

## Community Health Policy in Japan: Role of Health Center

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### 0. Purpose

This presentation examines how a health related institution established in the WWII time has survived in Japan. It would be one example of Kasza's argument, "War, despite its immediate, catastrophic effects on human well-being, has played a major role in the evolution of the welfare state." (Kasza 2002, pp.417)

### 1. Establishment of health center (*hokenjo*)

About 1920's – 30's, the death rates in Japan were higher than those in many western countries and the life expectancies in Japan were shorter (Table 1). The national government considered the necessity of health guidance measures besides medical treatments.

Table 1. Demographic Facts

	Japan	U.K.	France	Italy	Germany	U.S.A.	Belgium	Netherlands
Death Rate Per 1,000 population <sup>1)</sup>	18.2	11.7	15.6	14.1	11.1	11.3	13.3	9.1
Death Rate (Per 10,000 population) from Tuberculosis <sup>1)</sup>	18.6	9	16.1	11.2	7.9	7.2	7.5	9.1
Infant Mortality Rate Per 100 live births <sup>1)</sup>	12.4	6 <sup>3)</sup>	7.8	10.6	8.4	6.5	9.3	5.1
Life Expectancy (Male) <sup>2)</sup>	44.82	55.62	52.19	53.76	59.75			61.9
Life Expectancy (Female) <sup>2)</sup>	46.54	59.58	55.87	56	62.63			63.5

1) Value in 1930

2) Japan, Average between 1925–30; U.K.: Average between 1920–22; France, Average between 1920–23  
Italy, Average between 1930–32; Germany 1933; Netherlands, Average between 1921–30

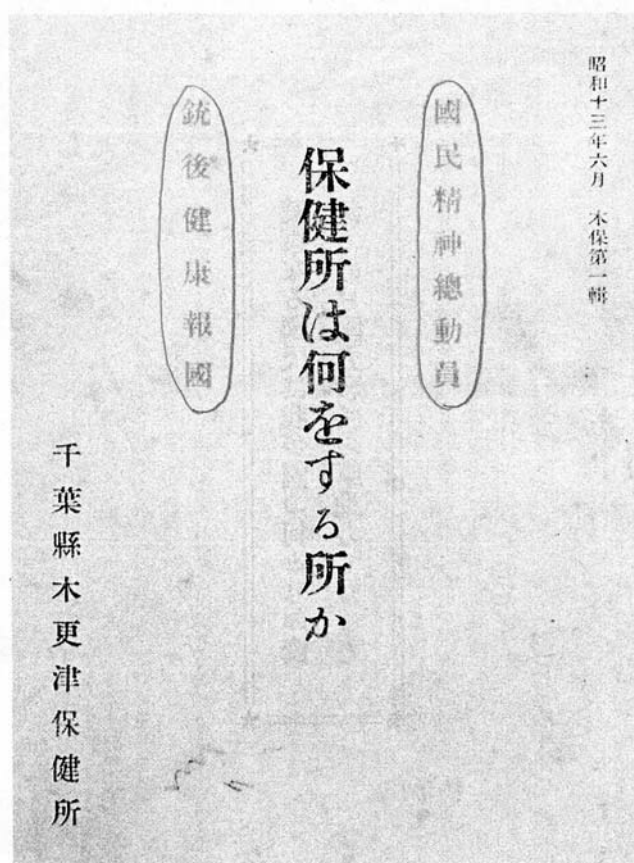
3) England & Wales

Source: *Kōshūeisei (Public Health)*, 55(5), 1937, pp.350–4

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Health counseling in maternal-and-child health was conducted since 1914 and that in tuberculosis prevention was done since 1923 in some areas of Japan. On the other hand, the activities of health centers in western countries, whose characters were varied among countries, were investigated (Kato 1937; Minazaki 1937). The establishment of health center (*hokenjo*) was planned and the (Old) Health Center Law was enacted in 1937<sup>1</sup>.

The work of the early health center was the public health activities which contributed to Strong Soldiers and Healthy People (*Kenpei-Kenmin*) policy. It was important that people were healthy, in order to make the strong army under the conscription system. As a pamphlet of health center entitled “What is health center? (*Hokenjo wa Naniwo Surutokoroka*)” shows, health center was a kind of war footing organization (Figure 1).



<sup>1</sup> In fact, two centers were established in Tokyo and Saitama by the contribution of the US Rockefeller Foundation in 1935 and these two centers were considered as prototypical health centers in Japan.

It was written to the first article of the Health Center Law that health center was the regional organization of necessary health guidance to improve national physical strength<sup>2</sup>. The high death rate from tuberculosis and the high infant mortality especially arouse the interest of the authorities concerned. Thus, primary roles of health centers were health guidance and preventive measures about maternal-and-child health, tuberculosis, and parasitic diseases etc.

Health center was the just only guidance organization in the beginning and shortly afterwards had administrative powers. The Ministry of Health and Welfare, established in 1938, planed arranging health centers all over the country. Health centers increased from 49 in 1937 to 770 in 1944. But, this project was interrupted by the defeat of war.

## 2. Restart of health center

The food shortage and the large movement of retreat from overseas and demobilization caused the prevalence of infectious diseases, such as typhus, smallpox, and venereal diseases. GHQ/SCAP (General Headquarters/ Supreme Commander for the Allied Powers) eagerly addressed the preventive measures against venereal and infectious diseases because these measures included the purpose to prevent parties concerned in the occupation army from these diseases. PHW (Public Health and Welfare Section) of GHQ conducted various preventive activities against epidemics, for example the DDT dispersion for typhus prevention. Health centers conducted many preventive works against venereal and infectious diseases as the first-line organization. In those days, there were 675 health centers.

GHQ proposed the Ministry of Health and Welfare that the treatment for venereal diseases would be performed at health centers. But, the Ministry opposed this proposal on the ground that health centers were different from clinics. As the result of the negotiation between GHQ and the Ministry, health center was primarily positioned as the base of comprehensive public health. The (New) Health Center Law was enacted in 1947.

The first article of this law mentioned that prefectures or ordinance-designated cities could set up health center to plan the improvement and promotion of regional

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<sup>2</sup> Titmuss also indicated that it was “necessary for the State to take positive steps in all sphere of the national economy to safeguard the physical health of the people” in the Second World War time Britain (Titmuss [1957] 2004, p.208)

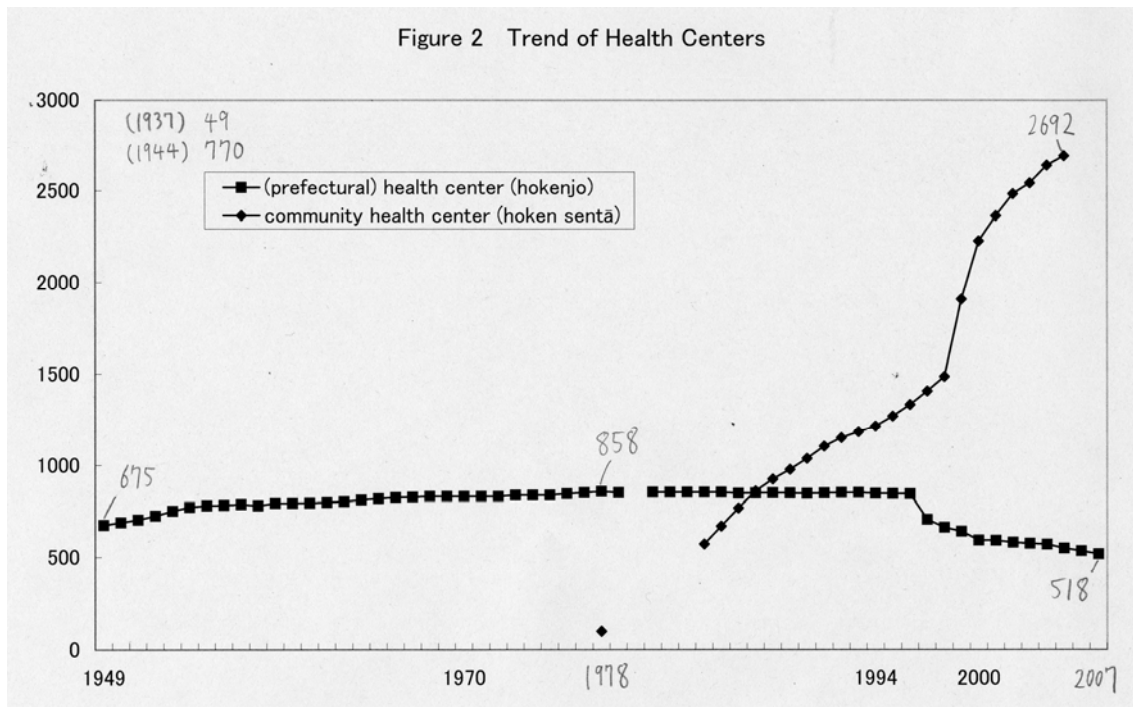
public health. The second article indicated the concrete activities of health center; promotion and improvement of health conception, demographic statistics, nutrition improvement and food sanitation, environment sanitation such as waterworks, items about public health nurse, promotion and improvement of public medical services, maternal-and-child health, dental hygiene, hygienic test, disease prevention, other items of regional public health. Thus, the health center's business included almost all health guidance activities. Medical treatments could be also in part conducted at health centers about specific diseases that the Minister of Health and Welfare designated, such as tuberculosis and venereal diseases. In addition, the management of public health administration of food sanitation and prevention against acute infection was transferred from the police section to the health section in local governments. The health center became the organization which comprehensively practiced guidance works and administrative works of regional public health.

GHQ eagerly addressed the arrangement and functional reinforcement of health centers. For example, Crawford F. Sams, Head of PHW, mentioned that the establishment of health center network was just one of GHQ's proud projects.

During the rapid economic growth period (50's – 70's), the service volume of health center increased. Let's show one example, the tuberculosis prevention. The death rate from tuberculosis decreased from 235.3 persons per 100,000 population in 1943 to 82.2 persons per 100,000 population in 1952. However, tuberculosis had occupied the first death cause of Japanese people till 1950 and there were still many tuberculosis patients (2,920,000 persons in 1953). By the amendments of the Tuberculosis Prevention Law in 1951 and 1955, the target people of medical checkup which health centers should carry out included almost all people without infants. Advice councils of tuberculosis were set up at health centers and the report of tuberculosis patients to health center also became the obligatory work of physicians, so that the service volume of health centers about tuberculosis prevention increased. The life expectancy in Japan increased rapidly during the second half of the 20th century. Marmot and Smith (1989) indicated the role of health centers as one of the reasons that might lie behind the fall in mortality in Japan.

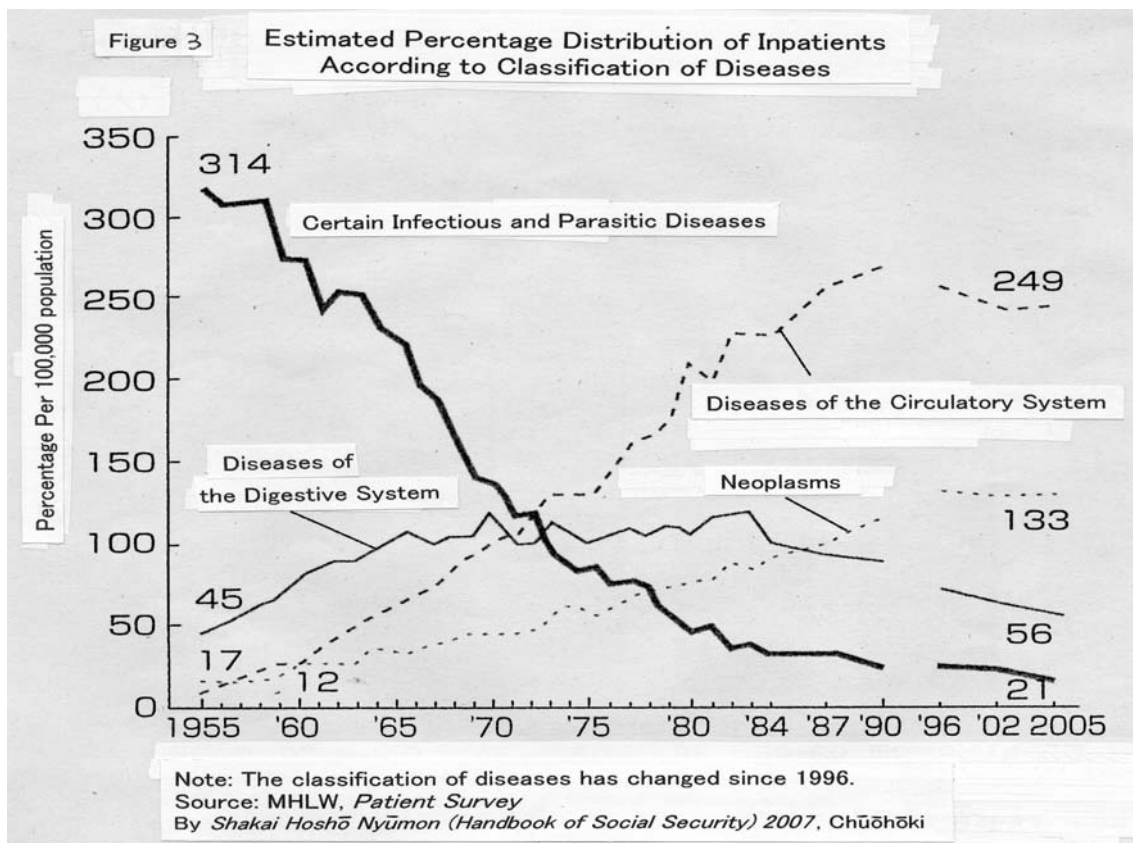
The development of welfare state system caused the creation of many health related law, such as the Welfare Law for Elderly People in 1963, the Amendment of Law of Mental Health in 1965 (now the Law related to Mental Health and Welfare of the Persons with Mental Disorders), and the Basic Law on Measures for Pollution in

1967 (now the Basic Environment Law). Therefore, health centers also engaged in these related works. Its number increased to 858 in 1978 (Figure 2).



### 3. Changes of social structure

While the roles of health centers became important, social structures in Japan changed. At first, the disease pattern of Japanese people changed. Patients with infectious diseases decreased during the second half of the 20th century. The importance of social defense measures such as preventive activities against epidemics declined in public health fields. On the other hand, patients with life-style related diseases increased. Though there were many inpatients with infectious and parasitic diseases during the 50's, inpatients who suffered from diseases of the circulatory system or neoplasms increased after the mid-70's (Figure 3). The first death cause changed from tuberculosis to cerebrovascular diseases (1951- 80) or malignant neoplasms (since 1981). The importance of personal health promotion measures rose. This change of disease pattern was common to developed countries.



Secondly, people had more various demands to public services, as their society became a rich country. The opinion was gaining power that public administration had better be decentralized in order to cope with their various demands.

The vision committee of community health discussed the future vision of community health for two years and published an official report in 1989. The report proposed that personal health services such as the prevention of life-style related diseases should be carried out at municipal (city, town and village) levels, and that prefectural health centers should mainly address the professional and wide area services such as mental health services, the promotion of home care, and some personal health services which municipalities hardly coped with.

#### 4. Restructuring health center's roles

45 laws concerning community health were amended all together in 1994 and the Health Center Law was renamed the Community Health Law. This law has two basic concepts. One is to construct a new community health system that stands on the level near residents, in order to react the aging society with a declining birthrate, the

change of disease pattern, the diversification of residents' demands, and the resident's rising consciousness on living environmental problems such as food safety. It is especially underlined that the community health system puts an emphasis on personal health promotion.

Second basic concept is to reexamine the role assignment of prefectures and municipalities, and promote decentralization. For example, maternal-and-child health services has been transferred from prefectures to municipalities. It is stipulated in this law that municipalities can set up community health centers (*hoken sentā*) on their own as the institution which carries out health counseling, health guidance, and medical checkup for residents<sup>3</sup>. On the other hand, prefectural health centers (*hokenjo*) are positioned as a wide area base and are to be basically reorganized per the secondary medical area which is the basic area of health care service arrangement. They are requested to reinforce professional and technical functions and carry out the works of project and arrangement besides guidance.

In sum, community health centers play major roles in personal health services and prefectural health centers play supporting roles in these services. Public health nurses at prefectural health centers actually also engage in various direct health services as the government survey on public health nurses shows (Table 2). However, prefectural health centers would grope for a new role other than carrying out personal health services.

Table 2 Activities of Public Health Nurses

	2006		
	Prefectures	Cities, Towns and Villages	Cities which establish health center
health and welfare activities (direct service provision)	32.2	55.0	53.5
area administration	17.5	10.4	11.0
coordination	16.3	10.7	12.2
education and training	5.6	2.0	2.7
supervision	6.0	3.1	4.2
business communication	16.1	12.6	11.7
participation to training	4.5	2.9	3.0
others	2.0	3.2	1.7

Source: MHLW, *Public Health Nurse Survey*

<sup>3</sup> Community health centers had been in fact set up since 1978 as the Figure 2 shows.

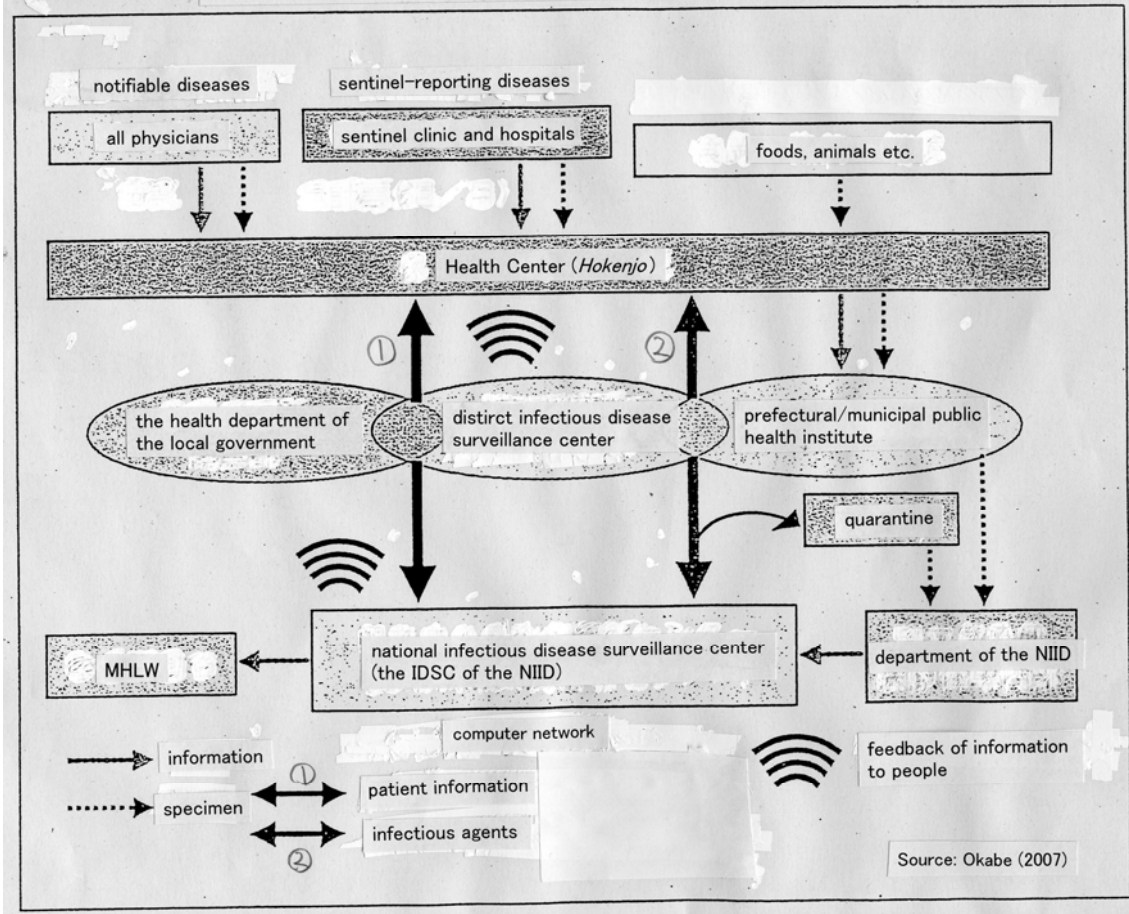
After the middle of the 90's, the accidents that we reappreciated the necessity of social defense measures occurred in Japan. For example, Hanshin-Awaji Earthquake, the subway sarin affair, the rise of emerging and reemerging infectious diseases. The immediate trigger that we realized the fear of infectious diseases was the outbreak of Escherichia coli O157 infection in 1996. 9451 patients and 12 dead persons were reported with this outbreak. The Ministry of Health and Welfare listed this disease as an infection designated by government ordinance that physicians have to report to local governors via the heads of health centers when they examine a patient with this disease. The Law Concerning the Prevention of Infections and Medical Care for Patients with Infections (the Infectious Diseases Control Law) has been enacted in 1999. The new law has been amended several times when the outbreaks of emerging and reemerging infectious diseases such as SARS occurred. This law reinforces the national epidemiological surveillance of infectious diseases system. Intensifying the surveillance system based on notification from physicians, collection, comprehension and analysis of the incidence and the trend of infectious diseases, and feedback of such information are proposed. This system consists of two lines, the patient information and the specimen (Figure 4). Data of patients with some designated infectious diseases is brought together into the national infectious disease surveillance center (the Infectious Disease Surveillance Center of the National Institute of Infectious Diseases) from physicians and medical organizations in national every place, and is periodically released on the web site of this central center<sup>4</sup>. Prefectural health centers play the important role as the relay station of the data collection of patients with infections<sup>5</sup>.

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<sup>4</sup> The National Institute of Public Health also manages the health crisis management system and supports the prevention of health crisis such as infection and the quick solution at the time of that generating.

<sup>5</sup> The infectious disease surveillance system depends on final diagnoses by doctors. So, it is not always the quick data collections system. Recently, the syndromic surveillance system has been noted in some countries including Japan, which use the data on popular drug sales, ambulance call, telephone counseling of health and so on (Okabe 2007).

Figure 4 National Epidemiological Surveillance of Infectious Diseases



## 5. Concluding remarks

Nowadays, while prefectural health centers (*hokenjo*) fulfill the administration and coordination function in wide area and are positioned as the regional core under the recent health crisis management system, community health centers (*hoken sentā*) are positioned as the regional core of personal health services. Thus, the health center system established in the wartime has survived after the WWII in Japan.

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