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The Politics of Mental Health: A Comparative Study of Policy Adoption and Implementation in Germany and Japan

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THE POLITICS OF MENTAL HEALTH:

A COMPARATIVE STUDY OF POLICY ADOPTION AND
IMPLEMENTATION IN GERMANY AND JAPAN

by

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ABSTRACT

In the aftermath of World War II, the Liberal Democratic Party of Japan followed Germany's blueprint in fashioning a universal health coverage system. Comparisons to Germany's welfare state during this same time period reveal markedly different social and mental health policy practices, as Germany's Christian Democratic Union and Social Democratic Party cooperated toward progressive policies while the Liberal Democratic Party largely neglected social welfare expansion. The effect of these practices is reflected in budgetary provisions, institutionalization practices, and mental health epidemiology. This research finds that a favorable economic climate allowed the Liberal Democratic Party to politically isolate the Social Democratic Party and focus on economic productivity as opposed to welfare expansion. In contrast, West Germany's competition with East Germany forced cooperation of its two largest political parties to balance economic policy and social progress, which is today reflected in mental health outcomes and policies markedly more favorable than those of Japan.

DEDICATION

The most difficult aspect of living with mental illness is the silent nature of the disease. Often, we find ourselves unable to speak about our troubles, and when we do, many people do not understand. This is through no failing of their own, but rather because of perpetuated misconceptions about the nature of mental illness that makes communication difficult.

This thesis is dedicated to people throughout the world who find themselves without voice because of their own battles with mental illness.

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INTRODUCTION

Following German unification in 1871, Chancellor Otto von Bismarck promoted legislation creating the world's first welfare state, establishing health, accident, and old age insurance in addition to protections for workers and children. These programs served to consolidate common support for the new German Reich, while politically isolating the Social Democratic Party and its proponents. In the aftermath of World War II and following consolidation of political power, the Liberal Democratic Party of Japan followed Germany's blueprint in fashioning an analogous universal coverage system. Closer inspection of each health system reveals markedly different outcomes, particularly concerning mental health, as a function of divergent political processes and context. In spite of delayed reforms due largely to political and economic constraints of World War II, the Bundestag has been fairly progressive in implementing social and mental reforms in the post-war period. Conversely, the Diet's social policy largely stagnated under Liberal Democratic governance, stimulated only by bursting of the "economic bubble" and the Democratic Party of Japan's ascension to power in 2008, creating vast disparity in provision of welfare and mental health services between both countries.

As of 2010, mental and substance abuse disorders account for nearly 10% of the global burden of disease and 28% of the non-communicable disease burden while its stigmatization generates self-esteem problems, impairs social & economic opportunity, and interferes with medical treatment (Corrigan 2004; Whiteford et al. 2013; Prince et al. 2007). In developed nations, mental healthcare programs are often under-resourced

and poorly implemented as expenditure data indicates budget expenditures non-equivalent to the mental health burden and insufficient human resources. Japan, for example, spends nearly 7.9% of its GDP on health, but allocates only 5% of that toward mental health services and provisions (Jacob et al. 2007).

Historically, world systems theory suggests that each state undergoes phases of development marked by exploitation of a state's natural resources, a shift towards industrialization, and the final shift towards a modern, post-industrialized society. Each shift is marked by an increased necessity for intellectual capital; nowhere else is that more evident than in the shift towards technological and knowledge based development throughout the Global North (Wallerstein 2004). Investment in intellectual capital means more than improved educational opportunities; intellectual success is predicated on optimized physical and mental health as the platform for all other endeavors. Optimized health, and thus intellectual capacity, depends on mitigating mental illness and its effects, but also addressing structural factors that are major contributors to mental health disorders. This would include guiding mental health treatment schemes away from isolated care facilities towards decentralized, community based care, improving access to treatment resources, legislating dedicated funding & resources towards mental health, and improving the various human resources necessary for appropriate treatment.

Japan and Germany have markedly different histories addressing mental health. The Federal Republic's reform of health and mental health occurred nearly 30 years following World War II, trailing significantly behind much of Europe, prompted largely

by the Student Protest movement of the 1960's which created widespread change and marked the beginnings of mental health reform for the Bundestag (Bauer M 2001). 1968's Student Protest movement manifested largely as a youth response to growing disapproval with West Germany's economic direction, university system, and in particular, its political direction (Siebert 2005). These internal pressures ultimately forced policy reform and welfare expansion, as the Brandt Administration built upon the social policy expansion seen during 1966's Grand Coalition (Mares 2006). Conversely, Japanese mental health and social policy reforms remained largely absent until the late 1980's, with most reform occurring at the turn of the century as the Japanese government made earnest efforts toward social expansion and reform.

The purpose of this research is comparing the political processes affecting implementation of progressive social and mental health policy in Germany and Japan. Japan began mimicking the German welfare state through the Health Insurance Law of 1922, but adoption of an identical laws has not lead to similar mental health policy. This research will study the effect of politics on legislation and policy, emphasizing the cooperation possible between Germany's Social Democratic Party and Christian Democratic Union in contrast to the singular policy direction adopted by the Liberal Democratic Party of Japan.

This study will address research questions concerning structural differences in the mental health systems and policies between Germany and Japan. This research will study the nature of welfare legislation and mental health policy for both countries in the post-World War II period, while contrasting the motivations of political actors involved

in progressive social reform in Germany to the political problems overcome in Japan before progressive social policies could manifest.

LITERATURE REVIEW

The focus of this research is the Bismarck Model and its implementation within Germany and Japan. The term Bismarck Model refers to Germany's welfare state in general rather than simply the method of health funding. It is codified into the Sozialgesetzbuch, or Social Code, as 12 Books which address unemployment, health insurance, old age pensions, invalidity, child support and social care. It began as a means to generate political support as low-income blue-collar workers sought financial compensation and public support in the case of illness or death (Leith, Astrid Knott, Mayer, and Westerman, 2010).

This system is a mixed-model system primarily funded through employer/employee contributions with government contribution focused primarily on subsidization of fixed capital costs such as buildings and equipment for public and private hospitals (Hurst 1991). There exist both private and public providers and citizens are legally required to carry insurance through the numerous sickness funds or through private insurance. This translates to 90% of coverage occurring through sickness funds, while those who surpass the salary minimum are able to obtain private insurance (Reid 2009).

While participation in the social insurance system is mandated, the Landër (states) focus on administration and policy decisions. The numerous sickness funds (about 230) compete with each other for enrollees through provision of benefits, though this high number of companies is expected to decline as time progresses. Thus, the German systems utilizes a plurality of competition to create effectiveness under the

purveyance and regulation of government. This model has been influential in a number of prominent Western countries such as France, Belgium, the Netherlands, Switzerland, Japan and in a few Latin American countries.

The Japanese welfare state began as a mirror to Germany's but has significant differences. Financing occurs through a similar social insurance system in which enrollment is mandatory and premium contributions are pegged to income. There is no ability to opt out for private insurance as there exists in the German system, and the Japanese system is more egalitarian through extensive cross-subsidization among insurance plans. There are low family premiums supplemented by significant employer contributions and moderate government assistance. Those lacking financial resources for healthcare are able to do so through public assistance, while the rest of the citizenry receives insurance through work or private non-profits. Contribution toward insurance follows a logical path. For the wealthiest population, employers are responsible for the greatest portion of contribution while employees make up the rest.

As ability to pay decreases, government involvement increases and so one sees the greatest contribution toward health insurance occur among the lesser wealth-brackets and the self-employed respectively. This last group is under the care of municipal governments while the central government contributes more than half of the bill. Pensioners are directly supported through pooled contributions by the insurance funds, and in effect the old are subsidized by the working youth. Payments to providers are coordinated through a national fee schedule, which establishes prices throughout the country without regard to location or health plan.

The majority of insurance companies in Japan are private and pricings are negotiated every two years through the Ministry of Health. This price negotiation results in significantly reduced costs and excellent overall outcomes for the health care system, however, these reduced costs mean that most Japanese hospitals operate at an unsustainable deficit. Reimbursement for services occurs through a retrospective review mechanism in which a team of local physicians analyze the distribution of services and remunerate accordingly.

There exist both large and small hospitals owned and operated by the government, volunteer organizations or universities while the latter is a product of family enterprises or solo practice. Private physicians do not work within hospitals, and those that do typically have salaries not related to services offered. This has the effect, for example, of creating an income system in which primary care physicians generate more income than specialists working within hospitals.

The Mental Illness Burden

The World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Üstün and Jakob 2005). Conditions such as cancer, diabetes, heart disease or infectious diseases such as malaria and HIV are generally clearly defined in function and physical impact, as a patient typically receives diagnosis and is then directed towards the appropriate avenue for treatment, if available. What one typically defines as disease is isolated to the individual, and so it is easy to ignore social impact. This is true even for infectious diseases which affect communities at large; treatment focus relies on

individual care while placing less importance on the social disruption caused by infirmity.

In Western medical practices, mental health services adopt largely the same perspective of ignoring social impact by following one of two routes: an individual copes and resumes functioning at some impaired capacity within society, or is in some fashion isolated from society. Historically, those afflicted with mental health disorders typically relied on family for continued care and rehabilitation, though it might be presumptuous to say these individuals rehabilitated, and data for such an assumption would likely be scarce.

As populations grew and as medical systems developed, governments acknowledged the increasing burden of mental disease and responded through policies of isolation. This created asylum systems, or the appropriation of mental illness to dedicated wards in hospitals (Fernando 2014). Currently, the World Health Organization estimates neuropsychiatric disease accounting for 28% of the global disease burden, which is defined as the years of life lost due to premature mortality or time lost due to living under less than optimal health, as measured by the disability-adjusted-life-year (Murray and Lopez 1996).

Available data suggests that this subset of non-communicable disease is largely constrained to the Global North, while low and middle income countries focus on curtailing of infectious disease (Prince et al. 2007). This form of disease causes increased long-term disability and dependency, while potentially interacting with other forms of disease. For example, neuropsychiatric diseases such as schizophrenia, major &

minor depressive disorder, and substance abuse disorders may interact with other non-communicable diseases such as diabetes and cardiovascular disease, as well as infectious diseases such as HIV/AIDS, tuberculosis and malaria. Some studies suggest that the interaction of neuropsychiatric diseases with non-communicable and communicable disease results in poorer prognoses for afflicted individuals and a higher comorbidity with other debilitating diseases. For example, Type II Diabetes patients are known to suffer schizophrenia at a rate of 15% compared to a normal population occurrence of 2-3% (Holt et al. 2005).

Mental health diseases additionally intersect with reproductive and sexual health; in states where gender is a significant determinant of socioeconomic status, resource availability and social roles, common mental disorders may have a higher risk, as is the case in Pakistan (Mirza & Jenkins, 2004). Thus, it is obvious that mental illness is a complex problem which intersects across many different issues.

Resources & Mental Health

Analysis of a mental health system involves studying policy and legislation, infrastructure, quantity and quality of human resources, and funding appropriations. About one-third of countries see no implementation of legislation specific to mental illness, which often translates to poor human and civil protections for the involuntarily treated, or in some cases means codified discrimination against those with mental health disorders through inaccessibility to services (Jacob et al. 2007; Saxena et al. 2007).

Concerning infrastructure, mental health disorders respond most effectively in community care environments; that is, decentralized and away from mental hospitals or asylums and under the supervision of health and social workers within the community. One often sees limited community care centers, a dearth of appropriately trained or dedicated human resources, and financial constraints due to a lack of explicit mental health budgeting (Saraceno et al. 2007) Inability to access mental health resources affects those of low education, women, youth, and those residing in rural communities. Individuals are sometimes affected by violation of their human rights, and are also under the attack of negative social stigma towards mental disease. Within developed countries, resource constraints are not as problematic as within developing countries, leaving more room to address these issues (*The Mental Health Context* 2003; Vrangbæk et al. 2007).

METHODOLOGY

As mentioned Germany gave birth to the first welfare state in the world which in modern times is known for progressive social policies and protections for its citizens, boasting universal healthcare coverage and a high standard of living. Its success influenced Japan to model its own state in kind, yet Japan has largely languished behind its Western counterpart in adopting progressive social and mental health policies leading to an underdeveloped mental health system. These cases were chosen to illustrate that the success of a welfare model is contingent upon more than just its adoption; success is heavily influenced by the domestic politics influencing legislation and policy.

Qualifying differences in mental health outcomes and resources is achieved by data derived from World Health Organization databases as well as information derived from the Organization for Economic Cooperation and Development, and available country databases.

Analysis of Germany and Japan's welfare states will begin following World War II, concurrent with the Federal Republic's revitalizing of their own social welfare system and Japan's creation of their own. For Germany, this will mean focus on the periods leading up to the OPEC oil crisis, followed by the period leading to reintegration of the Democratic Republic of Germany, at which point focus will shift towards the contemporary period.

Japan's welfare state model is an analog to Germany's, however the country has lagged significantly in developing their mental health system. The time period analyzed for Japan will encompass a few time points between 1950 & the late 1980's, however the bulk of research will focus on 1987 through the contemporary period, during which the Japanese government has redress of the their mental health policies and practices.

Determining the structure of a mental health system is difficult and it is only recently that states have implemented a policy of deinstitutionalization through community care rather than archaic and inefficient policies of institutionalization through psychiatric hospitals and patient isolation.

A variety of indicators are available which point towards reform processes seeking this decentralization of care. This includes indicators such as the number of psychiatrists and other human resources, the number of psychiatric hospitals, the number of psychiatric beds per 100,000 population, the presence and number of community health centers, the implementation of a catchment principle (allocating a specific number of resources per geographic area) and the localization of acute-in patient care and long term care (Becker and Vasquez-Barquero 2001).

Definitions:

Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

Psychiatric Beds: Hospital beds are a measure of resource availability when delivering services to inpatients at hospitals by denoting the number maintained and available for use. Psychiatric beds are a subset of these beds which are focused for psychiatric patients, and are useful indicators of the deinstitutionalization process.

Suicide Rate refers to the number of deaths in the population that occur deliberately and with full knowledge of the outcome.

COMPARATIVE CASE STUDIES

<u>Germany</u>

Health & Mental Health Structure

Modern Germany has had a progressive mental health policy since approximately 1970, beginning with the Psychiatrie-Enquete which assessed the state of its psychiatric services. As of 2011, the number of psychiatric/mental hospitals is 270, which is an increase from 202 in 2004 but represents an overall decrease since 1990. Many have decreased in size and reformatted to provide more comprehensive, acute treatment while decreasing the number of hospital beds (Heinrich Kunz 2004; OECD 2011). This overall small decrease is due to concurrent reformatting of general hospital structure to include inpatient psychiatric units. Germany also provides nearly 15.3 psychiatrists per 100,000 population and has seen a decrease in average hospital stay from 152 days in 1976 to 25 in 2009 (OECD 2011; Busse and Blumel 2014). Germany does employ catchment area principles, which limit the number of patients per geographic area to prevent overburdening resources and to allow ease of access to mental health services.

Resources

Figure 1: Total Health Expenditure

Data regarding expenditures is available for the years 1970 through 2015. There is a sharp increase in expenditures from 1970 through 1975, after which period total health expenditures remain constant excepting 1989 and 2008 (OECD 2015)
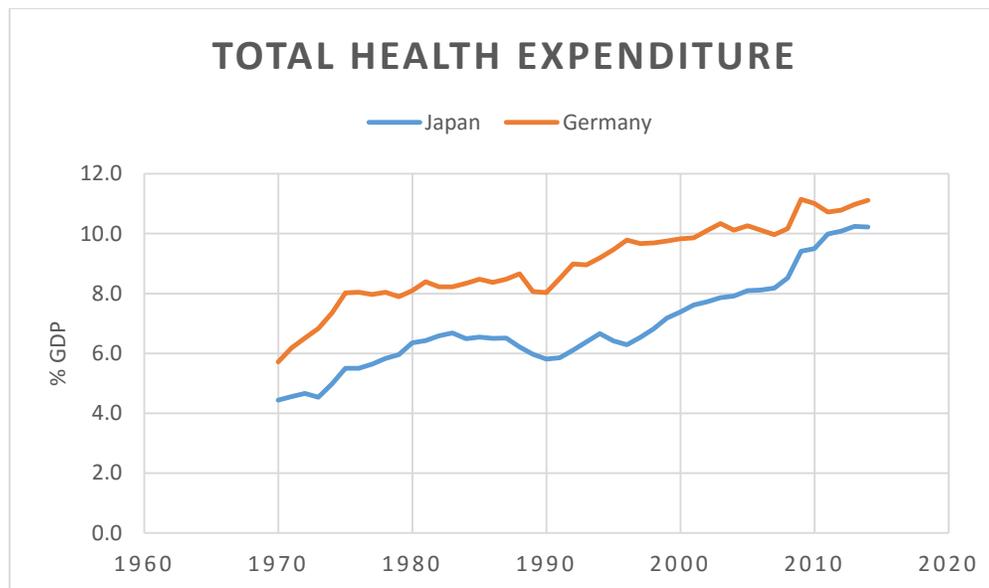
Source: Organization for Economic Co-operation and Development, 2015

Figure 2: Public Health Expenditure, % GDP:

Public health expenditures increase sharply from 1970-1975 (72-78%), leveling through 1980 and then decreasing until 1990 (75%), at which point expenditure trends sharply increase until the early 200's (81%), before experiencing gradual decreases until 2015 (76.6%) (OECD 2015).
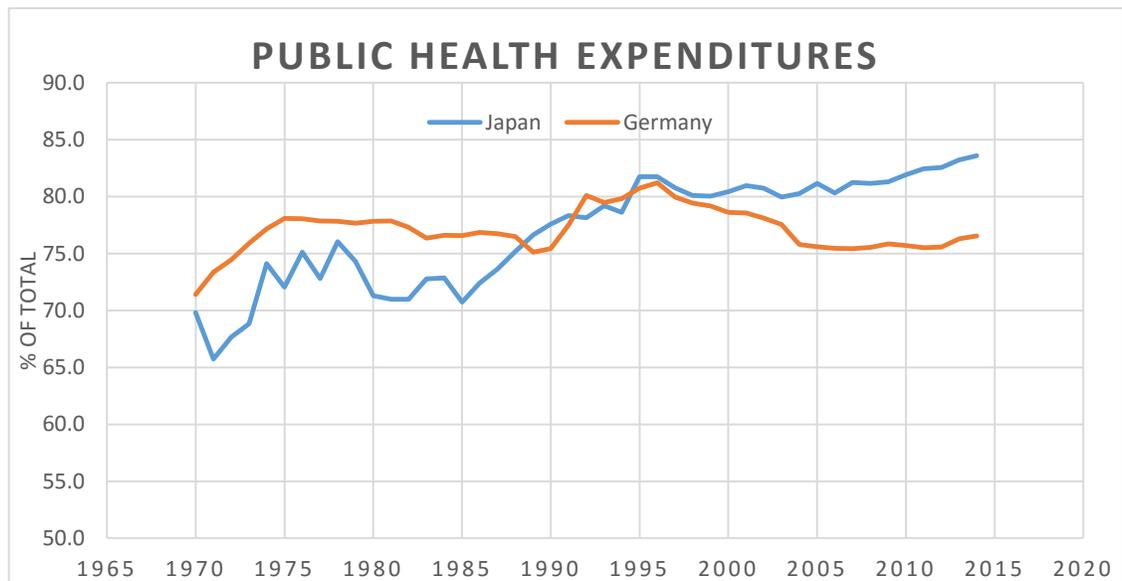
Source: Organization for Economic Co-operation and Development, 2015

Figure 3: Psychiatric Beds (1990-2015)

Trends indicate a gradual decrease from 120 beds per 100000 population in 1990 to 90 per 100000 in 2015 (OECD 2015)
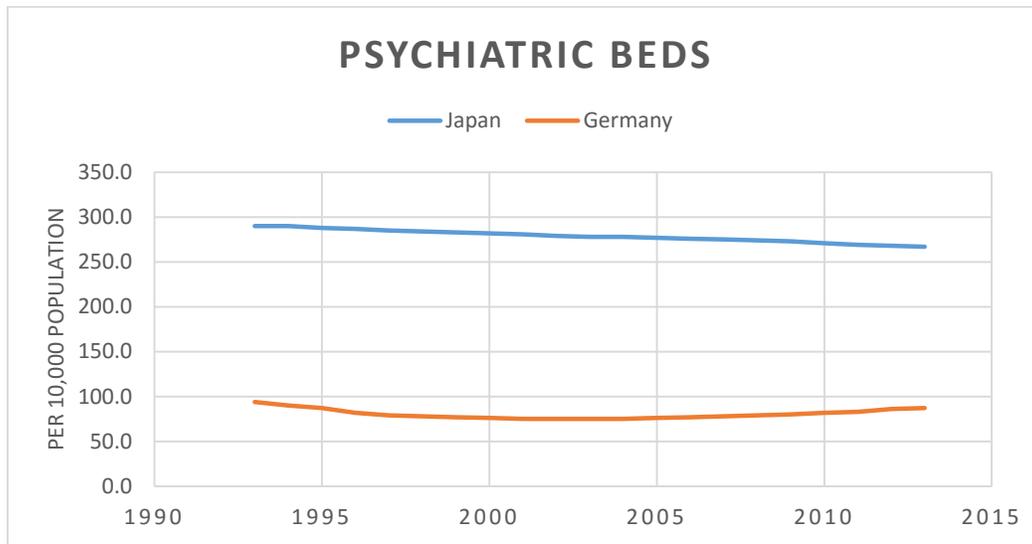
Source: Organization for Economic Co-operation and Development, 2015

Disease Burden

Figure 4: Suicide Rates (1991-2013)

Germany's rate of death due to suicides within the examined period decreases from 17.1 to 10.8 per 100,000 population (OECD 2016).
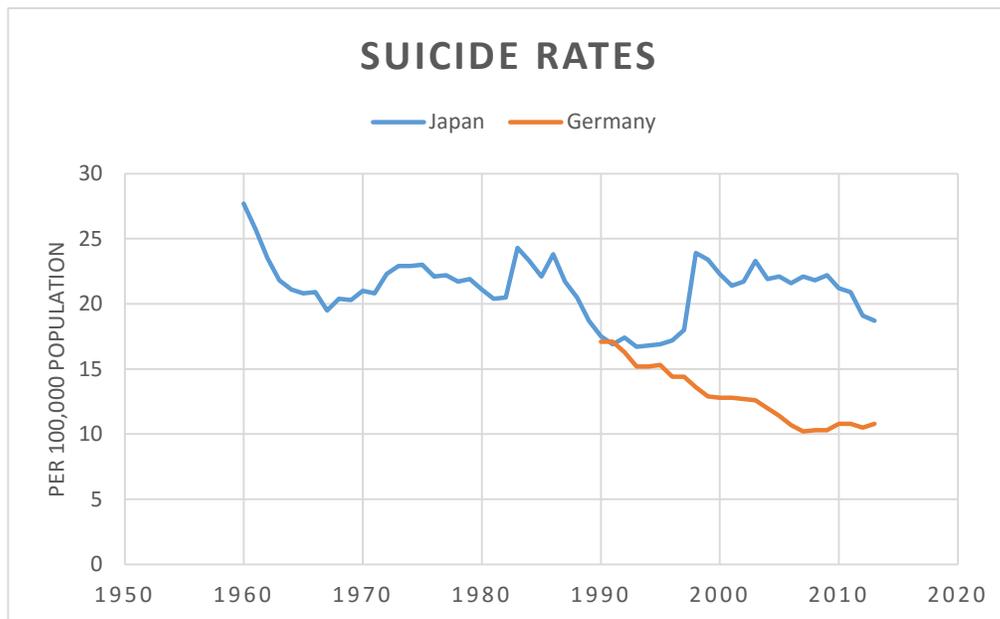
Source: Organization for Economic Co-operation and Development, 2016

Structurally, what is observed in the German welfare system is a predisposition towards progressive policies through increased expenditures and human resources, a trend toward deinstitutionalization through decreased psychiatric beds and dedicated asylums, and an improvement on mental health illness through a decrease in suicide rates. In addition, improved perception towards the mentally ill represent a

fundamental shift in the understanding of mental illness as a disease no different to other forms of disease.

Reform & Legislation

Health Reform

Because enrollment for health insurance in Germany is compulsory, and because revenue for sickness fund expenditures is derived directly through employee and employer contributions, health expenditures are tied directly to the country's economic health. The period following World War II saw a rapid increase in health care expenditures tied to economic recovery as well as through federally mandated expansion of benefits.

As rates of increase expanded beyond the rate of economic recovery, the system became unsustainable and thus a social and political concern. The Cost Containment Acts thus sought to align health care expenditures and contribution rates (Schneider 1991). As the initiator in the cost containment trend, The Health Insurance Cost Containment Act (1977) sought to peg the rate of health care expenditures to contributor income. It established the Concerted Action for Health Affairs to create bilateral discussion between sickness funds and states concerning health expenditures in ambulatory, dental, and pharmaceutical settings (Schneider 1991). In addition, it set the stage for the passage of the Hospital Cost Containment Acts of 1981 & 1982.

The purpose of Concerted Action was creating productive discussion between sickness funds and regulatory agencies. Under its mandate, policy recommendations

regarding expenditures only applied to sickness funds. However, hospitals derive much of their revenue through sickness funds but prior to this point were not subject to the same expenditure recommendations as the sickness funds. Thus, 1981 saw Concerted Action provisions also applying to hospital expenditures while also expanding the responsibilities of sickness funds through cooperation with the state in hospital planning (Hurst 1991).

The Cost Containment Amendments (1981 & 1982) saw changes in fee structures and reimbursement for dental procedures, the introduction of copayments for medical devices and appliances, as well as changing the admissions for the handicapped into sickness funds and attempting to limit the length of a hospital stay following childbirth. The Hospital Reimbursement Regulation (1986) introduced prospective operating budgets for hospitals with agreement from sickness funds, with the possibility of third party arbitration in the event of conflict.

The Health Care Reform Act (1989) introduced changes regarding eligibility and coverage pertaining to elderly groups, the student population, blue collar workers, and the self-employed. The principle of "pay first, reimburse later" was established, while also providing for family assistance as a "right" in addition to provisions for home care and for special continuous services. The act also gave sickness funds the ability to terminate contracts with inefficient hospitals while also changing certain provisions regarding contributions (Schneider 1991).

Mental Health Reform:

Mental health reform within Germany is punctuated by a few major acts: The National Inquiry into mental health care (Psychiatrie-Enquete), the Expert Commission of 1988, the Federal Directive on Staffing of Psychiatric Hospital Services, and the Guidelines for Commissioning of Community Services for the Mentally Ill (Bauer M 2001; Heinrich Kunz 2004).

The federal directive on staffing established new guidelines for staffing levels in psychiatric contexts. Previous guidelines for staffing levels were dated to 1969 and focused on a per-bed staffing level, while indicating only "appropriate" numbers of nursing & medical staff. In addition, there was incentive to maintain a high number of beds and extended hospital stays given the per-diem fee structure, though these funds were rerouted towards acute care conditions.

Reform involved staffing levels based on the type of care necessary, which would consequently standardize staffing levels while improving quality. This resulted in the organization of patients into 18 allocation groups, upon which each the required number of staff for each group allocation was based. These groups were primarily subdivided into general psychiatry, addiction, and geriatric psychiatry groups with a further 6 subdivisions focusing on the severity of treatment (Bauer M 2001; Heinrich Kunz 2004). Consequently, the new staffing standards forced a minimum 24% - 84% increase in personnel throughout the medical, nursing, social, psychiatric, and physiotherapist occupations (Bauer M 2001).

The National Inquiry sought to rectify the nature of psychiatric care in West Germany prior to its inception. At that point in time, mental care was relegated to psychiatric hospitals, each with a massive number of beds (1200-2000 when accounting for regional variation), an extreme lack of appropriately trained staff, no outpatient care and a typical length of stay nearing 1 year (Bauer M 2001). The National Inquiry began in 1971 and throughout its completion in 1975, assessed the state of the West German Mental Health system and informed mental health reform at the federal, state, and local levels. Noting the derelict conditions of psychiatric hospitals, future directions for mental health reform prescribed (as had occurred in other countries) a shift towards deinstitutionalization. This translated to a reduction in the number of dedicated psychiatric hospitals and asylums in conjunction with reduced numbers of hospital beds. New policies requested the integration of psychiatric units into general hospitals while expanding community care facilities to provide in-patient & out-patient care in areas proximal to a patient's community (Heinrich Kunz 2004).

In practice, Germany has only marginally reduced the number of psychiatric hospitals, though it has decreased their bed reductions and expanded the number of community support centers for mentally ill patients. Essentially, the National Inquiry established principles of proximal care, needs-focused care, needs-focused coordination in catchment areas, and equality between somatic (physical) and mental care regarding quality and resources (Bauer M 2001).

As a continuation of previous efforts, 1988's expert commission sought an analysis of progress in the decade since the National Inquiry. Conclusions

recommended further development of community centers as well as centers for social support, employment support, and day care centers in a way that is cognizant of catchment area size. In order to support those goals, an increase of about 500 community centers was necessary, however, as of 2001 that goal had not yet been reached. Despite this, there has been a significant increase in the number off office based psychiatrists, medical doctors who work as psychotherapists, and general practitioners who offer psychiatric care for milder cases (Bauer M 2001).

The Guidelines Commission sought to improve staff allocation and create a needs-based care paradigm within community areas for those suffering from long-term or severe mental illness. As the nature of illness progresses, patients with severe mental illness are subject to changing needs which are beyond the scope of community care and thus require institutionalization, creating a discontinuity in treatment and with the patients environment should these problems arise frequently (Heinrich Kunz 2004). Practically, implementation of these guidelines has occurred only through catchment areas covering 10% of the population with the biggest obstacle being the rigid stance of providers in allowing for a more flexible form of treatment.

Japan

Japanese Health & Mental Health Structure

Japan operates nearly 9000 hospitals, of which 12% of are mental hospitals. This number is third behind Korea, and Hungary, and suggests significant underlying issues regarding mental health treatment (Johnson and Stoskopf 2010).Trends towards community based care have occurred largely within the last 15 years. Japan still has the highest number of psychiatric beds at 269 per 100,000 population in the world along with excessive hospitalization stays of 400+ days. In addition, Japan only recently began implementing community treatment centers and providing centers for social support for the mentally ill , though very little data exists regarding the actual number of these centers available (Setoya 2012). As of 2009, Japan provides 10.6 psychiatrists per 100,000 population, an increase of 2.1 from the year 2000 (OECD, 2016**)**. It does not employ a catchment area principle, but this is due to the Japanese ability to attend any health service provider they wish.

Resources

Figure 5: Total Health Expenditure

      1993 through 2008 saw an increase in total health expenditure from 6.4-8.5%, averaging about .14% per year. 2008 to 2009's transition saw health expenditures increase .9% from 8.5-9.4, increasing at 6x the rate in 1/15th of the time. At this point the rate increase returns to .175% per year (OECD 2015).
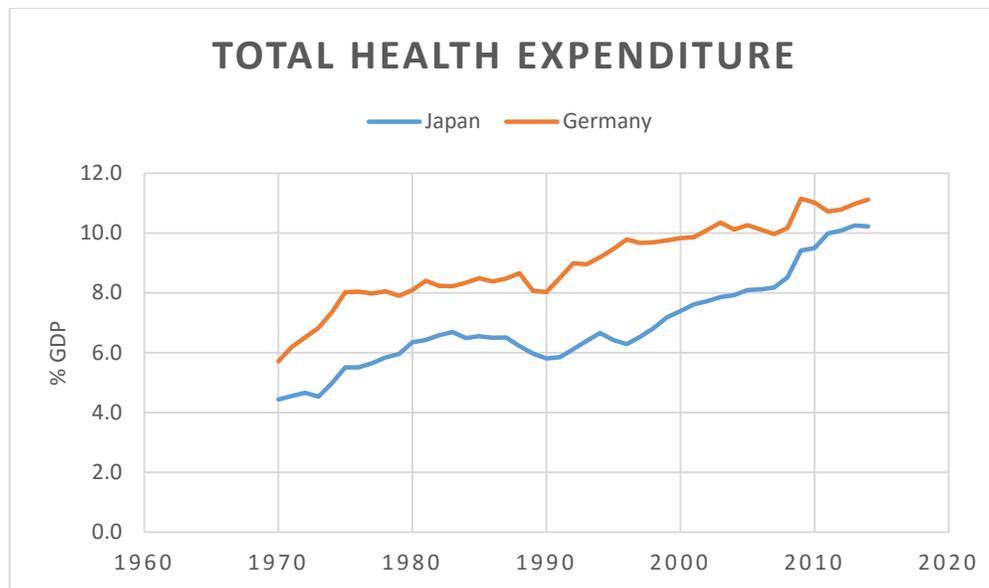
Source: Organization for Economic Co-operation and Development, 2016

Figure 6: Public health expenditure, % of GDP:

In general, health care expenditures increased from 5.9-7.4 % for the years 1990-2008. At this juncture with the arrival of the Democratic Party of Japan in 2009 and their overwhelming parliamentary majority and revocation of LDP policy, there is a sudden 1.1% increase in expenditures just following that election cycle (OECD 2015).
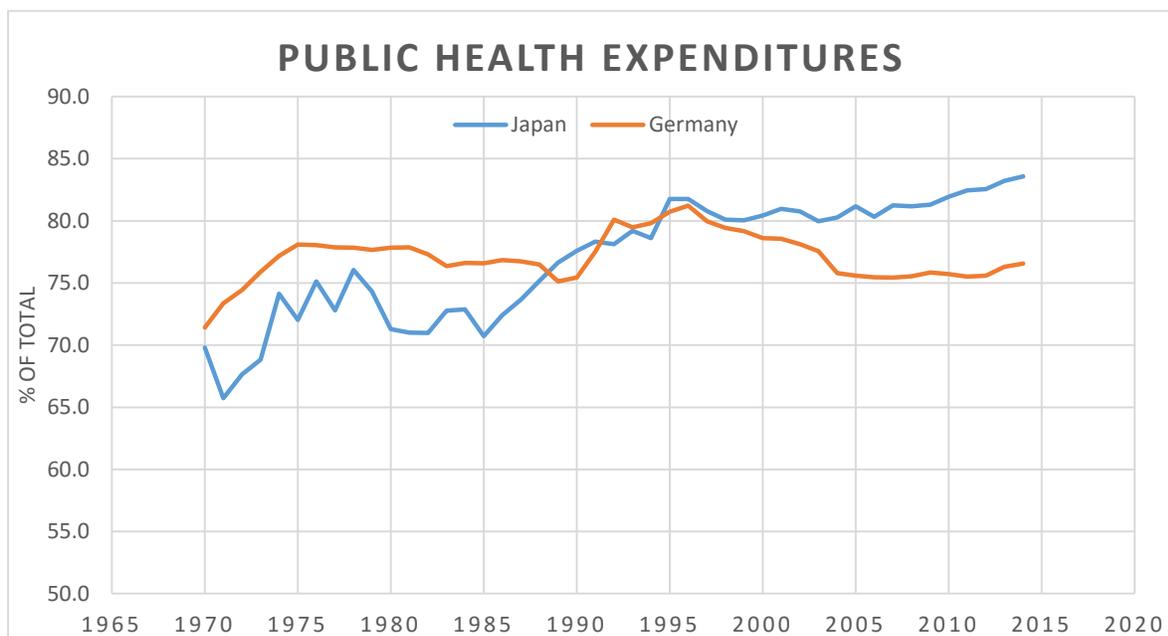
Source: Organization for Economic Co-operation and Development, 2016

Figure 7: Psychiatric Beds (1993-2015)

PSYCHIATRIC BEDS
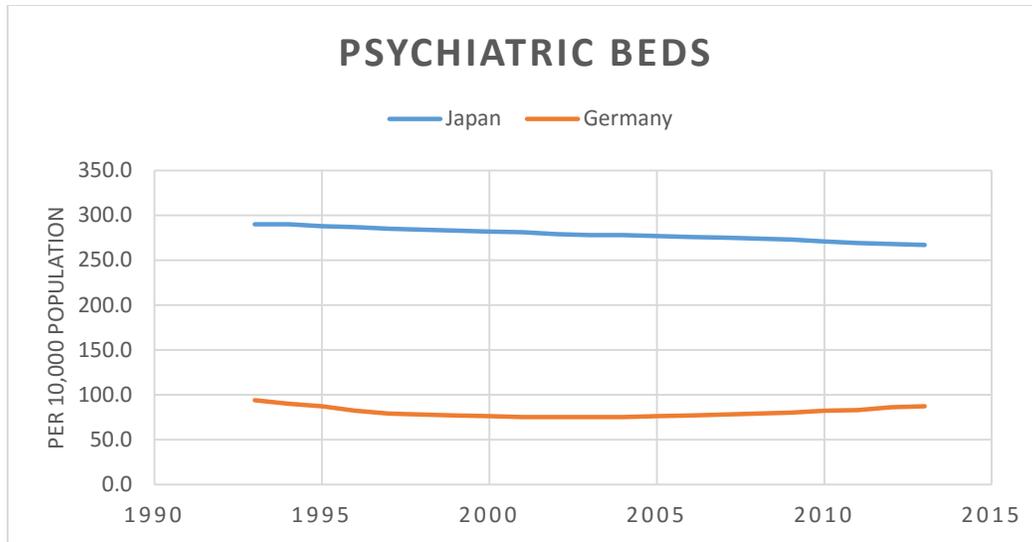
Japan — Germany

Source: Organization for Economic Co-operation and Development, 2016

Japan sees a gradual decrease in the number of psychiatric beds from 1993 through 2013. Currently, this number is 267 and is significantly higher than Germany's and the OECD average number of psychiatric beds (OECD 2015).

Disease Burden

Figure 8: Suicide Rates (1960-2013)

Japan's rate of death due to suicides within the examined period decreases from 27.7 to 18.7 per 100,000 population (OECD 2016).
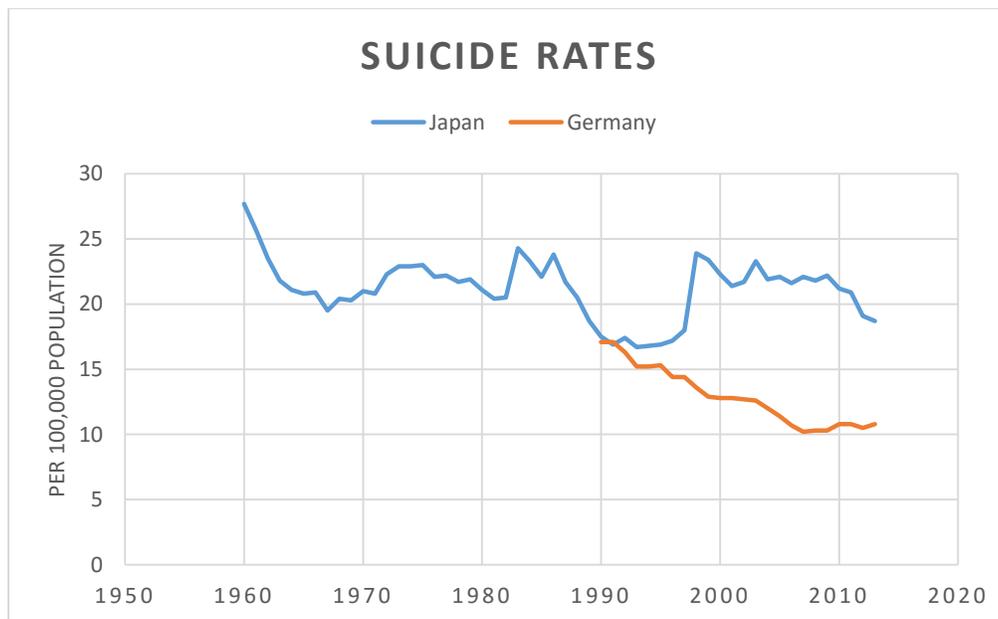
Source: Organization for Economic Co-operation and Development, 2016

In general, since 1993 Japan has structurally shifted towards progressive social policy as the country increased health and public health expenditures, decreased the number of psychiatric beds, and allocated an increased number of community centers. Since 2009, the suicide rate has only slightly decreased but has markedly changed

relative to the observed time period, possibly indicating an improvement in mental health outcomes.

Reform & Legislation

Mental health services in Japan have been severely underdeveloped historically, and currently when compared to its Western contemporaries. Care for the mentally ill occurred through a system of home confinement, legalized through the Law of Confinement and Protection of the Mentally Ill. This system persisted until 1950, at which point the Mental Hygiene Law permitted care for the mentally ill within hospital settings. A 1965 revision of the same law established a required minimum of one community mental health center for each of Japan's prefectures. Given that the 47 Japanese prefectures encompassed nearly 100 Million people, the progress these 47 centers still represented a severe lack of resources for the mentally ill.

Mental Health was only legally recognized in 1995 while also requiring the implementation of more stringent criteria prior to involuntary hospitalization. Mental health reform throughout Japan has occurred rather intermittently, though contemporarily (roughly 1990 through today) the Diet has rapidly passed legislation.

The period between 1958 and 1987 saw few pieces of legislation passed addressing mental health including new standards regarding staffing for mental hospitals, an addressing of the paltry financial allocations for mental health care, and a requirement for one community center per prefecture through the Mental Hygiene Laws and Medical Care Acts & Amendments. These very modest reforms characterized the

nature of mental health care in Japan throughout the majority of the 20th century: political and superficial rather than genuine attempts at resolution of a problem.

Beginning in 1987 and continuing through today, the Japanese Parliament passed a number of significant resolutions and laws in efforts to create a mental health system reflective of contemporary standards of treatment. 1987 established a psychiatric review board consisting of certified psychiatrists, one lawyer, and one other medical professional to review cases prior to involuntary hospitalization. The 1995 Mental Health Act acknowledged mental illness as an actual disability and established stringent criteria prior to involuntary hospitalization. In 2000, long term insurance was created for the growing elderly population, thought it lacked coverage for the mentally ill excepting special cases such as dementia.

One could characterize most progress in the mental health system of Japan since the 1950's as occurring on the grounds of patient protection and the recognition of basic dignities, though recognition of mental disorders as a disability did not occur until 1995.

At the turn of the millennium, the Future Direction of Mental Health and Welfare Policy of 2002 audited current mental health services in Japan and laid a plan for future directions. It legally confirmed the necessity for a shift from hospital/institutional care towards community based care and set the impetus for establishing the Mental Health and Welfare headquarters (Setoya 2012).

The Reform Vision for Health, Medical Care, and Mental Health Welfare (2004) expanded on the necessity for deinstitutionalization by setting quantifiable goals

regarding psychiatric bed decreases, while outlining plans for community education towards mental illnesses (in recognition of the stigmatization problem prevalent throughout Japan), reforming psychiatric care via specialization, and developing strong community support systems. The Future Policies for People with Disabilities and Community Welfare Act (2004) sought unification of welfare and health policies, support for an independent lifestyle of disabled people, and the development of sustainable health system.

The Act on Support for Persons with Disabilities (2005) primarily focused on securing of funds for the mentally ill and the provision of adequate service among the three service sectors (intellectual, physical, and psychiatric disabilities). In addition, it established support services for employment, easing the supposed burden of employing the mentally ill within Japanese society. Recently, the Further Reform of Mental Health and Welfare Act (2009) emphasized previous goals of transitioning from hospital care to community care through restructuring of the mental health system, improving quality of treatment, strengthening community support and also furthering public education.

The Mental Health Policy Framing Conference (2010), an important breakthrough in mental health reform, focused on integration of mental health services into the standardized Japanese health care system, while advocating services such as specialized care or community outreach. Prior to this period, a prefectures 5 year plan only assessed and made recommendations for somatic illnesses (cardiovascular disease, diabetes, stroke & cancer.), including 5 service domains. Prefectures at this point began

including mental illness in their 5 year mental plans as a result of the Inclusion of mental diseases to Medical Plan, Developed by each Prefecture Act (2011).

Since approximately 2000, mental health policy and legislation rapidly progressed the nature of mental health service provisions in Japan. This period improved upon poor resource provisions, established administrative oversight, streamlined mental health services into the established health system, focused on de-institutionalization and education of the general population, and improved upon social protections for the mentally ill. These policies represented a progressive and significant overhaul of previous mental health provisions but as of yet have not translated into an appreciable reduction in suicide rates throughout Japan.

DISCUSSION

Why are outcomes in Japan markedly different from those in Germany? Why does Japan implement socially progressive changes in their welfare state at a significant delay to not just Germany, but all OECD countries? The answer lies in understanding that the basis for progressive or regressive legislation and policy is the political process enabling or constraining those outcomes.

<u>Japan</u>

Following the end of American occupation in 1952, Japan's most powerful political party, the Liberal Democratic Party (LDP), congealed into a singular entity as a means of both retaining political power and ideologically isolating the Japanese Socialist Party, in modern times known as the Social Democratic Party (SDP), who sought social welfare expansion rather than economic growth. The LDP established itself with support from big and small business and agriculture, while excluding organized labor, with policies that favored economic prosperity and enabled the Japanese 'miracle'. These policies marginalized the Socialist Party, which was viewed as out of touch with currently prosperous economic climate. This period from 1952-93 saw unparalleled political dominance buoyed by economic prosperity, plentiful employment and the development of a healthy middle class. In addition, economic prosperity allowed the LDP to provide "pork" to those economic sectors representing a significant voter base, in spite of some being ineffective, and through an export oriented economy enabled their domestic protection, further solidifying political power.

The entire basis of this political dominance was the economic prosperity that existed until 1993, and so long as these economic conditions persisted the impetus for socially progressive policy would be minimal. In 1993, however, economic prosperity came to a halt, as GDP decreased to 0-1% and unemployment and suicide rates increased creating a demand for an expanded social safety net. 1993 also saw, for the first time, the LDP lose political power in parliament while promising politicians opted for opposing political parties, which created the foundation for internal divisions and factionalization which come to a head in 2009.

1993 is seminal to understanding progress regarding social policy as this factionalization underlined tensions within the LDP concerning returning Japan to prosperous economic conditions. At this juncture the Liberal Democratic Party had a choice to make in maintaining the policies that brought it political power and economic prosperity, or adapting to a new economic climate. Instead, the LDP fell guilty to the "politics of complacency", as T.J. Pempel describes it, by failing to adapt and focusing on maintaining status quo policies that brought them economic growth , while ultimately alienating the voter base keeping them in power. Thus, transition from the Liberal Democratic Party to Democratic Party of Japan was ultimately due to party implosion (Pempel 2010). In 2009, Japan transitioned from the Liberal Democratic Party to the Democratic Party of Japan after 54 years, losing a record number of parliamentary seats in process. The Democratic Party's victory drew on *labor*, consumers, and agriculture and focused on instituting shifts from public works

(effectively pork) towards social security, expenditures, science and education, child allowances, increases in pensions, while ending corporate contributions.

In addition to this political juncture, one significantly important catalyst toward this process was harsh criticism by the United Nations Commission on Human Rights Criticizing Japan's Mental Hygiene Law of 1950. These criticisms pressured the Japanese government toward finally instituting reform of their severely underdeveloped mental health system (Gostin 2004). Subsequent external pressure, such as the United Nations General Assembly Resolution on "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care," may have played a role in further reforming Japanese mental health policy, while 1993's World Federation for Mental Health, whose host was Japan, brought together 5000 participants from across the globe and numerous mental health professionals to discuss improving mental health services (Shimazono 1993).

Examining legislative practices in the period following 1993 reveals a slight shift towards socially progressive policy, beginning with 1995's Mental Health Act and culminating in the series of acts and resolutions that occurred with more serious social policy at the turn of the century. This is reflected in the increased health expenditures, while progressive mental health policies are reflected in the decreased number of psychiatric beds (deinstitutionalization), and decreased number of suicide rates from 2000 to the current period. Regressive, or delayed policies are also reflected in the first acknowledgement of mental illness as a legitimate disability as late as 1995, or the allocation of one community center per prefecture.

There are two important considerations to make when analyzing suicide, however. The first is the relationship between suicide rate and the state of the economy. Data tracking the unemployment rate, which is strongly tied to economic health, and suicide rate for the period of 1990 through 2008's found a strong correlation between these two factors. This data extends through most of the examined period suggesting that decreasing suicide rates may not be a product of improved social programs and safety nets, but rather a product of improved economic conditions (Chen et al. 2012). However, Chen's research also suggests that lack of safety nets and social insurance during times of unemployment force suicide as a consideration, enforcing the necessity for progressive social policies. The second concerns the Japanese perception of suicide, i.e., an accepted suicide culture. In Japan, suicide is often viewed as an honorable, dignified, and sometimes acceptable means to deal with any particular problem. This stems from the historical emphasis on honor, typified contemporarily through samurai culture or images of Kamakazi pilots during World War II, and its contemporary glorification (Flaskerud 2014). Thus, inflation of the suicide rate may be due to social perception, as opposed to delayed social progress.

2009's shift in Japanese politics from the Liberal Democratic Party to the Democratic Party of Japan represented a revocation of LDP policies. For 54 years, LDP policies focused on appeasing its constituents at the expense of policies that would protect its people. The Democratic Party of Japan platform focused on social policy expansion, education, and reducing the influence Japan's 'Iron Triangle' of politics. While in power, the DPJ accomplished a myriad of social reforms. For example, the DPJ

reduced public works projects and wasteful spending, established free high school education and improved upon university funding, increased medical school enrollments and number of doctors, and established a monthly minimum wage. Many of these policies were an antithesis to the Liberal Democratic Party platforms that focused on pork barrel concessions and an ultimate grab for political power as opposed to genuine concern over its citizenry which ultimately resulted in the LDP ouster (Kushida and Lipscy 2013).

Germany

The period following establishment of the Federal Republic in 1949 may be divided into two parts. Financing the war necessitated depleting the financial basis of the social insurance system and so required a new means for financing the system while promoting its development. This period continued until 1975, at which point the economic crises of 1973 provided impetus for the period of retrenchment and fiscal responsibility that occurs until the present day.

At the forefront of these two periods are the Social Democratic Party and the Christian Democratic Union of Germany, two ideologically disparate political representatives marked by labor representation and socialism contrasting social market economics and government oversight over competition and the social welfare system respectively. In spite of these ideological differences, the period of reconstruction sees the SDP and CDU working towards a more socialist direction, punctuated by the period of significant social reforms that occurred in the 1960's and 70's. While the 1950's

focused on reconstruction, the 1960's and 70's focused on welfare expansion and extending oversight of the German economy to trade unions and labor groups. In 1996, the Christian Democratic Union extended an invitation to the Social Democratic Party to govern in what became known as the Grand Coalition. This three year period of cooperation introduced the Stability and Growth Act of 1967, which focused on economic growth, while including representatives of government, banking, and labor in macroeconomic policy and welfare expansion discussions through the establishment of Concerted Action. This administration's social policies focused on redistribution and expanding the population covered under the social insurance system. The subsequent Brandt administration, a coalition between the Social Democratic Party and the Free Democrats, focused on expansion of sickness insurance benefits, unemployment benefits, and an overhaul of old-age insurance (Mares 2006).

This occurred in conjunction with Germany's 'economic miracle' but also against the backdrop of international competition as West Germany competed with East Germany not only regarding economics, but regarding social structure in general. This was particularly felt in East Germany, as Walter Ulricht, Chairman of the State Council of the German Democratic Republic, expressed dismay at the state of the East German welfare state, who had superior wealth, pensions, and health insurance (Schmidt and Ritter 2013). West Germany was viewed as exerting passive influence by virtue of its very existence, and in return, the German Democratic Republic's existence created policy shifts in the Federal Republic as Chancellor Kurt George Kiesinger sought steps

toward reconciliation through proposals for joint economic projects and cultural exchanges (Garton Ash 1993; Richardson 1968).

The German period of economic prosperity permitted social progress until the OPEC crisis of 1973, which forced a reconsideration of social benefit expansion as the world entered recession. In spite of the institution of retrenchment, the Federal Republic has a history of progressive welfare and mental health policies that are reflected in the aforementioned legislative practices, such as the National Inquiry into the state of West German mental health services, and the continual reevaluation of their progress. However, important to this process of cooperation is the unique relationship between 'capital, labor, and the state that creates the fabric of German social policy. German social policy is viewed as a collective enterprise in which employers and employees are both a valuable part of the economy. In order to further this collective enterprise, it is the state's responsibility to generate conditions favorable to both the economy and the working population, in other words, generate advantages to both sides.

Dating back to Chancellor Otto von Bismarck, the welfare state was formed as a response to the labor question and as a means to consolidate support behind the new Reich. Welfare has and likely always will revolve around this 'labor' question. In contrast, this relationship does not exist in Japan's welfare state given the exclusion of 'labor' following the end of American occupation. Consider the trends for total and public health expenditures for Germany during the examined period. There is a sharp increase in 1970 which continued the following period (1960's) of increased reform, with the expected retrenchment of expenditures in light of the oil embargo and subsequent

economic recessions. There is additional decrease in health expenditures from 1988-1989/1990, which makes sense given the reunification of Germany. Following reunification, expenditures continue the previous trend and are subject more-so to economic conditions rather than to large shifts in political power, as was the case in Japan.

CONCLUSIONS

Thus there is sharp contrast between the political conditions benefiting the progressive social policy found in Germany to those found in Japan. The social policies of the 1960's and 70's were driven by the Christian Democratic Union and Social Democratic Party's concerted efforts to continue reconstruction, overcome recession, and expand social policy, though this was additionally influenced by the Student Protest Movement. In addition, external pressures between East & West Germany may have influenced political co-operation in West Germany as a response to implicit criticism of the West Germany's social system (Schubert et al. 2009).

Conversely, Japan experienced no such existential pressures and was able to focus solely on domestic politics. This translates to a domestic policy divorced from questions of social structure and welfare expansion, permitting focus on more concrete policies such as fostering economic productivity, or rather, perpetuating the conditions of Japan's economic miracle. These policies were enabled by Japan's robust economic growth; so long as jobs and opportunity were plentiful, there existed little necessity for progressive social policies.

The aftermath of World War II left Germany's welfare state devastated, but the blueprint for progressive social policies intact as this tradition began nearly 70 years prior. Considering that the foundation of the German *welfare* state was a political solution in an effort to garner support for the new Reich, one might interpret progressive social policies in the post-war period as a means to generate support for the new Federal Republic. In Japan, policies focused on productivity were contingent on the

country's economic health. The year 1993, when the illusion of a flourishing economy ended, marked a turning point in Japanese politics as economic policies were now insufficient for maintaining political power, as evidenced by the factionalization of Japan's Liberal Democratic Party and its ultimate revocation in 2009. At this point, the Democratic Party of Japan began instituting significant social change while repudiating previous LDP policies.

Turning to the four questions this research sought to address, findings in this paper reveal that due to markedly different political contexts, Japan has a significantly regressive mental health structure when compared to Germany, as evidenced by resource allocations and the significant delays in instituting progressive social policies. This is due to differences in political motivation: the Federal Republic sought to restore a splintered society while Japan sought economic productivity and was not under the immediate influence of Cold War tensions. Thus, in Germany, welfare and mental health reforms manifested largely concurrent with reform in the rest of Europe, while the majority of Japan's reforms were delayed by nearly 50 years following World War II. Conversely, Japanese reform occurred only in light of social unrest driven by a stagnating economy, which created the conditions necessary for a shift from Liberal Democratic Party policies toward the progressive policies of the Democratic Party of Japan.

In general, this research speaks to the power of politics in shaping the ability of a welfare state to benefit its people. The cases of Germany and Japan demonstrate that positively affecting healthcare goes beyond simply the method of health care delivery; it

is directly influenced by party ideology as ideology dictates policy. In Germany, the Christian Democratic Union and Social Democratic Party are conservative and liberal respectively. However, despite its social and economic conservatism, the Christian Democratic Union successfully co-operated with the Social Democratic Party to revitalize and modernize their welfare state and ultimately have a positive effect on psychiatric services throughout the country. Since the 1970's, Germany has been progressive in de-institutionalizing the country, providing sufficient monetary and human resources, and educating its own people. Conversely, Japan's Liberal Democratic Party was unable to see beyond its own political agenda and enabled the poor state of its own psychiatric system, exchanging economic productivity for the health of its people. These tendencies manifest today in one of the highest suicide rates in the world, poor provisions for doctors and financial resources, and a delayed shift from institutionalization to de-institutionalization.

Today, Germany boasts one of the highest standards of living in the world and is on the forefront of progressive social policies. This is largely due to the history of co-operation and the understanding that economic productivity is contingent upon the welfare of its people. This is a lesson for both developed and developing states in that a narrowed party focus may alienate its base of support, or in the case of Japan, fracture its political power and force its revocation. The process of one state modeling itself after another is not limited to Japan. In order to avoid the pitfall of assuming that success is limited simply to structure, it is imperative that states scrutinize the nature of their own politics to maximize the benefit generated for its people.

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