたらす医療システムへの影響の対処方法への示唆を得ることである。得られた成果については 2018 年 11 月に Resilient and people-centred health systems; Progress, challenges and future directions in Asia で公表した。この研究から得られた知見は、UHC 達成を目指す各国にとって、社会経済状況や疾病構造の変化とそれが保健医療政策に及ぼす影響についての対処を講じるために有用となるとともに、今後、国際会議等の場における UHC 関連議論において、我が国が積極的に打ち出す内容への基盤となるものである。

A．研究目的

Japan, the world's third-largest economy, with a correspondingly high standard of living, level of development, safety and stability, has had great success in improving population health outcomes, such as boasting of the highest life expectancy in the world. However, the country faces many challenges, including an ageing population with a low fertility rate, a shrinking economy, and an increasing burden from NCDs and degenerative diseases, such as dementia, which all impose a considerable stress on the current health and long-term care systems in Japan.

C．研究結果

Performance of the health system

Effectiveness and quality

Empirical evidence is scarce regarding the quality of primary health-care services in Japan. Hashimoto et al. (2011) showed that, compared to the USA, effective coverage for control of hypertension and hyperlipidaemia was much less in Japan. Using an administrative dataset, Tanaka et al. (2016) also reported that clinical practices for control of diabetes, including screening for complications of diabetes, are of relatively poor quality in Japan compared to those of the USA and European countries. These concerns might be attributable to relatively low rates of compliance to guidelines, limited opportunities for training in general practice, and the division between preventive and curative services in Japan (Hashimoto et al., 2011).

According to the OECD Health Statistics 2015, the quality of acute care services in hospitals in Japan showed poor performance for acute myocardial infarction (AMI). The death rate due to AMI in Japan was 12%, compared with the OECD average of 8.0%. However, according to the national databases that cover around 90% of acute care hospitals in Japan, the in-hospital mortality rate due to AMI was around 7.2%, suggesting that databases need to be refined for cross-country comparisons.

Moreover, evaluation of performance is still limited for outpatient services and chronic-care inpatient services. These data are covered mainly by the national database, which was primarily intended to facilitate reimbursements under the unified fee control schedule. As this database was not intended for research purposes, crucial data needed to determine service efficacy are often missing.

For data-driven, evidence-based policy-making, the government has slowly but steadily evolved its policy to make data available for open public use. However, the organizational infrastructure needed to improve the quality of data and

to support wider use is lacking.

Accessibility

Watanabe and Hashimoto (2012), using methodology originally proposed by Wagstaff et al. (1991), measured horizontal inequality – in accessing a health-care facility by using cross-sectional, nationally representative household surveys. Horizontal inequality is calculated as the difference between two types of concentration indices – acute health-care visits over a household's income level and expected health-care needs based on demographic and clinical conditions. By using the dataset from the Comprehensive Survey of People's Living Condition, they calculated horizontal inequality in Japan and the results are presented in Fig. 7.3. The horizontal inequality (gaps between two indices) was negative, indicating that people with a lower household income were likely to withdraw health-care use despite their health care needs. This gap was at its largest in 284 2001, though it jumped back to approximately –0.05 in 2007 (Sakamoto et al., 2018).

Fig. 7.4 and 7.5 show horizontal inequality in access to health care for two age groups (20–64 years and 65 years and above, respectively). Compared with the younger group, horizontal inequality has been low in people aged 65 years and above, presumably due to the reduced co-payment rate, which contributes to equalizing health-care utilization regardless of income levels among the elderly. However, a further decline in horizontal inequality is seen in 2013 among the older age group, which may be an early sign of the declining household capacity to pay for health-care costs due to economic stagnation. Further monitoring is required to assess this trend (Sakamoto et al., 2018).

It is worth noting that the Japanese health-care system does not adequately address the cultural needs of ethnic minorities, especially with respect to language barriers and religious backgrounds. Some efforts are being made in this direction as part of the preparations for the 2020 Tokyo Olympic and Paralympic games, foreseeing that there will be many foreign patients at that time. However, systematic and empirical evidence is scarce, making it difficult to assess the magnitude and severity of this problem.

Resilience

The likelihood of rising expenditure poses risks to fiscal sustainability. The ageing population and increases in the prices of medicines and medical devices have been pushing the total health-care expenditure, which has put a significant burden on the health-care system in Japan. To tackle this challenge, in 2008, the government (both the ruling party and the opposition party) agreed to pass the "Comprehensive Reform of Social Security and Tax", a joint reform of the social security and taxation system that should improve fiscal sustainability for the health and long-term care

system in Japan. It originally planned to raise the consumption tax, with any additional funds from it being channelled for social security costs, including health and long-term care. Though the current Abe Cabinet originally planned to increase the consumption tax rate to 10% in October 2015, it has been postponed to September 2019, which has delayed social security and taxation reform. An increase in the consumption tax being a big political issue, the future progress of reform remains unclear.

Integrated community care system (ICCS)

A majority of the elderly wish to stay in their homes during the very end of their lives. However, because of the increase in the number of unmarried people, single-person households and parent–child separated households, more elderly persons are living alone. Consequently, it is difficult to provide arrangements for them to die at home (78.4% die at health-care facilities). In response to this, the government promoted an Integrated Community Care System (ICCS) in 2006. This system aims to provide appropriate living arrangements, social care and daily life support services within the community as well as integrate prevention, medical services and long-term care for the elderly.

Twelve years since its adoption in 2006, the ICCS continues to be the central core policy of health and long-term care in Japan. However, several challenges remain: how to encourage local stakeholders to participate in the community discussion, how to channelize diverse interests to evolve a consensus on efficient allocation of resources, and how to meet bureaucratic demands both at the central and local government levels.

D. 結論

Thanks to the overall efficiency of its health system and parallel advances in technology, Japan has for many years enjoyed increased life expectancy, decreased maternal and infant mortality, and a reduced burden of communicable diseases. However, the Japanese health-care system faces several challenges, including an ageing society, increasing health-care expenditure, economic stagnation and increasing inequity, all of which place a heavy burden on the current health-care system.

Fundamentally, what Japan needs is a health-care paradigm shift. Such a shift in Japan’s approach to health care has already been proposed in Japan vision: health care 2035, a report drafted by young Japanese leaders in health care under the leadership of the then minister Yasuhisa Shiozaki. The goal of Japan vision: health care 2035 is to build a sustainable health-care system that delivers better health outcomes through care that is responsive and equitable to all members of society, and that contributes to prosperity in Japan and the world. Bearing in mind these transformations by 2035, fundamental reforms that focus on outcomes, quality, efficiency, care and integrated

approaches across sectors will be necessary to maintain a low-cost, equitable health system in the future (Miyata et al., 2015).

E. 研究発表

1. 論文発表

Sakamoto H, Ghaznavi C, Shibuya K. **Country Chapter 7 - Japan**. In Legido-Quigley H, Asgari-Jirhandeh N, editors. Resilient and people-centred health systems: Progress, challenges and future directions in Asia. New Delhi: World Health Organization, Regional Office for South-East Asia, 2018.

2. 学会発表

特になし

F. 知的財産権の出願・登録状況

（予定を含む。）

1. 特許取得

特になし

2. 実用新案登録

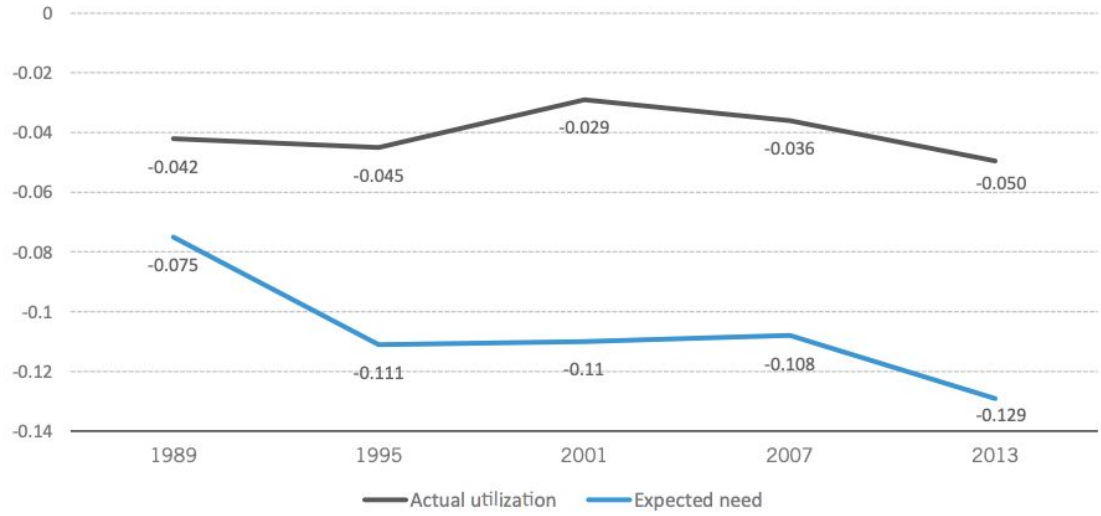
特になし

3. その他

特になし

Fig 7.3 Japan: Horizontal equity in access to healath caare

Fig. 7.3 Japan: Horizontal equity in access to health care (concentration indices over household income), age 20+ years, 1989–2013

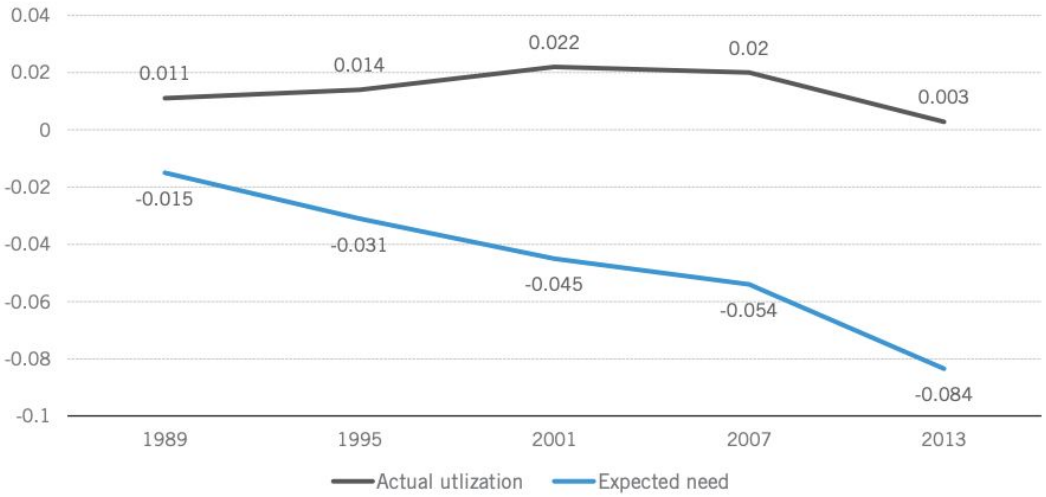


Notes: Actual utilization: concentration indices for actual health-care use; expected need: concentration indices for expected health-care needs (estimated health status)

Source: Sakamoto et al., 2018

Fig 7.4 Japan: Horizontal equity in access to health care (concentration indices over household income), age 20 – 64 yeaars, 1989 – 2013

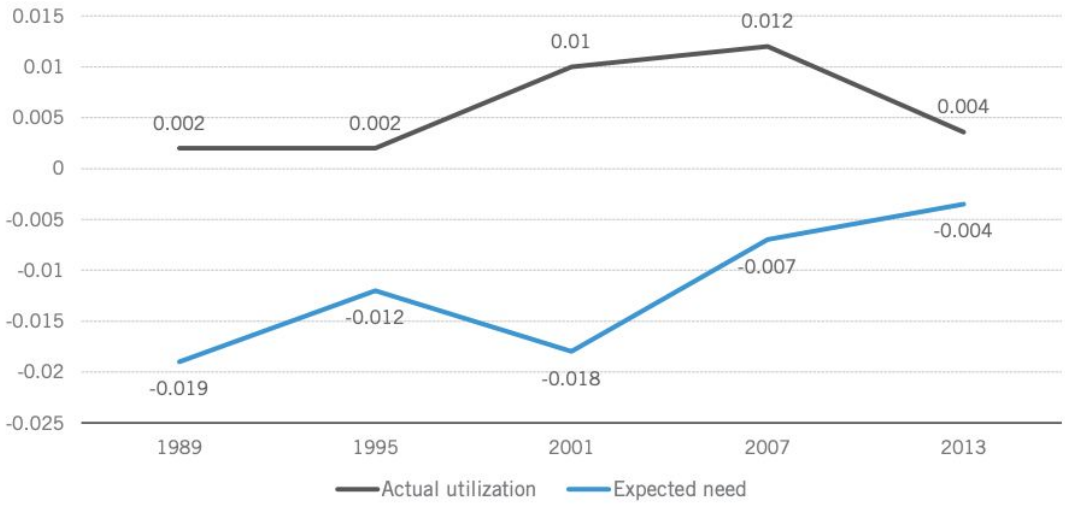
Fig. 7.4 Japan: Horizontal equity in access to health care (concentration indices over household income), age 20–64 years, 1989–2013



Notes: Actual utilization: concentration indices for actual health-care use; expected need: concentration indices for expected health-care needs (estimated health status)
Source: Calculated by Hashimoto from MHLW, 2016d

Fig 7.5 Japan: Horizontal equity in access to health care (concentration indices over household income), age 65+ yeaars, 1989 – 2013

Fig. 7.5 Japan: Horizontal equity in access to health care (concentration indices over household income), age 65+ years, 1989–2013



Notes: Actual utilization: concentration indices for actual health-care use; expected need: concentration indices for expected health-care needs (estimated health status)
Source: Calculated by Hashimoto from MHLW, 2016d