Socialized Medicine in Japan

Essays, Papers and Addresses

Taro Takemi, M.D.

Japan Medical Association

Socialized Medicine in Japan

Essays, Papers and Addresses

Taro Takemi, M.D.
President, Japan Medical Association

Japan Medical Association

Published by the Japan Medical Association, 5-12, Kanda Surugadai 2-chome, Chiyoda-ku, Tokyo 101.

Printed in Japan

Preface

I believe that those concerned with medical care problems might be interested in studying the activities of the Japan Medical Association (JMA). I, myself, have served as its president for twenty-five years, a record perhaps without parallel among other national medical associations, and one likely not to be soon repeated.

Medical care is an issue not only to physicians but also to people everywhere. The problems are such that they may develop into those major enough to challenge survival. It was with these possibilities in mind that I, as president of the JMA, began seeking advice among first-rate jurists and economists in Japan and eventually started formulating policies.

The idea underlying these formulations is that medical care is to be properly understood only when man — the patient — is seen as having a life cycle of his own. Further, since environmental changes have great influence upon environmental members, we attached the greatest importance to the relationship between group and individual members. Our premise remains that any medical care system must adopt technological developments with the greatest care and sensitivity.

The largest problem encountered was how to find proper means for rejecting controls which the government attempted to place upon science itself, and how to expand our realm of professional freedom. We also closely studied the economics of medical care in a free economy, and it is perhaps in this direction that the JMA has gone farthest.

While learning how to give continued education to medical practitioners, we considered a system which would determine what

sort of activities a medical association ought to carry out within its own community. The concept of medicoeconomics was something which emerged and which I proposed.

We believe that medical care should be seen as a form of investment, even though in the past it has been viewed as a form of consumption. Accordingly, our policy has been to minimize the latter assumption while attempting to maximize the investment effect aspect.

In reviewing our policy over the last quarter century we find that the cost of medical care for the aged in those communities where we conducted our initial experiments has been kept at one-half the level for the whole country. From this we learned that actual measures must precede legislation. Now that the aging process is beginning to affect the economics of all countries, we are thinking that perhaps some of our findings may be of more general use.

Our record of twenty-five years may serve as a starting point for medical care systems of the future. It was for this reason that we decided to compile this record into a single volume and to publish an English version. The thought that our work may be put to good use gives me the greatest pleasure.

March, 1982

Taro Takemi, M.D.
President
Japan Medical Association

TABLE OF CONTENTS

Introduction

A History of the Japan Medical Association

The Japan Medical Association (JMA) was founded in 1917 with Shibasaburo Kitasato, the famous microbiologist, as president. Kitasato had been a pupil of Robert Koch, and the pure culture of the diphtheria bacillus he produced was only one of his numerous achievements. His is also credited with having established the basis of epidemiology.

Kitasato also established a research institute for contagious diseases with the financial assistance of Yukichi Fukuzawa, the founder of Keio Gijuku University. The purpose of this institute was to found an anti-epidemic disease system to prevent the large number of deaths caused by each outbreak of an epidemic disease.

Kitasato was a graduate of the Tokyo Imperial University, but he was not welcome at his alma mater. He received tutelage from Fukuzawa, instead, to develop himself as a researcher in the private sector of medicine and a great pioneer in social medicine. It was he who thus established the JMA by bringing together a number of medical organizations that then existed. The JMA of those years was a body consisting of medical scientists affiliated with private universities, and there was a separate organization called Meiji Ikai (Meiji Medical Society), to which persons related to government universities belonged.

The inauguration of the JMA, which Kitasato created as an organization of physicians in the private sector, however, was a major event of those years. The newspapers of that time gave detailed reports on the activities of the JMA — a fact which indicates the importance

with which Kitasato was viewed. The central concern of the practitioners of those years was how to provide the poor with free medical care, and this meant that although the doctors did receive relatively large fees from the rich than from others, their income was not extraordinarily large. It was natural, therefore, that the securing of the livelihood of the practitioners was an important issue for the JMA.

Kitasato listened to the voices of the practitioners and racked his brains over the problem of securing the livelihood for practitioners as something that he could not skirt in dealing with the problems of medical care for the nation.

I believe, however, that Kitasato, as a microbiologist, had another, separate aim in organizing the doctors of Japan. This was the creation of a system to prevent the outbreak of acute contagious diseases. He thought that there was no more effective way than the organization of medical practitioners.

He gave lectures in microbiology and immunology and taught epidemiology, providing medical scientists with microbiological technologies while emphasizing community countermeasures.

The lectures received the enthusiastic support of practitioners, and the success of Kitasato's program is attested to by the fact that it did help to establish a system for preventing the outbreak of acute contagious diseases.

I believe that the success of the JMA is due largely to the fact that it moved forward toward a goal which had nothing to do with school cliques or other groups of doctors.

Furthermore, Kitasato thought of organizing a national system for preventing and checking the spread of tuberculosis which was at that time rampant throughout the country. As the financial basis for such a system, he organized the Dai Nippon Shiritsu Eisei Kai (Greater Japan Private Association of Sanitation) in order to expand the activities of that system. In retrospect, we can say that it was an effort to seek the participation of the people in the anti-TB drive on an enormous scale.

Because it was not possible for him to organize concrete medical

measures against TB, however, prevention was carried out in terms of the quarantine of patients in sanitariums and other very passive means. In those years the standard of living was very low, and I believe that Kitasato did not realize that one of the basic principles of preventing TB was to raise the standard of living itself.

Of course, Kitasato organized the JMA partly to protect their livelihood of the practitioners, but he also wanted to establish a system for combatting acute contagious diseases which threatened the very survival of our nation and to provide the practitioners with the necessary microbiological knowledge to do so. The high ideals for which the JMA was created accounted for the success of the association.

But there were people affiliated with government universities who were not pleased with the dictatorial manner in which Kitasato carried out his decisions. When they attempted to prevent his becoming the president of the JMA for a second term, Kitasato stated flatly that unless he was recommended for the office unconditionally, he would not become president. Thereupon all the members quietly recommended him for another term.

We must not forget that at the bottom of the character of the JMA was Kitasato's microbiology and the preventive and defensive medicine that applies it, and that a system of collective defense against diseases that organizes such medical knowledge was built upon a national basis. This characteristic should be perpetuated as the traditional spirit of the JMA.

But at regional conferences of members of the JMA, strong economic demands were presented by the practitioners and practically all the resolutions concerned the protection of their own livelihood. This fact deserves attention from a different point of view. That is, the JMA was a collectivity of practitioners, which manifested strongly the characteristics of a trade association. But Kitasato, as its top leader, was not pressured by such demands, and this fact accounts for the development of the JMA as an organization because Kitasato, without being brought to his knees by pressure, continued to think of the JMA as a scientific system concerned with medical care. It is unfortunately

true that the present members of the JMA are not aware of the fact that the JMA has grown as an organization firmly based on such strength.

The practitioner of those years had a social status as high as the mayor of a village or chief of police. He gave free medical care services to the poor while collecting large fees from the rich. In other words, the practitioner performed the function of income redistribution within a limited local area. When there was a famine which deprived people of sufficient food, a practitioner received sweet potatoes from poor farmers in lieu of cash payment because the farmers themselves had to live on sweet potatoes. And the families of a doctor, too, had to live on sweet potatoes. This meant that a practitioner lived *with* the people of his community, which was, in fact, his strength. He suffered with the members of the community at a time of famine and he shared their joy over a bumper crop. These are things people today cannot imagine that actually took place. At any rate, a practitioner thus became an integral part of a local community in which he practiced.

The close relations between a physician and his patients were essentially those between the physician and the families of his patients. The physician had a full knowledge of the lives of each of his patients as well as the environmental conditions of his home. The doctor also knew the conditions of the water in the family wells in an area prone to be affected by a contagious disease. Likewise, he was aware of the mental health background of each family in his community. We must not forget that this was indeed community medical care; it was the prototype for the community medical care we talk about today.

The farming families then were poverty-stricken and were always troubled by debts. In those years, one-third of the debts of a family arose from the cost of fertilizers, another one-third arose from marriages, funerals and other forms of family rites, and the remaining one-third arose from ill health.

The bureaucrats within the Ministry of Agriculture and Forestry developed a strong urge to rescue the poor farmers from this kind of financial instability. A leader among them was Tadaatsu Ishiguro,

who later became Minister of Agriculture and Forestry and an authority on agricultural administration. He conceived of a scheme in which a medical care utilization cooperative was to be incorporated into an industrial cooperative. The agricultural cooperative was a voluntary movement for farmers to become self-sufficient and self-reliant. But this system of incorporating medical care services into the cooperative system was viewed as a serious threat to the interests of the practitioners, who, under the aegis of the JMA, started a major opposition drive.

Because in those years the medical practitioners were under the supervision of the Home Ministry, that ministry and the Ministry of Agriculture and Forestry had a conflict of jurisdiction, which later developed into a major social issue. This scheme by Ishiguro, however, undeniably served as the starting point for the eventual establishment of rural medical care in Japan.

Under its second president, Taro Kitajima, the JMA, with a fairly strong sense of solidarity, delivered powerful counter-offensives against the incursion into the area of medical care by industrial cooperatives. Such counter-offensives were ineffective because they contributed nothing to the development of rural medicine and because they were conducted while the JMA admitted this shortcoming. President Kitajima of the JMA nonetheless succeeded in bringing this issue to an end by studying compromise measures with the Ministry of Agriculture and Forestry in cooperation with the Home Ministry.

The Home Ministry began conducting a survey on rural health and seriously introduced countermeasures for parasitisis, malnutrition and TB. This must be said to be a sign of remarkable progress.

Because I was involved in work with the Ministry of Agriculture and Forestry, I took part in this survey which was carried out by a team, headed by Dr. Makoto Koizumi, professor of parasitology at the School of Medicine of Keio Gijuku University. It also included some economists. The survey was conducted in three separate areas: mountainous villages, fishing villages and intermediate farming villages. Because I took part in this kind of survey work immediately

after graduation from university, I was able to know at first hand the realities of rural life, and was able to think deeply about the relationship between human life and disease. I feel gratified by the fact that when I became president of the JMA many years later, I had gained a basic knowledge with which to take up housing problems, water and sewerage problems, and labor, health and disease in rural communities.

One interesting fact that was learned at that time was that farm labor, in one of its aspects, was a technological labor and, because of this, a farmer in the peak season required 5,000 calories per day whereas in reality he was able to ingest only about 3,500 calories. His diet also contained too much salt while lacking in vitamins and protein, thus being highly deficient as a whole. I recall that it was highly effective in improving the diet to have a community cafeteria with a dietitian brought into the rural community.

We also learned that during immediately after the peak season, there was a sudden rise in the number of patients, which kept the hospitals in nearby towns busy. What happened was that various latent diseases, including TB, came to the surface. We were able to learn the causes of rural health problems and thereby establish proper countermeasures.

The Beginnings of the Health Insurance System

The health insurance system has its genesis in that which was instituted in Germany by Bismarck. It is evident that the German system was based on an insurance formula for compensation for material damage. In Japan, Shinpei Goto, the physician-statesman, who had studied in Germany, recommended to the then Home Minister and Dr. Kitasato that Japan should adopt the German health insurance system.

Before a health insurance system was introduced in Japan by legislation, there was already a voluntary form of health insurance in operation in Koshigaya, Saitama Prefecture. This fact made Koshigaya the home of health insurance in Japan. Though the system was in

operation within a limited area, it did lessen the financial burden of persons who became ill. Yet, it is also true that the system suffered from financial difficulties and, therefore, could not be labeled a success.

The Social Affairs Bureau of the Home Ministry later spent three years studying the health insurance issue before producing a health insurance system for Japan. At the beginning it was a welfare formula for major enterprises. In those years, the major enterprises of Japan were mostly spinning companies, many of whose employees suffered from TB. This is the reason why the spinning companies were quick in taking up health insurance. The first enterprise to adopt it is said to have been Kanegafuchi Spinning Company.

The major enterprises in Japan began adopting a health insurance plan one after another as an employee welfare measure and for securing a labor force. But serious problems, as it turned out, were inherent in such a system because of this very background. The way the system was instituted represented the easy-going administrative philosophy of the government of doing something first in areas where it is possible. In this instance, the spinning industry was the area where it was possible before others.

In fact, bureaucrats always tried to do something by starting it where it was possible. They did not give enough thought to what was the most proper way to institute a system in order to make it work best. Later, almost all major enterprises had health insurance associations made up of their employees as a welfare facility, which the managements were able to utilize. The health insurance system also played a big role in securing a labor force for the companies.

The employees of small businesses and cottage industries, however, were not able to benefit from such a system. The government gradually formulated a universal health insurance plan and decided to implement it in 1960.

First, a government-managed health insurance plan, to cover the employees of very small businesses, was created. In the case of such small businesses, the employees were working under unfavorable conditions and their living conditions, too, were poor. This accounted

for the high mortality rate among the insured. This government-managed health insurance plan was chronically in deficit, and the government had to subsidize it. Because the premiums were low, the deficits were inevitable. But the benefits, too, were very poor.

The government next studied a national health insurance plan designed to cover farmers, fishermen and self-employed people. But this plan was to cover mostly employees on even smaller scales than in the case of the government-managed health insurance plan. The idea was to establish a national health insurance association in each local government, city, town and village. In this scheme, the persons covered had incomes that were far smaller than those covered by the government-managed health insurance plan, and their mortality rate was high. Therefore, this plan later became a major burden on the finances of local governments.

The government decided to carry out the universal health insurance system at a time when its need was keenly felt — when Japan's militarism was steadily moving forward. Lt. Gen. Chikahiko Koizumi of the army, who was serving as Minister of Health and Welfare, emphasized the importance of implementing this health insurance system for augmenting the war-fighting ability of rural youth.

This meant that the national health insurance plan served the purpose of increasing Japan's war potential and the association health insurance plan and government-managed health insurance plan were resorted to in securing a labor force. As such, they were neither designed as a means of elevating the standard of health of the people, nor as a countermeasure for disease. Rather, we must note that they were used to serve a different social purpose. And it is noteworthy how the JMA dealt with these problems.

As for the inauguration of the health insurance system itself, the JMA was fairly well satisfied with the system, assuming that the government would give remunerations for the medical services rendered by the physicians. But the JMA had not anticipated the possibility of a universal health insurance system to come into being in

the future. In looking into the future, the physicians were able only to think in very short terms by welcoming what immediately appeared to be a plus to their income. They did not notice a big pitfall ahead of them: the physicians came to be forced to undertake medical treatment of patients for a pittance. They accepted the assignment on the assumption that it was better than nothing. But as the number of people covered by an insurance plan increased, they found themselves being financially strangled.

Even when society in general was becoming increasingly prosperous, the financial condition of the physicians under the health insurance system did not improve correspondingly. They had to be content with what they received. This meant that the drive for protecting their livelihood reached a second stage. The first stage consisted of the doctors escaping the threat to their lives, which arose from the treatment they gave their patients. The second stage, in which everyone was insured for their health care, the doctors had to think of means of protecting their right to survival under the pressure of a low medical care cost policy.

This is how Japan entered the war. In that situation, the doctors were forced to carry out the low medical care policy without ado while medical supplies became increasingly scarce and the quality of medical care unavoidably deteriorated.

It is necessary at this time to review what became of the JMA under such circumstances. The government which had gone through the two successive periods in the history of the JMA presidents, Kitasato and Kitajima, brought heavy pressure on the organization. This era was succeeded by the third president, Nakayama, who, having had no academic credentials at all, was rather a kind of political boss. The JMA then came under the complete control of the army. During this era, a retired professor from the Tokyo Imperial University was made nominal president while the organization itself faithfully carried out the commands of the army and the bureaucracy, conveying them to its members.

During this era, there was a full range of wartime laws in finance,

economics, and every other field, and the JMA not only lost all its freedoms but also tried to preserve its own existence by adulating the military.

The JMA in fact was reorganized as a special juridical foundation which every physician was compelled to join. No counter-policy to speak of emerged from the JMA of that time. It merely cooperated with the military by giving aid to the wartime civilian organizations in every area of the country.

But then the government organized a Japan Medical Care Corps, which deprived the JMA of all the hospitals. Under this system, every private hospital was brought under the control of JMCC, and the hospital managers lost all their freedoms. Though this situation lasted for a short period, it was, nonetheless, an era of serious damage to the medical profession of our country.

After Japan's unconditional surrender, the occupation army established GHQ in Tokyo, and gave directives to the Ministry of Health and Welfare concerning every aspect of medical care. One major contribution the Public Health and Welfare Section of GHQ made to the medical care of Japan was the thorough improvement of public health activities. Because Japan had no fiscal strength after the war, the government was unable to spend a large sum of money on public health. Yet, GHQ issued directives to improve public health through the ministry to the prefectural governments and then conducted inspections on how the directives were carried out. This measure enormously improved the standards of public health throughout Japan.

Another meritorious service rendered was the reform of the nurse training service, by which the educational level of nurses was measurably raised.

One difference between Japanese and Americans was noted. When Japanese receive a high-level education, they tend to dislike work requiring their personal participation at the practical level; they would rather make their inferiors perform these tasks. This is a serious shortcoming in the Japanese character. This, of course, was not a fault

of GHQ, but it created a serious problem that was difficult to resolve. The nurses of Japan today spend most of their duty hours doing clerical work while sitting in their chairs. This is what they think "high-class" nurses should be doing. Unfortunately, they think the real duties of the nurse are to be performed by nurse's aides. The nurses who are in charge of medical care information stay in their chairs while preparing reports on the basis of information obtained from their assistants. This kind of information cannot but be considered as being of little value. It is to be seriously regretted that Japanese physicians and the government itself did not know how to make highly educated nurses work, and they still do not have any idea today. As the union of nurses becomes more powerful, furthermore, the nurses tend to specialize in desk work and they no longer encounter the tense duty-hour situations of the kind the American nurses have. When people criticize GHQ for unwise advice on the nurse system they forget the responsibility of the Japanese themselves for having not known how to utilize the American system.

The Problem of Professional Freedom

The professional freedom of the Japanese physician was fully represented by Shibasaburo Kitasato and the JMA was capable of exercising that freedom. But as bureaucratic control gained strength and military pressure mounted, professional freedom became increasingly subject to these pressures. Particularly after the introduction of the health insurance system, this became very evident.

The Ministry of Health and Welvare, as the first step toward the implementation of a universal health insurance policy, deprived the physician of all his rights and authorities. This was done by revising the Health Insurance Law. First, professional freedom was neglected, and then medical care services were placed under increased restriction. Then social freedom was neglected when the government refused to recognize the physician's right to organize.

Thirdly, the government suppressed the physician's economic freedom by keeping medical care fees savagely low. It is an astonishing

fact that such a policy was formulated after the Occupation era. And the government attempted to carry it out in 1956 — some years after the end of the Occupation.

Thus, the physician lost his professional freedom and found his medical care services restricted, which meant that he had lost both his economic and social freedoms. I believe it was a disgrace in the parliamentary history of Japan that a democratic parliament authorized this kind of conspiracy by the bureaucracy. The medical profession could not tolerate the fact that the Liberal-Democratic Party, the party in power for practically all of the postwar years in Japan, favored such legislation that paved the way toward a universal health insurance system. Yet, the JMA at that time agreed to this legislation. This happened when the JMA was persuaded by the physicians who were members of the Diet, who argued that it was a means to check Communist doctors. But I believe that this was a case of deception.

When I became president of the JMA in 1957, I declared war on this system. I held a long talk with Hiroshi Kanda, Minister of Health and Welfare at that time and following our parley he admitted that the system was wrong. And the legal counsel for the JMA overhauled the ministerial and Cabinet orders to restore some of the freedoms for the profession. But because the law itself had been passed by the Diet, we were unable to reverse the situation.

After such preparations as this, the government, two years later, introduced the universal health insurance system.

Under the health insurance system, the substance of medical services rendered by a physician must be subject to what the Minister of Health and Welfare determines, and whatever service given beyond that limit is not to be compensated for. It is a fact that because of this universal health insurance system, the Japanese physician lost all of his freedoms. The way this was carried out was extremely dastardly, and the legislation concerned distorted the substance of medical care itself.

First of all, the basic policy of the government of Japan was to insure every citizen for health care by instituting a national health insurance system. Of course, a state-run medical service would require

an enormous amount of funds. But the idea was for the state to take over all the medical facilities where physicians were giving medical services. This would enable the government to provide the people with medical services without spending too much money of its own. This was the aim of the bureaucrats. And the JMA fell its victim without being able to put up any resistance. The bureaucrats established by law the health insurance medical care facilities that were to give medical care services to the patient on consignment by the insurer. The physician to provide such services had to be a doctor duly registered as a health insurance physician. What this meant was that a private practitioner who had his own clinic where he looked after his patients had to change his clinic into a health insurance medical care facility and that he could not engage in medical care services unless he registered himself as a health insurance doctor.

The contents of medical care he could provide, furthermore, had to be prescribed by the minister of Health and Welfare. This meant that the minister and the insurer now possessed absolute power and authority over the physician.

The only function the insurers performed was to collect premiums from the insured. Yet, in the case of association health insurance plan, they began carrying out their own medical service businesses as part of a welfare program of the business enterprises concerned. There is an exception made by law, by which these hospitals and clinics managed by health insurance associations need not conform to the standards set by the Minister of Health and Welfare. This is a notable characteristic of association health insurance.

These associations do not conform to the commands and directives of the minister even though they are supposed to be under the Minister of Health and Welfare. And when a physician gives medical services, he must obey orders from the minister, which spells a serious contradiction. Yet, the JMA agreed to this kind of law. By 1957 when I became JMA president, this bill had passed the Diet and was ready to be implemented.

The First Thing I Did as JMA President

The first job for me as JMA president was to make this law somehow inoperative, that is, to prevent the full control from being exercised by the bureaucracy and the insurers in order to maintain professional freedom. For this, it was necessary first of all to educate the doctors of the entire country.

Japanese doctors are extremely subservient to bureaucrats and have had no history of resistance. This is why they still abided by the law even though they might be deprived of economic and occupational freedoms. This was also due to the fact that they were not conscious of living in a democratic society, and also due partly to the fact that GHQ and the Ministry of Health and Welfare functioned as one body.

First of all, I asked two first-rate jurists of Japan to come together to have them study the validity of this law. As a result the jurists made it clear that this law was an abnormal law, without a parallel in the world and it was a kind of law that had never been discussed in the law faculty of Tokyo University (formerly the Tokyo Imperial University).

I brought the director of the health insurance bureau of the ministry before these two jurists, Professor Hajime Kaneko and Teruhisa Ishii of Tokyo University, to explain the law to them. The director confessed that he had to make the law because it was necessary to suppress the doctors in order to institute a universal health insurance system. That such a bill was passed by the Diet, I thought, was because the Diet itself was blind.

Then I contended against the then Minister of Health and Welfare to the end until I had him turn over to me in top secrecy the drafts of ministerial ordinances and regulations to implement the law. I had the two professors study these documents and had them revise them so as to make them totally ineffective. I decided, furthermore, to fight against the Liberal-Democratic Party (LDP), the largest political party of Japan. I had five or six debating sessions with Mr. Kakuei Tanaka, chairman of the political affairs council of the LDP (who later

became prime minister). At the end of our struggle against this law, we decided to stage a "walk-out" by all the member doctors of the JMA from the health insurance scheme. On the eve of the scheduled doctor's strike, we reached agreement with the government.

The terms of agreement included "the securing of freedoms based on the human relationship between a doctor and the patient," by which we had the other side recognize our right to refuse intervention by a third party. We also won agreement on the establishment of a system for remunerating the doctors in a free enterprise society. We also won the pledge to apply the latest achievements in medical science to day-to-day medical care services doctors provide. There was also agreement on a radical revision of the medical care insurance system.

According to these agreements, the government had to retract all the limitations that had been placed on medical care services, and all the standards established for medical care services had to be scrapped. It was also agreed that, in the process of checking and inspection, the doctor's bills had to be approved in principle except for extreme cases of unreasonableness. Thus, professional freedom was completely restored to the JMA. These agreements, however, were not of a nature that could be implemented immediately but had to be carried out little by little. But at least we were able to remove all the restrictions and limitations on medical care services. This is because we attached so much importance to professional freedom.

Health insurance medical care was thus placed under control and the remunerations for physicians were determined by the Minister of Health and Welfare. Yet, the remunerations must be such as to reflect immediately the progress of free economy. This is what we had the government confirm, and this confirmation proved an important basis for revising the remunerations. This is how we found a way out of the past policy of keeping medical care costs low.

Yet, the government was extremely tardy in implementing this policy. Accordingly, we carried out a walk-out from the health insurance system for one month during the time of the Sato Cabinet. This time, we had the government agree on 12 items. Even these did

not materialize promptly. But such actions as these taken by the JMA resulted in the demoralization of the insurers' organization who lost their past position as the ruler, and the fact that the health insurance bureaucrats realized that authoritarian administration was shut out of the academic world and that it was no longer possible to suppress professional freedom by legal manipulation. As a result, the inspection and examination of the doctors' bills practically ceased to exist, and we had agreement that these measures could be taken only with the consent of the JMA. It was also decided that the medical profession should be able to state its own case at the Central Social Insurance Medical Council, an advisory body to the minister of health and welfare, which was the organ to determine the remunerations for health insurance medical care. In other words, our economic freedom, too, was restored somewhat, along with the restoration of professional freedom. These developments meant that the livelihood of the Japanese doctors was restored.

Although we thus acquired professional freedom, it goes without saying that it also meant higher medical care costs. Fortunately, the nation was going through a period of high economic growth which enabled the people to pay for the higher medical care costs. In the sectors where economic growth was not fast, in agriculture and some other industries, the universal health insurance plans suffered deficits. This was also true with the government-managed health insurance plan which primarily covered small businesses.

On the other hand, there were increasing signs of the doctors, who had won professional freedom, wanting to make full use of it in augmenting their income from medical care services. The table of remunerations for medical care services basically did not recognize fees for basic technologies of the physician. This encouraged these doctors to seek compensation for their technological skills by finding a difference between the remunerations for the medicines they gave their patients and the prices they paid for these medicines. This was responsible for the phenomenon of the physicians prescribing and dispensing a relatively large number of medicines for their patients.

This was, of course, possible because the restrictions on medical care services had been removed.

I feel that expanded professional freedom should afford a physician a wider range of options in providing medical care, and that should be the guiding principle for the profession. Yet, it is regrettable that some of the practitioners devoted themselves to increasing their own revenue. Some diagnosed the ailment of a patient as 10 or 15 different diseases, for which he dispensed a great variety of medicines. Others gave numerous clinical tests to their patients, whose conditions did not change, thereby earning income from testing fees. The mass media described these practices as "immersion (of patients) in medicines and tests" by way of criticizing these doctors. As Japan's economic activities declined, the government as well as the National Federation of Health Insurance Associations, the paying organization under the insurance system, began joining the mass media in this criticism. Some of the doctors were deficient in ethics and occasionally provided material for newspaper articles. On each of these occasions, the epithets of "immersion in medicines and tests" were played up, gaining further currency.

I believe that this expanded choice reflected the characteristics of our profession. But I did resort to fairly strong leadership in an attempt to restrain the special groups of practitioners at the peripheries of our organization, which sought profit. But I was unsuccessful. The JMA also held lecture programs for postgraduate training for our members to enable them to further their academic studies, gave them pointers to new directions, showed them the direction in which pharmacology progressed and how to conduct tests, thereby helping them improve the substance of their medical care services. Yet, these practitioners responded to all of these measures only as a means of augmenting their income. This is the reason why the JMA and the avaricious members of the organization, even though both aimed at the same objective, eventually reached different destinations. Therefore, I resorted to the following measures as a means of improving this situation.

Dependency on 'Goods' Shifted to Technical Fees

Under such circumstances, I myself am not disturbed by the criticisms leveled against us from the public. Yet, it is a fact that we do have members who must search their souls. And I thought of guiding them to the right path within the realm of science. The first thing I did was to obtain payment for a second consultation by allocating points to it under the health insurance system. Many of our member doctors at that time thought it would be impossible to have this established. But we were able to get it even though the fee was only ¥25 per consultation. That figure has since been raised to ¥350.

Likewise I successfully won payment for new technical fees in the form of first consultation fee and medical management fee to be collected at the time of the hospitalization of a patient. That we won these fees for doctors indicated by common sense that in the future the remuneration for doctors should be based on technology or skill. The fees for many of the surgical operations have thus increased in some cases tenfold.

Besides having the physician's skill as an important basis for determining remunerations, we were able to incorporate into the health insurance system such a diagnostic technology as renal dialysis.

The cost of medical care has risen each year because of the addition of these medical care services to the health insurance system. This has prompted the government to consider means of restraining the expenditure, including a system of registration, though it has not been implemented.

On our part, we were annoyed with the fact that there were many doctors earning a big income by behaving like commission merchants. And we began our efforts to get rid of them. We tried hard to reduce the profit for the doctors, that derived from the margin of prices for medicines they dispensed to their patients. We succeeded in shifting the income of doctors from medicines to technical fees.

The first policy toward medicines I thought of was to establish a public pharmacy next to each post-office, where a prescription by a doctor may be filled free of charge. The then Health and Welfare

Minister Zenko Suzuki (who became prime minister in 1980) was all in favor of that idea. But it was not translated into reality because of the opposition by the association of pharmacists.

Meanwhile, I thought about group practice, which could be conducted on the basis of a community medical association at a "medical association hospital." The hospital will have a clinical testing center to do all the tests for the practitioners in the community. At this hospital, operations as well as tests are conducted by a practitioner who uses the facilities. This was complete group practice and the hospital was an open hospital. Such hospitals became the community center for home medicine. This system did not spread very rapidly, but more recently the number of these hospitals has suddenly increased. This is because those among the doctors who realized the need for self-defense, gained confidence in their ability to secure their income essentially with technical fees by means of making public their skill and finances.

The revision of the medical care remuneration table carried out this year was designed for finding a new direction in compensation for medical care services. It took us a quarter-centruy to reach this stage, and I think it has been much too long but perhaps it has been unavoidable. There was much difficulty attending the effort to make the doctors themselves abandon their old habits and to make them understand their new objective. It was also difficult to make the insurers' organizations and the government, who thought only in terms of old habits and past results, think of the future of medicine and understand the new sustem.

As I have described above, I have resorted to every possible means to establish a new medical service compensation system, based essentially on technical fees for the doctor. At the same time, I was able to complete the medical association hospital, which is without parallel in the world as a facility for group practice. I believe that this is the most advanced form in the world of group medicine. There, full postgraduate training is given, enabling the doctors, for instance, to undergo training in surgical operations under topnotch experts in the

field. It is also possible to map out a community medical care plan at this hospital and collect medical information and also have the hospital play the role of an emergency medical care center.

While I have made efforts in expanding the realm of our professional freedom, I have not been able to overlook the most regrettable conduct of those physicians who took advantage of this for dishonorable purposes. Nonetheless, ultimately we were able to establish the technical fee system, which represented the expansion of remuneration for skills, and the legal recognition for medical association hospitals as facilities for community use, which meant that the government authorized the hospitals to serve as the basis for community medicine in Japan. With such systemic improvements, it is now possible to reduce medical care expenditure even in state finances.

Lastly, concerning the increase in medical care costs due to the aging of the population, I have advocated for the past 20 years the management of life and nutrition for the aged. But society has not taken heed. The communities which made efforts according to our advice, however, were able to reduce the medical care costs for the aged to one-tenth of the normal. With this tangible result, the government suddenly realized the importance of medical care for the aged. But it is without any countermeasure, for because of 20 years of negligence medical care costs for the aged are rising sharply. I have always said that medical care policy must be based on an insight 20 to 30 years into the future. My advocacy is to deal with the reality by focusing on the future, not by extending the past. My way of thinking has received recognition only recently. But again it took a quarter century. At any rate, my JMA presidency of 24 years is now coming to its conclusion in the conditions I have described.

The JMA and the WMA

I have maintained that the World Medical Association (WMA) naturally should have an interest in the regional problems in the medical care of the world but it should also endeavor to build the

future by taking into account the future vision of world medical care which would include both the advanced and developing countries. This is the reason why I established a special committee on the development and allocation of medical care resources within the WMA and I became its chairman. I also served as chairman of the WMA's socio-medical affairs committee.

With these two committees I emphasized that the former way of thinking of economists about the relationship between economics and medical care for the people was totally wrong. I also repeatedly said that a large portion of medical care cost is investment and that it cannot be considered a mere form of consumption. I spent six years discussing this problem with economists and recently reached a conclusion. The conclusion concerned the relationship between medical care and economics with man in a life cycle, and I was pleased to note that it received the understanding of economists.

I also proposed a health insurance system which does not have the usual inclination of a health insurance scheme toward reducing the scale of professional freedom. This I should like to call the Takemi theory or the Takemi system. Earlier I had called it "bioinsurance" but I decided to rename it because this particular term seems to be inappropriate.

Thus, the WMA was able to establish a new concept called medicoeconomics, which perfectly combines medicine and economics on the basis of the development and allocation of medical care resources. It has been proven that the new health insurance system based on that concept, the Takemi theory — one in which there is no "insurer" as such — is possible in the computer era.

By way of summarizing the activities of the JMA, I am appending to what I have said a number of newspaper advertisements, consisting of my own articles, with which I attempted to appeal to the people over recent years.

Essays

Medical Care Administration — Epitome of Chaos

A free society must not be a chaotic society. The charm of a free society is to be found in the fact that it has an order, in which progress for the future is inherent. The people of Japan have a choice between a real free society and a chaotic free society.

Looking at the medical care problems in our country, we regret to find that our society has lost the basis of a choice for the future. Today's chaos consists essentially of complaints and dissatisfaction. But it is the responsibility of a professional organization and the government to integrate the complaints and sources of dissatisfaction to relate them to progress in the future.

Economically speaking, it is doubtful if the equalization of economic burden is consonant with the basic principles of a free society. In a so-called welfare society, which provides social security, fairness in medical care may be achieved through the redistribution of income by making the higher-income citizens pay more than the lower-income citizens. This is the way to give substance to the moral code that there should be no discrimination between the rich and the poor with regard to the preciousness of life.

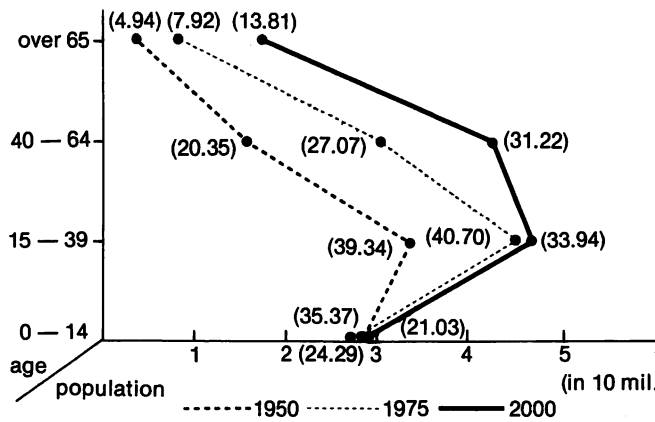
Because this is the starting point for a welfare state, it would mean that medicine must always play a role in the preservation and development of human life. People at the same time must enjoy the equal right to enjoy its benefits. There should also be a guarantee of health through generations — from parents to children and to their children. Generational ties are an important concept in a welfare state.

Then, the average length of life becomes a matter of great

importance. When the health insurance system was established in Japan 50 years ago, the average length of life of the Japanese people was 45. In those years, the disease pattern was different from today's. For instance, people were constantly exposed to the menace of acute contagious diseases or chronic diseases like tuberculosis. Because the standard of living was very low, furthermore, beriberi was prevalent, and people's resistance to disease in general was extremely low.

Medicine in such an age was a far cry from what we have today. Medicine was able to play the role of defending society largely by means of inoculations. Against tuberculosis in particular, there was neither countermeasure nor drug to deal with it. The demographical pattern was that of "many births and many deaths."

The above is a description of the socio-biological circumstances under which the health insurance law was legislated. In those years, the military and the bureaucracy set the policy objective of "fukoku kyohei (attaining national wealth through military strength)." This is in sharp contrast to today's requirements for health, which is essential for building a peaceful society.



Source: National Land Agency, People and Land in the 21st Century.
* Figures in parentheses are percentages in total population.
* Number of persons over 85 years of age was 100,000 in 1950 and 400,000 in 1975 and will be 490,000 in 2000.

After World War II, the average length of life of the Japanese people rose sharply. The number of births decreased, and so did that of deaths. Acute contagious diseases were stamped out and parasites exterminated. Likewise, tuberculosis was eliminated. Primary killers today are cancer and the adult diseases that characterize aged societies.

We in the medical profession consider changes in the demographic structure as the primary element in medical care. The percentage of the aged in the total population is constantly rising. When this happens, the cost of medical care inevitably rises. Today, the Government-managed health insurance plan is suffering from a notable deficit because of this aging of the population. We cannot discuss the deficit in the Government-managed health insurance plan without accepting this fact.

The deficit in the Government-managed health insurance plan is due to "structural defects" in the health insurance law itself. Major companies and enterprises have their own employees' health insurance associations, and there is no mechanism for income redistribution between these rich health insurance associations and the Government-managed health insurance plan that covers low-income people. The same is true between the health insurance associations and the national health insurance plan, which suffers from an even larger deficit than the Government-managed health insurance plan. In other words, in our health insurance system, the rich and the poor insure themselves separately — a system which appears to be a residue of a feudal society, being maintained by law.

The health insurance associations of major enterprises which benefited from the fast economic growth of the nation have constantly became larger. Even the people covered by the Government-managed health insurance plan withdrew from it to form their own associations. Those who are left behind are people in the lower income brackets. These people naturally have lower standards of living; their disease rate is high and their recovery pace, when they do fall ill, is slow.

Thus, we find that there is no rational redistribution of income

among the citizens of all economic strata, and the unfair disparity in medical care they receive is perpetuated by law.

Yet, we in the medical profession are often blamed for this state of affairs. But the physicians under this system are subject to strict restraints concerning medical care. There is no freedom in the health insurance system. Nor does the progress achieved by science in a free society find its way into it.

We thought it would be a fatal mistake for Japan to institute the universal health insurance system without first rectifying these built-in self-contradictions. This is the reason why we negotiated with the Minister of Health and Welfare in 1961 to have him agree to the following four principles:

1. A radical revision of the medical care insurance system.
2. Improvement of medical research and education for augmenting the people's welfare.
3. Freedom to be secured on the basis of human relationships between the physician and his patient.
4. Establishment of a medical care compensation system in a free economic society.

But no concrete steps have been taken toward these objectives since then. And the problems stemming from the aging of the population and the self-contradictions created by the anachronistic mechanism described above remain unresolved. This is the reason why all members of the JMA withdrew from the health insurance system for a period of one month during the Sato Cabinet days. But we did not walk out on the national health insurance plan at that time because we were well aware that medical care for the people covered by this health insurance plan could not be neglected.

Today, a cup of coffee in a coffee shop costs at least ¥250 and a beefsteak is priced at several thousand yen. This is possible in this free economy society. There are no such exhorbitant figures, however, in the income of the physicians in the "controlled economy society."

Every single medical fee is fixed by the Minister of Health and Welfare and there could be no deviation. Furthermore, the fees are

exactly the same for a professor and for his former pupil who received his medical license only yesterday. We must ask again whether this state of affairs should be tolerated in a free society.

We have maintained that we ought to have a system whereby an individual, no matter how poor he may be, should be able to receive medical attention from a first-rate physician. A patient, we believe, must be given freedom in choosing doctors. In today's Japan, there is no occupation other than that of health insurance doctors, in which wages are completely controlled. When the minister of a certain ministry in a so-called free society maintains a watertight control over the medical care revenue of all the physicians of the country in a manner similar to wartime control, it is seriously doubtful if this could be truly described as medical care in a free society.

The rights of a health insurance doctor are not all guaranteed by law. The health insurance doctor, furthermore, is like a slave compared with the worker whose rights are protected by law.

It has been loudly criticized that the tax exemption for health insurance fees for doctors is unfair. We wish to point out, however, that the tax consideration is the only means that maintains the unjustly small fees for doctors for medical examinations and operations. In every other respect, the physician is being sacrificed for the sake of the health insurance system. It is only in Japan that a social security system is sustained by the goodwill and sacrifice on the part of the individual physicians. There is no such social security system anywhere else in the world.

An office worker after work is completely free. He is not subject to being called back to work. But a physician is compelled to work 24 hours by the health insurance system. No matter how busy or tired he may be, he is not allowed to refuse to see his patient. There is no other social security system in the world which compels such self-sacrifice on the part of physicians. This is possible in Japan because the way of thinking that prevailed in wartime when the nation was under military control has been perpetuated by law.

From 40 to 45 percent of the total income of a physician is costs

of medicines, which are deducted from his gross income. An additional 35 to 40 percent covers the utility costs such as electricity, fuels and water besides rent and personnel expenses. Thus, the 28 percent of the gross income from health insurance medical services being taxable is not low but, in fact, high.

Public hospitals and the hospitals run by health insurance associations are completely tax-free. When the same medical care is provided for the same fees, there is this much discrimination between public and private medical facilities. There is no other example of such a terrible discrimination we can think of. Private medical care facilities pay tax from their income. Social security medical care is provided today with fees that are unjust as far as the physician is concerned by taxing him for 28 percent of his income as a "favor" given him in the past. If the politicians want to demonstrate the "public nature of the medical profession" in concrete terms, what do they, we wish to ask, expect of the physician and what do they intend to guarantee for him.

If the Government wants to abolish this tax exemption in order to be "fair" to all, then it would mean that the physician would be under no obligation to take on patients he does not wish to examine. He would claim the same freedom as retailers and ordinary wage-earners. He would be free to refuse to make emergency house calls unless he finds the fees agreeable. And he may refuse to perform at practically no fee such public functions as those of school doctors and conducting inoculations and public health services for the community.

The Japan Medical Association (JMA), however, attaches great importance to the "public nature of the medical profession." It is the JMA's conclusion that if the medical profession were to lose this public nature, it would mean the greatest misfortune for the people.

The Liberal-Democratic Party (LDP) says that abolition of the 28-percent tax exemption rate for the physician would prove to the people that its tax policy is fair. But we wish to ask: With what proof would the LDP be able to persuade the doctors? Revising a law may be within the power of the Diet. But revising a law by ignoring social

facts, we must say, would mean a revival of the military-bureaucracy era of our recent history.

(*The Japan Times*, November 23, 1977)

Medical Administration Fails to Keep Up with Medicine

Medical care administration, needless to say, is conducted on the basis of laws concerning medical care. The most important characteristic of these laws is that they deal with all the problems concerning our life from the time we are born to the time we die.

If, then, these laws of basic importance to our own existence were out of tune with the times, what would happen? And they *are* out of tune with the times.

What will happen, then? Medical administration will obviously become chaotic. The true cause of the chaos found in our medical administration is the contradiction between the outdated laws and the medical science that constantly moves forward.

Human society is made up of human beings, and it moves, changes, progresses and develops in various ways. Above all, the progress of science is something that notably alters the mode of human existence.

What we must be wary of is the fact that a great change occurs from day to day in places where we fail to observe it with our own eyes. Small changes that occur every day eventually cause a big turn, and destroy what was once considered as common-sense knowledge.

Take, for instance, the average length of human life. It used to be said to be about 50 years. But during the past three decades, it has been extended by as much as 25 years. This means that the accepted knowledge of 2,000 years has been destroyed.

The fact that plague disappeared from the face of the earth has destroyed a common-sense notion that had prevailed from ancient to

recent times. Other similar examples are typhoid and dysentery which have also disappeared since the end of World War II. Thanks to antibiotics, the diseases which in the past killed practically all patients over 60 years of age, are no longer fatal to 95 percent of them. These are examples of medicine repudiating common-sense notions.

The world of science makes constant progress and the repudiation of common-sense knowledge is a characteristic of the world of medical care. In the past, we used to describe something that went against common sense as nonsense. But today, the fact that a nonsensical notion becomes common sense signifies the progress of society. To reiterate, the source of the chaos we find in today's medical administration is the fact that those responsible for it refuse to recognize the reality of the world, in which common-sense notions are constantly repudiated. They think that the world is fixed and changeless. It should also be mentioned in this connection that very few persons have pointed out this fact.

A law is a principle that regulates society. When a law is made, systems are brought into existence. But the problem is that the laws concerning medical care do not incorporate the fact mentioned above, that medical science constantly makes progress and continuously repudiates common-sense knowledge.

A good example is the health insurance system we have. The law for this system was established 50 years ago when the average life span of Japanese was only 45. This means that the law does not take into account human life beyond that age.

In today's population structure, in which one out of every seven persons is over 65 years old, considerably more than one-seventh of the population is left outside the realm of the health insurance system. In other words, a large number of citizens do not receive coverage under the Health Insurance Law and their number will continue to grow. A law like this, which does not agree with reality, has been preserved since World War II and up to the present time. This inevitably has created a chaotic condition in the system that ought not to exist.

One illustration is the fact that there are several insurance plans.

As you all know, persons working in various occupational sectors are covered by such various health insurance plans as the association health insurance plan, government-managed health insurance plan and the National Health Insurance Plan. What's more, persons who are employed by major enterprises are covered by their own association health insurance plan while they can work and are healthy. After compulsory retirement, however, they must join the National Health Insurance Plan, which is a deficit-ridden scheme and gives much less benefit. In other words, the premium one pays while young and healthy does not help him at all in his old age when he needs more medical care.

The law that ignores changes in social conditions as illustrated by this example is the very source of confusion and self-contradiction found in the medical care administration.

In 1961, we questioned the government regarding this point when it was planning to introduce a system of universal health insurance. We negotiated with the government on the basis of four basic principles, including one for incorporating the progress achieved by medicine into the system.

Since then, much progress has been gained by the implementation of this principle. But the first of these principles, namely, a radical reform of the health insurance system, has yet to be carried out.

It is difficult to alter a system established by a statute once it has become fixed because the various organizations involved with vested interests tend to keep the system intact. Even when a system becomes fixed and static, however, life expectancy continues to become extended. The ultimate problem is the fact that the basic mechanism of the medical care system did not take into account the possibility of the extension of human life expectancy.

In other words, a law is bound to come to an impasse if its makers fail to realize that any system becomes superannuated due to the passage of time and because human life expectancy does become extended. These are two problems inherent in a law concerning health insurance.

In today's Japan, six younger persons support one aged person. At the beginning of the 21st Century, however, four younger persons will have to support one aged person. That is how much the older sector of the population will expand.

Under the social security system guaranteed by the Constitution, the younger persons must provide for the security in life of the older persons. But as long as the old-fashioned health insurance system is the basis of the present system, this will be impossible. As long as the system remains unchanged, healthful life cannot be guaranteed for the aged. Furthermore, a longer life would mean increased anxiety. The national pension system, too, will soon collapse. The pension plans in the various occupational sectors are threatened by bankruptcy as in the case of the Japanese National Railways.

Extended life expectancy, which ought to be a cause for felicitation, adds to human anxiety, which is indeed a new phenomenon. This has come about because those responsible for medical care administration have merely glossed over problems as they have arisen by patching up the law each time without examining the fundamentals of the system itself.

And what has this patching up created? It has meant grafting one branch after another on a 50-year-old tree trunk. It was as though branches of apricot, persimmon and peach were grafted on a single stock. Such grafting does not occur in nature. But this is what is happening in the realm of law at the hands of the people who apparently feel no qualms about it. The existence of many different health insurance plans, emergency medical care and pollution medical care, are the cuttings thus grafted. And this disorderly grafting is the cause of the big confusion we have today.

One false step made in the human survival order tends to multiply itself steadily. For correcting such mistakes, it is necessary to put the old tree trunk in order.

The existence of many different health insurance plans is wrong.

A man should be covered by a single health insurance plan throughout his life — into old age.

It is unfair that premiums and benefits should differ among individuals depending on which health insurance plan they join.

In 1971, the Japan Medical Association exchanged a note of agreement with the government, incorporating 12 points that included the following four:

Promotion of a sense of solidarity among the people.

Health insurance by a single plan throughout one's life.

Separation of labor relations, management and social insurance.

Fairness concerning burden and benefits.

The Japan Medical Association once again demands that the government carry out the 12 points of agreement including the above four because we believe this is the most fundamental approach to the normalization of the medical care administration we have.

(*The Japan Times*, February 9, 1978)

State of Emergency Declared for People's Medical Care

People's medical care must constantly receive the benefit of academic efforts that are not visible to the general public. And there must be efforts made, with the understanding of the people themselves, to relate the knowledge gained by specialists to people's health.

Medical science is required to make constant progress, and likewise the resources for people's medical care are required to expand constantly. This is because the development of medical care resources has a major impact on the prevention and treatment of new diseases.

There are, for instance, as many as 3 million persons in Japan today who are suffering from hepatitis because they were infected by the HB antigen germ. This is the most dreaded contagious disease in Japan today. But it has become possible medically to eradicate it. In order to save the lives of the patients and prevent infection in the future, however, we need the progress attained in the arduous research conducted by specialists and its encouragement by people.

Medical care is socially the most essential thing. But what kind of targets ought to be incorporated into the medical care system is a highly technical question. Medical education, the medical practice system, the postgraduate training system, and so forth, must all be taken into overall consideration. And it is the wish of the Japan Medical Association that people's medical care must not fail as a system.

It is recognized throughout the world that the postgraduate training system of the United States is achieving excellent results in clinical training. After the end of World War II, the U.S. wanted to

introduce this system to Japan, and the Diet and the Ministry of Health and Welfare promptly institutionalized it in this country. We must realize, however, that this merely means that a legal procedure was established, but it was not socially perfected. The status of the intern in Japan turned out to be that of neither student nor doctor. This ambiguous status that confused medical students became a serious problem.

In the U.S., a leader called instructor always works with two or three interns to give them clinical training, sharing their work from morning to evening. Through this process, the instructor teaches his pupils everything — from medical ethics, how to deal with patients, technical tests, how to summarize the results of tests, and how to determine treatment policy. This internship system, however, was introduced to Japan without the instructors. This was a big mistake. Both the Diet and the Government were admirably eager to adopt this good American system. But it eventually proved to be the source of the medical school dispute of recent years, and the students felt uncertain about medical education and developed a strong sense of distrust in clinical training. This is because there were no counterparts of U.S. instructors in the Japanese medical care facilities and hospitals.

It is also true that the U.S. internship system with instructors had many elements that confused the people who had undergone the old Japanese medical education. To begin with, the people concerned did not realize the fact that the medical educational system in Japan was basically different from that of the U.S. And this attempt at introducing the internship system led to the campus dispute, which was a serious development.

Among the persons who designed this internship system, not one is believed to have foreseen the possibility of the system triggering the worst state of affairs in the Japanese educational and social situations. In the light of the present situation of Japan, we of the Japan Medical Association are seriously concerned that if another mistake of this kind were to be made in Japan, it would lead to an irremediably disastrous situation.

There are many conditions that comple us to view the present situation as indeed a state of emergency.

The social insurance and social security systems have been enforced in Japan. But there can be no special medical care system that may be labeled "social insurance medical care" or "social security medical care." We can use the term "social security medical care" only when we take into account all the medical care systems imaginable within the context of the social security system. These should include environmental sanitation, community medical care, community comprehensive medical care, health education, etc. When any one of these is tampered with, it will affect others without anyone realizing it.

For instance, a citizen who pays insurance premiums has the feeling of security and confidence that he can receive a doctor's service whenever he falls ill. Yet, if the system were such that it does not provide a medical service that satisfies both the doctor and the patient, then there is the danger that it might foster mutual distrust and subsequently generate a distrust of the system itself and even social confusion.

The medical care provided under the social insurance system of today, furthermore, is, like the bureaucracy of Japan, vertically divided. Thus, it does not belong in the category of social security. Under this system, the more than 100 million citizens of Japan do not protect their own health together. People belonging to large enterprises and large labor unions insure themselves among themselves, while people in the lowest income brackets covered by the National Health Insurance Plan insure themselves separately. Such a division of the people into separate health insurance groups was unavoidably resorted to when the social insurance system was instituted in Japan. But it is obvious to anyone that this is not in accord with the philosophy of social insurance as such.

In today's society, however, welfare is required as a form of social security. It is natural, therefore, that popular discontent with medical

care should arise. Discontent and dissatisfaction are felt by both physicians and patients.

The basic requirement of the system is to resolve such discontent and dissatisfaction. In short, the problems cannot be solved unless thought is given to the fact that the concept of social security has replaced those of the old health insurance and mutual aid systems. Popular distrust of today's medical care has its origin in this background.

It is human nature that everyone should want to live as long as possible. But the wish to live long is based on the premise that one can live long happily, which means that there must be a well-developed social welfare system. The popular concept of an old person in Japan was an individual with a bent back and a walking stick. Today, however, we see few such old people. We must first of all understand that an old person of today is different from that of the past in terms of the shape and functions of the body.

The same may be said of children. Children of former times were often afflicted with a fatal disease called dysentery. But this is said to have nearly disappeared after World War II. In its place, however, diseases caused by viruses have come to occupy a dominant position in the area of infectious diseases. This has made it necessary for us to think of a new defense system that unifies both social defense and individual defense against these new diseases. Yet, regrettably, there is absolutely no sign of such a future-oriented defense system in the medical care system of Japan. This is another cause of anxiety among specialists on today's medical care.

The way a child develops and the way his cerebrum develops are quite different from prewar years. This might make it necessary to revise the system of education. Yet, there has been no such consideration given in the field of medical care.

In short, one of the characteristics of our time is that social changes and progress express themselves as discontent and dissatisfaction because the system we have is outdated. Yukichi Fukuzawa said, "Arguments in favor of fairness are heard first among the malcontent."

We should be able to expect the government to dissolve the discontent and dissatisfaction of today as we face the future. Yet, the government we have now is concerned merely with immediate problems. The future, therefore, is dark. Today, we have more than 70 medical schools in the country. And yet a clash between the old system and new desires, revulsion against the customs that had arisen in the old system and discontent with future welfare have resulted in anxiety about and dissatisfaction with medical care that have risen despite the increase in the number of medical schools. We earnestly desire the establishment of a system, in which the graduates of medical schools can serve society with high hopes and their unreserved service in the interest of the welfare of the people can be socially and technologically guaranteed.

Japan is achieving notable development as a free enterprise nation. On the other hand, however, because she has a social security system, it has become necessary to establish a new concept of "publicness," which will distinguish Japan from the free enterprise countries of the past. But the adjustment of problems between the rights and duties, particularly of the individual, and public requirements is a very difficult task. To dispose of this problem masterfully is a duty of politicians.

A physician, who is a specialist, must have professional freedom along with his professional duty. When there is an outbreak of cholera, the medical association of the community concerned devotes its entire effort to coping with it. If its members should demand a special hazard allowance or, when the request is not heeded, should refuse to engage in combatting the epidemic, it would mean that they were negating their own professional duty. But the Government of this country gives no guarantee to these doctors concerning their duty to engage in dangerous work. If a doctor should contract the disease and subsequently lose his own life, he is disposed of as having been "unlucky." Under a social security system, however, such sacrificial service should not be expected of a doctor.

As for emergency medical care at night, community doctors accept it as their duty when it could not be avoided. This is the reason

why medical associations are now building emergency medical care centers in their respective communities. Yet the reward for their services is very little. A doctor was killed when he was hit by a truck while making a house call late at night. Another was fatally stabbed by a neurotic patient. Only doctors in Japan are expected to accept sacrifices. But professional duty cannot be one-way traffic.

The economics of "publicness" is a modern science that recognizes full economic guarantee for public services. But this aspect of the economics has not been incorporated into our system. The so-called "unfair" tax exemption rate for doctors is a small part of this guarantee, but in today's society guarantees for the doctors should be far larger. Yet, if the abolition of this small guarantee is to attain "fairness," then it is the politicians' responsibility to make clear the guarantee to be provided for the duties of physicians in a social security state. The prevalence of irresponsible arguments makes no contribution toward the solution of the problem.

When all these things have been taken into account, we find that the qualitative improvement of public opinion and a better medical care system are urgently needed. The Japan Medical Association hereby declares a state of emergency for medical care and expresses its earnest desire to forge ahead, along with scientists and the people, toward a new welfare society of the future.

(*The Japan Times*, March 11, 1978)

A New Health Insurance Plan for a Democratic Society

The Ministry of Health and Welfare recently proposed a plan to radically revise the medical insurance system, which is now being studied by the Liberal-Democratic Party. Such a reform, however, ought to have been made before 1961 when the system of health insurance for the entire nation was instituted.

The Health Insurance Law we have today was enacted in the prewar, feudalistic society. This means that it allows no room for the independence and authority of the people in a democratic society. In the social atmosphere of those years, an employee and his family were taken care of by his employer. The system was called "employees' insurance," which smelled of feudalism. The working masses who became insured under this system thought there was nothing unusual about it.

The employer-employee relationship ought to be confined to one's working place. And the labor-management relationship should be an equal one. Yet, in this feudalistic society, the whole family of an employee had an employee status all their life. This is unthinkable today.

There are many possibilities for a new health insurance system. The most essential point, however, is that it must be based on the principle of separation of the place of work from the community. Once a worker leaves his place of work, he is a member of his community. When we view the employer-employee relationship with this in mind, we find that it is wrong to make the family of an employee subordinate to his employer.

Under a health insurance system, therefore, it is necessary for employees as independent individuals to join in the promotion of community health with their families. It is desirable that the present system, in which the employer pays a part of the health insurance premium for his employees, be abolished, and this expenditure of the employer should be added to the employees' wages. The employees then should join community health insurance plans. This would produce a single unified health insurance plan for the 100 million citizens of the country.

On the other hand, characteristics of the working place should be taken fully into account. The health environment of the working place should be protected entirely at the cost of the employer, and the maintenance of a healthful environment during working hours must be fully guaranteed.

Association health insurance came into being under the primitive capitalist system centered on enterprise, which prevailed in Germany in bygone days. It stemmed from the employer's desire to keep his employees healthy with minimum medical care because the employer wanted his employees to work.

A democratic society, however, requires medical care of a high level, that recognizes the dignity of human life.

Today's health insurance administration is association-centered and an increasing number of health insurance associations are being created in the social strata that have grown with major enterprises and large labor unions at their apex. On the other hand, the Government-managed health insurance plan that covers the employees of small enterprises continues to be financially handicapped. Farmers and employees of small businesses that have fewer than five employees each are covered by the National Health Insurance Plan, in which the entire premium is paid by the insured, unlike the case of the association insurance plan where the employers share the burden of the premium with the employees. Under this system, the smaller one's income is, the higher the rate of the premium he must pay. This is the reason why it is called "upside down health insurance."

How can these problems be solved? Let us list the principal steps:

1. Feudalistic elements must be removed to provide health insurance for a democratic society.
2. The association health insurance system that has nothing to do with society as a whole should be converted into a social security system, which it should have been to begin with.
   - Because health insurance associations are formed by enterprises, there is no mechanism for income redistribution, which makes for an unfair share of costs.
   - Benefits provided by health insurance vary among the associations, tending to create unfairness.
3. Differences in benefits among local governments under the National Health Insurance Plan should be eliminated.
   - If all citizens joined the National Health Insurance Plan in their own communities, its finances would improve.
   - It is entirely possible to supervise and check the administration of health insurance plans on a community basis.
4. Unfairness in taxation should be removed.
   - The profits earned by "mutual aid companies" that are in reality health insurance associations are untaxed.
   - The health insurance associations are authorized to acquire properties freely.
   - The health facilities at resorts owned by these associations are nontaxable.
5. The problem of "additional benefits" should be corrected.
   - The administrators of health insurance associations decide what additional benefits to give their members while the wishes of the members are completely ignored.
6. An employee should not be expelled from the association when he retires from the company.
   - Because of the lack of an income redistribution mechanism, a health insurance association ought to refund the excess premium (from ¥5 million to ¥7 million per person on the average) to a member when he leaves the association.

In short, the health insurance associations and mutual aid associations that have these defects should be quickly abolished to keep pace with the progress of the times. The enormous amount of assets these organizations possess should be incorporated into the new health insurance system to be created. Only by that, a fair and equitable health insurance system, in which all the citizens consistently insure themselves throughout their lives, can come into being.

The present health insurance system was created about half a century ago when the average length of life was 45 years, that is as much as 30 years shorter than today's 75. This would inevitably mean that those above the age of 45 are outside the pale of consideration of this system. The average life span of our people is expected to become 80 before long. This fact alone makes it clear that the present system is inappropriate for the aging structure of the population today.

Of essential importance in reforming the health insurance system is that it anticipates this aging in the future. It is no good saying that we cannot help people getting sick in old age and that they should be taken care of by health insurance. Such an attitude does not help the individuals, and it will eventually destroy the health insurance system itself. It is necessary to create, therefore, a separate "medical care insurance system for the aged," designed to attain the ideal of people "aging healthily."

Yet, the plan the Ministry of Health and Welfare has for the health care of the aged is a system that callously abandons the elderly.

Under the present system, an employee of a major enterprise severs his relationship with the health insurance association when he retires. After retirement, he must join the National Health Insurance Plan, which gives relatively poorer benefits while he is more disease-prone than before. In this way, the National Health Insurance Plan acquires an increasing number of elderly subscribers for whom conditions continue to deteriorate.

Under a new system, we must give priority to this National Health Insurance Plan. We must reject any plan, like the association health insurance plan or the mutual aid insurance system, that permits

the expansion of health insurance associations formed on the basis of the working place. The health insurance plans based on the place of employment at present offer work absence benefits for as long as 18 months whereas the National Health Insurance Plan gives no such benefits to those who must absent themselves from work.

To correct this inequity, it is necessary to provide a separate allowance covering absence from work.

We have stated ideas and basic understandings necessary in thinking about a new system. On the basis of these premises, we propose the following tentative plan and desire the prompt announcement and implementation of a reform proposal along these lines:

A health insurance system in a democratic society should be based on the principle of separating labor management from social insurance and be responsive to the aging of the population.

I. A community health insurance plan on the basis of city, town and village should be established (to give the benefit of regional health care to all citizens).

   Such a system should meet the following conditions:

   (1) The benefits provided by the National Health Insurance Plan at present should be unified.

   (2) Income redistribution on a nationwide basis should be effected.

   (3) The checking mechanism should be transferred from the prefecture to the community level.

   (4) The financial conditions of the National Health Insurance Plan ought to be improved by the inclusion in it of the employee and his family.

   (5) The National Health Insurance Plan should be qualitatively improved on the basis of community medical care.

II. Establishment of a working place health insurance plan.

   (1) The employer is to be held responsible for the preservation of the working environment. This is part of labor management.

   (2) Health should be guaranteed for people working in a poor

environment.

(3) Working place health insurance should be maintained entirely at the expense of the employer.

III. Establishment of a health insurance plan for the aged.

(1) A system should be established for building up the health of the aged.

(2) Characteristics of medical care benefits for the aged should be identified.

(3) The plan should be coordinated with an integrated health program within each community.

(4) The system of giving benefits for absence from work, which at present are given for as long as 18 months, should be abolished because it makes for a big disparity between members of association health insurance plans and those covered by the National Health Insurance Plan. A separate insurance plan should be established to replace this system.

(*The Japan Times*, April 6, 1978)

Let Us Consider Today's Inequality in Health

It used to be said that man's life span is 50 years. It took mankind 2,000 years to reach this level of longevity. Today, the average length of life for men in Japan is 72 and that for women 77, which makes Japan one of the longest living nations in the world.

This phenomenon, which may be called a "longevity revolution," has occurred for the first time in the history of mankind. Factors for this extension of life span are a decrease in infant mortality, the elimination of tuberculosis, a drastic reduction in the incidence of acute contagious diseases, improvement in the standard of living, and development achieved in health education — all accounting for changes in human life.

Japan has traditionally been a nation in which the aged are accorded much attention and reverence. In former times, old folks, taken good care of and respected in extended families, were able to live in security. And because the aged were relatively few, statistically speaking, the burden of supporting one aged person fell on about 15 younger persons. In this age of nuclear families, however, aged persons must live apart from their children and grandchildren. This situation has created a generation gap between the old and the young.

It is inevitable, therefore, that a new medical care system for the nation must be developed to respond to such changes in society. Yet, the health insurance system we have today is merely an extension of what existed before World War II.

The health insurance system was conceived by Bismarck, the great chancellor of Germany, toward the end of the 19th century.

The economics of that time, unlike the welfare economics of today, was aimed at helping people only in their pursuit of profit. The idea of democracy had not yet developed in Europe, either, nor were the concepts of basic human rights or the right to enjoy health known at that time.

The health insurance system, despite its name, therefore, was merely designed as a means of securing a labor force for the capitalists who did not want their employees to absent themselves from work for a long time on account of illness. Under this kind of health insurance system, called the association system, the employer and the employee share the premium on a fifty-fifty basis to secure a minimum medical service for the employee. When the employee's health standard rises, both the employer and the employee make profits. This system certainly is alien to the idea that life is more important than anything else.

Bismarck was a great statesman. But Rudolf Virchow, his political adversary and father of modern pathology, staunchly opposed this health insurance system from the humanitarian position of a physician. His criticism that the health insurance system served as a means of accumulating money is valid even today.

The health insurance system of Japan is an adaptation of this German formula, whose basic premise is to provide the insured with *minimum* medical care.

When in 1961 the Government attempted to introduce the system of insuring every citizen, the Japan Medical Association contested this policy by appealing for improvement of the quality of medical care to be provided under this "total insurance" system with a threat of withdrawing from the system itself.

As a result, we were able to conclude an agreement with the Government, according to which whatever is good for the patient in terms of medical service ought to be provided under the health insurance system. It was also confirmed at that time that there ought to be no discrimination among the citizens with regard to medical care. This event marked the start of the modernization of health

insurance. Very few people, however, understood its significance at that time.

With the economic growth Japan enjoyed in the subsequent years, the association health insurance system has enjoyed a tremendous financial surplus by collecting premiums from the younger employees working in major enterprises that have excellent health management systems. Even today when we have recession, the health insurance associations are earning a profit of ¥600 billion a year.

Under this system, however, an employee loses his status as an insured when he reaches retirement age at 55. The premiums he paid while he was younger for a rainy day are seized by the insurance association he once belonged to; they are not refunded.

The fact that a system with such a serious defect is still in force today is irrefutable proof of the underdevelopedness of government in Japan.

The National Health Insurance Plan that primarily covers the rural population, on the other hand, saw a much lower rate of increase in the income of the insured even during the high-rate economic growth era. Therefore, it could not possibly keep up with the association insurance plan in terms of benefits. With a large number of aged persons who have retired from work as well as the aged in the farming families to cover, this plan itself is like an assembly hall for the aged.

During these years, the local self-governments, controlled by their leftist mayors and governors, instituted systems of giving free medical care to the aged and won popular applause. Consequently, the Liberal-Democratic Party which controls the central government, too, was compelled to follow suit.

Despite the efforts made by the local governments and no matter how much premium the insured might pay, the National Health Insurance Plan could not keep its finances in the black. All this is due to changes in the pattern of life and in the structure of the population, which are basic problems for society as a whole. Yet, these problems were not taken up by the Diet because it was preoccupied with

immediate demands from the people while it neglected the most vital issue.

The Government-managed health insurance plan, which primarily covers small business employees, is also suffering from deficits. But such deficits can be readily dissolved if the surpluses from the health insurance associations are turned over to it. The health insurance associations of major enterprises own more than 3,000 health and recreation facilities throughout the country. These associations are completely exempt from taxation, no matter what facilities they may build or acquire. We cannot blame the farmers and employees of small businesses who see this and become disgruntled.

We of the Japan Medical Association wish to make an appeal about these defects in the present system on behalf of these dissatisfied citizens.

Every individual must have something that makes his life worth living. What, then, is this in the case of young people? We presume that it is to find a meaning in life and to give a concrete expression to one's true self in the way one lives. For such a purpose, the first requirement must be that one continues to enjoy good health.

We are surprisingly indifferent to our health when we are young. Even young persons, however, inevitably age as time moves on. The problems the aged of today face are not something that belong to a world other than their own. They, too, will inevitably come to face such problems. In other words, if the younger people make the aged happy today, they will secure their own happiness in their own old age.

From such a standpoint, the Japan Medical Association has promoted the concept of life science and has been conducting research on the premise that it is possible to create "old but healthy people." Life science is a new science of survival, concerned with the desire of mankind to live in a new survival order.

Viewed from the standpoint of this science, health is something that ought to be built on a life-long basis. For that, a consistent health insurance program is necessary for every individual throughout his

life. For health in one's youthful years is closely linked to that of the later years, which in turn produces the health of the next generation.

It is fundamentally wrong to differentiate the young from the old with regard to welfare. A welfare program at the expense of some people can never be regarded as a welfare program in our new society. Welfare means providing better conditions for survival and creating health for every individual on that basis.

The equality and public nature that ought to be found in social insurance cannot possibly derive from the present system, in which separate insurance plans exist. The basis for the public nature of such a system is to be found in the 100 million citizens of Japan insuring themselves. A health insurance plan under which some people insure only themselves is not social insurance. Furthermore, it is alien to the concept of health welfare.

Health insurance is a system that operates in a bureaucracy. Once it is institutionalized by law, the law does not change even though society changes from feudalism to democracy. This is the cause of numerous faults in the system and of dissatisfaction concerning medical care. We are painfully aware what horrors a superannuated system can produce. We can no longer tolerate in our parliamentary system the health insurance associations that, while enjoying complete tax exemption, callously abandon those who retire while they themselves gain enormous profits from the health industry.

The associations say they are considering medical care for the retirees. But the retirees live in a different society from that in which the health insurance associations operate. The medical care for the retirees the associations talk about, therefore, is a self-contradiction in terms.

It is indeed lamentable that the health insurance law is to be revised under such circumstances.

We are hoping that the health insurance system will incorporate the concept of the people's right to enjoy health on the basis of fundamental human rights and respond to the requirements of the people living in the present age. Only after this is done can we bring

an end to the health insurance system which had its genesis in the feudal society of Germany.

As a principal member of the World Medical Association, the Japan Medical Association is trying to create a new system to replace the old social insurance system.

We advise you to keep your eyes on the Japan Medical Association.

(*The Japan Times*, May 5, 1978)

Silent, Unorganized Masses Deserve Welfare

Because the outmoded Health Insurance Law, with its origin in the feudal period of Germany, is still in force in Japan, the Government has been compelled to amend it somehow every year. But this time, the Government said it would carry out a radical reform. So, the physicians and people alike anticipated a health insurance law that would be appropriate for a democratic society. At the outset, the Government indicated an epoch-making plan based on a very realistic view, namely, that the entire health insurance system would be reorganized as three separate plans — one each for the place of work, the community and the aged.

At the time when the present health insurance system was inaugurated, the average life span of the Japanese people was 35 years; but today it is 75 years. It is natural, therefore, that a separate health insurance plan should be established for the aged. The designation, "employee's health insurance system," is highly feudalistic, and cannot be said to be a designation that gives full recognition to the human rights of the worker. If it had been named as place-of-work health insurance, this problem of inappropriate appellation would have been solved.

But the Government avoided this, and it is necessary to give full thought to why it did so. We believe that this was because the Government wanted to preserve intact in our democratic society the authority of the insurer, which was established in the feudal period, namely, the status of the ruler in the health insurance system. That is the reason why it had to use the term "employee's insurance." Furthermore, the Government withdrew the original label of "radical

reform." This may be said to have seriously betrayed the expectations of the people as well as us who are in charge of giving them medical services.

The Health Insurance Law provides for "medical care benefits." What is meant by "medical care benefits" in this context is overall medical activities, including diagnosis, treatment, medication and patient transfer.

The Government reform plan, however, separates "goods" from "technology," making the patient responsible for paying for all medicines, oral or injected, on his own. If this were to be the case, we could not use the phrase "medical care benefits" in the health insurance system. If health insurance meant only diagnosis, not medical care benefits as well, it would be a "diagnosis insurance" plan, that has no parallel in the world now or will have in the future, and hence a crippled health insurance system.

If a patient goes to a hospital or a clinic merely to receive a diagnosis, he will have to pay for all treatment out of his own pocket. And if he were to receive a diagnosis concerning a complicated health problem, it would mean that he would have to take with him tens of thousands of yen in cash. At present all costs are covered by health insurance and, therefore, a patient can see his doctor without financial worry. If, on the other hand, he has to have such a large sum of cash with him, his opportunity to receive a diagnosis would be inevitably restricted.

"Curtailing consultations" is the primary objective in checking the increase of medical care costs, which is the aim of the Government and the insurers. But this would be indeed "counter-welfare" to the people. We don't believe that such a punitive action against the people should be tolerated.

A health insurance system, which regards its finances as the most important element without taking the dignity of human life into consideration cannot belong to a democratic society, in which human rights must be respected. If the law is to provide for specific acts in respect for human rights, what must be done urgently is to make its

medical care benefits conform to the changes of the times.

According to the reform plan, an employee's bonus, too, is subject to assessment for insurance premium, which means that an employee will have to pay a considerably higher premium than before. Furthermore, he must pay for medicines, whether they are to be given orally or as injections. This means that the value of benefits will be reduced by 20 or even as much as 40 percent. In other words, an individual must pay a higher premium and receive reduced benefits. This is a clear indication that the proposed reform will produce counter-welfare for the people.

If an individual must pay for his own medicines, the health insurance provided by the health insurance associations would not be able to give their members "additional benefits" as they do now. For this reason, the Government says the proposed plan would make the benefits even and equal to all citizens.

Yet, the richer health insurance associations are already thinking of giving "additional benefits" in other forms than social insurance. This would mean that those covered by association health insurance, though they will not receive additional benefits as such under the social insurance system, would receive additional benefits in a different form, thus being able to make full use of the privileges of the affluent. Therefore, the kind of "equalization" envisioned by the Government is not a true equalization at all. What we sincerely desire is a health insurance system that respects the true spirit of a democratic society.

As for the separation of goods from technology, the Government already emphasized this when it prepared the present system, consisting of Table A and Table B (options for medical care agencies working under the health insurance system), clearly stating that Table A was based on the system of separating goods from technology. But today, in actual practice, Table A is highly unrealistic, and, therefore, it is hardly used.

Table A, which is supposed to respect technology is falling into disuse with only a few percent of medical care agencies preferring it.

The Government should recognize this fact and admit its past mistake of separating technology from goods.

The separation of goods from technology planned this time is definitely intended to take issue with the prescription of medicines. Taking advantage of the criticism that doctors overmedicate, the Government is attempting this change, by which, if a patient is to pay for the total cost of medicines, the amount of medication would be reduced and this would in turn contribute to the improvement of the finances of the health insurance system.

The Government plan based on this principle of regarding the insurer's interests as the most important took advantage of the separation of goods from technology for its own contrary purpose.

The Minister of Health and Welfare has been earnestly advocating the separation of goods from technology. But in a free enterprise society, technology naturally ought to be liberalized while medicines may be placed under restriction. Yet, on the contrary, under the Government proposal, the technology of the physician will not freely be assessed but rather placed under strict control of health insurance, while medicines that ought to be controlled will be liberalized. In other words, the Government has misunderstood the idea of separating goods from technology.

When an unconscious patient is carried into a medical care agency, for instance, there is no way of telling if the person has any cash on him. It would be against medical ethics for the physicians to abandon him to die. So they would have to conduct all the tests and give him all the emergency measures. But they would not be able to send the bill to the unconscious patient. Yet, the proposed system does not make clear who is to pay for the costs under such circumstances.

Under the existing health insurance system, doctors take care of a patient, even though he may be unconscious, and later send him a bill. If the system were changed as the Government proposes to do now, however, a patient like this, we fear, would face a very tragic consequence. (According to the initial draft of the plan, the test medicines used in an emergency case like this were not to be covered by health insurance. When the member of the Japan Medical

Association (JMA) on the Social Insurance Council raised a question on this point at the council's April 28 session, the Government revised the plan so that such medicines would be covered by health insurance.)

The Minister of Health and Welfare has decided to carry out the system of separating medication from diagnosis so that medicines will not be covered by insurance. But is this progress in people's medical care? This is a point the people must not overlook. An individual, after paying a large amount of premiums, cannot receive full benefits when he needs them because only diagnosis and not the cost of treatment may be covered. This is indeed a puzzling social system. It is possible that a private medical care insurance plan may be inaugurated to operate in conjunction with the health insurance system. That, however, will mean only destruction of the health insurance system, and certainly not a new direction for it.

There is criticism that the cost of medical care is rising largely because patients receive medical examinations too often and the prices of medicines dispensed are rising sharply. The cost of medical care, however, can be reduced to a great extent by making individuals feel responsible for their own health through health education and by providing a comprehensive health education program.

The problem of the rising cost of medical care for the aged, too, cannot be circumvented. But if we can produce in the future old people who age healthily, which should be possible through health promotion drives, then it would be possible to reduce systematically the cost of medical care for the aged. Promotion of self-restraint on medical care cost by means of raising the standard of the individual's intellectual accomplishments would lead to social progress. But the reform proposal by the Government this time does not take into account at all such a rule of a democratic society.

If the goods and technology in medicine are to be separated from each other, an issue that will inevitably arise will be that of separating the functions of the physician from those of the pharmacist. In Japan, this separation has not yet been put into full operation, nor have sufficient preparations been made for it.

According to the Government proposal this time, a patient receives a prescription from his doctor, goes to a pharmacist's and has it filled, for which he pays cash. The amount of medicines that exceeds ¥20,000 a month will be reimbursed by the health insurance plan he belongs to. But if medical supplies were to be liberalized, this would create the problem of inequality in the share of medical care cost under this proposed system. In an emergency, too, a patient who has to take a prescription to a pharmacist's will have to wake up a pharmacist late at night. Night-time emergency centers are being established throughout the country by the efforts of medical associations. But pharmacists have no such program. As is clear from this, trying to implement a new system by merely changing the relevant law when there are neither social nor academic preparations, would create a state of serious confusion.

The term "reimbursement system" is being used for the first time in the current reform proposal. This system is in force in some other countries where a health insurance system is in operation. In most such countries, there are systems for loaning money to those who have no money. Only in a very few free economy countries partial reimbursement is made. In Denmark more than 10 years ago, the system of reimbursement for medicines was inaugurated — like the one the Government today proposes — but this was abandoned because in less than half a year, it had caused chaos.

The JMA is compelled to speak up for the unorganized masses among the people in order to view the reality correctly and to identify the progress of science with the interests of the people. The Social Insurance Council, Social Security Council and the Central Social Insurance Medical Care Council have representatives from major labor unions and major enterprises on their memberships but none from the unorganized masses in the lowest income bracket. But it is the welfare of these unorganized masses, who number nearly 50 million, to which the JMA attaches the greatest importance and which the JMA hopes to see improved. The present reform plan, including the reimbursement system, we believe, must be re-examined by taking into account the

silent voices of the unorganized masses. Their silent voices must be taken up as the basis of the new system.

In order to urge the Government to re-examine itself, we of the JMA wish to carry out a one-week program of giving prescriptions, not medicines, to our patients. At present, people who receive prescriptions from medical care agencies and go to a pharmacist's can receive drugs without having to pay any cash or by paying only a part of the cost. When the Government-proposed new system is put into effect, however, they will have to pay the entire sum. We believe it will be necessary for people to taste the pain of this system before they are able to make a judgment on this formula proposed by the Government.

We also hope that at this opportunity the people will become aware of the fact that, if the new law goes into force, they will have to do the same thing — that is, take cash with them — as they would during the one-week trial period. If people give thought to how much they would be inconvenienced and how they would cease to enjoy equal opportunity in medical care, it would, we believe, lead to the progress of politics in Japan.

If we shut out medicines from social insurance, it would become impossible for the Social Insurance Medical Fee Payment Fund to check whether a certain medication is proper or not. The JMA is cooperating in the rigorous review being conducted by the Payment Fund on the proper use of medicines. But under the proposed new law, this check would not be possible. That would be a serious loss to the people. The JMA also thinks that this check and guidance is absolutely necessary for the progress of science to become linked with the progress of people's medical care.

If we abandon this reimbursement system and instead adopt the partial payment system, by which a subscriber to a health insurance plan pays a portion of the total cost out of his own pocket, it will be possible for him to receive adequate medical care at any hospital or clinic even though he does not have cash with him. Partial payment must be a basic formula of social insurance, along with the concept of

self-accountability concerning diseases. The reimbursement system serves only the purpose of harassing the people and does not signify the promotion of self-awareness on the part of the people. It merely curbs consultations with doctors and results in wrecking the people's welfare.

Partial payment is in force in almost every country of the world, and many of them have a system by which 20 percent is paid by the patient himself. This self-accountability is recognized as a means of making an individual responsible for his own health. It is dangerous that our Government has deviated far afield from this world-wide trend.

JMA's Way of Thinking

1. We want the Government to show a year-by-year plan for measures that would enable the entire population to share equal burdens and receive equal benefits.

2. The deficit of the Government-managed insurance plan, which the Government is making a big issue of, is only a natural consequence of the system of creating more and more health insurance associations among the more affluent sectors of the nation. The Government-managed health insurance plan itself is not to be blamed for this state of affairs. The Ministry of Finance should accept this fact. The Government should realize that this deficit is a structural problem and take countermeasures accordingly.

3. The association health insurance plan should be abolished in five years and the entire assets accumulated over the years from the premiums should be turned over to the health insurance system of the entire nation.

4. It is a world-wide trend that an individual's responsibility for his own health is being emphasized and cost-sharing in social insurance is being rationalized. For this reason, there is a world-wide formula that the self-payment percentage should not exceed 20 percent. The

Government plan, which makes the individual patient responsible for payments for prescribed medicines, injections, tests, etc. is without parallel in the world.

5. The Government reform plan should omit the expression, "medical care benefits," under health insurance, and refer only to "diagnostic benefits." In other words, the new system would not be concerned with treatment. If a patient has to pay for medicines, it would mean not only the separation of goods from technology but the destruction of medical care itself.

6. The insurer is responsible for collecting insurance premiums and the payments from the individual for the part of medical care he is to share and pay into the insurance fund. He must not interfere with the substance of medical services provided by the physician or restrict the freedom of the insured or curb the opportunity for him to consult a physician.

7. Insurance medical care agencies specialize in medical services; therefore, they will refuse to function as agents to collect money on behalf of the insurer. It is important to clearly define areas of responsibility.

8. In 10 to 20 years, the population of Japan will age rapidly. In order to tide over this crisis, the Government must devote all its efforts to the welfare of the people. It is its responsibility to reveal what measures it intends to take so as to put the minds of the people at rest and allow them to live meaningful lives.

9. The survival order of mankind, globally speaking, requires that a world of peace and welfare must be built on the basis of this new order. In Japan, a welfare state that is closely linked to bureaucratic waste and that favors the privileged who are allied with bureaucrats, is being built. Because this will wreck the Japan of the 21st Century, it must be corrected now. For that purpose, the egoism of the health

insurance associations must be curbed. The people, on their part, cannot live by merely making demands.

10. What we need is a welfare plan to span three generations. The proposed health insurance reform plan is a game of bureaucrats which strays from this ideal.

(*The Japan Times*, May 16, 1978)

Medical Care for the 21st Century

Medical care welfare is not something that may be purchased when it is needed. Every individual in the entire nation must constantly make efforts to secure his own mental and physical health.

One of the most important characteristics of the 21st century as it dawns will be a sharp increase in the size of the aged population. Four younger persons will have to take care of one aged person. This will mean that no matter how much cost the younger people may shoulder, the whole nation will have to be content with low-level welfare. Nor can we hope for a high-growth economy. We must make plans now in anticipation of such a situation.

If we are to ensure that the new aged social stratum to come into being in a little over 20 more years will be made up of healthy aged persons who, unlike the aged of today, will not be subject to hypertension, cerebral hemorrhage and other gerontological ailments, what should we do now? This is a vital question. Our goal should be to consider "aging healthily" in terms of geriatrics and gerontology. If we do nothing about the situation now, the cost of medical care for the aged in the next century will be astronomical. And if we should face the situation unprepared, taking financial countermeasures will be of no use.

The medical care countermeasures of the Japanese Government are based primarily on financial countermeasures. It is not too much to say that there are absolutely no medical care countermeasures in the true sense of the term. True medical care countermeasures should involve matching financial countermeasures of each fiscal year with the

need of securing the mental and physical health of the people on a long-term basis. In reality, however, medical care has been given on a year-to-year financial basis, which means that we have had an enormous waste. Wastes in medical care costs are not of the kind the mass media and labor unions have been pointing out; the true cause of the great wastes must be sought in the fact that only financial countermeasures have been resorted to in medical care.

As our readers know, the aged people of Japan 50 years ago looked truly "old" with their bent backs and with their teeth gone. Today's aged, however, are not like that; many of them are still very lively. This situation has not come about naturally. It is an indirect result of medical care, which people today say was a waste of money. As is evident, whether we can make the aged of the 21st century truly healthy aged people or not will depend on the medical care welfare and finances we will have at of the beginning of the 21st century. Whether we shall succeed in this regard or not depends on the decision we make today.

The way the welfare administration is conducted in disregard of this important aspect of the next century, providing only financial countermeasures on a year-to-year basis and managing health insurance plans for the low-income social strata, may be regarded as an indication of indifference to the medical care welfare of Japan in the future. We must immediately establish a medical care policy with an entirely new basis today. A council of experts on medical care problems was organized a year ago and it has been tackling this problem that had never been dealt with before.

The Japan Medical Association (JMA) has always pursued financial countermeasures with priority on medical care welfare from a long-term viewpoint. When medical care welfare policies succeed, the financial burden will be reduced. A haphazard, unplanned medical care policy cannot be expected to produce anything worthy. Rather, it will create confusion in medical care. No one has pointed out the fact that what is today labeled as confusion in medical care derives from the welfare administration of the past which had no long-term, definite target. The JMA has been studying this problem by expending much

effort over 10 years. Representative of this effort is the new concept of medicoeconomics.

The Government has repeatedly talked about a radical revision of the Health Insurance Law. But "radical revision" meant only financial countermeasures concerning the Government-managed health insurance plan. It was for this reason that the total insurance system, a key element of our social security system, has revealed an abnormal aspect, namely, the deficits of the Government-managed health insurance, mutual aid society health insurance and association health insurance plans.

There is nothing more fraudulent in meaning than the term "total insurance" for the people. Every citizen may be found to be covered by one plan or another. But the reality is that the rich and poor insure themselves separately. This cannot be called social insurance. Unless this system is revised, how can there be a "radical revision?"

Another radical revision should be a revision of the Health Insurance Law that takes into account the essence of medical care countermeasures. If this principle were to be observed, we would need a community health insurance system that places the greatest emphasis on the community nature of health, a place-of-work health insurance plan and a health insurance plan for the aged. The place-of-work health insurance plan is to be established as a major reform of labor administration in the process of the progress of industrialization. An Industrial Medicine Research Institute has already been established, and so has an industrial medical college, indicating the approach to perfection of the academic background of industrial health and industrial health insurance based on the viewpoint of industrial medicine.

On the other hand, the community health insurance plan we have now is the half-crippled national health insurance plan. The funds for this plan are the premiums collected from lower income strata, whose members are insured by the local governments. These are the strata of people who have not benefited from the recent economic growth of the nation or from income redistribution. A resident of a community

has nothing to do with a community health insurance plan as long as he is employed.

A health insurance plan should primarily be one that is based on a community with a background of community medicine and that covers the whole nation. Industrial medicine has been established as a comprehensive industrial medical system under the jurisdiction of the Ministry of Labor. There is no basis on which it may be argued that industrial health insurance must combine with community health insurance.

The basic principle of industral health insurance is that the cost is to be borne by the employer while community health insurance must be based on the characteristics of community medical care. The community characteristics of health and disease would be the central problems of social insurance of the future. They would be subjects of reform in medical care welfare.

The JMA objected to the Health Insurance Law Revision Bill submitted to the last Diet (the Government did not call it a "radical revision bill" because it was not designed for a radical revision) because it did not link with medical care welfare of the future.

We issued the following statement on this bill to bring to light the subservience of party politics to the bureaucracy, urging the Liberal-Democratic Party to reconsider the matter.

Statement

July 25, 1978

The JMA has taken action in order to urge the Liberal-Democratic Party (LDP), the Ministry of Health and Welfare, and members of the Diet who are physicians to search their souls concerning the handling of the Health Insurance Law Revision Bill. To be specific, we discontinued our support of the LDP, issued prescriptions to patients instead of dispensing medicine for a week's period, and confirmed the existence of doctor-Dietmen. In a summing-up on these steps, we also severed all relations with the ministry.

Party politics in a democratic society must represent the popular

will and also be able to develop the future. The politics conducted by the LDP however, was such that it gave people the delusion that the revision bill, produced by inexperienced, low-ranking bureaucrats who had neither practical experience in the field nor social experience on the basis of their myopic visions, was a bill prepared by the LDP. LDP politics has also ignored its own member Dietmen who are specialists in the field of medicine. Merely because the ruling party can appoint one of its own members Minister of Health and Welfare, a bill prepared by immature bureaucrats took the place of a bill that ought to have been prepared by the party in power. This is a deplorable example of false thinking.

The Health Insurance Law Revision Bill stresses only the financial countermeasures concerning the Government-managed health insurance plan but not countermeasures for the future of the people's medical care as anticipated as of the present moment. This is evidenced by the fact that the bill was revised drastically six times from about the time when it was submitted to the minister's advisory council. This in turn proves that its basic ideas were unclear to begin with, reflecting the bureaucratic tendency to flatter public opinion.

The bill ought to have been scrapped by the LDP, which in its place ought to have sumitted its own version. Yet, Minister Tatsuo Ozawa of Health and Welfare did spadework with the opposition and persuaded the LDP to keep the bill in the Diet so that it would be studied in the next Diet.

The JMA has 10 doctor members in the Diet — in both houses. Yet, these JMA Dietmen were not consulted concerning the legislative attempt at its earliest stage. Furthermore, the bill finally submitted was a version prepared by the bureaucracy whithout any relationship with the LDP. The 10 doctor-Dietmen ought to have been responsible for the LDP version.

Yet, the LDP's own basic characteristics as a political party did not permit this. What did happen calls to mind the wartime system of the Imperial Rule Assistance Association (IRAA) supporting the military. What we have witnessed is an identical situation, in which the only difference was that the bureaucracy replaced the military. The

LDP is an embodiment of the wartime IRAA arrangement.

Because such a situation destroys the great expectations we have for 21st Century Japan, we, the JMA, resorted to firm action: each of the JMA member-Dietmen prepared a notice of withdrawal from the LDP membership and the notices were collected in the hands of one person ready to be submitted at any moment. Although these notices were not actually submitted to the LDP, it would have caused considerable confusion if they had been, in the light of the present situation of parliamentary government in this country.

The way this matter was handled left something to be desired when viewed by a third party. But the doctor-Dietmen, who had the absolute support of the JMA, were thus able to make their presence felt in the LDP with the preparation of the disaffiliation notices.

On July 19, LDP Deputy Secretary General Kunikichi Saito visited JMA headquarters as a proxy for the LDP Secretary General, Mr. Masayoshi Ohira, and promised that the LDP would officially create a subcommittee within the Medical Care Basic Problems Study Council. This subcommittee will remove subversive elements from its membership and in their place appoint at least four doctor-Dietmen. Mr. Ryutaro Nemoto, chairman of the council, is to serve as chairman of the subcommittee to prepare an LDP version of the bill to replace the Government version. At this meeting with Mr. Saito, I sharply criticized the attitude of the LDP, which I viewed as a political party that adulates bureaucrats, and noted some indications of Mr. Saito agreeing with me in his criticism of the LDP. To restudy the bill at the responsibility of the LDP with members on the subcommittee, who are physicians and members of the JMA, is something that the LDP naturally must do as a political party.

Because it was confirmed at this meeting that the fact that this had not been done represented a major error in our government, we decided to continue our support for the LDP.

On July 21, three members of the LDP, Messrs. Buichi Oishi, Shigesada Marumo and Noboru Minowa, visited the JMA headquarters and conferred with me. At this meeting, no one mentioned the matter of the party disaffiliation notices. Since the

matter had already been resolved, we decided not to pursue the subject.

I made strong demands that in revising the Health Insurance Law, full discussions should be conducted on not the problem of year-to-year finances but on how to deal with the aging of the population while maintaining the system of total insurance for the people, what kind of revision was necessary for that purpose, and what kind of health insurance law was needed against the background of the progress made in gerontology and geriatrics.

As seen from the above, we may say that the problems concerning the LDP and the ministry have been more or less resolved. The significance of the one-week period during which the doctors issued prescriptions instead of dispensing medicine was enormous. It made clear that there was very little desire on the part of the people for the so-called separation of the functions of the physician and of the pharmacist and an absolute majority of them wanted prescriptions filled at the place where they received medical diagnoses in the interest of saving time and trouble. It also became clear that because there were extremely few joint dispensing centers, which the JMA had strongly demanded of the Japan Pharmacists' Association, a sharp disparity between what the pharmacists' association had been advocating and what it practices was brought to light.

The issuance of prescriptions to patients has the effect of familiarizing them with the substance of the medicine they are to take. But the patients have an absolute faith in their physician, and therefore there was no indication of any desire on the part of the patients to know the contents of the prescription they were receiving.

The problem of medicines is a subject of various discussions, and many regrettable points have been exposed concerning the process of drug manufacture and distribution mechanisms. It was also brought to light that major hospitals had drug companies on the black market and were distributing medicines among themselves at unimaginably low prices. It was also found that state hospitals were collectively bargaining over pharmaceutical supplies.

Smaller medical facilities cannot possibly match these large

organizations in the amount of drugs they consume — a fact that made it clear that smaller-scale doctors were being forced to purchase expensive medicines. There are prices listed on direct mail pamphlets. But these are "decoy" items on the black market and are totally different from the items being purchased in large packages by practitioners. We cannot but entertain serious doubts about the sincerity of the Ministry of Health and Welfare, which, in collusion with some members of the Diet, revealed such figures as though they were honest figures.

The problems of drug prices are not those in which physicians are involved; rather, they are a responsibility of the pharmaceutical enterprises, drug wholesalers and the Government agencies that supervise them. From the standpoint of the physician who uses these drugs, we wish that good quality medicines can be obtained through proper channels, and we want people to understand the foolishness of the bureaucrats pressing demands on the doctors throughout the nation with the black market price list.

In short, the severing of relations with the LDP and the ministry and the one-week period of issuing prescriptions by the JMA had the salutary effect of promoting true parliamentary politics, clarifying the responsibility of medical specialists among the legislators, and bringing to light the enigmatic attitude of the administrators concerned that had given the people the impression that the entire pharmaceutical industry was operated on the black market.

We wish and also intend to see to it that the subcommittee of the LDP will prepare a good bill in the interest of the future of our country and the development of health for the people against the background of medicine and pharmacology.

Taro Takemi
President, Japan Medical Association

We must absolutely reject a Health Insurance Law, which refuses to recognize the existence of man by regarding disease as an ordinary risk without understanding the human body that is the object of health insurance coverage. The most important thing about the human body is its response to the environment. The creation of a healthful environment is of primary importance in medical care. We Japanese have been made painfully aware of how the destruction of the environment by industrialization affects man and impairs his health. The fact that we have attained the longest life span despite this unfavorable environment simply demonstrates the remarkable contribution made by medical care.

Therefore, we find it impossible to understand on what basis some people today claim that medical care is in a state of disarray. Of course, medicines must not be abused or overused. But the use of medical supplies with attention to details has been a major factor in salvaging the health of the Japanese people in the deteriorating environment. Those who say that medicines are the source of all evils ought to revise their attitude by realizing the fact that medicines have extended the longevity of the people of Japan in the deteriorating health environment of Japan.

The health insurance law for the medical care welfare in the 21st century must take into account the following:

(1) Community health insurance must cover the 100 million people of Japan against the background of community medicine that deals with the community characteristics of disease and health.

(2) Industrial health insurance ought to be separated from community health insurance. Industrial health insurance has industrial medicine in its background, and it should be managed by the Ministry of Labor. Community health insurance, on the other hand, should be under the Ministry of Health and Welfare. A general research institute for community medicine ought to be established to improve the academic background of community insurance.

(3) When the entire nation is covered by a community health insurance plan administered in each city, town and village, the finances of the present-day national health insurance plan will become entirely

new. Each local government will have its own health insurance center, which will have as its superstructure a national coordinating agency, that is to determine the benefits to be given by the health insurance plan. This will make for perfect income redistribution. Some of the payments now being made by patients, such as the initial consultation fee, can be handled without troubling the medical care agencies.

(4) The old people's health insurance plan should be based on the deposit formula by which the insured start paying at age 25. They will have their blood pressure and other matters checked for gerontological diseases when they reach 40. This system will establish a guideline to enable people to age healthily and to produce healthy old people. This will greatly reduce the cost of medical care for the aged in the future.

(5) Major support must be given an organization to encourage the development of the pharmaceutical industry for its modernization. It is also necessary to give medicines a more public position than they have today.

In short, medical care for the 21st Century has already been started. We cannot afford to keep out people under the old bureaucratic law even a day longer.

(*The Japan Times*, August 23, 1978)

Health Insurance System Should Be Radically Revised

The health insurance law created by Bismarck more than 100 years ago remains in Japan in a primitive form. The state-controlled medical care system based on prewar feudalistic ideas and bureaucratic power that ignore changes in life culture, the industrial structure and the increase and aging of the population, still prevails today.

The health insurance system produced two major errors in our postwar democratic society. One of them is that the system ignored the fundamental principle of 100 million people insuring themselves under the total insurance system. The other is that it deliberately forgot to give the Health Insurance Law the function of redistributing income as we progress toward a social security state.

That the system forgot the ideas of social security and guarantee of survival besides the primary purpose of insurance, namely, the dispersal of risk, resulted in a vacuum period of 40 years that cannot be retrieved. This is the reason why cries of financial crisis in the Government-managed health insurance plan and national health insurance plan, which cover the lower-income people, have risen.

The extension of the life of mankind throughout the world is altering human society. In the world of health insurance, the prevalence of geriatric diseases has driven into a crisis finances of health insurance plans for lower-income people. The Government is feverishly trying to make the aged pay their own medical costs and restrain people from receiving medical attention. There is no humanism here. Why does the Government keep intact the health insurance system of the eras when there were few people over 45 and cause anxiety to the people who can now live longer?

If we made full use of gerontology and geriatrics and stocked up premiums from age 25 to prepare for old age and started rational preventive medical checkups from age 40, the number of people who would age healthily would increase tremendously.

The system of community medicine is called the primary care system. When new scientific measures are introduced to it, a world of new welfare, which no amount of financial countermeasures can ever produce, will come into being.

The medical care system of Japan has provided merely financial countermeasures but not medical care countermeasures. Financial countermeasures accompanied by medical care countermeasures were denied by the bureaucracy. And party politics was unable to destroy this obstacle.

As we said at the beginning, what will be sought from health insurance in the welfare society of the future will be a system of social security.

Social security is a system of security for survival and not merely one for curing diseases. Survival security includes public health, environmental health, clinical medicine and health education. For our survival security we need to cure diseases just as in the health insurance era. But preventing people from becoming ill is survival security under a social security system.

The requirements for living long are aging healthily and building an enjoyable and peaceful society. Without health, there could be no peaceful and enjoyable society. To build such a society would require preventive measures against people suffering from geriatric diseases and other ailments. The health insurance systems of the past which were useful only when one became ill did not incorporate the idea of preventive benefits. When we enter the stage of survival security, we shall have to provide preventive benefits.

Therefore, when we try to guarantee survival from various positions, it will not be sufficient merely to improve the finances of health insurance. There has occurred a big change which makes it impossible to establish financial countermeasures unless we establish a sound medical policy.

In the old health insurance age, it was sufficient to provide financial countermeasures for making the insured pay their premiums and give them benefits within the limits of the revenue. When we enter the stage of social security, this will not do. On the contrary, we will have to make an "income redistribution mechanism" that fully works.

In order to fully carry out medical care countermeasures, we will need financial countermeasures. We have come to a point where we must bring to an end the social insurance system that incorporated the idea of dispersing risks on the basis of the old concept of financial countermeasures. Furthermore, we shall have to consider a new system, in which a medical care plan and a financial plan for new survival security are combined.

From now on the regionality of health and diseases will become highly important. Regardless of where one might work, one cannot get out of the bounds of community medicine. This is the reason why a community health insurance system becomes essential.

The basis of a health insurance system should be a community health insurance system. This should be organized at the city-town-village level and it would be desirable to create a city-town-village health insurance center equipped with a computer. Bookkeeping concerning billing for medical care services should be conducted at the community level, where full auditing is necessary.

If this city, town, or village health insurance center works fully, it can be connected to the insurance center at the state level by means of a computer. This will make it possible to adjust and coordinate the separate health insurance systems at the city-town-and village level. This will also mean equal benefits on a national basis. The great objective of equalization of health insurance benefits will be thus realized.

With the introduction of computer science, clerical work will be simplified and administrative costs will be greatly reduced. When all individuals join the community health insurance plan, furthermore, there will be no need for the state to subsidize 45 percent of the

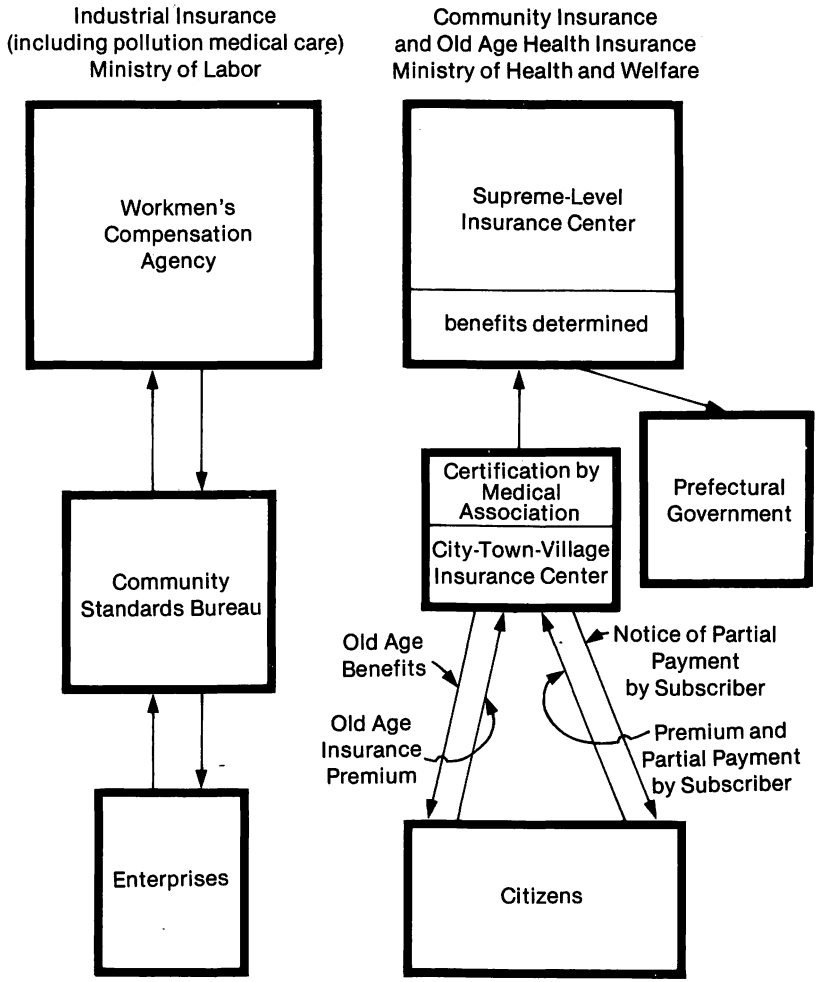
benefits now being given the subscribers to the national health insurance plan.

A baby born today is expected to live to be 80 years old. When the individual becomes 25 years old, he joins the old age health insurance plan by paying the premium. When he is 40 years old, he can receive the benefits of medical checks against health disruptions resulting from aging, as mentioned before. When this system is put into operation, it will perhaps be possible to reduce the mortality resulting from cerebral hemorrhage to less than one-third of what it is now. Other cerebrovascular disorders and old age diseases will also be greatly reduced with the consequent drop in the amount of health insurance benefits to be given for old age diseases.

People will be working in good health and they will have the double and triple joy of being able to contribute to social productivity. To unify all the health insurance plans for the 100 million citizens of Japan on the basis of the community health insurance system will not only effect smoothly the redistribution of income and equalize health insurance benefits but also unify the purpose of life for the Japanese people.

As for industrial insurance, the workmen's compensation health insurance system under the supervision of the Ministry of Labor, can be improved with industrial medicine as its background, which would make it possible to establish countermeasures for any problem that may arise with the progress of industrialization. Such an industrial health insurance system will make a very important contribution to the guarantee of survival in an industrialized society. The community health insurance system and industrial health insurance, when combined, will provide complete security for survival for every human being.

Industrial insurance will be at the expense of the enterprises as is the case at present. Today, allowances for injuries and diseases are provided by health insurance. Such payments that belong to the category of labor management, however, may be either covered by industrial insurance or paid directly by enterprises.



By establishing a system like this, it will become possible to operate social security completely on the basis of medicine and by planning. This will also mean eliminating financial waste.

We not only wish to make up for the lag of 40 years in health insurance but also hope to establish a perfect medical care insurance

system in Japan by revising the present system with forecasts for as far ahead as the first half of the 21st century.

(*The Japan Times*, September 21, 1978)

New Medical Care Provides Basis for National Development

In all ages, health is the foundation of human happiness. However, the meaning of health changes gradually with the times.

Japan is said to be heading into an age of stable economic growth. This means that there will be no business prosperity and that we cannot, or rather should not, expect the kind of reckless high economic growth we have hitherto seen in view of limited supplies of natural resources and environmental disruption. And we must not forget that this stable economic growth is coming on the heels of high growth in which we have experienced a rise in the standard of living and the diversification of wants.

It is repeatedly said that Japan will fast become an aging society.

In short, Japan needs to promote out health more than ever before in order to reduce the nation's economic burden. At the same time, health will become even more important as a prerequisite for human happiness; that is, the value of health will increase further.

Medical care is intended to maintain and promote health by applying medical science to society. It includes not only diagnosis and treatment of patients but also preventive care and rehabilitation. As a result of the progress of medicine and related sciences, the problem of heredity has arisen at the molecular biology level on the one hand, and it has become necessary to handle mental problems in terms of their relationship with society, in the form of community psychiatry on the other. Environmental problems must also be discussed not only in terms of pollution but also from the standpoint of ecology, and a psychiatric approach must be made to the social environment.

Medical science of today, which has such a broad scientific background, has been making progress hand in hand with many natural and social sciences. Contemporary medical care, based on such a broad scientific basis, is concerned with every aspect of human life, and health in our time cannot be protected without medical care in a broad sense.

Protection of the health of individuals also means protection of not only their happiness but also social health and social happiness. Medical care also can contribute directly to social health, as it should from the standpoint of medical care in a broad sense, and forms a part of the foundation of national administration. To our regret, however, Japanese politics is not aware of this. We cannot find an instance of measures incorporating long-term plans based on this idea. This is not limited to politics. We cannot but conclude that no one — among people ranging from those engaged in mass communications molding public opinion to insurance authorities in charge of the greater part of the finances of national medical care — seems to understand this veiw of ours on medical administration.

Application of medical science to society must be based on medical ethics. Medical care is directly concerned with human beings and it cannot exist without mutual trust, not only between doctor and patient but also among people, and without a mutual understanding of what is meant by respect for life. The ethics of contemporary medicine are based on respect for human life and for learning. Ethics, however, cannot be forced on people. Ethics can have a real meaning only when one understands and observe them on one's own. This is because ethics involves value judgments, which is a spiritual problem, in connection with the application of learning to society. Ethical behavior requires an environment that encourages and promotes human efforts based on understanding of medical care.

Making a great fuss about a very small number of extreme examples of unethical behavior does not contribute at all to creating a good environment. It is merely a harmful action that causes undue misunderstanding of the whole situation.

Ever-increasing medical expenses have become a problem in many countries of the world. This phenomenon is explained as a consequence of the increased value of health resulting from the progress and spread of medical science and the rise in the standard of living.

In view of the future aging of the Japanese population, it is no doubt important to reduce medical expenses. However, whether medical expenses are great or small is determined on the basis of long-term results of medical care and is also affected by the relationship between the standard of living and desire for health.

Needless to say, there should be no waste of medical expenses. The development of antibiotics due to the progress of medical science has made it possible to control many infectious diseases, and has changed medical therapy completely. It is a gross mistake to think that the resultant increase in medical expenses is a waste.

There are towns and villages that can more than balance their medical budgets despite the fact that they extend guidance on life care and health administration service to citizens from age 35 and free medical care to elderly people from age 60. Some spend only one-tenth as much as other small municipalities in medical expenses.

Under the Old Age Health Insurance Law, health control service is extended to citizens from age 65. However, this results in a big waste and is not effective. It is the government's policy to exclude elderly people from the Health Insurance Law in order to allow the health insurance plans run by health insurance societies to make money and continue to operate. If the situation is left as such, we will never be able to bring a welfare state into being.

The health insurance system is supposed to exist as a major part of the medical security system for the protection of the people's health. It provides the greatest economic basis for medical security.

Of course, this does not mean that all medical care should be provided under health insurance. However, any plan designed to cope with the aging of the Japanese population, which will become a most pressing problem hereafter, will call for a mass approach from the

standpoint of public health and also carefully thought-out measures for individual citizens. Medical care cannot produce effective results unless it is based on mental and physical medical data on individuals collected over a long period of time. It requires primary care, which harmoniously combines public health and therapeutics. It must also involve human relations between doctor and patient, which have been protected and fostered in this free society at the proposal of the Japan Medical Association in the course of medical care under insurance. This is the reason why we call for the inclusion of preventive care in old age health insurance.

To our regret, Japan's existing health insurance falls short of social security. We have repeatedly pointed out that it essentially cannot fulfill its function because it depends on profit-seeking health insurance societies, which are something like private enterprises, and also because there are too many insurance plans, constituting a structural defect. From the national viewpoint, it is very unfair to leave the big profits of health insurance societies untaxed and the medical institutions under their direct management uninspected, thereby permitting them to monopolize profits and medical care for the benefit of their limited members only.

It is nothing less than negligence on the part of government authorities to leave the situation as it is without dissolving the health insurance societies. It is hoped that they will deal with the problem resolutely. It is very gratifying for the future of Japan to note that the people have come to show a greatly increased understanding of this point. We hope that the health insurance system will be drastically reformed into a system capable of providing true medical security, that is, a system centering on community insurance.

The National Federation of Health Insurance Societies, a body of executives of health insurance societies, adopted a resolution at its national convention in November, calling for a campaign to demand maintenance of the system of profit-earning medical services offered by health insurance societies and at the same time to detect "illegal billings" by informing their members of the medical expenses incurred by them.

It was an attempt by the health insurance society executives, who felt a growing sense of crisis from the pressure of public opinion, to sidestep the true problem by giving the people the impression that it was "illegal billings" by doctors that were responsible for the increase in medical expenses.

Their act, aimed at estranging the people from doctors, is intended to undermine the relationship of trust between doctor and patient which is most important for medical care. As already mentioned, the sharp increase in medical expenses in recent years is a problem common to all developed countries, and they have been making efforts to cope with it. The national federation's campaign, which is detrimental to the relationship of trust between doctor and patient, will result in destroying the foundation of national medical care.

Although the health insurance societies talk about the welfare of salaried workers, they keep silent about the fact that their members must leave the insurance plan when retiring under the age limit, leaving behind several million yen in unused insurance premiums they paid while young, and join the national health insurance plan or other plans whose benefits are on a low level. It is most irresponsible for the societies not to say a word about this dark gap between the time of retirement and the start of free medical care for elderly people at the age of 70, the age group most susceptible to illness. From the standpoint of the lifelong welfare of salaried workers, the existence of health insurance societies of this kind is, if anything, a disadvantage.

In view of this situation, we propose once again the Japan Medical Association's idea that all existing health insurance societies should be dissolved, all people integrated into one community insurance plan and this plan supplemented with old age insurance and industrial insurance plans.

(*The Japan Times*, December 23, 1978)

The JMA in a Free Society: What It Thinks and What It Does

The Japan Medical Association (JMA) is making feverish efforts to link the enhancement of the health and welfare of the people of Japan with medical services. Under the feudalistic bureaucracy, the medical association was only a substructure of the bureaucracy. During the war in particular, there were times when officers of the medical association were appointed by the Minister of Health and Welfare. In the free society achieved after the war, the JMA came into being under the supervision of the Public Health Section of the GHQ of the Supreme Commander for the Allied Occupation Forces.

At that time, the Japanese doctors had an asset not known in other countries, that is, the fusion of their proud professional tradition and their patients. Yet, the Occupation forces, who were ignorant of this virtue of the Japanese system, revised all the medical affairs laws and regulations to conform to the American system. Serious excesses were noted in some sectors. An example was the newly imposed rule that a patient must not stay at a clinic longer than 48 hours. Another was the attempted forcible separation of the services of the physician and the pharmacist. The policy of the American Army occupation of Japan ultimately replaced the controls by the Japanese military. We must remember as a historical fact that this was done according to instructions by the military. Authoritarian administration was most prominently demonstrated by the Occupation Army. And many facts that we must not forget prove, furthermore, that the greatest servants of the Occupaton Army were the bureaucrats, particularly those of the Health and Welfare Ministry.

The JMA acted on its own, apart from the Occupation

administration only after 1957. The Occupation Army attempted to carry out several socio-biological experiments in Japan. The Health and Welfare Ministry bureaucrats respected its wishes and carried out steps in preparation for introducing a new controlled medical care system in this free economy society called Japan. They used such organs as councils or study committees under the name of democracy. But this ultimately amounted to sham democracy because these organs had as members those individuals who supported government proposals. The fact that the new bureaucrats, who had been trained before, during and after the war through controlled administration and controlled education, were inclined toward authoritarian controls even in this age of democracy was obvious in many of their plans.

In 1957, the Health Insurance Law was revised to institute a system of designating both medical care agencies and health insurance doctors. This meant that even a private practitioner with his own clinic had to be designated by the Government as a medical care agency operating under the health insurance system. Likewise, even if he practiced at his own home, he had to register himself as a health insurance doctor. Unless these two conditions were met, no one was authorized to provide medical care under the system. But we found out in time that the system was the major premise for introducing a state-operated health care system, and we succeeded in having it relaxed in its actual enforcement though the two conditions are technically still in force today.

The history of the relationship between the JMA and the Health and Welfare Ministry is one of a clash between an authoritarian bureaucracy and the medical profession underneath the surface. But when a minister happened to be one who considered a progressive democratic society, while checking the bureaucracy under him, the relationship became one of cooperation between the two. In reviewing the history of the past 20 years, we find that the ministers who clashed with the JMA have left nothing meritorious behind them, while the efforts of the ministers who followed democratic policies in cooperation with the JMA have gone down in the history of Japanese medical care as shining achievements. When the Liberal-Democratic

Party (LDP) proved a faithful spokesman for the bureaucracy by following the control-oriented consciousness of the bureaucrats, the relationship between the LDP and the JMA was a history of clashes. When government was conducted to achieve new democratic developments, then there was an invisible clash between the LDP and the Health and Welfare bureaucrats.

In effect, the history of the relationship between the LDP and the ministry on the one hand and the JMA on the other may be described as a history of confrontation with authoritarian administration rather than one of controversy in government concerning medical care for the people.

The JMA established the following basic principles from its professional position and with deep consideration for what the people's medical care should be:

Firstly, the establishment of **community health insurance study commissions.** Since 1957, we have established these commissions in cities, towns and villages, which were to have on their memberships representatives of people, autonomous entities, medical organizations and men of knowledge. On the common recognition of the importance of community health, these commissions were to compete with one another for the development of the communities they worked for. They were to serve as an organized, democratic forum on public health with the participation of inhabitants throughout the entire geographical limits of community medical care. The fact that such community health study commissions were created throughout the country means that such studies could not be conducted without the participation of the communities. They cannot be conducted by medical associations alone. In a large number of these communities where the commissions were established, medical care problems have been solved locally. The participation of inhabitants in dealing with community health problems represented a new form of citizen participation, different from the usual form of consumer sovereignty.

Secondly, **the opening to the public of technology and**

finances. In Japan's traditional medicine, the profession was passed on by heredity or from teacher to disciple. In any event, the generational transfer of medical knowledge was usually cloaked in secrecy. The JMA, however, established a policy of making medical knowledge open on the basis of the principle that in a democratic society both the technology and finances of medical care must be made public, and without this principle medical science could not hope to achieve a major development. This principle was established by the JMA without any relationship with the Ministry of Health and Welfare. This policy was implemented by the creation of **clinical testing centers** and **medical association hospitals** in the communities. With these facilities, the physicians in the communities were able to introduce new up-to-date clinical tests into community medical care and the substance of the technology thus introduced became public. The privacy of the patients, of course, must be respected, and this is 100 percent observed.

What a patient has been tested for and how much the cost was, however, are all open and public. In a medical association hospital, a member physician exhibits his technology to others or to leaders invited from outside to seek their comments in order that they can all benefit in terms of progress and development. When this system was introduced, furthermore, the checking of the payments for social health insurance compensations was being conducted by the auditing committees in cities, towns and villages. This meant that medical care on this basis was financially open and above board. It is an indisputable fact that the opening to the public of technology and finances has made a major contribution to the technological development of the communities. This system has made it possible for a remote village to offer medical care of the same standards as that in a city that has a medical college. Improvements made in the area of clinical tests have made possible early detection of diseases, which in turn enables early treatment. In some areas, this has created organizations designed for the promotion of health. The medical association hospitals of today vary in size from one area to another. In any event, however, the

hospitals enable private practitioners to use the kind of equipment and facilities they cannot own as individuals. The result is that the public benefits from high-level medical care.

Besides the items mentioned, in some communities, special homes for the aged play a major role. Furthermore, some communities have health promotion centers. All these create a wonderful picture of the development attained by community medical care.

In effect, the principle of making public the technology and finances of medical care will continue to be observed. The public nature of medical care, too, should be made absolutely firm on the basis of this principle. The medical association hospitals in the communities play the role of postgraduate training centers besides being general medical centers. In small communities in the mountainous regions, the hospitals serve also as emergency care centers and sometimes even as night emergency aid centers. This shows that medical association hospitals are performing varied roles according to the needs of the communities in which they operate. Some even have accepted the role of managing quarantine hospitals on behalf of the local governments in the areas.

The unpublicized endeavors being made by medical associations for the development of a new democratic society are very much appreciated by the inhabitants of the communities concerned. Yet, they do not have the dramatic qualities of the kind labor union activites have. But we must not lose sight of the essence of the scientific activities involved there.

The problem of mental hygiene is the most important problems not only in medical care in an industrialized society but in the societies to emerge following the era of industrialization. For problems of this kind, community mental hygiene activities are extremely important. The JMA has taken the initiative in developing mental hygiene activities in the communities and in workplaces in cooperation with Lions Clubs and other community organizations.

School health problems are of utmost importance to the youth who will be shouldering the country's future. Community medical associations are taking various measures to cope with the problems.

They hold, for instance, an annual conference of school doctors for school health, where doctors, auxiliary health personnel and dieticians get together to study their common problems. This is not widely publicized but we are pleased that this is one of the most important annual events for school health.

In the past the JMA often conducted a campaign for closing medical services on Sunday. But whenever this was carried out by the members of the JMA, there were always doctors on duty even on a Sunday in each community. In those years, doctors were working 24 hours a day, or they worked all day Saturday or even half day Sunday. In short, they had no regular weekend holidays. Under these circumstances, the average life span of doctors was shorter by two years than the national average. The treatment of the workers who worked with private physicians, too, left much to be desired. In view of such a situation, the JMA issued an order that the member physicians should not have to work on Sundays. But the duty doctor system later developed in each community and has become an established system. This doctor's holiday system also spawned the night emergency medical care centers and holiday emergency centers. Yet, we feel that very few people know this.

The JMA is not an organization whose activities are designed to cause the people trouble. We are conducting our activities at all times with the ultimate expectation that they will augment the welfare of the people. Thus, our activities should not be viewed in the same light as the activities of groups aiming at gaining a short-term wage raise. It is regrettable that people's understanding of this is lacking.

The JMA has developed a national blood donation campaign in cooperation with Lions Clubs with great results.

An even more remarkable achievement in the area of medical care by the JMA was the positive participation in the effort to establish the National Cancer Center. It was known that it was impossible for one university or a hospital to solve the problems of cancer. The JMA proposed to the government that it should be handled as a state project and played a central role the creation of the National Cancer Center. When this happened, the Ministry of Health and Welfare strongly ob-

jected to the term "center" used in the Japanese title, "Kokuritsu Gan Senta," on the ground that the world "senta", which is a loan word from a foreign language could not be used as the official title for the facility. The JMA, however, explained to the ministry that this proposed facility was a hospital and a research institute at the same time, and therefore, was to be a special medical care facility without a precedent. Thus, it had to be called a "center." The minister of that time understood this and acted in favor of the legislation.

After that, we saw the creation of adult disease centers, medical care centers, emergency aid centers. This creation of medical care facilities other than hospitals and clinics, with diversified functions was due to the endeavor by the JMA which destroyed an old barrier in thinking. And these were all directly related to medical care welfare for the people. More recently, we saw the birth of a circulatory disease center, where all researches and clinical consultations are carried out concerning circulatory disorders and cardiac disorders. This, too, was a consequence of the introduction of the "center" system.

This adoption of the "center" formula linking academic progress with the actual life of the people was indeed a splendid achievement or a global perspective. The National Cancer Center became the cancer center of the world in five years with its international position firmly established today. The initiative taken by the JMA made possible such an international accomplishment in the form of a cancer center by removing the barriers created by school cliques and factions and by abolishing undesirable old customs. The JMA fervently hopes that through the expansion of this center formula more clinical and research facilities will be established and efforts made for fully securing and adequately distributing the resources of medical care welfare.

In recent years such new sciences as medical care sociology and medical care economics have come into existence with major international impact. Yet, in Japan it is only the JMA that has been taking up these new sciences. We have a life science society as one of the specialized medical science societies, and we have held interdisciplinary conferences on the subject with the participation of specialists from the fields of economics, sociology and religion. We

also have an organization which enables the results of the symposiums to be reflected in medical care. We cannot find such a future-oriented interdisciplinary organization background anywhere else in Japan.

As for supplemental education for physicians, we hold social insurance leaders' training programs in Tokyo where, through the cooperation of the Ministry of Health and Welfare, personnel in the payment fund and of local insurance departments under the ministry take part in the program. Through the cooperation of the top-level leaders in the scientific field, we plan to have lecture meetings on the latest findings of basic medicine and clinical medicine which, combined, contribute to sociomedical measures. The substance of such lectures are, furthermore, to be disseminated to the local communities by the participants in the program in Tokyo through lecture meetings held in the provincial cities. Such a supplemental lecture program represents the new phase of training for doctors after their graduation from medical school and not an extension of medical school education. This is the characteristic of the leaders' lecture meetings.

For purely clinical matters, lecture programs essentially on clinical medicine are held in the interest of community medical care in each prefecture throughout the country. Every practicing physician is obligated to take this course once every five years. Unless public opinion as such has an understanding of these scientific activities in medicine, we cannot expect to find a perspective that spans the gap between the present and the future. In this regard, we believe that the people themselves must have a better understanding of the specialized nature of medicine.

The measures taken by the JMA are subject to long-term follow-up studies, which is something the ministry is totally unable to plan and execute. Take, for instance, our program of giving medical care guidance on a 15-year basis to villages in Japan with the highest infant mortalities and studying countermeasures by mobilizing specialists from the entire field of medical science. As evident from this illustration, we have always acquired preparations and means for the development of a new area of community medical care. We wish to state here that we cannot expect a systematic development of people's

medical care with a mere juxtaposition of haphazard ideas or with flippant arguments.

In a certain locality a night emergency aid center was created. On the first night of its operation, ambulances were called out 200 times in this city with a population of no more than half a million. People living in the neighborhood of the center were unable to sleep because of the sirens. Of these numerous calls for ambulances, only three cases required hospitalization of the patients concerned. The rest were cases that did not require emergency handling during the night.

This instance illustrates the social phenomenon of the abuse of a right combined with the lack of health education at home. What happened in this instance cannot be overlooked as a reflection of public opinion. The mass media tend to accept public opinion uncritically. We want the public to know that there is a big distance between such an attitude of the mass media and the professional attitude of the JMA concerning medical care.

It is from this standpoint that the JMA is conducting health education for the people's medical care. The Health Education Committee is always active in the JMA. At times, it is active in specified areas. At other times, the medical associations of cities, towns and villages give appropriate guidance. They sometimes give such attention to the parents-teachers associations of public schools, and they also participate in dealing with problems of school health, or in the administering of vaccination and other public health programs.

We regret very much the fact that the people merely accept these various medical care activities of a public nature being conducted by the JMA and its affiliate branches as their right.

The JMA is highly dissatisfied with the fact that the opinions of nonprofessional organizations such as the health insurance associations and the Japan Federation of Employers' Associations, which exclusively take sides with the consumer as sovereign, are given undue play in politics. The result is the confusion of the consciousness of the people through the mass media. The JMA participates in and co-sponsors programs with the mass media, such as the medical seminar sponsored by Asahi Shimbun. We want the people to know

that the JMA stints no cooperation in meaningful programs. There is no ground at all for our being criticized as a self-righteous academic organization. The JMA also cooperates with Nihon Keizai Shimbun, which annually organizes a health exhibition.

The biggest canker of medical care for the people of Japan is the medical care administered by the health insurance associations, which are medical care enterprises, and the activities of the health insurance associations. The public nature of medical profession is the largest basis of medical care welfare. If the government were to carry out measures that would deprive the profession of its public nature, we feel the future is dark for the people's medical care. And the JMA will not assume any responsibility for such an outcome.

(*The Japan Times*, January 15, 1979)

If the Health Insurance Law were Revised

The Health Insurance Law Revision Bill, introduced by the government to the Diet, is closely tied up with the budget, and the government seems to be firmly determined to have it passed.

The Health Insurance Law has been revised every year, while its feudalistic residues have remained intact, only to keep its financial balance. It divides the population roughly into the following three categories with their respective health insurance plans:

The wealthy — Association Health Insurance Plan; small business people — government-managed health insurance plan; self-employed ultra-small business people — National Health Insurance Plan.

All except a very few would wonder how such a class system of a feudalistic nature lives on in our strictly democratic society. The rich insure the rich and the lower-incomed people insure the lower-incomed, the rich not caring a rap about the others. This is the framework of the "total health insurance system" that has been placed over us as a residue of the feudal era.

Under this system, the government-managed plan covers only the lower-incomed while the self-employed persons in the lower-income category are covered by the National Health Insurance Plan. Both these plans are suffering from serious deficits.

On the other hand, the association health insurance plan is operated on the basis of each enterprise in total identification with the enterprise itself. The association pursues profits through medical services. Therefore, there is no ground for dealing with it as a social

insurance plan. And yet, the health insurance associations have a tremendously big say concerning the health insurance system itself. This must be said to be a reflection of the political posture of the government slavishly serving wealthy corporations and big labor organizations.

The association health insurance plan deprives individuals of a large amount of premiums while these persons are young, healthy and capable of work. During this period, one seldom falls ill, and by the time he retires at 55, he has forfeited from ¥2 to ¥7 million on the average in terms of premiums to the health insurance association he belonged to. The associations claim that they produce surpluses because of their "managerial effort." This however, is not an effort; the surpluses must be considered the result of the benefit gained by society as a whole through the improvement of the people's standard of living and of the progress achieved in medicine. The very fact that the health insurance associations use the term "managerial effort" indicates that theirs is not a social insurance plan. With this term the associations themselves are admitting that they are merely groups that make money by capitalizing on disease.

These associations yield profits of nearly ¥300 billion annually, but they do not reveal to the people how this money is used. Such "managerial effort" and shady income are sufficient to raise doubts about the "modern quality" of social insurance.

The Health Insurance Law, as we said above, deprive workers of a large insurance premium before they retire. In response to this criticism, the health insurance associations have been saying recently that they will look after their former members if they pay ¥300 a month. Yet, this is merely an example of "malequality." This is impossible for poor associations. Aside from that, it is unlawful to dispense medical services to individuals who are not members of an association. This measure is nothing but an instance of the health insurance associations deceiving the post-retirement ex-members only because they have been criticized. There is no nation-at-large basis at all.

Under the health insurance plan, when a person receives medical

service at a hospital or a clinic for the first time, he must pay out of his own pocket what is called "partial payment," which is not covered by health insurance. This is often commonly mistaken as a consultation fee or as part of the doctor's income. Actually, however, this "partial payment" goes into the pocket of the insurer, namely, the National Federation of Health Insurance Associations. It has nothing to do with the income of doctors. The doctors are, in fact, forced to act as agents to collect this fee without remuneration for the service. The health insurance association officers regard this "partial payment" as something like an admission fee with which to prevent the members from receiving excessive amounts of medical care. In the case of the admission fees for movies and plays, the higher they are set, the fewer people would go to see them. This is, in fact, the line of thinking by which the "partial payment" has been established. It is indeed an insult to the intelligence of the people.

This "partial payment" is at present ¥600, payable at the first consultation. When the law is revised by the current bill, however, the amount will be raised to ¥1,000.

The "partial payment" is charged against a person who is hospitalized on a daily basis. This, however, is also a device by which the health insurance associations hope to minimize the length of stay in hospital for each patient. It does not go into the treasury of the hospital. The money is paid back to the patient through his health insurance association, which means that the doctors, clinics and hospitals are being compelled to lend their hands to this wasteful system.

The proposed bill is designed to raise the "partial payment" by a large margin. And a patient might think that the ¥1,000 he will be paying will be a consultation fee. But it will not become a part of the doctor's income. It will all go into the coffer of the National Federation of Health Insurance Associations, the insurer. The plan to raise the fee is also designed to make it appear as though the doctor's income will go up that much. The people must be more watchful about such a trick being used by the health insurance associations in

the name of social insurance. The "partial payment" for medication is 50 percent of the cost. This reflects the intention of the insurer of allowing a patient to take as little medication as possible. It does not in any way represent what the doctor is thinking or the patient is hoping for.

If the bill is passed, as the government and the Japan Socialist Party hope, then the functions of the doctor and the pharmacist will be separated. It would mean that a patient receives a prescription from a doctor and then goes to a pharmacist where he has to pay one-half of the price of medicine. If he cannot pay this money, he will have to forgo taking the medicine that he needs.

Today's physician does not engage in such a heartless practice. It is regarded as a virtue among most physicians to make the "partial payment" for his patient when he cannot afford it. If the separation of medical services and the filling of prescriptions is put into effect, and if a doctor refuses to give his patient the medicine he needs only because the patient cannot pay the "partial payment," then the doctor will be denounced for his inhumanity.

The National Association of Health Insurance Associations promotes such an outrageous plan because it wants to boost its profit. The masses of our country must pay close attention to this fact.

The government intends to implement this kind of cruel policy of victimizing those people covered by the government-managed health insurance plan and the National Health Insurance Plan, who will be forced to pay a large amount of money when they become ill. The people must recognize the fact that this takes place because the health insurance associations do not surrender to the government the money they have taken from the people in the name of "health managerial effort." If it were not for these health insurance associations, the people would not have to sustain the increased financial burden.

Many of the associations refund the "partial payment" to the members afterwards. This means that a member of one of these associations who pays the "partial payment" at his doctor's clinic, for instance, has his money reimbursed surreptitiously. Some office

workers find this system convenient because it gives them some income unbeknownst to their wives. As far as the individuals are concerned, this may be an innocent pleasure, but the system is an instance of great social unfairness.

The proposed revision of the Health Insurance Law makes the burden heavier for the lower-incomed people, which would mean that they would have less chances of receiving medical care. Yet, this is exactly what the government aims to achieve. The lower-income persons include a large percentage of the aged. Yet, these aged persons had to pay premiums when they were younger and working. After they retire and are no longer young, they must join either the government-managed health insurance or the National Health Insurance Plan, under which they must pay the "partial payment" out of their pockets in order to receive medical care. This must be said to be indeed a cruel policy.

The Diet is now debating the revision of the Health Insurance Law. And the Japan Socialist Party is most ardently insisting that the association health insurance system be preserved. Yet, it does not dispel doubts about whether the system is really one for social insurance. The large labor unions, which belong to the Socialist Party, see nothing wrong with the amount of the "partial payment" to be increased because their members have it reimbursed by the health insurance associations they belong to. The enterprisers, on the other hand, are the ones who are trying to seize every opportunity to make profit. Therefore, they rather welcome their own health insurance associations pursuing profit. Debate in the Diet will now take up the bill article by article. The people must keep a watch on the debate.

The Liberal-Democratic Party is now considering the establishment of a unified fund system for the disparate health insurance associations we have. The health insurance associations, however, will not accept this plan because they have been pursuing a thoroughly commercial managerial policy. The entire system cannot be renovated unless the associations repent their past sins and the premiums they collected are turned over to a unified fund directly. If

we are to establish a health insurance system for the entire people and rid social insurance in our country of the feudalistic class system, it would be necessary to have the premiums paid into the unified fund. Only by this will it be possible to make a financial readjustment of the health insurance plans covering all the employed persons and also contribute to the solution of the problems of the National Health Insurance Plan. This, of course, would be difficult to realize as long as the big capitalists and large labor unions fail to understand the true essence of a democratic society.

The present trend is toward an increasingly larger number of the aged and an increasing disparity in income. Under such circumstances, there is no way of foretelling for how long the present conditions may last. There is nothing more unfortunate for the people of the future. The health insurance associations, where 11,000 welfare officials are enjoying their second careers, can continue to exist as agents for collecting premiums. The association can thus support these officials. It would be possible to augment the coverage of the workmen's compensation insurance by introducing modern industrial medicine into labor administration. It would be also possible to extend by a large margin the period of years of work for the aged by offering preventive medical benefits in terms of industrial medicine.

The only means with which to respond to the accelerating aging of the population of Japan would be to enable the aged to work longer through the achievements of modern industrial medicine. We must know that there is a limit to how long we can tolerate the present feudalistic system of health insurance being maintained under the label of social insurance. When Japan comes to the crossroads between doom and survival without being prepared for it, there would be no means for survival. The people of Japan can safeguard their own welfare if they reorganize the health insurance system during the next quarter century.

The Social Insurance Medical Fee Payment Fund is an agency which collects premiums and checks the doctor's bills before repayment. The health insurance associations are supposed to make an

advance deposit of one and a half months. Yet, many large labor unions have defaulted this. And, in reality, the premiums collected by the government-managed helath insurance plan are being used to make up for the deficit by the associations. This problem of the Payment Fund is being taken up as a realistic one in every prefecture.

How is one to explain the fact that this is not publicized at all? It merely indicates how cowardly the Payment Fund is toward the big capitalists and big labor unions. We want the people to know that in many prefectures the lower-income individuals are advancing payments for the more affluent.

Ultra-small businesses have very weak organizing power. Those covered by the National Health Insurance Plan have no power for organizing. The unorganized masses belonging to these minute businesses are the worst off, and their condition would become even worse if the revision bill were passed. This would indeed mean the loss of the basis for the people's health welfare.

The health welfare of the unorganized masses must be considered the basis for the health welfare of the entire people. The fact that the unorganized masses are victimized at every opportunity by the organized masses reflects the fact that a democratic society has been built on a feudalistic basis. Such an unnatural condition must be removed as soon as possible. The health welfare of the unorganized masses under a democratic government is what we most ardently wish for. And this will be the firm foundation for the Japan of the 21st century.

(*The Japan Times*, March 28, 1979)

Readjustment of the Health Insurance System — the Wish of Millions

The health insurance association system we have today is a relic of the age when labor management and health insurance were not separated from each other. If we were to build a welfare state now, these two would naturally have to be separated. By separation, the health insurance system can develop into a system in which the 100 million citizens of this country insure themselves.

Labor management, on the other hand, must be established as a separate system in each workplace in every category of work. By law, health insurance is a matter within the jurisdiction of the Ministry of Health and Welfare while labor management is under the supervision of the Ministry of Labor. These two have the historical destiny of having to develop both at the national and at the local community level.

The plan proposed recently by the Liberal-Democratic Party (LDP) to adjust the finances of the varied health insurance plans is designed to remove health insurance from the existing health insurance association system in order to allow it to develop separately from the labor management system. This is a praiseworthy plan that translates into reality a political ideal of Japan for the 21st century.

During the ages when our industry was at an undeveloped stage or at the level of small business or agricultural society, the association health insurance plan did have its responsibility as harbinger of health insurance in this country.

In those years the average life span of the Japanese was nearly 40 years. Today it is approaching 80 years. Japan has also become

one of the most developed industrial societies in the world. Under such circumstances, labor management naturally has had to achieve great development. And yet it remains still unseparated from the old health insurance system because the present system of labor management has come to be regarded as the bridgehead for providing the workers with worker's welfare in view of the industrial development achieved by Japan. With various standards for health management established, including those for safety and hygiene, and every conceivable statute in force, labor management has become highly specialized and it is now nearing a state of perfection along with the progress of industrialization in our society.

It is recognized by objective observers, however, that the outdated health insurance system can no longer work today.

A new system has been brought into existence for the worker's welfare by the enterprisers, who seek perfection in labor management. A further development of Japan as an industrial state will inevitably require a higher level of industrial medicine. For this reason, too, it is already evident that the health insurance association has outlived its usefulness.

While Japan's economy has attained remarkable development, it was inevitable that economic development in the farming regions of the country could not keep the same pace with that in the industrial zones. For this reason, the association health insurance system became confined within the industrial zones while the people's health insurance system, managed by the government, remained within the farming regions, and small businesses had to accept the government-managed health insurance plan. There was no income redistribution among the people covered by these three different health insurance plans. But this condition can no longer be tolerated.

The medical care system on the basis of a health insurance association formed by the employees of each enterprise may be said to be primarily motivated for seeking profit from giving its members medical care. It is an indisputable fact that health insurance associations have accumulated vast amounts of funds. In some hot-

spring resorts, there are more spas owned by these associations than there are inns. This must be said to be indeed a strange phenomenon. These spas, furthermore, are made use of by only a small portion of the membership of health insurance associations and not by all the members. Furthermore, the fact that these spas are tax-exempt must be said to represent a privilege enjoyed by the insurance associations. That the health insurance associations possess much real estate acquired with the profits from providing medical care is a clear proof of the true nature of these associations as business enterprises. Many of our citizens feel there is much inconsistency in the fact that these properties owned by the health insurance associations are tax-exempt. Likewise, everything that is classified as health-facilities derived from pursuit of profit represents dividends paid to association members.

On the other hand, the people's health insurance plan continuously suffers from deficits. The state is required to give it a large amount of subsidy annually in order to help people in the low-income bracket. The same is true with the government-managed health insurance plan that covers small businesses.

Profit-seeking enterprisers are making efforts to acquire whatever they desire through their business activities and to develop themselves further. But it is strange that the health insurance associations of business enterprises regard the ill health of their members as the basis of their profit-making activities. The fact that these associations call this a "business effort" in itself makes us suspicious of their true intentions.

The LDP's recent proposal for the fiscal readjustment of the health insurance system (which is designed to deal with not only association health insurance but also the mutual aid associations of civil servants, which have a far older history) proposes to remove the health insurance element from the system to make it distinctly separate from the labor management element. The scheme may be described as an example of great statesmanship aimed at developing the health insurance law of a welfare state.

That the enterprises with the labor unions at their core are

objecting to this scheme because of their own profit motivation signifies a retrogression to feudalistic society. It must be adjudged as moving in a direction opposite to the development of a democratic society.

The mutual aid associations have not objected to the LDP plan, showing their willingness to live with the new age. Economic organizations and labor unions, on the other hand, are fiercely opposed to the LDP plan. This must be said to be an indication of their failure to grasp the meaning of the era in which they live. If the people concerned are to think in terms of their enterprises, they ought to favor the policy of separating labor management from the health insurance plan in the interest of augmenting the welfare of the workers. That they should try to keep the medical care system of the future in the hands of labor unions, which are very much like feudal societies, must be said to represent a great anachronism.

The fiscal readjustment of the health insurance system need not be regarded as suggesting state-managed medical care. It is indeed illogical to conclude that this fiscal readjustment plan means a shift to state-managed medical care. Through a system of firm cooperation with the Japan Medical Association concerning the establishment of a scientific basis of health insurance medical care, the government is attempting to raise the level of medical services to a much higher academic level than that of today. This plan is directly related to the improvement of the medical care welfare of the people. It is diametrically opposite to the attitude of the insuring organizations that seek only monetary profits.

As it was recently reported to the World Medical Association, a meeting of the ministers of welfare of the EC countries decided, in the face of the rising costs of medical care, to nationalize the management of hospitals. This is one response to the fact that hospitalization constitutes a major portion of the medical care cost in the EC nations. But such a proposal cannot solve the problem of medical care expenditure, which in some of the advanced nations has already exceeded the level of 10 percent of the GNP. These countries thus suffer from a major financial problem.

The countries that have a complete state system of medical care welfare, including the three Scandinavian countries, have suffered a rise in the costs of medical care because of state management. As a result, their peoples have become idle and, because of their increased dependence on the state, the countries have suffered retrogression in industry. This is a fact well known throughout the world. The Japan Medical Association is doing its utmost so that Japan will not follow in the footsteps of these predecessors in welfare.

Preparations are already being made for the practice of a new medical care system by asking the government to establish primary care. A council of medical care specialists has been established within the Ministry of Health and Welfare to bring together the best brains in the field in Japan to lay the ground for the establishment of this new medical care system.

Today's medical care is essentially concerned with the cost of medical care needed when a disease has fully developed. In other words, it is an insurance system designed for dealing with the cost of terminal medical care. Under the primary care system, however, efforts will be made to come to grips with a disease at its more essential and primary stages. It is intended for detecting and dealing with diseases at early stages. This will mean that a major reform will be needed in the medical education and postgraduate training program for doctors. For such a major improvement in the systems for training and developing doctors, it will be necessary to consider the development of instructors. This cannot be done overnight, but efforts in that direction are now about to be started.

In order for such a primary care system to prevail throughout the country, too, the social insurance scheme should not inflexible. We believe that the unification of the various health insurance plans through fiscal readjustment will play an important role in the development of primary care.

It is from such a standpoint that the Ministry of Health and Welfare has already begun tackling the task of developing instructors needed for the implementation of a primary care program. Doctors sent overseas are now undergoing the necessary training. We believe

that what we need now is cooperation on a nationwide basis with the measures for the radical solution of the economic problem of medical care. We also need to introduce into our country the fruit of progress achieved in the world.

We find it difficult to understand the insistence at this time on the perpetuation of a health insurance association which came into being in a feudalistic society.

In the primary care system, the development of medical care is to be achieved in a comprehensive manner in each community against a background of the economics of new medical care. This means that we can anticipate progress at a far greater pace than under the present-day medical care circumstances.

Medical care for the people in the 21st century will have to be primary care. What we mean by primary care here is the kind of medical care we can attain by establishing medical care as well as the necessary economics for dealing with diseases in their early stages. This can be achieved by detaching ourselves from the medical care and economics of fully developed diseases.

For primary care, the system of medical care must be improved on a broad basis.

This will involve health education, including the problems of the welfare of mother and child based on human biology. It might also mean that pediatrics may achieve community-level development by fusing with the science of health for children. With regard to other diseases, too, primary care will totally renovate medical care. Such a system, we believe, will lead us into the 21st century.

The enthusiasm with which the Japan Medical Association hopes to turn the future of Japan into one that is rich in welfare for the people has a global basis in science. It has nothing to do with profit motivation. The Ministry of Health and Welfare has already demonstrated its interest in primary care by its cooperation with WHO on the implementation of a primary care program. If these conditions of the present time were to be obstructed in the interest of preserving the feudalistic association health insurance scheme, it would mean depriving the people of national welfare in the 21st century. The

proposal made by the government on fiscal readjustment is at least one of the measures that take into account what welfare administration of Japan in the 21st century ought to be. It often happens that a progressive policy is resisted by existing organizations. But if we surrender to these objections, it will mean our losing our future as a nation. It will also mean suicide for national welfare. We must start thinking at this very moment how to make it possible for a country like Japan that has few resources to improve the people's life and augment welfare while maintaining the present order. If we lost this opportunity today, we would lose our future forever. We wish to promote the effort from a nationally unified position to change over to a new system by discarding at all costs outdated views of society, workplace egoism and the egoism of business enterprises.

(*The Japan Times*, June 13, 1979)

We Want You to Know at Least This Much Before the Election

There are several things we want the people of this country to know by all means before the coming general election. The reason is that a general election is held every two or three years, yet the welfare for people that should be improved efficiently by government does not seem to be making much progress.

Take, for example, the first report prepared in 1950 by the Social Security System Council headed by Chairman Hyoe Ouchi. This report explicitly stated that the various health insurance plans should be integrated from a long-range standpoint. Another example is the fact that the same council recommended that a financial adjustment of the various health insurance plans be carried out immediately as though the council at that time had foreseen the deficits the system suffers today.

That the important recommendations by the Social Security System Council of 30 years ago have not yet even been implemented seems to prove that the improvement of government is a very slow process.

The people have been putting pressure on the government and parliamentary representatives by winning public pledges at times of election concerning emergency medical aid and other problems. Thus there appears to be considerable progress. And yet, the financial readjustment of the health insurance system, which is one of the basic premises of these health care problems, had not been carried out despite the 1950 recommendation that it be implemented immediately.

We want the people to know before the coming election about this irrational way of conducting government.

The first meeting of this council offered a long-term viewpoint in detail concerning medical care problems, the pension system, and other issues facing the nation. Giving a direction for improvement and progress for Japan's welfare, the document may be said to have been an epoch-making piece of advice. The fact is that none of the recommendations contained in this report has been translated into reality.

The recommendations made by the same council in 1962 were also very important. As in the case of those of the first meeting, however, there is hardly any possibility of their being implemented.

No matter how often elections may be held, government makes no progress at all. This we must understand.

Mankind's life expectancy has been extended measurably and we must think of things in terms of life cycles. Yet, Japan alone hangs onto a health insurance system adopted at a time when the average longevity in Japan was only 40 or above. The old health insurance system is still used by making peripheral adjustments for the present age when the average life span is 77. This is utterly unnatural. To impose an unnatural, deformed system on the people cannot be said to be an expression of proper government. This is another thing the voters must take into account at the time of election.

This is not all.

In the world of medical care, the trend now is toward the establishment of a comprehensive medical care system with emphasis on primary care by discarding the old health insurance system which was designed only for dealing with diseases when they became serious. This new medical system is making it possible on both short-term and long-term bases to deal with disease in its very first stages and prevent it from worsening. If the health insurance system, which is the basis of a health care system, however, were to remain stale and unimproved, progress in primary care would be inconceivable.

Primary care means the most fundamental medical care. And the

education of primary care physicians means education on what should constitute basic medical care.

In Japanese medical education, however, we find the curriculum, adopted from the Germany of 100 years ago, fixed by law. This is one of the problems that ought not ot be overlooked from the standpoint of educational administration.

As for the form of medical care, within the Ministry of Health and Welfare, the Medical Affairs Bureau is endeavoring to promote the fostering of primary medical care physicians to fit the new form of medical care. Yet, the Insurance Bureau within the same ministry is trying to stop it.

It is the destiny of the world to have to develop a new medical care system with a global view. To develop a medical care system under which the whole world lives peacefully and prospers together is a task that not only faces Japan but one that Japan as a major economic power must lead the rest of the world in developing. Japan must develop as a country that can offer to the world its medical science as a means for medical care through interchange with the countries of Asia, the Middle East and Latin America.

Yet, the fact that there is no such readiness for an international endeavor must be said to suggest the absence of government. In our country there is a highly developed technique for diverting the attention of the people from the lack of progress attained by government by satisfying their short-term desires. The people, therefore, must guard themselves against being thus deceived.

There is nothing more fearful in the world of welfare than to lose the whole future for the sake of immediate benefits.

When we review the bureaucratic government of Japan over the past 30 years, we find there has been very little that has rewarded the efforts of the people. The country is turning into a paradise for bureaucrats while there is very little prospect of a democratic people's culture blooming. We think this is a great shame. The public pledges made at election time should not represent the demands of the people for immediate gains. Politicians must attempt to solve immediate

problems while considering the welfare of the people from a long-term standpoint. At each election we wish to fulfill this duty as citizens of the country.

It has been reported that the government-managed health insurance plan is in the black and it has been explained that this is because there has been no outbreak of influenza recently. But we cannot agree.

When we conducted a survey on deaths in a certain area in Metropolitan Tokyo we found that 42 percent of these deaths occurred at home. This is hardly conceivable in Tokyo, where the number of hospital beds is larger than the average for the nation. Such a statistic actually shows the effects of the system that requires low-income people to pay a certain sum at admission to a hospital or an initial fee at each first consultation with a doctor. This is a highly alarming state of affairs.

The Insurance Bureau of the Ministry of Health and Welfare has said that the black ink in the government-managed plan is due to the fact that there was no epidemic of influenza as though the matter was of little concern to it. These health insurance bureaucrats seem to have no consideration for the people who, because of these extra fees they must pay besides the insurance premium, were unable to avail themselves of proper medical care and had to die forlornly at home after being abandoned by the medical care system. Even though the government-managed health insurance plan may be in the black, we as doctors view with great sorrow and alarm the fact that the lower-income people are suffering as victims of the system.

The ministry also seems to be pleased with the fact that, according to its survey, the number of outpatients at hospitals has decreased. What they must not forget, however, is that the greatest sacrifice is suffered by lower-income people, among whom impaired health is most prevalent.

We believe it is desirable that the voice of these unorganized masses be reflected in the results of the election.

The drugs used by doctors under the health insurance system,

that is, the prescription drugs, for which there are official prices, carry labels indicating the diseases for which they are designed.

When pharmaceutical companies produce a new drug, they report to the ministry with data to prove that the particular drug is good for a particular disease. As long as this is proven mathematically, the university professors on the Pharmaceutical affairs Council automatically approve it.

It is natural, therefore, for pharmaceutical companies to claim the effects of their drugs by listing the maximum numbers of diseases in order to seek maximum corporate profits.

Under such a system, there is no room for a clinician or a university professor, no matter how competent he may be, to intervene concerning the use of drugs.

A drug must be prescribed according to the knowledge and discretion of a doctor who uses it on his patient. Yet, under the old system, he has been restricted by the drug manufacturers who gave only names of diseases on their products. There has never been a more serious instance in history of the denial of the doctor's right to prescribe.

The Minister of Health and Welfare recently admitted frankly this ridiculous instance of pharmaceutical administration. This may be regarded as one instance of progress.

Previously, organizations which made profits from medical care, such as health insurance societies, used to conduct a check on the prescriptions written by doctors. From now on this will not be possible. Drugs will also be prescribed by doctors according to pharmaceutical principles, and this will mean that all patients can take medicines without anxiety.

The recent decision by the government solved this problem. But we must fully realize how serious the collusion was between the manufacturers and the drug administrators and how impotent medical scientists were.

As we said before, the financial readjustment of the Health Insurance Law is the first step in the radical revision of the law itself.

The major enterprises and their major labor unions that object to this change, however, are attempting to unify social insurance under big capital and major labor unions by bringing under their wing the small businesses that subsist by receiving orders from these major enterprises.

It is a serious thing that health matters should be brought under the influence of big capital despite the principle that disease must not be made an object of profit-making. This is because, if this were to be effected, those who are not affiliated with major enterprises might be accorded very inferior conditions concerning their health.

The lower the income of people, the better the terms of welfare they deserve. But if control by big capital becomes real, the situation will be the reverse of what it should be.

The Japan Medical Association is totally opposed to the attempt by the avaricious health insurance societies and major enterprises to bring under their influence the medical welfare of the people.

The heartlessness of these big corporations who are attempting to abandon the lowest-income-bracket people with their false sweet talk that they will give help to the deficit-ridden government-managed health insurance plan, we fear, casts a dark shadow over the future of Japan.

We must be on guard against this attempt by major enterprises at placing small businesses under their control.

A general election will be held soon. We want the politicians to formulate a bright and progressive welfare policy with this election in the interest of the people with a global outlook. If each general election serves to build a new future, then we can anticipate that government in Japan will become the sort of government that offers bright hopes for people in the next century.

We earnestly hope that this coming election will promise the start for a new future by eliminating today's social chaos.

(*The Japan Times*, September 19, 1979)

No More Need for 'Misimproving' Health Insurance

Under the social insurance system of Japan, there is an iron rule by which the rich insure the rich and the lower-income people insure the lower-income people without income redistribution between them. The health insurance society represents a combination of the power of the business enterprises and that of the labor unions. The health insurance association may be said to exist for sucking up profit from the people through medical care.

The government-managed health insurance plan covers people in the lowest-income bracket. Businesses even in this bracket, however, are encouraged to form their own health insurance associations if they are financially sound so that senior bureaucrats in the health insurance sector of the Ministry of Health and Welfare may join such health insurance associations as leaders to complete their formation. This is one of the reasons why government-administered health insurance plan remains one of the three major deficit operations of the government, the other two being the national railways and the rice distribution system. The deficit in the government-administered health insurance plan is structural. But the government never admits this.

Because the fees doctors got for their services were paid out of the funds derived from the revenue of this government-administered health insurance plan, the government's basic policy was to keep the payment to the doctors at a minimum. It is not too much to say that this way of determining fees for medical services on the basis of the finances of the government-administered health insurance plan has

distorted medical care in Japan. We must realize that this mistaken policy of paying a small amount of money to the doctors while refusing to pay them the proper compensation for their technical skill has been long followed. The doctors, in the meantime, have gained profits from the difference between the price of medication they administer to their patients and that of the medicines they obtain from pharmaceutical companies. Likewise with the profits the hospitals gained from the difference between the payment they receive for the meals of their inpatients and the cost of these meals. Such profits have been tacitly approved as compensation for the doctor's technical skill. This means of compensating the physician for his technical skill is not to be found anywhere else in the world.

The bill to revise — or misimprove — the Health Insurance Law now in the Diet is said to have been submitted because the Ministry of Health and Welfare insisted on reducing the deficit in one of the three major deficit operations of the government. In reality, however, the bill is a camouflaged device for bringing a huge profit to the health insurance associations. This is so because even though the lowest-income people may suffer terribly after the bill is passed, the wealthy health insurance associations will become even richer. With this legislation the government intends to help these health insurance associations become so rich that they can do anything they want to by themselves.

When this bill is passed by the Diet, a patient must pay ¥1,000 each time he consults a doctor. This initial consultation fee, however, goes into the pocket of the insurer, the health insurance association, and not the doctor's. A hospital patient pays ¥200 out of his own pocket under the present system. After the revised law goes into force, however, he will have to pay ¥1,000 a day instead. This would mean that people in the lowest-income bracket would not be able to stay in hospital for a long time. This system is designed to improve the finances of the health insurance plan by reducing the cost of medical care in hospitals by victimizing only the lowest-income people. Those with chronic ailments in particular would find it impossible to be

hospitalized. Such a system cannot be said to be one based on the principle of respecting human life.

Another change in the proposed law would be that the patient would have to pay one-half of the cost of medication. This, however, was criticized by all the opposition parties for its outrageousness. It is widely reported that the Liberal-Democratic Party (LDP) is now conducting behind-the-scenes negotiations with the Democratic Socialist Party and Komeito for a compromise by reducing the burden to ¥150 per medicine per day. This will still mean a considerable burden for a patient because he will have to pay out of his own pocket ¥150 for even such an inexpensive medicine as bicarbonate of soda. Such a price for medication is without parallel in the world. The fee for a prescription, on the other hand, is to be collected by the pharmacist on behalf of the insurer. The complications in book-keeping this would entail would be indeed formidable.

Such price raises in the health insurance plan would amount to a raise in the total cost of health insurance far higher than those in the electricity and gas rates, causing great distress to the low-income people. If a large number of people in the unorganized social strata must be subjected to such cruelties inflicted by the powers that be, then we cannot but wonder where the true principles of parliamentary government may be found.

The subscribers to the association health insurance plan, on the other hand, would not suffer any increase in the financial burden because the partial payment they must make out of their own pockets would be reimbursed. Here, too, is a major area of discrimination between the higher and lower income bracket people.

At meetings of the House of Representatives Budget Committee we occasionally witness Diet members who attack the medical profession after the manner of the weekly magazines, thereby winning the applause of representatives of the health insurance associations. The facts presented there, however, are grossly false. It was said, for instance, that members of a doctors' association in Osaka was making 90 percent profit from the medicine they sold to their patients. The

fact is, however, that this association does not handle medicines. A few other health insurance medical care facilities have also been mentioned in contexts of dubious propriety. But the cases in question were instances of miscalculation on the part of clerical personnel and not of fraud. It is totally unjust for anyone to charge on the basis of false information that doctors throughout the country are either padding their bills or are engrossed in unscientific money-making schemes.

That questions raised in the Budget Committee in the Diet — a body that ought to represent dignity and authority — should have fallen so low as these instances show is indeed deplorable. The citizens who thought parliamentary government was something respectable and that it represented the national interests and enhanced Japan's image in the world were sorely disappointed when they heard the questions and answers in the Budget Committee meetings in the Diet.

The government-administered health insurance plan has been one of the three major deficit operations of the government for a long time. That its deficit measurably decreased very recently has been admitted by the Ministry of Health and Welfare. Actually, its finances have come close to achieving a surplus. But the change has been so remarkable, the officials will not admit it. This change has occurred because the health education activities the Japanese Medical Association (JMA) has conducted for more than 10 years in the local communities has resulted in enormous savings in medical care costs. This was due to the patients' awareness of their responsibility for safeguarding their own health and also to the spread of medical knowledge among the public, which have resulted in a decrease of the frequency of their visits to doctors. The ministry bureaucrats have tried to account for the improved financial conditions of the health insurance plan by pointing to the absence of an epidemic of influenza last year. But this is sheer nonsense designed to fool people.

It is only natural that the government-administered health insurance plan is in deficit because the government keeps on creating health insurance associations composed of upper-income people. When

Mr. Tatsuo Ozawa was Minister of Health and Welfare, the JMA reached an agreement with him, by which the government would not authorize a new association until the financial readjustment of the health insurance system was completed. It was thanks to this policy that the government-administered health insurance plan began turning toward surplus. If the present policy of not creating more associations were adhered to, the government-administered health insurance plan would be completely rid of its deficit. This fact alone makes it clear how anti-modern the association health insurance plan is and how destructive it is to social security.

Association health insurance is maintained by profit-seeking organizations that make a business out of medical care. As long as this health insurance plan, based on the philosophy of never losing any money under any circumstances, is applied to social insurance, then association health insurance has no raison d'etre.

Under the association health insurance plan, a health insurance association can give any kind of benefit to its subscriber when he receives medical care in a hospital or clinic managed by the association itself without being restrained by the government. Such benefits, furthermore, are difficult to check. In other words, health insurance benefits given by a health insurance association through its own medical care facilities cannot be checked, while the benefits provided by ordinary practitioners or hospitals are rigorously checked before reimbursement by the Paying Fund. Yet, this serious discrimination has never been taken up by members of he Diet. This discrimination between two different systems of health insurance — strict regulation of the substance of medical services in one system and exemption from such restriction in the other — (i.e., the association health insurance plan) — must be said to be a discrimination worse than that between the civil service and ordinary citizens. The same kind of medical services as those in the association health insurance plan are also given in the Civil Servants' Mutual Aid Association.

In other words, there is a vast difference in benefits between a patient in a hospital under the direct management of the health

insurance organization of which he is a member and a patient in an ordinary hospital. Yet, no one cares about this state of affairs except the victims of the discrimination.

The government planned to solve the problems of health insurance by insuring separately the lowest-income bracket people and the wealthy by allowing the wealthy to earn all they can and confining the lower-income people in the abyss of deficits forever. Because of the powerful attack by the JMA, however, the government had to begin talking about financial readjustment of the health insurance system. At that time, Mr. Kunikichi Saito, secretary-general of the Liberal-Democratic Party, publicly pledged to modernize medical care by financial readjustment. A bill proposed under the name of Dietman Ozawa was submitted to the Diet, but it was shelved.

In the current Diet, Prime Minister Masayoshi Ohira, however, declared that he would not carry out financial readjustment. This statement is something that cannot be tolerated because it clearly indicates that the government has no intention to modernize medical care in Japan. If financial readjustment between the association health insurance plan and the government-administered plan is not to be made, then the former ought to be abolished in one fell swoop to provide all the people concerned with equal and uniform medical care. That would be the ideal of social insurance.

We feel that a modern political party should regard it as its own distinctive achievement to modernize medical care by eliminating the profit-seeking health insurance organizations. Yet, it is a sad fact that there is no political party in today's parliamentary government with the attributes of a modern political party. We heartily hope for a rise in the level of our parliamentary politics.

As for the question of whether or not to start paying the welfare pension at 65, the JMA has maintained that there is a difference in terms of the physiological ability and age of the beneficiaries between the system of starting to pay the pension at 60 following retirement at 55 and that of starting at 65 following retirement at 60. Faced with this rational argument, the LDP promptly capitulated. But, on

the other hand, it forced a bill to revise the health insurance system into the Diet through a deal with the opposition in order to serve the interests of the health insurance organizations. We expect the Diet to bury such a bill for good, which would definitely enhance the prestige and honor of parliamentary government.

Former Health and Welfare Minister Michio Watanabe never criticized or vilified the physicians while he was in the Cabinet post. After resigning, however, he has been constantly attacking the physicians, following the line of the National Federation of Health Insurance Societies. Among the issues he has taken up is the question of guidance and auditing. There is an old agreement reached between the JMA and a Minister of Health and Welfare. The agreement was made with the Diet as an intermediary because the Health Insurance Law is a vestige of the days of the military clique and bureaucracy, and, therefore, the system of guidance and auditing provided for by the law is not scientific but authoritarian and it smacks of old police authority. The present auditing system was established in order to modernize the auditing system under this Health Insurance Law, enacted during the military-bureaucracy age. There is an undercurrent of attempts being made to do away with it. But they must be said to represent a move to turn the clock back. Another design in this move seems to be to eliminate bad doctors. But there is the danger of such an effort involving good doctors. It was for this reason that the present system of auditing health insurance payment was established. In the light of this background, it is necessary to carry out democratization in every aspect of the system by modernizing the evil Health Insurance Law, which was enacted during the military-bureaucracy age, and by dismantling association health insurance itself.

The JMA has already presented this problem to the World Medical Association (WMA) and proposed a new insurance formula based on the premise that dealing with human life in the context of rights and duties is outdated and medicine and medical technology must be based on a new life ethic. The proposal is now being debated at the world forum. The JMA intends to implement its policy in Japan by seeking global consent.

The present health insurance system was created during the military-bureaucracy age when the average life span of the Japanese was about 45 years. That the same old system is still in force today when the average life span is nearing 80 is a reflection of negligence on the part of the Diet.

The JMA pointed out this fact ahead of all others with an article by its president, Dr. Takemi, entitled "How do we deal with the increase of the aged? — Gerontology and social security," carried in the monthly Chuo Koron in 1955. What this article pointed out at that time has since been proven correct as admitted by the knowledgeable. According to this view, the JMA has carried out a program of its own for dealing with the problem of aging in specially selected communities, where the cost of medical care for the aged is now only one-tenth of that in the neighboring communities. The program of dealing with the problems of aging under the slogan of "Aging Healthily," as championed by Dr. Takemi throughout the country, is steadily producing results.

The Health Insurance Law, based strictly on the concepts of right and duty, is indeed a vestige of the premodern age of bureaucracy and militarism in that it is devoid of humanity. The JMA is achieving results by conducting health education and old age programs even under this bad law by taking a position alongside the people in order to enable them to age healthily. But in the meantime what has the government done?

It is hoped that the people, after closely examining the JMA's achievements, will raise their voices to save Japan in its present crisis.

(*The Japan Times*, March 1, 1980)

For Living Vigorously in the Age of No Government

The flow of time is gaining speed. There are many ideas about the future. But the practical problems of the present are the ones we must give ample thought to.

The party politics of Japan after World War II made its appearance in a corner of Asia as a star performer carrying expectations for democratic government. We must remember, however, that Japanese, not Americans, are responsible for what happened here.

In 1950, just about the time when the world began moving toward an age of the welfare state and a social security system was established here, the Social Security System Council, chairmanned by Professor Hyoe Ouchi, submitted its first recommendations on the medical care system. Yet, the medical care system made no step forward during the 30 years of Professor Ouchi's lifetime after that. One problem we have is that there is no academic discipline which anticipates the effects of the stagnation in public administration. In the light of the complex society of the future, we believe that the science of forecast is a prerequisite for administrative reform.

There has never been an age of no government in Japanese history although I do not know if we can say the same about other countries. Having viewed the various developments in the course of the management of the Diet for the last four years or so, we realized that we had entered an age of no government without being aware of it.

Democratic government in postwar Japan was the activity of interest groups. When a group was strong, its views were accepted but not when it was weak. No thought was given to the direction in

which the future of mankind was to be found.

The ruling Liberal-Democratic Party abandoned the task of solving problems within its own party. The opposition parties, on the other hand, have lacked power to take over the government, tending to merely shout opposition. The opposition parties have insisted that in democracy minority opinion should be respected, and the party in power has agreed.

Under such circumstances, we expected the opposition parties to produce a picture of Japan in the world of the future, whereby calling upon the people to organize their effort. But this was hardly done.

We do not know how to describe this kind of situation except to call it an age of no government. Age of no government is probably not found in a dictionary of politics. Yet, a new age produces new facts. We in Japan must think harder about our responsibility to ourselves and to the world for having ushered in an age of no government, without precedent in history, in the name of democratic parliamentary government.

It is true that in such a situation certain politicians have made great efforts. A few among the ministers of health and welfare belonging to the Liberal-Democratic Party tried hard to carry out financial readjustment of the social insurance system even though only within the area of their responsibility. Yet, their efforts were totally nullified by a group within the party, which may be called a reactionary force.

Because our profession is medicine, we do not wish to touch on issues outside the realm of our professional interest. Yet, when we listen to arguments these days, we are shocked to find the large number of arguments which places the blame for all the evils on only the politicians as though the people were totally blameless. Take the official corruption issue, for instance. We can trace it to the fact that democratic government started in this country as a collection of interests of individuals and of groups. We are against dealing simplistically with Dietmen as evil politicians without realizing this fundamental problem.

Viewed from various angles, former Prime Minister Masayoshi Ohira may have been a hero in this age of no government. But we believe that his heart was filled with an intense interest in politics. The last action he took, we believe, was his supreme action. We wish to pay our respect to Mr. Ohira as a great statesman for having wanted to continue living in order to attend the Venice summit. For this reason we regret the fact that people lacked time to fully understand the ideas of the late prime minister.

Purifying politics actually means purifying people. This is our principal argument.

If the ethics and logic of the people are stained, this would lead ultimately to official corruption. When politics fails to respond to the progress of the times, it often causes serious substantial damage to the state and the people. This, too, is because of the egoism of interest groups, and we do not intend to blame the politicians.

The present-day stagnation of politics must be attributed to the failure to prognosticate the future and to the mountain of the laws that have failed to respond to the changing times.

We are of the firm conviction that Japan is a country that has the possibility of winning for itself the brightest future in the world. No one can deny that the progress of science and engineering and the maldistribution of natural resources cannot be properly dealt with by old-fashioned international politics.

We wish to take up here the problem of bioethics in particular.

Ethics of the past is a collection of old ethical ideas of the kind the politicians are today talking about. Bioethics, on the other hand, is a clear manifestation of the fact that the progress of science demands of human society a new ethic. We are mightily impressed with the fact that the Kennedy Institute of Georgetown University is leading the world in pursuing this task. It is also a well-known fact that the research done by this institute is having a major impact on Japan.

Political ethics must be wrapped up in the bioethics that is the ethics for mankind to live by in the future; it must not be isolated. Unfortunately, however, all the peoples of the world have been

concerned only with the preservation of their own interests without considering the question of what kind of relationship human beings of the next generation must have among themselves.

With the aid of the progress of science and technology, we have proposed a new bioinsurance for the survival of man. But this must coexist with bioethics. Without bioethics, it would be impossible to explain the economic phenomena of the future.

When such far-reaching changes are taking place, we find that matters related to medical care in our country are being safeguarded by outdated laws and institutions that totally ignore bioethics and bioinsurance.

An age of no government is incapable of grasping the passage of time. Nothing is done, and yet people are deceived into feeling that something is done. This state of affairs in our age of no government spreads throughout the country.

The Japan Medical Association has already made clear its own image of medical care for mankind in the 21st century, which is based on the two pillars of bioethics and bioinsurance. And we must admit that the same tendency is rising in political science and international politics.

Unless we realize that politics is not the pursuit of the interests of groups but thinking about the future of mankind, the age of no government will be with us forever. And that, we think, would be the greatest misfortune to befall Japan.

(*The Japan Times*, June 26, 1980)

Retiring Means Worse Insurance

The Health Insurance Law is about to be revised for the 53rd time in the Diet now. The bill for revising the law submitted by the Liberal-Democratic Party (which is in effect a bill for misimproving the original version prepared by the government) has passed the House of Representatives and is now in the House of Councillors for deliberation.

When this legislation is completed, the monthly premium each health insurance subscriber pays will be raised because its rate in relation ot one's salary will become much higher than at the present.

To begin with, the revision bill is designed to meet the deficit in the health insurance system (although the health insurance associations are in the black).

The bill is intended only for the purpose of raising the premium.

Incidentally, what do you think is the primary cause of the deficit the health insurance system is suffering from, along with the two other major deficit items, namely, the national railways and the rice rationing system?

It is to be found in the Health Insurance Law itself, which has been revised so often.

We now have one of the highest life expectancies in the world, and accordingly the number of our aged is sharply rising.

Among the aged there are many persons who are not well, which means their medical care costs are high. No matter how much the Health Insurance Law may be tampered with, the premium will have to continue to rise.

Although its finances slightly improved recently, the government-managed health insurance plan, which covers about one-quarter of the population of Japan, continues to register deficits. Its accumulated deficit as of the end of 1979 was ¥129 billion.

Entirely apart from this, however, the association health insurance plan, which covers about the same number of people, is enjoying a surplus which rises with each year.

The association health insurance plan, furthermore, offers "additional benefits," which the government-managed insurance plan does not. Under this system, the subscriber's share in the payment for medical care for a member of his family, which is paid at the time of the first consultation at hospitals and clinics, is refunded to him. (After retirement from the place of his employment, of course, he will not have this privilege.)

When the proposed revision is effected, the premium for the subscribers of the government-managed health insurance plan will be raised, and at the same time so will be his own share in the cost of medical services.

This will mean that the major instance of unfairness found between the association health insurance and government-managed plans will be further widened.

The revision bill offers no plan for mitigating this unfairness.

One can forbear a higher premium if it means an improvement in the quality of the benefits paid by the insurance plan.

Yet, this has seldom been the case. Why?

When the premium is raised and the finances of health insurance associations improve, some of the companies, whose employees have been subscribers of the government-managed plan, form their own health insurance association — to join the others of the same plan.

When this happens often, what remains under the government-managed plan is small business, whose employees are covered by the plan, which suffers from chronic deficits.

And the government always determines the uniform health insurance benefits according to the finances of the government-

managed health insurance plan. Thus, people never receive health insurance benefits that are appropriate to the premiums they pay.

The health insurance associations yield an annual surplus of approximately ¥100 billion. Besides, these associations spend another ¥100 billion for health care facilities (e.g., rest homes). This means that the system further enriches only the relatively rich health insurance associations.

Even the employees in the rich health insurance association group, who pay high premiums while they are in good health and working, must leave these associations upon retirement and join the poor health insurance plans such as the government-managed plan and the national health insurance plan.

In other words, these people leave behind the premiums they have paid over the years without receiving benefits from them. And when they do become ill (after retirement), they have to pay more out of their own pocket than they would have had to before retirement when they were covered by the association health insurance plan.

If we are to think seriously in terms of "equality in insurance benefits," then the surplus yielded by the association health insurance plan should be funneled into the deficit-ridden government-managed plan. That would remove the deficits and the people would be spared of having to suffer under unnecessary financial burdens.

Yet, the present bill for revising the Health Insurance Law seems to purposely ignore this unreasonableness.

It may be that making sick people regain their health and enabling people to live longer and more healthily inevitably means higher medical care costs. But even that has a limit.

Until we enter the 21st century, we in Japan, where the number of aged increases at the same rate as in Europe, must devise a system for protecting the health of the people at the least possible medical care cost.

You might wonder if there is indeed such a device. But there is.

It is for everyone to look after one's health and age healthily.

In some communities, the medical care facilities and the residents

have succeeded in minimizing the costs of medical care for the aged through many years of experimental efforts by starting health management for the residents while they are still young.

The Japan Medical Association devised a medical care system based essentially on the concept of "community medical care" which provides consistent medical care for people throughout their life, and has been putting it into practice in various communities in the hope of eventually spreading the results of the community experiment throughout the country. We have also announced our own scheme for health insurance, designed for promoting this system.

The device is the "old age insurance," which provides young people with preventive benefits in the interest of forestalling adult diseases toward the objective of enabling people to "age healthily."

If people take up a system that really makes them healthy, it will eventually stabilize the finances of health insurance.

The proposed revision of the Health Insurance Law in question, however, is without such a basic vision, and it does not at all incorporate the idea of the new insurance benefits that we are proposing.

Not only that, the Ministry of Health is planning to create a new health insurance plan called "Old People's Health Insurance," which resembles our "Old Age Health Insurance," by removing only the aged from the rest of the population. Though it resembles in name the "Old Age Insurance" we have proposed, it actually limits the benefits of health insurance for the aged.

As we have seen above, the present health insurance system contains major elements of inequality and unreasonableness. It prevents the advancement of a medical care system that deals with the entire population of our country as one unit.

This is because the present health insurance plan was inaugurated as far back as 50 years ago during the Taisho Era, under the feudalistic way of thinking that contained no element of respecting human rights.

It has been repeatedly revised since then. But the revisions have

always been stopgap measures, and there has never been a fundamental change. This is because the basic way of thinking underlying the system has geen that the burden should be imposed on the people.

The proposed revision of the law of this time, too, is not a radical reform; it is nothing but a counter-deficit measure for a short-sighted purpose, which only adds to the financial burden of the people.

The revision bill has been shelved three times during the past three years, and the same bill has again been submitted to the Diet after bargaining between the party in power and the opposition. In any event, the proposed bill represents only a peripheral compromise. Even as a deficit countermeasure, it will fail and produce a deficit quickly.

The Japan Medical Association has insisted since the late 1950s upon a "radical reform" that would unify the several, separate health insurance plans under a single system while pointing out the shortcomings in the present system we have cited above.

In 1961, the government and the Liberal-Democratic Party agreed on "four principles," by which the health insurance system was to be radically reformed. And yet, this radical reform has been neglected.

This is because the underlying philosophy is not respect for man, but the desire of insurers and the bureaucrats involved with health insurance, who think only of giving priority to the financial condition of health insurance. Their interest in expanding their political power has distorted government.

The way in which the politicians of both the party in power and of the opposition are without a proper political orientation because they have been beguiled by the health insurance bureaucrats may be described only as deplorable.

Many of the members of the Diet have understood the spirit of the insistence of the Japan Medical Association of these many years and are working hard toward its realization.

The reform plan these Diet members attempted to push forward as the first step toward a radical reform is the bill for the readjustment of the finances of the health insurance system, submitted last year. It

was designed for removing inequality from the system and for consolidating the basis of health insurance by pooling the resources of the separate health insurance plans.

These members of the Diet with medical Dietmen as their nucleus have endeavored to prevent the passage of the current revision bill through the House of Representatives. Unfortunately, however, they were unsuccessful.

The Japan Medical Association wishes to renew its insistence:

We strongly oppose a plan to revise the health insurance system like the present one, which will only increase the financial burden of the people and does not achieve an improvement of the insurance benefits or a reform of the system itself.

Let us all oppose the current revision bill and demand that it be scrapped in order to achieve a financial readjustment among the various separate health insurance plans as a starting point for a new health insurance plan, which will blaze the trail for the future of medical care and thereby correct the mistaken course of our government.

(*The Japan Times*, November 22, 1980)

There Are Not 'Too Many Doctors'

Toward the end of last year, the Ministry of Health and Welfare (MHW) announced a rough result of a survey it had conducted. According to this announcement, we are headed for an age of mass production of doctors, and, therefore, the ministry wishes to hold the number of doctors at the level of "200 doctors per 100,000 population."

There is one problem about this. It is a fact that sufficient study has not been made on whether this level of "200 doctors per 100,000 population" is an optimum figure.

On what basis and with what kind of vision for the future has the ministry come up with such a figure?

It was a well-known fact that an increase in the number of medical schools and colleges would mean a corresponding rise in the number of doctors. Concerned over this situation, the Japan Medical Association (JMA) steadfastly opposed the idea of merely increasing the number of doctors. The reason is that it has not been easy for Japan to expand the scale of medical education in keeping pace with world-wide progress in the field of medicine. It has been nearly impossible to do so in terms of finance and necessary personnel.

Rather, we urged the government to build the future of Japanese medicine from Japan's own standpoint.

Yet, the Ministry of Education and the MHW were overwhelmed by public opinion and committed the serious error of increasing the number of medical schools beyond the level of one per prefecture — in the name of eliminating "doctorless villages."

If the government now says it wants to check the increase of the number of doctors because we are going to have too many of them, we must say it is a totally inconsistent attitude.

Tampering with the number of doctors arbitrarily, increasing or decreasing it, suggests a terminal condition, in which the MHW, the protector of the insurers in the health insurance system, conducts administration solely in the interests of these insurers because the more doctors we have, the higher the cost of medical care.

We regret the fact that the people as a whole are not sufficiently aware of these facts. One of the wonderful virtues of democracy is that the people can state their demands frankly. Yet, in this country, not enough thought is given to the need of combining the future and the development of our national destiny. This points up the immaturity of our democracy, which members of the Diet as well as the people must become fully aware of.

All this means that we have learned a precious lesson at a high price. Since the problem of the government attempting to restrain the increase of the number of doctors poses a serious problem for the future, let me make clear our thoughts on the matter.

The problem of too many doctors actually arose with the inauguration of the system of dividing doctors into specialists and generalists during the early part of the Showa Era — in the late 20s. It was based on the assumption that a generalist who handled patients in all branches of medicine was immature. On the other hand, the concept of specialist lacked clarity. Today we have finer classification. But even in those early years, no one could tell what a specialist in internal medicine really specialized in — the kidney or the respiratory organs, for instance.

Therefore, we squarely opposed this specialization system. We believed it was much better to have a system whereby a practitioner indicated on his shingle the field he was most expert in. Yet, the MHW has long carried out medical administration and education on the basis of this concept of specialist vs. generalist.

The specialist system, to begin with, was an extension of the

so-called "ikyoku" (medical departments) system of medical schools, which represented school cliques and factions. It was a concept based on the highly self-righteous ideas of the medical schools. The system was totally devoid of the idea of community medicine, that is, that medicine is part of community life. In other words, the system itself neglected people.

It is little wonder that the specialist system has proved ineffectual. As a matter of fact our health insurance system started at the same time in the early Showa Era. The attempt to separate specialized medical care from general medical care under the health insurance system, too, had its basis in the idea of dividing doctors into specialists and generalists. This, we believe, was a serious mistake.

In the United States, where the medical system went through various phases and the people concerned realized the defects of the specialist system, doctors specializing in so-called primary care have begun to emerge recently. In Japan, however, we still cannot find any university where it is possible to develop primary care physicians.

After World War II, we of the JMA created the Chubu Hospital in Okinawa following discussions with the Occupation authorities there in order to have Japanese doctors intensively conduct primary care practice. We showed this program to our medical leaders. But they showed little response to what they saw.

Today, 35 years after the war, however, the Chubu Hospital is very much in the limelight because the doctors who finish the primary care practice program are found to be clinicians with superior abilities.

"Primary" in the term "primary care practice" does not mean elementary. Rather, it suggests the balance required of a clinician. Primary care is the direction in which American medical practice is headed. In Europe, the United Kingdom in particular, primary care practice, having been inaugurated some years ago, has come to stay. There are books for doctors on the subject.

Yet, in Japan, we cannot find proper people to write such books even if we wanted them. Today, because the MHW has taken up the problem of primary care, the term has spread throughout the country.

But we must realize that the substance of it is totally different from what the MHW is talking about.

This fact alone, if we may speak somewhat bluntly, testifies to the incompetence of those experts and scholars who serve as advisors to the Ministry of Education and the MHW.

If we are to conduct primary care practice in Japan according to the Okinawa formula, it would result in a notable rise in the level of medical care in Japan.

I know of a case occurring at the Chubu Hospital in which three residents who were only three years out of medical college conducted a first-rate operation on a patient, who had suffered damage to his abdominal aorta in an accident involving a truck. They completely restored the functions of the damaged aorta. In Japan, however, such an operation would have required 10 doctors — of the level of competence of medical college teaching staff at that.

As this case illustrates, there is a close relationship between the number of doctors and a medical system. Yet, no one seems to pay attention to it. What, then is the meaning of holding down the number of doctors without taking into account such an important fact?

If it is important to check the increase of a mere number, it should be left up to the Ministry of Finance. We do not think it is something that the MHW should concern itself with.

The JMA has been tackling the matter of primary care for a long time by advocating community medical care. At the same time, we have been conducting a continuing education program for our member doctors by making it obligatory for them to participate in a training program once every five years. Those who go through this program are given certificates signed by the president of the JMA.

We established such a system because we wanted to introduce in a concrete form the newest system that combines community medical care with primary care. If such a system were to become established, it would mean that both hospitals and private practitioners would have to reconsider their practices in order to achieve their qualitative

improvement. This would in turn mean the elevation of the level of medical care toward that of the "peer review" system in the United States.

It goes without saying that our medical care system ought not to be tampered with without a particular ideational system to replace it.

Today there is at least one medical college in each prefecture. This fact strongly suggests "election tactics." The people must realize that when election tactics make one false step we have such a situation. Therefore, they should be careful when they speak to the government.

Though this is a separate matter, public welfare administration, too, falls into the same pattern. This area is considered a "sanctuary," of which no criticism is permitted. But we believe that welfare administration in the future will lead to the ruination of the country. We think it is more important to protect the true welfare of the people with more positive welfare measures.

We must not allow ourselves to forget that, be it medical care or welfare, there is a close relationship between a system and numbers. A system in our country seems to change — for better or worse — when it goes through a change in other countries. And the government-hired scholars and experts ballyhoo such changes.

The people are unaware of the true situation. So, when their prefecture acquires a medical college, they greatly rejoice. Yet, we cannot find a medical college which has been organized specifically to meet the needs of the particular locality in which it stands.

The folly of creating a medical college in each prefecture is obvious from not only the fact that the number of doctors will increase but also the confusion and chaos into which it throws medical research and education. Yet, few seem to realize this.

Is it not more important to think about the absence of such foresight than to create a medical college in each prefecture?

Our urgent task is to destroy the status quo. To try to reduce the number of doctors by bringing pressure to bear on the young students who entered medical college with bright dreams for the future is "bureaucratic violence," which we deeply deplore.

We wish to propose the following reform measures. The hospitals attached to the medical schools in the prefectures should be left intact to play a regional role for clinical training. From 10 to 15 medical schools should be collected into one training center for basic medicine where world standards are maintained. This, we believe, is the responsibility of Japan to the rest of the world. There can be no solution of the problems we face if we forget this responsibility. If this is done, the number of medical schools will be smaller than one-quarter of what we have today. But the chances of producing medical men deserving a Nobel Prize would greatly increase.

The distribution of doctors is determined in various manners. During the "free practice" years of the past, doctors were distributed according to the accumulation of capital in the local areas. Since the inauguration of the "total insurance" system, however, the distribution of doctors in reality has been unrelated to the needs in medical care that rise in parallel to the distribution of the population. The government must take this into scrupulous consideration.

It may be said that we now have an excellent opportunity to re-examine the mistakes made by the Ministry of Education and the MHW concerning the building of Japan's future. This does not mean, however, that we approve of the present practitioner system or the hospital doctor system as they are.

If we considered with greater enthusiasm the matter of checking the increase of the number of doctors, it might lead to Japan's development in the future.

We earnestly anticipate discreet consideration by the knowledgeable people concerned.

(*The Japan Times*, January 8, 1981)

Let Us Radically Rethink Medical Care

Medical care means the social application of medical science, which is making rapid progress. The criteria for this application are the laws and regulations concerning medical care. Yet, the outdated laws legislated before World War II are today still in force. This we cannot understand.

Take the Contagious Disease Prevention Law, for example. This law has not a single article concerning viral diseases. Another example is the Health Insurance Law, which, because it is based on the prewar family system, is unsuitable for the family system of today in terms of the present Civil Code that has no room for the concept of the "dependent" of an insured person.

Thus, it is evident that medical care-related laws and regulations have not kept up with the various changes in social structure and other aspects of our society.

This is also true with the progress of medical science. The realm of medical care has been enormously expanded to cover a broad area ranging from prevention to rehabilitation. Yet, the Health Insurance Law is totally unrelated to this. Such new fields as clinical epidemiology are not at all made use of. Self-contradictions and complaints arise from the fact that our system is so designed as to impose old-fashioned medical care on the physician by ignoring the progress attained by medical science.

The complaint the masses have about medical care concerns chiefly the health insurance system and not the progress of medical science. If the people realized how petrified the health insurance

system itself is and how far removed it is from modern medical science, then they would be able to understand better the causes of their own complaints. Unfortunately, however, this is an area that is very difficult for lay people to understand.

The more progress medical science makes, the farther health education ought to be pushed so that its achievement may be allowed to infiltrate the life of the masses. But this, too, has not been much in evidence.

There are few instances of the insurers' organizations having provided the insured with health education. The insurers' organizations are either agencies that merely profit by being intermediaries between business enterprises and their employees or welfare agencies of the capitalists. As long as the working masses do not awaken to this fact, the existing health insurance system is most likely to produce a consequence having a serious bearing on the life and death of our nation in a little more than 10 years from now.

We have often warned against "delay in policy." That there should be delay in the formulation of policy, which, by its very nature, ought to be future-oriented should not be tolerated in the world of science. Of course, such a delay in policy formulation may be only natural so long as the outmoded laws of the early part of the present century dominate medical care.

A good example is the countermeasure for an aging society.

In areas where health education has fused with the life of the people, medical care costs for the aged could be only one-tenth of what they usually are. Such an example is found in Nagano Prefecture and also in Iwate Prefecture. This is a real countermeasure for aging.

But if we neglect health education and abandon the aged without bringing the soul of medical science into everyday life, it is only natural that the people would be placed under the enormous financial burden of medical care cost. If the government disposes of this by the simple phrase, "ravage of medical care," it illustrates nothing but governmental irresponsibility.

Japanese government is said to be bureaucratic government.

Indeed, in the field of medical care, it is purely bureaucratic government. Bureaucratic government has as its mission adherence to old laws. Yet, disease and society move on far beyond these old laws. This is the reason why policy formulation lags so far behind the reality. If, on the other hand, there had been no such delay, the costs of medical care for the aged would have been negligibly small, and there would have been no sacrificial cost to the people.

We mentioned the problem of aging. On the other hand, the number of neonates is steadily declining in our country. This is said to be a statistically temporary phenomenon. But it is correct to view it as a permanent phenomenon.

That is to say, while there is a rapid process of aging, there is, on the other hand, a great pitfall of declining population, which waits for us in the future.

At the present pace, the intellectual power of the young people of Japan, who are the source of the power of our science and technology, will be so inadequate that we will not be able to compete with other countries.

Countermeasures for aging ought to be countermeasures for the younger generation at the same time. Yet, the government is preoccupied with countermeasures for aging while being oblivious to those for the younger generation. We cannot acknowledge such an inadequate policy as a state policy.

There is a great potential danger inherent in the fact that the parliamentary government of Japan is government that depends heavily on bureaucracy. We cannot but be aware of the crisis that is likely to ruin our country in 20 years.

We mentioned at the outset that the present Health Insurance Law is outmoded because it was created to suit the society of the Taisho Era (1912-1926).

Labor relations, and the sense of value attached to human life, too, were totally different from those of today. And yet such a law has remained in force for more than 20 years after the end of World War II without being revised even once. This we must say is a serious matter for which the government should be held responsible.

Not only that, the government designated an agency called 'health insurance medical care agency' in 1957 and the status of 'health insurance physician' in inaugurating a health insurance system. Until that time, health insurance had been provided by physicians in their capacity as private individuals. After that year, however, it had to be provided under this system which we call "double designation."

These two major statutory revisions completely deprived the physician of his professional say. They also deprived him of his financial rights. The double designation system meant that the physician was merely to obey the orders of the bureaucrats. This could be a virtual repetition of the wartime draft system under which the bureaucrats were able to do anything with able-bodied men with postcard induction orders.

Yet, only we of the Japan Medical Association issued a warning against this evil law. All members of the Diet, including doctors, favored the law. But we knew that this law would only destroy medical care.

If only medical care had been administered at the individual discretion of responsible physicians, we would not have the "ravage of medical care" we have today. The rather special hospital in Kyoto Prefecture, which amassed enormous assets, and the case of a hospital in Tokorozawa, would have not occurred if only the physician had been given responsibility as an individual.

Just as the bureaucratic control during the war was the soil that produced the blackmarket during the war, the Health Insurance Law under today's double-designation system is the soil of ravaged medical care itself. What makes the situation even worse is the presence of the classic insurers' organizations.

Japan's medical care today is like a wanderer who has lost his way and doesn't know where to head for. What are the politicians thinking of the zenith of aging in our society anticipated in 20 years, the extreme decline of work force among the younger generation, and the diminution of the mental and technical power of our people?

We must realize the enormous obstacles that stand in the way of revising the outmoded Health Insurance Law. One of the obstacles is

the adherence to the vested interests in the name of democracy. Another is the rampant consumer movement.

The advocates of the consumer movement, however, do not know that it is only a movement concerned with things and as such it is essentially different from a movement concerning life. We may say that Japan is at present on the precipice of ruination.

The Suzuki Cabinet is now attempting to introduce into its administration the wartime government of suppression by holding a liaison council among three ministries after the unfortunate incident involving the medical care corporation of Tokorozawa, managed by a person who was not a doctor.

Likewise, when the Juzenkai incident occurred, it issued a warning against the absence of medical ethics.

Frankly speaking, however, we feel all this is laughable. Let us ask who created the medical corporation system in the first place. As medical care expands in scale, it requires introduction of more capital. Because this is not easy for private practitioners, the medical care corporation law was legislated to enable the acquisition of necessary capital.

Yet, this system was accepted by doctors only as a means of evading tax.

Furthermore, one needs no qualifications to become a director of a medical care corporation. He could be a loan shark or a member of an underground organization.

Among the medical care corporations created under these circumstances, a few that engaged in particularly outrageous activities happened to have been exposed recently.

We objected to the Medical Care Corporation Law when it was being legislated because we had anticipated the consequences that we see today.

The law, furthermore, requires capitalization for a medical care corporation, but it prohibits the giving out of dividends. The reason is that this kind of corporation, unlike a business enterprise, is not to seek profit. But as in the case of the clever method of tax evasion used

by Juzenkai the original purpose of the law was savagely betrayed.

More recently, some people are advocating a system whereby a private practitioner can become a corporation by himself.

Medical care, however, is primarily based on the personal relationship between a physician and his patients, not on the relationship between patients and a juridical person, or corporation. Despite this, there are attempts to ease the tax burden on medical care corporations or to have the government authorize one-man corporations.

But there is no indication of what obligations are imposed on such a corporation in case such a system is legislated. That's where political chicanery is found.

In such a situation where the idea is being established of medical care being given by juridical persons, and the responsibility of a physician as an individual is being lost sight of, it is only natural that medical ethics is not brought up to date. It is not difficult to understand why the tendency toward negating ethics emerges. Recently, some thoughtless members of the Diet are turning hospitals into corporations.

We have advocated life ethics. Today genetic engineering has enabled the rearrangement of genes. We participated in the discussion of this problem before anyone else and carried our views on life ethics in an English-language handbook. We have also endeavored to elevate the level of the physician's ethics through the life science society for seven years.

We believe it is unforgivable that there are attempts to create one-man medical care corporations, which is a tax-evading device, to replace the professional character of a physician.

We should pay the tax that is due to us. This is our way of thinking.

One thing we must consider in this connection, however, is that the persons in charge of medical care in a community are under a public obligation because of the very fact that they are in such a position. It is highly questionable, therefore, whether such a person

should be levied the same kind of tax a business enterprise is.

We do not mean to support the contentions of a small number of avaricious doctors concerning the present tax system. But we feel that a special consideration should be given the revenue of persons in professions of such a public nature as medicine in terms of either taxation or the amount of tax to pay.

In reality, however, problems are fairly well taken care of through negotiations between the tax office and the medical association in each community.

If the public nature of medicine is to be recognized, there should be no attempt at making doctors serve the public interest by sacrificing their own financial independence. Yet, archaic laws force the doctors to do that. When there is no basic understanding of this situation, the physicians tend to become egoistic in their claims to some extent and the same may be said of the claims of the people. It is indeed unfortunate that conflict is likely to occur to prevent mutual understanding.

After the war when the government became incapable of making necessary payments, the payment for health insurance was rather delayed. A law to prevent delay in payment was enacted at that time, making the government responsible for the delayed payment of public utility fees. But the payment for health insurance was not covered by this law on the ground that it was not a public utility fee.

Even today, the remunerations to be paid to doctors under a health insurance plan are not a public fee.

The public is demanding a public nature in the medical profession. But the law does not recognize medical fees as a public charge. As we said earlier, the doctors are forbidden to speak up about their finances because of the double-designation system we mentioned earlier.

As far as academic contentions are concerned, the Japan Medical Association has bravely fought for itself and has been successful to some extent in reducing the restrictions on medical service.

We are proud of ourselves in that we have been able to safeguard

our realm of medical science because we have not relied on parliamentary politics. But in the area where we had to rely on parliamentary politics, namely, the medical care system, there has been no progress at all.

Even the representative physician members of the Diet, whom the Japan Medical Association recommended in elections and who campaigned by saying they would abolish the double-designation system, have not so far fired a single arrow during their tenure in the Diet of 18 years.

Don't these physician members of the Diet know that protective articles for the rights of a physician that ought to be safeguarded are not found in the double-designation system?

The fact that the social status of the physician has thus fallen could not but induce a major change in the state of mind of the physician. The consequence of this is the fact that such incidents as we mentioned earlier have been befalling the people.

If there is no raise in pay for three years, not even maids and store clerks will continue to work. Yet, health insurance doctors have had to work quietly without having their revenue increased for three years because of the double-designation system. This is because there can be no raise as long as the Minister of Health and Welfare does not consult the Central Social Insurance Medical Council. The physician's pay is like the salary a samurai used to receive from his lord. It cannot be raised unless the minister decides to do so.

On the other hand, the physicians employed by public hospitals have all been receiving annual pay raises for the last three years.

Both public and private medical practitioners must be given equal opportunities. Both we and the government have long made the same arguments. But the Suzuki Cabinet resolutely destroyed this argument. In that sense it may be said to be a historic cabinet.

It established a firm distinction between the public and private medical care agencies and allowed a wage raise only to the public medical care agencies. Yet, it has proposed no future-oriented countermeasures.

Even this alone makes it obvious that Japan is standing on the brink of death.

Prime Minister Zenko Suzuki stressed the fact that there was no need to raise remunerations for medical service in the Diet. Minister Sunao Sonoda of Health and Welfare, too, made the same contention immediately after assuming the post. Against such unreasonable contentions, our medical association has held national rallies many times with tens of thousands of physicians assembled. Some times we imitated mass movements by waving red flags. But we think that such an era is long over. We are opposed to rallies and red-flag waving.

We think now is the time when we must seriously search our souls, think about the future and realize the mistake of having thought it might be possible to solve the problems through such mass activities.

We must start new action on the basis of a new life ethics.

Because we adhere to the basic principles of life ethics, we are very much saddened by the fact that we have to appeal to the people about the present state of affairs we have described.

(*The Japan Times*, February 21, 1981)

Why We Must Discard Outdated Insurance Plans

That the medical care cost for the entire nation has suddenly risen is becoming a big issue.

When we minutely calculate the ratio between the medical care cost and the GNP, we find that the former has rarely surpassed 4 percent of the latter. This percentage is below the world's average. In the United States it is higher than 6 percent.

It is said that in this country too much medicine is being used, the aged folks are abusing the free medical care system, and so forth. Even though these may be true, all the costs involved are within this figure of 4 percent of the GNP.

Therefore, the charge that the medical care cost in Japan has unwarrantably risen is totally without justification.

The foundation of the national medical care system of Japan is the Health Insurance Law.

This law, however, is a prewar law, which was legislated during the days when there was suppressive state control exerted by the military clan.

In those years, state control was enforced through administration under the directions of the military. There was no concept of the dignity of human life as we know it today. In the Faculty of Law at the Tokyo Imperial University, for instance, there was hardly any other course given than one on state control laws. The students who were educated in those years and later became bureaucrats, therefore, studied hardly anything but state control laws. They did not study laws of a free society at all. Therefore, these officials forget that

totalitarian control was accepted in their day only because those were war years. Even today they have not yet been freed from the state control orientation developed in those years.

The Health Insurance Law was left unaltered through the liberalization carried out by GHQ and SCAP, in the postwar years because the bureaucrats of the Health and Welfare Ministry tried to enforce the law in the free society that was brought into being after the war by the Americans who had not known such a law.

The Health Insurance Law was the basic medical care law for the people of Japan, who had endured sacrifices, including their own lives, during the war when everything was scarce and the people were told by the military to persevere. Yet, GHQ and SCAP were totally ignorant of this fact.

In the postwar free society and in this economic power that is Japan today, that such a regulatory law still exists is a crime that is more than outrageous.

Another example of the regulation-orientedness of the bureaucrats is the Food Control Law, enacted during the food-shortage years, that is still being preserved today when we have a major surplus of rice.

As long as the bureaucrats are prisoners of such an anachronistic propensity for state control, agricultural administration as well as welfare administration inevitably comes to an impasse.

The National Health Insurance Law was a form of health control by the military for the purpose of cultivating war potential in terms of agrarian youth.

When this idea is replaced by the health care of today, we find the Health-Care-for-the-Aged Law.

In the war years, the military thought up the National Health Insurance Law in order to produce strong youth to serve as soldiers in war. Today, the Health-Care-for-the-Aged Law is designed only for keeping medical care costs down.

People do not know that it is a trick of the bureaucrats to think up a stopgap countermeasure to deal with a problem without

considering its basic causes, thereby expanding their power and authority. But party politicians know this and they tolerate it.

The National Health Insurance Law is today turning into a health insurance system for the aged, which means it is becoming increasingly more expensive. Now the bureaucrats have begun thinking of means of reducing its cost. Their objective is to tighten as best they can the finances of medical care agencies, such as hospitals and clinics.

It is ridiculous, however, to assume that the medical care cost can be held down as long as clamps are placed on medical care agencies without thinking about the problems of the aged. This is true with the bureaucrats and the political parties.

Since Mr. Sunao Sonoda became Health and Welfare Minister, state control reminiscent of that of the military government prewar years has become notable. We feel it is our misfortune to have to accept such a constraining administration as indicative of a potential tendency of the Suzuki Cabinet.

The desire for peace has never been greater than it is today. The nation's defense policy is a policy of making a battlefield of our small land. We are certain that there are many others besides us who doubt if this should be our policy for preserving our land.

We can say that this is an age when such a philosophy of the Suzuki Cabinet clearly manifests itself in medical care.

When Japan was an agricultural country, the aged were heavily wrinkled, their backs bent, and their life expectancy extremely short. Malnutrition, inadequate health care and a low standard of living caused chronic ailments of the aged that affected many of them when they were still young.

Today, in our advanced industrial society such people are very few. This is because the standard of living has risen and much attention is being paid to matters of health.

At the same time, attention is paid to the problems of gerontological chronic ailments. It is only natural that the number of cases of chronic diseases among the aged should be larger than before,

both absolutely and relatively, only because the average life span of our people is nearing 80.

If an attempt is made to hold down the medical care cost for that particular sector of the population, therefore, it is obvious that such an attempt will ultimately fail. We think that Health and Welfare Minister Sonoda is a typical administrator who fails to realize this.

In any event, the burden of the medical care cost for the aged of today is a concrete manifestation of the characteristics of the aged who have lived through the transition of our formerly agricultural society to an industrialized society.

Now let us consider the time when the aged population of our country reaches its peak 20 years hence.

It is certain that our society will shift to an information-oriented society. In such a society persons who have experienced living in an agricultural society will be very few. It is important for the Japan Medical Society (JMA) to think about what kind of old people will emerge through the shift from an industrial society to an information-oriented society.

As is very obvious when we study this matter, the problems of the aged in an information-oriented society could not be disposed of without taking into account problems of mental health. In other words, the problems of the aged in such a society could not be solved at all by merely keeping down medical care costs. We must realize that there will be a big qualitative difference between the aged of the past and the aged who will have lived through an information-oriented society.

Yet, the Health-Care-for-the-Aged Law now proposed shows no concern about how the effect of living through changes of society might affect the process of aging even though it refers to the calendar age of old people.

It is obvious then that the policy for the aged 20 years hence will be definitely bankrupt.

The proposed Health-Care-for-the-Aged Law, if enacted, would cover those who have to become aged without receiving any

consideration to the problem of their own mental health. And when the problem of their mental health becomes a real problem for the nation, it would be too late, and the government — with no countermeasure on hand — would not know what to do. The JMA has given thought to that and is already conducting community medical care activities that attach much importance to the problems of mental health.

Even today, there is only one psychiatrist per 2,000 population in the local communities. Mental health care in the information-oriented society of the future would have to be on an entirely new footing that is far above the level of mental health care of the past. The proposed Health-Care-for-the-Aged Law, however, gives no consideration to this aspect of the problem.

In an information-oriented society, its culture and inhabitants can never be considered without taking into account the impact they have on the mental health of its members. Mental health, indeed, will have to be the highlight of measures to be taken for the aged.

If the difference between the aged of the past and those of 20 years from now were to be so vastly different as this, it is obvious that the medical care system based principally on hospitals and clinics would be of no avail. This is the primary shortcoming of the medical care system proposal of the Ministry of Health and Welfare.

Those political leaders who have no capacity to think about these problems ought to leave their posts. Then we should anticipate the advent of politicians capable of guiding public administration.

At least Health and Welfare Minister Sonoda of the Suzuki Cabinet will have to be asked to resign before anyone else.

Complex international interchange among the nations of the world is expected in the years ahead. Highly complex and multifaceted international relations are expected to come into being. If Japan maintains the present economic scale, she will surely be unable to free herself from its influence.

If we are to further develop our economy and heighten our creativity, originality and productivity, then it will be a very

important requirement for us to support today's youth, who will be Japan's real leaders 20 years hence, with regard to their mental health from a new international standpoint.

We have a splendid Constitution which renounces war. But seen in the light of the reality of the present-day government and administration, this Constitution may be said to be a mere luxury. We wish to emphasize that, if we are to allow the spirit of the peace Constitution full play in international society, then we need a new way of thinking for raising our productivity, creativity and originality and developing our culture and economy with primary emphasis on countermeasures for the aged.

Health and Welfare Minister Sonoda has been highly responsive to issues of medical care. We wish to point out, however, that his responses are totally lacking in time-perspective.

Welfare administration lacking in time perspective is most inappropriate for medical care that deals with man. It can deal with only the problems of the past and the present but is incapable of speculating on the future and developing accordingly. This all-important time coordinate is missing from the attempted partial revision of the Medical Care Law and the present-day welfare administration.

Another thing that is lacking in welfare administration is the biological coordinate, along which to consider man as a living organism.

All this suggests that we are now sowing the seeds of our own self-destruction 20 years from now. Yet, it must be that the people wish to get away from such government and administration as soon as possible. We hope that the people will make a cool-headed judgment on this point.

We of the JMA wish to state here in unmitigating terms that if the anachronistic, restraining law we described earlier were to become a reality, it would mean Japan's ruination in 20 years. For this reason, we cannot cooperate with the government in enacting it.

Under this proposal, the aged over 70 are to be given medical care according to a program set up by the Minister of Health and Welfare

especially for them and separately from the health insurance plan of the present by newly creating a health care machinery for the aged. If a litigation were to arise because a patient cannot receive full medical attention due to the program set up by the Minister of Health and Welfare, the physician involved is certain to be the loser in the suit.

As a matter of fact, there have been a large number of legal cases in which a physician has lost for having given the medical care designated by the Health and Welfare Minister. The judge, from the position of respect for human life, has always required the physician to provide medical care above and beyond what the government required. We feel that this is an admirable attitude.

For all these reasons we cannt cooperate with the government on the creation of new health care machineries for the aged, and we are compelled to decline the designation as physicians to work under that new system.

The JMA today follows the policy of making redress for malpractice. But when the outrageous law we have been describing here is legislated, then we must decide that we will not pay indemnity for any claim brought against us under the health proposed medical care system for the aged.

It is also impossible in reality for a medical facility to be a part of two separate, complicated medical care systems, namely, the present health insurance system and the proposed medical care system for the aged. Yet, the bureaucrats, in total defiance of such procedural impossibility, are attempting to force the new program on the medical profession.

We of the medical care facilities clearly refuse to participate in the health care system for the aged. But we have no intention of refusing to give unrestricted medical care, that is, medical services outside the realm of the health insurance system. We are resolved to respect the lives of the aged much more than the Health and Welfare Minister.

If the aged were to find the cost of medical care to be a problem, then we wish them to realize how indifferent the government is toward the lives of the aged.

As we have described, it is evident that when entirely new social

conditions come into being, it is impossible for the hospitals and clinics of today to support the medical care system of 20 years from now.

Speaking in terms of community medical care, the best that could be done would be for the local governments and local medical care associations to discuss and cooperate with each other to establish a full medical care program for each area. To carry out medical services suitable for each local community will indeed contribute to the welfare of the people.

It is totally anachronistic for the Health and Welfare Minister to control a medical care system in the same way that the wartime military regime placed national life under its own control. We urge the Suzuki Cabinet to vigorously search its own soul.

(*The Japan Times*, April 4, 1981)

Lest the Aged and the Young Fall Together

Prime Minister Suzuki promised to streamline administration by staking his own political career. But the Health-Care-for-the-Aged-Bill, prepared by the Ministry of Health and Welfare, will only further complicate the health insurance administration.

Even the aged over 70 years can receive much better medical care under the existing health insurance system. The essence of the proposed bill in question is to spend the minimum on people over the age of 70. What this means is that the government wants old people to die as soon as possible. This is a health insurance law which is concerned primarily with state finances but not with the health of man.

Health care may be preserved under the present system of public hygiene. The number of invalids among the aged has increased only because the Ministry of Health and Welfare has been negligent for 20 years. If care had been given the aged, the cost would have been only one-tenth of what it is today.

The attempt to further complicate the health care law is a typical example of political action that goes against Mr. Suzuki's policy. The people certainly do not support it.

If the Health Care Bill for the Aged is passed, it will fail to give proper health care to people when it should be given — only to create problems in 15 to 20 years. This is the reason why we object to it.

At the same time, the number of young people will become extremely small, and there will be an age of neurosis. The number of the aged with mental disorders will also increase, and the aged population will be greater than ever before.

Then it will also become difficult to maintain and develop our industrial strength and stimulate creativity among people. As the following chart shows, unhealthy aged persons will increase in number, and among the younger citizens, who are unable to shoulder the burden of caring for them, neurosis will become prevalent.

On the Social Security System Council, comprising scholars who are henchmen of the government, and the Social Insurance Council, there are only one or two persons who specialize in medicine. This is only about one-twentieth of the total membership. It is indeed incomprehensible that this should happen.

The members of the councils who have no understanding of the structure of the health care system of our country seem to labor under the impression that health care and medical care are aligned to each other. This is farthest from the truth. Not all of health care services directly lead to medical care. Nor does all of medical care depend on the extension of health care services. The recommendations by the councils like this comprising members who lack the basic understanding are really horrifying when viewed from the standpoint of the people. The policy of handling the aged over 70 years with cheap medical care is a blatant violation of human rights.

The Ministry of Health and Welfare created a separate council, the Council on the Health Care for the Aged, to which it appointed as members those who adulate the bureaucrats. This council, which writes ministerial ordinances and Cabinet orders according to its own whims without recognizing academic freedom and independence, and dares to ignore the human rights of the aged, is attempting to keep happiness away from people of the future.

We who are responsible for medical care cannot sit idly by when such a bill is submitted to the Diet.

This bill, when it becomes law, will compel every physician to work for the system for health care for the aged. But health care for the aged requires gerontologists. There are many physicians such as pediatricians and obstetrician-gynecologists who are not suited to

work for the health care of old people. Even in psychiatry, those specializing in the mental health of infants are different from those who specialize in the mental health of the aged.

If such distinctions are ignored and all physicians are put in charge of the health care of old people, there will be no greater misfortune for them. Such an outrage as this must not be tolerated particularly today when we do not as yet have a comprehensive clinical system.

Under the proposed Health-Care-for-the-Aged Bill, the payment of medical care costs will be placed on a contract basis instead of the existing fee-for-service system. Among the aged there is a great disparity from individual to individual in terms of health conditions regardless of age. Therefore, the idea of applying the contract system uniformly to all persons over 70 years of age is tantamount to asking them to die without causing the government much expenditure on their health care.

Can we tolerate such an outrage upon the aged persons who have devoted their lives to the development and prosperity of our nation?

As is obvious from the bill it is proposing, the Ministry of Health and Welfare has created several councils that erflect a total lack of understanding of medical care, thereby tring to manipulate the health care for the aged according to the will of the bureaucrats. We have resolved that such councils be promptly abolished under Mr. Suzuki's administrative reform plan.

The fee-for-service system of health insurance we have today at its beginning was practically the same as a system of paying a fixed fee for each case. But it was abolished because it did not suit the reality. In its place was adopted a contract system proposed by the Japan Medical Association (JMA). But the contract system, too, was not consonant with reality. Thus, the system of allocating points for various medical services was adopted, and it has remained in force for 50 years.

The present system of assigning points to each item of medical care is a paying formula based on materials. That is, the more materials a doctor uses in medical treatment for his patients, the more monetary

reward he receives. Therefore, a doctor cannot receive a great deal of income unless he is a specialist in a branch of medicine that requires the use of a large quantity of materials.

Under this system, the income of a pediatrician, for instance, cannot be much because in his field of specialization, the doctor cannot frequently collect blood samples, conduct tests and give injections, which are all unpopular with his infant patients. Only the use of a large quantity of raw materials, which allows him a proportionately large margin of profit, ensures a doctor an increase in revenue.

This system of fee-for-service, which is based on the consumption of materials and which denies the value of a physician's skill, already belongs to the past. And yet the outdated system has been preserved to date by our health insurance bureaucrats and parliamentary politics.

The JMA has always advocated a different fee-for-service system, which is based on the value of the physician's skill. The insurers' organizations have registered their objection to the fee-for-service formula at the meetings of various councils. But the system they object to is the fee-for-service system of the past, and not the fee-for-service system the JMA advocates, which is based on the value of the physician's skill.

In order to have this new system instituted, the JMA has endured the present health insurance system which provides the doctors with very small fees for their skill and technology. In 1967, the system of "reconsultation" was introduced to give a doctor extra points for remuneration for second and subsequent visits by his patients. At the beginning, however, the reconsultation fee was only three points, which was equivalent to the price of a cup of coffee and less than one-tenth of the price of a haircut. It was under such a system, which ignored the value of the physician's skill and technology, that the JMA proposed a fundamental shift in the orientation of the point system for computing remunerations for the physician.

The fees for surgical operations, too, are extremely low compared with international standards. For such fees, it is impossible to conduct an operation of a highly advanced level of today. This means that the

surgical operations of the past that depend on materials are no longer valid. This situation is forcing an increasing number of surgeons to drop their scalpels to become internists. This is a truly sad situation.

We think that when the new fee-for-service system is established, we can eliminate waste in medical services.

We often hear today the expression, patients being "inundated by tests." This phenomenon has arisen from the fact that the point allocation table has never been revised despite the progress achieved in clinical tests and testing equipment. The Health and Welfare Ministry is responsible for this.

When a new medical device is developed, it is studied by an advisory council of the JMA. This council decides the number of points to be assigned to its use on the basis of the existing point table, which is based on the principle of evaluating medical service in terms of materials. In other words, such points are determined totally independently of the skill of a physician.

Tests today are automated, enabling the testing of a large number of persons — 50 or 100 — at a time. This means testing chemicals could be small in volume and inexpensive. Yet, the fees for these tests have not been revised since the days when the doctors conducted them manually. This is at least one area of the system that ought to be revised.

When a newly developed medical service is to be resorted to, the part of the fee for high-level skills ought naturally to be proportionately high. But after that particular form of medical care becomes popular and special consideration becomes unnecessary, the points allocated to it should be lowered. That we think this way shows that the JMA is an organization of both professional conscience and common sense. We are not an organization, like those of the insurers in the health insurance system, that merely seeks our own self-interest.

Tests which do not make use of machines, on the other hand, do take considerable time even today. We have been demanding a major raise in the points for such tests because this is a legitimate demand. In

the case of the test of hormones, for instance, only one-half or one-third of the cost actually required in the test has been given points. This is another shortcoming of the system still based on the outdated point table.

If we created a system in which the point table may be constantly revised in response to the progress of science, we should be able to completely eliminate wastefulness in medical care payments. "Inundation with tests" is a phenomenon that has inevitably arisen from the fact that the point table is kept unrevised. It is an example of an ill effect coming from the refusal to accept new things.

Another expression, "inundation with medicines," is also heard often. This phenomenon derives from the fact that because of the progress attained in pharmacology, the purpose for which each medicine may be used has become extremely narrow.

One medicine is effective for only one symptom. Even an antibiotic does not have a uniform effect on all bacilli; rather, each has its own area of specialization. On the other hand, one biotic sometimes may destroy even the necessary intestinal microbes. This means that another medicine to prevent such a side effect must be administered at the same time.

Under the present system, medicines are produced according to the principle of one substance used in one medicine, which is contained in a capsule or a tablet. When they are added together, the total volume may give the impression of a large quantity. But each of the necessary medicines is not really very large. At university hospitals and state hospitals where high-level medical services are provided, the quantity of medicines dispensed to patients tends to be large as the patients themselves know.

The private practitioner gives his patients the smallest amounts of medicine. "Inundation with medicines" is a phenomenon that was created by the fact that the old payment system is applied to the medical services that utilize the latest achievements of pharmacology and the pharmacological industry.

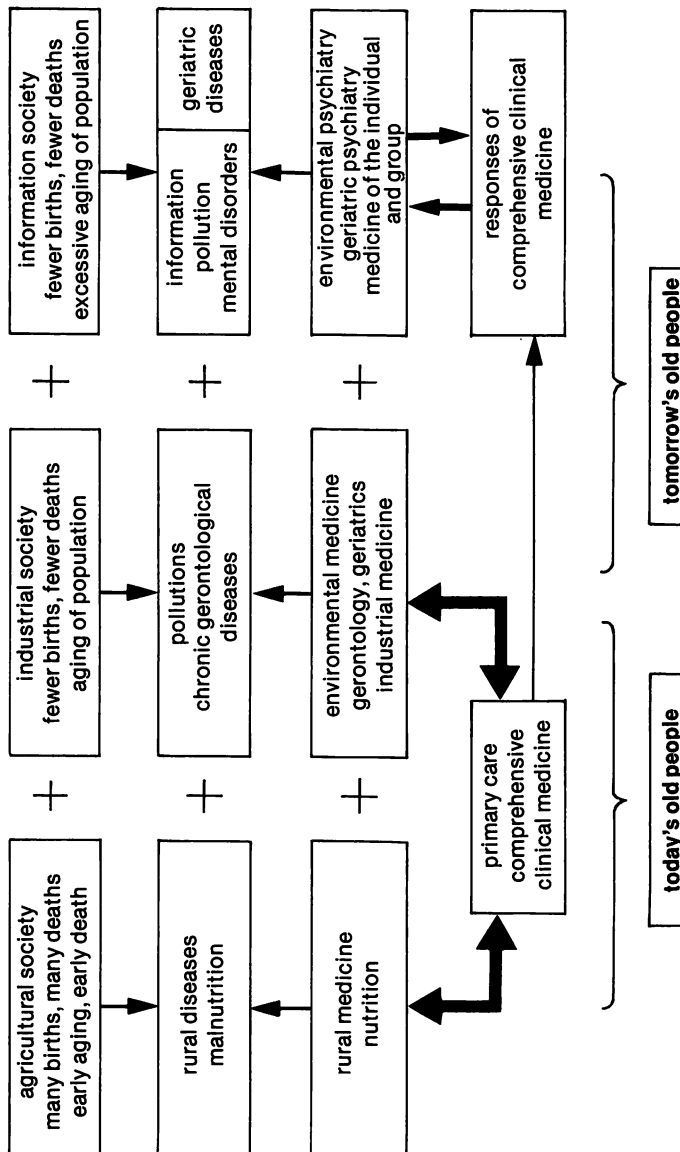
When Mr. Zenko Suzuki, the prime minister, was Minister of

Health and Welfare, President Taro Takemi of the JMA proposed that the prescriptions written by physicians should be all filled at public pharmacies without cost. The system envisioned the creation of a drugstore next to each post office so that the patient may have a choice between a public drugstore and a private one. To this proposal, the Japan Pharmacists' Association fiercely objected and the proposal was not carried out. If this system had been put into practice, however, the doctors today may be totally free of any kind of accusation no matter how many medicines they may prescribe.

There is another problem, that is, the so-called "second pharmacy," the pharmacy run by a practitioner or his relative in the neighborhood of his private clinic. People think this is a sin. Actually, however, this was a device thought up by doctors as a means to fill the gap when the pharmacists' association did not establish a sufficient number of drugstores capable of filling prescriptions. But even a "second pharmacy" does have a qualified pharmacist, and it does serve the purpose of separating the functions of doctor and pharmacist. So many of the ordinary drugstores combine the functions of a pharmacy and that of a notion store which sells cosmetics, sundry goods, etc., that people, as a matter of fact, are disinclined to take their prescriptions to these drugstores because they do not have full confidence in them as a pharmacy.

In such a situation, the president of the Japan Pharmacists' Association is attempting to force the separation of the functions of doctor and pharmacist in order to have that system serve the interests of the pharmacists. We cannot think of anything that slights people more than this. The pharmacists' association ought to take a lesson from the fact that in the field of medicine public medical care facilities and private facilities coexist.

Medicines, furthermore, are materials. Therefore, it is wrong for the vendors of these materials to demand the same fee for technology as in the case of medical service. Medical care costs must be computed on the basis of remuneration for skill as its main element. But the costs of maintaining a pharmacy is primarily that of materials while


agricultural society
many births, many deaths
early aging, early death
rural diseases
malnutrition
rural medicine
nutrition
industrial society
fewer births, fewer deaths
aging of population
pollutions
chronic gerontological
diseases
environmental medicine
gerontology, geriatrics
industrial medicine
information society
fewer births, fewer deaths
excessive aging of population
information
pollution
mental disorders
geriatric
diseases
environmental psychiatry
geriatric psychiatry
medicine of the individual
and group
responses of
comprehensive clinical
medicine
primary care
comprehensive
clinical medicine
today's old people
tomorrow's old people

technology is secondary. We wish that Prime Minister Suzuki would push the program of establishing public pharmacies while he is in office.

Prime Minister Suzuki has been advocating a broad administrative reform plan, on which he seems to be staking his political life. Yet, there are still hundreds of impotent councils that are manipulated at will by bureaucrats.

We hope that the Prime Minister will have a high-level, competent council to study this matter so as not to continue to harass the people by this institutionalized bureaucratic self-righteousness.

In welfare administration, too, officials who are no longer necessary continue to hold office along with outdated laws only because these laws are preserved. These officials are the ones that ought to go. Unless this aspect of administrative retrenchment is promptly carried out, there will be no meaning to the so-called administrative reform. The damage these antiquated laws and officials cause to the people in relation to the old health insurance association system and other undesirable institutions is enormous. The JMA sincerely hopes that these problems will be promptly dealt with in the administrative and fiscal reform programs.

(*The Japan Times*, May 22, 1981)

What We Want of the Council on Administrative Reform

Every citizen is in favor of eliminating "excess fat" from the administrative structure of our government.

The "excess fat" is found all over in our administrative structure — at places where outmoded laws do not suit the present conditions and prevent future development. And this proves a major financial burden on the people.

Elimination of this waste, of course, is what every citizen wants.

Administrative retrenchment, carried out by bureaucrats, is designed to fit the budget, not to fit the needs. What we need is the elimination of wastes. If you leave it up to bureaucrats, they would never cut their own budget or authority. It is indeed impossible in the light of the nature of bureaucrats. This is the reason why wastes continue to expand structurally and fiscally.

To accumulate all these wastes and remove them in one fell swoop seems to be the aim of the Special Council on Administrative Reform (SCAR). It is odd that this kind of reform must be left up to the SCAR. It seems to us that this makes people only wonder about the function of political parties under our party politics system.

Private individuals, that is, not bureaucrats, always think of "removing waste." And they think of making use of what has been cut and removed for future development. This is the wisdom of private people. This shows a major difference between the common sense of the bureaucrat and that of the private man.

The SCAR created this time is said to be under the domination of business people. But business people, too, are private persons,

nonetheless. Yet, they cannot but think of the interests of their own corporations. This may cause the people of the country to have some anxiety and dissatisfaction about the SCAR.

The financial world of Japan has had an increasing say in politics and administration, while causing the governments to accumulate a large amount of waste in certain areas. And these same people are now playing the role of someone cutting off the fat. It is inevitable that doubts should arise.

Throughout the world we see modern society, wherever it may be found, making a notable development as a systemized society. In Japan, too, great development was achieved first in the systematized sectors of society, making Japan develop to become a major economic power.

Likewise, administrative and social reform, too, should be conducted by systematization. This is what the people anticipate. Yet, the SCAR this time seems to be utterly withtout any inclination toward systematization.

The future development of Japan must be based on science and technology. In order to promote creativity and development in this area, the vertically divided Japanese society must be drastically overhauled.

Indeed, everything is vertically divided in our society — be it university education or research. Unless we give fundamental thought to transforming this vertically divided society into something else, administrative and fiscal reform will not get anywhere. At least, any reform program without this basic thought as its background is likely to be a waste of effort.

In the area of population, we need drastic measures now in order to cope with the major reduction in the population of young people 20 years from now. Without consideration for the social and educational bases for the fostering of young people with ability to create and develop, administrative and fiscal reform would have a dire consequence. It must be realized that, without this consideration, there could be no future for Japan.

Our welfare problems always start with local governments. The central government has taken up the equalization of welfare measures for all people. This may be appreciated as an achievement by the government. Unevenness in public welfare measures derives from the disparate welfare systems maintained by the local governments, which produce amazingly undesirable effects. The central government has reduced this unevenness without adversely affecting local government itself.

This time, however, SCAR is attempting to impose a burden on the finances of local governments in dealing with, for instance, the problem of reducing the state subsidy for the national health insurance plan. This is an instance of outrageous disorientation. It is likely to destroy the evenness in public welfare that has been attained by the central government.

Welfare in terms of medical care must be based on a long-term prospect of 20 years. There has been much waste because our medical care welfare has been implemented on a moment-to-moment basis according to election promises by politicians. The program has been notably deficient in planning and purposefulness.

These facts make it obvious that medical care welfare must be built up on the firm basis of a welfare system by the central government rather than being left to local governments. What is important, in fact, is that the central government take the initiative and make requests upon local governments as it thinks necessary. The arrangement at the local government level to enable the accommodation of welfare measures initiated by the central government also must be planned by the central government. If this could be done, our medical care would make a notable advance while eliminating much waste.

A haphazard welfare policy without much planning and purposefulness is doomed to die. But we do not believe that the cut proposed by the SCAR is confined within that margin. What is to be really feared is the possibility of the proposed cut by the SCAR damaging the substance of public welfare itself. At least, the people are apprehensive about it.

The concept of welfare in Japan is stale, namely, it is thought of as something that should be left up to the central government and as something to be paid for with money. This easy-going way of thinking has been the basis of our welfare program, with which the people have been content. But today, welfare for the people requires a major background of science and technology, not just a monetary background. It is also necessary for us to think of the problems of development and allocation of welfare resources at the same time.

The central task for welfare is "to provide conditions that enable the people to feel that their life is something worth living and to enable all people, young and old, to live their lives positively while being conscious of their social responsibilities."

The kind of welfare that may be likened to giving a lollipop to a child who wants it belongs to the past. If there is such a phrase as "election welfare," we think it is a very apt expression to describe this kind of welfare. Japanese welfare, it may be said, has been an accumulation of "election welfare" measures. These measures have been tidied up somewhat by administration to present the appearance of a welfare system. And yet the basis of that apparent system of welfare is no better than the concept of "election welfare." This has been amply proven through many aspects of it.

This kind of outdated concept of welfare inevitably means a big financial burden on the people, which they themselves have come to realize. At the same time, this kind of concept of welfare has, in this age of material affluence, come to be the object of popular contempt.

Vested interests are found within the area of election welfare. Though there are many difficulties today, we must seek a complete re-examination, if not reorientation of welfare now.

As for welfare for the aged, a reading of the provisions of the Health-Care-for-the-Aged Bill makes it clear that it is a welfare bill for the insurers in the health insurance system, and not for old people themselves.

Such phony welfare has been passed off as welfare by electioneering politicians. Other forms of welfare involving medical care all belong to the same category. We can expect welfare to develop

only when the people themselves give thought to it in the interest of social progress and of their own and their offspring's welfare.

Take the population problem, for instance. It is not progressing in the desirable direction. In 20 more years, it may decide the fate of the entire people of Japan. There should be countermeasures that ought to be taken to cope with this problem in the interest of the people's welfare, and yet nothing has been done.

This is only one example. But it is a fact that welfare in Japan is at a serious crisis because it has been turned into election welfare. Pensions, particularly those of the employees of the Japanese National Railways, have all but disintegrated. Other forms of pension also have many problems inherent in them.

This shows that welfare in Japan is a series of measures that have been left on the shelf, and few are offering any bright hopes for future.

As our society enters into the information age, we may find that our life is materially affluent in appearance, with each individual being assured of an adequate income. Yet, there is already a rising fear about whether in such an age people would have spiritual satisfaction.

We cannot think of welfare without measures for insuring spiritual satisfaction. What is most needed today is a welfare system that gives each individual spiritual satisfaction and spiritually wholesome social activity.

If we should come to need such a welfare system in 10 or 20 years, we should find that it is already too late. In order not to face such a tragedy, we must start preparing for it now.

The current SCAR ought to use its hatchet boldly and thoroughly in matters concerning welfare in Japan. But the hatchet must be used so as not to interfere with the progress to be achieved by welfare of the future. It also ought to turn the interest of the people in the proper direction.

Election welfare has been legislated by the bureaucracy, but it is devoid of future possibilities. The SCAR is also preoccupied with curtailment of the budget without future orientation. This is indeed dangerous.

People's welfare in Japan must be considered in terms of the population structure, life structure, environmental and housing problems of 20 years hence, so as to create a system in which mentally tough human beings who can cope with the problems of the new age may be fostered. That should be the condition for welfare. And the people are watching the SCAR for what it may do to create such a condition as the first step toward fulfilling the requirements for the future.

The political and administrative structures of today are producing much waste. When the people think about the future of our country, they must naturally want the SCAR to do something drastic about such structures. And yet, the wishes of the people do not seem to be heeded by the council at all.

We want the SCAR to use its hatchet boldly toward the great objective of eliminating wastes from Japan's politics, economics and finances and put Japan at the head of mankind on its march toward peace in the 21st century. If the SCAR were to build up a foundation for Japan in the 21st century by exerting a major influence on politics, economics and finances, the council would receive the support of the whole nation. If this happens, we anticipate the possibility of the people willingly abandoning the concept of vested interests.

The SCAR cannot be a body to last only one year and only for suppressing finances. It must be a body to reorganize politics, administration and public finance. It must, furthermore, serve as the starting point for linking the future peace of mankind with the people's welfare. The people have great expectations of it.

(*The Japan Times*, July 9, 1981)

Papers and Addresses

The Medical Association Hospital as the Starting Point for Renovating the Medical Care System

Today I wish to state my views frankly on the need for understanding the nature of the medical association hospital as the starting point when we consider a new medical care system. I conceived of the medical association hospital in 1950 when I became vice president of the Japan Medical Association (JMA). The first such hospital came into being in 1952. The reason why I conceived of such a hospital is that the medical science we had studied in the past was a science for treating invalids and it dealt only with organs of the human body. But it was not a medicine for human beings.

Those who are studying medicine say medicine is a science. But when it is considered from the standpoints of the physician and philosopher, it is not a science. The reason is that it stands on the single pillar of the mode of thinking peculiar to experimental biology. It relies on the results of experiments only, without theories with which to make critical judgments. This is the reason why medicine does not qualify as a science.

In physics, however, there is theoretical physics and experimental physics, enabling the physicist to make theoretical assertions and criticize the result of an experiment by comparing it with theory. There is also administrative physics, which is the social application of physics. Today, the practical application of atomic power has become a big problem. Physicists had thought about administrative physics already when theoretical physics developed.

This address was delivered by President Taro Takemi of the JMA at the fifth on-the-spot study meeting of the All-Japan Medical Association Hospitals held on August 22, 1981, at Kagoshima.

After I initially talked about administrative medicine in the JMA, many other people began copying me. But I do not hesitate to declare that there was no administrative medicine at that time within the framework of the three categories of physics. I thought that we must consider how we should behave when we enter society after having studied medicine while remembering the environment in which we had become physicians.

I was strongly aware of a spirit of rebellion within myself about the premise that medicine is not a science. The physicist does not deal with biological concepts. But I thought it was impossible to think about human society without biological ideas but only with physical theories. I thought that another concept of biology should be added to our thinking of society, and in order to do this many new ways of thinking were necessary. One of them was that biology and physics must combine. Even in administration, biology must fuse with it.

It is thus that my thinking reached the concept of "community medicine." The reason why I proposed the concept of "family medicine" after reaching the concept of "community medicine" is that I felt it was necessary to introduce the concept of biology to the categories of physics I mentioned. Today we have an academic discipline called biophysics, in which physics and biology have become fully fused together. But in the years 1950 and 1951, it did not exist. In such an age, I believed that it was impossible to discuss human survival without the concept of biology, and therefore I introduced the concept of ecology.

Ecology was founded by Ernst Heinrich Haeckel; that is, the Haeckelian theory of biology is ecology. Since the prototype of ecology is the simultaneous grasp of a community and its human inhabitants, I have espoused this approach. I believe that there is an ecological basis to disease, and disease, of course, also has a physical basis. Ecology is the largest element of the biological basis of disease. This is the reason why I began thinking about the problems of human ecology.

It so happens that at that time I obtained a book by Professor Lesly Banks of Cambridge University at Maruzen Book Store. He was

professor of human ecology at Cambridge. Having realized that Cambridge University had such an advanced course, I invited the professor to Japan, and he was pleased to come. With this as the beginning of our acquaintance, Professor Haruo Katsunuma of the University of Tokyo established, with Professor Banks' guidance, an independent course on human ecology at the university within the department of public health. After his retirement, his pupil, Professor Suzuki succeeded it. This shows the social and academic impact of my personal thinking.

The politician of those years who gave the utmost support to my way of thinking was the late Mr. Kiichi Aichi. When he became Minister of Finance, he proposed to me that I should establish a medical association hospital, for which he would offer financial assistance. This is how we established a medical association hospital in Tochigi City, which was the first such hospital to pave the way for others throughout Japan.

To sum up what I have said so far, the concepts in physics alone cannot define medicine; biological concepts must be introduced, and this is best done through ecology.

Having started in this manner, one thing I became keenly aware of is the enormous change that had taken place in the Japanese home.

The year 1950 was just about the time in postwar Japan when the family system became disorganized. At that time — a time of chaotic confusion in thinking about the family system — I searched for literature to find guidance on how to think about the home in Japan. Then I discovered a wonderful sociological study on the home by Professor Tongo Takebe of the University of Tokyo. His study was continued by his pupil, Professor Teizo Toda. Sociology at the University of Tokyo is essentially concerned with the home in Japan. Professor Takeshi Fukutake, who has recently become professor emeritus, has also carried on this sociological school of thought.

There is another school of thought — political — about the home in Japan. And there is legal thought about the home. In this area, the French jurist Gustave Emile Boissonade has made the sharpest study on the subject. The concept of the home, *ie,* in the civil law

studied by Boissonade is totally different from the home in Europe. Nor is it like the family. This is the reason why Boissonade used the Japanese word *ie* instead of any French or English counterpart for it — a fact that indicates how much peculiarity he recognized in the Japanese home.

I am not going to dwell on the *ie* today. But I wish to say that during the chaotic postwar years, I wondered about what kind of concept the physician should establish of the *ie* and how he should grasp it as a physician to be medically most effective and constructive.

There is great significance in the fact that I used the words "effective" and "constructive" together. By "effective," I mean that medical care cannot be "effective" unless the patient's family environment is good.

Another thing I thought about the *ie*, which is very important and has a very constructive meaning, is the question of how the family system may develop in our democratic society. If we imitated the American-style nuclear family here, how far can we go before becoming stifled in terms of our climate and our family custom? If we are to find a constructive new direction, how should we think about these things? I believed that unless this *ie* turned to a constructive direction, the medical care system would not turn to a constructive direction, either. It is entirely impossible that the medical care system alone should turn to a constructive direction.

A major basis of the medical system is the health of the individual, the condition of the patient and the immediate environment surrounding him, namely, the family environment. Then come the community environment, social environment and natural environment in concentric circles. If we are to count them ecologically, there is no problem in how many we may count.

I made an effort to theoretically organize the way of thinking about community medical care. I also attached much importance to the question of in which direction medicine as a science should move forward. I myself spent six years in the internal bureau of a medical college from which I had graduated. After that I was busy studying atomic physics for 15 years. This is the reason why I have been able to

take the vantage point of viewing the world of medicine from another world. At the Institute of Physical and Chemical Research where I studied physics, there were experts in botany and zoology, with whom I was able to study. This experience has enabled me to discuss the biological way of thinking found in the physics department.

The most important factor in building the future society of Japan was to think of the future course of the *ie*. I realized the enormity of the area in which the physician played his role and the weight he carried. This meant a heavy responsibility for the physician, not merely that of curing his patient, but much broader in scope.

Another important matter to be taken into consideration was economic development. We took into account the consequence of economic development as a kind of feedback mechanism in society. One person who heartily endorsed my way of thinking and cooperated with me was the late Ichiro Nakayama, the economist. A specialist in theoretical economics, he said to me, "Your theory resembles that of Adam Smith in that it places much emphasis on human biology. It's very interesting. I would like to work with you." This is how the JMA even today benefits from Professor Nakayama in that we have those scholars who have taken over his theory to look after the economics department of the JMA.

Economic development, for instance, could not be considered by separating it from making the home and society itself sound. And medical care must not be isolated in that context. Yet, most professors — or medical schools — teach medicine but not medical care. When they do think, they think within a highly isolated context.

One interesting illustration of this isolated way of thinking is the following episode. When Seiji Kaya, my friend, was president of the University of Tokyo, the dean of the school of medicine was Professor Tomizo Yoshida. President Kaya suggested to Professor Yoshida that the School of Medicine create a course on biophysics. To this suggestion, Professor Yoshida replied that in his school it was impossible to make a professor of someone who was not a doctor. This is how he turned down Mr. Kaya's suggestion. This is the reason why the course of biophysics at the University of Tokyo is offered in the

Department of Physics, and not in the School of Medicine.

When I became president of the JMA, I invited many first-rate scholars of law to the association. Fortunately, a personal friend of mine was Professor Hajime Kaneko, an authority on the law of criminal procedure. I asked Professor Kaneko and Professor Teruhisa Ishii of the commercial and labor laws to think about the basic structure of the JMA along with Mr. Nakayama, the economist. I also had Mr. Tetsuzo Tanikawa and Professor Seizo Oye, who are philosophers, to join us to study the basic problems of our organization. This is how the basic structure of today's JMA was formed.

One thing that should be borne in mind is the fact that the laws that control our activities such as the Medical Practitioner's Law, Medical Care Law and Health Insurance Law, were not products of a democratic society. The medical laws are also based on classic German medicine, which had no foresight for the future.

These are the reasons why we were compelled to choose a direction for our thinking, which was different from that in the past. The new policies and measures the JMA produced were products of the process of discussions held by us with these specialists in the various fields on how to apply the bases to the practical problems. They were, therefore, not haphazard ideas, but were spawned by thinking based on a new standpoint of integrated sciences. Even if I were a genius, I could not — and should not — think up these ideas. I wish to emphasize in this connection the importance of thinking basically and that the products of such a way of thinking have permanence.

When our society changed to a democratic society, there was a change in the economic environment; namely, a free enterprise society based on market economy, came into being. On the other hand, the concept of a welfare society also came into being, giving rise to the social security system in Europe. This social security system was created as an offshoot of the health insurance system. But it is also a fact that this includes the concept of the poor law.

When we considered what kind of medical care system we should have in Japan according to our own way of thinking, it was inevitable that we would clash with the Ministry of Health and Welfare. The Medical Practitioner's Law and Medical Care Law are not products of democracy but were laws designed for social control in a feudalistic society.

These laws negated all the freedoms recognized in a free society. This is not strange because these particular statutes were enacted in the age of feudalistic thinking when a citizen could be called up for military service by a single postcard to sacrifice his own life for the state. The Health Insurance Law, too, was based on the same line of thinking to help "the state grow affluent with a strong army." It was not a law designed for insuring the health of citizens. It insures against disease but not for health.

Under these circumstances I had to commence my tough struggle of 24 years. When I became president of the JMA I began thinking about how to break through the wall and with what as basis to solve the problems. I decided that I should try to break through the wall with professional freedom. If we could win it, we would seize the key to the solution of the problems concerning respect for life in a democratic society. And the physician who holds that key to the solution of the problems must be given by the people a high social status as the guardian angel of their life. This is to be given by the people, not by the government. Under a feudalistic system, the statutes are determined by law. In a democratic society, however, these statutes must be determined by the people. In that respect, the person who guards the life of the people is the physician, who has professional freedom. This is why I thought it was of vital importance to think of ways of expanding this professional freedom.

While I was vice president of the JMA, the Ministry of Health and Welfare had a commission to do cost accounting for medical care expenditure. There could be no such thing as cost accounting for medical care, and this was stated by such first-rate economists as Mr. Ichiro Nakayama and Mr. Kiyoshi Nagata. But the ministry was

shameless in sticking to the idea of reducing the medical care cost as much as possible while we concentrated our efforts on professional freedom. As you know, these two positions often clashed against each other. In our battle to safeguard our professional freedom, however, we first won the government confirmation of four principles. But this has not been carried out.

There is an interesting episode concerning this, which I should like to tell you. When I was in hospital recently, Mr. Kakuei Tanaka, the former prime minister, came to pay me a visit. And he said by my bedside, "As a politician, it was my policy not to commit an agreement to writing. But only once I was forced to — that is, to the medical association concerning the four principles. But those four principles are very good and important, and they ought to be put into practice. If I should ever return to the seat of power in politics, I will take this up before anything else."

He concluded, "Compared with your ideal and also with what I have learned, the present welfare administration is nonsense."

We also had the 12-item issue and then came to that occasion of all of our members resigning as health insurance doctors. In effect, we were fighting for professional freedom while preaching respect for the life of the people against the welfare ministry bureaucracy to which any means was justified for the purpose of crucial and unnecessary reduction of medical care cost and its way of thinking that their end could be achieved only by pushing the medical profession into a feudalistic system by law. The mass media of Japan, meanwhile, lacked the ability to understand our intentions because they were successors of the wartime military clan and bureaucrats. I still believe even today that the mass media have not changed.

It was at this stage that medical association hospitals were to be created. Now I will show you slides to illustrate my talk.

The origin of this concept of a medical association hospital is to be found in an effort to solve the problem, through close cooperation and studies among the staff, of seeking stability in the future from the shortage of materials and mental insecurity of the postwar era. (Diagram 1)

Diagram 1.

Origin of the Idea — 1950, when Dr. Takemi was JMA Vice President

1. Seeking stability in postwar shortage of goods and mental instability
2. Prediction of development of new human relations in a democratic society — in the organizing process
   a. New phase in inter-physician relations — participation and cooperation by technologists' groups
   b. New phase in physician-patient relations
   c. New phase in physician-community relations — proposal of concept of community medicine
      Patients to be grasped in the context of the community and its life

We thought of prognosticating the development of a new theory on human relations in a democratic society. There could be many theories on human relations. But we thought it was important how we formulate, from the standpoint of democracy, a theory of human relation between the physician and his patient. There is also a new aspect to the relationship between doctors. In the old days, a physician faced his patient on a one-to-one relationship. But from now on, because of increasing specialization, the relationship among doctors acquired a new importance. Medical care could not be dispensed without the participation of technologists in the related fields. When all these factors are taken into consideration there is a new relationship between doctor and patient. There is also the new relationship between physician and community, that spawns the concept of community medicine. This is understanding the patient within the context of his local community and life.

The "professional freedom" which we tried to expand was a concrete means for respecting human life and it does not mean license to avariciously obtain remunerations for medical care services. (Diagram 2) I also thought it was necessary to consider as concrete measures for respecting human life the question of remuneration for medical care services as well as the system of cooperative medical services by a number of doctors and the establishment of a new family physician system.

Diagram 2.

Expansion of the physician's professional freedom and its role as defense mechanism

a. Professional freedom as a concrete measure for respecting human life
b. Practice of cooperative medical care of several physicians
c. Establishment of a new family physician system
d. Expanded freedom and freedom of choice

The family physician of the old times was bound by the notion of holding on to his patients through a close, feudalistic relationship. The family physician system in the new age, however, should be one by which the doctor plays the role of commander in medical care to safeguard the lives of members of a family. The establishment of such a system has become necessary.

And when professional freedom is expanded, there is the new problem of selection within the realm of that freedom. Under the old health insurance system, there was very little leeway for options for doctors. A broader range of options means progress of science and also of human society. If there were no range of options, we would not be able to say that we live in a democracy. But the bureaucrats do not allow us a range of selection.

The recent recommendations by the administrative reform council include one for reducing the range of selection for doctors, which we find intolerable. I believe that that recommendation reflects the thinking of the members of the council who are like the "running dogs" of the bureaucrats. Obviously, we can have selection only within the expanded range of freedom. Only when we have this, can we have progress.

These basic concepts I am talking about today are important, and unless you fully understand them when you build a new medical association hospital, you are liable to have serious regrets later.

Now we have the problem of community response to the progress of medical science. (Diagram 3) This means response to heavier medical equipment. This is something a single doctor cannot

do anything about with his own finances. This makes it inevitable that facilities be developed for community use — by a number of doctors. A medical association hospital does play this role. One thing you seem to have totally forgotten is the matter of collection and presentation of medical information. I believe that the introduction of computerization to a community must be done essentially by a medical association hospital. Within a medical care facility, too, computerization has basically altered the form of hospital management.

Diagram 3.

Community response to progress of medical science

a. Response to heavier equipment
b. Development of facilities for community use
c. Collection and presentation of medical information
   Introduction of computerization to community
d. Local bases for life-long training

Today I have listened to three doctors talk about medical association hospitals and wish to express my heartfelt respect to them for the very serious-minded manner in which they are tackling the problems of medical care in their communities. It is in this connection, too, that I mention the importance of the role of computerization as the second stage after the establishment of a hospital.

As for geographical factors, we often hear that patients living near a medical association hospital can make good use of it but those who live far away cannot. This, however, is all wrong. The development of information science will, I think, resolve most of the problems of geographical distance. Unless you have an awareness of these things, you will see the raison d'etre of a medical association hospital vanish. The concept of geographical distance to a hospital is a concept of the age in which people moved on foot. In an information society, this concept will vanish because of computerization. The medical association hospital also must play a crucial role as the community base for life-long training for practitioners.

The public nature of medical care is based on open technology

and open finance. (Diagram 4) The public nature of medical care is cited only as a reason for lowering taxes. But I think this is totally wrong. Open technology and finance are not found in any other profession, nor with any business enterprise. This is the very reason why medical profession has a public nature. If we are to really concretize the concept of public nature, the medical association hospital must play a central role. It is also possible to reject intervention by third parties, e.g., bureaucrats and insurers.

Diagram 4.

Making technology and finance open — Public nature of medical care

a. Concretization of the concept of public nature
b. Elimination of intervention by third parties — bureaucrats, insurers, et al
c. Technological response to comprehensive medicine — community characteristic
d. Economic response to comprehensive medicine — community characteristic
e. Pushing forward the technology remuneration system

On the basis of this way of thinking, I have advocated the concept of "bioinsurance." At the recent meeting of the WMA's Follow-Up Committee on Development and Allocation of Medical Care Resources, I elaborated on this concept. Then we have this technological response to comprehensive medicine, which is a community characteristic, and economic response to comprehensive medicine, which is also a community characteristic. When these two community characteristics are put together, we have technological and economic responses. Then we have this matter of the progress of the technological remuneration system. The revision effected in June (1981) of the remunerations for medical care services reflects progress toward a technological remunerations system. Those (members of the JMA) who refused to listen to the JMA and always opposed it have turned out to be the worst losers while those members who earnestly heeded what we said now find themselves receiving 40 per cent more remunerations. This shows that those who do not heed

the need for responses to changing conditions are left behind.

Next, there are the problems of where to give a health education to patients and their families and of improving the level of the masses as recipients of high-level medical care. (Diagram 5)

Diagram 5.

Place for health education of patients and their families

a. Raising the level of masses as receptacles for higher-level medical care
b. Reforming the popular consciousness — arousing a sense of self-accountability
c. Scientizing life experience
d. Understanding of and effort for mental hygiene
e. Elimination of insurer's restraint on patients

Even though the level of medical care rises, it will not be part of the masses unless the masses themselves become organized as its recipient. In old times, Kaibara Ekken was able to offer a wonderful health education, in the sense of producing a good recipient of medical care in his time. By the same token, the consciousness of the masses must be renovated. And for that, I have been advocating the need for arousing the sense of self-accountability. In Europe, the social security system is in the terminal stage, and the major cause of it is the fact that the Europeans forgot to arouse the sense of self-accountability.

Diagram 6.

Functions and facilities at first-aid medical care center

a. Education and training of physicians and employees
b. Practical education in primary care
c. Family education

The idea of welfare state, too, is disintegrating because it did not have a receptacle in the masses. This, I believe, is becoming increasingly evident as a historical fact. It is also very important to scientize life experience. Then comes the understanding of mental

hygiene and related effort. Then there is the need for removing the restraining insurer's power on the patient. Please look at the moves made by the National Federation of Health Insurance Associations or those of the Insurance Bureau of the Health and Welfare Ministry. They are attempting by this means and that to strengthen their restraint of the patient. And they are conducting a campaign through the mass media against the JMA which is trying to remove the restraint from the patient. This, I must say, is nonsense. We are doing this through community health insurance councils and health promotion councils to remove the restraint on the invalids covered by health insurance. This the people must realize.

Medical Association hospitals have functions and equipment to serve as first aide centers. This first aid center actually should become the focus of primary care. (Diagram 7) There is such a special form of medical care called first-aid medical care or emergency medical care. It is actually the focus of primary care. When there is a first-aid center, it is possible to provide training for doctors and other personnel as well as for families. A first-aid center is not merely a place for accommodating an ambulance. Of course, ambulances must be accommodated but the accommodation means the practice of primary care. There is no way of knowing what kind of emergency patient will be brought in. Therefore, the small fry at medical schools who stubbornly adhere to specialization will not be able to handle this.

Diagram 7.

Adjunct facilities
- a. Clinical examination center — multipurpose
- b. Ward for chronic diseases
- c. Maternity ward, nursery — educational counseling
- d. Diagnostic center — multipurpose
- e. Industrial hygiene center — industrial zones

How is primary care being handled in the United States, where specialization is given much importance? I have heard of an instance in which a passenger aboard a ship had some foreign matter in his eye,

which caused a serious problem. The ship made an emergency call at an unscheduled port just for that patient —at midnight. It was a small port town where there were no eye doctors. But the doctor who was awakened at midnight was able to remove the foreign matter because he was a trained primary care physician, thus beautifully performing his function.

Someone this morning said he was not a specialist for something. This is the kind of situation we must be able to avoid by developing primary care physicians, to which we attach a great deal of importance.

If we are to consider reducing medical care costs, it will be impossible without primary care physicians. Yet, the medical schools we have were built after the German model of 100 years ago. We must reeducate these medical schools a bit. With regard to this problem of education of doctors, I am hoping that those doctors who came to medical association hospitals from universities become awakened. Since the state hospitals have the policy of sending their doctors to study in the United States, I hope that this problem of the education of doctors will be given attention even domestically.

Then there is the matter of adjunct facilities such as a testing center, a ward for chronic diseases, a maternity ward, a nursery, an educational counseling center, a clinical examination center, and an industrial hygiene center. You can build a ward for special diseases or even a center for agricultural hygiene in certain areas. A medical association hospital can perfectly meet the needs of the community in which it is located by having the right kinds of adjunct facilities.

As for the functions and structure, a hospital of this kind must be free from the ideas associated with the general hospital. If a medical association hospital were to be another general hospital where departments are based on the organs of the human body they deal with, then the medical association hospital would become outdated in 10 years. If a hospital were to exist as a useful part of community life, it must at all cost remove itself from the purview of the concept of the general hospital. A general hospital is a hospital created in a feudal era when medicine was at still at an immature state, and it usually carries the name of its specialization.

Diagram 8.

Functions and structure
- a. Becoming free of the concept of a general hospital
- b. Need for designing on the basis of function
- c. Establishment of facilities for information management
- d. Endless planning

I believe that primary care should receive major emphasis in hospitals. Then there is the need for designing a hospital according to its functions. These functions are the functions that may be utilized by the various departments. In other words, a function is something that is utilized by one particular department alone. Information on a patient does not have to be cloaked in secrecy there. This is the reason why this functional designing becomes important. There is the need for a facility for information management. There is also the important problem of endless planning in relation to responding to changes in the community in which the hospital is located.

Still another point of importance is the need for responding to the progress of science. There is also the problem of responding to changes in popular consciousness. This is where endless planning comes in. "Primary, secondary and tertiary" are the words used by bureaucrats, not scientists in a democratic society. The word to be used by scientists is "endless" planning.

Now, how does a medical association hospital differ from an open-system general hospital? Here, we must first of all deal with the question of collaboration between the functions of a community medical association and clinical activities. To combine clinical activities with the functions of a community medical association is a major requirement for a medical association hospital. An ordinary open-system hospital lacks the conditions of a public nature. Therefore, there is a difference in the capacity for development between the two types of hospitals. There is also a difference with regard to the protection of the rights of physicians and joint defense. In the area of information activities, a medical association hospital requires information of a broad scale whereas an ordinary open-system general

hospital does not. Therefore, when a public medical care facility makes one ward open to outside physicians and calls itself an open-system hospital, it cannot serve the same useful purposes as those of a medical association hospital. There is a great deal of difference between the two, to which I hope you will give much thought.

Diagram 9.

Differences between medical association hospital and ordinary open-system hospital

a. Cooperation between functions of community medical associations and clinical activities
b. Single open-system hospital lacking in public conditions
c. Differences in potentiality for development
d. Protection of the physician's rights; differences in joint defense
e. Differences in information activities

I think it is necessary to think about the medical association hospital in the manner I have just described and then give it the potential for constant new development. We do not need it as a facility for scientists. In this sense I am opposed to a medical association hospital which tends to be "preachy" on the basis of fixed concepts.

I have already exceeded the time allowed me by speaking rather freely about many things. Since I only rarely have an opportunity to meet with you, I would be happy to answer questions at this opportunity. Thank you.

Characteristics of Man in the Development and Allocation of Medical Care Resources

I have been involved with the work of the World Medical Association (WMA) since 1970. The duties assigned to me concerned primarily socio-medical affairs. When the World Medical Assembly was held in Tokyo in 1975 and I was appointed WMA president, I proposed that the WMA take up the question of "the development and allocation of medical care resources." Fortunately, my proposal was accepted, and it was subsequently decided that the socio-medical affairs committee alone would be inadequate to carry out this task. Therefore, it was decided that the Japan Medical Association (JMA) undertake to form a special committee to follow up on this theme. And the committee has met twice since then.

It has been recognized that the theme of "the development and allocation of medical care resources" is of utmost importance because it includes the most fundamental problems of medical care found in every country of the world.

It gives me great pleasure to be able to discuss what I regard as a central problem. Both medical science and economics are the most important basic branches of learning to human survival and living.

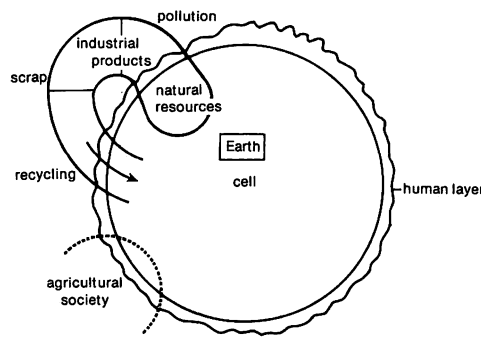
I thought that a new survival order — which includes a new social order, economic order and medical care order — and a new ethics, science and technology must be developed to bridge these two disciplines. Human survival and living must be examined from

---

WMA Follow-up Committee on Development and Allocation of Medical Care Resources, Palace Hotel, Tokyo, July 30-August 1, 1981

every angle, and man must be grasped both as an individual and as a member of certain groups, and in relationship with his environment. When man is grasped as an individual being, his economic life has a very important meaning. At the same time, medical care must be considered as something of great fundamental significance.

Diagram 1. Man in Metabolic Process in 'Cellular Membrane' on Earth's Surface



When we examine the mechanisms of human survival, we must start with a consideration of in what form human beings are spread over the surface of the earth. I use the ecological approach and regard human life as a thin film covering the earth. During the age of agricultural society, very little development of natural resources was carried out. There, human existence was found in terms of metabolism occurring in the surface layer of the earth.

As industrialization progressed, however, man began extracting natural resources from the deeper layers of the earth. With further industrialization, we entered the age of mass production with these natural resources. The things produced in this mass production stage were not recycled back to the earth after they served the purpose for which they had been intended. This is the reason why we had the pollution of the environment.

The industrial society developed during the height of economic growth, and it is a fact that this brought about an elevation of the standard of living. It is also a fact that the allocation of industrial goods became a major economic issue.

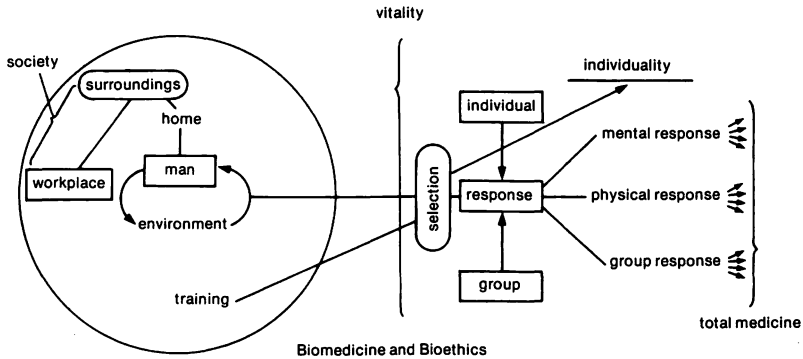
In agricultural production, the metabolic cycle was very simple, and natural resources were recycled locally in a very natural manner. In the industrial society, however, the situation was totally different. There was absolutely neither economics nor technology for the recycling of wastes — a fact responsible for a high degree of environmental pollution that occurred, threatening, in some local areas, the survival of man.

What is called the economics of pollution is an economics that came into being after pollution actually occurred. There was an element of prediction of industrial pollution in medicine and public health. But I don't believe there was an economics of prediction. Economics had a close relationship with ethics from its early stage of development. This is the reason why it has attained a major development in its relationship with the industrialized society as a survival order in terms of air pollution, industrial accidents, changes in working conditions, and improvements in the standard of living. Yet, economics was essentially a science of labor and consumption and had very little to do with the development of natural resources.

In the case of medical care, the development of its resources is highly important, and I believe that interaction between the process of development centering on medicine and the process centering on economics is extremely important to the stable development of human survival and living. The improvement of economic life is inevitably accompanied by an increase in the demand for medical care. The proper and effective allocation of the demand for medical care, I believe, is possible through cooperation between medical science and economics.

For this, it is necessary first of all to establish a goal in the development of medical care resources, but this must be done in both medical science and economics at the same pace.

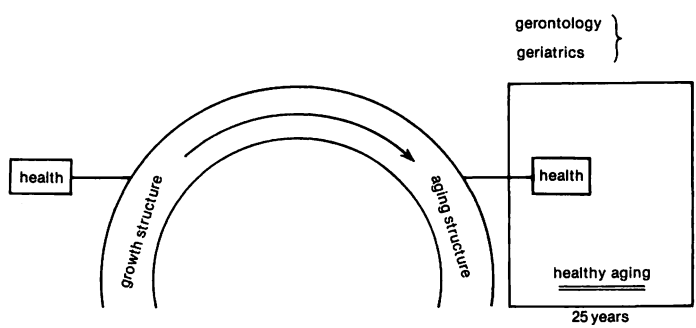
Diagram 2. Demand Side of Medical Care



Medical care must be developed by both individuals and groups as I said earlier. This means, in a nutshell, the question of how an individual or a group responds to a demand made by the human body. These may be mental, physical and group responses. And these three kinds of response must be considered in terms of total medicine.

Then there is the important question of the selection of what kind of response to make. This is where the question of individuality comes in. There are also the questions of the environment, the workplace and its surroundings, and the home and its surroundings. In every one of these questions, economics must become involved with both the natural and social environments. Participation by medicine also becomes necessary.

Diagram 3. Qualitative Change in Population Structure by Aging



The demand for medical care must be considered in terms of the various periods in the life of man just as it is so with regard to health. For instance, health at the stages of growth in a person must be considered separately from health in the stage of his aging because of the qualitative changes that occur during the latter process. In the stage of aging, geriatrics and gerontology become involved.

As for the structure of aging, the ideal is "to age healthily," and, therefore, the demand for medical care in the aging period is totally different from that for the periods of growth.

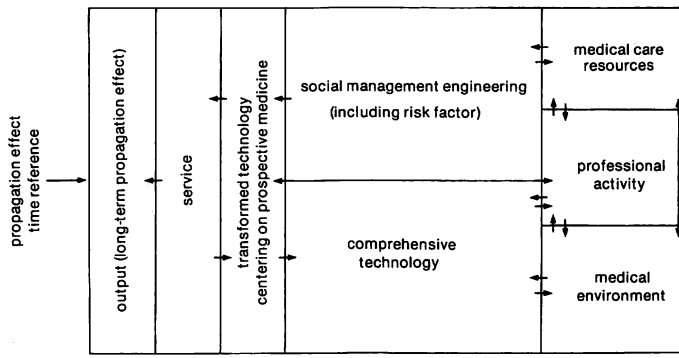
The development of medical care resources must be carried out according to these demands. For this development of medical care resources, there could be such varied targets as development by age bracket, for health improvement, for the prevention of disruption of health, etc. For these purposes, economic, rather than social, bases are extremely important, and this is where medical technology has a major role to play.

In short, the development of medical care resources, because it greatly differs from the social development of inanimate objects, must be conducted toward a target established according to the survival process of man. As for industrialization, development must be carried out from the standpoint of industrial medicine with regard to a large number of different types of occupations created by that process of industrialization itself. Here, the development of the environment for man as a group also has a great significance. The setting of medical targets in the development of medical care resources and the methodology that makes this possible must anticipate many contributions from economics. Economics of today is a science concerned with the state of "completed development." And little attention has been paid to the combination of economics with the technology necessary for the development of the future. Through the systematic study of the development and allocation of medical care resources that has been conducted, however, I have keenly felt the need for this.

The allocation of resources requires a large number of processes.

After the kind of development of medical care mentioned above has been achieved, it is to be supplied as a "professional activity."

Diagram 4. Supply Side of Medical Care



Because the medical environment is of extreme importance in this connection, medical care resources, professional activity and medical environment must be considered as paralled concepts. These three must be promoted by comprehensive technology.

Social management engineering, including the management of risk factors, and patient control also become necessary. Comprehensive technology includes medicine and the technologies surrounding it. Another important thing is that through this emerge prospective medicine and its surrounding technologies.

Prospective medicine today is still at a very infantile stage. To those who are on the side of supplying medical care, it is of great importance to establish prospective medicine, because it is impossible to conduct an efficient allocation of medical care resources without it.

Service in terms of the allocation of medical care resources based on data obtained by prospective medicine must be provided in such a way as to secure the maximum propagation effect in the long term. Unless the service is given on the basis of metabolic processes varying according to age groups, it would be wasteful. The concept of timing in relation to this service must be thought of as "time reference."

When the service is given just before it becomes necessary, it is likely to have a long-term propagation effect.

We have accumulated a large amount of knowledge in relation to the problem of medical care costs for the aged. What we have learned is that when medical attention, including that in mental hygiene, is given to individuals from the time when they are about 35 years old, medical care costs for the same individuals as they become aged are very small — about one-tenth of what is normal.

This seems to suggest that it is possible to think of the provision of medical services for human beings as an investment. In the past, medical care was considered a form of consumption. But when medical service is incorporated into a metabolic system, it makes new development within that system, raising expectations in a long-term propagation effect.

In other words, we must not think of countermeasures *after* a problem has arisen. Take the case of the prevention of contagious diseases, for instance. If all the countermeasures have been put into effect, prevention could be achieved at a very low cost. When there are no countermeasures in force, on the other hand, there is even the danger of a mass outbreak of a disease with a serious threat to human life, and medical care costs would be enormous. Measures in prospective medicine must be said to have long-term propagation effects.

Therefore, the supply side of medical care does not only include hospitals, clinics and physicians. It requires many new branches of learning, for which it is necessary to select the most effective points of action. Welfare location theory, for instance, which considers welfare in terms of where to locate facilities, may be also important. This means that when a medical care facility is to be established, we must think in terms of what is to be built where for a long-term propagation effect.

On the other hand, early detection and diagnosis make a major contribution to the preservation and promotion of health, and its relationship with social production deserves a serious assessment.

As seen from the above, it is obviously necessary to think anew of

the supply side of medical care. Its development and allocation must be considered simultaneously; placing emphasis only on allocation is not adequate.

The health insurance system as a form of allocation of medical care has expanded enormously throughout the world. Essentially, however, insurance is a system based on the idea of compensation for damages. In it the insurer collects premiums to have the insured pay part of the damages while he pays the remainder. Economic measures of this kind, dealing with inanimate matters are rather simple. But when we apply this idea to human society, we are compelled to think of human life, not of inanimate things. As I said earlier, human survival and living has many extremely complex conditions and relationships with the natural and social environments.

Yet, the health insurance system regards disease as a form of damage. As far as I have observed so far, this signifies that medical care resources have been thrown into the metabolic process through medical service. They are, therefore, not a form of consumption nor a redress for damages.

Unless we consider the human body in the context of its environment by ecological thinking and also in terms of age bracket, the health insurance system must be thought of as representing an entirely new mode of thinking and a health insurance plan must be formulated primarily on the basis of the concept of life.

This is what I call bioinsurance, which, to be sure, is not a system of compensation for damages. Its supply system must be considered as a form of investment. And effective investment in this system would be to maximize its propagation effect.

The development and the allocation of medical care resources are the two sides of a coin. Only when they are considered in terms of life cycles will new bioinsurance become possible.

In order to translate into reality the concept of bioinsurance, it is necessary to think of the development and allocation of medical care resources in highly rational terms. At the base of this rationality, there must be bioethics and biomedicine. To the evaluation of bioinsurance, economics will make a major contribution.

In the scheme of bioinsurance, the insurer is the people themselves, and the insurer under the present health insurance system will become unnecessary. The burden to each citizen in this scheme will be figured out by computer through the successive administrative levels of local government, prefecture and state. Bills by physicians checked by the examination machinery of the medical association will be paid by the bioinsurance center at each city, town or village. When any of these local governments is short of funds or payment, state funds will be used. If the state center is in deficit, additional premiums will be collected from the insured.

Details are to be worked out by the government of each country. In this system, the physician and the patient operate an insurance plan without the intervention of a third party, constantly improving the system of allocation of medical care resources.

Of course, we cannot expect a conclusion on such a large problem as this in a short time. But I have served as chairman of the socio-medical affairs committee of the WMA, and I am also president of the Japan Medical Association, which is in charge of this committee.

In lieu of greetings to you today, I have stated my views on the basis of what I have learned in these capacities. This matter, however, will require further studies in the months and years ahead because it includes many areas that will move forward through the progress of medicine and its collaboration with economics.

The Home and Health

I occasionally visit the Santama District because I have a great deal of interest in it from an ecological point of view. With the progress seen in current ecological studies, I believe that Santama will become a great city in the 21st century. Development is being conducted independently in various cities in other areas as well. This means of development, however, will not produce cities suited to the coming centuries.

City structures in the 21st century, I belive, will be totally different from those at present. It is because of this view that I have been very much interested in the urban structure of the Santama District for some time. Factories and housing areas are being built in areas where farming villages existed before. This is one district which will serve as commuters' town, but at the same time will have to be an industrial area. One thing that must be considered in each case is whether or not the existing environment is truly the best for the inhabitants of each area. This is a question of fundamental importance. Yet, as far as I have been able to observe things from an ecological standpoint, there has never been an instance of development conducted on that premise.

I believe that of our recent predecessors the greatest was the statesman Shinpei Goto. He went to Taiwan when Japan began gov-

---

This lecture was delivered on December 1, 1979, at Hino City, Tokyo, on the occasion of the inauguration of the Hino City Medical Association, and the original paper in Japanese was published in the Japan Medical News No. 442, Feb. 5, 1980. Reprinted from the *Asian Medical Journal,* Vol. 24, No. 6, June, 1981

erning that island, which had formerly belonged to China. Mr. Goto, the governor-general, went to Taiwan with Seitaro Okamatsu, a professor of law at the Tokyo Imperial University. He had this professor record all of the old customs of Taiwan, which became a document of enormous volume. The reason why Mr. Goto did this was that Taiwan was viewed as an uncivilized area by the Japanese, but he thought there must be some close relationships between old customs and the existing conditions of the land. He thought that customs with very close relationships with local conditions must be preserved while bad customs must be disposed of in proper order. This, I believe, represents Mr. Goto's sharp insight. Mr. Goto said that the first thing that ought to be taken up was dealing with malaria and other tropical diseases. Thus he established a central hospital and research institute. These were achieved after the survey of old customs. During this period, ecological studies, which were extremely difficult to carry out under the existing adverse circumstances, were conducted.

In Japanese politics, however, there has been no instance in which ecological studies served as a basis for government. When I say this, the press criticizes me, first of all saying that I am asking for the impossible. When I went to Prime Minister Hayato Ikeda and told him, "When you say you plan to double the national income, you mean you want to step up industrialization." Mr. Ikeda said, "Yes." So I said, "Industrialization means pollution, which may threaten the lives of the people. Are you prepared to cope with that problem?" Mr. Ikeda said, "We are trying to make this poor country rich by earning money. Don't interfere with my plan."

This shows how much distance was between us. It is a great tragedy that a man who had vastly different ideas from me should become the prime minister of Japan. As it turned out, I was right. At that time, Mr. Takeo Miki, who was chairman of the Policy Affairs Research Council of the Liberal-Democratic Party (LDP), thought I was talking nonsense and came to Mr. Ikeda's support. In a televised panel discussion, Mr. Miki and I debated the issue of pollution. Of course, Mr. Miki was an amateur on the subject and I had studied it.

So I very clearly defeated Mr. Miki in the discussion. I did it so as to let the audience know that even such a person, who had little knowledge about pollution, was able to serve as the chairman of the Policy Affairs Research Council of the LDP. When the program was over the audience was able to see clearly that Mr. Miki had been thoroughly beaten.

My purpose in participating in that TV program was not to browbeat a politician, but to make politicians understand that it is important to carry out development without creating pollution. In that program, I said that since the government was planning to create thirteen industrial zones throughout the country, I recommended that ecological studies be conducted in each of the thirteen locations before authorizing the citing of plants and making such authorizations based on the condition that the plants do not harm the environment and man. At the end Mr. Miki sounded as though he had accepted my recommendations without committing himself. Fate is a strange thing, however, and later he was made director general of the Environment Agency, upon which the first thing he did was to come rushing to me. He said, "Things are turning just as you said ten years ago, and now I am the director general of the Environment Agency. How should I go about my job?"

Japanese politicians have much to say during their election campaigns, but much of what they say is far from the truth. If they talk about things they understand, it's easier to forgive them, but they seldom even make the pretense of understanding what they are talking about. They merely tell lies in order to collect votes. That's Japanese politics. The people of Japan would not suffer at all even if the next prime minister could not be decided upon for a period of as long as one month. This gives away the truth about those politicians who claim they shoulder such heavy responsibility.

The Shiga bacillus was discovered by Dr. Kyoshi Shiga of Japan, and the discovery was indeed an achievement of global significance. Today the Shiga bacilli no longer exists. What is more remarkable, however, is the fact that the Shiga bacillus exists in our law. I have time and again asked the Minister of Health and Welfare to revise this

nonsensical law, but none of the ministers has undertaken the task. Furthermore, our law does not include viral diseases in the contagious diseases covered by the Contagious Diseases Prevention Law.

My conclusion, therefore, is that if you and the medical association join hands to grapple with the problems of health and welfare, we can produce something that is really good, while if we only listen to what politicians say, the lines of our people ten years hence will be dismal. When this happens, would the press take responsibility for that state of affairs? The press provides a wonderful service, as I see it, to its members because they have no responsibility for what they say. They are, on the other hand, experts at making money. What I dislike most is to become a phony mass media figure. Recently, a weekly magazine carried my picture as "the man who sacks Health and Welfare Ministers." My son came home and said: "Father, don't go too far in attacking the ministers." I told him, "I would be ashamed of myself if I were to become a star in the mass media. I would not do anything for which I might be made a star, and I would not do anything for which I would have to be ashamed of myself before my children." I am quite sure of what that means.

The most intelligent segment of society is that of the ordinary citizens. These citizens ridicule politicians who are content with receiving electoral support from them. As far as I am concerned, the citizens are the real people of power who maintain our country. As president of the JMA, therefore, I have advocated the establishment of a medical care system with the participation of the citizens of each community. If the people of Japan had relied on the central government alone, our country would have been ruined a long time ago. The only time our country prospered when the people followed the central government was after our defeat in World War II. The rehabilitation following the end of the war was, to be sure, wonderful. What happened after that, however, was not.

Prime Minister Mr. Ikeda is an interesting man when he has some alcohol in his blood. A few days after drinking with me, he telephoned me to say, "The other day, you left me after threatening

me. But when I thought about it, I realized it was something rather important." In other words, Mr. Ikeda seems to have his conscience restored when he has a few drinks and realizes what is really important.

Then Mr. Ikeda said, "Let's talk next time without drinking." "Okay, please come," I said. Then he came and listened to me lecture for about an hour-and-a-half. He took home with him the things that I jotted down on sheets of paper." He said, "What you say is quite true, but no one else has ever said what you say." He doesn't realize the fact that he is surrounded by ignoramuses. Ignoramuses, power-hungry men and academics anxious to sell themselves to politicians are worthless. You find these people among those who are toadying up to the LDP and the government. These are academics who have very little influence in their own circles. They are specialists among academics who flatter bureaucrats in order to get on the good side of them. They only say things that please the officials and they have been picked by the bureaucrats because they only say things that suit them.

This is the reason why administration becomes distorted and deviates from reality as time elapses. What is really most important under such circumstances is for the medical profession and the citizens to speak frankly to each other in order to infuse academic interests into the minds of the masses. If this cannot be done, we cannot expect a medical care system worthy of our participation.

Returning to my talk with Mr. Ikeda, he came back to talk to me after a month. At that time he said, "What you say is really good, but we still have no law to implement it." Of course, we don't. My idea is to establish an industrialized society by changing Japan's orientation. That would create a society with the kind of laws that are not found today. Mr. Ikeda says that when he proposed my idea to the government agencies concerned, he was turned down because there is no law to implement such ideas. He was rejected by the Ministry of Health and Welfare because there is no budgetary basis, and he was turned down by such and such department, and so forth. That's what Mr. Ikeda told me. So I said, "You are the prime minister. You can

build anything. Why don't you create a pollution bureau, for instance?" Then he created a pollution section in the Ministry of Health and Welfare. I became curious about what this section was to do. Then I discovered that it was motivated by bureaucratic thinking, which Diet members of the LDP like very much. LDP dietmen usually support bureaucratic ideas and they applaud them in the Diet.

If we are to create something that we have not had in this country, we need a new law which serves as a guideline, and it is in accordance with this new guideline that the plan is to be discussed in the Diet. If this could be done, I think we would be headed in the right direction. Politics of chicanery belongs to the past. We are now headed toward the 21st century, and our government ought to be geared towards understanding the minds of the people. I regret to say that neither the LDP, the party in power, nor the opposition parties have grasped the thinking of the masses in Japan. These parties are representatives of labor unions, capitalists, and they are utterly unrespectable.

Recently I visited Venezuela, and while there I read in the newspapers that there was a political interregnum around October, 1979 in Japan. I realized that no one could understand the reasons for this political vacuum. I met the Japanese ambassador and asked him about it, and he said that he could not understand it because he had not encountered it before. We were number one in the world in the wrong way — in having a political vacuum for a period of one month. If we could afford not to have a prime minister for as long as one month, we don't need one. That's what this event proved. Only those who want to become prime minister need that office, others would not suffer at all without it.

As I said before, Shinpei Goto was a great statesman. When he was in the Cabinet, he had an outstanding capacity for planning for the future. When a Cabinet member said stupid things, Mr. Goto ignored him and mumbled to himself, "Fool, fool, fool, ..." When this fool of a Cabinet member challenged Mr. Goto for what he said, Goto promptly left the meeting. When the prime minister, troubled by Goto's absence, sent his chief Cabinet secretary to his

home to offer an apology, he was induced to return to the Cabinet meeting.

This shows that in the old days there were good men among politicians. Today, however, we have none. In the old days, the business world had a great deal of influence on government. If the kind of event we saw the other day had occurred in the old days, the business world would have bawled out the party in power and the prime minister would have been dismissed and replaced.

Even the business leaders of today are men of small caliber. They give the LDP money when the politicians flatter them, but at a crisis, they cannot play a useful role. This was proven by recent events. The only kind of person who can rise to an occasion is the physician. When someone suddenly falls ill, who is counted upon but a physician.

As we head for the 21st century, we must have a different kind of welfare system for the people. The system we have today was something imported from abroad in form only, not in spirit. The social security system we have today does not have the spirit of the American and British systems.

Since man has a definite life span, laws made by man, ought also to have life spans. The fact is that laws have enormously long life spans. Japanese laws never disappear. They outlive government and go on forever. This means that the laws are not in accord with reality. A pollution patient is a patient with a new disease. More than 20 years ago when I became president of the JMA, there was a professor named Fletcher at Cambride University, who was a specialist in respiratory medicine. This professor was the first to record bronchitis caused by air pollution and he became famous for that around the world. When I learned that this professor was coming to Australia, I invited him to Japan and listened to his lecture. What I regretted then was the fact that the consensus among the famous professors who came to hear him from all over the country was that the kind of things Professor Fletcher talked about could not possibly occur in Japan.

Ten years later when I met Professor Fletcher, he said, "You now have in your country exactly what I predicted. Those university professors in Japan who had said such a thing would not happen in

Japan were nonchalant and were totally unpenitent about their having failed to look ahead."

There is no power structure standing today which we can depend on. In a society such as ours, where there is no reliable power structure, and for the reconstruction of Japan, I believe it is necessary for people who seriously want to live better quality lives to get together. That is the basic requirement. This is the reason why I have been strongly recommending the community activities of medical associations.

Now I come to the matter of "home and health." Let me talk a little about the "ie", the home, but the meaning is not as simple as "home" now. When Japan established its civil code in the Meiji Era, the government invited a professor of law called Gustave Emile Boissonade from France. After carefully studying local conditions, Professor Boissonade discovered that the concept of the "ie" did not exist in other countries. A young man who served as assistant to the French jurist at that time later became a professor at the Tokyo Imperial University and also founded Hosei University. He is Professor Masaaki Tomii. Reading papers left by Professor Tomii and reports by Professor Boissonade, I discovered that the "ie" of Japan has no parallel in the world. This was also something difficult to understand. This does not correspond with the family of the West. We have families as of the present, but the "ie" includes an element of time in that it runs from ancestors to offspring.

I believe that the "ie", be it under a feudalistic system or today's democratic system, must become a major unit of society. Japan survived the suppression of the feudal era. Reading the literature concerning how the "ie" supported Japan during such an era, prepared by historians specializing in the Tokugawa Period, I found that there was furious antipathy against the tyranny of the Tokugawa Shogunate. Yet in this era of furious antipathy emerged the haiku of Basho and numerous woodblock prints. The great arts of the Edo Era were products of hardship suffered by the disadvantaged classes of the era.

When I think about these things, I feel that the discontent and complaints we have today are extremely flippant. I seriously regret the fact that politics is incapable of converting this discontent and these complaints into a meaningful force for the nation, and the fact that the citizens as themselves lack the capacity to think. I truly believe it was a wonderful thing for our country that the "ie" was established as an institution during the Tokugawa Period.

Another thing I found interesting about the Tokugawa Period is the fact that during that period Chinese medicine was systematized by Japanese medical men. I went to China recently. Because China is the mecca of Chinese medicine, I had many expectations for learning about the wonderful Chinese medicine as it is practiced there. I did find some wonderful things being done there, but I also found that there was no system, no coherence in the practice of Chinese medicine. Chinese medicine in Japan, on the other hand, is extremely well systematized. This is because the doctors of the Tokugawa Period made a thorough study of it and established their own systems.

When I mentioned this fact, Mr. Liao Chengzhi, president of the Sino-Japanese Friendship Society, said, "In my country, everything in medicine was done in a slipshod way for the last 2,000 years, and nothing was ever systematized. In Japan, however, it was well systematized, and it became a source of national power."

Yet, people in Japan do not realize this wonderful capability of our nation. They instead become involved in the stupid contest for votes by politicians. This I think should be stopped. Of course, as I say this, I am really negating politics. Only a few days ago, the Asahi Shimbun, a major newspaper in Japan, played up an article that lamented the impotence of the Diet. I have been saying that all along, but the fact that a newspaper had to come out and say that itself is rather interesting.

I would like to consider with you another aspect of the "ie". If there had been no "ie" in Japan, I don't think the Japanese nation could have been powerful. The American "home" of individualism has no background of ancestors. It is the "ie" of only one generation,

and I doubt if it could be converted into national power. This is the reason why I think the "ie" is very important.

The idea of the nuclear family has spread as a principle of democracy. When problems with nuclear families emerged, I was a member of the Population Problems Council. The thing I first thought was alarming was the fact that the aging rate of the population in Japan was faster than those of most other countries — about twice that of France, for instance. I thought this would create serious problems. Yet little was being considered concerning that possibility. I mentioned this at a meeting of the population council, but few paid any attention to it.

As is obvious from this, the problems of our population, in fact, were known about 30 years ago. Demography can predict the age structure of the population of 30 years hence. Such data were made available by the Institute of Population Problems of the Ministry of Health and Welfare. Yet, the LDP never thought of studying population problems.

This means that Japan is very much handicapped. Meanwhile, I believe we ought to consider once again how we survived the postwar condition of famine. I think the primary factor in our survival during that period of privation was the "ie", which preserved the lives of the members of each family. What then constitutes an "ie?" First of all, there are the genes handed down by ancestors. These genes, which are great in number, contain all the necessary elements for living. When there is anything genes need, RNA provides whatever is needed without being commanded to do so. That's how well it works. Radical students talk about generational "discontinuity," but it is impossible to dissociate us from our ancestors. If these radicals become parents, they cannot dissociate themselves from their own offspring. This means that the nucleus of the biology of the "ie" is the gene. Today we can openly say that the gene was the heart of the "ie" before the war. Today, we can assert this because of the findings of molecular biology. Before the war, the continuity of the "ie" was talked about in terms of such an abstract concept as ancestor worship or religion. We have had a history of paying great respect to the gene,

which remains unaltered despite the progress of sociobiological sciences.

There is also the matter of the "ie" as a community of destiny, which a family is. A community of destiny, if it were to consist of only two members life a nuclear family, cannot help but be very weak. Our community of destiny had the form of "ie", and this is the reason why the Japanese "ie" was an enormous faculty in helping to endure things and create an accumulation of great cultural strength.

In an "ie" there is a great deal of cultural accumulation. If an "ie" is a nuclear family, however, this cultural accumulation is bound to be very limited. The preservation of nuclear families will become difficult in the future for two reasons: the increasing population of the aged and the decreasing population of the young. When this becomes evident, can we once again revert to the "ie" of the kind Boissonade discovered in Japan?

Not all old things are good. Among them is the feudalistic class system, which I don't think is commendable at all. We must accept the fact, however, that at certain stages of the progress of human civilization, it had to be tolerated. I believe it reflects on our own wisdom to select from the things and institutions of the past those that could be of use in the present and the future. By this I mean we can choose from among "old things." The things that we choose, however, must be used to serve our future. This must be done by collectively using our national wisdom. If we are to build a great future, or great social welfare, we cannot think about it individually or by family. The wisdom must be collectivized. In ancient times, priests tried to do this by themselves and Popes did this. From now on such a method will not work.

Now the question is how to collectivize national wisdom. This cannot be done in a democratic society which has become an old relic of the past. This is where we need a new survival order.

When we Japanese were suffering from the consequences of our unprecedented defeat in war, I happened to live with Prime Minister Shigeru Yoshida. He was defiantly saying at that time that there were instances in history of a nation being defeated in war but winning in

diplomacy. He meant Japan could be that. I was surprised by what he said. I also marveled at Mr. Yoshida's practical application what he meant. Today's politicians only think of how to collect votes from citizens, but Mr. Yoshida was thinking about how to deceive the occupation army. I realized that the most basic notion he had in dealing with the occupation army was the old concept of "ie." He was trying to preserve our nation by expanding that concept.

While he was living, he was denigrated by everybody. When he died, however, he was given a state funeral and today he is seen as a great man. There was not a single newspaper that did not condemn him while he was living. Today he is viewed as a great chancellor.

When we had very little to eat, he was ordered by the Emperor to form a Cabinet. I don't have time to elaborate on that particular episode in his life, but one problem he had was to find a minister of agriculture and forestry. Everyone declined the post because they were fearful of the possibility of being killed by a mob of hungry people. Mr. Yoshida, however, chased after these people with a smile on his face. I thought he was much too optimistic because he was smiling while he was chasing after the people he wanted to appoint to the post of agriculture minister. In the meantime, the "give us rice" campaign started and the communists swept throughout the country. Major General Charles Willoughby came to Mr. Yoshida and said, "I will stop that movement by issuing a directive in the name of the Supreme Commander of the Allied Powers." Mr. Yoshida said, "We don't need any such thing."

Later, I asked him why he did not need the directive. He said, "If we were swallowed up by red flags, America would bring something out of frustration. I can then form a Cabinet." This shows the difference between the ordinary politicians who are interested only in collecting votes and a statesman who knows how to save a nation even though both may use chicanery. Their adversaries are different.

One night, Gen. MacArthur sent a jeep to pick up Mr. Yoshida. He went out the back door and came back about 20 minutes later, smiling. He said, "Mac said he would not allow a single Japanese to

starve to death as long as he is the supreme commander. So I am going to form a Cabinet tonight."

During those several days, the Emperor was staying up every night in case a Cabinet was formed. At 8:00 p.m. he would personally telephone Mr. Yoshida. I couldn't find out what kind of conversation went on, of course. At any rate, it was like that in those years with Mr. Yoshida. He was totally different from the vote beggars of today.

Riding out crises in such a fashion, Mr. Yoshida was thinking about how to reestablish post-war Japan as a country with a new system, what kind of industries must be developed, and so forth. He formed a group of scholars to think about these problems. These people included Mr. Seiji Kaya, who later became the president of the University of Tokyo, Mr. Shunichi Uchida who became president of the Tokyo Institute of Technology, Mr. Yoshimichi Hori, professor in the School of Law of Keio University as well as such economists as Messrs. Seiichi Tohata, Hiromi Arisawa, Ichiro Nakayama and Kiyoshi Nagata. This was a radical departure from the traditional way of forming councils in the government, which barred experts. I recommended these specialists.

Mr. Kaya was included in the council membership for a specific purpose: to make America vulnerable. We were bombed by B-29s as you remember, but the magnet elements used in the B-29 was an invention of Mr. Kaya. The magnet Mr. Kaya produced after much struggle was manufactured by the then state-owned Yawata Steel Mills, where bureaucrats were throwing much weight around. At first, these bureaucrats made light of the magnet the young scientist produced without appreciating its value. Americans, however, knew it and studied the Kaya magnet and used it in their B-29 engines. This magnet made it possible for B-29s to bomb Japan after flying long distances over the sea. When this became known after the war, the Imperial Academy of Science awarded Mr. Kaya with its academy prize. At the presentation of the prize, the chairman of the academy, Mr. Hantaro Nagaoka, said in his awards speech: "Mr. Kaya's research is twelve years old, but we are awarding him the prize today

because we discovered the research to be of value even today." That is the kind of official language bureaucrats write.

In perspective, I believe that we must all take a second look at our "ie" system, which has few parallels in the world, from two positions, namely, the macro position from which to adapt it to the 21st Century, and the micro position so that we can develop a culture of "ie" in which health is promoted, and which, when collectivized, can be transformed into national power. I receive many letters of complaint which say that a certain hospital turned down a patient, etc., but when I consider these letters carefully, I discover that these are complaints about the fact that the correspondents were unable to exercise their rights provided by the health insurance system. Of course, these rights given under the health insurance system are important and the people are entitled to exercise them, but mere complaining does not serve any useful purpose. Rather, they should try to dispose of problems of the present with a target in the future. In the future, I believe, all politicians, both conservative and progressive, will be unified. The future will be an age in which there will be no such distinction. Therefore, we ought to think together about the "ie," which has lost its direction. We know what kind of dangers will menace human health in the 21st century.

Recently, I published a book on the problems of viral hepatitis. This is one such danger. Then there is the problem of mental disorders. I can anticipate a large number of both mental and physical diseases in the 21st century. This means that we must start contemplating countermeasures at least a quarter of a century in advance. These must begin with education, followed up by administrative measures, before we can be fully prepared for all kinds of health hazards. This will take at least twenty-five years. Without such a twenty-five-year plan, Diet members think only about tomorrow's election. They cannot possibly represent the electorate. Those voters who applaud what they think are their own representatives are really not very bright. When we think about our health, we must think of the 21st century now, otherwise it will be

too late. Today, people talk about "the 80s," but we should have thought about "the 80s" during the 70s. We must think about the 21st century during the 80s. It takes 25 years no matter how you do it.

In such long perspective, I must say that we ought to attach much more importance to the "ie." By attaching importance I don't mean spoiling children and old folks. What is important is to provide human beings with a purpose in life by creating a good "ie" in which to live in the future. When I see demonstrators who are ordered to chant senseless slogans without finding any meaning in their daily lives, I feel that I am watching miserable renegades. Those demonstrators, I know, are all serious, but they must think about what their demonstration may or may not produce.

I was once attacked by student radicals wielding clubs. I listened to what they had to say. I told them my ideas. At night a student came back to me and said, "After listening to you, I decided to leave my gang and go back to the country to help my father." This young man today is a full-fledged assistant professor in a college. This proves that if we face each other and talk sincerely truth can be conveyed. Had this been done earlier student radicalism would not have come about. Such a phenomenon occurs when truth is ignored for a long time. In the past, when a similar situation persisted, it developed into war. Today, pent-up feelings of the same kind explode as student violence. This state of affairs does not lead to progress for mankind.

As a man who studied medicine I would like to ask you to think about the "ie" in a truly responsible manner and propose ideas so that we can study them together for the future.

The Medical Practitioner in Japan

1. The Mental Structure of the Japanese Physician

The basic idea in the mind of the Japanese practitioner is the concept of medicine as a "benevolent art." By "benevolent art" is meant a medical art between two human beings. As such, it expresses the relationship between a physician and his patient.

The word "benevolent art" came into being during the feudal age, in which society was stratified. At the top was the Daimyo, the feudal lord, and samurai, his retainers, and below their class were those of the peasant, artisan and merchant. Yet, the physician belonged to a status of his own — outside the social hierarchy. This indicates that the physician was accorded special respect.

In the feudal age there were two occupations in which scientific technology played a key role. One of them was that of the swordsmith and the other that of the physician. The former, however, was closely related to the samurai while the physician was concerned with citizens of all strata.

The physician-patient relationship was a "vertical social relationshipé," that is, the physician held the upper social status and the patient the lower. For this reason, the physician did not in principle demand payment by assessing his own technology in terms of monetary value. The patient paid his physician whatever sum of money he could afford and the poor did not pay at all. That is to say, the physician played the role of a distributor of income in his community.

Reprinted from the Japan Medical Association, 1970

It was also in such an age that the word "seryo" (dispensing medical treatment) came into being. This word implied "dispensing free treatment," and it reflected the social relationship in which the physician held the upper social status and the recipient of his services the lower. It was from this vertical relationship that the moralistic concept of medicine as a "benevolent art" emerged. It reflected the moral view that the person of a higher social status must deal with another of a lower social status with mercy. The word "jinjutsu" (benevolent art) is still used today, but the fact that it is current in the Japanese vocabulary indicates problems.

It is about a century ago that European medicine was introduced into to Japan. And yet, the concept of "benevolent art" that had grown out of the feudal social background is the most important element in the mental structure of today's Japanese physician.

Feudalism, of course, is gone and Japan is a democratic state. A social security system has been put into force and the people are guaranteed the right to receive medical treatment. Therefore, a patient no longer receives medical care from a physician as he would have in the feudal age as a favor bestowed on him by a person of a higher social status. The people today have the *right* to receive medical care.

Under the Japanese social security system, medical insurance has attained great development; every citizen is covered by one kind of health insurance or another. This means that there is the insurer — the agent which manages the insurance. He collects premiums from the insured or their employers to administer social insurance. The premiums collected in this manner are paid into the Social Insurance Medical Fee Payment Fund. The Fund examines the claims for payments filed by physicians before making reimbursements to them. The insurer may be the mayor of a city, town or village in some health insurance systems. At any rate, it is strange that the insurer claims to be the person to superintend the services of the physician. Yet it is also a fact that this is authorized within the terms of the laws related to health insurance.

As it is clear from this, in this system of "every citizen being a

beneficiary of an insurance system," technically, it is the people who "employ" physicians. The relationship between the people and the physician is that of the person who has the "right" to seek the services of the physician. It is a strange phenomenon that in this day and age the people-physician relationship is based on the medical concept that originated in the feudal age. The physician of Japan today is expected to listen meekly to whatever his patient says. This is the reality of the "benevolent art" of Japan.

Under the health insurance system, public medical care institutions set office hours for their patients taking advantage of the health insurance system. But the private practitioner is not allowed to do likewise. A patient is able to call on a doctor at any time to receive attention. A doctor must be ready to receive a patient on a 24-hour basis. And this did not mean that he had to stand by for emergency cases alone.

The old concept of "benevolent art" has been turned upside down because of the drastic changes that have occurred in the Japanese social structure. And this is the major cause of the difficulties that beset the medical care problem of today.

There is no democratic relationship in Japan today, in which the physician and his patient give and take medical services on an equal, human basis. The reason is that the health insurance law now in force has its origin in the pre-democratic days when the social status system prevailed and the bureaucrats and the military ruled the nation.

I have always thought of the need for abandoning this outmoded concept of medicine as a "benevolent art." According to a new medical ethics I have in mind, the protection of the life of an individual is the responsibility of society as a whole and it is in such a society that the physician offers his technology and spiritual service. Therefore, I believe that the physician must become conscious of the fact the "technician to protect human life" deserves the strong support of society.

The basic ethical principle to govern the activities of the physician in this new age should be that the physician takes a positive interest in

measures to be taken to promote the health of the inhabitants of the community in his which he lives and offers technical services and knowledge for that purpose. A sound physician-patient relationship may be established only with this kind of social relationship as its background. Human relationships must be understood in its relationship to community.

This new concept of the moral role medicine is to play in society, I believe, incorporates all of the old medical ethics. Typical of the old medical ethics is the Hippocratic oath, which I believe, is entirely valid even today. The reality, however, is that old medical ethics are "bewildered" in the new social system.

A fundamental question in establishing a medical care system is whether the pertinent laws are legislated on the basis of an understanding of basic medical ethics. The medical laws and the health insurance law as well as related regulations must incorporate the new medical ethics in the context of the social ethics of the new age. When the medical laws lack this basic premise, they are unlikely to take root in society and among people. The medical system faces a crisis throughout the world today, and Japan is no exception. Yet, these basic considerations I have enumerated above are often overlooked when the causes of social problems related to medicine are considered.

2. Medical Education and the Practitioner in Japan

A large majority of the practitioners in Japan usually spend three to five years in a university hospital in order to specialize in a field of their choice after graduating from medical school. Some spend as many as nearly 10 years beyond this in order to produce a dissertation for the higher degree called *igaku hakushi,* which roughly corresponds to the Ph.D. A medical school graduate can open practice only after five years at the earliest. In the case of ophthalmology, for instance, a graduate spends five years doing academic research at the university while being engaged in clinical studies. In such a situation, the graduate conducts research on a theme determined for him by his professor. The results of such research are announced at meetings of academic societies and are debated. A medical school graduate usually

gains a great deal of confidence in himself about two years after graduation.

After about five years, however, he loses confidence and begins to try to "renew himself basically." This is the time when a graduate either starts his own practice or starts working for a hospital. Some are employed by major hospitals immediately upon graduation. There is no residence system in Japan, however. A young doctor is trained at a large hospital in a manner similar to that of the university classroom. This means that while an employed doctor and a practitioner both spend exactly the same number of years in medical school, after graduation they have little contact with each other. The reason is that there is no "open system" hospital in Japan — a fact which bars a practitioner from having contact with hospitals. This is a defect in the medical system of Japan.

Because of the traditional folk belief in Japan, Japanese tend to regard the physicians serving in governmental and other public hospitals as superior to private physicians. This "superstition" has been responsible to a great degree for the stunting of the development of private physicians.

Very few doctors employed by universities return to academic life as professors. Most of them serve all their life in their hospitals. The private physician, on the other hand, practices in many different forms and on varied scales. A practitioner may practice alone with a single nurse. Or he might employ several other physicians, diagnostic specialists, and nurses, and equip his clinic with X-ray machines and other diagnostic equipment. Regardless of the scale, a private physician usually prescribes examination devices. All this makes such a clinic appear to be too small for his patients. He even fills the prescriptions himself.

The western system of the pharmacist filling a prescription made by a physician has not taken root in Japan. It is in the psychology of the Japanese patient to entrust to his physician the entire matter of dealing with his ailment, including the dispensing of medicines.

In any case, a physician usually makes public the area of specialization in which he had specialized. There are exceptions,

however. For instance, a physician who had spent five to ten years, specializing in pediatrics in medical school, opens practice as a pediatrician. But when he finds that he does no earn sufficient income in this particular area or specialization, he may add another area of specialization on his shingle. In this case, pediatrics remains in large letters while the new addition, "internal medicine," for instance, is written in smaller letters.

There are, of course, pediatricians who specialize only in one area — pediatrics. This is usually the case also with such specialists as the otorhinolaryngologist, dermatologist and urologist. The law stipulates the areas in which physicians may claim to specialize. The areas of specialization thus prescribed by the law do not include neuro-internal medicine and gerontology. The law authorizes an anesthesiologist to claim to specialize in his field. In this case, he must be approved as a specialist by the Anesthesiological Society and his announcement of his specialization must be authorized by the Ministry of Health and Welfare. This is because during the days when there were no professors of anesthesiology in the medical schools of Japan, the Anesthesiological Society was created and it became necessary to have anesthesiologists indicate their specialization. The society, accordingly, devised a means of certifying the qualifications of its members.

This method of having an academic society certify the qualifications of a specialist, to be followed by the organization of the system by the Government, is a procedure which I proposed and had accepted. I wish to have this method used more extensively so as to prevent the emergence of physicians who advertise on their shingles whatever areas of specialization they think are lucrative, I believe the system I initiated has been successful.

In Japan, there is no legal provision for the establishment of specialists in medicine. The reason is, as I mentioned earlier, that a physician specializes in an area at his medical school and he is required to indicate it as his area of specialization. Another reason is that many specialists report the results of their research in their areas of specialization and their achievements are recognized. After the end of

World War II, voices arose in favor of the establishment of the American-style specialist system. I was not entirely in favor of this system because there are many private practitioners who have high-level techniques in their areas of specialization and are settled in their communities. These specialists were playing the role of medical consultants for the inhabitants of their communities besides being specialists which they were.

The general practitioners in other countries become such after taking up all areas of specialization by rotation. There is no such system in Japan, however. There is the title of *zenka-i* (all-field physician) but very few qualify as one. If Japan is to adopt the American-style specialist system, specialists would be destined to remain employed physicians all their life. That is because of the pattern of Japanese society. A specialist in Japan under the American-type specialization system would have to acquire the title of a specialist as well as the degree of *igaku hakushi,* referred to earlier. The degree of *igaku hakushi* was originally a form of recognition of medical merits attained by a doctor, but it has become an accepted institution. It would have been extremely difficult to introduce the American specialist system into Japan without taking into account the problems of adjustment between the new (American) system and the traditional system.

Some medical societies have their own systems for establishing specialists in their respective branches of medicine. But they have not been put into practice.

If a competent clinician is to inform the public of his specialization, we should have an "expert system." This would make far clearer what an "expert" is a specialist of than in the case of the conventional specialist system. This would, furthermore, enable an "expert" to obtain patients from a far broader geographical area than today's specialist does. The differences between the specialist and "expert" systems, I believe, should be carefully studied. Anyone who wishes to comment on the Japanese medical care system must first of all acquire the understanding that the Japanese practitioners are not general practitioners.

The name "family doctor" means, in Japan, that the doctor has a very close relationship with a certain family of patients. He is the person whom the family can consult about all matters related to health. Such a physician is often a specialist in internal medicine and pediatrics. But even if he is not, a family can consult him in a most frank and familiar manner.

The physicians working in governmental and other public hospitals, however, have no such relationship with citizens at all. Here is found the major characteristic of the Japanese practitioner.

It is interesting to note that even though two doctors may study beyond medical school for the same length of time, one may become a "closed" doctor while the other may become an "open" practitioner, giving specialized service. There is a vast difference between the two physicians in their statuses in relation to the community. If we were to adopt the American-style specialist system in Japan, there is the danger of our losing this existing system which I believe is most desirable.

3. Medical Associations and the Physician in Japan

In Japan, 90 percent of the doctors are members of the Japan Medical Association (JMA). The association is comprised of prefectural medical associations, which in turn are made up of local medical associations. For a physician to join the Japan Medical Association, he must be a member of a local medical association and of a prefectural medical association. Both practitioners and employed physicians can freely join a local medical association. But about one-half of employed physicians are not members of a local association. A member of a local association is obligated to participate in the social activities of the association. And this obligation, which is not always easy for employed physicians to live up to, is a major reason for not all of them being members of a local medical association.

School doctors are often provided by a local association, which organizes teams of specialists to look after the health of schoolchildren.

Likewise, a factory with a large number of employees receives the services of "industrial doctors," in the community, who receive special training by Japan Medical Association. As many as 80 per cent

of the industrial doctors in Japan are local practitioners who serve in their capacity after receiving an industrial medicine education given by the Japan Medical Association.

Local medical associations actively cooperate with local governments in preventing contagious diseases and in taking measures against parasites. The drive against parasites has been so effective that today there is no longer much need for it. The local medical association today plays a role not dissimilar to that of the "staff" in a military organization in relation to health development programs carried out by the communities.

These are a few examples of practitioners being engaged in community activities, which tie them closely to the areas in which they practice. The local associations of doctors also make many contributions to public health and pollution problems and the problem of improving the nutrition of the inhabitants of their communities.

When viewed in the light of such activities, it becomes clear that medical associations are not "trade associations," which merely pursue the interests of their members. Rather, they are organizations that make major contributions to the development of the health of the inhabitants of their local communities. Such activities by the affiliates of Japan Medical Association have been planned and begun by the JMA for years. They have now become an established nationwide institution.

There are a few exceptions: the local medical associations that are under the control of Communists, which do not participate in such community-minded activities. Their teamwork is directed toward only one goal — raising medical fees.

Progressive local medical associations have established their own clinical testing centers in the interest of the citizens of their own communities and have established "open system" hospitals of their own. The Government of Japan has recognized that the activities of these medical associations are highly effective and has been giving them financial assistance for the establishment of such hospitals and other facilities.

With these hospitals equipped with expensive clinical testing

instruments, private physicians can have various tests conducted by sending samples to these facilities. This obviates the necessity of sending their patients to the hospitals.

One examination center sends reports made by an autoanalyzer to a requesting physician. In the case of a medical association hospital, it serves as the center of group practice, where all the physicians in the community can cooperate with one another to determine the best possible measure for a patient. It is possible at these facilities also to invite the most outstanding authority in a particular branch of medicine to observe and participate in his operation or conduct a discussion with him. Thus, in these ways, the techniques and economics of the physician are kept wide open and the physicians stimulate one another in their constant studies, contributing to a high level of medical services in the communities.

That the activities of the local medical associations have come to have close professional relations with the health of the inhabitants of the communities in concrete manners represents great progress. These facilities include about 50 hospitals and 200 testing centers established by medical associations.

JMA conducts supervision of these testing centers in order to insure the accuracy of their tests. This is one means of standardizing the levels of the testing centers throughout the country. Through these institutions, the medical service standards of the practitioner have been measurably raised. Today, the community medical association is indispendable for both the physician and the inhabitans.

4. The Status of the Practitioner

The system of the practitioner in Japan 50 years ago was a very simple one. He received his patients in the morning at his own clinic and made house calls in the afternoon. In most cases he used a rickshaw for his house calls although in a very few instances some used a horse buggy. In prewar years, the average number of patients a practitioner handled in one morning was from seven or eight to 15. In the afternoon, he made about five or six house calls. He trained nurses at his own home, in principle, by himself. A practicing surgeon had an

operating room and usually had an assistant. In most cases, however, practicing surgeons practiced in the form of a hospital rather than a clinic. In the prewar years, anesthesiology was not a recognized branch of medicine, and accordingly, the surgeon himself administered anesthesia.

Practitioners in one area formed their own association, and they had a very close relationship among themselves, exchanging views relative to medical services. Views and knowledge among physicians of different fields of specialization were conducted at this "clearing house" which took the form of a discussion meeting.

Even in those years, the local association of doctors often held academic lecture meetings twice a year — in the spring and autmn. This was the incipient form of group medicine in Japan. In those years, clinical examinations were very simple. Urinalysis was concerned primarily with protein, sugar and the conditions of the liver and kidney. Stool sample tests were conducted primarily to determine the presence of parasite eggs and occult blood.

Blood tests were started much later. The serodiagnosis of contagious diseases, however, has been conducted for many years. A private practitioner usually practiced by himself with the assistance of a few nurses. His clinic was a part of his own residence and there were also facilities for filling prescriptions, which he wrote by himself for his own patients. There were practically no doctors who wrote prescriptions for their patients and had it filled by a pharmacist.

It is true that the income of a practitioner like this was highest in the local community in which he lived and practiced. There were cases of hospitals being built by many doctors pooling their resources. There were also cases of first-rate physicians building their own private hospitals. There were university professors who operated their own hospitals during the hours when they were off duty from the universities. In the early part of the history of private hospitals in Japan, those operated by university professors as their side businesses were the most prosperous.

Because the hospitals developed in such a manner, most of them

specialized in certain branches of medicine. Public hospitals, such as those established by prefectural or city governments or by the Japanese Red Cross Society were general hospitals. Nonetheless, in those years, those specialized hospitals operated by university professors held the highest prestige.

This kind of private practice pattern, however, has undergone changes with the progress of medicine. Private practitioners gradually tended to conduct clinical tests by themselves. In a limited number of areas, they began establishing facilities for joint use. This actually began about 20 years ago when I became vice president of JMA and recommended that all practitioners be required to study the ways of conducting clinical pathological tests and establish testing centers in their communities. I did this because I felt that the old pattern of private practice would not enable the practitioner to incorporate clinical tests into his daily medical services.

I also believed at that time that the techniques and finances of the physician should be made open to the public and recommended that medical associations establish community hospitals.

These two organizations — testing center and community hospital — developed as representative institutions for group practice. I personally favored the system of a practitioner prescribing for his patients and the prescriptions filled by pharmacists. This idea did not work out because the pharmacists were not prepared to accept this system. Accordingly, the medical associations today are planning to establish pharmacological centers so that they themselves would not have to fill their own prescriptions. This plan, however, is yet to be put into practice.

Today there are about 6,000 medicines which are used under the health insurance system. It is impossible for every practitioner to have all these 6,000 medicines ready in his own dispensary. This means that there must be pharmacological centers where all the necessary medicines are available. A private drug store now finds it nearly impossible to fill every prescription. I believed that under our system whereby every citizen is covered by a health insurance system, every medication prescribed by a physician should be given to the patient free of charge.

Accordingly, I proposed the establishment of a public pharmacy in each local community, where prescriptions by all physicians in the area may be filled free of charge. This proposal, however, was vigorously opposed by the association of pharmacists and it is difficult to put it into practice.

The fact that the number of medicines has increased to a great extent and the fact that the life of medicines has become shorter has presented Japanese medical care with a difficult problem that requires solution from both financial and technical angles.

Today's practitioner is expected to handle about 50 outpatients a day. In the case of an otorhinolaryngologist, the number is even higher and 100 is a minimum. It may be difficult to believe that these figures are realistic. Nonetheless, this is a fact because the demand for medical care has become highly extensive under the system of covering every citizen with one insurance system or another.

In Japan all hospitals take outpatients and pick up patients to be admitted from among these outpatients. In such a hospital, one doctor may handle more than 50 outpatients a day. This is definitely not a desirable state of affairs. Yet, the problem is to be traced to the fact that there is one doctor per 950 persons in the population in Japan and demand for medical care has increased to the extent we see today.

Even under the Japanese system of every citizen being covered by health insurance, a patient has the freedom of choosing physicians. In this system, however, is inherent a serious shortcoming. That is, a patient who chooses a doctor for his first consultation and finds that this physician does not give him the diagnosis he expected, often changes doctors frequently — trying one after another. An emotionally unstable patient also tends to change doctors frequently. And that there is no way of checking this is another reason why there are so many patients in Japan.

One possible solution being contemplated by the insures is that when a patient seeks a medical consultation he must pay part of the cost. This system, the insurers think, will reduce the number of patients. The scheme, however, is pregnant with the danger of rendering the social security system basically meaningless, because a

patient, when he needs a medical consultation, must make a new payment despite the fact that he is supposed to be covered by his health insurance. In the extreme case, a poor man, even though he is paying the premium for his health insurance, cannot make medical services available to himself because he cannot afford the cost involved in each consultation. The same thing is basically true with citizens with higher income. It might appear that they would be able to burden the cost of each consultation. But these higher-income citizens are paying higher-rate insurance fees. If, therefore, they are required to pay extra for each medical consultation besides the premiums, there would be objection even from them. Objection would be raised by doctors, too, because the extra financial burden on patients would mean fewer patients.

The basic medical care system in Japan today is one in which a patient has the right to choose physicians in exercising his right to receive medical care. When doctors handle as many patients as described above, the patients are likely to be handled as though they were moving along an assembly line. There are many cases in which a large number of personnel in paramedical professions are required. Such a physical burden on the part of medical workers does not contribute to the improvement of the quality of medical service. It is in fact harmful to the health of the physician. The life span of the Japanese physician is a few years shorter than that of the population as a whole.

There are also vast differences among the incomes of physicians. Those in densely populated areas have a fairly large number of patients while those in sparsely populated areas have fewer patients. In Japan's social security system, the material reward for the physicians' skills are equal. An expert and a fresh graduate from a medical college receive exactly the same fee. It is natural, therefore, that doctors tend to concentrate in densely populated areas. The number of doctors in sparsely populated areas, accordingly, tends to decrease. With progressing industrialization, the nation's communities become increasingly more clearly divided between overly crowded and sparsely populated areas. The prospects are that there

is little that could be done about the maldistribution of doctors between these two separate regions.

During the "free" medical practice years, the distribution of practitioners was determined by the amount of capital available in the communities. That is to say, in areas which had relatively little capital, there were relatively fewer practitioners. But today, the distribution of practitioners is determined by, not capital distribution, but by the density of population, which also determines the financial status of the practitioner.

In a large majority of cases, the practitioner works with his entire family. His wife and daughters often serve as his assistants. This is because the fees are very low, the practitioner finds it difficult to employ necessary personnel and, instead, depends on the services of members of his own family.

This type of operation is radically different from that observed during the pre-health-insurance era. A practitioner who must depend on the services of his family cannot expect his practice to develop. Here, too, the hospitals established by medical associations may be considered as one means of obviating this difficulty and they are receiving increasing attention. In an area where there is a medical association hospital, the private practitioner is like the reception window of a hospital. Thorough medical checkups are also conducted increasingly at the hospital. Under such circumstances, the families of the practitioners are freed from the duty of helping the practitioners. In today's Japan, this system of private practitioners making use of medical association hospitals is the most progressive pattern, and it is becoming rapidly prevalent. The life of the physician cannot be modernized unless he depends on a medical association hospital and testing center. This is being increasingly understood. One inevitable question to arise in the process of modernization is that of the separation of the functions of the physician and the pharmacist.

The income of a practitioner today belongs in the highest category in an area where the rate of capital rotation is low. In an industrial city, where the rate of capital rotation is faster, the physician ranks in the middle. Generally speaking, however, the physician's

standard of living is among the highest in his community.

Japanese practitioners can conduct checkups and deal with their patients in his offices to some extent. They can conduct X-ray examinations, for instance, except in the case of photographing particular blood vessels. Most of the private clinics specializing in internal medicine have ECG's. It is common practice among private physicians to conduct on-the-spot checkups for their patients, and many of them have their testing facilities, including even automatic analyzers, in their own clinics. Thus, the practitioner in Japan can minimize the time required for the sake of the patient by conducting tests, if they are simple ones, at his own clinic, even though they may be practicing in an area where community facilities are available. This means that a patient who visits a private physician can have diagnostic tests made and have his prescription filled — all at one place. If a patient should require complex tests for a diagnosis, he is referred to a community facility or a hospital. The advantage of this system is that the responsibility of those who give medical services is not divided among testing agencies, pharmacists, etc., but rests with the practitioner himself. Thus, the physician can serve his patient in a manner in which he has the supreme responsibility to his patient, which is an ideal system.

A testing center or a medical association hospital replace the practitioner in making the initial contact with a patient. But the responsibility of the physician is not reduced in the slightest. Rather, the physician in charge actively seeks the cooperation of his colleagues and endeavors to find the best possible medical care for his patient.

A private hospital is authorized only when it is managed by a physician. Some of the largest hospitals have nearly 1,000 beds and smaller ones may have only 20 beds. Each exists with its own characteristics to suit its locality. There is no friction of any kind between these private hospitals and medical association hospitals. I believe, however, that private hospitals should try to develop as specialized hospitals rather than general hospitals. All in all, the practitioner system of Japan has developed in its own unique way, when compared with those of other parts of the world.

5. The Practitioner's Community Medical Services

A practitioner is always a member of his local medical association which carries out various community activities. School doctors, for instance, are organized by the association by making available the services of specialists. The association also participates in the school lunch program. Innoculation and other operations concerning preventive medicine are a part of the services rendered by all the practitioners in a community with the consent of the particular local government and the medical association of the community.

Another service is the examination of the aged, and local medical associations also carry out "circuit examinations" for remote areas by sending teams of physicians. The private practitioners and hospitals in local communities are responsible for 85 per cent of first aid and the treating of traffic accident victims. The central and local governments, however, offer no assistance in the reservation of hospital beds for emergency cases and the covering of personnel costs. These are all carried out as "voluntary services" by private physicians in their own communities. This state of affairs is extremely unreasonable and, therefore, must be systematically revised. It may be said that first aid services in Japan are carried out at the expense of the practitioner.

Another important function of the practitioner is that of a consultant for families as family physician. About 60 per cent of the citizens in Japan have such "family physicians" who serve as their "consultants." By custom these citizens do not pay their family physicians a "consultation fee" as such. In some local communities, such a family doctor is "hereditary" that is, a practitioner's son, who succeeds his father, continues to play the same role to his father's patients. The relationship between the physician and his patient's family is like that between relatives. In such a situation, the physician has full knowledge of the life pattern and habits of the members of an entire family. This physician-patient relationship is a legacy of the "free practice" system during the era when the family system of Japan had a strong hold on the life of the citizen. Yet, this old pattern is still found in the new community activities by the physician.

6. The Future of the Practitioner

Although the medical practice system in Japan is that of "free practice," it cannot be said to be "completely free" because of the health insurance system which covers every citizen. The "free system," therefore, may be said to be under some state control.

The health insurance system has its origin in the era when the military and bureaucracy had all the powers of government. And there has been a debate on its basic revision.

Our contention is that under the existing system, the physician should be the principal in the dispensing of medical care. And the substance of medical care should be freely determined by the academic conscience of the physician. The physicians in Japan have been arguing that under the comprehensive insurance system, in which every citizen must be insured according to law, the restrictions one placed on the medical services that may be given a patient covered by a health insurance system contradict the purpose of the system itself. This argument has been heeded to a great extent and it is a fact that there are very few restrictions now.

Nonetheless, organizations of socialists are contemplating the state control of medical care agencies. According to their scheme, all physicians would be employees of state medical service agencies to which the physicians are to offer their technical services.

The principal advocates of this system are labor unions, which argue that medical services should be controlled by them. State-managed medical service has been advocated by the bureaucrats of the Health and Welfare Ministry. They dreamed of an era in which their idea would become a reality. But they know that such an idea is not practicable. They have established state hospitals, social security hospitals and welfare pension hospitals, which they can manage. But they have done nothing at all about the hospitals to accommodate the physically handicapped children and the aged because these hospitals are more difficult to manage. They leave these hospitals to private goodwill because they do not wish to shoulder the responsibility of managing them if these difficult-to-operate hospitals were to become a state responsibility.

The question of medical services given by private physicians may be best answered by answering the question of whether the activities of medical associations which provide medical services in their respective communities are being carried out systematically. This is the crucial question that seals the fate of a particular medical association. In a community where the medical association serves it well with full results, state and public medical care agencies are sternly rejected by the inhabitants. In such a community, there are opportunities for private discussions between the medical association and the inhabitants in such forms as the Community Health Research Council and the League of the Insured. It was also at the community level that a training system for practitioners has been established.

JMA holds lecture sessions for leaders in social security and lectures for such varied subjects as the substance of medical services to be given by the practitioner, rehabilitation and medical administration. JMA also endeavors to hold such lectures at the community level.

The prefectural medical associations consist of country and city medical associations whose memberships include governmental and public hospitals. Thus, medical service agencies, both private and public are often engaged in social activities without any distinction between them. There are unavoidable reasons, however, for the fact that in certain community activities, public agencies drop out. This is partly because the personnel in public agencies, who are civil servants, are not authorized to engage in overtime work for the community. Another reason is the fact that such personnel — doctors working in public hospitals — have no sentimental attachment to the community in which they happen to be working.

The community health research council makes plans for health programs for the community. Its main components are the physicians of the community and other members include representatives of the citizens and the local government concerned. Such a system as this helps to promote the concept of group medicine and in many cases it has successfully developed health programs in remote areas.

The "free practice" system of the Japanese physician operates within the strongly restrictive framework of social security.

Nonetheless, the physician's consciousness of his function is being elevated in accordance with the development of Japanese society. The efforts of the physicians to establish themselves as a professional group in a free society while being fully aware of its close relationship with the society are receiving increasing recognition. Because of this, the attempts by labor unions and bureaucrats to bring medical services under state control have made no progress. This proves the fact that their advocacy has no bearing on the solution of the problems of the most unfortunate.

7. Factors for the Creation of the Future

Factors for determining the future of the Japanese practitioner are many. Firstly, there is the need for an improvement of medical education. Today's medical education offers nothing for the education of physicians on the means of the adaptation of medical science to society. Nor does it offer any information on comprehensive medicine and community medicine. The system produces doctors of the old model, who are to play their role only when the health of human beings is disrupted. When a graduate of a medical school, who receives such an education, serves a community, he is compelled to study ways of the maintenance of the health of healthy people, the prevention of disease and social rehabilitation. He has specialized in his own field for about five years after graduation at a large hospital, as I mentioned earlier, and he had written a few papers before beginning practice. Yet, he must teach himself to qualify himself as a leader in the health of the citizens of the community in which he practices.

Another difficulty with the present medical education system is that physics and physiology, which are the basis of medical education, are taught according to their old concepts. Medical education is given primarily through memorization and little training is offered on how to think.

For these reasons, I believe that the medical education of the future must be divided between two sections: the necessary section and the sufficient section. The former means six years of undergraduate education, which must give the student all that is

necessary. In giving what is necessary, however, not only memorization but thinking must be stimulated. A comprehensive education in terms of biology, biochemistry, pathology, anatomy, microbiology, and immunology should be given in a hospital in their relationship with clinical medicine in a comprehensive way. For studies in physiology, pathology and immunology, of course, students can acquire knowledge through their own studies and discussions with their professors so that they can develop new ideas. The necessary part of medical education may be spent in this manner for six years.

Postgraduate training is to give the student the "sufficient" part of medical education, which should be about five years. The specialist being contemplated today is expected to undergo such training for five years to become an expert in his field. In an industrial area, the student may study in an industrial hospital. In a rural area, he could study likewise in a rural medicine hospital. In either case, he can receive sufficient education under the guidance of competent supervisors and develop an area in which they may excel most.

I wish to call this system the "expert system." The results of an expert's research are to be recognized by the academic society of the area concerned and his status as an expert will be established. Such an expert will be useful to the fullest extent to the community which needs his professional skill and knowledge. When we consider the systematization of community medical services, the solution of the problem of medical education must come first. (See "A Medical Education Reform Plan" by Taro Takemi)

The expert can also serve the function of a consultant for the inhabitants of his community. He will also be equipped as a consultant in a new sense of the term for factories, schools and business. Thus, many experts suited for various types of community may be developed.

Such an education for the "sufficient part" of medical training is today offered by the medical association hospitals and clinical testing centers where group practice is conducted. Thus the future of the practitioner of Japan is very bright.

A Japanese practitioner, no matter how superior a specialist he may be, is also well-established as a family physician. No matter how much of a specialist a practitioner may be, if he does not have the capacity to be consulted by families, he does not command the respect of people in the true sense of the term. The physician today must study by himself how to grasp in medical and physiological terms the community in which he works and how he can engage in medical activities accordingly. And then he must practice what he has learned. This would be one of the factors to brighten the future of the practitioner. It is most likely that the Japanese practitioner will have the greatest responsibility over the health of the people of Japan and they will be the supplier of medical services that would be indispensable for industrial development.

8. Social Insurance and the Medical Practitioner's Law

Since the social insurance system covers the entire population in Japan, when a person's health fails, he can receive medical care under a health insurance system except when he does not wish to do so. Medical care under a health insurance system is computed in terms of points, and the point system was worked out with the lowest income bracket as the basis. Accordingly, the income of the physicians of Japan is extremely low, compared internationally. It is normal, therefore, that a internist handles as many as 50 patients a day and an otorhinolaryngologist often more than 100 patients a day. A physician conducts tests, gives injections, takes X-ray photos and fills prescriptions. All these services are computed in terms of points alone and the experiences and academic levels of physicians are not taken into account. A doctor who won his license yesterday and a university professor are rated exactly the same as health insurance doctors.

On the side of the insured, the patient, when he is the insured person, generally receives all medical services without extra payment while a member of his family must pay 30 per cent of the cost. Under such a system, a health insurance beneficiary calls at a clinic without hesitation. Accordingly, there is a tendency toward the abuse of medical services in Japan.

Early detection of disease, of course, is to be encouraged. But there are cases when patients take advantage of this system even when their ill health is due to their own intemperance. A physician has no authority to determine whether his patient deserves to take advantage of a health insurance system.

Many patients are, therefore, very minor cases. This means in turn that the time allowed for each patient must be shortened, and it has become a problem.

Another problem of the health insurance system is that a physician must spend a large number of hours preparing papers to demand payments from the insurers. He must submit reports with the contents of the medical services he has given each patient for the computation of points for which he will be reimbursed. This bookkeeping work takes up one hour per each working day of every physician on the average. Since the bills are to be submitted toward the end of each month, some physicians must work through several nights. This bookkeeping work, required of the physician, is the greatest shortcoming of any social insurance system. Then it becomes necessary for a physician to acquire a skill to carry out this complex and cumbersome paper work. Yet, for this non-professional work, a physician receives no compensation, no wage.

The health insurance system recognizes fully the patient's right to receive medical service but does not give the doctor any right to the maintenance of his own health or time for his own studies. Thus, every physician, if he is to become an insurance doctor, is bound all his life to this kind of condition. This problem must be solved in a different sense from that concerning the demand of the labor unions for shortening their working hours.

A health insurance doctor is a health insurance doctor only when he deals with a health insurance beneficiary. But the same doctor must spend some time with a patient who is on government relief or as a school doctor, as a factory doctor, etc. Yet the insurers in the health insurance systems expect the doctors to serve as health insurance doctors 24 hours a day.

Against this demand, I have proposed that a physician's working

hours should be limited to 40 a week. When he handles an emergency case, outside his working hours, he should be paid extra. And his own time should be spent for his "free practice."

I believe that these hours for "free practice" should be the time when a physician should perform new family service and community service in the world of positive health. Japanese physicians today are concerned with the problem of positive health only when they engage in the activities of their local medical associations. They have yet to serve families in the same manner.

It is my belief that the development of this new field could be one direction in which physicians can make progress as home doctors. My views on this matter have been opposed strongly by the mass media and the health insurance organizations. Yet, I am convinced that when the physician is liberated from the 24-hour-a day working hour system and becomes active in the world of positive health, the number of patients will be halfed in the future, and thus halfed reduce the work load on the physicians.

9. The Welfare of the Physician

JMA has established a pension system for the practitioner who, unlike the employed physician, has no other pension system. According to this system, which is based on a combination of life insurance and trust, a practitioner is entitled to receive a pension at 65. If he starts paying a premium of ¥4,000 a month at the age of 30, he will receive ¥5,000 per month after 65 until he dies. If his premium is larger, of course, his pension will be larger. The system was instituted a year ago and there is much expectation placed in this system by members of the JMA. The Japanese physician's working capacity notably drops at about 65, which means his income sharply decreases. The pension will help to meet this reduction in revenue. Since a practitioner has no retirement age limit, he can be active as long as his health lasts. And this pension will help him a great deal in his old age. There is also a plan for a pension for the physician to finance his children's education.

For a physician there is also a health insurance association, which

covers his illness as well as the illness of his family and his employees. This health insurance system is called the Physician's Special Health Insurance, which covers practically all of a doctor's health problems.

There is no system, however, to guarantee the living cost of a physician who is unable to earn income because of illness. In some communities, medical associations have organized mutual aid societies for helping a physician in this respect. This is an area where fuller welfare measures must be taken on a nation-wide basis.

10. Conclusion

The conditions of the Japanese medical practitioner radically differ from those of his counterpart in Europe because of the structure of Japanese society and Japanese tradition. The differences are also due to the system of medical education in Japan. Medical care in Japan, however, is most likely to attain notable development primarily on the basis of community medical care.

The Life Cycle and Social Insurance

1. Introduction

In recent discussions of welfare problems, life-long security and the life cycle are often mentioned. One thing we must pay attention to in this connection is that all the persons who refer to these concepts represent the way of thinking that aims to accomplish welfare by means of social insurance or social security. Most recently, some economists seem to have summed up discussions on the life cycle. I believe, however, that it is necessary for us to reconsider when and for what purpose the social insurance system we have today was initially designed.

An essential requirement for social insurance is that its design be reviewed while its basic conditions are taken into consideration. Yet, in Japan such a redesigning of social insurance has never been done during the past half century. It is therefore ridiculous to argue about life-long security without responding to the living society in which it is expected to operate. Here I wish to take up this problem and give it some thought.

2. Development of the Environment for Life-long Security

According to Article 25 of the Constitution, all people of Japan have the right to maintain the minimum standards for wholesome and cultured living. I believe this is the only goal for which we should

---

This paper is an English translation of a talk in "The Special Medical Course" broadcast of September 7, 1975, Nihon Shortwave Broadcasting Co., and the original paper in Japanese was published in *The Journal of The Japan Medical Association,* Vol. 74, No. 7, pages 863 to 866, October 1, 1975. Reprinted from the *Asian Medical Journal,* Vol. 18, No. 10. October, 1975.

strive. What the people of today look forward to is consistent security, coupled with security of living and security of welfare, to be provided for the entire life span of each citizen. To guarantee security for life and welfare throughout one's lifetime, however, is easier said than done. When it comes to the question of how to achieve this, we must realize that a great variety of elements are involved.

One of the things important in this regard is, first of all, that we consider security of life from the standpoint of life science. We are now at a stage where it is impossible to consider this with the concepts of welfare economics of the past because the technological field today comprises too many elements, which cannot be properly dealt with by economics alone.

I. Development of the Environment for Security
   1. Development of the Consciousness Environment for People
   2. Development of the Economic Environment
      —market economy organization
      —nonmarket economy organization
   3. Development of the Administrative Environment
      —as a structure for the development and allocation of security resources

What is necessary first of all is to realize that the problem of the development of the environment for security is being forgotten today. It is impossible to carry out a social plan without considering the development of an environment necessary for it. When human ecological thinking is introduced into life science, we find that the problem of environmental development becomes extremely important.

What are the elements of primary importance in environmental development for life-long security in a social environment? Firstly, it is the development of the consciousness environment. The kind of life-long security the people seek today is one by which the government enables them to have no difficulty in making a biological existence—without starving. This is the prototype way of thinking

in the dependence welfare age. The future of mankind on this planet, however, will have no room for this kind of thinking. Welfare, I believe, may be divided into the dependence welfare and self-reliant welfare models. When these two are synthesized, they will produce a new welfare system through combination with new technology. I believe the concept of dependency-type welfare, based on the idea of aid for the weak, is not viable in our age. This is the reason why I maintain that the development of the consciousness environment for the people is of primary importance.

Secondary, there is the need for the *development of the economic environment.* It is necessary to consider if it is possible to provide life-long security through social insurance-type means under the present economic environment. I believe the development of the economic environment has an enormously important meaning.

It would not be possible in the future to maintain life-long security in the economic environment, based on today's market economy organization, with nonmarket economy organization, that is, public economy, and many others as its antithesis. Then the economic environment will have to undergo major changes. It would be obviously impossible to provide life-long security within the economic environment of the loose free economy society we have today.

Thirdly, we need the *development of the administrative environment.* The administration conducted today by the government is highly one-sided, like one-way traffic. Welfare administration reigns over the people on the premise that, no matter how old it may be, it reigns as long as it exists. This is the environment created by power. But it is wrong that an environment created by power rules welfare in all of its aspects.

Thus I believe it is proper to consider the development of the environment for life-long security in three separate areas. Yet, there has been no discussion of the development of the environment for security while people merely wanted to get what they wanted and the politicians merely wanted to earn credit by giving. This is highly undesirable. Security must be considered in terms of a long span of

time; it must be an extention of the past. When we speak of life-long security in particular, we must realize that the period of security might be as long as one century. In the past, the period required for giving security was only from 40 to 50 years. But today it must be double that length.

Another matter of importance is that the three kinds of environment I listed above — the economic, administrative and consciousness environments — will vary depending on how we recognize the sociobiological environment. I believe it necessary to study thoroughly the question of developing the environment for social security or life-long security.

When we speak of environments, have in mind cultural environment, life environment, educational environment and many others, and their relationships with life-long security must be fully considered. It is my belief that under the present administrative, popular consciousness and economic environments, there is very little possibility of achieving life-long security. If we are to have life-long security provided by the power of the government under the present environment, there are bound to be many serious conflicts.

3. Developing and Securing Security Resources

The next major issue is that of developing and securing security resources. The primary resources are food, shelter and clothing. But the securing of these resources is now faced with a very large technological renovation. Clothing, for instance, no longer consists of cotton and silk but of many new textiles. People do not wear kimono as much as they used to; rather, they are wearing more and more Western clothes. This is a result of a change in life style and technological renovation.

The same is true with food, which now has more protein than in the past. We are not taking sufficient fat and vitamins but their quantities are on the rise. In the old times, our food was extremely meager in nourishment and quantity. There is a phrase meaning "poor clothes and poor food," which characterized our way of life.

As for shelter, there were ages in which it was sufficient only to

have a roof over one's head to keep rain and winds away. But today, we must think of shelter as something that enables us to have "cultured living." When we consider security resources, therefore, we must now consider what kind of effects the types of food people like today will have on their health and activities. It is of extreme importance to the question of nourishment to develop food at all times.

I regard these items as primary resources among security resources. With regard to food, when we consider changes in the temperature and climate of the earth, we find our food security faces a serious danger in relation to changes in our planetary conditions in the future unless we can develop new technological renovations in agriculture. I wish to pay particular attention to these points.

II. Developing and Securing Security Resources
Primary Resources: food, shelter and clothing
Secondary Resources: education, medical care
Tertiary Resources: arts, culture, religion

Secondary resources include education and medical care. As for education it is obvious that we must add many new things to it in this age when the life expectancy of the Japanese is about to top 75 years, compared with the age when it was about 44 or 45. The question of how to deal with the question of the survival system of mankind in education and how to make individual pupils understand it is linked up with the problem of the consciousness environment, mentioned earlier. It is natural that for that we need a new place for life-long education.

Surprisingly enough, it is seldom pointed out that education has a major role to play in life-long security. When we consider the question of life-long security, the problem of education as a problem of the people's consciousness or a problem of technology would loom large.

Another key element of education for fully providing life-long

security would be that of strengthening a sense of solidarity among the people. Yet, very few people have pointed out that this element is very little in evidence in the area of education. Education must attain one more stage of development in this age when the life expectancy of the people has become extended, because life-long education must be given in parallel to life-long security. If this is not done, there will be serious problems in the survival of the segment of the people, whose education has a shortcoming. This is the reason why the Japan Medical Association takes a very serious view of the problem of life-long education.

Another problem is that the term "medical security" is being used rather flippantly. Presumably, we have medical security through health insurance and other forms of social insurance. But old age medical security was not necessary or at least hardly necessary in the past. When this requirement is added, social demand for medical care develops and expands greatly.

When our society changes from an industrialized society to a techno-electronic society in which the two types of society exist side by side, medical care appropriate for such a society must be provided. As in the case of education, there will be the very difficult problem of developing medical care resources.

I have already written several theses on the development and allocation of medical care resources. The development of educational resources and that of medical care resources in a certain sense have a great deal of related meaning. In the field of medical care, there are many technical, finely compartmentalized areas. When it is seen from the standpoint of utilization of medical care, the readiness of the people who receive medical care must be considered as one of the objects of development. In other words, we must consider the readiness of the people to receive medical care in terms of health development. Individuals must acquire the will and a technological understanding to safeguard their own health through health education. The Japan Medical Association is doing its utmost promote this, but the government has hardly done anything in this regard.

The third source is arts, culture and religion. Even in an

underdeveloped society in which human beings died young, there were always arts and culture. When there were human beings, there was a religious mind in them. Arts attained their own development as arts, and social culture as a whole, too, made progress. Religions have come to assume their present forms after many transformations.

The question of how to develop the resources of arts, culture and religion may sound somewhat strange. But it becomes clear when we take cultural development as an example. In cultural development, the culture man has accumulated since ancient times has always been undergoing development. New cultural development has always been in demand in response to social changes. I believe the same thing may be said of arts and religion.

To develop and secure medical security resources, I have thus considered three of them. But it is not impossible to consider the fourth resource.

4. Life-long Plan

One thing extremely important to life-long security is how to incorporate it into social planning.

III. Life-long plan—technological combination of the individual and society
Development of social technology—new welfare

I believe that the conscious and technological combination of the individual and society is highly important. As social technologies are developed, new welfare planning must develop. This is how a new planning formula is produced. In other words, social planning necessitates new designs.

5. Principles of Planning Social Insurance

On the basis of the three major problems mentioned above, we must seek, for instance, principles for designing social insurance. There is discussion today about life-cycle, but no thought at all is

being given to a new design for social insurance.

The first thing required designing social insurance is the introduction of the individual's life-long plan into social planning. I believe that the life-long plan of an individual living in a free society must be respected. Such a plan is also a responsibility of the individual. And when it is properly introduced into social planning, his security becomes complete. A social insurance system which has no relationship with the life-long plan of the individual of today, I believe, is a problem that must be basically revamped.

The second requirement is the individual's positive response to social planning. When the state tries to provide the individual with life-long security with social planning, the individual's life-long plan must respond to it. These two requirements mentioned so far may seem to conflict with each other. But they are mutually complementary. And this is a major characteristic of the life-long security and social insurance of the future.

The third requirement concerns justice and equality. The equality part, I believe, must be covered by social insurance. Fairness may be achieved when the individual's plan becomes integrated into social planning as its major element and the essence for free society attains new development. It is regrettable, I believe that the concepts of fairness and equality are very much mixed up to the detriment of the future development of society.

IV. Principles of Social Design
   1. Introduction of the Individual's Life-long Plan into Social Planning
   2. The Individual's Positive Response to Social Planning
   3. Fairness and Equality—Equality Area and Fairness Area Correction of Mechanical Redistribution

---

We must recognize the areas of equality and fairness in social fairness. Equality does not simply mean a mechanical redistribution

but it must be a more fine redistribution. What is even more important is the fairness area.

When we consider fairness and equality, we must not simply regard them as concepts on a par with each other. Rather, we must discuss what is fairness in a free society and that in a Communist society.

A social security system is considered in general as an income redistribution function. But mechanical redistribution must be carefully handled even in the equality area. In this sense, the designing of social insurance must be basically revised. Facing this new phase, today's social insurance is at an impasse where it cannot turn in any direction. The question is how to make it possible to design a new social insurance by taking into account all these new conditions.

Such a task must be accomplished by sociobiologists, economists and specialists in law when they consider life-long security through a combination of all the sciences on the basis of the principles of designing social insurance I have discussed above.

6. Conclusion

In this respect, I find that today's discussion on life cycle tends to adulate the public too much, and I wish to urge people concerned to muster up new courage and conduct soul-searching. I believe that mankind is at a stage where we must consider a new social plan for life cycle by determining it sociobiological, social-scientific and scientific-technological elements.

The Structure and Function of Community Medical Care

Medical care for the nation, viewed in terms of structure and function, has its basis in community medical care. When the structure and function of community care improve, it would be possible to consider medical care agencies at successively higher levels. That is, community medical care is the most fundamental part of the medical care structure for the nation.

As for its structure, the Government is thinking of establishing a network of public medical care agencies. The so-called "improvement of medical care system" actually refers to the improvement of the system of public medical care agencies. It is, therefore, an authoritarian improvement but not the improvement of an academic system.

The most important element of the structure of community medical care, when we speak of its systematic improvement, is the area of direct contact between the physician and his patients. This area is, in fact, the very starting point and the basis of medical care. This is the point where the human relationship between the physician and his patients is established. It is the point where the social relationship involving social insurance and social security systems begins. It is also the point where the academic relationships of medicine are generated.

The human relationship between the physician and the patient has a great deal of ethical element in it, that is, it links up personal

---

This paper is an English translation of a talk for "The Special Medical Course" broadcast of January 18, 1976, by Nihon Shortwave Broadcasting Co., and the original paper in Japanese was published in *The Journal of The Japan Medical Association.* Vol. 75, No. 5, pages 539 to 543, March 1, 1976. Reprinted from the *Asian Medical Journal,* Vol. 19, No. 4, April, 1976

problems and social ethics problems. This, I believe, should be regarded as the medical micro-order, whose importance is not fully recognized. Superficially splendid medical care agencies spring up in rapid succession, giving the impression that they represent a wonderful medical care system.

Yet, in reality, there is no way of building a high-level medical care system unless we first establish the physician-patient relationship at the very basis of the structure. The relationship between the physician and the patient could be one of personal ethics or social ethics which do not lend themselves well to codification. I believe that people often forget the great importance of the section of society, that does not lend itself well to codification. And yet, the erroneous view that everything could be codified prevails. This is the first area that requires modification.

A macro-order in medical care may be conceptualized as a so-called medical care system. The relationship between the physician and the patient represents a micro order in medical care, which cannot be stated in terms of law. I wish to regard this micro-order as the most important section of the community medical care structure. This is a micro, not macro, structure.

At the point of contact between the physician and the patient, people of many occupations are needed. But it is commonly supposed today that front line medical care can exist if there were a physician and his patient. Actually, however, there could be no front-line medical care without collaborators, including the patient, for the physician.

Why is the patient a collaborator? First of all, he must have an education appropriate for receiving medical care. It is commonly thought that any person can be a patient who deserves medical care as a matter of right. But it is often forgotten that he must meet the requirement of having had an education that entitles him to receiving medical care.

There should be nurses, clinical psychologists, test technicians and roentgenologists. We also need welfare people. And all these

people must be well integrated to complete front-line medical care, at the center of which is the physician. It would be ideal if the physician can have contact with his patient in such an environment.

When private medical care facilities are operated in such a form, the physicians who have only inadequate knowledge and skill or are not very thoughtful to the patients or those whose employees are not well trained and disciplined and therefore prove to be unpopular with the patients, would become subject to the process of natural selection. A free economy society cannot achieve progress without this process of selection.

There is an argument favoring front-line medical care facilities to be operated as public agencies. This is undesirable because under such a system public medical care agencies would become authoritarian and bureaucratic; no matter how arrogant physicians may be and no matter how saucy the nurses and how rudely they may speak to the patients, and no matter what they may do, medical care facilities operated as public agencies would not go bankrupt.

Therefore, I believe it would be the greatest misfortune to front-line medical care facilities to have no built-in mechanism for natural selection. Only when they are subject to popular criticism and to the process of natural selection and, therefore, they seek to improve their services, can we expect better human contacts. The idea of replacing private medical care agencies with public agencies may have been meaningful during the early Meiji Era or the early Taisho Era when medical care was in the stage of being spread. Today, there is no need for such an idea.

Furthermore, in the present system of front-line medical care, emergency medical care is almost entirely given by members of the medical associations. Only in rare instances do public medical care agencies participate in emergency services. Thus, community medical services are given by hospital and medical care centers operated by medical associations, which I believe is a serious problem that ought to be pondered by the people as a whole. Practically all of the state hospitals and other public hospitals refuse to give services except

during their usual working hours whereas 24-hour services and emergency care are provided by private medical care agencies.

Viewed in this light, we know that natural selection is an intangible right for the masses; the people have this major right which is not acknowledged by law. Private medical care agencies which are not good enough for the masses are unavoidably eliminated. The public agencies which are not subject to this process of elimination produce great waste in medical care expenditure. This means that we are promoting such a waste by creating more public medical care facilities. And, in fact, we are in an era of random creation of such facilities and there is no prospect of the situation being improved. If this trend were to continue into the 21st Century, front-line medical care in the next century would be built on a very rigid basis. And the medical care facilities on the higher levels would not be able to perform their functions to the fullest extent.

Front-line medical care agencies include those for emergency care, school health, mother-and-child health and medical care for the aged. These are hospitals and clinical examination centers operated by medical associations.

People are not conscious of the process of natural selection in medical facilities as their great right. But I hope that the 21st Century would be an era in which people would become fully aware of this right.

At the same time, the physicians, who provide medical services, too, must always think of health education for the people and try to improve the people's understanding of medical care as a part of their cultural refinement. It is necessary to handle the matters of education, research and development in medicine in this manner.

There are peculiarities to community medical care even with regard to data processing. Medical information must be thoroughly utilized, and yet, only very little has been achieved in this regard. Data processing in medical information is about to be utilized by almost all public hospitals while private medical care agencies have a vast amount of information. Data collection by public medical care agencies alone,

therefore, would mean a serious imbalance, which I regard as a major problem.

There is also the problem of an allocation structure for the technological resources for the clinical examination center itself. This problem of allocation of technological resources for front-line medical care have not been discussed in concrete terms. But it is true that an appropriate allocation of technology is necessary with regard to the industrial physician, the school doctor, mother-and-child health and health care for the aged. And then there should be secondary, tertiary, and subsequent-level medical care agencies to be established for dealing with special diseases and difficult-to-treat conditions.

Take the use of cyclotron for treating tumors. This may be handled by a technology development center if it is operated in an integrated manner, or it may be handled at any other facility that deals with radiation therapy. In any event, if the system works according to the manner I have just described, there would be no overlapping of facilities. This, I believe, is the way of medical care in the 21st Century. At present, however, the system is based on Governmental authority, and it rejects the principles of metabolism, survival of the fittest and natural selection. This I believe would create a great burden, contradiction and confusion for the people in the future.

One important element in a medical care facility is the technology to be installed in it. This is not a problem of a physical structure but the technology to be built into it. Take the thyroid gland, for instance. There should be information on who is the best authority on diseases of the thyroid gland and who is next best, and so on. If such a data processing system is to be applied to all areas, it would be possible to raise the level of medical care along the entire line. An integrated technological development center can also develop technology for not producing human "vegetables," and then the technology may be handed down to the successively lower levels of medical care facilities. This way, it would be possible to provide physicians with highly effective re-education — far better than the re-education program we have now.

Such an ideal system, however, cannot be expected to be brought forth by the present administrative structure of medical care. According to the concept of integrated technological unit, it would be possible to allocate such units at places where they are needed, according to the needs of various localities. Through this system, medical care facilities themselves would be able to exchange information, thus contributing to the improvement of medical care in their respective communities.

If we are to follow this kind of thinking, it would be possible to utilize in a very rational manner the educational facilities under the community medical care program conducted by the Japan Medical Association. It is also possible to dispose of problems either by specialty field or in a general way.

The systematization of front-line medical care, therefore, should be that of a technological system, rather than of a bureaucratic system. And if we allow the masses to conduct a sharp but invisible surveillance to enable natural selection, I believe that medical care would achieve constant progress.

On the other hand, if medical care were left up to the medical care agencies under Government control, we shall have a serious problem. This is to say that the medical care facilities we have today, that are protected by the state, local government and by law, are not making any contribution to society at all.

Other important problems of community mdical care are those of health promotion, disease prevention, early detection of disease, and early therapy. To solve these problems, measurement of the life environment must be conducted in the communities. If this is done, measurement is taken of the life environment on a community basis and the standard of living is determined. Then it would be possible to consider the environmental element of disease. It would be impossible to solve the problem without taking into account this environmental element.

There are other problems, too. I believe that health education is the most important means to make collaborators out of patients. This,

furthermore, would lead to school health programs and industrial health programs. In this sense, the industrial workers will have to make effort to learn industrial medicine by themselves. Occupational welfare would also become very effective when it is combined with the establishment of the sense of responsibility for the workers themselves. Put in another way, an industrial worker who tells himself that if he fell ill, someone would do something for him under the terms of the Labor Standards Law, would not survive the industrial society. The new era requires a new awareness.

Not only problems of the structure of community medical care but also the function of it may be successfully dealt with by people with a better education. Expansion of the function cannot be achieved without the cooperation of the patients as well as of various other people. I do not believe it is impossible to solve the problems of environmental development or disease prevention through expansion of the function.

If the residents of a community are found to need high-quality protein, and supposing that the soil of the community is contaminated by a heavy metal, it would mean need for a drive to enable the residents to acquire more of high-quality protein than they have been taking. This drive arises primarily with technologists. And if high-quality protein is supplied, it would conceivably prevent the sedimentation of heavy metals in the human body.

In an industrial society which breeds many new diseases, there would be diseases that are not worth considering. The contamination of atmosphere and soil by radioactivity of the atom, for instance, has not been pragmatically measured, nor is it possible to anticipate the degree of its contamination. And yet, there has been an excessive amount of allergy-like reaction in the masses as though they had been seriously affected by it.

In view of these factors, it is extremely important that community medical care have both popular and academic aspects. This popular aspect is highly important in bringing medical care to the masses in a community. In the technical aspect, excessive allergic

reaction to industrial pollution, will not help industrial development. How to prevent problems arising from pollution by a heavy metal, for instance, should be studied through the integrated technical development center in collaboration with the physicians in the particular area. Such a joint endeavor would give rise to a new function in community medical care.

We have the question of whether or not community medical care should be provided primarily by the medical college in the area. The fact that each prefecture in the country will soon have at least one medical college might encourage such a tendency. But I do not believe that the level of achievement of such a medical college is likely to come to that to be maintained by the medical care technology development center we anticipate in the future. The separation of education and research would be necessary. How much the area of research in community medical care should be expanded is to be determined by the community health research council.

It is most desirable that the element of specialization and the desires of the masses are fused in the community health research council. This situation would affect the medical facilities of the future, where there would be systematization of medical care and community medical care, and structure and function would be clearly separated from each other.

Take, for instance, the case of brain hemorrhage. We have emergency hospitals, but an emergency hospital for a brain hemorrhage case would be quite different from one for a victim of traffic accident. For the former, the first consideration should be how to prevent the patient from becoming a human "vegetable." This problem could be solved by both the understanding of the patient based on his education and by the introduction of technology of a high-level medical care technology development center.

Another thing we must take into account in considering community medical care is the establishment of a system whereby medical care may be provided for the aged without a heavy burden on the younger population.

This would not be a simple problem, but it would be unavoidable in view of the future of the population structure we shall have.

The Basic Problems of Medicine and Medical Care

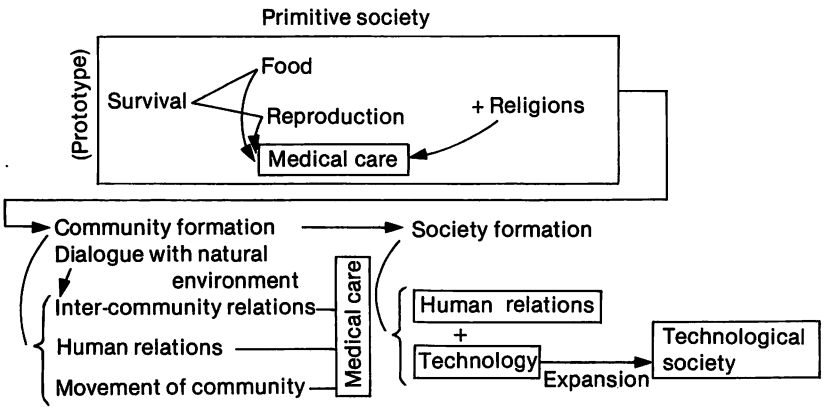
I believe it is of utmost urgency that we grasp the problems of medicine and medical care within the framework of the history of the development of human culture. In primitive life, medicine and medical care were not separate entities. We find clear evidence in the life of primitive man that medicine, medical care and religion were not separated from one another. The defense of life meant problems of defending against attacks by wild animals, collection of food and many other activities. Yet, it is conceivable that even in such primitive human activities was found the origin of the separation of medicine and medical care concerning the defense of life, which was to become established in later periods of human history. Therefore, we cannot deny that, despite the changes and vicissitudes human history has gone through, something essential that has not changed from the early beginnings of human life has also been inherited.

The medical care thought of primitive man consisted of how to defend human life against attacks by fellow men and natural calamities. In such primitive thought about medical care are found the beginnings of medical science as we know today. For instance, when we consider the methods used in stopping bleeding and the religious analysis of the causes of diseases in an age when there was no medical supply, we find something common between primitive medicine and the psychosomatic medicine of our own age. Primitive man's attitude

---

This is an English translation of the original paper in Japanese published in The Proceedings of The 19th General Assembly of The Japan Medical Congress, pages 34—39, 1975. Reprinted from the *Asian Medical Journal*, Vol. 18, No. 8, August, 1975.

Fig. 1



toward hunger and shortage of goods also indicates that our early predecessors were thinking of the defense of life. It is extremely interesting that such facts are found in the sutras of primitive Buddhism. In the process of the development of such primitive medical thought, metals were used as medicine for the first time during the era when Buddhism was at its peak. It is not clear how this came about, but it is presumably a result of the accumulation of the endeavor and wisdom of mankind in its early stage of development. Likewise, there are many bits of evidence of relationship between disease and Christianity in the records of primitive Christianity. A study of primitive medical care thoughts as a source of human civilization is a highly interesting exercise.

Japan has already achieved a great deal in the history of religious thought and history of Buddhist economics. In contrast, we find that the study of primitive medical care thoughts in the field of medicine in our country has lagged behind considerably. In trying to solve many of the difficulties mankind faces today, we might find a clue to their solution in the study of such primitive medical care thoughts.

It is a fact that primitive man paid a great deal of attention to pain and to the fact that bleeding was a serious threat to life. In many

instances, he thought these biological phenomena were forms of punishment in the religious sense of the term. This meant that therapy was primarily psychosomatic in nature, and it is historically established that the use of medicine came into the picture much later.

When we consider the separation of medicine from medical care in its historical context, a question arises as to which of the two came first. I believe that medical care made progress first and in its background medicine became an independent discipline in human culture as the fundamental science of medical care. There are many theories concerning in what era in history the separation took place. But if I were to express my own view, assuming that medicine became independent of medical care, the medical therapist and medical scientist were the one and the same person. The beginnings of medical science were found in the medical care thoughts of the early years, and it was the medical therapist who fostered these early buds. The therapist in this context, of course, means the physician.

It is natural that the physicians of ancient times and those of today are vastly different, separated by differences in their academic backgrounds and social functions. Viewed historically, however, the period when the medical scientist and the physician became separated was not as old as one may think. I believe that the proposal made by Karl von Rokitansky (1804-1878) concerning body humoral pathology may be considered an epoch. Modern medicine began to acquire its thought and system later with the cellular pathology of Rudolf Virchow (1821-1902). About this time, medicine began to influence medical care greatly with Koch's bacteriology, Pasteur's microbiology and other new sciences. This was a period of great change in the medical culture of man. I regard with great interest the thoughts found in Virchow's cellular pathology. He was not merely a morphologist but he should be more properly regarded as a biologist. It is also evident that Virchow's thoughts on human biology were inherent in his cellular pathology. It is extremely interesting that his activities as politician were carried out on the basis of human biological conceptions.

As for our own country, it is clear from history that ancient

Chinese medicine introduced into Japan developed under the apprenticeship system and the feudal system. During these eras, however, medicine and medical care were not yet separated. But the physician in those years took far greater social interest in medical care than we can ever imagine today. Take Hirata Atsutane, for instance, he was a Japanese nationalist scholar and at the same time a physician. Hirata's nationalistic thought should be viewed as having developed regionally through his medicine, and it is presumed that his medical education and his education of his disciples were strongly characterized by his nationalist thoughts. Likewise, Motoori Norinaga and Ueda Akinari, besides others, were doctors with nationalist scholarship in their background. This may be partly due to the fact that for economic reasons they practiced medicine while they were nationalist scholars. But it is also shown in many historical documents that their skills as physicians were developed with the introduction of social ideas against their nationalistic background. It is noteworthy when we view the history of medical care in Japan that the development of medicine in this country was achieved primarily by nationalist scholars. In those years, of course, medicine and medical care had not yet been separated, but empiric accumulation was far greater than we can imaging today. This is found in the documents that record these medical men's statements dictated to their pupils.

The separation of medicine from medical care in Japan began with the modernization of medical education. Under the state policy, medical education was to be given at the Tokyo Imperial University which was established for medical education and conducting research. There, the professors came to assume a heavy social responsibility not only as researchers but also as educators. Graduates of this university were assigned to public hospitals throughout the country and these hospitals served as regional bases from which medical care spread.

The fact that the university is the source of research and education remains the same today. It must be said that the basis of the mission of the university was consolidated over a long period of time after the introduction of German medicine during the early Meiji Period.

We can say that during a period of about 100 years of

institutionalization, medicine and medical care became strictly separated. The spread of medical care in these years was conducted by the cooperation of the central government and local autonomies and also by private medical schools and other private institutions for training medical men. That this was the starting point of medicine in a free society is worth our reconsideration even today. The reason is that one of the basic principles of a free society is that there is no distinction made between education given by public institutions and private institutions. This principle was promoted primarily by the government and the spread of medical care was encouraged without the government ever giving undue pressure on private institutions. This shows, I believe, that the government of these eras was extremely liberal concerning freedom. And the medical administration of those years is worthy of note.

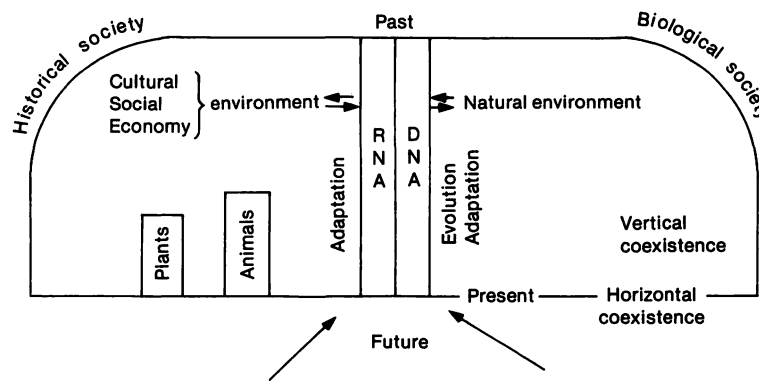
It is inevitable that when medicine and medical care become separated, new problems of medical administration will naturally arise. Japan's medical administration began, as might be expected, with countermeasures for contagious diseases and the persons primarily concerned were bacteriologists.

Outstanding medical leaders of the era personally participated in medical administration to play a major role in the substantive improvement of Japan's medical care as well as in the spread and development of medicine in Japan. It is historically known that the countermeasures for contagious diseases taken by the bacteriologists of the University of Tokyo, with Professor Masanori Ogata as the principal figure, played an important role. It was also noteworthy in the history of Japanese medical administration that later such names as Dr. Shibasaburo Kitazato and Shimpei Goto were added to the list.

It has not yet been historically pointed out that, when medicine and medical care are separated, medical administration should come into existence. But I wish to attach importance to this. We must note the fact that medical administration as a new concept of administrative medicine is assuming an established position in society. We must not forget that in our experience the start was made in the early Meiji Period.

In considering the survival order of mankind — the social and biological order from the primitive age to the modern age — we must realize that man's survival order is not determined by man alone but also by the orders of his relationship with other living things, of material metabolism, of the process of distribution and of many other kinds. It is natural that we should consider the problems of survival resources in considering the problems of human survival. At the same time, the problems of the development and allocation of resources are also important elements. Take energy resources, for instance. Their development may be said to have entirely paralleled the progress of human culture. It is also a historical fact that the development of survival resources have also greatly improved the survival order of man. It is also a historical fact that at certain stages a state of war continued among nations in their struggle for survival resources. According to what history teaches us, we should grasp the contradictions between science and human life in our age as the "trouble of the century" and try to find a place for medicine in the framework of the problems of new survival order and survival resources. There are also problems trouching the essence of humanism, which require solution.

Fig. 2



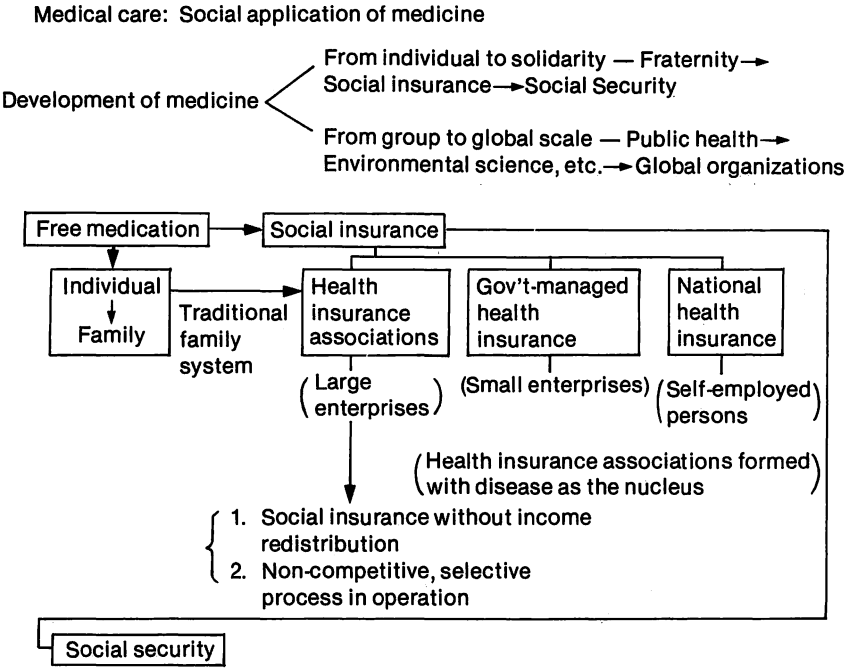
Cellular pathology since Virchow has greatly reoriented modern medicine. The minute compartmentalization of medicine has gone on apparently without an end, but this compartmentalization raises serious questions when we consider man himself. The first question is whether man is an existence that should be broken up into many elements. Man ought to be grasped as one organism, as one unit. In this sense, any compartmentalization is artificial and it can at best grasp only one part of a whole.

An example of compartmentalization in medical resources reaching a major turning point is the progress of molecular biology. Although this is a result of compartmentalization, it deserves credit for having come near the true essence of humanity by making clear the problems of the continuity of life through new information in genetics. This is the reason why we must not take up compartmentalization merely as such but as a means of grasping an element of a whole. Molecular biology is believed to have proven the fact that there is a continuity of unchangeableness within the process of change. In this sense, it has demonstrated what is inherent in the essence of man. What in general is called progress in medical research, however, occurs within the realm of compartmentalization and has not been regarded as an element of a unified whole. I believe it cannot be denied that a gap has occurred between the development of medicine and that of medical care.

Medical care is what is provided to human beings, and these human beings have a meaning only when they are grasped as an element in a coherent whole of many phenomena. A study of man in this sense becomes most necessary when we take up medicine for the human individual rather than for human society.

That medicine cannot exist apart from medical care has been proven by the history of mankind. And problems of the individual human being are expanded to those of the human community, society and eventually the entire glove. This is the reason why I have defined medical care as "the social application of medicine." When we consider medical care from this standpoint, we can show the

Fig. 3



1. Unitary solidarity for entire nation
   - i. Income redistribution
   - ii. Redistribution of medical resources
   - iii. Individual's contribution to society
2. Basis and conditions for development of social security
   - i. People's consciousness
   - ii. Economic development — reversion of benefit to society
   - iii. Development and allocation of medical care resources
   - iv. Population policy

relationship between the individual and the society, or that between the society and the individual in the following diagram.

Thus we see the development of medicine of a micro-order and medicine of a macro-order such as exemplified by public health and

ecology. As this diagram shows, man has been repeating social adaptation and adaptation to nature. Through the alterations, however, there has been a continuity of constance.

For the social application of medicine, it would be necessary to conduct a study of man from an entirely new position. It would also become necessary to consider survival from the position of survival in relation to society. The progress of civilization and the progress of medicine depend on how to increase the number of elements of adaptation. In its social aspect, man has repeated the adaptation process through the flow of historical time.

Medical care of the past established the physician-patient relationship on the basis of morality with, of course, the technical background of the physician as a part of the basis. However, when the social insurance system was inaugurated, the physician had to transform his traditional nature. Yet, this is, surprisingly, not well recognized.

In the stage of free economy society, the physician himself operated the income distribution structure. In other words, he was beneficent to the poor while seeking ample payments from the rich. This insured the physician his economic independence in a primitive free economy society. In such a society, of course, he was assured of academic freedom and independence. But when society turned into the stage of social insurance, the situation was radically altered. Social insurance attaches importance to social responsibility for disease and regards disease as something an individual personally cannot avoid.

Initially, enterprises formed their own health insurance association system as a countermeasure against chronic ailments such as tuberculosis. This system is medical care service established by each individual enterprise, and it is now clear that they do not contain the social element of social insurance.

When this form of social insurance was started, however, it was believed that the employer was meeting his social responsibility by paying one-half of the cost of medical care for his employees. Viewed conversely, this was a kind of defense mechanism for the enterprise.

Under such a system the insurer was able to decide unilaterally the cost of medication and it was also possible for the employer to build a hospital and clinic. This means that the economic liberty that the physician had in the preceding era was totally lost and his function of income redistribution was suspended. Yet, I do not believe anyone pointed out at that time that the new system of medical care seriously altered the physician-patient relationship. That is, the insurer who, as the payer of the medical care cost, intervened in the human relationship between the physician and his patient and brought the physician under his control. It is also a fact that in order to reduce the burden of medical care, the employers pursued the policy of giving low-cost medical care. The fact that this system did not include the contribution to the progress of medicine and the social development of medical care in its cost has at least exposed the most serious shortcoming in the social nature of social insurance. There is no instance anywhere in the world of social insurance in practice having promoted medical research. This cannot be concealed no matter how much the promoters of the health insurance association system may prevaricate to the contrary.

When this system was instituted in some quarters, however, a government-managed health insurance system, covering primarily the small enterprises, was inaugurated with the government serving as the insurer. Because the insured in this system were employees of small businesses with a low income, health management in their places of employment was inadequate and the standard of living of the insured was low. This meant that the insured were prone to diseases and their resistance to disease weak.

On the other hand, the health insurance associations covering the employees of large enterprises enjoyed a high standard of living with a high wage and consequently a high premium. In these cases, the health insurance associations as the insurer have had to pay relatively small medical costs and the result is that they have accumulated an enormous amount of assets from the premiums from their members. We must record clearly in history the fact that the substance of

medical care became distorted in the name of society.

The National Health Insurance Plan was established mostly in the rural areas with the cities, towns and villages as the insurers. Their income redistribution structure is of an extremely small scope. The living standard and financial status of the farming population were low, and this situation has remained unchanged.

It was under these circumstances — various different health insurance systems existed without an income redistribution structure among them and the rich helping only themselves and the poor helping only themselves — that the decision was made in 1950 to inaugurate a new social security system. The new health insurance law of 1957 clearly codified this spirit of social security and renovated the nature of the health insurance medical care agencies. That is to say, to the inanimate things called health insurance medical care agencies were assigned the task of prividing medical care with the doctors, nurses and other workers providing technology. This meant that the health insurance system would not recognize the human relations between the doctor and his patient and also the self-reliance of the physician. All this indicated that the system was underscored by the principles of a medical care trade unionism.

On the other hand, the professional freedom of the health insurance physicians was suppressed by the system of registering insurance physicians which kept them virtual prisoners of the health insurance law. The 1957 revision of the health insurance law represented the greatest humilitation the Japanese physician experienced because it forced him to discard his social status. This law has not been revised since, and in the meantime, this state of affairs deprived the people of their sense of responsibility to themselves concerning their own health, allowing them merely to make more demands on society.

As demand for medical care has risen, a new concept of the right of the insured has come to the fore, replacing the old consciousness of the patient. This is to say that under the health insurance law, the physician is the employee of the insured and he is held in bondage for

24 hours a day. This new consciousness on the part of the people, who are the insured, may be said to have measurably increased the demand for medical care.

The Japan Medical Association pointed out what was wrong with the system and in 1961 confirmed the four principles with the government under the Liberal-Democratic Party. Yet, no progress at all has been made since then, reflecting the complete stagnancy of government.

As time elapsed under these circumstances, medical care demand in Japan has undergone a major qualitative change. The law has become fixed and the benefits under the health insurance system restricted, and inevitably, while professional freedom of the physician remained restricted, a qualitative change in the spontaneous demand for medical care has taken place. The problem now is the aging of the population. Because of the increase in the number of the aged in the population, it has become necessary to have new ways of thinking about welfare and chronic ailments among the aged. Yet, there is little awareness of the fact that the aged form a new social stratum brought into existence by modern civilization. While its essence has not been ascertained, how to prevent the increase in the volume of medical care for the aged is being thought of as the only pressing issue. This must not be tolerated from the standpoint of humanism. That we now have a new breed — the aged — among us means that we cannot solve the new problems without making efforts to establish a new survival order.

The Japanese society in the meantime developed from the agricultural age to the light industry and heavy industry age, and the high economic growth has introduced notable changes in terms of environmental science, including pollution of various forms. At the same time, the problems of industrial health, which had not been heard of in the past, came to the fore. That the health insurance law has not reacted meaningfully to these social changes may be said to be the principal cause of the bemuddled state of affairs which characterizes the medical care system.

Today's medical care is beset with major difficulties because the relevant law remains unaltered and government is conducted without giving heed to the sociobiological fact that mankind is making a major shift. We need new ways of thinking in order to extricate ourselves from this condition.

As the world tends to become aged, there is an increasing advocacy of a stationary population. It is widely agreed, however, that a stationary population means a dysgenic process for mankind. When we consider the population problems, we cannot allow ourselves to fall into a state of dysgenesis. Therefore, the advocacy of a stationary population requires serious second thoughts. In this sense, I am hoping in particular for the development of the ecological population theory by Professor Akira Koizumi. We must tackle as a new problem the question of how to develop and allocate medical care as a survival resource. This problem is not exclusively Japanese but should be considered on a global basis.

Today we often hear of the medical care supply system. But we cannot allow the medical care agencies to be manipulated freely in response to the demand which is purposeless and unrelated to the survival order without first establishing a survival order. For this purpose, the development and allocation of medical care resources are of extreme importance. The micro-order of survival in particular is concerned with the entire life span of mankind from the stage of embryology to that of gerontology. The problem of the development of medical care for people as a group must be considered in relation to how to allocate medical care resources. In order to develop medical care resources for a purpose to be established by the cooperation of entire mankind and allocate the medical care resources thus developed, we need understanding and cooperation not only within the country but on a global basis. The question of the solidarity of entire mankind, therefore, must be reviewed in an entirely new perspective.

The development of medical care technology and the allocation of resources are inseparable. I have a plan for a medical care technology development center.

Fig. 4

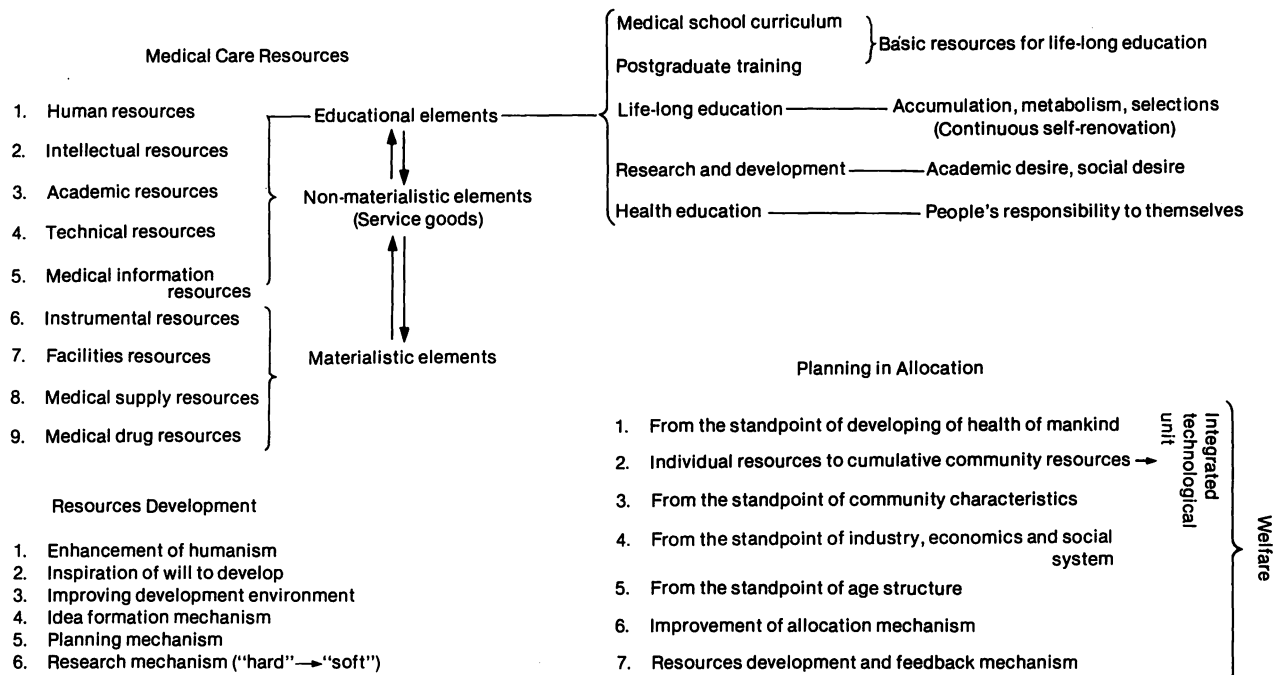
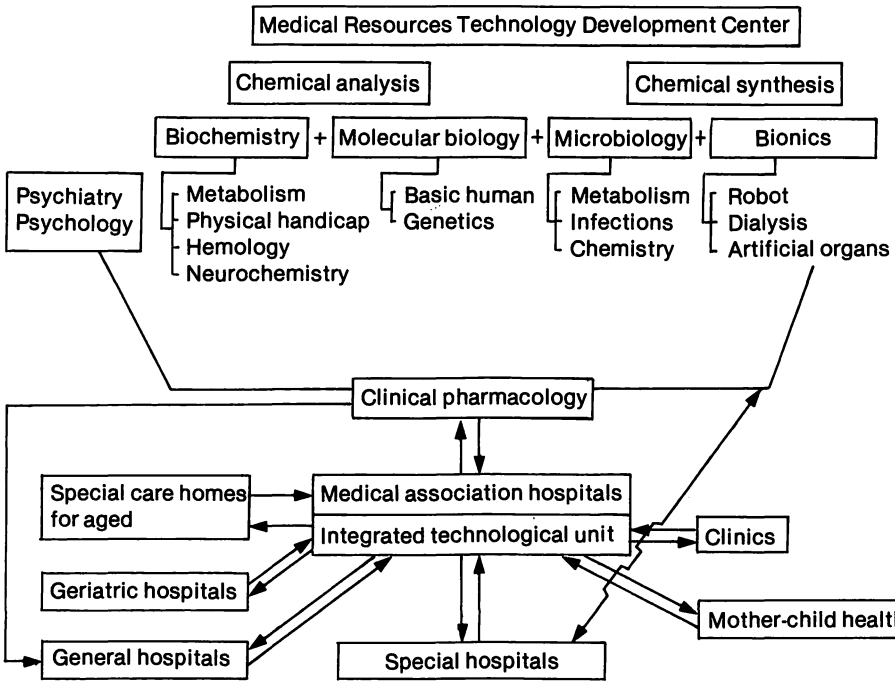

Medical Care Resources
1. Human resources
2. Intellectual resources
3. Academic resources
4. Technical resources
5. Medical information resources
6. Instrumental resources
7. Facilities resources
8. Medical supply resources
9. Medical drug resources
Educational elements
Non-materialistic elements (Service goods)
Materialistic elements
Medical school curriculum
Postgraduate training
Basic resources for life-long education
Life-long education
Accumulation, metabolism, selections (Continuous self-renovation)
Research and development
Academic desire, social desire
Health education
People's responsibility to themselves
Resources Development
1. Enhancement of humanism
2. Inspiration of will to develop
3. Improving development environment
4. Idea formation mechanism
5. Planning mechanism
6. Research mechanism ("hard"→"soft")
7. Evaluation mechanism
Planning in Allocation
1. From the standpoint of developing of health of mankind
2. Individual resources to cumulative community resources →
3. From the standpoint of community characteristics
4. From the standpoint of industry, economics and social system
5. From the standpoint of age structure
6. Improvement of allocation mechanism
7. Resources development and feedback mechanism
Integrated technological unit
Welfare

Fig. 5



It is my conclusion that medicine as the science of survival order must be fully combined with humanism. Humanism in this context is not that of the past historical stage but one with a built-in possibility for future development. That is to say, this is no longer an age when humanism merely meant relief for the weak. This is an age in which we must consider humanism as a responsibility of mankind for a new order for mankind.

The life of man took a big stride forward after the industrial revolution. The standard of living, too, has steadily risen, and also scientific technology was developed. It is ultimately true that the progress has created a dilemma for man himself. This dilemma, however, does not merely mean that man developed and accepted scientific culture somewhat carelessly. These only represent hindsight.

The essential problem, I believe, is that man has accepted a logic which did not have the human spirit in it.

It is impossible to grasp man as a unified whole with modern science. Professional objectivity in science cannot combine with humanism. It is necessary for an individual to overcome the consciousness of an individual and the concept of the state and face mankind squarely as a unified whole of the future. Before we consider the problems of the future, it is necessary that we who have lived in the world of science build an impersonal, universal self. That we have reached the stage where we can think of the intellectual completion of universal humanism and of its moralistic practice means that mankind is at a starting point for the next phase of progress.

As the only nation that has been atom-bombed and as a country which has suffered from pollution mostly because of the overly accelerated industrialization and adoption of Western civilization, we have, I believe, the global responsibility to make the kind of statements I have made above concerning the destiny of mankind.

Social Development and Community Medical Care

I wish to consider community medical care in relation to social development.

Social development is a matter that must be constantly considered. Yet, in our country, it has been seriously retarded in its aspect of medical care. This is due to the fact that there has been no progress since the Meiji Era with regard to the question of how hospitals and clinics should be run while only tradition has predominated.

Social development has been carried out entirely under the pressures of the demand of the community. Actually, social development in the true sense of the term cannot be achieved without community planning. Social development in the future must be carried out by incorporating medical care into community planning. Preventive medicine, therapeutic medicine and rehabilitation — all comprehensive medical care systems — must be incorporated into community-based social plans.

When we consider in these terms, we find that several pillars for such a way of thinking are needed. In social development, pollution problems are becoming increasingly serious even when we confine our attention to the realm of industrial development alone.

Industrial development is a form of social development. But what I wish to point out is the fact that it has neglected man. It is my view that social development must be considered in terms of biological factors without forgetting the existence of man. In the past, it was

---

Reprinted from the *Asian Medical Journal*, Vol. 19, No. 11, November, 1976.

considered by way of how to improve national income. From now on, however, social development must be carried out with health development as its central concern. And when we think about medical care problems along such a line, we find that an individual's responsibility to his own health is one of the major pillars.

If an individual, when he feels ill or uneasy in the slightest degree, runs off to a doctor's, it shows that he is must too irresponsible about his own health. That all the individuals think about responsibility to their own health would be another of the major pillars of social development.

Then there is the problem of the social and community nature of diseases. Take neurosis as an example. It is a commonly accepted theory that when national income is doubled, the number of neurosis patients is trebled. If we are prepared about this possibility when we try to double our national income and tackle the problems of mental health accordingly from the beginning, it would be possible to double national income without problems.

There are many other major elements besides these. One problem which I believe must be seriously studied is that mankind is now seeking a new survival order. In terms of the micro-order for survival, molecular biology and genetic engineering have made some progress, bringing to light the micro structure of human survival. Furthermore, many new enzymes have been discovered. The micro-world has been enormously developed along the broad range from metabolism to the nervous system and to the gene.

On the other hand, when we think of adaptation to the social, historical and natural environments, we are compelled to think in terms of adaptation to macro-survival. Here is another major pillar.

The establishment of these major pillars — the micro- and macro-orders for survival — and thinking about what I have mentioned above would be the task for social development of the future.

We now live in an industrial society, but our society in the 21st Century would be an information-dominated society. An information-dominated society would be flooded by a large quantity of informa-

tion, and it would be important for man to make a positive choice of it. This would be the case with the problems of health, too.

When there is a flood of information, it would be impossible to maintain and promote health without this positive choice of information. Unless this is possible, the number of persons suffering from neurosis would multiply by five or six. And the mental order in society would be disrupted. In this sense, social development is inevitably accompanied by community medical care. But it must also incorporate the concepts of micro- and macro-orders for human survival as well as the theory of adaptation. Viewed in this light, community medical care of the future, unlike that of the past, will have a great deal of time elements — future elements in particular. For these reasons, in developing community medical care, we must first of all consider the social development of the community in question.

Social development must also be considered in terms not of the social development of the past but of the biological factors for man. No experiment in this respect, however, has ever been conducted anywhere on the earth. But such an experiment is now being prepared by Japan Medical Association serving as the nucleus, to be conducted on a worldwide scale. In the social development of medical care, we find such words as "hospital" and "clinic" belonging to the past. In their place, we must think in terms of the technological integrated unit, a new medical care system, in which physicians and those in related fields work together. The system will incorporate anaesthesia, clinical tests, CCU, ICU and even the new activities in the field of psychiatry.

A hospital may be "large" not because the number of beds is great but because of the high level of technological integration it has. And there, a new system must come into being. For instance, primary care is highly important at the first phase of technology, for which there will be a fairly intensive integration of technology to work in cooperation with it. This will be followed in the subsequent stages by secondary and tertiary medical care, which will require a high level of integrated technology.

At the end, a medical care technology development center will be established in each community, to conduct the development of medical care technology and its administration.

In the past, technological development was conducted without being accompanied by administration. From now on, there would be no true research institute for technological development unless it is accompanied by administration.

Administration will be a highly important element in research institutes in other fields, too, in the information-dominated society of the future. Thus, it would be impossible to consider technological development without taking administration into account. That this would have a serious bearing on the field of medicine was anticipated at the time when administrative physics was brought into being by the development of nuclear physics. There would be even a greater impact on medicine when we enter the phase of social development of medical care.

In conclusion, I wish to state that the social development of medical care of the future must begin with the development of community medical care as its primary phase. To this is to be added various factors of the community, which are to be disposed of mathematically to create a pattern in which man can live most comfortably.

Comfortable living must be considered in terms of healthfulness, which would lead us to the way of thinking that, no matter how society may change, the value of man is highest.

If this plan gets on the right track, therefore, it would include in it the problems of leisure, and there will be no medical care development on the basis of a single community isolated from others. Such a major change, I think, would be the starting point for tackling the problems of human health, which the world in the 21st Century would face.

The Social Position of the Physician

It may be said as a rule that as a society rises the status of the professions goes up. I believe it is our responsibility to try to analyze and improve the social status of the physician on the basis of that rule. The professions are callings that have a direct bearing on the welfare of mankind. These professions require specialized knowledge different from the requirements for other types of occupation. They also require specialized responsibilities of their members. Furthermore, such qualities peculiar to the professions must be properly evaluated by society. During the feudal age in Japan, the social status of the medical man was fairly high. The physician in those years was not a noble man but he enjoyed a similar status. During the Tokugawa Period, too, the social status of the physician was extremely high.

When we consider the social status of the physician in today's highly civilized society, I believe it is necessary to reexamine the debate that took place between Bismarck, the German chancellor, and Rudolf Virchow, the pathologist who is known as the father of modern medicine, in a historical review.

Bismarck, as you know, conceived of a social insurance system, which played a major role in the popularization of medical care. In order to spread medical care, Bismarck thought of this unique idea, which was basically to insure a person against risks. Since disease is a

---

This paper is an English translation of a talk for "The Special Medical Course," broadcast on May 2, 1976, by Nihon Shortwave Broadcasting Co., and the original paper in Japanese was published in *The Journal of The Japan Medical Association,* Vol. 75, No. 10, pages 1227 to 1231, May 15, 1976. Reprinted from the *Asian Medical Journal,* Vol. 19, No. 9, September, 1976.

risk, we can say that it was Bismarck who originally proposed the idea of disease insurance.

On the other hand, Professor Virchow, the foremost leader in the academic world, took a position which was squarely opposite to the chancellor's. From the standpoint of examining what kind of status the physician was to have in a social insurance system, Virchow developed a big debate with Bismarck who was his close friend. Virchow throught that this system, as proposed by Bismarck, did not help improve but lower the social status of the physician. When the insurer or the persons to whom the masses pay money play the central role in such a system, those persons inevitably tend to amass power. Then the physicians would come to become "employees" of these people. Such a relationship between the "employer" and the "employee," Virchow thought, would have a very harmful effect on the independence of the medical profession.

After a big debate, however, the insurance system conceived by Bismarck won, and what Virchow had feared was proven. The physician's social position definitely went down. This was not only a fact of that time but it has also had a big impact on subsequent developments. The independence of the physician can be maintained only when he can assess his own skills, determine his own fees and thus enjoy financial independence. Under a social insurance system, he has lost his financial independence and become an "employee" who provides medical care at the rates determined by the insurer.

It is already five to six decades since the health insurance system was introduced to Japan. It originally began as insurance for industrial workers. Under this system, the fee was paid by the worker and his employee on a 50-50 basis, and there was the insurer apart from them. The catch-phrase was that the insurer collected fees from both the employer and the insured to conduct a fair management of the system.

The reality of the world, however, does not allow such a system to work out well. Because of this system, the status of the physician went down to that of employee. In our society, too, the physician was

no longer permitted to assess his own technology, which had to be rated within the system of social insurance.

Thus, I believe, it is an indisputable fact that both in Germany of 100 years ago and in Japan of 50 years ago, the social status of the physician became degraded. But if respect for human life is one of the requirements in a highly developed society, the lowering of the social status of the physician, who is in a leading position with regard to human life, would be defeating the purpose of improving society. Now let us consider the problems of the future while reviewing our history.

Another problem is the fact that our social security system issued from welfare economics. The physician in a social security system is no more than the provider of technology of medical care. He has completely lost his independence. The medical profession was turned into a group of such technicians, which is to provide medical care to another group called the people. Such an arrangement could not possibly overcome the crisis of the life of the people. But such was the nature of the social security system we had. This may have been necessary at a particular era in our history. But it is to be seriously doubted if such a system could function well when great economic prosperity envelopes the whole globe.

During the second stage of development of the social security system, medical care agencies were designated and health insurance doctors were also designated in order to lower the social status of the physician and to hold it there fast. According to Virchow, a downfall of the physician occurred in the first stage. Another downfall occurred in this second period, introduced by the enforcement of social security. And now the physician is about to confront a third problem.

First of all, we must realize that a social security system is a system that is designed for making use of medicine. It is not a system for developing medical science and regarding it as a resource for the enhancement of the welfare of people. Social insurance and social security both deal with medicine as a means for attaining the objective of maintaining the life of people. I consider this as a very serious

blasphemy of medical science. Medicine must be developed on the basis of national demand.

The most important way of thinking in this connection is the attitude of considering these problems in terms of the development and allocation of medical care resources. The substantive position of the physician in medical care may be secured by this way of thinking. The same may be said of the matter of the development of medical care resources. I have been insisting on this ever since the World Medical Assembly was held in Tokyo in October last year as a basic, concrete means for improving the physician's social status. The social status of the physician was lowered by state power under the health insurance and social security systems in the past. This is just as Virchow had pointed out. Another cause for this phenomenon, I believe, is public opinion, which has been led in the direction of challenging the professional privileges of the physician.

Now the question is how to improve the social position of the physician under these unfavorable circumstances. This can be done only by the efforts of the physician himself. Since I became president of the Japan Medical Association, I have promoted the community activities of medical associations and the systematic improvement of community medical care in order to establish the position of the physician in the community and improve his social status.

The existence of the medical profession has an enormous influence on the welfare of a community. In a health insurance system and a social security system the public favors anything cheap, and the insurer must obey such a "public opinion." And the physician is often made to serve as his agent. I believe that the social status of the physician is determined by the balance between the force that tries to lower it and the power that tries to raise it. For this reason we must scrupulously consider the social status of the physician in terms of balance.

A profession is considered to have privileges to go with it. But I believe a profession is endowed with professional rights — the rights that go with the profession. These rights come from medical, cultural and social factors. The so-called "doctor's stop" — the orders that

you must not travel, for instance, is one of the physician's professional rights. It is his occupational privilege. Another example would be a physician's orders that the environment which is bad for health must be improved. This right is related to social and cultural factors. And if a physician wants to put into practice such a professional right, he will have to have a subsequent right — to improve his professional rights. This should be called a privilege. I believe a professional right and professional privilege must be distinguished.

When we consider medical care in 21st century Japan from such a viewpoint, we find that the key to the question of how to build health and peace is in how we think about the physician's professional rights. It would also become necessary to consider what the physician must advocate concerning the development of medical care resources. The same may be said of their allocation.

Medical care problems must be developed with the physician as the core of the problems. Development centering on public opinion imperils medical science. As society rises, so would the professional rights of the physician. And also the privileges to go with them would rise. But the expansion of the privileges is merely a means for enforcing the professional rights. It is not an end in itself. We must not engage in social activities for the purpose of acquiring more privileges.

As for the relationship between the physician and medicine, we cannot but conclude that the development of medical care resources is the supreme mission for the physician. This should apply to the university, too, and every physician must devote himself to the development of medical care resources according to his individual capacity. Therefore, the development of medical care resources is a right, which the physician must have a privilege to exercise. And yet conditions in Japan today are such that the physician today cannot insist on his professional right even though it is highly appropriate for society. This is a contradiction inherent in our society that I must point out.

In a highly developed society, medical knowledge as a cultural

factor is very much needed. In an "information-intensive" society, it is a fact that excessive information creates an increase in mental diseases. The problem of positive choice in an information-intensive society must be very much discussed from the viewpoint of mental hygiene. And if this were to be carried out as a medical requirement, and it is to be conducted in the community or at the schools, this would be another privilege of the physician.

Community medical care in a community became a place where the social demand on the physician may be fulfilled. There is also the problem of determining the most effective way of allocation for the developed technology. The most efficient way is to allocate medical care resources in terms of technological integrated units, into which medical care facilities would be classified. This allocation must be done systematically. But here I would like to explain the reason why I would not use the expression, "systematically" in this context.

To deepen the primary care layer, for instance, would be a very urgent need for Japan's medical care. No matter how big a hospital may be built, it would be meaningless unless the primary care layer is thick. Emergency care, for instance, can be provided in the thick primary care layer. Under the present system of allocation of medical care resources, it is necessary to consider emergency medical care separately. Once primary care layer becomes thick, however, it would not be necessary to think of emergency medical care separately.

There is a big difference between the way of thinking about making the primary care layer thicker and the way of thinking about primary care under the present system. The former I think would become a very major factor in thinking about medical care problems.

If the development and allocation of medical care resources were to be carried out as a matter of a professional right of the physician, the social status of the physician would be entirely different from what it is now. There would be no subservience of the physician to the insurer. Another difference would be that science would attain group independence. Accordingly, the status of the physician would rise considerably. And this would lead directly to improved welfare of the

patient. It is indeed impossible to think of the welfare of the patient unless the status of the medical profession is sufficiently high. When we consider means of thickening the primary medical care layer, we must expect various changes in the system, which we must also forebear.

When we have a systems-oriented society, the status of the physician would be determined within the framework of the systematization of the problems of research, development and allocation, which, in fact, would mean an entirely new kind of environment. This, of course, would be the case if we were to regard the change-over to a systems-oriented society as a foregone conclusion. But I am not certain if that would be very simple. There are many problems in this regard, too. Whether or not a systems science will really determine the position of the physician is truly a very important question. I believe that from now on the medical association must make considerable efforts concerning this matter.

In summarizing what I have said, let me say that there would be no health welfare and medical care welfare for the people without the improvement of the social status of the physician. Another point of importance is that the status of the physician might be lost in a systems-oriented society. In order not to lose his position in such a society, the physician must exist as the person in charge of the development and allocation of medical care resources. If the physician were to be in charge of these matters, then his status within the system would be very much elevated.

I am seriously concerned about the social perils inherent in such a systems science. Economics would be influenced by systems science but I think medicine, too, would be subject to its influence. In order for the physician and medicine to function within systems science, it would be necessary to carry out a radical reform of the present medical care system. Such a reform is not yet planned. Experiments are being carried out in terms of information, but I don't believe they will succeed.

This is the reason why I wish to stress the importance of the

determination of the social status of the physician within the problem of the introduction of systems science into society. The physician must fully understand systems science. To the development of medical care, it is a tool, while the substantive role must be played by the physician. This is the area in which I wanted to examine the problems of the social status of the physician in the present and the next centuries.

The WMA of the New Age

It may be said that the history of the World Medical Association (WMA) is the history of free medical associations. Most of the founders of the WMA were Europeans, and later some Americans joined. The first Secretary General, Dr. Bauer, an American, was an embodiment of liberalism. Therefore, one might say that the WMA was a body of medical associations of free nations of the world.

One of the reasons why such an organization as this was formed is that it had been felt that there ought to be an organization of physicians to be distinctively apart from an organization of governments, i.e., the WHO. In other words, it was an inevitability that there should come into being a private organization entirely apart from a bureaucratic organization of governments. The WHO is an organization which has in its background the power of governments. The WMA, on the other hand, is a free, private organization.

The WHO has been very active particularly in the area of assisting the developing countries. It has also been active in spreading precise and detailed information concerning contagious diseases. It set up very strict standards concerning the manufacture of vaccines. I believe that such programs as these prepared by the organization of governments have reached a fairly high level of accomplishment. An organization like the WHO, however, is to do things which a private

---

This paper is an English translation of a talk in "The Special Medical Course," broadcast on April 18, 1976, by Nihon Shortwave Broadcasting Co., and the original paper in Japanese was published in *The Journal of The Japan Medical Association,* Vol. 75, No. 9, pages 1075 to 1079, May 1, 1976. Reprinted from the *Asian Medical Journal,* Vol. 19, No. 8, August, 1976.

organization of medical associations cannot do. Nor should the WHO do what a private organization does. This is the reason why two international medical organizations have inevitably come into being to deal with problems of health and hygiene.

Governments have spent a large amount of money in these fields of health and medical care. But when it comes to the question of efficiency, the WHO has not achieved as much as it could have. It has produced voluminous reports that fill a large room. But these reports have not been very much utilized throughout the world.

On the other hand, the WHO deserves credit for having put out reports by experts which are of great value to specialists. This is one area where the WHO is distinctive. In the case of Japan, for instance, the National Institute of Health and other similar institutes and agencies are making a fairly good use of WHO reports. In the Ministry of Health and Welfare, however, the reports are not fully utilized though it might be too harsh to say that they are completely unused.

Under these circumstances, it is impossible to differentiate clearly the WHO, which is primarily concerned with the technology of science, and the WMA which is largely involved with the physician-patient relationship in medical care. The problems to be dealt with by the WMA are those of the relationship between the physician and his patient, the relationship between the physicians and the entire nation, human relations based primarily on public health and environmental science, or the personal relationship between the physician and his patient. In the light of these facts, there ought to be no conflict or confrontation between the WMA and the WHO. In the past, the WMA has been seeking a direction in which it could achieve development primarily with regard to the relationship between the physician and his patient.

If this has been the case, the WHO is an international organization essentially concerned with the technology of medical care and aimed at the technological development of developing countries. Yet, the WMA is not an organization with a big financial background

of governments. It is an association of national medical associations, which is financially rather weak. How should such an organization cope with the problems of medical care? If I may be allowed to use a somewhat vulgar expression, I think the WMA fights it out with its head. All the problems of the relationship between the physician and his patient in this world must be ultimately disposed of by the WMA from its global standpoint. This is a problem to become a global problem, and I believe that the WMA, which is to dealt with it, had been founded with a great foresight.

At the beginning, it was designed to be a highly social organization. In a few years, however, it tended to become a substantial organization. Its 29th assembly was held in Japan in 1975, and the 30th assembly is to be held in Sao Paulo this year. In reviewing the more than 30 years of its history, I find several epochs marking it.

1. Medical Ethics and Elimination of Doctorless Communities

The first epoch is related to the work of medical associations on the problems of medical care, which I touched upon at the outset. As the scope of the concept of medical care expanded, so has the range of work of the WMA. The scope of the concept of medical care expanded because initially, one might say, there was only one pillar, namely, the old medical ethics based on the personal relationship between the physician and his patient. Another pillar was established around the problems of the elimination of doctorless communities and the popularization of medical care. The third pillar was the elevation of the standards of specialization and the academic quality of medical care.

2. Introduction of Social Medicine, e.g., Preventive Medicine

Most recently, we are concerned with the problems of services in the area of preventive medicine in connection with environmental hygiene in our daily life. This means a new major field of public health. In this area the WMA has had to take a major step forward from the area of the physician-patient relationship toward the relationship between the group of medical men and the community.

Another recent problem is that of malpractice. With the advance of industrialization, we also have to face problems of pollution. Under these circumstances, the WMA now has to consider social problems from the purely medical standpoint. This represents the second epoch.

3. Problems of Malpractice

The third epoch is the one in which problems of malpractice became a worldwide issue. This problem has been compounded by the harmful effects of drugs. Because we cannot ignore the dangers inherent in the progress of medicine, this must be said to be a very important issue.

In the past, medical services were administered largely as a form of charity, which served as the basis of the concept of medical ethics. With the rise of such problems as those of the definition of death and of heart transplant, problems arising from the progress recently attained by medicine cannot be solved by the ethics of the past. When a physician replaces the diseased heart of a patient with the heart taken out of a dead body, it creates various accompanying phenomena, such as immunity. For such an operation, it is necessary to remove the heart from a dead body first. Then the question arises of how to determine when the donor is dead. This cannot be done without the academic basis of medicine and an ethical basis. One cannot remove a heart on the assumption that the man is dead merely because it stopped beating. The new definition of death must take into account the function of the brain stem. The WMA is facing such new problems of ethics that have arisen because of the progress attained by medical technology.

Viewed from such a standpoint, we can say that the human relationship between the physician and his patient has been seriously influenced by the progress attained by medicine, particularly because of its technological impact. Testing methods have been radically altered because of the progress achieved in the field of clinical pathol-

ogy or of progress in functional examination. When we have diagnostic activities different from the past, it requires us to have a new medical ethics.

This is the reason why the work of the WMA must become extremely diversified. It cannot look at medical care only for its face value. Rather, it must look deep below the surface. One such attempt was the 29th World Medical Assembly held in Tokyo last year. The Tokyo assembly for this reason constitutes one epoch in the history of the WMA — by making a major "digging" into the meaning of medical care.

It dealt with the problems of the development and allocation of medical care resources from a new standpoint. Because the development of medical care must be carried out on an international scale, its allocation, too, requires an ethical quality.

The concept of medical care resources in the past consisted mostly of medicine, doctors and medical technicians. Medical care resources of the new era, however, cannot merely consist of medicines and instruments. This is also true with problems of nutrition.

A major problem for mankind is the problem of increasing population. What should be the position of medicine with respect to this problem entails a major problem of ethics.

How must we think then? The concept of medical care resources in the past was cited by some economists in their discourses on resources in economic terms. But medical care resources incorporate ethical, technological and scientific attributes and an ultimately philosophical background. These medical care resources, therefore, have a meaning different from economic resources. For this reason, too, it is necessary to dig deeper below the surface of these concepts. This is the reason why we decided to discuss the problems of medical care resources in collaboration with scholars from all over the world.

In the past, medical care economics considered medical care resources in terms of cost. This problem of cost is a very difficult one. But because of the enormous changes that have taken place in medical

care, it is no longer meaningful to consider whether the cost of medical care is high or low or whether it is efficient in terms of the costs involved. Today, we need a different economic approach to the problems of medical care resources. What we need is a public economics approach, where we find that the new economics and the new human medicine can merge. With the 29th World Medical Assembly as a turning point, therefore, a new type of work has been incorporated into the functions of the WMA.

As for the allocation of medical care resources, it must be in conformity with social needs. This is valid in any century. This is not a new problem. Yet, because what was formerly considered impossible in terms of treatment has become possible through technological development, we must now consider how to allocate the availability of such a technology in treating diseases. This is a new, major problem and there are more.

I chose the theme of allocation of medical care resources for the Tokyo assembly because I believed that this was a problem the medical association must study from now on toward the 21st Century. Half a year after the assembly, I attended a meeting of the Council of the WMA. A member of the Council said the problems of development and allocation of medical care resources would be problems of great importance in the next century for the whole world, and they will be the sole problems for the WMA to tackle. He also said that if the JMA reviewed these problems every two years, it would mean that the JMA would be acting almost entirely on behalf of the WMA. The position of the JMA in the WMA has been very much elevated since the 29th assembly.

There are many problems that concern medicine and economics, that must be solved. There are also problems related to medicine and demography. World population problems are problems for the WHO and at the same time they are problems for the WMA's action strategy. There could be no ready conclusion on these questions because of such problems as that of the gene pool.

The WMA is destined to find a new direction in which it can

develop the human relationship between the physician and his patient of the new generation while being faced with these big problems. Therefore, about the problems of malpractice, which started primarily in America to become a worldwide problem and the problem of chaos in medical care, we in Japan have taken measures to solve them through bringing together top legal experts and top medical men in Japan. We are also considering the establishment of criteria for the prevention of these problems for each branch of medicine.

These problems have arisen because of the progress attained by science. In the former times when science had not reached a high level, patients died without receiving the benefit of new methods to prolong their life. Because of the very development attained by medical science, however, today we face a new kind of problems. We also have the new problem of human rights. It is, therefore, necessary to consider problems of individuals in a broad worldwide perspective.

The WMA has two legal counsel, and we discuss all kinds of issues. Through observations of the proceedings of the WMA Council which I have attended often, I have noted that national power makes the difference in an international organization. There should be no historical racial discrimination, and it is a fact that it exists. Take the issue of South Africa, for instance. We are forbidden by the United Nations to have cultural interchange with that country. I believe that there should be no such ban on medical interchange with a particular nation. But this actually exists under the United Nations, about which I am deeply dissatisfied. The JMA thought of taking it up with the U.N. General Assembly through the WMA. But the U.N. Secretary General chose not to do anything about it. This is merely one of the many problems.

The WMA, therefore, must consider what kind of medical care we must provide the new generation of mankind in terms of both theory and practice. This should be an important question not only to medical sociology but also to medical care economics. Mankind is now groping for a new direction for the world. To try to dispose of the problems of the present in groping for the future is a job appropriate

for an international organization. But this does not necessarily mean that such an awareness is prevalent in all the countries of the world. This in itself is a problem.

At a recent meeting of the WMA Council, the Secretary General and the Council President unexpectedly resigned. Looking at these events happen, I felt we should grasp them as a response of the old trying to become new — which is a change in the way of thinking. If the old WMA is to get out of the carcass of old medical care, it should first of all take up the problem of renovating the structure of the Secretariat and the Council.

Under such circumstances, if the Secretary General stuck to the old way of thinking of the old medical association, he would become disoriented in dealing with new problems. Such an old structure and old mentality, as I have found through attending other international conferences, have no relationship with the new structure of the WMA revolving around Japan. This is the reason why the position of Secretary General lost its root. For instance, if he had to attend the numerous meetings of medical care organizations, his head might become void. In order for him to fully explain the way of thinking of the WMA to each of these organizations, he would have needed the up-to-date academic background I have described earlier. But this would have been impossible for him as Secretary General.

Thus, while the Secretary General of the old style tried to go about business, the new atmosphere in the Council inevitably had to contradict him. This is the reason why the Council Chairman, too, had to resign. And now we have a new cooperative relationship in the form of a collective leadership of Councilors. The WMA, as I mentioned earlier, is now headed in the direction in which it is to deal with the problems of today while groping for the future.

This is being done specifically by the Committee on Automation and other Committees, which, with the cooperation of nonmedical experts, are solving the problems smoothly. It is under these circumstances that the JMA steps forward in dealing with the problems of the development and allocation of medical care resources

by combining the efforts of specialists in other branches of science in a new form.

Human Survival: The Environment and Medical Care

I am not academically qualified to address this symposium today. As a person responsible in the host country for the holding of this symposium, however, I feel it is my duty to speak frankly about what I have been considering. This is the reason why I accepted this assignment.

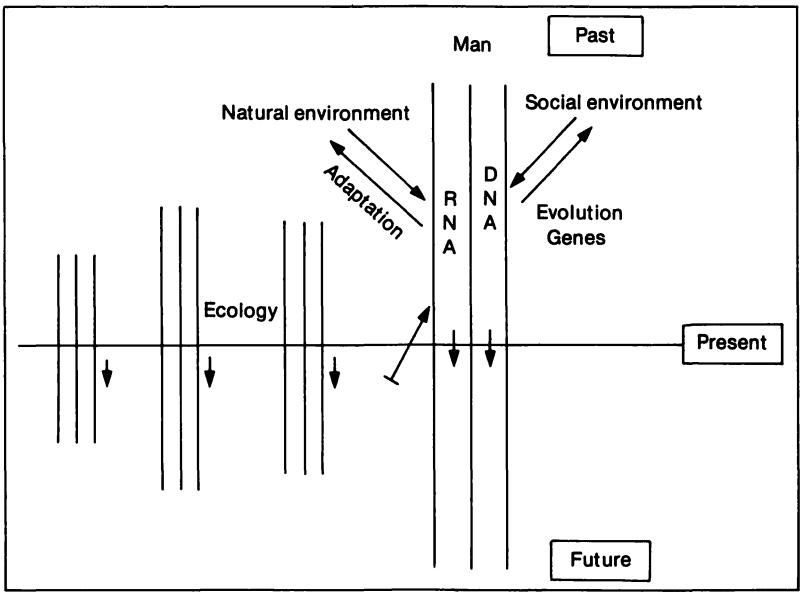
The title of my address is "Human Survival, the Environment and Medical Care." But the basis of it is the concept of life science. I base my thinking about medical care problems on this concept. I wish to sum up my thoughts about it, which have both direct and indirect relations with this subject.

The subject of this address may be illustrated in this way. The horizontal line represents the present time. DNA and RNA run through the past, present and future, incorporating evolution and heredity. DNA and RNA are adapted to the natural and social environments, in which there is the process of feedback. There are, likewise, other living things as the other vertical lines show. All these forms of life are connected by a horizontal line, which represents the present time. This diagram represents ecological thinking. I believe that ecology must be the science which moves forward toward the future.

One thing we must consider here is that RNA is known to start functioning before receiving instructions from DNA. I would say that it is RNA which functions by receiving impulses from the future.

This paper is the text of a talk given on June 8, 1976, during The Korea-Japan Medical Economics Symposium at the JMA House, Tokyo.

Human Survival and Its Order



Only RNA functions in response to the future on this "present" line.

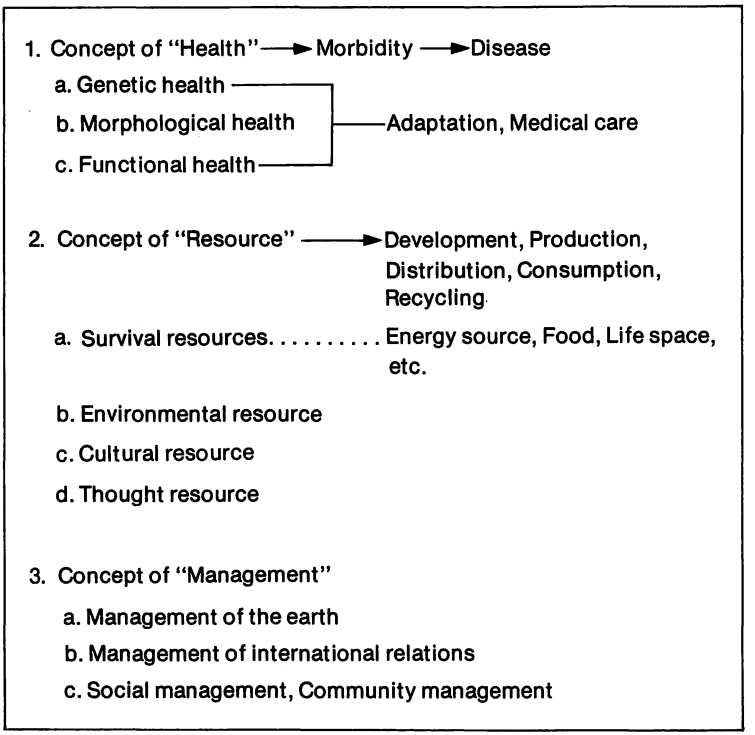
This represents an extremely interesting function of a living body. I want to establish the concept of "functioning in response to the future," as one of the phenomena concerning the gene. The social and natural adaptation of RNA also sums up various phenomena.

There is also ecological survival order, and while this moves forward, the structure of evolution functions.

Thus far, I have explained rather briefly. But when we consider the survival and survival order of mankind in the form of life science, I believe this is how it may be represented as a diagram.

Now let us consider survival elements. One of the most important of them is the concept of health. Health has already been defined by WHO as social health, both physical and mental. From the standpoint of life science, I would like to think in terms of genetic health, morphological health and functional health, which may be all reduced to the phenomenon of adaptation. This makes medical care an inevitability that is linked to morbidity and disease. In other words,

Survival Elements



when a human being exceeds the limit of adaptability, he enters the state of morbidity and then that of disease.

One thing we must take into account in this context is that while there are many problems discussed such as those of pollution and environmental disruption today, how these problems affect genetic health is a very important element for medicine. Also of great importance is how the family and social environments that might affect the gene would have a great importance to the fate of mankind in the future. I believe it is necessary to firmly grasp the concept of genetic health in forming the concept of health itself.

Morphological health, therefore, is anatomical while functional health is physiological in form. Therefore, the functional health of the cerebrum would involve mental factors. This may be somewhat

dogmatic, but I believe we cannot postulate about health unless we regard it as an element of survival in the form of adaptation.

Here, we have various survival resources, which include energy, food and life space. Environmental resources include healthful environment and cultural resources. In human society, we must also consider thought resource.

Concepts of resource include those of development, production, allocation, consumption and recycling. We have noted that the process of converting natural resources into goods has attained a good deal of development through engineering. But there is much room for development in the area of recycling the resources. I believe that there ought to be an economics and science of recycling. When we consider the fact that matter is indestructible and that we must utilize the resources of our planet, an economics and science of recycling will have a very important role in the future. This is the reason why I have presented this concept of resources.

Survival Order and Adaptation

1. Microscopic order —	Atomic and molecular levels, Molecular biology
2. Macroscopic order —	Ecological order Social order Economic order
3. Order of adaptation —	Micro-macroscopic order

Next comes the concept of management, which should include management of the earth. Here we have the problems of over-excavation and abusing of resources, air and environmental pollution and pollution of the earth itself. Earth management, therefore, must be considered together with survival resources.

There is also the problem of management of international relations. I believe that the concept of management must be given due attention as a resource. Such a concept of management, of course, has not been presented before, but I wish to present it here on the basis of the thinking of life science.

Next come the problems of survival order and adaptation. Survival order is to be divided into microscopic order, macroscopic order and adaptation order. Microscopic order includes molecular biology at the atomic and molecular levels. Macroscopic order should include ecological order, social order and economic order. If we take the standpoint of life science and consider survival order concretely, we come to this kind of subdivision of order. The order of adaptation I referred to a few minutes ago is also highly important. This adaptation order, too, consists of a macroscopic adaptation order and a microscopic adaptation order. I believe that unless we carefully consider this adaptation order, the survival of mankind would be seriously endangered.

Here we must consider the historical change in the concept of medical care. In the old days, medicine and medical care were not separate from each other. These two became completely separated about the time of the advent of Rudolf Virchow's cellular pathology or, even before him, Karl von Rokitansky's humoral pathology. In the age of life science, however, medicine and medical care are again united in some areas. Medical care has expanded because of rising social demand. Here, I believe, there is much that can be explained only with the cooperation of economists.

Historical Changes in the Concept of Medical Care

1. Separation of medicine and medical care
2. Expansion through social demand
3. Changes through the development of medicine
4. Relations among life science, medical care and related sciences

There are also changes due to the progress attained by medicine itself. There is the question of relationship between life science and its related sciences. The concept of medical care has undergone many changes. I have always included in the concept of medical care the social application of medicine. This is the reason why I have thought this way.

Structure of Medical Care

1. Components of the social application of medicine
2. Development structure and composition of medical care
   —Technological integrated unit, development center
3. Regional distribution of medical care and regional composition
   Social basis for social distribution and development
4. Social insurance, Social security — Economic mechanism of distribution.

In formulating the concept of the social application of medicine, I have created the concept of technological integrated unit, rather than those of hospital and clinic. This means the technology of hospitals and clinics is to be presented by this unit. When there is the question of what system to establish for the preservation of health, I believe we should consider it in terms of what technological integrated units should be combined to suit the social purposes of a particular community. Today, we have the system of specialists. But this is a system of the past — of Europe of about 100 years ago.

Unless we make a new start with the concept of technological integrated unit, we shall not be able to meet the social demands of the future. In the area of development, too, we would not be able to make progress if we only have a vertically divided structure.

The technological integrated unit would be the system of the future. Under the specialist system, we may have many specialists, but then they would tend to concentrate in large urban communities while rural communities would suffer miserably from a shortage of physicians. One might argue that the rural communities should have only general practitioners. But a general practitioner must essentially play the vital role of providing primary care. Primary care can be considered only in relations to the structure of technological integrated units. Thinking of primary care merely in terms of how many doctors to be stationed where and how many clinics and hospitals must be established where, I believe, belongs to the past.

We must consider for a farming community how to organize

medicine in terms of what units. If it is an industrial zone, different units must be established.

The specialist system belonged to the past. It played a very important role in certain stages of the development of medical science. Today, we must augment medical science at the level of primary care. A doctor who functions at this stage must be able to have a good idea of the future of a particular case he first examines. The term general practitioner does not necessarily mean a physician to play a key role in primary care. In Japan, it is not being contemplated to strengthen medical service at this primary care level because it is not possible under the present laws. But I fear that now that we have as many as 70 medical colleges and each of them works toward the same goal of producing specialists, it would tend to reduce the vital social functions for providing primary care.

There are the matters of regional distribution and regional structure of medical care. Regional distribution means we must consider simultaneously both social distribution and the social basis of development. Social insurance and social security are concerned with the economics and mechanism of distribution. Only after social insurance and social security were brought into the structure of medical care was economics brought into the order of medical care and became an indispensable element of it. This, I believe, started with the idea of social insurance created by Bismarck. It is already 100 years ago, but this concept has not changed at all.

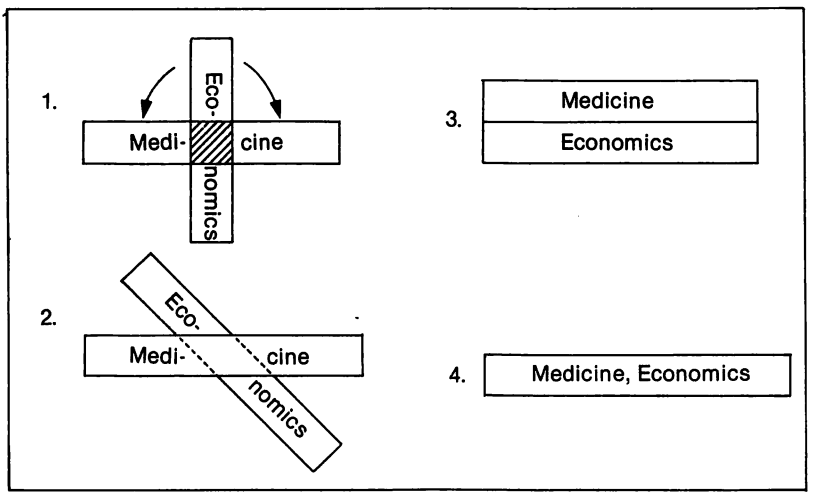
Today, we must also consider the next item.

This diagram shows medicine and economics crossing each other. In medicine, there was Harvey's blood circulation, and in economics we have the economic cycle. This, I believe, is the first instance of the two sciences crossing each other. The two can cross each other at various angles. When they are at a right angle, they have a merely peripheral meaning. The second diagram shows the two crossing each other at an angle. This represents the idea that the concept of social insurance developed in economics and it has had a certain impact on medicine.

Initially, social insurance was adopted by business enterprises as a

means of defense. But in view of the development social insurance has attained today, we must consider the incipience of social insurance as the germination of the idea of welfare and thus it signified the origin of the concept of welfare economics.

Medicine and Related Sciences, Economics in Particular



No. 3 indicates the establishment of the social security system through the combination of economics and medicine. In this social security system, economics is the principal agent to which medicine provides merely technology. Social insurance and social security have completely combined with each other to produce a new system for the future.

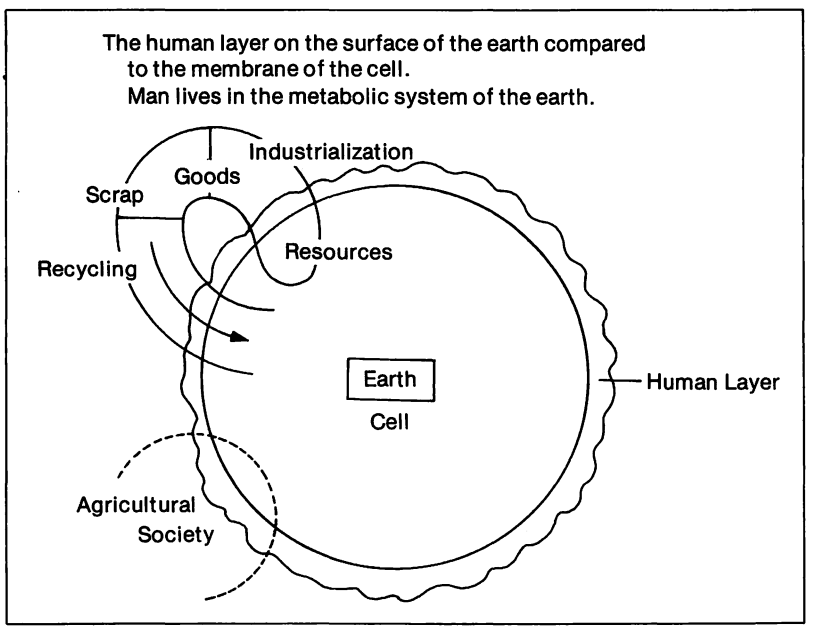
When welfare becomes a major question in economics, perhaps we should have a new concept of medicoeconomics which should combine survival and welfare. Medicoeconomics is the next stage after medical economics. Medical care can be considered in terms of the relationship between medical care and economics, rather than the interrelationships among various branches of medical science, and these diagrams may be revised on the basis of various imaginable situations.

Still another problem is that mankind covers the surface of the earth as a thin film. When we consider the earth as a cell, humanity

Medical Care and Economics

Economic approach to the development of medical care resources
Economic approach to the allocation of medical care resources
Economic approach to reproduction and recycling of resources in medical care

corresponds to the membrane forming the cell. In an industrialized society, natural resources are extracted from the depths of the earth's crust. In an agricultural society, man utilized resources on the surface of the earth and recycled them. In an agricultural society, therefore, man has affected only a small portion of the surface of the earth, but in an industrial society, it has affected the earth much more deeply and over a larger area. Minerals converted into goods must be scrapped and then reused again. Unless we have the technology and economics for



reusing and recycling them, it would be impossible to maintain the integrity of the cell — the earth.

Membrane phenomena of the cell are multifarious, and unless human activities are considered in terms of this analogy, we would have a serious problem about our resources and the problem of recycling them.

There is also the problem of speed. Take the matter of liquefaction of coal, for instance. This is to achieve in a few hours what it took nature hundreds of millions of years to achieve. Therefore, I believe it is possible to speed up this process of recycling of resources. It is from this kind of standpoint that the Japan Medical Association wishes to develop this kind of basic way of thinking with the participation of you gentlemen.

I have only mentioned key points. When we consider the health environment that exists on this thin membrane of the earth, we must have both fairly artificial and natural parts. In such an endeavor, I believe life science plays a role. With this I shall conclude my talk that has shown you the ideas I have formulated.

Thoughts on Medicoeconomics

Medicine is a science that grasps man in his totality. As it stands today, the mind is considered a part of the human body. This is the reason why psychiatry is included in medicine. Medical science today takes up human beings as components of a group and man in his relationship with his environment. This represents a very great expansion of the concept of man in medical science.

Man cannot live without being a component of a group. Nor can he live without other animals and plants. We live by constantly responding to the changes that occur in our environment. That man has adapted himself to the environment in a very sophisticated way is well accepted in medical science. All the functions of the human body contribute to homeostasis, in which an equilibrium is maintained of temperature, fluid content, etc. of the body.

On the basis of such thinking, we maintain that medicine must study man from all possible angles. I would like to regard man as a thin film covering the surface of the earth. Man maintains a metabolic relationship with the components of the earth, through which he takes into his body animals, plants and air. Through metabolism, our body goes through the process of growth, development and aging until it dies. We are struck with a sense of wonderment when we realize that the human body functions fully in this natural process.

This paper is an English translation of a talk in "The Special Medical Course," broadcast on August 1, 1976, by Nihon Shortwave Broadcasting Co., and the original paper in Japanese was published in *The Journal of The Japan Medical Association,* Vol. 76, No. 6, pages 727—736, September 15, 1976. Reprinted from the *Asian Medical Journal,* Vol. 19, No. 12, December, 1976.

Alexis Garrel, the famous physiologist, called man "the unknown," in the title of his work (*Man, the Unknown*). What he meant is that an unknown thing has a very important element, which cannot be understood by science.

What I wish to take up as a particularly important issue now is that economics, too, is a science for human survival. A branch of knowledge which studies economic phenomena of man living on this planet is economics. Economic phenomena produced by man are various, but few of them were observed outside the sphere of metabolism on the earth. *The Wealth of Nations* by Adam Smith, who is considered the founder of economics, is, as we see it, actually a book on ethics. It makes us realize, without our becoming aware of it, that man is an integral element of earth metabolism. Economics takes up the economic phenomena of human survival, but we must realize that this means these phenomena occur within the thin film covering the earth with man as an element of earth metabolism in it.

Modern economics has employed mathematical methods to solve various problems or making long-term predictions. Yet, we must realize that it cannot go out of the sphere of earth metabolism. Now, let us consider the historical fact of how medicine and economics have been involved with each other.

It is an indisputable fact that the "economic table" of François Quesnay incorporated into economics the theory of blood circulation, discovered by William Harvey in this metabolic relationship. A superior physician in the service of Louis XV, Quesnay produced the outstanding achievement of adapting Harvey's theory of blood circulation to economics. His economic table would not have come into being if it had not been for this theory of circulation.

I wish to think that a coherent relationship was established between the human body and economics and that this signified a certain development. Bismarck, another historical figure, conceived of a social insurance system, which represented medicine and economics crossing each other at an angle, as it were.

This social insurance system of Bismarck covered only a portion of society, not all its members. In other words, those individuals who

were found within the angle formed by the lines of medicine and economics conducted redistribution of their income. The economic measures they took against the risk named disease meant in effect social insurance.

I believe Bismarck was a great statesman who thought of an economic measure called social insurance. I think he was also an economist.

When the lines representing medicine and economics are parallel and close to each other, what happens? This, I believe, represents the social security system, the philosophy of the welfare state of today.

It was not so long ago that welfare became a subject of economics. But there was an age of political economy before that time. Welfare, which did not exist in the very old ages, became a subject of economic studies. Welfare, a very essential element for human survival, is important to medicine, but, coincidentally, it is also a subject of economic considerations. This means that an analysis of various phenomena surrounding man is ultimately reduced to the question of welfare for man. The number of economists who take such a standpoint is increasing.

Welfare economics is now sweeping the world. But I believe that no matter how much its specialists give their thought to it, they cannot reach true human welfare if they used economics alone as a means. We need medicine and means of living, engineering, molecular biology and many other such sciences, which are involved with man from his birth to death, and these I believe represent true medicoeconomics.

When we take the standpoint of medicoeconomics, we think in terms of adaptation in considering not only material metabolism and circulation but also welfare economics. But in considering adaptation, we must think of its superstructure that adjusts itself at various levels — at the peripheries of the nervous system and the level of the cell, the organs and even of the human body as a whole. It would mean that the many lines of command of adaptation must be able to function in a highly orderly manner. There is a group of people who think of human survival in these terms.

We also find that many economists have adopted biological conditions to economics. If we take a standpoint of mathematical ecology, it is not impossible, I believe, to quantify the position of man even in the field of econometrics, which lends itself poorly to biological methodology.

We can think of adaptation in terms of passive and active adaptations. By active adaptation is meant adaptation based on the building of the environment through the training of one's own physical body. Passive adaptation, on the other hand, is concerned with the functions which man has inherited as instincts inherent in living organisms. In economics, it seems there are no concepts of control centers at the high, middle and low levels. But I believe that control centers must be considered to be performing human functions in their various phases.

As for the passive adaptation mentioned a few minutes ago, the building of the environment is of extreme importance. In an industrialized society adaptation is not carried out in the metabolic relationship that takes place on the surface of the earth as was the case with the agricultural period when man maintained his existence through his metabolic relationship with the surface of the earth.

In the industrialization period, man extracted natural resources from the deeps of the earth, and in this process economics became involved to a great extent. Exploitation of natural resources was conducted but the process provided man with extremely rich materials. These materials were turned into manufactured goods and they were consumed. Production continues but consumption has, because of various factors, picked up or dropped. This is the area where economics has been very active. Ultimately, however, the economics of the industrialized society has come to a dead end because this economics is not an economics that is concerned with the reproduction of natural resources out of the finished products. There is yet to be developed a technology for remaking natural resources out of finished products. This is the reason why industrialization has resulted in the contamination of the surface of the earth. Through such phenomena as environmental pollution and air pollution that

contribute to a very bad environment for human survival. If economics and medicoeconomics had cooperated with each other fully, this kind of problem might have been avoided through adjustment by a high-level nervous control center.

Economics determines how it is possible for man to conduct self-adjustment while medicine determines what can be done about man's own body. In other words, economics is concerned with determining the overall picture while medicine is concerned with the determination of parts. If we accept these definitions, the question of medico-economics becomes much simpler.

One of the phases of medicoeconomics is to find a systematic order in all the phenomena ranging from those which may be grasped by molecular biology to all economic phenomena on the surface of the earth. It seeks to discover that order and find a regularity in it. This regularity within the order may be concerned with the problem of adaptation, that of reproduction or disease and health. Only after the establishment of this system, then is it possible to think that economics and medicine must not be separate disciplines.

There are many problems today that may be considered from the viewpoint of medicoeconomics. Some people say that all men, spread throughout the world, are brothers. This philosophy, for instance, is represented by world federalism and it is also found in some religions. In the past, there were many armed clashes for the acquisition of natural resources. But during the past 30 years, there has been hardly any such clash. The oil shock of a few years ago, I think, might have developed into an armed conflict if it had happened in the old times. Today, it is possible to avoid it. This, I believe, was an instance of an economic regulation and a political regulation influencing economics. But we cannot forget the important fact that underneath it was the vital truth that human existence received great attention.

Oil was produced underground through many hundreds of millions of years. When mankind began extracting it to make use of it as a source of energy, and from which to manufacture many chemical substances, the question arose of whether or not these new products suit the human body.

There are partial and total adjustments. In our industrialized age, many products were developed without thoughts about their relationship with man. The result was that after they were developed, man has had to adjust himself to them. Such an industrialized society, I believe, has deviated from the essential way of life of man. And I cannot help thinking that recently there has been a kind of soul-searching about it.

Having thus considered, we may say that economics is ultimately a form of welfare that guarantees human survival. Therefore, both the branch of medicine that deals with micro-welfare and the area of welfare concerned with public health completely overlap with economics. We must get out of the way of thinking about social security that marked the era in which these two closely paralleled each other, and we are now in a new era of medicoeconomics. It is from this kind of way of thinking that the scientific session of the World Medical Assembly held in October last year in Tokyo took up the problem of medical economics and a thorough-going debate was held among participants from many countries. This discussion was participated in by economists, sociologists and medical scientists. Thus, I believe international understanding was very much deepened.

With the advent of medicoeconomics, I think that the problem of adjusting earth metabolism will become the most important question. Adjustment of earth metabolism, how to produce what kind of high-level, middle-level and low-level regulation centers and how many of them to produce would be a major problem.

This concept of a regulation center, I believe, would be considered just like a nerve center with its control of metabolism. And then a new world of medicoeconomics would come into being within the thin film phenomena, one of the forms of earth metabolism. The concept of medicoeconomics we used to think of in our world in the past has already become obsolete.

Human society may be regarded as a thin film on the surface of the earth and the aging of world population signifies a change in this film, which in turn would affect earth metabolism. A part of the adjustment falls within the area of economics and a part falls in the

area of medicine. It is already an old story that these two adjusted separately. In the era of medicoeconomics, adjustment must be made jointly, but joint adjustment would inevitably need something like an upper-level adjustment machinery, a machinery above that level and another still above even that level.

For this reason, the concept of medicoeconomics which interests me most may be a way of thinking that enables us to grasp simultaneously both the present and future of the reality of mankind.

Medical Care Welfare in the Future

The most important thing about welfare I wish to say today is that this is an age of welfare, but the welfare of the present is something that is imposed on people, and, therefore, it is not social welfare. When some people form a group and gang up on a member of the Diet with demands, he, knowing that unless they respond favorably he will lose votes, bows to the demands.

This self-destructive, self-serving welfare, I think, is the canker of the Japan of our time. If our country, because of its financial straits, were to go bankrupt, it is because the people are buried in this kind of welfare.

We face this danger at present. Therefore, I have proposed a revision of the concept of welfare.

Today's economics is said to be welfare economics. But its concept is one of relief for the weak. Welfare in politics, too, is all "relief for the weak." This means that anyone calling himself weak and seeks relief can become the object of this kind of welfare. The sector within our national budget, that deals with welfare, increases each year.

I do not agree with this concept of self-assertive welfare. It is my belief that welfare is something that offers better conditions for survival. This concept of welfare allows room in which people make efforts on their own to enhance their own welfare, whereas in the

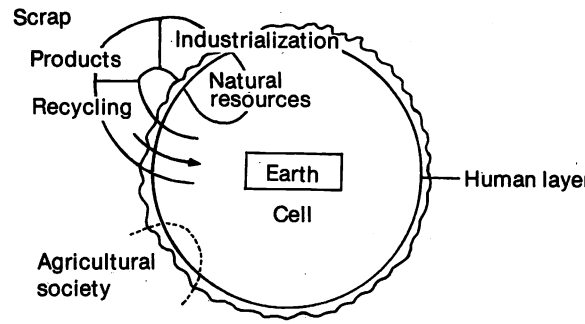
---

This is a translation of the lecture, delivered on March 5, 1977, in Nagoya, on the occasion of the completion of the Nagoya Medical Society Hall, published in Japanese in the *JMA* (Japan Medical Association) *News*, No. 374, page 4, April 5, 1977.

concept of welfare as a form of "relief for the weak," there is no expectation of self-help by people.

I came to entertain this concept of welfare when I thought about the pollution problems, which had changed the environmental conditions for the survival of man on this planet. Please refer to Fig. 1.

Fig. 1. Human Layer on Earth as Cell Membrane —Man Living in Earth Metabolism



This is the earth and its surface is a layer of human activities. While man lived in an agricultural society, he extracted resources from the earth and returned them after using them on the surface. Recycling of natural resources was the natural course in this agricultural society.

In the industrialized society, however, an enormous amount of natural resources extracted from the interior of the globe was converted into products through industrialization. The products were consumed and turned into scrap. But there was no economics as a science that reconverted this scrap into resources. Economics as such deals with consumption and marketing that precedes that phase. But there is no part of the economics that we have today that deals with the recycling of products as resources. There is no technology for that, either.

In this world, which is without either an economics or technology for the recycling of natural resources, the scrap mankind has produced during the past century is overflowing, contaminating the air, water and soil and drastically changing our living environment.

Despite this fact, no one has thought about matters beyond the phase of industrial production. Although we live unmindfully in this society, this industrialized society is highly defective.

In such a society, welfare should mean not "relief for the weak" but how to put the brakes on this industrialization and recycle the resources, thereby normalizing the metabolic relationship of man and earth. If this could be done, we can establish better conditions for survival. If not, pollution would multiply steadily and even healthy persons will be all harmed.

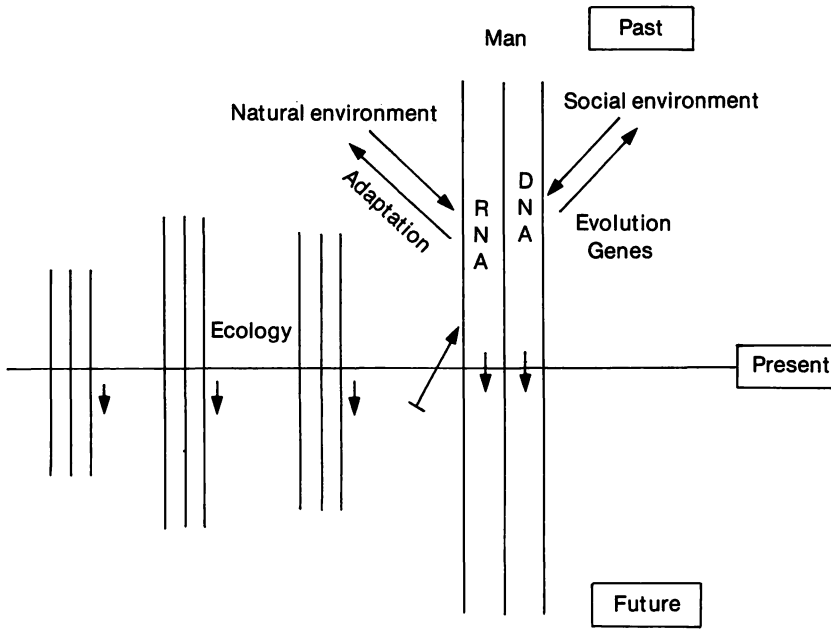
This means that thinking about medical care welfare for the people is no easy matter. To help the weak and those in trouble is wonderful. But that is not enough.

Now, I want you to look at this model of global metabolism of human life in which the human layer is compared to the cell membrane (Fig. 1). When we think about human welfare, we find that human existence would be in jeopardy unless we provide better conditions for human survival. If nuclear explosions were to continue for 90 more years, for instance, it is known, on the basis of calculations, that the pollution of the earth will not tolerate human existence. To remove such a negative condition, therefore, would be a major part of welfare. To collect votes by helping the weak does not contribute to welfare directly but make victims out of the majority of human beings. I believe that this must be dealt with as a political problem common to all the countries of the world.

Now, this is the survival map I prepared (Fig. 2). Man with DNA and RNA adapts himself to the natural environment as well as to the social environment. And we have this science of ecology. An interesting thing is that the RNA in man starts moving with stimuli received from the future to respond to the demands from the DNA. It is highly human of the human being, in fact, that this basic pattern in

Fig. 2. Human Survival and Environment and Medicine

I. Human Survival and Its Order



the existence of man is based on this response to the future. This shows that politics must think of the future of 20 to 50 years from now to make responses. The human body is already doing it.

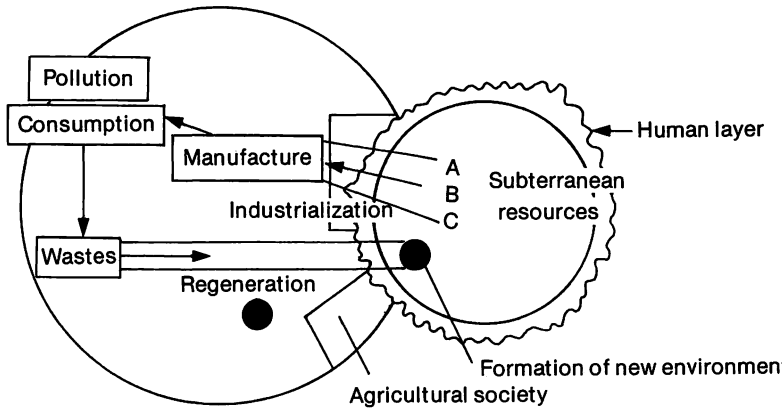
This is something new which molecular biology understands, and this is the pattern in which I consider the human survival order.

Medicine becomes related to human life in the process of human evolution and also to the ecosystem referred to earlier. And clinical medicine becomes involved with human adaptability. The number of the areas of specialization in medicine constantly increases, and the particular branch of medicine concerned with the disruption of health is one of the branches of the large category of medicine.

Fig. 3 is an elaboration of what I stated before in regard to Fig. 1. This is how pollution occurs. How to create a new environment in an industrialized society, therefore, is a question closely related to

Fig. 3. Health Environment of Future

I. From Standpoint of Environmental Science to Destruction of Natural Environment → Suspension → Rebuilding
II. Formation of New Natural Environment



Increase and Acceleration of Natural Purifying Power

welfare. The environment for Japan in the 21st century will probably be buried in pollution of all kinds. A schema like this becomes necessary for us to get out of that.

In medicine we must consider the micro-order based on molecular biology, the macro-order and the order of adaptation. For example, the problem of aging is becoming a serious issue. A relevant question here is whether or not an aged person is a semi-invalid. Even an old person should be allowed to work according to his ability so that he can contribute to society (Fig. 4).

This means that in dealing with problems of the aged, it becomes necessary to raise their adaptability. This cannot be done only in the field of medicine, but adaptability must be enhanced. And this inevitably creates new fields different from the medicine of the past.

Rehabilitation is a passive form of adaptation. But heightening the adaptability of the healthy, too, becomes a major role for medicine to play. But this kind of endeavor does not bring in any examination fee and any profit for those who take it up. This all-important area, in

Fig. 4. Survival Order and Adaptation

1.	Micro-order	Atomic and molecular levels Molecular biology
2.	Macro-order	Ecological order Social order Economic order
3.	Order of adaptation	Micro-order and macro-order

fact, is left as a hiatus by the government of today. There is some debate on the budget in the Diet. But what the Diet is discussing concerns the world that is an extension of the past and not a budget for the exploitation of the future.

As I have stated, the historical changes of the concept of medicine may be expressed in the form of a table as in Fig. 5. In former times medicine and medical care were not separate. But today, we have the problem of both expanding. The two have created a science of integration that may be called life science.

The content of medical care, formerly, was the treatment of the sick. As you know, it has undergone changes because of industrial medicine and mental hygiene, etc. (Fig. 6).

When we think of elements for production, I feel that I must loudly emphasize the need for a more correct definition of health. The WHO defines health as being healthy physically, mentally and socially. But, as I stated before, hereditary health is a very important

Fig. 5. Historical Changes in Concept of Medical Care

1. Separation of medical science and medical care
2. Expansion by social demand
3. Changes according to progress of medical science
4. Life science and medical care — relationship with related sciences

Fig. 6. Composition of Medical Care

1. Component elements in the social application of medical science
2. System and development of medical care and its composition
   integrated technological unit, development center
3. Community allocation and community composition of medical care
   — social allocation and social basis of development
4. Social insurance, social security — economic mechanism of allocation

Fig. 7. Element of Survival

Concept of 'health' → morbid state → disease

a. Hereditary health
b. Morphological health } adaptation, medical care
c. Functional health

matter (Fig. 7). Molecular biology has improved the hereditary mechanism, thus creating an entirely new element. If the gene has some defects, it cannot create health at all. Therefore, I wish to consider genetic health as the first element in the definition of health. The second is morphological health and the third functional health, the last including mental health.

These three kinds of health — hereditary, morphological and functional — may be also viewed as the three aspects of adaptability. They also serve as the starting point for future medical care.

Recent developments in genetic engineering, for instance, can eliminate imperfect genetic elements. Morphological health can be achieved through training and so can functional health.

Thus the concept of health as an element of survival becomes highly important.

The survival resources include not merely material resources but cultural resources and ideas that are resources. It is usually said that because Japan is a country without resources our future is viewed pessimistically. But in the future world, ideas would be an important resource (Fig. 8).

Another resource is the concept of management, which, though in the past, was a highly ambiguous concept, will have a vitally

Fig. 8. Concept of 'Resources' → Development, Production, Allocation, Consumption, Recycling

a. Survival resources . . . energy sources, food, living space, etc.
b. Environmental resources
c. Cultural resources
d. Thought resources

Fig. 9. Concept of 'Management'

a. Earth management
b. International management
c. Social management and community management

important role to play in many fields, such as international, regional and social management (Fig. 9).

Yet, in reality, politics and administration operate by the manipulation of statutes, that is, a managerial pattern without foundation. This is the reason why it often turns into power administration. Take the matter of emergency medical care, for instance. The government this time is demanding an appropriation of 10 billion yen for this and this is likely to be approved. Of this amount, however, only 180 million yen will go to private medical institutions while the remainder will be turned over to the public medical institutions which are trampled upon by labor unions. It is the people who lose out. Social management, I think, is impossible by the present government. The fact that social management is being carried out by the kind of bureaucratic structure we have today will deprive the people of a great possibility for the development of social insurance in the future. There are many problems concerning this point, but since the time is limited, I shall not go further into this.

When we consider the relationship between medical care and economics, we find that Japan lags far behind the other advanced nations in regard to the economic approach to the development of medical care resources, or, more specifically, the development of drugs

or facilities for the prevention of pollution. Even if all the medical schools in the country got together, they can not equal the strength and facilities of even a single major pharmaceutical company.

As for the allocation of medical care resources, we find the mass media often talking about physicians immersing their patients in drugs. But this is completely wide of the mark. In today's Japan, medical care resources are allocated by the natural process, that is, not according to the needs for medical care resources but by wants. This is the basic way of thinking of Japanese politics. When the consumer power becomes strong, resources are allocated by the consumers' wants. This is not allocation according to social needs. This is the reason why the system ceases to function after a few years.

Then we have the problem of reproduction in medical care, which is related to the problems of the development and redevelopment of medical resources. But here, too, we have no consistent planning at all. Everything is conducted haphazardly. For instance, when someone said there were not sufficient medical schools, Mr. Kakuei Tanaka, the Prime Minister at that time, replied, "Let's build one in each prefecture," as though he were distributing things throughout the country. This is the level of intelligence we have at the top level of politics. There was no planning at the beginning about how Japan might be able to lead the world in 10 years with what kind of and how many medical schools. National medical schools were scattered throughout the country like the beans scattered during the festival in February. In less than 10 years the number of physicians will increase so that there will be a big confusion. And the time will come when we have to reduce the number of medical schools.

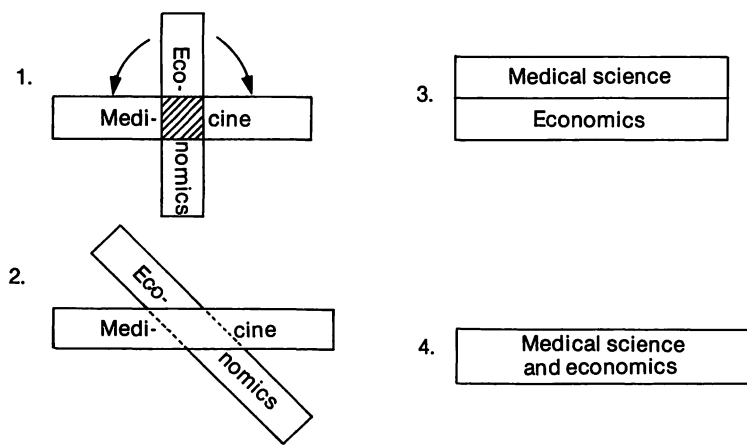
I am indignant about this kind of politics being carried out with the authority of the Diet. I don't think there is any evidence that we have a shortage of physicians today. It seems as though physicians are short from the viewpoint of the people's wants. But if we take them seriously, we will have to make one-half of the population physicians, that is, the "ideal" will be for each citizen to have one physician. This

is the epitome of people's desire in today's politics. And each physician is to have large machinery. At this rate, there is bound to be a shortage. This, I think, is a sign of primitive parliamentary politics, which forces us to conclude that there is no politics in Japan that leads to the future.

I shall briefly touch on the relationship between medicine and economics, which may be expressed in terms of these phases (Fig. 10). The parts where medicine and economics cross each other indicate the theory of blood circulation of William Harvey and the economic table of François Quesnay, chief physician to Louis XIII of France. Harvey applied the theory of blood circulation to economics, and ever since then economics and medicine have had a close relationship. Today, they are linked together by another form, social insurance. This is shown by the crossing of the two at an angle.

Fig. 10. Medical Care and Economics

Economic approach to the development of medical care resources
Economic approach to the allocation of medical care resources
Economic approach to reproduction and recycling of resources in medical care



No. 3 indicates another relationship between the two in the form of social security system. When the two become much more integrated, then we have medicoeconomics.

I know you have various problems concerning social insurance, which was originally started by Bismarck, the great statesman of Germany, who created socialized medicine by combining economics and medicine. He was very clever. He had the employer and employees share the risk for health on a fifty-fifty basis without government intervention. Thus, in this system, the government, though it has the responsibility of supervising it, has no further responsibility. In Japan, however, the government is financially responsible because otherwise the social insurance system would collapse.

Today you are studying very hard and trying to apply social insurance in the concrete context of treating your patients. But the medical care costs tend to rise every year. According to my calculations, in five more years the government-managed health insurance plan and the National Health Insurance Plan will become bankrupt and insolvent. This will be a very serious matter. This is partly due to the fact that the rate of economic growth has become smaller but what is more important is the self-contradiction inherent in the health insurance structure itself.

When Mr. Kakuei Tanaka was chairman of the Policy Research Council of the Liberal-Democratic Party, the Japan Medical Association conducted negotiations with the party by total refusal to give medical care under the health insurance system. The party promised to radically reform the social insurance system, but it did not do anything.

The Minister of Health and Welfare knows nothing about the system because he is only sent from the Diet, not according to his choice or qualification. I describe this as an employment agency that sends out housekeepers because a housekeeper does not know what home she might be assigned to. Like such housekeepers, the minister is suddenly appointed to a certain post and is subjected to a briefing, which is a test for him given by the bureaucrats. These bureaucrats

decide how to make use of the minister. Thus, there is no future for the minister. Politics must have a future, but the Liberal-Democratic Party has been carrying out this kind of politics that has no future, and this is the reason why the Liberal-Democratic Party finds itself today in great difficulty.

If, on the other hand, it had carried out politics with a future, the party would have become an excellent conservative party. I give it credit for rehabilitating Japan from the ravages of the war. But it did not think of Japan in the world after the war. This is the reason why it finds itself at the nadir of its fate.

The social insurance system we have today will be dead in five more years, no matter what we say. During the term of Prime Minister Eisaku Sato, we carried out a one-month walkout by which we refused to give medical care under the health insurance system. At that time we agreed on the details, but they proved of no use. Politics that does not feel the pressures of science does not find its way to the future. The politics of the Liberal-Democratic Party does not feel the pressure of science. Politics of the Japan Socialist Party feels the pressure of the labor unions, but this, too, is insensitive to the pressure of science.

Fig. 11. Realities of Social Insurance

1. Social insurance system becoming antiquated
2. Failure of uniting social security with social insurance
3. Retreat of principle of insurance association in health insurance
4. Absolute principal in insurance economics
5. Absolute lack of system to receive medical care
6. Lack of response to progress of medicine

We want to protect politics by guiding it in the right direction. But I feel that a conservative regime, in order that it may prove to be a genuine conservative regime, must regenerate itself more than just once (Fig. 11).

This is the present situation of social insurance. When you request payment for your services for this month, you receive the payment the month after next. In five more years, the health insurance system will not be able to pay you and will become bankrupt. The national pension system, too, will explode in five or six more years. In other words, we are on a brink of a cliff. Yet, no one discusses these matters in the Diet.

Take the budget debate this time. There is a great deal of discussion on how to reduce the taxes by 1,000 billion yen. I really fear for the future of Japan. The first thing to burst would be the health insurance system, to be followed by the national pension system. This is the process of the collapse of Japanese politics.

We must think about something to replace the social insurance. The concept of social insurance, created in feudal Germany 150 years ago, does not work in a modern free state. In Japan, however, the old system is forced on the people on the basis of the theory that there is a law and that this is a country ruled by law. But when the reality breaks down, the law turns out to be wretched.

In the light of these facts, we find that the social insurance system we have today does not have the confirmation of the social solidarity of health, as I have listed in Fig. 12. The position of medical care as a survival resource, listed as No. 2 in Fig. 12, cannot be established as an

Fig. 12. Alternatives to Social Insurance

1. Confirmation of social solidarity of health
2. Establishing position for medical care as a survival resource
3. System for development and allocation of medical care resources
4. Awareness by the individual of the responsibility for their health and disease
5. Building of a health environment — in the workshop and in the community
6. Improvement of the medical care system in the community
7. Improvement of the medical care part of the individual
8. Structural combination of medical care and economics
9. Renovation of the concept of medical care welfare
10. Introduction of management and evaluation.

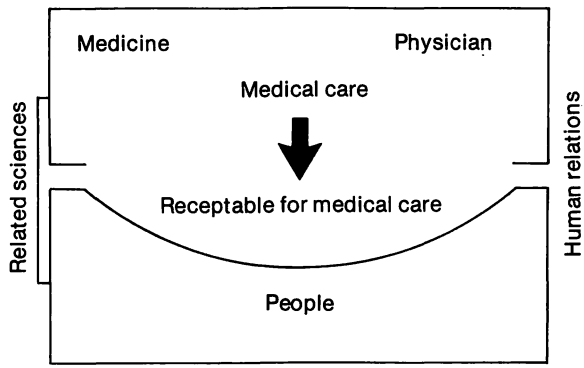
extension of the risk of factory workers. This is because there is yet no established system for the development and allocation of medical care resources.

As I mentioned earlier in reference to welfare, the government we have today does not expect the individual to be responsible for himself. Therefore, the people have forgotten about responsibility to themselves, which, I think, is terrible. The idea that one must safeguard his own health has disappeared. Instead, people tend to think that the responsibility of the parents may be fulfilled if only they take their sick child to a physician. I don't think that the problems of human life can be solved merely by the concepts of right and of obligation. I even sense a great danger here.

I referred to the problems of pollution earlier; a healthful environment is necessary for the health of an individual both mentally and physically. As for the improvement of the community medical care system, we know for a fact that as much as 85 per cent of night emergency care is handled by private medical institutions. And yet, out of 10 billion yen allocated, only 180 million yen are being allocated to the private medical institutions while the remainder is allocated to the public medical institutions. This, in short, is an outrageous national budget. Yet, no one attacks this kind of budget because everyone is naive.

The improvement of the medical care part in the private life of the individual also requires improvement. Nor is the structural combination of medical care and economics complete. This is the reason why social insurance only produces a bloody struggle among the labor unions, insurance organizations and the physicians, which I deplore very much. The concept of medical care welfare was already touched upon. The last item "introduction of management and evaluation" means that we must build a new system by systematizing all these elements as something to replace social insurance. Otherwise, the continuation of the system, with its origin in feudal Germany of 150 years ago, under the power of the law, means making the people groan under the pressure of the Diet politics. I believe that this kind of system cannot last long.

Fig. 13. Medical Care in Free Society



Medical care in a free society consists of the people, the physician, and medical science as shown in Fig. 13. There must be a receptacle for medical care, and yet there is no such thing in the life of the people today. Since there is no receptacle, medical care is like water being poured into a bamboo basket. It goes right through it.

Because of the totally unreasonable medical care cost of this country, I believe that the national finances will collapse in five or six years. We have been wasting medical care resources all these decades without considering the need for a receptacle.

The universal insurance system is shown on Fig. 14.

Fig. 14. Establishment of Universal Insurance System

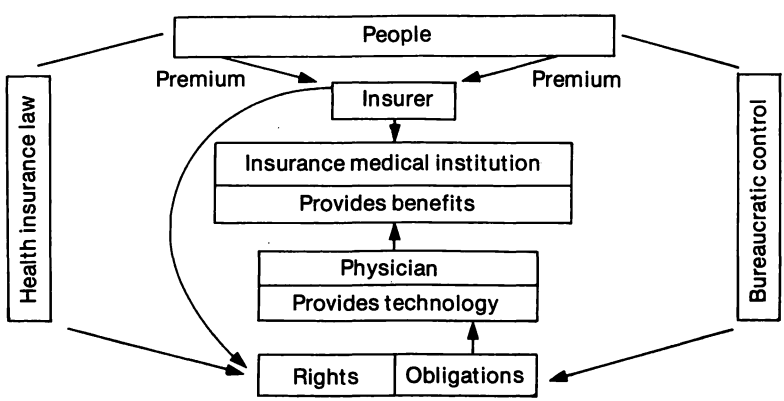
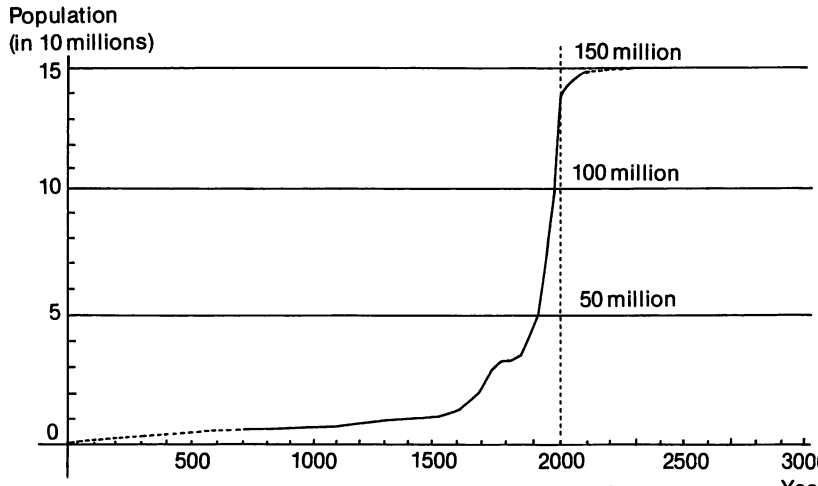


Fig. 15. Long-term Trend of Population in Japan

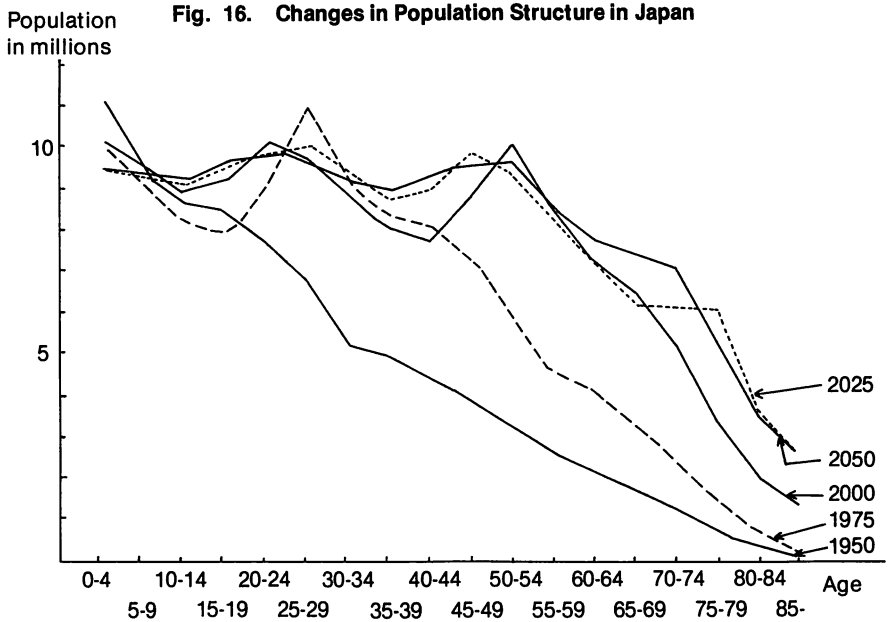


Source: People and Land in the 21st Century by National Land Agency

What we must think about now becomes clear when you look at Fig. 15 which shows the population structure of the 20th century. Japan's population becomes stationary at the level of 150 million. Our population was kept at a very low level during the past centuries. But after the end of World War II, it expanded enormously. Yet, what has the government done about this tremendous population revolution? Absolutely nothing. The 300-year history of the Tokugawa rule ended in 1867. After that, the policy of the government was to increase the population to make the nation become a major military power.

While thus increasing the population, however, the government had no idea of what to do about the survival of the people and how the government should guarantee it. We have been able to survive, thanks to divine succor, but the health insurance and national pension systems will collapse in five more years, to be sure. We must consider the medical care of the future in the year 2000, 2500, 3000, etc. when the population becomes stationary at 150 million. The health insurance system began when the nation's population was only about 60 million. And if the population should more than double, it stands to

Fig. 16. Changes in Population Structure in Japan



Source: People and Land in the 21st Century by National Land Agency

reason that the same old health insurance system would not work. This is what I want you to consider.

We are now approaching the year 2000 along the sharp upward curve. Yet, there is not a single statesman in Japan today, who can think about the problems of society, food supply and energy on the basis of this kind of a figure. When I explain these things to statesmen they say that, since they are to last only half a year, or a year at the most, they want to be spared of the difficult talk. Ministers of Health and Welfare constantly change. I have to deal with these people. No wonder that I am called "Taro the fight-picker."

Changes in our population structure are shown in Fig. 16. In the year 2000, the population growth is slowed down somewhat, and the middle-aged population increases very much while the old people population decreases. These are changes in the population structure. And we must determine the social structure in response to these

Fig. 17. Changes in Actual Number and Percentage of Population by Age Group

Age \ Year		1925	1950	1975	2000	2025	2050	2075
Actual number in millions	Total population	59.18	83.20	111.93	136.74	145.18	148.02	149.00
	0～14 yr.	21.71	29.43	27.19	28.75	28.55	28.68	28.91
	15～39 yr.	22.32	32.73	45.55	46.41	48.02	48.02	48.07
	40～64 yr.	12.16	16.93	30.30	42.69	43.66	45.12	45.10
	over 65 yr.	2.99	4.11	8.86	18.88	24.95	26.20	26.92
	A	(7)	(10)	(40)	(149)	(271)	(276)	(300)
Percentage	Total population	100.00	100.00	100.00	100.00	100.00	100.00	100.00
	0～14	36.68	35.37	24.29	21.03	19.67	19.38	19.40
	15～39	37.72	39.34	40.70	33.94	33.08	32.44	32.26
	40～64	20.55	20.35	27.07	31.22	30.07	30.48	30.27
	over 65 yr.	5.05	4.94	7.92	13.81	17.19	17.70	18.07
	A	(0.12)	(0.12)	(0.36)	(1.09)	(1.87)	(1.86)	(2.01)

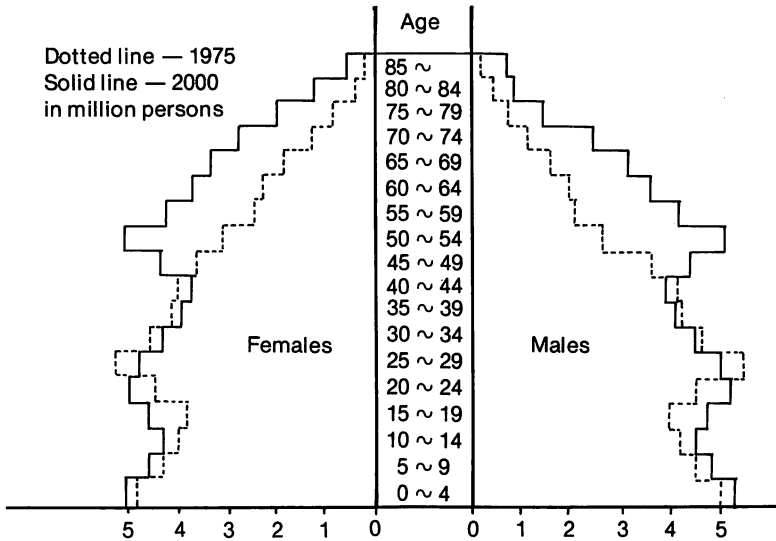
Source: People and Land in the 21st Century by National Land Agency
Note: A indicates the number of those over 85 years old in the group over 65 years.

changes. How to determine the social structure is something that has not received consideration as yet.

Politicians think that there is nothing we could do about it. This is absolutely wrong. When the population of the youth and the middle-aged increases and the old-age people population decreases in number and the population growth becomes stationary at 150 million, how should society be structured? This is something we must consider.

Fig. 17 shows the changes in the actual number and percentage of age groups since 1925. Medical care measures from now on must take this population structure into account. This cannot be achieved

Fig. 18. Comparison of Population Pyramid for 1975 and 2000



Source: People and Land in the 21st Century by National Land Agency

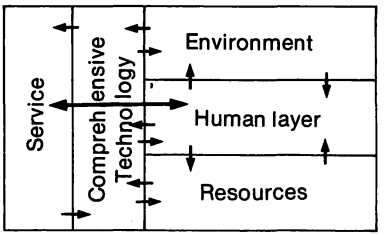
by merely amending the old laws. The age in which we could manage by simply patching up the old laws is gone. We cannot keep ourselves blind to these facts which require an entirely new program rather than revision after revision of the old laws.

This is the pyramid of population change (Fig. 18). The solid line shows the pattern at the time when we enter the 21st century. The dotted line shows the pattern in 1975. We find the pyramid bulging at 60 years and 70 years of age for both men and women.

We must prepare a medical care program by taking into account this "pyramid" in the population change configuration.

Fig. 19 shows how economics and medicine become integrated. In the center is the human layer with the layer of resources below it and the layer of environment above it. There is a feedback among all these layers. Then there are technologies to produce goods and to retrieve the resources and there is a comprehensive technology, which

Fig. 19. Conception of General Economics



laterally moves between "service" and "human layer." All of this may be considered as "general economics."

Today, service economics is broken up into several parts such as environmental economics, resource economics and technological economics. But it is possible to consider general economics with the human layer at its center.

The environment in which we live has been left behind by anachronism in the law and politics. And we have been living in this difficult environment, in which our demands are not heeded to. The Liberal-Democratic politicians often say, "Let's listen to the voices of the people." But this slogan is like a narcotic drug. And we must not allow the people to be addicted by this narcotic technique of the politicians. The people must consider the future with their own offspring: they must try to build the future with their descendants, then their unreasonable desires will be controlled, and thus the desires that help build the future assume a concrete form.

For these reasons, I must say that Japan is undergoing a political crisis. If Japan is to become the Japan of the 21st century, people must unite to make a major effort. And I cannot but hope for the advent of politics that responds to that effort.

Medicine Is the Practice of Humanity

I wish to offer my greetings to the participants in the 9th Instructional Course of the International Society of Aesthetic Plastic Surgery being held in Tokyo.

The view that medical ethics is something immutable is undergoing change. Medical ethics must be equated with humanism itself. Humanism in the west and that in the orient have something in common. As long as medical ethics has its basis in humanism, the guarantee of the right to survive and the right to enjoy health will be recognized globally. At this stage, medicine is a science which serves as an important support for these rights.

Old medical ethics has its genesis in the sympathy for the invalid. It was the basic principle that heightened the social responsibilities of the physician. Today's medicine gives a major support to the rights of survival and health, and the concept of medicine has been greatly expanded. That it has expanded into the micro world has been proven by the development of molecular physiology.

And when we consider problems in terms of molecular biological concepts, we realize that we must think of health also in terms of genetics, morphology and function. Today we have a clear view of the arrangement of genes: we cannot think of health without thinking also of genetics. In functional health, which also includes social health, both mental health and physical health play important roles.

This is an English translation of the lecture given in Japanese before the 9th Instructional Course of the International Society of Aesthetic Plastic Surgery held in Tokyo on August 25, 1977. Reprinted from the *Asian Medical Journal* Vol. 20, No. 7, July, 1977.

When we consider such a concept of health, we find that genetic health has much to do with aesthetic plastic surgery in many areas. As for morphological health, views have varied from age to age. But here, too, aesthetic plastic surgery gives it much support.

Also in the third kind of health — functional health — aesthetic plastic surgery plays a major role.

When we think along these lines, it becomes clear that the concept of health of the whole being of the human individual does have a very close relationship with your field of specialization. In this sense, I believe that the new idea of health has much in common with aesthetic plastic surgery. I am much pleased that such a new field has come into being within medicine to serve the welfare of mankind. The old concept on medical ethics did not include such a new concept of aesthetic plastic surgery as we have today. But this is only an example of the fact that the concept of medical ethics does expand its scope.

In Japan, since olden times, medical ethics has been characterized by numerous meticulous rules that have their roots in oriental philosophy. Humanism in oriental philosophy has dominated medical ethics in Japan. This matter was dealt with by Professor Kojiro Yoshikawa of Kyoto University, who is an authority on Chinese classics, at the 29th World Medical Assembly, in his lecture entitled "Humanism in the Orient." This address, I am pleased to say, left a profound impression on his foreign audience.

I believe that medicine will ultimately develop a new area of medical ethics, whose scope will greatly expand. Medical ethics is an ethics that exists along with medicine, and it is only natural that the development of medicine would be accompanied by the development of medical ethics.

I have been strongly appealing to the world about the problems of the survival order of mankind. I believe that mankind as a whole must realize that medicine is responsible for many areas of the survival order of mankind.

In agricultural society, for instance, the relationship of metabolism between man and the earth was a very simple process. There was hardly any need for medicine to intervene in it. Metabolism

for both man and the earth went on very smoothly because of the functions of nature.

In industrialized society, however, the development of new scientific technologies have produced many substances that contributed a great deal to the survival of mankind. Yet, on the other hand, we have created the problem, for instance, of using up the vast resources of the earth in a short span of time. And now we face the problems of the finiteness of the natural resources of our planet. Nor have we been able to prevent the production of substances that are harmful to human life in the development of chemical industry. And we could not expect these harmful products to be dealt with in the process of the earth's own self-purification. Thus, these harmful substances have accumulated and covered the surface of the earth, creating many forms of what we call pollution to the unfortunate degree of their threatening the survival of mankind.

Old economics was supposed to be able to explain all the economic phenomena in terms of land, capital and labor. But the global activities of industrial science have brought major changes into the metabolic relationship between man and the earth. Such problems ought to have been taken into account as problems not only of technology but also of medical ethics.

What I wish to point out is that old medical ethics is an ethics that concerns the very personal human relations between the physician and his patient. But this must be studied in an entirely new light from the standpoints of public health and life sciences.

I wish to point out that chemical engineering and other areas of engineering lacked the panhuman ethics behind their scientific knowledge, with which they ought to have reconsidered the problems they created. And when industrialization progressed on the world-wide basis, only the expansion of its scale was the goal while no process for reconverting the industrial products into resources was ever developed.

If, therefore, we had had thoughts and technologies based on life science, which produced industrial products from natural resources and reconverted the products after use into resources and if the

economics and technology of reconversion of natural resources had coexisted, then the industrialized society of mankind would have achieved an ethical development. But I have not heard of an ethics of engineering. The fact that medical men have a deep consideration and long perspective of human survival in itself demonstrates the concreteness of medical ethics.

Medical ethics of the future, therefore, must be based on a global, panhuman viewpoint. It must be one in which there is a meaningful relationship between each individual human being and the physician at all times. I believe that we must clearly recognize the fact that the concept of medical ethics today is expanding to a global scale.

And in the interest of welfare with its background of a new ethics we must also realize the fact that such a new area of specialization as aesthetic plastic surgery is making a major contribution to the development of a new survival order of mankind.

In concluding, I wish to say that I consider it a great honor to be able to address this instructional course of the International Society of Aesthetic Plastic Surgery and also wish to offer my thanks to Chairman of Local Arrangements, Professor Omori and Dr. Furukawa of the Organizing Committee.

Aging of the Population in Asia and Oceania and How the Physician Must Cope

It is only natural that the Tokyo Congress of the Confederation of the Medical Associations in Asia and Oceania (CMAAO) should choose as its theme a problem of global scale that is most common among all its member medical associations. The assembly is held biennially, and as organizer of this year's event, I have decided to take up the problem of aging from a panhumanistic standpoint.

In 500 B.C., the average length of life of mankind was, it is said, only 16 years. In Japan, during the recent 30 years in particular, the life span of the people was extended by as much as 25 years. This is not a phenomenon noted in Japan alone but it is a worldwide trend. If the population of the world is 3.8 billion, the problem of aging is one that faces all of these 3.8 billion people.

In the European countries, a major extension of the average length of life was noted during approximately 100 years. This was due to the decrease in infant mortality before the process of aging took place. This extension of life span of mankind has no parallel in history.

One of the primary factors for this is the improvement of the standard of living without which the extension of life span is unthinkable.

For a nation or a region to prolong the life span of its inhabitants, it is necessary for the area concerned to achieve an overall improvement of the standard of living and the popularization of

---

This is the text of the article published in *The Japan Times* on November 24, 1977, on the occasion of the Xth Congress of the Confederation of the Medical Associations in Asia and Oceania (CMAAO) in Tokyo. Reprinted from the *Asian Medical Journal*, Vol. 20, No. 11, November, 1977.

medical care. The improvement of the living standard has been measurably expedited by the process of industrialization. The extension of the life span of the individuals constituting a group, too, is due to these two factors.

After World War II, the world had to take into account the extension of the life span of the people throughout the planet, that is, the problem of the aging of entire mankind. When man notably extends his life expectancy by his own effort, it also means the creation of many new problems. One of them concerns the family system as an element of social order — the problems of the nuclearization of the family and the extended family system as its opposite.

Today families in the advanced nations tend to become nuclearized and in some nations the shift has already been completed. In Japan, the traditional family system has become disintegrated, and there is a rapid trend toward nuclearization. Yet, pressures due to the aging of the population seem to be forcing the trend to make a notable turn.

The percentage of the aged portion in the total population of Japan is steadily rising. In the past, for instance, 13 persons supported one aged person. Today, nine persons have to support one. In the near future, only four will have to do the same.

This makes it clear that, at this rate, our social security system will collapse. At the same time, there are many related problems such as those of employment, industrial structure, etc., that must be solved. This means that it cannot be dealt with only as a problem related to the family system. Because of its complexity, it cannot be discussed without taking into account the development of a new socioeconomic system.

I believe it is possible, however, to draw a certain conclusion by considering human survival in terms of welfare. That is, we can think of what kind of environment, economic system and form of employment that we must create in order to give the aged better conditions for their survival. Then we find that a mere state subsidy cannot really solve these problems. Particularly when the economic

development of the world shifts from the stage of fast growth to that of slow growth, the problems become extremely difficult. And the need arises for a new basis for consideration such as life science. It is on such a new basis that we can provide the aged, as well as youth, with better conditions for their survival. I believe that life science is essential for the survival of entire mankind.

It is from such a standpoint that the Japan Medical Association (JMA) has been holding a life science symposium annually, attended by many experts in fields other than medicine, since about 10 years ago, making it an important basis for establishing its policies.

The CMAAO Congress is a meeting of physicians, but we have social scientists attending it to conduct discussions on these problems in Asia and Oceania. If we in this region can make any progress in identifying the starting point in a new direction in the study of the problems of the aging of population, then I believe that CMAAO will have played an important role.

Life science studies human life at the level of the molecule, the atom, heredity and the survival of mankind on a global scale from a macro-viewpoint. This particular science grasps man not only at the molecular and atomic levels but also in his environment. This is where it promises a major development as a science of the future.

In an industrialized society, for instance, the destruction of the environment is, of course, a consequence of industrialization. Even though industrial production may be carried out in a highly efficient manner, through the progress attained in chemical engineering, the contamination of air and soil and the environment as a whole cannot be neglected. For if it is neglected, the survival of mankind will be jeopardized.

In other words, medicine and public health must become involved in the disposal of the problems of the contamination of the environment, caused by the activities of the early stages of industrialization. Life science must also deal with the problems of the process of recycling large quantities of industrial products as resources. But today, the mass-produced materials are abandoned on the surface

of the earth to pollute the soil, sea water and rivers while recycling of resources is not considered. This is the reason why we have the secondary contamination of the environment.

This means that the primary contamination of the environment occurs with industrialization, and the secondary contamination of the environment occurs with the improvement of the standard of living, following industrialization. If this is the case, we must effect a smooth transfer of materials in the global system of human life by means of the development of a technology and economics of the recycling of resources. This was carried out very smoothly during the period of the agricultural society. But in the agricultural society it was impossible to raise the standard of living. It was natural then that man's life span was very short.

Yet, in the agricultural society, there was no problem concerning earth metabolism and there was no need to worry about the pollution of the environment. This is the basic difference between the agricultural and industrialized societies. It is of vital importance, therefore, to study the role of medicine in these two different social systems.

An agricultural society needs parasitology and tropical medicine, and a very naturalistic enzymology is useful. Medicine in those years was concerned with human beings as individuals. In an industrialized society, however, medicine must deal with groups of human beings, bringing the environmental elements into the picture. And subsequently, medicine went through a basic change.

Human communication in the industrialized society, which is far more concentrated than in the agricultural society, has developed on a global scale as proven by facts. In other words, human beings on the earth become so closely involved with one another that the concept of solidarity among them has become necessary. I regard the concept of solidarity as the new starting point for the survival of mankind.

New demands brought by the industrialized society upon medicine may be summed up as the development of public health and a better environmental science and responses by politics and economics to them.

The solidarity of entire mankind on the earth is an important element for human survival and development. If we are to enhance the solidarity of mankind, we must be able to solve peacefully all the problems that had to be solved by war in the past. To achieve this, it would be necessary to have communication on a global basis with solidarity as its core. It is natural that CMAAO should share a part of that responsibility. And the physicians of the world must be prepared to play the role of the herald of ideals for mankind through the World Medical Association.

Mankind will achieve evolution within this global solidarity and a new start will be guaranteed for the information-oriented society of the future. Health, I believe, is a key element of this solidarity. The regional solidarity of health cannot be achieved by us alone. But the individual's effort must be made within the total framework of the effort of the region, in which the individual finds himself.

There was no such requirement in the human society of the past. History proves that the concept of self-defense on an individual basis has existed for centuries.

In order to achieve such a solidarity and the ideal of peace, it is necessary to discuss the development and allocation of resources for human survival and the development and allocation of medical care resources. This means that we cannot study the questions of solidarity and peace in the Asia-Oceania region without also discussing the development and allocation of medical care resources.

In some areas of this region, acute contagious diseases are found, and such chronic ailments as tuberculosis and leprosy are also reported in some areas. In the agricultural nations, parasite-induced diseases are numerous. And if these diseases are to be found in all kinds of climatic and social conditions, then it would mean that difficulties concerning them must be expected in the development and allocation of medical care resources. Yet, in view of the lofty ideals of mankind, I believe that all the physicians in the region are obligated to endeavor to overcome these difficulties.

In some areas of Asia and Oceania, industrialization has progressed and there are many areas where industrialization is to take

place soon. In view of this fact, we must anticipate major changes in the demand for medical care in this region. The development and allocation of medical care resources cannot be carried out independently of the speculation on the demand for medical care. Here, too, we find the significance of the CMAAO congress.

Thus, in the idea of solidarity must be inherent the element of constant progress, and the inhabitants of the region, too, must constantly attempt at consciousness renovation.

The physician must think of health education not as one for the education of the individual about his health but one that aims at the improvement of the degree of health of a human community. Furthermore, it must move toward the construction of a peaceful society based on a global vision. At the base of all this is the idea of the development of solidarity in human survival. If this were to be the case, then this concept will have a great significance.

It is also to be expected that the substance of solidarity will become highly diversified and multi-structured. I wish to point out that the aging of the population is the most important part of this. And it should be dealt with in relation to the solidarity of peace and mankind. Then such an effort will, I believe, make a significant contribution to the development of the human society. Viewed from such a standpoint, CMAAO is likely to succeed in establishing concrete countermeasures.

From the standpoint of sociobiology, the problem of aging must be considered in terms of social policy. This means that the problem must be considered within the framework of each and particular region. Regional characteristics of aging are the problem which all the physicians in the region must become aware of. Differences in the natural and social environments inevitably parallel the differences in the health environment. This is the reason why there must be regional variations in the research facilities for aging problems.

There are many research institutes concerned with the problems of the aged in the advanced countries. But globally speaking, they are highly maldistributed. Even during the period of the agricultural

society, the extension achieved in life expectancy had no parallel in the preceding history, and this was due to the progress achieved by medicine. If this is so, then the problems of aging in the agricultural society require a handling different from the case of that in the industrialized society.

Characteristics of research on aging in this region must be studied with the aim of finding a key to solving the problems of solidarity in this region. I once studied how much the aged contributed to production in a remote agricultural community that had a very low productivity. If the productivity of a male adult were to be expressed by the figure 10, the productivity of the aged was rated somewhere between 3 and 4, regardless of sex. This was the conclusion obtained from the study on the agricultural productivity of a farming family, which depended on family labor, conducted from the viewpoints of economics and public health. It was also true that the aged engaged in household chores such as taking care of infants, preparing meals and washing, which gave them a purpose in life.

The sensitivity found in the aged about weather conditions was fairly important as a form of technical assistance for agricultural production. A similar condition was observable in the remote fishing villages.

How to prevent the disruption of the health of the aged and how to dispose of their diseases would be an important element in the community medical care of the future in the light of the anticipated increase of the aged population. When these points are taken into consideration, we find it is impossible to disregard the relationship between the biology of aging and ecology. At the same time, the medical care plan in a community must have ecology and life science as its basis.

This means that regional characteristics are not merely mental and physical in nature but they have a great deal to do with employment and economic structure concerning productivity. This is the reason why there ought to be the development of socioeconomic measures besides a comprehensive medical care system. The Tokyo Metropolitan Institute of Gerontology is one example.

The problems of the aged in large cities cannot be solved without, first of all, solving the problems of living space. There are problems facing the aged in large cities, which are entirely different from the problems facing the aged in the farming and fishing communities.

How to solve the problems of living space depends to a great extent on the structure of the buildings in the cities and the structure of the cities itself. There are also major differences between the rural and urban communities in the mental attitude of the aged. The importance of mental health activities in the aged has been recognized throughout the world. I believe that the mental health activities of an individual while he is young plays a key role in keeping his mental health sound when he becomes old. This means that it is easier to adapt the mental health activities for the lower-aged person to their community than that for the aged.

It is a fact that the adaptability of a human being decreases as he grows older, as proven even by serology. Therefore, it is highly important in preserving the health of an individual to preserve his adaptability in his old age. In Japan, the Japan Medical Association recently began tackling this problem in cooperation with the Ministry of Health and Welfare, and the result obtained so far has been very interesting. Concerning the living space, the aged desire a life pattern, in which three generations live together. In such a life pattern, the aged insist on a private room for themselves.

In other words, for the aged, to live with their kind in the same housing unit is a factor for their mental stability. Sharing the responsibilities of a community life with their kin also gives the aged meaning in life. At the same time, if the aged take pleasure in looking after bonsai and flowers, this in turn provides the younger members of the family with sources of mental comfort. This survey found that although the aged have relatively a low adaptability, the problem can be solved by taking proper measures concerning the environment that surrounds them.

It is desirable that the diseases of the aged be disposed of within the family. For that purpose, the younger members of a family

require a health education that would facilitate their understanding of the aged. And this, I believe, would form the common ground of adaptability between the young and the old. The problems of adaptability cannot be solved by the aged alone but also by the efforts of the people surrounding them.

The problems of adaptability for the aged are entirely different from those for the young. In other words, in order to augment the adaptability of the aged, it is necessary, first of all, to improve the conditions surrounding the individuals. Then there ought to be the efforts of the aged themselves and of the members of their family.

There are many homes for the aged throughout Japan, but not much thought is given to the problems of the adaptability of the aged. If anything, adaptability is being handled through the assistance by third parties rather than by their own voluntary action. We must realize that the homes for the aged are not based on the understanding of the true nature of the aging of human beings but the homes for the aged are there merely as facilities for accommodation. I have personally had some experience in regard to this problems, which I wish to relate here.

It has been pointed out that the undereducated among the aged often have difficulty in community living. Community living decreases the adaptability of the aged, causing them serious problems. Without trying to solve these problems, they often point out the lack of efforts by others. And when the second party does not satisfy his desire, he often tends to acquire what he wants by force.

For instance, when old people watch television in a group, the best place is often taken by the strong man among the members of the group. If that particular place happens to be taken by someone else, he is annoyed, and sometimes there develops a physical conflict. This kind of egotism in its raw form, which is the antithesis of the ideal of community life, is observed in all the homes for the aged. This sharply points out the importance of the mental health education to prepare people in their youth for their later age. In such facilities, furthermore, the inmates are not given any opportunity at all to enhance their adaptability.

In Japan, a day care system is about to be considered for the homes for the aged, while facilities are expected to be developed for night care in the near future. The facilities which merely accommodate old people, however, do not hold a key to the solution of the problems of the aged.

In Japan there is also a system of providing special facilities for the aged who are invalids. These are in large part supported by religious organizations, and medical care activities there are not entirely sufficient. In the near future, however, gerontological measures for the homes for the aged invalids will have to be considered.

In some areas of Japan, medical society hospitals have homes for the aged and special facilities for the aged invalids attached to them. The old people accommodated there have good communication among themselves, and their communication with the outside world is carried out through their families. This means adequate measures for these aged invalids in terms of both physical and mental health. Characteristics of the home for the aged attached to a medical society hospital is that the adaptability of the aged is allowed full play there. The special facilities for the aged provide thorough medical attention. I believe that these facilities in question give the aged in Japan the highest degree of happiness.

If medical care activities arise only by demand from the popular masses, as it has been the case before under our system, then the possibility is very small of their solving the problems of the aged population in a community. Although the urgent need for emergency medical care is being loudly talked about in Japan, there is no strong demand for medical care for the aged as yet.

We must realize that human beings inevitably age, and as the population in a community ages, medical care policy, too, must necessarily change. For the long life of a human being, there ought to be a comprehensive plan for providing medical care on a longtime basis. The provision of medical care on a longtime basis means health education for the youth to teach an individual how to prevent the problems concerning cerebral blood vessels or the heart in order to

maintain health. It should be an education which teaches the individual what kind of activities are appropriate for him as he becomes older and what kind of living conditions and attitude toward life are the most desirable.

An aged person produced by this process of education is expected to be different from his counterpart in the past, who had simply come about spontaneously. This means that it is highly important to provide individuals with psychosomatic medical knowledge about preserving their health before they get old and, at the same time, it is highly meaningful to establish a long-term system to accommodate such long-term medical care.

When we consider the problems of medical care for the aged, it is necessary to think of both the young and old people. It is highly inefficient to consider the aged alone, separating them from the young. We must have a goal for the efforts to create a receptacle for medical care. That a young individual inevitably becomes old is the fate of every human being. If it is impossible to escape this fate, then it is necessary to understand the meaning of becoming aged and that of the aged society while one is still not old in order to remain happy when one does get old.

The Asia-Oceania region has many, varied facets and it is multiple-structured. In order to grasp the region as a single entity, therefore, it would be necessary to understand the region from an overall viewpoint as I have done here. For coping with the detailed, particular characteristics of the communities in the region, the medical associations in their respective area must be responsible. The overall understanding of the region, I am sure, will eventually be accepted on a global basis.

Gerontology of the past was primarily concerned with the prevention and treatment of diseases that accompany the process of aging. It was, of course, an urgent need for the survival of mankind. What I wish to stress here, however, is that one must "age healthily." Gerontology from now on must attempt to bring the process of "aging healthily" together with the life of the individual. It

is along this line of thinking that the disruption of health, that is characteristic of the aged, must be considered so that gerontology will acquire a new system. In other words, gerontology must be a branch of medicine that considers diseases on the basis of the structure of aging. The structure of aging must be considered in terms of "aging healthily," and it also must be sound as a branch of science. The study of the phenomenon of aging, furthermore, is one of a general structure, in which we can consider the problems of local disruption. Gerontology is concerned primarily with the problem of healthy aging, rather than the prevention of aging. It should be a medical science concerned with the disruption of health in the aged.

In this sense, studies on the problems of arteriosclerosis, aging of the organs, senile psychosis, etc., conducted separately, ought to be integrated to achieve major advances in gerontology. I believe that the research institutes of gerontology must be developed regionally. For this reason, I expect a great deal in the future development of gerontology in our region, which is rich in diversity and the complexity of structure. Here we can expect highly interesting medical care activities that combine with welfare.

CMAAO has reached the stage where it can establish a new survival order for the region, involving a group of high-age individuals of the kind mankind has never experienced before, by taking into consideration the problems of the aging of the population, regional characteristics and industrial, economic and social characteristics. For this reason, I highly rate this CMAAO Congress as a landmark in history, and I wish it great success.

Educational Activities of the Japan Medical Association

I wish to talk about the educational activities of the Japan Medical Association (JMA). The new postwar constitution of the Japan Medical Association provides for the establishment of a medical education committee, which is similar to that stated in the constitution of the American Medical Association (AMA). Under the American system, the AMA's medical education committee prescribes minute details including the curricula for the medical schools. The JMA's committee, however, can be said to have been an appendage-like type of committee. The reason is that bureaucracy in this country is very strong and the Ministry of Education has a firm control over medical education.

The basic thinking of the general headquarters (GHQ) of SCAP (Supreme Commander for the Allied Powers), which controlled Japan after the war, was to separate medical education from the Ministry of Education. But even the all-powerful GHQ of SCAP was unable to carry out this reform.

The JMA's committee, on the other hand, encouraged education and held educational lectures throughout the country but no major work with a definite purpose was carried out at all.

When I became president of the JMA in 1952, the first thing I did was to establish a system under which we can listen to the lectures

---

This paper is an English translation of the original paper in Japanese which was broadcast on December 4, 1977, over the Japan Shortwave Network, as one of the series of the "Special Medical Courses," and published in *The Journal of The Japan Medical Association,* Vol. 79, No. 2, pages 237 to 241, January 15, 1978. Reprinted from the *Asian Medical Journal,* Vol. 21, No. 5, May, 1978

by professors of universities from whom we have not been taught so far. This was to destroy the academic clique in the medical world, which prevented students from learning from professors other than from those in their own medical school. The idea was originally proposed by President Takeo Tamiya of the Japanese Association of Medical Sciences (JAMS) in 1950.

Medical education in Japan originally followed the German system. This was the biggest problem we faced.

The German system of medical education, which had continued for 70 to 80 years, was replaced overnight by the American system. The American style textbooks were used. Hospital administration was also the same. All this caused great confusion.

In the medical schools also the American system of bedside teaching was introduced. Yet, it is a fact that the postwar system introduced from the United States could not really supplant the German system.

The American system was that a medical school graduate was to take the national board examination after one year of internship. Thus this system was introduced, but the hospitals were not prepared to become hospitals for the interns. If the internship system were to be implemented, there was a need for instructors. But the Japanese hospitals did not have an instructor system. So, what happened was that an intern simply had to learn without instructors and were trained by the physicians whose chief duty to see patients, being taught on the side. In other words, there was no system in this country that enabled an intern to learn from one or two instructors from morning to night as in the United States.

The intern under our system, furthermore, was neither a student nor a physician but a person in between. This ambiguous status created many problems, which turned out to be one of the causes of the medical school dispute that rocked the universities later.

What replaced this unsatisfactory internship system is the postgraduate training system, by which a medical school graduate, immediately after graduation, takes the national board examination

and after that goes through a two-year training period on a voluntary basis rather than being required to do so by law. The postgraduate training hospitals also had no system for providing instructors to the trainees.

What this meant is that medical education in Japan was shaken loose by the American system rather than being reinforced by the introduction of the good points of the American system.

What are the causes of all this? Japan had a well-established, old system of medical education and if it were to be replaced, the relevant laws had to be revised. At that same time, the changes needed for implementing the new system in terms of personnel and facilities did not take place. Nor was there a system preliminary to starting the clinical training program.

By the general attitude of the Japanese that a system is established by merely introducing a new regulation and by the excessive sense of self-importance on the part of the bureaucrats, everything failed.

When we look at today's medical education, I find that it is not medical education of a truly independent country.

The JAMS I referred to a few minutes ago is the academic component of JMA. It held a general medical assembly once every four years but in between it did not do anything. When I became president of JMA, I proposed to the board of trustees that the JAMS be always active. I also reformed the system to convert the JAMS, which had been an extension of the university chair system or lectureship and an embodiment of the academic clique, into a new medical science organization which will be active always.

This new system proved surprisingly successful. The JAMS, for instance, began holding six regular symposiums a year, which helped to make up for the shortcoming in the old lectureship. The symposiums also dealt with subjects not confined to the medical school but dealt with subjects concerning the related sciences. The system, in effect, introduced a new broader horizon in contrast to the formerly narrow-visioned medical education system. The JAMS symposiums, which are of the high academic level, have taken root among the

younger medical scientists, helping their way of thinking about medical organizations.

On the other hand, in addition to carrying out this work there is at the same time the problem concerning those who are going to become physicians and those who are already members of a medical association. For those who are about to become physicians, the Ministry of Health and Welfare has its own policy, which I described before. But as far as I can see, this is a really halfway and inconclusive system. The ministry carries out the system by setting up various criteria. But the thorough-going clinical training seen in the United States medical education system is impossible to put into effect in Japan. Yet, I did find one way of making this possible in Japan, which I shall describe now.

I went to Okinawa at the request of Prime Minister Eisaku Sato to observe the medical situation there. When I spoke with the United States High Commissioner, I suggested that clinical training be carried out in Okinawa by the American physicians.

At that time, about 50 Okinawa students were being sent to the medical schools in mainland Japan on government scholarship. But in some years, none of these students, after completing their study, went back to Okinawa to work as physicians. The main reason for this was that the young doctors did not wish to return to Okinawa where they could not continue their medical studies.

There were also other reasons. But the High Commissioner understood the situation and accepted my suggestion. The United States military hospital was to be used as the place for clinical training for the Japanese physicians. Dr. Neal L. Gault, vice president of the University of Hawaii and a pharmacologist, came to Okinawa with about 10 instructors to work under him.

At that time, there was considerable difficulty in gathering a sufficient number of Japanese students to undergo training in Okinawa under this American system. I had Dr. Gault come to Tokyo and talk with the deans of the medical schools and directors of hospitals to encourage them to send their students. Yet, we were able to see only six or seven students go to Okinawa.

But these students were paid American-level wages to work as real interns while living in decent rooms in the hospital. Because they, like the true interns that they were, lived in hospitals, they were conscious of their being physicians 24 hours a day. And this system gradually came to be appreciated. Today, the number of applicants is several times the number accepted.

What I wish to say is that in Japan persons who had no idea of the superior American system of clinical training used to be in charge of the administration of medical education by bandying about the term "clinical training." And now people are beginning to realize the mistake, though the medical schools themselves have not completely shed their old cocoons. The same may be said of the government. Today, the Chubu Hospital of Okinawa, which I referred to, is serving as a truly important hospital in the medical training system of Japan. This, I believe, is one of the wonderful achievements left in Okinawa by the Americans.

Another achievement is the establishment of the school of health at the University of the Ryukyus which was established to educate health scientists. This was also my idea. For this purpose, we created the New Naha Hospital attached to the university. One year before this hospital was to be completed, however, Okinawa was returned to Japan, and the hospital as well as the university was placed under the jurisdiction of the Ministry of Education. And then it became evident that this university had many up-to-date and superior facilities, which were not found even at the University of Tokyo.

The ministry's position was that a provincial university like this one in Okinawa should not be permitted to have such facilities. Thus, the new program at the New Naha Hospital had to be turned over to the Okinawa Prefectural Government. The hospital today is managed in the Japanese style as the Okinawa Prefectural Hospital.

It was unfortunate that the wonderful plan had to die stillborn, while the Chubu Hospital escaped the same fate after the return of Okinawa to Japan because the American-style training program had been established there before the return.

This means that the Ministry of Education has no capacity to

conduct educational administration in medicine or to accommodate new ideas. The entire medical education system of the nation is centered in the University of Tokyo and the other universities are only appendages. Although there are more than 1,000 universities in Japan, there is not one that has a distinctive individuality.

Under these circumstances, those doctors, who obtained their license many years ago and are practicing now, merely accumulate experience but not new knowledge except those who continue to learn new things of their own will.

Postgraduate training was unheard of among these medical practitioners. Therefore, I started the JMA Medical Lecture Series Program. This is intended for the medical practitioners to attend every five years, and those who take part in this program receive a certificate. The lectures given in the various parts of Japan conducted by the prefectural medical societies are published in one volume.

On the other hand, basic medicine has undergone a considerable change. But basic medicine and clinical medicine are not linked together in the medical schools. So we produced a series of lectures on lifelong education as a means of carrying out lifelong education. We first published textbooks on a certain subject by obtaining the cooperation of the specialist in first-rate universities to provide the medical practitioners with information on the new aspects of medicine, by which basic education and clinical education can be integrated. This, however, was not to give the physicians merely knowledge on technique or facts but to orient them basically in terms of philosophy and way of thinking.

This program the JMA created has no parallel in the world. We have textbooks for this program and we hold lecture meetings for the physicians who will be the leaders in their prefecture, who in turn conduct their own lecture meetings at the prefectural level to disseminate the knowledge among the other doctors. This has greatly helped the progress of medicine in our profession.

When antibiotics were introduced in Japan, it was said that it would take three years before the medical practitioners could make full

use of them. At that time, the JMA decided to hold lecture meetings to familiarize its members with the new concept on antibiotics and their mechanism of action. This proved the start of what has become a successful postgraduate training program for the medical practitioners.

In the case of the antibiotics the knowledge about antibiotics was known to all physicians in the country in six months. This proved clearly that the lecture meetings for the leaders make new knowledge reach the individual medical practitioners throughout the country in a six-month period.

In Japan, however, information in every field travels only in one way, from the university teacher to his students. When a medical practitioner encounters a problem to which his experience and knowledge provide no answer, he has no means of finding an answer such as by the method of discussion.

In the Japanese medical education system, the professor is the god, who has a status entirely different from that of his students. To the traditional Oriental way of thinking, "discussion" which is a two-way communication is unthinkable because it is disrespectful to the professor to do so. This is the reason why there is no discussion for the enlightenment of parties on both sides in our medical education.

The medical lecture program and the lifelong education program of the JMA are both based on the principle of thorough-going discussion among the participants. This is a definite departure from the conventional educational method.

Over the years, this new approach to medical education has brought out to light two types of physicians — those who, encouraged by this system, make wonderful progress and those who drop out. Those who adhere to the old pattern of education cannot make full use of this new system. I think that this is only one phase of the history, however, and whatever happens will have to be tolerated. Time will eventually solve the problems.

The monthly journal of the JMA has also changed in character. Edited on a year-long basis, the journal systematically introduces new knowledge and publishes lectures given at the JAMS symposiums as

well as other papers. It also publishes the proceedings of the scientific and administrative meetings and the minutes of the meetings of the board of trustees. A member of the JMA can keep up with the progress of medicine as long as he continues reading this journal.

The JMA also has the Committee on Drug Information Cards and the Committee on Long-term Measures on Drugs. These committees consist of first-rate specialists who collect data on drugs and study them not only when they are approved for use by the Ministry of Health and Welfare but make a study on them continuously.

We have also published numerous books on clinical laboratory tests. Concerning medical ethics, also, we have published a collection of essays. The academic activities of the JMA are aimed at the medical education of the future, while at the same time emphasis is placed on the development of the character of the physician.

One of the bases of JMA's medical activities is the lifelong education for its members. Under the Japanese system, we cannot do anything in this area compulsorily. Thus, we do not compel our members to participate in any program. Nonetheless, ours is a highly advanced form of education, of which we can be proud.

We make use of the system of providing medical insurance to every citizen, who lives in this country today, though this system itself is imperfect in some ways. For instance, even in one of the remotest corners of the country, we find a clinical laboratory testing center even though only seven or eight physicians may be using it. There are excellent facilities in such areas for the prevention of disease and for treatment. It serves as the center for comprehensive community medical care and, at the same time, as the place for clinical education and training. Medical education, as the JMA sees it, is thus seen in all the clinical activities in which the physician is engaged.

What then should be done from now on? The task for the JMA in the future would be to reorganize the clinical laboratory testing centers and other facilities as integrated technological units and reorganize and allocate them to the communities.

I have been strongly urging the government to introduce many new technologies into the health insurance system, and the government responded. Yet, one obstacle we encounter is the fact that there is an order of ranking among the hospitals such as national hospital, local government hospital, Red Cross hospital, etc., which has nothing to do with the academic order. Therefore, I talked with the people in the government and first of all established the National Cancer Center and also the Adult Disease Center, which are a combination of a research institute and hospital.

I established these institutions to allocate the integrated technological units to the communities, which should be the starting point for what we must endeavor in the future.

The fundamental spirit of the medical education activities of the JMA is to be found in the fact which I have just cited, namely, that the starting point for the future is inherent in the present. We believe that the present education builds the future, but at the same time education of the future builds today's education. According to this way of thinking, we have carried out the educational activities within the JMA, as I have described with concrete details, which, of course, are independent of the government system. Our program does not have to be approved by the Diet, and we do have a truly free academic world of our own.

In this country, in which the strong tradition of the government dominating the private sector prevails, people tend to rely on government power when they face a problem. The educational activities of the JMA, however, are conducted freely according to the conscience of the JMA itself and the main aim is to have each of them be linked with medical care.

The JAMS, the high-level academic division of the JMA, can develop itself through the JMA on a nationwide basis, which is a highly effective means of preventing it from becoming dogmatic. In other words, medical knowledge, no matter how high a quality it may be, must have the support of not only of the academic people but also of the people. This is very significant. This is how we grasp the future

and how we try to determine the medicine of today. Such is the basic policy for the activities of the JMA.

Human Response and Biological Response

It is a great honor for me to be given this opportunity to address this distinguished Technicon International Symposium.

I have observed for a long time the activities of Technicon through President Takeshi Tsubo and have always respected Technicon for creating for itself the vital role of providing information on the state of health of mankind of the present and of the future.

Recently, I was invited to visit the research laboratory of Technicon in the United States and found the basic scheme of the laboratory to be highly superior. There I found that information concerning the human body was presented in a well-organized manner and research being conducted on the measurement of environmental information on a global scale. On the basis of all these, I believe that Technicon is not merely a business enterprise but an organization that has made a major contribution to human existence and survival. In other words, it is playing a vital role in human history.

I have heartfelt respects for such Technicon activities of global significance and this is the reason why I have participated in the symposium every year.

When Mr. Tsubo asked me about the theme for this year's symposium, I suggested the subject of "Environmental Changes and Biological Response," which was accepted.

In the Japan Medical Association, we have a special committee on life science, which is held every year and is probably the symposium of

---

This lecture was given at the Technicon International Symposium on "Environmental Changes and Biological Response" held in Tokyo on July 7, 1978.

the largest scale on this subject in Japan. It is from this experience that I felt that this particular subject must be taken up by Technicon.

I also wish to take this opportunity to express my appreciation for the measuring instruments which Technicon kindly donated to the Radiation Effects Research Foundation.

When the first atom bomb was dropped on Hiroshima, I was working with Dr. Yoshio Nishina. I was sent to Hiroshima to conduct a study there, and I measured in the bones of the victims a radioactivity that was 2,500 times as strong as the natural radioactivity. As of 1945, physicists generally thought that Hiroshima would be inhabitable for 20 to 30 years because of the effect of radioactivity. But as you know, Hiroshima has been rehabilitated magnificently. We must think seriously about the restorative power of natural environment.

I believe it is dangerous for us to consider the problems of human health or human response to environment without realizing this great restorative power of the natural environment. This is the reason why I suggested this particular theme for this Symposium.

I believe that scientists must consider the welfare of mankind as a problem of the future. I believe scientists should deal with the problems of the present while anticipating about the problems of the future. If, on the other hand, the scientists were to deal with the problems of the present without taking the problems of the future into account, it would be impossible to explore the future. It is my wish that life science be developed in such a way that it would make a major contribution to the welfare of mankind of the future.

Today I do not have time to make a systematic presentation. Much of what I wish to say is stated in the abstract. Therefore, I would like now to choose some of the things I have in mind without being bound by the contents in the abstract.

The matter of biological response to environment — this concept of response — has not yet been fully discussed. At present, this problem of biological response is being dealt with only as a superficial phenomenon. This aspect of superficial phenomenon is an important

element of biological response to the environment. But it is not all of the responses.

There are many other aspects in which it can be grasped. One of them is the genetic or evolutionary approach. There is also the approach from the standpoint of behavioral science. There are also many other approaches. In the future, many new studies must be conducted on the responsive function of a biological being. This is my basic way of thinking.

This response, furthermore, must be dealt with as that of the individual, of the masses and ultimately of the entire mankind.

We human beings have our own nationality and there are also national boundaries. The earth has become smaller. Yet, not much thought has been given to the question of how the sense of national identity and national boundary should respond to the present situation, in which the earth has shrunk.

In this regard, I don't believe that international organizations such as the League of Nations of the past or the present United Nations have been successful. I believe that this is the time when we must consider this problems in the most fundamental way. The creation of an organization that reconsiders the problems of national egoism and boundaries from the global point of view is the most fundamental and ultimate form of an organism responding to the environment and at the same time the problem which must be tackled first.

As it is obvious, a single organism cannot exist by itself. This is true with nations as it is true with individuals. This is the reason why we must consider the ways of response in the new era. For response, furthermore, resources for response are highly necessary. These include energy resources and other resources.

One item I wish to take up here now is the concept of information resources. This, I believe, will become one of the most important problems of the 21st century. We have an enormous amount of information today and we also have the problem of selection. Selection of information will be a major problem in the next

century. I have been strongly impressed with the fact that Technicon is concerned with not only the supply of information but also with its selection.

Of the survival resources of mankind, besides information there are many such as those of energy, food, etc. But there is also another important resource we must consider and that is thinking as a resource. It is not sufficient for us to think merely of information as a resource without also regarding thinking as a resource. The fact is thinking is not yet an object of economic consideration. Nor is it considered as a resource. But we would like to regard it as such.

For developing various new resources, it is inevitably necessary to develop new technologies. There can be no progress and development of mankind without the development of resources and technologies. When the development of resources makes progress, the development of technology comes into the picture as a problem.

When we consider these problems in terms of human existence that takes place on the surface of the globe, we find that the agricultural society existed as a part of earth metabolism with an extremely smooth metabolic relationship taking place between the human society and the earth.

After the emergence of the industrialized society with technological innovation, the metabolism of the agricultural society underwent changes. Because of the effects of technological innovation, resources were developed from the deep subterranean layers of earth and, through technology, were converted into finished products.

In this process, we had primary pollution, which contaminated the surface of the earth. This is a new fact we came to face in the phase of technological innovation. This has resulted as a consequence of the process of industrialization. But we must also realize that this had not been predicted at first.

We living organisms must attach great importance to prediction. Speaking from the viewpoint of molecular biology, I think that prediction may be one of the mechanisms found in the gene in terms of the relationship between DNA and RNA. There are many instances

where the RNA receives the reflection from the future and acts and gives something to the DNA.

Viewing these matters from such a viewpoint, it is obvious that when we started to have technological innovation, we should have predicted the problems to arise in the future. But there was no such prediction.

Therefore, I believe that at present we must consider the problem of prediction in the form of "reflection from the future." I believe that human existence would be useless unless there is prediction. This may be an extreme statement. I believe that prediction is vitally important but prediction is impossible with just the mere accumulation of the knowledge of the past. I think there must be provided a new problem.

As I said earlier, the surface of the earth is polluted by the scientific technologies of technological innovation that produces products that are in turn consumed. Phenomena up to this phase were objects of economic thinking. But there has been little thinking about how the industrial waste may be recycled as resources or about the problem of the pollutants spreading over the surface of the earth. It is only very recently that recycling technologies have come to be considered.

When we take this new standpoint, we realize the problem of how to deal with primary and secondary pollution that have been occurring so fast that the environment has not been able to restore itself. This concerns the way of responding to environmental changes that requires our thinking.

What I have said so far concerns primarily the problems that are common to man and other biological beings. In terms of their mechanisms of response, we find two basic concepts. One is that of control and the other of management.

These two concepts have much effect on the human response. These two major concepts of control and management have become increasingly pragmatic, thanks to the development of systems science. I believe that we have come to the stage where the problems of

survival efficiency and security are presented to us in a fairly concrete form.

We must also consider whether the way medicine responds to the problems of survival efficiency and security is proper.

There is much talk nowadays about the problem of security. But the problems of survival efficiency and security cannot be separated from each other. This is where I consider the possibility of the emergence of a new science.

We must not think of human survival in terms of the extension of the existing science. Rather, we must always anticipate the birth of new sciences. We must face the fact that as we live on the basis of the extension of the existing sciences and, because of that, we face a very difficult situation with regard to our response to the environment. This is the reason why I wish to insist that we must regard thinking as a resource.

For instance, it is said that oxygen on the earth in the primordial age was very diffuse. Oxygen became more abundant later. But now with industrialization and demographic changes on the earth, it is once again becoming deficient.

This was confirmed by the late Professor Ukichiro Nakaya, who measured the oxygen content of the ice of the Arctic Ocean for periods in history of every 500th year and found that the oxygen content decreased at a cycle of 500 years in proportion to the extent of industrialization and population increase.

Thus, even with just the problem of oxygen, I think there are serious problems from the point of enzyme chemistry and also from the point of metabolism and there must be applied various thinkings about which I stated earlier.

In the past, we tended to make light of the self-purification function of the environment while paying much attention to the artificial defense mechanism of man to cope with pollution in the environment. But I believe that it is necessary to conduct a deep study of the self-preservative and self-restorative functions of the environment. If we succeed in recycling waste and resources and in establishing an orderly relationship between the surface environment

and the internal environment of the earth, a new condition will be created for human survival on the earth.

So much about the problems of oxygen. Now the question is how we should conduct the development of resources in order to respond to our environment. Development of creative resources must depend on education, training in thinking and technological development. But it is also important to consider that, depending on how we combine these methods and what kind of mechanism we produce on the earth, we may obtain quite different results. Therefore, I think it becomes necessary for us to control the way of thinking that is based on national boundaries and nationalistic egoism and conduct education and training in thinking about resources development on a global scale in our new response to the environment.

The reason why I discussed about human response is that I wanted to touch on the problems of response primarily in the field of medical science of the past half century. Social security is being developed under law in all countries except in the developing nations. Social security is being considered against the background of economics. But I feel that economic guarantee for the survival of man in the future is not taken into account.

I believe that the most important element in our thinking about how we should live must be the consideration of the problem by thinking about a certain thing concerning our future survival and then to dispose of the problems of our present existence by applying that way of thinking. Therefore, we must amalgamate, rather than combine, biological and social factors. In a social security system, regrettably, we cannot find a biological basis. This is because the social security system of today has only the economic foundation. In the thinking on medical security in a social security system, I think medical science is applied indirectly by the way of economics and not directly. This is the reason why I feel that the application of medical science and economics must be conducted in the form of amalgamation and must be considered in the form of medicoeconomics.

In the present situation, we have in Japan five or six different

health insurance plans and there are many health insurance association plans. Various kinds of security is provided only to the members of each of these health insurance associations but not to the members of other health insurance association. It is, in other words, a very isolationist system. The way of thinking is that the whole system is built up by joining together these separate health insurance associations.

This, I believe, is a highly inappropriate system for guaranteeing human survival. Human survival must be assured at the national, regional and global levels. Yet, in a small country like Japan, we have a mutual aid plan, health insurance association plan and a health insurance plan to cover the employees of small enterprises employing more than five persons. Farmers and still smaller enterprises employing less than five persons are covered by the National Health Insurance. Though this insurance is called "national," to my thinking, it is not really "national." There are various other health insurance plans and each Japanese belongs to one or other of the various plans. I do not believe, however, that it is possible to safeguard the health of the entire nation with this kind of a system. A health insurance plan providing medical care benefits only when a patient falls ill is no longer possible, I believe.

We also have the problem of aging. The average span of life for the Japanese has expanded much. The aged population has increased and infant mortality has been reduced very much. With this new situation we must consider the problems of aging in terms of biological, socio-medical and economic bases but there has been not much discussion on how these various bases enter into the mechanism of aging.

It is common knowledge in medicine that aging is dealt with as a naturally occurring phenomenon but I believe that, besides this naturally occurring aging, there are other forms of aging related to economic, sociological and behavioral science factors. To age healthily, I believe, should be the concept of health in aging but it has not gone that far yet.

From the very end of the 20th century to the beginning of the

21st century, in Japan four young people will have to bear the cost of taking care of one aged person, which we expect will create a very difficult situation. There is discrepancy in that, while foreseeing such a situation, we see on the other hand the old health insurance system being maintained and this situation cannot be solved. Globally speaking, comprehensive medical care alone will not prove adequate in dealing with the problems of medical care for the aged when human beings live for a long time. Nor will community medical care alone be adequate. I believe that in this aspect, too, we must have creative thinking.

When we take these problems sufficiently into account, we realize that this symposium will provide a wonderful forum for discussion, for which I am indeed grateful.

I have spoken in a rather disorganized manner, but, by considering the things I just now but are not included in my abstract, I believe that it is not impossible to create more farsightedly and more accurately the solution to the problems of how to cope with the environment of the human beings of the world.

Thank you for your kind attention.

Trends in Public Opinion Concerning Medical Care and Political Response

Views concerning the medical service system in Japan have been increasing in variety and quantity, and it is a high time for us to get them straight out. The reason is that there is no end to these divergent opinions even though one might say that the more diverse opinions there are, the better. Also, self-centered demands made for the sake of making demands does not solve the problems of medical care.

I want to respect public opinion in general. But public opinion in general in Japan is something peculiar. It is formed by the press and some particular organizations. These organizations generally build up public opinion by presenting unrealistic arguments on the basis of a few exceptional actual examples.

Within what we call the medical care system, there is the public health system. In this respect, people tend to complain particularly about pollution & a few other unusual cases. Arguments concerning pollution, which is something that has horrible consequences, have steadily escalated. But the way these arguments are couched increasingly deviates from science in an entirely different direction.

The next problem concerns social defense, as exemplified by vaccination. Problems of this kind have been more or less settled by what we might call "popular strength." Vaccination is a form of social defense and, therefore, individuals, even though they may not like it, cannot refuse it. There is no guarantee, however, that

---

"Special Medical Lecture" broadcast by Nihon Shortwave Broadcasting Co. on March 5, 19, 1978. Reprinted from the *Asian Medical Journal,* Vol. 21, No. 11, November, No. 12, December, 1978.

vaccination by no means causes accidents. Although they are extremely few, they cannot be totally avoided. If this should be the case, there must be a state compensation for any accident. In response to such a demand, much study has been conducted with the result that an accident accompanying such an act as above is clearly of social defense character, and the Government made a decision to employ countermeasures for it.

When public opinion is correctly developed as in this instance of vaccination, it does produce fruit. When arguments are of the kind that produces no meaningful result, they are merely wasted words.

There are many arguments raised from among the people of Japan concerning medical care. But many of these arguments are, in essence, demands concerning medical care by those persons who do not fully understand the fact that they are all beneficiaries of the social insurance system. I think, they must realize that they are making demands without considering the social insurance system.

The complaints from the beneficiaries of a social insurance system and the complaints of general public concerning medical care should be in reality different. However, since all Japanese citizens are covered by their respective health insurance plan, no such difference is observed in their complaints.

When we examine the complaints concerning medical care, we find many of them derive from frustration. These include complaints about a doctor who does not make a house call immediately or complaints of similar kinds.

Complaints also concern economic dissatisfaction. A good example is one concerning the payment of differential — the differential one has to pay for the room in a hospital. There are also problems concerning the cost of the woman attendant a patient employs in hospital. About the "differential" bed, the differential one must pay may range from ¥500 to ¥1,000 and to even ¥50,000. These figures are determined freely by a patient and the hospital, and it is nothing that concerns the health insurance system itself. Nevertheless, there is much debate on this extra-insurance burden on the insured.

On the one hand there is only such a debate, but on the other hand there is no argument on the differences of the insurance burden on the insured. This indicates a gap between my way of thinking and public opinion.

Let me here state my conclusions first. As to public opinion it is dubious of logical precision. Public opinion could be persuasive only if it is logically precise, even though it may have a narrow scope. One cannot have persuasive opinion by merely copying someone else's opinion.

Big-letter headlines in the newspapers also give an impact on public opinion and even the Diet. Yet, in Japanese society there is no place where public opinion may be properly judged on the basis of its substance and not by the size of headlines. This is one of the basic problems of a democratic society.

Political response comes from the Diet, which in turn reflects public opinion. When the Diet discusses issues by representing public opinion as its supreme source, academics have no place to speak up.

Recently, there has been much interest aroused in the emergency medical care system in Osaka Prefecture where there is a movement to enact an ordinance. Active in this movement were leftist organizations, mostly trade unions. What the ordinance in question amounts to, when we closely look at it, is like the wartime mobilization ordinance, which is unthinkable in democracy like the one we have today. I think we must pay attention to the fact that this kind of ordinance, which closely resembles the wartime mobilization ordinance, came out of a supposedly democratic movement in our society.

As clear from these illustrations, public opinion in this country is continuously split and does not produce any consensus — not even in the Diet.

One thing that is amusing is that there are many who maintain that the medical care system in Communist states in enviable. They talk about the state-managed medical care in Communist states. But

there is a tremendous difference between the state-managed medical care in the Communist bloc and free societies. Theirs lags for behind ours in terms of content, structure, etc., as you all know. Yet, there are people who advocate state-managed medical service.

The only country among the free states where state-managed medical care is given is Britain. But in Britain, the state-managed medical care, an escape route authorized by the government has a built-in safety valve, namely that it is the system of free medicine. This is the reason why the state-managed medical care provided in England is essentially different from that of a Communist state. In Britain, professional freedom is recognized while medical care is under state management.

There is also an argument that favors the elimination of the financial burden for a subscriber to a health insurance plan. This financial burden comes, at present, from the differential one pays on the bed in a private or semiprivate room in a hospital. To reduce this extra cost on the bed, however, would mean that all the patients must be accommodated in the same room. There is also an argument which favors the elimination of the cost for hiring a woman attendant for a patient in hospital. This means that the hospital must provide all the services including those now done by the attendants, employed at the patients'/own cost.

In the reality, we still have first-class seats on trains and airplanes in Japan. There are class distinctions in every other sector of life. In a free society such as ours, one should take what one desires. The state should provide basic guarantees, but there should be room for one's preferences. That Britain, while giving state-managed medical care, does allow medical service provided by physicians at their liberty, giving the patient a right to self-guarantee besides state guarantee. This is the way of free states.

Even in these free states, at the time of the inception of health insurance, a minimum level of medical care was provided. But today it is said that the life of human beings is heavier than the earth itself. This means that we cannot make light of the life of a human being and

there could be no such thing as minimum, lowest-level medical care.

When we look at this system from its financial aspect, we find that the insurers would like to make the system as inexpensive as possible. But when you make the health insurance system less costly, it means that the medical care thus provided is of minimum quality.

The director of a certain hospital was chided for having deficits in hospital operations. But this director declared that it he had to lower the level of services in order to make ends meet, he would rather quit his post. This should be the spirit of physicians.

Yet, the spirit of those who call themselves "insurers" regard as their supreme mission the stabilization of the finances of health insurance. Their mission is of an entirely different nature from that of the physician.

The cost of medical care in Japan today is more than ¥10 trillion. In 10 more years it is expected to exceed the ¥20 trillion mark. And it is said that this is terrible. People are told so and they are thrown into a state of serious anxiety.

At such a point as this, there are very few places where the opinions of those who provide medical care are taken up in concrete forms. There is an organization called the Social Insurance Council, where various opinions are aired. Yet, the Japan Medical Association is represented by only one member on the Council.

This council is supposed to discuss the management of the Government-managed health insurance plan. But practically all of the members of the council are representatives of health insurance associations. This is the reason why it is easy to predict how a certain issue will be disposed of by the Council.

Public opinion in Japan is very skillfully made use of by bureaucrats and, as a consequence, people are thrown into the worst possible position. The bureaucrats claim they listen to all the people, but this is not true at all.

Take for instance, the insurance plan for the aged, which the bureaucrats say they will establish. The reason why the Government tries to establish this kind of insurance plan is that the officials want to

relieve the association health insurance plan and mutual aid health insurance plan of the burden of covering the cost of medical care for the aged. In other words, a health insurance plan for the aged is being established in order to perpetuate the existing health insurance plans. There is no room for the spirit of 100 million citizens insuring one another as one unit.

What I have spoken of so far concerns the problem of medical care costs. There is also the demand that when a patient pays fees to this doctor, the doctor should provide him with a receipt. In almost all instances, members of our association issue receipts when they receive fees. Of course, there is absolutely nothing wrong with issuing these receipts. But in many instances the fees a member of the medical association receives is the money that the insurer should receive and not a part of income for the physician. For instance, the cash payment a subscriber to a health insurance plan makes at a hospital or a clinic is not the doctor's income but the doctor is merely receiving the fees on behalf of the insurer. It is strange, therefore, that a physician must issue receipts for the fees which are not his income.

Moreover, when there are reports of a plan to increase the payment of medical fees for health insurance subscribers, their voice is never printed by the newspapers. What the insured are thinking about is never carried in the newspapers while the newspapers carry only what the insurers say. We are willing to listen to what the insurers say, of course, but as long as what they say is concerned only with "stabilizing the finances" of health insurance plans in disregard of the contents of medical care, we cannot deal with them.

What we must give thought to at this point, therefore, is that it is necessary for us to consider two elements. They are economic and medical care problems. Unless these two are synchronized with each other, a medical care system does not work well. If only demand increased on the one hand while there is no system to accommodate it on the other, there is no synchronization. In our country there is so much diversity in opinions that many arguments without synchronization go on all the time.

What kind of problem does this kind of situation produce eventually? Often it happens that arguments end up agreeing with the views that suit the bureaucrats, the insurers, or the real issues are replaced by some irrelevant ones without our notice. This is a ridiculous situation, yet we must remember that such a ridiculousness does arise from confusion in public opinion.

The next problem is the fact that the insurer is the manager of insurance and not a mere collector of money. In many cases the Government is the insurer — a fact that encourages this tendency. The reason why this happened is the fact that we adopted the old German system without modifying it.

The insurer who collects money from both sides naturally thinks that the cost of medical expense should be as little as possible.

People often talk about eliminating wastes in medical care, but I don't understand what "wastes" in medical care means. What they mean by wastes refers to overmedication or the patient abusing his right to see a doctor. What these people say is that patients go to a doctor too often and the doctor gives the patients too much medicine and injections. In any event, this does not explain facts but a fabrication on the basis of imagination. Yet, such arguments fill the newspapers and radio and TV programs.

When this happens, the Diet, which has the supreme authority in the nation, makes decisions by itself without seeking the views of professional organizations. And the members of the Diet seem to feel pretty good when they make laws based on their decisions. But there is great danger inherent in this situation.

This is an old example, but the intern system failed in Japan. This is an excellent example of the fact that a system based on learning cannot be established merely by legislation but it takes five to 10 years of preparation. Yet, this is not understood.

There are many trials and errors by the Diet and by the people. In the meantime, the bureaucrats, too, engage in trials and errors by taking advantage of their position as insurer. These factors make up public opinion concerning the medical care issue. We should be

settling this before long. But just how to settle it — that's the difficult part.

So, I issued a declaration of a state of emergency for medical care. The reason why there is a state of emergency for medical care is that the bureaucrats are trying to toy with medical care when they do not understand the substance of the matter but merely rely on manipulation of laws. They also make a blatant attempt at white-washing the immediate problems by shifting things around within the old framework, established on the basis of the laws of feudal Germany.

All these things lead us to the conclusion that we must present views of an academic organization in a positive manner and to appeal to the people. This is the reason why we have been running full-page ads in Asahi Shimbun to appeal to public opinion, and this has, fortunately, evoked great response.

One thing I have in mind in this regard is that at this time we must stop thinking medical care problems in terms of bureaucratic ideas, which are confined in the pale of archaic social insurance system. I say this because when specialists on this subject within the Liberal-Democratic Party get together, all the ideas that come up are actually made up by the bureaucrats of the Health and Welfare Ministry. They are at least 100 years olds, inflexible, and without forward-looking elements. This means that as long as the bureaucracy's ideas are the basis, the LDP's policy cannot but spoil the next century. Now, the question is how the health insurance system based on the archaic, feudalistic system of Germany must be replaced in a new democracy of our society.

Another idea I have is the fact that bureaucrats are indifferent to changes in the social structure. The present health insurance system was one that was created in an agricultural age, and therefore is not suit for industrial society. Although when this system was created, there was an incipience of the industrial age, but its social structure had nothing to do with the present one.

Another problem is that there is the prevailing view that all of the medical care for the population must be provided by the health

insurance system. This actually means that there is a health insurance system, but there is no real medical care. Health insurance medical care in itself means it controls even extra-insurance medical care without heeding the basic principles of medical care. Medical care must be considered in terms of both micro- and macro-worlds, which are coordinated. Yet, there is no such notion found in the way of thinking about medical care among the Health and Welfare Ministry officials.

I believe that synchronization is highly important. Yet, such a notion cannot be found in the inflexible thinking of the bureaucrats. They do not think in terms of social biology at all, nor do they take into account changes in the population structure, problems of aging, and changes in the social structure.

Since this kind of inflexible thinking develops among the bureaucrats, we must think on our own. The old health insurance system we have today is a residue of the old model, originally established in Germany but has been abandoned in Germany itself. This old system is being guarded by the bureaucrats, with inflexible thinking. This is the reason why when these officials propose, what they call, a new system, it is not at all new but still incorporates the feudalistic elements of old Germany.

How to make an old thing look new depends on the skill of bureaucrats. They do this by reassembling old things. But this operation takes much time, and that time is totally wasted. This is the reason why government and administration in Japan wastes a great deal of time. Bureaucrats do not freshen their thoughts. Japanese bureaucrats before the war were traitorous in that they tied up with the military. After the war, they have pretended to be pacifists and stayed on without being purged out of office.

(1) Attempts to Preserve Association Health Insurance

The officials of the Health and Welfare Ministry want to preserve the health insurance associations and mutual aid association health insurance as much as possible. To do this, they find the aged a nuisance. Therefore, they want to eliminate the aged from the burden

of the association and mutual aid health insurance plans by establishing a separate plan for them. They do not want to spend money on the aged, so they want to dispose of them as part of the "health care" program, not as part of social insurance. This way of thinking is found in what these officials write. We must seriously about whether we should let this go to result in the abandoning of the aged.

(2) Medical Care System to Be Organized Under Health Insurance

The ministry officials also evidently want to organize the medical care and medicine systems under the insurance system. There is, in fact, already a system that incorporates this idea. A drug, whose sale has been authorized by the Ministry of Health and Welfare, for instance, must be listed by the Health Insurance Bureau of the Ministry with a standard price before it may be used by a physician practicing under the health insurance system. In other words, a certain medicine is authorized by Pharmaceutical Bureau for prescription. And yet the same medicine cannot be used for medical care under health insurance unless the director of Health Insurance Bureau says yes. All the troubles concerning medicines today stem from this system.

(3) Insurance Finances Are Top Priority Item

Another problem is the absolute top priority given to the finances of the health insurance system. The purpose of this idea is to eliminate deficits in the system. They do not appreciate how much the deficits have in fact contributed to the health of the nation. Officials think only in terms of deficits as something that are absolutely undesirable. But I believe that deficits have contributed to the health of the people. The reason why I say this is that just about the time when health insurance plans began having deficits, the average length of life of the Japanese people began to lengthen. On the other hand, while the health insurance system was in the black, the life span of the people did not lengthen. Thus, we can say that deficits in the health insurance system are a blessing to the people. I believe it is absolutely wrong that people in general think that deficits in the health insurance system are something that must be eliminated.

A question we face now is how to convert the feudalistic, classic health insurance system into a democratic one. This is a very difficult problem, and if Ministry officials were to discuss this in earnest, their authority would become discredited. This is the reason why they avoid touching on the subject.

It is also a fact that there is a group of bureaucrats who manipulate public opinion by making use of certain newspapers or by putting pressures on political parties concerning this problem of vital importance.

(1) The Insurer System That Ought Not to Exist

I wish to say one thing very clearly: The insurer system cannot exist in a democratic society. The reason is that when there is an employer paying the insurance premium for his employee and his family, it means that there is a master-servant relationship between the employer and his employee and his family. The idea of an employer looking after the health of the family of his employee is admirable. But this is a residue of feudalism. In democracy, the system should be such that the employer gives that much more wage to his employee so that the latter can pay the insurance premium to cover himself and his family.

When we move forward along this way of thinking, we come to the point where we must say that we should not receive any money from the insurer. Instead, the insurer should pay money to eliminate all the problems of environmental pollution within the place of work under his care so that the insured need not spend a cent for it.

The place of work insurance, therefore, is paid for by the enterpriser, as in the case of the workman's compensation system. The workman's compensation law provides for compensation for the worker, not his family. When a man who works at the place of his work returns home, he is no longer a worker but a resident of his community. Therefore, for the worker to abandon the right as a member of his community while depending on his employer does not represent a social insurance system in its pure form.

For all these reasons, we must by all means dismantle the

employees' health insurance system. What we need is a system under which the employee's wage is increased so that he pays his own health insurance premium, while his employer pays for the preservation of the environment. This way, the health of the worker is very well protected locally and occupationally.

(2) Ideas About Establishing Old Age Health Insurance

The bureaucrats are now thinking about establishing a health insurance plan for the aged. This idea derives from the fact that the present health insurance system was created in the days when the average life span of Japanese was only 50 years. Today, many people live up to 80, which means that the present system does not work well. At the beginning of the 21st Century, the average life span would be 80 years old. In such an age, if all the old people were to be invalids, they would create a tremendous problem. Therefore, the health insurance system for the aged and the present health insurance system to cover human beings other than the aged must be separated. One is for the aged and the other the ordinary health insurance.

But for the ordinary health insurance which covers the period during which the human individual grows, there is a fairly long period during which the individual is maintained. And the length of this period has much to do with the aging structure. Therefore, how to grasp the condition of health of the individual during this period has a great meaning. If we are to economize the cost of a health insurance plan for the aged, we must decide how to deal with the growth structure and aging structure of the human individual and deal with these periods both medically and sociologically. This, I believe, is the biggest factor for minimizing the cost of medical insurance for the aged.

When we consider academic bases of health insurance and health insurance plans, we find that the finances of a health insurance plan must be geared to the health of the people. This means that we cannot go by the principle of giving top priority to the finances of a health insurance plan. Yet, this point is not receiving any thought at all.

This means that we must alter our way of thinking. In the past

we were talking about preventing aging. But we cannot stop the process of againg. Aging is a natural phenomenon, which cannot be artificially arrested. There are many academic theories about aging, but none has been firmly established. One of them concerns self-immunization, and there are many others. Yet, there is no consensus. Speaking from the standpoint of the principle of large numbers, there is a period during which health based on the growth structure and that based on the aging structure coexist. This makes it clear how social insurance must be divided.

The problems of health based on the aging structure must necessarily be covered by an insurance plan for the aged. Insurance for the aged, however, cannot exist outside a community. The most basic one is community health insurance. A man or a woman who goes to work in a company or a factory is a member of his or her community when they return home. When they are at their place of work, they are subject to considerations of industrial health; when they are at home, they are subject to considerations of community health.

(3) Emphasis to Be Placed on Community Insurance

I believe that, in the light of these considerations, community health deserves the greatest attention and measures must be taken accordingly. But if a national health insurance plan were to be renamed as a community insurance plan, it would not work and would show its defects very soon.

In community health insurance, primary care is a big problem. This primary care, the first phase of medical attention given a patient, includes many social and medical meanings mixed together. The Government's way of thinking, however, places emphasis only on serious diseases. The Government's attitude is that a patient should pay for himself when his illness is not serious. This policy is pursued because the Government is concerned with the finances of the health insurance plans.

Yet, whether a certain disease is of a serious nature or not cannot always be determined in its initial phase. Therefore, the Government's policy of placing emphasis on serious diseases is unrealistic; it is a

formula drawn up by bureaucrats on their desk.

This way of thinking may also be regarded as an indication of the Government's policy of promoting hospitals, state and public hospitals in particular. All this suggests a serious peril as far as we can see in this system.

(4) Primary Care Is Japan's Pride

The most important thing is to pursue throughly this problem of primary care. Primary care in Japan is provided by a combination of semi-specialists, which is at a high level not paralleled elsewhere in the world. In other words, primary care problems are handled in Japan better than in any other country — Britain, America or elsewhere. A proof of this is the fact that, the other day, an official from the U.S. Department of State came to Japan, and now leaders of the American Medical Association plan to come here to study the matter for several days. If we are to take a constructive step forward, we can do so with primary care. When the gears of social insurance in primary care and that of primary care in medical care mesh, then we have a good start.

(5) Health Insurance Association is Source of Unfairness

Another amusing thing is that this Government's emphasis on serious disease is, as I said before, not practical. Even more ridiculous is the fact that officials of the Ministry of Health & Welfare are insisting on equality in social insurance. If there is unfairness, then where does it come from. It is a fact that this stems from the health insurance association system. The benefits given by the Government-managed health insurance plan, are fair and equal; but the benefits by associations are uneven and unfair. If fairness in benefits were to be adhered to, then the only way to achieve this would be to abolish all health insurance associations and mutual aid societies.

When we consider a single consistent health insurance plan to cover the entire span of a human individual, we find that there ought to be no unfairness in the benefits he receives in the course of his life. Yet, some health insurance associations own bowling alleys and golf courses, for which they pay no tax. While such unfairness is tolerated,

there is much talk about the deficits in the social insurance administration itself. This is indeed outrageous, and yet, this is not talked about. I fear that this state of affairs would lead to horrible consequences.

(6) Fairness and Equality

Another thing I wish to mention here is the matter of fairness and equality. I believe insurance premiums should be assessed fairly. The more one's income is, the more premium he has to pay. This is the fair redistribution of income. But when benefits must be equal, the only way to achieve this equality would be to unify all the various insurance plans. For this, the primary condition would be the dissolution of health insurance associations. But the reform plan by the Ministry does not provide for this.

Another very interesting thing is that the Government, while maintaining the premise that benefits should be equal, it does not allow the injury and disease allowance to be given under the national health insurance plan. That is to say, an individual working for a small enterprise with fewer than five employees, or a farmer — persons who are covered by the national health insurance plan — do not receive the injury and disease allowance when they fall ill and are unable to work. On the other hand, a person covered by the Government-managed health insurance plan or a member of a health insurance association in a similar situation receives the allowance for one year and six months. This is an instance of great inequality.

The Government claims that it will try to remove such inequalities, but this is nothing but a lie. When this injury and disease allowance for 18 months was legislated, I told those Dietmen who favored the bill that in the name of fairness of insurance benefits, the same allowance should be given to those covered by the national health insurance plan.

I think this is very difficult to effect. But if this allowance system were to be preserved, it would require a separate insurance system.

It is natural that we should help make high-cost medical care free to people under a social insurance system. From this viewpoint, I find

that the Government plan submitted to the Diet by Minister Ozawa of Health and Welfare, as printed by today's Yomiuri Shimbun, is a scheme that is most unlikely to last until the next century. Rather, it will fall to pieces two or three years hence.

I believe it is the responsibility of us physicians living in this age to try to synchronize the medical care of the 21st century with social insurance in an entirely new scheme on the premise of dissolving the existing health insurance associations.

The JMA's Health Education Activities over a 20-Year Period

The organization of the Japan Medical Association (JMA) is the most appropriate for developing health education activities in a community.

The program for health education activities is prepared by the JMA's Health Education Committee, which is in charge of this. The Committee is composed not only of medical scientists but also of prominent persons who represent the public, providing forum for thinking about health education in a nation-wide perspective.

The visions thus produced by the Committee are transmitted to the local medical societies, which carry out the program in a manner most suitable to the particular community.

The local medical society is the organization that has the highest responsibility for creating a place for primary care.

Primary care in Japan is under the charge of semi-specialists who have been trained clinically for at least 10 years following graduation from a medical school. These semi-specialists do not merely perform their duties as family physicians but consult other specialists whenever necessary. Therefore, primary care in Japan is provided by a group of specialists at a fairly high level. In this manner, the relationship between the physician and the people of the community becomes very close.

Of utmost importance in health education is the question of in what particular manner the closeness of the relationship between the

---

This lecture was given at the Fourth International Seminar on Health Education and Its Practice in Community Health Care held in Tokyo on September 1, 1978. Reprinted from the *Asian Medical Journal*, Vol. 22, No. 1, January, 1979.

physician and the people in his community is achieved. In Japan there was a time when acute contagious diseases were prevalent, but this was more than 50 years ago. In those days, the physician and the people in his community joined hands to prevent the spread of such acute contagious diseases.

At the time when tuberculosis was prevalent, there was a close coordination in the efforts made between the physician and the people in his community to prevent this disease. An association like the Tuberculosis Prevention Association was created by Dr. Shibasaburo Kitasato. This was a private organization, which served as a bridge between the people and the specialist, and leaves behind a history of playing a major role.

It was twenty-two years ago that I became president of the Japan Medical Association. At that time, I wanted to achieve the following objectives by carrying out a health education program.

One was to establish a bridgehead for health education in a community primarily for the schoolchildren by bringing together teachers, nurse-teachers and school physicians as well as the Parent-Teacher Association (PTA) to solve the problems about school health care. The school physicians were composed of specialists in internal medicine, pediatrics, ophthalmology, otorhinolaryngology and dentistry. We were able to improve the health of the schoolchildren by these physicians holding discussions with the PTA based on the knowledge they gain from examining schoolchildren. Guidance in nutrition was also vigorously promoted in such a manner.

The second was to establish community health survey committees by local governments, prominent citizens and physicians. The work of these committees is to consider the measures for promoting the health of the people of the entire community, which is appropriate to the characteristics of the community. In this, the participation of the people played a key function. The establishment of these community health survey committees, I believe, was the basis for the success of health education in Japan.

In this regard, the JMA conducted several experiments. For instance, the JMA made great efforts to raise the level of knowledge

about health by conducting health education in the isolated, remote areas, where the standard of living was very low, and at the same time endeavored to make smoother the delivery of medical care.

As a result, we achieved the great result of reducing the mortality of infants and young children in the area from 35 to zero in five years. Such an achievement, I believe would have been impossible without the activities of the local medical societies which carried out community medical care and health education together. Another result achieved was that, because of the emphasis placed on the importance of mental health, the psychiatrists came to have much say concerning the mental health problems in the area. The local medical societies, I believe, played an important role in not only providing countermeasures for diseases but also in encouraging the people to be aware of their own health and in teaching them about the concept of health by having the people take the responsibility of protecting their health in their daily life.

It was in such a manner that we reviewed the accomplishments of the first 10 years before thinking about the next decade. In concluding the first 10 years, the JMA published a book entitled "Your Health" to serve as a guide for health education activities in the years to follow.

This was intended to make the people become aware about the concept of health in their own community and think about their health, which is invisible, in a concrete manner. With various statistical tables and charts, this book explains about the significance of health. It was published in order to make its readers realize that, just as their relation to their environment, they themselves live among the problems concerning the health of the individual, of the health of the masses in a community and of the health of the entire nation. We believe that the results of this book were very good.

In the present era, which corresponds to the second era of the JMA, various conditions have improved remarkably due to the improvement of the standard of living, but at the same time, this era has seen the increase of pollution problems, such as air pollution and water pollution, because of increase in industrialization. Thus it has

become necessary for us to make the people realize the problems of health environment. Because of the rapid increase of population on this planet, which is ever becoming smaller, deep thought must be given promptly to the finiteness of resources.

It is a fact that, due to such results, the rate of population increase has decreased considerably. I believe that the rate of increase will become zero in the near future. At that stage, the increase of the population of the aged will be very large. It will be expected that the population structure will be that four young people will have to support one aged person.

The government is trying to devise means for checking the increase of the cost of medical care for the aged population but this, however, is a financial policy for medical care and certainly is not a medical policy. It is necessary of course to have also a financial policy for any medical policy but the purpose of such medical policy must be made clear.

If we are to establish health education in the community while considering the rapid increase of the aged population and the welfare of the aged, we can not avoid touching on the welfare of the aged. The JMA at present is making efforts to increase the number of healthy, not sick, aged people, with the slogan of "aging healthily," and deal with most of the problems of health education in an aging society. This would be impossible if we did not have a health education program to begin with. The reason for this is that one should have the concept of self-responsibility developed from the time when one is young. In order to make it possible for the aged to create their own healthy and cheerful life, health education is absolutely essential. To solve the problems of the mental and physical stability of the aged as well as the problem of how to situate the aged in the society requires our thinking of these problems as those of the entire mankind. This is the reason why the JMA is carrying out its health education program by taking into account the qualitative change in the aged to achieve the goal of making people "age healthily."

It is evident to anyone that chronic diseases in the aged put a

burden on the finances of medical care and we must have the legal people, who neglect the biological factors, reconsider their thinking that financial policy alone is of no use.

It is not only in Japan where a country has financial policies but no medical policies, a problem common to all the countries of the world. The well-developed demography we have today makes it possible to predict the size of the population 30 years from today. It is not impossible but it is difficult to establish long-term economic plans. When we take these factors into account, we find that it is possible to make people live a life worth living when they become old by making them wish, while they are still young, that they will become healthy old people since we all become old.

The government is making efforts to have people live a life worth living but a life worth living is something that comes from the individual's mind or body and that given from the outside is, I think, weak. A life worth living given from the outside has been seen since a long time ago throughout the world in the name of "welfare for the aged" but from now on I think it is necessary to evaluate "voluntary welfare" highly.

Thanks to industrialization, the living standard has been raised, the mortality of the infants and young children has been reduced and the old people live longer. At the same time, people have become too sensitive to the problems of environmental pollution, especially to those of new pollution. With regard to these problems, the JMA is considering such matters as the self-purification function of the environment. We have also been successful in dealing with these problems by increasing the ability of adaptation by man along with the countermeasures for dealing with the causes of environmental pollution.

As for the places for conducting health education, there are the school, community and place of work. The last must be classified into many categories by its characteristics, and health education must be adapted to the particular place of work and must be done by a specialist in industrial medicine. The members of the JMA are all

encouraged to obtain qualifications as industrial physicians and this is making steady success.

In concluding, I believe that the health education activities the JMA has carried out during the last 20 years have been successful in making people highly conscious of the impact of the community on one's health or the relation of health to the community. At the same time, people have come to understand fully the numerous elements required in maintaining and developing health. I have also made it clear that the thinking of the people has progressed to the point that health does not belong to the individual alone but to his family and to his community and is related to the entire mankind. Such a sense of the solidarity of health must be given great attention in health education. When the problems of nutrition, housing and environment is planned concretely, with the concept of self-responsibility and solidarity in regard to health as the core, the knot between the local medical society and the people becomes stronger.

The JMA has sent its personnel to the United States to receive health education and its Health Education Committee is proposing many meaningful measures in this regard. I believe that the fact that the JMA has taken up recently the problems of mental health had a very large impact on school education. It is my conviction that health education can never be successfully carried out without it becoming closely related to the people of the community. I can say also that it would be nonsense to carry out financial policies for medical care without first establishing visions for health education.

The beginning of the 21st century will be faced with many problems, including those of resources and of health. Also in order to be ready, I hope that peace and welfare of mankind will be increased greatly by establishing concrete measures for health education from the global point of view with the cooperation of entire mankind.

The Main Points of Revision in the Health Insurance Law as Seen from Academic and Social Science Viewpoints

When we consider the problem of revising the health insurance system, we find two major elements.

One is the social science position from which to consider the revision. The other is the viewpoint of medical administration. Unless these two elements become completely unified, it would not be possible to manage a health insurance system. If consideration from the social science viewpoint alone should receive attention, it would mean neglecting the position of medicine. The most serious problem would be that the financial problem becomes the central issue. Yet, considerations from the medical standpoint are given a stutus secondary to the financial question. This is the way the health insurance system is today, and this is the reason why almost every year or every other year, we must revise the Health Insurance Law under the slogan of "conducting a radical revision."

I have considered the problem in various ways. First of all, I wish to probe what we might call the genealogy of this problem. The basic concept of insurance is the dispersion of risk. If one's home burns down in a fire, he may not be able to sustain the loss. But if he had a

---

This paper is an English translation of the original paper in Japanese published in *The Journal of The Japan Medical Association,* Vol. 80, No. 7, pages 909-913, October 1, 1978. "Special Medical Lecture" broadcast by Nihon Shortwave Broadcasting Co. on September 17, 1978. Reprinted from the *Asian Medical Journal,* Vol. 22, No. 2, February, 1979.

fire insurance policy, then it would be possible for him to have other persons to share the damage.

In the case of loss by fire, however, it is possible to recover it with money through this system of dispersion of risk among the persons who also take out fire insurance policies. This means the full dispersion of risk. When we deal with material things, it is possible to have an adequate insurance system by means of the payment and accumulation of premiums. The most important point we must note is the fact that here the concept of dispersion of risk is its basis. Furthermore, in the case of fire insurance, there are individuals who want to share the risk by paying the premium.

Fire insurance is a voluntary insurance while there are other compulsory insurance schemes. The difference depends on whether there are individuals who feel the need for insurance to disperse the risk of a certain kind.

The health insurance scheme, in which the insured pay the premium and disperse the risk among themselves, was conceived of by Bismarck of Germany more than 100 years ago. A health insurance system is designed against a prescriber's falling ill. Like a fire, there is no way of foretelling when one might become ill. It was indeed a great idea to regard the illness of an individual as an unforeseeable risk like a fire. If we were to call something the first medical care revolution, I would without hesitation choose this health insurance system.

Bismarck called this medical insurance "social insurance," which must be conducted on a society-wide basis. In other words, such a health insurance scheme must cover all the individual making up a society. We cannot have an insurance scheme covering only the unhealthy. Then many subscribers may become ill and the system will not work because the premiums collected from them would not be sufficient. On the other hand, we cannot exclude those members of society who say, because they feel they are healthy, they would not need health insurance. This is the reason why medical insurance must be compulsory.

In a very early stage of this system, a business enterprise had its own health insurance association of the employees. This was

unavoidable in the early stages of our health insurance system. But this cannot be called a social insurance system.

At any rate, this is the reason why we have so many health insurance associations comprising the employees of individual enterprises. But there is no lateral relationship among the associations. The individual associations are not concerned about others; they are merely concerned with the question of whether they themselves are viable. This means that a society in which these separate health insurance schemes exist cannot be said to have a social insurance system.

Later, however, the idea of insurance spread gradually, and even very small businesses and self-employed persons like farmers became subject to the insurance system.

In postwar Japan we even had a health insurance scheme covering day laborers, thus insuring all the citizens of the country for medical care. Yet, the system was not one of social insurance. The fact is the old health insurance associations for the employees of business enterprises make up the major portion of the system.

When we analyze in terms of social sciences this association health insurance, that is, intra-enterprise insurance, we find that this kind of enterprise-based insurance is not social insurance. To include these insurance schemes in the nation-wide social insurance system was a serious remission on the part of the Japanese Government, which cannot be rectified. The fact that this serious remission was left intact for a long time in itself created a serious problem.

Because of various causes the social structure of Japan has changed. Before the war in Japan we had a health insurance system, which was under the rule of the military. After the war, however, Japan became a democracy, in which the people are sovereign. The civil code and penal code as well as the Constitution were drastically reformed. And yet the Health Insurance Law was not amended at all and has remained the same old feudalistic, bureaucracy-controlled law. Here is the basic reason why we must stress the fact that the health insurance system we have today does not suit democracy.

The second point of importance is that the industrial society of

the age when Bismarck conceived of health insurance was an infantile one in terms of the level of technology and the scale of enterprises, compared with today's industrialized society. The old enterprise-based health insurance scheme does not work in today's large-scale industrialized society because of the difference in environment and in the principal insurers. The old scheme was unable to make appropriate adaptations to the modern industrialized society.

The system was extremely primitive in terms of social sciences because the old enterprise-based insurance system was designed for promoting labor relations at the same time. In the earlier years of health insurance, labor relations were not at such a level as to be carried out separately. Therefore, in those early years, it was possible to combine labor relations with enterprise-based health insurance. Today, however, the labor laws have very specific countermeasures for the maintenance of the health of factory workers on the basis of labor hygiene.

As it is clear from the above, the most urgent task for us is to realize that the health insurance law has been preserved intact without modifications in response to changes in society. This, I believe, is the best illustration of the negligence on the part of the party politics of Japan. What is important to point out is that the politicians skirted this crucial problem. This is due to the fact that Japanese politicians have not undergone training in social sciences; they had no understanding of the progress of science and technology and of the profound changes that have occurred in terms of environmental science. I believe we should interpret what has happened as an indication of politicians having been buried in outdated law rather than having been preoccupied with the importance of law.

Today, we have problems such as industrial poisoning and other forms of pollution, which must be considered separately from the framework of the old health insurance system. These are problems for the Environment Agency. But the very origin of these problems is the industrialized society. One thing we cannot avoid giving serious thought to in this context is the increasingly important problem of environmental science in an industrialized society. This problem is

exclusively the responsibility of the enterprises and, therefore, it is necessary for us to consider an industrial health insurance system and closely re-examine enterprise-based health insurance.

If the enterprise-based health insurance scheme is in an isolated condition, it is unable to make any meaningful response to changes in its environment. All it does is to collect the premiums in the same old manner as before, minimize the payment for the medical care of the subscribers and accumulate wealth as much as possible. This is a highly "unpublic" scheme. This means that a system that was public in nature to begin with has turned into something that is highly "unpublic" because of changes in the objective circumstances as time elapsed.

Another major problem is that the social basis of disease has undergone a profound change. Neurosis, for instance, was not recorded in Bismarck's time. Today, it is a very serious problem. We have many old industrial diseases, but today there are many new industrial diseases, too. This is particularly so because of the diversification of chemical industry, which has given rise to a large variety of industrial diseases. With regard to this problem, the Labor Standards Law plays an important role. But the Health Insurance Law itself assumes no responsibility concerning diseases that occur within a workplace.

This means that while at the time when the system was established, the health insurance scheme covered all the diseases whose causes were found in the workplace, today such diseases are handled separately under the Workmen's Compensation Insurance Law. This is to be expected in terms of labor management and also as a response to the progress of chemical industry. Yet, despite the introduction of this Workmen's Compensation Insurance Law, the health insurance system itself has remained unchanged. Furthermore, there is no benefits provided by the health insurance scheme to supplement the coverage by the Workmen's Compensation Insurance Law. This is because the workmen's compensation insurance is provided by the employers who are under the supervision of the Government. This means that workmen's compensation insurance is administered on a

peculiarly Japanese basis without any relationship with the enterprise-based health insurance system.

In the light of this, we can say that at the time when the workmen's compensation insurance was instituted in Japan, the health insurance system ought to have been revised. But again, this, too, was overlooked by politicians. This is the reason why the health insurance system alone was left behind without being modified to suit the changes in society. The system we have today is one that does not respond at all in terms of medicine, social sciences and the practical aspect of industrialized society.

After the war the idea of social security was introduced in Japan, and a social security council was created. This council submitted its first recommendations in 1950. But social security must be predicated on the concept of survival security, which, of course, does not exclude the concept of dispersion of risk, but this alone is not enough. Survival security is a requirement far more important than the dispersion of risk. And yet, this was overlooked by Japanese politicians, who have always skirted the issues that touched the real substance of health insurance.

This is due to one reason, namely, the association health insurance based on individual enterprises is an extremely wicked system. The scheme becomes established within each enterprise and maintains a very close relationship with the employees' union of that enterprise. What happens is that the health insurance association of an enterprise acquires a huge profit, which is tax-exempt, and the members become a privileged class that colludes with the employees' union. This, I believe, is an indelibly tarnished spot in the political history of Japan, that was left untouched by politicians.

Its consequence, furthermore, is that because of the existence of such affluent health insurance associations of large business enterprises, other health insurance plans like the Government-managed plan or the National Health Insurance Plan, which cover the underprivileged segments of the nation, are approaching bankruptcy. The reason is that in these poor health insurance schemes, the poor are insuring one another while the health insurance associations of larger enterprises

become increasingly more affluent as they gain more profits thanks to the economic growth of Japan. In other words, this is a system in which there is no income redistribution. Such a social security system cannot be approved anywhere else but Japan.

In 1971, we of the Japan Medical Association, fought with the Liberal-Democratic Party (LDP) all the way to have the party promise that it would clarify these points to the public. Yet, the Liberal-Democratic Government has done nothing about the promise. Later, during the Sto Cabinet days, we withdrew from the health insurance scheme for a period of one month in a clear confrontation with the Government, which had to admit its own failing. Still, the LDP has done nothing to implement its promise.

The reason for this state of affairs is that the health insurance associations, in collusion with the employees' unions, have come to possess such a power that the bureaucrats become extremely hesitant about parting with it.

The labor unions, too, in collusion with the capitalists and bureaucrats, find it impossible to part with this enterprise-based health insurance system so long as it is a means for acquiring huge amounts of funds. The LDP, which is a party that thrives on political contributions, pays the utmost respect to the health insurance associations. It may be, therefore, natural for the LDP to skirt the issue. But we do not think that the top leader of the LDP can be tolerated for maintaining such an unscientific and unacademic system.

Another major problem we must face is that of the lengthening of the average span of life. When Bismarck considered health insurance, the average longevity of human beings was about 35 years. But today this has been about doubled. This means the question of what we must insure ourselves against. The most serious problem is how to maintain the health of aged persons, that is, the question of how to prevent the diseases that are due largely to old age.

The association health insurance plan rules out the aged because the subscribers do not receive any benefit from this scheme when they leave the place of their employment upon reaching retirement age.

These people who retire from companies are covered by the National Health Insurance Plan or the Government-managed plan. Because of this system, the Government-managed plan is perennially in the red, and the National Health Insurance Plan must be subsidized by the Government up to 45 per cent of the benefits it gives out. And yet, the ruling party refuses to face the problem of the redistribution of income, which actually means defaulting its responsibility as a political party.

In the face of such a situation, we gave thought to the possibility of the aged population greatly increasing in the future and realized that it was necessary to keep the aged as healthy as possible and to make effort for that goal. As our standard of living rises, the aged population will increase. Therefore, it is of basic importance that people give thought while they are still young to not falling ill in old age. This is the basic concept of survival insurance. And this is the reason why we conceived of a health insurance system for the aged to provide primarily preventive benefits to the insured.

The insurance scheme for the aged the Government had planned and we, too, had thought about was one that would provide free medical care to the insured after they reach the age of 65 or 70. But this is not what we need. Rather than the idea of providing free medical care only after an individual falls ill, what we ought to have is an insurance plan that provides preventive benefits to keep the insured from becoming ill. This is what ought to be provided in terms of both science and the idea of the protection of the rights of the individual.

And that is the kind of health insurance for the aged we have proposed this time. The community insurance system provides primary care. No matter where one may be employed, one belongs to a particular community. The workplace has its own peculiar conditions, which necessitate labor management and workmen's compensation insurance. But these are to be separated from a health insurance system. Because we believe that it is about time that we removed elements of labor management from the health insurance system we have for employees, we proposed a separate industrial health insurance

system. This is to be established with the existing workmen's compensation insurance system as its core. For Japan's further development as an industrial nation, this system is expected to be highly effective.

When we consider community medicine, that is, primary care in terms of the regionality of health and disease, we come to face an entirely new vista. Here, our proposal is to have the insured start paying the premium at the age of 25 for preventive benefits to be given after the age of 40. When this is put into practice, it would be highly effective in preventing chronic ailments of the aged, as has been proven by experiments.

When we view the medical care of the 21st century in a long-range perspective, we find that the system we proposed must be instituted now. Otherwise, it would be too late. In the next century, three younger persons will have to take care of one aged person. Now is the time when we must start building up the health of the aged.

Japan's Medical Care System from the Long-Term View

I am indeed honored to have this opportunity to give this special lecture at this 32nd General Meeting of the Federation of Prefectural Medical Associations of the Tohoku District.

My talk for today is on the medical care system of Japan from the long-term viewpoint. Recently, it has become necessary to consider all problems from the long-term view, in order that difficulties may be avoided and there has been a cry for more and more long-term thinking. As an example, Prime Minister Fukuda's tour of the Middle East was from the policy of securing long-term supplies of oil. His tour of Europe also came from reasons attributable to long-term policies. I think it is quite natural for the politicians, who are the first to jump on anything, to jump on the matter of long-term policies, however, it is also characteristic of the politicians to jump without producing fruitful results. I believe that it is the private sector that jumps in and comes up with good results. At the time of the Sendai earthquake, it was the private medical institutions that rushed forward initially, being followed generally by public medical organizations. I have just heard that government offices do the least and this is quite the case in general in Japan. If we are to consider the case of medical care along these same lines, on the long-term basis, it would amount to something awful.

In considering the medical care system, it becomes necessary to

---

This paper is an English translation of the original paper in Japanese published in *The Journal of The Japan Medical Association,* Vol. 80, No. 7, pages 914-921, October 1, 1978. Reprinted from the *Asian Medical Journal,* Vol. 22, No. 3, March, 1979.

reflect upon the history of the past. As to how the reflection should be made, let us envision the time when Japan's medical care system was formed with the aid of Western medicine. While I most certainly recognize the great achievements by persons such as Tomoyasu Sagara, who ventured into German medicine, the government's decision to accept it was a great fete in itself, worthy of high praise. It is quite doubtful that the Japanese government of today would have the guts to make that kind of decisiveness, and the Meiji Regime, which took action on the advice of Tomoyasu Sagara, the Tomoyasu Sagara who was supposed to have been pushing German medicine, most certainly must have been looking at the world 100 years beyond their time. You can see from this that observing matters from the long-term view is not an attitude that was created today but one that existed even in the early days of Meiji, which is a fact worth thinking about.

Furthermore, the long-term thinking in the days of early Meiji was performed by responsible persons, in responsible positions. When sitting in a respectable position, each person maintains the face of a responsible person, but when a certain Watanabe becomes the Minister of Health and Welfare, it is like having a Minister of Health and Welfare without a brain and accordingly he is nicknamed "brain-lacking illness," and in the presence of this type of a person, all the great thinking of the responsible persons go to waste. It is necessary that a responsible person must possess professional education. The success in the long process of the Meiji medical care policy finds its base in the long historical foundation. It succeeds the tradition started by Ogata Koan and encompasses the group surrounding Sensai Nagayo, who became the first Director-General of the Bureau of Hygiene and Sanitation. These people were all physicians and government administrators of the highest level. They were the highest ranking leaders of the academic world, and, at the same time, were government administrators. In Japan today, a physician, no matter how brilliant a Diet member he is, cannot be appointed to the position of the Minister of Health and Welfare by the Liberal Democratic Party. This is because the fairness and impartiality of the office will be destroyed, according to the Party's thinking. Whenever politicians,

who are the roots of unfairness tries to do something right, fairness becomes lost, and this sort of loss of sense of direction which prevails in Japan today, I believe, cannot be stopped. When long-term viewing is maintained, as it was during the early Meiji Era, such is bound to succeed.

The Tokyo Imperial University was established and in it the medical school was set up in the form as it is now and a network of national and prefectural hospitals was set up. On the other hand, the "Saisei Gakusha" which trained physicians and through the national examination system produced many private practitioners. From a matter of social needs, the fact that the Tokyo Imperial University could not meet such needs allowed the existence of the "Saisei Gakusha," and with the Tokyo Imperial University with its high level of education, followed by the establishment of many medical schools in the imperial universities in the other parts of Japan, followed by the establishment of special medical colleges, there was no need for the "Saisei Gakusha" and by that time it disappeared. It is evident from this chain of events that qualitative improvements were originally planned in the long-range view. It is my firm belief that a long-term plan, lacking in planned qualitative improvement, is quite meaningless.

Then, how does one go about making future progress within a long-term plan? The biography of Shimpei Goto is one of my favorites and while the field of ecology was not completely understood in his days, the thinking of Shimpei Goto is clearly along the lines of today's ecology of the Haeckel school and is thus incorporated in the policies of Shimpei Goto. With Sensai Nagayo in the center, Shimpei Goto being the youngest, with people like Shibasaburo Kitasato in between them and as private persons Yasushi Hasegawa and others running the "Saisei Gakusha," the educational facilities were expanded and the educational level was raised.

This, I perceive to be an ideal example of history concerning the diffusion of medical care. And, amidst the efforts to prevent and suppress contagious diseases, the Institute of Infectious Diseases was

established. It is wonderful the way they met the social needs of the time. Further, to check chronic illnesses like tuberculosis, the tuberclosis prevention associations were formed by the joint efforts of private and government interests. Today, we talk about community medical care and comprehensive medical care, but in reality, the physicians of the Meiji government had already succeeded in carrying out their thinking on regional medical care under the comprehensive medical care system for the entire Japan. We are now confronted with the responsibility to find out why this successful history disappeared and was lost.

We now wonder, then, why did this spirit stop in its tracks and did not continue, and I would venture to state that in the first place the leaders of the Japanese medical society disassociated themselves and became isolated from the government. The bureaucrats controlled the medical care programs and the Director-General of the Bureau of Hygiene and Sanitation was a bureaucrat. Later, Chikahiko Koizumi was appointed the Minister of Health and Welfare, but since this was under the military rule, the situation was somewhat different. It is my belief that, when the medical care program was forcibly taken from the hands of the physicians and handled as one of the many legal matters, the cause of the medical care policy of Japan going the wrong way was created. It was not only the medical care policy, but in all aspects and policies this change for the worse was brought about.

When we read the ecological ideas of Shimpei Goto, one sees much about the concept of metabolism. The great idea of Shimpei Goto lies in grasping society as a dynamic metabolic society, on the pre-requisite that our natural surrounding is in a state of constant metabolism. And, his grasping of the progress of society in the form of a product of metabolism is a point of greatness surpassing many centuries in thought.

Considering these matters, it can be said that Shimpei Goto was a clinical physician. He then turned a politician and Minister of the Interior. He was even appointed Minister of Foreign Affairs. He is credited with great accomplishments as the Minister of the Interior,

and as the Minister of Foreign Affairs he had Mr. A. Joffe, ambassador plenipotentiary of Soviet Union, come to Japan and negotiated for the purchase of the Maritime Province of Siberia, which was indeed a daring venture, but this is an extraordinarily characteristic idea in terms of the history of political thought, in that Shimpei Goto, as explained earlier, tried to create a new channel by making two metabolisms clash against one another. Shimpei Goto, after some time, became disgusted with the corruption of politics and passed away, but whenever I study the medical care problem, I come to realize that Japan's medical care system has shown no progress at all since the death of Shimpei Goto. It was Shimpei Goto, who introduced the medical health insurance system. Shimpei Goto went to Europe and was greatly impressed with the German health insurance system and wrote about it to Adachi, the Minister of Interior, and Shibasaburo Kitasato, including even a letter of recommendation. This recommendation is said to be in the library of the Juntendo University, which was once in the possession of Dr. Tasuka Yamazaki.

Accordingly, we must put our thinking together that this concept of Shimpei Goto's can be applied towards all and many different fields. I recently read a book entitled "Ecology of Economical Progress." This book was written by a person of Oxford, and also a professor of the University of Tokyo has written a book with a title of close resemblence, Ecology of Economic Development. From these facts, it is perceivable that the attitude of Shimpei Goto, in his endeavour to realize the dynamic grasping of society ecologically, is found not to be anything old or obsolete in the eyes of the economists of today. These are the points that compel myself to have a great respect for the thinking of Shimpei Goto, who was basically an ecologist.

From that point, we entered into the era of the government control of medical care, and the characteristics of government control over the medical care finds itself in the legal arrangements. This means controls through legislation. Bureaucrats do not consider about

medical science or the techniques of the physicians; as long as a closely knit network of legislation exists, preventing any legal inadequacies, they think that the matters have now been corrected. Therefore, an active and dynamic manner of thought does not enter into the thinking of the lawmakers. The lawmaker's closely knit laws breed the thought of total neglect of social dynamics and considers society as one of continued static nature and considers only the narrowmost application of medicine towards society. It is almost resemblent of totally fixing the schedule of the National Railways. It is meaningless to fix the railway schedules, as they must be flexible to meet fluctuations of the seasons and increase of passengers and would have to change when the income of people double. The bureaucrat's concept is like fixing the timetables of the National Railways; that the trains will run when the time comes, regardless of whether there are any passengers or not. The fact that the physicians had tolerated with this type of concept is something that is worth studying deeply and retrospect.

There is another story that I came to know on the important thought of Shimpei Goto. It was the year of the great Kanto earthquake when I entered the premedical class of the Keio University Medical School, and in the following year I had the occasion to visit Professor Goto to ask him to come and lecture at Keio. Professor Goto asked me to come into his house. As I was quite timid at that time, and since this was the house of a great person, I hesitated to enter the house. "When the master of the house asks you to come in, you do as you are told!" When I entered the house, a large map of Tokyo was hung on the wall, which showed even the Chuo Line going through underground passageways, all linking with the subways, where I was shown that you can change lines at one place, from where you can go in all directions and that this plan would cost some astronomical amount of 20 or 30 billion yen. Another thing that surprised me was that the Tokyo Bay would be filled in after that, but this story of Shimpei Goto's filling in Tokyo Bay turned out not be a mere bragging hoax. At the time, I listened with half belief and half doubt, but as it turned out, it is far from being a hoax and the matter is now

under serious study. Immediately after the war, Premier Yoshida also thought of a plan to fill in Tokyo Bay and made serious studies by inviting two men from Holland who were supposedly the world experts in filling reclaimed land. You can see that great men look 100 years ahead and think accordingly. Bureaucrats can see and think only two years ahead. Those at the Ministry of Health and Welfare today are "two-year men." When they are given a promotion, it is usual that they stay in that position for two years and, therefore, measuring everything on the basis of two years is enough. As a result there doesn't exist a long-term policy.

Today, we have a system called the National Pension Program but five years from now it is evident that it will collapse. The people at the Ministry of Finance know this too. The various mutual aid associations, including the National Railways Mutual Aid Association, are so heavily in the red that there is nothing to save them. The National Railways Mutual Aid Association expanded immensely after the war and with the increasing number of people retiring, it cannot pay the pensions, so, in each ticket you purchase, there is included a portion of money to pay for the long-term benefits of the National Railway Mutual Aid Association, which is absolutely ridiculous. Mutual aid associations are the ones which should consider matters in the long-run more than any other organizations. However, while this is well known and understood, there is nothing they can do about it. And, in the same fashion, all the other mutual aid associations will collapse, and the Ministry of Finance bureaucrats all know this. But, they do nothing. Within the Ministry of Health and Welfare, problems are arising, in that some of the health insurance associations are now slightly in the red. The number is still small, but it is happening. The bureaucrats are playing hands off and are advising that the respective health insurance associations help each other, while they play the game of extending their policies at intervals of two years.

Now, the draft for the revision of the health insurance law drafted when Ozawa was the Minister of Health and Welfare was the one that was drafted during the days of "no-brain disease" when Watanabe was the minister. The thing that I find most disagreeable is

that there is no long-term thinking or planning, and when people live to the ripe old age of 80, as they do today, their thinking is still unchanged from the time people were dying at around 36 or 37. The only change is in the manipulation of the legislation, which will tide them over during their time in office without creating too much trouble, which I call impudent, but not ignorant. Mr. Ozawa has been very successful in politics as a government official, who is far from being ignorant, but has certainly developed into a crafty politician. As there are no long-term plans in the draft, I think that there was an all out effort to pass it regardless of consequences.

As far as we are concerned, we question the necessity for any basic and drastic revision of the health insurance law, as far as they are only interested in the financial policy of the government controlled health insurance program. There are 7 or 8 associations, including the mutual aid health insurance, government controlled health insurance and national health insurance groups, but they are interested only in supporting the government controlled health insurance, which is the more troubled financially and desire to reinforce financially the health insurance system for the low income group. Here, the reinforcing is done not by obtaining funds from the national budget, but by changing the health insurance law so that it will be difficult to visit the physician by making the patient himself pay more for the medical bill. In this manner, if the visits to the physician can be discouraged, the health insurance associations will also show great approval. The health insurance associations that are doing well financially can discreetly return any excess to the insured, but for the associations that are in financial trouble, the idea of discouraging the insured from visiting physicians would be a great relief. I can understand why they are smiling.

Then, when it comes to the Diet members of the Liberal Democratic Party, this is a party which pushes legislative revision bills as their own although it was drafted by and large by the bureaucrats and behaves in complete reliance on the others, petty bureaucrats in particular. My thinking is that the Liberal Democratic Party should be

called the "Unliberal Government Official-Oriented Party," which should adequately describe its character. The intelligence inherent within their own party is totally disregarded. There are ten physician Dietmen in the party, but not one of them were consulted while the revision bill was drafted. Both Dr. Oishi, who previously served as a minister, and Dr. Marumo, who was also a former minister, were circumvented. The party would have nothing to do with them. And, like the gathering of small industries which did not benefit from the growth of economy, the mass level which is financially the weakest gets hit with a heavy share of medical payments, thus creating suppression of visits to the physician and, in addition, burdened with the payment of half of the drug and medical fee out of patient's own pocket.

By doing this, the insured or the client, upon having visited his physician, would find that it costs him a certain sum of money, actually half of the bill, and bear a considerable grudge. This is precisely what the archvillian politicians are aiming for. Good natured people such as yourselves do not notice this. I, being a villian myself, know all about this. In this fashion, the bureaucrats think that by creating friction between the doctor and his patients, it would serve as a method to obtain stability of their policy. When you think along such lines when putting together a revision bill, it results in the likes of what we see in the current revision bill for our health insurance law. The next step is that Minister Ozawa would approach the opposing party and ask them for cooperation to have the bill passed or at least have the bill discussed at the next session.

At the time I was elected chairman, Mr. Ozawa was a section manager for health insurance. During those times, there were many episodes and clashes, in particular with Dr. Marumo. At that time, Dr. Marumo was energetic and held his ground, but, of recent, Mr. Ozawa has become quite clever and tends to leave Dr. Marumo far behind. And, since he was the section manager in charge of health insurance, he knows all about health insurance. His knowledge, however, is at the section chief level, since he left the ministry at that

point, and is lacking in visions from the standpoint of a director-general of a bureau or that of a minister. But this man became a minister. So, the resemblence here is like that of a clock with only the second hand moving, while the minute and hour hands are stationary, and when this clock, which only has a moving second hand, moves in segments of two years, we have a problem on our hands. This is why I have been putting up such an exhaustive fight.

This time, the elders of the Liberal Democratic Party began to think that I might create some trouble during the elections and tried to bury me by establishing a subcommittee in the Committee on the Study of Basic Problems in Medical Care, whose chairman is Mr. Nemoto. The 15 subcommittee members include 6 physicians. We thought that 6 members, being physicians, would be satisfactory, but this is where we were mistaken. Their ultimate aim was in obtaining the sanction of the Japan Medical Association, because the subcommittee included 6 physicians. A member of this subcommittee Dr. Oishi does not oppose anything to what is said. He tells me that he will not object to anything said by his elders. At the last meeting of the Board of Trustees I shouted to him and others "What are you talking about? It is preposterous that an eminent Diet member should talk about his personal status!"

Diet members of the House of Representatives are elected once every four years, while those belonging to the House of Councilors are elected every six years. So, those in the lower house can think only in terms of two years. Therefore, today's politics must be perceived in blocks of two years at a time. Then, there is no room for consideration of long-term planning. So, the only means to overcome this is to gather and foster public opinion. But, look at the Japanese newspapers, which, in the olden days was defined as the leader of public opinion and a guide for society, is becoming the most inferior profession that takes on the lowest of people as reporters. Today's newspapers are on the surface not bent towards political parties, but in effect, they all are. And by patting the readers on their backs, their aim is to sell the greatest number of papers. All they are concerned about is

selling the greatest number, so, the responsibility of leading public opinion does not exist. Since they carry no responsibility for any article they write, their business is a heavenly paradise. You write something that appeals to the man or woman on the street, and you just sell newspapers, a very easy task. And these journalists have become completely aligned with the small politicians.

There are many problems. For example, the matter of radioactivity, the matter concerning the "Mutsu," the nuclear powered vessel, not a penny should be paid. However, it was paid. Mr. Zenko Suzuki was pushed into it by the public opinion of the mass media.

I am sure that all of you are aware of this way of doing things, such as in the case of medical care, where the newspaper public opinion act willfully in many different aspects. Legislation for the matter covering emergency medical care was pushed by the press. In Osaka, Dr. Yamaguchi did his uttermost to block it. Then, it appeared in Yamagata Prefecture. These movements are directed by the Socialist Party and others without any heed to long-term planning, and here I would like to refresh your memory to the fact that the autonomy of medical care in the past was guarded by the Director-General of the Bureau of Hygiene and Sanitation. But today, it has become necessary to promote these efforts through a special organization with a social mission, such as the organization of the Japan Medical Association. This is where the medical association has changed greatly from that of the olden time. The environment, in which the medical association finds itself today is entirely different. The people of the past, when the medical care system were realized by the efforts of Sensai Nagayo, accepted it graciously with appreciation and approached their physician with a sense of gratitude. The populous of today regard their health insurance policy as a right and appear before the physician with the sense that they are the supreme ruler of the medical care system. As a physician, one must notice these changes that are taking place in the environment, lest their feet be swept away from under them. Since the days of Marx, the thought of

world rule by labor unions is still being maintained, but the link of this thought with Japan takes the form of the establishment of laws and regulations, backed by the press, which produces the labor union's supremacy over medical care. Where guidelines from Sensai Nagayo brought about medical care, today the labor unions which have absolutely no knowledge of medicine whatsoever have come to deal in the medical care system from the position of union supremacy.

This, however, on the other hand, can be taken as an aspect of long-term thinking, as this was the dream of Marx. Although, I believe, Marx was a great social scientist, the three predictions he made did not come into being. His theory was so centered on the battle of the classes that it left no room for progress in science and technology, which lead to the downfall of his predictions. The mistake that was made by Marx, the great economist and scientist, was that he forgot to incorporate the progress of scientific technology in his predictions, so, all went wrong. The unions of today have salvaged the remains of his theory and, as if to act according to his will, they are creating a union-controlled and dominated medical care situation. The unions are taking over the National Railways. Anything that the unions take over goes into the red. The deficit of the National Railways can not be entirely due to the union takeover, but it certainly appears that way.

The mentality of the labor union is unchanged from what Marx thought over a hundred years ago. Marxist economy was more dynamic than the political economy and inherits some of Hegel's dialectic theories and is very precise in its thinking, but the thought of progress of scientific technology was omitted. It has been proven in the past that in the world of medicine, progress of scientific technology plays the most important part and it is creating a new environment outside the activities of medical care, such as in the matters of nuclear power medicine and matters of system sciences.

When we think of something on a long-term basis, we must understand and absorb the progress of other scientific technologies within our environment and the idealogical background of these scientific technologies. And, we must think of how these scientific

technologies will contribute towards the shaping of the new era to come. If one supposes that medicine as we know it today will remain status quo, this would parallel the thinking or mentality of the bureaucrats of the Ministry of Health and Welfare. Medical science is constantly the energy for science and is in the state of metabolism. The sponsoring by the Japan Medical Association of seminars for the leaders of the local medical societies and seminars, the contents of which are to be communicated to the other members of the local medical societies, is an activity based on the theory of metabolism in the academic world and not because of our intent to keep up with today's academic science. If the papers presented were to be read, I believe that they will be understood easily but I am disappointed to know that the majority of the people throw it away before reading, but nonetheless, it is important that things be approached in the sense of the long-term thinking. When checking the condition of a patient, long-term thinking as an attitude is necessary to cope with the aging society, if medical care is to survive. When we consider medical care in this aging society (society where older people are increasing), long-term thinking becomes unavoidable. It becomes unpermissible to diagnose the patient's condition based only on clinical data, without considering the long-term view.

This is why I have proposed community health insurance, with particular regard towards primary care, and to unify all insurances therein. However, when you consider the trend that a newborn baby will live to be 80 years old, the planning of medical care becomes one of urgent importance. This is why the concept of preventive medical benefits must be introduced, because, without this concept, it is natural that a nation will go into bankruptcy paying out medical care expenses. The thinking is that through the implementation of preventive benefits, a financial crisis can be avoided. Even today, we heard the report on brain hemorrhage in Akita Prefecture and if preventive measures through the regulation of daily activities and other measures can be utilized, this will probably have a great influence on the problem of brain hemorrhage.

Thinking along these lines, it is my wish to avoid the increase of

"human vegetables" and to create people who can work and be productive and that preventive medical benefits should be considered with this in mind. My preventive medical benefits not only include guidance in daily life and health checkups but also include the establishment of true primary care planning, where the physician becomes involved in the planning together with his patient.

In continuing my thinking, medical economics at the end of this century will see 3.8 young person supporting 1 aged person. It is not possible to realize a high level welfare with a high level burden, therefore, I feel that the world will change into one that will have a low level welfare with a high level of burden or contribution. It will become a world of destruction and living hell. This is what I want to avoid and it is sound thinking, but since the ordinary citizen is lacking in long-term thinking and, with the government system as it is today, the going is indeed difficult.

During the meeting of the House of Delegates, there were voiced opinions from you members to step up public relations, and I ventured to put in a full-page advertisement in the Asahi Shimbun and went further by placing the same advertisement, translated into English and placed it in the Japan Times, directing the public relations towards the whole world. An interesting episode followed, when five members of the American Medical Association visited Japan. They stated that the American Medical Association has unconditional praise for the campaign launched by the Japan Medical Association in their advertisement in the Asahi Shimbun. Recently, when the XIth International Conference of Gerontology was held, an opinion advertisement of the Japan Medical Association entitled "Let us think about medical care for the 21st century" appeared in the Japan Times. The chairman of a committee, a professor of community medicine from Cornell University, surprised everyone by saying that "The only text we have in studying this problem is the contents of this newspaper advertisement." When coming from a foreigner, it is accepted with dignity, but when it comes to a matter of approving amongst the Japanese, acceptance may be very difficult. Thinking

ahead is not easy and when we talk about the end of this century, which is only one-quarter of a century away and, even if we do know about it sufficiently, we do nothing about it by saying that it is not a problem of today. When we consider the medical care matters, it should be on the basis of long-term views and individual planning of the medical care system must be established. In this process, the systemizing of primary care is also an important problem.

A few days ago, when an assistant chief of the Fire Defense Board came to see me and asked for my approval on the establishment of a foundation for the education of emergency medical care procedures, I opposed the idea. It is unthinkable that the Japan Medical Association agree to establishing a foundation for emergency medical care procedures set up by the Fire Defense Board. So I said, "I am sorry but I must decline. However, there is one thing that I would like to ask a favor of you and that is to train automobile drivers in first aid, just as we did to our soldiers, and if one fails this test, do not give them a driver's license and also to equip all motorcars with first aid kits, such as antihemorrhage tapes and so on, like the Germans are doing. This will cause a distribution of medical supplies to the extent that one household will have at least one kit." He was somewhat surprised and said that he did not know about this. I told him to come to the experts for information and help.

There are many things that remain unheeded and overlooked. Even those things that are at our very finger tips, but when a long-term thinking becomes basic, those matters before your very feet or fingers become intelligible. However, the reverse is not true in that no matter how many small things before your feet or fingers are put together, this does not make long-term planning. Medical care is also in the process of dynamic metabolism. The life of the citizen is also in the state of dynamic metabolism. And, social activities itself is in the process of dynamic metabolism. Amidst all this, only law maintains its static stance. Therefore, when law is applied only against the major important parts, appropriate to the realities of the society, leaving the remainder to go through the process of metabolism, then, long-term

planning becomes possible. The present health insurance is set up in periods of two years, very rigidly, therefore, no matter how long one waits, long-term planning becomes impossible and it will most likely turn out to be a continuation of confusion.

It is assumed that the party politics of Japan will bring about self-destruction. A true future objective is not to be established when thinking is at intervals of two years at a time. Only leading opinions can create future objectives. And, leading opinions is necessary to break the old established bureaucratic system. This makes the Liberal Democratic Party look very dismal, as they are being led by bureaucrats. Everybody, please open your eyes. Observe how the Liberal Democratic Party, which was supposed to be a party to Japan and manipulated by the bureaucrats by their bureaucrat-originated ideas, and how it is now degenerated to a party which is travelling down the path to destruction.

Accordingly, there is no other association in Japan, which as an organization is scientifically based, respects the dignity of life and is developing social activities, other than the Japan Medical Association. In this sense, although it appears that the medical care system proposed by the Japan Medical Association is, in its long-term view, in direct conflict with the direction of politics, when I think of how we can progress with the people of this country in this form, I firmly believe that we will gain the most stable position and serve to improve the welfare for the entire nation. And in accordance with our long-term thinking, after the initial thirty years of the 21st century, we will attain the most stabilized structure of population. However, as this will bring a direct burden on the young population, the welfare system must undergo some changes.

An era of drastic changes will come in regard to the welfare conditions during the end of the 20th century and the beginning of the 21st century. I believe that Japan's global status in the 21st century will be determined on how we will be able to overcome this period of drastic change. In this context, the current bill to amend the health insurance law has an influence on the fate of our nation and the welfare of our people and should be considered as the most important

supralegal issue, and because of its nature, your understanding of this problem is being asked here and I ask for your support and cooperation to enable myself to fight it effectively.

On the World Medical Association

The World Medical Association (WMA) has had a long history. But when one views it, one finds some ups and downs. When it was inaugurated, the WMA had the good fortune of having an excellent secretary general in Dr. Bauer, who built its framework.

The term "medical association" was clearly defined as an academic society within a free society. Therefore, none of the Communist bloc nations was a member to begin with. The reason is that there could be no voluntary society of physicians in a Communist nation.

One point of importance I wish to draw your attention to is that there is a basic difference in the positions of the physician in a free society and a Communist medical care system. This difference was clearly recognized at the time of the inauguration of the WMA. The position of a physician in a Communist state is that of a member of a labor union. A physician is on the same status with medical service workers. He does not have any leadership in medical care; a physician participates in medical care as part of his trade union activities. This shows the big difference between a free society and a Communist society.

In a Communist state, there is also an auxiliary medical worker, somewhat like the *feldsher.* In Communist China there is the

---

This paper is an English translation of a talk in "The Special Medical Course" broadcast on December 3, 1978, by Nihon Short-wave Broadcasting Co., the original paper in Japanese was published in *The Journal of The Japan Medical Association,* Vol. 80, No. 12, pages 1633 to 1637, 1978. Reprinted from the *Asian Medical Journal,* Vol. 22, No. 4, April, 1979.

"barefoot doctor." These are auxiliary medical workers who have not undergone regular medical training in a medical school.

The physician in the Communist bloc may be characterized in another way, that is, he is a political functionary. This means that a doctor is like a member of Sohyo, the largest labor federation of Japan. He has no professional freedom. He has no self-reliant position of his own like the doctor in a free society.

In a free society, a doctor is a professional. He counts as a member of his profession like a lawyer or a member of the clergy. His work is not the pursuit of profit; it is a vocation. Nor is his work that of vending his labor for money. It is neither the pursuit of profit nor the vending of labor. Rather, it must be nothing but service. The doctor pursues his vocation by clearly accepting the proposition that his is work of a public nature. But he does so voluntarily without being compelled.

One of the most important tasks for the WMA is not to equate this wonderful status of the physician in a free society with that of the doctor in a Communist state. Unfortunately, however, any international organization has ups and downs. By this I mean—as I myself have witnessed this—such an organization is bound to decline in power and prestige unless concrete efforts are made to follow a global direction.

An international organization must always have a leadership that leads it to take a new step forward. When it is an intergovernmental organization, it is likely to fall into a rut while existing in name only. A private international organization in such a situation is bound to find many of its members withdrawing from membership.

It is important, I think, to compare the times when the WMA was active and when it was not active. Of the greatest importance is whether the Council exerts leadership and the secretariat is in good shape.

Take, for instance, the fact that the American Medical Association (AMA) seceded from the WMA—about four or five years ago. The reason why the AMA withdrew from the WMA is that it did not like the situation, in which small members that defaulted the

payment of dues had the same vote as the AMA while ignoring the wishes of the big power member associations. Canada, too, withdrew for the same reason, and the British Medical Association was also intending to disaffiliate but somehow stayed on, trying to improve the situation.

When such major members secede one after another, the WMA would become an association of small-power members, whose say dominates the say of the bigger members. This I think is the major reason for the decline of the WMA.

Dr. Romualdez, the former secretary general of the WMA, is a Filipino. He is familiar with the conditions of small countries. He also has a certain ideal about the development of the developing nations. Dr. Romualdez was successful in leading the smaller nation members. But after he resigned from secretary-generalship to devote himself to work concerning his own country, his replacement was an extremely bureaucratic Australian. When he took over the secretariat, the secretariat system itself collapsed and disintegrated.

I was member of the Council when this happened. I thought that this would result in the financial debacle of the WMA, and I was compelled to deal with this problem immediately. It so happened that I was trying to invite the WMA to hold its assembly in Tokyo. I became concerned that with the secretariat in such a condition, it was doubtful if the assembly could be held at all. At Council meetings I sharply attacked the bureaucratic secretariat system. But the American Medical Association, which was a key member, was no longer in the WMA. Nor was Canada. Yet, I devoted myself to the preventing of the collapse of the secretariat.

Fortunately, the German Medical Association was very cooperative with us. It accepted all the financial problems and prevented the financial collapse of the WMA. For instance, the German Medical Association undertook to finance the publication of the WMA magazine, and WMA managed to survive.

The Tokyo Assembly of the WMA was held. The Council ought to have sternly dealt with the secretary general for his unwarranted

conduct. But at the assembly, I made a strong report on the matter, which I believe left a deep impression on the chairman of the council of the AMA. The AMA withdrew from the WMA, but it participated in the WMA assembly in Tokyo when the Japan Medical Association (JMA) invited the AMA to the Tokyo meeting. We felt that this reflected the fact that the AMA was still very much interested in the medical organizations free societies.

That my understanding was correct has been proven by subsequent developments. One of the main tasks for the Tokyo Assembly was to tackle a major permanent undertakings. At the same time, it faced an immediate task confronting it. The WMA had adopted the Helsinki Declaration, which had been taken up by the WHO as well as the United Nations. With the belief that we should not be content with declarations and resolutions alone, we wanted to carry out some realistic work. Therefore, I proposed the creation of a special committee on "the Development and Allocation of Medical Care Resources," and my proposal was adopted. The AMA took keen interest in this fact and it decided to work with us by joining the WMA. The AMA, however, is demanding that the bylaws and regulations be revised because the old ones were of no use. Concerning this proposal, Acting Secretary General Dr. Wynen conducted negotiations with the AMA and reached agreement.

The question of the return of the AMA to the WMA was studied from the time of the WMA assembly held in Ireland. It was decided at the Council meeting at least that the new formula should be followed. But at that time, the three Scandinavian member associations indicated their strong objections. The reason is that they were opposed to the dictatorship by a big member although the new bylaws were not designed to create it. At any rate, these three Scandinavian members used strong expressions and, before long, Holland, too, joined their ranks. I don't think there was pressure behind the scenes for this development by the Communist bloc. Dr. Wynen, the acting secretary general of the WMA, too, made remarks which indicated his desire to invite Communist bloc associations to the WMA. This

represents a considerable departure from the way of thinking of the WMA secretary general at the time of the inauguration of the WMA.

Those who objected to the admission of the AMA announced that they would withdraw if the new proposal were adopted. I feel that they probably will withdraw and that we should take countermeasures now, which would permit them to withdraw temporarily while we will have to allow them to rejoin the AMA in the near future. The reason for their wishing to secede from the WMA is that these small countries of Europe seem to want to insist on their say by allying with the small countries of Africa. But the fact remains that not all of these small countries pay their dues. But the new proposal is such that it allows even those who do not pay their dues to have a big say. Such a structure in a private organization would lead to its collopse though it may be acceptable to an intergovernmental organization.

In other words, this new proposal on the one hand stands for a strong wish for accommodating small countries as members while, on the other hand, it has seeds for its financial collapse. I thought that this was not a sound proposal. Yet, it was accepted unanimously at the Manila conference. Therefore, I believe that the withdrawal from membership of these member countries is to be expected very soon.

The Manila Assembly was a great success. At the Tokyo and Sao Paulo Assemblies before that, the JMA and the Brazilian Medical Association each paid for the total cost of their respective Assemblies, thus making a contribution to the finances of the WMA. This has left a strong impression on other members.

The Philippines Assembly this time witnessed the decisive moment, at which the AMA rejoined the WMA and at the same time the three Scandinavian countries and Holland withdrew. These members, one coming in and others going out, had a frontal clash. I believe that the future activities of the WMA will be largely dependent on the question of how this decisive moment is to be assessed in the history of the WMA. The activities of the WMA in the future must be equated with rational contributions to all the countries,

developed or developing, which would be a departure from the kind of discussions the WMA has had in the past. Ultimately, the Council and Assembly of the WMA would prove to be a place for discussing the question of the "development and allocation of medical care resources." That would be the new character of the WMA. In this sense, the decisive moment of the Manila Assembly was a new line of departure for the WMA.

I wish to take this opportunity to consider politics and medical care in the Philippines. Fortunately, the academic session of the Manila Assembly dealt with problems of rural medicine. In the Philippines, doctors are being developed but many of them go to developed countries in a brain drain, leaving many rural areas in the Philippines without a doctor. Many charges were leveled against the developed countries in this regard. But I feel that it is natural for a physician to seek a place where what he learned in medicine can be put to practical use.

Concerning this question, Mrs. Marcos, wife of the president, holds the position of Minister of Ecology and Human Settlement. I feel that she is perhaps the only minister in the world in charge of ecology. Her function as minister of ecology and human settlement includes those of the ministers of local government, welfare and finance. Therefore, I think that these ministers serve under Mrs. Marcos. This I thought was an extremely interesting setup.

Compared with the time when I was there three years before, Manila was vastly improved. But in the suburbs there was still much room for improvement. With understanding gained with the leaders of the University of the Philippines and other leaders concerning ecology and human settlement, a national institute of health was built in remote rural communities. As you know, the Philippines consists of many islands, and one of these islands was chosen to be the local for this institute. I thought this represented a very interesting mode of thinking.

This mode of thinking included the idea of first developing health scientists for dealing with medical care. A health scientist, however,

must have a love for the area where he works. If he leaves one area for another, he would not serve the purpose for which he was developed. Therefore, the idea was to train and educate health scientists on the basis of recommendations by local interests. These persons were to be trained with main emphasis on outdoors work. Therefore, the trainees undergo training outdoors. Of course there are classrooms where they receive training. But the primary training ground is outdoors where they receive practical training. After a certain number of years, they can be on their own to serve as health scientists, and after that, they can become medical doctors. There is no training of this kind in the case of Japan. A person who pursues a certain training course must be content with being a paramedical for all his life. The Philippines scheme, on the other hand, enables a person who wishes to become a physician to become one. There is a way open for such a person who endeavors to develop himself. This is something the Philippines can be proud of, which Japan does not have.

The trainees are those who are recommended by local committees, and this means that they have a strong attachment to the area they come from. The system provides for an arena within the community medical care system, in which creative ideas of these health scientists may be given full play. These personnel cooperate with doctors and with health centers; they engage in preventive medical care, help the citizens increase their physical strength, and take care of simple diseases though they are not physicians. But they can become doctors when they study. This I found an extremely interesting system.

Reports on these community medical care activities were submitted at academic meetings. From Japan Dr. Wakatsuki, president of the Japanese Associations of Rural Medicine gave his comments. One of Dr. Wakatsuki's comments, which was highly interesting, was that the conditions in the doctorless communities of the Philippines of today closely resemble those of the rural communities of Japan in the Meiji Era (1868—1912) and the early years of the Taisho Era (1912—1926). The scientific session of the

World Medical Assembly in Manila was such that it could be held only in the Philippines; it could not possibly have been held in an advanced country. It also showed the creative way of thinking that could not be imagined in an advanced country. We also learned that in the political organization there was the minister of ecology and human settlement, and this had an impact on university education, and the functions of a university extension service produced excellent results in a remote village. I felt that this will continue for some time to make a contribution to the improvement of the public hygiene conditions and a basis for medical care in the Philippines.

Another thing that impressed me about the Philippines is that, as you know, the Philippines is a free society and, therefore, there was no indication of a desire to place medical care under state control in the form of health insurance. It is not possible to adopt the U.S. system intact. Apparently, they are thinking of a health insurance plan for civil servants or for workers in certain special plants. As for citizens at large, however, there seems to be no possibility of a health insurance plans as yet; nor is there any financial resource for it.

I was very much interested in the Manila World Medical Assembly in the sense that it presented scientific problems in a practical way, and for this reason it was not an abstract academic conference.

As I have just said, the last WMA Assembly showed one pattern of an assembly for the WMA. With the AMA joining the WMA, the WMA will come to play a major role that is apart from that of an intergovernmental organization.

The Medical Ethics of Today

The importance of medical ethics is being talked about a great deal today. I think this is wonderful. In talking about the promotion of medical ethics, however, we must first of all consider its substance.

First of all, we have had medical ethics since the feudal age, and it boiled down to the doctor respecting the life of his patient to the utmost.

Today, however, the idea of health has undergone change, in this democratic age, the value of health, too, has changed. We have also seen the rise of the concept of the right to health as part of the right to existence. This has meant the expansion of the realm of the concept of medical ethics.

If we are to advocate the promotion of Medical ethics, we must consider what today's medical ethics consists of.

As shown in the table, we have here the establishment of the medical basis of the dignity of human life. The dignity of human life is an abstract term, but concretely speaking, the establishment of the medical basis of the dignity of life has been facilitated by the knowledge about the gene gained through molecular biology. That is, one's life has been handed down from one's ancestors and is handed down to one's offspring. This represents a change in our outlook on human life. This is an evolutionary progress.

This paper is an English translation of a talk "The Health Promotion Age," broadcast of July 24, 1977, and the original paper in Japanese was published in *The JMA News*, No. 382, page 5, August 5, 1977. Reprinted by The Japan Medical Association, April, 1979.

Expansion of the Concept of Medicine

1. The Establishment of the Medical Basis of the Dignity of Human Life
2. Basic Human Rights and the Right to Health
3. The Value of Health
4. The Right to Existence and the Environment

Secondly, we have basic human rights and the right to health in our democratic society as established concepts. Under feudalism, not much thought was given to basic human rights and the right to health. At the time when a health insurance system was established by Bismarck, there were no such ideas. The reason why medical ethics is intensely discussed in the context of health insurance is that these concepts are not part of the health insurance system we have.

The value we attach to health is another problem. In olden times, people thought that their own health was their own concern. Today, we have an entirely different way of thinking about health; we have a strong sense of solidarity with our parents, siblings, neighbors and residents of our own community. This has had a great impact on the value we attach to health.

Fourthly, there are the right to existence and the environment in which we live. In order to establish our right to existence, we must first of all establish a good environment.

The first and the fourth items have been the factors for the emergence of environmental science, which measurably altered the concept of medicine. It is impossible to expand the realm of the concept of medicine without taking environmental science into account. The idea of medicine has been greatly expanded socially through molecular biology and in terms of philosophy as well. It is only after we grasp how much change the concept of medicine has undergone that we can appreciate how much progress the concept of medical ethics has made. We wish to consider the ethical quality of

Medical Ethics

1. The Development of the Classic Ethics
2. The Promotion of Ethics in the Establishment of Medical Care as a System
3. Social Conditions for Medical Ethics
   - Community Conditions
   - Scientific Conditions
4. The Relationship Between the Patient and His Physician in Medical Ethics

medicine by a scientific, philosophical and sociological approach to examine the framework and contents of medical ethics.

Next, we have the development of classical ethics, which was essentially concerned with the life of the sick. In the old days, ethics tended to be religious in nature. Even today and in the future, of course, we have no difficulty with religious ethics. But unless it acquires medical and social elements, we could not expect the rise of a new medical ethics.

A major question is how this medical ethics can be woven into the medical care system we have today. When we create a medical care system without knowing about medical ethics, it would be impossible to establish ethics afterwards. A medical care system and ethics are two entirely different things. A medical care system must be created while ethics as well as science are accorded due respect. Unfortunately, a law nowadays is not established with such attention to details; rather, a law is created in the manner of regulating traffic. This is the reason why, I believe, we have ethical problems in the reality of medical care system.

In the social legislation of the future, therefore, it would be necessary to adopt the concept of ethics in its modern sense of the term. I do not believe it would be possible to adopt an old ethical concept, which will be neither popularly accepted nor understood by the people. This means that when there is no fundamentally human attitude like this, it would not be possible to bring to life ethics in any

of the health insurance systems or any of the advisory councils. To elaborate, social conditions for a medical ethics are of extreme importance. In old Japan, there was no democratic society. It is only 30 years since democracy was inaugurated in this country. During these 30 years, many social conditions have changed, and among them, one of the most important is the change in the self-awareness of the people.

There have also been changes in the conditions of the community. Another is the academic condition. When a medical man considers his own medical care acts or his own behavior, he finds many conditions to which they are subject.

People talk flippantly about euthanasia. But I do not believe it is possible to solve the question of euthanasia unless there is a national consensus concerning in which area euthanasia coincides with the medical ethics of today and in what area it does not in terms of social, community and academic conditions we have today.

When we consider the problems of medical care welfare concerning the survival of the persons who have been stricken with incurable conditions such as spinal damage, we find medical ethics to be of enormous importance. I believe that we need social conditions under which medical ethics reacts extremely to the persons who have been given unfavorable conditions for survival.

The promotion of medical ethics must be accompanied by the promotion of medical science and technology. In other words, the promotion of medical ethics is not unrelated to science and technology in medicine. This is where the medical ethics of today differs from the didactic medical ethics of old.

The table at the end shows "the relationship between the patient and his physician in medical ethics." In this area, there is possibility of many problems between the patient and his physician. As I said a few minutes ago, it is not possible to establish a medical ethics by handling it as though it were a traffic problem — like establishing a one-way street. If the two agree in terms of basic morality, then an ethical relationship can be established.

It is necessary for an individual to look after his own health even

when he is healthy. To keep one's own body in good health is a matter of social ethics. I believe that one's own health is not a matter of concern to oneself alone but also a matter of social ethics.

We also have many problems related to aging. In this area, too, there must be complete agreement between social ethics and medical ethics.

Thus, medical ethics must be applied to every aspect of society and to every stratum of mankind. This bespeaks the importance of medical ethics, philosophical thinking and pragmatism. Ultimately, therefore, medical ethics must be reconsidered, not demanded of the medical profession. The Japan Medical Association, as a professional organization, is carefully studying these problems by obtaining the cooperation of religionists and philosophers. This is the most central issue we face today.

Thoughts on Primary Care

There has been much discussion about primary care in the WHO and elsewhere throughout the world, in particular in the United States. I have read a great deal of literature on the subject published in the United States have commented on it on many occasions. I wish to add the following to what I have already said.

American medicine has been finely specialized and each area of specialization has become extremely limited in scope. I the results of such specialization were to be applied to society on the basis of clinical medicine, it would require new inventiveness. Internal medicine, for instance, no longer makes much sense as an area of specialization. Extremely specialized basic research is conducted by clinicians so much so that the distinction between clinical research and basic medicine is becoming blurred. This would mean that the task of fusing basic research with clinical medicine in order to develop it further socially would require an entirely new way of thinking. This, I think, is analogous to the situation in physics where atomic physics in the phase of practice requires administrative physics, which it did not require in the stages of research and theory.

In view of the fact that medical research develops in the form of clinical medicine and then at the community level, I believe it is of great advantage to us to build up the pattern of primary care.

The education for primary care must not concentrate on

This paper is an English translation of the summary of the talk given at the second meeting of the Japan Medical Association Primary Care Committee, published in January 20, 1979, issue (No. 417) of the *Japan Medical Association News.* Reprinted from the *Asian Medical Journal,* Vol. 22, No. 5, May, 1979.

information on small details but it must be medical education as a whole. This holistic approach should be the approach to clinical medicine. When a physician faces a human being as a clinician, he must apply his holistic knowledge rather than knowledge on individual details.

In summary, it may be said that medicine in the United States today has achieved a very high level of accomplishment in basic research and as a result it has become necessary to have something between this high level of research and clinical medicine. This is what primary care is.

The three-year training curriculum for developing primary care technicians in the United States shows that most of the time is devoted to administrative physics while the remainder is intended for training in sociobiology. The socialized medicine of the past had a considerable amount of ideology in its background. But just as socialized medicine in Great Britain has little ideological background, primary care in the United States has very little of it while the emphasis is on biological social development. Biological social development can be conceived only in the area of medicine. This I believe is a strong characteristic of primary care in the United States.

This education curriculum for primary care contains a great deal of elements that belong in the category of social sciences. There are elements of economics, for instance, and of public administration. What interested me a great deal is this element of the idea of public administration. This, however, is not like the public administration of Japan but of the United States. What is of great interest in the chapter on the curriculum on the ideas of public administration is that it was not built up by statutes but by the accumulation of social facts, which resulted in a set of rules. This I believe indicates the basic difference between the American system based on democracy and the Japanese approach to public administration, which is based on Germanic law.

There is a certain amount of confusion in the field of medical administration. In our country, we have, for instance, medical society hospitals which are not established within the legal system of medical

administration. This, I think, is a major difference between the Japanese and American systems.

Another point that deserves notice is that in the United States sociological problems are dealt with in a very scientific way. American sociology is characteristically based on social research, rather than on abstract concepts. This kind of realistic sociology is not found in Japan.

Next, let me touch on the problems of education. I observed the curricula of two universities. Here I found that a considerable amount of time is devoted to education with emphasis on health education. This is something which is not found in the educational program of the medical schools. One notable difference in this respect between our system and the American system is that the American system provides for a great deal of feedback in education and training.

This means that in the United States, the assessment of education is given a great deal of importance. In the case of Japan, the assessment of education does not yield numerical data. In the United States, however, this is possible to a great extent. In Japan, there is a great deal of piecemeal vending of medical knowledge in health education. In the United States, health education has a system of its own as a specialized branch of science. There, the piecemeal vending of medical technology is not considered health education.

What is even more interesting is that life-style occupies a very important place in sociology. In the medical education of Japan, on the other hand, we seldom hear the word life-style. Yet, in the program to train primary care technicians, the problem of life-style plays a vital role. I found the American medical educational system to be of great interest because it makes one think about the problems of health and life-style.

Now let me touch on the problem of the development of primary care in the community. Here we find administrative science playing a very important role, which is clear from the fact that computer science has been introduced into this area. With computer science being highly prevalent in the community many data concerning individuals

are stored in the computer system without inviting criticisms of violation of civil rights. This is remarkable in view of the fact that the individual's freedom is highly protected in the United States. There are many data collected on individuals, of the kind that would never be possible in Japan.

What I have said so far is the most noticeable characteristic of the training curriculum, in which case study and field work are given great prominence. Case study is conducted by field work in the United States to the extent that is unthinkable in Japan.

I believe there is too much private interpretation of the term in Japan. When we understand primary care as I have described above, we learn that a technician in primary care is not like the general practitioner of yesterday. That is, a primary care technician is different from the general practitioner with regard to the academic basis on which they operate. What I have said above is something that is not found in the education and training of the general practitioner, namely, the primary care technician is trained with specifics from the social standpoint besides the general medical knowledge provided to the general practitioner.

In the United States, the policy used to be one for developing general practitioners (GP) and specialists (SP). But this policy, I believe, came to an impasse. Immediately after World War II, in Japan too, there was a time when the GP-SP system was highly rated and many medical societies jumped at it. A review of this system, however, began in the United States about 20 years after World War II. This was due to a financial reason, namely, too many SPs were created while the number of GPs declined. At least this was the superficial reason. On the other hand, if a better administrative system came to be developed within medicine, the GPs who could not surpass it would naturally be weeded out. I think it is not wide of the mark to assume that anything without a scientific foundation promptly disappears when it faces a change and that this is a characteristic of the American society.

Now let us consider how primary care, which developed with a background like this may be developed in Japan. I believe that there

are areas in which we can not copy the American model quickly and areas where the United States cannot copy the Japanese model. For instance, there is no such human resources system that consists of health scientists, nurses and social workers. If we are to develop primary care with the physicians alone without such auxiliary personnel, we are bound to come to a limit. One the other hand, the medical society hospitals, which the Japan Medical Association has promoted, have built health promotion centers. This, in fact, may be something the Americans want to learn a great deal about. To the Americans, it is inconceivable that medical societies should engage in non-profit social services.

I have spoken with Professor H.M. Somers, a political scientists, and Mrs. Somers, an authority on administrative medicine and health education, and have read literature by such people. And I feel that what the Japan Medical Association has been doing is not far from what has been achieved in the United States. One point on which I agree most with Mrs. Somers in the area of health education is that one cannot become a primary care technician unless one becomes part of life in a particular community.

In a farming community, for instance, it used to be that all the houses were built in such a way that they faced one direction with the bedroom being the room with the least exposure to the sun. In some areas, furthermore, the disposal of drainage from the kitchen is extremely unsatisfactory. Eating habits vary from one home to another. In such a community, a primary care technician must become a part of life there before he can grasp the basic facts relevant to health.

To propound visions of all kinds and spread them is not education. Rather, a primary care technician must dive into a certain life environment and share life with its inhabitants if he were to become a successful primary care specialist. In this sense, the Japanese medical practice system may be said to have established a certain direction in which primary care technicians may be developed on the basis of accumulated facts even though it may not be on par with the systematic way of education in the United States.

As for community-level activities, it is possible to learn the

manner of the spreading of contagious diseases if one had information on the rivers and the flow of subterranean water. Knowledge about waste water disposal also helps to identify the causes of various diseases at the community level. These are things a primary care technician can deal with. In short, a primary care technician is a person who gains facts about patients from the standpoint of environmental science, instead of diagnosing patients on the bed in a hospital. This is indeed the major characteristics of a primary care technician.

To be part of life in a community is one of the qualifications for a physician, and this means that a primary care technician can obtain genetic data concerning individuals with whom he has close relations, such as relatives. In addition, new data can also be stored as input. Thus, in 10 or 20 years, such data would be of considerable value in a community where the population is sedentary.

Thus, there is a natural difference between the activities of primary care technicians in rural communities and urban communities. The difference is to be found in the background as viewed from the standpoint of environmental science.

In this age of industrialization, manufacturing is done in the large factories while the home is no longer the place of production. Industry has left the home. This is also an area where changes take place in the traits of primary care technicians. In the area of industrial medicine, industrial physicians must assume the role of the primary care technician.

Next, about the role of the primary care technician in a large metropolis. According to the case studies in the United States, there are not as much data as in the case of rural communities. It seems that a primary care technician in a large city seems to be following the procedures of the general practitioner of today. Even in the United States, it seems that health education is not carried out satisfactorily in the large cities.

As for Japan, health education has been extremely successful. Once I visited a remote village on the boundary between Niigata and Nagano prefectures. There, at the primary school, the principal asked

the pupils who had brushed their teeth in the morning to raise their hands and only one pupil raised his hand. When I asked the principal about the child's family background, the principal said he was the son of the village mayor. I visited the mayor's home, stayed overnight there and established a friendly relationship with the officials of the mayor's office to hear them speak. One thing I learned is that all kinds of official papers are sent to the mayor's office from the Ministry of Health and Welfare. The village officials said they replied with what they thought were proper data without really conducting a survey. They said this is the way it is in all similar remote communities. When a health inspector comes around from the prefectural government, he goes back to the prefectural capital after being feasted in the remote village. And the physicians in the village, too, are inured to this kind of custom. So I decided to conduct an experiment. I calculated the caloric intake of the villagers during the busiest farming season and learned that the amount of energy spent per day was 5,000 calories while the food intake was 3,500 calories, the difference being the nutrition consumed from one's own body. As a result, after the end of the busiest farming season, the hospital in the nearest town to the village become filled with patients from the village. But during the busiest season, there were no patients from the village.

We recommended that the farmers resort to community cooking to produce meals with nearly 5,000 calories even during the busiest farming season. As a result, even after the season was over, there were no patients to fill the hospital, which, consequently, suffered a deficit.

The director and manager of the hospital complained to me. Because this was a matter related to agricultural cooperative association, I went to the Ministry of Agriculture and Forestry and met with the director of the agricultural administration bureau and the vice minister. The director of the bureau at that time was Mr. Tadaatsu Ishiguro and the minister was Mr. Fumio Goto. Mr. Goto, however, told me that it was wonderful that a hospital suffered a financial deficit because of a shortage of patients and they would make up for the deficit in toto.

In those years, a minister was able to make a decision like this on his own without consulting his subordinates.

About 20 years later, when I visited the same village, I found it to be a new place in terms of the level of health of its inhabitants. It was the most healthful community in the area.

Another remote village had an infant mortality of 35 percent at the time when its mayor came to us. Professor Haruo Katsunuma worked hard for the village and in five years infant mortality was reduced to zero. In this particular care, proper instructions on food and life-style played a major role in the promotion of health in the village.

In a few other areas where we conducted guidance on an experimental basis, we followed this up with data. In one area, where there were many in the age bracket of 32-33 who became incapacitated for life with cerebral hemorrhage, we carried out a nutritional improvement program and restriction of salt intake. After 10 to 15 years, people in their thirties with cerebral hemorrhage disappeared.

We have had such successes in the rural communities, and yet the problem is that the matter is not as simple in the urban communities. What can be done, however, is to incorporate the activities of a primary care technician into the school health program so that a new primary care program may be instituted through the parent-teacher association aside from the medical examinations conducted for the schoolchildren.

The same should be developed at the workplaces, where mental health care, too, is necessary. All this suggests that primary care in the metropolises is very difficult.

This is something entirely different from the regional approach. But I think it would be meaningful to take up the problems of hypertension as a problem in primary care on a nationwide basis. It is not meaningful for a physician to merely lower the blood pressure of his patients with medication. Even though it may be difficult to grasp the true nature of hypertension, the present tendency is merely to deal with high blood pressure without trying to pursue its mechanism.

Under the present health insurance system, a doctor does not have to learn the cause of hypertention of his patient in order to ask payment from the health insurance association. But if we had a system whereby a doctor who finds out the cause of his patient's hypertension may be paid a compensation of 3 to 10 times the present fee, then the doctors may work harder.

Another point of importance is that there are many diseases which start out with high blood pressure. A treatment program designed for the prevention of these diseases while dealing with high blood pressure would, be to a great extent, primary care treatment. Among the diseases induced by hypertension, the recent trend is toward a higher incidence of myocardial infarction and fewer cases of cerebral hemorrhage. This may be due to the fact that the requirement for protein in our body has increased or also that our tastes in food have changed. In any event, the incidence of myocardial infarction is rising to the European level. Even in this regard, instructions on food through primary care would be of great importance.

In summary, it may be said that medical care cannot be properly provided merely on the basis of medical research. To medical research must be added the social factors before medical care becomes possible. And these social factors include elements of environmental science, ecology and various social sciences. The basis of medical care provided by the physician must be said to have extremely broadened, compared with that of the past.

I believe that for one specialized field of medicine to become fused with the welfare of the popular masses, it is necessary that administrative medicine on a broad basis must be developed at the community level.

Politics and the Mass Media

No matter what occupation one may have or what class of society one may belong to, the relationship between politics and the mass media cannot but have great importance to him. I believe that whether Japan may be led to a destiny of ruin or to become a leading nation of the world would depend on both politics and the mass media.

Viewing the state of politics and the mass media from our position of medical care, we find that politics has come to possess very little professionalism and likewise the mass media have become extremely unprofessional. Science has become so specialized along vertical lines of division that it is difficult for these specialized branches of science to become involved with politics and the mass media.

The Meiji and Taisho Eras (1868-1926) were a period of authoritarian rule. Those in power "ruled" the people. In those eras, the distinction between the ruling class and the ruled was sharply made. Those in power were at the apex of the authoritarian hierarchy from which they exercised their ruling power.

In those eras, the mass media served as a powerful force of criticism, maintaining an excellent balance with the authorities. In those eras, the authorities also had great power while those critical of this power had a serious handicap because it was difficult to organize

---

This paper in an English translation of a talk in the "Special Medical Course," broadcast on April 1, 1979, by the Nihon Short-wave broadcasting Co., and the original paper in Japanese was published in the *Journal of the Japan Medical Association,* Vol. 81, No. 8, pages 1035 to 1039. Reprinted from the *Asian Medical Journal,* Vol. 22, No. 8, August, 1979.

the popular will. Yet, the mass media in those years fought the ruling power very well.

Great leaders outside the government entrenched themselves in the newspapers, the only form of mass communication existing in those years when there were no radio and TV. From the stronghold of the daily journal, these critics of the government played their role to the hilt not merely as a critical force but rather a leading voice for the people. In the sense that the press in those years provided an open forum for leadership, the mass media, I believe, were in a situation quite different from that of today.

Leaders in government, also listened to the voices of criticism with a sense of humility. As you well know, however, in the era of a military clique the leaders refused to listen with humility, and this was the era of suicide for our nation. All the mass media were under tight control by the military regime, which imposed humiliating subservience on them. The era of autocracy that destroyed critical forces was a dark age in our history. I suppose this is how it was also in the Nazi era of Germany.

In short, I find it interesting about autocracy that the critical force and the powers that be maintained a sort of balance. Among the critical forces, there was a powerful leadership which we could rate highly. The Meiji Era was a very interesting period, during which the government developed Japan into a strong country while adopting Western civilization without prejudice to raise Japan to a higher level of civilization.

The mass media in those years fought against those in power by representing the people, which I believe is a wonderful historical fact. Yet, today the mass media to play such a role remains in name only.

The person who embodied this critical spirit of the era was Mr. Nyozekan Hasegawa, but there were also, before Mr. Hasegawa, such figures as Mr. Tsunego Baba, Mr. Masanori Ito and Mr. Takuzo Itakura. I also rate highly Mr. Sanzan Ikebe as newspaper publisher. It was also remarkable that such an erudite scholar as Mr. Soho Tokutomi activity engaged in debate, making an excellent

contribution to the country. But such a wonderful critical spirit gradually lost force, upsetting the balance I mentioned earlier.

As the military clique developed in the later years, it asserted itself as the protagonist in the governing of the country to wield absolute power. The power of command of the armed forces was in the hands of the military. But during the military clique days, this military power controlled the entire population. During such a period, therefore, the precious critical spirits were wiped out.

During the Meiji and Taisho Eras, there was no openness of government. In the postwar era of democracy, however, the openness of government was brought before the people as an essential element of democracy. This openness of government, I believe, represents great progress. But this was something that was given us by the American Occupation Army. During the Occupation era, there was the power of the Occupation army behind this openness of government, conducting its supervision. In this sense, the openness of government in Japan during the Occupation era was merely pie in the sky.

During the less than 10 years of Occupation, the Supreme Command for the Allied Powers (SCAP) made an effort to foster forces critical of government to promote its openness. One example is the fact that SCAP revived the Jiji Shimpo, a newspaper which was once published by Mr. Fukuzawa. This may have been an indication of the interest on the part of SCAP in rehabilitating the mass media. In any event, however, the openness of government, which was engineered by SCAP, and the increase of power of the mass media, which was also manipulated by SCAP, could not possibly have produced a true balance.

This Occupation era, furthermore, on the surface was an era in which SCAP supervised the development of democracy in Japan. But actually, the Supreme Commander for the Allied Powers had more power than the Emperor. For this reason, I strongly doubt the wisdom of the United States in attempting to transplant democracy in Japan in that manner.

It became clear to us that democracy required open government. But the big question is how this openness should take root in Japan. In order for the openness of government to became well established in this country, it must be considered on the basis of a balance to be maintained between the mass media on the one hand and government on the other.

The kind of government we have today is not to be called naked government; rather, it is government covered up with cosmetics. None of the essential, wonderful qualities of government has been made public. Nor can we say the whereabouts of political ideals has been made open.

To keep government open to people does not mean to parrot lovely slogans or catch-phrases. The most important question is what the Japanese nation can do for mankind. In the process of government, the people of Japan must emphasize their responsibility and duties to mankind as a whole and strive for attaining that goal. In postwar Japan, except during the years when Mr. Shigeru Yoshida was prime minister, government was covered under the veil of bureaucratic secretism. And this veil of secretism has become increasingly thicker, and the openness of government has not been improving at all.

We are thus in an age where we must be highly conscious of these problems. What is important to opening up government to foster the true qualities of democracy is, in my opinion, a clearly identified guiding principle. And around this guiding principle, the power of the private sector, particularly the mass media, must be developed to be able to cope with the power of the government. Yet, the veil of bureaucratic secrecy has prevented such development while the bureaucracy itself has expanded.

What kind of mass media, then, do we have today? The mass media, which had been subservient to the military clique, gained stature later by being subservient to SCAP. Under such circumstances, the Jiji Shimpo, a critical force of yesteryear, inevitably trod the road to downfall. I believe that a mass medium that attempts to survive by hanging on the coattails of someone else will inevitably follow such a road.

I am compelled to conclude that the mass media of today are obsequious to the bureaucracy in many ways. I could not say that they entirely ignore the power of the people. But it is fearful to realize that the mass media which are supposed to be a spokesman for the people, actually, fabricate what they call "the will of the people" by using big type on their pages. This, I think, is as dreadful as the era in which the military clique was rampant.

The following era, that is the present age, must be considered as an age of reversal. By this I mean this is an age of the predominant mass media. In this age the mass media, which at one time represented a great critical force, lost that position and assumed the predominant position in society. This is most evident in the arrogant attitude of the mass media people.

Take, for instance, a press conference with the prime minister. It is the prime minister who courteously bows, but the mass media people do not. In a press conference with the American president, the reporters bow their heads. This shows that the people who handle the mass media have today a consciousness entirely different from before. That consciousness is that this is an age of the predominant mass media. In one way, this means that ours is an age in which public opinion is ignored.

And even this so-called public opinion is misrepresented. The mass media pretend that the opinion of a small number of agitators is public opinion. It requires neither ability nor knowledge to misguide society in this manner. The mass media in our authoritarian era in the past represented superior competence and knowledge. But today's mass media fabricate public opinion by joining hands with a small number of agitators without competence or knowledge. That this is possible today means that this is an age of reversal, that is, the past has been brought back.

At the end of the Allied Occupation when Japan was to sign a peace treaty with the Allied Powers, the biggest problem for the Yoshida Cabinet was that the mass media played up "total peace" with big type. That is, they insisted that Japan sign a treaty of peace

with all the Allied Powers including the Soviet Union. That this advocacy did not represent the will of the people but that of a small agitator force has been proven by history. Furthermore, I believe it is entirely correct to say that the mass media did not bring into play good sense against the agitator force of those years.

In short, we live in an age in which power is not well balanced in society but is in the hands of a small number of people, such as those of the mass media. This, I believe, is more terrifying than the time when we power was in the hands of the military.

Now, how did this age in which the mass media hold a predominant position in society come about? This has become possible because of the development of radio and television. The advent of radio and television has indeed ushered in the age of a mass media-dominated society. And today very few people give thought to the question of what would have happened if in 1951 Japan, by bowing to the advocacy of a total peace, had failed to sign the partial treaty.

I believe it is important for people, be they in government or in the private sector, to have foresight. In the old days it was very easy to have foresight. This is because the preoccupation of the Japanese was to catch up with the advanced countries of the West, and "foresight" depends to a great extent on the models Japan tried to catch up with. Today's Japan, however, is a vertically divided, highly efficient society, which attempts — with considerable success — to catch up with Western civilization. In such a society a highly important question is what element of society should take a predominant position. This, along with the question of diversification of values, has become a very difficult problem.

It is exactly at such a juncture that the mass media as a critical force in society should stand between government and the people. If this were the case, it would serve as an agent to develop a political climate in Japan and train the brains of the people. But the reality is that the daily press of Japan is of value only for twenty-four hours.

The popular movement against the Japan-U.S. Security Treaty was the largest popular movement in Japan. If such a mass movement

had been conducted during the military clique years, Japan might have been spared of the tragedy of entering a major war. The mass media which remained silent at such a critical time in our history, of course, had no power with which to mobilize such a popular movement. Nor did any other force have power to do likewise. Today there is very little argument in favor of the abrogation of the Japan-U.S. Security Treaty.

Ideals are ideals and they must be set as apart from reality. But mankind must approach a new ideal step by step. The people of Japan must try to get out of this age of reversion with foresight into problems of the future. If this mass media-dominated age were to last long, Japanese government will enter an age of total darkness. And in such an age government throughout the world, wrapped in the veil of bureaucratic secretism, will be conducted according to the will of the bureaucrats.

The last issue I wish to take up is one of the establishment of a balance between government and the mass media. This is an age of downfall and of reversion. For restoring the substantive position to government and the predominant position for the mass media as a critical force, I long for the advent of a great statesman who would be able to stimulate the intelligence of the people. A great statement in any event does not have to be a man of great power. In the past, a great leader was a powerful man. In a democratic age, a leader need not be a strongman. In this sense, I believe everyone must realize that the world has changed. A great leader was a powerful man in the true sense of the term in the past. But an age in which a powerful man was a leader was an age of immaturity in the history of the development of mankind.

One problem we must consider at all costs is that of the intelligence of the people. Intelligence means one half a faculty for making criticism and another half that for making judgments. These two faculties will enable the people to do what they ought to. In this sense, I must look forward to the advent of a great leader. Whether such a leader should be a statesman or a private individual, this matter

of awaiting the advent of a great leader is of utmost importance to today's Japan.

Medicine and Medical Care in the Future

I believe that the future holds great hope for mankind and man can find a meaning to life by finding a link between the present and the future. As the term "forecasting the future" suggests, we attempt to foretell the shape of things to come. But predictions must be made in a comprehensive manner. A future considered in any other way would be dark.

Yet, it may be said that forecasts of the future, no matter how great the forecasters may have been, have generally been wrong. In recent years, futurology, which sounds like an academic discipline, has come into being. But I believe this is still incomplete as an academic system and in its relationship with humanity. The bigger the forecast of the future, it may be said, the bigger its error.

When we consider the future of medicine, we may consider as matters within the realm of our imagination what kind of scientific changes our present medicine will undergo and what kind of situation medical progress will arrive at. But as a social system or a system of human survival, the future of medicine cannot be foretold. An attempt at foretelling it in itself must be said to be unscientific.

I define medical care as the "social application of medical science." By this I mean the following. Medicine is a science and we cannot tell how much progress it may achieve and how it may change in the future. It may create new harms to mankind or it may bring a

---

This paper is an English translation of the keynote address at the opening ceremony of the 20th General Assembly of the Japan Medical Congress held from April 7th to 9th, 1979, in Tokyo. Reprinted from the *Asian Medical Journal*, Vol. 22, No. 7, July, 1979.

new form of welfare to man. In this sense, medical care has a vital role to play, selecting in the course of its progress to become fused with the survival system of mankind. In other words, the progress and development of medicine must always be accompanied by soul-searching by medicine. This, I believe, should be a major criterion, according to which medicine can move forward. Medicine without medical care is bound to degrade itself as a science without humanity.

Few among medical men have tried to foretell the future. Likewise, among the great scientists there are few who do so. I do not believe that Robert Koch, the father of microbiology, for instance, predicted the future from the standpoint of microbiology. Nor did Rudolf Virchow make predictions about the future of mankind from the standpoint of pathology. History shows, however, that both Virchow the biologists and Koch the microbiologist had solid bases in their thoughts. Great scientists seldom — if ever — try to predict the future at least in the area of natural sciences. I wish to consider future trends in medicine and medical care in the next quarter century.

It is a great honor for me to have this opportunity to deliver the keynote address on the occasion of the opening of the 20th general assembly of the Japan Medical Congress. For this, I wish to pay my tribute to the late President Higuchi.

My address is entitled "Medicine and Medical Care in the Future." In this address I wish to consider problems of medicine and medical care of the future society and also what new functions the progress of medicine might bring to medical care of the future. The future society is expected to have a highly complex structure. And something like a systems science will develop to reduce the degree of its complexity. When viewed in terms of the history of development, medicine in the future is likely to have a highly expanded scope, and both its magnification and minimization will progress side by side.

When considering the relationship between medicine and medical care, the most important science to support medical care, of course, must be medical science. Only that part of medical science that has a relevance to medical care may be regarded as a sign of progress of medical science. On the other hand, the elements of medical science

which has either no meaning to medical care or raises apprehensions about possible harms to it must be given careful consideration as an object of research. The relationship between medical science and its marginal sciences will also become closer. In the area of medical care, social sciences and humanistic sciences will have a closer relationship with each other. In such an event, social management engineering as an agent to tie together the social positions of the two will have to be created. However, I cannot discuss all of these subjects within the time allowed me today. Therefore, I wish to comment on only the question, "What is future?"

First of all, there is *the natural future,* by which I mean the future we shall have by accepting the natural control of various conditions through the passage of time. This concept is valid in the field of pure medicine and also in the field of medical care. This natural future may be viewed as the principal direction, in which we shall continue to exist. Then we can consider the planned future within and around it.

The planned future is a future that is to be built on the basis of philosophical and scientific thoughts. It has a great deal of the element of the selective future. In what is known as the development of civilization, I believe, the element of the selective future will have a preponderant position. And in this *selective future,* scientist will be responsible for a broad area.

We need the planned future because we must correct the unreasonableness and distortions that have come into being in the natural future we have realized before. For example, we have had the problems of pollution in the industrialized society, and the so-called self-contradictions found within the capitalist society. It was for resolving such self-contradictions that mankind may at some times be exposed to a tragic destiny. There have been instances of such an experience when mankind has blazed a new trail. In order for mankind to maintain and develop its position in the world while preserving peaceful and stable development, a planned future is of great importance. I believe that all the sciences, not to mention medical science, must become enveloped in this planned future to serve the

interest of mankind. When the selective future is introduced into the natural future from the latter's peripheries, then there will be a planned future.

From such a standpoint, we certainly cannot negate even views on the future based on narrow fields of specialization. Yet, I believe that an outlook on the future based on limited areas of specialization will have only a minor significance for the formation of the future. In order for new research and development to survive in limited areas of specialization, it will be necessary to have a new science of administration akin to social engineering.

Under any circumstance, however, my basic view is that there is no future that is greater than the natural future, and I believe I am correct in saying that the biological basis of that natural future will be DNA. In other words, the natural future will blossom on the extension of DNA. This becomes combined with the selective future to form the planned future.

Now, let me discuss several kinds of the selective future. First of all, there is the sociobiological future. The picture of mankind in *the sociobiological future,* primarily based on demography, may be drawn with considerable accuracy up to 30 years ahead. There are various other sociobiological factors that must also be considered. But when we attempt to foretell the future as a problem of medicine and medical care, the sociobiological future is one major yardstick.

Then there is *the sociological future.* It is well known that sociological conditions have an important impact on the medicine and medical care of the future. Without some financial affluence and improvement of the standard of living, we cannot anticipate major progress in either medicine or medical care. One thing I wish to emphasize strongly is that it would be wise to remove social science-based judgments influenced by ideology from the prognostication of the future. I wish to emphasize that the survival of mankind of a global basis has an aspect that needs a sociological basis.

Next, let me consider *human relations-based future.* Human relations, either as relations among individuals or among groups or in

a contrast between the individual and the group, there will be instances in which extraordinary changes may be anticipated. Under a feudalistic system, the pattern of human existence may continue for hundreds of years. As we ourselves have experienced, however, in a democracy, the problems of the nuclear family creates major changes in human relations. We must take into careful consideration all these factors in dealing with the problems of the future of human relations. This will create a very serious problem in the area of medical care.

Next comes *the future of science.* In the past, as far as our experience is concerned, science made much progress by war. While science was at an undeveloped stage, small-scale war brought about small-scale progress. In the age of big-scale war, big-scale development was achieved. This historical fact cannot be denied. With the development of atomic power, however, the pattern of war has been completely altered. Now, mankind is at a historic crossroads between the choices of either establishing a new bridgehead for scientific progress by abolishing the pattern of war of the past on the one hand of allowing the earth to be devastated by atomic power on the other.

Every effort must be made to abolish large-scale, global war. In that process, I believe, the unreasonable solution by unreasonable war, achieved by politics of the past, will cease to exist. International solidarity will hod the key to the solution of this problem. But we cannot deny the problem of conflict between nationalistic egoism and a pan-humanistic vision. In the field of medicine, much progress was made during war in the area of physiology of the brain. In our present stage, there is a definite possibility of such research being conducted in peace time. We can say, in fact, that the denial of war can establish new research methods in our age.

There is also the problem of *the environmental future.* It has been proven that the environment always changes even when it is left alone. Man as well as other living things exists only in relation to the environment, maintaining an order of its own. Therefore, we must consider genetic and physiological responses to environmental changes.

By imagining the futures of the kinds I have just described, we

must consider the progress of medicine and medical care in these various futures as well as the problems of medicine and medical in the naturalistic future. If human intelligence and the progress of science are to account ultimately for much of the future, then I feel that scientists have the responsibility for creating a planned future. This planned future, as I said before, must be planned on the basis of an overall grasp of the futures of various kinds.

With the above remarks as an introduction, now I wish to consider the future of medicine and medical care as the main part of the address.

First of all, we must deal with the problem of interrelationship between medicine and medical care. The science that principally supports medical care must be, of course, medical science. As its subsystems, there are sociology, economics and other academic disciplines. There is a major problem in how these branches of learning combine and are to be developed, how resources are to be allocated and how all this is to combine with welfare. In this regard, the most important thing is how we *denken* (think) and what we *meinen* (intend) about medicine.

When we conduct a specific research program, there is also to be a philosophy behind it. It is known by the name of design-philosophy. This problem may not be ignored when medicine develops as a science in the future. Design-philosophy serves as the most influential background in the stage of idea formation which, indeed, cannot be realized without this background. Then there is planning, which, too, will need design-philosophy. Planning is a problem that cannot be separated from idea formation.

In the third stage, we have the problem of practice. In the stage of evaluation, too, we need a new philosophy. This new philosophy is then to be returned to idea formation through the process of feed-back. This should be one basic factor for the planned future.

Speaking of historical facts of medicine, a Pasteur Exhibition is to be held in Tokyo. The instruments Dr. Pasteur used in his time are a far cry from what we have today. Yet, it was with these instruments

and machines that Dr. Pasteur discovered epoch-making facts in a broad range of science. This compels us to conclude that philosophy as a science of thinking stimulated logic formation, which in turn developed experiments with hardly any trial and error. For the science of the future, obtaining reliable information through precision machines and instruments is an indispensable element for future science.

But I believe that *the medicine of thinking* will be given an important plane in the science of the future. The logic to be derived from the medicine of thinking, in my opinion, will form the framework of the medicine of the future. This will be analogous to the fact that the progress of theoretical physics has enabled the testing of whether the results of experimental physics have achieved major progress.

Medicine, however, is an experimental science like other sciences dealing with life. There was a possibility of a theory of criticism of the results of experiments in medicine coming into being. But in those years, a juxtaposition of experimental facts in itself was the basis on which theories were formulated. This way of thinking, of course, is fallacious in part. But as a theoretical system of science, theoretical medicine creates experimental medicine, which in turn creates administrative medicine. This is the way of thinking that follows the systematization of science.

The world of administrative medicine combines with medical care. The humanistic nature of medicine must also be considered at the same time. The reason is that when we consider the future of human relations, we find that human welfare largely derives from the worlds of human relations and scientific technology.

The development of any scientific technology cannot directly regulate human welfare. Rather, it is desirable that scientific technology be spread by administrative medicine or by a theory of human relations.

Viewed from such a standpoint, medical care does depends on medical science as a major branch of science. But it is clear that it cannot exist without the support of other branches of science. We

must make it clear that the kind of science that is difficult to apply to medical care or is harmful if applied is of very small value as an area in which to conduct medical research. Value to medical care, of course, does not have to be direct but could be indirect. But it is necessary to make a positive choice about sciences with the results of medical research as its primary condition. Therefore, progress by medical science can reach the realm of human welfare when medical care to which it contributes receives recognition in human history for its humanistic values.

There are several more specific questions. In the early years of the Meiji Era (1968-1912), tuberculosis both as an acute contagious disease and a chronic disease attacked our nation. This was a virulent disease that seriously menaced the welfare of entire mankind. Against this disease, however, biological therapy, vaccine and serum therapies, chemotherapy and many other therapeutic technologies have been developed. Because of such progress, the acute contagious diseases, which were a threat to mankind, have been all but totally contained.

Yet, today we have a new problem of slow viruses. I think it is an urgent task for the entire medical science world to establish a research system for this problem as a task for the 21st century.

I believe that in *the world of science predicting the future* is possible. In dealing with disease itself, of course, it is possible to predict the future by an epidemiological approach. And an epidemiological approach in the framework of comprehensive prediction of the future is highly meaningful. When the progress of medicine and the future of human relations became fused, the most central issue would be the values system concerning health.

The values system concerning health varies widely depending on social structure and the degree of the progress of science. We may say that the values system concerning health has progressed largely according to the development of civilization. In this age of diversification of values, the value of health must be heightened rather than diversified.

I have given some thought to health, namely, I think of health in terms of hereditary health, morphological health and functional

health. If this functional health is to include mental health, it would become a little more specific than the definition of health by the World Health Organization (WHO). The progress of molecular biology has thrown much light on the problem of hereditary health. Rehabilitation science has provided a new field for functional health. Rehabilitation is expected to achieve major progress in the future particularly in the field of mental health. It is from such a viewpoint that I wish to consider the problem of *promoting health.*

The central question in this context would be hereditary health. This is combined with congenital elements as well as problems related to the process of evolution. Therefore, the problems of hereditary health must be said to have a great significance for the future of mankind. This should be considered in relation to the dysgenic problems of living things, which we cannot afford to circumvent.

Functional health and morphological health, of course, must be improved and promoted. Specifically, there ought to be progress in the adaptability of human life to the environment.

Progress in this connection must be considered in terms of voluntary progress and progress that requires assistance. If the problems of school health, etc., were to be considered in such a context, the basis for providing the citizens of the future with high adaptability must be laid to a great extent in their infancy. When this notion is developed, it will create the concept of community medical care.

The concept of *community medical care* was brought into being largely through the research conducted by R.M. MacIver on the concept of community. When this concept is brought into existence, it would be impossible for it to attain progress without the utilization of *medical care information science.* In this sense, medical care information science is a new branch of learning, but it must be considered as something that responds to a social need. Information science, furthermore, will play an important role in the area of clinical medicine. It is necessary to grasp micro-information science in community medical care are as well as macro-information science.

One thing we must give much thought to concerning the future

of clinical medicine is the question of medical care information. It is a source of much joy to us that the progress of information science has been introduced into medical area. Yet, there are many problems concerning data processing that cannot be solved by information science alone. The progress of the computer has allowed a giant step forward for medical care information science. But excessive information we have today does create a problem of its own — that of information — which did not exist in the years when information was deficient. One thing that can never be forgotten in clinical medicine even for a moment is that excessive information must not be allowed to confuse the diagnosis of individual patients.

The technology of data processing is making steady progress. But it is also a fact that the rate of increase in the amount of information outpaces it. In the training and developing of the primary care physician, it will be necessary to plan simultaneously for medical care information and data processing science. In the area of the science of data processing, there has been considerable scientific progress attained in dealing with data represented by patterns. But there is still much room for improvement in the evaluation of the relationship between information of every kind to the individual patient.

The last problem in this sense cannot be separated from the problem of the physician's professional ability to think. There will develop, I feel, areas in which mechanical processing would be impossible. That is where differences between a profession and other occupations become apparent.

Another major problem of change in clinical medicine would be that of formalization of diagnosis and treatment. In the area of treatment, in particular, there has been a tendency toward formalization noted in the guidance and standards prescribed for medical care dispensed under the health insurance system. But there is a totally undeveloped area of individualization. At an advanced phase of medicine, there is the problem of how to define the individuality of the patient.

Rudolf von Krehl (1861-1937) the founder of pathological physiology in his *Krankheitsform und Persönlichkeit* dealt with the

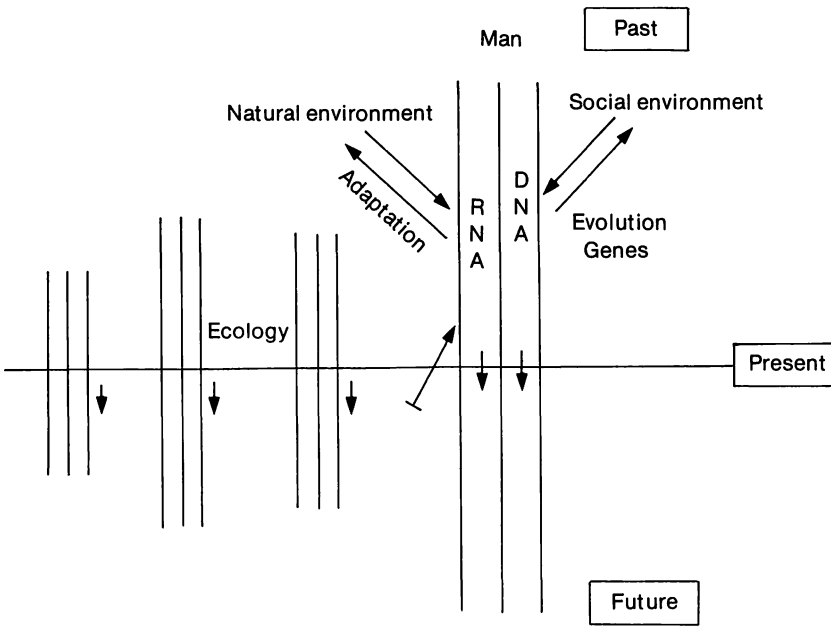
problem from the standpoint of pathological physiology. With the increase of medical care information of all kinds in the years since then, many new ways of thinking have come into being. But none seems to have become an established theory. Only the question of individual differences in the effect of medicine is being discussed. Individual variation in response to a drug is one yardstick, but it is not everything. The concept of individualization includes immunological elements as well as other biochemical conditions. But there might also be other *unknown conditions* that have to be taken account. For all this, this area does have problems that future medicine, clinical medicine in particular, will have to tackle.

Discussions are often conducted from the standpoint of constitutional medicine. But nothing specific has been done about the problem of individualization in terms of clinical medicine. It is possible to assert that the ultimate aim of clinical medicine is individualization. In Chinese medicine, there seems to be some consideration given to the individual factors of a patient. Chinese medicine starts out with observation that combines with the principal complaints of a patients before he may be properly diagnosed. It is possible to say that in Chinese medicine an observer fully criticizes and evaluates his own observations and the patient's complaints. The accumulation of such activities has created a certain system. In Western medicine, pathology was established on the basis of cytology, and its morphological and physiological phases have combined to establish clinical medicine. But there is no specific indication of responses to be made to individual variations.

The response of an individual to a particular stimulus may express a part but not all of its characteristics. For this reason, I believe that the problem of individualization will be the central issue in the clinical medicine of the future.

I have studied the problem of the survival order of mankind as a basic structure of medical science. In this drawing (Fig. 1), the right-hand side illustrates human relations, and the other side describes natural conditions. The future comes to us in the context of the natural and historical environment — the past, present and future

Fig. 1 Human Survival, Environment, Medical Care
Human Survival and Its Order

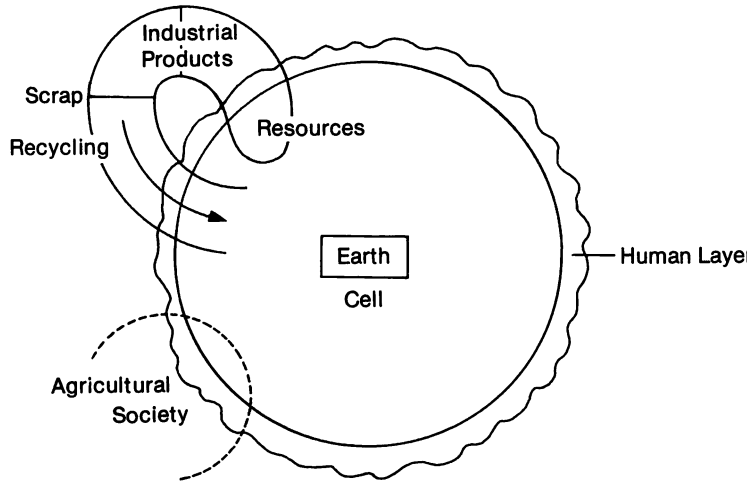


social environment. The historical world comes to the present, in which the natural world and civilized society coexist in society. *Adaptation* occurs with regard to all of these factors, and it is under that circumstance that survival order comes into being. I believe it is necessary for us to consider at least once the achievements made by scientific civilization in that *survival order.*

Fig. 2 shows that human life takes place within a thin film covering the surface of the earth. In the agricultural society of mankind, there was metabolism on the surface of the earth. In the industrialized society, natural resources were dug out of the deeps of the earth. They were turned into goods through industrialization and were consumed.

We must realize here that in this industrialized society there is no natural course of recycling resources as in the case of the agricultural society. The recycling of natural resources has two sides: industrial

Fig. 2 Human Layer Compared to Cellular Membrane Man Living in Earth Metabolism System



recycling and economic recycling. Neither economics nor industrialization has taken into account the problem of recycling of resources. This is the reason why the surface of the earth has become polluted. Primary pollution occurs at the stage of industrialization and also in relation to the extraction of resources from the earth. Secondary pollution occurred because of defects in the process of resources recycling. The economics of recycling expected in the future society of mankind, however, is believed to be able to solve this problem.

If we had had a science of prediction, we would not have the problem of pollution that we have today. The science of the future, I believe, will have a great need for a science of prediction. Such a science, of course, would be possible only after all kinds of science become integrated. The elements that might threaten human survival would create disaster unless they are predicted by this science of prediction. The faster science progresses and the farther its scale expands, the greater the need for the science of prediction would be. This science will, along with management science, determine the survival order of mankind.

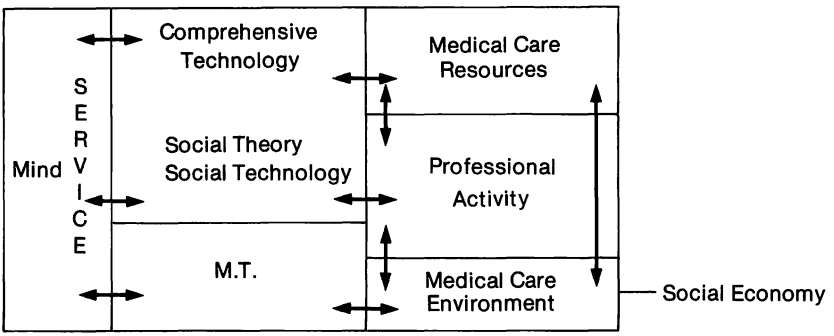
A major problem we face is the fact that medical science dealing with human health cannot skirt the problems of aging. Molecular biology and epidemiology concerning aging have attained much progress. But they are yet solve the problem itself. It is a fact that any biological being with a beginning must have an end. In this sense, the elixir Shih Huang-ti of ancient China ordered his retainer, Hsu-fu, to obtain from a foreign land was a highly unnatural thing. Now I wish to describe my concept of "aging healthily" in the context of the survival order of mankind.

If we cannot prevent aging, aging healthily should be the biggest desire for man. And yet this desire may not be fulfilled without the contributions of a comprehensive science. Today, the speed at which the population of Japan ages is enormous. When we consider human welfare on the basis of science against the background of this fact, how to age healthily would be the biggest problem facing us at the beginning of the 21st century.

At the beginning of the next century, one out of every four young persons of Japan will have to support the aged. If so, it would be impossible for the people to expect a life of high-level welfare due to such a high cost. Then there would be the problem of the labor productivity of the Japanese. If the aged segment of the population were to have no productivity, they would constitute a heavy load on the younger generation. On the other hand, if the aged have productivity even at a low level, they could make a contribution to society and reduce the burden on the younger generation.

Even in the 21st century, Japan will not be a country rich in natural resources. Therefore, we must make a maximum use of the individual's productivity. This will be a national requirement. It would mean that raising the productivity of the aged of Japan would be an important element in industrial medicine. Contribution to the preservation and promotion of the health of the worker would be the primary objective of industrial medicine. In view of the circumstances under which Japan finds herself today, however, how to produce the aged who have high productivity would be an enormous problem. When these problems are fully taken into account, we shall find the

Fig. 3 The Function of the Physician



problem of medical education coming to the fore.

It is possible to maintain the present form of medical education. But a future-directed system I have just mentioned may also be necessary. When medical education is fundamentally reconsidered in terms of the future, a major change may be anticipated. Since medicine is essentially to be applied for the future of human society, this is only natural. Medicine ought not to be something isolated from mankind.

It is from this standpoint that now I wish to consider the future changes expected of the role of the physician. As Fig. 3 shows the function of the physician is the professional activity situated between resources and the environment. When this becomes developed, it is presented to the people as a social service. When we consider this kind of model, we find that there are ways of dealing with the problems of aging and that thee are also problems medicine alone cannot solve. If I may be permitted to use the term "medical care service," this will have to be assessed as a major economic act.

As I have just said, the physician's professional activity, placed between medical care resources and medical care environment, turns into a comprehensive technology, social theory and technology and eventually into service. This service includes problems of the mind. That the mind has entered into the picture unlike in the past when only matter was considered as significant in terms of biology. This way of thinking stems from the new discipline called the economics of service.

Fig. 4 Present Health Insurance System of Japan and Primary Care

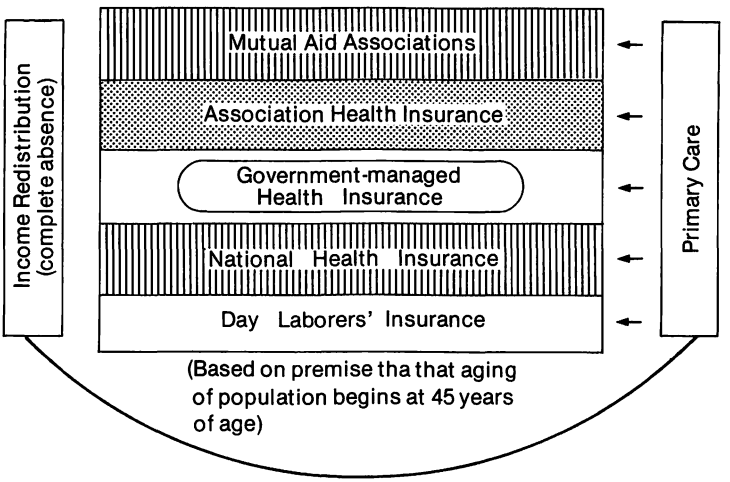
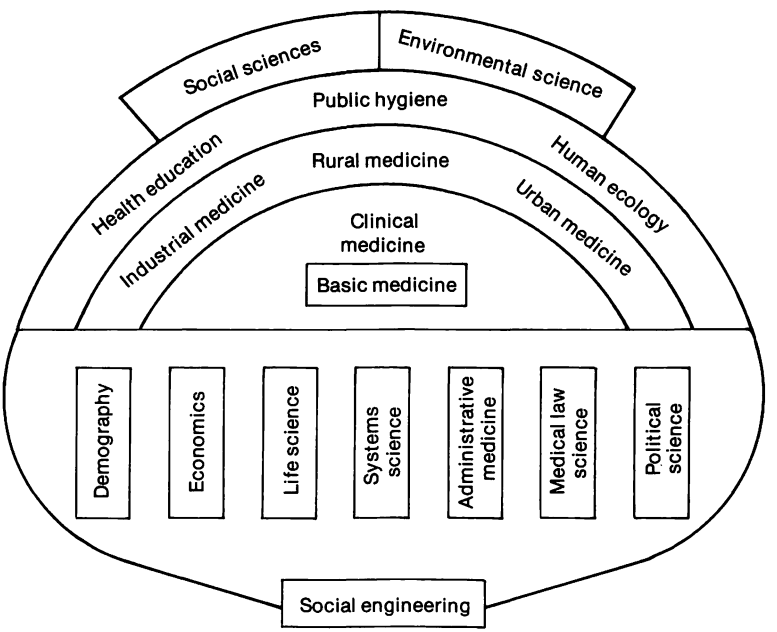


Fig. 5 Establishment of a Medical Care System



Today's health insurance system, however, has very little economic interest in medical care service. In this regard, I proposed at a World Medical Assembly the creation of a special committee within the World Medical Association to deal with the "development and allocation of medical care resources." With the cooperation of people from all fields of learning, the Japan Medical Association has taken the initiative in pursuing the subject matter with a follow-up committee.

According to this way of thinking, the future physician will have to deal with the reality along the direction of the future. This would mean that medical care will be considered as a professional and comprehensive system. The physician would not be a mere technician, but he will have to *denken* and *meinen* and move ahead by thinking about the relationship between his profession and the future society. In this connection the problem of primary care has drawn much attention of late. I feel that it is totally impossible to develop primary care physicians with the present postgraduate training system we have. To cope with the demands of the times concerning industrial medicine, in particular, we will need a great turnabout. Fig. 4 and 5 show what I believe is necessary as the background for the development of primary care physicians and show the pattern in which medical science can be applied to society.

Today I was allowed 40 minutes. I hope you will forgive me for having presented you with subjects much too important and large to fully discuss in such a short time.

Let me conclude by offering my thanks to the Japanese Association of Medical Sciences for giving me the honor of addressing you today.

Bio-Insurance, a New Concept of Health Insurance

All the medical care systems that have been made public so far were created by the lawyers, politicians or economists. The age in which the physician was the principal in the administration of medical care now belongs to the past.

Today, economics dominates medical care. The economics of medical care is, in essence, the economics of medical care insurance in all the countries of the world.

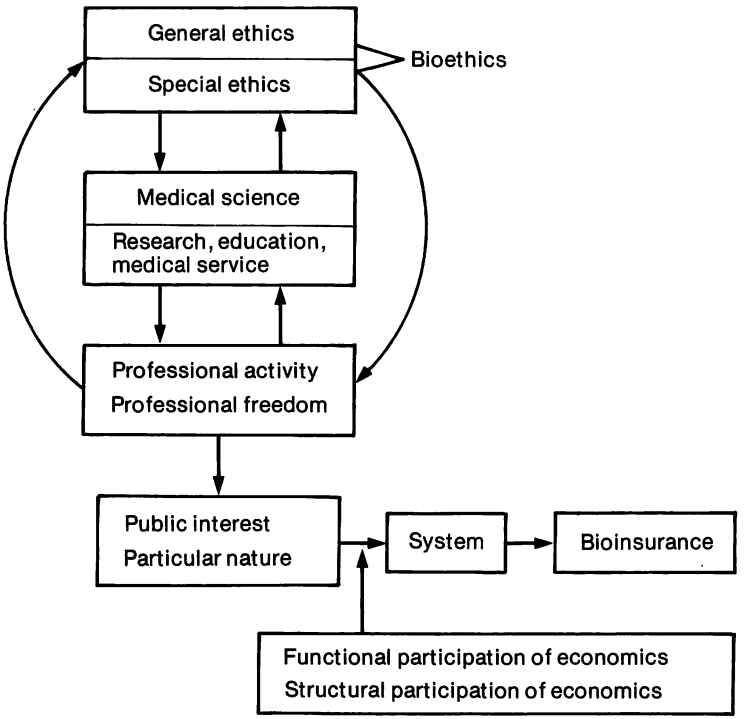
Insurance economics functions according to the principles of insurance. This means that the insurer's economic stability is protected to the utmost. Therefore, the insurer will never tolerate the situation, in which higher medical care costs threaten his economic stability. This is the reason why the economic problems of medical care have become prevalent throughout the world.

I wish to stress here that we have had no history of ethics and medical care systems fused together. Systems were created at will while medical ethics has been imposed on the physician since the days of Hippocrates. Today, however, medical care must be re-examined from every possible angle, and the physician himself must create a system that he thinks is the best by bringing together all the related sciences.

We need general ethics, which ought to be common to both the

This paper is an English translation of the original in Japanese which is published in the *Journal of the Japan Medical Association*, Vol. 82, No. 10, pages 1189 to 1190, November 15, 1979. This paper was presented at the 97th Council meeting of the World Medical Association in Caracas, Venezuela, on October 27, 1979. Reprinted from the *Asian Medical Journal*, Vol. 22, No. 10, October 1979.

Social Progress of the Medical Care of the Future



masses and the physician. Medical ethics for the physician has been very much stressed. But medical ethics and general ethics must go hand in hand and cannot be independent of each other. That kind of ethics is bioethics.

Medical education, research and medical care must have a feedback mechanism for bioethics which combines general ethics and medical ethics. And it must develop into a major professional activity. For that, professional feedom ought to be firmly established because, without professional freedom, it would be impossible for the physician to be responsible for his professional activity. Needless to say, both professional activity and professional freedom have a built-in mechanism for the feedback of bioethics.

Let us now consider the basic pattern of medical care by looking

at the map that shows what I have said (see diagram). The public nature of medical care must be considered in terms of science, economics and social conditions. At the last Council meeting, I presented a detailed paper on professional freedom. To follow it up, I believe that it is necessary to study the public nature of medical care along a very broad range.

Medical care as a business has its own peculiarities. That the privacy of a patient must be protected is one example. It is also necessary to have life-long education for the physicians. I believe it is of great importance to distinguish clearly the public nature and the particular nature of medical care for the development of the professional activity of medical care.

Only after these elements have been identified, may we take up the question of the structural and functional participation of economics in medical care. Only after this is done, will the entire process be turned into a system.

We could establish a medical care system with a definite direction by coordinating social technology and modern technology, apart from the existence of intra-hospital systems or community systems.

On the basis of such a system, I wish to propose the new concept of bio-insurance by eliminating all the past concepts of insurance. Bio-insurance is different from the old insurance, which was designed to protect the interests of the insurer. It is an insurance that is primarily concerned with the health of the nation. Under such a system of insurance, the society would be without organizations of insurers.

According to the principles of insurance, there could be no such thing as the provision of medical care in terms of goods. In the case of a fire insurance company, for instance, when damage occurs, part of it must always be paid for by the insured while the insurance company pays for the remainder. The idea of the insured being forced to pay a part of the cost of medical care under a health insurance plan derives from this principle of commercial insurance. But this principle is totally alien to the essence of medical care.

In non-life insurance, the amount of damage for which the

insured is responsible is estimated, and the insurance company pays for the remainder. In bio-insurance, however, the idea is to insure the health of the insured by providing him with benefits. In other words, bio-insurance is a form of insurance, in which the physician is the principal, and the principle that runs through the entire system is bioethics.

I believe that this committee must take up such a system for a thorough study in the interest of the medical care system of the world 20 years from now. I believe that it would be possible to establish a bio-insurance system nationally and internationally by adding the individual characteristics of various countries to this basic form I have proposed.

Sino-Japanese Medical Interchange

A Japan Medical Association (JMA) mission recently visited China. As leader of the mission, I stayed there with the mission for five days while the other members of the parts stayed for seven days. This mission, in the formal sense of the term, signifies the start of medical interchange between China and Japan. It also signifies a new stage in our relationship with China in that the mission was intended for organized cooperation. Not only did we think in this way but also the Chinese we dealt with definitely thought likewise.

The Japanese Red Cross Society and the Ministry of Health and Welfare invited Mr. Qian Xinzhong, president of the Chinese Red Cross Society, in January this year (1979). Mr. Qian, at that time, held a post equivalent to that of minister of health and welfare. The JMA hosted a dinner party for him one evening to promote the exchange of views in the presence of the Chinese ambassador and minister to Japan, and others. This occasion was the first instance of interchange between the medical associations of Japan and China.

In March, a Chinese mission headed by Mr. Tu visited Japan. All those who had visited China in the past participated in the program already prepared. However, the program shown to us at first indicated that we were to spend only one day out of the seven-day visit

---

This paper is an English translation of a talk in the "Special Medical Course," broadcast on July 1st, 1979, by the Nihon Short-wave Broadcasting Co., and the original paper in Japanese was published in the *Journal of the Japan Medical Association.* Vol. 82, No. 2, pages 250 to 254, 1979. Reprinted from the *Asian Medical Journal,* Vol. 22, No. 11, November, 1979.

inspecting medical institutions. If we followed this program, we thought, we would be merely guests at dinners acting like tourists and would be unable to produce concrete programs for medical interchange between our two countries. I passed on our way of thinking about this, and Mr. Tu said that our views would be fully taken into account. For two days, we exchanged opinions with Mr. Tu, then we showed him various facilities in Japan, taking him to medical colleges and research institutes, in which he showed keen interest. I believe that Mr. Tu was able to learn a great deal about the actual state of medicine in Japan.

After this mission's visit, it was expected of us that we would visit China to study actual medical conditions in that country. Accordingly, we organized a group, which comprised myself as head of the mission, Vice Presidents Matsuura and Saito, and Directors Nakayama (as an internist) and Kamei (as a psychiatrist). From the Japanese Association of Medical Sciences, we also had the participation of president Kumagai and Vice Presidents Ota and Oshima. Professor Koizumi of the University of Tokyo and President Tsuchiya of the Industrial Medical College also participated.

I wish to make clear my way of thinking about the composition of this mission to China. I carefully considered what the prerequisites of understanding would be for us to engage in medical cooperation. Then I thought that cooperation would be easier in the field that our levels were close to each other. I firstly, therefore, selected Professor Kumagai, a pharmacologist, and Professor Ota, a pathologist, because these two men would be able to understand the conditions of basic medicine in China and also determine the contents and levels of medical education there. They would also be able to understand the research system in China.

For the future of China, public health must inevitably be a very important problem. The implementation of public health programs in that vast country is an important problem on which our views had to be organized. Thus, I asked Professor Koizumi to join in the mission. I selected Professor Koizumi also because his *Ecological Population*

Theory would make a major contribution to the solution of the population problems of China.

Industrialization is the supreme requirement for China as a country. Whether this all-important requirement is to be successfully met or not will decide whether in China's destiny China's economy is to prove viable or not. China must achieve industrialization at any cost. And then, if this is to succeed, it will inevitably create problems of pollution, occupational diseases, etc., which fall under industrial medicine. Thus, I asked President Tsuchiya of the Industrial Medical College to join our mission.

Besides these specialists in basic medicine and social medicine, we had another group of specialists in clinical medicine, consisting of JMA Vice President Saito, a surgeon, Vice President Matsuura, an obstetrician, and Director Nakayama as an internist, and Director Kamei as a psychiatrist.

If our mission were only to be an ordinary goodwill mission, it would not have been composed of these members. But my main consideration was medical interchange between Japan and China. This meant that we ought to be able to speak directly with each other, and I made full preparations for this.

The Chinese side responded to our policy with great sincerity and full preparations in organizing individuals and visits to institutions to make our mission meaningful. For all these efforts I am most grateful.

A important factor in conducting medical interchange is to determine where to start extending the hand of cooperation. This requires, a frank exchange of views.

While Mr. Tu's mission was in Japan, there was a through study of problems concerning medical education. What remained to be done was for us to go to China to see for ourselves.

One thing that impressed me was that there is a great deal of effort being made by both professors and students in medical colleges to build their country. The preparation of teaching materials was being done with special favor. They still do not have complete state-edited textbooks of medicine. But they are being prepared now with

great enthusiasm. Some texts have already been completed, and we were able to visit facilities while studying these textbooks.

There is, however, one serious problem in the present state of affairs with regard to medicine in China. This is the distortion of Chinese Society by the Cultural Revolution and by the subsequent more than 10 years of rule by the Gang of Four. The Cultural Revolution ravaged the field of learning or, at least, it disrupted academic research, and all cultural and educational activities. This must indeed be counted a tragic experience.

We heard detailed reports from our hosts on this matter. As one illustration of this disruption, a professor of brain surgery, whose attitude the Gang of Four did not like, was forced to work as a grass-cutter. In these circumstances, medicine in China was constrained in a special way.

For this, I give the following explanation: In Japan, too, during the years when the military clique was in power, we had no academic freedom and war took priority. It took Japan 10 years to recover from the effects of this. The first five years was a period of hard struggle and the next five years produced the fruit of the constructive endeavor. Thus Japan overtook the United States in 10 years. We agreed that in any country, wrong government brings a great misfortune to the people. This should be a lesson for us in the future.

It became necessary for us to learn clearly what kind of medical education policy the government of China is pursuing. China is a communist state, where the direction of academic research is determined by the government. Academics have not the right to determine policy autonomously. This is the basic difference between free and Communist societies. In Communist countries the state decides the supreme policies. One of the policies of China, we found, is to create a wonderful medicine by fusing Chinese medicine with Western medicine. This sounds very good as a political slogan. But there is no discussion of whether this is academically possible because the state does not such discussion. The state merely sets down the policy as a supreme order. This we had to acknowledge as a fact.

Wherever we went, we found constituents of drugs derived from traditional Chinese drugs administered by injection and orally. The pharmacological process involved here is very immature and dangerous when viewed from the standpoint of Western medicine. It was reported, however, that there were surprisingly few accidents in this system. At least, there was no process like the one in Japan to develop a medicine for injection, and yet such a medicine is used as drugs for intravenous injection are in Western medicine. We found this and other interesting phenomena.

At the Chinese Medical College, acupuncture seemed to play the dominant role. There were instances of treating even schizophrenia with acupuncture. But we were not able to obtain sufficient information on the results of such therapy. At least we can say that many things are going on beyond the realm of our own knowledge.

This Chinese Medical College, however, is not exclusively for Chinese medicine. It does provide some Western forms of treatment. This is the reason why they talk about "cooperation between Chinese and Western medicine."

Before going to China I studies Chinese medicine by reading relevant literature. But as far as we were able to observe on our visit, the Chinese way of thinking is based entirely on life itself and is not idealistic I feel it can be said that such politically oriented purposes derive from ancient Chinese philosophy, which is, of course, different from Western philosophy. It is from this Chinese philosophy that acupuncture came into being.

Yet, there is hardly any processed data on the results of the education conducted by the Chinese Medical College. This lack of processed data is indeed the most important characteristic of the Chinese medical administration. It is not possible to know whether a certain therapy or medicine is effective or not. The naming of diseases is as in Western medicine. But the treatment of them is Chinese. If, then, there is no processing of data, it is utterly impossible to determine the actual situation. On my first trip to a medical institution, I discovered that Chinese medicine totally lacks a systems

orientation or a structure for processing data as is done in information science.

In Shanghai, we visited the Second Medical College where we attended lectures. The contents of the lectures were, of course, different in kind from Japan's but were of a fairly low level. This was partly due to the need to fill the void created by the Cultural Revolution. I realize that the professors were obliged, to provide elementary lectures to students who were at a very early stage.

In discussing with the professors, we learned that there was hardly any study of Japanese. Unless, however, there is Japanese language education, we would find serious difficulties in cooperation. If only Chinese medical terms are to be used, furthermore, this cooperation would not be useful in Japan. Thus, even on the basis of our visits to the Chinese Medical College alone, it was obvious that cooperation would be extremely difficult.

At the Second Medical College, which is Western oriented, we found that the professors were making experiments in basic medicine of the kind they themselves engaged in when they were studying in Japan 30 years ago. China was a closed society for a long time, and therefore no information entered the country.

Given this background, China indeed deserves our sympathy. And we held long discussions with those intelligent people who represent Chinese medicine. One think we certainly agreed upon is the importance of learning Japanese. Another is the fact that professors were aging without being able to develop successors. We asked them about this problem. In China, which is a Communist state, university graduates are all ordered to go to rural areas or to cities, wherever they may be. Wherever they are sent, they find senior colleagues. But few find sufficient leadership. These young graduates have to become full-fledged doctors largely through their own efforts.

We heard about the "barefoot doctors," the special doctors. But the state requires that university graduates be assigned to the provinces for a number of years. It is absolutely impossible for a person to go where he wishes. This situation is inconceivable in Japan.

Interestingly enough, there is no such thing as medical licensing of doctors. What this means is that a fake doctor cannot take advantage of the system. In any event, a medical college graduate, whether he is trained in Chinese or Western medicine, must go where he is ordered practice.

Another problem is that of medical care standards. These are also set by the state. Thus, the development and allocation of medical care resources are also determined by the state. The same is the case in the assignment of doctors. Everything is determined by the state — totally unlike the situation in a free society.

But, in any event, we must conduct cooperation in medical care. And, the first such item on which we conducted full discussion with our Chinese hosts was curriculum. In China there are up to 550 students in a class, and the 90 medical colleges have 90 different curricula. Therefore, we must think of standardizing these various curricula to some extent. Another practical problem is to close the gap created by the Cultural Revolution.

The development of successors to aging professors is another serious problem that must not be neglected. I have considered one possibility. That is, those who are now teaching could come to Japan for short periods and observe the condition in universities and research institutes. Each person who thus learns about Japanese institutions on his return to China can form a group and act as its leader. Such groups, I believe, must be primarily concerned with basic medicine; otherwise we cannot expect Chinese medicine to develop in the future.

We met with Mr. Qian on every day of our visit, and Professor Tu was with us throughout the whole period. Our views, as discussed with these two persons, were presented to Mr. Lian Chengzhi. At that time, The People's Congress was in session and by extending our stay in Peking by one day, we were able to listen to the views of the government and we were also able to state our views to them. We were fortunate to be able to spend two hours with Mr. Lian.

Mr. Lian is, as perhaps you know, a graduate of Waseda

University of Japan and can speak Japanese. The others we met did not speak Japanese, and we had to use an interpreter.

I was very much impressed by what Mr. Lian said initially. He said that China has carried out many things during the past 2,000 years. But in the field of medicine, there has been no scientific reorganization at all. This indicates that the problem of the handling of information scientifically is in his mind.

During the one-and-a-half-hour talk with Mr. Lian, I focused on the question of how to develop leaders' groups. One way this could be accomplished is by having leaders visit Japan for short periods to study with us. Another is to have younger people in Japan for longer terms — at least two years. This must be preceded by study of Japanese. Other forms of interchange may be also conducted. But when these leaders can spend 20 years in Japan, it will be possible to have a complete union of the leaders of the Chinese Medical Association and the Japanese medical profession.

On our visit we discussed particularly the problems of human development and the development of leaders, and Mr. Lian gave his full endorsement to the views I expressed. Mr. Qian, the Chinese minister of welfare, made no comment. Thus, we had full agreement with Mr. Lian. And, we were able to accomplish our mission's objectives.

What remains to be done is for both China and Japan to implement the proposed interchange program with enthusiasm. We expressed the hope that the place Asian medicine holds in the world will become greater. And this is how we ended our meeting with Mr. Lian.

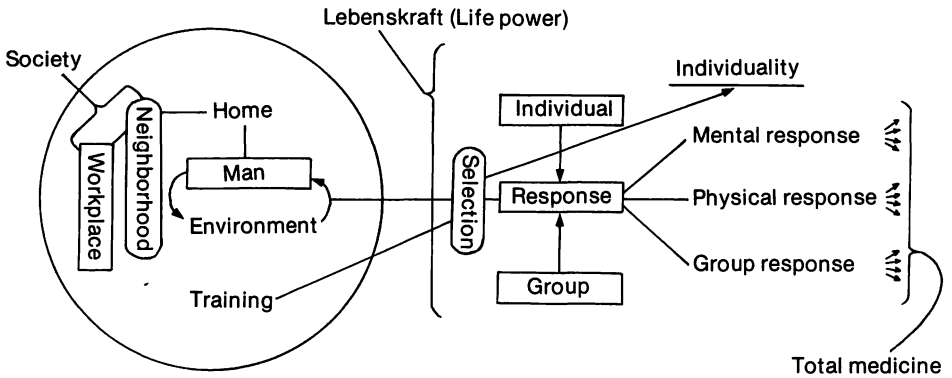
Mental Health — the Individual and the Group

I have been speaking to you for many years and I am asked again this time. I was rather reluctant to accept the invitation for fear of boring you again with my uninteresting talk. But upon your insistence, I am here again.

So far I have spoken to you about the basic things which in medical terms are like those concerning physiology and cytology. Today I would like to discuss something beyond that realm. The reason is that today we have systems science introduced into medical science with its engineering technology and the method of collecting data, and the way of thinking in medical science have undergone major changes. I find many problems that remain unresolved in this situation, and this is the reason why I chose this subject for today's talk.

When we take the position of mental health and psychosomatic medicine, the most important requirement is to consider man as a whole. What this means is that, as I wrote here, to grasp man as a whole means to grasp him and his environment as one (see chart). To consider man by extracting him out of his environment, I believe, is like dealing with a dead body. To grasp man with his environment is the ecological way of doing it.

This is an English translation of a lecture delivered on May 14, 1980, at the 2nd Mental Health Conference organized by the Japan Productivity Center. Reprinted from the *Asian Medical Journal*, Vol. 23, No. 12, December, 1980.



In psychosomatic medicine, the mind and the body are regarded as inseparable. We shall discuss this later. But as I wrote in this chart, the feedback process in man's environment always takes two forms, that of the individual and that of the group. And the balance between these two kinds of response—that of the individual and that of the group—is very important. If this balance is ignored, a disruptive phenomenon may occur.

When we think about these phenomena, we must consider how they occur and how we can return these phenomena to a normal situation.

As I said, we must grasp man in his environment—in the ecological way of thinking. But this does not mean that we can grasp all the elements in this circle (in the chart) all at once.

In attempting this grasp of man medically, I would like to offer the following: there are three responses: mental, physical and group-medical. These three responses are identified separately to facilitate the explanation, but they cannot be completely separated because they are closely interdependent on and related with one another.

A psychiatrist places emphasis on man's mental response, an internist on his physical response and a specialist in public health on his group response. And each of these responses is further finely divided.

What brings all these subdivided responses of man together is total medicine. When you deal with a patient, it is highly important

how you place him within the framework of total medicine and not be bound by the symptoms alone. This kind of thinking does not weigh very much in contemporary medicine, but I think this will become accepted before long.

We have today the term "biomedicine," which roughly corresponds with total medicine. Therefore, we can say that what I must discuss as the most basic is contained in this chart.

When we consider mental and physical responses, we find one more interesting worldwide phenomenon in terms of biomedicine, that is, the concept of bioethics.

This concept of bioethics is a product of work over a long period of time done at the Kennedy Institute of Georgetown University of the United States. Bioethics has been translated as life ethics but actually it sets a new direction for medicine.

At the very beginning of the 20th century, *Lebensphilosophie* became very popular in Germany. This may have been one of the bases of the new concept of bioethics. Yet, bioethics is different from *Lebensphilosophie* of Germany. Rather, it is a more modern ethics which is a combination of the recent macro- and micro-worlds of medicine.

In the conventional sense of the term, ethics means rules, such as "don't do this and that" or "you must do this and that." In our age of rapid development of scientific technology, our environment changes very much. As I remember having drawn a chart here before to explain my ideas, man's ability to respond to changes in his environment is enormous. Of course, if man had no such ability, he would have perished long ago. This ability to respond is called adaptability.

When we consider this adaptability, we find that we need some concepts that are not found in medicine today. Response may be considered in terms of that between individuals and groups or by individuals and by groups. But medicine still does not understand the individual. We don't know what is individuality. I have observed with great interest the various data you at the Japan Productivity

Center have collected. But this most basic question of what is individuality is one that medical men must probe further.

To understand individuality, we need a new concept, which is in German *Lebenskraft* or life power. This life power is something today's medicine has not probed although we find a very primitive concept of it in folk religions. It is not in the world of new science. But now there is a dominant view in the world of biomedicine and bioethics in favor of introducing the concept of *Lebenskraft* as a new concept in an attempt to reexamine human adaptability.

If we were to follow this way of thinking, in thinking about neurosis caused by a sense of insecurity, for instance, we must take into account many causes of this insecurity neurosis. These causes may be found in the patient's home.

And now this concept of home in Japan, I am told, is something that is very difficult to understand. I made a study of it myself to some extent. The French jurist Gustave Emile Boissonade de Fontarabie, I believe, made a thorough study of the concept of home (*ie*) and used this Japanese word, *ie,* in foreign languages because it is so unique. This means that the Japanese home is a unique unit of existence of mankind, which forms the basic environment of every Japanese.

Home, as you know, is a group of consanquineous individuals or people who are related by blood. This is a highly colloquial expression, and yet this blood relationship is one expression of the gene. In other words, home is the carrier of the gene, and I believe it is very important to grasp this gene carrier as the most fundamental unit of the human environment.

I have spoken here before about the nucleus of the cell and the environment, which is home. Family lineage runs through the past, present and future, carrying genes through the individuals related to one another by blood. This is the reason why home, which enables this transmission of genes, is a special environment.

Another problem is that of the neighborhood, which is the real physical periphery of one's home. Home is the cytophysiological environment of man, which is inevitably subject to the influences of

the immediate neighborhood. There is another environment—that of workplace. And later there is the social environment.

In his responses to these varied environments, man can be selective. This means man has selective responses. A man who suffers from anxiety or a sense of insecurity has a problem in this process of selective response.

The social environment, we speak of, is highly complex. That in a country like Iran, where there is a strong religious rule, is vastly different from that of Japan where there is no strong religious impact on society. Ours is also different from that of the U.S.A. It is also different in terms of economics. The complexity of our environment makes selective response difficult for some individuals.

When we speak of an individual as a strange character, it means that the particular individual has made his own selective responses, which make up his individuality and which we find strange, and this strangeness in turn controls his selective responses. It is obvious, therefore, that selective response is a very basic concept.

As I said before, selective response is made by an individual and by a group. There are, of course, all kinds of groups—trade unions, interest groups, etc.

But in today's medicine this kind of reasoning does not receive much attention. Of course, there is a little bit of theoretical medicine, but there is hardly any of this kind of reasoning. I have been lecturing on these problems to medical students for some years and found this theoretical issue rather interesting.

Now we have found many problems according to this way of thinking. And some of them require quick disposition, for which academic discourse is not useful.

Take the case of someone who finds that he has a patient with neurosis within his own family. If we regard this as a problem, the question is how to dissolve it. If we draw a line connecting home with environment and neighborhood and further with workplace, we may find a key to the cause of neurosis and to its solution. I feel that it is

characteristic of a living organism that the cause of a problem and its solution are often identical.

One of the problems we face in thinking about biomedicine and bioethics is that of training. Training is often thought of as a universal formula applicable to all individuals. But it should be individualized. There is training in selection and training in response.

If we apply this way of thinking to the case of neurosis patient, we find the major question of whether or not we have not been deficient in giving training to such patients in selection. If this has been the case, we have to expect neurosis. If we have been dificient in giving training in response, this, too, could have caused self-disruption.

If we apply this way of thinking about the next century, I feel that we might have a new medical science, which I might name "medicine of prognostication."

When we think of the future we find an interesting road ahead of us though it is still highly vague. At present, we conduct an experiment and find a new technology, with which we can make one step forward. In medicine we have had no such procedure as that of physics, in which a theory precedes an experiment that proves it. This is, in fact, one of the reasons why there is popular distrust of medical science. This is due to the fact that medicine has been a science which has unduly leaned toward morphology. This, I believe, was unavoidable in the process of the progress of science.

But now we have the advancement of a functional medicine. We have such new concepts as *autoregulation* and homeostasis as independent entities. But in the future, they may be brought into one coherent pattern of medical science.

I believe that a qualitative improvement of the activities of numerous groups will be a prevailing force in the future of Japan. For instance, a group which pursues profit, I feel, will not live in the 21st century. In the next century, the power of the groups which contribute to the improvement of the quality of human life will rule the world.

I am very pleased for these reasons that you are studying hard the problems of psychosomatic medicine and other problems of the workplace, and we in medicine place much expectation in your endeavor. Earlier, I stressed the importance of placing an individual within total medicine. I also wish to stress the importance of *directionality.*

This is the reason why I chose as the subject for today's talk the problem of the individual and the group, which will be of some use to you. I think that the day when uniform ways of thinking can dispose of the problems of man is over. From now on, the way of thinking about human management must undergo a major change with regard to both individuals and groups of human beings. And groups will not be merely seeking greater profit but attempting to achieve their own qualitative improvement. Thank you for your kind attention.

The Development of Bioethics

Old-fashioned ethics comprised a system of unilateral commands not to do this or not to do that. Of course, it contained a great deal of truth. Today, however, we must give thought to the fact that science has progressed to the point where man can remodel himself by using genes. We also talk about man conquering nature. For these reasons it is now doubtful if the old-fashioned ethics of prohibitions are adequate for coping with the progress of scientific civilization.

Man has, therefore, come to realize that it is necessary to establish new ethics for fostering and safeguarding human welfare. In this age of test tube babies, old ethics are fast becoming out-of-date. This is the reason why there is now a desire for thinking about a new order for mankind with new ethics.

Among the new ethical systems, the most notable and vital is bioethics. The bioethics movement represents a very positive form of ethics, intended for building a new concept of welfare based on closer human relations. This positive form of ethics is in sharp contrast to the old type ethics, which were, if anything, passive. The enthusiasm of those concerned with this new, positive form of ethics is enormous. Already there has been published an encyclopedia of bioethics, a reading of which makes us painfully aware of the need for global development of a new code of ethics.

This is an English translation of the text of the paper in Japanese, broadcast over the Nippon Television Network on May 4, 1980, for the "Age of Health Promotion Program" and published in the May 20, 1980, issue (No. 449) of The Nichi-i News (Japan Medical Association News). Reprinted from the *Asian Medical Journal*, Vol. 24, No. 2, February, 1981.

These new ethics also play an important role in our thinking about a new social order. For instance, pollution may be grasped as an example of resistance put up by scientific civilization against new ethics. It was, therefore, inevitable that a positive ethical movement should have come into being.

Among the systematic forms of this development the largest was the study make by the Kennedy Research Institute of Georgetown University in the United States. There are many other people with the same interest in the United States and Europe.

The table shows the process through which new ethics replaced the old ethics. The new ethics are concerned with contributions to human civilization, which was not the case with the old ethics.

The Development of Bioethics

I. Promotion of Bioethics

Department from classical ethics
- Contribution to the development of human civilization
- Rapid progress of scientific civilization
- From the micro-world to the macro-world

Bioethics
- Soul-searching about the conquest of nature
- Self-development of ethicality
- Ethics and logic of the individual, society and workplace

II. Development of Bioethics

(1) Finding a place for ethics in the human survival order
(2) From national participation to human participation
(3) Medical logic and bioethics in a medical care system
(4) Development of human welfare and bioethics
(5) Community medical care and bioethics—primary care
(6) Bioethics and public administration
(7) Medical insurance system and bioethics

The rapid progress of scientific civilization has produced environmental disruption and destruction of nature. How the new human ethics would react to these developments would be are possible criterion for its evaluation.

Bioethics also cover the whole range from the gene to the human

environment. This means that ethics, which were concerned with problems among individuals, are now concerned with the problems of the genes, the environment and groups.

Man proudly thinks that he has conquered nature. Yet, on the contrary, man still suffers terribly from nature. Therefore, the new ethics could be developed only by being in tune with the times and environment in which they are to operate. Without this way of thinking, there could be no real new ethics.

The old ethics could not survive because they would be buried in our contemporary civilization and environment. We must take into account the ethics as well as the logic of the individual, community and workplace.

Seen from this viewpoint, the development of bioethics means the question of finding a place for ethics in the new survival order of mankind. Our thinking must be entirely new. It cannot but be radically different from the ethics of an age in which barbarians inhabited the earth by coexisting with nature. The survival order of mankind in our industrial or information-intensive society is radically different from that of an agricultural society.

When scientific technology progresses so much that it covers the infinitesimal world, where heredity and human qualities can be tampered with, the position ethics should hold will be totally different from that of ages gone by.

If we were to develop this big problem globally, it would involve political and social thinking. If this problem of bioethics could be taken up as a political problem, I believe its solution would be greatly facilitated.

For bioethics, participation of peoples or of the whole human race would be extremely important. On a smaller scale, it requires participation by a whole nation. On a larger scale, there must be participation by mankind as a whole. This also calls for international consideration, not the kind of thinking based on the interests of one particular nation alone.

In the field of our own profession, namely, medical care, bioethics

must undergo a great change because of the progress achieved by medical science. This progress in medical science has made it possible to cure diseases which were previously incurable. There are, however, serious genetic problems awaiting solution. For such reasons, medicine must take up the welfare problems in earnest.

The old concept of welfare was concerned primarily with "giving." The welfare element of the new bioethics is based on the new condition of contribution to human survival. In other words, a more act of giving is not enough as ethical conduct.

Community medical care also has much to do with bioethics. In thinking about the primary care and human medicine, we have been talking about recently, we find it necessary to think not only of the various organs of the human body, but in terms of the personality of the individual, his family, his community and even the larger environment. We must also think in terms of time, that is, how a disease in a young human being changes as he grows older. In other words, our medical care cannot be content with treating a patient for here and now, but must consider the future. Thus, bioethics of our new age cannot but involve medical education to a great extent, and also the medical care system.

Bioethics also inevitably involve public administration to a great extent. The existing Medical Practitioner's Law and the Health Insurance Law are based on the idea that medical care can be given as a benefix in the makeshift pattern. From now on, however, we must consider what kind of medical care must be provided from the standpoint of bioethics.

The medical care insurance system of today is not different from the non-life insurance; it is administered in terms of either cash or goods as benefits. This kind of thinking, however, must undergo a serious change toward a basic respect for the patient's life and welfare for the sake of his family and others involved. When we introduce this kind of new ethics on a global basis, we will be bringing forth a new form of welfare. At the same time, the world in which the powerful survive at the expense of the weak will disappear. Thirdly, human

progress goes hand in hand with world peace. I wish to take up the question of bioethics in terms of these three major points.

The Japan Medical Association will carry out its activities on a global basis with the question of bioethics as its core. At the same time, the World Medical Association is responding to our way of thinking.

A New Development in the Free Private Medical Practice System

In looking at conditions anywhere in the world, I believe it is obvious that the free private medical practice system is one which has and will continue to develop spontaneously. The first free private practice system in Japan was started by Nagata Tokuhon, the pioneer private medical practitioner of the Tokugawa Era, with whom you are probably familiar from history.

Nagata, as a free private medical practitioner, was well known for his policy of not charging his patients very high fees and for living among the common people. These two facts make us feel that we can regard him as a pragmatical medical practitioner.

In the Meiji Era, Japan, as a modern state, acquired many new state institutions. One of these implemented the state medical examination system and a system of certifying physicians without examinations. It is significant, however, that a medical system exclusively based on Western medicine was establisheds, contributing much to the development of medical care in Japan. This was due largely to the great influence exerted by such outstanding medical leaders of the time as Dr. Sensai Nagayo, who were directly involved in administration.

The medical care system, which was introduced from the West in

---

This is an English translation of the text of the special lecture in Japanese given at the commemorative lecture meeting on April 10, 1980, at the Keio Plaza Hotel in Shinjuku in the honor Dr. Toshiro Murase being made recipient of the Japanese Medical Association's highest award for merit for the contribution made to the society in medicine on November 1, 1979, and published in the May 20, 1980, issue (No. 449) of The Nichi-i News (Japan Medical Association News). Reprinted from the *Asian Medical Journal*, Vol. 24, No. 3, March, 1981.

Japan's early years as a modern state, was established by the physicians. Studying the histories of the other countries of the world concerning this point, I found that Japan is the only country in which this occurred. In our case, the establishment of a medical care system was achieved by Dr. Nagayo and others around him, including Dr. Tai Hasegawa, the founder of a school called *Saisei Gakusha.*

Within this system of medical care, the free private medical practice system was clearly recognized while public medical care facilities were established to create a nationwide medical care system. Looking back, I believe this procedure was a highly appropriate one in terms of spreading medical care and maintaining steady improvement in the substance of medical care.

The private medical practice system of that time was a truly spontaneous development. Most of the medical practitioners were graduates of *Saisei Gakusha,* who had passed the state medical examination. These medical practitioners, who came to Tokyo from the various parts of the country to study medicine, went back to their native home land after graduation, thereby, in effect, causing physicians to be distributed throughout the country.

It was the ideal of Dr. Tai Hasegawa of *Saisei Gakusha,* that the graduates return to the provincial areas from which they came. I believe this way of thinking was humanistic. It was, in fact, an excellent idea that young physicians went home out of their love for the particular area of the country and introduced medical practice there.

I myself "borrowed" this idea about 15 years ago when I was consulted by the mayor of Sawauchi Village in Iwate Prefecture on developing medical care there. I advised the mayor that he should try to train nurses, public health nurses and nutritionists from among the local people. When this advice was followed, there was a wonderful fusion of love for one's home land and medical technology, which in turn brought great achievement. This was entirely different from a system in which someone from an entirely different geographical area of the country would be employed merely for monetary purpose.

In view of these facts, we must think that the basis of the private medical practice system in Japan is to be found in one's love for one's home land. This spirit naturally develops in many forms. In the early years of modern Japan, there were no large cities in the provinces, in fact, three were very few urban communities. This is the reason why a primitive love for one's home land fused nicely with the necessary medical technology. This arrangement, however, has changed since then due to a member of factors, including changes in the local autonomies.

The most significant change took place between the end of the Meiji Era and the early part of the Taisho Era. Japanese capitalism, though still in a premature state, blossomed during those years and produced a class of exploiters, while on the other hand a labor movement came into being. The labor movement of that time was quite unlike what we have today. The exploiting class, however, was patterned fairly closely after its Western model. The labor movement was handicapped in coping with this, because the consciousness of the workers had not yet developed sufficiently.

Under these circumstances, how did the private medical practitioner behave? We have historical evidence that, in a situation where a capitalist revolution envelopes, an entire country, the doctor, also, must be enveloped by capitalism.

In about 1935, I studied the conditions of a village in the Tohoku Region with no physicians. There were no medical practitioners where there was no capital accumulation. Private medical practitioners spread throughout the country with the accumulation of capital. This is due to the impact of capitalism on Japan, which caused the disintegration of her old, pre-capitalist private medical practice system.

In the next phase, that is, the Taisho and Showa Eras, capitalism brought major developments in Japan, stimulating a further spread of medical practitioners parallel with the accumulation of capital.

It is necessary to examine the history of how scientific problems were disposed of socially in such a situation.

While, Mr. Yukichi Fukuzawa was still alive, Dr. Shibasaburo

Kitasato returned from Germany with an outstanding reputation and was invited to the United States. At that time, Mr. Fukuzawa persuaded Dr. Kitasato to stay in Japan and devote himself to the people of Japan. Mr. Fukuzawa then collected contributions through Mr. Ichizaemon Morimura, the business magnate, and created an institute in Shiba Park for research on contagious diseases, though it was of a modest scale. The circumstances surrounding the establishment of this institute are related in detail in the history of *Keio Gijuku.*

I am very much interested in the question of how Dr. Kitasato developed the medical association. In his time, there were no means available for preventing or containing acute contagious diseases. Dr. Kitasato won great fame as a microbiologist but also in the field of immunology he was the discoverer of the antigen-antibody reaction theory.

In that modest research institute, Dr. Kitasato initiated the private medical practitioners into microbiology. These lectures on microbiology continued until the days when I was a student in medical school. His microbiology lectures, I believe, served as an academic base for the private medical practitioners in the towns and villages of Japan. The private medical practitioners in the rural communities were also very pleased to attend these lectures. These physicians, who loved science, took the course by paying for it out of their own pockets for as long as three to six months. Those doctors who received the lectures at the Kitasato Institute returned to their respective local community and devoted themselves to the prevention and containment of contagious disease while giving guidance to the other practitioners. This, I believe, contributed a great deal to the scientific development of medical care throughout the country.

I wish to emphasize at this moment that these free private medical practitioners on the one hand were subject to the social system under which they worked, but on the other hand, they acquired scientific knowledge at their own expense as their own social responsibility. This illustrates the laudable spirit of the free private medical practitioners, which deserves to be rated highly. In other

words, these people were not the physicians who would say they would not attend lecturers unless they were paid per diems and travel expenses.

At any rate, a system for preventing acute contagious diseases was established and this in turn became a social base for the private medical practitioners. This fact represents the identification of love for one's home land and the spirit of a private medical practitioners. I feel that the private medical practitioners of these early years deserve admiration for having combined their love of their own home land with scientific technology.

Local medical societies were created after that in various forms. They were essentially societies for promoting friendship among the physicians but at the same time they served as a medium for holding study sessions on medical cases for their members. Case studies in those days were not as scientifically meticulous as those of today. At least we can say that the fact that front-line physicians got together to study cases made an immeasurable contribution to the development of medical knowledge.

Today, case study sessions are held in all six regions of the nation lead by the Japanese Society of Internal Medicine. Yet, we find that the origin may be traced to the case study sessions by the physicians of the early Taisho Era, which I have described above. When we consider the problems of the free private medical practice system, it is important that we fully understand the historical base before thinking about the next phase.

The free private medical practice system came into being under the above circumstances, after which Japan entered a period of blossoming capitalism. This period was followed by an era in which the military clique gained power. Under this military clique, government control of medical care was inevitable, and the private medical practice system was subjected to rigorous suppression. Private hospitals were absorbed by Iryodan (medical care corporation), turning into semi-state-managed medical care agencies with which you

are most likely familiar. Under the control of the military clique, restricted medical care was also unavoidable.

After that period, came the war, followed by a period of a shortage of materials and food. While private medical practitioners did not have sufficient food for their patients, most of the public medical care agencies stopped functioning. During constant air-raids, the physicians continued their practice to safeguard the people in their community. It was not the public medical facilities but private medical practitioners, who amidst exploding incendiary bombs, flares and flames, protected the sick and the injured. We must forget the devotion and the sacrifice made by the local private medical practitioners. I am convinced that wartime experiences prove that the spirit of the free private medical practitioner lives on, even when public medical care agencies cease to function.

These physicians, in those days of shortage of everything, devised various means of serving their patients. This, I believe, was an excellent opportunity to infuse spirit into the free private medical practice system of the postwar era. This gave the private medical practitioner a chance to think about how he in a democratic society must behave. It was also a subject that the government authorities, members of the academic societies and people in general ought to have considered.

Yet, the presidents of the Japan Medical Association of those years were the people who inherited the legacies of the wartime bureaucratic control or the people interested in politics. This is the reason why the opportunity was missed to consider these basic questions. Instead, they made economic demands because they were pressured by economic insecurity, giving the people the impression that the private medical practitioners were people who were only interested in such demands. This, I think, was an irredeemable error made by us.

In the last Diet elections (June 22, 1980), through my own efforts I prevented a member of the Diet from becoming the president of the Japan Medical Association. I did so because I was fully aware of the

fact that immediately after the war a Dietman president of the Japan Medical Association darkened the future of this Association. The question of what kind of private medical practice system should be established in a democratic era has not been fully studied.

As president of the Japan Medical Association, and even as vice president before that, I maintained that the most important task for the physician in a democratic era is to respect human rights through medicine. During the feudal, military and bureaucratic eras, the idea of human rights found no expression at all. In such eras, only the physicians respected the life of a patient. In the era of democracy, protecting the rights of a patient with medicine must be the ultimate goal.

From this standpoint, I thought that the restricted medical care system must be abolished in the interest of the rights of the patient. The first task I undertook upon becoming president of the Japan Medical Association, as you recall, was the abolition of restricted medical care.

When I became president there was the problem of the so-called "double designation" system under the Health Insurance Law. This represented an attempt to preserve the system of bureaucratic control from the military clique days. I opposed this to the hilt, but none of the Diet members who were physicians, seven or eight at that time, did. Dr. Maruyama, who was vice president of the Japan Medical Association and a former member of the Liberal Democratic Party, favored the system.

From the standpoint of physicians protecting the human rights of people in a democratic society they ought to have objected to this "double designation" system. Those politicians who had been growbeaten by the bureaucrats and the military did nothing and have done nothing about it to this very day. Although Dr. Marumo, member of the House of Councilors, seems to be going around as if he owns the world, I think he should feel ashamed in regard to this matter.

The free private medical practice system has been on the brink of becoming drawn into the vortex of time-wasting politics for the past ten years.

In the meantime, I considered the Japanese-style development of the concept of community medicine about 15 years ago. This concept represents the application of the field theory of physics to medicine. This field theory, I thought, served as the criterion for rearranging the concept of community medicine in a very effective manner.

Because I thought it was desirable that the private medical practitioner establish his own status in the framework of community medicine by means of this new "field theory," I urged the creation of clinical examination centers and medical society hospitals. The field theory itself has many physical elements. When it is applied to medicine, we must consider several mechanisms and structures. Among them I find particularly important the problem of immunity. In terms of the field theory I think that the basis for a health defense system must be built from the standpoint of "community immunity." The immunization center of Shibuya, about which Dr. Murase was extremely kind and helpful, is a real immunization center. The basic science of it is that of immunity. Community immunity is a major problem that will continue to be a problem in the 21st century. I believe that the private medical practitioner who protects his community will not be able to work from day to day without becoming involved with this.

For this reason I watched Dr. Murase's work with great interest, and the more I observed it the more demand I thought I found for a similar service throughout the country. Today, there are a considerable number of similar services, though on a smaller scale, found elsewhere in the country.

Prominent among the problems of community immunization is that of hepatitis, to which Dr. Murase and Dr. Nakayama, the executive member of the Board of Trustees of the JMA, have been devoting themselves.

The most important thing to think about in relation to the field

theory of community medicine, is the immunization center. The problems of immunity and other factors related to immunity come only after that.

The scientific study of the various elements that influence immunity are still in an early stage. This, I believe, can be better studied through community medicine rather than in a research laboratory. I sincerely hope for the development in this particular area.

The private medical practice system, therefore, ought to develop in the manner I have described above. On other hand, new developments achieved in the area of medical care economics, which have occurred at the expense of the private medical practitioner himself, contravene the principles of democratic economics. According to the principles of democratic economics, I believe that medical service for protecting the interests of the public must be offered totally at the expense of the government.

There is much to be achieved in this respect. Yet, members of the Diet have not realized this at all. I have been speaking with extreme bluntness about this to the Diet men, and, strangely enough, I find that those Dietmen who understand what I am saying are not the medical people in the Diet but those non-medical politicians who have real power. I find that those Dietmen who studied medicine in the past may be good at talking like physicians is and collecting votes but they do not achieve anything in terms of real work. I am afraid that, if elections become degraded in this manner, it will only trigger the collapse of the free private medical practice system.

If I may dwell upon this a while longer, new developments in the free private medical practice system ought to be achieved in terms of coexistence with public service care agencies. There is much room for re-examination, however, concerning the question of whether the public medical service agencies are truly of a public nature under the existing laws. What we need is a legal definition of what kind of services public agencies must perform in what community. New developments in community medicine may be conceived according to such a definition, in a manner similar to the field theory of physics. I

discussed the theory of "welfare location" before, and the basis of this theory is closely related to what I have been discussing today.

The reason why I attach much importance to the question of medical care economics is that it does not function at all in relation to the public service part of the work of the private medical practitioner. This is really pre-modern, and yet a survey conducted by the Ministry of Health and Welfare does not show this at all.

This is the reason why we proposed a few years ago that the World Medical Association consider the problem of the "development and allocation of medical care resources," which has been studied with us playing the central role.

Therefore, we can say that a nations which is unable to protect and preserve the private medical practice system cannot but follow the road to decline in the area of medical care welfare. I cannot agree with those legalists who maintain that the private medical practice system may collapse at any time. Nor can I side with those authoritarian adherents of parliamentary government. I believe that our free private medical practice system may be developed as a new system only when we recognize the process of its historical development with its roots in the lives of the people.

A good example is found in England, which is a nation with complete social security in which semi-socialist state controls prevail. Yet, the wise English people have allowed the existence of a free private medical practice system quite apart from this socialistic control. In recent years, this system has made much progress with imported capital being used to build large hospitals, etc.

In Japan, attempts have been made to eliminate the free private medical practice system by introducing a total health insurance system. Thanks to efforts, of you physicians, however, we have essentially been able to foil this attempt, and today we have a system of social insurance maintaining the free private practice system, which is the most advanced system in the world.

The biggest problem in this unique system is the fact that people with stale ideas, mostly Diet members, still praise the free private

medical practice of the Tokugawa and Meiji Eras and agitate the greedy private medical practitioners with the dream of an old-style, free-for-all medical practice system. No country in the world today tolerates such a system.

I studied the questions and responses heard at the last meeting of the House of Delegates and same to the conclusion that it is best to develop a free private medical practice system after the pattern of the field theory in physics by making a new start with medical ethics.

This is the reason why I made a new proposal for bioethics. This new concept of bioethics was propounded essentially by the Catholics in the United States, primarily at the Kennedy Institute at Georgetown University.

I made a strong proposal on this subject at the first meeting of the Board of Trustees and also at the meeting of the House of Delegates. I hope that you will understand what I have said and concentrate your wisdom on dealing with the problems of developing a proper kind of private medical practice system to salvage the medical practice from the politics of conspiracy and rebellion. If this could be done, I am convinced that the medical care system in Japan, with its historical background, will have acquired bright prospects for the future to develop into the best system in the world.

The Importance of the Year 1981

I believe that in 1981 we must once again review the history of our medical care system, which is now under a heavy burden. The burden stems from the fact that our society is plunging into an era of increasing numbers of aged people; something it is not prepared for.

One of the first problems we face is the recent revision of the Health Insurance Law. This revision failed to consider numerous problems, such as the increasing percentage of aged people in the population, anticipated decreases in the young labor force over the next 20 years and expansion of scientific technology. This revision was carried out with only one purpose — to bring financial stability to the insurers involved in the health insurance system. This fact clearly demonstrates the degradation of welfare administration in our country.

The Liberal Democratic Party (LDP) reportedly manages a stable government, an impression that comes from the fact that it seized a comfortable majority in the Diet as a result of the June 1980 elections. Actually, however, a government may only be said to be stable when it satisfies certain sociobiological conditions. A government that operates with politics such as this one, established merely for the stabilization of the finances of the insurers in the health insurance system with no attention given to the sociobiological situation involved, cannot by an means be termed stable.

To the people of Japan, who hold great expectations for the

Reprinted from the *Asian Medical Journal*, Vol. 24, No. 1, January, 1981

government of Japan, there is nothing more infuriating than this recent action of the Suzuki Cabinet. The attempt to reorganize our entire medical care system on the basis of one extremely localized incident, fabricated by the mass media, proves beyond a doubt that there is neither "government" and "administration" in this country. In their actions we can also see that the politicians involved lack the required acumen for fulfillment of their duties, and that the present administration maintains no comprehensible notion of welfare.

The second problem here involves both medical care and the concept government based on public opinion. Government by public opinion is, as we see it today, largely formed by mass media. Though this may appear to represent the voice of the people, it really does not. The present situation in which the government is swayed by public opinion generated by mass media has brought about a grave, unprecedented condition. During the era in which the military clique ran rampant, all public activity was carried out on the basis of public opinion formed by mass media and the results were catastrophic for the entire nation. This we can never forget. Now, however, a similar situation is upon us with the threat of new social chaos on the horizon; chaos which is likely to obstruct the building of a future order.

I do not say that we in the field of medicine are faultless. We must correct ourselves in order to be loyal to eternal truths. What I want to do is to stress to the members of our association the importance of bioethics and matters of medical logic and ethics, because this is the only constructive measure that can be taken in facing the situation I have just described.

The most important point of which we must be aware in this current situation, is that within our own association views which purportedly represent public opinion are being circulated, while they are actually just the cleverly disquized private desires of a number of people who wish to monopolize the association. These rumblings represent the very lowest form of exercise of one's right to freedom of speech. The medical men in our association must have the intelligence and character with which to identify such views. I believe that

accurate information is the shortest road to freedom from misleading statements. I sincerely hope, therefore, that the activities of this segment of our association will develop into something that may be regarded as a form of public opinion that no one has to be ashamed of.

What is important is for us to establish measures for the creation of a stable medical care system with promise for further development. History has taught us that we can expect nothing from parliamentary politics. Nor can we expect anything from mass media. The world of the physician must built upon a base of professional independence with bioethics as its core. When professional freedom does not find itself on the same track as professional development, social disorder is inevitable.

The most conspicuous example of social disorder involving medical care is the preservation of the feudalistic attitude of our insuring organizations. The current combination of big capital and big labor organizations is building a medical care system designed to enable business enterprises to pursue profits, what is known as the "piecework payment system," in which a physician is compensated for the amount of medical service he performs, is presently the economic system with the most solid medical base. To replace it with a contract system or other formula that allows insurers to use dictatorial powers for the purpose of stabilizing their finances is totally wrong. The terror of a government moved by public opinion is that without the implementation of the required logic it comes to resemble an insane man. I do not think it is wise for our nation, which experienced this terror 25 years ago, to repeat the same mistakes once again.

Government through public opinion could be one element in a wonderful society if it is socially developed in the proper environment. When it is tied to power structures, or when it works in collusion with labor organizations, however, it is in serious danger of losing its future. The most serious defect in government moved public opinion is that it cannot free itself from such pitfalls.

In the early part of the Meiji Era in our country, such leaders as Yukichi Fukuzawa, Shigenobu Okuma and Toshimichi Okubo built

such a type of government in stages, starting with a phase of public enlightenment and then gradually fostering more intellectually oriented society.

By the time this was achieved, the views of these leaders were having an active influence on the press. This government, which was brought into existence by the press during an era when the military clique ran rampant, was unable to correct itself because the press was in collusion with the military clique. Today our nation is once again on a perilous precipice. Our politicians are unable to provide any kind of guide for social activities in our country for the next 20 years. This also would seem to indicate that government by public opinion is a haphazard phenomenon.

Under these difficult circumstances, the Japan Medical Association (JMA) is attempting the development of a new order based upon the ethics and logic of the medical world, rejection politicians, who possess neither ethics nor logic. The particular means employed by the JMA include the promotion of community medical care and various ways of arousing international public opinion with the goal of reorienting public opinion within the country. To systematize community medical care, the JMA has also been active in developing numerous relevant new concept including primary care. White American society, which has been proud of the emphasis it gives to freedom of choice, is nearing an impasse, the JMA has propounded bioethics and bioinsurance, new concepts indispensable for the survival of mankind. For this reason it holds a responsible position and has received worldwide attention.

In the year 1981, the JMA must stifle the contrived government by public opinion that envelops our country and build new roads for contribution to the survival and development of our nation. In this year we must also abandon our past posture of relying on others and try to secure the supreme position in our society by the efforts of our own intellect and the sweat of our own brows. I hope that 1981 will be a year of action for the JMA; one which will go down in world history.

Characteristics of the Japanese 'Ie' and Tradition

I believe that in planning health education, I have paid special attention as president of the Japan Medical Association (JMA). Health education at school is being given primarily by school doctors and teachers who are in charge of the pupils' health in both the practical and theoretical aspects of it. It is also provided at workplaces from the standpoint of industrial medicine, which takes into account the particular conditions of each workplace. Designed for the improvement of work efficiency as well as for the prevention of occupational diseases, it belongs in the category of special health education.

The JMA has two different teams of specialists concerned with school health and industrial health. For school health care, attention is paid to the peculiarities of each community as well as to the conditions of the mental and physical development of the pupils in teaching them how to be responsible for maintaining their own health. This policy, I believe, has been quite successful.

For instance, the children are taught to wash their hands before meal. They are given full instructions on how to cleanse their hands under running water. It often happens that when this training is given in earnest for one year, the custom of washing one's hands sticks with the individuals. I have attached much importance to health education in primary and lower secondary schools because it establishes the most fundamental habits in the pupils. I also believe that table manners and

---

This paper was presented at the Seventh International Seminar on "Education and Training Programs of Family Medicine" of the Life Planning Center, Tokyo on September 4-5, 1981.

etiquette, though they have no direct relationship with health education, are highly effective. I have been very pleased with the fact that health education of this kind given in some areas at my request have produced great responses no matter how remote such areas may be.

In Japan, teachers have lunch with their pupils. This offers an excellent opportunity for the teachers to teach their pupils table manners. Unfortunately, however, the teachers nowadays do not have much interest in these matters. They do not, for instance, tell their pupils to wash their hands nor do they teach them table manners. The teachers tend to engage in their occupation, thinking of themselves essentially as members of a trade union. In many schools, the teacher-pupil relationship has completely collapsed.

In Japan, table manners require in the first place that before carrying food to one's mouth one must thank all the people who have produced the food — those engaged in farming and fishing, etc. This is table manners according to Buddhist teachings. This requirement which was a major element of mental health, however, is now being lost.

But there has been great success in the places where I advocated the practice of this particular element of traditional table manners. In the schools where no table manners were being observed and the teachers had no leadership, the pupils were taking in food as though they were animals. The total absence of spiritual elements was a serious shortcoming in education.

In the days when pupils carried to school the lunches their mothers prepared, this kind of situation was not observed anywhere. Today, almost everywhere, school lunch is provided, and this is the reason why lunch-taking becomes a routine procedure.

In reality, however, in areas where some families are so poor that their children cannot afford a lunch, school lunch is serving a very important purpose. If school lunch were given while the teachers provide their pupils with instructions on table manners, it could play a very important role in the development of character as well as of the body of the pupils.

I believe that health education is not an education given because it is needed; rather, it is an education that ought to be given an individual as part of one's cultural refinement. As such it must become an integral part of one's daily life. I believe that health education in the school health program is of most fundamental importance.

The tradition of the Japanese *ie* runs through a long succession of generations. This manifests itself in the way food is prepared and the menu is made and in table manners, which in some families have characteristics of a rather high order. In the old days, many homes, a meal was preceded by a prayer though today this custom is rarely observed. Practically all people eat about the same things, and the characteristics of the home are disappearing. In seasoning meals, however, there are still distinctive characteristics of various homes, representing the complex ways of seasoning handed down through generations. In poor homes, seasoning is simple and entails little problem. One becomes used to the seasoning pattern of the family in which one grows up, which often forms one's eating habit.

The civil code of Japan was formulated about 100 years ago by the French jurist Gustave Emile Boissonnade. At that time Boissonade is said to have had great difficulty in expressing the concept of *ie* and he ultimately decided to use the Japanese word itself rather than translating it into a foreign language.

Each *ie* has its own pride in its ancestry, heritage and dignity of its own and also confidence in the health of its members. It also has a faith handed down by the ancestors. All these are shared by its relatives, and, therefore, they do not crumble easily merely because one *ie* abandons them.

Under such a family system, much emphasis was placed on the importance of *shitsuke,* discipline. *Shitsuke* is primarily a matter of manners and etiquette and also becoming conditioned about matters of health. Therefore, a child who receives good *shitsuke* is very healthy, and looking after one's own becomes his second nature. Children of homes with poor family discipline, on the other hand, have no such built-in mental asset and subsequently were handicapped throughout

life. Yet, society was so organized that even children of these homes were educated when they joined other homes. But after the war such a system disintegrated both within and outside the home.

Health education was considered and given as something that had nothing to do with the home or tradition. That health education must be given by conditioning to make it a part of one's daily life pattern has been forgotten. This is the reason why a major shortcoming in health education in Japan has come into being after the war.

Because of this situation, the JMA had to realize anew that health education in both the physical and mental senses of the term must be given with the home as its basis. Thus, the community medical associations, numbering nearly 800, began conducting health education that was based on the home. After 10 years of this program, a big difference became evident between the communities where the health education of this kind was carried out in earnest and where it was conducted in a haphazard way. In the areas where health education based on the home was successful, demand for medical care services notably decreased and a much smaller budget for them was sufficient. In the areas where this kind of health education was not conducted, the tendency toward abusing health insurance became very pronounced.

The collapse of the *ie* system of Japan which has occurred after the war proved a great disadvantage to the people of Japan in that it deprived them of the ultimate unit for their survival, which the *ie* was. The traditional families were split into nuclear families, and none of the nuclear families carried out the traditional family-based health education. These families merely resorted to the use of a health insurance plan whenever there was a health problem — by going to see a doctor. There is no longer the discipline that compelled each individual to look after his own health.

The new health insurance system insured every citizen of the country. But what happened is that this system was introduced when there was no health education conducted on the basis of the family as the basic unit of society and as part of the basic education for each individual. The result is that the system taught people to abuse

medical care funds. This, I believe, is the result of the fact that the government lost its health program.

The most important element of health education is the formulation of this program, which should be prepared separately from its curriculum. It is also necessary to consider a health program separately for the nuclear family and for the traditional *ie*. We are fully aware of the fact that in the case of a nuclear family health education is extremely ineffective. When a child seems to have a slight health problem in a traditional family, the grandparents would advise that the child be taken to a doctor's. In a nuclear family, however, the young mother would do nothing until her child develops patent symptoms such as a high fever. And after taking her child to a doctor's, the mother would request medicines, injections and other forms of medical care. Actually, in a traditional family, where the older adults are attentive to children, minor health problems for children are usually resolved when they notice there is something wrong with the children and the family physician is consulted. In such a situation often no medication is necessary.

Nowadays there are many cases of children suffering from dehydration, but in these cases it is not necessary for a physician to treat them by means of intravenous drip. These can be dealt with simply by giving the patients water at an early stage.

The prevalence of both health insurance and nuclear families has driven the traditional families of Japan to extinction. Under these circumstances, health insurance medical care moves along its own path while health education moves along its own and the most necessary basic education is not made a part of the health program.

The medical association, which is a private organization, is most closely connected with the daily living of people. The doctors, therefore, have all the answers to such questions as inhabitants of what geographical areas are most prone to have disorders of digestive organs, those drinking water in what kind of areas are liable to contract digestive diseases, how to prevent parastioses, and so forth. But it is all but impossible to bring into the nuclear family system of today such matters that are accepted as part of medical knowledge and

must be grasped in relationship with the localities in which people live. People of Japan have destroyed traditions without thinking about the disruptions such a destruction would bring upon their next generation. This has gone on for 30-odd postwar years, and now we know that this has resulted in a big financial burden on the people.

It is obvious, therefore, that the family physician represents a very important function. One of the characteristics of Japan today is that while large enterprises have developed, there are still many cottage industries in which all kinds of chemicals are used in the workshops that are homes of the workers at the same time, often creating symptoms of poisoning. When children are members of the family in such an environment, the damage done to their health is horrifying.

As evident from this, there is a vast difference in scale between the health management of a large industrial enterprise and a cottage industry workshop. This is the reason why a general practitioner can play a very meaningful role to people's health by serving as an industrial doctor who gives health education and medical checkups.

In Yamagata Prefecture of northeastern Japan, there are many cases of industrial poisoning occurring in cottage industry workshops. In such communities, the JMA is now experimenting with a system of having family physicians, who pass the test to qualify as industrial doctors, give advice to the families concerned. We have already been successful in preventing industrial disasters by identifying them at early stages and giving the people concerned proper education for receiving medical attention.

Health education in Japan today cannot be given only as part of school education. Practitioners in local communities who acquire knowledge in industrial medicine and understand the problems of the community and home are now creating a new health education system. The health education committee of the JMA is pushing this movement vigorously as its primary motive force. The situation has drastically changed during the past five years because of these efforts by the JMA.

The biggest headache we have is the fact that new foods are constantly brought into the market in large quantities. Because these

new foods are simple to prepare without requiring much time on the part of the housewife, families are being deprived of the traditional tastes in the meals they consume while they become accustomed to the tastes of "instant" foods. They tend to expect an increase in the number of these instant food items. This situation has created a new wave of cases of vitamin deficiency. Today, we can no longer expect the development of complex tastes in food that can be created only by time-consuming food preparation and cooking. It is in this area where the JMA with its nearly 100,000 members is concentrating its effort most.

In Japan, there is as yet no educational system for developing teachers in this area. This means that we have a big task for making further efforts. It appears in Japan that when there is a general election, people state their demands, which in turn move forward our politics. The fact is, however, that the people's demands lack the knowledge of specialization and the depth of education. In this respect democracy in Japan is still at an immature stage of development. If we remain at this stage, we are bound to encounter major obstacles in the future.

In this regard we must say that the mere development of family doctors is not enough. At the same time, unless we reconsider the present family structure that negates the most democratic family system of the feudal age, family doctors, regardless of what kind, will not serve the purpose of guaranteeing survival for the people.

I feel that for the past 24 years I have been the custodian of the JMA, an organization that academically supplies what society needs most. One of the accomplishments of the JMA during my tenure is the fact that in the communities where health education was carried out in earnest, the cost of medical care services for the aged was one-tenth of the normal. Infant mortality, too, has reduced drastically while cases of cerebrovascular disorders have become extremely rare. There are instances of poor villages of Tohoku, the northeastern part of Japan, that have regained cheerfulness and are able to start their life anew as modern farming communities. We wish to emphasize that mere allocation of knowledge does not solve the problems of health.

Characteristics of Man in a Life Cycle in the Development and Allocation of Medical Care Resources

I have been involved with the work of the World Medical Association (WMA) since 1970. The duties assigned to me concerned primarily socio-medical affairs. When the World Medical Assembly was held in Tokyo in 1975 and I was appointed WMA president, I proposed that the WMA take up the question of "the development and allocation of medical care resources." Fortunately, my proposal was accepted, and it was subsequently decided that the socio-medical affairs committee alone would be inadequate to carry out this task. Therefore, it was decided that the Japan Medical Association (JMA) undertake to form a special committee to follow up on this theme. And the committee has met twice since then.

It has been recognized that the theme of "the development and allocation of medical care resources" is of utmost importance because it includes the most fundamental problems of medical care found in every country of the world.

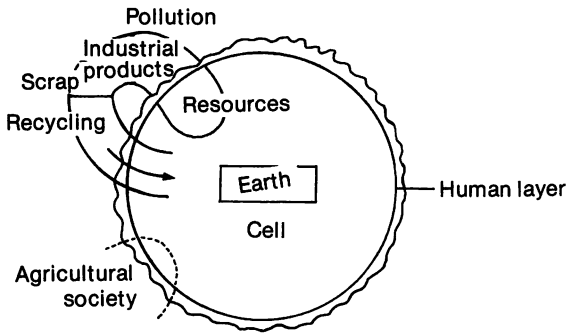
It gives me great pleasure to be able to discuss one of what I have regarded as central problems. Both medical science and economics are the most important basic branches of learning to human survival and living.

I thought that a new survival order — which includes a new social order, economic order and medical care order — and a new ethics and science and technology must be developed, bridging these

---

This paper is the lecture as an opening address at the third WMA Follow-up Committee on Development and Allocation of Medical Care Resources held in Tokyo from July 30 to August 1, 1981. Reprinted from the *Asian Medical Journal*, Vol. 24, No. 9, September, 1981.

Diagram 1 Man in a Metabolic Process in 'Cellular Membrane' on Earth's Surface



two disciplines. Human survival and living must be examined from every angle, and man must be grasped as an individual and groups and in his relationship with his environment. When man is grasped as an individual being, his economic life has a very important meaning. At the same time, medical care must be considered as something of great fundamental significance.

When we examine the mechanisms of human survival we must start with a consideration of in what form human beings are spread over the surface of the earth. I use the ecological approach and regard human life as a thin film covering the earth. During the age of agricultural society, very little development of natural resources was carried out. There, human existence was found in terms of metabolism occurring in the surface layer of the earth.

As industrialization progressed, however, man began extracting natural resources from the deeper layers of the earth. With further industrialization, we entered the age of mass production with these natural resources. The things produced in this mass production stage were not recycled back to the earth after they served the purpose for which they had been intended. This is the reason why we had the pollution of the environment.

The industrial society developed during the height of economic

growth, and it is a fact that this brought about an elevation of the standard of living. It is also a fact that the allocation of industrial goods became a major economic issue.

In agricultural production, the metabolic cycle was very simple, and natural resources were recycled locally in a very natural manner. In the industrial society, however, the situation was totally different. There was absolutely neither economics nor technology for the recycling of wastes — a fact responsible for a high degree of environmental pollution that occurred, threatening, in some local areas, the survival of man.

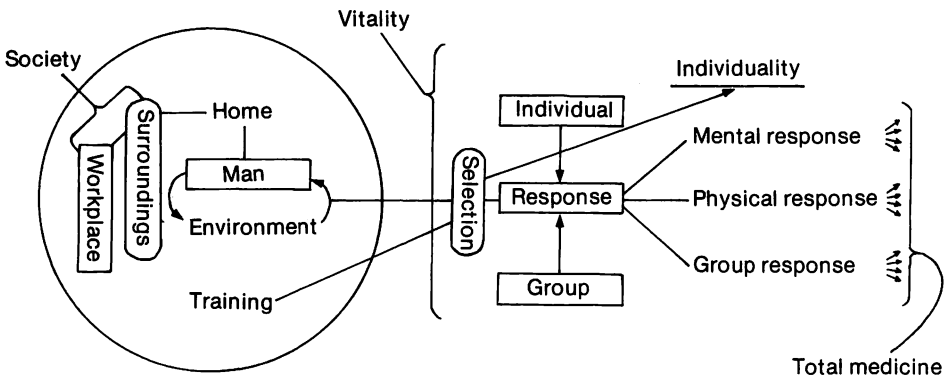
What is called the economics of pollution is an economics that came into being after pollution actually occurred. There was an element of prediction of industrial pollution in medicine and public health. But I don't believe there was an economics of prediction. Economics had a close relationship with ethics from its early stage of development. This is the reason why it has attained a major development in its relationship with the industrialized society as a survival order in term of air pollution, industrial accidents, changes in working conditions, and improvement in the standard of living. Yet, economics was essentially a science of labor and consumption and had very little to do with the development of natural resources.

In the case of medical care, the development of its resources is highly important, and I believe that interaction between the process of development centering on medicine and the process centering on economics is extremely important to the stable development of human survival and living. The improvement of economic life is inevitably accompanied by an increase in the demand for medical care. The proper and effective allocation of demand for medical care, I believe, is possible through cooperation between medical science and economics.

For this, it is necessary first of all to establish a goal in the development of medical care resources, but this must be done in both medical science and economics at the same pace.

Medical care must be developed by both individuals and groups as I said earlier. This means, in a nutshell, the question of how an

Diagram 2 Demand Side of Medical Care



individual or a group responds to demand made by the human body. These may be mental, physical and group responses. And these three kinds of response must be considered in terms of total medicine.

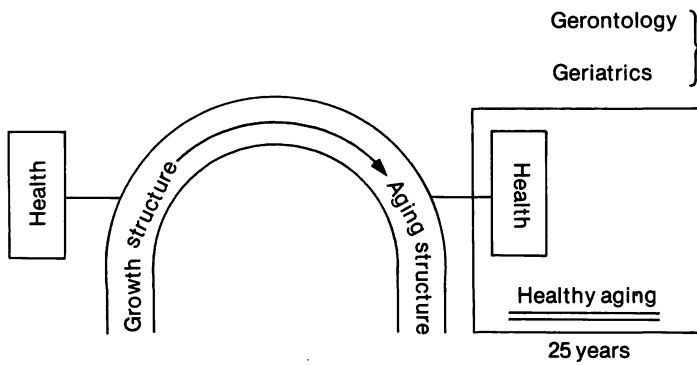
Then there is the important question of the selection of what kind of responses to make. This is where the question of individuality comes in. There are also the questions of the environment, workplace and its surroundings, and the home and its surroundings. In every one of these questions, economics must become involved with both the natural and social environments. Participation by medicine also becomes necessary.

Demand for medical care must be considered in terms of the various periods in the life of man just as it is so with regard to health. For instance, health at the stages of growth in a person must be considered separately from health in the stage of his aging because of the qualitative changes that occur during the latter process. In the stage of aging, geriatrics and gerontology become involved.

As for the structure of aging, the ideal is "to age healthily" and therefore, demand for medical care in the aging period is totally different from that for the periods of growth.

The development of medical care resources must be carried out according to these demands. For this development of medical care resources, there could be such varied targets as development by age

Diagram 3 Qualitative Change in Population Structure by Aging



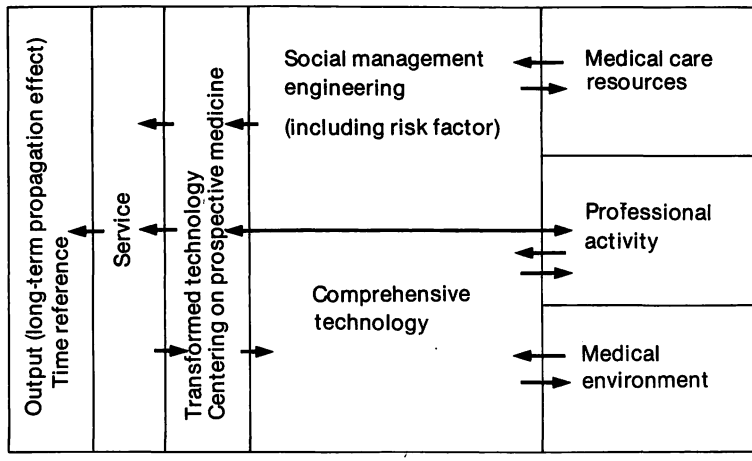
bracket, for health improvement, for the prevention of disruption of health, etc. For these purposes, economic, rather than social, bases are extremely important, and this is where medical technology has a major role to play.

In short, the development of medical care resources, because it greatly differs from the social development of inanimate objects, must be conducted toward a target established according to the survival process of man. As for industrialization, development must be carried out from the standpoint of industrial medicine with regard to a large number of different types of occupations created by that process of industrialization itself. Here, the development of the environment for man as a group also has a great significance.

The setting of medical targets in the development of medical care resources and the methodology that makes this possible must anticipate many contributions from economics. Economics of today is a science concerned with the state of "completed development." And little attention has been paid to the combination of economics with the technology necessary for the development of the future. Through the systematic study of the development and allocation of medical care resources that has been conducted, however, I have keenly felt the need for this.

The allocation of resources requires a large number of processes. After the kind of development of medical care mentioned above has

Diagram 4 Supply Side of Medical Care



been achieved, it is to be supplied as a "professional activity." (Diagram 4) Because the medical environment is of extreme importance in this connection, medical care resources, professional activity and medical environment must be considered as parallel concepts. These three must be promoted by comprehensive technology.

Social management engineering, including the management of risk factors, and patient control also become necessary. Comprehensive technology includes medicine and the technologies surrounding it. Another important thing is that through this emerge prospective medicine and its surrounding technologies.

Prospective medicine today is still at a very infantile stage. To those who are on the side of supplying medical care, it is of great importance to establish prospective medicine because, for one thing, it is impossible to conduct an efficient allocation of medical care resources without it.

Service in terms of the allocation of medical care resources based on data obtained by predictive medicine must be provided in such a way as to secure the maximum propagation effect in the long term.

Unless the service is given on the basis of metabolic processes varying according to age groups, it would be wasteful. The concept of timing in relation to this service must be thought of as "time reference." When the service is given just before it becomes necessary, it is likely to have a long-term propagation effect.

We have accumulated a large amount of knowledge in relation to the problem of medical care costs for the aged. What we have learned is that when medical attention, including that in mental hygiene, is given to individuals from the time when they are about 35 years old, medical care costs for the same individuals as they become aged are very small — about one-tenth of what is normal.

This seems to suggest that it is possible to think of the provision of medical services for human beings as an investment. In the past, medical care was considered a form of consumption. But when medical service is incorporated into a metabolic system, it makes now development within that system, raising expectations in a long-term propagation effect.

In other words, we must not think of countermeasures *after* a problem has arisen. Take the case of the prevention of contagious diseases, for instance. If all the countermeasures have been put into effect, prevention could be achieved at a very low cost. When there are no countermeasures in force, on the other hand, there is even the danger of a mass outbreak of a disease with a serious threat to human life, and medical care costs would be enormous. Measures in prospective medicine must be said to have long-term propagation effects.

Therefore, the supply side of medical care does not only include hospitals, clinics and physicians. It requires many new branches of learning, for which it is necessary to select the most effective points of action. Welfare location theory, for instance, which considers welfare in terms of where to locate facilities, may be also important. This means that when a medical care facility is to be established, we must think in terms of what is to be built where for a long-term propagation effect.

On the other hand, early detection and diagnosis make major contribution to the preservation and promotion of health, and its relationship with social production deserves a serious assessment.

As seen from the above, it is obviously necessary to think anew of the supply side of medical care. Its development and allocation must be considered simultaneously; placing emphasis only on allocation is not adequate.

The health insurance system as a form of allocation of medical care has expanded enormously throughout the world. Essentially, however, insurance is a system based on the idea of compensation for damages. In it the insurer collects premiums to have the insured pay part of the damages while he pays the remainder. Economic measures of this kind, dealing with inanimate matters are rather simple. But when we apply this idea to human society, we are compelled to think of human life, not of inanimate things. As I said earlier, human survival and living has many extremely complex conditions and relationships with the natural and social environments.

Yet, the health insurance system regards disease as a form of damage. As far as I have observed so far, this signifies the fact that medical care resources have been thrown into the metabolic process through medical service. They are therefore, not a form of consumption nor a redress for damages.

Unless we consider the human body in its context of the environment by ecological thinking and also in terms of age bracket, the health insurance system must be thought of as representing an entirely new mode of thinking and a health insurance plan must be formulated primarily on the basis of the concept of life.

This is what I call bio-insurance, which, to be sure, is not a system for compensation for damages. Its supply system must be considered as a form of investment. And effective investment in this system would be to maximize its propagation effect..

The development and the allocation of medical care resources are the two sides of a coin. Only when they are considered in terms of life cycle will new bio-insurance become possible.

In order to translate into reality the concept of bio-insurance, it is

necessary to think of the development and allocation of medical care resources in highly rational terms. At the base of this rationality, there must be bioethics and bio-medicine. To the evaluation of bio-insurance, economics will make a major contribusion.

In the scheme of bio-insurance, the insurer is people themselves, and the insurer under the present health insurance system will become unnecessary. The burden to each citizen in this scheme will be figured out by computer through the successive administrative levels of local government, prefecture and state. Bills by physicians checked by the examination machinery of the medical association will be paid by the bio-insurance center at each city, town or village. When any of these local governments is short of funds for payment, state funds will be used. If the state center is in deficit, additional premiums will be collected from the insured.

Details are to be worked out by the government of each country. In this system, the physician and the patient operate an insurance plan without the intervention of a third party, constantly improving the system of allocation of medical care resources.

Of course, we cannot expect a conclusion on such a large problem as this in a short time. But I have served as chairman of the socio-medical affairs committee of the WMA, and I am also president of the Japan Medical Association, which is in charge of this committee.

In lieu of greetings to you today, I have stated my views on the basis of what I have learned in these capacities. This matter, however, will require further studies in the months and years ahead because it includes many areas that will move forward through the progress of medicine and its collaboration with economics.

Response to Changes in Medical Care

I had never been in the hospital until recently when I went through one disease after another as if to make up for the 70 years of healthy life. This may have been meaningful, after all, because it was a sort of "settling the accounts."

Because of this experience I received kind attention from many doctors, and the result is the way I now look.

Being in bed, I had a lot of time. So I counted how much energy I lost. During the 150 days on a hospital bed, I found out, I lost a total of 150,000 calories. And I made a new start in life from the point of this loss of energy. I checked my calculation later and wondered if I had not made a mistake. This resulted in my having lost 50 kilograms from the 93 I used to weigh before I lost 150,000 calories during the three months of near fasting. And that's where I made a new start in life.

There are many ways of looking at human life. As for myself, my conclusion was that I had undergone medical care believing that I must die according to the logic of medicine just as I had lived according to the same logic of medicine. This is the reason why I did not panic in the least. When I did not fare well, I did not panic. Likewise I did not rejoice very much when I recovered. All I was concerned about is that I live according to medical logic — or die likewise.

This is the reason why, I recall, I had no stress during the period

---

This is the text of the address delivered on September 19, 1981, at the 35th general meeting of the Tohoku Federation of Medical Associations held at the Iwate Medical Association Hall in Morioka.

of my ill health. In other words, I had reached a certain stage of enlightenment — nirvana. That's appropriate to a medical man. This must be quite different from the case of a Buddhist priest. Nonetheless, I believe I was in the state of nirvana of a sort. I wrote about this for the monthly *Jitsugyo no Nippon.* Then I was asked to make it a book, which I did.

I believe that there could not be a healthy development of mankind unless medicine and medical men come to be respected. I have been thinking, accordingly, about changes in medical care and what ought to be the responses to these changes. In the 100-year century after the Meiji Restoration, there have been notable changes in medical practice, and there have been responses to them. Then came the war, followed by the era of postwar democracy. We must think about how these political changes have affected medicine. And we must think about how technological development has affected medicine. My idea is that the concept of human homeostasis must be central to our thinking about responses to these changes.

When we think about these questions, we find that in five or six more years, we shall be having more doctors than society needs, and in 10 more years, there will be a fair number of unemployed doctors. This is one problem, response to which we must be thinking about today. We cannot skirt it by merely saying that with more doctors we could have ample medical care every day. There is a tremendous difference between being prepared for a problem in advance and trying to cope with it after the problem confronts us. Therefore, I believe that we must be forward-looking in dealing with these problems. An important way of thinking in this respect would be the introduction of biological concepts in thinking about our responses to changes.

Iwate is a great prefecture that produced Mr. Shinpei Goto, and this is the reason why I wish to make a special mention of this man. Mr. Goto's politics was full of biological concepts. This is obvious when you look at the history of his governing of Taiwan as, for instance, described in *A Biography of Shinpei Goto* by Yusuke Tsurumi. Mr. Goto's way of thinking was that of an ecologist though in his

times there was no ecology as yet. Today, we have a school of thought in Europe and America, which introduces ecology into politics, giving rise to many new ideas in politics. But I believe Goto was the first statesman who practiced politics with ecological ideas before anyone else in the world.

Mr. Goto was extremely cautious in tinkering with statutes. Compare his attitude with the fact that today the Health Insurance Law is being tampered with every year with a revision bill. Once every three years it is subjected to "radical revision," as publicized by the mass media. Actually, this "radical revision" amounts to nothing. If Mr. Goto were living today, he would have had none of this nonsense.

Mr. Goto, however, seems to have had something in common with me. This sound rather presumptuous of me, but what I mean is that Mr. Goto, I understand, used to leave a Cabinet meeting when a stupid politician made a stupid statement. He would return to the meeting only after the prime minister sent the chief cabinet secretary to him with his apologies. Apparently, Mr. Goto seems to have thoroughly despised the ignorant. At the base of his thoughts was biology.

I marvel at the fact that Mr. Goto governed men by fully understanding this *Gedankengang* of biology. His concept of law, too, furthermore, was based on biological thought, which no jurists of his time ever thought of. This is clear from the fact that Mr. Goto, when he was governor general of Taiwan invited Professor Santaro Okamatsu of the Tokyo Imperial University, a specialist in civil law, and asked him to prepare a report on the customs of the people of Taiwan. Professor Okamatsu produced a major work after completing his research with his assistants. I don't own this work, but Professor Seiichi Tohata, who went to a great deal of trouble to collect his works, has a fair number of volumes of this book. I happened to have seen a part of it, which concerned medical care.

Mr. Goto's legal thoughts are based on the idea of placing climate, geography, human psychology and custom at the base of law. In other words, his policy of government in Taiwan was to create reasonable laws on the basis of his understanding of the living environment of the

people in terms of sociology, economics and natural sciences. Until a preliminary study was completed during five years, Mr. Goto forbade anyone to tamper with the existing laws. In other words, he did not allow legal-minded bureaucrats, who are always prone to tamper with statutes, to do that in Taiwan. This was the greatest element of the success of his governing of Taiwan.

Compared with this, the present state of affairs in Japan is indeed deplorable. There has been much talk about administrative reform. But it is impossible to achieve it by collecting presidents of major enterprises as members of the commission on administrative reform. The assumption is that a government may be run like a corporation. But this is not valid. I sincerely believe that laws that give forth light for our future will not issue from the present environment even though laws that will darken our future may.

In this sense, I hope that people of Iwate, which produced Shinpei Goto, to rise to the occasion. Iwate also has produced a prime minister. Mass media say many things about Mr. Suzuki. But I rate him highly as a statesman who has faith in the Japanese people.

Mr. Shigeru Yoshida when he was prime minister after the war said, while walking through the ruins of Tokyo with: "You watch. It was necessary to destroy old machinery in order to establish new industry. But this was done by the Occupation Army. Thanks to that, we can rebuild Japan without fail if we installed new machinery with new brains. We can become the best industrial power in the world. We can do it as long as we have our industriousness and knowledge." Premier Yoshida had absolute faith in the Japanese people. I am convinced that Premier Yoshida's faith in the people brought to us the prosperity we have today.

Likewise, I believe, Premier Suzuki definitely has faith in the people. Recently, I was talking with an influential member of the Diet. I told him that I gave Mr. Suzuki credit for having faith in the people and that I regard him as a superior statesman. Then this member of the Diet said, "You and I couldn't have that faith." This was somewhat uncalled for because this is not the case with me. But at any rate he said that. And because I could not blame him entirely for

saying that, I did not disagree. Now let me get into the main part of my talk.

I am now very much concerned about how you would be able to devote yourselves to the task of saving society and human lives without thinking about how to cope with changes in medical care. The fact is those lawyers who know nothing about medicine are making laws related to medicine. The Health Insurance Law of today is based on the insurance formula of Lloyd's and the theory of indemnifying damages. There is not yet an insurance formula designed for protecting human life anywhere in the world. I proposed the concept of "bio-insurance" concerning this problem, and it was taken up as a major issue by the World Medical Association (WMA) and the World Health Organization (WHO). When Prime Minister Suzuki met with President Reagan, Mr. Suzuki heard from the American President about me. But because Mr. Suzuki knew nothing about my ideas, he could not chime in with Mr. Reagan. After returning to Japan, he asked Foreign Minister Sonoda, but Mr. Sonoda knew nothing. He asked Mr. Kunikichi Saito, the Health and Welfare Minister, who knew nothing about it, hastily came to see me.

Discussion on this matter was concluded at the recent meeting of the follow-up committee of the WMA on the subject. So I gave Mr. Saito the relevant data, and Mr. Saito said to me, "You ought to have announced such an important matter *in* Japan." So I told him, "It's my policy not to make statements important things in the country. I don't speak to Japanese politicians. I have faith in people but not in politicians." Mr. Saito laughed.

I believe that there will be many laws that are revised. And if you decided whether to agree or not to agree with the revisions by rough guess, you will in trouble. If we can create an insurance system that is dedicated to saving society and human lives and to respecting human life and does not deal with human life as an object of indemnification, I think it would be a wonderful system. That I have called "bio-insurance." This is the subject of my talk today. Of course, I

Diagram 1

Changes in Medical Care
(Basic items)
1. When state system changes
   - pre-feudal age and feudal age — from limited-area primitive economy to feudal economy
   - constitutional monarchy — start with early capitalism — laissez faire economy democracy — sovereignty rests with the people ... collapse of primitive free economy — incursion of public economy

don't have time to discuss all of it; therefore, I will deal with only its key points.

(Diagram 1) This shows that one of the macro-factors for changes in medical care is a change in the state system. There were eras before the feudal age, then the feudal era. It was in these eras that primitive economy turned into feudal economy. This era spans from the last part of Heian Period (794-1185), the Kamakura Period (1192-1333) and the Tokugawa Period (1600-1867). In these periods, doctors belonged to the imperial court, who were able to offer medical services to common people as a benefit bestowed upon them. There were doctors who were allowed to have free practices at the same time. The economy in those years was primitive economy in the limited sense of the term. So, a doctor did not demand how much his patient ought to pay him. His practice was almost entirely the "art of benevolence" that medicine used to be.

In the later feudal era, there was some change. This was an era of *daimyo* economy, which was followed by the period of constitutional monarchy of the Meiji Era. This is the beginning of capitalism; an era of laissez faire economy. I am sure all of you know that it was during this period that the free practice system developed. The free enterprise system, however, creates the class of the extremely poor while it creates super-rich corporations on the one hand. This is in a way an era of the law of the jungle.

In Germany, during this period, the social insurance system came

into being. This came into Japan under our own health insurance system.

I shall dwell upon the problems of the Meiji Era later. For now, however, we have here the era of democracy following the end of the war, in which sovereignty rests with the people. After the disintegration of the primitive free economy, the concept of "public nature" came to play an important role in the free economy system. It manifested itself in the social security system, which meant the invasion of our profession by public economy. The result is that the health insurance system we have today belongs in the category of public economy. The physicians, however, have no clear awareness of how their life has changed by stages in response to these changes in our history.

Now we go into the cultural system (Diagram 2). Here we are concerned with an outlook on life. We can clearly identify as examples of "thought culture" those of the Nara (645-794) and Heian Periods as contrasted with that of the Warring Nation Era. There was also the folk culture that developed among the masses, who were suppressed under the feudalistic economic system of the Tokugawa Period. *Ukiyoe* and *haiku* were part of this culture. There were also *senryu* and *zappai* during this period, though culture and folk culture had close relationships with medical care. This fact characterizes the way of thinking of the Japanese people.

Next we have an outlook on life and health. The outlook on life of the Japanese considered life as something mysterious, and I think that there is a great deal of Buddhistic influence on it. The same may be

Diagram 2

Changes in Cultural System
- thought culture and folk culture, religious outlook on life and health — in plebeian life
- life culture and medical care
- science culture and medical care

true with the Japanese outlook on health. This outlook on life has had close relationships with life culture and thought culture. The people's outlook on life and health was controlled by the idea of "rich country, strong armed forces," propounded by the military clan throughout the Meiji Era as Japan fought two major wars. Medical care in such an era is totally different from what we think of it today when the nation has renounced war and the way of looking at medical care has changed throughout the world.

Life, too, has really changed in this country, particularly since the income-doubling policy of the Cabinet, which has drastically reduced the disparity between the rich and the poor. Most of the people are classified as middle class. But unless we consider how thought culture is found in our present life culture, we cannot think about the relationship between them and medical care.

We also have the question of the relationship between science culture and medical care. Medicine as a science has made steady progress. Ultimately, it has developed as organic medicine, which means that medical care, too, has developed througout on the basis of organic medicine. This means that we have now medical culture which is based on organic medicine. But we have also had molecular biology which has expanded our micro world. We must realize that, because of this, the range of medicine for human beings as expressed as outlooks on life and health has become narrower. That is, the range of human medicine has become narrower because it has been overwhelmed by science culture. I believe that this is due to the commonly accepted view of our times that scientific medicine corresponds to organic medicine.

(Diagram 3) How have Japanese physicians lived through these changes. The answer reflects the physician's outlook on man. The Japanese physician's outlook on man is based on mutual respect between doctor and patient as human beings. This outlook on man, I believe, runs through the history of Japanese medical care. Japanese physicians, even when they served the Imperial Court, did not serve as agents of political power. Even when in the employ of *daimyo,*

Daigram 3

Through History of Japanese Medical Care
- problem of physician's view — physician's outlook on man
- negation of political power
- physician's morality and freedom
- learning medicine and teacher-pupil relationship

physicians never acted as their agents to engage in political conspiracies. There is no evidence of that in Japanese history. In the histories of other countries, there have been examples of physicians taking part in politicical conspiracies, but not in Japan. We must not forget the splendid tradition of Japanese physicians having preserved their own outlook on man even though they worked under political power. This is the morality of the physician, which ought to achieve a new development once again in free society. We lived through the eras, in which we worked in feudalism or under the bureaucracy of constitutional government or under the military clan, in which our freedom was seriously curtailed. From now, we must have a new morality of the physician based on the physician's outlook on man. This is the starting point for the bioethics you will be grappling with from now on.

Another characteristic that runs through the history of medical care in Japan is related to the acquisition of medical knowledge and the relationship between teacher and pupil. This was most manifest during the Tokugawa Period. The relationship between parent and child and that between teacher and pupil have been considered feudalistic. But these relationships developed in Japan as a morality. It is true that these relationships, too, are now being compelled to change. This is something the physicians of today must think about. And I believe how this splendid mentor-disciple relationship must be developed in the future is something to be determined by the physician's morality. It should not be a morality, by which everyone observes what he has been told. But bioethics is a morality that adapts

itself to the new world. How the teacher-pupil relationship is to be developed in this regard is a matter of absorbing interest.

This characteristic running through the history of Japanese medical care is something that I extracted from our history as an indigenous product of our country. I hope to pursue this subject further in the future.

Here we have our ethnic orientation toward medical care. (Diagram 4) This may be summed up as our awe and respect for human life that one shares with his physician, and not by one's self alone. Having awe and respect for human life together with one's physician is a Japanese peculiarity. It is important that in the center of Japanese respect for life was the physician.

Then there is respect for medicine and the physician, which, historically speaking, is wonderful. Just as it was the case with the physician of Chinese medicine during the eras when Chinese medicine was in full force in our country, the same respect for medicine was observed even after the Meiji Restoration when European, or German, medicine replaced Chinese medicine. And this is also true with the more recent era in which Japanese medicine won independence. This I believe is an ethnic characteristic of our nation.

Nowadays there is freedom of occupation, and there are people who can make a living by disparaging physicians. There are some journalists who contribute to an increase in the circulation of newspapers by disparaging physicians. Against such a background, it is important that we do not forget this ethnic peculiarity of respect for medicine and the physician. Now let me cite an illustration of

Diagram 4

Ethnic Orientation Toward Medical Care
- respect and awe for life — with physicians
- respect for medicine and respect for physician
- accommodation for medical care — individual, family, community

whether, in this age of anti-physician agitation, people follow it unthinkingly.

Actually, there are some people who, regret to say, began to have considerable anxiety about medicine. When you probe the cause of that anxiety, you find that it is newspaper articles, official announcements or weekly magazines. Recently I heard from the director of a hospital about the following case. A patient, who was in serious condition because of extrauterine pregnancy, was brought into this hospital. When the patient was told that an immediate operation was necessary, her family said, "Is it really so?" The hospital director was a very serious-minded man, so he told them to get out. "If you stay here and I did not give treatment, I would be charged with a violation of the Medical Practitioner's Law. So take her out right away." Then the husband said something to the effect that the operation might be conducted. Then the patient was operated upon. When she was opened up, there had been a great deal of internal hemorrage. The doctor threw a piece of gauze, with which he had wiped the blood, at the husband's face. The husband who had doubted if the operation was really necessary was squelched.

I feel that a physician must have courage of the kind this hospital director showed. Otherwise, we cannot rectify the distrust in the physician reflected in the mass media or in the Diet. I think that a physician who has no courage does not deserve respect for medicine. In this sense, I wish all the physicians would have courage.

For the accommodation of patients, we need the three basic elements — the patient, his family and the community. In this respect, I feel that Kaibara Ekken was a great precurser in our medical history in having enlightened the public about this accommodation idea. At the same time, he was a wonderful herb medicine doctor and naturalist.

Yet, today, we do not attach sufficient importance to the idea of accommodation of patients in medical care. In our democratic society, which is also known as participatory society, we need an accommodation system in which the individual patient, his family and his community must work together.

During the Meiji Era, the systematization of medical care was carried out under the full initiative of the physician. (Diagram 5) Principal among the leaders in this respect was Professor Ogata of the Tokyo Imperial University, who served as a director of the Public Health Bureau in the Home Ministry to establish an excellent medical care system. He was at the same time a superior administrator. Then some private organizations such as the Tuberculosis Prevention Society were also organized under the leadership of the physician to establish the accommodation system.

The national organization led by the physician was organized under the initiative of Dr. Shibasaburo Kitasato, and a university medical education system was completed. Although it suffered some disruptions during the war, medical education went on satisfactorily.

The system for the polarization of medical care also went on very satisfactorily because in this area the civilian administrators and the military worked together while private organizations in this area also developed. A private organization meant private practitioners while "official and military" means military surgeons and state and public hospitals, which were placed in coordination with each other.

This worked out beautifully in Japan, but today there is no country in Southeast Asia or elsewhere, which has succeeded in the establishment of the dual — official and private — system of medical care.

Diagram 5

(Historical facts)

1. Systemic adjustment in the Meiji Era
   - physician-led systematization, administration
   - physician-led national organization
   - completion of medical education system
   - dualization of spread of medical care — bureaucracy and the military — private sector
   - unification with Western medicine; preparation for unification of medical education
   - creation of private training institution — Kitasato Research Institute's lecture course

Why was this possible in Japan, then? This is essentially because popular education was highly prevalent as of the end of the 300-year Tokugawa Period.

Another factor was the exclusive replacement of Chinese medicine with Western medicine. What is really wonderful, however, is that there is nothing to prevent the physicians who study Western medicine from also studying Chinese medicine. Today, a Japanese doctor can prescribe Chinese medicines as well as Western medicines.

The private training institutions were also created. An example is the lecture courses offered by the Kitasato Research Institute. This pioneer in our history, served as the center of training for private practitioners throughout the country. It played an important role in the establishment of an anti-epidemic disease system. This is a private defense system against the spread of acute contagious diseases. It was a private training system built on an academic basis. I marvel at the fact that an excellent and highly efficient system was devised at that time.

In those years, medical care was in the hands of the police administrators within the Home Ministry. (Diagram 6) Later, it was shifted to the social affairs bureau, which mean that medical care was reexamined as a social issue rather than an object of police administration. This I think spelled a phase of progress. Later, when the Ministry of Health and Welfare was created, medical care was

Diagram 6

2. Characteristics of Medical Care in the Taisho and Showa Eras
   Home Ministry — from police to social affairs bureau
   To Health-Welfare Ministry — introduction of social insurance — association health insurance
   Military-led medical care system — military medicine system
   - suppression of physician's independence — no history of resistance
   - bureaucracy-led, military-guided medical care from completion of wartime medical care system to its defeat absolutization and eternalization of bureaucratic control

transferred to the social affairs bureau of the new ministry. It was to be considered as a social issue, which I think meant a phase in progress. But when the Health and Welfare Ministry took the leadership in medical care, it also meant that academics stepped back. This was the beginning of the disorientation of our medical care system.

On the advice of Shinpei Goto, social insurance was brought into this country and health insurance societies were created. Then, under the military-led medical care system, military medicine was created. The physician's freedom and autonomy began to be suppressed. But there was little resistance to this. Of coure, in those years, resistance was extremely difficult. Nonetheless, Japanese doctors began turning into a state of gutlessness. After this, that is, immediately before, during and after World War II we had only medical care led by bureaucrats and the military.

The goal of medical care was to produce citizens who can serve as strong soldiers as a means of making the country powerful. The absolute control of medical care by bureaucrats which was established in those years has persisted to this day.

Of course, after the retreat of the wartime medical care system, the control by bureaucrats should also have disappeared. But when this ought to have occurred, members of the Japan Medical Association and university professors did not deal with this sort of problem. This is the reason why the Medical Practitioner's Law, Medical Care Law and the Health Insurance Law, which preserve the control of the military and bureaucrats have been perpetuated to today. That this is the source of the problem of today's medical care is often forgotten.

Now, how is today's medical care? (Diagram 7) We have, of course, parliamentary democracy. But the medical care system from the Occupation era has been preserved along with the development of the conspiratorial bureaucratic system in the post-Occupation era. The Health-Care-for-the-Aged Bill which is now talked about, for instance, is one offshoot of the conspiratorial bureaucratic system and not a product of parliamentary democracy. I believe that physician

Diagram 7

3. Present-day Medical Care — Under Parliamentary Democracy
   1. residue of GHQ medical care — development of conspiratorial bureaucratic system
   2. forced implementation of universal health insurance — the rich insuring the rich, insurance for small business, insurance for farmers
   3. business-favoring society — as a form of the law of the jungle
      employer + labor union = insurer + bureaucratic power
   4. unorganized labor, small-income earner, the aged — policy of abandoning people (report by Administrative Reform Council)
      Health-Care-for-the-Aged Bill

members of the Diet must assume heavy responsibility for the fact that we have the present state of affairs about medical care.

The universal health insurance system in force ought to cover the entire nation. (Diagram 8) In reality, however, it is a system under which the rich insure the rich while the poor insure the poor. Why don't the physicians throughout the country wonder about the fact that the Diet, the parliament, tolerates this conspiracy by conspiratorial bureaucrats? If you say you are so busy with your day-to-day work that you have no time to think about such things, then you must leave it up to the JMA. We were partially successful in our

Diagram 8

5. health insurance association — monopoly of medical care by high-income-earners
6. status of physician under universal health insurance — negation of physician's independence — double designation
7. suppression of professional freedom
8. suppression of economic freedom
9. suppression of social freedom
   rule by bureaucrats and labor unions of enterprises by preservation of feudalistic Medical Practitioner's Law, Medical Care Law and Health Insurance Law

fight when we resigned en masse from the health insurance system. But the problem has not been totally solved, and the laws have not been revised.

Welfare states that have social security, be they in Europe or in America, are now slightly declining. Welfare society is now branded as no good and today we have business enterprise-dominated society. This is a form of the law of the jungle. Today, the National Federation of Health Insurance Associations is singing praises about many things. But this represents another form of the system established by the conspiratorial bureaucrats in collusion with the insurers in the association health insurance plan.

The current Health-Care-for-the-Aged Bill is the result of the policy of abandoning unorganized labor, small income earners and the aged.

Many serious problems are inherent in this bill. Immediate problems have been roughly resolved. But I am afraid the people do not understand that the conspiratorial bureaucratic system, which has its basis in the unreasonable wartime legislation, has manifested itself in the bill in question in our parliamentary democracy. The association health insurance plan is a system by which high income earners monopolize medical care. There is nothing to stop the health insurance associations from making all the money they can.

The status of the physician under the health insurance system made it impossible for him to be independent and self-reliant. And our professional freedom is now being threatened with suppression. Economic freedom, too, is being suppressed, and so is social freedom. This is because we have here a sudden emergence of a society in which business enterprise have priority. I suppose by now you understand what kind of future destiny we medical men will face. You are making all kinds of demands even at this late date. But if you think calmly, you will understand what kind of destiny you will have. If all the leaders of the medical associations of the entire country really gave serious thought to the future, I don't think they can be so calm and complacent. I have doubts about part of their heads.

I have defined medical care as a social application of medical

Diagram 9

Responses of JMA to Changes in Medical Care (Basic ideas)
- medical care — social application of medicine (position of human history)
- elevation of value on life; recognition of value of health
- development of logic and ethic of medicine
- practice of medico-economics — new theory on investment and allocation in medical care

science. This is based on human history. And today this definition has been accepted throughout the world. (Diagram 9)

What we need is the elevation of the value on human life. But the Medical Practitioner's Law, Health Insurance Law and Medical Care Law we have today do not elevate that value on life because these laws were made during the years when the citizens were expected to dedicate their lives to the state as something very cheap. The value placed on health reflected the recognition of the value of the health of citizens as soldiers to be used in making the country powerful. But the value we have for health today is that for the peace and welfare of mankind. Despite this change in the evaluation of health, laws have not changed. They have remained in force for 35 years after the war despite the fact that they were made by those evil bureaucrats on the basis of the complete control exerted by the military. That these laws have been left intact all these years is sufficient ground on which I seriously doubt the meaning of the existence of physician Dietmen.

We must think about the development of the logic and ethic of medicine. The logic of medicine has been buried into organic medicine, and macroscopic medicine has vanished. This is the reason why there is no relationship between logic and ethic.

Another serious problem is the idea that medical care is a form of consumption and, therefore, it should be restrained as much as possible. When this is done, so goes the argument, the status of the insurer will become stable.

I have proposed, however, that medical care must be considered

Diagram 10

History of Resistance
- cost accounting of medical care — refutation of the basic ideas of Health and Welfare Ministry Bureaucrats (1952)

Double designation of insurance doctors — planting for universal insurance system
  a. negation of professional freedom — restricted medical care
  b. negation of social freedom — denial of the right to organize
  c. negation of economic freedom — policy of keeping medical care cost low

JMA's response begins with pledge of LDP-Government following walkout from health insurance
- pledge approved by JMA in blind agreement with bureaucrats-LDP (by persuasion of physician Dietmen)
- restricted medical care abolished in principle — securance of professional freedom (1960)
- response to progress of medicine — abolition of restrictions on insurance — expansion of medical care (1967)
- expansion of freedom and freedom of choice (1977)
- economic independence of technical fee (1981)

as a form of investment and that the effect of investment must be maximized. This way of thinking, fortunately, has been accepted worldwide and Harvard University is now planning to put this way of thinking into a program.

How did I resist all these wrongs since I became involved with the JMA? (Diagram 10) For one thing, when the Health and Welfare Ministry bureaucrats were trying to introduce the notion of cost accounting for medical care, I rejected it. Of course, you cannot apply cost accounting to a highly academic technology like medicine.

We also rejected the idea of "double designation" (making an independent practitioner an agent in the universal health insurance system) because this meant the negation of professional freedom. There were cases of conscientious doctors committing suicide when this happened.

The double designation of the health insurance medical care

facilities and health insurance doctors completely negates the right of the doctors to organize.

The government negated our economic freedom in order to stick to the policy of keeping medical care cost as low as possible. We won a pledge from the government when we resorted to the universal walkout from the health insurance system. This resulted in a reduction to a great extent of restrictions on our medical practice. This, however, gave rise to the charges that medical care cost has sored, that doctors are using too many medicines, and so forth, because restrictions were removed from medical care services. But I believe we must accept criticisms if we deserve them and we must mend our ways where we must.

As for response to the progress of medicine, we have achieved the rejection of restraints in health insurance medical care services. There are many illustrations of this response to progress also in the area of rehabilitation and in psychiatry.

The expansion of freedom means a widening of the range of choice. When the expanded choice is computed into health insurance points, it is possible for a doctor to demand payment for about 50,000 points for a patient with a common cold. If a doctor should do this kind of thing, I believe, he is forfeiting his own freedom of choice.

Now we must prepare ourselves for information society because information revolution will, whether we like it or not, progress. (Diagram 11) And in what form information science will be introduced into medical legislation will be a big problem. If, for instance, evil conspiratorial bureaucrats should win the approval of the

Diagram 11

(Preparations for Information Society) — Response to information revolution

- introduction of information science into medical legislation
- progress of information engineerings and its introduction into medicine
- collapse of social insurance system through information revolution
- status of the physician in information society

Diet in medical legislation, I think, the most odious form of state-managed medical care like that of the Soviet Union will emerge.

And if information engineering is introduced into the progress of medical care, it would bring about a situation in which the government can conduct surveillance on medical care services at all times without the kind of inspection and checking that exist today. We must think about how to protect our professional freedom against the progress of information engineering. In the future, when you doctors purchase medicines from pharmaceutical companies, you needn't record them because everything will be recorded and payments made automatically. No calculations will be necessary at all; you will receive what you earn at the end of the month. This will come in five or 10 more years when glass fiber will be used to increase the capacity of cables by about 3,000 fold.

Another problem is the systematization of medical care. There could be all kinds of systems. Bureaucratic control could be one. But we can have an excellent system while maintaining private medical care, under which we need no insurer. In that system, the people themselves will be the insurers.

This will mean that the social insurance system will collapse with the coming of information revolution. Then we shall have the establishment of information processing technology and a new status for the physician in information society.

It was in anticipation of these problems that I suggested that community health study groups be created in all the prefecturers. But apparently, people listen to suggestions only if they meant instant money making. But there are too many people who cannot see ahead, and my suggestion has not been put into practice. This is where I see a grave danger in the future of doctors.

Still another important matter is the question of what will happen when we have too many doctors. I have been thinking that someone representing some region of the country might raise the question at a meeting of the board of directors of the JMA. But none has ever raised it. The meeting is held once every week, but the question has not been

raised because this requires a great deal of preparation to discuss it. What I am concerned about, however, is that what we can do in five or six more years when we do have an excess number of doctors. I understand that in Germany there was a time in the past when doctors had to work as streetcar conductors. A similar situation occurred in America, too.

More than 10 years ago, I proposed the question of the development and allocation of medical care resources, and the WMA adopted this as a subject for discussion. Conclusions were reached by the recent meeting of the follow-up committee.

What are the government and insurers thinking about this problem? First of all, they will think of limiting the number of insurance doctors as the easiest way out. Another is the problem of retirement age for doctors.

Still another is the limitation to be placed on the opening of practices in the urban areas. When a medical association in a certain area tries to place some restraint on doctors who open a practice, the Fare Trade Commission (FTC) intervenes. But if the government does this with law, the FTC will not intervene. These three measures I have just mentioned are the most likely steps to be taken first.

And if you panic when these measures *are* taken, it will be too late. This is the reason why I have been urging you to build medical association hospitals and give medical care services by making technology and finances public. The medical association hospital found only in Japan is a very good system in terms of economics, medical care equipment and manpower. It fosters medical care that is truly based on family medical care offered by family physicians. I think that from now on medical care will be given patients at home and it will be as good as that given in the hospital. The medical association hospital should become the center for home medical care. It must not merely imitate the other big hospitals that offer services in all departments. It should play the role of an information center in the community in which it is located. In that sense, it will be a new type of hospital, which we must build in large numbers.

As the result of the recent revision of the table of fees for medical care services, the practitioners in an area where a hospital of this kind had been built have vastly improved incomes. Those who had been earning an income by offering only antibiotics and those in certain areas who did not build a hospital of this kind are now in trouble. Therefore, those who are dissatified with the recent revision of the points for fees for medical care services ought to adapt their thinking to the new table of fees. You should not be quibbling about whether your revenue for this month is larger or smaller than that of the preceding month by simple arithmetical calculations. You will not be able to survive that way from now on. The medical association hospital will play an important role as a defense center in the new age of too many doctors to come. And people, too, will have to count on hospitals of this kind because medical care will be primarily given by family physicians.

I think that there is something wrong with those prefectural medical associations that meekly accept the ridiculous health centers built by cities, towns and villages in their prefectures, where public health nurses employed by local governments supervise the work of physicians. When I caution these prefectural medical associations about such a situation, they do nothing as long as the individual physicians continue to have the same income. Five or 10 years later, only when they suffer terribly, they will make fuss. This is the way doctors are — the doctors of today. They do not have the traditional spirit of Japanese medicine.

Therefore, how to cope with the age of too many doctors is not a problem of the future but of the present. The future should have been solved by now. There are many ways of solution. One of them is primary care medicine that I have proposed. But the curriculum in medical schools is ancient and is not based on the policy of developing primary care physicians. Therefore, I am afraid that this will not succeed.

Steps must be taken immediately to cope with the age of too many doctors. Bureaucrats will do whatever they want to do with the

power they have, and good-natured doctors will be their victims. There are many problems I want you to think seriously about from now on.

In Europe, wholesalers of pharmaceuticals have been liquidated. In England, there are only 20 or 30 wholesalers whereas in the past there were thousands. A similar situation is found in Germany, where the pharmaceutical industry has become a major export industry rather than one to provide the German people with medicines. In France, medical care is now state-managed. In other countries, doctors have all suffered setbacks in one way or another. Only in Japan and the United States are doctors breathing the air of freedom to some extent. In America, President Reagan has an aide who has closely studies my ideas, and I am going to have a discussion with him shortly. I plan to experiment with my ideas by using the U.S. as a guinea pig. Japan was mercilessly used as a guinea pig by GHQ, SCAP, and now the tables must be turned.

For these reasons, I cannot understand why so many doctors are content with their present life without thinking about the problems of too many doctors to come very soon. There are a great many problems, but they all derive from the fact that wartime legislation has remained in force even after the war. My conclusion is that unless we drive a wedge into an issue which has no direct bearing on our earnings, there could be no victory for the doctor and the welfare of the people will be destroyed.

The Japan Medical Association: a Description

The Japan Medical Association: a Description

The JMA is a professional organization that bears the greatest responsibility for the people's health and diseases. On the other hand, it also holds itself responsible, as a member of the World Medical Association, for the survival, health and diseases of the human being on a global scale.

Medical Education — The JMA is directing its greatest efforts to the undergraduate and postgraduate education of physicians. Also, the JMA president has been required by law to serve on the committee on the state examination for the licensing of medical practitioners.

What part medical care should play in the people's life, especially when our standard of living is rising steadily as at present must be our greatest concern. In the past 20 years, the JMA has done much toward bringing the nation's medical care system to the level where it ought to be. During this time, the local medical associations, under the JMA leadership established their own hospitals and started community health investigation societies jointly with the local people and the autonomous governments concerned, thus extending the scope of their activities throughout the entire Japan. They are pushing vigorously with their respective plans for better community medical services.

As of April 1, 1975, the membership of the JMA was as follows:

Reprinted from the *Asian Medical Journal*, Vol. 18 No. 9, September, 1975.

Class A Member (Practicing and employed physicians, who have taken out the physician's indemnity insurance)	66,663
Class B Member (Employed physicians)	22,845
Class C Member (Unsalaried physicians)	2,205
Total	91,713

Joining the JMA is optional, not compulsory. And the fact that about 80% of all those eligible are members of the JMA testifies to the JMA's influence. By profession, the members include university professors, government officials, physicians employed in hospitals and private practitioners. The organization and character of the JMA follow:

Organization and Character of the JMA

Voluntary Affiliation Of the nation's total of 110,000 physicians, 91,713 are members of the JMA.

By profession:

- Private practitioners
  - County, city and ward medical associations → Prefectural medical associations → Japan Medical Association
- Physicians employed in hospitals
- Government officials
  - Ministry of Health and Welfare Medical Association, prefectural government medical associations, etc.
- Professors at medical colleges, etc.
  - University of Tokyo Medical Association, Keio University Medical Association, etc.
- Scientific Branch
  - Japanese Association of Medical Sciences . . . 66 academic societies Special medical societies, largely in the domain of life science

As its scientific branch, the Japanese Association of Medical Sciences (JAMS) is amalgamated in the JMA and has a total of 66 academic societies under its control. The JAMS holds 6 symposium each year, and general assembly once every 4 years.

List of Member Academic Societies of the JAMS

1. Japanese Society of Medical History
2. Japanese Association of Anatomists
3. The Physiological Society of Japan
4. The Japanese Biochemical Society
5. The Japanese Pharmacological Society
6. Japanese Pathological Society
7. The Japanese Cancer Association
8. Japan Haematological Society
9. Japan Bacteriological Society
10. Japanese Society of Parasitology
11. Medico-Legal Society of Japan
12. The Japanese Society for Hygiene
13. Japanese Society of Race Hygiene
14. Japanese Society of Food and Nutrition
15. The Japanese Association of Physical Medicine, Balneology and Climatology
16. Japan Endocrinological Society
17. The Japanese Society of Internal Medicine
18. Societas Paediatrica Japonica
19. The Japanese Association for Infectious Diseases
20. The Japanese Society for Tuberculosis
21. Gastroenterological Society of Japan
22. The Japanese Circulation Society
23. The Japanese Society of Psychiatry and Neurology
24. The Japanese Surgical Society
25. Japanese Orthopaedic Association
26. Japan Society of Obstetrics and Gynecology
27. Japanese Opthalmological Society
28. Oto-Rhino-Laryngological Society of Japan
29. The Japanese Dermatological Association
30. Japanese Urological Association
31. The Japanese Stomatological Society
32. Japan Radiological Society
33. The Association of Life Insurance Medicine of Japan
34. The Medical Instrument Society of Japan
35. Japanese Leprosy Association
36. Japanese Society of Public Health
37. The Japan Society of Sanitary Zoology
38. The Medical Association of Transportation Hygiene and Casualties of Japan
39. The Japanese Society of Physical Fitness and Sports Medicine

40. Japanese Society of Industrial Medicine
41. The Japan Broncho-Esophagological Society
42. The Japanese Society of Allergology
43. Japan Society of Chemotherapy
44. The Society of Japanese Virologists
45. Japan Society of Anesthesiology
46. The Japanese Association for Thoracic Surgery
47. The Japan Neurosurgical Society
48. Japan Society of Blood Transfusion
49. The Japanese Society for Medical Mycology
50. The Japanese Association of Rural Medicine
51. Japan Diabetic Society
52. Japanese Association of Correctional Medicine
53. Japanese Society of Neurology
54. Japan Geriatrics Society
55. The Japan Society of Human Genetics
56. The Japanese Association of Rehabilitation Medicine
57. Japan Society of Chest Diseases
58. The Japanese Society of Nephrology
59. The Japanese Rheumatism Association
60. Japan Society of Medical Electronics and Biological Engineering
61. The Congenital Anomalies Research Association of Japan
62. Japan Society of Hepatology
63. Japan Society of Plastic and Reconstructive Surgery
64. Japan Society of Tropical Medicine
65. The Japanese Society of Pediatric Surgeons
66. Japanese College of Angiology
67. Japan Society of Neonatology
68. Japanese Society for Artificial Organs and Tissues
69. The Japanese Society for Immunology
70. The Japanese Society of Gastroenterological Surgery
71. Japan Society of Clinical Pathology
72. The Japanese Society of Nuclear Medicine
73. Japanese Society of Fertility & Sterility
74. Japanese Association for Acute Medicine
75. Japanese Society of Psychosomatic Medicine
76. Japanese Society on Hospital Administration
77. Japan Gastroenterological Endoscopy Scociety
78. Japan Society for Cancer Therapy
79. Japan Society for Transplantation

Together, these committees cover all the fields of medical care, with their committees participated in also by many non-medical specialists. These committees are under the control of the Board of

Trustees, which integrates the results of their efforts that constitute the JMA's activities. Under this setup, the JMA can study various problems in a broader perspective, that is, not only from the medical standpoint but also from the social and cultural viewpoints. Further, this enables the JMA to obtain realistic pictures of the existing comprehensive medical care system and community medical care systems.

As one of its businesses, the JMA has a special insurance to indemnify physicians for compensations for malpractice. And there is established for this system an appraisal organ by the highest medical and legal authorities.

As a program for postgraduate education, the Social Insurance Leaders Training Course is annually given by the JMA. The purpose of this course is to introduce the advances both in basic and clinical medicine to the social insurance services in this country. The program consists of a central meeting and the local meetings that move from county to county or from city to city for the convenience of those unable to attend the central meeting.

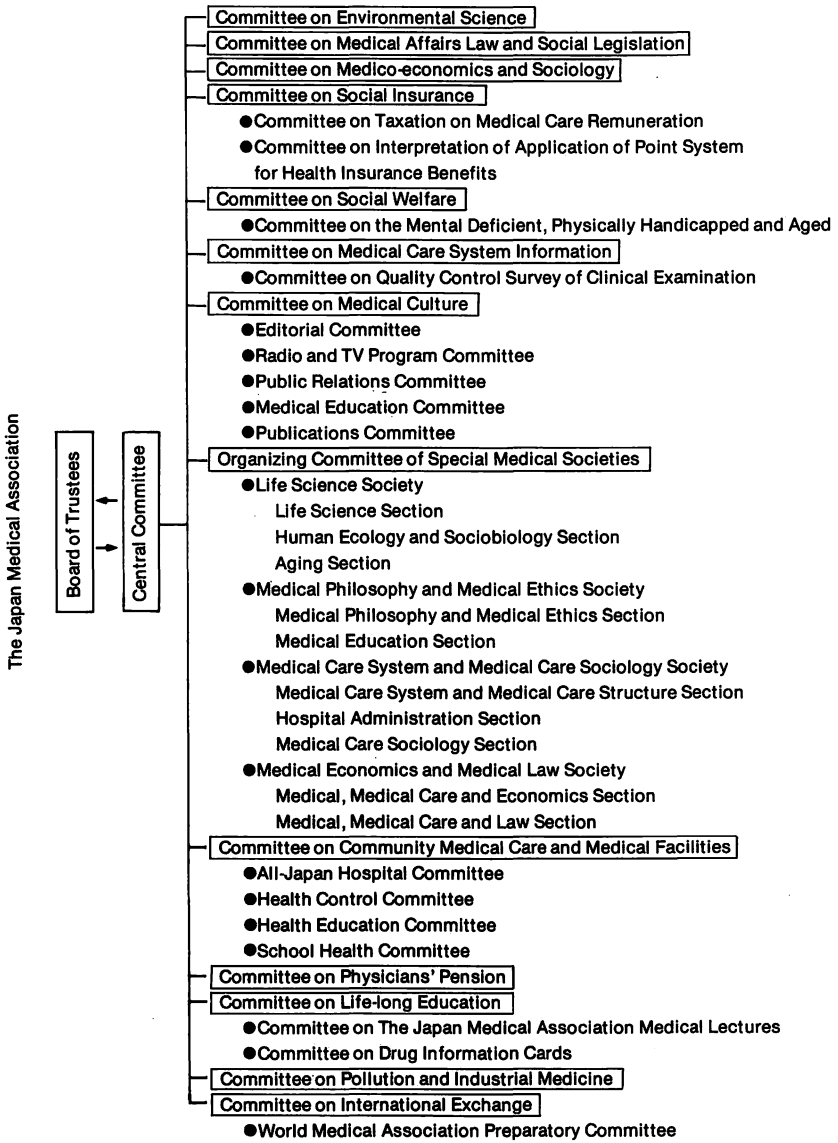
The JMA Medical Lectures are provided particularly for the benefit of practitioners, and all members of the local associations are obligated to be present at one of the lectures once every five years.

As for the welfare of physicians, the old age pension of the JMA provides for physicians retired from service, which has now grown into the largest system administered by any non-governmental body. There are also available to the JMA members the National Health Insurance of Physicians, the Credit Association of Physicians and the Finance Corporation.

Working under the organization and setup as outlined above, the JMA has come to be held in high esteem also for its social functions. In fact, the JMA is now playing a leading part in the matter of the health insurance system and social welfare in this country.

JMA periodicals are listed in section VIII-5.

The JMA has the following committees:



Medical Education

Medical education of the German type was introduced into Japan in the early part of the Meiji Era and was included in the university curriculum by the Ministry of Education. It continued up to the end of World War II.

After the war, however, the medical education of the German type has been replaced by that of the American type. However, the introduction of the intern system failed to produce the expected results due to the lack of preparations on the receiving side and had to be abolished. Instead, a new system was started under which medical students, upon graduation from school, are required to take the state examination for medical practice, to be followed by two years of internship at one of the hospitals designated by the government.

To promote this postgraduate education, the JMA makes its representations, whenever considered necessary, about its improvement, government subsidies to private medical schools, etc.

With regard to postgraduate education, the JMA is putting into practice the following programs.

1. Postgraduate Education

1) JMA Medical Lectures

It is often pointed out that the education of physicians is a life-long affair, which is true. In recognition of the urgent need in the postwar Japan for extensive postgraduate education for physicians to enable them to better meet the community medical care needs by keeping them up to date, with the ever advancing medical knowledge and technology as well as structural changes in disease, the JMA in 1962 instructed all the member prefectural medical associations to give the JMA Medical Lectures as follows:

a) One term will be for five years, and each member is expected to participate.
b) Accordingly, at least one-fifth of all the members will attend the first-year course.
c) Upon completion of the course, a certificate will be issued to each participant.

d) Practical training will also be provided at a designated hospital.

The result was that the physicians who attended the first-year course of 1st term (1962—1966) numbered 12,057 in the entire country, much in excess of the earlier expectation and achieving a most brilliant success for a program of this sort. For the second and later years, "JMA Medical Lecture Series" in book form was published for the benefit of not only the participants but also those who were unable to attend in spite of their wishes because of the limit in the capacity of the lecture program. This series was distributed free of charge to all the Class A members up to 1974, and will be done so to both the Class A and Class B members from 1975 on.

While this year falls on the 4th year of the 3rd term (1972—1976), the attendances for the preceding two terms were:

1st term (1962—1966)	60,905 physicians (74.3%)
2nd term (1967—1971)	56,931 physicians (64.9%)

2) JMA Special Medical Societies

With the JMA is amalgamated the JMAs with a total of 66 academic societies. These societies are subdivided and specialized bodies working independently of each other. To guard against the shortcomings of excessive compartmentalization and to see things from a broader viewpoint, the special medical societies has been newly formed by the JMA.

Not only medical experts but specialists from all other related branches of science assemble in this meeting to integrate the fruits of work in many specialized fields of study so as to discover and point out new directions in medicine and medical care as they relate to life science.

The 1st meeting was held in Tokyo for 4 days from December 10, 1973. It was participated in by scholars and researchers on philosophy, psychology, economics, law, sociology, physics, chemistry, engineering and information technology, who considered various problems from the standpoint of life science. In early December of last year, the 2nd meeting took place also in Tokyo for 4 days, when lively discussions were held among scholars from various

branches, centering on the main theme of "human survival order" and obtaining highly satisfactory results.

3) TV Medical Study Course and Topics in Medicine

Since April 1964, the JMA has been sponsoring a 30-minute program, "TV Medical Study Course," on Tokyo Channel 12 (8:30—9:00 a.m. every Saturday) as an advanced course for postgraduate education. This is a series of courses prepared by the JMA specifically for broadcasting, each course lasting for 3 to 6 months. These TV broadcasts have also been made available in 16-mm films, video tapes or 8-mm cassette tapes and are being widely used at supplementary training courses for local private practitioners. The subject of the course for the first half of this year (Jan.—June) was "Vital Adjustments," Series No. 39, and that for the latter half (July—Dec.) is "Receptors," Series No. 40.

"Topics in Medicine" is being broadcast on the same station from 8:15 a.m. for 15 minutes every Saturday, or immediately before the program just mentioned. This program was started in 1960, and is designed to introduce to physicians and researchers current topics of medicine and their bearings on clinical practice.

4) Short Wave (Medical) Broadcasting

Since 1954, the JMA has also been planning two radio programs, "the Medical Course" and "the Special Medical Course" by the Japan Short-wave Broadcasting Station to support and further promote the postgraduate education. Particularly the Special Medical Course is organized as a long-term program to cover systematically progress in both health administration and the basic and clinical medicine. On the other hand, the Medical Course is planned by the Radio and TV Program Committee of the JMA, and is on the air from Monday through Saturday every week, for 20 minutes from 10:00 p.m. The Special Medical Course is being broadcast on every Sunday, for 30 minutes from 10:00 p.m.

In commemoration of the 20th anniversary of the medical course on the Japan Shortwave Broadcasting network, a special program

entitled "Progress of Japanese Medicine during the Past 20 Years" was planned by the JMA and broadcast over three months from October of last year (for one hour every Sunday morning).

5) JMA Film Library

The JMA Film Library was set up in 1964. Since then, the number of films collected continues to grow year after year as new films are received frequently, in addition to the video tapes of the TV Medical Study Course mentioned earlier. And the JMA is lending out these films free of charge on request, with the utilization rate rising steadily.

On the other hand, taking the opportunity of the opening at each prefectural association of a "health room" as a project to promote health education in the local community, the JMA has decided to make use of these films as audio-visual aids for the purpose. To facilities this and other general uses, 16-mm films are being reprinted in 8-mm cartridge films. Also, the TV Medical Study Courses given during and after April 1973 have all been copied as films for use in the "Health Forum."* Thus the JMA Film library now represents one some 800 16-mm films, 8-mm cartridges and video tapes.

2. Medical Prize and Medical Research Grant

The "JMA Medical Research Encouragement Prize" was created in 1961 and was renamed simply as "JMA Medical Prize" in 1968, to encourage efforts to contribute to the progress of Japanese medicine. This prize is awarded to two persons each year for important achievements in the fields of basic medicine, clinical medicine or social medicine, each winner being granted ¥2 million.

In the following year, 1962, the "JMA Medical Research Grant" was founded. This grant is given on a total of 15 subjects of important researches eacy year in the fields of basic medicine, clinical medicine or social medicine. The amount of the grant is ¥1 million for each

* Under the guidance of the JMA, prefectural medical associations hold "Health Forum" for the health of the community residents on the level of community medical associations.

subject, and subjects yet to be taken up for research already under way are not considered.

The presidents of the academic societies of the JAMS, deans of the medical faculties of universities, presidents of medical colleges and heads of all other related institutes are requested to recommend one candidate each for the Medical Prize and three subjects for the Medical Research Grant. On the basis of their recommendations, the final selection of the winners of these two awards is made by the Medical Education Committee of the JMA. The winners are presented with their respective awards at the anniversary of the JMA, which is held on November 1 to commemorate its foundation.

3. The Japanese Association of Medical Sciences (JAMS)

JAMS is a branch of the JMA, and has under its control a total of 79 academic societies (also see the description under this heading). A general assembly used to be held every four years to coordinate the efforts of all these societies. With the rapid progress of specialization and compartmentalization of medical science of late, however, the increasingly urgent need for integrating their separate activities has been felt. As a step in this direction, the 1st JAMS symposium was held in Sapporo in 1965 on the main theme of the "Kidney and Electrolyte." Since then, four to five symposiums were held each year. For this year which falls on the 10th year since the 1st symposium, the 40th JMAS symposium was held in Keidanren Hall, Tokyo, on JUly 4 on the main theme of "Hormones and Receptors."

These symposiums are designed for participation mainly by young researchers, taking up most up-to-date topics. Lively discussions characteristic of these meetings are winning very favorable comments in many quarters, and they are attracting more and more participants.

In contrast, the JAMS general assembly, it must be admitted, has now grown perhaps a little too big in the course of time, with problems coming to the fore. To cope with the situation, a special committee has been formed to consider "How JAMS Should Be," while how to maintain necessary order in the medical circles and other

related matters are often items for discussion at the Board of Directors meetings. Thus, the JAMS is making strenuous efforts, working closely with the JMA, toward the progress and development of Japanese medicine.

As one of its projects, the JAMS has compiled the *The Japan Medical Terminology*. With the advance of medicine, medical terms used become more and more numerous as well as complicated. If these terms are adopted and used in each field independently of other fields of medicine, confusions detrimental to the progress of medicine as a whole is likely. For this reason, the JAMS had long been advocating the standardization of medical terminology. At its general assembly for 1940, therefore, the Medical Terminology Committee was started.

After many twists and turns including the World War II as the greatest obstacle in the way, *The Japan Medical Terminology* was brought to completion and published in April this year. A fruit of 35 long years, this much-awaited dictionary is meeting with very favorable reception by all those interested. Thus, it is expected that this dictionary will prove highly useful not only in the standardization of medical terms in Japan but also in establishing internationally the Japanese equivalents to foreign medical terms.