Municipal Anxiety about Local *Healthy Japan 21* Plans

Kei Kudo [1)]

Abstract

The Japanese health policymaking system traditionally consisted of the central government (the Japanese Ministry of Health Labour and Welfare), prefectures, and municipalities. This system is the so-called "three-decker" system. The central government legislated for health, the prefectures (i.e. prefectural health centers) developed prefectural health policies according to the nation's health laws, and the municipalities (i.e. municipal health centers) carried out these prefectural health policies. In 1994, the Community Health Law was introduced. The key concept of the new law is decentralization. This law transformed the traditional three-decker system for health policymaking, and now inexperienced bureaucrats must do the municipal local health planning instead having it done by prefectural health centers. Many municipalities have been unable to develop the local plans which the Ministry of Health Labour and Welfare requests, and prefectural health centers have not been able to effectively support the municipalities. This situation suggests that municipal policymaking ability should be upgraded.

Key words : *Healthy Japan 21*, Health policymaking system, Community health law, Prefectural health center, municipality

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Introduction

The Japanese Ministry of Health Labour and Welfare presented a ten-year plan, "National Health Promotion Movement in the 21st Century (*Healthy Japan 21*)," covering the period from 2001 to 2010. This *Healthy Japan 21* plan is equivalent to the UK's *Our Healthier Nation* and the USA's *Healthy People 2000*. *Healthy Japan 21* has numerical targets (landmarks by which the results of the plan can be evaluated) for each health field for the first time in Japan. At first *Healthy Japan 21*, however, was not linked to law and later formalized by Health Promotion Law in 2002. The Ministry of Health Labour and Welfare developed the *Healthy Japan 21* project as third-phase measures for the promotion of national health. The first-phase measures for national health promotion, which improved both the health examination system for early detection of disease without symptoms and the early treatment of diseases and developed facilities such as municipal health centers, began in 1978. The second-phase measures promoting healthy lifestyles for disease prevention started in 1988. Then, in April 2001 *Healthy Japan 21* started as third-phase measures. *Healthy Japan 21*, based on scientific evidence, intends to promote comprehensive efforts to expand lifelong health and to enhance quality of life by setting objectives for improving nutrition, diet, exercises, and relaxation, each of which can be related to such lifestyle-connected diseases as cancer, cardiac disease, cerebral apoplexy and diabetes.

Regional *Healthy Japan 21* plans

Japan consists of 47 prefectures, so there are 47 prefectural governments plus approximately 3,200 municipalities[1]. The prefectural governments support and advise the municipalities. By the end of 2002, the prefectural governments had developed prefectural *Healthy Japan 21* plans. These prefectural plans are obligatory for prefectural local governments under the new Health Promotion Law induced in 2002. On the other hand, municipal *Healthy Japan 21* plans are not obligatory. However, the municipalities provide prenatal care, other health check-ups, and immunizations, services for the disabled and the elderly and health education, so the municipalities play a crucial role in health services. In 1994, the Community Health Law was enacted and under it most health services, except for those related to AIDS, tuberculosis and some rare incurable diseases, are the responsibility of the municipalities and the prefectural health centers prepare regional health plans and provide support for the municipal health plans.

Although the municipalities intend to develop municipal *Healthy Japan 21* plans, if possible, many municipalities have been unable to, because these they do not have the capabilities necessary for developing such long-term health plans with numerical targets. However, the Ministry of Health Labour and Welfare provides technical support for municipal planning. For example, it develops statistical databases of various health data and distributes guidelines on "local health planning"[1]. Also, the Ministry of Health Labour and Welfare holds training frequent sessions on how to develop regional *Healthy Japan 21* plans for prefectural and municipal personnel. Unfortunately, no more than half of the 3,200 municipalities are expected to have prepared municipal plans by 2005. So far, the national technical support system has not functioned very well.

Japanese public health service and local health policies

Japanese public health service consists of the so-call "hierarchical three-decker" service system. The Ministry of Health Labour and Welfare decides national policy by introducing health laws and issuing circulars and notices for prefectural governments. In turn, the prefectural governments (prefectural health centers) support the municipalities (municipal health centers) that provide almost all direct public health services. Under the Health Center Law, which was introduced in 1937 and amended in 1946, the prefectural governments supervised the municipalities and controlled municipal public health services until 1996. After the Health Center Law

was transformed into the Community Health Law in 1997, the municipalities provided public health services politically independently of the prefectural governments, which now play a support role for the municipalities' health policies. Most municipalities, however, do not yet have the capability to plan effective local health policies. Traditionally, in Japan there has been a strong tendency toward political centralization. The Collective Decentralization Law came into effect on April of 2000 for the purpose of establishing an equal and cooperative relationship between the central and the local governments. The local governments are now expected to carry out the administrative work for themselves. So, quite recently, the Japanese government (the central government) adopted decentralization as a basic national policy. Until then, Japanese municipalities were accustomed to providing public health policies in obedience to the prefectural governments (i.e. prefectural health centers), which in turn were following the central government's policy. Moreover, in some prefectural governments, staff members from the Ministry of Health Labour and Welfare were occasionally appointed to multiyear, meaningful posts in the prefectural governments. These people then administered local public health policies in strict obedience to the central government. Thus, local prefectural governments and municipalities did not previously need to be engaged in the planning of a local administration system. Now, inexperienced local municipal policy makers, who are usually public health nurses[2] or clerical officers, must prepare the regional plan by themselves. Therefore, guidelines of all kinds from the Ministry of Health Labour and Welfare are literally bibles for local health policy makers nowadays. The municipalities develop their plans from these guidelines, and the prefectures support the municipalities' efforts by virtue of these guidelines.

Who prepares regional *Healthy Japan 21* plans?

In the Japanese prefectures, clerical officers, public health nurses and medical doctors, whose specialties are public health, make local prefectural health policies. There are also prefectural health centers, where the directors are medical doctors. So, the Japanese prefectures at least have the capacity to develop policy independently of the central government. All 47 prefectures have prepared prefectural *Healthy Japan 21* plans, which have numerical targets corresponding to the nation's plan.

On the other hand, the municipalities (i.e. municipal health centers) are not staffed by medical doctors. In the municipalities, public health nurses or clerical officers generally develop the health plans. When clerical officers make a health policy, they usually consult the public health nurses. Sometimes municipalities employ private think tanks (consultants) to develop the health plans. Since the municipalities are not obligated by law to make *Healthy Japan 21* plans but are requested to develop policies if possible, most municipalities do not employ such organizations in light of various budget restrictions. Consequently, public health nurses and clerical officers do the vast majority of *Healthy Japan 21* planning. Public health nurses, however, are essentially educated to play the role of community health worker, so they are frequently not academically prepared to make health policy. Most Japanese public health nurses attend a 1-year course for public health nurses after graduating from a 3-year nursing school. Only a few of the public health nurses have graduated from a university. Therefore, most public health nurses have not studied policymaking or politics as part of their formal school education.

It is prefectural health centers that support municipalities for making health policies.
Unfortunately, so far, this support has not been very effective. The Community health law halved the number of prefectural health centers to match the secondary medical care zones, which are legally defined for the prefecture by Medical Service Law for the purpose of providing necessary medical care services within residential areas and for systematizing community medical services[3]. The zones which

the prefectural health centers cover are consistent with the secondary medical care zones, but current prefectural health centers must support twice as many municipalities. So, there is a strong possibility that prefectural health centers do not understand the municipalities' capabilities well and thus are not able to support municipalities very well. Consequently, no more than half of the 3,200 municipalities are expected to have prepared municipal plans by 2005.

Are there flaws in the guideline from the nation?

The prefectural health centers support the municipalities by using the guidelines from the Ministry of Health Labour and Welfare and the municipalities make their plans based on these guidelines. There appear to be some flaws in the guideline so that no more than half of the 3,200 municipalities are able to make regional plans, even with the prefectural health centers' support.

Strangely, the guideline[1] on "Local health planning for regional local *Healthy Japan 21* plans", which was distributed by the Ministry of Health Labour and Welfare, does not explain how to set the numerical targets in the plans. Instead of numerical targets, the guideline emphasizes the participation of citizens in all aspects the planning process. The nation's and prefectures' *Healthy Japan 21* plans have numerical targets, however, the municipal *Healthy Japan 21* plans do not have numerical targets at present. This discrepancy is probably due to this guideline.

The participation of citizens essentially makes the citizens involved in making their own healthy communities and organizing healthy lives for themselves. Thus, the participation of citizens is a potent factor in health education. On the other hand, the participation of citizens in the process of developing regional *Healthy Japan 21* plans could cause confusion for local policy makers due to amateurish opinions from citizens who do not really understand the concepts of health planning. Under these circumstances, some public health personalities, who are so charismatic that they can easily control unbridled opinions from the citizens, are popular in Japanese public health community. Books and manuals about methodologies for the participation of citizens written by these people also sell well. Moreover, many municipalities frequently invite them to give presentations on the participation of citizens, and they are becoming undeservedly popular and their ideas uncritically accepted. Since there are, however, as many as 3,200 municipalities in Japan, even these personalities cannot affect all the municipalities. Furthermore, we cannot learn from their methodology, because their methodology itself depends not on scientific logic but on their individual charisma. These charismatic public health personalities are concerned with promoting their own reputations and their books. Thus, the participation of citizens is bottleneck for many municipalities trying to develop their *Healthy Japan 21* plans, because they cannot plan without charismatic personalities.

There is a possibility that the participation of citizens has another flaw. Epidemiologically, the participation of citizens contains a "selection bias" in recruiting participants from the citizens for planning regional *Healthy Japan 21* plans. The citizens, who participate voluntarily, are relatively healthy and affluent in their community, so they can easily afford to attend planning committee meetings for the local plan. Without deliberation on the selection of participants from community, regional local *Healthy Japan 21* plans might be planned for the sake of relatively healthy and affluent citizens. Nowadays, health plans inevitably require equity-oriented and poverty-alleviation strategies. So, there is a possibility that the participation of citizens deteriorates the validity of public health planning. Unfortunately, the guideline does not mention such the potential bias in citizens' participation, but merely recommends the participation of citizens without due deliberation.

The guideline from the nation is not suitable for municipalities and prefectures in regard to developing local *Healthy Japan 21* plans, because it mainly consists of theories from charismatic public health researchers.

The Japanese public health education system of public health doctors and nurses is still very fragile[2] so some public health staffs depend on charismatic methods rather than the scientific method.

Conclusion

The Japanese public health research community ought to have an important part to play in distinguishing charisma from science, and supporting public health staffs by proposing scientific methodologies for developing public health plans[3]. The Japanese Ministry of Health Labour and Welfare also should never lose sight of research and evaluation in health policy training for the prefectures and municipalities. Although the Community Health Law halved the number of prefectural health centers, the Ministry of Health Labour and Welfare and the prefectures ought to study the municipalities' actual abilities independent of charismatic researchers.

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Note

1 At the municipal level, 109 cabinet order-designated cities and 24 special wards have their own health centers which are equivalent to a prefectural health center. To avoid confusion, in this paper the term 'municipalities' does not include these cabinet order-designated cites nor the special wards.

2 In this paper, public health nurses includes male public health nurses, although there are only a few male public health nurses in Japan.

3 In Japan, primary, secondary and tertiary medical care zones are defined by the prefectures under the Medical Service Law to meet the increasingly diversified medical needs of people. Primary medical care zones are covered by one clinic or hospital. Secondary medical care zones are where ordinary diseases (except for heart transplantation for example) can be diagnosed and treated. Usually, tertiary medical care zones are a whole prefecture.

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