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The number of medical treatment bills exceeding 5 million yen per month per patient amounted to some 2,500 in 2004. In reforming the medical service system, the issue of rising costs incurred as a result of the progress of technology cannot be ignored, and any waste of medical service must be thoroughly eliminated. Preventive medicine should be promoted, and the family doctor system that can be closely connected with the long-term care system should be introduced during a sweeping review of the medical service system.

The government decided to increase the rate of copayments paid by seniors. In order to use the limited insurance premium revenue effectively, consideration may well be given to the introduction of an "insurance exemption system" in which all expenses of low-cost medical treatments are paid by patients, and only high-cost medical treatments are covered by insurance.

While the number of low-income persons has been increasing among participants in regional health insurance programs, the rates of insurance premiums paid by participants under these programs are higher than are those of any other health insurance program. Regional and occupational health insurance programs should be integrated to equalize insurance premiums. With respect to long-term care insurance, insurance premiums must also be collected from the age segment of 20 through 39 years.

In improving medical care and nursing care for seniors, priority should be given to the "quality of life." To enable seniors to live at home as long as possible and to live their remaining days comfortably, a home hospice network must be established. Medical care insurance and long-term care insurance are closely related.

With advances in medical technology, issues that cannot be dealt with using the traditional sense of ethics have been emerging one after another, such as informed consent, fertility medicine, organ transplants, death with dignity, etc. These issues should be resolved on the assumption that priority is given to the right of individuals to make their own decisions.

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I Review of Long-Term Care Insurance Program in 2004

During the period from the latter half of 2004 to the end of 2005, the long-term care insurance program (LTCI) was reviewed by the government and, at the same time, studies were made on the introduction of the medical insurance program for seniors. The following section outlines these moves and provides future prospects.

1 Collection of Insurance Premiums from Persons Aged 20 through 39

The major issue of the long-term care insurance program in the latter half of 2004 was whether to collect care insurance premiums from members of the younger generation, aged 20 through 39. Currently, the benefit amount paid under the long-term care insurance program is 6 trillion yen. This amount is expected to reach 20 trillion yen in 2025. The principal issue facing long-term care insurance is the source of these funds. At present, half of these funds is paid from taxes and the remaining 50 percent is covered by insurance premiums. With respect to insurance premiums, 18 percent is collected from persons aged 65 or over and 32 percent from persons aged 40 – 64.

At the introductory stage of the long-term care insurance program, because opposition to collecting insurance premiums from the younger generation aged 20 through 39 was expected, the matter of collecting premiums from this generation was shelved. Nevertheless, under the circumstances where fiscal rehabilitation constitutes one of the nation's most important issues, it is not reasonable to expect the government to finance 50 percent of long-term care insurance. The portion covered by insurance premiums must be increased.

Because many persons aged 65 or over live on pension benefits, increasing premiums for this generation is highly unlikely. If the range of persons subject to the payment of premiums is not expanded to include those aged 20 through 39, the burdens on those aged 40 to 64 will become excessively large. The collection of premiums from persons aged 20 through 39 was considered a critical issue in the 2004 review regarding the long-term care system.

In return for requesting the younger generation aged 20 through 39 to pay long-term care premiums, a new proposal was released.

At present, people over 65 are allowed access to long-term care services. The new proposal abolishes this age limitation. At first, the present long-term care system was established primarily targeting seniors. However, persons who need care benefits due to an accident or sickness exist throughout all generations. Accordingly, in this review, the proposal of expanding the range of the payment of insurance premiums was submitted in return for abolishing the age limits in providing benefits.

2 Unrealized Expansion of Age Range of Persons Paying Premiums

However, the proposal of expanding the range of premium collection was opposed by many groups. Because the premiums of company employees are covered by the employees and companies on a fifty-fifty basis, such expansion would lead to an increase in company costs. Local governments (the principal operators of long-term care insurance) opposed this proposal on the grounds that it would not be possible to obtain the consent of members of the younger generation to pay the premiums.

The background factors behind this opposition are the increasing ratios of nonpayment of public pension and medical insurance premiums by younger part-time workers in their 20s. The ratios have reached about 50 percent and 25 percent, respectively. Under the circumstances, local governments thought that it would be extremely difficult to collect newly imposed long-term care insurance premiums from young self-employed and part-time workers.

As a result, the proposal of expanding the range of long-term care insurance premium collection to persons aged 20 through 39 was shelved and was scheduled for review in 2009.

Japan has two types of public pension and medical insurance systems. One is chiefly for full-time workers and the other is for part-time and self-employed workers. In the former system, pensions and medical insurance premiums were withheld by individual companies, but the latter system depended on voluntary payment.

The number of young part-time workers with small incomes and those who have unstable incomes has been increasing through a long depression between 1990 and 2003. Such individuals tend to fail to pay insurance premiums because the payment system is voluntary. This could be a reason for the increased ratios of nonpayment in the pension and medical insurance systems.

The major issue of the next public pension reform in 2009 is how to absorb part-time workers into the full-time workers' public pension system. The same could be said for reform of the medical insurance system. The solution is to shift from a "voluntary contribution" to a "withheld deduction."

If withholding insurance premiums from part-time workers under public pension and medical insurance programs becomes possible, this will serve as a favorable sign for expanding the range of collecting long-term care insurance premiums to persons aged 20 through 39 during the next review of the program.

3 Introduction of Preventive Care

As of the end of March 2004, the number of persons entitled to receive long-term care insurance benefits was 3.84 million. Among them, the number of persons needing care level 3 or higher who were seriously frail

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was 1.41 million. Many eligible persons are not in such serious condition. With the acceleration of the trend towards aging, the total amount of long-term care insurance benefits is projected to be 20 trillion yen in 2025, as stated in Item 1. However, it is not yet clear how to finance the 20 trillion yen.

In order to reduce long-term care services, focus is being given to preventive care. During the review in 2004, it was determined that exercise should be included for persons who are categorized as "needing minor support to live independently" and "needing care level 1." Preventive care includes preventing eligible seniors from falling under the categories of needing higher levels of care through sound eating habits, and appropriate exercise to develop leg and waist muscles.

The Ministry of Finance clearly insisted on decreasing the share of tax injection for long-term care insurance. During the review in 2004, in order to maintain stable financing for long-term care insurance, the ministry proposed an increase in the rate of long-term care insurance copayments from the current 10 percent to 20 percent. While this proposal eventually was not adopted in this review, such an increase would become inevitable from the long-term perspective.

Furthermore, an increase in insurance premiums would also become inevitable. While the monthly long-term care insurance premium to be paid by persons aged 65 or over is currently 3,300 yen (average), this premium is projected to increase to about 6,000 yen after ten years.

4 Establishing Private Rooms in Nursing Homes

In considering the quality of life of seniors, the matter of living space is important. While various factors contribute to a person's need for care, such as cerebral paralysis and Alzheimer's disease, falls at home cannot be ignored.

In 2003, more than 11,000 persons died of accidents at home such as falls ("Vital Statistics 2003" by the Ministry of Health, Labour and Welfare). This number exceeds the number of traffic accident fatalities, or 10,913 persons. Among the more than 11,000 persons who died of accidents at home, the number of seniors was 8,654. The number of seniors who suffered an injury such as a fracture must be several times this number. The risk is high for seniors whose capacity for the power of locomotion has declined to live in houses that are not barrier free. To prevent such accidents, it is desirable for an individual to remodel his or her house before turning 70 in addition to continuing to exercise to maintain appropriate muscular strength.

A senior must enter a nursing care facility if care at home becomes insufficient. However, nursing care facilities are in short supply. Rooms in nursing care facilities are usually shared by four or six persons, so individual privacy is difficult to maintain. During the review in 2004, it was determined to promote the development of private rooms at nursing care facilities. In order to deal with the associated increases in costs incurred by providing private rooms, housing and food expenses were excluded from the coverage of long-term insurance benefits at nursing homes, and were to be paid by the residents themselves.

In a case where a senior needing care level 5 lives in a private room in a nursing home and if this senior receives monthly nursing-care benefits totaling 260,000 yen, the total amount paid by the user is 128,000 yen (26,000 yen as 10 percent of benefits that must be paid by the user plus 60,000 yen for monthly living space expense plus 42,000 yen for monthly food expense). This cost may be reasonable because, in the case of a couple receiving a monthly public pension benefit of 250,000 yen, a wife receives a survivor's pension benefit of about 140,000 yen after her husband dies. A typical widow can easily shift her living space from her house to a private room in a nursing home under the budget of her monthly pension benefit.

Because nursing home operators can easily recoup construction costs by collecting living space expenses, the improved profitability will stimulate the further construction of such facilities. Through the promotion of the development of private rooms, the quality of life (QOL) of persons who need care will increase substantially, and the heavy burdens on family members who are forced to provide bothersome care at home will no doubt decrease considerably. An official decision to set the price table of private rooms in nursing homes made during this review will facilitate the additional construction of nursing homes and increase the number of large private rooms.

5 Reducing Number of Days of Hospitalization

In relation to long-term care services, discussions are ongoing regarding the introduction of a special account for medical care for seniors to resolve the issue of the rising costs of their medical care. However, introducing a special account itself will by no means lead to the reduction of medical costs.

A comparison of the annual per capita medical cost among age segments indicates a rapid increase of such cost for the older ages. Specifically, such cost is 153,000 yen for persons younger than 65 years old, 610,000 yen for persons aged 70 through 74 and 871,000 yen for persons aged 80 through 84 (all figures are based on statistics for 2001). As the population aged 65 or older is expected to account for 30 percent of the total population in 2025, there are concerns over the rise in medical costs for seniors. The per capita medical cost for seniors must be reduced by all means possible.

In comparing the average number of days of hospitalization between Japan and the United States, the number in Japan is 28.3 days, which is four times longer than

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that in the United States (6.6 days) (Table 7). Prolonged hospitalization has resulted in a rise of medical cost for seniors. In order to shorten hospital stays, a framework must be established where minimum necessary treatment such as postoperative care is provided at a hospital and the patient is then encouraged to receive treatment at home after such minimum necessary hospital treatment.

In the future, it is expected that a trend will rapidly spread in which operations and, to some extent, rehabilitation are conduced at large hospitals offering advanced medical services, and a patient is then promptly released for care by a family doctor. Because patients receive care at home or at a nursing care facility after leaving the hospital, the need arises to enhance long-term care services along with the shortening of the period of hospitalization.

Major worries for family caregivers must be responses during the night and emergencies. With the growth of an aging population, cases where care is provided at home are expected to increase. Policy makers must acknowledge this situation. During the review this time, the government decided to construct more small-scale, multifunction facilities that are equipped with diverse functions such as short stay, day care and helper services as community centers supporting family caregivers.

6 Deployment of Small-Scale Multifunction Facilities

At the introductory stage of the long-term care insurance program, bedridden seniors have been assumed to be major users. However, five years after the introduction, it has become clear that the number of seniors suffering from cognitive disorders has been unexpectedly large. In 2030, it is projected that 3 million seniors will suffer from such a malady, a number that is 10 percent of the population aged 65 or over.

In 2005, over 24,000 Dial 110 calls were made throughout the country to ask the police to search for wandering seniors. Of this number, 18,000 seniors were safely discovered and went home, 5,000 went home by themselves and about 1,000 died or are still unaccounted for. Measures must be quickly established in each community to deal with seniors suffering from cognitive disorders, and this situation requires helpers to provide more psychological care than physical care.

Major difficulties are involved in providing care for seniors suffering from cognitive disorders who need care level 3 or higher at home. Because a group home is considered the most desirable facility for accepting seniors suffering from cognitive disorders, accelerated construction of group homes is under way.

At a group home, about ten persons needing care live together with helpers in a large house. As of the end of March 2005, there were about 7,000 group homes in Japan. It is desirable that seniors suffering from cognitive disorders whose care at home becomes difficult move to a group home at a place where they have frequently visited. It has been said, therefore, that the functions of day care, short stay and helper center functions should be added to a group home to reduce the trouble caused by patients moving. However, the purpose of small-scale multifunction facilities should not be restricted to only seniors suffering from cognitive disorders.

The breakdown of the projected number of households as classified by family composition in 2025 is as follows: 34.6 percent for a single household (person living alone), 24.2 percent for a household consisting of a couple and children, 20.7 percent for a household consisting of only a couple, and 9.7 percent for a household consisting of a single parent and children (Table 1). These statistics indicate that the number of single households largely exceeds the number of households consisting of a couple and children. Among single households, attention must be given to senior females aged 75 or over living alone (such households account for about 15% of all households, or 3 million households).

While it is projected that the number of female seniors who live at home receiving long-term care services or at nursing homes will rapidly increase, the issue of home care for seniors living alone cannot be overlooked. To address this issue, support facilities are needed for seniors living alone who need care at home. Small-scale multifunction facilities that are small, special nursing homes for seniors are also expected to support elderly women who live alone and are in need of long-term care services.

Currently, nursing homes have little community contact. They only provide care services for the elderly inside the facilities. With respect to the assignment of a visiting helper who plays an essential role for care at home, the patient is not allowed to assign the same helper for convenience. This situation requires reliable home care service facilities, especially for elderly females living alone. Small-scale multifunction facilities are expected to fulfill both the functions of helper centers and nursing care facilities, and are expected to serve as nursing care centers in each community for seniors suffering from cognitive disorders and receiving care services alone at home.

Turning to consider long-term care insurance expenses, 25 percent of such expenses are covered by

Table 1. Changes in Family Composition

(Unit: %)

	2000	2025	Difference
Living alone	27.6	34.6	7.0
Couple only	18.9	20.7	1.8
Single parent and children	7.6	9.7	2.1
Couple and children	31.9	24.2	– 7.7
Other	14.0	10.9	– 3.1

Source: “Overview of Household Projections for Japan” by the National Institute of Population and Social Security Research, October 2003.

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local governments. Seniors cover 18 percent. Because the increase in the number of nursing homes leads to an increase in burdens on local governments and seniors, local governments have recently been far from enthusiastic about facilities such as group homes. This is one of the issues preventing the development of small-scale multifunction facilities. In addition to the increase in the number of such facilities, it would be desirable that functions such as day care, short stay and nighttime-supervision functions by helpers be added to existing nursing homes in order to relieve the tension of care-givers at night, and provide assistance to elderly females living alone at home.

7 Issues to Be Addressed during the Review in 2009

The issues to be addressed under the future long-term care insurance program reforms include, first of all, verification of the progress of measures determined during the review in 2004 that include: (1) accumulating expertise on preventive care, (2) promoting the development of private rooms, (3) increasing the number of small-scale multifunction facilities and (4) improving nursing care technology for seniors suffering from cognitive disorders and establishing support facilities for them.

From the perspective of securing long-time care service for every generation, the issue of expanding the range of people who contribute to long-term care insurance premiums (also targeting the age segment from 20 through 39) is important. What is similarly important is the review of compensation paid to helpers.

With the progress of aging, it is predicted that the depopulation trend will be accelerated in rural areas in the next 20 to 30 years. For example, the total population of Kochi Prefecture decreased by 10,000 people over the ten years preceding 2000. Conversely, the population of Kochi City (the capital of Kochi Prefecture) increased by 10,000 people. The population of Kochi City accounts for 41 percent of the total population of Kochi Prefecture. People moving from rural areas lacking an adequate infrastructure for everyday life to urban areas include seniors moving from rural areas where adequate nursing care services are not available. Many medical service facilities located in the environs of Kochi City are increasingly providing medical care services for seniors.

Future forecasts predict that senior households will account for one-third of all households. If viewed by prefecture, senior households will account for more than 40 percent of all households in more than 20 prefectures. This is why the establishment of a sufficient nursing care structure in rural areas is of urgent concern.

It would be necessary to review and increase the compensation of helpers to the level at which they can earn a living sufficient enough to maintain a middleclass lifestyle. Currently, travel time is not included in the compensation of home-visit helpers. Furthermore, most helpers are not regular employees but are registered, part-time employees, and are unable to secure stable income. In order to maintain home care in rural areas where the trends of aging and depopulation are accelerating, helpers' salaries must improve to maintain the number of home helpers in rural areas.

Other issues include integration of the long-term care insurance program with the support system for disabled persons. While such integration was discussed during the review in 2004, no agreement was reached. The promotion of normalization is the need of the times. The concept of normalization that requires the establishment of an environment where disabled persons are able to live a life in the same way as healthy persons do was developed in Denmark after World War II. Specific goals in this direction in Japan would include that disabled persons live in a community independently with necessary support.

Currently, 6.56 million people are disabled (3.52 million are physically disabled, 460,000 are mentally retarded, and 2.58 million are mentally disabled). Among the 460,000 mentally retarded persons, 130,000 live in facilities, and 340,000 of the 2.58 million mentally disabled persons are in long-term hospitalization. Among the 340,000, 70,000 persons are hospitalized for reasons other than for medical treatment such as that no community assistance is available for the disabled to live at home.

To establish an environment enabling the disabled to be cared for at home by helpers, day care and short stays as well as the construction of group homes are necessary. Long-term care service facilities are useful for providing programs for the disabled. Group homes are also expected to play a major role as venues for supporting the rehabilitation of disabled persons in addition to seniors suffering from cognitive disorders. These two systems must be integrated to reduce cost and to help disabled persons live at home.

As explained above, the major themes for the 2009 review of the long-term care insurance program will include: 1) the development of universal care services including the integration of the long-term care insurance program with the support system for disabled persons; 2) the expansion of the range of people from whom insurance premiums are collected and 3) the promotion of a policy to secure human resources in light of the depopulation trend in rural areas.

II Reforms of Medical Service System for Seniors in 2005

The medical insurance system is a mutual aid program in which people pay premiums to ease monetary burdens if someone becomes sick. However, if the expenses for medical treatment to be paid by a patient are set at zero

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Table 2. Draft Fiscal 2008 Reforms of Ministry of Health, Labour and Welfare in Rates of Medical Care Expenses Paid by Seniors

	Persons in the lower income brackets	Persons in the upper income brackets
69 or younger	30%	30%
70 – 74	20%	30%
75 or older	10%	30%

Note: Persons in the upper income brackets: annual households having a taxable income of 5.2 million yen or over.

(or the rate of expenses to be paid is lowered), medical costs will increase endlessly, which will result in a rise of insurance premiums. This is because the frequency of hospital visits may rise because patients have no awareness of costs, or hospitals may tend to administer undue treatment. For these reasons, the rate of copayment paid by a patient is currently set at 30 percent for the actively employed and 10 percent for seniors.

While expenses for medical care generally increase with the age of the patient, the rate of copayment by seniors is set at a lower level than that of the working generation in consideration of the fact that most seniors live on pensions and have no leeway for additional expenses. However, the burdens imposed on the working generation have been becoming excessive due to accelerating societal trends towards fewer children and aging. Under these circumstances, there are growing calls for seniors to pay more reasonable amounts.

Of the total national medical care expenditure in fiscal 2003 amounting to 31.5 trillion yen, 50 percent of the total expenditure, or 16 trillion yen, was spent for seniors aged 65 or over, accounting for only 20 percent of the total population. In addition, in terms of annual per capita medical expenditure in fiscal 2003, the amount spent by persons aged 64 or younger was only 150,000 yen, the amount spent by persons aged 65 or over was four times this amount, or 650,000 yen. The relationship between the benefits received by and the burdens imposed on seniors is extremely imbalanced. The reforms of medical service for seniors (targeting seniors aged 75 or over) that started in 2005 have been moving in the direction of reviewing the policy providing preferential treatment to seniors by regarding them as weak. This tendency is represented by the proposal made by the Ministry of Health, Labour and Welfare to revise the rates of medical care expenses paid by seniors, as shown in Table 2.

1 Occupational and Regional Health Insurance Programs

Medical insurance programs are also under review. Currently, large companies have their own corporate health insurance systems. Employees of small and mid-sized companies that cannot organize their own health insurance system participate in the government-managed health insurance program. In addition, there are mutual aid associations for public sector workers. Corporate health insurance programs, the government-managed health insurance program and mutual aid associations for public service workers are termed the three major occupational health insurance programs (80 million participants). In occupational health insurance programs, employees and their companies pay insurance premiums on a fifty-fifty basis (premiums are withheld from wages). The insurance premium rate of the government-managed health insurance program is 8.2 percent of salary.

Workers in the agricultural, forestry and fishery industries, self-employed persons, employees of small businesses (such as restaurants) that do not participate in occupational health insurance programs participate in the national health insurance program managed by municipalities. (In addition, the national health insurance program includes part of industry-specific health insurance programs that have been established by members of the same industry such as doctors and lawyers.) These schemes are known as regional health insurance programs. In most occupational health insurance schemes, insurance premiums are paid equally by employees and their companies. However, one half of medical care expenses is paid by the central government because there are no contributions by sponsors in the case of regional health insurance. In addition, 20 million seniors have joined the health and medical service system for seniors and/or the medical care service program for retired employees (explained in Item 2).

2 Medical Insurance Service Systems for Seniors

The participants of occupational health insurance programs who reach retirement age must withdraw from such programs and join regional health insurance programs after retirement. From the viewpoint of regional health insurance operators, however, the income of retirees moving from occupational to regional health insurance programs is low and increased premium revenues cannot be expected. In contrast, medical care expenses spent by retirees increase as compared to the expenses spent by the working generation. Because this situation inevitably worsens the fiscal balance, the system design indicated in Figure 1 has been implemented to deal with the problem caused by retirees moving from occupational health insurance programs.

Specifically, seniors aged 70 or over have been treated as those covered by the health and medical service system for seniors, for whom the rate of medical care expenses paid by patients was set at 10 percent (12 million participants in this health and medical service system). The portion that cannot be covered by patients and insurance premiums are covered by tax injection and contributions from regional and occupational health

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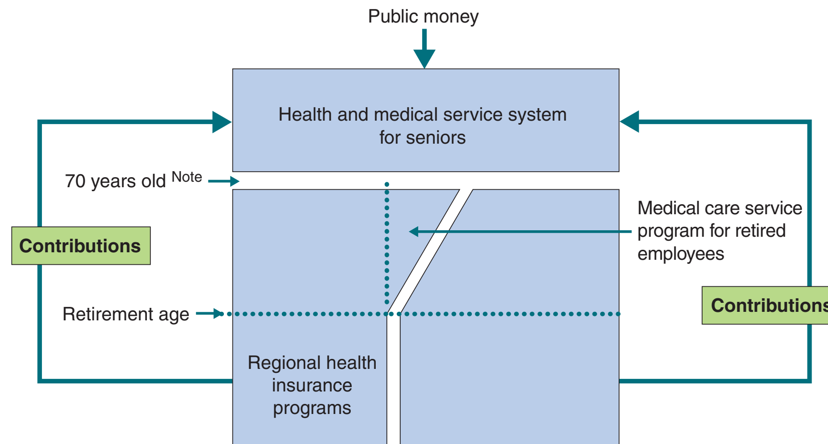
Figure 1. Current Medical Insurance Systems



Note: While the health and medical service system for seniors was initially applicable to seniors aged 70 or over, this starting age is being raised on a phased basis from October 2002, and will become 75 years from October 2007.

insurance programs. This is nothing less than using taxes and insurance premiums paid by the working generation to cover most medical care expenses spent for seniors.

The health and medical service system for seniors had been applicable from age 70, and the retirement age in most companies used to be 60. Where to find the funds for medical care expenses for seniors aged 60 to 70 during which they join regional health insurance programs was one of the issues that must be resolved. If all retirees join regional health insurance programs, the financing of regional health insurance programs would collapse.

Under such circumstances, a medical care service program for retired employees has been established (7 million participants). Under this system, with respect to medical care expenses for seniors who joined a regional health insurance program after retirement, the portion that cannot be covered by patients' insurance premiums and their hospital copayments is covered by the occupational health insurance group to which one belonged before retirement.

Thus, it was decided that, in actuality, occupational health insurance groups cover medical care expenses for seniors who belonged to the group before retirement up to the age of 70, and that regional health insurance programs cover such expenses for the seniors who have been members of these programs.

3 Reforms of Medical Service System for Seniors

Because there is no doubt that the number of seniors will rapidly increase due to the acceleration of the trend towards aging, medical care expenses for seniors that totaled 13 trillion yen in fiscal 2004 will amount to nearly 40 trillion yen in 2025 unless drastic reforms are implemented. Such an estimated increase requires a review of the means of fund procurement for the health and medical service system for seniors. Under these circumstances, the applicable age of the health and medical service system for seniors that was initially 70 or over has been raised on a phased basis from October 2002 to address financial difficulties, and is scheduled to be 75 from October 2007.

During the review of the medical service system for seniors in 2005, the Ministry of Health, Labour and Welfare proposed establishment of a medical insurance system for seniors (targeting persons aged 75 or over) in which, while half of medical care expenses are covered by public money, insurance premiums corresponding to 10 percent of total medical expenses is collected from seniors, and the rate of copayments paid by senor patients who belong to the upper income brackets is increased. The intention behind the Ministry's proposal was to lighten even slightly the burden (contributions from regional and occupational health insurance programs) of the working generation by increasing the coverage by public money and contributions by seniors.

However, to reduce the burdens of occupational health insurance groups (i.e., to reduce the burdens on companies), Nippon Keidanren (Japan Business Federation) called for wider coverage by public money and seniors that exceeds the amount of coverage proposed by the Ministry of Health, Labour and Welfare. Nippon Keidanren proposed that the portion covered by public money should be increased to more than 50 percent, and that all seniors aged 65 or over must be eligible to join the medical insurance system for seniors on the assumption that the retirement age would be raised to 65 or over. The proposal also included an increase in the rate of copayments paid by patients to 30 percent for outpatient hospital treatment and to 20 percent for situations requiring hospitalization.

Eventually, a final proposal to reform the medical system for seniors aged 75 or above was adopted. This could be regarded as a modified version of the original proposal of the Ministry of Health, Labour and Welfare.

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Four topics must be discussed to complete the reform of the medical-service system for seniors up through 2008.

(1) Because under current occupational health insurance programs, insurance premiums are paid on a fifty-fifty basis by employees and their companies, about 40 percent of company health insurance funds is absorbed into the medical insurance system for seniors. Increasing the contribution rate by companies is a major matter affecting corporate profits. An increase in contributions by a company related to medical insurance programs for seniors means an increase in the total compensation of employees. Accordingly, such an increase may lead to the acceleration of direct investments abroad where total labor costs are lower than in Japan, which may negatively affect the domestic employment environment in Japan.

In order to minimize a company's burden, consumption taxes paid by individuals will be regarded as an important source of funds to finance the government's contribution. A major point is whether consumption taxes can be positioned as taxes only for welfare purposes to finance increasing medical-care expenses for seniors.

(2) As measures to minimize increases in medical care expenses for seniors, the government is strengthening its activities to prevent lifestyle-related diseases. Medical expenses for diseases considered attributable to lifestyle such as diabetes are in no way negligible. In addition to structural reforms, everyone must keep in good health to decrease medical expenses for lifestyle-related diseases. A national movement pursuing these purposes is needed.

(3) The proposed reform of medical service for seniors initially calculated the average annual insurance premium paid by seniors at about 55,000 yen. However, a figure recently released exceeds 70,000 yen. Furthermore, there are moves to increase the upper monthly limits of copayments in the case of high-cost medical treatments. In 2004, there were 2,500 cases in which the monthly amount billed by hospitals to health and medical insurance managers was more than 5 million yen per patient. This increase in the number of cases is attributable to the fact that health insurance programs started to cover advanced medical treatments such as organ transplants from living donors and artificial hearts. Because the monthly average household insurance premium is 40,000 yen, premiums paid by 125 households are required to finance medical treatment costing 5 million yen.

Because advanced medical treatment is expected to increase in the future, as part of the measures to deal with such an increase, a proposal was made to increase the upper limit of copayments of high-cost medical treatments (Table 3). However, as the proposed amount of such an increase is small (increasing the amount paid by a high-income patient in a case where the patient received medical treatment requiring 1.5 million yen monthly from 84,000 currently to 92,000 yen), there will be no change to the situation in which the greatest portion of such expenses is covered by health insurance. Because the budget for medical expenses is limited, the increase in expenses for advanced medical treatment might result in a shortage of expenses for basic medical treatment. Attention must also be given to the distribution of medical treatment in addition to controlling the total amount of medical expenses.

Table 3. Monthly Upper Limits of Medical Expenses Paid by Seniors Aged 70 through 74

(Unit: Yen)

	Current limit	Proposed limit
High-income persons	84,000	92,000
Other than the above	40,000	62,000

Note: These upper limits are in cases where monthly medical expenses are 1.5 million yen.

(4) As part of the measures to address this problem, it would be necessary to permit a mixed medical payment system that combines insured and non-insured medical care services. As a result, the payment ratio of advanced treatments might be higher than that of regular medical treatments.

Progress in medical science is occurring on a daily basis, and it is remarkable to see the development of leading-edge medical treatments and the emergence of new pharmaceuticals. However, if all advanced medical care expenses are to be covered by medical service insurance programs, insurance premiums will continue to grow. Since the working generation is contributing a large portion of medical expenses, it would in no way tolerate such an increased burden. In the future, the introduction of a two-tier medical insurance system is highly likely. Under this system, the insurance coverage ratio will vary based on types of illnesses. On the one hand, basic medical care that is a fundamental need of national life would be mainly covered by insurance (with low copayments). On the other hand, the rate of copayments for leading-edge medical care and new pharmaceuticals would be higher than that for basic medical services due to the low rate of insurance coverage.

With the acceleration of society's trend towards aging and fewer children, it has become difficult to maintain the assumption that everyone can receive the best medical treatment at the minimum

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cost. If the rate of expenses paid by patients for leading-edge medical treatment were increased, the need to personally join private sector medical care insurance programs such as cancer insurance in addition to contributing to public medical insurance programs will increase. This is nothing less than a situation in which people who cannot afford to participate in private sector medical care insurance programs cannot receive necessary medical treatment. A major point in future medical service reforms would be to what extent such unfairness in medical treatment could be tolerated in Japan.

III Restructuring of Regional Health Insurance

1 Five Problems Facing Regional Health Insurance

In addition to the measures taken to constrain the expenses for medical care for seniors, the regional health insurance system, which is based on self-employed and part-time workers and is operated by local governments is one of the major issues in the reform of the medical service system. In the past, major participants in the regional health insurance programs consisted of persons engaged in agriculture, forestry and fishery and the self-employed. However, as affected by changes in the industrial structure and the decline of independent businesses, the number of participants engaged in agriculture, forestry and fishery as well as the number of self-employed participants has decreased. In addition, the average age of the participants has risen. (Although participants engaged in agriculture, forestry and fishery and the self-employed accounted for 60 percent in 1965, the percentage decreased to slightly less than 20 percent in 2002.)

Since the 1990s, the number of new regional health insurance participants has rapidly increased. This number included persons made jobless due to companies' restructuring, part-time workers who are not eligible to participate in occupational health insurance programs and freelance workers. Despite the increase in medical expenditure with the aging participants, the annual income of new participants such as part-time workers is low, substantially worsening the financial situation of regional health insurance programs.

In regional health insurance programs, the central government covers half of the medical care expenses. Because participants' income is low (average taxable income per household in fiscal 2001 was 1.5 million yen) and revenue from insurance premiums is insufficient to cover expenses, regional health insurance programs continue to record deficits. As a result, in fiscal 2003, local governments were forced to inject 380 billion yen to offset the deficits of regional health insurance systems although the central government covers half of medical care expenditures.

Specifically, there are five problems.

(1) Originally, regional health insurance programs were established to support the self-employed such as farmers and store owners. However, due to changes in the industrial structure, the decline of independent businesses and an increase in the number of part-time and freelance workers, these programs have virtually become characterized as health insurance programs for low-income people who are unable to join occupational health insurance groups. This situation requires that local governments inject a vast amount of public funds although they must undertake fiscal restructuring.

While discussions continue about the reform of medical service system for seniors, it should be recognized that the central government contributions to regional health insurance programs (3.8 trillion yen) exceed medical care expenses for seniors (2.5 trillion yen) (Table 4). The central government's medical care expenditures are spent primarily for public assistance for three groups of people. The first group includes members of regional health insurance systems such as low-income part timers and middle-aged, self-employed workers. The second group includes members of health insurance plans for seniors. The third group includes people fully assisted by public money. It is necessary to find out the best way of assisting the poor under the process of regional health insurance reform.

(2) The deficits of regional health insurance programs are financed by the general accounts of local governments. From the perspective of local participants of occupational health insurance programs, their local taxes are used to offset the deficits of health insurance programs in which they do not participate (in fact, this is the same as a double payment of insurance premiums). Is this situation acceptable from the taxpayers' perspective?

Table 4. Breakdown of National Medical Care Expenditures (Budget for Fiscal 2004)

(Unit: Trillion yen)

Budget item	Amount
Contributions to regional health insurance programs	3.8
Contributions to government-managed health insurance programs	0.8
Contributions to the medical service system for seniors	2.5
Medical care expenses for households under public assistance	0.9
Total including other expenditures	8.1

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(3) Despite the fact that many participants earn small incomes, the rate of insurance premiums must be increased to obtain the necessary funds (according to materials released by the Japan Association of City Mayors, the ratio of insurance premiums paid by individuals to annual income is 10.8 percent, which substantially exceeds the ratio of 4.2 percent for occupational, government-managed health insurance programs). Consequently, the burden of the poor has become increasingly higher.

(4) Medical insurance is a scheme to lighten the burden of medical care expenses for a sick participant through the monthly payment of insurance premiums. Accordingly, non-payment and/or delinquent payments cannot be tolerated. For persons who intentionally do not pay their insurance premiums even though they have an income, strong measures must be taken to obtain all the delinquent insurance premiums. A medical insurance certificate requiring full payment to receive medical care services is issued to persons who have not paid their insurance premiums on a continuous basis. While the number of such certificates issued in 1998 was 50,000, it amounted to 300,000 in 2004.

Issuing such certificates might be effective for persons who have an income but intentionally fail to pay premiums. However, if such certificates continue to be issued automatically to long-term delinquents who have no income due to losing their job but are not eligible to receive full public-assistant services, such persons will be unable to receive medical treatment. All expenses for medical care for persons under public assistance are covered by public funds. Accordingly, persons who have only small incomes that are not enough to cover medical insurance payments but try to sustain themselves without receiving public assistance undergo extreme hardship without receiving any support for medical care. Some forms of relief measures must be taken for these people.

(5) The rate of non-payment of insurance premiums under regional health insurance programs reached 9.8 percent in 2004 (5.5% in 1994). Among others, the rate of non-payment of people in their 20s including part-time workers is estimated to be close to 30 percent. If the number of people who do not pay insurance premiums because they think medical insurance is not necessary because the likelihood of becoming sick is low, the burden on those who devotedly pay insurance premiums becomes much greater. It is risky for social security systems to allow free riders not to pay premiums. The solution to this problem is as follows. Part-time employees including freelance workers should be covered by occupational health insurance programs at the companies where they work, and insurance premiums should be directly deducted from their wages.

2 Insurance Premium Rates under Regional Health Insurance Programs

The following section describes the actual status in calculating insurance premium rates under regional health insurance programs. The annual insurance premium can be calculated from the following three items (in the case of Chiba city, the capital of Chiba prefecture located on the east side of Tokyo).

(1) Amount proportionate to income: (taxable income – 330,000 yen) x 7.1 percent
(2) Amount proportionate to the number of household members: 16,680 x number of household members
(3) Fixed amount: 21,600 yen per household

Accordingly, if the number of household members increases, the insurance premium increases even if income is small. Because the amount proportionate to salary accounts for only about 50 percent on average and the fixed amount is high, the current insurance premium is a heavy burden for households with small incomes. (From the standpoint of regional health insurance programs, this means that a fixed amount of insurance premiums can be obtained regardless of the annual incomes of the participants.)

The following example considers the case of a single-parent family consisting of a mother and two children. In many cases, single mothers are part-time workers taking care of children by themselves. Most of them participate in regional health insurance programs. Suppose the annual income is 2.49 million yen (2.12 million yen was the average annual income of a family consisting of a mother and children in 2003, plus 370,000 yen for public child-support allowance), the annual insurance premium is 140,000 yen (in the case of Chiba city). Under occupational health insurance programs (the government-managed health insurance program), the insurance premium rate for the same income is 4.2 percent, and the number of dependents is not taken into account. Accordingly, the annual insurance premium for such income is 89,000 yen, which is 50,000 yen less than the case of the single mother mentioned above.

The insurance premium rate of a regional health insurance program is discounted in the case of low income (currently, if the taxable income in the preceding fiscal year is 330,000 yen or less, a 60 percent discount is given). In the case of a couple who lives on public pension benefits of 790,000 yen (maximum payment amount for the elderly self-employed) each for a husband and wife, the taxable income is zero because the pension income deduction is 1.2 million yen (2005) each for a husband and wife. Because the taxable income is

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zero, the amount proportional to income is zero, and a 60 percent discount is given. In the case of Chiba city, the annual insurance premium for this elderly couple is (16,680 x 2 + 21,600) x 0.4 = 21,984 yen. Compared to the family of a mother and two children mentioned above (140,000 yen), this elderly couple is treated far more favorably.

Under the Tax Law, there is a difference of 550,000 yen between the deduction for pension income (1.2 million yen) and the deduction for salary income (650,000 yen). This difference causes a major differential between the insurance premiums of a couple living on a pension and a family living on income from a salary. In other words, this situation demonstrates that the advantage given to the elderly living on a pension increases the burden on poor members of the working generation. Compared to occupational health insurance programs, the medical care expenditures of regional health insurance programs are increasing more rapidly due to the trend of aging. Income tax law gives greater favor to the pension beneficiaries than salaried workers, and there is a tendency that many of the people who become ill are those who pay smaller insurance premiums.

As a result, the burden imposed on the low-income working generation becomes even greater. The average taxable income of participants in regional health insurance programs is 1.5 million yen, which is lower than that of occupational health insurance programs (4 million yen for corporate health insurance programs in 2003). Such a situation has led to the following vicious circle: in order to finance increasing medical expenditure, the rates of insurance premiums become higher. However, the participants' income are lower than that of the participants of other insurance systems. As a result, the number of poor who are delinquent in paying their premiums and have lost their right to receive medical care services at low cost increases sharply.

3 Integration of Occupational and Regional Health Insurance Programs

The only remedy to this situation would be integrating the government-managed health insurance programs with the regional health insurance programs. The current situation in which low-income people account for a major share in regional health insurance programs cannot be said to be fair and is not desirable. Presently, plans are moving ahead to divide the government-managed health insurance programs covering small- and mid-sized companies by prefecture as part of the reform of the Social Insurance Agency. Once this regional division is achieved, insurance premiums can be set in accordance with an individual's income in each area. This is a good opportunity to integrate regional health insurance programs and the government-managed health insurance program for each prefecture.

The majority of participants in regional health insurance programs are no longer people operating independent businesses, but are part-time workers. Although the wages of part-time workers are lower than are those of regular employees, the insurance premiums of part-time workers are comparatively higher. This situation cannot be considered fair. Because the insurers of regional health insurance programs are local governments, there are as many as 3,500 regional health insurance programs throughout the country. These programs should be consolidated to provide a single program in each prefecture and, at the same time, should be integrated with the government-managed health insurance programs, establishing only one health insurance program per prefecture.

After implementing such integration, the establishment of new insurance premiums will eliminate the differences in insurance premiums between occupational and regional health insurance programs and will reduce the number of certificates issued for low-income persons who cannot afford to pay insurance premiums. This will deny low-income persons low-cost medical services.

Most of the working generation that participate in regional health insurance programs consist of part-time workers and freelance workers from whom insurance premiums should be withheld in the same way as for full-time workers' occupational health insurance programs. With respect to the self-employed, the National Tax Agency should collect insurance premiums in proportion to income on behalf of regional health insurance systems. For persons having no income because they have no job, the issuance of a certificate that essentially means blocking them from receiving medical care should be avoided. Instead, social workers should play an important role in this issue. Considering the financial situation of individuals, social workers should permit late payment and collect insurance premiums when the individuals begin to earn an income. Instead of bureaucratic treatment, assistance from social workers would be more desirable.

The major purpose of the integration of occupational and regional health insurance programs is to reduce the burden on poor, part-time workers participating in regional health insurance programs. Because higher premiums for medical insurance for low-income persons are unreasonable, the insurance premiums of the occupational health insurance programs would be increased through integration. A structure enabling everyone to readily receive reasonable medical care under the same insurance rates is desirable. Participants in occupational health insurance programs should accept the increase in the insurance premiums in this medical reform.

There is another difference in the methods of collecting insurance premiums between regional and occupational health insurance programs. While the number of family members is considered in the regional health

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insurance programs, the insurance premiums of the occupational health insurance programs are determined solely on the annual income of the householder. Insurance premiums are determined only in proportion to salaries under the occupational health insurance programs. Accordingly, if a wife does not have a job and the husband pays an insurance premium, all family members will be covered by the occupational health insurance program. In contrast, under the regional health insurance programs, insurance premiums are determined by household income and number of family members. These two insurance systems collect the premiums by different methods.

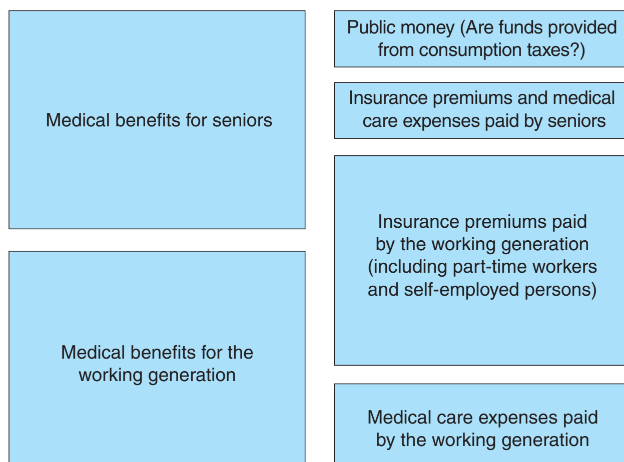
In determining the insurance premiums in the future, it would be more reasonable to consider the number of family members. After integration, insurance premiums should reflect household income and number of family members.

The major points at issue during the medical insurance system reforms in the next five years will consist of the method of raising funds for medical care insurance for seniors and integrating the government-managed and regional health insurance programs. If these issues can be resolved, the future medical insurance system will be as indicated in Figure 2 on the assumption of decentralization.

Because the extent of aging differs according to prefecture, the rate of aging in each prefecture must be reflected in calculating the central government's contribution to each prefecture. If the insurance premiums to be paid by seniors and the rate of medical care expenses to be paid by senior patients and the central government are determined, the remaining portions must be covered by members of the working generation in each prefecture.

If a single health insurance system is established in each prefecture and if each Prefectural Assembly supervises major university hospitals and large public hospitals in each prefecture, the Prefectural Assemblies should be in charge of determining the medical insurance premiums under the forecast of medical expenditures for the following year. They would have to examine the contents of medical treatments to use insurance funds effectively and also promote advanced medical treatment for the purpose of residents' welfare in accordance to the revenue from within the prefecture. This would be the perfect decentralized medical service system.

Figure 2. Future Medical Insurance System



IV Reviewing the Distribution of Medical Care Expenses

1 Rejection of the Opinions of the Medical Association

There has continued to be a difference of opinion about ever increasing medical costs between the Japan Medical Association, which believes that all expenses should be covered by insurance, and health insurance groups, which believe that they should cover only the amount that they can afford (i.e., they cannot cover medical expenses that are rising at a far faster rate than wages). However, with the overwhelming victory of the Koizumi administration, which was reelected in the 2005 House of Representatives election, it appears that this issue has been settled as represented in the budget compilation for fiscal 2006. Because reducing the fiscal deficit is a major policy concern (although the amount of government bonds to be issued in fiscal 2005 was initially budgeted at 34.4 trillion yen, this amount was reduced to 30 trillion yen in the initial budget for fiscal 2006), the position of the Japan Medical Association, which has long asserted that medical expenses are a sacred trust, was perfectly rejected.

When we look at the initial budget for fiscal 2006, we find that while the budget anticipates tax revenues amounting to 46 trillion yen, government bonds to be issued total 30 trillion yen (even though reduced by 4.4 trillion yen), constituting 37.5 percent of total revenues (Table 5). Annual expenditures include 20.5 trillion yen for social security, 14.6 trillion for local allocation tax grants, and 7.2 trillion for public works projects, giving a total of 42.3 trillion yen, which is almost equivalent to the revenues from taxes. All other expenses must be covered by borrowing (issuing government bonds).

2 Priority Given to Reducing Annual Expenditures

To successfully reform public finances, we must either increase taxes or reduce spending. Table 6 shows the amount of tax and social insurance paid by a salaried worker (with a wife who is a homemaker and two children) on an annual salary of six million yen (in 2004, the average salaried worker earned 5.4 million yen, but this case assumes a worker in his 40s who is also paying long-term care insurance premiums).

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Table 5. National Budget (Fiscal 2006)

(Unit: Trillion yen)

Revenues		Change from original budget for the preceding fiscal year
Taxes	46	4.3%
Bonds issued	30	– 12.8%
Other revenues	4	1.3%
Total revenues	80	– 3.0%
Expenditures		Change from original budget for the preceding fiscal year
Social security	20.5	0.9%
Bond-related expenditures	18.8	1.7%
Local allocation tax grants	14.6	– 8.7%
Public works expenditures	7.2	– 4.4%
Education and science technology development expenditures	5.2	– 8.7%
Defense expenditures	4.8	– 0.9%
Other expenditures	8.9	
Total expenditures	80	

Table 6. Average Household Tax and Social Insurance Premiums (Annual Income of 6 Million Yen)

(Units: 1,000 yen)

Employee's pension insurance premiums	407	Income tax	190
Government-managed health insurance premiums	246	Consumption tax	200
Long-term care insurance premiums	33	Local residential tax	100
Unemployment insurance premiums	42	Fixed property taxes, etc.	120
Total social insurance premiums	728	Total taxes	610

Notes: (1) A 20-percent tax reduction introduced as part of measures to stimulate economic growth is not taken into account in calculating income tax.
(2) Consumption tax is calculated assuming that the percentage of disposable income consumers spend is 65 percent.

As shown in Table 6, this worker's annual social insurance bill is 728,000 yen, while he also pays 610,000 yen in taxes, which together constitute 22.3 percent of his annual income. Increasing taxes or social insurance premiums will increase the burden on individuals, leading to a slowdown in personal consumption and a decline in the economic growth rate, which may result in a reduction in tax revenues. Therefore, any increase in taxes or social insurance should be undertaken gradually, while huge efforts must be made to reduce annual expenditures.

Many people believe that social security is financed by social insurance contributions such as employees' pension insurance premiums. However, in fact, tax amounting to as much as 20 trillion yen is injected. Moreover, because the ratio of the government's financial aid to benefits is fixed, if the benefits do not decrease, it is also impossible to reduce the amount of public money being injected into the system. Because the accelerated societal trends towards aging makes it virtually impossible to reduce the cost of social security, any increase in social security expenses must be minimized, while at the same time major cuts must be made in other spending programs to achieve fiscal reconstruction.

The main social security costs covered by the government are basic pension benefits (50%), regional health insurance medical benefits (50%), medical expenses for seniors (40%) and long-term care insurance benefits (25%). Thus, we cannot separate social security reform from fiscal restructuring.

The central government's social security spending includes about 8 trillion yen for medical insurance (corresponding to slightly less than 20 percent of the 46 trillion yen in tax revenues). The reforms of the medical service system for seniors in 2005 are aimed at limiting increases in medical expenses to minimize the burden on the central government.

In 2004, the Ministry of Health, Labour and Welfare estimated that the cost of providing medical care to the country would reach 60 trillion yen by 2025 (of the current 32 trillion yen cost, half of that is for providing medical care to persons aged 65 or over). However, as a result of the current reform, whereby increases are kept to 2 percent, this estimate has been reduced to 48 trillion yen.

Although Japanese society will continue to age and the share of the seniors who spend four times as much in medical expenses as the working generation is going to increase, medical expenses are to be kept at the same

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rate of increase as nominal wage increases. In order to secure the control on medical expenditures, national medical expenses are to be reviewed every five years to check whether the actual rate increase is similar to the planned rate increase.

3 Increasing the Rate of Medical Care Expenses Paid by Seniors

Any changes to the laws of the social security system must be determined by the National Diet. However, the decisions currently being made by the National Diet may simply reflect the desires of the working population with regard to the allocation of the tax and insurance premiums they pay. Most taxes and social insurance premiums are paid by this working population that consists mainly of persons in their thirties to fifties. For them, the payment of taxes and social insurance premiums means nothing but to allocate a portion of the fruit of their labor to provide education for their children and medical care and nursing care for their parents.

It is highly likely that the payment for the education of their children is more important than the payment for the daily life of their parents. Despite the fact that seniors constitute only 20 percent of the population, their medical expenses account for half of the nation's medical expenses. It would be difficult for the working population to accept the fact that they must bear the burden of such expenses that are expected to increase constantly into the future. As part of the current reform of the medical service system for seniors, older persons are not automatically assumed as being weak, but are required to cover a reasonable portion of their medical expenses. Based on such thinking, the rate of medical expenses paid by seniors was decided to be increased. For example, medical expenses paid by seniors aged 70 through 74 (other than those with higher incomes) is planned to be increased from 10 percent to 20 percent.

What becomes important after the 2005 reform, which sets a limit on the nation's total medical expenditures and increases the share of medical expenses paid by seniors, is how to allocate the limited medical resources effectively. At the same time, we must ensure that no one is denied appropriate health care simply because he or she cannot afford it.

4 Placing a Cap on Total Medical Expenditures

Medical treatment can be classified into three types, namely, low-cost treatment (such as that for colds), medium-cost treatment, and high-cost treatment (such as organ transplants). If we assume that there is a limit on total medical expenditures, we are probably forced to shift to a new medical system whereby low- and medium-cost treatment (primary care) is provided to everyone at low cost, while an appropriate share of the cost of highly advanced medical treatment is paid by the patient (a two-tier system whereby the cost of primary medical care is kept low while recipients of leading-edge medical care pay a much higher proportion of the cost of such care).

Of course, the majority of people wish to receive leading-edge medical care with low copayments and will expect their insurance to cover the total cost of their treatment. However, due to financial restraints, insurance cannot completely cover the cost of treatment to meet people's wishes. If, however, this kind of system were to spread whereby leading-edge medical care requires a higher copayment than does basic medical care, the poor will be denied access to leading-edge medical care. If clear discrimination were to be seen in medical care and voices demanding an equal opportunity to receive medical treatment were raised, the stability of Japanese society might be disturbed. To prevent this from becoming a serious social problem, we would have to implement various measures such as enhancing the use of preventive medicine.

5 Promoting Preventive Medicine

Lifestyle-related illnesses such as diabetes incur a considerable cost (there are currently 7.4 million diabetes patients, each of whom requires insulin costing 180,000 yen yearly, giving a total cost of 1.3 trillion yen). If we are to successfully counter the problems of smoking, obesity, high blood pressure and cholesterol, and encourage healthful eating and exercise, we could reduce the incidence of lifestyle-related diseases and, as a result, reduce medical expenditures.

The Social Insurance Agency examined the 1993 and 2003 data for Mie Prefecture and found that those persons whose medical problems in 1993 included a diagnosis of obesity, high blood pressure, high cholesterol or high blood sugar had, during the ten years, incurred medical expenses of 450,000 yen. This amount is three times greater than was the amount persons who were not diagnosed with any of those problems in 1993 required for treatment (140,000 yen).

The results of the "National Nutrition Survey," undertaken by the Ministry of Health, Labour and Welfare (1997 and 2004) reveal that people are walking less and the rate of obesity is increasing. Furthermore, people are eating fewer vegetables. The Americans were successful with their "Five servings of vegetables a day" campaign. As one aspect of preventive medicine, Japan also needs to promote the consumption of vegetables.

While the recent years have seen increased attention paid to generic medications (those medications for which the patent has expired, and which are produced at low cost by other than the original manufacturer), there is still an urgent need to further promote the use of generics as well as for the spread of preventive medicine to keep medical expenditures in check.

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6 Introduction of Insurance Exemption System

While prostate and liver cancer can be effectively treated with proton therapy, this treatment is extremely expensive. Despite its efficacy, because this treatment is not covered by insurance, it is not accessible to persons who cannot afford it. If collected insurance premiums could only be used for the purpose of high-cost medical treatments, the medical system might sustain appropriate copayments by patients in the future. An insurance exemption system has been proposed in this regard. That is to say, low-cost treatments are paid for entirely by the patient, which frees up funds for covering medium- and high-cost treatments. In this way, we can increase the amount of funds available for medium- and high-cost treatments.

While this system was discussed as part of the medical reform talks in December 2005, the government refused to adopt such a system on the grounds that it might lead to an increased burden on individuals. Medical insurance is, however, a mutual aid system whereby we all contribute to the system in order to reduce our own financial burden if we ever suffer from serious illnesses and need medical attention. It is considered more rational to use a large part of insurance premiums to reduce the rate of copayments imposed by medium- and high-cost treatments that have a direct bearing on preserving life. Such an insurance exemption system may have to be introduced in the future.

7 Review of the Provision of Medical Services

In comparison with other industrialized countries, one of the issues examined as part of the current reform is the extremely long hospital stays in Japan (Table 7). In addition, the excessive number of beds was also recognized as a problem. An excessive number of beds forces hospital managers to fill those beds with patients who do not need to stay in hospitals so as to improve the facility's utilization figures. This leads to the lengthening of hospital stays.

During the current reform deliberations, the Ministry of Finance pointed out that while the increase in per-person medical costs cannot be avoided as we age, average hospital stays in other countries are about one week, whereas in Japan they are about four weeks. The Ministry pointed out that any meaningless hospitalization after the completion of treatment should be eliminated.

The purpose of medical insurance is to provide primary medical care and, to a degree, advanced treatment to the entire population at low cost. Costs to stay in hospital rooms and meal charges should not be covered by insurance if patients are staying for non-medical reasons.

In particular, regarding hospital beds for long-term medical care (380,000 beds), the Ministry of Health, Labour and Welfare pointed out that a large share of these beds are occupied by patients for reasons other than necessary medical treatment such as that there is no one who can take care of the patient at home. The Ministry announced a policy of ultimately reducing the number of beds to 150,000 that are truly necessary for taking care of seriously ill patients by replacing hospital beds with fee-based homes for seniors and/or nursing homes.

Currently, it costs an average of 450,000 yen per month to maintain a bed for long-term medical care, with about 60,000 yen of that being paid for by the patient. Therefore, reducing the number of hospital beds to 150,000 would reduce costs by 1 trillion yen per annum. Of course, any sudden change would bring on confusion, and long-term care services at home would have to be steadily improved before any such changes are made.

After reducing the number of hospital beds for long-term stays, the next step would be a division of labor related to medical treatment. The existing medical treatment system would gradually be reorganized. The family doctors would be closest to most people, and would be responsible for health care, low-cost and some medium-cost treatment. When faced with a patient suffering from a problem that falls outside the range of their abilities, the family doctors would refer that patient to a multi-disciplinary, large-scale hospital. If that hospital is unable to provide treatment, it then refers the patient to a specialty hospital.

If we can establish a system of dividing medical labor in the form of "(1) family doctor → (2) general specialist → (3) expert specialist," we could eliminate the waiting rooms of large hospital outpatient departments full of people with colds. By having experts concentrate in their own fields, the quality of medical care could be maintained and costs could be reduced.

Table 7. International Comparison of Bed Count and Length of Hospitalization (2000)

	Number of beds/ 1000 people	**Average length of hospitalization** (days)
Japan	12.8	28.3
USA	3.6	6.6 (2002)
Germany	9.1	11.6 (2001)
UK	4.1	8.1 (2002)
Sweden	3.6	6.2 (2002)

Source: Financial Systems Council "Basic Thinking Behind Budget Compilation for Fiscal 2006," June 2005.

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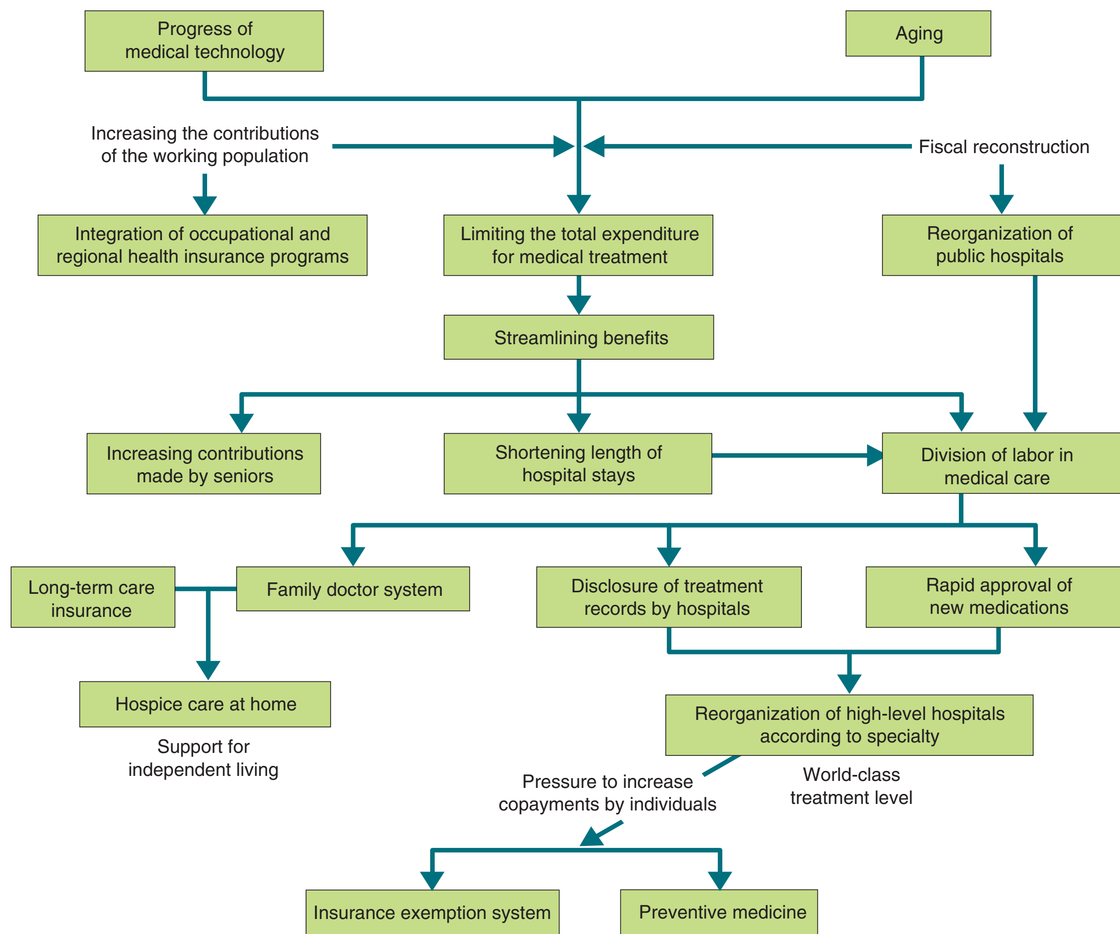
Figure 3. Flow of Medical Service System Reform



As part of the current reform, it is expected that the copayment of a patient's initial visit to a specialist hospital would once again be raised. The system of first visiting a family doctor would gradually spread. In addition, as it is wasteful to repeat the examinations required in processes (1) through (3), an IT network should be established to enable the sharing of X-rays and other information. Furthermore, high-level hospitals should share treatment procedures as much as possible, striving to reduce the cost of expensive treatment procedures.

8 Long-Term Care and Medical Treatment

To reduce the length of hospital stays, patients should return home as soon as their hospital treatment has ended, where they can be cared for under the family doctor system. The system, which focuses on the standpoint of reducing medical costs, is not just one aspect of the division of labor in the medical field, but also plays a major role in terminal care.

One-quarter of the medical care provided to seniors in the United States is said to be aimed at prolonging the lives of terminal patients. In Japan, terminal care costs on the order of 100,000 yen per day, or 3 million yen per month. These costs must be covered by the medical insurance contributions of the working population. In view of the costs that can accrue with four to six months of terminal care, there are very few people who do not question this high spending.

In hospitals, probably many patients themselves would rather not want to continue with this meaningless terminal care. Rather than letting patients pass away in a hospital, we need to introduce a home hospice network to the family doctor system so that patients can spend their final days at home.

As the cost of social security increases due to the aging of the population, we are approaching a point where we will be forced to make a choice between funding the enhancement of long-term care or medical treatment. If we respect the quality of life of seniors at home, resources for medical treatment must be shifted to a long-term care system. It is essential, therefore, that we stress the introduction of a home nursing care network so that we can quickly start to reduce the current number of 380,000 hospital beds being used for long-term care.

What is important is to ensure that everyone enjoys the best possible quality of life. To this end, we must also strive to instill in everyone from an early age the preventive benefits of healthful eating and exercise. As we age, of course, there will be cases where we simply cannot maintain our independence. However, with visits

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by helpers and nurses, and the support of family doctors, even patients with chronic illnesses will be able to maintain a lifestyle at home. Rather than staying in a hospital bed for a long time, and in order to enable us to continue living at home to a certain degree, we have to put all our efforts into establishing a system based on a nursing-care network, family doctors and a home hospice approach.

Accordingly, the following measures were adopted during the review of the medical service system for seniors in 2005. Anticipated increases in the costs of medical care that go hand in hand with the aging of the population have to be kept in line with increases in nominal wages, while seniors must be asked to shoulder a larger portion of their medical expenses. The next issue that we must address is how to improve the full level of medical care with only the limited funds available for medical services. Adoption of the insurance exemption system will enable the use of insurance premiums to pay for medium- and high-cost treatments. This will reduce the number of cases involving situations where the poor do not have access to leading-edge medical care because they cannot afford it. Furthermore, in order to improve the quality of life of seniors, the funds should be allocated to the establishment of family doctor systems and nursing care networks that are essential for the independent living of seniors and the promotion of terminal care at home, rather than attempting to use most of the budget for meaningless treatment in the hospital.

The reforming of medical and long-term care insurance programs would enable seniors to enjoy their final days by the establishment of medical and nursing-care networks within a limited budget and also the improvement of medical technologies of specialist hospitals.

9 Establishment of a Cancer Treatment System

While we can be proud that surgery in Japan is as good as it is anywhere in the world, ironically this has led to our anticancer drug and radiation treatments falling behind those of Europe and the United States. In Europe and the United States, surgical departments generally work together with radiologists, anticancer drug specialists and pain practitioners (doctors whose specialty is the relief of pain) in cancer treatment. Unfortunately, a chronic shortage of anticancer drug specialists and radiologists makes this cooperative effort impossible in Japan. Furthermore, of the 111 anticancer drugs commonly used in the United States, 35 are not approved for use in Japan. There is also only a limited number of anti-cancer drug-based treatment specialists (the first test for anticancer drug-based treatment specialists, "drug-based cancer therapists," was offered in March 2006, and 47 doctors were approved).

In the future, if the performances of the large hospitals are made public, patients would be able to choose the hospital they prefer. However, without fostering anti-cancer drug specialists, radiologists or pain specialists, we cannot expect to be able to receive the same level of cancer treatment as that available in Europe and the United States. Because cancer is the number one cause of death (about 30 percent in Japan), and because we are essentially lagging behind Europe and the United States on a technological level, we must not allow this situation to be left unaddressed.

In Japan, the costs of medical treatment are borne by health insurance programs, with the fostering of medical personnel such as doctors being chiefly funded by public money. Despite such a situation, the majority of hospitals are privately managed. Even though the number of cancer patients continues to increase, cancer treatment is plagued by two issues. Universities have not had the foresight to reorganize the educational system to nurture the kind of professionals that are needed, and hospital managements have pursued profit in the short run. Policy makers hesitated to publicize the results of cancer treatments at large hospitals to avoid competition between hospitals. Under these circumstances, large-scale anticancer programs have not been put in place.

Finally, in October 2005, in order to integrate the source of providing information to cancer patients, it was decided that the National Cancer Center will provide basic information on cancer treatment to 135 prefecture-based cancer treatment centers throughout the country.

In the United States, the National Cancer Institute makes information available on the Internet. With the rapid development of anticancer drugs and the enhancement of pain clinics, many cancer patients manage to carry on with their daily lives while undergoing treatment. In view of such a situation in the United States, it is desirable that Japan establish a cancer treatment system giving importance to the maintenance of the quality of life, such as providing anticancer drug therapy on an outpatient basis, in addition to improving cancer treatment by training anti-cancer drug specialists and radiation specialists.

V Respect of Self-Determination and Medical Treatment

To date, if we exclude malpractice cases, there has been little relationship between law, ethics and medicine. This situation is now changing. Individuals have the right to make decisions about themselves by themselves.

". . . the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. (Portion omitted.) Over himself, over his own body and mind,

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the individual is sovereign" (John Stuart Mill "On Liberty").

Summarizing what Mill said, we can say "a person capable of making a decision shall be allowed to make decisions regarding his or her own life, body, and property, provided that others are not adversely affected, even if that decision would actually be disadvantageous to the individual."

Article 13 of the Constitution of Japan stipulates, "All of the people shall be respected as individuals. Their right to life, liberty, and the pursuit of happiness shall, to the extent that it does not interfere with the public welfare, be the supreme consideration in legislation and in other governmental affairs."

When we consider the medical field, however, we find that the individual's right to decide raises many issues that are difficult to resolve. Especially nowadays, when minimizing increases in medical care expenses incurred by the aging of the population has become a vital political issue, there is a need to build a national consensus on medical ethics among society as a whole.

1 The Need for Informed Consent of Cancer Patients

With grave sorrow over the cruel human experiments performed by the Nazis during World War II, the 1964 general meeting of the World Medical Association adopted the "Declaration of Helsinki," named after the city in which the meeting was held. The Declaration recognizes that experiments on human beings are essential to furthering medical science. However, it also states that any experimental procedure should, in principle, give priority to the benefit and welfare of the test subject over the development of medical science. Specifically, the declaration laid down the following three requirements.

- The use of human subjects is absolutely unavoidable.
- Subjects must be told exactly what to expect.
- Subjects must voluntarily agree to participate based on their own rational decision.

Of the above requirements, the explanations to be given to the subjects, and the agreements to be obtained from them, came to be regarded as patient rights in the United States in the 1960s. In 1973, the American Hospital Association adopted the "Patient's Bill of Rights." This stated that, in the course of providing medical treatment, the medical practitioner must provide the patient with accurate information and obtain the patient's agreement to proceed. That is, the Patient's Bill of Rights stated the necessity for "informed consent."

At that time, informed consent was intended to counter practitioner paternalism (the tendency whereby the practitioner assumes an overwhelmingly superior degree of knowledge and determines the course of medical treatment without considering the wishes of the patient), and gave the patient the right to make his or her own decisions. Cases where the patient had not provided explicit informed consent resulted in lawsuits that the medical practitioners frequently lost. Under these circumstances, informed consent has gradually become a requirement.

However, with the rapid development of medical technology, the meaning of "informed consent" has changed to one in which, when several possible methods of treatment are available, the practitioner explains the advantages and disadvantages of the different methods so that the patient can choose the method to be used.

It is worth mentioning here that informed consent, despite seeming obvious to many, has not yet been uniformly adopted throughout Japan. In fact, only 46 percent of patients with less than half a year to live are provided with the related information (while 96% of their families are informed). This situation clearly indicates the tendency not to provide information to patients who are approaching death. Of course, there may be instances where providing information discourages a patient and worsens his/her overall condition. In fact, continuing a situation where the patient is ignored would obviously be a problem.

Progress is rapidly being made in medical technology and many therapeutic techniques are available. When we have a choice of methods of treatment, the practitioner has a responsibility to explain the advantages and disadvantages of each to the patient (thus allowing the patient to decide which treatment method he or she wishes to pursue). Cancer is responsible for one-third of all deaths, and had usually been treated by surgery in the past. However, increased attention is now being given to the efficacy of treatment by anticancer drugs and radiation therapy. However, doctors cannot explain the selection of medical treatments and patients are not informed of the availability of these treatments. If Japanese doctors continue to avoid the concept of informed consent, cancer patients are denied the opportunity to select and receive the treatments that might enable them to live longer.

The introduction of new drugs also raises some problems. New drugs are tested on animals and then humans, after which they are approved or disapproved for medical use. Compared to the United States, Japan's approval process takes much longer. The approval period is shorter in the United States because there are many patients who are willing to participate in the human testing phase of a new drug, despite the risk. Provided that patients are aware of the risks associated with new drugs and if they are able to choose to use such drugs by themselves, the pace of the development of new drugs will obviously increase.

In Japan, however, new drugs that are already being used in the United States still require several years of

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medical trials before they can be approved for use. As a result, about one-third of the drugs that are commonly available for cancer treatment in the United States cannot be used in Japan. It would be an improvement if we could use American experimental data in order to shorten the trial period.

We should also start providing patients with drugs that have been approved for use in Europe and the United States, even though the drugs are still undergoing trials in Japan. While drugs that are still undergoing testing do present some risk, the use of such drugs should be proposed to patients for whom no other treatment is available, provided the risk is fully explained. Patients should have the right to decide whether to use such drugs based on precise explanations by doctors. That is informed consent itself.

2 Increases in Later-Life Marriages and Infertility Treatment

In Japan, the average age at a couple's first marriage continues to increase. Since 1970, the average age at which women marry for the first time has risen by 3 years, as has the age at which they have their first child (currently 29 years old). Half of the women who gave birth in 2003 were over 30.

Later marriages have led to women giving birth later, while it is estimated that around 500,000 couples are faced with problems of infertility. The most common treatment for infertility is in-vitro fertilization, with 17,000 children being conceived in this way in 2003 (1 out of every 65 births), with the total to date being around 120,000. It seems that if the average marriage age continues to increase, so will the number of children born through in-vitro fertilization.

In-vitro fertilization currently has a rate of success of more than 25 percent. This rate also includes young mothers in their 20s. As the mother's age increases, the likelihood of successful implantation falls, while the chances of a miscarriage increase. Accordingly, women in their late 30s and later have a fairly low chance of conceiving. It is thought that two-thirds of miscarriages are caused by chromosomal aberrations in the fertilized egg, with the probability of such aberrations appearing in the egg, sperm, or implanted egg increasing with the age of the parent.

As one means of preventing in-vitro fertilization from ending in a miscarriage, a pre-implantation diagnosis is performed. The purpose of this diagnosis is to implant the mother only with fertilized eggs that do not have any chromosomal aberrations.

In 2004, an obstetrician in Kobe announced that a woman who had had recurrent miscarriages had given birth through undergoing pre-implantation diagnoses. However, the physician was criticized as supporting the pro-choice movement. This is the same as criticizing abortions.

In the first instance, a woman has the right to choose whether or not she gives birth to a child. Provided it does not adversely affect the well-being of the public as a whole, an individual has the right to pursue his or her own happiness. In the case of a woman, therefore, we cannot deny her the right to choose abortion if giving birth would adversely affect her lifestyle. Abortion is completely legal in those cases where it could endanger the mother's health, or lead to economic hardship. In recent years, the abortion rate has been high, at slightly more than 300,000 cases per year, or about 30 percent of the total number of births.

Between implantation and birth, we refer to the unborn child as the "fetus." Because a fertilized egg that has not yet been implanted, which is the target of criticism by pro-life proponents, has a much lower chance of leading to a live birth, it naturally has much less legal protection than an actual fetus. In fact, given that abortion is legal, we should not make such a fuss about performing pre-implantation diagnoses as a means of preventing recurrent miscarriages. In the first instance, the majority of the fertilized eggs that are discarded would not have been implanted due to chromosomal aberrations.

It is everyone's wish to give birth to a healthy child. To this end, it will be necessary to make fertility treatment more widely available, while relying on pre-implantation diagnoses.

Some people argue strongly that gender selection is against divine providence. However, a study has found that the male to female ratio of babies born through gender selection was 55 percent versus 45 percent, which is the almost same ratio as for natural birth. Because gender selection would have little effect on public welfare, there are basically no grounds for denying gender selection. We must further respect an individual's right to pursue his or her own happiness as stipulated under Article 13 of the Constitution.

In the future, personal banks of eggs seem positioned to present a new issue. This system involves the harvesting of eggs while a woman is young, and then keeping those eggs in cryogenic storage. In Japan's metropolitan areas, it is believed that 50 percent of all women under 30 are single. Given that these women are marrying in their late 30s, it is inevitable that problems associated with infertility will increase. In the United States, it is said that the success rate of in-vitro fertilization using eggs provided by young women is around 50 percent. To give women greater freedom, we need to accept the use of these "personal egg banks" where women can cryogenically store eggs harvested up to their early 30s.

3 Organ Transplant Laws

In Japan, the Organ Transplant Law was passed in 1997. Table 8 lists the annual number of transplants performed. In 2002, 2,155 heart transplants were performed in the

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Table 8. Number of Organ Transplants from Brain-Dead and Living Donors in Advanced Nations (2002)

		Heart	Lung	Liver
Japan	Brain-dead Living	5 –	4 12	7 433
US	Brain-dead Living	2,155 –	1,029 –	4,964 361
Germany	Brain-dead Living	380 –	183 –	671 85
UK	Brain-dead Living	158 –	112 –	695 2

Note: Figures are based on surveys by transplant-related organizations in each country.

United States and 380 were performed in Germany, while only 5 were performed in Japan (the total number of donations from brain-dead donors was 36). In 2001, 2,249 kidney transplants were performed in Germany, but 10, 200 patients are currently waiting for transplants at a wait of six years. Possible means of shortening this wait time have again become an issue to the extent that there is even talk of buying and selling organs. In terms of organ transplants, Japan lags far behind the United States, Germany and the United Kingdom.

The first reason why Japan performs so few transplants, especially compared to Europe and the United States where they are commonplace, is that we have failed to come to a consensus on adopting brain death as the definition of death (under the circumstances where the use of artificial hearts is increasing, many people still define death as cardiac death). To overcome the Japanese reluctance towards organ transplants, our society as a whole must come to recognize brain death as a state where personality has been irreversibly lost and as the death of a person, even if the donor's heart is still beating.

While cardiac death was accepted as being the definition of death in the past, respirators nowadays enable us to keep a person's heart beating even after the brain has died. In Europe and the United States, organ transplants have become a possibility with advances in medical science and society accepting brain death as the definition of death. In order to form a consensus on the acceptance of brain death as the definition of death as is accepted in Europe and the United States, education is needed to promote the acceptance of brain death in Japan as well as the adoption of donor cards (indicating one's intention to provide one's organs after brain death). The act of providing one's organs to a living person after one's own death is an altruistic gesture towards one's own society.

The second reason for the low number of transplants in Japan is that the intentions of the deceased's family are often seen as having a greater weight in the eyes of the law than those of the person himself. As things stand currently, even if a person wishes to have his or her organs donated after death, this is not possible if the family objects. If our wish to donate our organs is clearly stated by carrying a donor card, our wishes should take priority regardless of the intentions of our family.

In many cases, there is a tendency for the intentions of the family to take precedence over those of the patient, as suggested by the fact that a doctor will communicate about such matters with the family members rather than with the patient. If we are to respect the decision of the patient, priority must be given to the patient's intentions under the amendment to the Organ Transplant Law in the future.

Another problem that we must consider when promoting organ transplant is how to handle those situations where the intentions of the individual are unclear. To increase the supply of organs available for transplant, some countries in Europe have adopted a system whereby it is assumed that an individual agrees to donate organs unless specifically stating otherwise. In Japan, we must at least establish a system whereby we can gain consent from a patient's family when the patient has not made his/her intentions clear.

In order to save the lives of many people, we should push ahead with system reform. It merits consideration to introduce rules to give priority to persons carrying organ donor cards in providing organs.

In addition to organ donation, another topic that has long been the subject of an ongoing debate is the use of aborted fetuses for research. As yet, we seem to be far from any conclusion on this issue. Many researchers believe that stem cells taken from aborted fetuses could be used to treat Parkinson's disease, etc. Once organ donation presuming brain death has been accepted, there will be no strong reasons for prohibiting the use of aborted fetuses for research on moral grounds. We must establish a system whereby aborted fetuses can be used for research provided, of course, that appropriate consent is obtained from the mother based on her rational decision.

For all issues including pre-implantation diagnosis, the use of aborted fetuses, personal egg banks and organ donation, we must give priority to the right of an individual to make his or her own decisions rather than the traditional values of family and society.

4 Death with Dignity

Since 1998, the annual number of suicides has remained steady at about 30,000 (32,000 in 2004). While this is the highest level among industrialized nations, our rules about euthanasia are very strict. As a prerequisite to accepting euthanasia, we must ensure that the following four conditions are satisfied (as determined by the Yokohama District Court, 1995).

- There is unbearable pain
- Death would, in any case, come soon
- No other course of action is available

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- There is an explicit intention of the patient to accept euthanasia

However, it may be difficult for a patient who is facing death to make his or her intentions clear and, in fact, doctors who help patients end their lives are legally guilty of causing the patient's death. In a similar vein, a mother whose son was suffering from amyotrophic lateral sclerosis and who complied with his wishes by turning off his ventilator was also held responsible for her actions. The court even made no mention of the possibility of her being justified in complying with her son's wishes to help him die with dignity. At present, we can do nothing under the law to help terminal patients die with dignity.

In the Netherlands, if a person carries a so-called "life passport" in which a person makes it clear that he/she wishes euthanasia and the method that they wish to use for euthanasia is indicated, euthanasia is possible even if a person cannot make his/her intentions clear as death approaches.

A distinctive feature of euthanasia in the Netherlands is that it is not based solely on physical pain during the last few days of life. Euthanasia is accepted for a person who does not wish to tolerate the worst symptoms of cognitive disorder (based on his/her intentions before the onset of symptoms). Euthanasia of minors, aged 12 to 16, is also acceptable with the consent of the parents. There is also a movement to give over-75s the right to possess drugs for ending their own lives, but perhaps unsurprisingly this has yet to be accepted by the population as a whole.

In the Netherlands, the thinking is that anything that does not harm others cannot be regarded as a crime. Thus, prostitution and narcotics are not illegal. Behind this legalization is a mindset that seeks to prevent the spread of illegal acts/businesses by legalizing them. By taking the point of view that a person is free to choose how to lead one's life, including death as part of a person's life, euthanasia has also been legalized.

Euthanasia is currently legal in both the Netherlands and Belgium. Also, in Oregon in the United States and in Switzerland, there are specific procedures whereby a doctor can prescribe a lethal dose of drugs that can be given to a patient who is facing death. The patient takes such drugs at the patient's own will. In Japan, at the very least we have need for a system such as that used in Oregon, whereby a person can die with dignity, while clarifying the law so doctors are justified in their actions, and to give people facing death the hope of dying with dignity.

5 Self-Determination and a Spirit of Altruism

Provided they do not affect the well-being of others around them, individuals have the right to pursue their own happiness. The issues of life and death are also thought of as being individual matters. However, we have yet to form a consensus with respect to euthanasia, fertility treatment and organ transplants. We are also lagging behind the world in accepting brain death as the definition of death. Partly due to such delays, fewer than a total of 50 transplants from deceased donors have so far been performed.

We recently saw a living donor case whereby a member of the Diet donated a kidney to his father. Over the last seven years, living-donor kidney transplants have been performed over 1000 times even through risks accompany such procedures. Given the risks associated with living-donor transplants, we need to move toward accepting brain death to enable organ transplants and abandon our current ways of thinking that prevent transplants from brain-dead donors. We need to reform the current system to provide help to many in need.

As society changes, it seems that the spirit of altruism is fading. Around ten years ago, there were 6.6 million blood donors. However, by 2003, the number had fallen by 1 million to 5.6 million. Similarly, the foster family system (for children who cannot be cared for by their parents) had 6,000 families registered at its peak. However, even with an increase in the number of abused children and a need for more foster families, there are currently fewer than 2000 foster families.

One of the reasons why transplants from brain-dead donors are not popular is that our spirit of altruism is being lost. There is need for a consensus within society while we push forward with law reforms to further respect the right of a person to make his or her own decisions, including death with dignity, so as to provide support to those persons who come face to face with difficulties such as serious illness.

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