

# Globalisation of the Healthcare Services Sector: Employing Foreign Physicians in National Strategic Special Zones in Japan

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**Abstract**— With the continuing increase in the ageing rate of the population, Japan must establish a system for the quantitative expansion of healthcare services and the improvement of the efficiency of service provision in order to respond to the increasing demand for the provision of healthcare services. In addition to these quantitative needs, the country needs to respond to the diversification of healthcare needs. The diversification of needs requires careful approaches towards changing disease structures and complex needs; healthcare needs that have diversified as a result of the increase in the number of foreign patients give rise to the need for diverse restructuring of the conventional healthcare service system in Japan. Discussing the viewpoint of globalisation which is needed in order for healthcare services in Japan to focus on guaranteeing denizenship, this study introduces the following measures as means to respond to the diverse medical needs of residents, including foreigners: development of a system for multilingual healthcare services in medical practice; consideration of the social customs of foreign patients and the lifting of restrictions on foreign doctors practising in the National Strategic Special Zones.

**Keywords**—healthcare, foreign physicians, national strategic special zone, denizenship.

## I. INTRODUCTION

### A. Purpose and Subject of This Paper

This paper aims to discuss the expansion and diversification of service demands as a challenge faced by healthcare in Japan and to examine the structure of healthcare services provided to foreign patients in particular as an issue related to this diversification.

Maintaining healthcare services is a fundamental mechanism of a welfare state and is related to the protection of the right to live specified in Article 25 of the Constitution of Japan. Japan's universal healthcare system has been established and developed as a social security system in accordance with Article 25, which regards the protection of citizens' right to live as a public responsibility. Due to the existence of a so-called 'nationality requirement', the National Health Insurance Act was only applicable to Japanese nationals until 1986. Nonetheless, after the ratification of the Convention Relating to the Status of Refugees, the nationality requirement was eliminated, and Japan modified its system to include foreign residents.

To respond to the healthcare needs of foreign residents, in addition to the removal of the nationality requirement from the healthcare system, it is also important to develop a healthcare service system which considers linguistic, cultural and religious differences. For example, many of the problems presented here could be solved if patients were able to consult doctors in Japan from their home countries. In this regard, Japan imposes strict regulations on healthcare services provided by foreign doctors. For a mod-

ern welfare state that needs to be reorganised into a system that protects the lives of diverse people, it is necessary to globalise medical services to respond to foreign nationals' medical needs.

### B. Analytical Framework of This Paper

Among other public services, healthcare is deeply connected to the welfare state and is also an area with implications for people's health and safety. Thus, the question of whether the right to healthcare services is guaranteed is a crucial matter concerning the protection of citizenship. A seminal study of citizenship theory by the British sociologist T. H. Marshall, *Citizenship and Social Class*, published in 1950, details the establishment of a welfare state in the 20th century through the maintenance of a system guaranteeing social citizenship. His citizenship theory was modelled on Britain and strongly linked to the concept of a nation state. In other words, this theory did not include a guarantee of citizenship to foreigners. In that sense, Marshall's citizenship theory considers the concept of citizenship almost synonymous with nationality.

However, the increasing international migration of people that took place mainly in Europe after the overthrow of the rule of imperialism resulted in a deviation from this rather nationalistic theory of citizenship. In the countries under imperialist rule, including the case of the United Kingdom, people moved from colonies to the ruling countries. Many of these people were subjects of the ruling countries where their citizenship as foreigners was never a problem. Nevertheless, as foreign workers started moving abroad as a result of the expansion of labour immigration after decolonisation, it gradually also became necessary to consider citizenship theory in relation to the protection of the rights of foreigners who had settled in different countries.

It was the Swedish political scientist Tomas Hammar who aimed to establish a theoretical framework to guarantee citizenship for foreign residents. He attempted to describe the status of foreign residents using the term 'denizen', coining the concept of 'denizenship' as a status existing somewhere between citizens and foreigners, on the basis of his concern over the status and the rights of people living in foreign countries not as citizens but as residents. His idea of a system for guaranteeing citizenship based on the residence status known as 'denizenship' raised a question about the concept of nation states. Hammar's theory of denizenship is a theory that mainly advocates for the voting rights of foreign residents, i.e. their political rights. Although the question of being a citizen or a foreigner has been proposed as the criteria for providing public sector services such as medical welfare services, in reality, both nationals and foreign residents living in a country need the same social services. Therefore, the concept of guaranteeing rights based on a residence status akin to denizenship needs to be incor-

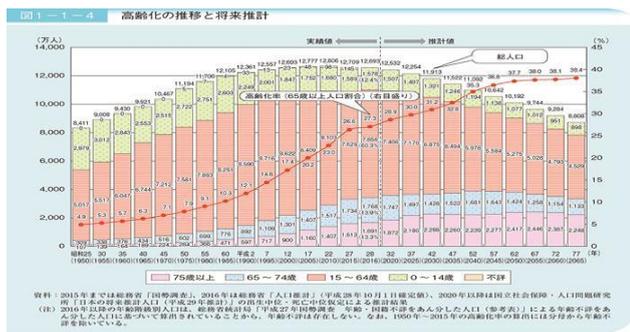
porated into the provision of actual medical welfare services and other public services.

As discussed in Chapter 1, with the continuing increase in the ageing rate of the population, Japan must establish a system for the quantitative expansion of healthcare services and the improvement of the efficiency of service provision in order to respond to the increasing demand for the provision of healthcare services. The establishment of a mechanism to respond to the medical needs of the growing number of foreign residents, in other words, creating a system that can meet diverse needs, is another challenge currently faced by healthcare services in Japan. Discussing the view-point of globalisation which is needed in order for healthcare services in Japan to focus on guaranteeing denizenship, this study introduces the following measures as means to respond to the diverse medical needs of residents, including foreigners: development of a system for multilingual healthcare services in medical practice; consideration of the social customs of foreign patients and the lifting of restrictions on foreign doctors practising in the National Strategic Special Zones.

C. Summary of Previous Research

As international migration expands, Hammar’s concept of denizenship is increasingly needed on a more practical level. In such circumstances, various studies have been conducted on the granting of rights to foreign residents in

Chart 1: Current and Future Trends of Ageing in Society



Source: [7]

It is generally known that an increase in the elderly population creates greater demand for medical welfare. Therefore, in order to respond to the increasing demand for medical welfare in the future, enhanced collaboration between healthcare and nursing services focusing on the establishment of a regional comprehensive care system has been promoted in Japan in preparation for the 2025 Problem. A regional comprehensive care system is a system in which housing, healthcare, nursing care, preventive care and living support are holistically provided, enabling people to continue living in their own ways and in familiar areas, even if they require intensive nursing care. This cooperation between healthcare and nursing care aims to provide highrelatation to the theory of denizenship [1] [2] [3] [4] [5] [6]. As explained above, because the theory of denizenship focused on guaranteeing political rights to foreign residents, most studies on the theory have also developed discussions on the basis of this perspective.

Along these lines, the present research explores the possibility of taking ideas generated through the theoretical study of denizenship within citizenship theory and introducing them to actual systems and policies, through a consideration of the construction of a system that allows residents, including foreigners, to receive healthcare services. In terms of the residents’ needs, the creation of a

mechanism to provide necessary healthcare services to all residents is needed in order to respond to both quantitative institutional needs and the diverse needs of individuals. As discussed earlier, when designing a system in addition to establishing a mechanism that does not exclude foreign nationals, it is important to examine its functions to consider if the system is actually accessible to them.

II. PRESENT STATUS OF HEALTHCARE SERVICES IN JAPAN

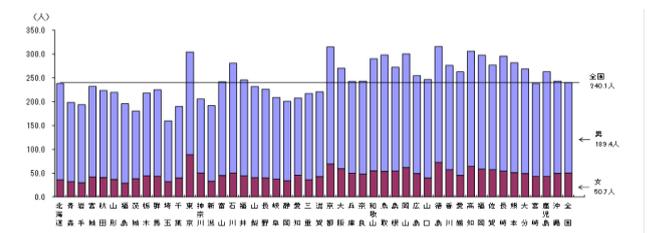
A. Increase in Healthcare Needs

(1) Increase in Ageing Rate and the 2025 Problem quality and efficient services. The continued growth of medical needs with the ageing of the population requires the establishment of an efficient system for providing services.

(2) Uneven Distribution of Doctors among Regions

Because it takes 10 years to qualify as a doctor, the number of trainees at the national level has always been controlled in consideration of increasing or decreasing future healthcare demands. In addition to the management of the number of doctors at the national level, the uneven distribution of doctors among regions is also an important issue concerning the training of doctors in Japan in recent years.

Chart 2: Number of Doctors Working in Healthcare Facilities per 100,000 People by Prefecture (31 December 2016)



Source: [8]

As indicated in Chart 2, the number of doctors per 100,000 people in each prefecture of Japan tends to be greater in the west and lower in the east. Although increases in the ageing rate and population decline are more prominent in the Tohoku region, the number of doctors in the prefectures in metropolitan areas including Saitama, Chiba, Kanagawa and Ibaraki falls well below the national average.

Mori attributes the uneven regional distribution of doctors to medical schools having been founded in each prefecture at different times [9]. As indicated in Chart 2, the Kyushu area has a relatively large number of doctors. The seven prefectures of the Kyushu area have 10 medical schools in total, many of which, including their predecessor organisations, were founded shortly after or just before the end of the war. Among the regions currently having a large number of doctors, Kyushu has a long history of training doctors.

The issue of uneven regional distribution of doctors needs to be solved in order to efficiently respond to the increasingly expanding medical needs that would result from a lack of medical personnel in the future. To address this unevenness, since 2010, the government has been providing funds for the recovery of community healthcare services to prefectures that have formulated plans to revive healthcare services and solve healthcare problems. Under these plans,

many prefectures have incorporated a ‘regional framework’ into their plans in order to secure personnel for community healthcare services, in which students who wish to engage in community healthcare are selected in conjunction with the scholarship system. According to a survey conducted by the Ministry of Education, Culture, Sports, Science and Technology, 71 medical schools and universities across the country incorporate the regional framework system as of 2017 [10]. This system secures reliable caregivers for community healthcare services.

In terms of both the right to live guaranteed by the Constitution of Japan and in terms of guaranteeing citizenship, it is problematic that healthcare services are unavailable in some areas when residents need medical attention. To respond to the growing demand for healthcare services and improve the efficiency of the current service over the expansion of the number of doctors, priority must be given to addressing the uneven regional distribution of doctors.

### B. Diversification of Healthcare Needs

#### (1) Increase in the Number of Foreign Residents

According to a survey conducted by the Immigration Bureau of the Ministry of Justice, the number of medium and long-term residents as of the end of 2017 was 2,232,026, and the number of special permanent residents was 329,822. With those two categories combined, the total number of foreign residents increased by 179,026 people (7.5%) compared to the end of the previous year and reached a record figure of 2,561,848 at the end of 2017. The number of foreign residents in Japan is increasing every year, and although permanent residents and special permanent residents account for 40% of the total population, the number of foreign nationals staying in the country as technical trainees and highly skilled workers has also been growing in recent years.

Chart 3: Trends in the Number of Foreign Residents in Japan and their Proportion to Japan’s Total Population



Source: [11]

Chart 3 describes the trends in the number of foreign residents since 2007 and their proportion to Japan’s population. In addition to increasing in number, foreign residents are also increasing in proportion to the total population as indicated by the green line in the graph.

#### (2) Provision of Healthcare Services and Increase in the Number of Foreign Residents

As the number and proportion of foreigners living in Japan increase, public services are required to meet their needs. Access to healthcare services that ensure quality of life and health should especially be guaranteed to all people equally; moreover, broadening knowledge about foreigners’

languages, cultures and lifestyles is also important in medical practice.

Healthcare services are needed to meet the expansion and diversification of demand, and recruitment of personnel is a challenge which needs to be met in taking action to achieve this. Healthcare is a labour-intensive industry, and the number and quality of doctors are directly linked to the quality and safety of healthcare services [12]. In this regard, this paper discusses how to meet the expanding and diversifying healthcare needs by focusing on the recruitment of doctors and medical personnel.

The diversification of healthcare needs poses a range of new challenges to healthcare services such as changes in people’s lifestyles, disease patterns and complex healthcare needs. In particular, the diversification of healthcare needs resulting from an increase in foreign patients requires the existing Japanese healthcare system to be restructured on various levels. This paper examines the diversification of healthcare needs prompted by the growing number of foreign patients as a result of the expansion of foreign residents.

### III. APPROACH TOWARDS THE RECRUITMENT OF A SUFFICIENT NUMBER OF DOCTORS

#### A. Means for Quantitative Expansion of Healthcare Services in Japan

##### (1) The Government’s Approach towards Increasing the Number of Doctors

There are only three ways to increase the number of doctors: (1) increasing the number of trainees, (2) promoting retention rates and return after leave and (3) overseas recruitment [13]. In addition, because the training of doctors generally takes 10 years and their number cannot immediately be increased or decreased, workers need to be trained from a medium- to long-term perspective.

In Japan, the number of doctors has been managed with regard to social conditions including potential future outcomes, through public intervention in the number of medical schools and their capacities. The number of doctors has not always failed to meet demands. In fact, there were times when measures were taken to address an oversupply of doctors by limiting the number of medical school students.

The Medical Practitioners Act in Japan only permits those with a Japanese medical licence to perform medical practice domestically, stipulating that ‘No person except a medical practitioner shall engage in medical practice’ in Article 17 and that ‘A person who wishes to become a medical practitioner shall pass the National Examination for Medical Practitioners and receive a licence from the Minister of Health, Labour and Welfare’ in Article 2. To be qualified to take the National Examination for Medical Practitioners, candidates must complete six years of medical education at medical schools or courses.

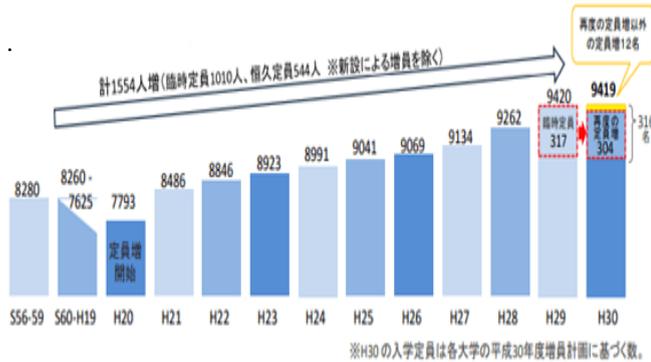
Healthcare demand increased as a result of the establishment of the universal healthcare system in 1961, and the vision to establish at least one medical school or university with a faculty of medicine in each prefecture was included in the Basic Economic and Social Plan determined by the Cabinet under Kakuei Tanaka in 1973. Although 15 prefectures did not have medical schools or universities with medical faculties at that time, medical schools and universities began to be established in 1973 on the basis of the plan in those prefectures, achieving the vision to set up at least one medical school per prefecture in just seven years. The number of admitted students increased each year and reached a record high of 8,280 in 1984.

However, an oversupply of doctors in the future gradually became a matter of concern with regard to keeping the

training of doctors at a high standard. An oversupply of doctors in the future began to be considered as an issue in the mid-1970s because there was concern that an oversupply of doctors could lead to an increase in medical expenses. In 1982, the Cabinet decided to establish a pragmatic doctor training plan based on the Measures for the Implementation of Future Administrative Reform, and in the mid-1990s, measures such as reducing the number of students admitted to public and private universities were proposed in order to reduce the number of medical trainees by 10%.

Each university took measures to reduce the number of students; however, in 2007, the policy was changed due to a shortage of doctors. Under the Emergency Measures for the Recruitment of Medical Practitioners, the government announced a policy to increase the number of medical trainees.

Chart 4: Trends in the Admission Capacity of Medical Schools



Source: [14]

The Cabinet decided to increase the number of medical school students under the Basic Policy for Economic and Financial Reform 2008 to address the problem of the short age of local healthcare workers who serve as the main providers of community healthcare services. Chart 4 describes the changes in the number of medical trainees in Japan from 1981 to 2018. Based on the above proposal, the number of medical school students was kept low in the mid-1990s, and this trend continued until 2007. However, the number started to grow in 2008 and has been increasing up to the present day. The policy to increase the number of medical students will also continue to be implemented in 2019.

The number of trainees has also increased as a result of establishing new medical schools. In 2016, Japan's first medical faculty in 37 years, the Faculty of Medicine of Tohoku Medical and Pharmaceutical University, was established as a special project for recovery from the 2011 Tohoku earthquake and tsunami. In 2017, the Faculty of Medicine was also established in International University of Health and Welfare to develop international healthcare human resources as a project of the National Strategic Special Zones.

*B. Response to the Quantitative Expansion of Overseas Medical Services*

*(1) Acceptance of Foreign Doctors in the UK*

The UK has aimed at improving the supply of healthcare services by increasing the number of medical trainees in the country and welcoming foreign workers. Although the UK has had a public healthcare system called the NHS since 1948 and all residents have access to healthcare services free

of charge (apart from certain treatments), prolonged waiting for medical treatment and surgery has been a major problem.

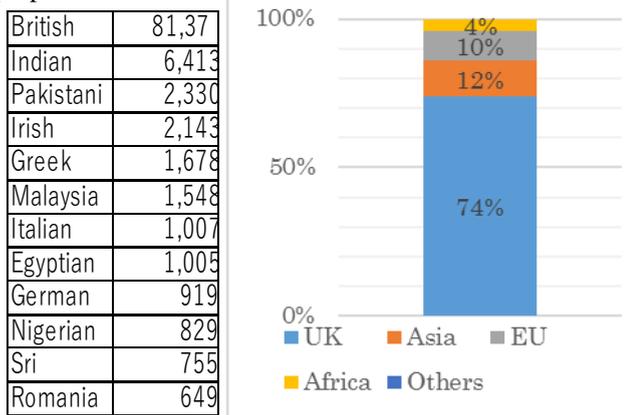
The Labour Party, under Prime Minister Tony Blair, began to address this issue in 1997. In The NHS Plan: a plan for investment, a plan for reform (Cm4818-I) the Blair Government referred to increases in the number of hospitals, beds and healthcare workers including doctors, nurses and therapists. In particular, a large increase was proposed for the number of healthcare workers, with 7,500 specialists, 2,000 GPs, 20,000 nurses and 6,500 therapists [15]. Because healthcare is a labour-intensive industry and the number and quality of doctors are directly linked to the quality and safety of healthcare services [16], increasing the number of doctors was the best way to reduce waiting times for medical treatment and surgery and improve the service supply of NHS.

The first step taken to increase the number of doctors was to expand the domestic training of doctors. As a reform to increase the number of doctors in the country, the Blair Government increased the number of medical students from 5,050 in 1997 to 7,662 in 2003 [17]. This expansion of domestic training was accompanied by the acceptance of workers from abroad. Britain formerly had colonies all over the world; even after decolonisation, people continued to frequently move between Britain and former colonies in the Commonwealth of Nations. Therefore, the NHS has employed foreign doctors since its foundation; yet, in the early 2000s, the Ministry of Health, holding jurisdiction over the management of the NHS, introduced a programme to hire specialists needing employment from abroad on the basis of intergovernmental agreements as a scheme to hire foreign doctors. As a result, the proportion of doctors who had qualified outside the UK in relation to the total number of doctors increased from about 30% in 1996 to 38% in 2005.

In 1994, before the expansion of admission quotas for domestic medical schools and the acceptance of foreign medical personnel had been promoted, waiting times for admission to hospital had reached an average of 19 weeks. Nevertheless, as a result of the increase in the number of doctors, the waiting time was reduced to an average of nine weeks in 2005 [18]. Thus, the UK chose to improve its healthcare service system by inviting doctors from abroad in order to efficiently meet healthcare needs.

Since then, the UK has continued to welcome foreign doctors. Chart 5 indicates the nationalities of doctors working for the NHS and their proportions as of September 2017. Apart from the British, Indians, Pakistanis and the Irish are the dominant nationalities. India in particular, which is a former British colony and joined the Commonwealth of Nations after achieving independence, greatly contributes to the supply of doctors in the UK. According to the stacked bar chart, 74% of the doctors working in the NHS are British while foreigners account for 26%. Further, 12% of the doctors are of Asian origin, 10% are European Union (EU) member countries other than Britain and 4% are African nationals and other nationalities. Australians account for the majority of other nationalities [19]. Many of the foreign doctors working in the UK are member states of the Commonwealth and the EU. Because the language barrier between the two countries is low, the UK has welcomed a large number of doctors from India to address its healthcare needs.

Chart 5: Origins of doctors working in the UK and their proportions



Source: [20]

(2) Outsourcing of the Training of Doctors in Singapore

Singapore also has a system to respond to quantitative needs for domestic healthcare services by inviting doctors from abroad. In Singapore, the National University of Singapore (NUS) was formerly the only university with a faculty of medicine. However, since the Duke NUS Graduate Medical School and the Lee Kong Chian School of Medicine were opened in 2007 and 2013, respectively, to address the shortage of doctors, all the three institutions have been functioning as domestic doctor training institutions.

Opened in 2013, the Lee Kong Chian School of Medicine admitted 54 students in the first year, after which the number has increased to 78, and the quota is planned to be increased to 150 or more in the future. According to a report by Singapore’s Ministry of Health, the number of medical students in Singapore was only 230 in 2003, when the country had only one medical school. However, in 2013, the number increased to 413 students after the establishment of other medical schools.

Singapore has been approaching the training of doctors by increasing the number of medical training institutions. Meanwhile, the country has also focused on employing foreign doctors and Singaporean doctors trained in overseas medical training institutions. Singapore highly depends on overseas medical training institutions due to the limitation of its domestic training of doctors. The Singapore Medical Council (SMC), the institution that maintains the Register of Medical Practitioners in Singapore, registers doctors who have graduated from one of the 158 medical schools in 28 countries and regions around the world including Japan, selected by the SMC.

Chart 6 classifies the doctors registered in the SMC in 2015 into whether they were trained domestically or abroad, whether they work in public or private medical institutions and whether they are citizens, permanent residents or foreign nationals in Singapore. The following points can be identified in Chart 6. First, the registry contains doctors trained in both Singapore and abroad, and those trained abroad account for about half of the total number of doctors in public hospitals and a third in private hospitals. Second, many of the doctors trained abroad are citizens or permanent residents of Singapore. Doctors who trained abroad are not necessarily foreigners, and in fact, many of them are Singaporean citizens. This is related to the lack of medical training institutions in the country as explained earlier.

Chart 6: Number of Registered Doctors by Location of Training, Employment Sector and Resident Status.

Registration Type	Public	Private
Local Trained Singapore	4,01	2,92
Foreign Trained Singapore	1,14	752
Local Trained Singapore	234	191
Foreign Trained Singapore	1,00	374
Local Trained Non-	111	10
Foreign Trained Non-	2,05	191
Total	8,56	4,44

Source: [21]

Singapore is a small country where approximately 5.53 million people live in the territory of the same size as the 23 wards of Tokyo. Largely relying on foreign countries for the training of doctors is, in a sense, an efficient means to provide a stable supply of healthcare services in such small countries. Due to its diverse ethnic composition, the official languages of the country are English, Malay, Mandarin and Tamil. Although its national language is Malay, because Singapore was formerly a British colony, English is the most commonly used official language, including in education [22]. This is also why it was possible for them to rely on medical training schools in English-speaking countries, mainly in the UK and the US.

IV. MEASURES FOR GLOBALISING HEALTHCARE SERVICES IN JAPAN

A. Introduction of a Certification System for Medical Institutions Providing Healthcare Services to Foreign Patients

(1) Outline of the System

Based on the concept of denizenship, access to public services necessary for the residents of Japan is as important to foreigners as it is to Japanese citizens. Healthcare services in particular need to be equally accessible to all because they concern people’s health and safety. As argued earlier, the first step in guaranteeing foreigners’ right of access to services is to establish a legal framework that does not exclude foreigners from the services in question.

Elimination of language barriers to provide safe and secure healthcare services to foreign patients can be achieved in the following ways: addressing cultural and lifestyle differences by offering multilingual healthcare services that use medical interpreters, images and information and communication technology facilities; contracting international medical coordinators specialised in healthcare and the provision of services to foreign patients and preparing hospital meals and setting up prayer rooms in consideration of patients’ religious beliefs.

Under these circumstances, the Japan Medical Service Accreditation for International Patients (JMIP) was adopted as a support system of the Ministry of Health, Labour and Welfare in 2012, operating under the Japan Medical Education Foundation. As of May 2018, 43 medical institutions nationwide have received this certificate, expanding from the first three medical institutions that received certification in March 2014. The criteria for accreditation include provision of multilingual healthcare services using medical interpreters, arrangement of international medical coordinators and installation of prayer rooms. As the number of foreign residents and visitor’s increases, the accreditation system is expected to facilitate enhanced choice regarding medical services.

The JMIP's assessment process is as follows<sup>1</sup>. First, after medical institutions wishing to be accredited submit an application, the Japan Medical Education Foundation which operates the JMIP provides an accredited investigator to prepare a written assessment and a field survey of the institution. Document analyses are based on a questionnaire about the current situation, a self-assessment form and the documents submitted prior to the application. In field surveys, the facilities for receiving foreign patients are examined via group interviews and surveys conducted within the institution. Based on the results of the survey visits, the final decision is made by the Accreditation Review Board, which consists of a panel of experts.

Decisions are made on the basis of the evaluation of items related to the provision of healthcare services to foreign patients, classified into five categories: (1) framework for the provision of services, (2) patient service, (3) management of healthcare provision, (4) organizational structure and management and (5) approach towards improvement. (1) concerns systems to treat foreign patients in-hospital departments and methods of notifying them about the details of medical expenses and payment methods; (2) pertains to the status of interpretation and translation services and preparation of the hospital environment in consideration of the religions and customs of foreign patients; (3) is a category concerning the methods of communication with foreign patients, gaining informed consent in medical examinations, testing and nursing care; (4) concerns the roles and safety management of departments that treat foreign patients and (5) is related to the education and training of in-hospital staff who provide healthcare services to foreign patients, as well as the methods of surveying the opinions of foreign patients [23]. The accreditation is valid for three years, and institutions are required to be reassessed to renew the accreditation.

(2) Issues and prospects

What follows are current issues regarding the JMIP and services for foreign patients involved in this system, and future prospects of the system. The first issue is the shortage of professional workers in creating an accessible healthcare environment for foreign patients. As already explained, the presence of skilled and experienced personnel such as medical interpreters and coordinators is indispensable for medical institutions to be accessible to foreign patients.

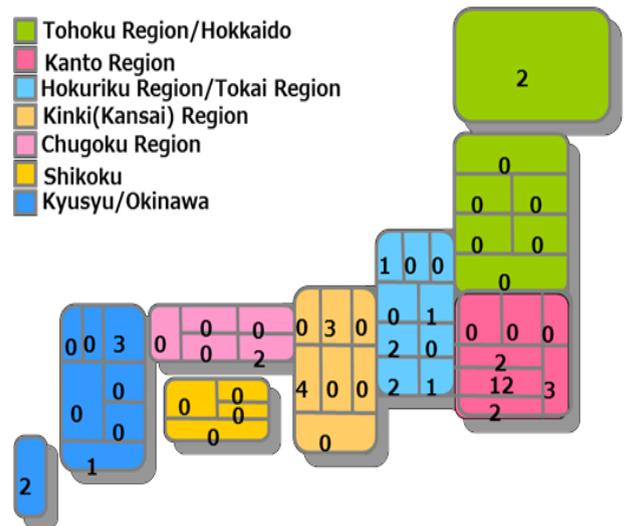
In particular, medical interpreters are the most important elements in solving the problem of language barriers. The United States, for instance, under the Civil Rights Act of 1964, states that 'No person in the United States shall, on the ground of race, colour, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any programme or activity receiving Federal financial assistance'. Because this act also covers the prohibition of discrimination through language, access to medical interpretation services is guaranteed to patients who do not speak English as their native language when they require medical attention. The right to healthcare services through interpreters is guaranteed to foreigners who speak other languages as their mother tongues.

In Japan, the General Incorporated Medical Interpreting Association of Japan has been conducting certificate examinations for medical interpretation since 2009. Nevertheless, a certification system as a national qualification has not yet been established for medical interpretation, and as a result, recruitment of medical

interpreters is a rather complicated process. Establishing a professional status for medical interpreters by creating a qualification system will also serve as a means of securing workers.

The second issue is the uneven geographic distribution of medical institutions certified by the JMIP. Chart 7 shows the distribution of 43 medical institutions certified by the JMIP in Japan as of June 2018. Over 40% of certified medical institutions are concentrated in the Kanto region including Tokyo; seven of them are in the Kinki region including Osaka and Kyoto; three are in Fukuoka; one is in Kagoshima and two are in Okinawa. Neither the Tohoku area nor Shikoku has any certified medical institutions. Therefore, they are unevenly distributed across the country.

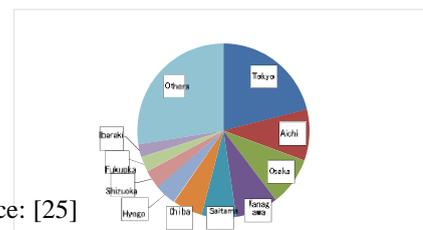
Chart 7: Locations of Japan Medical Service Accreditation for International Patients (JMIP)-certified Medical Institutions across the Country (as of June 2018)



Source: [24]

The proportion of foreign residents distributed in each prefecture is indicated in Chart 8. Many foreign residents live in Tokyo, Aichi, Osaka and in prefectures near them, concentrating in the so-called three major metropolitan areas. This chart and the locations of the JMIP-certified medical institutions presented in the Japanese map above reveal that the distribution of JMIP-certified medical institutions reflects the residential area of the foreigners in Japan to some extent. Because it has only been four years since the three medical institutions were accredited first in 2014, the number of medical institutions prepared to treat foreign patients' needs to grow further.

Chart 8: Component Ratio of Foreign Residents (by Prefecture) as of June End



Source: [25]

<sup>1</sup> The JMIP website was referred to for the following JMIP assessment process. URL: <http://jmip.jme.or.jp/> (browsing date: 18 June 2018)

B. Medical Practice by Foreign Doctors in the Nation- al Strategic Special Zones

(1) Definition of the National Strategy Special Zone

The Abe administration has promoted regulatory re- form in various policy areas including the recruitment of foreign professionals in healthcare and welfare. In the elec- tion for the House of Representatives held on December 16, the Liberal Democratic Party, which had been out of power since 2009, became the dominant ruling party again. Following the results of this election, the Second Abe Cabinet was launched on 26 December 2012. It named economic policies consisting of three ‘arrows’: bold monetary policy, flexible fiscal policy and a growth strategy encouraging private investment. This was collectively called ‘Abenom- ics’ and intended to promote an economic policy package to stimulate the economy and move away from deflation. In relation to these economic policies, the National Strategic Special Zones were established under the sponsorship of the Abe administration. Based on the Act on National Strategic Special Zones enacted on 13 December 2013, the special economic zones were subject to a regulatory reform system for deregulation and tax incentives, mainly to enhance the international competitiveness of Japanese industries. These are called the ‘National Strategic Special Zones’. The National Strategic Special Zones constitute part of the growth strategy for encouraging private investment, the third of the above three arrows, aiming to surmount strict regulations. The establishment of the National Strategic Special Zones was also part of pillar of the reform of Abe’s second Cabinet, which developed the growth strategy of Abenomics.

Chart 9: Locations of the National Strategic Special Zones



Source: [26]

As described in Chart 9, the National Strategic Special Zones are currently located in 10 areas: the Tokyo area (Tokyo Pre-fecture, Kanagawa Prefecture, Chiba City and Narita City in Chiba Prefecture); the Kansai area (Osaka Prefecture, Hyogo prefecture and Kyoto Prefecture) and Niigata City, Yabu City, Fukuoka City/Kitakyushu City, Okinawa Prefecture, Sem-boku City, Sendai City, Aichi Prefecture, Hiroshima Prefecture and Imabari City. These areas were designated according to the following purposes: the Tokyo area for international business and innovation, the Kansai area for medical innova-tion and support for challenging human resources, Niigata City of Niigata Prefecture for largescale agricultural reform, Yabu City of Hyogo Prefecture for agricultural reform in hilly and mountainous areas, Fukuoka City and Kitakyushu City of Fukuoka Prefecture for global business establishment and employment reform, Okinawa Prefecture as a special zone for international tourism innovation, Semboku City of Akita Pre-fecture as a special zone for regional revitalisation in the near future, Sendai City of Miyagi Prefecture for

promotion of participation by women and social business reform, Aichi Prefecture as a centre of growing industries and advanced technology, and Hiroshima and Imabari City of Ehime prefecture as a special zones for international exchanges including tourism, education and business as well as for the use of big data. In the above mentioned 10 areas, a total of 264 businesses are certified. These certified businesses include those in line with the 11 categories of regulatory reform, such as urban regeneration, business creation, overseas workers, tourism, healthcare, nursing care, childcare, employment, education, agriculture, forestry and fisheries and future technology. Fifty of the 264 businesses reflect these categories of regulatory reform.

(2) Existing Regulations on Healthcare Services Pro- vided by Foreign Doctors

The National Strategic Special Zones have also brought reforms to healthcare service systems. Healthcare is one of the regulatory reform categories of the National Strategic Special Zones and includes the aforementioned establishment of new medical schools as one of the means to increase the number of doctors. This is in addition to the partial lifting of restrictions on the healthcare services provided by foreign doctors, which is the subject discussed in this section.

As already explained in relation to the qualification system for doctors in Japan, the country only permits those having a Japanese medical licence to domestically per- form medical practice. This is based on Article 17 and Article 2 of the current Medical Practitioners Act enacted in 1948. Therefore, those who have completed medical school and are qualified as doctors abroad are in principle required to pass the National Examination for Medical Practitioners in order to be able to practice as doctors in Japan. The provision of healthcare services by foreign doctors in Japan has been limited to the following exceptions.

First, foreign doctors are allowed to practice if they obtain medical licences issued by the Minister for Health, Labour and Welfare after taking and passing the National Examination for Medical Practitioners in accordance with the Medical Practitioners Act. Those who have completed medical school abroad are required to be examined for the ability to provide healthcare services in Japanese to be eligible to take the National Examination for Medical Practitioners.

The second case where exceptions are made is for medical practice under a clinical training programme for foreign medical practitioners. The system began in 1987 and permits foreign doctors without Japanese medical licences to engage in medical practice for two years under the guidance and supervision of clinical training instructors in hospitals designated by the Minister of Health, Labour and Welfare. The system is aimed at contributing to the progress of international exchange in the medical field and the improvement of healthcare standards in developing countries.

The third exception is the recruitment of doctors under bilateral agreements established between Japan and the United Kingdom, the United States, France and Singapore. The bilateral agreement with the UK was based on the Agreement on the Mutual Recognition of Medical Licences between Japan and the UK in 1964 and with the US on the Letter on the Treatment of Foreign Nationals and For- eign Companies after the Return of Okinawa to Mr Mayer, the United States Ambassador to Japan from Aichi, Foreign Minister of Japan in 1971. The same agreement with France was established under the Agreement on the Mutual Recognition of Medical Licences between Japan and France in 1996 and with Singapore upon the conclusion of the EPA(Economic Partnership Agreement) in 2002 through the

exchange of the Verbal Notes on the Recruitment of Singaporean Doctors. Those bilateral agreements accept only a few doctors who are required to pass the National Examination for Medical Practitioners in English.

### (3) Deregulation in the National Strategic Special Zones

Only a small number of foreign doctors are accepted under bilateral agreements, and their medical practice has been limited to residents who share the same nationality as the doctor in question. However, the restrictions on the medical practice of foreign doctors under bilateral agreements in the aforementioned National Strategic Special Zones in the Tokyo area have been lifted. Bilateral agreements formerly permitted foreign doctors to provide healthcare services exclusively to patients who shared their nationality; however, after the enactment of this act, foreign doctors began to provide healthcare services to all foreign residents in Tokyo, excluding Japanese nationals.

Under this system, a British doctor was offered a position at Keio University Hospital, an American doctor and a French doctor at Juntendo University Hospital and two American doctors at St Luke's International Hospital and St Luke's Medilocus in December 2015. In September 2017, a British doctor was hired by Tokyo medical and surgical clinic.

Because medical practice is related to people's health and safety, it is desirable for a patient to receive medical treatment from a doctor with the same native language, in order to prevent medical malpractice. However, the number of people living outside their home countries has been increasing each year in Japan and the rest of the world for various reasons, and many of them use languages other than their native languages in the countries they migrated to. For foreign residents in Japan, the linguistic barriers between their mother tongue and Japanese are likely significant.

The relaxation of the restrictions imposed on the provision of healthcare to foreign patients by foreign doctors in the National Strategic Special Zones solely applies to the bilateral agreements between the Japanese government and the governments of the four countries with a more flexible framework and has not yet been developed sufficiently to meet the quantitative demands of foreign patients. Nevertheless, the deregulation has undoubtedly brought about a remarkable change in the medical field, which has been subject to strict restrictions in Japan. This holds a great promise for the construction of a healthcare service system for foreigners living in Japan as denizens. It will be worthwhile to witness how this system develops in the future as a means to respond to the diversification of society.

## V. CONCLUSION

Because Japan has the highest ageing rate in the world, a quantitative response to healthcare needs is needed in order to address the anticipated increase in the ageing rate in the future. Furthermore, as healthcare is related to people's health and wellbeing, satisfying their needs is crucial to guarantee their social right of citizenship.

Japan currently needs to adopt a policy to expand the number of doctors on the national level and address the uneven regional distribution of doctors. To meet the expanding healthcare needs, it is important to first address the problem of uneven regional distribution of doctors in order to improve efficiency, and then address the lack of doctors by enhancing training within Japan.

Meanwhile, in the UK and Singapore, where the institutional infrastructure encouraging the movement of people has been developed, doctors from abroad are welcomed to compensate for the shortage of medical personnel in addition to enhancing domestic medical training with an aim to increase the number of doctors. Singapore in particular relies on other countries for the

training of doctors. In other countries, especially English-speaking countries, because the language barrier tends to be low compared to Japan, hiring foreign professionals has enabled a response to the expansion of domestic demand.

Furthermore, because it takes 10 years to train a doctor from scratch, recruiting qualified professionals from abroad has reduced the cost of training workers, thereby streamlining the provision of services. However, with greater language barriers in Japan, and the regulation of the Medical Practitioners Act, hiring foreign doctors in the same way as the UK and Singapore is not an appropriate means to address the expansion of healthcare demand in Japan in the short term.

In addition to these quantitative needs, the country needs to respond to the diversification of healthcare needs. The diversification of needs requires careful approaches towards changing disease structures and complex needs; healthcare needs that have diversified as a result of the increase in the number of foreign patients give rise to the need for diverse restructuring of the conventional healthcare service system in Japan. Although the lifting of restrictions on the medical practice of foreign doctors in the National Strategic Special Zones and JMIP-certified medical institutions is still subject to some restrictions, these systems are expected to promote the expansion of the provision of safe and secure healthcare services to foreign patients.

Responding to the healthcare needs of foreign residents in Japan in particular is indispensable from the perspective of the application of the concept of denizenship to the real society.

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