

NURSING IN JAPAN



Japanese Nursing Association

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Preface

In Japan, the population is aging faster than in other countries and the birth rate is declining. This is causing concerns about social infrastructure becoming weaker and inequality spreading at many levels. Additionally, there are challenges related to health and medical care because the groups of people who need them are getting larger and more diverse. This makes it harder to meet the increasing demand and also harder to maintain quality.

As Japan's demographics change, society is also changing gradually. A key target for current policies is the year 2025, when the challenge of an aging population is expected to shift rapidly from being about the speed of aging to the high percentage of elderly people. To prepare for this, the Japanese government is promoting the Community-based Integrated Care System that supports home-based care for mainly the elderly by 2025.

Under these circumstances, the Japanese Nursing Association (JNA) developed and published the "Future Vision of Nursing" in June 2015. Considering the nature of nursing that takes perspectives of both medical care and living, the vision reiterates the value of "Nursing that Supports and Sustains Human Life, Living and Dignity". To support this vision, the JNA shared a 10-year action plan that runs until 2025 to promote nursing in various community settings and has been working on projects to achieve this goal.

Five years have passed since the announcement of the vision, and discussions have already begun on what lies ahead beyond 2025. There is an urgent need to establish a social security system for all generations, including not only the elderly, but also people with disabilities, children, those living in poverty, and even healthy individuals with latent needs.

We have already reached the point where we must consider the next vision for nursing, looking ahead to 2025 and beyond. The rise of non-communicable diseases (NCDs) and the progress of diversity are affecting the concept of "health". Physical, mental, and social well-being have become increasingly important following the COVID-19 pandemic. As such, we hope to present a vision of nursing that can make a significant contribution to sustaining universal health coverage (UHC) well into the future.

"Nursing in Japan" has been published by the JNA since 2005. It introduces the institutional framework in Japan for nursing professional qualifications, the nursing delivery system, and more. This edition is the first update in six years, since the 2016 edition, and the first after the COVID-19 pandemic. It summarizes the current framework of nursing, its historical development, and current challenges in a compact manner. Japan is recognized in international comparisons as a country that achieved UHC early on. Needless to say that discussions on reforming the system to sustain and enhance UHC in Japan are a valuable experience. Given this context, we hope that this booklet will deepen understanding of Japanese nursing among many countries and people involved in global health and provide an opportunity to discuss common issues related to achieving and sustaining UHC.

I . Overview of Social Security System in Japan

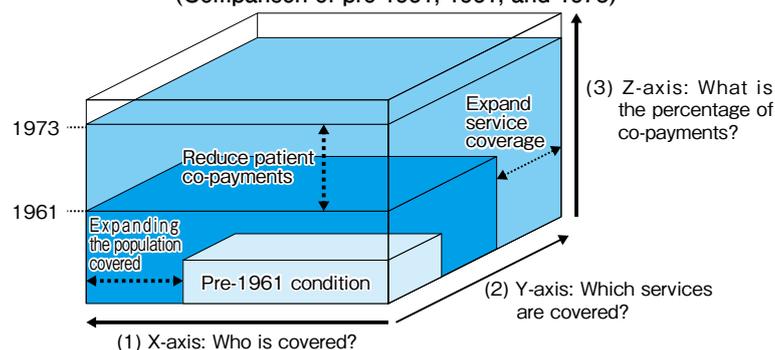
1. Universal Health Coverage in Japan

In Japan, the provision of health care services to all people, one of the three components of universal health coverage (UHC), was achieved with the introduction of universal health insurance in 1961 (Figure 1-1). Subsequently, efforts were made to expand the services covered and reduce co-payments, and UHC was largely achieved by 1973. As a result, Japan has been recognized for extending life expectancy to the highest level in the world, reducing health disparities, and achieving a high standard of health care.

However, in recent years, it has been pointed out that disparities in health care accessibility exist within the universal health

insurance system, based on socioeconomic factors such as income and occupation.^{1,2)} There have also been concerns about regional disparities in medical care due to an uneven distribution of doctors and nurses. Despite the significant social changes expected due to a decreasing working-age population as the birth rate declines, extreme population aging, and the concentration of the population in urban areas, the challenge is to build a high-quality health care delivery system that makes efficient use of limited health care resources while maintaining the social security and health care insurance systems.

Figure 1-1 Achievement and development of universal health insurance (Comparison of pre-1961, 1961, and 1973)



Source: Kenji Shimazaki: Essence of Japan's Universal Health Coverage: What and how should be conveyed of Japan's experience, FY 2014 International Medical Research and Development Fund (Issue No. 26, Directive 1) Research Report Symposium, "Health Security System: How to apply Japan's experience to UHC in developing countries," Report on July 16, 2015

2. Social Security System and Reform Efforts

1) Overview of the social security system

In Japan, the social security system serves as a safety net to support the security and stability of people's lives. The system consists of four pillars: social insurance, social welfare, public assistance, and health care and public health. It plays a crucial role in supporting people's lives throughout their lifetime. Among these, the system for supporting healthy lifestyles and medical services in case of illness is stipulated in "Health Care and Public Health", and the system for providing medical and long-term care services is stipulated and enhanced in "Social Insurance". Efforts are being made to enhance both systems.

The latter system includes a health care insurance system, which allows anyone who falls ill or gets injured to receive medical care with peace of mind, and a long-term care insurance system that supports, by society as a whole, those who require long-term care as they age. This is a compulsory insurance system that provides in-kind benefits (provision of services) to ensure a healthy lifestyle and has income redistribution as its foundation. According to a 2017 survey, the income gap has narrowed, with a Gini coefficient of 0.3721 after redistribution, compared with 0.5594 for initial income.³⁾

The universal health insurance system, established in 1961 based on the National

Health Insurance Act, introduced the health care insurance system. The long-term care insurance system, established in 2000, was based on the Long-Term Care Insurance Act to address the progress of aging, changes in the social background, and changing demand for services, providing a mechanism for society as a whole to support the elderly in need of care.

2) Population and social security expenses forecasts

As the aging of the population combined with a dwindling birth rate continues to progress, the total population has shifted from an increasing to a decreasing trend since 2010. The total fertility rate in 2021 was 1.30, indicating that the declining trend is expected to continue. Therefore, even if the elderly population begins to gradually decrease after 2040, the aging rate in the total population is expected to remain flat (Figure 1-2). There are regional differences in these demographic changes, which are expected to progress more rapidly in rural areas than in urban

areas.⁴⁵⁾

With the aging of society and other factors, expenditures on social security benefits for public services such as health care, pensions, welfare, and long-term care continue to increase year by year, reaching 1.296 million yen (23.2% of GDP) in 2021 (Figure 1-3). This GDP ratio exceeds the OECD average of 21.4% in 2017 (Figure 1-4). As a result, spending is regularly higher than social insurance premium income, and this difference is financed by a large amount of public funds.

To make the social security system sustainable, the government strengthened financial resources through a consumption tax hike (raised from 5% to 10% in 2019) under the policy of Comprehensive Reform of Social Security and Tax. The government is now making strong efforts (as described in the next section) to address the aging of the baby-boom generation (those born during the first postwar baby boom from 1947 to 1949), with a key target being the year 2025, when 8.06 million baby boomers will be 75 or older.

Figure 1-2 Japan's Population Trends and Outlook

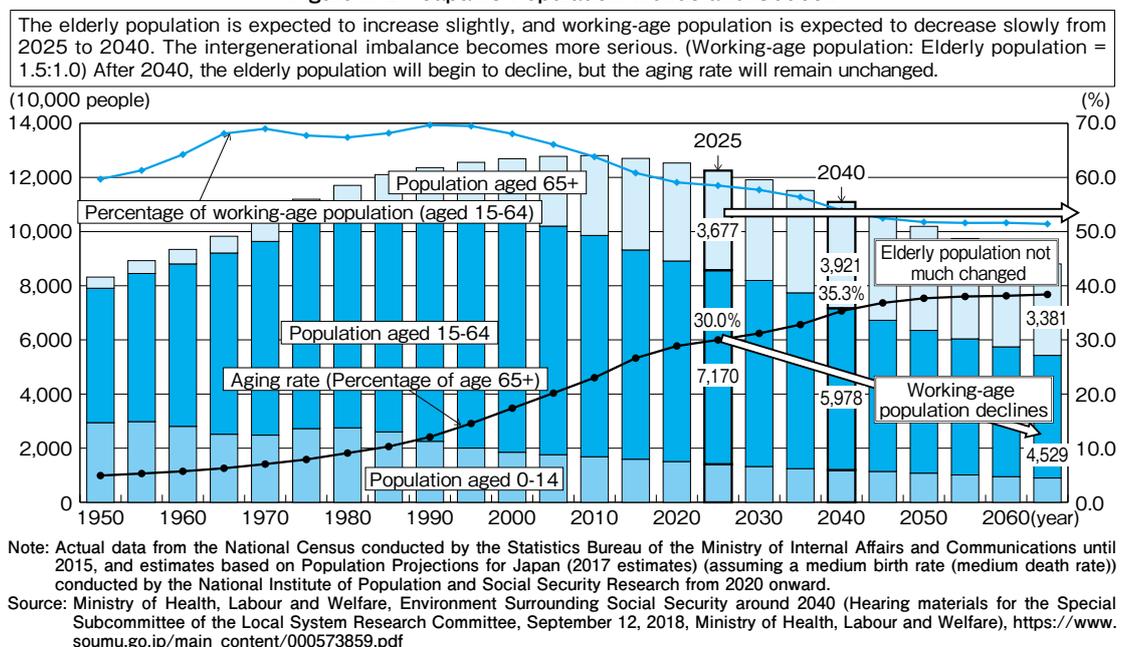
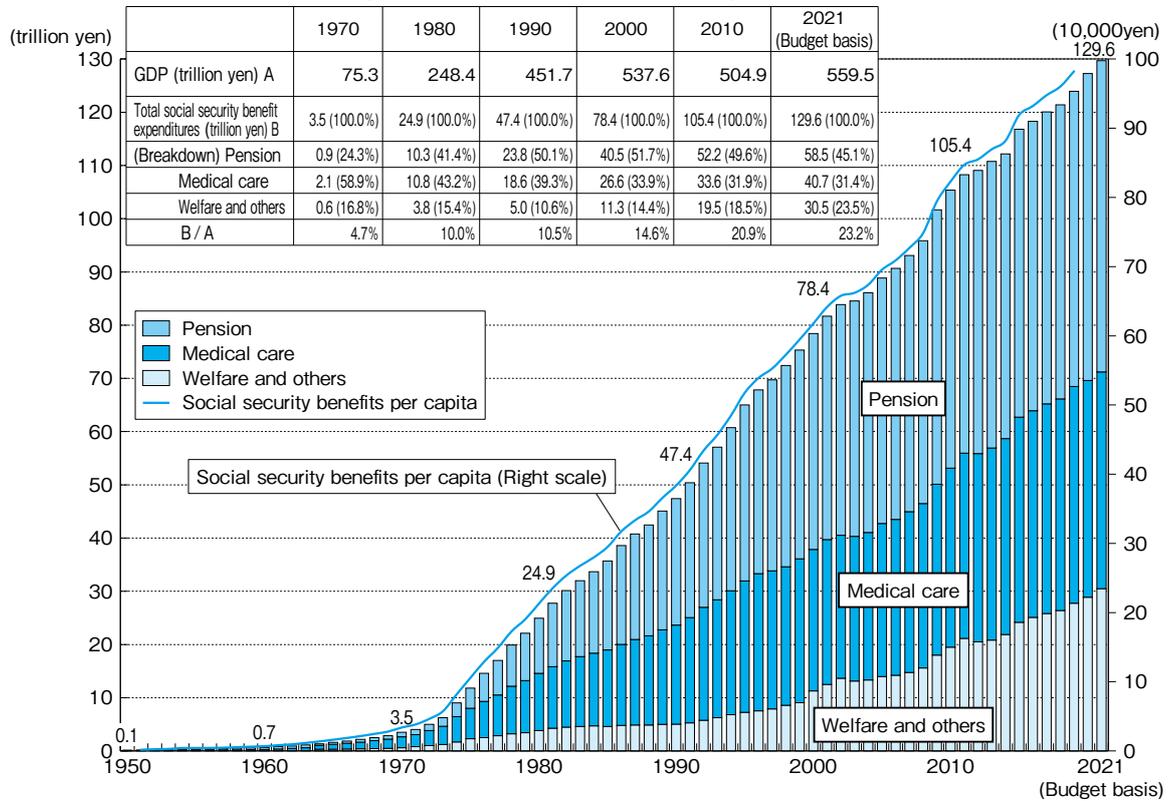


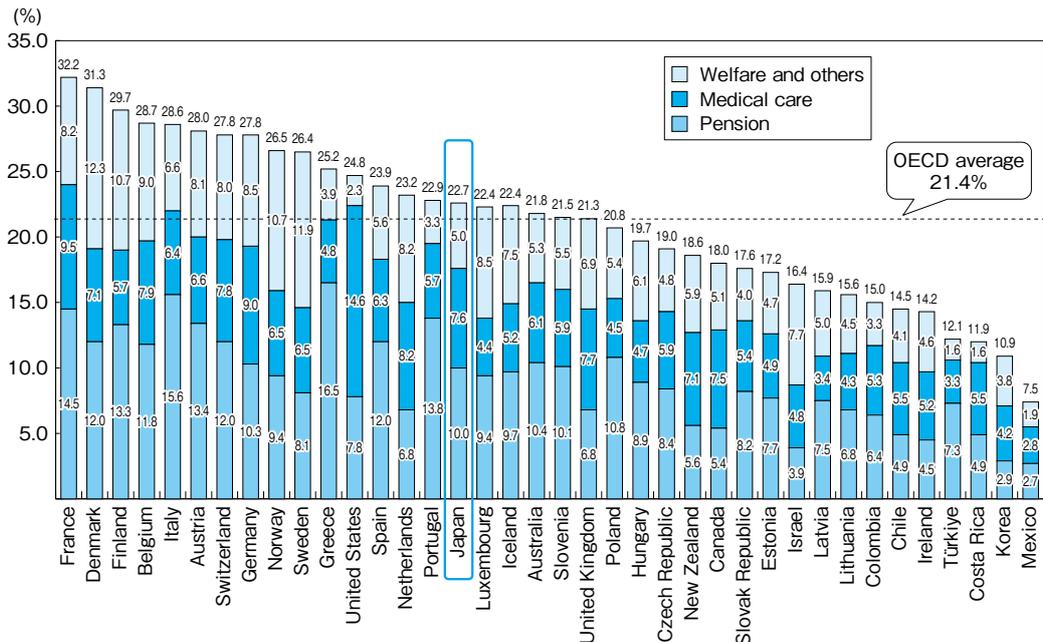
Figure 1-3 Trends in Social Security Benefits



Data: "The Financial Statistics of Social Security in Japan FY 2019" by the National Institute of Population and Social Security Research; the estimates are those of the Ministry of Health, Labour and Welfare for FY 2020 to 2021 (budget basis), and the gross domestic product for FY 2021 is based on the "Fiscal 2021 Economic Outlook and Basic Stance for Economic and Fiscal Management (decided by the Cabinet on January 18, 2021)"

Note: The values in the figure are social security benefit expenditures (trillion yen) for FY1950, 1960, 1970, 1980, 1990, 2000, 2010, and 2021 (budget basis). Source: Ministry of Finance, Social Security (reference data, April 13, 2022), https://www.mof.go.jp/about_mof/councils/fiscal_system_council/sub-of_fiscal_system/proceedings/material/zaiseia20220413/03.pdf

Figure 1-4 International comparison of social security benefits by sector (% of GDP)



Note: Based on the OECD Social Expenditure Database and calculated by the Counsellor Office for Policy Management of the Director-General for Policy Planning and Evaluation, Ministry of Health, Labour and Welfare (2017 figures). Social expenditure data based on the OECD Social Expenditure Standards is included a wider range of costs (e.g. facility maintenance costs) than social security benefits.

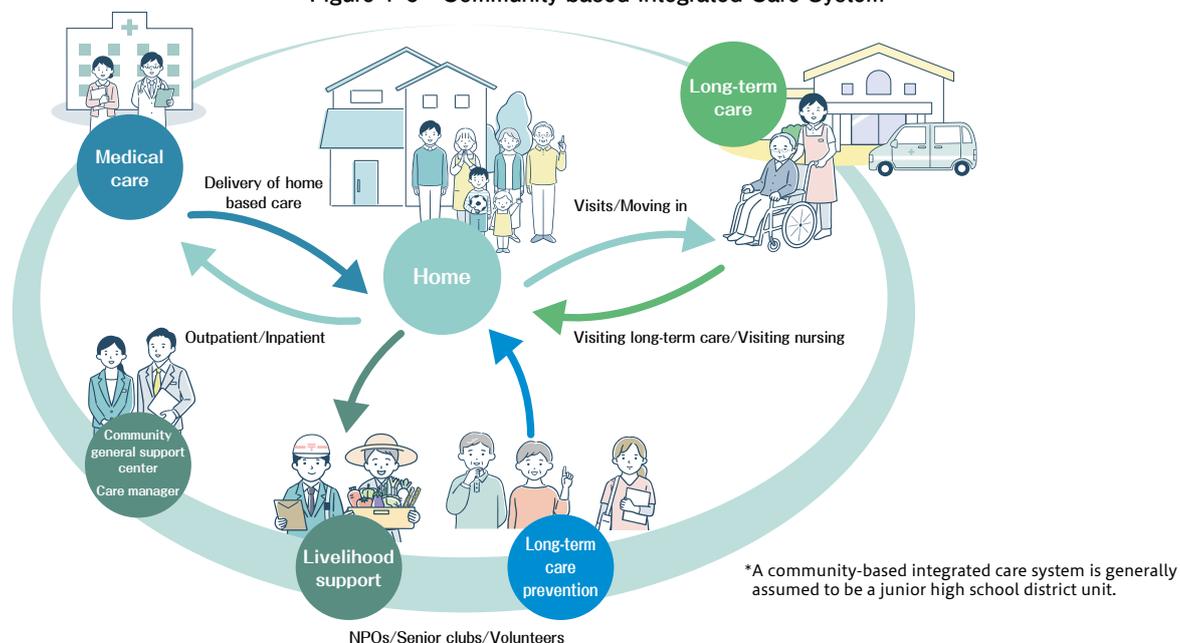
Source: Ministry of Health, Labour and Welfare, Composition and Overview of Japan's Social Security System, <https://www.mhlw.go.jp/content/12600000/000984355.pdf>

3) Reforms toward 2025

By 2025, the baby boomer generation will be 75 years old or older, and there are concerns that social security benefit expenditures will increase due to the growing latter-stage elderly. To sustain the social security system despite demographic changes and regional differences, it is necessary to establish a health care delivery system that meets the health care needs of each region. Therefore, the government is promoting efforts in each region to build a more efficient and higher-quality health care delivery system toward 2025. This includes securing professional human resources

such as doctors and nurses, who are the key to health care delivery, differentiating and coordinating the medical functions of medical institutions, and enhancing home-based care. The government's aim is to achieve the Community-based Integrated Care System in which health care, long-term care, prevention, housing, and livelihood support are provided in an integrated manner, focusing on the community as the key to the daily lives of the elderly and allowing them to live in their familiar environment as long as possible (Figure 1-5).

Figure 1-5 Community-based Integrated Care System



Source: Partially modified by the Japanese Nursing Association based on Toyama Community-based Integrated Care System, what is a community-based integrated care system?, <http://toyama-chiikihoukatsu.net/about/>

4) Considerations for 2040

The "2040 problem" is predicted to be the next major social issue after 2025. By around 2040, Japan's population will continue to be in decline, exacerbating the aging society with fewer children and resulting in an even smaller working population to support society. At the same time, the elderly population that is supported by society is expected to age even further, with nearly 30% of the elderly being 85 years old or older. The imbalance between those who support and those who are supported will therefore become a major issue. Furthermore, economically, it is said that economic disparities and impoverishment

between and within generations will continue to deepen as a generation in which many work under precarious employment or without a job because their job hunting coincided with a difficult employment environment reaches old age in 2040.

The government aims to increase the total number of workers and to realize health care and welfare services that can run with fewer people as the workforce continues to decrease. Specifically, the government will work to promote diverse employment and social participation, extend healthy life expectancy, and improve productivity through health care and welfare service reforms.

II. Health Care Delivery System

1. Medical Care Delivery System

1) Situation of medical institutions

Table 2-1 shows the total number of medical institutions in Japan as of October 1, 2021. In terms of hospitals by the number of their beds, those with 50 to 99 beds accounted for the largest number (2,048 facilities, 25.0%), and

those with less than 200 beds accounted for 70.0% of the total (Table 2-2). The total number of hospital beds is 1,583,783 (Table 2-3), which is about 13 beds per thousand people, ranking Japan first in the world (Table 2-4).

Table 2-1 Number of medical institutions by institution type

As of October 1 of each year

	Facilities		Change over the year		Percentage distribution (%)	
	2021	2020	Number	Percentage (%)	2021	2020
Total	180,396	178,724	1,672	0.9
Hospitals	8,205	8,238	△ 33	△ 0.4	100.0	100.0
Psychiatric hospitals	1,053	1,059	△ 6	△ 0.6	12.8	12.9
General hospitals	7,152	7,179	△ 27	△ 0.4	87.2	87.1
(Regrouped)						
Hospitals with beds for long-term care	3,515	3,554	△ 39	△ 1.1	42.8	43.1
Medical clinics	104,292	102,612	1,680	1.6	100.0	100.0
With beds	6,169	6,303	△ 134	△ 2.1	5.9	6.1
(Regrouped)						
Medical clinics with beds for long-term care	642	699	△ 57	△ 8.2	0.6	0.7
Without bed	98,123	96,309	1,814	1.9	94.1	93.9
Dental clinics	67,899	67,874	25	0.0	100.0	100
With beds	21	21	-	-	0.0	0.0
Without bed	67,878	67,853	25	0.0	100.0	100.0

Source: Ministry of Health, Labour and Welfare, Outline of Results, I. Survey of Medical Institutions, Summary of Dynamic Survey of Medical Institutions and Hospital Report 2021, <https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/21/dl/02sisetu03.pdf>

Table 2-2 Number of medical institutions by number of beds

As of October 1 of each year

	Facilities		Change over the year		Percentage distribution (%)	
	2021	2020	Number	Percentage (%)	2021	2020
Hospitals	8,205	8,238	△ 33	△ 0.4	100.0	100.0
20- 49 beds	908	909	△ 1	△ 0.1	11.1	11.0
50- 99	2,048	2,061	△ 13	△ 0.6	25.0	25.0
100-149	1,421	1,424	△ 3	△ 0.2	17.3	17.3
150-199	1,365	1,368	△ 3	△ 0.2	16.6	16.6
200-299	1,032	1,036	△ 4	△ 0.4	12.6	12.6
300-399	674	677	△ 3	△ 0.4	8.2	8.2
400-499	366	369	△ 3	△ 0.8	4.5	4.5
500-599	162	161	1	0.6	2.0	2.0
600-699	110	111	△ 1	△ 0.9	1.3	1.3
700-799	38	42	△ 4	△ 9.5	0.5	0.5
800-899	29	28	1	3.6	0.4	0.3
900 +	52	52	-	-	0.6	0.6
Medical clinics (with beds)	6,169	6,303	△ 134	△ 2.1	100.0	100.0
1- 9 beds	1,774	1,787	△ 13	△ 0.7	28.8	28.4
10-19	4,395	4,516	△ 121	△ 2.7	71.2	71.6

Source: Ministry of Health, Labour and Welfare, Outline of Results, I. Survey of Medical Institutions, Summary of Dynamic Survey of Medical Institutions and Hospital Report 2021, <https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/21/dl/02sisetu03.pdf>

Table 2-3 Number of beds by bed type

As of October 1 of each year

	Number of beds		Change over the year		Percentage distribution (%)	
	2021	2020	Number	Percentage (%)	2021	2020
Total	1,583,783	1,593,633	△ 9,850	△ 0.6
Hospitals	1,500,057	1,507,526	△ 7,469	△ 0.5	100.0	100.0
Psychiatric beds	323,502	324,481	△ 979	△ 0.3	21.6	21.5
Psychiatric hospitals	244,422	246,006	△ 1,584	△ 0.6	16.3	16.3
General hospitals	79,080	78,475	605	0.8	5.3	5.2
Infectious diseases beds	1,893	1,904	△ 11	△ 0.6	0.1	0.1
Tuberculosis beds	3,944	4,107	△ 163	△ 4.0	0.3	0.3
Beds for long-term care (A)	284,662	289,114	△ 4,452	△ 1.5	19.0	19.2
General beds	886,056	887,920	△ 1,864	△ 0.2	59.1	58.9
Medical clinics (Regrouped)	83,668	86,046	△ 2,378	△ 2.8	100.0	100.0
Beds for long-term care (B)	6,310	6,936	△ 626	△ 9.0	7.5	8.1
Dental clinics	58	61	△ 3	△ 4.9
Beds for long-term care (total) (A)+(B)	290,972	296,050	△ 5,078	△ 1.7

Source: Ministry of Health, Labour and Welfare, Outline of Results, I. Survey of Medical Institutions, Summary of Dynamic Survey of Medical Institutions and Hospital Report 2021, <https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/21/dl/02sisetu03.pdf>

Table 2-4 International comparison of health care delivery system in 2019

Country	Average length of stay in hospitals	Hospital beds per 1,000 people	Medical practitioners per 100 hospital beds	Medical practitioners per 1,000 people	Nurses per 100 hospital beds	Nurses per 1,000 people
Japan	— (16.0)	12.8	*19.2	*2.5	*90.6	*11.8
Germany	*8.9 (*7.5)	7.9	55.5	4.4	176.2	14.0
France	8.8 (5.4)	5.8	54.3	3.2	#189.6	#11.1
United Kingdom	*6.6 (6.2)	‡2.5	120.1	3.0	334.2	8.2
United States	— (*5.5)	*2.8	*92.2	2.6	**420.2	#12.0

OECD. Stat (as of September 1, 2021)

Note1 [#] includes staff working in research institutes, etc., in addition to staff engaged in clinical work.

Note2 [*] indicates data for 2018.

Note3 [E] is the estimated value.

Note4 The number of medical practitioners and clinical nurses per 100 beds is simply the total number of clinical doctors, etc. divided by the number of beds and multiplied by 100.

Note5 The bracketed average length of stay in hospitals is the average length of stay in acute care beds (general hospital beds in Japan).

Source: Ministry of Health, Labour and Welfare, Estimates of number of hospitals, Current status of health care delivery system, <https://www.mhlw.go.jp/content/10800000/001029753.pdf>

2) Situation of health care professionals

In Japan, in addition to nurses, health care professionals including physicians, dentists, pharmacists, and others are also engaged in health care. The number of health care professionals in each profession is shown in Table 2-5. Of these, approximately 1.68 million are engaged in the nursing profession (as of 2019), with the number increasing by about

30,000 each year. Compared to other countries, Japan's number of nursing professionals per 1,000 people (11.8) is not significantly different from Western countries. However, the number of nursing professionals per 100 hospital beds (90.6) is very low, less than half of that in France and Germany, and one-fifth of that in the United States (Table 2-4). Currently, the functional differentiation of hospital beds (i.e.,

the optimization of the roles of hospital beds and personnel allocation according to those roles) is underway. In conjunction with this discussion, it is necessary to optimize nurse staffing according to the functions of the hospital.

As for the current challenges related to securing nursing professionals, uneven distribution by field (by place of employment) and shortages in some regions in relation to

demand (uneven distribution by region) are more serious than the issue of quantitative maintenance. If the uneven distribution by field and region continue to progress, even under a universal health insurance system, it will lead to differences in accessibility to and the content of health care services depending on the nature of the medical and nursing care needed and the area of residence, which may lead to an expansion of health disparities.

Table 2-5 Number of health care professionals

· Physicians	323,700
· Dentists	104,118
· Pharmacists	250,585
Source: Health Statistics Office of Director-General for Statistics and Information Policy, Ministry of Health, Labour and Welfare, Statistics of Physicians, Dentists and Pharmacists 2021	
※ Physicians and Dentists employed in medical institutions, pharmacists employed in pharmacies and medical institutions.	
· Public health nurses	64,819
· Midwives	40,632
· Nurses	1,272,024
· Assistant nurses	305,820
Source: According to a survey by Health Policy Bureau, Ministry of Health, Labour and Welfare 2019	

Source: Ministry of Health, Labour and Welfare, Number of health care professionals, Overview of the system and the basic statistics, Annual Health, Labour and Welfare Report (2019), <https://www.mhlw.go.jp/wp/hakusyo/kousei/21-2/kousei-data/siryou/sh0202.html#sec02>

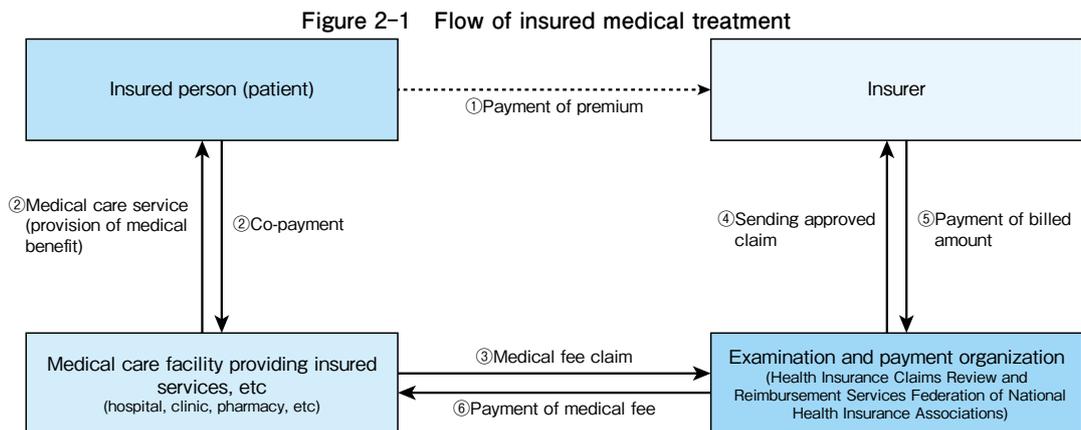
2. Medical Insurance System

1) Overview of the system

The universal health insurance system provides medical care to all citizens. It has four main characteristics: [1] universal coverage for all citizens under public health insurance, [2] freedom to choose medical institutions (free access), [3] access to advanced medical care at low cost, and [4] a social insurance system as the basis, supplemented by public funds.⁶⁾

Citizens are obligated to enroll in public insurance and pay premiums. However, they

can receive medical care with a partial cost burden (co-payment) when they visit medical institutions (Figure 2-1). The co-payment is 30% of the medical costs, but the co-payment ratio varies depending on age and economic status (Figure 2-2). Citizens are generally free to choose their medical institutions. The operation of these mechanisms is broadly divided into two types: employee's health insurance, in which employed individuals and their family members enroll through their place of

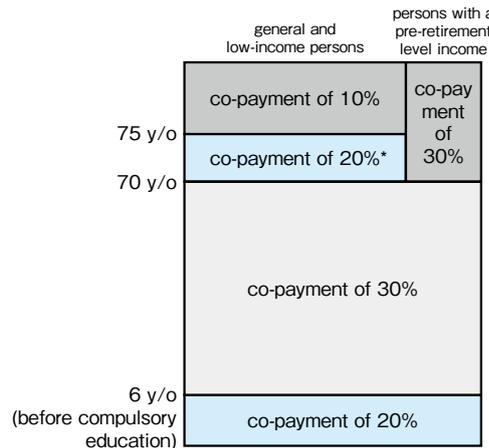


Source: All Japan Hospital Association, Medical Fee System, <https://www.ajha.or.jp/guide/1.html>

employment, and national health insurance, in which self-employed and unemployed individuals and their family members enroll based on their place of residence (municipality). Through the payment of insurance

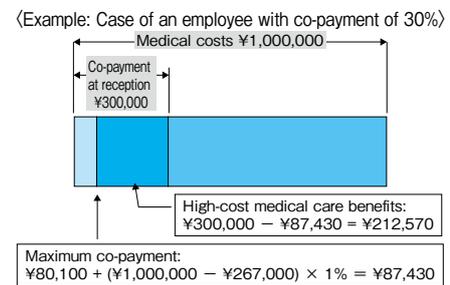
premiums according to ability to pay, a mutual assistance system was established early on, whereby anyone can receive medical services anytime and anywhere without a heavy financial burden.

Figure 2-2 Patient's co-payment of medical costs
 [Patient's co-payment ratio of medical costs]



***High-cost Medical Care Benefit System**

A system that provides reimbursement for the amount exceeding the monthly maximum co-payment in order to avoid co-payments for medical costs becoming too expensive for family budgets.



*Since April 2008, the co-payment for those aged 70 to 74 had remained unchanged at 10%, but was gradually increased to 20% for insured persons who turned to 70 from 2014 onwards.
 (Note) The maximum co-payment is divided into general, high-income, and low-income categories according to the income of the insured.
 Source: Ministry of Health, Labour and Welfare, Characteristics of the Universal Health Insurance System, <https://www.mhlw.go.jp/content/12400000/000377686.pdf>

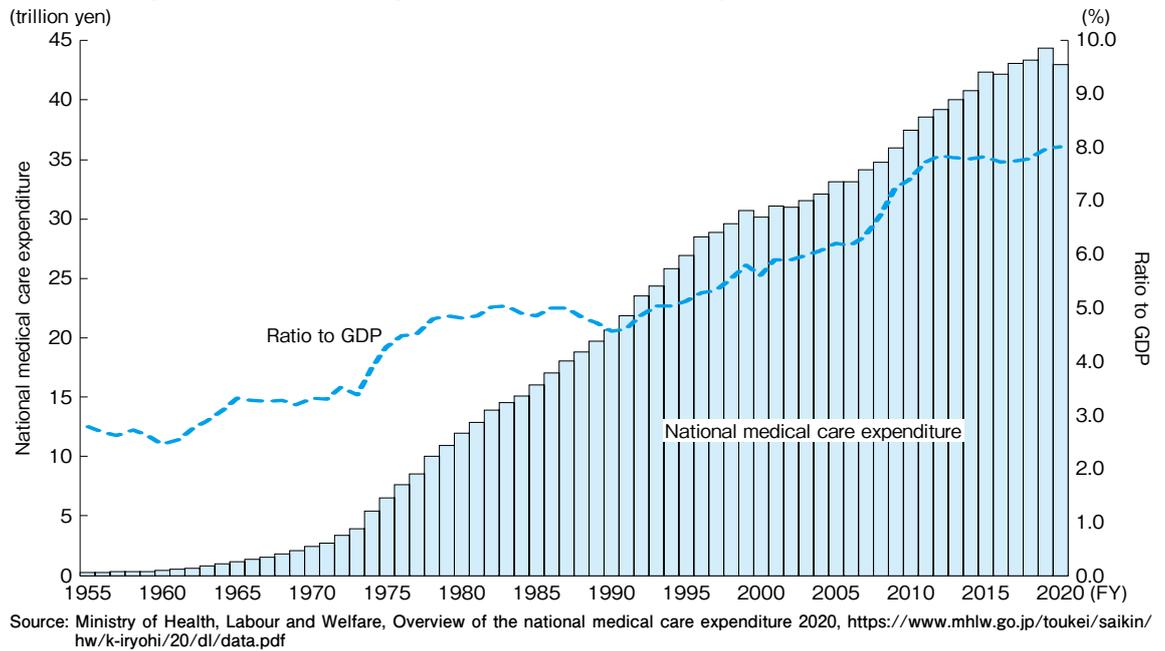
2) Payment mechanism for medical costs

The payment of medical costs is based on a fee-for-service system, where a fixed number of points are assigned to each medical procedure, including examinations, tests, treatments, hospitalizations, surgeries, and medications. As of 2022, the unit price for one point is set at 10 yen. The total number of points for the medical procedures provided is multiplied by 10 yen to calculate the medical costs, and the patient pays a certain percentage of this amount as a co-payment (see above). Under the current fee-for-service system, medical practitioners are incentivized to perform more medical procedures because their compensation increases with each procedure. Therefore, there is less incentive to control costs. As a result, a comprehensive payment system has been adopted for some hospitalizations and outpatient services to address this issue.

3) Trends in medical care expenditure

Under the universal health insurance system, national medical care expenditure has been increasing steadily due to the aging of the population, changes in disease structure leading to increased use of health care (including an increase in the number of users and longer usage periods), and medical advancements (Figure 2-3). The national medical care expenditure for fiscal 2019, just before the outbreak of the COVID-19, were 44.3895 trillion yen (up by 994.6 billion yen or 2.3% year-over-year (YoY)), with 351,800 yen per capita (up by 8,600 yen or 2.5% YoY). This accounts for 7.93% of GDP, gross domestic product (up by 0.02% YoY) and 11.06% of GNI, gross national income (up by 0.33% YoY).⁷⁾ (For reference, national medical care expenditure for fiscal 2020 were 42.9665 trillion yen (down by 1.423 trillion yen or 3.2% YoY⁸⁾), and it is believed that impacts affecting this decrease included a reluctance to visit medical institutions due to the COVID-19 pandemic.)

Figure 2-3 Annual changes in national medical care expenditure and its ratio to GDP



3. Long-term Care Delivery System

1) Types and number of long-term care facilities

The current situation of long-term care service providers nationwide as of October 1, 2021, is shown in Table 2-6. There are currently four types of long-term care insurance facilities available for long-term care insurance services: welfare facilities for the elderly requiring long-term care, health care facilities for the elderly requiring long-term care, integrated facilities for medical and long-term care, and sanatorium-type medical care facilities for the elderly requiring long-term care. Facility standards for each type are regulated by law according to their different functions.

Long-term care service establishments are broadly categorized into five categories: preventive long-term care service establishments, community-based preventive long-term care service establishments, in-home service establishments, community-based service establishments, and in-home long-term

care support establishments. Among these, visiting nursing stations, which provide nursing care by visiting nurses for people recuperating at home, were first established in 1992, and the number of these stations has increased to 13,554 (up by 1,161 stations YoY). In terms of the establishing entities of these stations, the highest percentages are for-profit corporations (companies), accounting for 59.2%, followed by health care corporations (21.9%).⁹⁾ Additionally, combined multiple services (nurse-led comprehensive community care) were established in 2012 as a system in which a single establishment provides four services (visiting nursing, home-visit long-term care, day service, and overnight service) so that people can continue to live out their lives in their familiar communities even if they need medical treatment or long-term care. The number of these facilities has been increasing year by year and has reached 817 in 2021 (up by 106 facilities YoY).

Table 2-6 Results of Survey of Institutions and Establishments for Long-term Care for 2021

As of October 1 of each year

	2021	2020	YoY	
			Change in number	Percentage change (%)
Long-term care insurance facilities				
Welfare facilities for the elderly requiring long-term care	8,414	8,306	108	1.3
Health care facilities for the elderly requiring long-term care	4,279	4,304	△ 25	△ 0.6
Integrated facilities for medical and long-term care	617	536	81	15.1
Sanatorium-type medical care facilities for the elderly requiring long-term care	421	556	△ 135	△ 24.3
Preventive long-term care service establishments				
Home-visit bathing service for preventive long-term care	1,483	1,561	△ 78	△ 5.0
Visiting nursing stations for preventive long-term care	13,221	12,115	1,106	9.1
Outpatient rehabilitation service for preventive long-term care	8,225	8,274	△ 49	△ 0.6
Short-term admission for daily preventive long-term care	11,256	11,134	122	1.1
Short-term admission for recuperation for preventive care	4,966	5,098	△ 132	△ 2.6
Daily preventive long-term care admitted to specified facilities	5,174	5,033	141	2.8
Lending preventive long-term care welfare instruments	7,648	7,463	185	2.5
Sales of specific preventive long-term care welfare instruments	7,636	7,506	130	1.7
Community-based preventive long-term care service establishments				
Outpatient care service for preventive long-term care for dementia patients	3,445	3,536	△ 91	△ 2.6
Multifunctional preventive long-term care in a small group home	5,145	5,076	69	1.4
Daily life care service for preventive long-term care in communal living for dementia patients	13,703	13,612	91	0.7
Preventive long-term care support establishments (community general support centers)	5,280	5,249	31	0.6
In-home service establishments				
Home-visit long-term care	35,612	35,075	537	1.5
Home-visit bathing long-term care	1,705	1,708	△ 3	△ 0.2
Visiting nursing stations	13,554	12,393	1,161	9.4
Outpatient day long-term care	24,428	24,087	341	1.4
Outpatient rehabilitation	8,308	8,349	△ 41	△ 0.5
Short-term admission for daily life long-term care	11,790	11,668	122	1.0
Short-term admission for recuperation	5,068	5,220	△ 152	△ 2.9
Daily life long-term care admitted to specified facilities	5,610	5,454	156	2.9
Rental service of equipment for long-term care covered by public aid	7,770	7,545	225	3.0
Sales of specified equipment covered by public aid	7,657	7,529	128	1.7
Community-based service establishments				
Regular visiting/on-demand home-visit long-term/nursing care	1,178	1,099	79	7.2
Home visit at night for long-term care	221	220	1	0.5
Community-based outpatient day long-term care	19,578	19,667	△ 89	△ 0.5
Outpatient long-term care of dementia patients	3,753	3,868	△ 115	△ 3.0
Multifunctional long-term care in a small group home	5,614	5,556	58	1.0
Communal daily long-term care for dementia patients	14,085	13,977	108	0.8
Daily life long-term care for people admitted to a community-based specified facility	365	354	11	3.1
Combined multiple services (nurse-led comprehensive community care)	817	711	106	14.9
Community-based welfare facilities for the elderly requiring long-term care	2,474	2,413	61	2.5
In-home long-term care support establishments	39,047	39,284	△ 237	△ 0.6

Note: Establishments that provide more than one service are accounted for in each item.

Source: Ministry of Health, Labour and Welfare, Results of Survey of Institutions and Establishments for Long-term Care for 2021, https://www.mhlw.go.jp/toukei/saikin/hw/kaigo/service21/dl/kekka-gaiyou_1.pdf

2) Situation of long-term care workers

Various health care professionals work alongside care staff and certified care workers in providing long-term care services. The largest number of nurses is engaged in visiting nursing stations (92,139), followed by day-care

service for long-term care (38,225), health care facilities for the elderly requiring long-term care (29,732), and welfare facilities for the elderly requiring long-term care (27,418) in 2021.⁹⁾

4. Long-term Care Insurance System

1) Overview of the system

The long-term care insurance system is a mechanism by which society as a whole supports the care of the elderly, and its key provisions are stipulated by the Long-Term Care Insurance Act. As the population ages, the number of people requiring long-term care increases, and the duration of long-term care lengthens, family structures that provide long-term care are also changing, with the shift to nuclear families and the aging of caregivers. In response to these changes, the long-term care insurance system was established in 2000, with municipal governments as the insurers responsible for its operation. All citizens over 40 years old, including the insured persons mentioned above, have an obligation to pay insurance premiums, and benefits are provided to primary insured persons aged 65 and older as well as secondary insured persons aged 40–64 (Figure 2-4). However, in order to use this system, it is essential to receive a certification of needed long-term care to classify the level of long-term care needed according to the degree severity. The basic mechanism is similar to that of health insurance, providing in-kind benefits (long-term care and preventive care benefits) under partial co-payment, but the financial structure is more complex. The amount of partial co-payment is 10% of the cost of services used but varies depending on income (Figure 2-5).

2) Payment mechanism for long-term care costs

The payment of long-term care costs is calculated by adding regional and labor

supplements based on the location of the service provider to the basic remuneration set for each service. The monthly upper limit for using long-term care services is determined according to the level of care needed, based on the certification of needed long-term care. While users mainly choose the services they want to use, for in-home long-term care services such as visiting nursing, care managers intervene and create a care plan that combines services according to individual needs. Users pay a certain percentage (as described above) as co-payment, but they are responsible for paying the full amount exceeding the upper limit. With the promotion of community-based integrated care and the shift from medical institutions to the community, the number of users with high medical needs is increasing, and the assessment of medical needs is also increasing in care management.

3) Trends in long-term care expenditure

As society rapidly ages, the number of people with the certification of needed long-term care has been increasing every year (Figure 2-6), resulting in an increase in the total expenditure of long-term care insurance. When the long-term care insurance system was established in 2000, the total expenditure was 3.6 trillion yen. However, in 2018, it had nearly tripled to 11.0 trillion yen (up by 400 billion yen YoY). Under this system, the insurance premiums paid by primary insured individuals aged 65 and over are also increasing. This trend is expected to continue in the future.

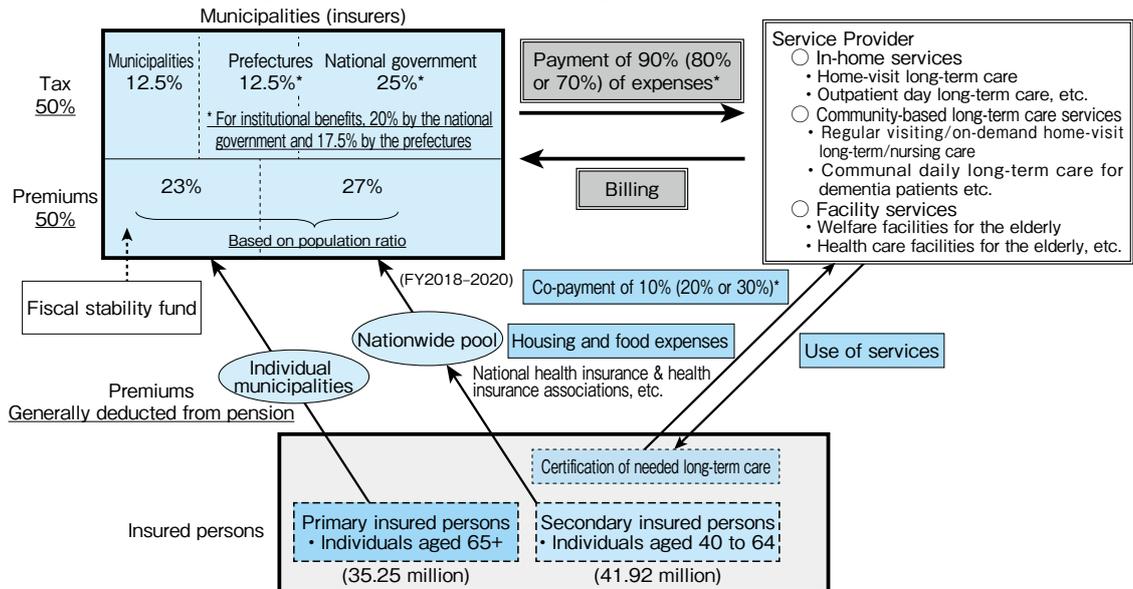
Figure 2-4 Insured individuals in the long-term care insurance system

- The long-term care insurance system covers (1) individuals aged 65 and older (primary insured persons) and (2) individuals aged 40 to 64 with health insurance (secondary insured persons).
- Long-term care insurance services are available to those aged 65 or older when they require support or care regardless of the cause, and to those aged 40 to 64 if they require support or long-term care due to aging-related diseases such as terminal cancer and rheumatoid arthritis.

	Primary insured persons	Secondary insured persons
Covered persons	Individuals aged 65+	Individuals aged 40-64 with health insurance
Number of people	35.25 million (aged 65-74: 17.3 million, aged 75+: 17.96 million)	41.92 million
Requirements	<ul style="list-style-type: none"> • In need of long-term care (condition requiring long-term care due to being bedridden, dementia, etc.) • In need of support (condition requiring support in daily living) 	Limited to cases where the condition requiring long-term care or support is due to age-related diseases (specified diseases) such as terminal cancer and rheumatoid arthritis
Number of persons certified as requiring long-term care /support and their percentage of the insured	6.45 million (18.3%) (aged 65-74: 730,000 (4.2%) aged 75+: 5.72 million (31.8%))	130,000 (0.3%)
Insurance premium burden	Collected by municipality (generally, deducted from one's pension)	Collected together with health insurance premiums by health insurers

(Note) The number of primary insured persons and persons certified as requiring long-term care/support is based on the "Status Report on the Long-term Care Insurance System" and reflects the figures as of the end of fiscal 2018. The number of secondary insured persons is based on reports from health insurers for the Health Insurance Claims Review & Reimbursement Services to determine the amount of long-term care benefit payments, and reflects the monthly average for fiscal 2018. Source: Ministry of Health, Labour and Welfare, Overview of the Long-Term Care Insurance System (May 2021), <https://www.mhlw.go.jp/content/000801559.pdf>

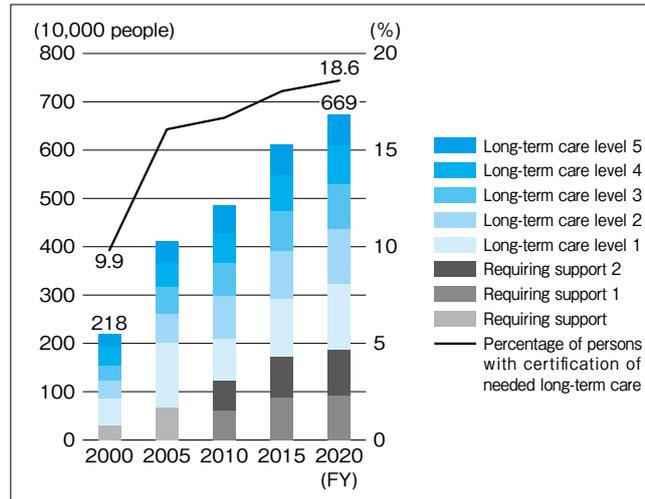
Figure 2-5 Mechanism of the long-term care insurance system



(Note) The number of primary insured persons is based on the "Status Report on the Long-term Care Insurance System" and reflects the figures as of the end of FY2018. The number of secondary insured persons is based on reports from health insurers for the Health Insurance Claims Review & Reimbursement Services to determine the amount of long-term care benefit payments, and reflects the monthly average for fiscal 2018. * For those with incomes above a certain level, 20% of the expenses (effective August 2015) or 30% of the expenses (effective August 2018). Source: Ministry of Health, Labour and Welfare, Overview of the Long-Term Care Insurance System (May 2021), <https://www.mhlw.go.jp/content/000801559.pdf>

Figure 2-6 Trends in the number of persons certified as requiring long-term care/support

The number of persons certified as requiring long-term care/support has increased by about tripled over the 20 years from 2000 to 2020 (nearly doubling its ratio of the total elderly population). The increase in the number of persons certified as requiring long-term care level 1 or less is particularly large.



Requiring support		Long-term care					Total
1	2	1	2	3	4	5	
3.83 times		2.94 times	2.78 times	2.42 times	2.07 times	3.06 times	

* Percentage of persons certified as requiring long-term care/support is the percentage in the population aged 65 and over

Source: Compiled by the Japanese Nursing Association based on the results of basic complete tabulation on population and households, Population census 2020, Statistics Bureau, Ministry of Internal Affairs and Communications, <https://www.stat.go.jp/data/kokusei/2020/kekka.html>

III. Nursing System

1. Development of Modern Nursing

In Japan, modern nursing developed rapidly with the introduction of Western medicine in 1868. The beginning of Japan's nursing education system dates back to 1874 and the establishment of the "Isei" medical regulation,

which provided for the education and licensing of midwives, and marked the start of their training. In 1885, Japan's first nurse-training institute was established, and modern nursing education began.

2. Regulations and Current Challenges in Nursing Qualifications

In Japan, regulations governing nursing qualifications were established through the Midwives Ordinance of 1899, the Nurses Ordinance of 1915, and the Public Health Nurses Ordinance of 1941. The National Medical Care Act of 1942 designated public health nurses, midwives, and nurses^{Note 1} as medical professionals alongside physicians and dentists.

Following World War II, the Allied Forces established the General Headquarters of the Supreme Commander for the Allied Powers (GHQ) to oversee the occupation of Japan. Under GHQ, the laws governing public health nurses, midwives, and nurses were consolidated into the Act on Public Health Nurses, Midwives, and Nurses of 1948. This law mandated nursing education for those seeking to become public health nurses or midwives and made nursing licenses a national qualification. Its purpose was "to improve the qualities of Public Health Nurses, Midwives, and Nurses, and to thereby promote medical care and public health." Additionally, the nursing system was reorganized under GHQ's direction, and in 1948, the then-Ministry of Health and Welfare established the Nursing Division, which began nursing administration by nurses.

As the medical system changed after the war and hospitals increased in terms of size and number of beds, a shortage of nurses emerged and issues with working conditions such as the workload and working hours of nurses surfaced. In response, the Ministry of Health and Welfare revised the nursing system by eliminating the classification of nurses into Class A and Class B according to job content, creating an assistant nurse system in 1951, introducing nursing education at four-year universities in 1952, and

improving treatment.

Nowadays, as the birth rate continues to decline and Japan becomes a super-aging society, and as social needs change and medical care becomes increasingly advanced, nurses are required to provide comprehensive nursing care that addresses complexity and diversity. The Act on Public Health Nurses, Midwives, and Nurses has been amended 21 times since its enactment. The revisions made in 2009 included specifying "university" as the first qualification for taking the national nursing exam, changing the educational period for public health nurses and midwives from "six months or more" to "one year or more," and requiring employers to "make a sincere effort" to provide training for new nursing personnel.^{Note 2} Furthermore, a 2015 revision initiated a new system that allows nurses who have completed the stipulated training to perform certain medical interventions, such as intravenous drips for dehydration, according to procedure manuals without waiting for the judgment of a physician or equivalent professional, in order to promote home-based care and other goals.

Today, as treatment and recuperation settings spread throughout the community and become more diverse, and as work-style reforms are implemented across society and task shifting and sharing are introduced in health care professions, discussions regarding the role of nurses are becoming increasingly important.

Note 1: In 2001, the Act on Public Health Nurses, Midwives, and Nurses was amended to change the Japanese terms for public health nurses, midwives, and nurses from words specifying them as women to gender-neutral words. The Japanese version of this document uses the gender-neutral terms throughout.

Note 2: The clinical training for newly-graduated nursing personnel is stipulated by the Act on Public Health Nurses, Midwives, and Nurses and the Act on Assurance of Work Forces of Nurses and Other Medical Experts.

3. Occupations Involved in the Provision of Nursing Care

Public Health Nurse

A public health nurse is a person who has acquired a public health nurse license (national qualification) from the Minister of Health, Labour and Welfare (MHLW) to use the title of public health nurse and provides health guidance as a profession (Article 2 of the Act on Public Health Nurses, Midwives, and Nurses).

The role of public health nurses is to conduct health activities so that people can lead healthy lives. Many public health nurses work for local government health and hygiene administrative organizations such as health centers. They provide support to individuals with health problems in the community and work to identify local health issues and take measures to address them in an effort to improve the overall health of the community.

Therefore, the target for their work is diverse and multi-layered, including all people living in the community, from infants to the elderly, from healthy people to those with illnesses or disabilities, and both individuals and groups within the community. They are also involved in local government policies related to health. At companies, public health nurses provide health counseling, health guidance based on the health check results, and environmental adjustment. In recent years, their roles have expanded to include supporting the continued employment of people with illnesses and mental health support in the workplace.

Public health nurses are mainly employed by health centers, municipal governments and other administrative bodies, as well as industry (e.g., corporations), hospitals, and other health care facilities (Table 3-1).

Table 3-1 Status of employment

Public Health Nurses

Year	Grand total			Health centers	Prefectures	Municipal	Hospitals	Clinics	Health facilities for the elderly	Visiting nursing stations	Social welfare facilities	Welfare facilities for the elderly	Home services etc.	Industries	Nursing schools, institutes	Others
	Grand total	Increase over previous year	Index													
2017	63,022	904	116.1	(12.4) 7,798	(2.3) 1,450	(45.9) 28,908	(9.3) 5,887	(16.3) 10,303	(0.1) 57	(0.6) 356	(0.8) 507	(0.1) 75	(1.6) 1,020	(4.7) 2,967	(1.9) 1,224	(3.9) 2,470
2018	63,969	947	117.8	(12.7) 8,100	(2.1) 1,351	(46.4) 29,666	(9.3) 5,947	(16.2) 10,377	(0.1) 40	(0.4) 259	(0.7) 421	(0.1) 39	(2.0) 1,257	(5.2) 3,349	(1.8) 1,148	(3.1) 2,015
2019	64,819	850	119.4	(12.9) 8,357	(2.2) 1,395	(46.7) 30,299	(9.9) 6,427	(15.6) 10,106	(0.1) 42	(0.4) 274	(0.7) 424	(0.1) 44	(2.2) 1,429	(4.6) 2,974	(1.8) 1,142	(2.9) 1,906

Midwives

Year	Grand total			Health centers	Prefectures	Municipal	Hospitals	Clinics	Maternity homes				Social welfare facilities	Industries	Nursing schools, institutes	Others
	Grand total	Increase over previous year	Index						Total	Establishers	Employees	Home visit only				
2017	39,720	107	122.3	(0.8) 323	(0.1) 21	(2.8) 1,106	(60.8) 24,164	(25.5) 10,124	(5.2) 2,057	1,004	428	625	(0.2) 70	(0.2) 94	(3.9) 1,557	(0.5) 204
2018	40,272	552	124.0	(0.9) 368	(0.0) 18	(3.2) 1,273	(60.7) 24,451	(25.5) 10,257	(5.2) 2,103	1,144	396	563	(0.1) 24	(0.1) 23	(3.8) 1,533	(0.6) 222
2019	40,632	360	125.1	(0.9) 384	(0.1) 25	(3.5) 1,409	(60.9) 24,738	(24.5) 9,968	(5.6) 2,281	1,246	430	605	(0.1) 27	(0.1) 26	(3.8) 1,531	(0.6) 243

Nurses and Assistant Nurses

Classification	Year	Grand total			Health centers	Prefectures	Municipal	Hospitals	Clinics	Health facilities for the elderly	Visiting nursing stations	Social welfare facilities	Welfare facilities for the elderly	Home services etc.	Industries	Nursing schools, institutes	Others
		Grand total	Increase over previous year	Index													
(Grand total)	2017	1,555,181	△3,159	112.4	(0.1) 1,193	(0.0) 759	(0.5) 8,292	(62.7) 975,672	(19.7) 307,082	(2.9) 45,432	(3.2) 50,093	(1.7) 26,715	(2.6) 41,127	(4.3) 66,886	(0.4) 5,792	(1.1) 16,635	(0.6) 9,503
	2018	1,578,782	23,601	114.1	(0.1) 1,286	(0.1) 1,036	(0.5) 8,144	(62.3) 984,075	(19.4) 305,578	(3.1) 48,717	(3.6) 56,806	(1.8) 28,872	(2.7) 41,947	(4.4) 69,210	(0.4) 5,832	(1.1) 16,913	(0.7) 10,366
	2019	1,577,844	△938	114.0	(0.1) 1,336	(0.1) 1,231	(0.5) 8,195	(62.6) 987,247	(18.8) 296,073	(3.1) 48,993	(3.8) 60,375	(1.9) 29,331	(2.7) 42,950	(4.4) 69,806	(0.3) 5,156	(1.1) 17,199	(0.6) 9,952
(Nurses)	2017	1,223,322	12,657	123.0	(0.1) 1,121	(0.1) 740	(0.6) 7,217	(69.4) 849,341	(15.5) 189,891	(2.0) 24,403	(3.7) 45,328	(1.4) 17,176	(1.9) 23,227	(3.0) 36,142	(0.4) 4,599	(1.4) 16,553	(0.6) 7,584
	2018	1,256,970	33,648	126.4	(0.1) 1,237	(0.1) 1,003	(0.6) 7,139	(68.8) 865,090	(15.3) 192,662	(2.1) 26,430	(4.1) 51,740	(1.5) 18,897	(2.0) 24,579	(3.0) 38,261	(0.4) 4,784	(1.3) 16,867	(0.7) 8,281
	2019	1,272,024	15,054	127.9	(0.1) 1,278	(0.1) 1,182	(0.6) 7,249	(68.9) 876,227	(15.0) 190,343	(2.1) 27,092	(4.3) 54,951	(1.5) 19,533	(2.0) 25,624	(3.1) 39,126	(0.3) 4,174	(1.3) 17,148	(0.6) 8,097
(Assistant Nurses)	2017	331,859	△15,816	85.3	(0.0) 72	(0.0) 19	(0.3) 1,075	(38.1) 126,331	(35.3) 117,191	(6.3) 21,029	(1.4) 4,765	(2.9) 9,539	(5.4) 17,900	(9.3) 30,744	(0.4) 1,193	(0.0) 82	(0.6) 1,919
	2018	321,812	△10,047	82.7	(0.0) 49	(0.0) 33	(0.3) 1,005	(37.0) 118,985	(35.1) 112,916	(6.9) 22,287	(1.6) 5,066	(3.1) 9,975	(5.4) 17,368	(9.6) 30,949	(0.3) 1,048	(0.0) 46	(0.6) 2,085
	2019	305,820	△15,992	78.6	(0.0) 58	(0.0) 49	(0.3) 946	(36.3) 111,020	(34.6) 105,730	(7.2) 21,901	(1.8) 5,424	(3.2) 9,798	(5.7) 17,326	(10.0) 30,680	(0.3) 982	(0.0) 51	(0.6) 1,855

Note (1): "Hospitals" are recorded according to the Hospital Report (2010-2016), the Medical Facilities Survey and Special Tabulation (2017) and estimates (2018, 2019).

Note (2): "Clinics" are based on the Medical Facilities Survey (2011, 2017) and estimates (2010, 2012-16, 2018, 2019). The figures for 2011 exclude the Ishinomaki and Kesennuma medical zones in Miyagi Prefecture and the whole of Fukushima Prefecture.

Note (3): All categories other than hospitals and clinics are based on the Health Administration Report (2010, 2012, 2014, 2016 and 2018) and estimates (2011, 2013, 2015, 2017 and 2019).

Note (4): Brackets are percentages of the total number.

Researched by Nursing Division, Health Service Bureau, Ministry of Health, Labour and Welfare

Source : Japanese Nursing Association Publishing Company, Statistical data on nursing service in Japan 2020, <https://www.nurse.or.jp/home/statistics/index.html>

Midwife

A midwife is a woman who has acquired a midwife license (national qualification) from the MHLW to practice midwifery or provides health guidance for pregnant women, puerperal women, or newborn babies as a profession (Article 3 of the Act on Public Health Nurses, Midwives, and Nurses).

The role of midwives is to assist in childbirth, provide health guidance and advice to pregnant and parturient women leading up to childbirth, and provide care for mothers and babies after childbirth. They also deal with sexual and reproductive health issues throughout women's lives, including providing parenting guidance, counseling for couples undergoing infertility treatment, and sexual health counseling during puberty and menopause. In addition to working in hospitals and clinics, they can also establish their own midwifery homes.

As the location of childbirth has shifted from the home to medical institutions, such as hospitals and clinics, have become the primary places of employment for midwives (Table 3-1).

Nurse

A nurse is a person who has acquired a nursing license (national qualification) from the MHLW to provide medical treatment or assist in medical care for injured and ill persons or puerperal women as a profession (Article 5 of the Act on Public Health Nurses, Midwives, and Nurses).

The roles of nurses are to provide care for injured or sick persons or puerperal women and to assist in their medical treatment. From the unique perspective of nurses, they comprehensively assess information, looking at the individual from various aspects such as physical, mental, social, and cultural factors to

accurately determine the necessary nursing care. As professionals who support people's lives and livelihoods, nurses work in a wide range of settings and roles, from medical institutions such as hospitals and clinics to home-visit nursing and long-term care facilities, as well as in schools and other places where people work.

Hospitals and clinics are the primary places of employment for nurses, although the percentage of nurses working at visiting nursing stations, which have been established since 1992, is increasing (Table 3-1).

Assistant Nurse

An assistant nurse is a person who has acquired a nursing assistant license from the prefectural governor to provide medical treatment or assist in medical care for injured and ill persons or puerperal women under the direction of a physician, dentist, or nurse, as a profession (Article 6 of the Act on Public Health Nurses, Midwives, and Nurses). Licenses for assistant nurses are granted by prefectural governors, but the license allows assistant nurses to work anywhere in Japan, not just the prefecture where the license was issued.

The difference between a nurse and an assistant nurse is the need for instructions when performing their work. Assistant nurses are required to receive instructions from a physician, dentist, or nurse to perform their duties (Article 6 of the Act on Public Health Nurses, Midwives, and Nurses). While the basic education for nurses requires at least three years after graduation from high school, the basic education for assistant nurses requires at least two years after graduation from junior high school, thus differing in terms of admission requirements and length of education.

IV. Nursing Education

In order to become a nursing professional in Japan, it is necessary to complete basic nursing education, pass the national public health nursing, midwifery, or nursing examinations, then obtain a license (national qualification) from the Minister of Health, Labour and Welfare (MHLW). In the case of assistant

nurses, it is necessary to pass a prefectural examination and obtain a license from the prefectural governor. Nursing profession licenses in Japan do not have a requirement for essential ongoing education—they are a lifetime license without a renewal system.

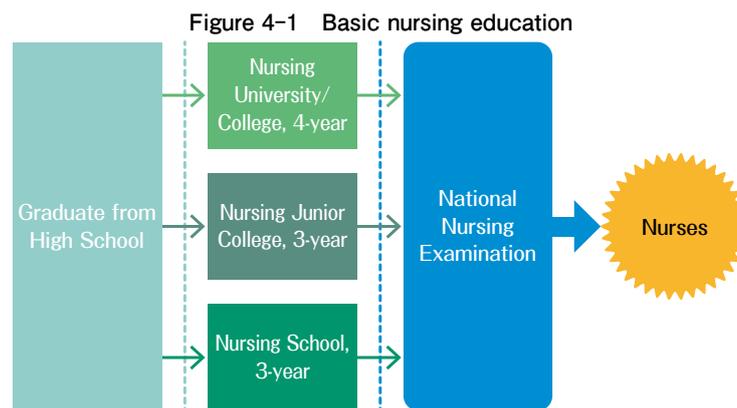
1. Basic Nursing Education

For basic nursing education, which is the education required prior to obtaining a nursing license, the pathway for high school graduates includes studying at university/college (four years), junior college (three years), or nursing school, such as vocational school (three years^{Note 1}). The jurisdictional government agencies differ between educational institutions, so while universities/colleges and junior colleges are under the Ministry of Education, Culture, Sports, Science and Technology (MEXT), nursing schools are largely the jurisdiction of the MHLW.

In order to become a public health nurse or a midwife, individuals must undergo basic nursing education and pass the national nurse examination. Education for public health nurses and midwives is conducted at colleges/

universities, one-year junior colleges, nursing schools, and master's programs at graduate schools. As part of four-year nursing programs at colleges/universities, if there is a public health nurse or midwifery education program, it is possible to become eligible to sit the national examination for not only the nurse qualification, but also for the public health nurse and midwife qualifications. However, with the increase in credits for education in recent years, there are significant time constraints in terms of completing concurrent education for multiple qualifications over four years, so public health nurse and midwife education is gradually transitioning to graduate schools (Figure 4-1).

Note 1: There are also nursing schools with four-year programs.



Source: Prepared by the Japanese Nursing Association

2. Contents of Basic Nursing Education

The content of basic nursing education is based on the Act on Public Health Nurses, Midwives, and Nurses and set out in the joint ministerial (MEXT and MHLW) “Ordinance for Designating Training Schools for Public Health Nurses, Midwives and Nurses” and various revisions have been made in

accordance with social nursing needs. In the 2020 revision of the ordinance, consideration was given to the competencies of future nurses that should be strengthened, and the associated educational content. As a result, the number of credits for Community Health/Home Care Nursing and more increased,

meaning that the total number of credits also increased (Table 4-1).

At the main institutions offering courses for students wishing to become nurses, including colleges/universities (four years), junior

colleges (three years), and nursing schools (three years), the educational content was set down using the same criteria, regardless of the educational institution type.

Table 4-1 Appendix 3 of Ordinance for Designating Training Schools for Public Health Nurses, Midwives and Nurses

Education contents		Credits
Foundational studies	Basics of scientific thinking	14
	Understanding of humans, living and society	
Specialized basic studies	Human body structure and functions	16
	Disease mechanism and recovery promotion	
	Health support and social security system	
Specialized studies	Basic nursing	11
	Community health/Home care nursing	6 (4)
	Adult health nursing	6
	Gerontological nursing	4
	Child health nursing	4
	Maternal nursing	4
	Mental health and psychiatric nursing	4
	Nursing integration and practice	4
	Clinical training	23
	Basic nursing	3
	Community health/Home care nursing	2
	Adult health nursing	4
	Gerontological nursing	
	Child health nursing	
	Maternal nursing	2
	Mental health and psychiatric nursing	2
	Nursing integration and practice	2
Total		102 (100)

Source : Ministry of Health, Labour and Welfare, Appendix 3 of Ordinance for Designating Training Schools for Public Health Nurses, Midwives and Nurses, <https://elaws.e-gov.go.jp/document?lawid=326M50000180001>

3. Development of University Education for Basic Nursing Education and Graduate School Education

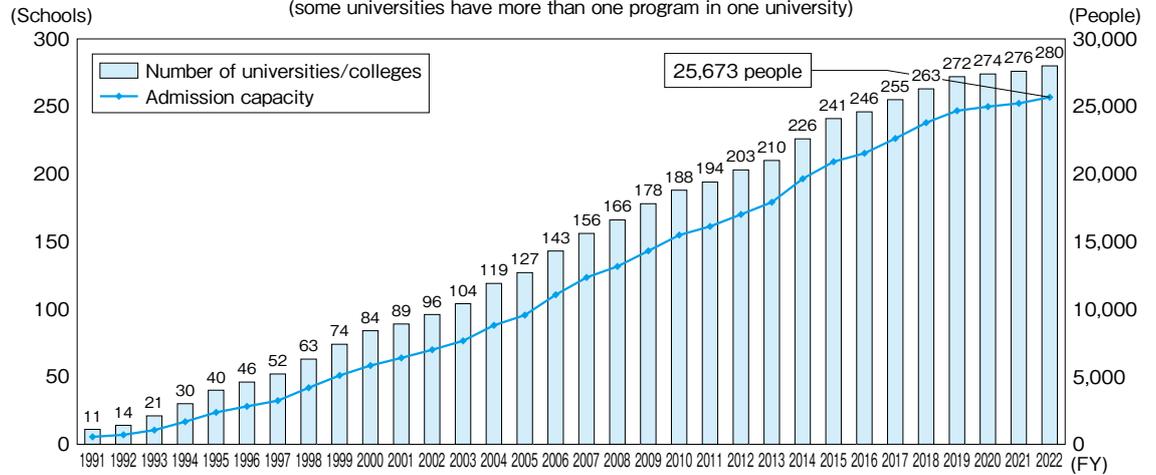
Since the introduction of basic nursing education in four-year universities in 1952, the development of university education for basic nursing education has progressed over a short time, with flexible curriculum organization in accordance with the university establishment standards outlined in 1991 and basic principles concerning nursing college/university establishment prescribed in the Act on Assurance of Work Forces of Nurses and Other Medical Experts enacted in 1992. In 1991, there were only 11 colleges/universities, with a capacity for enrollment of only 558 students, but since then there has been a

sharp increase in numbers. In recent years, with increasingly low birth rates and increasing rates of students moving on to university, there have been moves to establish nursing faculties in universities in order to secure student enrollments. As of 2022, the numbers have reached 280 colleges/universities and 25,673 students (Figure 4-2).

Combined with the transition to graduate schools offering midwifery programs and public health nurse programs, similar increases have also been observed with regard to graduate school education (Figure 4-3).

Figure 4-2 Changes in the number of nursing universities/colleges and admission capacity

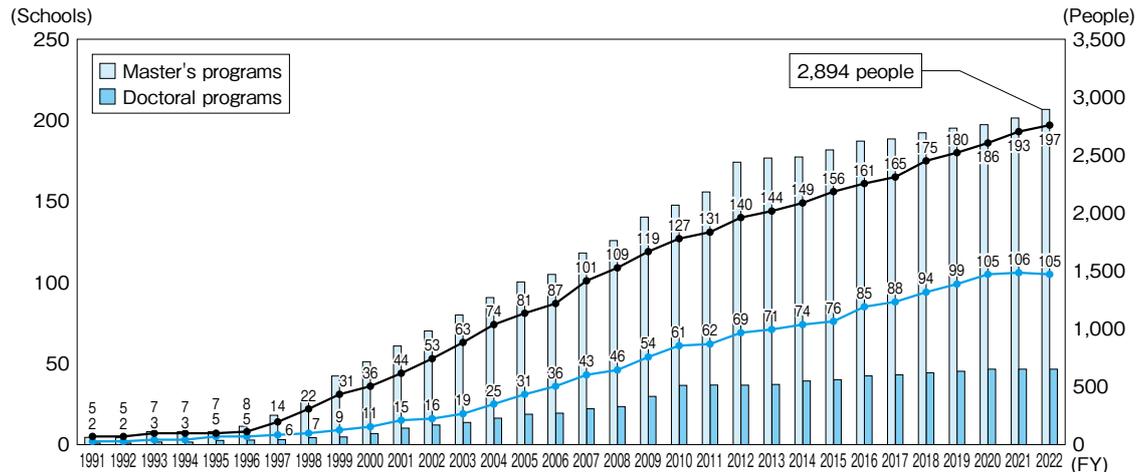
Number of nursing programs in 2022: 280 universities/colleges, 296 programs
(some universities have more than one program in one university)



(Researched by Medical Education Division, Higher Education Bureau, Ministry of Education, Culture, Sports, Science and Technology)

Source : Ministry of Education, Culture, Sports, Science and Technology, Draft budget for nursing in 2023, Reference material of Sub-Committee on Nursing Issues, Health and Labour Sub-Committee (14 February, 2023)

Figure 4-3 Changes in the number of graduate nursing programs and admission capacity



(Researched by Medical Education Division, Higher Education Bureau, Ministry of Education, Culture, Sports, Science and Technology)

Note : Master's programs after 2004 include one professional graduate school (admission capacity of 40 students).

Source : Ministry of Education, Culture, Sports, Science and Technology, Draft budget for nursing in 2023, Reference material of Sub-Committee on Nursing Issues, Health and Labour Sub-Committee (14 February, 2023)

V. Improvements in Credentials

1. Current System

Given that nursing is a profession that is deeply connected with human life and the lives of people, that medical and nursing techniques and knowledge systems are

constantly progressing, and that societal needs are always changing, it is stipulated in law as a pursuit that requires life-long diligence (Figure 5-1).

Figure 5-1 Nursing-related legal descriptions of professionalism in the nursing profession

<p>■ Medical Care Act Article 1-2 (1) Medical care is to be provided in accordance with the physical and mental state of the medical care recipient, based on a relationship of trust between the physician, dentist, pharmacist, nurse, or other medical care professional and the medical care recipient, in a way which respects life and ensures the dignity of the individual, and not only the medical treatment, but including measures to prevent illness and rehabilitation measures must also be of high quality and well-suited. Article 1-4 (1) Physicians, dentists, pharmacists, nurses, and other medical care professionals must endeavor to deliver high quality and well-suited medical care to medical care recipients, based on the concepts provided for in Article 1-2.</p> <p>■ Act on Public Health Nurses, Midwives, and Nurses Chapter IV Nursing Practice Article 28-2 Public health nurses, midwives, nurses, and nursing assistants must undergo clinical training and other training (excluding refresher training for public health nurses, and refresher training for nursing assistants), must strive to improve their professional quality, even after having acquired the license.</p> <p>■ Act on Assurance of Work Forces of Nurses and Other Medical Experts Article 6 Nurses and other medical care professionals shall strive to develop and improve their abilities on their own initiative, such as by receiving training, and demonstrate confidence and pride in their nursing duties in an effort to respond to the increasingly sophisticated and diverse demands of the public for health care services with the realization that they are the key providers of health care.</p>
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1) Clinical Training for Newly Graduated Nursing Personnel¹⁰⁾

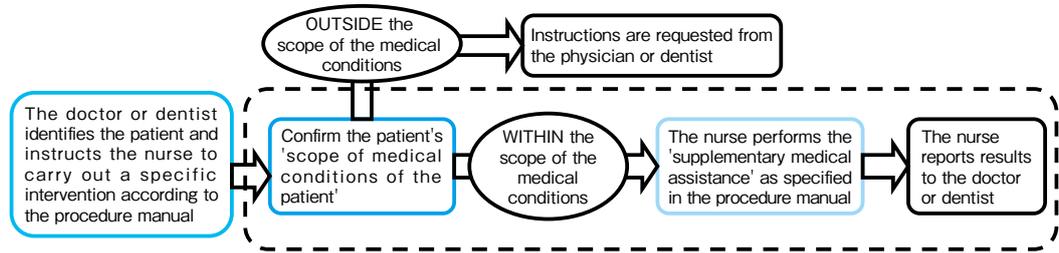
From 2010, it was made obligatory for hospitals, etc. to endeavor to provide Clinical Training for Newly Graduated Nursing Personnel, which is undertaken to acquire the basic practical clinical skills required for work. It improves the quality of nurses and prevents early departure of nurses. As of 2020, training in accordance with the government's Guidelines on Clinical Training for Newly Graduated Nursing Personnel is provided at almost all hospitals where newly graduated nursing professionals work. Hospitals can also utilize the general fund for community health care and long-term care.

2) Training System for nurses performing specific interventions

With the advance of the aging society in Japan, there has been an increase in the number of people in the community living with chronic diseases or with multiple conditions. A reform of the health care provision system (a

shift in the location of some treatment from medical institutions to communities) is currently underway, given that in 2025, the entire baby boom generation will be aged 75 or over. As part of this, in 2014 the "Training System for Nurses Performing Specific Interventions" was established to upskill nurses to be able to work in any situation including home-based care and to encourage the use of advanced clinical practical skills. Nurses who have completed the designated training are now able to perform specific interventions that have been established in advance based on a procedure manual prepared by doctors (in the form of one physician instruction) (Figure 5-2). Specific interventions are supplementary medical treatments, and include 38 interventions that, when performed by nurses according to the procedure manual, particularly require practical comprehension, thinking, and decision-making skills as well as advanced and specialist knowledge and skills¹¹⁾.

Figure 5-2 Flow of supplementary medical treatment in the case of system applicability



Source: Ministry of Health, Labour and Welfare (MHLW), Overview of Training System for Nurses Performing Specific Interventions, <https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000070423.html>

Table 5-1 Clinical Ladders

Name	Publication Year	URL
Clinical Ladder of Competencies for Midwifery Practice : CLoCMiP	2012	https://www.nurse.or.jp/nursing/josan/renewed/clocmip/index.html?utm_source=whats_new&utm_campaign=20220627
Clinical Ladder for Nurses (JNA Ladder)	2016	https://www.nurse.or.jp/nursing/education/jissen/index.html#ladder
Management Ladder for Hospital Nursing Managers	2019	https://www.nurse.or.jp/nursing/practice/management_ladder/index.html

Source: Prepared by the Japanese Nursing Association

2. Assistance for Improvements in Credentials of Nursing Professionals (Professional Organization's Initiatives)

1) Continuing education

The Japanese Nursing Association (JNA) states in its Code of Ethics for Nurses (2021 revised edition)¹²⁾ that “Nurses always endeavor to develop, maintain, and improve their abilities through continuous learning as part of their individual responsibilities” and as a nursing professional organization, it has supported nurses in ongoing learning and skill development. In 2000, it designed and published the “Continuing Education Standards” and provided support for education provided by various organizations targeting the wider nursing professional population in terms of maintaining/improving the quality and systematization of education. The JNA also conducts continuing education appropriate to the various careers of nursing professionals.

In addition, the JNA also designed a ladder to be used as a framework for improving in credentials, and it has standardized the index for the practical skills required by nursing professionals and has supported nurses in acquiring these skills. (Table 5-1). In 2016, the MHLW examined the skills required by municipal public health nurses to form a standard career ladder, and the JNA assisted in its design.

2) Establishment of a system supporting lifelong learning

Given the changes in society and working styles since 2020, the current system of ongoing training has been reviewed, and the JNA is working on a shift toward a new system (the system supporting lifelong learning) to support independent learning by nursing professionals and the practical utilization of learning and experience. Currently, the JNA is working on the base of this system, through clarification of nursing competencies and designing a new ‘ladder’ to guide nurses through step-by-step acquisition of these competencies. In addition to the practical skills in the current ladder, skills, competencies required from an ethical and legal perspective, leadership and management, etc. have been added (scheduled to be published in June 2023).

3) Training of highly specialized nurses (Table 5-2, Table 5-3)

The JNA runs the Certified Nurse Specialist System, Certified Nurse System, and Certified Nurse Administrator System. These credentialing systems are intended to provide high-quality health care to people in Japan. In order to establish the systems, investigations were carried out so that the consensus of the

nursing community would be reflected. As a result, there are currently a number of organizations and societies that provide certification systems in their field, but the credentialing systems by the JNA are socially recognized and highly respected.

In order to guarantee quality, the

credentialing system for each qualification involves certification of the educational institution, stipulation of the eligibility to take the examination, and performing the credentialing examination according to various criteria and a five-yearly renewal process¹³⁾¹⁴⁾.

Table 5-2 Role of credentialed professionals

Certifications	Roles
Certified Nurse Specialist	Play a role in practice, consultation with care providers, coordination between health and social care professionals, ethical coordination, education and research, through excellence in nursing practice.
Certified Nurse	Play a role in high standards of nursing practice, instruction and consultation with the nursing professionals and others with high level of clinical reasoning and judgement of pathological conditions.
Certified Nurse Administrator	Play a role in the development of a creative organization with excellent managerial qualities.

Source: Prepared by the Japanese Nursing Association

Table 5-3 Overview of the credentialing systems

Certifications	Year of inauguration	Year of issuing first certification	Number of fields	Number of programs	Duration of education	Number of certificated personnels*1
Certified Nurse Specialist	1994	1996	14	112 Graduate Schools 319 Courses*2	2 years 38 credits	2,901 (13 fields)
Certified Nurse	1995	1997	21	24 institutions 35 courses	6 months · 600+ hours	20,660 (21 fields)
		2021	19	26 institutions 42 courses	Within 1 year · Around 800 hours	1,495 (19 fields)
Certified Nurse Administrator	1998	1999	—	First: 69 Second: 59 Third: 32	105 hours 180 hours 180 hours	4,468

* 1 : As of April, 2022 * 2 : Accredited by the Japan Association of Nursing Programs in Universities

* 3 : A Course=Does not Incorporating Training System for nurses performing specific interventions · B Course=Incorporating Training System for nurses performing specific interventions

Source: Prepared by the Japanese Nursing Association

VI. Situation of Nursing Professionals in Japan

1. Status of Employed Nursing Professionals

In order to respond to increasing health care and nursing needs, the number of employed nursing professionals has increased year by year as a result of initiatives to secure health care personnel. The number of employed nurses is about 12.1 per 1,000 people (2020), the fifth highest among OECD countries (Figure 6-1).

The total number of employed nursing professionals was 1,683,295 in 2019, about five times the figure of 349,251 in 1970 (Figure 6-2). The number of assistant nurses has been on the decline since 2003 (Table 3-1). For that reason, the total number has only been an increase of 272 workers compared with the previous year. The number of employed nursing professionals who are male has been slowly increasing, and is around 8% of all nursing professionals¹⁵⁾.

The main workplace for nursing professionals in 2019 was hospitals for more than 60% of nurses and midwives, and around the same amount (35%) each at hospitals and clinics for assistant nurses (Table 3-1). For public health nurses, the highest proportion was in government agencies (public health centers, prefectural/municipal offices) at approximately 60%. Furthermore, in recent years, there has been a gradual increase in

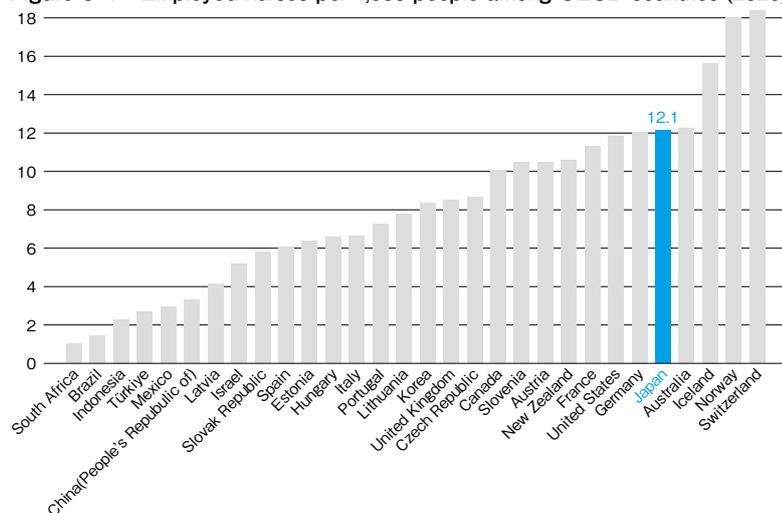
nursing professionals working in global health/nursing fields, such as at U.N. agencies, JICA, international NGOs.

Looking at employed workers according to age bracket, most nurses and public health nurses are in their 30s or 40s, but most midwives are in their late 20s.¹⁶⁾ In all professions, after the peak in worker numbers, the decrease from age 45 onward is particularly significant.

By contrast, the number of nursing professionals aged 60 or older who continue to work after the official retirement age or who are reemployed is increasing year to year. In 2002, they accounted for 3.4% of all workers, but in 2020 they totaled approximately 360,000, or 11.8%; in other words, about 1 in every 9 working nursing professionals was aged at least 60.¹⁷⁾

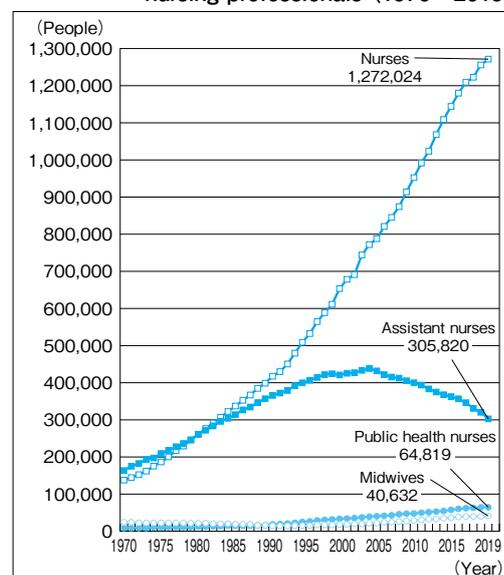
In November 2019, it was estimated by the Ministry of Health, Labour and Welfare (MHLW) that the demand for nursing professionals¹⁸⁾ would be 1.88 to 2.02 million workers, in contrast to the national supply of nursing professionals of approximately 1.75 to 1.82 million in 2025, which is expected to be a shortfall of at least 60,000 workers. Furthermore, in addition to the lack of numbers, amid expanding nursing needs in

Figure 6-1 Employed nurses per 1,000 people among OECD countries (2020)



Note 1: Some countries (France, Ireland, Italy, the Netherlands, Portugal, Slovakia, Türkiye, and the United States) include nurses who are not in clinical practice such as managers, educators and researchers.
 Note 2: Austria and Greece include only hospital-employed nurses.
 Note 3: Midwives and nursing assistants (not qualified as nurses) are usually excluded, although some countries include midwives who are considered professional nurses.
 Source: OECD Data, Nurses, <https://data.oecd.org/healthres/nurses.htm>

Figure 6-2 Trends in the number of employed nursing professionals (1970~2019)



Source: Japanese Nursing Association Publishing Company, Statistical Data on Nursing Service in Japan 2021

various areas such as home-based care (associated with diversification in treatment settings and the promotion of community-based integrated care) and long-term care insurance services, it has been identified that overall, there is a shortage of nurses in some

regions, including remote areas, as well as an uneven distribution of nursing professionals by area (by place of employment), such as shortages in visiting nursing and long-term care facilities, while medical institutions have sufficient numbers of nurses.

2. Impact of COVID-19 Pandemic on Working Conditions of Nursing Professionals

Since 2020, the COVID-19 pandemic has impacted both the working environments and the work of nursing professionals. In a fact-finding survey of staff working in jobs related to COVID-19, 55.3% of respondents said that

overtime had increased.¹⁹⁾ Other impacts observed were “fear/anxiety of infection,” “deterioration of working environments,” and “discrimination/prejudice/insensitive comments from others”.

3. Efforts for Nursing Professionals Who Have Left the Profession or Who Are Not Currently Working

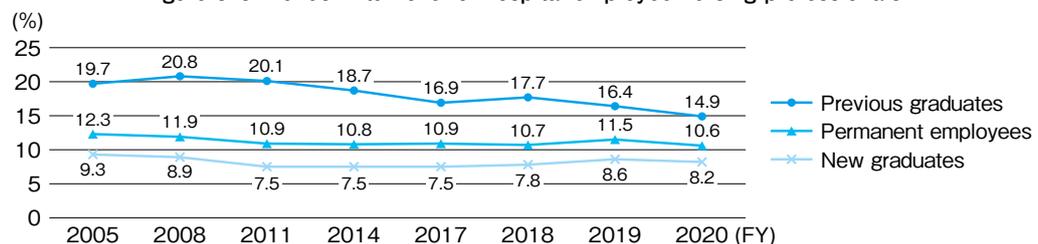
1) Status of nursing professionals who have left or who are not currently working in the profession

While the number of employed nursing professionals in Japan is increasing, there are also nursing professionals who are leaving or who are not currently working in the profession. In a JNA survey from FY2020, it was estimated that the proportion of permanent employees (hospital nursing professionals) leaving the profession was 10.6% and that of newly graduated employees was 8.2% (Figure 6-3). Factors leading to nurses leaving the profession vary depending on the area, it is thought that in nursing this is due to the fact that more than 90% of

workers are women, and that shift work is required including night shifts when working at a medical institution (Figure 6-4).

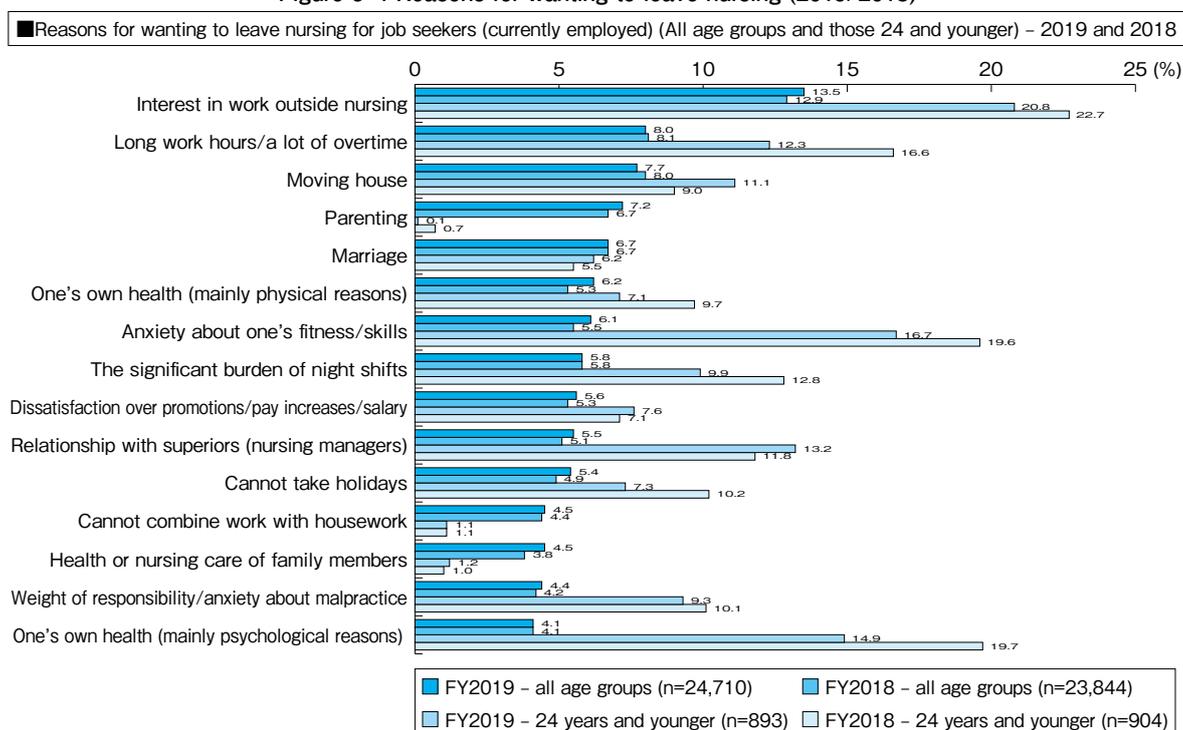
It is estimated that those not currently working as nursing professionals (not working in the nursing profession after leaving) total approximately 700,000 under age 65, which is 31.1% of those who hold a nursing license (2018). For nurses, the proportion of those not working as nurses is high in the 35-39 age group (34.15%) and the 55 and over age group (28.48%-65.65%).²⁰⁾ By contrast, 36.1% of nursing professionals who are not working in the profession say, “I want to work as a nursing professional,” but this ratio decreases the longer they are away from the profession.²¹⁾

Figure 6-3 Trends in turnover of hospital-employed nursing professionals



Source: The Japanese Nursing Association, Survey on the Actual Situation of Nursing in Hospital and Outpatient Nursing 2021, https://www.nurse.or.jp/home/up_pdf/20220401121744_f.pdf

Figure 6-4 Reasons for wanting to leave nursing (2019/2018)



Source: Compiled by the Japanese Nursing Association based on FY2019 and FY2020 the Japanese Nursing Association Report of Analysis of job seekers, job vacancies, and employment for nursing professionals based on Nurse Center Registration Data

2) Initiatives for continuing employment and being reemployed

In order to ensure the nursing service delivery system and to promote the work of nurses as professionals, assistance for continuing employment and returning to work is important.

Since the Act on Assurance of Work Forces of Nurses and Other Medical Experts was enacted in 1992, there have been various initiatives, mainly at hospitals, to introduce a range of work options. Initiatives include alleviating the burden on workers in terms of making night shift work more decent and remedying long working hours, and creating systems for regular workers to be able to work short shifts. In recent years, the issue of harassment has emerged, either between staff at workplaces or from patients (users) or their families, which has resulted in initiatives being launched to ensure healthy and safe workplaces. Regarding assistance for returning to work, prefectural nurse centers have been set up, where initiatives have been introduced for securing nursing professionals in these prefectures. As part of reemployment support for nursing professionals who are not

currently working, there is a free service for work referrals, and support in the form of training for returning to work. The Japanese Nursing Association (JNA) has links with governmental projects, moves forward with initiatives to secure nursing professionals, such as improving working environments, and runs the Central Nurse Center designated by the MHLW.

Furthermore, a new nursing personnel utilization system is set to start in 2024, which uses the Individual Number (personal ID number) system. It is expected to provide a more comprehensive structure for ongoing career support based on work experience and training courses undertaken, the promotion of more effective continuing education, and support for returning to work for nursing professionals currently not working in the profession.

In addition, there are also moves to improve the working conditions of nursing professionals, specifically in terms of wages. Led by the government, from February 2022, efforts were made to increase the wages of nursing professionals using government subsidies and medical reimbursement fees, and

measures were put in place so that the wages of nursing professionals were increased by about 3% (12,000 yen per month) at hospitals providing COVID-19-related treatment. Furthermore, in November 2022, the salary schedule for national public servant health care workers, which influences Japan's nursing wage system, was revised, and in December,

the MHLW notified health care facilities around Japan to promote consideration of improved working conditions of nursing professionals associated with career enhancement. Various policies to raise the wages of nursing professionals have been promoted.

Ⅶ. Foreign Nurses Working in Japan

1. Foreign Nurses Working in Japan

Mutual recognition of nursing qualifications by other countries is not carried out in Japan. As a result, foreign nurses who wish to work in Japan need to pass the Japan national nurse examination and to obtain a license, but if they gain a position in nursing after that, they can work in Japan without any restrictions on the period of employment. Their visa status will be “medical services” but because it is the same category as doctors and other related occupations, the number of workers with only a nursing-related qualification is unknown. For reference, according to the Ministry of Justice’s published statistics on foreign nationals living in Japan, there were 2,534 foreign nationals as of June 2022 who were residents (working) in Japan with the visa status of “medical services.” The main countries of origin were China (1,821 people), Indonesia (176 people), Vietnam (145 people), South Korea (140 people), Taiwan (105 people), and Philippines (95 people).²²⁾ In the case that international students study at nursing schools, etc. in Japan and take the national exam, they are not classified as international students at the point of passing the exam, so it is not possible to gain an understanding of the

number of people gaining nursing qualifications through the international student route. However, if they are later employed as nurses, their visa status changes to “medical services” and they are included in the above statistics. It should be noted that among foreign nationals, for people with no work restrictions (visa status based on position/relationship) including spouses of Japanese nationals, permanent residents, special permanent residents, and spouses of permanent residents, it is not possible to obtain information on the number of those with nursing qualifications or the number of those working as nurses.

Obtaining qualifications is divided into those who have graduated from an MHLW-accredited nursing school just like Japanese nationals, and those who have graduated from an overseas nursing school and gained an overseas nurse’s license and then received certification of eligibility to sit an exam in Japan. In reference to the latter, the following section sets out information on the acceptance of foreign nurses based on Economic Partnership Agreements (EPAs) as an outline and official framework for obtaining qualifications.

2. Acceptance of Foreign Nurses

1) Overview of methods for obtaining qualifications

For someone with an overseas nursing license to take the Japan national nurse exam, it is necessary for them to gain eligibility to sit the exam via “certification of eligibility to sit the exam.” The requirements for eligibility include being a graduate of an overseas nursing education institution, having a nursing qualification, and having achieved the N1 level of the Japanese Language Proficiency Test. The review for certification of eligibility is carried out by the Ministry of Health, Labour and Welfare (MHLW) in accordance with the certification criteria based on the Act on Public Health Nurses, Midwives, and Nurses (Act No. 203 of 1948) Article 21 (5). Those who are certified are issued a certification from the MHLW, and they can then start the procedures for taking the national exam. The certification of eligibility

to sit the national exam for public health nurses and midwives is the same. For the processes and review methods for certification of eligibility to sit the exam (public health nurses, midwives, nurses), see the MHLW website.²³⁾

2) Outline of the framework and the track record of accepting foreign nurse candidates under EPAs

(1) Framework for acceptance of foreign nurse candidates under EPAs

The acceptance of foreign nurse candidates based on EPAs is carried out with an official framework and with special provisions from the perspective of stronger economic ties between Japan and another specific country.

In line with this framework, a nurse candidate who has entered Japan has a duration of stay set out as part of the agreement (three years), and during this time,

they work at a hospital while undergoing training to prepare for the national exam. If the candidate obtains a national qualification either during their stay or after returning home, they are permitted to work in Japan as a nurse.

Currently, agreements have been signed with Indonesia, Philippines, and Vietnam, and acceptance of nurses based on these agreements has been carried out since 2008, 2009, and 2014 respectively.

The Japan International Corporation of Welfare Services (JICWELS) is a coordination institution for the support and acceptance of those working and training toward acquisition of a national qualification. From the perspective of properly accepting candidates, it is the only coordination institution for acceptance. The MHLW acts to supervise JICWELS' services, such as work referrals, along with closely liaising and operating with the Ministry of Foreign Affairs, the Ministry of Justice, and the Ministry of Economy, Trade and Industry²⁴⁾.

For the latest information on this framework, see the MHLW website.²⁵⁾

(2) Japan's EPA-related projects

In order to carry out the smooth and appropriate acceptance of foreign nurse candidates entering Japan based on an EPA, and toward increasing the number accepted, the government is conducting the following projects including induction training for nurses, on-site instruction and assistance with learning environments for the facility accepting candidates, and support for candidates for learning Japanese and acquiring specialist knowledge.

- Project to support the acceptance of foreign nurses/Project to support the learning of foreign nurse candidates

① Project to support the acceptance of foreign nurses

For the smooth acceptance of foreign

nurse candidates, the government provides support for the costs required to hold information sessions within Japan, to hold basic training in the nursing field, and to conduct on-site visits by nursing specialists at facilities accepting candidates.

② Project to support the learning of foreign nurse candidates

For enhanced Japanese study and training focusing on specialist nursing fields for foreign nurse candidates, the government has set up and operates an e-learning support system, and provides support for the costs required to hold regular group training for candidates and to assist training planning for trainers at institutions accepting candidates.

- Project to support the work-related training of foreign nurse candidates

For the foreign nurse candidates to achieve the level of Japanese language ability required to work, the government supports the acceptance institution for the costs required to appoint a Japanese language teacher and for the costs for trainers and the training location.

(3) Track record of acceptance via EPAs

Of the nurse candidates accepted via EPAs, the number of people who have passed the national exam by the end of their stay is as shown in Table 7-1 (up until 2018). The system allows for multiple attempts at the exam during their stay, or, after the end of their stay, another entry into Japan to take the exam.

The pass rate for the national exam is low, which is associated with the insufficient Japanese language ability of the nurse candidates, so the government is working on a number of improvements to the framework, including more comprehensive learning support for the national nurse exam, and the compilation of national exam questions using wording that is easier to understand for nurse candidates whose first language is not Japanese.

Table 7-1 Track record of acceptance and the number of successful national nurse exam candidates (up until 2018)

	Indonesia (2008~)	Philippines (2009~)	Vietnam (2014~)	Total
Track record of acceptance	653	546	101	1421
successful national nurse exam candidates (% of Track record of acceptance)	193 (29.6%)	199 (36.4%)	91 (90.1%)	516 (37.2%)

Source: Compiled by the Japanese Nursing Association based on the Japan International Corporation of Welfare Services (JICWELS). Booklet for Acceptance of Foreign Nurse and Care Worker Candidates under EPA in FY2023, <https://jicwels.or.jp/wp-content/uploads/2022/03/2023%E5%B9%B4%E5%BA%A6%E7%89%88%E5%8F%97%E5%85%A5%E3%82%8C%E3%83%91%E3%83%B3%E3%83%95%E3%83%AC%E3%83%83%E3%83%88.pdf>

VIII. Response to Disasters and Pandemics

1. Response to Disasters (Disaster Relief Nurses)

1) Disaster relief nurses

In response to the Great Hanshin-Awaji Earthquake (Kobe Earthquake) of 1995, the Japanese Nursing Association (JNA) set up the Disaster Relief Network System so that in times of large-scale natural disasters, disaster relief nurses could be sent to affected areas. Disaster relief nurses, as members of professional nursing associations, are nursing professionals who take on the role of providing

appropriate health care/nursing in disaster-affected areas, working to support nursing professionals in affected areas to alleviate physical and mental stress, and to maintain the health of disaster victims. They are registered with prefecture nursing associations (Table 8-1). As of the end of March 2021, the number of registered disaster relief nurses was 10,251.²⁶⁾

Table 8-1 Registration requirements for a disaster relief nurse

- Currently a member of prefecture nursing associations
- At least 5 years of work experience
- Approval of the head of the facility upon registration if working at healthcare facilities
- Completed the disaster nursing training course

Source: Japanese Nursing Association, How to become a disaster relief nurse, <https://www.nurse.or.jp/nursing/practice/saigai/index.html>

2) Framework for dispatching disaster relief nurses²⁷⁾²⁸⁾

In terms of dispatching disaster relief nurses, the JNA or the nursing association in the prefecture where a disaster has occurred coordinates the dispatch of disaster relief nurses according to the disaster response classification (Level 1, 2, 3) set out based on disaster scale levels. The priority for disaster relief nurses is generally to work at medical institutions/social welfare facilities and emergency shelters (including emergency shelters for the vulnerable). The target period of work in affected areas is from the third day to one month after the disaster, and the period for disaster relief nurses to be individually dispatched is, as a rule, three nights and four days, including travel. Nursing support work by disaster relief nurses is carried out on the basis of self-sufficiency. In case of Levels 2 and 3 in which the JNA coordinates dispatch of nurses, the JNA provides disaster relief nurses with travel accident insurance, travel expenses, accommodation expenses, and daily allowances.

3) Track record of activities: 2011 Great East Japan Earthquake (Tohoku earthquake and tsunami)²⁹⁾

The Great East Japan Earthquake on

March 11, 2011 was the largest earthquake since national records began, at magnitude 9.0 with a maximum intensity of 7 on the Japanese seismic intensity scale.³⁰⁾ On the day of the earthquake, the JNA set up the Disaster Management Headquarters. Due to poor transport connections in the aftermath of the earthquake, the JNA hired large buses and transported 20–30 disaster relief nurses to the affected areas each day. The nurses were available 24 hours a day at emergency shelters and medical institutions in the affected areas. They cared for evacuees who required medical or nursing assistance, managed infection assessments and environmental hygiene, dealt with infection control measures, cared for those in isolation, and assisted with getting people to medical institutions and emergency shelters for the vulnerable depending on the health status of the evacuee in question. From March 21 to May 17, 2011, 938 disaster relief nurses (cumulative total of 3,770 nurses) were dispatched to 49 emergency shelters and medical institutions affected by the disaster, to carry out support work.³¹⁾

2. Response to Pandemic

1) Response to the COVID-19 pandemic³²⁾

COVID-19 was first confirmed in Wuhan City, China, in December 2019, after which it spread around the world. It was declared by the World Health Organization on January 30, 2020, as a Public Health Emergency of International Concern. The first person to be infected in Japan was confirmed on January 15, 2020. On February 1, the Japanese government designated it as a “designated infectious disease,” which made compulsory hospitalizations possible and the relevant care to be at the government’s expense. The Novel Coronavirus Response Headquarters was also established. After that, there were repeated waves of infection, and up until February 17, 2021, when COVID-19 vaccinations started in Japan, the total number of positive cases had reached 416,812, with 6,487 deaths (231 deaths under the age of 60, 6,244 deaths over 60, and 12 unknown).³³⁾

As COVID-19 spread around the country, nursing professionals treated patients in a variety of settings including health care, long-term care, government, community, in-home, and educational facilities. Certified Nurse Specialists (CNS) in Infection Control Nursing and Certified Nurses (CN) in Infection Control (certified by the JNA) used their expertise and experience, moving out of their own facilities and into other health care facilities, public health centers, and elderly care facilities to provide support for infection control.³⁴⁾ With a shortage of nurses to respond to the pandemic,

6,745 nursing professionals who had not been working answered the call of the Nurse Center to return to work in COVID-19 accommodation facilities for mild cases and at vaccination sites (as of June 20, 2021).³⁵⁾ While there was greater public concern for health care workers working on the front lines of the pandemic, these health care workers who were treating positive cases were also on the receiving end of prejudice and mental abuse. In the results of a survey conducted in September 2020, it was found that one in five nurses had experienced prejudice or discrimination as a result of the spread of COVID-19.³⁶⁾

2) Treatment support from public health centers³⁷⁾³⁸⁾

As a base for public health administration in the community, infection control is part of normal public health center operations. When an infection occurs, they take outbreak responses to prevent further spread of infection, as well as preventive measures for future recurrences. Public health centers were responsible for confirming and reporting total numbers of positive COVID-19 cases to their respective prefectural offices as well as arranging hospitalizations for positive cases (excluding hospitalizations where they were transported by ambulance). Public health nurses at the centers provided a range of support for the treatment of positive cases (as of February 2021, Table 8-2).

Table 8-2 Main treatment support for positive cases provided by public health nurses at public health centers

1. Treatment for people with symptoms (not tested)
 - Telephone consultations at the fever consultation center
 - Taking specimens
 - Arranging and supporting physician visits, transport
2. Treatment for positive cases following receipt of a “COVID-19 Case Notification”
 - Active epidemiological investigation (for positive case/facility)
 - Arrangements for the receiving hospital/support for transport
 - Hospital Admission Admonishment and work restriction notification for the positive case
 - Transfers from hospitals assisting with infectious diseases to designated medical institutions for infectious diseases
 - Grants for medical fees during admission
 - Treatment support and consultation for those recuperation at home
 - Communication at the time of discharge

Source: Compiled by the Japanese Nursing Association based on Nursing White Paper (2021): The Work of Nurses during the Spread of COVID-19, JNA (Ed)

3) Overseas comparison of mortality rates in elderly care facilities³⁹⁾⁴⁰⁾⁴¹⁾

In the early stage of the pandemic, deaths of elderly people with a high risk of severe disease were significant. As of the end of April 2020, approximately 14% of the national deaths from COVID-19 in Japan were those using elderly care facilities. By contrast, in Europe and the U.S. at the same time, people in elderly care facilities made up nearly half of the national death. The reason for the low mortality rate in Japan's elderly care facilities is not clear, but some news reports point to the efficacy of measures such as the following: in the early stage of the pandemic, the government called for infection control measures in elderly care facilities around the country (e.g. visiting restrictions), and there was thorough infection control in these facilities. Furthermore, it is thought that the support of CNSs and CNs specialized in infection control was effective.

4) Treatment of foreign nationals living in Japan

With the global spread of COVID-19, from February 1, 2020, Japan began entry restrictions on visitors from some countries and regions. By contrast, the number of foreign nationals living in Japan at that time was approximately 2.93 million⁴²⁾, and the number of positive cases of foreign nationals increased at the same time as positive cases among Japanese nationals increased. In the early stage of the pandemic, issues emerged such as in treating foreign patients and those with symptoms as well as lack of availability of information in other languages. Subsequently, there was a gradual increase in COVID-19 call centers and support centers for those recuperating at home, operated by local authorities with multi-language support available. A multi-language COVID-19 website was set up by the Ministry of Health, Labour and Welfare, and a 24-hour free telephone interpretation service for public health centers, health care facilities, and accommodation facilities for mild cases was started.⁴³⁾⁴⁴⁾

3. Restructuring of Dispatch System of Relief Nursing Professionals in Natural Disasters and Pandemics

National frameworks will be set up, in which health care personnel can be widely dispatched in times of infectious disease outbreaks/pandemics, trained and registered in normal times. In December 2022, with the revision of the Act on the Prevention of Infectious

Diseases and Medical Care for Patients with Infectious Diseases and the Medical Care Act, disaster relief nurses and nurses who have completed the current "COVID-19 Response Training" can be trained and utilized in a new framework under government policy.

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Japanese Nursing Association

5-8-2 Jingu-mae, Shibuya-ku, Tokyo, 150-0001 JAPAN

URL: <https://www.nurse.or.jp/> (in Japanese)

<https://www.nurse.or.jp/english/>

E-mail: inquiry@nurse.or.jp (Department of International Affairs)



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