Systems and Reality of OH Professionals in Japan ：Has Legal Institutionalization Succeeded?

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・Today, I will discuss the topic in a narrative manner from the standpoint of someone who has been involved with Japan's occupational health policy, scholarship, and professional networks for about 20 years.

・In addition, I have recently been receiving financial support from the national government and have been coordinating a comparative study of the occupational health systems of four countries—UK, US, Germany, and France—and have just completed the primary research phase.

1. What I most want to say

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・In Japan, occupational health (hereinafter, OH) starts from form (legal system) rather than substance.

・It is unclear whether it will become the mainstream in the future.

2. What does that mean?

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・Historically, Japan's Occupational Physician (hereinafter, OP) system spread as a means of securing personnel to administer penicillin injections for tuberculosis prevention in the munitions industry.

・Japan legally mandates the establishment of an OH system in workplaces with 50 or more employees,

and in 1978 it established—through a national policy initiative—the University of Occupational and Environmental Health, Japan (UOEH), the only university in the world created specifically to train OH Professionals.

Formally it is a private university, but a large amount of public funds is provided to the organization that operates it.

2. What does that mean?

Students receive a scholarship of approximately £100,000 per person, and if, after graduation, they work as OPs for a certain period, repayment is waived.

Because of the attractiveness of this system, many applicants seek admission to UOEH; however, most of them do not wish to become full-time OPs.

・Furthermore, Japan's MLHW [the relevant ministry] is currently focusing on expanding OH systems to SMEs. However, many employers do not regard OH as indispensable. The reasons are that SMEs often lack the capacity, are fully occupied with pursuing business performance, and cannot see tangible outcomes from occupational health.

2. What does that mean?

・Not only in OH, but across OSH as a whole, Japan's legal policy has advanced prescriptive, compulsory measures rather than goal-setting approaches that rely on voluntary initiatives.

"Top-down" measures have been pursued, such as

: legally mandating the appointment of persons in charge of OSH management

: turning the health officer (eisei kanrisha) into a national qualification

: creating national qualifications for OSH consultants who guide SMEs

: and recommending administrative use of such consultants at workplaces where serious accidents have occurred.

3. Reasons why the UK does not legally mandate an OH system, as indicated by Prof. Diana Kloss [Kloss, Diana. 2020. Occupational Health Law. 6th ed. Chichester: Wiley-Blackwell, Kloss, Diana. 2024. Occupational Health Provision in the United Kingdom. Journal of Work Health and Safety Regulation 3(1): 72–83.]

3. Reasons why the UK does not legally mandate an OH system, as indicated by Prof. Diana Kloss

・Unlike the ILO (Convention No. 161), the UK adopts a voluntary approach. The idea is that employers should be obliged to secure OSH and welfare, but the means of achieving that should be left to the employer.

・Because the NHS provides free medical care, the UK has tended to consider that placing medical professionals in workplaces would be a wasteful duplication.

*I am aware that the SOM is calling for national support for OH for SMEs and freelancers.

3. Reasons why the UK does not legally mandate an OH system, as indicated by Prof. Diana Kloss

・In OH, the work environment is important, and there is a governmental view that the expertise needed to improve it lies more with engineers and hygienists than with physicians.

・The Gregson Committee also held the view that, rather than compulsory measures, guidance through guidelines and incentives such as tax benefits should be used.

4. Assumptions that should be kept in mind when comparing Japan and the UK

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・Japan's OH policy and practice have aimed to separate OH from clinical medicine (treatment) like France and Germany.

In other words, OH Professionals in Japan have evolved in the direction of not providing clinical treatment.

5. Japan’s OH Professionals system

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・In workplaces with 50 or more employees, there is a legal obligation to appoint an OP.

Statutory duties of the OP include

: giving opinions on work accommodations based on workers' health check results

: workplace patrols

: attending the health committee

: and similar activities.

Work management and work environment management are also included, but it is difficult for part-time (contract) OPs to carry these out.

5. Japan’s OH Professionals system

Health examinations are also included, but in reality they are entrusted to specialized institutions, and OPs themselves do not conduct them very much.

If a full-time OP has gained the trust of the company, they may lead the design of the company’s health management system, or be consulted in advance by HR staff about personnel placement of workers with health problems.

5. Japan’s OH Professionals system

・As a general rule, when a workplace reaches 1,000 or more employees, a legal obligation arises to appoint a full-time OP.

In administrative practice, the benchmark for being “full-time” is engaging in OP duties at that workplace for three or more days per week.

Workplaces with 3,001 or more employees are required to appoint two or more full-time OPs, but even if the workplace becomes larger, the legally required number does not increase further.

However, in many cases, large Japanese companies appoint more full-time OPs than legally required. In many cases, the decision on such appointments is made by HR staff, who often work in collaboration with OH.

5. Japan's OH Professionals system

・Japan's MHLW places very great importance on its relationship with the Japan Medical Association (JMA) in operating the OP system.

The JMA is a federation of local medical associations and seeks to protect physicians' interests in medical policy.

It corresponds to the UK's BMA.

Physicians are not obliged to join the medical association, but the JMA has more than 180,000 members, which is over half of all physicians in Japan, and it has strong political and policy influence.

5. Japan’s OH Professionals system

・Japan’s MHLW has granted the authority to confer the national OP qualification to the JMA and to UOEH. This qualification can be obtained by completing 50 credits (typically 50 hours), and once obtained, it is not lost for life.

The credits include health management, work environment management, work management, and also practical training such as workplace patrols, but there is no certification examination for acquiring the qualification.

The number of persons holding the national OP qualification exceeds 100,000, and most of them hold a qualification issued by the JMA.

5. Japan’s OH Professionals system

・Separately from the national qualification, the JMA has created its own qualification and grants it to those who have obtained the national qualification. This one is on a renewal basis.

Because Labor Standards Inspection Offices instruct physicians to hold the JMA’s own qualification, it effectively functions like a national qualification.

・UOEH was established in 1978 because OH was legally mandated but there were few physicians capable of performing it, and it will soon mark its 50th anniversary.

Many graduates do not become full-time OPs, but among those who do, many become full-time OPs at large companies.

Some of them later become independent and serve as contract OPs for multiple companies.

5. Japan’s OH Professionals system

・OH nurses in Japan, as in other countries, play practical, on-the-ground roles in OH. Especially in workplaces where no OP is appointed or where the OP does not actively engage, the role of OH nurses is important.

There is no legal obligation to appoint them, but Japan’s Industrial Safety and Health Act (ISHA) specifies PHNs as persons who may provide health guidance in SMEs and serve as implementers of stress checks.

・In OH practice, some persons who have only a nursing qualification (and not a PHN qualification) also engage in OH activities.

Japanese PHNs are similar to the UK’s SCPHN, and to become a PHN, higher-level education and qualifications are required, premised on holding a nursing license.

For this reason, there is conflict among stakeholders as to whether a PHN qualification should be a pre-requisite for being an OH nurse.

6. Japan’s situation with legally mandated OH

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・It cannot be said that the system is working effectively; however, while the average age of OH professionals is rising in the UK, Japan continues to recruit younger professionals and has not seen a similar increase in average age.

Rather, OP work is seen as enabling a better work–life balance than clinical medicine, which tends to become harsh in working style, and it is becoming an attractive option for young female doctors.

The proportion of women among OPs is increasing.

6.1. Hollowing-out (formalization without substance)

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・Of the approximately 100,000 who hold an OP qualification, only about 30,000 actually engage in OP activities, and among them, those who work as full-time OPs are only around 1,500 (only 0.2% of all physicians).

This includes both full-time OPs who are assumed to work for one company and contract OPs who are assumed to cover multiple companies.

Among OPs who are actually active, many treat OH work as a secondary sideline—giving it noticeably lower priority.

Very few are deeply familiar with the people and organization at their workplace, the tasks and business, and are trusted by both labor and management.

6.1. Hollowing-out (formalization without substance)

- Labor Standards Inspection Offices closely check compliance with the obligation to appoint OPs, and provide guidance for violations. However, because of the insufficient quantity and quality of OPs, strict guidance is difficult.

  Policymakers are “patching” the situation by allowing one full-time OP to concurrently serve multiple workplaces and by enabling remote work, among other measures.

- In the medical profession, there is a tendency to look down on OPs as deviating from the “proper path” of doctors—namely, treatment.

  In companies, there is a tendency to agree with disease prevention in general, while downplaying it in specific cases.

  Both have changed considerably but remain deep-rooted.

6.1. Hollowing-out (formalization without substance)

・Many contract OPs work only a few hours per month per company, and provide opinions based on health check results, conduct interviews with workers in distress, attend the health committee, and conduct workplace patrols.

There are few cases where they engage in proactive preventive activities such as building OH systems or managing the work environment.

・Also, probably because doctors are not educated in handling disputes and because there are few OPs with a strong professional identity, OPs tend not to take risks in case handling.

For example, in mental health responses, the fitness (matching) between the worker and the person, and between the worker and the job, has particularly important meaning, but many doctors lack knowledge about people and organizations, and about work, and do not take risks to lead such processes.

6.1. Hollowing-out (formalization without substance)

・Many physicians have a strong clinical mindset and try to impose clinical medical ethics within the company.

・About 70% of UOEH graduates do not work as full-time OPs. Those who repay their scholarships tend to become clinical physicians.

・Those who became full-time OPs after graduating from UOEH tend to have their occupational medicine expertise highly valued, but they also tended to struggle with identity issues—whether they are organizational members or physicians.

Some physicians obtain an MBA after graduating from UOEH to differentiate themselves from clinical physicians and to promote the penetration of OH within companies.

Some place such a strong emphasis on epidemiology that they drift away from the concrete workplace context (the realities of the shop floor).

6.1. Hollowing-out (formalization without substance)

・OH nurses often play practical and substantive roles in OH. It is reported that there are about 4,000 PHNs and about 6,000 nurses (Japan Nursing Association survey in Reiwa 4).

However, it is pointed out that OH nurses sometimes avoid taking risks that are necessary for their duties, or create their own territorial domains.

・Currently, leadership within the OH nurse community is asking the administration to raise the legal status of OH nurses—for example, by establishing an appointment obligation in ISHA.

However, I have told them that if OH nurses are legally positioned, they will be completely incorporated under the control of OPs, so it would be better to seek to national-qualify OH nurses.

6.1. Hollowing-out (formalization without substance)

・Among OH Professionals, those other than OPs do not have high income and status.

In particular, there are few hygienists with expertise in hazardous substance management, and limited recruitment of younger entrants has led to an increasingly older age profile in this workforce.

6.2. Gradual growth of contextual substance

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・Legal institutionalization of OH Professionals also has achievements.

・For example, it has led to the emergence of a small number of successful models. In the early days of UOEH, OPs were regarded as part-time work for elderly physicians retired from clinical practice. Now, although still a minority, highly motivated and capable OPs have appeared.

6.2. Gradual growth of contextual substance

For example, among full-time OPs, some are trusted by both labor and management and lead the building of occupational health systems and personnel placement of workers in distress. Some are skilled in handling disputes (coordinating conflicting interests).

There is also an increase in professional OPs who work full-time as OPs and serve as contract OPs for dozens of companies.

Some OPs have improved retention rates after return-to-work by taking leadership in coordinating workplace interventions for mental health issues. Some also prevent disputes through appropriate judgment on fitness to return and communication.

・An organization has been formed, centered on UOEH graduates, and it engages in active information sharing and exchange.

6.2. Gradual growth of contextual substance

・In regions where access to medical care is difficult, services have been developed in which a provider concludes a contract with a company to offer simple treatment and OH services as a set, providing OH services free of charge.

Precision health is also being pursued through integration of data obtained from both sides. This is being promoted by Dr. Tanaka, a graduate of UOEH.

・In Tokyo and other areas, which are Japan's capital and major urban centers, supply of OPs has exceeded demand, and companies are beginning to demand higher quality from OPs.

6.2. Gradual growth of contextual substance

・Various career developments of OPs are observed, such as becoming policy makers, taking executive positions in large companies, responding to SMEs, and founding OH businesses.

This can be described as a kind of social experiment in the utilization of medical resources.

・There are increasing examples of OH nurses deepening their learning actively through academic societies and taking proactive leadership in OH.

It is becoming a career option after obtaining nursing qualifications.

7 Finally

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・The presenter, Mishiba, views Japan's OH/OH Professionals system as being at a crossroads now. I also feel there is a risk of it reaching a dead end if it remains as it is.

・I believe that measures that force utilization by law have limits, and that it is necessary to evoke employers' authentic needs.

7 Finally

・In order to be truly needed by employers in the future, I believe it is necessary to establish an academic field that integrates and practices several important preventive domains for corporate management, and to train experts in that field.

I am conceptualizing a “Preventive Architecture” that integrates four domains: disease prevention, accident prevention, dispute prevention, and bankruptcy prevention.

Prevention of AI and cyber issues is included within bankruptcy prevention.

I am planning to publish a Position Paper soon.

Preventive Architecture

①disease prevention (Occupational Health etc.)

②accident prevention (Safety Engineering etc.)

③dispute prevention (legal study etc.)

④bankruptcy prevention (business administration etc.)

An increasing number of themes now span multiple units.
For example, harassment measures span (1) and (3), and also extend to (4).
Because a deterioration in business performance deprives people of psychological leeway and, in turn, triggers harassment.

Procedural Rationality etc.