Right to Health and Access to Health Services

Japan Support Centre for Activity and Research for Older Persons

1 & 2

The right to health is guaranteed by the Constitution (Article 25(1)) and embodied in public health, hygiene, medical insurance and a publicly-funded medical care system. However, national and municipal governments, and even the people, have poor awareness of human rights. Medical workers, including doctors, speak of medical ethics but are ignorant of right to health as international norms.

The government stresses personal responsibility for individuals' health and is strengthening the social security policy to provide "minimal" assistance, not "highest attainable standard of health".

The double burden of mandatory medical insurance premiums plus out-of-pocket expenses, which is unique to Japan, has increased, resulting in more uninsured persons, reduced access to medical care, and reported cases of serious illness and death.

Furthermore, in rural and underpopulated communities, the number of national, municipal and public medical facilities has fallen since 1980s due to consolidation and realignment, which has worsened access to health care for patients and residents.

A healthcare insurance system specifically for adults aged 75 or older was launched in 2008, requiring older persons to pay a premium. This is discriminatory as it lowers the quality of healthcare for older persons compared to that of other age groups.

4

Medical Care Act stipulates that national and prefectural governments and hospital administrators shall provide, or endeavor to provide, training for their workers. However, such training consists of mere explanations of relevant laws and does not address problems in current Japanese health coverage for series situations nor basic principles expressed in international treaties on rights to health and rights of patients.

5

The government has been making minimal, rather than maximum use of resources, hence ignoring the international trend of realizing human rights.

6

Out-of-pocket medical expenses for older persons have continued to rise significantly in recent years. For instance, in 2022, out-of-pocket costs for individuals aged 75 or over and above a certain income threshold rose from 10% to 20%, severely affecting their lives by leading to fewer doctor visits, growing poverty, and deprivation of decent living. While 51.7% of older people said their life was “hard” in 2019, the ratio increased sharply after the Covid-19 pandemic. Answers to a survey by the Japan Senior Citizen’s Council (2022) revealed: 65.5% refrained from buying new clothes or shoes; 62.6% reduced spending on hobbies and leisure; and 38.7% cut socializing expenditure. The increase was badly timed, harshly affecting older persons to the extent that some even said it was a struggle to continue living.

Dealing with Covid-19, the government followed the policy of not allowing infected older persons living in nursing homes to be hospitalized, but made them recuperate in place using the excuse of a shortage of hospital beds. This not only reduced their access to adequate medical care but also caused group infections at many facilities. From a healthcare point of view this was discrimination against nursing home residents. Nursing home staff also voiced their anger.

7

A series of comments made by some state ministers and influential legislators include “It’s not about eliminating discrimination. Healthcare is not necessary for older persons. Living long is a nuisance.” A system of low medical quality and standards has long been continued where long-term care wards accommodate older patients at severe chronic stage of decline. Beds where this occurs amount to 290,000 against 890,000 beds for general patients (2021).

8

Based on the Constitution and Medical Care Act, to guarantee self-determination right of patients, doctors have an obligation to inform patients and consent is required from patients before any medical intervention. However, in medical situations where an older individual is unable to express his/her will, treatment is offered in many cases with consent from the family. If it is determined that life-prolonging treatment is of no more benefit, life support is removed from the patient and further medical care is terminated. This kind of “imposed” self-determination is commonly seen in medicine.

Recently the government has been promoting ACP (Advance Care Planning) for medical

care during the final stage of patients' lives as one of the measures to reduce publicly-funded healthcare costs. Although medical costs for the last stage of life (one month before death) are merely 3% of national medical expenses, the government is pushing adoption of ACP hard to cap healthcare costs by encouraging dying at home rather than in a hospital.

9

Persons who are dissatisfied with any action regarding right to health, such as issuance or return of health insurance cards, insurance benefits, and insurance premiums or any other money collected, can request a review based on laws relating to health insurance. Persons can file complaints or ask for consultations at Medical Safety Support Centers established in all prefectures.

10

Both nationally and locally in Japan, the participatory system for groups of concerned parties, namely older persons and patients, is insufficient in the area of healthcare.