

An overview of the role of government in the organisation and provision of health services in Japan

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This article is illustrated with reference to health services in the Tokyo Prefecture. It seeks to describe the role of government in the organisation and provision of health services in Japan. It is based on experiences gained from a three-month placement at the Tokyo Metropolitan Government Bureau of Public Health in late 1994. Wherever possible the article identifies similarities and differences between the Japanese and Australian health care systems. Part of the analysis has been to identify areas where opportunities exist for Australian health service providers to develop further cooperation with particular sectors of the Japanese health system and also where the potential for the export of health services may exist.

The health systems of Australia and Japan have points of similarity and difference. Essentially both systems operate within the context of a compulsory universal health insurance system. However, unlike Australia, the bulk of service provision in Japan is left to the private sector, while government retains the primary role of regulator. It is interesting to observe that while the Australian health care system is currently exploring options to expand the service range and level of participation of private sector services in health care delivery (within the context of universal health insurance), the Japanese health care system appears to be examining options through which further government intervention can improve service access and service efficiency. Japan presents opportunities to observe the benefits and disadvantages of predominantly private sector provision within the context of universal health insurance coverage.

Structure of the Japanese Government

Demography

Japan has a population of approximately 124.4 million and is one of the most densely populated countries in the world (approximately 334 persons per square kilometre compared to Australia with 2 persons per square kilometre) (Australian Bureau of Statistics 1995). Japan has a very homogeneous society, although there are some minority groups, notably Koreans and Chinese. The total population of foreign-born residents, however, has not yet reached 1 per cent of the total population. Japanese citizens have the longest life expectancy in the world, the average for males being 76.09 years and for females 82.22 years (Tokyo Metropolitan Government 1994b).

Government

The form of government in Japan is a parliamentary system and the Japanese Constitution defines the national government, the Diet, as the highest organ of state power. Below the national government, Japan has established a two-tier system of local government. The top tier includes the prefectures, the largest local government units, which are in turn composed of a lower tier of municipalities: cities, wards, towns and villages. In 1990 Japan had 3293 local governments. This included 47 prefectures, 633 cities, 23 special wards in Tokyo, 2003 towns, and 587 villages (Abe, Shindo & Kawato 1994, p 63). In terms of administrative responsibility there is no essential difference between cities, towns and villages. Generally speaking, prefectures and municipalities stand on an equal footing, with prefectures being in charge of regional administration and municipalities handling affairs more directly related to residents.

Financial arrangements

The administrative activities of the national government and local governments are primarily funded by taxation. With the exception of expenditure for defence and other duties performed solely by the national government, the majority of services affecting the lives of the nation's citizens are provided by local governments. This is referred to as the *agency delegated function* of local governments (Abe, Shindo & Kawato 1994, p 60). Local governments (prefectures and municipalities) execute functions

delegated to them from the national government and this activity is generally supervised by a national ministry. At present, more than half of the functions performed by prefectural governments are agency delegated (Shibata 1993, p 170). Thus when reviewing the financial relationship between governments it becomes evident that while local governments may account for 67 per cent of all government expenditure, funds raised at the local government level only account for 30 per cent of all government expenditure.

Similar to Australia, there exists significant vertical fiscal imbalance between the national and sub-national levels of government in Japan. To ensure adequate funds are available at the local government level to match their areas of responsibility, the national government undertakes a number of financial transfer processes. The two major transfers are the Local Allocation Tax and the National Government Disbursements.

Local Allocation Tax is allocated to local governments to equalise their financial capacity and to ensure sufficient funds for the public services local governments are required to provide. There is no limitation on the use to which these funds can be put. The tax is similar to the Financial Assistance Grants provided by the Australian Commonwealth Government to the States.

National Government Disbursements. There are over 1000 national government disbursement programs. These cover all activities of local government and are generally specific-purpose payments which must be spent as stipulated and accounted for to the appropriate national ministry. Almost all of these payments are cost-sharing grants. These grants make up about 17 per cent of total revenue for prefectural governments (Shibata 1993, p 174).

Japanese bureaucracy

Any examination of the role of Japanese government in the provision of health and social services must encompass a broader examination of the nature of bureaucracy in Japan. There are particular characteristics of bureaucracy in Japan which influence the formulation of policy and the implementation and delivery of services and programs.

Centralised control

It has been argued that Japanese society has a much longer history of living with and understanding bureaucracy than do western societies. The modern Japanese state (the Meiji Government 1869) began under an oligarchy which created and nurtured a powerful bureaucracy to serve its own interests (Johnston 1978, p 141).

This highly effective, centrally controlled state operated until the end of the Second World War, however, despite the purge of wartime leaders, the Occupation chose to rule Japan indirectly through the bureaucracy. Hence the bureaucracy is considered to have actually increased its influence during the Occupation.

Today this control is exercised through the democratic institutions established by the Occupation. The national ministries retain their control over major policy areas primarily through a complex system of regulations. These detail agency delegated functions and guidelines and in addition set standards for other services which may fall solely within the realm of local government responsibilities. The inducement to adhere to these national guidelines occurs in the form of specific-purpose payments from the national government. The basic principle which underlies national government control is uniformity throughout the country (Shibata 1993, p 170). It is generally recognised that national and regional administrative and fiscal systems hinder the independence of local government (Abe, Shindo & Kawato 1994, p 66).

Cooperation and selective involvement with the private sector

Historically Japanese government has shown a reluctance to intervene in many areas of private sector and social welfare activities. The government and bureaucracy have been highly selective in the scope and direction of their actions, intervening forcefully in some areas but remaining only on the periphery in many others (Pempel 1982, p 12). While state institutions have always been powerful they have not been comprehensive in their activities, leaving many critical functions to the private or civil society. In most areas of social welfare the government has avoided direct involvement. The government has a history of actively encouraging the private sector, but also utilising its power to actively steer the economy in the national interest (Pempel 1982, p 14). Thus Japan developed a strong state alongside a tradition of privatisation.

Transfers and secondments

Another important feature of Japanese bureaucracy which has in many ways contributed to the uniformity and consistency of government regulation applied throughout all levels of government is the staff transfer and secondment process. This is practised by all bureaucracies. Employees in all levels of government are frequently transferred to different ministries or bureaus and are also transferred to different levels of government.

In the Tokyo Metropolitan Government most employees are transferred to a different bureau every two years. Thus it is not uncommon to find someone who, having previously worked in the Health Bureau, is now working for Housing or Welfare. Further to this, it is not uncommon to find bureaucrats from national ministries working at prefectural bureaus or in the offices of local municipalities.

It is argued that this constant interchange of public servants helps avoid job stagnation and enables staff to train as generalists in a variety of fields. This process also helps ensure that each level of government has access (often through personal networks) to other levels of government and various bureaus and ministries.

Whilst the process has been criticised for allowing many public servants to avoid taking ultimate responsibility for certain policies or plans (since they are likely to have been transferred before any major problems or issues of continuity arise), the process does create a certain level of policy consistency across all levels of government. Conflict between levels of government and between ministries does exist, but the overwhelming impression created is that all levels are generally working together in a consistent and uniform manner, chiefly driven from the centre (national ministries).

Respect and prestige

Whilst in recent years the bureaucracy has come under increasing criticism from both abroad and within Japan, it has nevertheless managed to maintain a highly esteemed position within Japanese society.

In Japan...the civil service continues to attract and indeed is actively sought by the best graduates of the country's leading universities. The attractions of the civil services are not especially the material rewards – although financial security and steady progress are in fact assured – but prestige, respect and power.

The bureaucrats themselves the watchdogs of the national interest and are esteemed as such by the general public (Powell & Anesaki 1990, p 106).

The organisation of health services in Japan

Introduction

There are many different systems of health services delivery throughout the world. Each of these systems has developed in keeping with the cultural values, economic status and political conditions of the country. Yet despite these indigenous characteristics, the trend in each country to a greater or lesser extent has been for government to have greater responsibility and control in the financing and organisation of health services (Powell & Anesaki 1990, p 8). In general the trend has been to improve patterns of delivery to enhance access and increase cost-efficiency. Developments in Japan are no exception to these general observations.

By international comparison, the cost of health services in Japan has always appeared relatively low. For example, in 1991 the total health expenditure as a percentage of gross domestic product for Australia was 8.2, Canada 10.0, New Zealand 7.6, the United Kingdom 6.6, the United States 13.4 and Japan 6.6. Japan's average gross domestic product expenditure on health services between 1970 and 1992 was 6 per cent (Australian Institute of Health and Welfare 1994, p 287). To some extent this low cost to the state is the result of cultural and social factors specific to Japan. Most informed observers argue that social services in Japan are 'notoriously under-developed for a country of such obvious wealth and which espouses egalitarian principles' (Powell & Anesaki 1990, p 4). The official neglect of social welfare services has been possible because traditional values and customs have meant state provision is either unnecessary or unwanted by the community.

Japan is recognised for its strong feelings of responsibility for members of the group. The family is the foremost group to which allegiance is required and traditionally the family has looked after its members. Whilst in recent times family ties have loosened somewhat, the level of independent social welfare support provided among families in support of members is still significant compared to standards prevailing in western societies. The major issue facing Japanese health and welfare policy-makers is to what extent government services should supplement family support to compensate for the pressures of living within a modern economically advanced society which is rapidly ageing.

History

During Japan's period of modernisation in the second half of the nineteenth century, it modelled its health care system along German lines. Yet, unlike Germany, Japan did not support any generous development of social insurance or pension programs. The government sponsored medical education and research based on the German model but left the provision of direct health care services to the private sector.

In 1922 the first health insurance law was introduced and this was aimed at protecting workers employed in small enterprises. This basic insurance structure has remained intact and over the years has been incrementally expanded. By 1961 the National Health Insurance and Pension Act provided for universal health insurance coverage (Powell & Anesaki 1990, p 131).

In Japan there is considerable functional, institutional, and territorial fragmentation of responsibility for health care provision so that the application of coherent policies and planning instruments to effect overall provision is difficult. The divisions of service and planning responsibilities for aged care clearly illustrate this point. Government policy is to primarily rely on the private sector to provide hospital and primary medical care. However, the government recognises that it has a responsibility in areas which are not well served by the private sector, areas such as emergency services and services for the disabled. For example, in Tokyo the public hospital system represents 5 per cent of all beds in the prefecture, however, it has 40 per cent of available emergency services (Tokyo Metropolitan Government 1993).

The Ministry of Health and Welfare

The national Ministry of Health and Welfare is the key policy-maker and regulator of health and welfare services in Japan. The ministry is responsible at the national level for the general administration of public health, social welfare and social security programs. The ministry also coordinates health and medical affairs with other state activities. Apart from the management of a few specialist national hospitals and research centres, the ministry is not involved in the direct provision of health care services. Public health care provision is left to prefectural and local government authorities.

Prefectures and local authorities

Each prefectural government has a department or bureau which is responsible for planning and carrying out health programs in compliance with the policies and directions of the national Ministry of Health and Welfare. Below the prefectures are the local authorities (city, ward, town and

village government) which also carry out an administrative function responsible for planning and implementing health services and programs at the appropriate local government level. Local governments are also required by law to establish health insurance programs for the local population not already covered by the other larger employer-based or national insurance schemes.

Key features of health care services in Japan

Before proceeding to elaborate on some of the major characteristics of the health care system in Japan, it may be appropriate to summarise the key features. The following observations were made in the late 1980s and are indicative of where major policy initiatives have been targeted over the past decade to improve the system.

- Although there is a substantial public sector involvement in medical care, the bulk of medical services are delivered through the private sector (about 80 per cent of hospitals and 60 per cent of hospital beds and more than 90 per cent of clinics are privately owned and operated).
- The delivery of services is highly competitive, with hospitals and clinics, both public and private, offering very similar services, resulting in considerable overlapping, redundancy and excess capacity.
- Since there are few special long-term care facilities, acute, chronic, short-term, long-term, inpatient and outpatient care tends to be delivered in the same institutions for young and old alike, with a resulting average length of stay in hospitals of about 40 days.
- The closed staff system means that every clinic and hospital is exclusive with respect to its patients and tries to offer 'all in one' medical services.
- Even though all Japanese physicians are officially described as specialists, most actually are engaged in general practice.
- The coordination and continuity of services from primary care to specialised care to rehabilitation and prevention are seriously deficient, and regional medical care planning is hampered by basic legal and structural constraints.
- Since physicians are permitted both to dispense and prescribe drugs, over-utilisation of medicine has been a serious health hazard as well as a financial problem for consumers.

- The combination of predominantly private, fee-for-service, physician-centred medical care with compulsory, universal health insurance offering free choice of provider for insurers has created a serious financial crisis that requires substantial state intervention (Steslicke 1987, p 45).

The following discussion will seek to elaborate on some of these key features and indicate how they are being addressed.

Health expenditure and other system indicators

In 1991 national health expenditure in Japan was approximately 6 per cent of gross domestic product (about A\$311.8 billion). Per capita expenditure was approximately A\$2514. Since 1985 the annual rate of increase in national health expenditure has averaged about 6 per cent (Ministry of Health and Welfare, *National Medical Expenditure*, p 80). As with Australia, the increase in medical expenditure correlates with the ageing of the population, changes in patterns of illness, and developments and increasing use of medical technology.

The Japanese health system is characterised by a lengthy hospital stay. In 1991 national average length of stay was 49.3 days. This figure is somewhat misleading since it includes all patient categories (acute and nursing home type). Efforts have been made to reduce the length of stay in the acute sector and with the gradual expansion of aged care services the range of length of stay now varies from 25 to 40 days. The occupancy rate for hospitals in 1991 was about 86 per cent.

In 1994 the average length of stay in the Tokyo Metropolitan Government public hospital system was down to 25 days. The explanation for this exceptionally long length of stay is as follows.

1. The hospital system predominantly accommodates aged care nursing home type patients because the nursing home sector is still underdeveloped.
2. Home support, home care and community-based care are virtually non-existent and therefore patients are encouraged to stay until they have completely recovered and no longer require any form of care.
3. The recurrent budget of hospitals primarily consists of receipts from health insurance firms and the bed-day payment does not reduce until after a patient has stayed 25 days. Thus in a situation where beds are oversupplied, the insurance system creates an incentive for hospitals not to discharge patients until after a stay of 25 days.

Private practice and referral networks

In Japan there are no officially identified general practitioners. Doctors either operate surgeries (clinics) or are employed at hospitals. Clinics are staffed by specialists in a particular field. Therefore patients are required to conduct a certain degree of self-diagnosis when choosing to identify which type of specialist surgery they should attend.

Clinics are defined as facilities with the capacity to admit 0 to 19 inpatients. Hospitals are non-profit institutions which have the capacity to accommodate 20 or more inpatients. General hospitals provide comprehensive outpatient services. Until recently it has been a requirement by law that both hospitals and clinics be managed by qualified medical practitioners. While clinics are generally owned and operated by a medical practitioner, hospitals are generally owned by non-government not-for-profit organisations, with salaried medical staff in managerial and clinical positions.

In general, medical care is accessible and convenient in Japan. Patients rely on local doctors for primary care and the system allows them to seek treatment at any clinic or hospital at will. To receive treatment at a hospital or clinic, patients need only present proof of their health insurance arrangements.

The hospitals and clinics essentially delineate two systems of personal medical care. The hospitals provide inpatient and outpatient care while the clinics provide ambulatory care and offer some limited inpatient services. Links between the two levels of services are not well established and the coordination of services is extremely difficult.

Hospital operation is based on a closed system, whereby only in-house hospital staff and consultants can treat people on an inpatient and outpatient basis. Private practitioners who are not staff doctors at a hospital are denied access to its facilities. This system encourages a competitive relationship between clinics and hospitals for the recruitment of new patients (Lane 1993, p 9).

This problem has been recognised by health authorities in the Tokyo Prefecture and in 1993 the Tokyo Metropolitan Government Bureau of Public Health introduced a system to establish regional public hospitals in each planning zone. The role of these hospitals is to facilitate improved referral networks which direct patients to the appropriate level of service. Regional hospitals are secondary base hospitals and provide general health services (non-tertiary) and an emergency service. The aim of these hospitals is to improve the role of private sector facilities in treating patients and to ensure that patients requiring primary care are seen at primary care clinics. It is hoped that this system of appropriate referrals will decrease the rate of cost increase and maximise the value of finances derived from health insurance funds.

Hospital funding and finances

The financing of all public and private hospitals and clinics is regulated by the insurance reimbursements defined by the national Ministry of Health and Welfare. All facilities and practitioners are required to submit detailed billing forms to the government-operated Social Insurance Medical Care Fee Payment Fund. Here bills are verified and payment authorised in accordance with the prescribed fee schedule (Powell & Anesaki 1990, p 159).

For owner-operated clinics these insurance reimbursements are made directly to the clinic and make up the major component of a physician's income. For hospitals the reimbursements are made to the hospital to cover operating costs and physicians derive the bulk of their income from salary.

In theory the income of each hospital and clinic is regulated by the reimbursement system operated by the government. However, there are other opportunities to boost income. In particular, unique to Japan, is the informal recognition and acceptance of the 'kick back' system. This is a significant source of unreported income whereby Japanese doctors benefit from under-the-table 'gift' payments made by pharmaceutical companies and grateful patients. The size of the gift payment is generally discussed directly by doctors with their patients and relates to the level of expertise and prestige the doctor commands (Lane 1993, p 11). This is how senior and expert physicians can supplement the flat rate paid by health insurance funds.

Health and welfare services for the aged

Health and welfare services for the aged are combined at the national level, separated at the prefectural level and combined at the local government level. Local government has primary responsibility for the provision of aged care services. All levels of government contribute to the funding of aged care services.

The development of aged care services has, in general, been directed by the national government through the passage of laws requiring specific action from prefectural and local governments. The National Health Aged Care Law directed prefectural governments to establish a range of care services and health promotion activities directed specifically at the aged population (health promotion being targeted at people aged from 40 years plus).

Aged Care Facilities

Under the National Health Aged Care Law, prefectural governments also established specific health care facilities for the aged (Aged Care Facilities). These facilities provide rehabilitation services for the aged who have recently been discharged from hospital, provide rehabilitation for the elderly in an effort to prolong their capacity to live independently at home and also provide respite services. In Tokyo there are currently 12 Aged Care Facilities. Their size ranges from 50 beds to 100 beds. The national plan developed by the Ministry of Health and Welfare has set bed targets for Aged Care Facilities for the nation and each prefecture up to the year 2000.

The funding of these facilities is shared between the national government and prefectural governments. Government contribution is to cover construction and furnishing costs. These facilities are then administered by non-government organisations and recurrent funding is obtained from rebates under the national health insurance schemes.

Aged Care Facilities are staffed with one doctor and have a range of therapy and nursing staff. These are non-acute facilities and are generally planned and operate in coordination with local hospitals. The average length of stay of residents is three to four months. This service is also used before admission to a nursing home.

Home Nursing Stations for the Elderly

In addition to Aged Care Facilities, the national government legislated in 1992 for the establishment of Home Nursing Stations for the Elderly. These are funded under the same principles as Aged Care Facilities, that is, establishment costs are covered by the national and prefectural governments. Home nursing stations are managed by non-government organisations and recurrent funding is obtained through insurance rebates and client contributions. As the name suggests, home nursing stations provide nursing care to elderly people in their own home. Services are generally free or require a minimum client contribution, for example, 250 yen (approximately A\$3.50) per visit. This service concept is relatively new in Japan and there exists significant demand for service expansion.

Client referral to either facility (aged care or nursing station) can be by family doctor or self. Planning for the location of an Aged Care Facility or a Home Nursing Station for the Elderly is done jointly by the national, prefectural and local government.

Nursing homes

Planning for the provision of nursing home places is a local government issue. However, the national government has set indicative figures for the country, that is, available beds should equal 1 per cent of the population aged 65 years and older. These figures are part of 'The Golden Plan', a comprehensive 10-year plan for aged care services that the national government produced and revised in 1994.

Prefectural and local governments are free to further increase this ratio; however, funding for the extra places must come from their own revenue. Standards for nursing homes (required services, construction regulations, standards of care and staffing levels) are determined by the national government. Most prefectural governments and local governments regard these standards as minimum and generally provide services above these requirements. The extra costs associated with providing services above the minimum standards must be met by the local government. For example, the Tokyo Metropolitan Government has determined that the number of nursing home beds should be 1.47 per cent of the 65+ population; given that this is 0.47 per cent above the national recommended level, the prefectural government must meet this additional cost from its own resources.

Nursing home ownership and management

Nursing home services are predominantly owned and operated by private sector and non-government organisations. The operating agencies are approved by the appropriate local government authorities. In some instances the local government may own the facility and contract out management to a private for-profit or non-government (not-for-profit) agency. The nursing home management authority receives funding from all levels of government to provide services. This is one particular aspect of the aged care sector which is similar to the Australian situation. In both Australia and Japan private and non-government providers operate within a framework of government regulation and subsidisation to provide nursing home care.

Nursing home access and assessment

Access to nursing homes is decided by welfare officers located at local municipal government offices. The assessment is done by non-medical welfare workers, who assess each individual's family situation. This assessment determines the need for nursing home placement and also determines the level of contribution to be paid by the applicant if accepted for placement.

The assessment does not use uniform criteria determined by the national or prefectural governments. Each local government determines its own criteria to apply. The assessment does not involve a home visit. In general, the assessment ostensibly focuses on welfare issues, particularly the family situation, to determine if home support from relatives will continue.

Health insurance arrangements

Essentially Japan has a system of comprehensive national insurance. National legislation obliges employers to provide insurance for employees and local governments to provide coverage for their employees and residents who otherwise may not have access to insurance through the employer-based schemes. Insurance coverage may be obtained from a number of sources, depending on an individual's personal circumstances. The insurance system is based on a standard subscriber contribution system and the incursion of costs and payments is based on a fee-for-service system. The eight major health insurance schemes can be classified into two broad groups: Employee Health Insurance (for employed individuals and their dependants) and National Health Insurance (for the self-employed, unemployed, retired and their dependants).

An interesting feature of the insurance arrangements is that contributions and benefits tend to vary according to the type of scheme with which one is registered. Generally, the society-managed and mutual aid associations provide better benefits than the government-managed funds. Under the Employee Health Insurance scheme both the employer and the employee make monthly contributions. Under the National Health Insurance scheme it may be either the employer or the municipal government, as well as the individual, who contributes to the monthly insurance premium. This varies according to an individual's circumstances.

Under the Employee Health Insurance scheme the insured employee is required to make a 10 per cent co-payment for any service, whilst under the National Health Insurance scheme the co-payment is set at 30 per cent. Both systems have a ceiling for total monthly out-of-pocket expenses and excess costs are met directly by the government under the Costly Medical Expense Benefit scheme.

In addition to the above, the national government introduced in 1982 the Law of Health and Medical Services for the Aged. This has been operative since 1984 and essentially guarantees free medical care to individuals aged 70 and over and disabled persons aged 65–69. The program operated under this law provides the whole range of medical

benefits individuals received under the Employee Health Insurance scheme before their retirement. The medical care expenses are financed via contributions from national government (20 per cent), local government (10 per cent) and all other health insurance carriers (70 per cent).

In addition to employee and national health insurance, individuals may purchase private health insurance to cover the co-payment and extra health and medical expenses. Various policies are available. These policies pay directly to the insured. However, private health insurance policies attract high premium payments and are generally only taken out by high income earners. (Lane 1993, p 15).

Opportunities for cooperation and the export of health services

Already there may be numerous opportunities for cooperation in the areas of health personnel education, scientific and medical research. As in other countries, these can generally be accessed via research institutes and universities. Experience gained from a three-month placement with the Tokyo Metropolitan Government Bureau of Public Health tends to indicate that in the field of health administration and services planning, further cooperation may develop in the following areas.

- *Aged care.* Services planning, funding systems and service management.
- *Hospital management.* Improving the efficiency and effectiveness of hospital services.
- *Nurse education and career development.* This includes advice on ways to improve professionalism and nurse retention.

Aged care services

As indicated above, the development of aged care services in Japan is somewhat disjointed and still at an early stage. The potential to cooperate in the development of services in this area is great. However, given the devolvement of responsibility for service development and provision to local government, it is likely that only small, locally based partnerships could be established rather than connecting with an authority with statewide (prefecture) or regional planning responsibility.

Nevertheless, the nature of doing business in Japan is such that this type of approach would be most effective in terms of cost-effectiveness and

gaining experience in the way aged care services, business and government operate in this area.

Specific areas in aged care where opportunities exist include the following.

- The development of home nursing services. Assisting local governments in the planning and management of home nursing services.
- Provision of advice on how to develop more integrated systems of aged care which link primary care and hospital services at the local level.
- Design and construction of nursing homes and hostels.
- Advice on the planning, development and operation of aged care assessment services (similar to aged care assessment teams in Australia). This is one model of service assessment and service coordination being promoted in Japan.
- Nurse education in specialised areas of aged care/geriatrics (as is already being done by the Queen Elizabeth Centre at Ballarat). Educational opportunities also exist for other health workers involved in aged care such as personal care assistants and allied health professionals.

Hospital management

Information published by the national Ministry of Health and Welfare indicates that between 30 per cent and 70 per cent of hospitals in Japan operate in the red (Austrade 1993). Both private hospitals and government hospitals are seeking ways to improve their cost-effectiveness. There may be opportunities to assist hospitals to improve their management.

Nursing services

Japan currently has a shortage of nurses and supply is not expected to meet demand until the year 2000. Medical workforce planning has extensively focused on how to improve the recruitment and training of nurses to match demand. This includes strategies to encourage the return of trained nurses to the workforce by providing refresher training (free of charge) for trained nurses who have not been in the workforce for some time and by promoting nursing as a long-term career. All these strategies are aimed at creating a more stable and professional nursing workforce.

State governments have significant experience in developing nursing as a profession and this experience could be of great value in Japan.

Opportunities exist to assist in the areas of nurse education (curriculum development and postgraduate course development), career development, recruitment and retention.

Conclusion

This discussion has sought to provide a general outline of the major features which define the operation of government in Japan and, within this framework, the provision and regulation of health services. In many instances the similarities to the Australian situation are quite surprising. There is significant vertical fiscal imbalance between levels of government, the policy framework for health services (particularly in terms of financing through health insurance) is primarily driven by the national government and service delivery issues are predominantly dealt with by local (state/prefecture) governments. Whilst in both countries national policy ensures universal health insurance coverage, the mechanisms used to deliver this coverage differ. And whilst service providers in both Australia and Japan raise income through insurance arrangements, unlike Australia, service provision in Japan is dominated by the private sector.

The problems in aged care are similar in both countries, yet the development of solutions appears less advanced in Japan. It is in this area that perhaps the greatest opportunities for further cooperation and the export of services exist.

References

- Abe H, Shindo M & Kawato S 1994, *The government and politics of Japan*, University of Tokyo Press, Tokyo.
- Austrade 1993, *Health issues in Japan, briefing notes*.
- Australian Bureau of Statistics 1995, *Pocket year book*, Australian Government Publishing Service, Canberra.
- Australian Institute of Health and Welfare 1994, *Australia's Health 1994*, Australian Government Publishing Service, Canberra.
- Campbell JC 1992, *How policies change: The Japanese Government and the ageing society*, Princeton University Press, Princeton, New Jersey.
- Emi K 1978, *Essays on the service industry and social security in Japan*, Economic Research Series No 17, The Institute of Economic Research, Hitotsubashi University, Kinokuniya, Tokyo.

- Johnston C 1978, *Japan's public policy companies*, AEI - Hoover Policy Studies, 24, Washington.
- Lane L 1993, *Medical services in Japan: Targeting patient flow to Australia*, A consultants report prepared for Austrade, Tokyo.
- Levin PJ 1989, 'Health care in the balance: Japanese eurythmy', *Hospital and Health Services Administration*, vol 34, no 3, pp 311-23.
- Ministry of Health and Welfare (no date), *National Medical Expenditure*.
- Ministry of Health and Welfare (no date), *Medical Insurance Scheme*.
- Ministry of Health and Welfare 1992, *Outline of the medical care delivery system*.
- Ministry of Health and Welfare 1994a, *Ten-year strategy to promote health care and welfare for the aged*, The Foundation of Social Development for Senior Citizens, Tokyo.
- Ministry of Health and Welfare 1994b, *Health and welfare for the elderly - An outline of systems and trends*, The Foundation of Social Development for Senior Citizens, Tokyo.
- Morohashi Y 1994, *Outline of the Japanese health care system*, Paper presented to the 1994 International Hospital Federation Pan-Regional Conference, 'Health Care: Ideals and Reality', Japan Hospital Association, Tokyo.
- New South Wales Government Office Tokyo 1992, *Notes for visitors to Japan*.
- Norbeck E & Lock M (eds) 1987, *Health, illness and medical care in Japan: Cultural and social dimensions*, University of Hawaii Press, Honolulu.
- Pempel TJ 1982, *Policy and politics in Japan. Creative conservatism*, Temple University Press, Philadelphia.
- Powell M & Anesaki M 1990, *Health care in Japan*, Routledge, London.
- Shibata T (ed) 1993, *Japan's public sector. How the government is financed*, University of Tokyo Press, Tokyo.
- Steslicke 1987, 'Health care delivery', in Norbeck E & Lock M (eds) *Health, illness and medical care in Japan: Cultural and social dimensions*, University of Hawaii Press, Honolulu.
- Tokyo Metropolitan Government 1989, *The fiscal outlook for the metropolis of Tokyo*.
- Tokyo Metropolitan Government 1991, *Plain talk about Tokyo*.

- Tokyo Metropolitan Government 1994a, *A hundred years of Tokyo city planning*.
- Tokyo Metropolitan Government 1994b, *Tokyo metropolis: Facts and data*.
- Tokyo Metropolitan Government 1994c, *Tokyo Metropolis: Organisation*.
- Tokyo Metropolitan Government Bureau of Public Health 1993, *Striving to make a healthy city. Health care for Tokyo residents*.
- Yamamura K & Yasuba Y (eds) 1987, *The political economy of Japan*, vol 1, Stanford University Press, Stanford, California.