Policy trends of community health in Japan

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A. Introduction

The Community Health Law, a comprehensive law attempting to promote and strengthen measures to cope with the rapid aging of the population and changes in disease structure, was enacted in June, 1994. The law constitutes a partial amendment of the Public Health Center Law, and purports to ensure a system by which the laws concerning community health, such as the Maternal and Child Health Law, can be effectively carried out in the community. The law aims to contribute to the maintenance and promotion of health among community residents through a clear, codified system. The system consists mainly of (1) clarification of the responsibilities of local public entities and the national government, (2) establishment of a basic national policy to promote community health measures, (3) establishment of a plan for support of securing local resources, (4) establishment of regulations for public health centers and municipal health centers, and (5) decentralization of community health care by involving local public entities. This article describes the Community Health Law and discusses various problems with it.

B. Features of the Community Health Law

1. Basic philosophy

The measures being considered by national and local governments for the purpose of maintaining and promoting residents' health in the community are designed for widespread dissemination. The measures (1) shall be relevant to the rapid aging of the population and changes in Japan's health and medical cares, (2) shall be designed to improve and promote community health, (3) shall be responsive to the diverse demands of community residents concerning health, sanitation and living environment, and (4) shall take into consideration the characteristics of individual communities and their interface with social welfare systems.

2. Responsibilities of the national and local governments

1) Responsibilities of cities, towns and villages: to endeavor (1) to create relevant institutions and facilities and (2) to secure human resources and provide training with the aim of smooth implementation of community health measures.

2) Responsibilities of Prefectures: to endeavor (1) to create institutions and facilities, (2) to secure human resources and provide training, (3) to carry out inspections and investigations, and (4) to provide technical aid requested by cities, towns and villages, with the aim of smooth implementation of community health measures.

3) Responsibilities of the nation: (1) to collect, codify and implement information on community health, (2) to carry out inspections, investigations and research, (3) to cultivate the human resources involved in community health measures and to improve these resources, and (4) to provide technical and financial assistance to local governments.

3. Establishment of basic guidelines

The Minister for Health and Welfare shall determine basic guidelines concerning the following matters after consideration of the opinions given by the "Public Health Council" of the Ministry of

(from Department of Public Health Administration, the Institute of Public Health)

Health and Welfare : (1) basic policy of the promotion of community health measures, (2) creation, re-creation and administration of public health centers and municipal health centers, (3) recruitment and training of personnel, (4) inspection, investigation and research, (5) integration with other related programs such as social welfare, and (6) others.

4 . Personnel recruitment

Prefectures shall establish a plan to support the recruitment of personnel in response to requests from small towns and villages on the basis of recommendations made in each town or village according to the basic policy established at the national level. The national government shall provide financial and technical support.

5 . Municipal health centers

Cities, towns and villages can create municipal health centers, with part of the cost burden borne by the national government. Municipal health centers are to provide health consultations, health guidance and health check-ups for to residents and to carry out activities necessary for community health.

6 . Public health centers

Public health centers are to plan, regulate and guide the following : (1) promotion and improvement of the concept of community health, (2) compilation of vital statistics, etc., (3) improvement of nutrition and food sanitation, (4) environmental sanitation, (5) medical and pharmaceutical affairs, (6) public health nursing, (7) improvement in public medical services, (8) maternal and child health, and the health of the elderly, (9) dental health, (10) mental health, (11) countermeasures for intractable diseases, (12) prevention for diseases such as AIDS, tuberculosis, venereal diseases and infectious diseases, (13) testing and examination relating to sanitation, and (14) others regarding the maintenance and promotion of residents' health. Furthermore, as occasion demands, the following items are to be included : (1) collection, publication and use of information on community health, (2) investigation and research, (3) treatment of dental diseases. etc., and (4) promotion of utilization of facilities for testing and examination in the public health center by physicians. According to the new regulations, a "public cealth henter management council" can be organized ; it is not mandated.

From the viewpoints of cooperation with the measures regarding health and medical services and social welfare services, public health centers instituted by Prefectures would be required to be re-organized and re-established in the territorial jurisdiction, taking into consideration the "secondary medical service area" provided by the Medical Services Law and the "health and welfare service area for the aged" provided by the Health Services for the Aged Law. They shall have central jurisdictional communication and control among cities, towns and villages, and shall provide technical advice and training for local health officials in response to requests from cities, towns and villages.

7 . Administrative reforms

1) Maternal and child health : The Maternal and Child Health Law was partially amended. Activities that have been carried out by public health centers, i.e., health check-ups of 3-year-old children, health guidance for pregnant women, nursing mothers and infants, guidance for pregnant women, nursing mothers and neonates through personal visits, and health check-ups of pregnant women, nursing mothers and infants, shall be included among the activities carried out as services by cities, towns and villages. The main administrative activities relating to maternal and child health services shall be centralized in cities, towns and villages. The health check-ups of 1.5-year-old children, which have been performed as a service by cities, towns and villages, as a result of a budgetary measure, shall be included in the category of legal affairs. However, premature infant guidance through personal visits and provision of medical benefit for nursing of premature infants, which are considered to require special

knowledge, shall remain as public health center activities.

2) Nutritional improvement: The Nutrition Improvement Law was partially amended. General nutrition guidance shall be included in the activities provided as services by cities, towns and villages. Public health centers shall deal with nutritional guidance requiring special knowledge and techniques, and shall provide support and guidance to feeding facilities.

3) Transfer of authority: The Medical Services Law and other laws were partially amended, so that conventional authorities of Prefectures, which deal with the licensing of clinics, sanitary testing institutions, pharmacies, etc., and acceptance of notification relating to these institutions, shall be transferred to the "public health center ordinance cites" mentioned below in their jurisdiction. The Infectious Disease Prevention Law was amended so that activities related to prevention for infectious diseases shall also be transferred to these cities. The Eugenic Protection Law was also partially amended, so that the authority to permit the initiation of eugenic protection counseling business shall be transferred to Prefectures and these cities from the nation.

8. Implementation

The amendments relating to public health centers and to the transfer of authority are to be implemented in fiscal 1997; other amendments are to be implemented in 1995.

C. Discussion

1. Historical trends and decentralization of power

The existing Public Health Center Law was promulgated in 1947, and has not been revised since. At that time, public health centers were considered front-line organizations in the enforcement and administration of public health, and their direct contact with the general public was emphasized. One public health center was established per 100,000 population. Thus, public health centers were established as services of Prefectures. In cities with a large population, public health centers were established as designated by government ordinance. This policy was called the "public health center ordinance city" system. It was so rational that the scale of public health centers was dependent on population scale, since public health centers provided health services directly to residents, and this system was based on the concept that a local self-governing body responsible for a population of 100,000 and more should manage the public health centers. In establishing this system, the role of cities, towns and villages as fundamental units in providing personal health services may have come into awareness.

Thereafter, cities, towns and villages became consolidated, and regional economies developed. Thus, the fundamental concept of local self-governing bodies changed. The capacities of cities, towns and villages have been extended, and the services provided by them have expanded. With these changes, the opinion that parsonal health services should exist at the municipal level has become stronger. This was a leading opinion in the discussion when the Maternal and Child Health Law was legislated in 1965, but eventually, maternal and child health activities were still included in the activities of public health centers, as before. The Ministry of Health and Welfare addressed an idea in 1968, in which public health centers would be divided into "key" public health centers that enforced environmental sanitation and ordinary public health centers that did not carry out enforcement. However, the public health centers were strogly opposed, and the idea was abandoned. In 1977, the Ministry of Health and Welfare established health check-ups for 1.5-year-old children as a local municipal service of cities, towns and villages without revising the Maternal and Child Health Law. This was done as a budgetary measure. This new system was counter to the fact that public health centers

had enforced health check-ups for pregnant women, nursing mothers and infants since 1948 and health check-up for 3-year-old children since 1961, and was considered to interfere with the continuity of data obtained from health check-ups of children. Opinion was divided on the system. In 1978, "national health promotion measures" were initiated, and municipal health centers were established to prepare for expanded health promotion. The Ministry of Health and Welfare positioned municipal health centers as important for comprehensive implementation of personal health services for the promotion of regional residents' health, e.g., health counseling, health education and health check-ups, and as a place for the efficient development of various activities for health promotion. The Ministry affirmed that municipal health centers were not an administrative organization like public health centers. In actuality, however, cities, towns and villages have placed offcials in the centers, and have positioned them as administrative organizations. Municipal health centers were then employed as institutions for the promotion of health among the aged and the middle-aged after the promulgation of the Health Services for the Aged Law. Thus, the concept of municipal health centers became more firmly established. At present, municipal health centers exist in about one third of all cities, towns and villages. In 1978, control of the position of public health nurses, who have been involved in the national health insurance system in cities, towns and villages, was transferred to the level of cities, towns and villages, placing these nurses under direct municipal control. Thus, both nominally and actually, public health nurses assumed responsibility for health activities at the local municipal level.

The Health Services for the Aged Law was enforced in 1983. The law promoted health maintenance and promotion starting from the middle-aged as a countermeasure to the steep rise in medical costs for the aged. The law placed great emphasis on preventive measures for chronic degenerative diseases, such as cancers, cardiovascular diseases and cerebrovascular diseases. However, since the measures to counter high medical expenses for the aged were carried out at the municipal level, preventive countermeasures such as health check-ups, health education and health counseling were also included among the activities carried out by cities, towns and villages.

Therefore, the public health center was again positioned as supportive local organization by virtue of its role in preventive measures for these diseases, an important field of personal health services. Reconsideration of the role of public health centers in overall health care became no longer an important topic of discussion. To promote the preventive measures for these diseases, municipal health centers were expanded and more public health nurses were recruited. In 1989, the "cooperative 10-year strategy for elderly health and welfare promotion" (so-called "gold plan") was announced by the Minister for Finance, the Minister for Health and Welfare, and the Minister for Home Affairs, and the goal of providing health and welfare services for the elderly at the municipal level in 1999 was established. In 1993, all municipalities were required to prepare an elderly health and welfare plan, which would establish concrete target values for future health and welfare services for the elderly, on the basis of need.

In this way, the center of personal health services has shifted from public health centers to cities, towns and villages. It was natural that cities, towns and villages, i.e., the administrative bodies most familiar to residents, should provide these services, since they have been administered on a personal basis. This way of thinking has been present since the initiation of personal health services, and the activities of cities, towns and villages have expanded along with improvements in their administrative abilities. This shift was further advanced by the

stream of decentralization of power. The "extraordinary administrative reform promotion council" established by the Prime Minister in 1989 encouraged decentralization of power, reconsidered the function of public health centers, and presented a report on the relationship between the national and local governments regarding health services. According to the report, provision of personal health services should be transferred to cities, towns and villages. In 1993, the Public Health Council advised the Minister for Health and Welfare its comprehensive reconsideration of community health, which included a transfer of authority from the Prefectural to the municipal level and promoted decentralization of power by recognizing the role of cities, towns and villages in providing health services, promoting cooperation in health and welfare services, and encouraging the establishment of public health centers in large cities. The goal of the Council was to reconsider enterprises ralating to community health and the enforcement system from the viewpoint that health services for the general public be provided according to the actual needs of the community. The role of cities, towns and villages was a major theme. Revision of the Public Health Center Law and legislation of the Community Health Law were greatly aided by the Council's recommendations.

2. Changes at the municipal level

1) Major activities: Of the health services familiar to residents, only preventive vaccination, health check-up of 1.5-year-old children, and preventive countermeasures for chronic degenerative diseases based on the Health Services for the Aged Law have been carried out at the level of cities, towns and villages. However, the responsibility for life-long health promotion now rests with the centers. Namely, guidance for pregnant women, nursing mothers and infants through personal visits, health check-ups of pregnant women and nursing mothers, health check-up of infants, and health check-up of 3-year-old children have been added, as has general nutritional guidance.

2) Legal support: Although the establishment of municipal health centers has been advanced, the system had no legal support. Now the Community Health Law supports municipal health center system legally. Their establishment was not permitted in "public health center ordinance cities." However, this rule han been revised by the Community Health Law, which allows for the establishment of municipal health centers as well as public health centers in their jurisdiction.

3) Cooperation with welfare: Owing to revision of the Elderly Welfare Law and others in 1990, welfare services are now included in activities carried out by cities, towns and villages. The provision of health services by local administrative bodies has led to the establishment of a system by which health and welfare services are provided together to residents. In this way, decentralization of power is expected to consolidate administrative procedures. However, the historical development of welfare services has been different from that of health services, and there are gaps between these service workers in terms of their education and level of consciousness. Therefore, the combining of such services is likely to be accomplished with great difficulty.

4) Recruitment and training: At present, there are about 12,000 public health nurses responsible for health services in cities, towns and villages. This number would be doubled by fiscal 1999, and welfare service training would be given to them. However, there is no concrete plan to increase physicians or nutritionists, and this may create problems.

5) Support for small municipalities: Prefectures must consider plans to recruit health personnels in small towns and villages. Financial and technical support for these plans will be available on a national level. While the promise of support is encouraging, the details of the plans will be impor-

tant. Active national support is desirable.

3. Changes in public health centers

1) Activities: Health services familiar to residents, e.g., health check-up of 3-year-old children, shall be transferred to cities, towns and villages so as to strengthen special, technical and comprehensive functions of public health centers. In other words, implementation of inspection and research adapted to the particular community, and implementation of aid for cities, towns and villages including training of local administrative offcials, technical advice and communication among municipalities will be included in the activities. However, implementation of the new activities will depend on an accurate understanding of the situation in the territorial jurisdiction of the public health centers and the compliance of cities, towns and villages. The elimination of traditional view of the public health center as a local government office would be important in implementing the changes in activities.

2) Scale: One public health center has conventionally served a population of 100,000. The scale shall be expanded to strengthen the functions of and promote cooperation among health and welfare services. The re-organization and re-establishment of public health centers by Prefecture would be decided, so that conformity would be maintained between the medical services stipulated by the Medical Services Law and the health and welfare services stipulated by the Health Services for the Aged Law. The number of public health centers, 848, at the end of 1993, would be gradually reduced in the future. That this change may lead to reduced community health services has been a concern of those at public health centers. Rapid reduction of the number of public health centers should be avoided and changes should be supervised by residents in the community.

3) "Public health center ordinance city" system: 164 public health centers as of the end of 1993 are established in 32 cities, each of which has a population of at least 350,000 as stipulated by the Ministry of Health and Welfare as the administration standard. The standard shall be changed to at least 300,000 population, for expansion of the system. The authority to accept notification of activities concerning health services and to permit them has conventionally belonged to Prefecture, but the rule was revised so that public health centers would have authority equal to those established by Prefecture. This revision follows the concept of decentralization of power.

4) Recruitment and training: Several professional categories serve the public health centers, and training and study are being carried out. The reduction of special technical officials in response to the transfer of services familiar to residents to cities, towns and villages shall be avoided, and endeavors shall be made to meet new health and welfare needs of residents.

Study and training shall also be expanded to include welfare, for example, which previously has not been included. These changes may allay the fear that the number of public health centers might be reduced along with the expansion of scale and may lead to a decrease in the functions of public health centers.

However, the results of these changes may not be satisfactory without a clear understanding of the public health center's functions, and these changes may create problems leading to future reductions in the number of officials and a decline in function. These problems will become the main points of discussion in the present revision, and will be the touchstone for the future public health centers.

D. Conclusion

Public health centers have been responsible for many achievements including infectious disease control, decreased morbidity of tuberculosis, and improved environmental sanitation. The role of public health centers has been debated precisely

because of these past successes. In the 1950s, measures to counter chronic degenerative diseases were initiated, but the argument appeared that public health centers were like the "setting" sun after the brilliant successes. The Ministry of Health and Welfare announced the concept of initiating joint health plans involving local administrative bodies and the concept of altering the traditional role of the public health center depending on the characteristics of the community in each jurisdiction in 1960. And the concept of establishing key public health centers proposed by the Ministry in 1968, a plan presented in a "keynote report on the problems of public health centers" of the committee established by the Ministry in 1972, and a proposal at the "committee to examine future plans regarding community health" established also by the Ministry in 1989 were put forward, but none of them was realized effectively. The present Community Health Law is the first clear reform likely to take place in more than 45 years of public health center's history. The background of reform includes the decentralization of power, and in the undercurrent, the poor condition of the national finance, i.e., apportionment to the financial resources of municipalities. The present revision carries great signifcance for community health. Much consideration should be given to the Law and its application so that the revision would not lead to a decline in community health.

地域保健の政策的動向

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(要旨)

日本の地域保健の基本法は1947年に制定された保健所法であり，そこでは保健所は公衆衛生の第一線機関であった．一方では，社会経済状況の変化の中で市町村の保健サービス遂行能力は向上し，70年代後半以降は厚生省の予算措置で地域保健での役割の増大が図られ，83年老人保健法では成人病予防対策が市町村の業務と位置づけられた．保健所はこのような変化の中で何回となく改革が模索されてきたが，いずれも実現にはいたらなかった．さらに，近年地方分権の動きが顕著となり，市町村の役割がますます重要視される中で，地域保健における市町村の役割を明確化し，保健所の機能を高度化・広域化する気運が高まり，厚生省は保健所法を改正し，地域保健法を制定することとし，94年6月国会で成立した．この法律は，母子保健法や栄養改善法の改正も含んでおり，市町村の母子保健・栄養改善等の地域保健における業務を拡大し，市町村保健センターの整備を図る一方，保健所については，保健，医療及び社会福祉に関わる施策の有機的連携を図る観点から，医療圏及び老人保健福祉圏を参酌して所管区域を設定することとし，管内市町村相互間の連絡調整を行い，市町村の求めに応じて技術的助言，市町村職員の研修などを行うこととされた．さらに，国は地域保健に関する基本的方針及び小規模町村の人材確保計画等を定め，地域保健の向上を図る責務を負うこととなった．また，地方分権を推進するため，各種の権限が都道府県から保健所政令市に委譲されることとなった．

地域保健法は45年以上の保健所の歴史の中で実現が確実となった初めての改革であり，市町村を組み込んだ新しい地域保健の体系を構築するものである．地方分権化の流れの底流には国の財政から地方の財政へのふり替えの側面は厳然として存在する．今回の改正が，地域保健の前進をもたらすよう努力しなければならない．