The Fifth Revision and the Beyond---Health Care Reform in Japan

Submitted by:

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BIBLIOGRAPHIC SKETCH OF THE AUTHOR'S BACKGROUND

Koichi KAWABUCHI, MBA, is a professor of Health Care Economics, Department of Health Science Policies, Division of Public Health, Graduate School of Tokyo Medical and Dental University in Japan, since 2000. His main field of research is health economics and health policy in Japan. He is currently exploring the applicability of Diagnosis Related Groups (DRGs) to Japan, the feasibility of desirable health insurance fee schedule, and a comparative study of health care systems in other countries.

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1. Introduction

Reforms under Prime Minister Koizumi have been taken in more speed, diversity and depth. He has changed the way Japan is. Most recent of such in health care is the bill on fifth revision to the Medical Service Law. The revision is based on the plan that the Liberal Democratic Party (LDP), the ruling party, has prepared in December, 2005. It proposes the establishment of Health Care System for the Elderly along with plans for life-style related diseases, promotion of home-care, as well as increase in the share of out-of-pocket payment from the elderly. Koizumi's term is expected to end in September 2006 as he has already announced his intention of not running for the next term, but what he had started will go on as if to keep the legacy of his campaigning word, "Don't stop the reform."

In this paper, after a brief on previous revisions, authors intend to explain the fifth revision of the Medical Service Law in detail, to discuss its implication, and to contemplate on the still remaining issues.

2. The Medical Service Law and the Revisions in the Past

a. The Medical Service Law

The Medical Service Law today is based on the Medical Regulations issued in 1874.

What has been kept consistent since the beginning is the freedom given for doctors to open a practice. Only doctors are allowed to be hospital administrators, and distribution of share is prohibited. Aside from these small restrictions, administrators are free to open and manage hospitals and clinics, and to process profit and property as their own.

The current form of the Medical Service Law, the Constitution in the world of Medicine in Japan, was issued in 1947, and the system of health care entity was added in 1950. It mainly 1) defined a hospital as equipped with 20 or more beds and clinics as those with 19 or less in which no longer than 48 hours of stay was allowed, 2) required hospitals to satisfy certain criteria in facilities and personnel, 3) introduced general hospitals and positioned them as model hospitals responsible for conducting researches and training, and 4) established midwife system.

b. First Revision (1985)

Health care in Japan had experienced little intervention. Aside from the restriction on the number of public beds in 1962, there had not been significant revisions. Health care in Japan had been left alone to enjoy the freedom for long. The picture changed in the 1980s. The Ministry of Health (the former Ministry of Health, Welfare and Labor)

began to examine the system in need to tighten the budget. Just then, the medical accident involving Fujimi hospital ("doctors" without license suspected of giving fake diagnosis) also turned the heads of the public to the spoiled world of health care. The first revision in 1985 came in the mid of these attention.

It was the first major revision in 40 years. The highlight of this revision was the "Regional Medical Service Plan". The Plan determined how many number of beds are to be provided for each medical service area, and prefectures were required to keep the set number. Unreasonable bed increase exceeding the number was no longer admitted. This signified a shift from pursuit of quantity to quality, and it did sacrifice doctors' freedom to open a practice in some degree. Especially for the private hospitals that depended on the benefit coming from bed increase, the Regional Medical Service Plan became a major restriction.

Influence of the Plan appeared in the form of last-minute bed increase. Hospitals rushed to increase their beds just as the revision came into effect, and this in turn triggered shortage in nurse. The consequence still lasts even in the current health care system, and in fact, it was not until the FY 1992 that the number of beds began to turn down. It clearly was a man-made disaster lead by the government's mistake.

c. Second Revision (1992)

1992 was also the year when the second revision took place. There were 5 main purposes in this revision. They were to 1) designate specific functions to hospitals, 2) provide more health care information to the public, 3) clarify and express the direction in which health care in Japan should aim for, 4) maintain the quality of outsourcing services, and to 5) approve certain related businesses to be run by health care entities. Among the five, the first two were especially important.

Two new functional types were introduced. One is the Hospital for Highly Advanced Medicine[1]. They are hospitals that provide high-level medical care. This type of hospital was to prioritize the care of patients with need for high-level medical care, and thus accepted such patients referred from other hospitals and clinics. These hospitals were encouraged to make use of this referral system, to aim for 30% of all the patients to be from referral. In theory, the system was designed to shorten the patients' waiting time, but no such effect was gained. The trick was that the patients without referrals could

[1] After some retire and entries along the way, 82 hospitals are currently designated as Hospital for Highly Advanced Medicine as of April 1st, 2006. The list is consisted mostly of university hospitals, the National Cancer Center, and the National Cardiovascular Center.

still be seen by paying extra cost. As for the other type of function, Extended Care Beds refers to a group of beds prepared in consideration for the daily life of long-term inpatients. It embodied the shift from “cure to care”. Incentives were provided in the form of generous reimbursement and grant for enhancing bed space. As of the end of 2005, there were about 380,000 Extended Care Beds, far over the set goal of 190,000, and the plan has reached its end. In anyway, this was the first time when hospital beds were specified with a function for their use.

The purpose of the second point of the revision was to provide patients with medical information. It became the first time since the start of the Medical Service Law that advertisement of information related to health care was deregulated. Type of services provided (i.e. whether appointment and house calls were available), hospital facilities, and the care system by nurses were allowed to be advertised.

The third highlight of the second revision was the fact that it clarified philosophy in provision of health care for the first time. It stated that health care should be based on the trust between the provider and the receiver, and that it should extend beyond mere procedure to include preventive care and rehabilitation as well. It also called for citizen’

awareness and effort to maintain their own health, and for effective provision of care in accordance with the capacity of each facility. Fourthly, the second revision admitted involvement of health care related services from outside, and aimed to maintain the quality by providing certification for those with certain level of quality. Finally, the revision allowed health care entities to run facilities such as athletic clubs and spa that work to enhance the effect of health care.

d. Third Revision (1997)

Let us now look into the third revision in 1997. It followed the trend of the second revision. Main points of the third revisions were; 1) extension of Extended care Bed system to clinics, 2) establishment of Regional Care Hospital, and 3) preparation of rules on related businesses by health care entities.

People with the need for long-term care were rapidly increasing, and common disease types have changed in consequence. However, the goal of 190,000 Extended Care Beds had not yet been reached. Thus, it was extended to include clinic beds in response to this growing and unfulfilled need. The "48 hours rule" (refer to page 4) was exempted for these Extended Care Beds in clinics. Then, long-term care insurance was introduced to

stop non-medical hospital stay by separating the cost of long-term care from that of medical care, and to control the rising health care cost in the long run. Along with this introduction of long-term care insurance, hospitals and clinics had to determine whether their Extended Care Beds were to be covered by the health care insurance or the long-term care insurance. However, the separation between the two was not easy, and confusion lasts till today. There were 250,000 health care type and 130,000 long-term care type as of the end of July, 2005.

Regional Care Hospital was limited to hospitals with 200 beds or more, and was required to fulfill such criteria as; 1) network function (acceptance of referral, cooperative use of facilities and equipment with other hospitals), 2) ER function, and 3) training function. It was designed to become the core hospital in a region. The system of General Hospital was terminated in turn. Compared to Hospital for Highly Advanced Medicine, Regional Care Hospital did not have to be a university hospital or the like. However, only 118 hospitals have been recognized as Regional Care Hospital as of the April 2006, due partially to unattractive economical merit in reimbursement.

The third revision further extended the related side-businesses approved for health

care entities. In addition to Home Care Center, Care house (Nursing homes) approved in the second revision, Home help business, Day service business, and Short stay business were now approved. Some were also eligible for running meal delivery, pharmaceutical sales, and transportation service for patients.

e. Fourth Revision (2001)

The fourth revision came in 2001 to establish an efficient system that provide quality health care. Three main points were 1) change in the bed classification, 2) more deregulation in advertisement, and 3) mandatory clinical training for doctors and dentists.

Previously, beds other than those classified as psychiatric, tuberculosis, and infectious disease were all classified as one group called “other beds”. Extended Care Beds had also been included in this “other beds” category. Now, the fourth revision divided the “other beds” category into two categories, general beds or Extended Care Beds. All those who operate any “other beds” were to decide one way or another, and register the choice at prefectures until the end of August 2003. As long as the total number did not change, no restrictions were given on the distribution, permitting any

combination of the two, or just one.

With this new classification, the government hoped to pinpoint the root of the infamously long average length of stay (ALOS) of 32.8 days that is connected to the increase in health care cost. However, there is a story behind this. Calculation of the ALOS includes data from long-term care institutions (with ALOS of 300 days or more counting for 9.7% and ALOS of 180 days or more counting for 15.0%). When ALOS is recalculated eliminating these outliers, the figure actually drops to 15.9 days for 50-99 beds, 18.8 days for 100-149 beds, and 20.4 days for 150-199 beds. Thus, classification between the general beds and the Extended Care Beds did not have to involve any revision, and was actually a matter of statistics. The government, deliberately or not, missed to let out this matter and went on to carry out the revision.

Second highlight of the fourth revision is the even more advanced deregulation of advertisement. Additional items included brief of doctor and dentist's curriculum vitae and age, names of long-term care businesses referable, and whether or not second checkup and health guidance are offered that are covered by workmen's compensation insurance.[2]

[2] Internet is exempted from the advertisement regulation. The MHLW's opinion on this is that it is intended for users searching at their own will, and thus does not qualify as

Another important point of the fourth revision is that the internship for doctors and dentists became mandatory. Previously, such training was not mandatory. Though over 80% have attended, it was consisted mostly of materials from the interns' own specialty. As result, doctors had been criticized for lacking in even the basic knowledge of other specialty beside their own, and for having trouble communicating with patients. In response, the revision required doctors with intention of future clinical practice to receive clinical training of 2-year or more at university hospitals or hospitals designated by the Minister of MHLW, and ruled that hospital managers have to be doctors who have finished the training.

Hospitals have to be equipped with facilities stated by the law. The fourth revision partially deregulated these rules on lab test, sterilization, and laundry on the condition that they are outsourced. Outsourcing market had already been in place from 1960's, and is now a size of 2.2 trillion yen ($2 billion)[3,4]. In order to insure the service quality

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advertisement by the Medical Service Law, which is defined as notification intended for the general public. Thus, information on the homepages are far more in detail, listing clinical outcome data such as percentage of Caesarean section and 5-year survival rate, as well as price data, and also the kind of clinical path used in the hospital.

[3] Currency is calculated at $1=110yen throughout the paper.

[4] Markets for linens, medical waste disposal, and lab tests have already matured with outsourcing rate of over 95% in 2003. Following are meal service with the rate of 53.8% (up from 44.5% in 2000) and office work with 41.9% (up from 39.0%in 2000). Only 21.0%

of this growing business, MHLW has designated eight types of services most influential to patients' procedure, and hospitals willing to outsource one of the eight are required to choose outsourcing firms certified by the Foundation for Medical Related Services. As of February 1st 2006, 2,368 firms have been authorized. However, since major hospitals take on competitive bidding style and firms decide to win a contract even with loss, concerns on quality are rising.

3. The Fifth Revision

The fifth revision bill to the Medical Service Law was introduced in Diet, together with a revision to the National Health Insurance Law as a single bill. Though they come into effect at different time[5], this is a monumental revision that marks the beginning of the simultaneous reform on the finance and the delivery of health care.

a) Financial Reform: Control in Health Care Cost

Policies in the past have been driven economically. The fee schedule[6] has been

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of sterilization and 6.7% of patient transportation service are currently outsourced and are still in the starting stage.

[5] Revision to the National Health Insurance Law becomes effective in October 2006, followed by the revision to the Medical Service Law in January 2007.

[6] The fee schedule is the price (i.e. amount of reimbursement) list of medical services covered by the health insurance. In effect, it determines which services are covered by the insurance, detailed contents of these services, and their point (10 yen per a point). It uses both the fee-for-service method and capitation method.

reviewed in the same year or the year after the revisions to the Medical Service Law, and they have always been closely linked together.

The review of the fee schedule includes changes in calculation of Standard Fee for Hospitalization. Standard Fee for Hospitalization evaluates a medical institution in total, and is calculated based on multiple factors such as the ratio of patients per nurse. The true purpose behind this is again reduction of beds, disguised as an effort to increase the number of staff. MHLW asserts that the calculation was simplified to reflect today's realities, and insists that the change will not have much economical impact. However, the author calculates otherwise. If all the beds currently satisfying the 4:1 ratio (4patients per nurse) increased the number of nurses to meet the new standard of 3:1 ratio, we estimate the additional cost to be roughly 58.5 billion yen ($530 million), which equals to 0.253% of health care cost. Considering substantial increase in the fee schedule was 0.2% in 2000, one can relate to the impact of this raise. As we hear in the news of malpractices, it is obvious that we need more nurse staff. However, there is always cost involved. Changing the standard of personal without reliable financial resources is quite dangerous.

The revision to the National Health Insurance Law includes review of the Exceptional Fee System[7]. In place of the Exceptional Fee System, Combination Payment System will be established in the revision. The new system will regroup the exceptional service items into two categories, Preliminary Services and Supplementary Services. The former will include highly[8] and moderately advanced procedures and prescription of drugs not domestically approved, on the premise that they be covered by the public insurance when the time comes. On the other hand, Supplementary Services are not expected for coverage by the insurance any time in the future. They are such that relate to patients' amenity and convenience, and examples are, upgraded bed, treatment by appointment, increase in the number of treatments beyond the standard. This new classification should give a better order in balance billing.

Another change in the line between the items "covered" and "not covered", occurs for patients aged 70 years old and over using medical-type Extended Care Beds, which begins in October 2006. The "hotel cost" (room and board) will be excluded from

[7] In principle, balance billing is not permitted in Japan. That is, patients cannot mix services covered and not covered by the public insurance. If patients decide to include even a single service not covered by the insurance, they had to pay for the entire cost out-of-pocket, including even the services covered by the insurance (instead of the usual self-payment of 10-30% for the covered services). However, there is the Exceptional Fee System that allows certain services to be exceptional to this rule. Patients can use the insurance and pay the usual 10-30% out-of-pocket payment for the covered services, and pay 100% for such exceptional services.

[8] As of April 1st, 2006, 101 services are listed as highly advanced procedures.

coverage, and patients will have to pay on their own. Similar increase in the self-payment has already been introduced to patients using long-term insurance.[9] Upon this experience, the government estimates the self-payment to be 94,000 yen ($855) a month in average[10]. In April 2008, it will be further expanded to include those aged 65 and over using the medical-type Extended Care Beds. In addition, "Health Care System for the Second Stage Elderly[11]" will be established, and its insurance premium will soon be checked off from pension. Pressing need to control health care cost no longer leaves any sanctuaries.

b) Reform of Delivery System: Control on Number of Beds

In August 2003, new classification for former "other beds" began and they had been changed either to General Beds or Extended Care Beds. Now with the fifth revision, Extended Care Beds are to be further regrouped. 380,000 Extended Care Beds are to be reorganized into, 1) Extended Medical Care Beds (150,000), 2) Preparatory Long-term Care Beds, and 3) Temporary Long-term Extended Care Beds. The new Extended Medical Care Beds is limited for long-term care patients with high medical need, and it

[9] October, 2005
[10] Consisted of 10% self-payment for services other than "room and board", 42,000 yen ($382) for boarding, and 10,000 yen ($91) for lighting, heating, and water supply.
[11] Health Care System for those aged 75 and over.

will be covered by the health insurance. On the other hand, the other two are designed for long-term care patients with low medical need. These two, moreover, are to be further turned into long-term care related institutions such as nursing homes, care houses, and home care support headquarters by 2012.

Along with the regrouping of Extended Care Beds, standards on personnel for each group are redefined in several plans by the government. Currently, the stationing standard of nurse staff is 6:1 and 4:1.[12] For the new Extended Medical Care Beds, it will be raised to 4:1 and 4:1. This is to respond to the high medical need expected from patients using Extended Medical Care Beds. On the other hand, personnel requirement for the Preparatory Long-term Care Beds and Temporary Lon-term Extended Care Beds will be lowered, in response to the expected low medical need of the occupants.[13] Together with exemption on room size requirement for the starting six years, measures to promote the switch are ready. The Medical Section of the Social Security Council has already approved these plans, and the Central Social Insurance Medical Council is

[12] The maximum number of patients per nurse is limited to 6, and the maximum number of patients per nurse assistant is limited to 4.
[13] As for Preparatory Long-term Care Beds, the minimum number of doctors required will be reduced from 3 to 2, and the ratio to the number of patients will also be lowered from 48:1 to 96:1. The requirement for nurse staff (nurses and nurse assistants) will be eased as well to 3:1 (of which equal to or more than 1 out of 3 has to be a nurse). Standards for Temporary Lon-term Extended Care Beds is also planned as 2 doctors, nurse stuff ratio of 8:1, and long-term care stuff of 4:1.

expected to start discussion on the fee schedule. Total make over is just about to start.

However, it does not necessarily mean that the providers are also ready for the change. The case of an administrator of a health care corporation based in Osaka (with over 3,500 staffs and total of 4,695 beds, 2,780 of which are Extended Care Beds, consisted of half medical-type and half long-term care type) probably speaks for many. He claims that the change means lay off of hundreds of staffs if the corporation decides to focus mainly on long-term care. Long history of much confusion over the Extended Care Beds now has the management and the personnel of the health care at serious risk.

c) Reform on Manpower: Strengthening and Competition

The fourth revision made internship mandatory for doctors and dentists, and introduced the matching system. Previously, instructors in university hospitals had strong power over the future of interns. With the revision, interns were now able to choose and apply for interns themselves, and they are leaving away from the old custom. University hospitals used to account for 70% of the internship, but the number decreased to 59%, while that of clinical training hospital increased to41%. The revision

also insured interns for monthly wage of about 300,000 yen. The environment surrounding interns has improved in overall. However, they still seem to be in a great deal of stress. According to a research by Assistant Professor Maeno of Tsukuba University, 40% of interns were found to be in a state of depression. The problem of serious doctor shortage in rural areas also still continues.

Following the trend of the fourth revision, the fifth revision strengthened health care manpower by preparing more severe penalty. For doctors, dentists, pharmacists, nurses, maternity nurses, and district nurses, revisions to each applicable law clearly stated the maximum of 3 years of suspension. In addition, when the license is revoked, 5 years is now required to regain the license.

Deregulation in advertisement has also progressed since the fourth revision, promoting more competition among the hospitals, and motivating service providers to improve themselves. The fifth revision added new items (average LOS, number of patients, etc.) to the list of items permitted to advertise. The list is still a “positive list”, but the steady progress will make it a “negative list” sooner or later.

d) Establishment of Social Health Care Corporation

There has always been a question on the principle that health care providers have to be for non-profit, and the voice is growing. As if to partially respond to it, the fifth revision offered a new option by creating the Social Health Care Corporation that is capable of floatation of Social Health Care Bond as a public bond.[14] However, for-profit entities are still strictly prohibited to provide health care, and it seems the principle is even tightened in some way. Health care entities are now required to limit the recipient of its residual property to a public entity or another medical service providing body, and to specify the names in the articles of association. Also, annual general meeting is mandated for health care corporations, and establishment of council is required for health care foundations. It may all seem contradicting, permitting hospital bond and strengthening non-profit principle at the same time, and could further trigger the discussion of possibility of hospitals run by stock corporations.

e) Other Points of the Fifth Revision

[14] Social Health Care Bond will be treated as corporate bond regulated by Mortgage Bond Trust Law, but the use of floatation revenue will strictly be limited to management of health care business. Social Health Care Corporation is required to provide certain medical services, and no more than one third of its board member can be a related family. Approval and suspension of the Corporation will be authorized by prefectures upon consultation with the Health Care Council in each prefecture. At the time of dissolution, Social Health Care Corporation has to choose public entities or other such Corporation for recipient of its residual property.

Medical Service Plan will be also reviewed, and the regional health care network will be established. The network will be established for each of the emergency medical service projects in the purpose to enhance regional collaboration. Goals will be specified in the plan, and it will be evaluated once in every five years together with the state of health care cost. Thus, the plan will have to be rewritten if the cost is not controlled as scheduled. For the time being, however, the current delivery system based on bed volume will be maintained.

Reform on clinics with beds will be enforced from January 2007. Not only the Extended Care Beds, but also the General Beds will be included in the bed volume based system. Thus, the "48 hour rule" (refer to 2a) will be completely abolished, and any change in the number of beds will have to be approved by the prefectures. Moreover, the prefectures will be given the authority to cut down on beds that are not in use without some legitimate reason.

4. Forecast for the Next

a) Issue 1: Tax Loss among Health Care Entities

The current consumption tax law limits deduction on tax to procedures that are subjected to tax. Procedures covered by the public insurance are tax-free. Thus, providers who rely mainly income from covered services cannot deduct tax on drugs and supplies at all. When the time comes to raise the current consumption tax rate of 5% in response to the growing consensus on such need, and if the fee schedule stays unchanged in the mean time, the burden for such providers will be increased even more.

There are two options for solution of this problem. One is to set a lower tax rate, and the other is to set the rate at 0%. The former stands on the concept that health care services are common goods, and thus should be taxed at a lower rate. Then, all the income will be taxable, and providers can deduct tax from all the purchased cost. However, opposition is expected from the patients who will suffer the increased economical burden. It is no surprise that the government insists on this option to come into discussion only after the consumption tax rate reaches to 10% from the current 5%. The other option is to set the tax rate on medical services at 0%. This idea has already been applied to the export trading businesses. Health care services will be taxable, and thus providers can include tax on purchased materials into calculation without putting any additional burden on patients. Nevertheless, tax reform is a difficult political matter.

b) Issue 2: Regrouping of Extended Care Beds

Extended Care Beds is to be regrouped under the fifth revision (refer to Section 3b). In order to proceed with the plan smoothly, the government has prepared subsidies for transforming to the latter two facilities. Waiting to be given through prefectures is total of 11.2 billion yen from the health insurance fund, being prepared to those changing into Preparatory Lon-term Care Beds. As for Temporary Long-term Extended Care Beds, 50 billion yen is ready to be subsidized through municipalities. The shift is also supported in the form of deregulation on room size criteria. Rooms of Health Service Facilities for the Elderly are required to be larger than 8.0m^2 per bed, but the present Extended Care Beds (room size of 6.0 m^2 per bed or larger) will be exempted from the requirement, and is allowed to turn into Health Service Facilities for the Elderly without enlargement for the next 6 years. To clear the way for speedy process, revision to the National Health Insurance Law is incorporated with backup measures as well. Starting with the name change of Health and Medical Service Law for the Elderly to Health Care Law for the Elderly planned in April 2008, 1) MHLW and prefectures will each be required to draw out the Control Plan on Health Care Cost once in every five years (effective from April 2007), 2) prefectures are to complete bed transformation by the end of FY 2011 (from

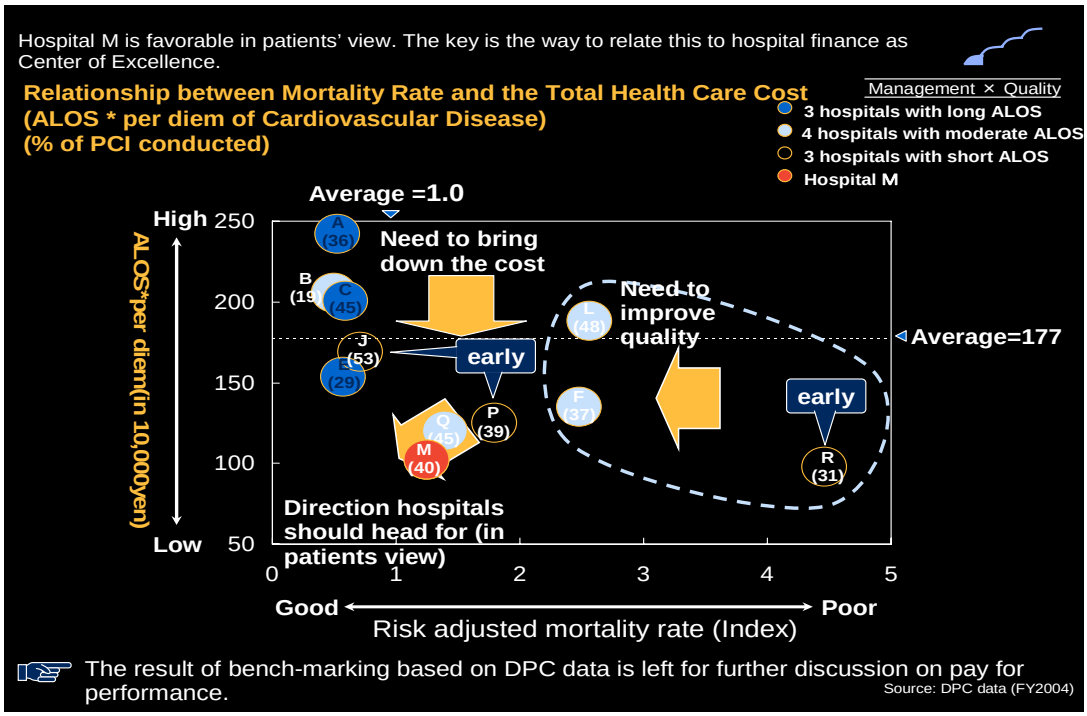
April 2008), 3) Minister of MHLW will consider increase in capacity of various Facilities for Elderly upon setting the underlying policy for the Long-term Care Insurance Law (from April 2008), and 4) Medical and Health Care Facilities for Elderly will be terminated by the end of FY 2011.

The real issue is the effect of the bed reduction. Are we absolutely positive that we should proceed with this? Does it bring about excess in health care manpower? Will it truly improve our quality of health care? It all depends on how we estimate future demand for health care and long-term care. Farmers who stopped growing rice following the government's policy of reduction in rice acreage say that, once a rice field is turned into recess, it will never return to the way it was.

5. Conclusion

In any way, it is no doubt that we are in urgent need for efficient and quality health care. The common knowledge is that the cost spent on health care trade offs risk adjusted mortality rate. The more spent results in lower mortality rate. However, this does not hold true when we take a closer look. Actually, mortality rates differ even when the cost spent is the same, and vice versa. The authors conducted an analysis on DPC

data from hospitals, and found out that some hospitals required 500,000 to 1,000,000 yen more than the other hospitals to yield identical mortality rate. In other words, if all the hospitals in the country followed the latter way of delivering treatment as the "best practice", health care expense should be reduced and better quality would be assured. Then eventually, the "best practice" in Japan can be compared to the "globally best practice" derived in the similar way, and it would be even more refined.



Each hospital will have to select and clarify the direction of their future, and need to focus on their choices. Will they attend to acute patients rather than chronic patients? Will they value generality over specialty? Should they concentrate more on inpatient care than outpatient care? They should try to draw out their future in specific details,

and then should study possible strategies to realize it. Recent reforms have presented them with more margins, such as deregulation on advertisement for one example. In this sense, building and managing of medision is one idea. It is a mansion with medical care, built with barrier-free “reversible” rooms that are equipped with covert medical facilities like oxygen and aspirators to be used when necessary. Unlike the nursing homes, it is offered for sale or for rent.

The fifth revision may seem to bring solution to many of the issues. However, faced with decreasing population and the issue of economical related gap among us, true health care reform has just begun. Pursuit of sustainable health care still continues, and we should all be alert for what is to come.