NURSING IN JAPAN

Japanese Nursing Association

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1. Japanese Society

Socioeconomic situation

Japan is an advanced developed country, as shown by its G7/G20 membership. However, Japan's economy has been stagnant since the economic bubble burst in the beginning of 1990's. In recent years, the population decrease and population aging is progressing simultaneously. The employment pattern in Japan has been changed. This raises the proportion of non-regular employment workers with the issues of unstable employment and low wages. In 2013, non-regular employment workers accounted for 37.4% of all the employed workers excluding executives[1]. The increased number of elderly household and unemployment caused by socio-economic situation resulted in the upward trend of public assistant recipients and the challenge of poverty[2].

Transition of population

Japan's population is 127.01 million as of January 1, 2015[3], accounting for approximately 1.75%[4] of the world's population.

After the birthrate declined around the end of World War II, Japan's population showed an increase, experiencing two baby booms in 1947-49 and 1971-74. However, the population decrease was seen in 2005 for the first time after WW II and it showed increase and decrease thereafter. Since 2010, the population is on the declining trend.

Since around 1970, the elderly population has been increasing dramatically. The proportion of the population aged 65-year or over to the total population was 26.5% in 2015[3] and will reach 39.9% in 2060[5]. In contrast, the proportion of the population under 15 will decline from 12.7% in 2015[3] to 9.1% in 2060[5]. This means one in 2.5 people will be an elderly person.

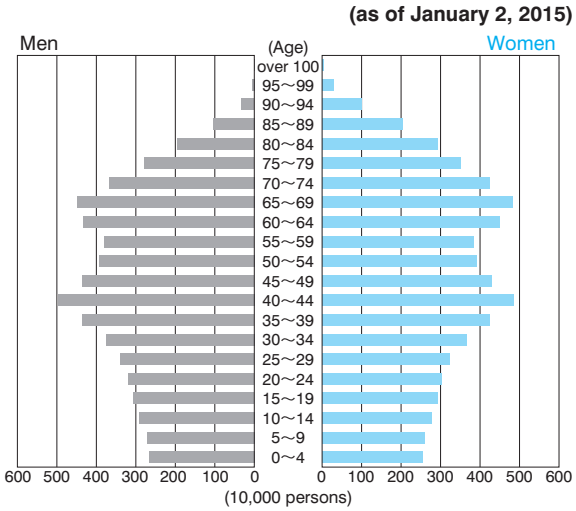


Figure 1: Population pyramid[3]

Health situation and trend

Japan's health situation has continuously improved in all health-related indicators, such as the average life expectancy of men is 80.21-year and that of women 86.61-year[6], while the infant mortality rate is 2.1[7] as of 2013.

The healthy life expectancy of men is 71.19-year and that of women 74.21-year as of 2013, which indicates the length of life without activity limitation caused by health problems. Although the healthy life

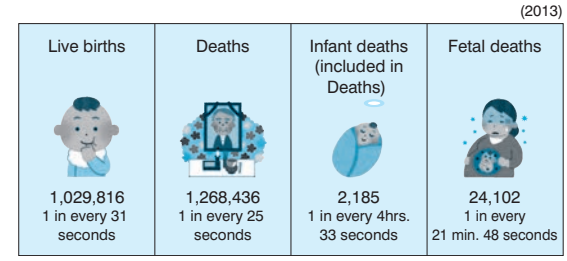


Figure 2: Vital statistics overview[9]

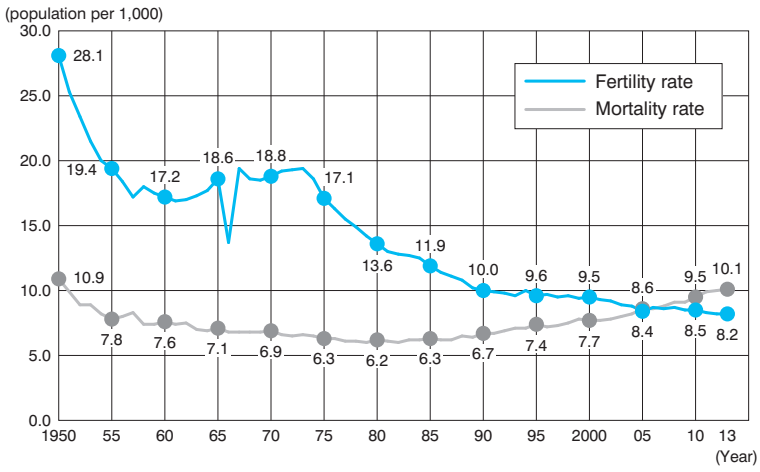


Figure 3: Transition of fertility and mortality rates[7]

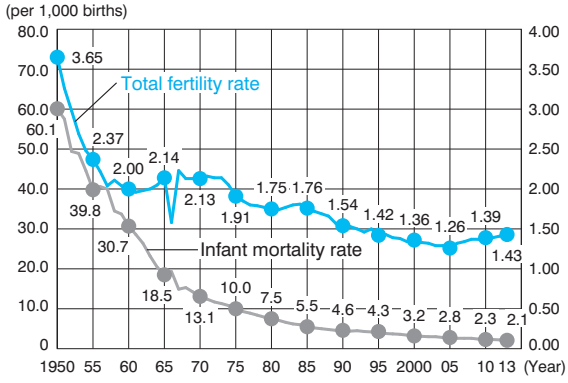


Figure 4: Transition of infant mortality rates and total fertility rates[7]

expectancy is extending, the gap between healthy life expectancy and life expectancy are approximately 9-year for men and 12-year for women[8]. As aging progresses, the measures "to prolong the healthy life expectancy" are taken which will lead the advancement of quality of people's life and reduction of the burden of social security expenses.

Concerning the birth trend in Japan, the birthrate (per 1,000 population) hovered in the 30s from the Meiji period (1868) through the beginning of the Showa period (1920s). Immediately after World War II, an increase in marriages triggered the first baby boom with high birthrates. However, after its peak in 1950, the birthrate declined rapidly. Those who were born during the first baby boom reached their childrearing age, showing a temporary increase in the birthrate during the second baby boom in 1971-74. Since then, however, the birthrate has remained at a low level with some fluctuations.[7]

The total fertility rate was 3.65 in the 1950s, but declined to 1.43 in 2013. This has many possible causes. In addition to lower neonatal and infant mortality rates due to advancement in health care, the decline in the 80s can be attributed to the trend toward delayed marriage and increase in unmarried people and in the 90s can be attributed to a change in the number of children per couple. The average age of mothers giving birth to their first child was 25.7-year in 1965 and 1975, and risen to 30.4-year in 2013.[7]

Although the mortality rate (crude deaths per 1,000 population) in Japan had hovered at the 20s around the Meiji period (1868-1912), it declined to 16 in 1941. After the War, the rate showed a continuous downward trend, reaching the lowest point of 6.0 in 1982. However, this rate has been showing an upward trend with the aging population and was 10.1 in 2013.[7]

The primary cause of death was pneumonia throughout the Meiji period, then it changed to tuberculosis (TB). From the latter 1950s deaths from TB greatly decreased and the causes of death in Japan shifted significantly from communicable diseases to non-communicable diseases. Since 1958, malignant neoplasms, heart disease and cerebral vascular disease have formed the three major causes of death, and currently account for approximately 60% of all deaths. Under these circumstances, measures to prevent non-communicable diseases are stressed. Amid the ongoing population aging, efforts are taken "to prolong the healthy life expectancy" so that people can live their life longer without activity limitation.

Although the number of deaths due to communicable diseases has been reduced, there are still some issues like HIV/AIDS, TB and hepatitis.

The prevalence rate of TB (per 100,000 population) reached below the 20s level in 2007 for the first time, and was 16.1 in 2013.[10] Although it shows a continuous downward trend, Japan is a country with a medium tuberculosis epidemic in the world. Among the patients with persistent viral hepatitis, 1.1-1.4 million are estimated to have type B and 1.9-2.3 million to have type C[11]. It has become an issue since the time of infection can hardly be identified and the infection is often asymptomatic, patients who have not received treatment at an appropriate time can easily develop cirrhosis or liver cancer. In addition, the number of people with mental problems has also been increasing due to the stress of severe work environments, including overwork, in modern Japanese society.

Among the in- and outpatient rates (per 100,000 population), the survey in 2011 showed that persons aged 65 or older accounted for over 68% of inpatients and 46% of outpatients[12].

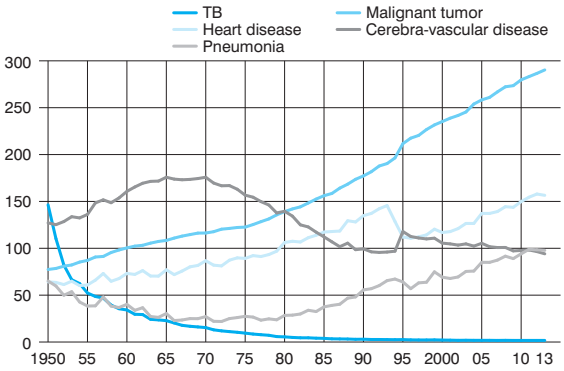


Figure 5: Transition of mortality rates by the primary cause of death[7]

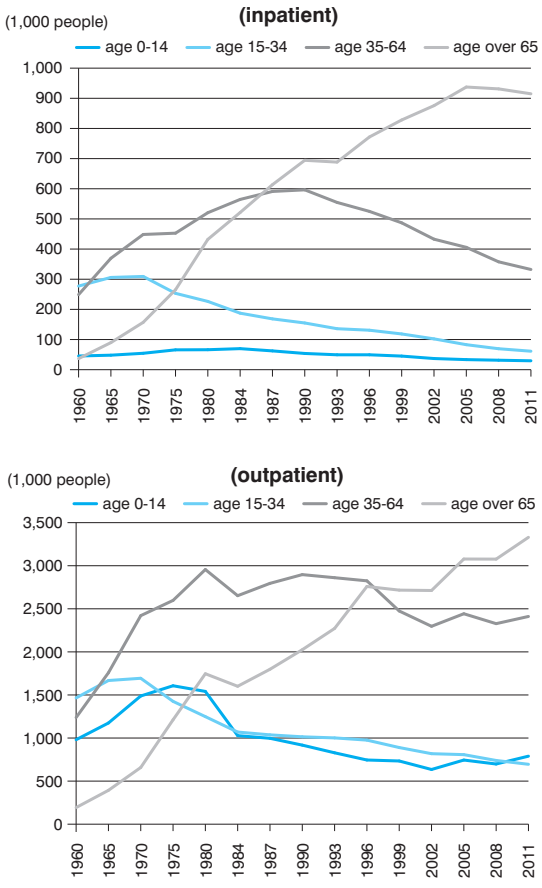


Figure 6: Annual transition of patient estimates by age group[12]

2. Japanese Healthcare System

Health insurance system and medical fee

Japan's social security system are roughly divided into four component pillars: social insurance, social welfare, public assistance and public health. The core social insurance is a compulsory system that ensures the livelihood of citizens by providing a given amount of cash or in-kind benefits in case of "events insured against, " namely, disease, injury, childbirth, death, old age, disability, loss of job, etc. Within this framework, a universal healthcare insurance system extending to all citizens has been established in 1961 in accordance with the National Health Insurance Act so that anyone can obtain appropriate healthcare anywhere at any time. Japanese citizens have to be covered by any of the following medical insurances: 1) employee's health insurance for employed individuals, 2) national health insurance for self-employed individuals and those out of employment, and 3) the healthcare system for later-stage elderly for the people aged 75 years or over.

In the health insurance system, the insured pays a given amount of money every month to the insurers, and in case of a consultation pays part of the costs of the received healthcare services to the healthcare institutions. Healthcare institutions claims medical fee to the screening and payment institutions and receive the payment from insurers. Healthcare expenditures are paid on a fee-for-service basis. Medical fees for which healthcare institutions claim are figured out by counting the points of the individual medical practices.

In 2012, the national health expenditure reached 39,211.7 billion yen, and more than half of them which equals to 56.3% are the healthcare costs of elderly people aged 65 or over. National health expenditure per capita was 177,100-yen for those who are under 65-year and 717,200-yen in 65 year or over. The ratio of national health expenditure to national income was 11.17%[14]. In these years, the national health expenditure has been increasing at a higher pace than the growth of the national income. The total health expenditure to GDP was 10.1%, and ranked 10th among the major OECD countries[15].

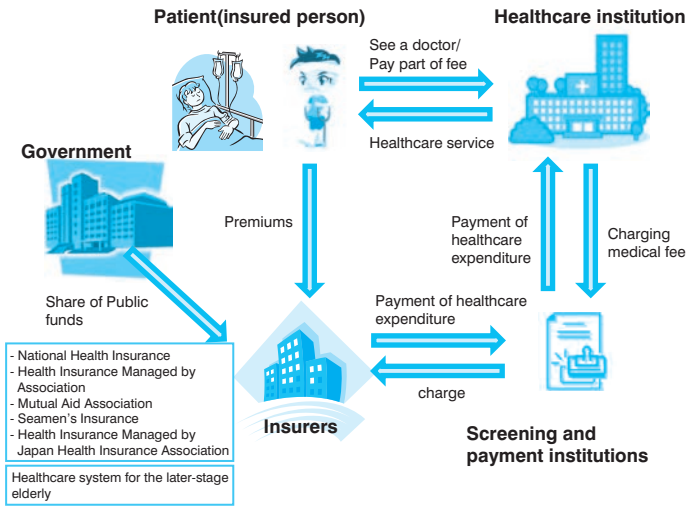


Figure 7: Overview of Japan's healthcare system[13]

Healthcare provision system

Japan has established the healthcare provision system which ensures easy access and availability to everyone. However, healthcare reform is required to achieve a sustainable system that can respond the emerging issues such as the changing disease structure, the gap between life-expectancy and healthy life-expectancy, diversification of healthcare needs of population, increasing needs for health and long-term care and skyrocketing national health expenditure.

Showa University Hospital

Table 1: Healthcare facilities[16]

Healthcare facilities		Number
Hospital	National	273
	Public	1,242
	Others	7,025
Clinic		100,528
Dental clinic		68,701

Table 2: Human resources for health[16]

Health human resources	Full-time equivalent (people)
Physicians	206,658.6
Dentists	10,103.6
Pharmacists	45,680.4
Public health nurses	5,176.2
Midwives	21,596.4
Nurses	747,009.2
Assistant nurses	142,304.7
Physical therapist	61,720.6
Radiology technicians	41,323.4
Clinical laboratory technicians	51,759.5

Long-term care insurance system

The long-term care insurance system took effect in 2000 based on the Act on Long-term Care Insurance, as a mechanism for supporting long-term care for the elderly by the entire society. As Japan's society ages, the population that requires long-term care has increased, and the duration of long-term care has been extended. In the meantime, the forms of family have also been changing, with increased nuclear families and the aging of caregivers. The long-term care insurance system was established in response to these changes. Municipalities are responsible for operating this system as the insurers, and the scope of the insurance includes people aged 65 years or over as primary insured persons and those aged 40 to 64 years as secondary insured persons. When long-term care becomes necessary, insured persons can use the long-term care services with the copayment of 10% of the incurred expenses (20% for persons above certain income). Ceiling amounts are predefined for respective services in accordance with the long-term care level. When services exceeding the ceiling are used, insured persons need to pay the full excess amount. Long-term care services based on the long-term care insurance are mainly categorized into facility service, home-based service, and community-based service. "Facility service" includes services provided to the residents of special nursing homes for the elderly and other facilities. "Home-based service" signifies home nursing, daycare service and other services that are required for assisting living at home. "Community-based service" refers to group homes for the elderly with dementia in addition to the above.

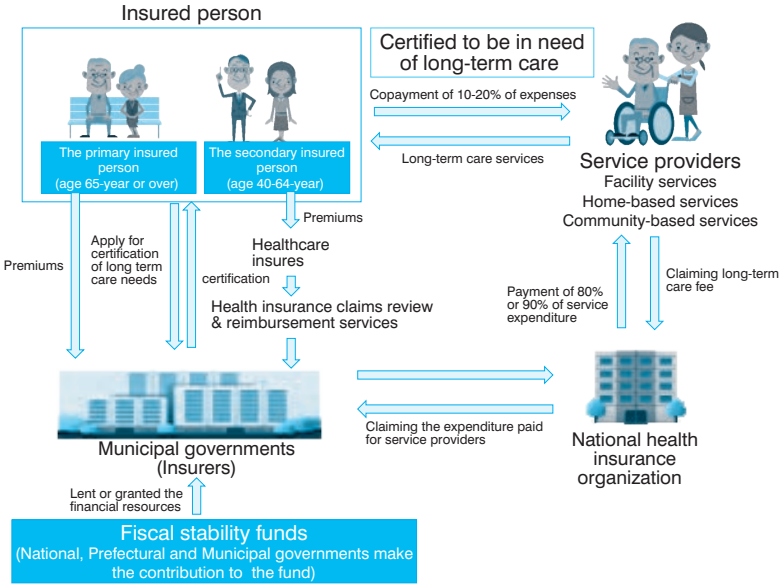


Figure 8: Overview of Long-term care insurance system[17)]

Reforms in health and long-term care services

Social environment in Japan has been changing due to aging of the population with the declining birthrate, changing employment pattern, issue of poverty and disparity, and other factors. Social security expenses for healthcare, pension, welfare, long-term care and other public services have rapidly increased over the past 20 years, and are expected to further increase as the aging of population proceeds. In line with increase in social security expenses, the gap between the social insurance premium income and the social security expenses has widened, which is filled by a large amount of public fund. To make up for shortage in the public fund, the government of Japan

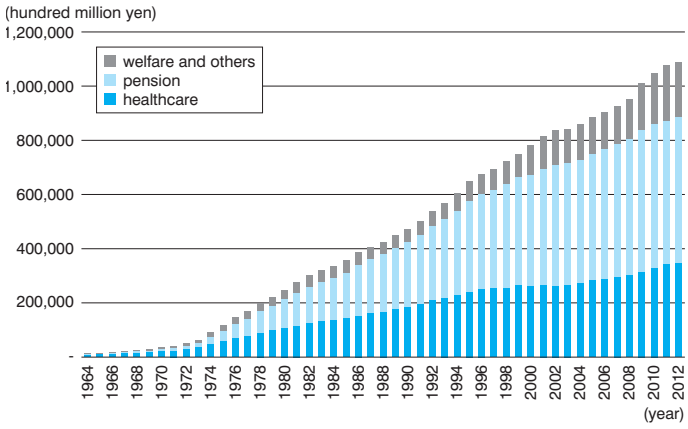


Figure 9: Transition of social security expenditure by category[18)]

continues to issue an increasingly larger amount of bonds. To stabilize the social security system both financially and structurally, and to achieve a sustainable mechanism, a comprehensive reform of tax and social security became necessary. The government has raised the consumption tax rate from 5 to 8%, and will further raise it to 10%. The entire amount of increased tax revenue will be put into social security. At the same time, the government proceeds the reform of social security system so that all generations can live with assurance. With respect to social security system, reforms are in progress with a focus on children and child rearing, health and long-term care, and pension.

The government is seeking to establish a healthcare and long-term care service system for supporting population in a more multi-layered and integrated way, shifting emphasis from hospitals to communities, toward the year 2025, when the baby boom generation reaches the age 75 or over. The plan is to establish a system for providing efficient and high-quality health care that is aimed at early recovery into community, through the functional differentiation of hospital beds, mutual collaboration, promotion of home-based care, and other measures. At the same time, a community-based integrated care system is being established for the comprehensive provision of housing, healthcare, long-term care, preventive care and livelihood support, placing the hub of daily life of the elderly in communities, so that they can live through to the end of life, as long as possible, in communities that they are familiar with. The community-based integrated care system is established based on the independence and autonomy of local communities, and in accordance with the characteristics thereof.

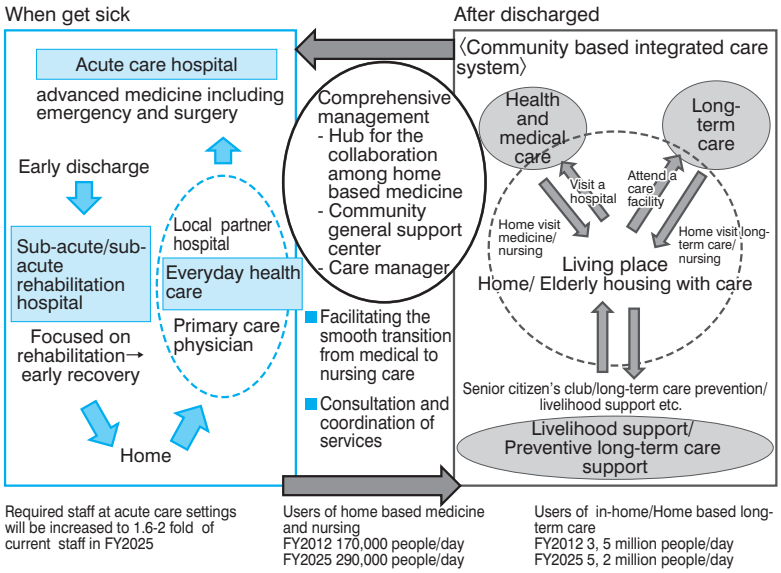


Figure 10: Reform of healthcare system[19)]

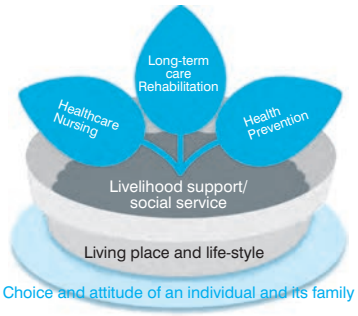


Figure 11: Community based integrated care system[20)]

Multi-disciplinary team meeting at Himeji St. Mary's Hospital

3. Overview of Japanese Nursing System

History and system

Although nursing has a long history in Japan, modern nursing rapidly developed with the switchover from traditional Chinese medicine to Western medicine after the Meiji Restoration. The beginning of nursing education system in Japan provided midwifery education, licensing and training in accordance with the Medical Regulation enacted in 1874. Modern nursing education started in 1885. Modernized nursing professional qualifications were established by Midwives Ordinance of 1899, Nurses Ordinance of 1915, and Public Health Nurses Ordinance of 1941, respectively. The National Medical Care Act enacted in 1942 regulated public health nurses, midwives and nurses as healthcare professionals along with medical doctors and dentists.

After World War II, under the GHQ (General Headquarters of the Supreme Commander for the Allied Powers), placed during the allied powers' occupation, the existing three Ordinances for nursing professionals were unified into the Act on Public Health Nurses, Midwives and Nurses in 1948, based on the philosophy of integrated nursing. The purpose of this Act was defined as "to enhance the quality of public health nurses, midwives and nurses, and thus to promote and improve healthcare and public health."

Today, nursing personnel in Japan can be classified into public health nurses, midwives, nurses and assistant nurses. The Act above specifies their qualification and practice in Article 2-6.

Japanese nursing system was reorganized under the command of the GHQ so that a nursing division was installed in the then Ministry of Health and Welfare in 1948 to start nursing administration by nursing personnel. However, with the subsequent changes in the healthcare provision system and the increase in hospitals, the shortage of nurses became serious, and issues about nurses' work conditions including workloads and working hours surfaced. To address them, the Ministry took measures to improve the nursing system, establish a higher nursing education, and enhance the nursing education.

In these years, enhancement of nursing services has been required to meet the advanced and diversified healthcare, the aging society with fewer children, and the diversified citizens' needs. In 2009, amendment bills for the Act on Public Health Nurses, Midwives and Nurses and other laws by lawmaker-initiated legislation gained approval for the first time in 60 years. The main amendments are specifying graduation from a 4-year college in the opening of the provision on the eligibility to take the nurse's examination, revising the course terms of public health nurse and midwife education, and making the endeavor to provide newly-graduated nursing personnel training obligatory. In 2015, the partial amendment of the Act on Public Health Nurses, Midwives and Nurses was enforced. It expanded the role of nurses who took the certain training to practice specific medical interventions.

Chronology

1868 Meiji Restoration
1874 Medical regulation was established.
1885 The first nurse-training institute was established.
1899 Enactment of the Midwives Ordinance
1900 The first nurse regulation was established (Tokyo only, subsequently expanded nationwide)
1915 Enactment of the Nurses Ordinance
1929 The Association of Nurses was established.
1933 The 7th ICN Congress approved membership of Japan's Imperial Nurses Association.
1937 Promulgation of Public Health Center Act (The term of Public Health Nurse was used for the first time in law)
1941 Enactment of the Public Health Nurses Ordinance
1942 Enactment of the National Medical Care Act
1945 The WWII ended. Japan was placed under GHQ control.
1946 A new nurse education system was launched under GHQ guidance.
The Japanese Association of Midwives, Nurses and Public Health Nurses was established (today's JNA).
1948 Enactment of the Act on Public Health Nurses, Midwives and Nurses
The Act changed the status of these nursing professions into formal license qualifications granted upon passing examinations.
1949 Enactment of the ordinance for designating training schools for public health nurses, midwives and nurses
1951 Introduction of the assistant nurse system
1952 Introduction of the first four-year university course on nursing
1955 JNA joins ICM.
1957 Introduction of a two-year nursing education course (for assistant nurses preparing for the government examination for nurse qualification)
1959 The Japan Nursing Federation was established as a political lobbying organization.
1965 National Personnel Authority ruling on the regulation regarding night shifts of nurses (up to 8 days a month, ban on single-person night shift)
1967 Establishment of the Japan Nursing Society
1977 The 16th ICN Congress was held in Tokyo.
1987 Ministry of Health and Welfare reported the need to establish training institutes for nursing education, organize forums / training sessions, step up the standard of nursing education and create more undergraduate / postgraduate courses on nursing.
1990 May 12, the birthday of Florence Nightingale, was officially declared the Nursing Day in Japan.
1992 A prefecture nursing association opeued the first visiting nurse station.
Enactment of the Act on Assurance of Work Force of Nurses and Other Medical Experts
1994 The first male public health nurse received an official license.
1995 The Great Hanshin & Awaji Earthquakes
Initiatives for disaster nursing gather momentum.
1996 The first group of Certified Nurse Specialists received certification.
1997 The first group of Certified Nurses received certification.
2007 ICN Conference was held in Yokohama.
2010 Enforcement of partial revision of the Act on Public Health Nurses, Midwives and Nurses
Introduction of novice nurses' clinical training project

2011 The Great East Japan Earthquake
Devastating impact on socioeconomic infrastructure as well as healthcare provision.
2015 Enforcement of partial revision of the Act on Public Health Nurses, Midwives and Nurses
Introduction of training system for nurses to perform specific medical interventions
Enforcement of partial revision of the Act on Assurance of Work Force of Nurses and Other Medical Experts
Commencement of notification system when leaving nursing (obligatory to make efforts)

To become a public health nurse, midwife or nurse in Japan, it is essential to complete a required curriculum at an educational institution set forth by law, pass a national examination that can be taken once a year, and obtain a license granted by the Minister of Health, Labour and Welfare. To become a nurse, basic academic background for twelve years and three years' basic nursing education are required. To become a public health nurse or midwife, training for nurses plus one or more years of education are required. Foreign nursing personnel who wish to work in Japan are required to take Japan's national nursing examination to obtain a Japanese license because nursing licenses obtained overseas are not accepted.

Licenses for assistant nurses are not issued by the Minister but by prefectural governors. However, licensed assistant nurses do not need to stay and work within the prefecture but they can move to work any other prefecture in Japan. The term of training for assistant nurses is two years. Nursing services by them require the supervisions of a physician, dentist or nurse.

Japanese nursing qualification doesn't have any renewal system, and lasts for the rest of nursing personnel's lives. However, dispositions including the rescission of a license may be rendered as grounds for disqualification set forth by the law or in case of acts that compromise dignity.

Public health nurses

A public health nurse is a person who engages in health guidance using the title of public health nurses under the license of the Minister of Health, Labour and Welfare (Article 2 of the Act on Public Health Nurses, Midwives and Nurses) .

The workplaces of public health nurses are public health centers, public administration including those of municipalities, cities or villages, as well as in industry, schools or hospitals. Among these, those working for municipalities, cities or villages have been increasing year after year. The ratios of workplaces in 2013 showed that health centers and municipalities, cities and villages accounted for 59.2%, hospitals and clinics for 25.7% and other establishments for 7.1%[21].

Public health nurses, being the leaders of public health nursing operations, are professionals who conduct such operations as community activities or methods of getting into communities. Through the activities, the professionals find common health problems within a community and seek solutions valuing partnership and collaboration with residents. To solve diversified and complicated health problems, there are great expectations of public health nurses. Particularly in these years, their roles in urgent and troublesome issues including measures against lifestyle-related diseases and suicide are critical. And there have been increased needs for their activities.

Midwives

A midwife is a woman who engages in midwifery or health education to pregnant and postpartum women or newborn under the license of the Minister of Health, Labour and Welfare (Article 3 of the Act on Public Health Nurses, Midwives and Nurses). Midwives are granted the right to establish a midwifery home.

As the birthrate declines and the number of obstetricians and gynecologists decreases, a perinatal care system was established thorough integration of delivery facilities according to the medical functions as such. Midwives are expected to exercise their specialty in this system.

The workplaces of midwives include hospitals, clinics, midwifery homes and other facilities. More than 60% of midwives work for hospitals, approx. 25% for clinics, approx. 5% for midwifery homes, and approx. 7% for other facilities (public health centers, administrative organs, educational institutions, etc.).[21] Meanwhile, roughly half of childbirths in Japan are taken care of in hospitals and the other half in clinics, suggesting a problem that specialized care by midwives is not adequately provided to mothers who give births at clinics and their children. This also affects the process for midwives to acquire practical skills.

To tackle this problem, five midwives organizations (Japanese Nursing Association, Japanese Midwives Association, Japan Academy of Midwifery, Japan Society of Midwifery Education, and Japan Institute of Midwifery Evaluation) established a CLoCMiP®* Level III Certification System. This system provides objective evaluation that a midwife has acquired practical skills which satisfy specified criteria. It is expected that the establishment of this system will cater to the enhancement of practical midwifery skills.

* CLoCMiP: "Clinical Ladder of Competencies for Midwifery Practice"
clinical ladder for midwives developed by Japanese Nursing Association.

Nurses

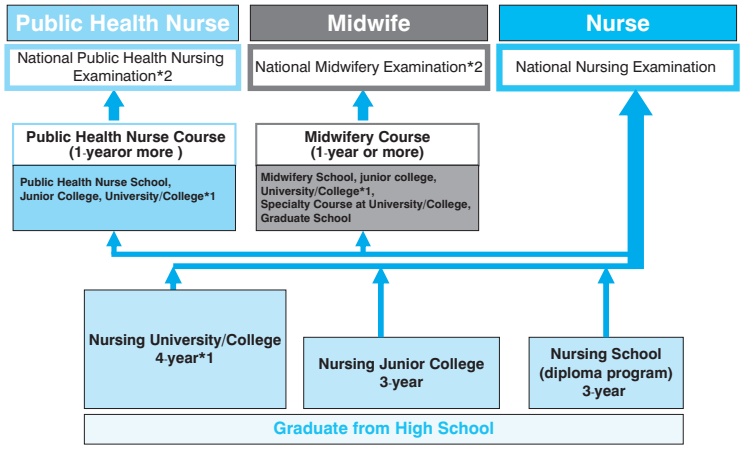
A nurse is a person who engages in providing care to person with injuries and/or illnesses or postpartum women, or to assist medical treatment under the license of the Minister of Health, Labour and Welfare (Article 5 of the Act on Public Health Nurses, Midwives and Nurses).

Sophistication and advancement of healthcare as well as the emergence of an aging society with fewer children have triggered changes in the healthcare provision system and disease structure. Consequently, citizens' needs are diversified so that it is required to meet such needs. Nurses are working at various settings including healthcare institutions, home-based care, social welfare and business industries in order to support people from the perspective of health and healthcare and their life.

Combined Service Provider AOI in Tomiya

4. Nursing Education in Japan

Basic nursing education



*1 Nursing University/College provided Public Health Nursing Course and/or Midwifery Course in 4-year education, those graduates could get qualification to sit for national examination for Public Health Nurse and/or Midwife in addition to Nurse.
*2 To obtain Public Health Nursing/Midwifery License, it is required to hold Nursing License.
*Assistant nurse courses are omitted

Figure 12: Main basic nursing education courses

There are several courses of basic nursing education in Japan. In the main courses, basic nursing education is provided at 4-year colleges/universities, 3-year junior colleges or 3-year training schools after graduation from high school to take a national examination to obtain the national license. The educational institutions offering these three courses are under different regulating authorities; colleges/universities and junior colleges are under the jurisdiction of Ministry of Education, Culture, Sports, Science and Technology (MEXT) while most training schools are under the jurisdiction of Ministry of Health, Labour and Welfare (MHLW) .

Education for public health nurses and midwives is provided at colleges/universities, one-year colleges or training schools, and master's programs at graduate schools. If a 4-year college/university education includes a training program for public health nurses and/or midwives, graduates can qualify to take the national examination, not only for nurses, but also for public health nurses and/or midwives.

Contents of education

The education contents required to be eligible to take the national examination are prescribed jointly by the MHLW and MEXT. Although there are several courses of basic nursing education in Japan as mentioned above, standard of education are equally appropriated to irrespective of the type of educational institution, or whether it is a 4-year college/university, a 3-year junior college or a 3-year training school. For other educational institutions than those offering the main courses, there are different standards.

Table 3: Education contents of nursing schools[22)]

Content		Credits
Foundation studies	Basics of scientific thinking	13
	Understanding of humans, living and society	
Specialized basic studies	Human body structure and functions	15
	Disease mechanism and recovery promotion	
	Health support and social security system	6
Specializations I	Basic nursing	10
	Clinical training	3
	Basic nursing	3
Specializations II	Adult health nursing	6
	Gerontological nursing	4
	Child health nursing	4
	Maternal nursing	4
	Mental health and psychiatric nursing	4
	Clinical training	16
	Adult health nursing	6
	Gerontological nursing	4
	Child health nursing	2
	Maternal nursing	2
	Mental health and psychiatric nursing	2
Integration	Home care nursing	4
	Nursing integration and practice	4
	Clinical training	4
	Home care nursing theory	2
	Nursing integration and practice	2
Total		97

(Appendix 3 of Designated rule for Public Health Nursing, Midwifery and Nursing School and Training School)

Development of university nursing education

The first nursing university was inaugurated in 1952. There used to be just eleven nursing colleges/universities, but they sharply increased since 1992 with flexible curriculum organization in accordance with the university establishment standards outlined in 1991, and basic principles concerning nursing college/university establishment prescribed in Act on Assurance of Work Forces of Nurses and Other Medical Experts, enacted in 1992. In addition, lower birthrates and increasing rates of students advancing to college or university encourage schools to launch the training for nursing personnel in high social demand from the perspective of ensuring students. As a result, nursing colleges/universities numbered 234 as of 2014 while 158 master's programs and 82 doctoral programs provided at graduate schools.

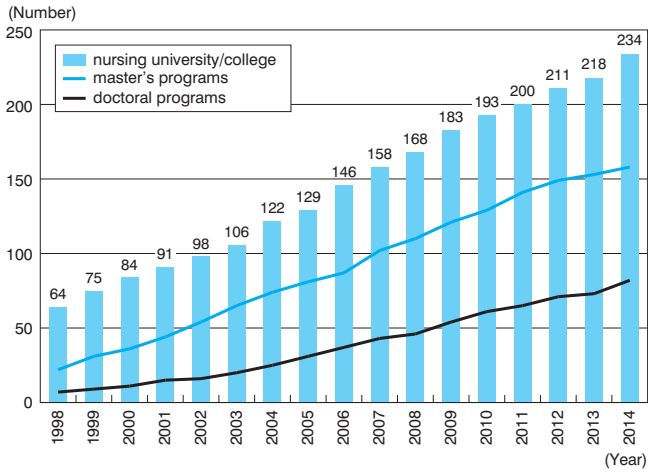


Figure 13: Transition of colleges/universities, master's programs and doctoral programs[23)]

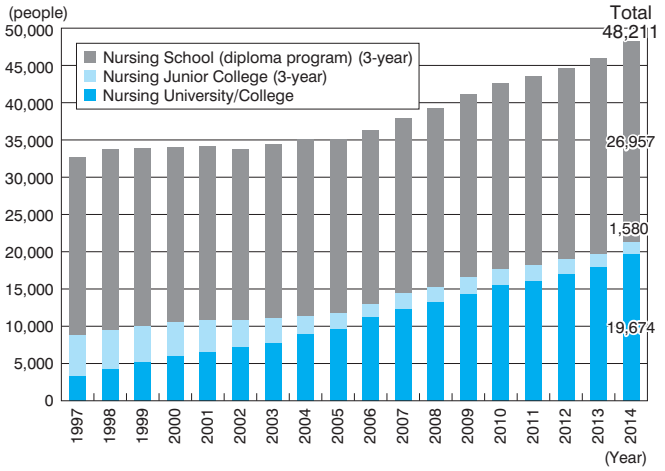


Figure 14: Transition of quota for year (nursing university/college, nursing junior college and nursing school (diploma program))[23)]

Clinical training for newly-graduated nursing personnel

The amendments of "Act on Public Health Nurses, Midwives and Nurses" and "Act on Assurance of Work Forces of Nurses and Other Medical Experts" made it obligatory to endeavor to give postgraduate clinical training to newly-graduated nursing personnel from April 2010. The government formulated guidelines aiming to provide the training at all healthcare institutions and launched partial subsidization of training costs.

It is expected to improve the quality of nursing, secure medical safety and prevent early turnover of newly-graduated nursing personnel.

Continuing education

The qualification of nursing personnel in Japan lacks any renewal system so that continuing education after obtaining a license is not compulsory. However, it is essential for nursing personnel to continue to improve their expertise to meet advanced healthcare and diversified citizens' needs. Therefore, opportunities for continuing learning are offered, including on the job training at the workplace, training and workshops provided by Japanese Nursing Association (JNA) or prefectural nursing associations, and various scientific meetings.

Credentialing system

In Japan, the qualification of public health nurses, midwives, nurses and assistant nurses is stipulated by law, while the certification of specialized nurses is not specified by law. Although many organizations and societies certify such personnel, credentialing system by JNA is socially recognized and appreciated.

This credentialing system by JNA, intended to offer quality healthcare to citizens, certificates the following three; certified nurse specialists, certified nurses and certified nurse administrators.

Certified nurse specialists

Certified nurse specialist (CNS) system is designed to contribute to the development of healthcare and welfare as well as to improve nursing science by forwarding CNSs with specific advanced nursing knowledge and skills into society to provide high-level nursing care efficiently for individuals, families and groups having complex and intractable nursing problems.

The roles of CNSs are excellent nursing practice, consultation with care providers including nurses,

coordination among the concerned parties, ethical coordination to protect the rights of individuals, etc., education of nursing personnel, and research activities at clinical settings. A nurse is certified as a CNS upon completing a master's program at a graduate school after obtaining a national license for nurses, and then passing the credentialing examination given by JNA after accumulating a certain amount of experience. It is required to renew the certification every five years.

Certified nurses

The certified nurse (CN) system is designed to diffuse quality nursing care at nursing sites by forwarding CNs who can provide high-level nursing practice, using skilled nursing expertise in specific nursing fields, into society.

The roles of CNs are nursing practice at high level, instruction of nurses, and consultation with nurses.

A nurse is certified as a CN upon accumulating a certain amount of experience after obtaining a national license for nurses, and then passing the credentialing examination given by JNA after completing the required education program for certification. It is required to renew the certification every five years.

Certified nurse administrators

The certified nurse administrator (CNA) system is designed to provide quality organizational nursing services to individuals, families and local residents with diversified healthcare needs, establish frameworks for training of CNAs meeting certain standards, help to maintain and improve the quality of CNAs and the standard of nursing, and thereby contribute to the development of healthcare and welfare.

A nurse is certified as a CNA upon accumulating a certain amount of experience after obtaining a national qualification for nurses, and then passing the credentialing examination given by JNA after completing a master's program at a graduate school or an education program for certification. It is also required to renew the certification every five years.

Table 4: Number of certified nurse specialists by field (as of July, 2015)

Field	Registered number
Cancer Nursing	581
Psychiatric Mental Health Nursing	207
Community Health Nursing	25
Gerontological Nursing	79
Child Health Nursing	140
Women's Health Nursing	49
Chronic Care Nursing	117
Critical Care Nursing	177
Infection Control Nursing	32
Family Health Nursing	37
Home Care Nursing	22
Total	1,466

Table 5: Number of certified nurses by field (as of July, 2015)

Field	Registered number
Emergency Nursing	1,021
Wound, Ostomy and Continence Nursing	2,166
Intensive Care	1,033
Palliative Care	1,849
Cancer Chemotherapy Nursing	1,384
Cancer Pain Management Nursing	769
Visiting Nursing	500
Infection Control	2,317
Diabetes Nursing	775
Infertility Nursing	150
Neonatal Intensive Care	366
Dialysis Nursing	206
Perioperative Nursing	399
Breast Cancer Nursing	283
Dysphagia Nursing	595
Pediatric Emergency Nursing	228
Dementia Nursing	653
Stroke Rehabilitation Nursing	583
Radiation Therapy Nursing	200
Chronic Respiratory Nursing	220
Chronic Heart Failure Nursing	238
Total	15,935

Training system for nurses to perform specific medical interventions[24)]

As the aging of society proceeds in Japan, an increasing number of people live in communities with chronic diseases and/or with more than one disease. Toward the year 2025, when the entire baby boom generation reaches the age 75 or over, reforms in healthcare service system are in progress.

Starting in October 2015, the Act on Public Health Nurses, Midwives and Nurses was partially amended to oblige nurses who perform specified medical interventions in accordance with procedure manuals (a type of instructions rendered by physicians) to take training for the specified interventions. The establishment of this new system enables trained nurses to perform the specified medical interventions without waiting for decision making by physicians every time.

Thirty-eight interventions are specified and grouped into 21 categories. They are "assistance

to medical treatment that requires the following competency of nurses, particularly who should perform them in accordance with the procedure manuals: practical comprehension, ability to think and make decision, as well as knowledge and skills that is highly advanced and specialized."

Procedure manuals should be prepared in advance by physicians or dentists in collaboration with nurses to provide instructions to nurses for assistance to medical or dental care. The physician or dentist should identify the patient(s) and nurse(s) who are subject to the procedure manuals, and indicate the range of conditions of the patient(s), description of assistance to medical treatment, how to report following the specified intervention, and other details.

Training for the specified interventions is held at training institutions designated by the Minister of Health, Labour and Welfare. The training course consists of common subjects (315 hours) and category subjects (15 to 72 hours per category) that should be learned for each category of specified interventions, and participants learn through lectures and exercises/practices.

Those who have completed the course receive a certificate of completion from the training institution, and are qualified to perform the relevant specified interventions based on procedure manuals, though the qualification does not have legal basis. The training institutions submit the listing of persons who have completed the course to the Ministry of Health, Labour and Welfare.

Table6: Specific medical interventions and their categories[25)]

Categories for specific medical interventions	Specific medical interventions
Respiratory system (airway management)	Adjusting the position of an oral tracheal tube or nasal tracheal tube
Respiratory system (mechanical ventilators)	Changing the mode settings for invasive positive ventilation, Changing the mode settings for non-invasive positive ventilation, Adjusting the dose of sedatives for persons under mechanical ventilation management, and Weaning from mechanical ventilation
Respiratory system (long-term respiratory therapy)	Replacing a tracheal cannula
Circulatory system	Operating and managing a temporary pacemaker, Removing temporary pacemaker leads, Operating and managing a percutaneous cardiopulmonary support device, Adjusting the assistance frequency of an intra-aortic balloon pump at the time of weaning off
Pericardial drainage catheter management	Removing a pericardial drainage catheter
Thoracic drainage tube management	Setting and changing suction pressure levels for a continuous low-pressure suction drainage system, Removing a thoracic drainage tube
Abdominal drainage tube management	Removing an abdominal drainage tube (including the removal of a puncture needle placed within the abdominal cavity)
Fistula management	Replacing gastrostomy tube, jejunostomy tube or gastronomy button, Removing a suprapubic catheter
Nutrition management (central venous catheter)	Removing a central venous catheter
Nutrition management (peripherally inserted central catheter)	Inserting a peripherally placed central catheter for injection
Wound management	Removing necrotic tissues with no blood circulation for the treatment of pressure ulcers or chronic wound, Negative pressure wound therapy
Wound drainage tube management	Removing a wound drainage tube
Arterial blood gas analysis	Collecting a blood sample by direct arterial puncture, and Securing a radial artery line
Dialysis management	Operating and managing a hemodialysis machine or hemofilter for acute blood purification therapy
Administration of medications for nutrition and fluid management	Adjusting the dose of high-calorie intravenous fluid during the continuous infusion, Correcting dehydration symptoms with intravenous fluid
Administration of medications for infections	Administrating temporary medications as needed to persons with signs of infection
Administration of medications for blood glucose control	Adjusting the dose of insulin
Postoperative pain management	Administering analgesics via an epidural catheter, and adjusting the dose of analgesics
Administration of medications for hemodynamics	Adjusting the dose of catecholamine during the continuous infusion, Adjusting the dose of sodium, potassium and/or chloride during the continuous infusion, Adjusting the dose of hypotensives during the continuous infusion, Adjusting the dose of intravenous fluid with carbohydrates or electrolytes during the continuous infusion, and Adjusting the dose of diuretics during the continuous infusion
Administration of medications for psychiatric and neurological symptoms	Administrating anticonvulsants (temporarily) as needed, Administrating antipsychotics (temporarily) as needed, Administrating of anxiolytics (temporarily) as needed
Administration of medications for skin injury	Injecting steroids locally in the case of extravasation of chemotherapy or other agents and adjusting the dose of steroids

5. Working Conditions in Nursing in Japan

Employment status of nursing personnel

In response to the continuously increasing needs for healthcare and nursing, measures have been taken to secure necessary human resources, and the number of nursing personnel in workforce has increased year after year. The number stood at 1,571,647 in 2013[21], as large as 640% compared to the 1960 level. The number of nursing personnel in workforce per 100,000 population increased from 261 in 1960 to 1,245 (470%) in 2013. The largest work places of nursing personnel are hospitals, employing 61.2% of all nursing personnel in workforce, followed by clinics (20.8%).[21]

Following the enactment of the Act on Long-term Care Insurance in 2000, the place for the treatment and rehabilitation of the elderly with diseases is shifted from hospitals to long-term care facilities or to home. The number of nursing personnel who play an important role in communities is expected to rise.

By age group, the population of nursing personnel in workforce is the largest in their 30s and 40s. The average age of all nursing personnel in workforce is 41 years. While the employment rate is high in their early 20s, the rate rapidly declines from the late 20s to the 30s. This is probably attributable to the difficulty in achieving work-life balance during the childbirth and childrearing periods. On the other hand, an increasing number of nursing personnel continue to work after their mandatory retirement age that is set at around 60 year-old, through the postponement of retirement or through re-hiring. The share of such nursing personnel in the entire nursing workforce has increased from 3.6 to 8.4%. In the meantime, the ratio of male nursing personnel stands at approx. 6%, showing slight increase every year.[21]

In Japan, "supply and demand for nurses" has been formulated every five years since 1974, in order to forecast the supply and demand for nursing personnel, and to take measures for satisfying the demand. The government has taken measures for securing nursing workforce, including the introduction of a scholarship system for nursing students in 1962, the increased fund allocation to nursing educational facilities in 1963, the initiation of free-of-charge placement service by establishing nurse banks across Japan in 1975, and the introduction of maternity leave system targeted at nursing personnel and female teachers in 1976. Furthermore, in order to respond to shortage in nursing workforce caused by the rapid aging of society and environmental changes in public health, the Act on Assurance of Work Forces of Nurses and Other Medical Experts was enacted in 1992, stipulating the responsibilities of the national and local governments concerning the development of nurses and other healthcare personnel, improvement of working environment, and the enhancement of skills and abilities. These endeavors have led to steady increase in nursing workforce.

Still, the Ministry of Health, Labour and Welfare estimates that approx. two million nursing personnel will be required by 2025, as needs for healthcare grow in line with the aging of Japanese population, and healthcare itself is getting much more advanced and specialized. Because decrease is expected in the number of human resources who newly enter the practice due to the declining birthrate, fundamental actions are needed to assure nursing workforce.

As part of the required actions, "the Act on Assurance of Work Forces of Nurses and Other Medical Experts" was amended to oblige nursing personnel to make efforts to notify the information items specified in the Ordinance of the Ministry of Health, Labour and Welfare (e.g. address, name and license number) to the prefectural nurse center when they leave jobs at hospitals or other facilities, effective October 2015. The prefectural nurse center keeps track on the status of unemployed nursing personnel based on the reports. "Nurse Centers" were established when "the Act on Assurance of Work Forces of Nurses and Other Medical Experts" was enacted in 1992, and each prefecture has at least one nurse center that is operated by the prefectural nursing association with the designation from the prefectural government. The major services provided by the nurse centers include the free-of-charge placement for nursing personnel, the implementation of training courses to support re-employment, and the conduct of surveys to identify non-practicing nurses. The notification system and function enhanced nurse centers ensures the link with non-practicing nursing personnel, and provide supports including employment consultation service, information provision, supportive training for nurses who return to practice. These measures should ensure early return to practice and uninterrupted career paths for nursing personnel.

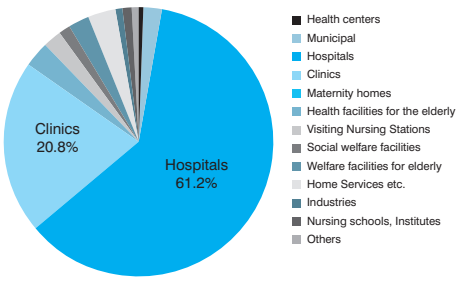


Figure 15: Workplace of nursing personnel[21] (2013)

Nagasaki Nursing Association Visiting Nursing Station YOU

Improvement of work environment

According to the 2013 survey by Japanese Nursing Association (JNA), the turnover rate of full-time nursing personnel who work at hospitals stands at 11.0%, without substantial increase or decrease over the past four years. This figure includes the turnover rate of newly graduated nursing personnel at 7.5%.[26)]

While the number of nursing personnel in the workforce is increasing in Japan, many of them are leaving their jobs and practice. The underlying cause for this phenomenon is the demanding work environment that makes it difficult for nursing personnel to continue working. While the most common reasons for nursing personnel to leave their jobs are "marriage, childbirth and/or childrearing", factors in workplace environment are also significant, including the irregular shift work, long work hours, burden of night shift, heavy responsibilities, and poor treatment.

To tackle this, the national government released the "Intra-MHLW Project Team Report concerning the Improving 'Quality of Jobs' for Nurses and Other Professionals" in June 2011, and has promoted measures for the improvement of working environment for nursing personnel and other healthcare workers. Seminars were held for labor managers at healthcare institutions and other facilities, while measures were promoted to introduce and set in place a short-time regular staff system. Measures for the development and assurance of human resources included the implementation of the training service for non-practicing nursing personnel and other healthcare workers before their return to practice, and financial support to clinical training for newly graduated nursing personnel. The government released the "Project Team Report concerning the Improving the 'Quality of Jobs' in the Healthcare Setting" in 2013, thereby enhancing and bolstering said measures, and expanding the scope to the entire healthcare workers.

The amendment of Medical Care Act took effect in October 2014, establishing a system for improving the work environment of healthcare workers. Managers at healthcare institutions are obliged to take efforts for improving work environment in healthcare. This amendment of Medical Care Act positions the improvement of work environment for healthcare workers, including physicians and nurses, as one of the requirements for assuring and retaining healthcare human resources, and requires relevant measures to be promoted in a broad perspective including work-life balance. To achieve this, "support centers for improvement in healthcare work environment" were established in each prefecture. These centers support healthcare institutions that pursue better work environment, in collaboration with related local organizations (e.g. medical associations, nursing associations, labor and social security attorney's associations). In addition, the Ministry of Health, Labour and Welfare formulates guidelines and handbooks concerning the management system for improvement in healthcare work environment, targeted at healthcare institutions, in support of activities by prefectural governments. The "management system for improvement in healthcare work environment" is aimed at enhancing the quality of healthcare and assuring the safety of patients, through the formulation of positive work environment, and the assurance of the health and safety of healthcare workers, at respective healthcare institutions. Under this system, continuous activities to create better work environment should be voluntarily promoted through collaboration among healthcare workers.[28)]

In alignment with the governmental projects, JNA operates projects to improve work environment and to promote the employment and retention of nursing personnel, through the publication and dissemination of guidelines for night shift and shift work, and the recommendation of work-life balance based on diverse working styles.

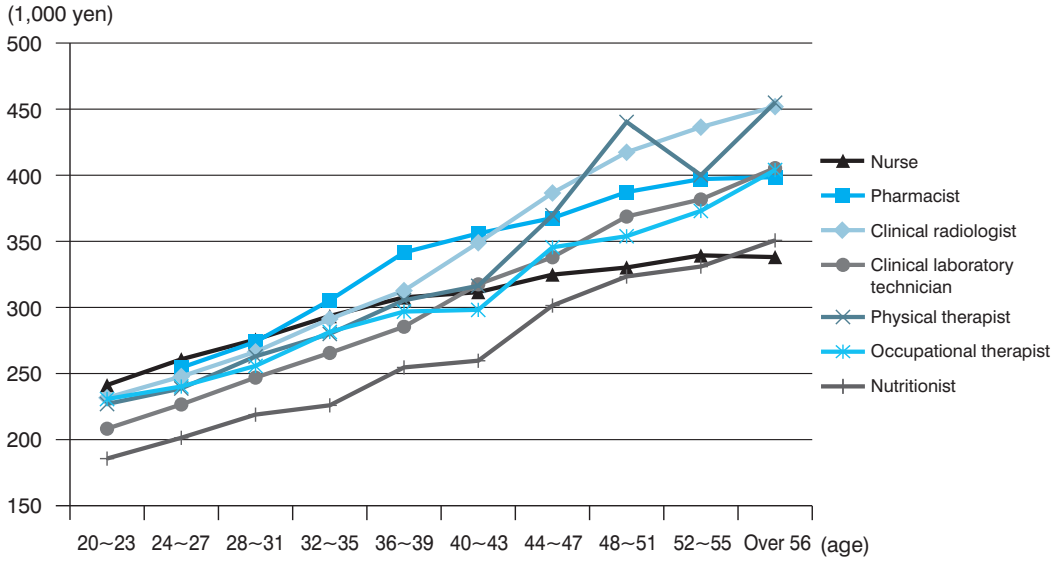


Figure 16: Routinely paid salary by profession[27)](April 2014)

References

1. Ministry of Health, Labour and Welfare, Current situation and issues of “non-regular employment”,available at: http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000046231.html (in Japanese) (accessed on July 29, 2015)
2. Ministry of Health, Labour and Welfare edit (2014). White paper on Health and Labour 2014, Tokyo.
3. Statistics Bureau, Ministry of Internal Affairs and Communications(2015), “Population estimates” available at: http://www.stat.go.jp/data/jinsui/pdf/201506.pdf (accessed on July 13,2015)
4. Statistics Bureau, Ministry of Internal Affairs and Communications(2015), “World statistics 2015”, available at: http://www.stat.go.jp/data/sekai/0116.htm (accessed on July 13, 2015) simple calculation using the data of world population and Japanese population
5. National Institute of Population and Social Security Research (2012),“Population Projections for Japan”(January 2012), available at: http://www.ipss.go.jp/site-ad/index_english/esuikei/gh2401e.asp (accessed on July 29, 2015)
6. Ministry of Health, Labour and Welfare, “Abridged life table for Japan 2013”, available at: http://www.mhlw.go.jp/english/database/db-hw/lifetb13/dl/lifetb13-06.pdf (accessed on October 28, 2015)
7. Ministry of Health, Labour and Welfare(2014), “Vital statistics in Japan 2013”, available at: http://www.e-stat.go.jp/SG1/estat/List.do?lid=000001127021 (in Japanese) (accessed on July 13, 2015)
8. Ministry of Health, Labour and Welfare (2014), Documents of Community Health, Health Promotion and Nutrition, Health Science Council, the second special committee on promotion on Health Japan 21(second term), available at: http://www.mhlw.go.jp/file/05-Shingikai-10601000-Daijinkanboukouseikagakuka-Kouseikagakuka/sinntyoku.pdf (in Japanese)(accessed on July 13, 2015)
9. Ministry of Health, Labour and Welfare(2015), Vital Statistics in Japan- the latest trends, available at : http://www.mhlw.go.jp/toukei/list/dl/81-1a2.pdf (accessed on October 16, 2015)
10. Ministry of Health, Labour and Welfare , “Aggregate results of annual survey on TB enrollment”, available at: http://www.mhlw.go.jp/bunya/kenkou/kekkaku-kansenshou03/13.html (in Japanese) (accessed on July 29, 2015)
11. Ministry of Health, Labour and Welfare , “Promotion of comprehensive measurement on hepatitis, available at http://www.mhlw.go.jp/bunya/kenkou/kekkaku-kansenshou09/index.html (in Japanese) (accessed on July 29, 2015)
12. Ministry of Health, Labour and Welfare(2012), “Survey on Patient 2011”, available at: http://www.mhlw.go.jp/toukei/saikin/hw/kanja/11/index.html (in Japanese) (accessed on July 29,2015)
13. Ministry of Health, Labour and Welfare, “National Health Insurance System of Japan”, available at: http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/iryouhoken/iryouhoken01/index.html (in Japanese)
14. Ministry of Health, Labour and Welfare(2014), “National medical care expenditure 2012”, available at: http://www.mhlw.go.jp/toukei/saikin/hw/k-iryohi/12/index.html (in Japanese) (accessed on July 14, 2015)
15. OECD Health Statistics (Data extracted on 15 Jul 2015 00:06 UTC (GMT) from OECD iLibrary)
16. Ministry of Health, Labour and Welfare (2014), “Survey on Health Care Facility and Hospital Report 2013”, available at http://www.mhlw.go.jp/toukei/saikin/hw/iryosd/13/ (in Japanese) (accessed on September 9, 2015)
17. Ministry of Health, Labour and Welfare, “about the long-term care insurance”, available at: http://www.mhlw.go.jp/file/06-Seisakujouhou-12300000-Roukenkyoku/0000080254.pdf (in Japanese) (accessed on July 14, 2015)
18. Portal site of official statistics of Japan(e-Stat)(2014), “Social security expenditure 2012”,available at: http://www.e-stat.go.jp/SG1/estat/List.do?lid=000001127918 (in Japanese) (accessed on July 14,2015)
19. Created by edited the figure of Public Relations Office, Government of Japan website http://www.gov-online.go.jp/tokusyu/201208/naniga/img/jujitsusaku_01_l.gif (in Japanese) (accessed on September 18,2013)
20. Issues in the future discussion about establishing community based integrated care system by Research group of community based integrated care , April 2013
21. Japanese Nursing Association Publishing Company (2015). Statistical Data on Nursing Service in Japan 2014. Tokyo.
22. Designated Rule for Public Health Nursing, Midwifery and Nursing School and training school, appendix 3
23. Japanese Nursing Association Publishing Company, Statistical Data on Nursing Service in Japan
24. Ministry of Health, Labour and Welfare(2015), “Training system for nurses to perform specific medical intervention”, available at: http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000077077.html (in Japanese) (accessed on August 14, 2015)
25. Ministry of Health, Labour and Welfare(2015), “Category of Specific medical intervention”, available at: http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000077098.html (in Japanese) (accessed on October 15, 2015)
26. Japanese Nursing Association (2014),Survey on the Demand and Supply of Hospital Nurses 2014.
27. National Personnel Authority(2014), Survey on Salary by Occupation in private sector 2014, available at: http://www.jinji.go.jp/kyuuyo/minn/minnhp/min26_index.htm (in Japanese), (accessed on October 30, 2015)
28. Research and Study group on establishment of the method to improve the work environment for healthcare workers, Ministry of Health, Labour and Welfare (2014). Guide for introduction of management system for improvement in work environment that will enhance the quality of employment in healthcare.

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