Development of Clinic Based Health Promotion Program in Kitakyushu, Japan

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Abstract
The health reform program in 2006 was the biggest one for the last 30 years in Japan. According to the plan a nation-wide health promotion program for healthier population will be introduced. As a main program of health promotion, the specified health checkup and follow-up health guidance and intervention program will be introduced from 2008. This program is a Japanese disease management program. However, it is predicted that the new program will face to a number of operational difficulties, especially in the community setting, where not so much resources are available. In order to make the system more practical and operational, we have developed the clinic based health promotion program under the collaboration of local medical association, local government, and university. In this article the authors presents the general feature of this new program.

Key words: health reform 2006, health promotion, disease management, local medical association, Kitakyushu model

Introduction
Along with the socio-economic development, the Japanese disease structure has changed from the acute diseases dominant to the lifestyle-related chronic diseases dominant pattern. Lifestyle-related diseases are defined as the group of diseases in which such lifestyle as the habits of eating, exercise, rest, smoking and drinking contribute to their outbreak and development.

As reported previously1), the life style related diseases account for two third of death, one third of health expenditures in Japan. In order to realize a healthy nation, Ministry of Helath, Labour and Welfare (MHLW) has published the Health care reform plan in 2006. According to the new law, for insureds over 40 years old is introduced a new health promotion program, so called “the specified health checkup and intervention program”. It is obligatory for public health insurers from April, 2008. The main target of the specified health check-ups is so called Metabolic Syndrome. It is planned that the insured are to be stratified into 3 groups for the following health promotion programs according to the checkup results.

MHLW has launched a series of feasibiolity studies of new program in 2006 and 2007. According to the results, there have been many points to be amended in order to make this new program “feasible”. For example, it is indicated that the new system is too heavy and complicated to cover the entire population, especially in the community setting. Considering the actual constraints in available materials and human resources, we have developed a physician’s office based model for the new program. This system uses the already existed network in the community. In this article, we would like to explain this new model, so called “Kitakyushu model” as one of...
the most feasible options for the specified health checkup and intervention program from April, 2008.

❖ Health Check-up Program in Kitakyushu City

According to the Health and Medical Service Law for the Elderly, the municipal government has been required to organize a series of preventive activities and health promotion programs. These activities include annual health check up, health education, community rehabilitation services, home visit by public health nurses for the frail elderly and handicapped, etc. The expenditures required for these activities is borne one third each by the state, the prefecture government, and the municipalities, although individuals are charged part of the cost for the health check up. The people over 40 years old who are not covered by the health check up program by the Occupational Safety and Health Law are eligible for these programs.

In the case of Kitakyushu city, members of the local branch of the Japan Medical Association (Kitakyushu Medical Association) have been contributing to this scheme to great extent as shown in Figure 1. The Kitakyushu Medical Association makes a contract with the Kitakyushu city office to offer preventive services for the inhabitants. A citizen can receive above-mentioned public health services at the office of contracted practitioners. The physician sends the results of each individual to the municipal office, and then according to the results, municipal public health nurses offer the follow-up services, such as individual counseling, health education, and home visit, if necessary.

Based on this collaboration, Kitakyushu city has constructed a various kind of community health services, such as screening program for the pregnant women and children, school health program, and ADL prevention program under the Long Term Care Insurance.

❖ The Specified Health Checkup and Intervention Program

As a main program of Health Care Reform 2006, the specified health checkup and follow-up health guidance and intervention program will be introduced from 2008. Figure 2 shows the system. All public health insurers have to organize health check-up and the following health promotion programs for the insured over 40 years old. The main target of screening is “Metabolic syndrome”.

* HMSLE: Health and Medical Service Law for the Elderly
** Citizens who are not covered by the Occupational Safety and Health Law

Figure 1 Kitakyushu model of health services for under the HMSLE*
A standardized computer program was developed for the stratification of recipients. The insured is categorized into one of three levels according to their risk level; active support required, giving incentive required, only information required. If an insured is evaluated as active support required or giving incentive required, he/she must follow a standardized disease management program that is offered by the health support organization contracted with the insurers.

According to the results of model projects in 2005 and the estimation of MHLW, 13% and 11% of insured will be categorized for active support required and giving incentive required, respectively. This result indicates that one fifth of the Japanese between 40 and 74 have to receive some kinds of health education. There are many critics for the operational feasibility of program, proposing the modification of program.

In the case of occupational setting, the employer is required to organize the annual health check-up program for the employee. This program can substitute the new health check-up program. Therefore it will be relatively easy for the Employee Medical Insurance Scheme (Note 1). On the contrary, the situation is very hard for the National Health Insurance scheme that covers self-employers and the retired.

Kitakyushu Model for “The Specified Health Checkup and Intervention Program”

As mentioned in the preceding section, under the new program, all citizens of 40 years old and more must receive the annual health check up. In the case of the employee under the Employee Medical Insurance (EMI) scheme, as the Occupational Safety and Health law requires for employee to organize it, it will be relatively easy to adapt to the new program. On the contrary, the NHI scheme does not have such pre-existed system. Therefore it is a very critical issue for NHI how to organize the health check up and following health education system under the new law.

As most of the insured between 40 and 75 under the NHI are self-employed, it is rather difficult to participate at the health check up that is prefixed by the insurer for time and place. So that it will be very reasonable to prepare the access points for new program as many as possible in order that the NHI insured can receive the health check up and health education at their convenient time and place.

As a model case of such a system, in Kitakyushu city, we have developed a model for the specified health checkup and follow-up health guidance and intervention program, based on the experience of...
clinic based health promotion program under the Health and Medical Service Law for the Elderly. Figure 3 shows the system. The Kitakyushu NHI will make a contract with Kitakyushu Medical Association for the operation of new program. A NHI insured receives health check up at the member physician’s office. The laboratory samples are transferred to the contracted laboratories. They examine the sample and send the labo-data to the NHI office by the standardized electric format. The NHI office stratifies the insured into the three intervention classes and determines the insurers for health education. The selected insured receives the letter from NHI and recommended to receive health education program at the physician’s office where he/she has received the health check up. The physician sends a report to the NHI via Kitakyushu Medical Association office and receives the payment.

For the 2007 feasibility study, the sixteen clinics are participating. Most of participating doctors positively evaluate this system being manageable and feasible. From April 2008, this Kitakyushu model will be extended to other member physicians of Kitakyushu Medical Association. In order to operate the system efficiently and appropriately, the IT system is planned to be equipped. The detail of system was already explained in the previous article2).

❖ Future Perspectives

We regard that the Kitakyushu model will be one of the most practical and reasonable solutions for the local NHI fund and that will be adapted in other local Medical Associations. In fact, we have received many contacts since the first presentation of this system in September 2007.

Another important motivation of the development of Kitakyushu model is to construct an integrated health care system for the aged society. Even though the new program succeed to control the body weight of high risk individuals, finally most of them will develop some life style related diseases. This situation requires a medical treatment. In order to offer appropriate treatment, it is necessary to organize an integrated service delivery system which covers from the primary prevention to treatment and tertiary prevention. The Kitakyushu model offers each physician’s office a new function to assure the continuity of care. In this way we will be able to bridge the two disease management programs: one for high risk
“healthy person” and the other for chronic diseases patient.

From 2008 we are planning to develop the Japanese model of Disease Management based on the Kitakyushu model. The Japanese Physician Law and Health Service Law prohibit the medical practice by non-medical professional. Therefore in the Japanese health system it is difficult to develop the business model of the American type of Disease Management, that the for-profit private DM company directly offer their service to the patient. The DM support service that is used by medical professional will be the most acceptable and feasible in the Japanese health care system.

Now we are planning to construct the Kitakyushu DM model based on this concept. We would like to report the results of coming feasibility study in the future literature.

❖ Note 1 The Japanese Health Insurance Scheme

Japan’s universal health insurance system, which covers the country’s 120 million population, is segmented according to workplace and living place. The type of company one works for determines the insurance society to which one belongs and the financial contributions one must make. The health insurance scheme is categorized into two basic groups according to age and employment status; Employee’s Medical Insurance scheme (EMI) for employers and their dependants, and National Health Insurance scheme (NHI) for self-employed, farmers, retired and their dependent.

In the case of EMI, each enterprise organizes its health insurance fund. The contribution rate is about 8.5% of the salary and generally one half comes from the employee and the rest from the employer. In the case of a small company, the health insurance fund is substituted by a governmental organization (the Seikan-Kenpo).

In the case of NHI, each municipality (or their association) organizes its NHI fund and gathers a premium from the insured. The formula of calculation of the premium is different among the funds to some extent, but basically based on the income, the number of family members, and the amounts of other wealth (i.e., land) of each household.

❖ References