

Editorial

Is health a right or an obligation?

Imagine that your waist size is measured annually and your data from annual health checkups are stored in the database. A big brother keeps track of you and dictates what you should eat and how much when it exceeds a certain limit. Not a novel by George Orwell, it is an essential part of Japan's health care reform 2008.

“Disease management programmes (DMP)” aimed at chronic diseases with a hope of controlling cost, have become popular agenda in many countries but Japan's reform plan might go too far and may stir a national debate: is health a right or an obligation? According to the reform law passed by the congress in June 2006, health insurers will be required to provide annual health checkups to all beneficiaries aged 40–74 years starting in April 2008 and give ‘health guidance’ to those who are found to be at risk of ‘metabolic syndrome’ to change their unhealthy life-style or maintain good control of their diseases.

The ambitious goal is to reduce the number of metabolic syndrome patients by at least 25% between 2008 and 2015 with a hope that health care cost may be controlled consequently. Japan has the highest number of dialysis patients per population in the world. The number of dialysis patients per 100,000 population in Japan was 194.3 in 2004, larger than the US (155.5) and more than double that of Germany (73.9) and Korea (73.7)¹. Since half of chronic renal failure results from diabetes and annual cost for dialysis amounts to \$50,000, it would be reasonable to assume that savings can be achieved by preventing dialysis by one patient or by deterring it one year.

The proposal sets diagnostic criteria for metabolic syndrome including waist size ≥ 85 cm for men and ≥ 90 cm. Since Japan has a national health insurance programme and the number of beneficiaries aged 40–74 years is estimated to be over 52 million (44% of the population), the programme will be the largest national DMP in the world.

While most DMPs practiced in the world are voluntary, Japan's programme is unique in that it expects all eligible beneficiaries to participate. For example, if a person switches the workplace from one company to another and thereby switching the insurer, all the health checkup data will also be transferred. To

accommodate the enormous data exchange need of transferring millions of individual records among three thousand insurers every month, a new information network is being developed.

Although participation to health checkups is by no means compulsory, the goal targets 100% participation and financial penalty will be imposed to insurers whose participation rate is unsatisfactory. In a sense, the beneficiaries may be collectively penalized as a form of increased premium unless the majority of them participate in the programme.

As the ambitious plans unfold, controversies arise. Some of them are evidence-based, challenging the effectiveness of the programme for cost containment with lack of supporting evidence. Others are, however, more ideological. Critics question the legitimacy of the government to intervene into the individual's privacy of life-style such as diet. They argue that, unlike infectious diseases, life-style related diseases are more of personal choice rather than public health. Some went so far as to call such state intrusion into privacy as ‘fascism’ hinting the dark history of Japan's National Health Insurance Act enacted in 1938 as part of the war efforts.

Apart from the local debate in a country, the question whether health is a right or an obligation will present an ideological challenge to DMP provided as part of the health insurance programme. Health is essentially an individuals' right, but turns into an obligation when it is insured as ‘accidents’. Whatever the insurance, the insured has a legal (not moral) obligation to avoid accidents and cooperate with insurers to minimise damages when accidents happen. Insured drivers carry the obligations to drive carefully and home owners with fire insurance have to take due precautions to avoid fire. Any insurance policies include fine-printed disclaimers to exempt the insurers from liabilities if accidents are caused intentionally or by grave misconducts of the insured.

If such universal principles are applicable to health insurance, beneficiaries carry a legal obligation to avoid diseases as much as possible. Japan's NHI Act explicitly states that insurers “shall refuse reimbursement if disease or injury are intentionally caused by the insured (article 116)”, or “caused by grave misconduct or negligence (article 117)” and “may withhold reimbursement if the insured refuses to follow

¹ OECD Health Data 2006.

doctor's directions (article 119)". Doctors are required to report to the insurers when they find such patients (Practicing Rules, article 10).

These fine-printed disclaimers are necessary to prevent moral hazards and protect the common interest of the insured population. If so, then, why can't insurers keep track of individuals and intervene for

diseases which individuals, not society, can prevent or at least control exacerbation? The controversy evoked the long-overlooked fine prints and is painfully reminding everyone of the value of health as an obligation not as a right.

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