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Legislative Council
of the
Hong Kong Special Administrative Region

Delegation of the
Panel on Health Services

Report on the duty visit to study
Japan's healthcare financing system

5 to 7 September 2010

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Chapter 1 – Introduction

Purpose of report

1.1 A delegation of the Panel on Health Services of the Legislative Council visited Japan from 5 to 7 September 2010 to study the country's healthcare financing system. This report presents the main findings and observations of the delegation.

Background

1.2 The Panel on Health Services is tasked to monitor and examine the Government policies and issues of public concern relating to medical and health services.

1.3 On 13 March 2008, the Government published the Healthcare Reform Consultation Document "Your Health, Your Life" ("the Consultation Document") to initiate the public consultation on healthcare reform. The healthcare reform aims to address the challenges to Hong Kong healthcare system brought about by the rapidly ageing population and rising medical costs, and to ensure the future sustainability of the system in delivering healthcare protection and quality services to the community. The first stage public consultation conducted from March to June 2008 aimed at consulting the public on four service reform proposals and the pros and cons of reforming the current healthcare financing arrangements through six possible supplementary financing proposals -

(a) social health insurance (mandatory contribution by workforce);

(b) out-of-pocket payments (increase user fees);

(c) medical savings accounts (mandatory savings for future use);

(d) voluntary private health insurance;

(e) mandatory private health insurance; and

(f) personal healthcare reserve (mandatory savings and insurance).

1.4 The Government released the report on the first stage public consultation on healthcare reform on 19 December 2008. Results of the consultation reflected a broad recognition among the public that Hong Kong's ageing population will result in significantly increased healthcare expenditure, and hence the need to address the issue of healthcare financing. The public, however, have expressed reservations on various mandatory options of supplementary healthcare financing proposed in the Consultation Document. Moreover, many members of the public favour voluntary medical insurance and consider that it could have a bigger role to play with enhanced government regulation and supervision.

1.5 To enable members to grasp the latest development on healthcare financing and facilitate their deliberations on the issues concerned, the Panel on Health Services found it worthwhile to make reference to overseas experience. The Panel asked the Research and Library Services Division ("RLSD") of the Legislative Council Secretariat to gather information on the healthcare system in Japan, which has been highly rated by the Organisation for Economic Co-operation and Development ("OECD") as one of the best in the world in terms of access, effectiveness and efficiency. According to the OECD, the system provides health insurance coverage to all citizens, allowing them universal access to medical care services from any institution at any time, subject to a co-payment at the time of services. Regarding effectiveness, the health status of the Japanese people ranked at the top of the OECD countries in a number of categories in 2007. The healthcare system in Japan features the presence of about 3 560 health insurers at end-March 2008. In 2006-2007, insurance payment accounted for 49% of Japan's total health expenditure, followed by government subsidies to various health insurance schemes of 36.6% and co-payments by the insured of 14.4%.

1.6 Having regard to the research findings of RLSD, members agreed that the Panel on Health Services should conduct a visit to Japan to learn about the operation of the country’s healthcare financing system, visit some public and private hospitals and hold discussions with the relevant organisations. The Panel also agreed that the visit should be open to non-Panel Members.

1.7 On 4 June 2010, the Panel on Health Services obtained the House Committee's permission to undertake the visit to Japan.

Membership of the delegation

1.8 The delegation comprised the following Members -

Dr Hon Joseph LEE Kok-long, SBS, JP
(Panel Chairman and leader of the delegation)
Dr Hon LEUNG Ka-lau (Deputy Panel Chairman)
Hon Fred LI Wah-ming, SBS, JP
Hon CHAN Kam-lam, SBS, JP
Hon WONG Yung-kan, SBS, JP
Hon LAU Kong-wah, JP
Hon TAM Yiu-chung, GBS, JP
Hon LI Fung-ying, SBS, JP
Hon CHAN Hak-kan

1.9 Mary SO, Chief Council Secretary (2)5, and Theresa CHEUNG, Senior Legislative Council Assistant (2)2, accompanied the delegation on the visit.

Visit programme

1.10 The delegation visited Japan from 5 to 7 September 2010. During the visit, the delegation received briefings by the Ministry of Health, Labour and Welfare and the Health Insurance Claims Review & Reimbursement Services, and visited one public hospital, namely Tokyo Hospital, and one private hospital and one private medical centre, namely Sanno Hospital and Sanno Medical Centre. The delegation also visited two nursing homes, namely the Fukushi (Welfare) Plaza and the Shinjuku Keyakien.

1.11 Further details of the visit programme are in **Appendix I**. A list of the Government officials and representatives with whom the delegation met is in **Appendix II**. A list of the reference materials obtained during the visit is in **Appendix III**.

Chapter 2 - Overview of Japan's healthcare service delivery system

2.1 In Japan, healthcare services are delivered through clinics and hospitals, most of which are operated in the private sector by medical practitioners. There are no regulations mandating a clear division of roles and responsibilities between clinics and hospitals; the only distinction is size (according to government information, hospitals are medical institutions with 20 or more beds, while clinics are medical institutions without beds or 19 or less beds). Most hospitals, for example, offer out-patient primary care; and some clinics provide in-patient acute care, long-term care or both.

2.2. Private clinics and hospitals are not allowed to operate for profit. Patients in Japan can choose either a clinic or hospital as their first point of contact and may choose any provider of their choice. There is no established referral system with general practitioners playing the role as the gatekeeper to specialist or hospital services, and the distinction between generalists and specialists within the health system is weak.

2.3 In 2007, there were 8 862 hospitals in Japan, of which around 80% were in the private sector offering some 1.62 million hospital beds in total. Comparing with OECD average in 2007, Japan had a higher number of acute care hospital beds per 1 000 population (8.2 comparing to the OECD average of 3.8), a long average length of stay for acute care (19 days comparing to the OECD average of 6.5 days) and a higher number of doctor consultations per capita (13.6 comparing to the OECD average of 6.8). On the other hand, Japan had only 2.1 doctors per 1 000 population in 2007, which was below the OECD average of 3.1.

2.4 There are six National Centers for Advanced and Specialised Medical Care responsible for clarifying the causes and symptoms, researching on new diagnosis and treatment methods, developing advanced and pioneering medical care, and training specialised medical professionals relating to diseases that constitute high percentages of deaths and medical expenditure in Japan. The six National Centers, including the National Cancer Center, National Cardiovascular Center, National Center of Neurology and Psychiatry, International Medical Center of Japan, National Center for Child Medical Health and Development, and National Center for Geriatrics and Gerontology, offered 4 959 beds nationwide in 2009.

2.5 Other than academic studies which rely on hospitals providing data to researchers on a voluntary basis, Japan has few mechanisms for evaluating hospital performance or even for ensuring that the treatments have actually been delivered. For example, it does not systematically collect and analyse treatment and outcomes data from all hospitals as in the United Kingdom, the United States and many developed countries.

Chapter 3 – Japan's health insurance system

Visit programme

3.1 The delegation visited the Health Insurance Bureau of the Ministry of Health, Labour and Welfare ("MHLW") and received a briefing on Japan's health insurance system. The delegation also visited the Health Insurance Claims Review & Reimbursement Services and received a briefing on its operation.

Presentation of souvenir to Mr Kimihiko SAKURAI,
General Affairs Division, Health Insurance Bureau,
Ministry of Health, Labour and Welfare

Presentation of souvenir to Mr ASHIKAGA, Senior Executive Director of the Health Insurance Claims Review & Reimbursement Services (centre)

Major funding source of Japan's healthcare system

3.2 Japan's healthcare system is based on a social health insurance model, with the first health insurance scheme coming into place as early as 1927 to cover blue-collar workers. The health insurance scheme for the self-employed was introduced in 1938, and universal coverage was achieved in 1961.

3.3 The Health Insurance Bureau under MHLW is responsible for planning and regulating the health insurance system to ensure that everyone in the country is covered and sustainability of the system can be maintained.

3.4 Enrolment in the health insurance system is compulsory in Japan and applies to all residents including foreigners on condition that they are legally residing in the country (short-period visitor are excluded). Participants of the system are covered under one of the following categories of insurance -

(a) Employees' Health Insurance provided by their employers;

(b) Community-based National Health Insurance ("NHI") provided by the municipalities in which they reside; or

(c) Long Life Medical System for people aged 75 or above.

3.5 Under the universal coverage of health insurance, supplementary private health insurance is also available for covering co-payments or non-covered costs required for hospitalisation and surgery.

Employees' Health Insurance

3.6 Employees' Health Insurance is an employment-based insurance scheme, which can be broadly separated into the Society-managed Health Insurance ("SHI") and the Government-managed Health Insurance ("GHI").

Society-managed Health Insurance

3.7 SHI is a corporate-managed programme for employees of large corporations (with more than 700 workers) and their dependents. Under the Health Insurance Act, a large corporation can establish an insurance

society to establish and manage its own health insurance programme. These insurance societies operate with government regulations to determine their own benefits and contributions.

3.8. As of March 2009, there are about 1500 insurance societies covering some 30 million people. Premium rates range from 3% to 10% of the monthly salary of workers, reflecting the difference in the income levels of the insured in each SHI. Monthly contributions to SHI are normally shared evenly by employers and employees.

Government-managed Health Insurance

3.9 GHI is a government-managed programme covering employees of small and medium-sized firms (between five and 700 workers) and their dependents. GHI is managed by a public corporation established in October 2008 - the Japan Health Insurance Association - which is responsible for, among other things, setting the premium rates for GHI schemes run in various prefectures of the country. The premium rates for GHI schemes, ranging from 9.26% to 9.42% of the monthly salary of workers, are determined based on the health expenditure, demographic structure and income level of each prefecture. As of March 2009, about 35 million people are covered by GHI.

3.10 Since employees of small and medium-sized firms tend to have a salary level lower than those working in large corporations, the premium revenue alone is not enough to sustain the operation of GHI. To supplement the deficit incurred, the Japanese government provides subsidy to help finance 13% of the healthcare cost of GHI. Monthly contributions to GHI are shared equally by employers and employees.

National Health Insurance

3.11 In Japan, legal residents who do not qualify for Employees' Health Insurance are required by law to enrol in NHI run by the municipal government in the area where they reside. NHI covers the self-employed, unemployed, workers at companies with less than five employees, and retirees. In general, an employee is first enroled in the Employees' Health Insurance. Upon retirement, he will be transferred to a NHI managed by the municipal government based on his place of residence. Altogether, there are about 2 000 insurers covering some 40 million people as of March 2009.

3.12 Each municipal government has its own way of calculating insurance premiums for its NHI schemes. In general, the calculation is based on the number of persons insured in a household and the annual income of the family. The insurance premiums typically account for around 2% of the average wage, although there is a wide variation among municipalities. Same as GHI, the Japanese government provides subsidy to help finance 43% of the healthcare cost of NHI.

Long Life Medical Care System

3.13 In Japan, a resident will no longer be covered by Employees' Health Insurance or NHI when reaching 75 years of age. He will be transferred to a third insurance scheme - the Long Life Medical Care System - run by the prefecture where he resides. However, people aged 65 or above with certain disabilities are also eligible to enrol in the Long Life Medical Care System.

3.14 Annual insurance premiums for the Long Life Medical Care System consist of two components: (a) a fixed amount paid by the insured and (b) an income-based amount determined by the insured's individual's ability to pay. The premiums so collected finance 10% of the healthcare cost of the Long Life Medical Care System. The remaining 90% is covered by subsidies from the government (50%) and cross-subsidisation from the insured under the age of 75 (40%).

Coverage of the healthcare insurance schemes

3.15 All the insurance programmes offer patients a free choice of service providers and are similar in terms of the range of medical services covered. However, there are significant differences among the different health insurance programmes in eligibility, co-payments, cash benefits and the level of government subsidy provided to cover administrative costs and to recover deficits.

3.16 Mandatory coverage includes ambulatory and hospital care, extended care, most dental care and prescription drugs. In addition, various forms of cash benefits are also available under the health insurance schemes, such as lump sum allowances for childbirth and childcare, as well as funeral and hospital meal expenses.

3.17 Health services not covered by the health insurance schemes include abortion, cosmetic surgery, traditional medicine, certain hospital amenities (e.g. private room) and some high-technology procedures.

Fees and charges

3.18 All health insurance plans pay health services providers (e.g. hospitals, clinics and pharmacies) according to the national fee schedule set by the government. The schedule lists all the procedures and products covered by the health insurance and the prices charged for them. Payment to the providers is based on the listed prices for each service or product delivered to the patient, multiplied by the number of services or products provided.

3.19 The national fee schedule applies to all patients regardless of the health insurance scheme they belong to and the provider from whom they receive services. In other words, medical fees are uniform throughout Japan with little concern for differences in the types of medical facilities, level of wages or cost of living in various municipalities.

3.20 The national fee schedule is revised every two years based upon the recommendations of the Central Social Health Insurance Council, an advisory committee to MHLW consisting of representatives from health services providers and payers, and academics.

Cost sharing by patients

3.21 While the extent of coverage and payment mechanism varies little under the health insurance schemes, there are differences in the level of cost sharing by the insured and their dependents. Patients aged three to 69 are required to pay 30% of the medical costs, whereas the co-payment rate is reduced to 20% for children under the age of three. In view of the fact that rapid population ageing has challenged the sustainability of the Long Life Medical Care System established in 1983, a co-payment of 10% was introduced in 2002. The government has also raised the youngest age eligible for the Long Life Medical Care System gradually from 70 to 75 in five years from October 2002 to September 2007. Starting from 2008, elderly people aged 70 or above are required to pay 10% or a higher rate of 30% if their income is comparable to when they were working. Further reform will be implemented starting from April 2011 whereby a co-payment of 20% will be imposed on elderly people aged 70 to 74.

3.22 All health insurance schemes have built in a catastrophic cap feature that limits the amount of monthly out-of-pocket medical expenses. When a patient's monthly co-payment exceeds a certain ceiling, the excess will be refunded upon request by the insurer. The following table shows the ceiling of co-payment by patients aged below 70 under different income groups -

	Monthly co-payment ceiling (for the first three months of treatment)	**Monthly co-payment ceiling (beginning with the fourth month of treatment)**
General households	¥81,000 (HK$6,723[(1)]) + A × 1% (A = covered medical expenses minus ¥267,000 (HK$22,161))	¥44,400 (HK$3,685)
Low income households[(2)]	¥35,400 (HK$2,938)	¥24,600 (HK$2,042)
High income households[(3)]	¥150,000 (HK$12,450) + B × 1% (B = covered medical expenses minus ¥500,000 (HK$41,500))	¥83,400 (HK$6,922)

Notes: (1) Based on the average exchange rate of HK$0.083 per Japanese Yen in 2009.
(2) Including households living on public assistance.
(3) Households with an annual income exceeding ¥6 million (HK$498,000).

Review and reimbursement of health insurance medical fee claims

3.23 The Health Insurance Claims Review & Reimbursement Services ("HICRRS") was established in September 1948 under the Act on Health Insurance Claims Review & Reimbursement Services as a specially designated public corporation to review medical fee claims from medical institutions and pharmacies and settle payments with them after reimbursement are made with the insurers. In October 2003, HICRRS was re-organised as a specially designated private corporation.

The delegation toured the facilities at the
Health Insurance Claims Review & Reimbursement Services

3.24 HICRSS is headquartered in Tokyo with 47 branches in each prefecture in Japan. For the fiscal year 2010, it has 4 934 employees and 4 536 assessment committee members who are doctors, insurers and academics. HICRRS charges 114.2 yen for each claim from medical institutions and 57.2 yen for each claim from pharmacies. A lower fee for each claim will be charged if the claim is in electronic form or made online. For the fiscal year 2009, HICRRS examined about 8 600 million claims and paid approved claims totaling some 9.6 trillion yen to medical institutions and pharmacies.

3.25 In Japan, payments for out-patient care are predominantly on a fee-for-service basis while in-patient care is paid through a mixture of flat-rate per visit/episode basis and fee for service. Under the fee for service system, each medical service is expressed in "points" and each medical treatment is expressed as the sum of the points allotted to the medical service(s) provided. Each point is 10 yen, and the total fee is calculated by multiplying the points by 10 yen. To claim payments for the medical services delivered, each provider must prepare a medical fee claim form specifying the number of points for the treatment and the medication/injection composing the treatment for submission to HICRRS by the 10th day of the following month. (Similar procedure for requests for payments by pharmacies applies.) The claim forms received from medical institutions and pharmacies are examined individually by HICRRS and approved claims are then sent to the respective insurers. Insurers pay HICRRS the medical fees specified in the approved claims as well as the charges for examination of the claims. Such payment should be made following the month when the claim is made to HICRRS, i.e. two months after the medical service has been provided or the drug has been dispensed to the insured. Payments to medical institutions and pharmacies through financial institutions, such as banks, and post offices are made by HICRRS by the 21st of the second month after the provision of medical care and dispensing of drugs.

Chapter 4 – Prevention and control of lifestyle-related diseases in Japan

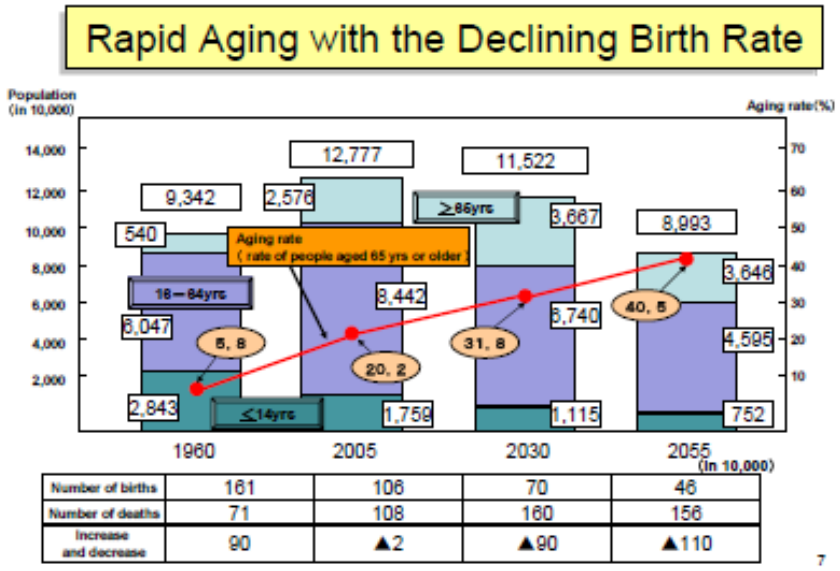
Visit programme

4.1 The delegation received a briefing from the Health Service Bureau of MHLW on the prevention and control of lifestyle-related diseases in Japan.

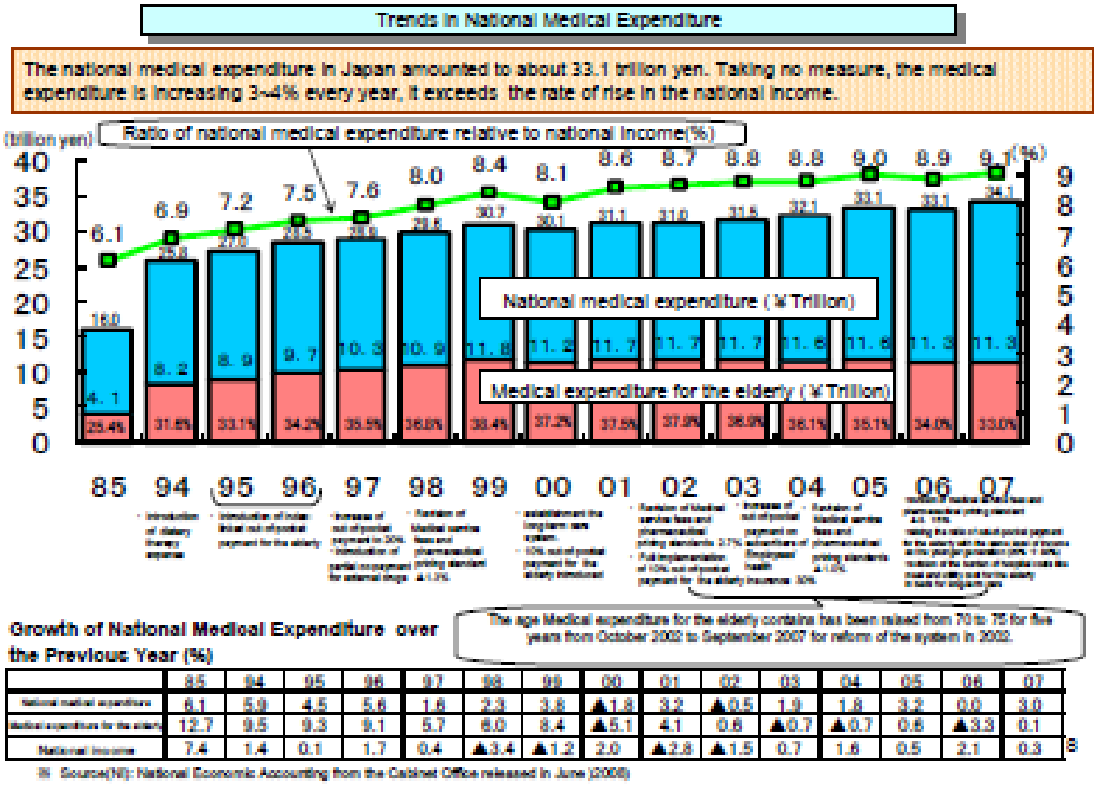
The delegation received a briefing from MHLW on the measures for lifestyle-related disease

Measures against lifestyle-related diseases

4.2 Japan has a growing ageing population with declining birth rate. By 2055, about 40.5 % of the population will be aged 65 or older, whereas the number of births per 10 000 population is projected to drop to 46. The following table shows the ageing rates in Japan from 1960 to 2055 as well as the numbers of births and deaths in Japan during the same period -



4.3. According to the statistics released by Japan's National Economic Accounting Office in June 2008, the country's annual healthcare spending amounted to 34.1 trillion yen in 2007 and increasing at 3% to 4% a year which is faster than the increase in national income. At the same time, healthcare expenditure for the elderly as a percentage of the total amount of national healthcare expenditure has been growing steadily from 25.4% in 1985 to 33% in 2007. According to Japan's Annual Report of Medical Services for the Elderly, the healthcare expenditure per elderly person in 2007 is 870 000 yen which is 4.8 times of the healthcare expenditure of a non-elderly person at 181 000 yen a year. The following table depicts the trend of healthcare spending in Japan from 1985 to 2007 -

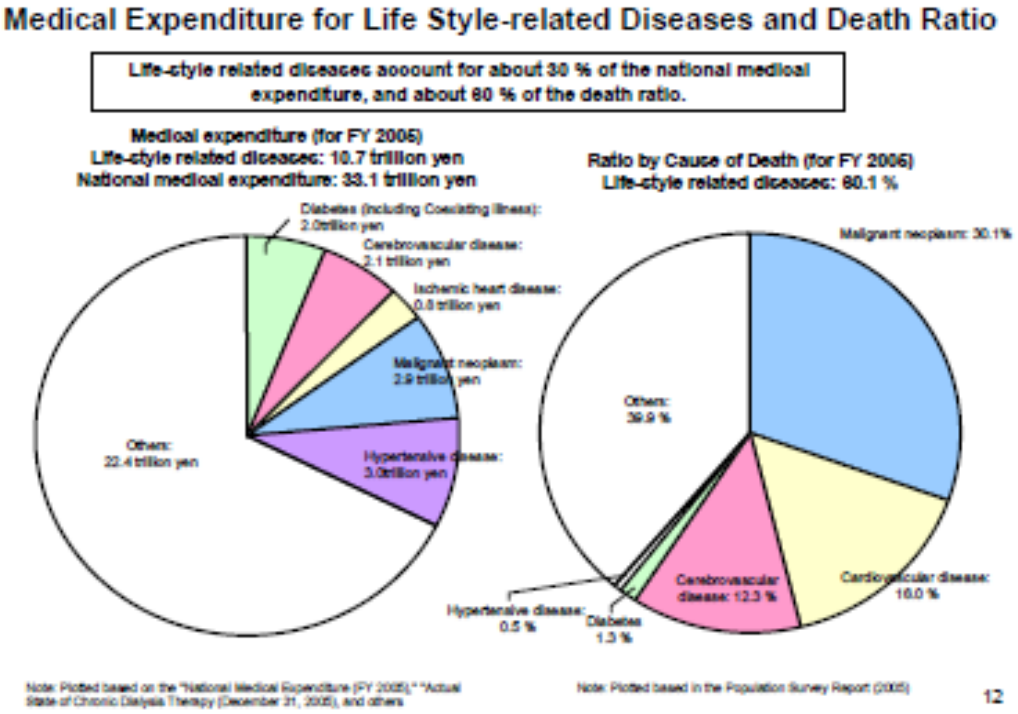


Growth of National Medical Expenditure over the Previous Year (%)

	85	94	95	96	97	98	99	00	01	02	03	04	05	06	07
National medical expenditure	6.1	5.9	4.5	5.6	1.6	2.3	3.8	▲1.8	3.2	▲0.5	1.9	1.8	3.2	0.0	3.0
Medical expenditure for the elderly	12.7	9.5	9.3	9.1	5.7	6.0	8.4	▲5.1	4.1	0.6	▲0.7	▲0.7	0.6	▲3.3	0.1
National income	7.4	1.4	0.1	1.7	0.4	▲3.4	▲1.2	2.0	▲2.8	▲1.5	0.7	1.6	0.5	2.1	0.3

※ Source(NI): National Economic Accounting from the Cabinet Office released in June (2008)

4.4 To contain the rising healthcare costs due to rapid ageing population, MHLW has been implementing the "National Health Promotion Movement in the 21st Century" ("Health Japan 21") which aims at promoting and supporting people's lifelong self management of health since 2000. In Japan, lifestyle-related diseases, notably, malignant neoplasm, diabetes, hypertensive disease, heart disease and cerebrovascular disease, account for about 30% of the country's medical expenditure and about 60% of its ratio of cause of death. The following table lists the medical expenditure for lifestyle-related diseases and the death ratio -



4.5 In "Health Japan 21", 70 specific targets are set in the following nine areas for improving people's lifestyle through focusing on primary prevention in collaboration with various bodies including non-governmental organisations and private companies -

(a) Nutrition and dietary habits - promoting and issuing guidelines on nutrition and healthy dietary habits;

(b) Physical activities and exercise - raising public awareness about the importance of physical activities and creating more places where these activities can take place;

(c) Rest and mental health - educating the public about the importance of rest and mental health;

(d) Tobacco - educating the public about the adverse health impact of smoking as well as passive smoking;

(e) Alcohol - reducing the number of heavy drinkers, prohibiting minors from drinking and disseminating information on appropriate alcohol intake;

(f) Oral health - carrying out oral health campaigns on the prevention of periodontal disease and tooth decay and enlightening the public on the importance of retaining at

least 20 teeth at the age of 80;

(g) Diabetes - launching programmes to encourage early detection of diabetes through body check and acquiring healthy eating habits and continued treatment of the disease, and subsidising research on "Japan Diabetes Outcome Intervention Trial" since 2005 with the aims of halving the rate of transition from the pre-diabetes stages to actual diabetes, halving the discontinuation rate of treatment by diabetes patients and reducing diabetic complications by 30%. According to the results from the National Health and Nutrition Survey conduced by MHLW in 2007, approximately 8.9 million people are strongly suspected of having diabetes and those with possibilities of having diabetes are approximately 13.2 million people;

(h) Cardiovascular disease - raising public awareness about the importance of early detection of cardiovascular disease through primary prevention and subsidising research on the prevention, diagnosis and treatment of cardiovascular disease; and

(i) Cancer - providing public subsidy on conducting cancer research. Furthermore, following the enactment of the Cancer Control Act in June 2006, the "Basic Plan to Promote Cancer Control Programmes" was approved in 2007 to combat cancer in a comprehensive and systematic manner.

4.6 As part of the preventative focus of health care, the government has been pushing back against obesity-related health problems, known as "metabolic syndrome". There is compulsory obesity screening for 70% of the population. If people are found to be too fat around the waist, they are required to receive counseling on exercise and diet.

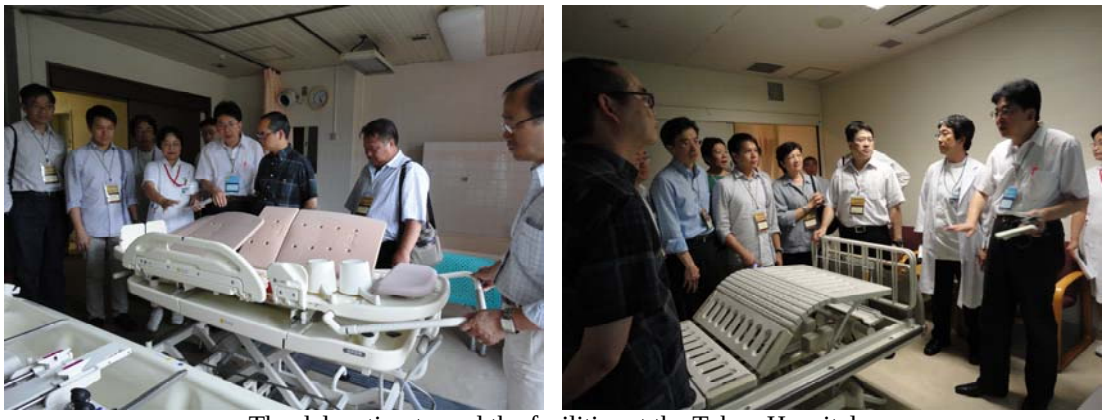
Chapter 5 - Public and private hospitals

Visit Programme

5.1 The delegation visited one public hospital, namely the Tokyo Hospital, and one private hospital and clinic, namely the Sanno Hospital and the Sanno Medical Centre, to receive briefings on the provision of medical services in Japan. Tours were also taken after the briefings to observe the facilities at these hospitals.

Tokyo Hospital

5.2 Tokyo Hospital was established in 1962 by combining the National Tokyo Sanatorium and the Kiyose Hospital. It is a 560-bed public hospital for preventing tuberculosis, treating survivors of atom bombs and treating patients who are covered under various health insurances and social welfare schemes. Tokyo Hospital has 15 medical departments, including Medicine, General Surgery, Neurology, Ophthalmology, Radiology, Orthopedic Surgery, Urology and a few other specialty departments.



The delegation toured the facilities at the Tokyo Hospital

Sanno Hospital

5.3 Sanno Hospital is a 75-bed private hospital established in 1937 and operated by the Medical Cooperation Junwakai. It was originally known as Sanno Internal Clinic and renamed Sanno Hospital when it moved from Minato Ward to Chiyoda Ward. Sanno Hospital has 17 medical departments, including Internal Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Orthopedics, Otorhinolaryngology,

Dermatology, Urology, Ophthalmology, Radiology, Dentistry and Oral Surgery, and several other specialty departments. It also has four medical centres providing specialised treatments and services -

(a) Centre for Human Reproduction : infertility counselling and treatment;

(b) Centre for Respiratory Diseases : treatment of lung and respiratory diseases;

(c) Preventive Health Examination Centre : health check-up; and

(d) Tokyo Voice Centre of Sanno Hospital and International University of Health and Welfare : treatment of pharyngeal diseases and voice diseases.

The delegation received a briefing from the representative of the Sanno Hospital

The delegation toured the facilities at the Sanno Hospital

Sanno Medical Centre

5.4 Sanno Medical Centre is a 19-bed private medical centre established in October 2009, belonging to the same group as Sanno Hospital and located in its proximity. Sanno Medical Centre has seven major medical departments, including Internal Medicine, Gastroenterology, Endocrinology, Division of Nephrology (Dialysis), Vascular Surgery, Gynecology and Radiology. It also has five medical centres providing specialised treatments and services -

(a) Centre for Preventive Medicine;

(b) Women's Centre for Gynecologic Cancer;

(c) Dialysis Centre;

(d) Centre for Vascular Access Surgery; and

(e) Health center.


The delegation toured the facilities at the Sanno Medical Centre

Chapter 6 - Nursing homes

Visit Programme

6.1 The delegation visited two nursing homes, namely the Fukushi (Welfare) Plaza and the Shinjuku Keyakien, to receive briefings on the provision of care services for the elderly and the mentally-handicapped. Tours were also taken after the briefings to observe the facilities at these homes.

The Fukushi (Welfare) Plaza

6.2 The Fukushi (Welfare) Plaza was established by a social welfare organisation in 2006 to provide residential and rehabilitative care services for elderly persons aged 65 and above and the mentally-handicapped. The Fukushi (Welfare) Plaza provides 100 residential care places for elderly persons aged 65 and above requiring special care and long-term care respectively and 100 residential care places for the mentally-handicapped. It also provides home-based community care services to help elders with long-term care needs age in the community.

The delegation toured the facilities at the Fukushi (Welfare) Plaza Sakurakawa, The Social Welfare Corporation Nagaoka.

The Shinjuku Keyakien

6.3 The Shinjuku Keyakien is a six-storey nursing home, established in 2008 by a social welfare organisation to provide care services for the elderly. It provides 100 long-term care places and 10 short-term residential care places for the elderly people and also provides day care service for up to 20 elderly people with dementia.

The delegation toured the facilities at the Shinjuku Keyakien (nursing home)

Chapter 7 - Observations

General

7.1 The delegation is of the view that the information obtained during the visit has provided useful reference for Hong Kong in the area of healthcare financing. The observations of the delegation are given in the following paragraphs.

Healthcare financing system

7.2 The delegation notes that under the social health insurance approach, the Japanese enjoy universal access to high quality and low-cost care and the country scores well in terms of life expectancy, infant mortality and other public health measures.

7.3 To tackle ageing population, the central government in 1983 established the elderly insurance, a common fund for providing medical care to elderly people aged 70 and above that is financed by pooling contributions from all the social health insurance schemes and by government subsidy. Both central and local governments subsidise the elderly insurance by contributing at least 30% of the total medical expenditure of the elderly insurance and the proportion is expected to increase to 50% in the coming years.

7.4 The sustainability of Japan's healthcare system is, however, threatened by a low growth of revenues due to a stagnant economy for the past two decades and a strong pressure on spending due to rapid ageing of population.

7.5 The delegation has observed that in Japan, government intervention in the healthcare system is minimal, apart from the fact that the reimbursement rates are heavily regulated. The country does not use any gatekeeper systems, i.e. patients are free to consult any provider (primary or specialist) at any time and no proof of medical necessity is required. Hospitals are expected to treat all patients who need care, unless they have severe capacity constraints. As a result, the number of out-patient visits per capita per year is more than twice the OECD average and the average length of stay is about four times more than the OECD average, with many acute care beds having taken on the long-term

care function for the elderly. On the other hand, patients in Japan have limited opportunities to obtain differentiated treatments for similar health problems or advanced medical services under the healthcare financing system which emphasise equitable access to medical services for the entire population at a relatively low cost compared with many developed countries such as the United States of America.

7.6 Hospitals have also been providing significant level of out-patient service not only because it is an attractive revenue source arising from the generous payments by insurers but also because it represents an important source of admission to beds. As a result, many private clinics have developed a small in-patient capacity and evolved into small hospitals. The situation of everybody trying to do everything has contributed to wastage and inefficiency. Also, there has been a rapid increase in drug spending, largely due to volume expansion stimulated by the fact that doctors' incomes depended heavily on dispensing drugs.

7.7 The delegation has observed that the combination of the predominantly fee-for-service payment, competition in the market for patients leading to over-supply of service, and an ineffective third payer control of service provision have resulted in the expansion of service volumes beyond what might be necessary on clinical grounds.

7.8 The delegation notes the following measures adopted by the Japanese government to control healthcare expenditure -

(a) adjusting the national fee schedule to constrain the overall rate of price increases and to encourage the most cost-effective services;

(b) increasing co-payments to dampen demand, though this effect seems limited because of a capping at a relatively lower level compared to a relatively high average high monthly disposable income per household; and

(c) controlling the supply-side through regulation of the number of medical students and hospital bed numbers.

The Japanese government has also tried to cut down on over-prescription by making drugs less attractive as a source of income for doctors and hospitals by promoting the separation of prescription and dispensing of drugs.

7.9 Members are impressed by the steps, albeit incremental, taken by the Japanese government in reforming the healthcare system to make it sustainable in the long run.

7.10 Members are highly impressed by the efforts put in by the Japanese government in promoting and implementing numerous measures against lifestyle-related diseases as a national campaign, in collaboration with various bodies, including private companies and non-government organisations.

Public and private hospitals

7.11 The delegation has found the facilities provided at the public and private hospitals which they visited, namely the Tokyo Hospital and the Sanno Hospital, and a private medical centre, namely the Sanno Medical Centre, to be of a very high standard. Wards of all classes are airy, clean and well fitted-out, and are on par with any modern world-class hospitals and clinics.

7.12 The delegation notes that the Tokyo Hospital, being a public hospital providing healthcare services mainly to patients suffering from chronic diseases such as respiratory disease, is trying to increase its income by admitting more acute patients and helping stable chronic patients to transfer to long-term care homes so as to reduce their stay in the hospital. To cope with the phenomenon whereby an increasing number of patients are being turned from emergency care from one hospital to another, the Tokyo Hospital plans to set up a department to provide emergency care. The reasons why hospitals turn away patients seeking emergency care are due to the lack of specialists to treat emergency care patients and/or that the hospitals do not have the capacity to take in these patients.

7.13 The delegation has observed that the Sanno Hospital provides hotel-style private room to its patients, the fee of which is not covered by the healthcare insurance. There are six types of private hospital rooms ranging from 20m^2 to 70 m^2 for patients to choose from. The Sanno Hospital also has a high doctor-to-patient ratio in that it has 80 full-time doctors and some 130 part-time doctors. In addition to providing in-patient care, the Sanno Hospital also provides out-patient primary care. The daily average out-patient attendance is 850. Members also note that the Sanno Hospital is a very popular hospital among Japanese people for

giving birth. In 2009, some 829 babies were delivered at the Sanno Hospital. The fee charged for childbirth ranges from 800 000 to 1.2 million yen.

7.14 The delegation has observed that the Sanno Medical Center also provides hotel-style private room to its patients, the fee of which is not covered by the healthcare insurance. Sanno Medical Center mainly offers health check-up (also not covered by the healthcare insurance) using the latest medical technologies. Patients' stay at Sanno Medical Centre generally ranges from two to three days.

Nursing homes

7.15 The delegation notes that in recognition of the huge financial burden on the medical institutions caused by the growing ageing population, the Japanese government launched the long-term care insurance system in 2000. The insured under the system are people aged 65 and above (Category I insured persons) and (2) people aged 40-64 covered by health insurance program (Category II insured persons). Long-term care insurance services are provided for people aged 65 and above requiring long-term care, and for people aged 40-64 suffering aging-related diseases such as terminal cancer and rheumatoid arthritis. The types of long-term care range from community-based daily home care to residential care. For Category I insured persons, their premiums are collected by the municipalities they are residing through deduction of their pension benefits. For Category II insured persons, their premiums are collected by the healthcare insurers together with their healthcare premiums. The insured is required to pay 10% of the service, food and accommodation expenses. For the low-income group, the amount of co-payment will be reduced or covered by public assistance.

7.16 Members are highly impressed with the facilities of the two nursing homes which they visited, namely, the Fukushi (Welfare) Plaza and the Shinjuku Keyakien. Members are particularly impressed with the home-like environment which these homes have successfully created for their residents as well as the adoption of a unit system (10 residents are formed into one group under the care of five staff) to provide personal and attentive care to the residents. Members note that residents have to pay a monthly fee ranging from 15 000 to 80 000 yen depending on the types of meals and rooms they choose.

7.17 Members, however, note that there is a long waiting time of up to

two to three years for admitting to these nursing homes, due to the lack of such facilities and the fact that the great majority of residents will stay in these homes until they pass away.

Conclusion

7.18 The delegation considers the visit useful in that it has enabled Members to better understand Japan's healthcare financing system. The delegation has also observed the facilities and services provided by some private and public hospitals/medical centre and nursing homes for the elderly and the mentally-handicapped. Although the relevant factors in Japan may not be directly applicable to Hong Kong, information obtained from the visit will facilitate Members' consideration of the recommendations to be made by the Hong Kong Government in respect of healthcare financing options for Hong Kong.

Council Business Division 2
Legislative Council Secretariat
14 December 2010

Appendix I

Panel on Health Services

Duty visit to Japan
(5-7 September 2010)

Visit programme

Sunday, 5 September 2010	
2:55 pm	**Arrival at Tokyo**
Monday, 6 September 2010	
10:00 am – 12:00 noon	**Visit to the Ministry of Health, Labour and Welfare** - Briefing on Health Insurance Scheme, including healthcare financing by Mr Kimihiko SAKURAI, General Affairs Division, Health Insurance Bureau - Briefing on the measures for lifestyle related disease by Mr Ryou TAKAGI, Deputy Director, General Affairs Division, Health Services Bureau
2:00 pm – 3:00 pm	**Visit to the Health Insurance Claims Review & Reimbursement Services** - Briefing on Social Health Insurance Scheme by Mr ASHIKAGA, Senior Executive Director, Mr NISHIZAKI, Head of Tokyo Branch, Mr IHARA, Deputy Head of Investigation Committee, Mr Kan, Planning Division
4:00 pm – 5:30 pm	**Visit to the Tokyo Hospital** - Briefing on the operation of public hospital in Japan by Mr Masao CHINO, Deputy Director, Mr Shunsuke SHOUJI, Mr Minoru MITAMURA, Ms Ikuko NAGATA

Tuesday, 7 September 2010	
10:00 am – 11:30 am	**Visit to the Fukushi (Welfare) Plaza Sakurakawa,** **The Social Welfare Corporation Nagaoka** - Briefing on the operation of nursing homes in providing care to the elderly and mentally handicapped by Mr Satoru ISHIZAWA, Head, Mr Masaru HIRANUMA, Head, Mr Tatsuki OOTOI, Ms Yumiko SEKI, Mr Akio TAKATSUKI, Ms Suzuyo NISHIKAWA
12:30 pm – 2:00 pm	**Lunch with Diet Members hosted by Mrs Jennie CHOK, Principal Hong Kong Economic and Trade Office Representative**
3:00 pm – 3:45 pm	**Visit to the Sanno Hospital** - Briefing on the operation of private hospital in Japan by Mr Osamu TSUTUMI, Director cum Professor of Graduate School, International University of Health & Welfare
3:50 pm – 4:20 pm	**Visit to the Sanno Medical Centre** - Received by Mr Takahiro AMANO, Director cum Deputy Dean of International University of Health & Welfare
4:50 pm – 5:35 pm	**Visit to the Shinjuku Keyakien (nursing home)** - Briefing on the operation of nursing homes in providing care to the elderly by - Ms Motoko SUGIHARA, Head

Appendix II

List of Government officials and representatives with whom the delegation met

Ministry of Health, Labour and Welfare

Mr Kimihiko SAKURAI, General Affairs Division,
Health Insurance Bureau
Mr Ryou TAKAGI, Deputy Director, General Affairs Division,
Health Services Bureau
Mr Nobuhiro IWASHITA, International Affairs Division,
Minister's Secretariat

Health Insurance Claims Review & Reimbursement Services

Mr ASHIKAGA, Senior Executive Director
Mr NISHIZAKI, Head of Tokyo Branch
Mr IHARA, Deputy Head of Investigation Committee
Mr Kan, Planning Division

Tokyo Hospital

Mr Masao CHINO, Deputy Director
Mr Shunsuke SHOUJI
Mr Minoru MITAMURA
Ms Ikuko NAGATA

Fukushi (Welfare) Plaza Sakurakawa, The Social Welfare Corporation Nagaoka

Mr Satoru ISHIZAWA, Head
Mr Masaru HIRANUMA, Head
Mr Tatsuki OOTOI
Ms Yumiko SEKI
Mr Akio TAKATSUKI
Ms Suzuyo NISHIKAWA

Diet Members

Hon Hiroyuki NAGAHAMA, Senior Vice Minister of Health, Labour & Welfare
Hon Yukiko MIYAKE, Member, House of Representatives
Hon Shozaburo JIMI, Minister of State for Financial Services, Minister of State for Postal Reform
Hon Banri KAIEDA, Member, House of Representatives, Secretary General of Japan Hong Kong Parliamentarians League

Sanno Hospital

Mr Osamu TSUTUMI, Director cum Professor of Graduate School, International University of Health & Welfare

Sanno Medical Centre

Mr Takahiro AMANO, Director cum Deputy Dean of International University of Health & Welfare

Shinjuku Keyakien (nursing home)

Ms Motoko SUGIHARA, Head

Appendix III

Reference materials obtained during the visit

Powerpoint materials on “Japanese Health Insurance System” provided by the Health Insurance Bureau of the Ministry of Health, Labour and Welfare

Powerpoint materials on “Outline of Health Insurance Claims Review & Reimbursement Services" provided by Health Insurance Claims Review & Reimbursement Services

Powerpoint materials on “Prevention and control of lifestyle-related diseases in Japan” provided by the Office for Lifestyle Related Disease Control of the Health Service Bureau of the Ministry of Health, Labour and Welfare

Japanese Health Insurance System

Health Insurance Bureau-Ministry
of Health,Labour and Welfare

An Outline of the Japanese Medical System

- Senior Citizens (70 yrs +)
  75yrs + 10%
  70～74yrs 20% (※)
  (or 30% for those persons with income comparable to when they were working)
- General
  30%
- Until the entry into primary school
  20%

(※)From 2008 Apr to 2011 Mar, it remains 10%.

Patient (the insured)

[2] Amount paid by patient for consultation

[3] Medical treatment

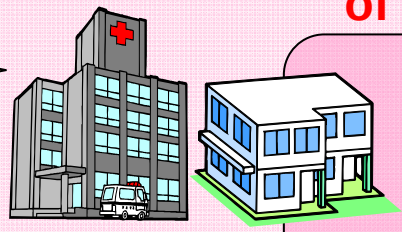
[1] Premium

[5] Payment

[4] Claim

Insurer

System of the Provision of Medical Care



Hospital, Clinic } Medical Care Law

Doctors	Medical Practitioners Law
Dentists	Dental Practitioners Law
Pharmacists	Pharmacists Law
Health workers, Maternity nurses, Nurses	Law for Public Health Nurses, Midwives and Clinical Nurses

For all other health workers

All other holders of national qualifications must adhere to the relevant law

The Medical Insurance System

Civil Service

National

Prefectural

Local

Pay Public Expenses

Pay Public Expenses

insurer

grants

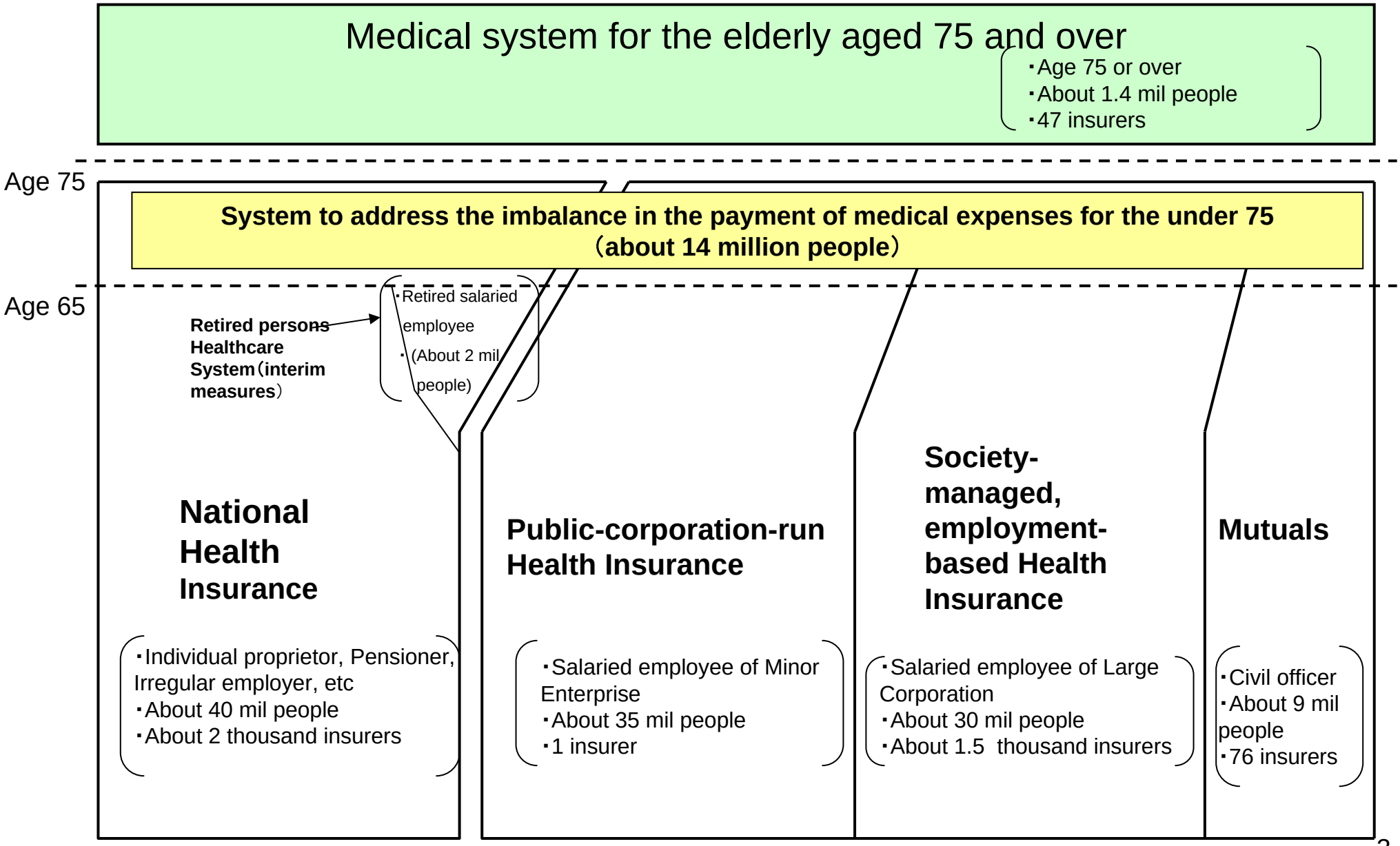
(Type of System)	(No. of insurers)	(No. of members)
National Health Ins.	1953	39 million
Public-corporation-run health insurance	1	35 million
Society-managed, employment-based health insurance	1497	30 million
Mutuals	77	9 million

• Numbers of insurers and members are accurate as of March 2009

Medical system for the elderly aged 75 and over	47	13 million

* Numbers of members are accurate as of March 2009

Outline of the Healthcare Insurance System



※ Numbers of enrolled members are the quick estimation as of the end of September 2009

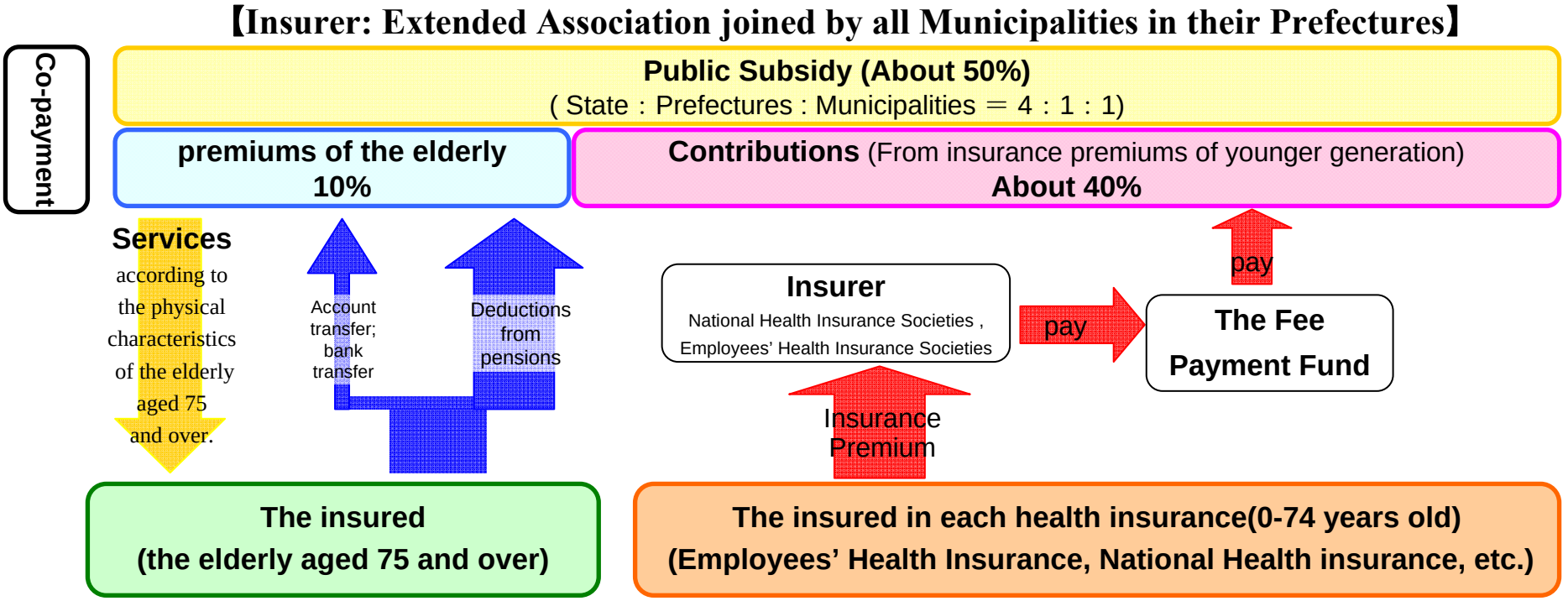
Management Process for Medical System for the Elderly aged 75 and Over (FY2008~)

○ Financial resources (not including co-payments from patients);
About 50% will be financed by public subsidy, About 40% from contributions of National Health Insurance and Employees' Health Insurance, and the remaining 10% will be from premiums collected widely and thinly from the elderly themselves.

○ The amount of contribution from National Health Insurance and Employees' Health Insurance will be based on the numbers of each insurer' affiliate; National Health Insurance = about 42 million people, Employee Health Insurance = about 71 million people.

＜**Number of the target**＞ About 13 million elderly citizens aged 75 and over

＜**Medical expenditure for the elderly aged 75 and over**＞ About 11.9 trillion yen
- Benefits : 10.8 trillion yen
- Co-payment : 1.1 trillion yen



(Note 1) With regard to the elderly with the same level of income as the younger generation , there is no public subsidy (50%) as is the same in the case of Act of Health Services for the elderly, and as such public subsidy will account for 46%, and contributions from younger generations' premium for 44%.

(Note 2) The total amount of public subsidy will be 58%; because there are another subsidies for the contribution of National Health Insurance (50%) and Government-managed Health Insurance (16.4%), and more, subsidy for burden-relief policy about premiums for lower income persons.

National Health Insurance & Health Insurance Benefits

(From October 2009onwards)

Payment		National healthcare insurance (local authority)	Healthcare insurance
Healthcare payments	Healthcare Benefits Visiting nursing healthcare	Until the entry into primary school ; 80% After junior high school to 74years: 70% 70~74years: 80% (70% for those with an income comparable to working persons*)	※From 2008 Apr to 2011 Mar, self-pay for 70~74years remains 10%.
	Meals during hospitalization expenses	Standard amount borne for meals: \260 per meal Low income persons after the 90th day of hospitalization: \160 per meal	Low-income persons: \210 Persons of particularly low income (70 years old and over): \100 per meal
	Living care during hospitalization	Living care standard fee: \ 460 per meal (meal cost) + \320 (residential cost) Particularly low-income persons: \130 per meal (meal cost) + \320 (residential cost)	Low-income persons: \210 per meal (meal cost) + \320 (residential cost) Persons receiving senior citizens welfare benefits: \100 per meal (meal cost) + \0 (residential cost)
		* The amount borne by patients with serious diseases will be the living care standard fee	
	High-cost medical care expenses (with individual limit)	Young people (High income) \ 150,000＋(medical expenses)×1% (\ 83,400) (General) \ 80,100＋(medical expenses)×1% (\ 44,400) (Low income) \ 35,400 (\ 24,600) (figures in parenthesis are for the fourth month onwards)	Senior Citizens Hospitalization / Outpatients (per person) (Working income level) \ 80,100＋(medical expenses)×1% / \ 44,400 (General) \ 44,400 / \ 12,000 (Low income) \ 24,600 / \ 8,000 (Particularly low income) \ 15,000 / \ 8,000
Cash payments	Lump-sum allowance for childbirth	Contents of benefits are decided by separate regulations. (Most insurers pay \420,000)	Lump-sum allowance for childbirth / Lump-sum allowance for childbirth and nursing: \420,000 paid in the instance of the insured person or their dependent giving birth
	Lump-sum funeral allowance, burial costs	Contents of benefits are decided by separate regulations. (Most local authorities pay at a rate between \10,000-50,000) Practiced by most local authorities	Burial costs: Fixed amount of \50,000 paid in the instance of the insured person or their dependent dying Family burial costs: Fixed amount of \50,000 paid in the instance of the insured person or their dependent dying
	Invalidity benefit	Voluntary benefit (Not practiced by any local authorities)	In the case that the insured person becomes unable to work because of medical treatment being received for a cause not related to work, an amount approximate to two thirds of that persons standards daily wage will be paid daily for a maximum period of 6 months.
	Maternity allowance		During the maternity leave taken by the insured person, an amount approximate to two thirds of that persons standards daily wage will be paid daily for a maximum period of from 42 days prior to the birth to 56 days after the birth.

*Persons with an income comparable to that of a working person are those persons with a taxable income of around the same level as that of the average taxable income for a person currently working (approx. 14.5 million yen)

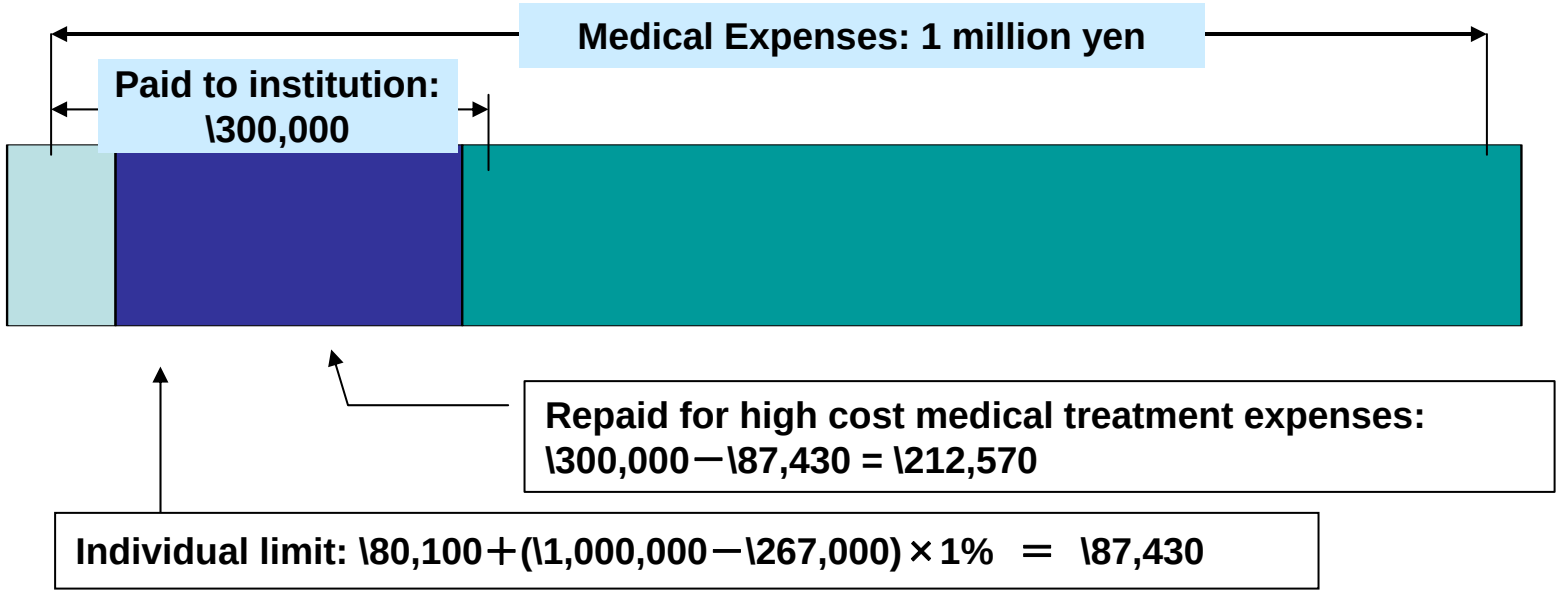
Outline of the High Cost Medical Treatment System

○ High Cost Medical Treatment System

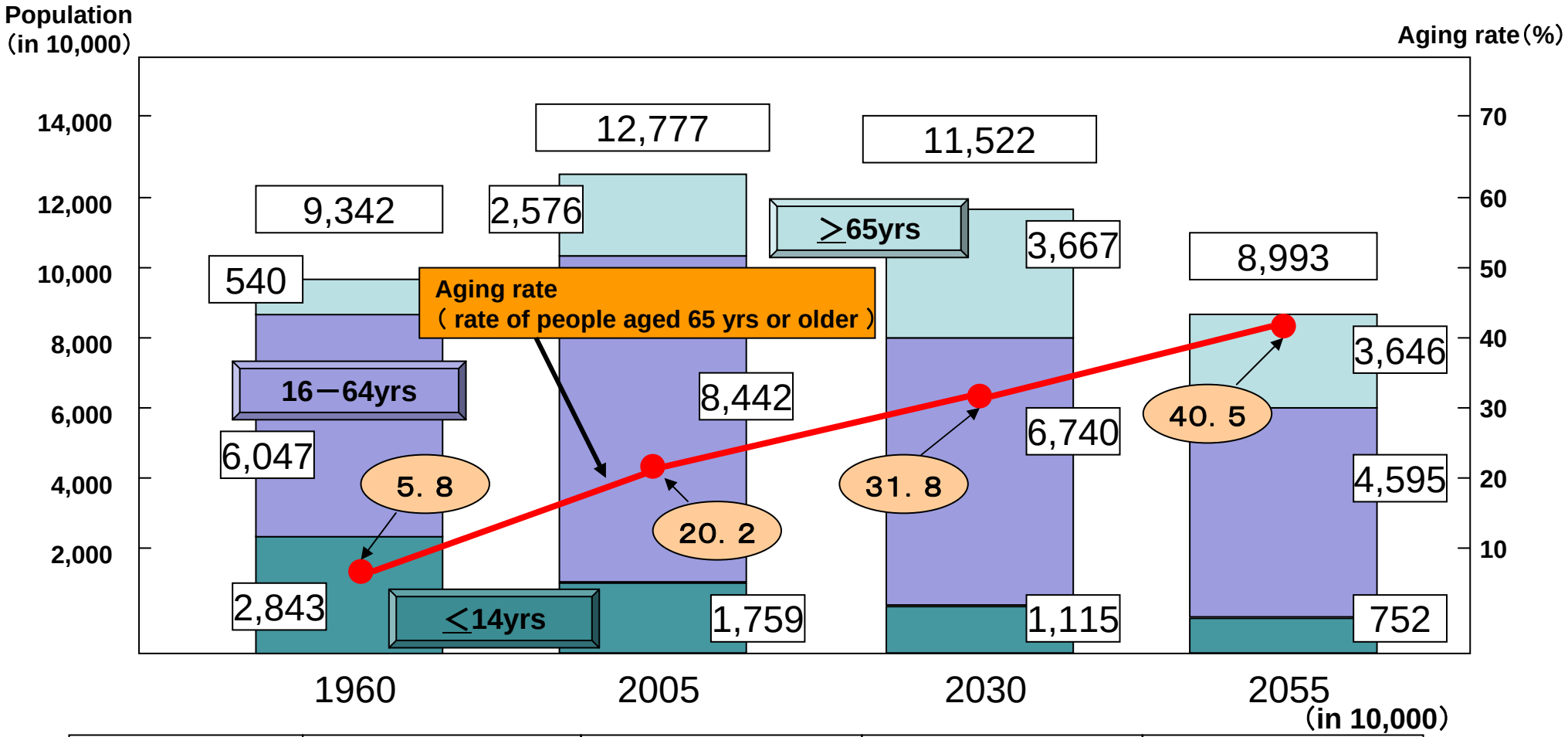
After the fixed rate has been paid at the relevant medical institution, any amount that exceeds the fixed monthly limit will be paid ex post facto by the insurer, in order to ensure that the financial burden on the patient does not become too great.

The monthly individual limit is calculated according to the patient's income, which is classified as either high income, low income or general income.

<Common Example: Case of a person with Employee Insurance (30%) on a general income>



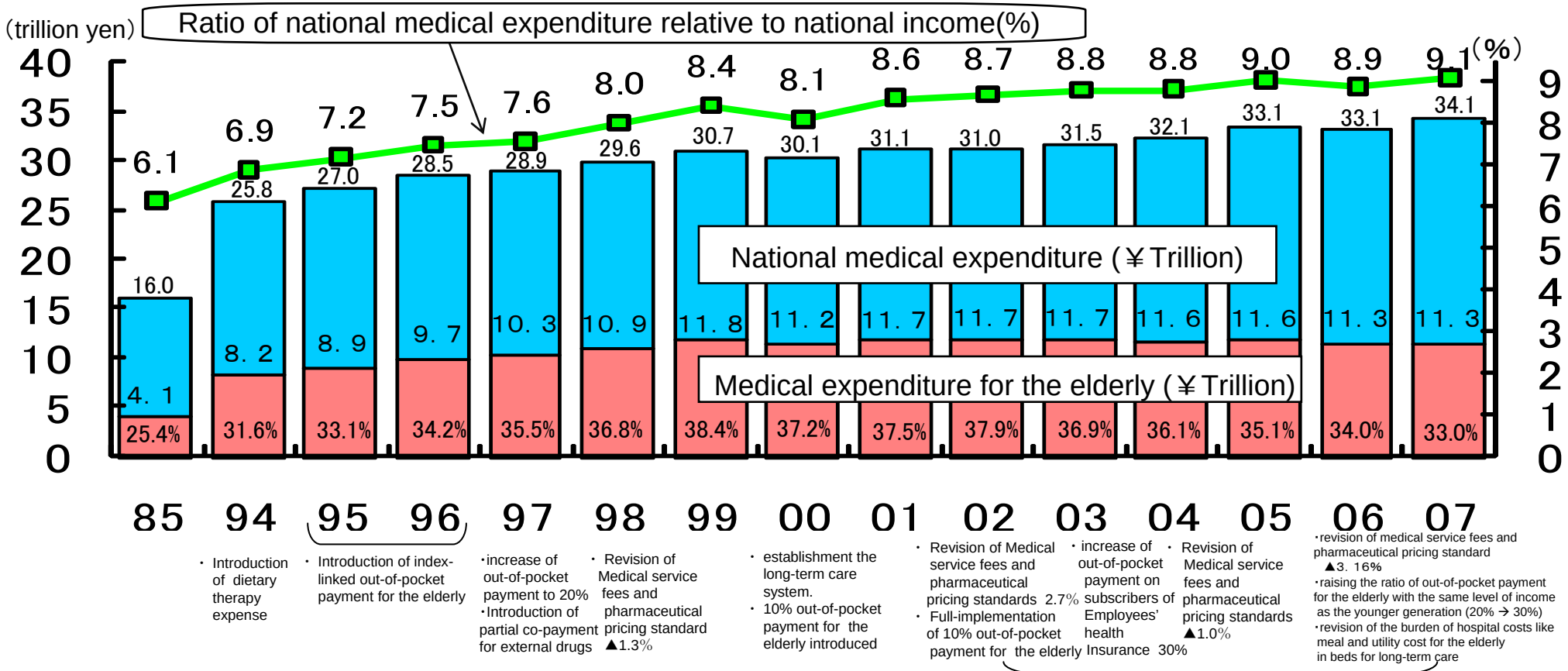
Rapid Aging with the Declining Birth Rate



Number of births	161	106	70	46
Number of deaths	71	108	160	156
Increase and decrease	90	▲2	▲90	▲110

Trends in National Medical Expenditure

The national medical expenditure in Japan amounted to about 33.1 trillion yen. Taking no measure, the medical expenditure is increasing 3~4% every year, it exceeds the rate of rise in the national income.



The age Medical expenditure for the elderly contains has been raised from 70 to 75 for five years from October 2002 to September 2007 for reform of the system in 2002.

Growth of National Medical Expenditure over the Previous Year (%)

	85	94	95	96	97	98	99	00	01	02	03	04	05	06	07
National medical expenditure	6.1	5.9	4.5	5.6	1.6	2.3	3.8	▲1.8	3.2	▲0.5	1.9	1.8	3.2	0.0	3.0
Medical expenditure for the elderly	12.7	9.5	9.3	9.1	5.7	6.0	8.4	▲5.1	4.1	0.6	▲0.7	▲0.7	0.6	▲3.3	0.1
National income	7.4	1.4	0.1	1.7	0.4	▲3.4	▲1.2	2.0	▲2.8	▲1.5	0.7	1.6	0.5	2.1	0.3

※ Source(NI): National Economic Accounting from the Cabinet Office released in June)2008)

Future Prospects for the national healthcare expenses, healthcare benefit expenses and healthcare expenses for elderly senior citizens

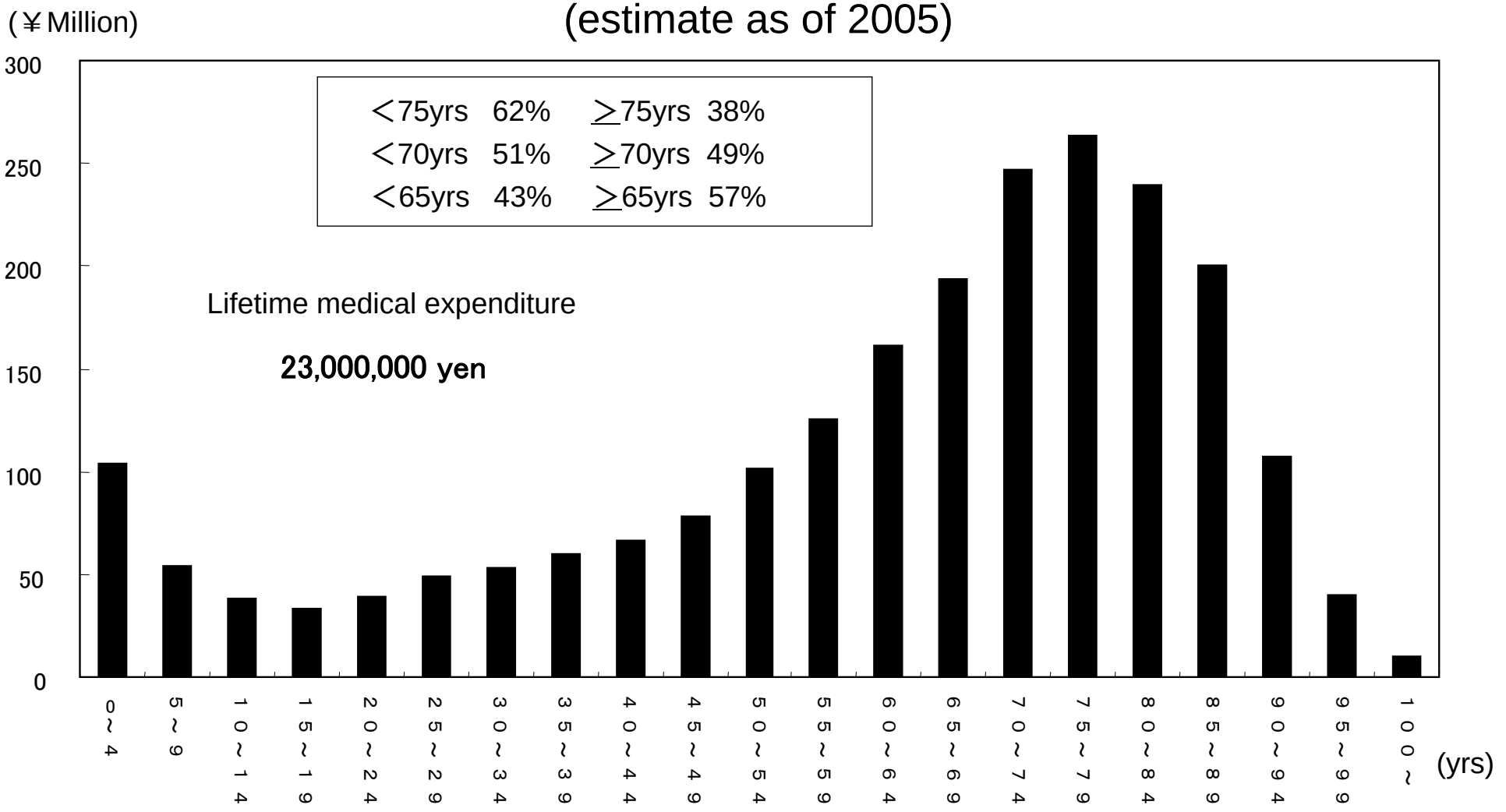
- National healthcare expenses before implementation of the reform were estimated to rise to around 65 trillion yen by 2025. The rate of increase is around 3-4% per year.

Future Prospects for the national healthcare expenses, healthcare benefit expenses and healthcare expenses for elderly senior citizens (based on 2006 Healthcare System Reform)

Year	2006 Base	2015	2025
Post Reform			
National healthcare expenses (trillion yen)	33.0	44	56
Healthcare expenses for elderly senior citizens (trillion yen)	10.8	16	25
Healthcare benefit expenses (trillion yen)	27.5	37	48
Before Reform Implementation			
National healthcare expenses (trillion yen)	34.0	47	65
Healthcare expenses for elderly senior citizens (trillion yen)	11.1	18	30
Healthcare benefit expenses (trillion yen)	28.5	40	56

(Note) Healthcare expenses for the elderly (healthcare expenses for elderly senior citizens) are payable to those senior citizens more than 74 years old age, and by 2015 and 2025 the eligible age will have risen to 75 years of age and above.

Lifetime Medical Expenditure
(estimate as of 2005)

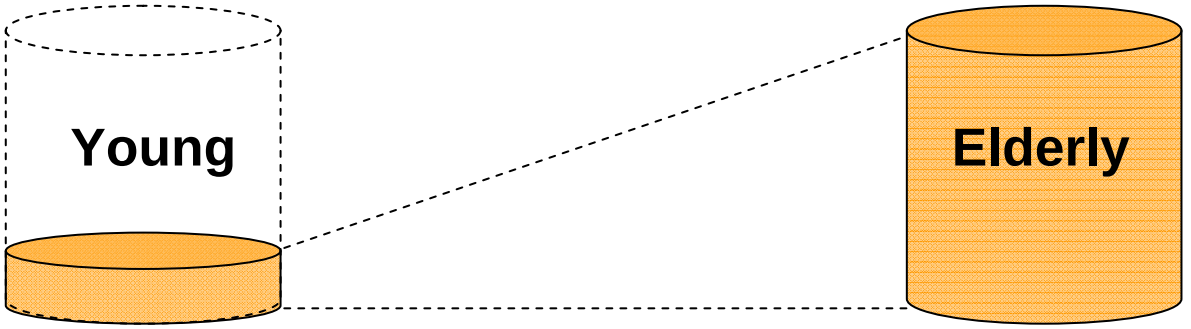


※ Under the medical expenditure per person by age group in 2005, this figures are estimated by applying static population of the simple life table in 2005.

Characteristics of Medical Expenditure for the Elderly

○ Health expenditures are 870,000 yen per elderly (Elderly Health Care System), and it is 4.8 times the costs of people who are not considered elderly, which is 181,000 yen.

【Comparison of Health Expenditures per Person (2007)】



181,000 yen

- **In patient: 58,000 yen**
- **Out patient: 102,000 yen**

870,000 yen

- **In patient: 432,000 yen (x7.4)**
- **Out patient: 399,000 yen (x3.9)**

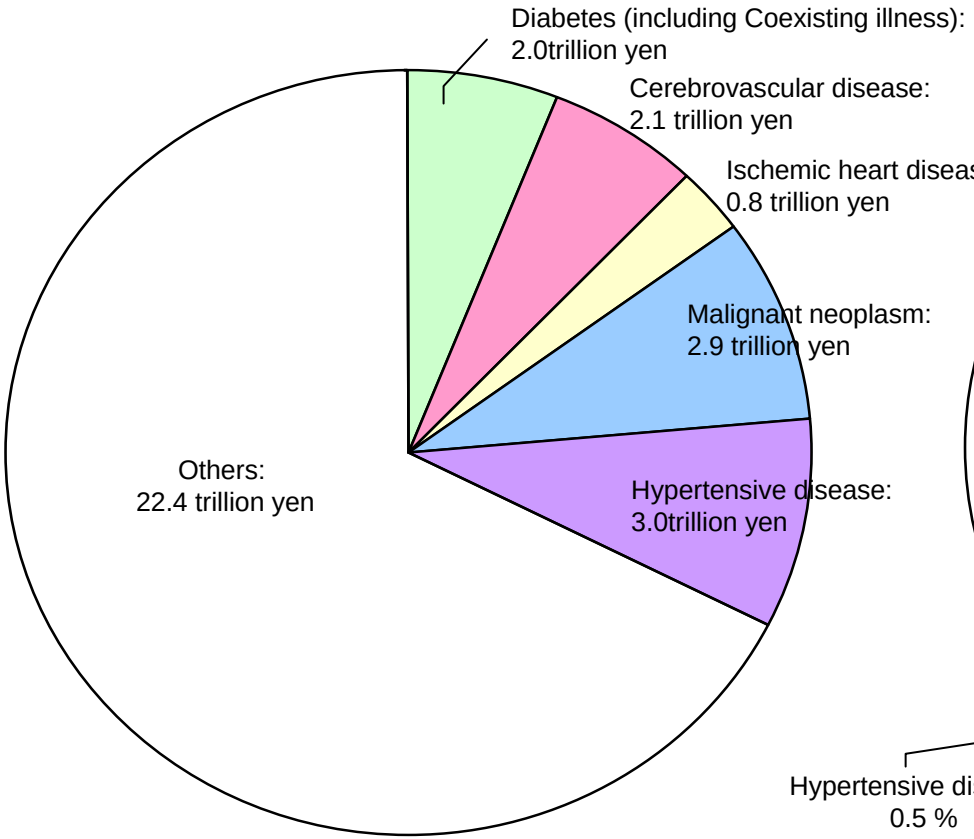
◆ Comparing each country in the ratio of the medical expenditure per person for the elderly to the young, it shows about 3~4 times in Western countries.

Reference: Annual Report of Medical Service for Elderly

Medical Expenditure for Life Style-related Diseases and Death Ratio

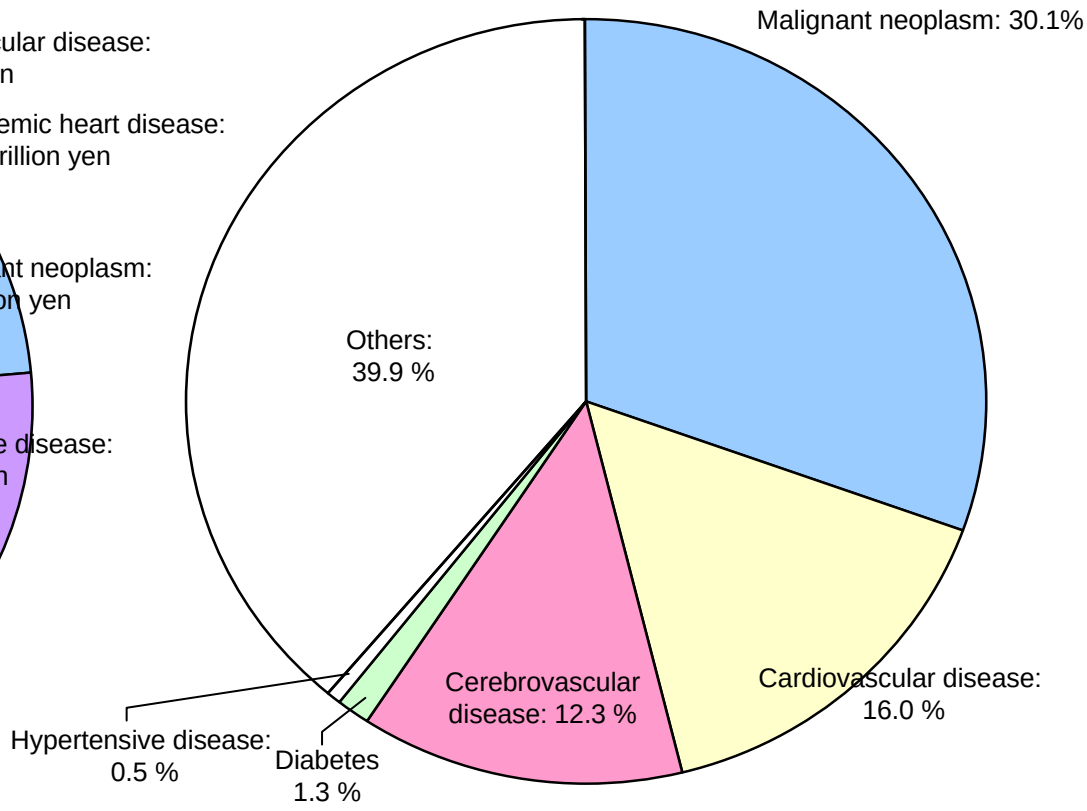
Life-style related diseases account for about 30 % of the national medical expenditure, and about 60 % of the death ratio.

Medical expenditure (for FY 2005)
Life-style related diseases: 10.7 trillion yen
National medical expenditure: 33.1 trillion yen



Note: Plotted based on the "National Medical Expenditure (FY 2005)," "Actual State of Chronic Dialysis Therapy (December 31, 2005), and others

Ratio by Cause of Death (for FY 2005)
Life-style related diseases: 60.1 %



Note: Plotted based in the Population Survey Report (2005)

Measures to Prevent Lifestyle Diseases

Basic Directionality

- Examinations and healthcare guidance must be carried out with particular attention to metabolic syndrome, for insured persons (national healthcare & employees insurance) and their dependents aged 40 years old and over
- In addition, the data from the results of implementation must be kept and managed
- Each healthcare insurer must then either make additions or reductions to the amount paid in support to elderly senior citizens, according to the conditions of and results of the implementation of this.
  (From 2013)

Main Contents

- Each insurer must implement measures deliberately in according with national guidelines (from 2008)
- Thorough healthcare guidance must be provided to those persons established to be in need of such through examinations
  → must be demonstrated in guidelines
- Regarding dependants of the insured, measures must be put in place to allow these dependants to undergo medical examinations and receive healthcare guidance within the national healthcare insurance system provided by the local authority.
  - → also possible for healthcare insurers to utilize programs provided by the local authority controlled national healthcare insurance system
    (Expenses will be borne and data management will be carried out by the healthcare insurer to whom the person making use of the service/s is affiliated)
  - → Within Councils of Insurers, set up within each prefecture, discussions and organization will be carried out, led by the prefecture, to ensure that effective service can be provided.
- Healthcare insurers must use the examination data effectively to carefully select those who need to undergo healthcare guidance training. In addition, they must undertake an evaluation of the program. Further, the results of the examinations must be provided to the insured and their dependents in a way that is easy to manage and store.

* For programs of examination held through local authority controlled national health insurance systems etc., public funds will be used to provide some financial support

- Standards for determining Metabolic Syndrome
  - Those persons whose measurement around the waist is 85cm or more (men) or 90cm or more (women); and who have at least 2 of the following: a high proportion of body fat, high blood pressure, high blood sugar

International Comparison of Healthcare Facilities and Workforce (2007)

Country	Average Length of Stay	No. of beds per 1,000 population	No. of doctors per 100 hospital beds	No. of doctors per 1,000 population	No. of nurses per 100 bed	No. of nurses per 1,000 population
Japan	34. 1	13. 9	14. 9	2. 1	66. 8	9. 4
Germany	10. 1	8. 2	42. 5	3. 5	120. 7	9. 9
France	13. 2	7. 1	47. 2	3. 4	108. 2	7. 7
U.K.	8. 1	3. 4	72. 7	2. 5	294. 2	10. 0
U.S.	6. 3	3. 1	77. 5	2. 4	337. 2	10. 6

(Source): OECD Health Data 2009

* No. of doctors and nurses per 100 hospital beds are calculated by dividing the No. of doctors and nurses by the # of hospital beds and then multiplying by 100.

* The definition of beds for calculating Average Length of Stay used in OECD statistics is below.

- Japan: All hospital beds
- Germany: acute care beds, psychiatric care beds, beds for rehabilitation (exclude beds in nursing facilities)
- France: acute care beds, long-term care beds, psychiatric care beds, other beds
- U.K.: all the beds run by the NHS (exclude long-term care beds)
- U.S.: all the beds registered with AHA (American Hospital Association)

Measures to Reduce the Average Number of Hospitalization Days

Basic Directionality

○ Each Prefecture must, together with the cooperation of medical institutions and other related parties, take measures to ensure that all residents have access to treatment appropriate to conditions and stage of their illness, by promoting the separation of and partnerships between medical institutions, home healthcare, and the conversion of recuperation wards.

○ In response to these prefectural measures, the national government will put the following support measures in place:

- Formulate basic guidelines regarding the revision of Healthcare Plan Systems & draw up a manual
- Evaluate examination fees in relation to the specialization/collaboration of medical functions and the promotion of home healthcare
- Utilize the combined subsidy fund and the organizational funds for medical healthcare provision systems
- Programs for conversion and organization using healthcare insurance funds

Main Contents

[1] Specialization of & Collaboration between Medical Facilities

○ Through a revision of the Healthcare Plan, concrete collaborative frameworks should be created between facilities providing care during the period of recuperation from acute illness, convalescence, nursing care for the elderly etc., for each particular program, for example measures for stroke victims, in order to ensure that appropriate care can be received at each stage without any gaps

[2] Promotion of Home Healthcare & Nursing

○ In order that recuperation from hospital to home can take place smoothly, collaboration should take place between the chief medical officers and care managers at the time of discharge, and a framework should be put in place that can oversee home nursing. Further, efforts should be made to promote a variety of residences, apart from just those designed to accommodate the elderly, that can be used for convalescence and home nursing.

[3] Conversion of Recuperation Wards

○ Support will be provided for the conversion of convalescence wards into healthcare and residential facilities for the elderly (paying residential homes, care houses etc).

Mechanism behind Increases of Medical Expenditure

Factor analysis

Low rate of recuperation at home (including care at Nursing-homes etc.)

Increase of the population/potential population with diseases such as urinal disease, hypertension, and hyperlipemia

Long hospital stay (**average hospital days**)

Outpatients' way to visit hospital with major concern being life style-related diseases

Increase of inpatient medical expenses per person (50% of the contribution)

Increase of outpatient medical expenses per person (50% of the contribution)

The key factor is the increasing medical expenditure for the elderly.
Increase of the elderly population
Medical expenses per elder person = five times of the expenses for a young person.

Medical expenses per elder person vary significantly from prefecture to prefecture
(Average: 750,000 yen, Max.: about 900,000 yen in Fukuoka, Min: about 600,000 yen in Nagano)

Increase in Medical Expenditure

Solution system

・Specialization and cooperation of medical functions

Acute phase
Recovery phase
Recuperation phase
Recuperation at home

Cooperation

Long-term care services providing system

・Emphasis on living functions of the elderly in the community

Measures against life-style related diseases

① Proliferation and enlightenment of information in concerted effort of the insurers and communities to help promote health.
② Extensive and effective health check
③ Individualized health guidance for high-risk groups

Sep 6 2010

Outline of Health Insurance Claims Review & Reimbursement Services (HICRRS)

社会保険診療報酬支払基金の概要

Contents

Outline of Health Insurance Claims Review & Reimbursement Services
社会保険診療報酬支払基金の概要

1　Established(設立)

Established in September 1948 as a specially designated public corporation　昭和23年9月に特殊法人として設立

Reorganized in October 2003 as a specially designated private corporation　平成15年10月に特別の法律により設立される民間法人として再編

2　Objectives of the Fund (事業目的)

Assessment of medical fee claims　適正な審査

Prompt and appropriate payment of medical fee　迅速適正な支払

3　Main Business of the Fund (事業概要)

① Assessment and Payment of Medical Fee (Duties entrusted by insurers)
審査・支払業務(保険者からの委託業務)

- Assessment of medical fee claims submitted by medical care institutions.
  医療機関から提出のあった診療報酬請求書の審査
- Payment of medical fee to medical care institutions.
  医療機関に対する診療報酬の支払

② Duties Related to Medical Care System for the Elderly
(Duties based on "Law concerning securing medical care of the elderly ")
高齢者医療制度関係業務(「高齢者の医療の確保に関する法律」に基づく業務)

- Collecting contributions from insurers of medical care insurance, and granting them to "regional alliance for the medical care of the latter-stage elderly" in each prefecture.
  保険者からの後期高齢者支援金等の徴収及び後期高齢者医療広域連合への交付

- Financial adjustments among medical care insurers relating to medical care for the early-stage elderly (65 to 74 age group)
  前期高齢者(65 歳から 74 歳)医療に関する財政調整

- Collecting contributions from insurers of medical care insurance, and granting them to prefectures for the purpose of subsidizing the expense of converting sickbeds.
  保険者から病床転換支援金を徴収し、都道府県への交付

- Receiving personal data of the dependents of the insured, from insurers of medical care insurance, and providing them to "regional alliance for the medical care of the latter-stage elderly" for the purpose of discounting contributions.
  保険者から被扶養者情報の提供を受け、後期高齢者医療広域連合への情報を提供

③ Duties Related to Medical Care Service for Retired Employees (Duties based on "National Health Insurance Law".)
退職者医療関係業務(「国民健康保険法」に基づく業務)

- Collecting contributions from insurers of employees' medical care insurance, etc. and granting them to municipalities.
  被用者保険等保険者からの退職者医療拠出金の徴収及び市町村への交付

④ Duties Related to Long-Term Care Insurance (Duties based on "Long-Term Care Insurance Law".)
介護保険関係業務(「介護保険法」に基づく業務)

- Collecting contributions from insurers of medical care insurance,and granting them to municipalities.
  医療保険者からの介護給付費納付金の徴収及び市町村への交付金の交付

4 Organization (組織)

Headquarters (Tokyo) ,47 Branch offices (One in each prefecture)

東京に本部、各県に47支部を置く全国組織

5 Number of Employees for the fiscal year 2010 (平成22年度定員)

Employees (職員)	4,934 persons
Assessment committee members (審査委員)	4,536 persons

6 Number of claims examined by the Fund in the fiscal year 2009

about 860,000 thousands

(平成21年度取扱件数 約8億6千万件)

- Medical department : about 490,000 thousands
- Dental department : about 110,000 thousands
- Pharmacies : about 260,000 thousands

(医科 約4億9千万件・歯科 約1億1千万件・調剤 約2億6千万件)

7 Total amount of payment by the Fund in fiscal 2009

Medical Fee : about 9,600,000 million yen

(平成21年度取扱金額 約9兆6千億円)

- Medical department : about 7,100,000 million yen
- Dental department : about 900,000 million yen
- Pharmacies : about 1,600,000 million yen

(医科 約7兆1千億円・歯科 約9千億円・調剤 約1兆6千億円)

8 Budget (予算)

- General account budget in the fiscal year 2010 about 84,700million yen

平成22年度一般会計予算 約847億円

- Commission charges for each statement 1件当り事務費

Assessment and Payment	114.20 yen	審査支払
(Promotion Rate:		
claims with electronic data	108.20 yen	電子媒体請求促進分)
online claims	104.00 yen	オンライン請求促進分)
Payment (Pharmacies)	57.20 yen	調剤支払のみ
(Promotion Rate:		
claims with electronic data	51.20 yen	電子媒体請求促進分)
online claims	47.00 yen	オンライン請求促進分)

9 Board of Trustees and Executive Committee (理事会及び幹事会)

Fair and Neutral Business Management 公正中立な事業運営

Members of the Board of Trustees and Auditors (理事会・監事の構成)

Board of Trustees 理事会	Trustees 理事	No more than 17 persons 17人以内	Representatives of insurers(4) of insured persons(4) of doctors(4) of public interests(4) 保険者・被保険者・診療担当者・公益代表
	Consultants 参与	No more than 5 persons 5人以内	Experts on the Public Assistance Law(1) on the Long-Term Care Insurance Law(1) Medical Care System for the Elderly(1) Representatives of pharmacists(1) 生保・介護・高齢者医療・薬剤師関係
Auditors 監事		4 persons 4人	Representatives of insurers(1) of insured persons(1) of doctors(1) of public interests(1) 保険者・被保険者・診療担当者・公益代表

Members of the Executive Committee (幹事会の構成)

Executive committee 幹事会	Executives 幹事	8 persons 8人	Representatives of insurers(2) of insured persons(2) of doctors(2) of public interests(2) 保険者・被保険者・診療担当者・公益代表
	Consultants 参与	No more than 4 persons 4人以内	Experts on the Public Assistance Law(1) Law concerning the Prevention of Infectious Diseases and Medical Care for Patientsof Infections(1) Medical Care System for the Elderly(1) Medical Care Service for Retired Employees(1) 生保・感染症・高齢者医療・退職者医療

10　Assessment Committee（審査委員会）

Headquarters (Tokyo) 本部	Special Assessment Committee 特別審査委員会	Representatives of doctors of insurers of academic experts 診療担当者代表・保険者代表・学識経験者 それぞれ同数
Branch office (each prefecture) 47 支部	Assessment Committee 審査委員会	

Organization of the Assessment Committees

(Legal Basis) 根拠法令等

1. The Act on Health Insurance Claims Review & Reimbursement Services
   社会保険診療報酬支払基金法
2. Provisions of Assessment Committee and Special Assessment Committee of Social Insurance Medical Payment Fee Claims
   審査委員会及び特別審査委員会規程
3. General Rules of Assessment Committee
   審査委員会運営規程準則

(Prefectural Branches) 基金支部

Assessment Committee of Social Insurance Medical Payment Fee Claims.
社会保険診療報酬支払基金請求書審査委員会
Chairman and vice chairman are elected by ballot.

Committeemembers' term of services = 2 years
- Doctors
- Insurers
- Academic experts

Primary assessment（第1次審査）
Secondary assessment — assessment decided.
（第2次審査） 審査決定

(Headquarters) 基金本部

Special Assessment Committee of Social Insurance Medical Payment Fee Claims
社会保険診療報酬支払基金請求書特別審査委員会
(Committeemembers' term of services = 2 years
- Doctors
- Insurers
- Academic experts

Primary examination
Secondary assessment — assessment decided.

Studying Committee
審査研究会
(All committee members)

(Academic research, etc.)
Studying Committee give academic lectures.
学術研究
学術講演

Drug Dispensing Assessment Sub-Committee
調剤審査部会
Chairman is elected by ballot.

This committee shall assess medical fee claims concerning drug
調剤報酬請求についての審査

Re-assessment Sub-committee
再審査部会
Chairman is elected by ballot.

(The-assessment Sub-Committee shall deal with the appeals for re-assessment from insurers and insurance medical care facilities.)
保険者及び保険医療機関からの再審査申し出処理

Fund's Law: 15-1-3
Provision of Assessment Committee: 2-3

Assessment Sub-Committee
審査専門部会
Chairman is elected by ballot.

This committee shall specially assess statements of medical fee bills with maximums greater than the fixed point.
一定点数以上の高点数明細書を専門的に審査
This committee shall re-assess:
(1) Statements of medical fee bills with maximums greater than the fixed point.
一定点数以上の高点数明細書の審査
(2) Statements concerning medical care institutions, etc. entrusted by Assessment Committee.
その他審査委員会から付託された医療機関等に係る明細書の審査

Assessment Steering Committee
審査運営委員会
Chief of the committee = Chairman

This committee shall discuss the whole management, assessment and etc.
This committee shall discuss:
審査委員会の運営等審査全般について協議
(1) Promotion for smooth management of assessment committee
審査委員会の円滑な運営推進
(2) The way of assessment
審査方法についての審議
(3) Inspection of assessment result
審査結果の確認
(4) The other important matters regarding assessment.
その他審査に関する重要事項の協議

Ranges subject to assessment conducted by Special Assessment Committee
特別審査委員会対象範囲
(1) Statements with more than 400 thousands points of medical care. (In case that it includes cardiac or pulse operations, points related to specified treatment materials are excluded.)
医科診療 40 万点以上の高点数明細書
（心・脈管に係る手術を含む場合は、特定治療材料に係る点数を除く）
(2) Statements with more than 4000 points of oriental medicine and medications.
漢方・投薬料４千点以上の明細書
(3) Statements with more than 200 thousand points of dental care.
歯科診療２０万点以上の高点数明細書

診療費の請求支払手順
Procedure for the Claim and Payment of Medical Fee

1　保険医療機関から支払基金への医療費の支払請求

現在、医療保険制度における診療報酬の支払については、各診療行為及び薬剤についてそれぞれ点数評価（１点＝10円）を行い、個別に行った各診療行為の評価額の合計額を診療報酬として支払う方式（「個別出来高払方式」という。）を用いている。

各医療機関においては、診療行為１件ごとに診療報酬点数を記載した明細書（レセプト）を作成し、これを添付した診療報酬請求書を審査支払機関である社会保険診療報酬支払基金（国民健康保険では国民健康保険団体連合会）に各月分につき翌月１０日迄に提出することにより、医療費の支払請求を行う。

保険薬局からの調剤報酬請求についても同様である。

1 Requests for payment of medical care expenses from medical care institutions to Helth Insurance Claim Review & Reimbursement Services

At present, a fee-for-service system is used to calculate the medical fees for social insurance.

Under this system, each piece work of medical services and dispensing of medicines is expressed in "points," and each act of medical treatment is expressed as the sum of the points allotted to the piece work consisting of the treatment. Each point is ￥10, and the total expenses are obtained by multiplying the number of points by ￥10.

Each medical care institution prepares, for each of the medical services it provides, a medical care fee claims specifying the number of points for the treatment and for the medication and injections composing the service. Then, the medical care institution requests payment of medical expenses incurred by submitting the Health Insurance Claims Review & Reimbursement Services (National Health Insurance Organizations in the case of the National Health Insurance).

The medical care fee claims for each month should be presented by the 10th day of the following month.

The procedures for requests for dispensing expenses made by insurance pharmacies are the same as the above.

2　審査済の請求書の保険者への送付

保険医療機関や保険薬局から支払基金へと送られた請求書及び明細書については、支払基金において医療機関や薬局ごとに１件１件審査が行われた後、保険者に送付される。

2 Delivery of approved medical care fee claims to insurers

The medical care fee claims sent from medical care institutions and pharmacies are examined individually by the Fund, and approved claims are delivered to the respective insurers.

3　保険者から支払基金に対する診療報酬の支払い

保険者は、提出された請求書に認められる診療報酬額に基づき、診療報酬支払基金に対し、１か月にかかった診療報酬の総額に基金に対する業務委託事務費を乗せた額を支払う。支払いは現在のところ、保険者と支払基金との間の委託契約の内容により、医療機関から支払基金に対して請求のあった月の翌月、つまり、診療の行われた月の翌々月に行われている。

3 Payment of medical fees to the Fund by insurers

Insurers pay the Fund the medical fees specified on the medical care fee claims for each month as well as commission charges for examination of the claims. At present, payment is made in the month following the month when the claim is made by medical care institutions to the Fund, that is, two months after medical care is provided, in accordance with the contract between insurers and the Fund.

4　支払基金から医療機関への診療報酬の支払い

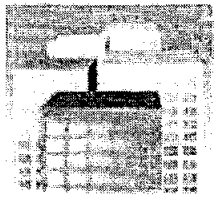
支払基金から各医療機関への診療報酬の支払いは、診療の行われた月の翌々月２１日までに、金融機関または郵便局への口座振込の形で行われている。

4 Payment of medical fees to medical care institutions by the Fund

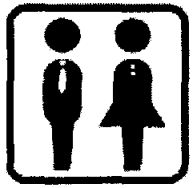
Payment of medical fees to each medical care institution by the Fund is made by the 21th of two months after the provision of medical care through financial institutions such as banks and post offices.

保険請求の手順 (Procedure for the Claim and Payment of Medical Fee)

保険料 Premium Payment



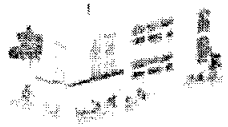
事業主
Employers



被保険者
(本人・家族)
Insured persons and their dependent family members

① 受診

① Receipt of Medical Care



医療機関等
Medical Care Facilities

保険取扱い
Health care providers

医科医療機関 <96,720>
Hospitals and Clinics

歯科医療機関 <71,292>
Dental Hospitals and Clinics

保険薬局 <52,902>
Pharmacies

訪問看護ステーション <6,749>
Visiting Nursing Stations

227,663 facilities

[2010.7]

② レセプト提出
診療費請求
(診療翌月10日)

② Submission of Claim Bills for medical fee (by the 10th of the following month after the provision of medical care)

≪Online≫

≪FD or MO or CD-R≫

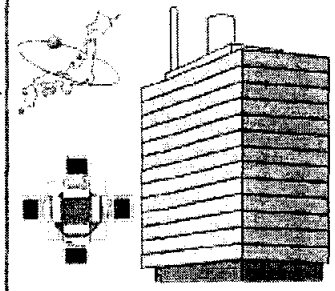
≪Paper≫

請求書
(A monthly Bill)

明細書
Medical Fee Claim Form
Contents and price itemization of Medical fee

社会保険診療報酬支払基金

Health Insurance Claims Review & Reimbursement Services in each prefecture
(47branch offices)



1. 受付
Receipt of Claims and Related items

2. 事務点検 ・ 審査事務
Inspection of Documents and Preliminary Assessment

3. 審査
Assessment of Medical Fee Claims

4. 計数整理
Calculation Process

5. 保険者別分類 ・ 請求支払計算
Sortation of Claims and Payments according to Insurers

6. 請求
Payment Request to Insurers

7. 支払
Payment to Medical Care Facilities

【再審査 : Reassessment】

⑤ 診療費の支払
(診療翌々月21日)

⑤ Payment of medical fee (by the 21st of the 2nd month after the provision of medical care)

③ レセプト送付
診療費請求
(診療翌々月10日)

③ Sending Claim Bills for medical fee (by the 10th of the 2nd month after the provision of medical care)

明細書
(Medical Fee Claim Form)

≪Paper≫

or

≪electronic medium≫

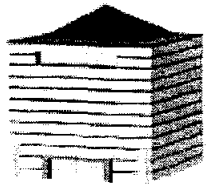
or

≪Online≫

④ 診療費の払込
(診療翌々月20日)

④ Payment of medical fee (by the 20th of the 2nd month after the provision of medical care)

保険者<47 prefectures>
Insurers



全国健康保険協会
Japan Health Insurance Association

船員保険
Seamen's Insurance
(Government-managed)

国家公務員共済組合
National Government Employees' MAA <898MAAs>

地方公務員共済組合
Local Government Employees' MAA <143MAAs>

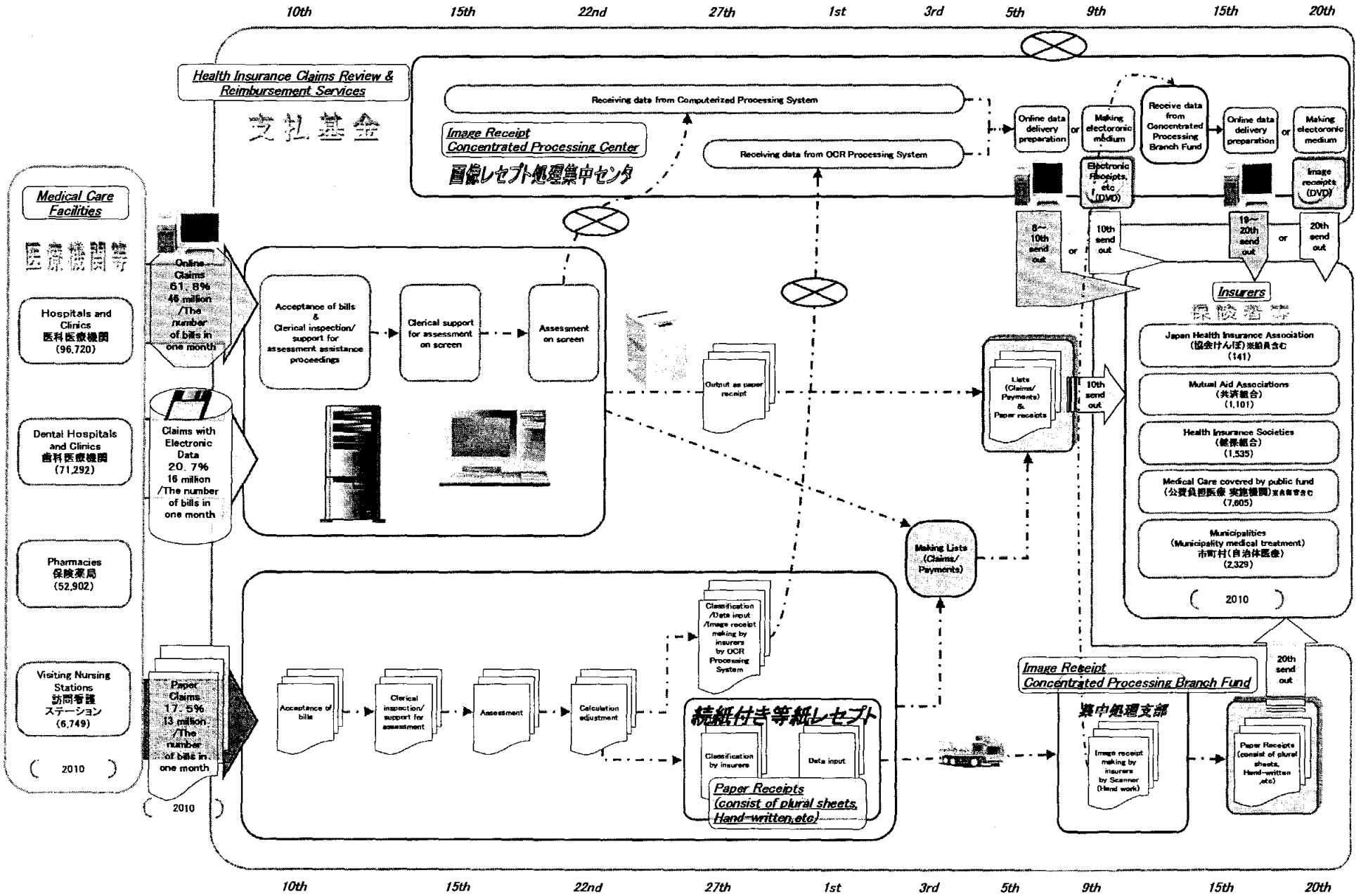
日本私立学校振興・共済事業団
Private School Teachers' and Enpioyees <1MACorp>

健康保険組合
Society-managed Health Insurance <1,535 Societies>

MAA = Mutural Aid Associations

[2010.7]

Workflow of the Monthly Operation in Prefectural Branch Offices
支払基金支部における1ヶ月の業務処理の流れ



Medical Fee Claim Form

診療報酬明細書

Number Code of the medicalcare

Kinds of Insurance			
1	1 3 2 4	1 2 3	2 6

the part of ____ month ___ year _____

Number of municipalities		Recipient Number	
1. Number of Public Assistance Medical Care		(1) Recipient Number	
2. Number of Public Assistance Medical Care		(2) Recipient Number	

Number of the Insurance corner	
Number and mark of Insurance card of insurance pocket ledger	

Patient Name	Particular Code
Sex M・F Birthdate Accident at work	

Name and Place of Medical Care Faculty

Name of Sickness	Startingday of medical care	Actual days			
(1)	(1)		First		
(2)	(2)		Recovery	Death	Stop
(3)	(3)				

		Public point
1 First medical treatment Overtime・Holiday・Midnight	point time	
2 Retrial Retrial Adding of care Overtime Midnight Holiday	time time time time time	
3 Guidance care		
4 Home care Visit Night Midnight・Urgent Examine		
5 Medication 21 Internal medicines 22 Draft of medicines 23 External remedies 24 Dose per medication 25 Prescript 26 Narcotic 27 Compounding of medicines Benefits for highcost	unit time unit unit time unit time time	
6 Injection 31 Hypodermic 32 Vein 33 Others	time time time	
7 Injection Medicines	time	
8 Operation Narcotism Medicines	time	
9 Examination Medicines	time	
10 X-ray diagnosis Medicines	time	
11 Others Prescription Medicines	time	

Sum Total	Determination	Partical Cost-sharing			
			Benefits for Highcost		

平成22年9月3日(金)
社会保険診療報酬支払基金

香港立法会衛生事務委員会・食品安全及び衛生委員会の東京支部視察

1　視察日時等　　平成２２年９月６日（月）１４：００～１５：００

2　場　所　　東京支部　　４階会議室
豊島区南池袋２－２８－１０
ＴＥＬ　０３－３９８７－６１８１

3　出席者

香港視察団　（１２名）	支払基金
代表 ジョセフ・リー・コックロン李國麟　博士 副代表 フレッド・リー・ワーミン　李華明　議員 他１０名	足利専務理事 西崎　東京支部長 井原副審査委員長 菅経営企画部企画課副長　　他

4　視察スケジュール【１時間】

時間	内容	説明者等	備考
14:00～ （5分）	1　開会 挨拶	西崎支部長	会議室（４階）
14:05～ （35分）	2　社会保険診療報酬支払基金の概要	足利専務理事	
	質疑・応答		
14:40～ （10分）	3　審査委員会室視察	担当課長 （井原副審査委員長）	審査委員会室（７階） （医科）
14:50～ （10分）	4　ＯＣＲ処理システムの デモ	担当課長	３階 ・OCR処理室（３階）
15:00～	記念撮影 閉会		４階会議室

Prevention and control of life style related diseases in Japan

Ministry of Health, Labour and Welfare (MHLW), Japan

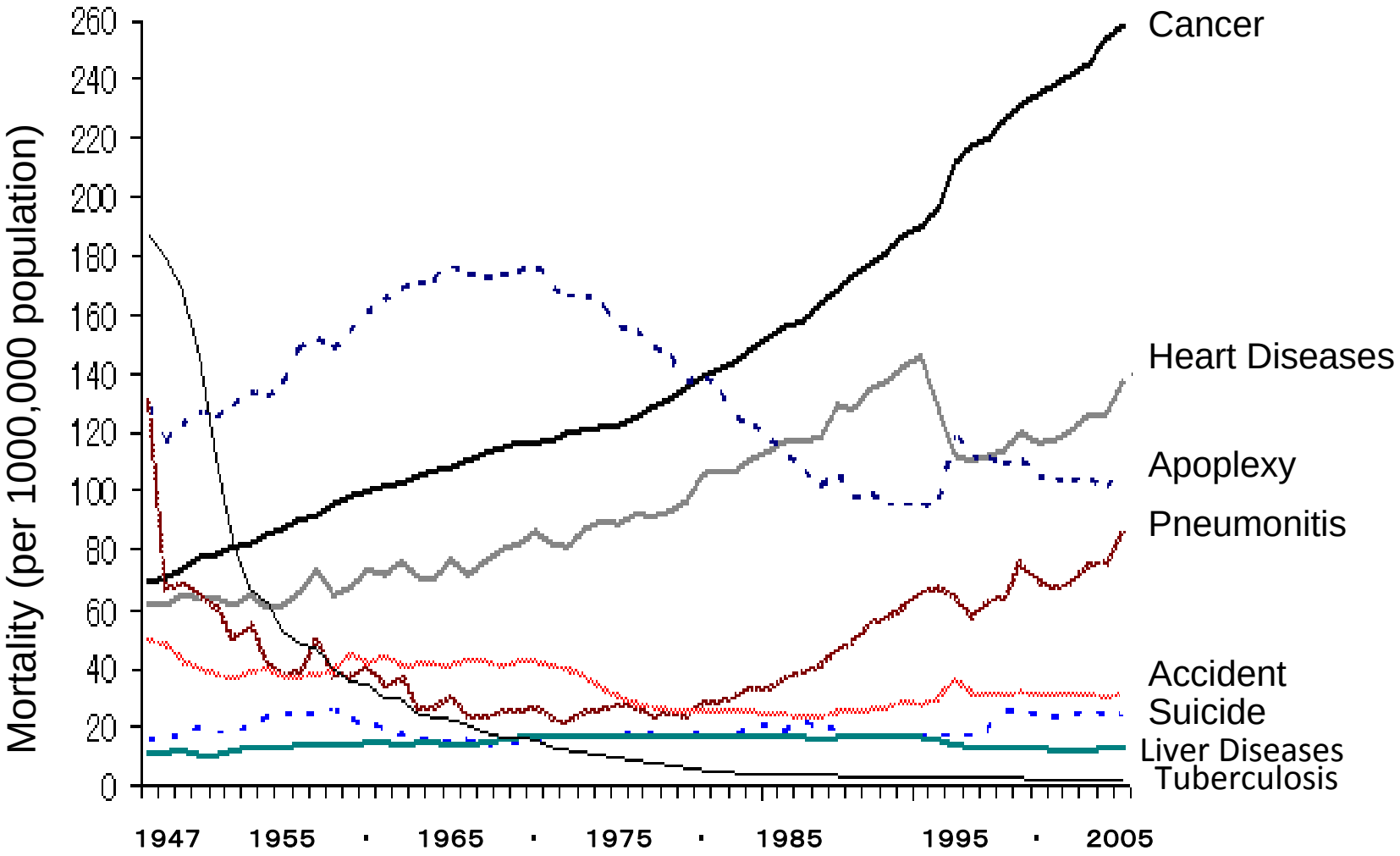
Office for Lifestyle Related Disease Control
Health Service Bureau
MHLW, Japan

Outline

- **Trends of major health and health economics statistics**

- National health promotion and disease prevention plan ~Health Japan 21~
  Mid-term Review and new challenge

Annual Trend of Mortality by Causes of Death

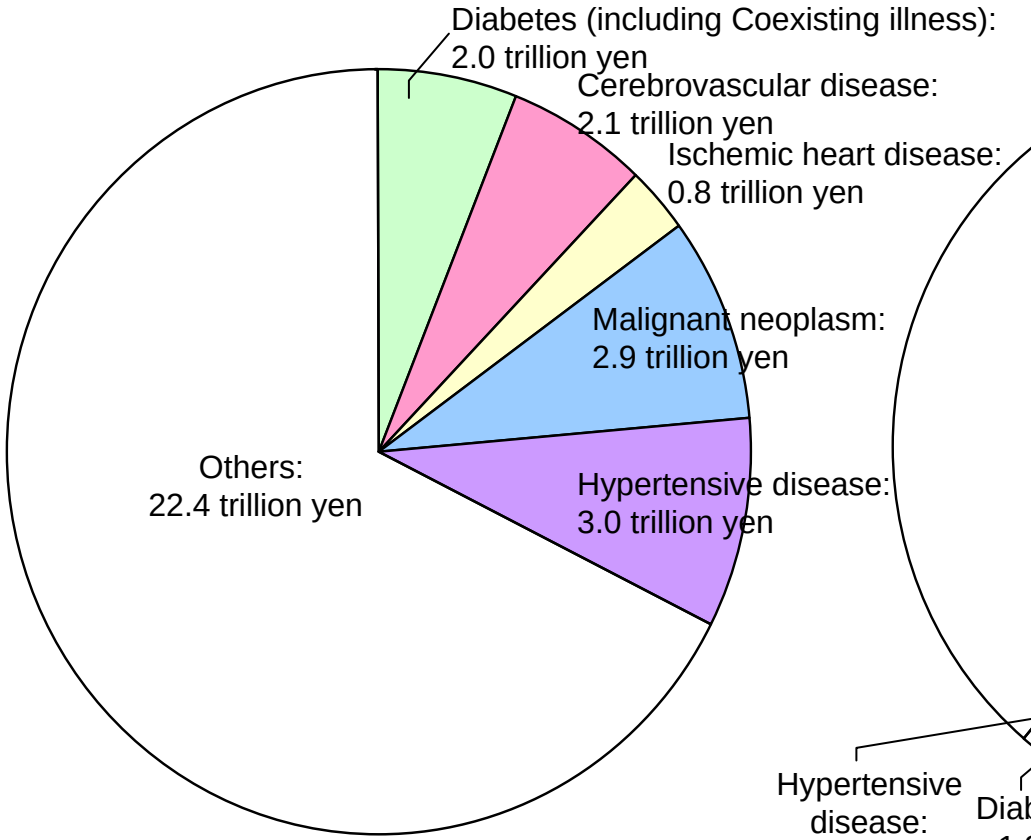


Source: Vital Statistics, Japan

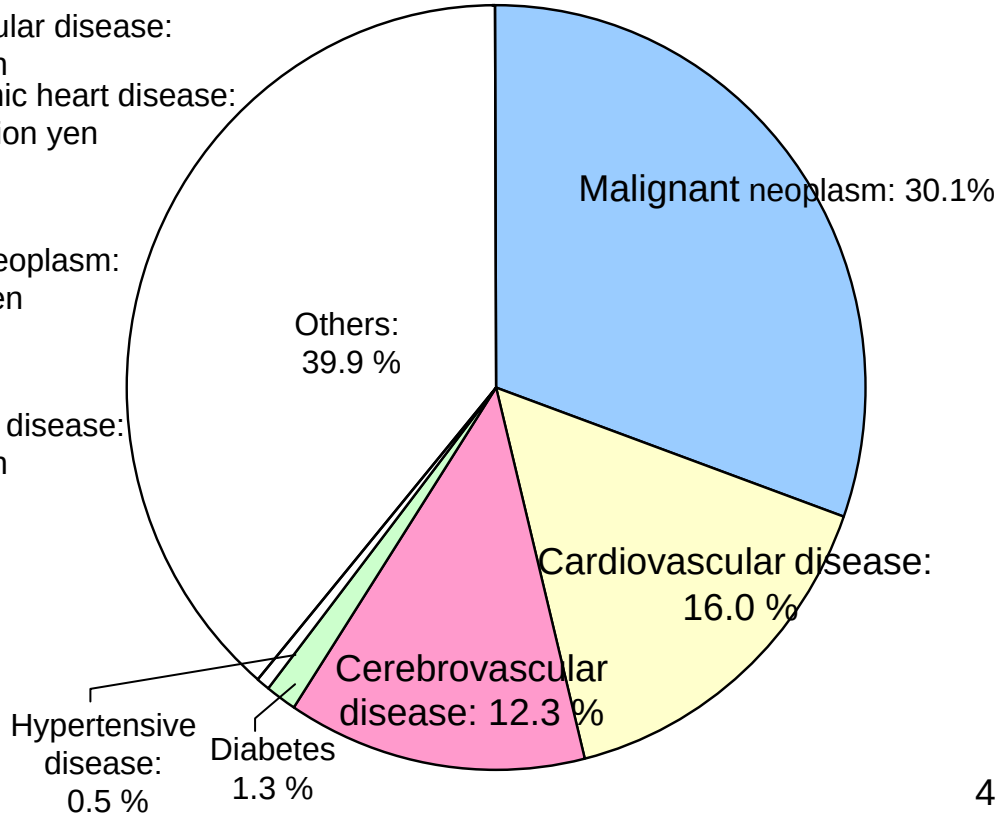
Medical Expenditure for Life Style-related Diseases and Death Ratio

Life-style related diseases account for about 30 % of the national medical expenditure, and about 60 % of the death ratio.

Medical expenditure (for FY 2005)
Life-style related diseases: 10.7 trillion yen
National medical expenditure: 33.1 trillion yen



Ratio by Cause of Death (for FY 2005)
Life-style related diseases: 60.1 %

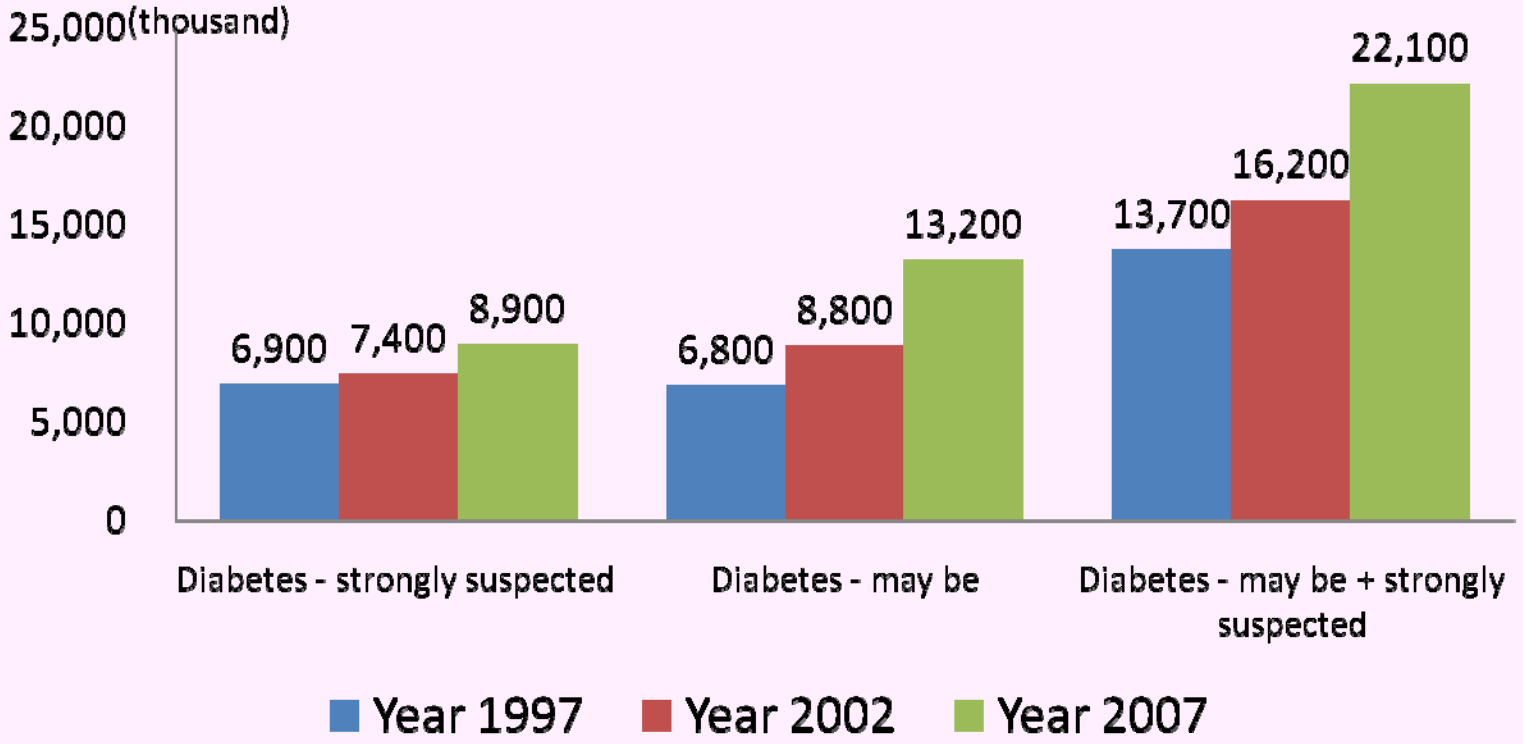


Trends of diabetes prevalence in Japan

Estimated prevalence of clinical and sub-clinical diabetes

(Source: *National Health and Nutrition Surveys by MHLW*)

- Diabetes (strongly suspected)： 8.9 million
- Diabetes (strongly suspected AND may be) : 22.1 million



- Trends of major health and health economics statistics

- National health promotion and disease prevention plan **~Health Japan 21~**
  Mid-term Review and new challenge

Health Japan 21 (2000~)

-Put priority on primary prevention

-Improvement of social environment for staying healthy

-Specific targets and assessment

-Cooperation with various bodies including NGOs and private companies

Health Japan 21

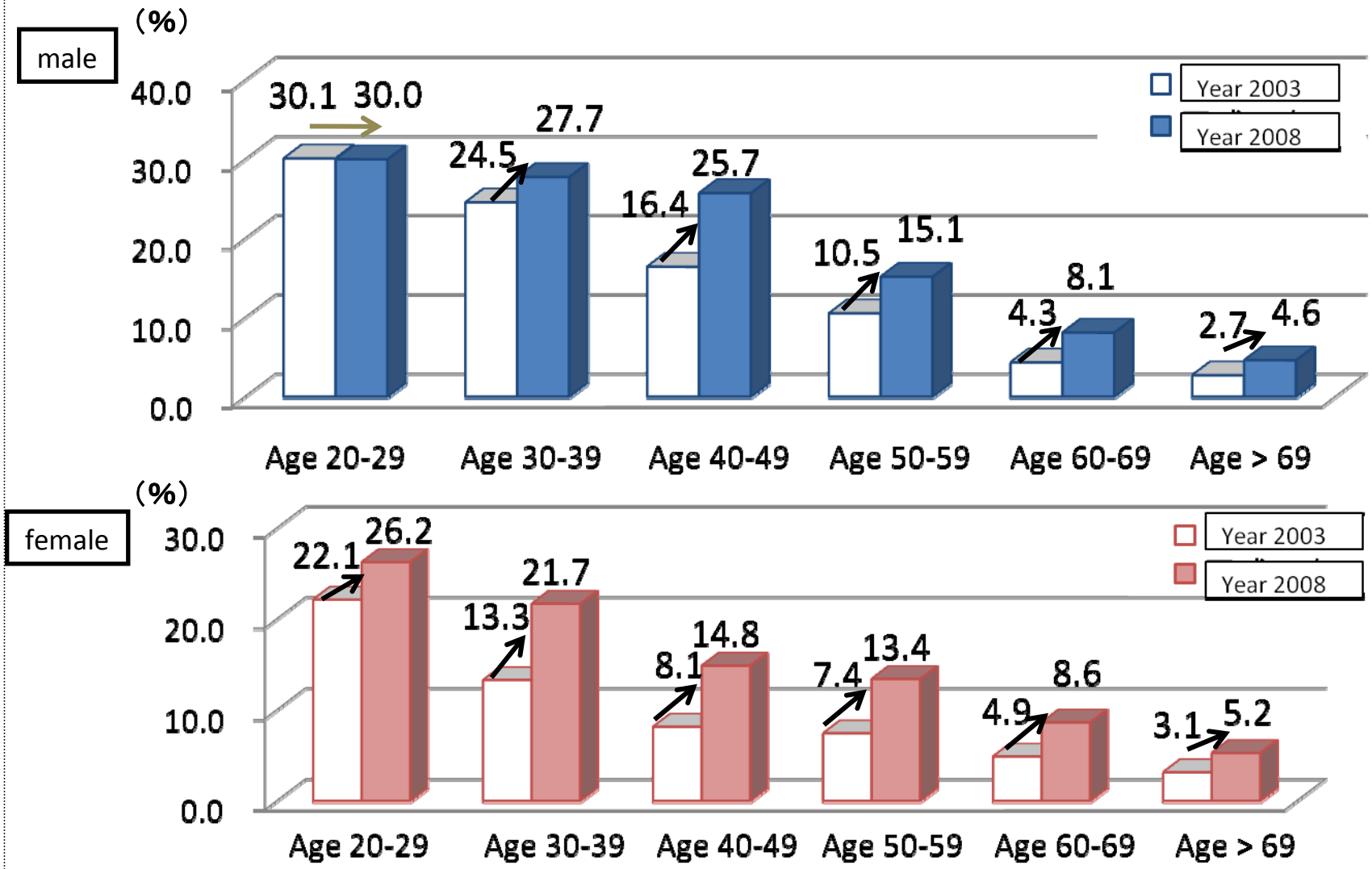
(Plan for 2000 – 2012)

1. Nutrition and diet
2. Physical activities and exercise
3. Rest and promotion of mental health
4. Tobacco
5. Alcohol
6. Dental health
7. Diabetes
8. Circulatory diseases
9. Cancer

70 specific targets

9 areas

A slight increase in the percentage of those skipping breakfast



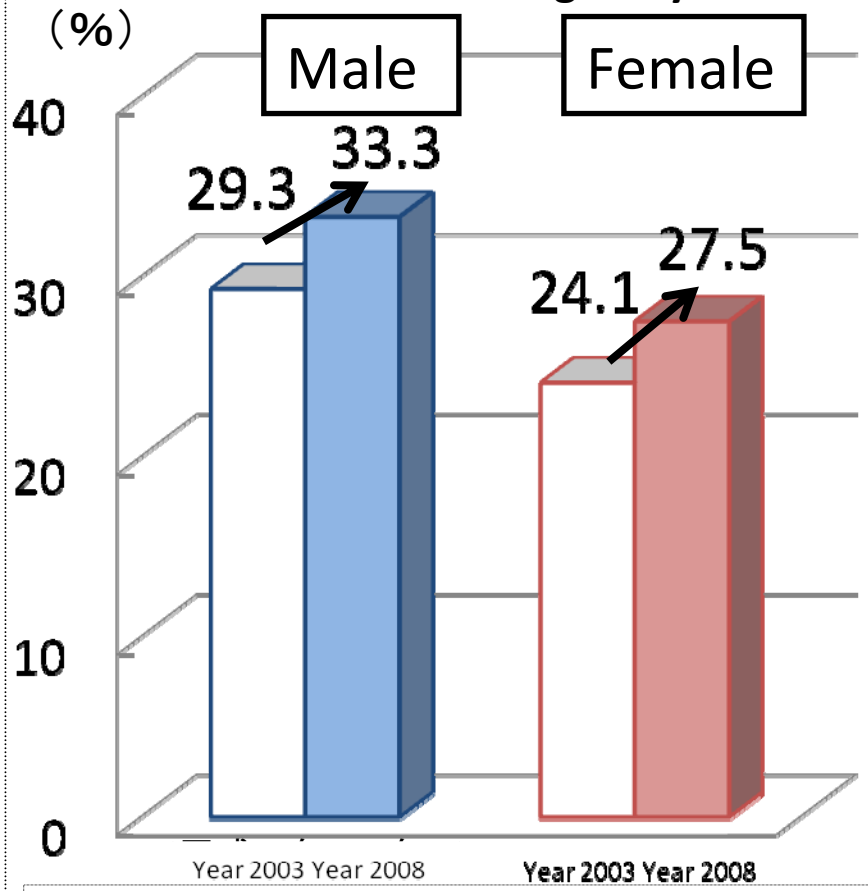
A target for Health Japan 21: reduction in the percentage of those skipping breakfast regularly

target figures : 0% of adolescents, less than 15% of male (age 20-39)

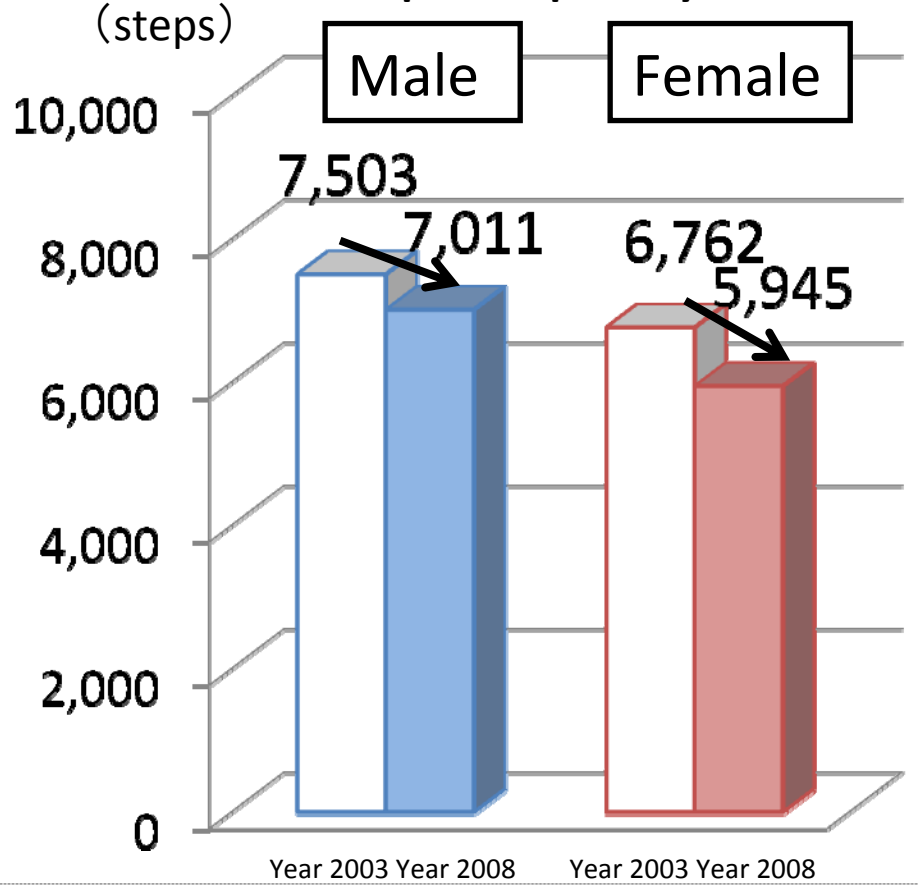
More of Japanese do regular exercise, but….

mean number of steps per day per person is slightly decreasing……

The percentage of those who do exercise regularly



Mean number of steps per person per day

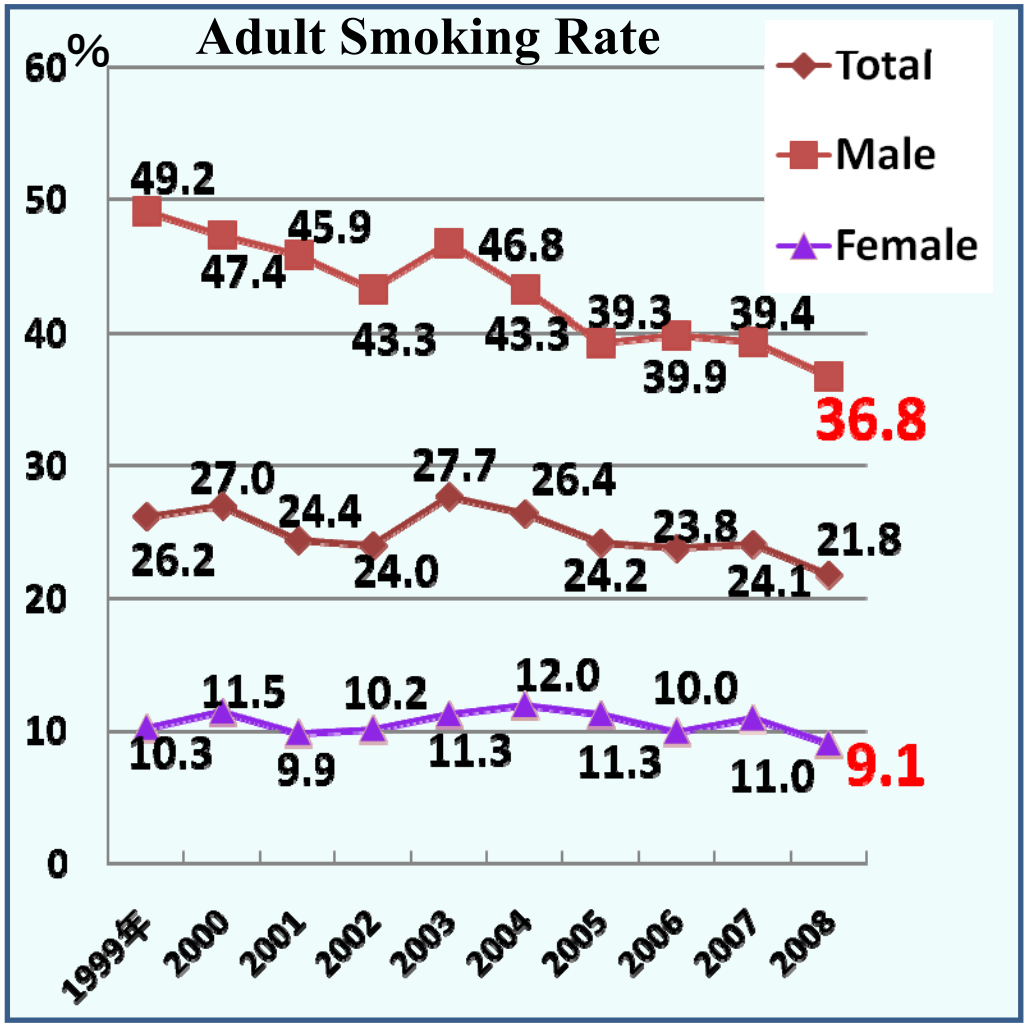


Targets for Health Japan 21

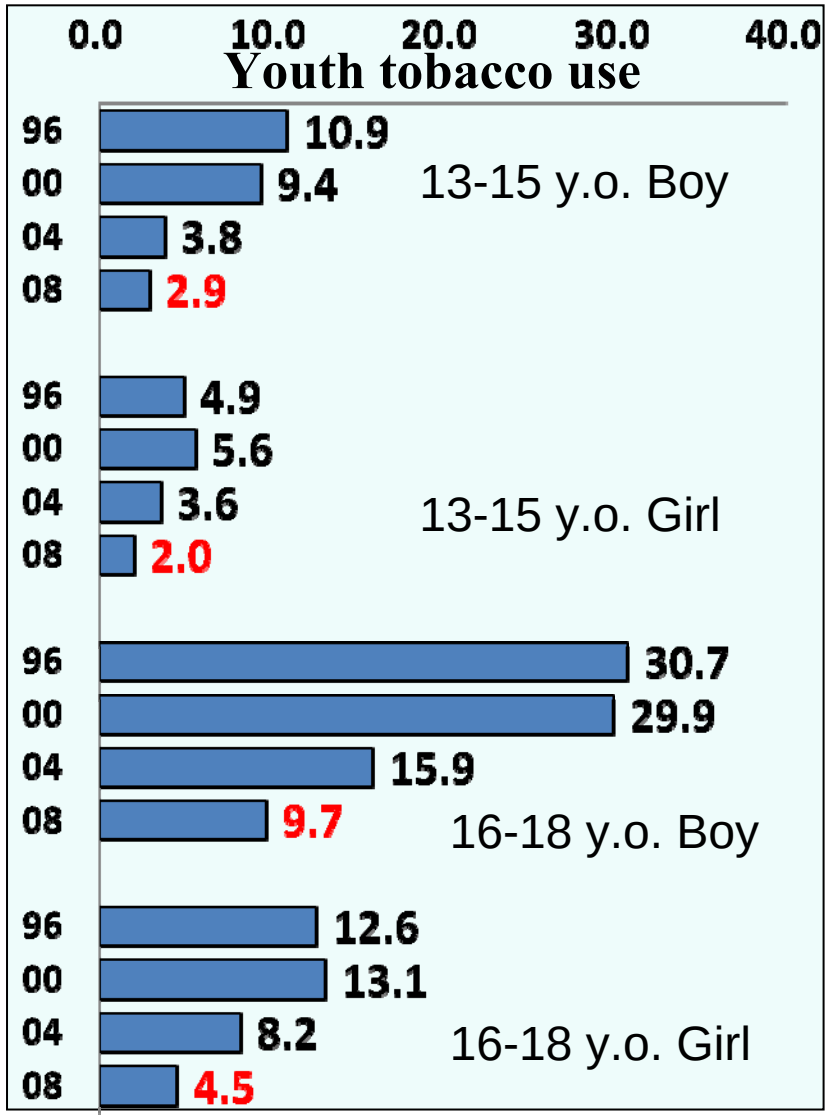
Increase in the percentage of those who do regular exercise : male > 39%, female > 35%

Increase in the number of steps per person per day : male > 9,200, female > 8,300

Smoking Rate in Japan



Reference: National Nutrition Survey (until 2002) National Health and Nutrition Survey (from 2003)



Uehata(1996,2000), Hayashi(2004), Ooida(2007)

Homestretch of Health Japan 21

~Health Japan 21 mid- term review ~

- 70 targets might be too many for people to be aware in daily life
- The coverage of the promotion was not well specified

~Health Life-Style Campaign~

- Focus on 3 areas **Tobacco, Nutrition & Physical activities**
- Specify the promotion target
- Reconstruct strategy with evaluation methods

Compilation of “Textbook for Health Communication”

Message Samples for healthy diet promotion (vegetable)

SAMPLE 01

For Women in 20s and 30s

A half piece of Tomato is enough to correct the deficit .

野菜不足は、あとトマト半分。

じつは日本人はけっこう野菜を食べています。
すでに国目約250gの野菜を食べています。
しかし生活習慣病予防の観点からは350gが推奨量。
ですからあと100gだけ足りないというワケです。
トマトなら半分。野菜炒めなら半皿分。
むずかしい量ではありません。
野菜メニューも充実している夕食ではなく
朝食や昼食でプラスするのがコツです。

SAMPLE 02

Show how much you have to take.
Both sexes in 40s and 50s

温野菜なら、
不足100ｇも食べやすい。

You can easily take 100g of vegetable if it is boiled.

生活習慣病予防の観点から、われわれ日本人は
あと100gほど野菜の摂取量が足りません。
わずか小皿ひとつ分なんですが。
そこでちょっとしたコツとして生野菜ではなく
温野菜だと食べやすくなるということを覚えてください。
スープでも煮物でも。忙しいときはレンジでチンで。
野菜そのものの味や食感も変化するので
食事自体が豊かになるところがおすすめです。

Message Samples for healthy diet promotion (breakfast)

SAMPLE 03

Show the knack for eating breakfast easily
Both in 20s, 30s, 40s, and 50s

朝カフェで、
一日をはじめましょう。

Start your day at café.

朝食は「これからすることのエネルギー」になります。
ですから、いい一日を過ごすために欠かすことはできません。
しかしとくに単身者の場合は「めんどうな気持ち」が
先に立ってしまい朝食抜きになることが多いようです。
自宅から勤務先までの動線にある喫茶店やカフェ
あるいはファストフード店などで15～20分の朝カフェ。
午前中の仕事効率の向上という観点からも
朝食を摂ることはとても重要な生活習慣といえます。

Good morning with Onigiri (Japanese rice ball)!.

おにぎりでオハヨウ。

おにぎりこそ！ われらが誇るファストフード。
朝、出かける支度をしながらでも頬張れる。
あるいは職場に着いてからでも
ちょっとした隙間があれば手軽に食べられる。
自分でつくるんだったら
なかの具をいろいろ工夫しておけば
たのしめるし経済的でもありますし。
忘れてましたネ、日本人のちょっとした知恵。
朝食はすこやかな生活習慣の第一歩です。

SAMPLE 04

Try healthy fast food.
Both in 20s, 30s, 40s, and 50s

Message Samples for exercise promotion

SAMPLE 05

Show how long you should walk
Those in 40s and 50s

Ten minutes rapid walking everyday is enough.

毎日なら、10分間のはや歩き。

くるしくならない程度にスピードをあげてはや歩き。
それは立派な「運動」になります。
生活習慣病の予防に効果がある運動として
はや歩きは、すでに科学的に実証されています。
通勤通学のときや、ちょっとした移動時間に。
一日10分間の運動習慣。ちょっと汗ばむくらいの
運動強度でじゅうぶんに効果があります。

SAMPLE 06

Show how long you should run.
Women in 20s and 30s

週末なら、合計40分ランナー。

毎日運動をつづけるのはむずかしい。
そんな、じぶんに対する「やらない言い訳」で
すっかり運動をあきらめてしまっていませんか。
じつは、週末だけの40分程度のジョギングにも
生活習慣病の予防効果があることが
科学的に実証されています。
いっぺんに40分でなくてもかまいません。
土日であわせて40分程度のまとめラン。
くれぐれもムリしすぎないことは前提ですが。

You should just run for a total of 40 minutes in every weekend.