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## The 25th CMAAO Congress and the 43rd Council Meeting: SYMPOSIUM —Arts and Science of Healthy Longevity—



Hotel Royal Cliff Beach and Resort, Pattaya, Thailand  
November 18–20, 2007

The 25th CMAAO (Confederation of Medical Associations in Asia and Oceania) Congress and the 43rd Council Meeting was held from November 18 to 20, 2007, in Thailand and attended by a total of some 50 representatives of 13 National Medical Associations. This issue of the JMAJ provides the presentations delivered by 8 speakers from NMAs of Hong Kong, Indonesia, Japan, Korea, Malaysia, Singapore, Taiwan and Thailand at the symposium on the theme “Arts and Science of Healthy Longevity” that was held on November 20.



Participants in the CMAAO Meeting in Thailand

[Hong Kong]

# Towards Healthy Longevity

CHOI Kin\*<sup>1</sup>



## Towards Healthy Longevity

Dr. CHOI Kin MFM, FRCPI,  
DGM (Glasgow), PDCG(HKU)  
President,  
Hong Kong Medical Association

## Geriatric population in Hongkong

- 1996 10.2% population >65
- 2001 11.2% population >65
- 2031 24.0% population >65

## Geriatric Medicine in Hongkong

- 1973-74 Dr. Chan Sik sent to UK to observe British Geriatric Service
- 1975 First geriatric unit in Princess Margaret Hospital
- 1979 Geriatric included in curriculum in HKU
- 1981 Founded HK Geriatric Society
- 1994 First Geriatric Medicine Professor in CUHK – Jean Woo

## Life after 80

- Life expectancy of woman after 80 in HK is 11 years
- Life expectancy of men after 80 in HK is 8.4 years
- Over 85 spend 13 days a year in hospital
- 75-79 year old spend 6 days a year in hospital
- 65-69 year old spend 2 days a year in hospital

\*1 President, Hong Kong Medical Association, Hong Kong (yvonne@hkma.org).

### Elderly Health Services

- 18 Elderly Health Centers by Department of Health
- Annual Enrolment fee \$110 for >65
- Health assessment, physical check up, counseling, curative treatment and health education
- 18 visiting health teams for vaccination in community and residential care settings to increase health awareness & self-care ability

### Residential Care Facilities 2003

	No.	Total capacity
• Hostels	7	113
• Home for aged	78	7343
• C & A Homes	87	11499
• Self-financed homes	36	3112
• Long stay care homes	4	770
• Contract Homes	5	504
• Nursing Homes	7	1776
• Private Old Age Homes	573	45926
• Bought place scheme		(5931)
• Grand Total		70943

### Financial assistance to elderly citizens of Hong Kong

- Normal OA Allowance 65-69 \$625
- Higher OA Allowance >70 \$705
- Normal disability 100% \$1120
- allowance loss of work capacity
- Higher DA +24 hrs attention \$2240
- Diaper allowance On diapers \$900
- Diet allowance Special diet \$795

### Community Support Service

- Neighborhood Elderly Center 114
- Health education, information, referral center on community resources, volunteer development, social and recreational activities, meal services, counseling, reaching out and networking, support services, drop in services

### Community Support Services

- 60 Social Centers for the Elderly
- Organize Social and Recreational services
- Information giving regarding elderly welfare services
- Organized group activities
- Will be upgraded to Neighborhood Elderly Center

### Community Support Services

- 40 District Elderly Community Centers
- Community support services at district level
- Community education, case management, support team for elderly, information and referral centers on community resources, volunteer development, care giver support, meal and laundry services, social and recreational activities. Provide support and training to other elderly service unit

### Community Support Services

- 40 Support teams for the elderly
- Based in District Elderly community centers
- Provide social networking services and outreaching services to vulnerable elderly
- Telephone contacts and home visits
- Escort to clinics and household chores

### Community Social Services

- 50 Day care center for 2957 elderly
- Center based care and support services in day-time for frail and demented elderly
- Personal care, nursing care, rehabilitation training, meal and transport

### Community Social Services

- Home Help Services for disabled elderly and families incapable of looking after themselves.
- Bathing, feeding, household cleaning, purchase and delivery of daily necessities, laundry service, escort service to hospital and clinics, meal services

### Community Social Services

- 60 Integrated Home Care Service Team
- Multidisciplinary Team approach – nursing care, personal care, rehabilitation service, social work service.
- Planned and coordinated package of home care and community care service tailor-made for individual service

### Community Social Service

- 18 Enhanced Home and Community Care services
- Similar service to IHCST
- Will be upgraded to IHCST

### Senior Citizens Card Scheme

- Proof of Age to elders
- Facilitate access to concessions, discounts, priority services offered by government, public companies, private and commercial establishment
- >65 years old are eligible

### Elderly depression

- WHO: depression will be the second most important cause of disability world wide, after ischemic heart disease, by 2020.
- World wide prevalence of depression in the elderly 9-35%, 13% of community dwellers, 43% of nursing home residents

### Screening for depression

- US Preventive Service Task Force:
- Overall, screening and feedback reduced the risk for persistent depression
- Compare with usual care, screening for depression can improve outcomes, particularly when screening is occupied with system changes that help ensure adequate treatment and follow up

### Screening for elderly depression

- 1424 patients over 65 were offered a psychiatric interview when they were seen in a primary care practice in Hong Kong
- 31 patients were diagnosed with dementia and excluded from the study
- 25 patients were excluded because they were known to have depression
- 4 patients were excluded because of deafness and difficulty in communication

### Prevalence of depression in the elderly in Hong Kong

- 9.6 % of elderly interviewed were diagnosed with major depressive disorder
- 7.4% of male interviewed were depressed
- 10.7% of female interviewed were depressed
- Chinese version of GDS-15 could be used for screening of elderly depression and AMT-10 for dementia

### The Problem with Dementia

- |                    |      |               |      |
|--------------------|------|---------------|------|
| • World prevalence |      | HK Prevalence |      |
| • 65-69            | 1.5% | 60+           | 4%   |
| • 70-74            | 3.5% | 70+           | 6.1% |

### Cholinesterase inhibitor

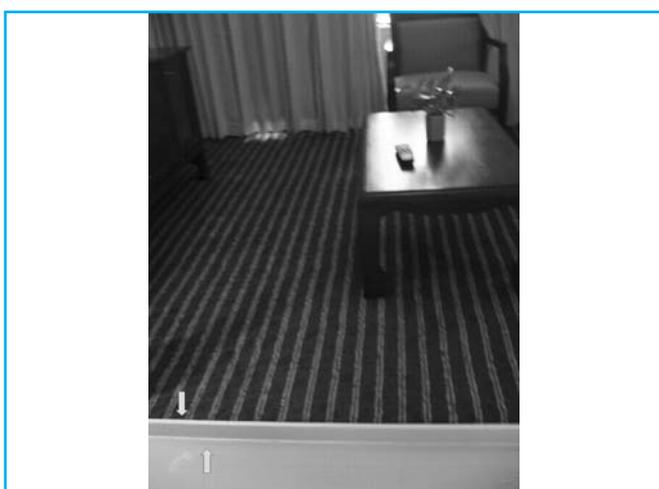
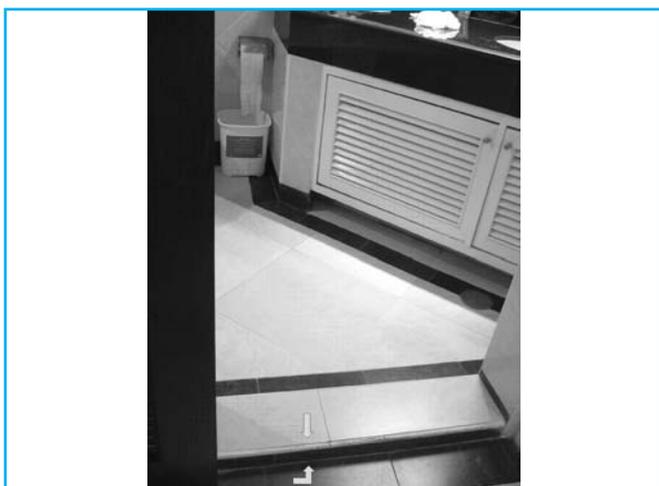
- Cholinesterase inhibitor
- Cost-effectiveness
- Memantine
- NICE guideline
- Advocate for our elderly patients

### Fall Prevention

- 30% of community dwelling elderly fall each year
- 20% of falls require medical attention
- <10% of falls result in fracture
- Together with accidents and suicide, falls rank the sixth leading cause of deaths in Hong Kong

### Environmental hazards

- Furniture- unstable &/or of inappropriate height
- Beds/toilets – inappropriate height
- Uneven stairs & inadequate or no railing
- Steps and kerbs at entrance
- Cracked and uneven sidewalks
- Obstacles on the floor e.g. wires, cords
- Slippery floors and bathtubs
- Poor lighting or glaring



### Community Geriatric Assessment Team

- Occupational therapist to look at the environment.

[Indonesia]

## **Towards Healthy Longevity in Indonesia**



Czeresna H. SOEJONO,\*<sup>1</sup> Purwita W. LAKSMI

The population is aging. By the year 2050, 12 countries are projected to have more than 10% of oldest-old population. They include not only countries in Europe, but also in Asia Pacific region. Furthermore, five countries will have 10 million or more people over 80 years old, including China, India, the United States, Japan and Indonesia [United Nations Information Centre].

In 2005, there are 16,440,500 people age 60 years and older in Indonesia and it is estimated that the number will increase to 19,079,800 people or 8.15% of total Indonesian population in 2010 (BPS, 2005).

Many diseases and disabilities will then ensue, ranging from infection, hypertension, diabetes mellitus, instability, immobility, osteoporosis, and fracture to depression, dementia, overactive bladder and insomnia. The health problems are thus inevitable. Elderly people are bound to place an enormous personal and socioeconomic burden on their families and society, unless prompt action is undertaken to quickly develop better prevention and treatment programs for many of the physical and mental ailments associated with old age. Compared with younger patients, older patients have longer and more frequent hospitalizations and their illness severity is greater. Cost of hospitalization are higher in elderly patients compared to younger adults.

Geriatric patients are elderly patients with certain characteristics: coincidence of multiple health problems in one person, tendency for polypharmacy, decreased or limited physiologic reserves in multiple organ system, decreased functional status, atypical presentation of illness, and usually have malnutrition condition and psychosocial problems. Thus the approach to the elderly person requires a perspective different from that needed for medical evaluation of younger persons, which called comprehensive geriatric assessment (CGA).

Traditional medical evaluation typically focuses on the medical care of disease-specific and life-

threatening illnesses, while less attention is given to functional outcomes such as physical and cognitive functioning which may be critical determinants of the quality of life, physical independence, cost of care, and prognosis among elderly patients. CGA extends beyond the traditional medical evaluation to include assessment of cognitive, affective, functional, social, economic, environmental, and spiritual status, as well as a discussion of patient preferences regarding advance directives. In addition, to improve clinical outcomes of hospitalization, CGA are conducted by interdisciplinary team to include doctors from kinds of specialties, nutritionists, pharmacists, gerontological nurses, therapists (physical, occupation, and speech), and social workers.

The health care system of geriatric care consist of hospital-based care which include acute care and sub acute care and community-based care which include nursing home care and home care services. Acute care setting is comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process, while sub acute care setting is designed for someone who no longer required acute care services and did not need (or want) long-term care placement, but who was not yet sufficiently recovered from his/her acute illness to return home and still requiring medical management and/or functional rehabilitation within the skilled nursing facility. The interdisciplinary process of discharge planning in acute care unit serves to identify patients who will need nursing home placement or home care services, to estimate the patient's hospital length of stay, to educate the patient and family about the patient's diagnosis, prognosis, and choices for discharge location, and to review medications, home safety, and the promotion of self-care.

Bearing in mind the imminent health problems in the elderly, it is important to make it possible to deliver the right care, in the right place, at the right time, by the right practitioner and to organize

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\*1 Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).

good insurance health care financing program.

The long and winding road to the establishment of geriatric care in Indonesia has begun since 1966 when one of the pioneers of our geriatric care, R. Boedhi Darmojo, MD, studied gerontology and geriatric medicine abroad. This was followed by the first national symposium on geriatric medicine 10 years later. In 1994, three hospitals (Ciptomangunkusumo Hospital, Jakarta; Kariadi Hospital, Semarang, Central Java; Sardjito Hospital, Yogyakarta) were appointed by Ministry of Health to be the pioneer hospitals which serve integrated geriatric care. But it was not until 1996 when geriatric medicine became part of the curriculum and being taught to internal medicine residents/undergraduate students and the Indonesia Medical Gerontology Association being established under bow the Indonesia Medical Association.

Now, the Indonesia Medical Gerontology Association has 15 branches all over Indonesia (Medan, Padang, Pekanbaru, Palembang, Jakarta,

Bandung, Semarang, Solo, Yogyakarta, Malang, Surabaya, Denpasar, Makasar, Manado, Banda Aceh) with 7 branches as center of education which teach geriatric medicine to undergraduate students and 4 branches which also teach geriatric medicine to internists who want to be internist-geriatricians. The contribution to the community-based geriatric care is through training of PUSAKA personals.

Indonesia still lack of human resources concerning that there are only 15 internist-geriatricians until now who have to serve more than 10 million elderly people. We are also lack of facilities of geriatric care, research and training in geriatric medicine for internists, GPs, nurses, and layman. Lastly, government support and health care insurance support system are all still needed to make better health management, as well as international collaboration to exchange information and experiences vital to the advancement of health and research in geriatric medicine in Indonesia.

## **TOWARD HEALTHY LONGEVITY IN INDONESIA**

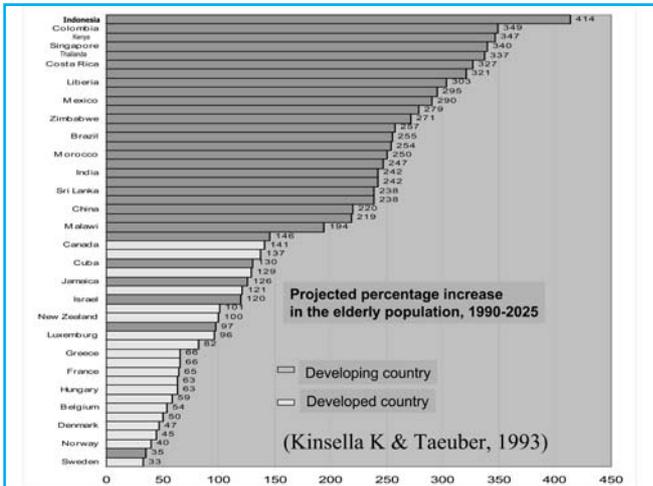
**CZERESNA H. SOEJONO, MD, PhD**  
**Internist-Geriatrician**

**INDONESIA MEDICAL ASSOCIATION**  
**INDONESIA MEDICAL GERONTOLOGY ASSOCIATION**

## **The population is aging...**

- In 2050:
  - 12 countries will have >10% of oldest-old population
  - 5 countries will have >10 million people age >80 (China, India, USA, Japan, **Indonesia**)

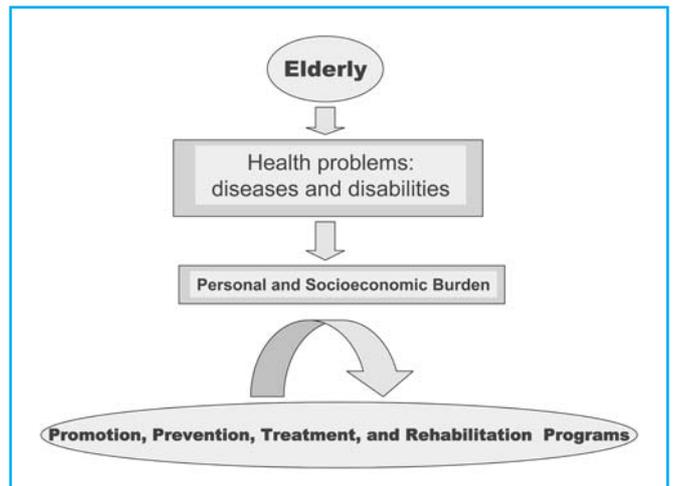
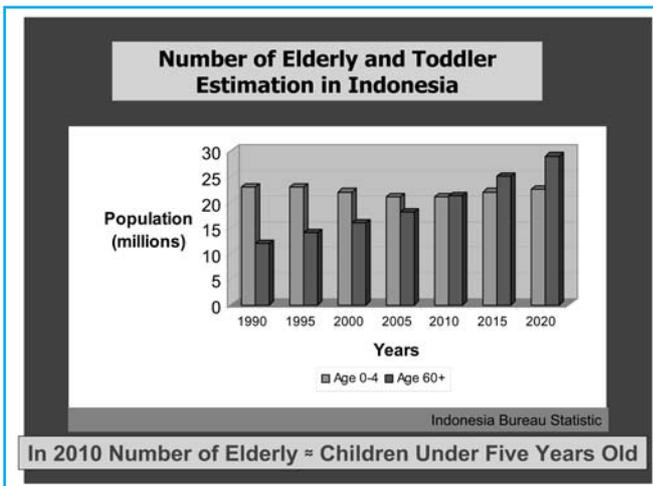
United Nations Information Centre, 2000



## Elderly in Indonesia

YEAR	PEOPLE AGE >60
2005	16,440,500
2010	19,079,800
≈	
8.15% of total population	

Indonesia Bureau of Statistics



- Coincidence of multiple health problems in one person
- Tendency for poly-pharmacy
- Decreased or limited physiologic reserves in multiple organ system
- Decreased functional status
- Atypical presentation of illness
- Usually have malnutrition condition and psychosocial problems

↓

**Geriatric Patient**

Medical assessment different from younger adult

**COMPREHENSIVE GERIATRIC ASSESSMENT**

## Comprehensive Geriatric Assessment (CGA)

- CGA different from traditional medical evaluation
- Include assessment of cognitive, affective, functional, social, economic, environmental, and spiritual status
- Discussion of patient preferences regarding advance directives
- Conducted by **interdisciplinary** team

### Health Care System of Geriatric Care

#### Hospital-based Care

- Acute Care
- Sub Acute Care

#### Community-based Care

- Nursing Home Care
- Home Care

It is important to deliver the right care, in the right place, at the right time, by the right practitioner and to organize good **insurance** health care financing program

### Geriatric Care in Indonesia -1

YEAR	ACTIVITY
1966	R. Boedhi Darmojo, MD, studied gerontology and geriatric medicine abroad
1976	The 1 <sup>st</sup> national symposium on geriatric medicine
1994	3 hospitals became pioneer to serve integrated geriatric care
1996	<ul style="list-style-type: none"> <li>• Geriatric medicine became part of the curriculum</li> <li>• Indonesia Medical Gerontology Association was established</li> </ul>

### Geriatric Care in Indonesia -2

- Indonesia Medical Gerontology Association has 15 branches all over Indonesia

7 branches as center of education to teach geriatric medicine to undergraduate students

4 branches also teach geriatric medicine to internists who want to be internist-geriatricians

### Geriatric Care in Indonesia -3

- Contribution of Indonesia Medical Gerontology Association in Indonesia
  - Conducts training for nurses and GPs from primary health care annually
  - Conducted training of PUSAKA personals (community-based geriatric care service)
  - Conducted training in hospital-based geriatric care for internists, medical rehabilitation consultants, and psychiatrists from 52 hospitals (of 427 hospitals all over Indonesia)

### Geriatric Care in Indonesia -4

- Contribution of Indonesia Medical Gerontology Association in Indonesia
  - Conducted training of PUSAKA personals (community-based geriatric care service)



### Geriatric Care in Indonesia -5

- Contribution of Indonesia Medical Gerontology Association in Indonesia
  - Conducts National Geriatric Annual Scientific Meeting
  - Will hold the 3<sup>rd</sup> Asia Pacific Geriatric Congress, Nov 13-16, 2008 in Bali

## Geriatric Care in Indonesia -6

### Still lack of...

- Human resources
  - Only 15 internist-geriatricians who have to serve >10 million elderly people
- Geriatric care facilities
  - Only 4 hospitals with Acute Geriatric Care
  - Only 1 hospital with Day Hospital Facilities



## Geriatric Care in Indonesia

### Still lack of...

- Training in geriatric medicine for internists, GPs, nurses, and layman
- Public facilities that elderly friendly
- Government support
- Health care insurance support system

### On-going process...

- Research in geriatric medicine
- International collaboration

## Conclusion

- Indonesia is facing a new epidemic: **geriatric giant**
- Geriatric Care in Indonesia is still far from ideal
- Indonesia needs so much support from the Indonesian Government and International Collaboration to improve Geriatric Care toward healthy longevity in Indonesia

Discovery Kartika Plaza Hotel, Bali, Indonesia, 13-16 November 2008

# APGC

ASIA PACIFIC GERIATRIC CONFERENCE

**GERIATRIC GIANTS: THE NEW EPIDEMIC IN THE 21st CENTURY**

**TOPICS:**

- Biology of aging, role of stem cell and successful aging
- EBM in geriatric: applicability of valid and importance study in geriatric medicine
- Caloric restriction and its role as anti aging
- Nutritional assessment for elderly patient in the hospital and community
- Immunology of aging and infection
- Osteoarthritis in the 21<sup>st</sup> century: growth factors, exercise and medications
- Aging of cardiovascular system and atherosclerosis
- Complimentary and alternative medicine to overcome pain problems
- Improving the care of the older person with Diabetes Mellitus
- Assessing balance and gait, reducing falls: translating research to the community

**CONFERENCE SECRETARIAT:**  
 Division of Geriatric Medicine,  
 Department of Internal Medicine,  
 FKUI / RS. Cipto Mangunkusumo  
 Jl. Diponegoro 71, Jakarta 10430, Indonesia  
 Phone : 62-21-3149523/190275  
 Fax : 62-21-3149523/190275  
 Email : apgc@pharma-pro.com  
 Website : www.apgc08.com  
 Contact Person:  
 •Carolina H. Soejono, MD, PhD (Internist Geriatrician)  
 •Ms. Irmayanti

## MAIN TOPICS

- **Biology of aging, role of stem cell and successful aging**
- **EBM in geriatric: applicability of valid and importance study in geriatric medicine**
- **Dementia care in homecare setting**
- **Caloric restriction and its role as anti aging**
- **Osteoarthritis in the 21<sup>st</sup> century: growth factors, exercise and medications**
- **Immunology of aging and infection**
- **Complimentary and alternative medicine to overcome pain problems**
- **..... and much more**

ASIA PACIFIC GERIATRIC CONFERENCE, BALI 13 – 16 NOVEMBER 2008

## Why you cannot miss this event?

- ✓ Superb scientific program
- ✓ Gorgeous congress location
- ✓ Bali...countless times voted as "World's Best Tourist Island"
- ✓ Registration fee (USD 300 only) include buffet lunch, coffee break, cultural dinner and full day sight seeing program
- ✓ Range of accommodation options within walking distance to congress venue. Convenience budget hotel range from USD35/night.



## See you in Bali .....



Asia Pacific Geriatric Conference  
13 – 16 November 2008  
Discovery Kartika Plaza Hotel  
Bali, Indonesia

Contact:

Email: [apgc@pharma-pro.com](mailto:apgc@pharma-pro.com)  
[isma@pharma-pro.com](mailto:isma@pharma-pro.com),

Web: [www.apgcbali.com](http://www.apgcbali.com)



[Japan]

## Health Policy toward the Longevity Society in Japan



Takashi HANYUDA\*<sup>1</sup>

### Introduction

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With regard to the rights of Japanese citizens to life and health, Article 25 of the Japanese Constitution, promulgated in 1947, stipulates that: “(1) All people shall have the right to maintain the minimum standards of wholesome and cultured living” and “(2) In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.”

Based on Article 25, various social welfare related laws such as the Living Protection Law, Child Welfare Law, and Physically Handicapped Persons Welfare Law, as well as social insurance related laws such as the National Health Insurance Law, National Pension Law, and Unemployment Insurance Law, were established one after the other in the past 60 years. These laws have contributed tremendously to the stabilization of people’s livelihoods, preservation of life, and maintenance and enhancement of health.

Since that time, the living conditions in Japan have improved with high economic growth and changes in industrial structure; moreover, with the nationwide spread of public health endeavors such as vaccinations and medical examinations, Japan came to have the world’s highest longevity. In 1947, the average life expectancy for men in Japan was 50.06 and for women 53.96; in 2006, the average life expectancy for men was 79.00 and for women was 85.81—and increase of around 30 years for both men and women over a half century.

According to World Health Organization (WHO) data,<sup>1</sup> Japan is also ranked Number 1 in the world for healthy life expectancy.

People living into their eighties and beyond has become a reality, and so the important challenge for the future is to not simply extend life

—in other words, a quantitative response—but to devise and implement measures for improving Quality of Life (QOL)—in other words, a qualitative response.

### Attitude towards “Healthcare”: from consumption to investment

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National healthcare expenditure in Japan has grown from 513 billion yen or 4 billion US\$ in 1961, when the universal healthcare system was established, to some 33.1289 trillion yen or 2,760 billion US\$ in 2005. Behind this increase in healthcare expenditure are a range of factors including population growth, aging of society, and advancement of healthcare; however, with the long-term stagnation of the Japanese economy in the wake of the collapse of the so-called economic bubble, the Japanese Government in recent years has continued to strongly move to restrict healthcare expenditure.

Approximately one-quarter of funding for national healthcare expenditure is provided through public funds, and this has led to the constriction of benefits and restriction of healthcare expenditure.

However, according to Organization for Economic Cooperation and Development (OECD) data,<sup>2</sup> in 2004 Japan’s total healthcare expenditure was 8% of percentage of GDP, which places Japan nine points below the OECD member country average of 8.9% with a ranking of 22 out of 30 countries. In other words, low expenditure in healthcare compared with the country’s economic strength supports the improvement of citizens’ health.

With the growth in public expenditure to cover increasing healthcare expenditure, healthcare is now frequently discussed in terms of “consumption.” However, as Japan becomes an increasingly aging society with fewer children, it is

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\*1 Executive Board Member, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

imperative that both the government and the general public develop an awareness of healthcare as a useful “investment” for advancing the health of citizens, thereby maintaining and improving the nation’s vitality.

### **From Secondary to Primary Preventative Measures**

With the improvement in living conditions, raising of living standards, and changes in dietary habits over the past decades, disease composition in Japan has also changed tremendously. From a time when tuberculosis and respiratory tract infections were the most common diseases, today cancer, cerebral stroke, and heart diseases are the cause of death in some 60% of cases. These diseases are also known as “lifestyle related diseases,” with clinical and epidemiological research clearly showing the influence of individual people’s lifestyles on their health.

Measures that take this situation into consideration recognize the importance of focusing on primary prevention through improving people’s lifestyles rather than on secondary prevention that centers on conventional health checkups aimed at early detection and diagnosis of diseases.

The WHO Ottawa Charter for Health Promotion states that health is an important resource for both individuals and society as a whole, and proclaims the necessity of improving and promoting health.

In Japan, too, the Health Promotion Law was promulgated in 2002 with the aim of establishing an infrastructure for actively promoting health improvement and disease prevention through national consensus.

Moreover, a new law to ensure healthcare for the elderly will come into force in April of 2008, implementing new measures for preventing lifestyle related diseases by, for example, requiring “health check-ups and guidance for specific diseases” to be provided for all people in Japan with healthcare insurance as a means of preventing and treating metabolic syndrome in particular.

In this way, Japan’s health policies are shifting from secondary prevention-centered measures to primary prevention focusing on preventing diseases from developing, and there is furthermore a gradual shift towards measures and policies that focus on “health promotion” that actively raises health levels.

### **Establishment of the Lifelong Healthcare Service Program**

Lifelong healthcare services in Japan have been systemized centered on medical check-ups, with Maternal and Child Healthcare for children younger than school age, School Healthcare for children of school age, Occupational Healthcare for people during their working years, and Elderly Healthcare for seniors.

However, different ministries, departments, and agencies administer each of these healthcare services and they are implemented independently; consequently, health information for any individual person is not managed in an integrated manner. These systems have been organized as lifelong healthcare services, but they cannot be said to be operating appropriately overall if no system for managing health information over a lifetime is maintained.

The quality of individual citizens’ health is expected to improve as a result of the implementation of healthcare services such as health check-ups, education, and guidance tailored to people’s lifestyles as well as the detection of changes in health through integrated management of health data. To this end, it is vital that objective evaluation indicators be developed for viewing the accumulation of “Capital of health” through these services.

The cooperation on coordination of allied health personnel is imperative for the development of comprehensive and effective health services. It is hoped that local medical associations, which have developed various community-based health services over their long histories, will make systematically contributions in response to these needs.

### **Concluding Remarks**

In order to create a system that maintains and improves the “Capital of health” for citizens over their lifetimes, it is vital that not only are the laws and ordinances that form the foundation for individual healthcare services revised in a comprehensive manner, but that a framework for comprehensively providing health insurance and healthcare be secured. To achieve this, financial support is imperative and many issues must be resolved.

In particular, as mentioned above, the Japanese Government in recent years has been eagerly working to contain social security expenditure, especially healthcare expenditure. Consequently, insufficiencies have arisen in the absolute numbers of doctors and other health professionals, whose responsibility it is to protect the health of the public, and reviews of these and other “burdens” that have resulted from reforms that have gone too far are now being discussed.

Considering the situation in Japan, where the aging of society is progressing at an unparalleled speed, environmental improvement measures such as the enhancement of healthcare services and spread of new medical technologies based on a stable financial foundation for enhancing health insurance and healthcare are imperative.

In other words, by enhancing the health capital of citizens through measures such as these, it becomes more possible to extend the age up until people can work and to encourage employment.

This in turn leads to increased GDP and tax revenue and contributes to the establishment of a financial foundation.

Transforming the inherently unstable aging society with fewer children into a stable society by creating “positive” cycles such as this is regarded as the response that Japan is demanding.

As mentioned at the beginning, Article 25 of the Japanese Constitution stipulates that the nation has a mission to endeavor to improve and advance social welfare, social security and public health.

Considering the improvements in living standards in Japan that accompanied the remarkable economic development and changes in the social environment, such as the strengthening of people’s awareness of their rights, it is imperative that the national government take a stance of promoting social welfare, social security, and public health at a consistently higher level.

References

1. WHO, The World Health Report 2004.
2. OECD Health Data 2007.

**CMAAO Symposium**  
Arts and Science of Healthy Longevity

**Health Policy toward the  
Longevity Society in Japan**

Takashi Hanyuda, MD  
Executive Board Member  
Japan Medical Association  
November 20, 2007

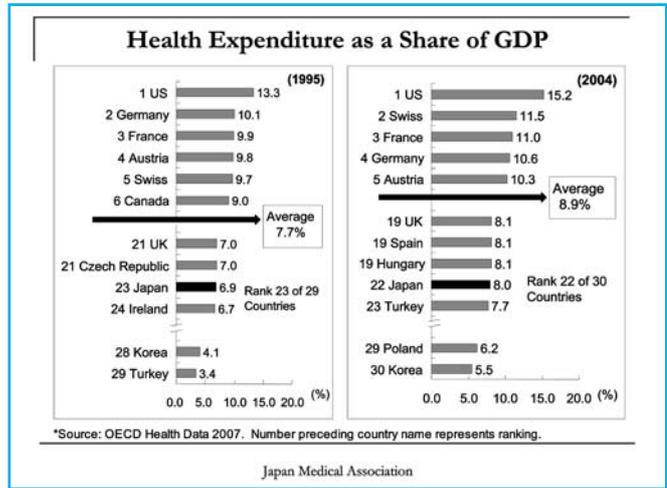
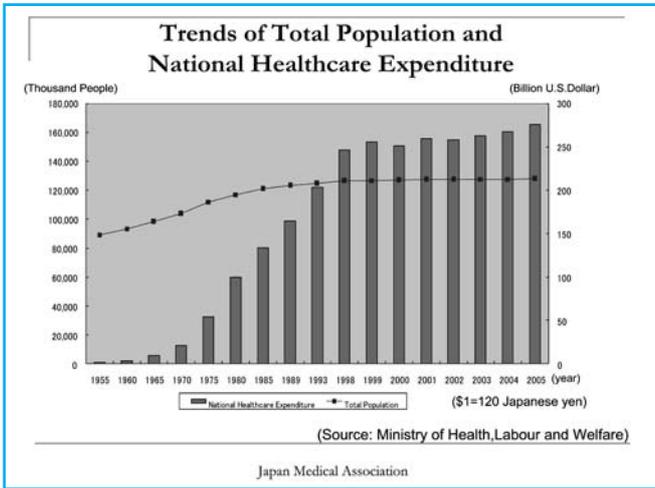
Japan Medical Association

**Health Care in Japan is ranked highly among  
countries throughout the world.**

	Health Achievement/ WHO		Infant Mortality Rate (per 1,000 Birth) OECD 2002	Life Expectancy at Birth WHO 2002	
	Health Healthy Life Expectancy 2002	Overall Rating of Health Achievement 1997		Male	Female
JAPAN	1	1	3.0	78.4	85.3
SWEDEN	3	4	2.8	78.0	82.6
ITALY	7	11	4.7	76.8	85.2
FRANCE	11	6	4.2	76.0	83.6
GERMANY	14	14	4.3	75.6	81.6
U.K.	24	9	5.3	75.8	80.5
U.S.A.	29	15	6.8	74.6	79.8

Source WHO: The World Health Report 2004, 2000  
OECD: Health DATA 2004, OECD: National Accounts 2004

Japan Medical Association



### Ottawa Charter for Health Promotion

#### First International Conference on Health Promotion Ottawa

21 November 1986 - WHO/HPR/HEP/95.1

**Advocate**  
 Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Japan Medical Association

### Improving Lifelong Healthcare Services by the Health Insurers

- ➡ The new law requires the health insurers health check-up and health guidance for preventing lifestyle related diseases such as diabetes.
- ➡ Increase of 20% in the medical check-up rate  
 Current situation: 60.4% for those who have a health checkup in 2007.

Japan Medical Association

### The Constitution of JAPAN

**Article 25**  
 All people shall have the right to maintain the minimum standards of wholesome and cultured living.  
 In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.

Japan Medical Association

*Thank you  
 for your attention!*

Japan Medical Association

[Korea]

# Long-term Care Act in Korea



Dong Chun SHIN\*<sup>1</sup>

## Long-term care Act in Korea



**Korean Medical Association**

CMAAO Symposium

November 20, 2007 Pattaya, Thailand

Presented by Dr. Dong Chun SHIN  
Executive Board Member, KMA

Professor, Department of Preventive Medicine, Yonsei University

## Basic Concepts

- Biological /Lifestyle/Environmental aspect
- Socio-economical aspect
- Cultural aspect



Korean Medical Association

## 1. Introduction

### 2) The need to establish Long-Term Care Act

- Korea is one of the fastest aging society among OECD countries with 7% of its population over 65 years old and the rate is expected to reach 14.3% by the year 2018.
- Over 90% of senior citizens are found out to suffer from more than one chronic diseases and half of them are suffering from more than three diseases (Korea Institute for Health and Social Affairs)
- Need for institutional support to cope with rapid aging and people's need  
⇒ Long Term Care Services will start in July 2008



Korean Medical Association

## 2. Contents of Long-term care Act

### 1) Recipients and requirements

- The system will apply to people over 65 years and people less than 65 with senile diseases

### 2) Type of services

- Home care benefits: To help beneficiaries do physical or housekeeping activities, take a bath, assist with medical treatment, provide trainings for recovering physical functions



Korean Medical Association

\*<sup>1</sup> Executive Board Member, Korean Medical Association. Professor, Department of Preventive Medicine, Yonsei University, Seoul, Korea (intl@kma.org).

**2. Contents of Long-term care Act**

**2) Type of services**

- Facility care benefits : admission of the elderly to facilities offering trainings for recovering physical functions
- Financial benefits:
  - Compensation for families of a recipients who have no option but to receive care from their families due to geographical limited access to institutions providing long-term care services or due to disasters and so forth.
  - Special compensation for undesignated convalescent facilities for providing services



Korean Medical Association

**2. Contents of Long-term Care Act**

**3) Procedure to get services**

Submission of application form ⇒ Determining whether to provide services or not and the level of services (Judging Committee) ⇒ Sending of approval sheet to applicants for care level and plans for standard care ⇒ Agreement about care benefits

**4) Financial resources**

Social health insurance (contributions) + Governmental aid (funded from tax)+ co-payment of recipients



Korean Medical Association

**2. Contents of Long-term Care Act**

**5) Parties involved**

- National Health Insurance and Corporation (NHIC)
  - : overall management and operation (collecting contributions)
- The Elderly Care Committee
  - : establishment of main policies and plan (decision on contribution rate, criteria for special benefits)
- Medical Institutions
  - : designated by NHIC to provide long-term care services
- Service Providers
  - : Care managers and care providers



Korean Medical Association

**3. Limitation and Challenges**

**1) Limitations in population coverage**

- According to the LTC executive committee’s research, about 15% of the senior population is in need of LTC by 2008.
- The Government plans to assist only 3.4% of them to minimize its expenses. Seniors who have serious illnesses will be prioritized to get covered by the LTC and this low population coverage may bring complaints and dissatisfaction among people eligible for the services.



Korean Medical Association

**3. Limitation and Challenges**

**2) Limitations in financial resources**

- Korea is expected to suffer shortage in service centers and home care services in 2008. The Government is planning to fund this shortage leveraging from the public sector.
- The government encouraged hospitals to specialize in the elderly care with financial supports at the beginning of the LTC and this motivated many insolvent hospitals to specialize in the elderly care as a result.
  - ⇒ Saturation in the number of senior hospitals



Korean Medical Association

**3. Limitation and Challenges**

**3) Exclusion of medical services**

- Elderly patients suffering from multiple chronic diseases (such as senile dementia) need to be admitted in hospitals or nursing homes.
- However, elderly patients in serious conditions have difficult time in getting necessary services from nursing homes, as they provide very limited medical services.
- The collaboration should be properly arranged between nursing homes and physicians so nursing homes can provide better medical services.



Korean Medical Association

### 3. Limitation and Challenges

#### 4) Future plans

- Promotion of disease prevention and senior life improvement  
: Most recipients of the LTC are in mild condition and preventing them from getting worse will go a long way in reducing of additional expenses
  
- Expansion of community-based care management  
: Korea's long-term care services are mainly focused on facilities and equipment. Development of community-based care management including elder house call program, day-care center, or group homes



Korean Medical Association

*Thank you.*

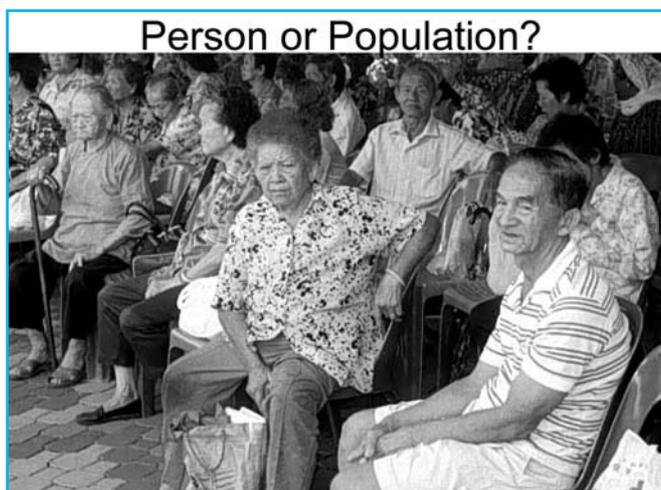
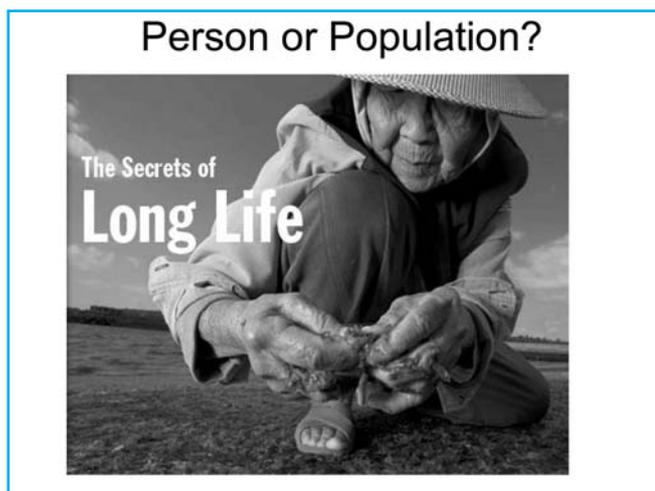


Korean Medical Association

[Malaysia]

# Towards Healthy Longevity

Siang Chin TEOH\*<sup>1</sup>



### Healthcare in Malaysia

- Better & More Facilities
- Health care system funding
- Doctor : Population ratio
- Epidemiology
- Maternal and Child Health
- Health care workers – skills

\*1 Immediate Past President of Malaysian Medical Association. Chairman of Medical Association of South East Asian Nations (MASEAN), Kuala Lumpur, Malaysia (coolhealth@gmail.com).

**ACHIEVEMENTS:50 YRS SINCE 1957:**

The life expectancy at birth : -  
 1957 : males 55.8 years and females 58.2 years  
 2006: Males to 71.6 years and females 76.8 years  
 Maternal mortality rate declined significantly from 320 to 30 per 100,000 live births.  
 Similarly, the infant mortality rate had fallen from 75.0 to 5.1 per 1,000 live births in 2005.  
 Malaysia's rate : 5.1 per 1,000 live births  
 Singapore: 3 per 1,000 live births  
 United Kingdom : 5 per 1,000 live births  
 U.S. : at 6 per 1,000 live births  
 Indonesia 28 and Thailand 18 per 1,000 live births

**Cross Cultural Multi-racial / religious Population**



Physical access: 90% of the population within 5 km of a static health facility

**BETTER ACCESS TO CARE**



**Reaching to the rural poor**

outreach services such as mobile clinics, riverine services, the flying doctor service, mobile health teams and dental clinics .

Starting: from Cradle

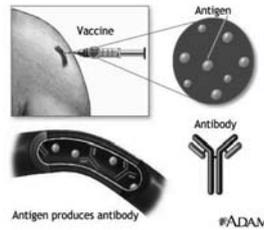
IMPROVE MATERNAL HEALTH

### Immunization:

DPT (for diphtheria, whooping cough and tetanus) in 1958, BCG (for tuberculosis) in 1961, Oral polio and measles vaccines in 1972, Rubella vaccine in 1987 and hepatitis B vaccine in 1989.

2002 : Replacement of measles & rubella vaccines - MMR (Measles, Mumps & Rubella). 2002 Introduced immunization against Haemophilus influenza type B, an important cause of meningitis in the country.

Overall coverage of Childhood immunizations has been sustained above 90%



### Special Focused Public Health Areas

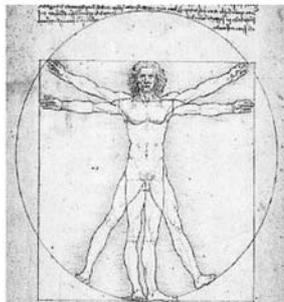
- Outpatient care
- Water supply and environmental sanitation
- Nutrition
- School health services
- Health promotion and education
- Oral health
- Women's health
- Elderly health
- Adolescent health
- Community mental health
- Children with special needs



Higher Technology & better skills



**INSTITUTE OF MEDICAL RESEARCH**

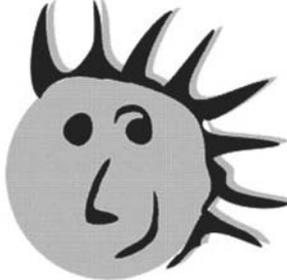


**MEDICAL BIOTECHNOLOGY**

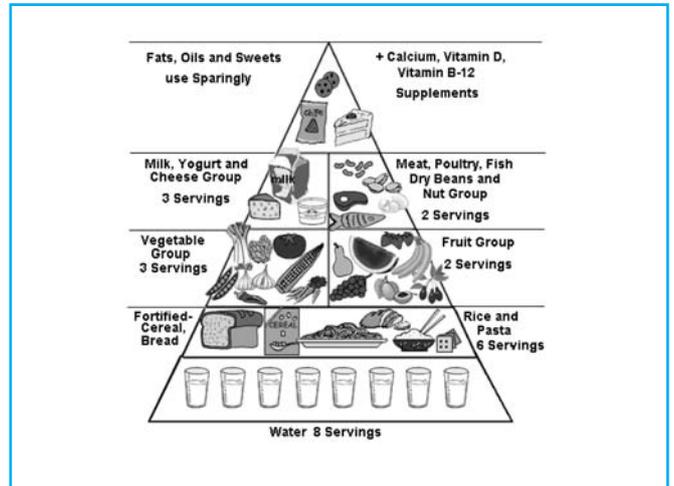


Minister of Health Dr Soi-Lek CHUA

Focus on Personal care



# Health Education



Healthy Heart Campaign




**HOME CARE**



**SELF CARE**

**CHALLENGES:**

- Spending on Health Care
- 3.2% of GDP (Public 1.8% Private 1.4%)
- Health Resource Funding / Allocation Issues



**Table Four: Distribution of Health Resources in Malaysia 1999**

	Hospital Public	Hospital Private
Admissions	1,500,000	500,000
C.T. Scan*	19	67
Specialists*		
- Medical	33%	67%
- Surgical	34%	66%
- O&G	20%	80%

Source: Eight Malaysia Plan. Pg 486

We now have a situation where 75% of the admissions are still to the government hospitals, but 75% of the specialists are in private hospitals. The distribution indicates that high tech facilities are much easier to avail in the private sector over-stretched government sector.

### NATIONAL HEALTH FINANCING SCHEME

**Issue paper**

Health financing reforms are a core part of health sector development in low and middle income countries. The current focus of the international debate is on the need to move away from excessive reliance on out-of-pocket payment towards a system which incorporates a greater element of risk pooling (for example through health insurance) and thus affords a greater protection for the poor.

This paper summarises what is known about the effects of the main health care financing systems, and how they can be designed and implemented to be 'pro-poor'.



**DFID**  
Health  
Systems  
Resource  
Centre

**Health financing:  
designing and  
implementing  
pro-poor policies**

Sara Bennett  
Lory Green

27 Old Broad  
Street  
EC2N 1HL  
Tel: +44 (0)20 7526 2332  
Fax: +44 (0)20 7526 2333  
Email: [hsr@dfid.gov.uk](mailto:hsr@dfid.gov.uk)



### MALAYSIA VISION FOR HEALTH



INTERNATIONAL COLLABORATION

### THE 3 P'S:

- 1.PERSON OR POPULATION?
- 2.POPULAR OR PROPER POLICIES ?
- 3.PROVIDER AND POVERTY



# Thank You

[Singapore]

# Towards Healthy Longevity

CHIN Jing Jih\*<sup>1</sup>



**TOWARDS  
HEALTHY LONGEVITY**

*Presented by*

A/Prof CHIN Jing Jih  
Council Member, 48<sup>th</sup> Council  
Singapore Medical Association

Senior Consultant  
Dept of Geriatric Medicine  
Tan Tock Seng Hospital, Singapore

25<sup>TH</sup> CMAAO CONGRESS & 43<sup>RD</sup> CMAAO COUNCIL MEETING  
18 – 20 NOVEMBER 2007, PATTAYA



## Outline

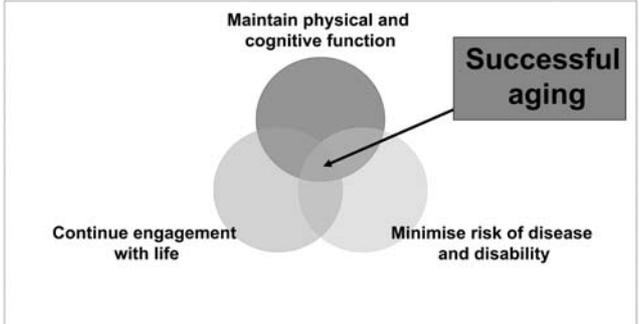
- ❖ Concepts of successful aging
- ❖ Ageing population in Singapore
- ❖ Strategies in Singapore



## Concepts of successful ageing



### Structure of successful aging: Rowe-Kahn or MacArthur Model Rowe JW and Kahn RL (1998)



The diagram shows three overlapping circles representing the components of successful aging: "Maintain physical and cognitive function" (top), "Continue engagement with life" (bottom left), and "Minimise risk of disease and disability" (bottom right). The intersection of all three circles is labeled "Successful aging".

\*1 Council Member, 48th Council, Singapore Medical Association, Singapore (sma@sma.org.sg).



### Continued engagement with life Rowe JW and Kahn RL (1998)

- **Close social relationships**
- **Involvement in activities that are meaningful and productive**
- **Use of valued skills and abilities**



### Successful aging

- **Combination of 3 elements or domains**  
→ complete concept of successful aging
- **But success – a matter of degree and some may be limited in one domain while enormously successful in others.**
- **To succeed is to flourish, not necessarily to attain perfection, and there are degrees of success; less than perfection is NOT failure.**



### Evolution of theories on aging

- **Disengagement model** → disengagement from life, relationship and life itself
- **Baltes model** → what individuals can do to cope with age-related losses in functional level and reserves
- **Riley model** → what society can (and hence should) do to enable active and productive old age
- **Rowe-Kahn model** → what individuals can do for themselves to maintain vitality in old age



### Successful aging: predictors and associated activities. Strawbridge WJ, Cohen RD, Shema SJ, Kaplan GA. Am J Epidemiol. 1996;144:135-41.

- **356 men and women aged 65-95 years measured prospectively in 1984 and followed to 1990.**
- **Successful aging was defined as:**  
"minimal interruption of usual function, although minimal signs and symptoms of chronic disease may be present."  
– **needing no assistance nor having difficulty on any of 13 activity/mobility measures plus**  
– **little or no difficulty on five physical performance measures.**



### Successful aging: predictors and associated activities. Strawbridge WJ, Cohen RD, Shema SJ, Kaplan GA. Am J Epidemiol. 1996;144:135-41.

- A. Needing no assistance nor having difficulty on any of 13 activity/mobility measures:**
1. Bathing
  2. Eating
  3. Dressing
  4. Grooming
  5. Using the toilet
  6. Walking across a room
  7. Transferring from bed to chair
  8. Shopping
  9. Cooking
  10. doing housework
  11. walking a half mile (0.8 km)
  12. walking up a flight of stairs
  13. Having no problem getting where they needed to go.
- B. Little or no difficulty on five physical performance measures.**
1. Lifting or carrying weights over 10 pounds (4.54 kg)
  2. Stooping, crouching, or kneeling
  3. Pushing or pulling a large object (like a living room chair)
  4. Lifting arms above the shoulders
  5. Writing or handling small objects



### Successful aging: predictors and associated activities. Strawbridge WJ, Cohen RD, Shema SJ, Kaplan GA. Am J Epidemiol. 1996;144:135-41.

- **After adjusting for baseline successful aging, sex, and age, 1984 predictors of 1990 successful aging included:**
  - income above the lowest quintile (OR = 1.67, 95% CI 0.98-2.84)
  - > or = 12 years of education (OR = 2.12, 95% CI 0.93-4.86)
  - white ethnicity (OR = 0.10, 95% CI 0.01-0.79)
  - Absence of diabetes (OR = 0.41, 95% CI 0.17-0.97)
  - Absence of COPD (OR = 0.43, 95% CI 0.26-0.71)
  - Absence of arthritis (OR = 0.48, 95% CI 0.25-0.89)
- **Adjusting for all variables, behavioral and psychosocial predictors included:**
  - Absence of depression (OR = 1.94, 95% CI 1.10-3.42)
  - Having close personal contacts (OR = 1.82, 95% CI 1.05-3.18)
  - Often walks for exercise (OR = 1.77, 95% CI 1.00-3.12).
- **Cross-sectional comparisons at follow-up revealed significantly higher community involvement, physical activity, and mental health for those aging successfully.**



### Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies.

Depp CA, Jeste DV.  
Am J Geriatr Psychiatry. 2006 Jan;14(1):6-20.

- mean reported proportion of successful agers was 35.8%
- multiple components of these definitions were identified, although 26 of 29 included disability/physical functioning.
- most frequent significant correlates of the various definitions of successful aging were:
  - age (young-old)
  - nonsmoking
  - absence of disability, arthritis, and diabetes.
- Moderate support was found for
  - greater physical activity
  - more social contacts
  - better self-rated health
  - absence of depression and cognitive impairment
  - fewer medical conditions.
- Gender, income, education, and marital status generally did not relate to successful aging.



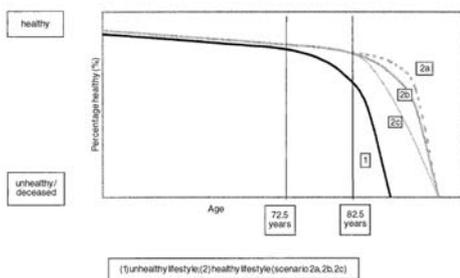
### Definitions and predictors of successful aging: a comprehensive review of larger quantitative studies.

Depp CA, Jeste DV.  
Am J Geriatr Psychiatry. 2006 Jan;14(1):6-20.

#### CONCLUSION:

Despite variability among definitions, approximately one-third of elderly individuals were classified as aging successfully. The majority of these definitions were based on the absence of disability with lesser inclusion of psychosocial variables. Predictors of successful aging varied, yet point to several potentially modifiable targets for increasing the likelihood of successful aging.

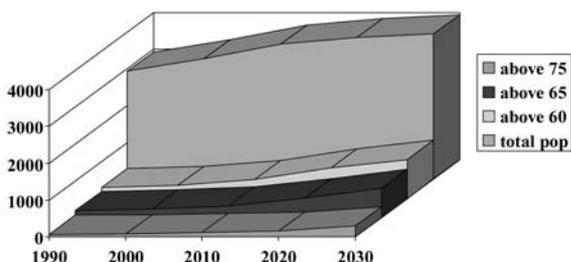
### Compressed morbidity



### The Ageing Population in Singapore



### Singapore: population projections

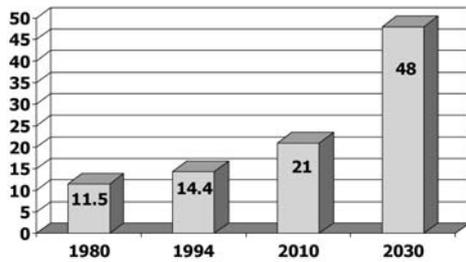


### Elderly population aged 60 and above

Year	Number	Per cent of total
1980	170,400	7.5
1990	246,900	9.1
2000	341,000	10.5
2010	505,600	13.8
2020	818,600	21.3
2030	1,055,000	26.8

*P Cheung: The Ageing Population.  
In: Geriatric Medicine for Singapore 1996*

### Old Dependency Ratio\* (Singapore)



\* Number of elderly persons to 100 adults of working age



### Ageing population: how fast?

- **Proportion of Elderly<sup>1</sup>**  
(Residents aged 65 years and over)

**Year 2005** 8.4%  
**Year 2030** 18.7%

- **Old-Age Dependency Ratio<sup>2</sup>**  
(Population aged 65 years and over divided by population aged 15 to 64 years)

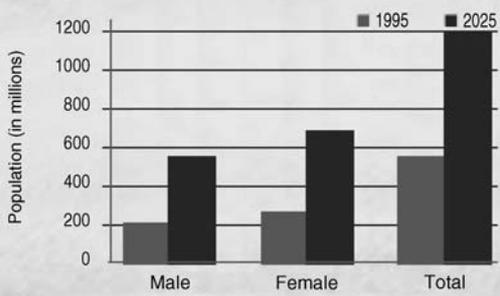
**Year 2005** 11.6 per 100  
**Year 2030** 29.5 per 100

1 Department of Statistics, Singapore (2005)  
2 The Committee on Ageing Issues: Report on the Ageing Population (2006)



### Ageing population: how fast?

Projected growth in the global population aged 60 years and older, 1995-2025



### Healthy Longevity: Strategies in Singapore



### Strategies

- ❖ **Primary prevention (“well elderly”):**
  - ❖ Health promotion and disease prevention
  - ❖ Preservation of function, self-esteem and social role
  - ❖ Continuing social engagement
  - ❖ Postponement of retirement
- ❖ **Secondary prevention:**
  - ❖ Emphasis on chronic care, esp vascular diseases
  - ➔ prevention of IHD, CVA
  - ❖ Attention to mental health issues
- ❖ **Tertiary prevention:**
  - ❖ Integration of acute, intermediate and chronic care
  - ❖ Development of rehabilitation services



### Primary prevention (“well elderly”)

- Health promotion and disease prevention
- Preservation of function, self-esteem and social role
- Continuing social engagement
- Postponement of retirement (age), with adjustments in roles, duties and wage-expectations
- Healthy psychological attitude

**MYTH #1**

**“I’M ALREADY 65 YEARS OLD,  
SO WHY BOTHER, I’M GONNA  
DIE SOON ANYWAY.”**



**But the TRUTH is.....**

	1990	2000	2001
Life Expectancy at Birth (yrs)	75.3	78.1	78.4
Life Expectancy at Age 65 (yrs)	15.7	17.0	17.2

**MYTH #2**

**“SUCCESSFUL AGING IS  
ALL ABOUT  
LONGEVITY.”**



**But the TRUTH is.....**

- **It is not how long, but how well, one lives that ultimately matters**
  - Medical illness
  - Physical function
  - Psychological well being
  - Social engagement

**MYTH #3**

**“TO BE OLD IS  
TO BE SICK.”**



**But the TRUTH is.....**

- **Although the population is aging, seniors are getting healthier than before**
- **Need to distinguish age-related changes from disease**



### What happens in “normal” aging

- **Changes experienced are gradual and insidious (never abrupt)**
- **No restriction in basic physical and mental function**
- **Not the cause of disease (or death)**



### MYTH #4

**“It’s all in the genes.  
I can’t do anything about  
how I age.”**



### But data shows that .....

- As one grows older, the contribution of genes become less and less significant
- It is the way you live, ie environmental factors (NOT the genes that you are born with) that chiefly determines the quality of how you age



### MYTH #5

**“It’s too late to do  
anything about  
my health.”**



### But the TRUTH is.....

- It’s **never** too late to start!
- With cessation of smoking, the risk of disease falls with time and can approach that of non smokers
  - Heart disease: FIVE years
  - Stroke: TWO to FOUR years
  - Lung Cancer: FIFTEEN years



### MYTH #6

**“You can’t teach  
an old dog  
new tricks .”**



But the TRUTH is.....

- Seniors can, and do learn new things and learn them well
- Trained seniors can do better than untrained young people



“...as long as I can stay abreast of events, learning new ways of working, then I can draw on my wealth of experience, data which I can use to make a contribution *which a younger fellow, more active but less experienced, cannot come to the same conclusion...*”



### Secondary prevention

- ❖ Emphasis on chronic care, esp vascular diseases
  - ➔ prevention of IHD, CVA
- ❖ Attention to mental health



### Chronic and primary care

- General or family practitioners
  - Doctors in Home or Domiciliary care
  - Doctors in Long term Residential or Aged Care
- Master of Medicine (family Medicine)
  - Graduate Diploma in Geriatric Medicine
  - Continuing Medical Education Programmes in Geriatric Medicine



### Tertiary prevention

- ❖ Integration of acute, intermediate and chronic care
- ❖ Development of rehabilitation services



### Geriatric Medicine Departments in Singapore

- Located in acute hospitals
- Inpatient services – acute services, taking patients directly from Emergency departments
- Outpatient services – based on geriatric syndromes
  - Geriatric assessment clinics
  - Dementia / Memory Clinic
  - Continence Clinic
  - Falls & balance Clinic
  - Palliative Care Clinic
  - Geriatric Pain Clinic



### **Approach in Geriatric Medicine**

- **Problem-based > age-based, with stress on functional status and quality of life**
- **Syndromes:**
  - Impaired cognition
  - Incontinence
  - Instability
  - Immobility



### **Geriatric Medicine Departments in Singapore**

- **Tan Tock Seng Hospital (since 1988)**
- **Alexandra Hospital (since 1994)**
- **Changi General Hospital**
- **Singapore General Hospital**
- **National University Hospital**



### **Intermediate Care: Community Hospitals**

- **Focused on rehabilitation and convalescent care (immediate post-acute care)**
  - Physiotherapy
  - Occupational therapy
  - Speech and swallowing therapy
  - Palliative care
- **5 community hospitals**



### **Facilities in the Community and Long-term Care**

- **Community:**
  - Social day care
  - Rehabilitative day care
  - Dementia day care
- **Institutional:**
  - Nursing homes
    - Voluntary (government-subsidised)
    - Private
  - “old folks’ home” or “Sheltered home”



### **Challenges in Singapore**

- **Seamless integration**
- **“Right-siting” of care**
- **Funding mechanisms**
- **Community perceptions**
- **Staffing & communications**



### **Multi-dimensional approach**

- **Biomedical**
- **Psychological**
- **Social**
- **Ethical & Legal**



## Caution

**The need to avoid inappropriate  
discrimination and biases  
both in attitude and in allocation  
of healthcare resources  
towards those deemed NOT to be  
ageing successfully.**



## Thank you

**Acknowledgement: Dr Lim, Wee Shiong for contributing  
some of the slides used in this presentation**

[Taiwan]

# Towards Healthy Longevity

Liang-Kung CHEN\*<sup>1</sup>



**Towards Healthy Longevity**

Dr. Liang-Kung Chen  
Taiwan Medical Association  
Center for Geriatrics and Gerontology  
Taipei Veterans General Hospital  
National Yang Ming University

Taiwan Medical Association

**World's fastest aging country**

WHO definitions  
Aging society: elderly population 7%  
Aged society: elderly population 14%  
Aging speed: years required from 7-14%

26 years 1992-2018  
26 years 1970-1996  
85 years 1890-1975  
115 years 1865-1980

Taiwan Medical Association

**Population aging in east Asia**

Percentage of population aged 65+

1. Similar population aging speed  
2. May share common cultural background  
3. An integrated healthcare system for older people is often lacking  
4. Geriatrics development is mostly lacking

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**Population aging**

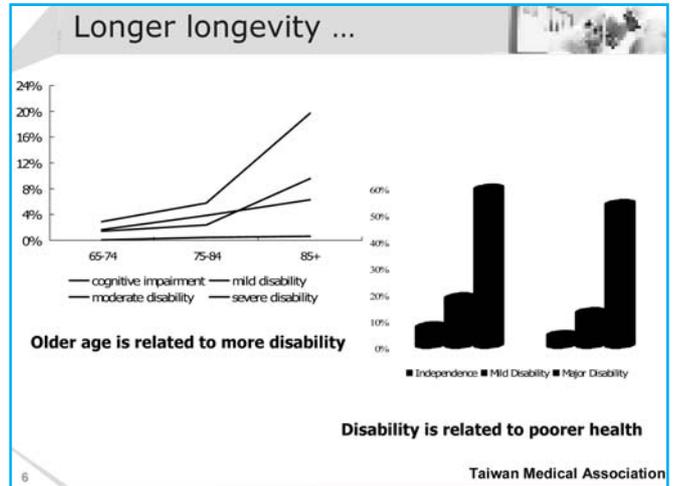
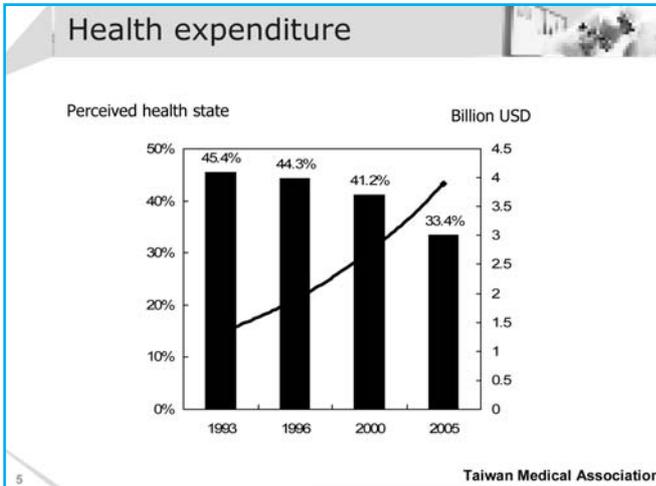
Life expectancy

Life prolongation of elderly  
71.6%

Life expectancy  
44.1%

Taiwan Medical Association

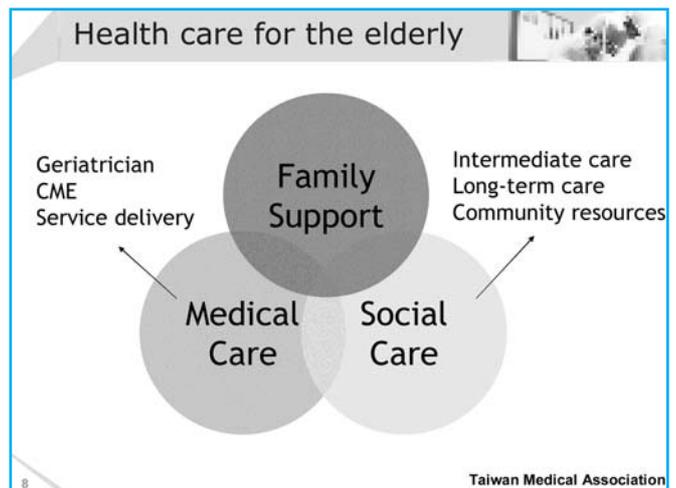
\*1 Taiwan Medical Association, Taipei, ROC (intl@tma.tw).



### Disability can be postponed

- Longer longevity
  - Disability compression
  - Disability expansion
  - Dynamic equilibrium
- Postpone disability
  - Elderly friendly health care system
  - Integrated services
  - Continuing care

Taiwan Medical Association



### International collaboration



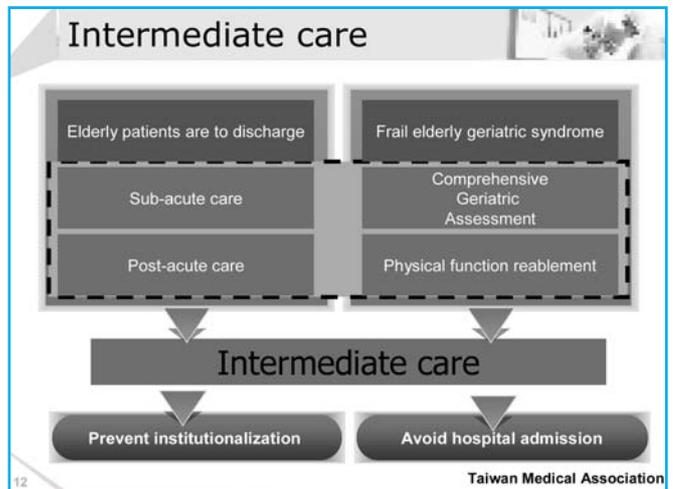
Geriatric Medicine  
Education, Training and Research

Collaboration with British Geriatrics Society

- Periodical teaching sessions
- Bi-monthly Geriatric symposia
- Young staff exchange program
- Yearly international Geriatric conference

Taiwan Medical Association

### Intermediate care



Elderly patients are to discharge

Frail elderly geriatric syndrome

Sub-acute care

Post-acute care

Comprehensive Geriatric Assessment

Physical function reablement

Intermediate care

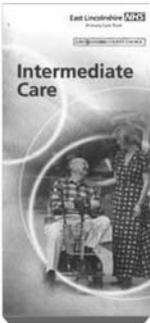
Prevent institutionalization

Avoid hospital admission

Taiwan Medical Association

### Intermediate care

- ◀ Hospital-at-home
- ◀ Day hospital
- ◀ Community rehab team
- ◀ Nurse-led units
- ◀ Care home Medicine
- ◀ Community hospital



East Lincolnshire NHS Foundation Trust  
Intermediate Care

Taiwan Medical Association

### Community hospital reform



Care for older people

Community health

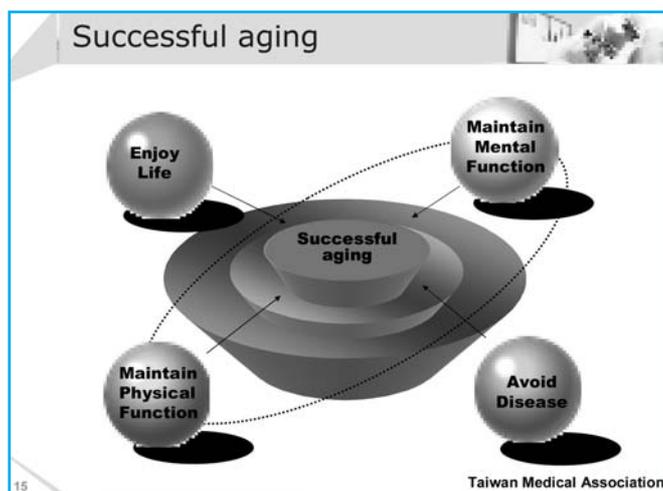
Reform

Long-term care

Mental health

Taiwan Medical Association

### Successful aging



Enjoy Life

Maintain Mental Function

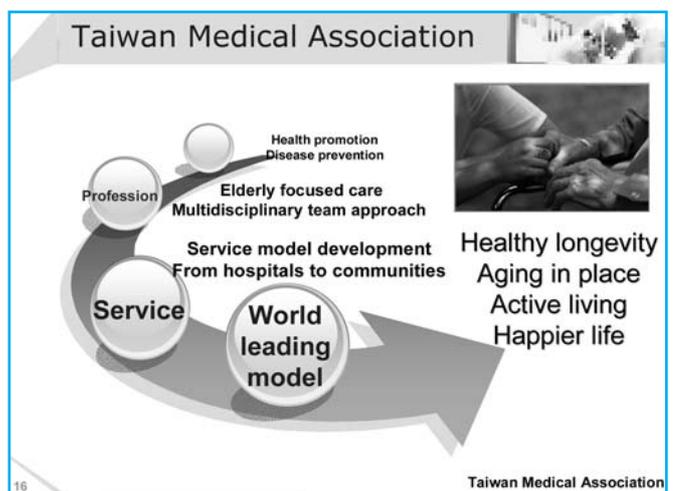
Successful aging

Maintain Physical Function

Avoid Disease

Taiwan Medical Association

### Taiwan Medical Association



Health promotion  
Disease prevention

Profession

Elderly focused care  
Multidisciplinary team approach

Service model development  
From hospitals to communities

Service

World leading model

Healthy longevity  
Aging in place  
Active living  
Happier life

Taiwan Medical Association

[Thailand]

## Longevity of Thai Physicians



Pornchai SITHISARANKUL,\*1 Somkiat WATTANASIRICHAIGOON\*2

Arts and Science of Healthy Longevity  
CMAAO 2007

**Longevity of Thai Physicians**

Pornchai Sithisarankul, MD, MPH, DrPH  
Somkiat Wattanasirichaigoon, MD

Arts and Science of Healthy Longevity  
CMAAO 2007

We would like to share our experiences in:

- What and how these approaches are being conducted in Thailand and in which way Thai Medical Association is involved?
- What are the achievements and/or failures?
- What are the lessons learned?
- Are there any aspects that international collaboration can improve and upgrade the result?

**Background and rationale**

- Physicians are supposed to be health team leaders
- Their tasks are 3Ds - difficult, dirty and dangerous
- No previous systematic studies on Thai physicians' health – notion that they were short-lived
- Opportunity: CCME (under TMC) has physicians' database and periodically updated; occupational medicine physicians are interested in physicians' health and health hazard exposures

**Were Thai physicians short-lived?**

\*1 Professor, Department of Preventive and Social Medicine, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand (fmedpss@md.chula.ac.th).

\*2 Professor, Dean of the Faculty of Medicine, University of Srinakarintaviroj, Bangkok, Thailand.

## Target population

- Total 30,000+ doctors
- Growth rate 1,500 doctors/yr
- Increased female physicians
- Death rate 60-100 doctors/yr

## Thai physician health promotion program

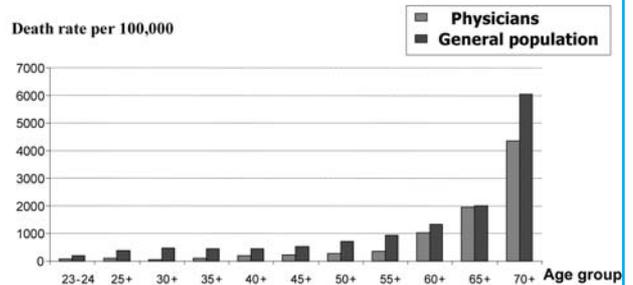
- Phase I: Thai physician health study (2 years)
- Phase II: Longevity of Thai physicians (1 year)
- Phase III:
  - Intervention and Health Promotion (1 year)
  - Dissemination to Public (3+ years)

## I: Thai physician health study

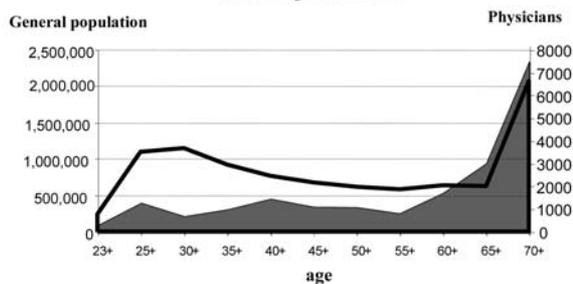
### 3 projects

1. Retrospective review - causes of death of Thai physicians during 1992-2001
2. Cross-sectional survey of Thai physicians' health and risk factors
3. Psychological autopsy of Thai physicians who committed suicide during 1992-2001

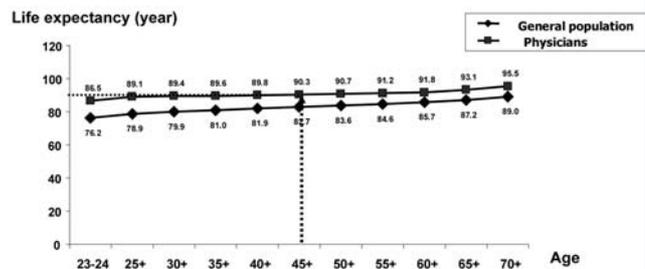
## Death rate of Thais 1998-2002



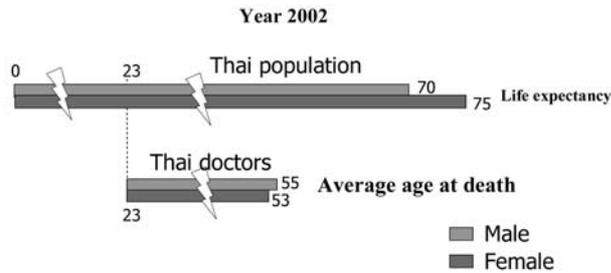
## Years of Life Lost of Thai population at the year 2002



## Life expectancy of Thais 1998-2002



## Were Thai physicians short-lived?



## II: Longevity of Thai physicians

- Quantitative study – survey
- Qualitative study – in-depth interview

### Quantitative study – survey

- 983 questionnaires (responded 327) to 840 males (responded 272) and to 143 females (responded 55)
- Age 68 - 93 years ( $75.1 \pm 4.86$ )
- majority were married suggesting that their spouse were also long-lived
- $\frac{1}{2}$  still provided clinical services,  $\frac{1}{4}$  did charity work,  $\frac{1}{4}$  did more than one volunteer work, some did several jobs

Majority were not obese : BMI 16.53-34.16 ( $23.97 \pm 2.80$ ); only 8 had BMI over 30

4/5 had disease – one or more – top 5 were HT, DM, IHD, DLP, BPH

Majority did exercise – walk

Majority did not drink alcohol or drank occasionally

Majority practiced religious activities regularly

Majority had hobbies

### Qualitative study – in-depth interview

**Financial stability – saving and invest while young**

**Increase positive lifestyles – exercise, proper diet, etc.**

**Decrease negative lifestyles – smoking, DUI, etc.**

**The mind-set to be non-attachment**

**To be mentally ready to die**

**Physicians as role model – practice and advice family/friends/patients/ relatives/society**

### III: Intervention and Health Promotion & Dissemination to Public

- Funded by Thai Health Promotion Foundation
- Direct to public – mass media, conference, publications, internet [www.thaihealthy.org](http://www.thaihealthy.org)
- Indirect to public
  - Physicians as means, role model, and multipliers
  - Physicians & health care personnel as means, role model, and multipliers
  - Government expands pension system and encourages individual savings

## Boundary partners

- Thai Medical Association
  - Thai Health Promotion Foundation
  - Thai Medical Council and CCME
  - All Royal Colleges of Thai physicians
  - Medical Schools & students
  - Medical Societies & Associations
  - Public & private hospitals
  - Other health personnel councils & associations
- Love to share and network with other countries'  
Medical Associations

## Thank you



*JMA Health Policy Symposium on National Finance and Social Security*

# Stably Securing the Financial Resources for Social Security and Fiscal Reconstruction\*<sup>1</sup>

JMAJ 51(2): 103–112, 2008

Takero DOI\*<sup>2</sup>

## What Drove National Finances to (de facto) Bankruptcy?

In this article I will discuss the causes that drove national finances to (de facto) bankruptcy. Following Table 1, I will begin by discussing my personal thoughts and how to break free from this situation, particularly in regards to the manner in which social security should be positioned.

To start out, Fig. 1 indicates the causes for the increase in outstanding government bonds following the collapse of the bubble, using figures that were provided by the Ministry of Finance, as these are at the very least objective.

In the first half of the 1990s, public works projects as part of measures to boost the economy particularly increased, naturally serving as the cause for the increased issuance of government bonds. In this sense it was undoubtedly the expansion of public works projects in this period that caused an increase in debt outstanding. However, from the year 2000 on—with the Koizumi Cabinet beginning in 2001—reductions of public works projects were duly promoted. Owing to this as well as the aging of society which has been unavoidably visited upon us, social security expenses have expanded. Accordingly, this could not be adequately compensated for through revenue.

In terms of the revenue side, government debt increased because even though expenditures eventually increased, revenue was not able to adequately make up for this. This was affected by the reduced tax revenue which came in the wake of the tax reductions and economic recession.

As to why expenditures inflated in the 1990s following the collapse of the bubble, this was undoubtedly due to the fact that public works projects increased, along with a variety of other causes. However, if these were to be combined and all lumped together under some sort of catchphrase, I believe it would carry the connotation that expenditures increased due to payments of social security benefits.

## Debt Expansion due to a Shifting of Expenditures to “Provisions of Insurance Benefits”

Insurance benefits are provided to people who are faced with some sort of risk. In the case of automobile insurance, insurance benefits are paid to people who have experienced an automobile accident, and are granted to people who have become ill in the case of medical insurance.

The Japanese government increased “provisions of insurance benefits” in the 1990s, when it increased debt outstanding (see Table 2).

Public works projects are actually supposed to be conducted for the sake of creating infrastructure pertaining to the lives of the people. But in looking at several, it almost appears as if payments were made to start up public works projects so as to stave off unemployment for rural areas in which employment had dried up.

Furthermore, measures for small and medium-sized enterprises were actively carried out during the financial crisis of the latter 1990s, as it would be problematic if small and medium-sized companies were to go bankrupt. Due to this, it is

\*1 This is a revised English version of a paper originally published in the Journal of the Japan Medical Association (Separate Vol.135, No.12, 2007, pages 23–34). The article is based on a presentation made at the Health Policy Symposium on National Finance and Social Security hosted by the Japan Medical Association at the JMA Hall on December 1, 2006.

\*2 Associate Professor, Faculty of Economics, Keio University, Tokyo, Japan (tdoi@econ.keio.ac.jp).

Table 1 Outline

1. Causes that drove national finances to (de facto) bankruptcy
  - Status of insurers who excessively underwrote "insurance"
  - Status of not being able to take in "insurance premiums" proportionate to the risk, however
  - Worsening financial condition due to mounting payments of "insurance benefits"
2. Concept of social security under fiscal reconstruction
  - Social security consistent with fiscal reconstruction and alleviating intergenerational disparities
  - To what extent can fiscal expenditures be reduced?
3. Stably securing the financial resources for social security
  - Intention of making consumption tax a financial resource for social security
  - Clearing up misunderstandings surrounding consumption tax

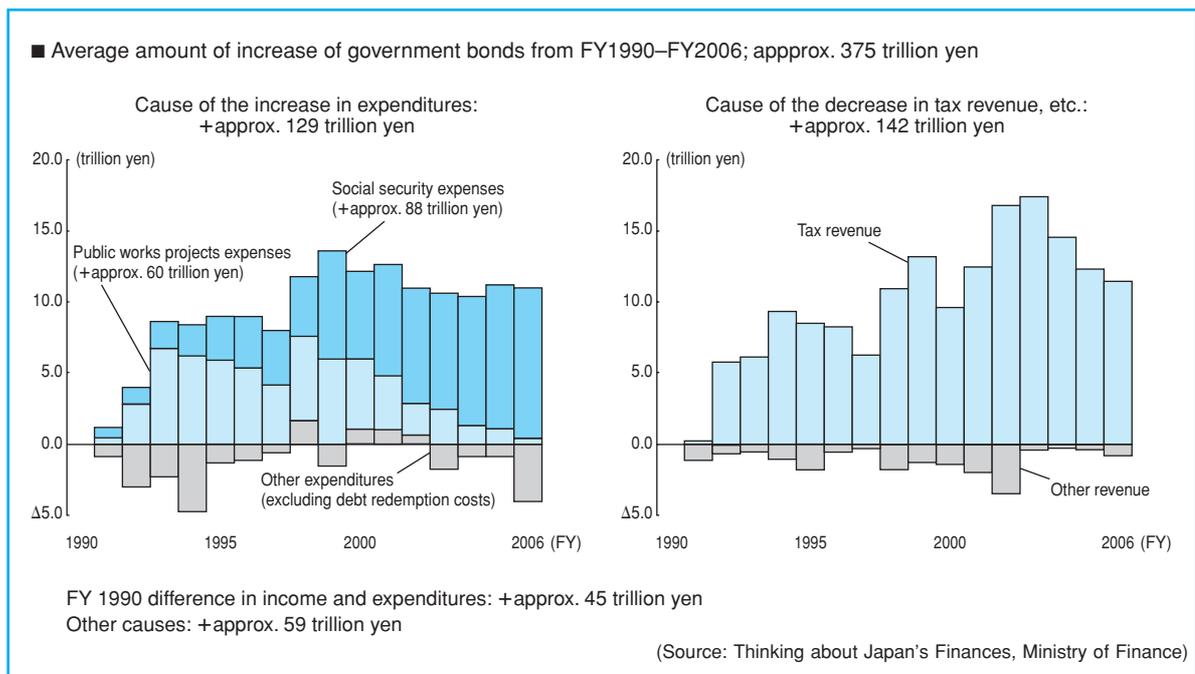


Fig. 1 Causes for the increase in outstanding government bonds

possible that expenditures were given out in a form such as insurance so as to avoid having the people that work at these companies become unemployed.

Local Allocation Tax Grants to local governments have the inherent role of compensating for areas where tax revenues of local municipalities

are insufficient.<sup>\*3</sup> Yet in reality, because the tax revenues of the local governments have plunged following the collapse of the bubble, the central government has provided expenditures to compensate for this. As a matter of course, social security has come to fulfill the role of insurance regardless of whether the business climate is

\*3 Local Allocation Tax Grants are a certain proportion of national tax that the central government transfers to local governments as a tax source whose purpose is not restricted to balancing local revenue sources between the central government and local governments without prejudicing the independence of local governments.

**Table 2 Causes that drove national finances to (de facto) bankruptcy**

<p>■ Shifting expenditures to “provisions of insurance benefits”</p> <ul style="list-style-type: none"> <li>□ Public works projects—“unemployment insurance” for rural areas</li> <li>□ Measures for small and medium-sized enterprises—“unemployment insurance” for small and medium-sized enterprises</li> <li>□ Local Allocation Tax Grants—function of securing financial resources = “insurance” against insufficient tax revenue of local municipalities</li> <li>□ Social security—“insurance” for illness, primary nursing care, insufficient living expenses in one’s old age</li> </ul> <p>In the economic sluggishness of the 1990s, we entered a stage wherein insurance companies had mounting payments of insurance benefits</p> <p>However, they were not collecting “insurance premiums” proportionate to risk</p>
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**Table 3 Concept of social security in an age of fiscal reconstruction (1)**

<p>Conventional concept of social security</p> <ul style="list-style-type: none"> <li>□ Article 25 of the Constitution of Japan</li> <li>□ Assistance principle <ul style="list-style-type: none"> <li>Benefits provided according to need, burden borne according to ability</li> <li>→ To receive such benefits is a right</li> <li>Benefits should not be affected by the policies of the administration at the time</li> </ul> </li> </ul> <p>➢ But there have been enormous fiscal deficits and unprecedented aging of society</p> <ul style="list-style-type: none"> <li>• The procurement of financial resources must be considered before providing benefits</li> <li>• Focus on the insurance function of social security</li> </ul>
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good or bad.

I am not necessarily saying that this is a bad thing. However, when the economy is sluggish, the populace as a whole is faced with risks. As such, the situation reaches the point where insurance benefit payments for these risks are given out with abandon. What is more, it has become nearly impossible to put a stop to this. At the same time, this naturally means that financial resources are necessary in order to pay out suitable insurance benefits. However, since financial resources—including these insurance premiums and taxes—could not be secured in proportion to the risks, this eventually resulted in government debts of such an unprecedented magnitude arising.

### **Is Fiscal Reconstruction Feasible with a Concept of Social Security Under the “Assistance Principle”?**

As a result of this, talk of fiscal reconstruc-

tion began to be voiced around the time of the Koizumi Cabinet. For future social security, when you ignore issues like fiscal reconstruction and merely advocate firmly maintaining the necessary benefits, it is considerably difficult to obtain broad-based understanding from the people. Yet even while exhibiting an attitude of cooperating for fiscal reconstruction, one must advocate the necessity of appropriate social security. In doing so, the conventional concept of social security must inevitably be revised.

For example, regarding social security there have heretofore been numerous arguments which are grounded in Article 25 of the Constitution of Japan or on the “assistance principle” in technical terminology (see Table 3). The assistance principle essentially states that social security is to be provided under the general rule that benefits be given according to need and the burden borne according to ability. This led to the appearance of the so-called theory of curbing social security benefits, which will be discussed later on.

• Insurance principle  
Benefits and burdens are proportionate to risk

	Low income	High income
Low risk	Low burden Few benefits	Low burden Few benefits
High risk	High burden Numerous benefits	High burden Numerous benefits

Intolerable burdens

Fig. 2 Concept of social security in an age of fiscal reconstruction (2)

If you follow the reasoning behind the conventional concept of social security, such benefits are an inherent right. It is said that for living one's life it is the right of each and every person to, at the very least, be enabled to lead a minimum cultural life and to be capable of living in such a way. However, simply having this right is meaningless unless there is the requisite money for it. Social security cannot be described solely in terms of money, but social security is not feasible when this requisite money is absent. We are living in a tough world where we have to be mindful of money in a variety of capacities, particularly these days when fiscal deficits have been allowed to accrue.

It is necessary to make social security sustainable by means of better associating it with the issue of financial resources. I think that embedding the function of insurance in the social security mechanism in a more refined manner would be effective in terms of proficiently advocating the necessity of social security for the future.

### **Intergenerational Disparities Brought about by the Assistance Principle**

The principle behind insurance essentially boils down to bearing burdens and providing benefits in proportion to risk. This does not take one's amount of income into account. If this is done in regards to social security, for example, when you consider people for whom the risk of illness is

high or people with a high chance of receiving nursing care, then going by the insurance principle such people would naturally be provided with benefits according to said risk. Owing to this, such people come to be granted greater benefits.

What about the burden for these financial resources? If the insurance principle is followed thoroughly, those people with large incomes would not be the ones to bear most of the burden, but rather it would be those with a high risk who should bear the majority of this. Those people at low risk—regardless of whether or not they have a high or low income—would not have to bear that much of the burden when the insurance principle is followed stringently. This could prompt the question: couldn't this also be handled by insurance companies in the private sector? Yet this is how it turns out, at least when you thoroughly adhere to the insurance principle (see Fig. 2).

But what soon becomes apparent is that for people with low income yet at high risk, symbolically speaking this could refer to elderly persons with low incomes, even if they are belatedly told to go out and earn money, their bodies cannot perform labor. In this situation it is natural to wonder whether or not these people will be compelled to shoulder a heavy insurance premium burden. In the conventional system with the assistance principle—in other words where people bear the burden according to ability (ability were to be replaced with income)—this would mean providing benefits according to need by means

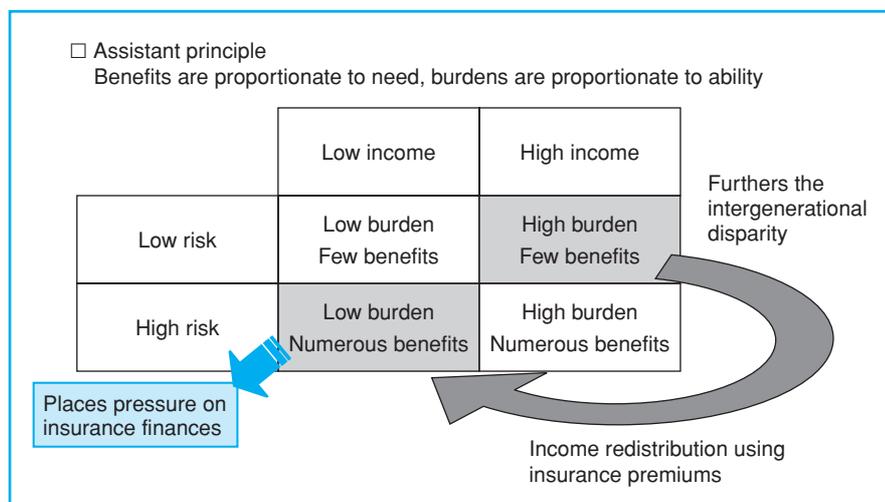


Fig. 3 Concept of social security in an age of fiscal reconstruction (3)

of imposing heavy burdens on people with high incomes, and not imposing burdens on people at high risk but with low incomes. The situation would be one where benefits are provided when risk arises.

What would happen if this were to be carried out? As it shows in Fig. 3, that would allow a gap in the balance of payments to arise in finances for such insurance. If you were to go by the assistance principle, people with a high income but at low risk would receive benefits that would be almost entirely out of proportion to the high burden they shouldered. People with a low income but at high risk would come to receive a great deal of benefits while shouldering a low burden. While it would be preferable to make this balance of payments correspond, what we have been doing is to take a great deal from high income with low risk people and distribute it to low income with high risk people.

Speaking in terms of health insurance for a young person with a high income, unless that person falls considerably ill, they will not receive benefits to an extent that is proportional to the significant burden that they have borne. As was stated previously, since considerable benefits are provided to elderly persons with low incomes, what this amounts to is conducting a transfer between generations. Speaking in terms of recent social security as a whole, somehow the claims by people of the younger generations that their benefits are relatively low and that they are

dissatisfied carry an implicit recognition of such aspects.

### No End in Sight for Provisions of Benefits to the Low Income with High Risk Group

One further point to be made is that beneath the assistance principle there is the possibility that it will in fact be nearly impossible to put a stop to benefits provided to low income with high risk people. If benefits cannot be suitably held in check, this will serve to put pressure on insurance finances. It was undoubtedly for this reason that the theory of curbing benefits appeared under the Koizumi Cabinet. There was talk of macroeconomic slide for pensions, as well as talk of a macroeconomic linkage for medical benefits appearing as well. These are pretty outrageous disputes, but a state of affairs came to pass where this theory of curbing benefits could not be stifled by arguing from the view of the assistance principle.

In my view, if you ground yourself on the assistance principle, there are all too many points of overly slipshod accounting when it comes to the benefits and burdens. Some people say that for the time being we should just go ahead and hand out benefits and then later have whoever is capable foot the bill. Seeing this, other people begin to criticize that benefits will go on increasing without end. I believe that it has come to have

**Table 4 Concept of social security in an age of fiscal reconstruction (4)**

- Social insurance method
  - Emphasis on assistance principle and insurance premium method (≠insurance principle)
  - However, slipshod accounting for the benefits and burdens
  - Complete harmony between the insurance and income redistribution functions
  - For "benefits corresponding to need" there will be no end to such benefits
  - Appearance of the theory of curbing benefits
    - Macroeconomic slide for pensions
    - Macroeconomic linkage for the net amount of medical benefits (held down to a GDP growth rate adjusted for the aging of society)
    - Differentiation (to the extent possible) of the income redistribution and insurance functions within social security

**Table 5 Concept of social security in an age of fiscal reconstruction (6)**

- For example, cases where a person making a 100,000 yen monthly salary would have to pay insurance premiums of 50,000 yen when said premiums are proportional to the risk
- Currently... Insurance premiums set at 5,000 right from the start
  - Insurance premiums proportional to risk are not indicated at all
- Strengthening the insurance principle... together with imposing insurance premiums of 50,000 yen, provide subsidies (using taxes as their source) of 45,000 yen
  - Income redistribution through tax resources based on an awareness of insurance premiums proportional to risk (a thorough insurance function)

just such a composition.

This severe theory of curbing benefits can be overcome by means of making the relationship between the burdens and benefits more transparent (see Table 4). Who will bear the burdens, who will receive the benefits and why these benefits are necessary should be precisely explained. Doing so would have some persuasiveness in calming radical assertions that benefits should be interlinked absolutely with economic growth.

### **Insurance Premiums Corresponding to Risk and the Income Redistribution Using Taxes**

One way of clarifying the relationship between the benefits and burdens is that for people who are unable to endure a burden proportionate to their risk it would be best to move away from insurance and conduct redistributions of income using taxes. As Table 5 shows for example, for

people with a low monthly income of 100,000 yen, if they are made to pay insurance premiums corresponding to risk, it would come to 50,000 yen. Therein, if they pay insurance premiums of 50,000 yen per month out of a 100,000 yen monthly salary, they would be unable to make a living. However, under the current system it is said that they should pay 5,000 yen in insurance premiums, for example. Whether this 5,000 yen figure is the correct figure or not is a separate matter. However, in the present condition the basis for these reduced insurance premiums is explained by saying that since people with a low income cannot bear the burden of exceptionally high insurance premiums of 50,000 yen, this has been lightened to 5,000 while setting aside the reasoning for this figure.

But why 5,000 yen? Insurance premiums of 5,000 yen are not indicated anywhere in the current system. In terms of why low insurance premiums are best for these people, the explanation for this is surely because these people have a

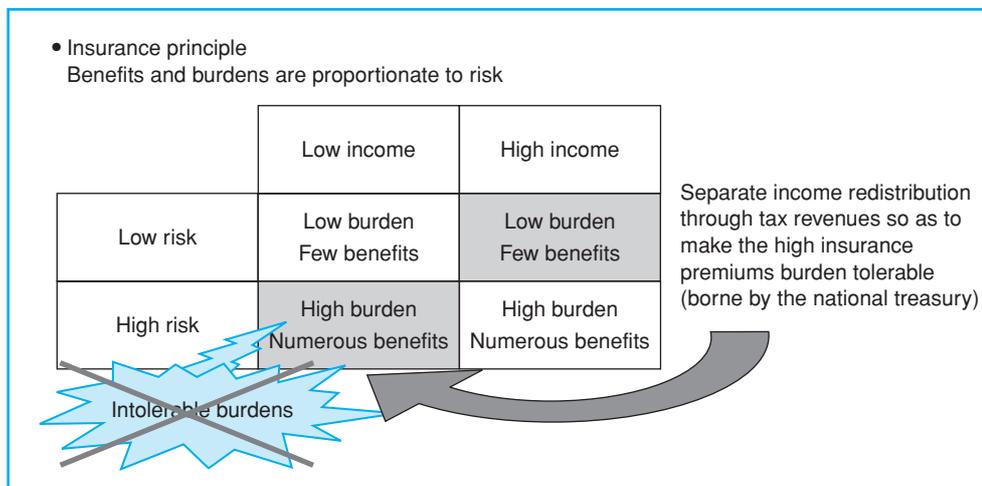


Fig. 4 Concept of social security in an age of fiscal reconstruction (5)

Table 6 Concept of social security in an age of fiscal reconstruction (7)

- Merit of separating out insurance premiums proportional to risk and (income redistribution nominal) benefits from tax resources
- ◆ Impress upon the insured a cost awareness regarding the fact that in social insurance when benefits accumulate this leads to a hike in insurance premiums (in local districts this is not linked with income redistribution of tax resources)
- ◆ Initiatives to reduce the risk for the insured  
→ (Noncompulsory) voluntary curbing of benefits effects
- ◆ Can clarify who bears the burden and receives the benefits and to what extent. Doing so will make it possible to increase the reliability of the social insurance system

low income. However, if you were to ask whether these people are really bearing a burden that is proportionate to the risk, the answer would be that this is not the case. But naturally for the question of why 5,000 yen the current system is operating in a manner that does not fully comprehend how much insurance premiums proportionate to risk would be.

If this were made more transparent, when it comes to people for whom 50,000 yen in insurance premiums was proportionate to risk, these people would be requested to pay exactly 50,000 yen. Instead, for people that would not be able to lead their lives if this is done, then 45,000 yen would be provided in the form of income redistribution using taxes, which would be separate from medical insurance. In this way, materially the burden for these people would amount to 5,000

yen. It becomes possible for them to properly receive medical insurance and to lead their lives (see Fig. 4). In addition, we will be able to clearly see who shoulders insurance premiums and in what manner redistributions of income are carried out (see Table 6). Of course this does not mean that it will be possible to make it this clear-cut in reality, but it would be beneficial if such aspects were to be expressed within the system.

### Unclear Stabilization Policies regarding the Financial Resources for Social Security

Next, there is naturally criticism that if we reduce benefits in such a reckless manner then social security would not last. In response to this, the opinion can be heard that for the Ministry of

**Table 7 Stably securing the resources for social security (1)**

- Fiscal System Council (advisory committee for the Minister of Finance) “Basic Reasoning for the Expenditures and Revenues Combined Reforms” (June 2006)  
(<http://www.mof.go.jp/singikai/zaiseseido/tosin/zaiseia180614/zaiseia180614.htm>)
- *Organizing the Issues for Stably Securing Financial Resources pertaining to Social Security* is a document attached to this proposal  
“It is extremely important that we stop postponing for future generations and aim to strike a balance between the benefits and burdens by means of stably securing financial resources regarding the burden for public expenditures for the necessary benefits  
“For the resources for the burden for public expenditures, it would be appropriate to have the burden broadly and evenly distributed to the public as a whole”
- However, “converting the consumption tax into a special purposes tax for social security” is not stated definitively

**Table 8 Stably securing the resources for social security (2)**

- Assertion that “The way to curb social security benefits is to reduce costs for public works projects or personnel expenses for public servants, as just curbing social security benefits would be outrageous”
- But are advocates of social security benefits actually toiling in order to reduce costs for public works projects or personnel expenses for public servants?
  - No such sense of duty to go that far
  - Eventually pressure to reduce expenditures other than social security expenses abates to some extent, which is not conducive for fiscal reconstruction
- Rather, the way of advocating securing financial resources for social security benefits is able to maintain social security benefits

Finance in its capacity as financier to cut social security left and right is outrageous, but perhaps the condition has begun to change since the closing stages of the Koizumi Cabinet.

An attached document affixed to the proposals issued in June 2007 by the Fiscal System Council, “Organizing the Issues for Stably Securing Financial Resources pertaining to Social Security” incorporates wording found in Table 7. The Ministry of Finance has essentially begun to make the claim that it is necessary to continue properly securing the financial resources for social security.

There have been mass media reports that this document advocates converting the consumption tax into a special purposes tax for social security, but in fact there is no mention of the consumption tax within the text. It is a peculiar document in that no matter where you search, even holding

it up to the light and looking for writing in invisible ink, shows absolutely no mention of this matter. Yet for some reason the mass media has read between the lines and characterized it as a document which places emphasis on creating a special purposes tax for social security. The proposal issued by the Fiscal System Council is not in any way advocating total commitment to proceeding with reducing benefits.

So for the future we must engage in a national debate over the question of how to stably secure the financial resources for social security. However, the Abe Cabinet sealed off debate on increasing taxes. When the House of Councillors election is over, there is the possibility that the conditions will change again, but at least that is how it stands under the current situation.

The Abe Cabinet was saying that it will reduce expenditures and refrain from raising taxes. But

**Table 9 Stably securing the resources for social security (3)**

- Assertion that “Japan’s fiscal deficits are inherently not a serious problem, and there is no need to go so far as to curb social security costs to suddenly restore finances”
- Regarding the government bond market, if the government dulls its initiatives for fiscal reconstruction even slightly this may possibly cause interest rates to suddenly rise steeply and a drop in national bonds
- If the fiscal deficits are left as they are, then living generations will skip out on the bill by just benefiting with only a light burden, while transferring a heavy burden to future generations
- Fiscal reconstruction is indispensable for the sake of alleviating the intergenerational disparity

**Table 10 Stably securing the resources for social security (4)**

- If we attempt to improve the primary balance solely by reducing expenditures this will not be accomplished unless social security costs are curbed substantially
- As a result it would not be possible to maintain social security insurance and pensions for everyone
  - “Americanization of social security system”...would that be a good thing?
- In order to avoid this, the financial resources for social security must be reliably covered through taxation to some degree
- Consumption tax is important as a tax resource for social security
  - Income tax is already withheld in the form of insurance premiums, and this will increase hereafter

when it comes to talk of reducing expenditures, why do it by curbing social security benefits? There is still a great deal of wasteful spending, such as costs for public works projects or personnel expenses for public servants, that remains to be trimmed before curbing social security. Along these lines, I am also of the opinion that this is the proper way to proceed. Unfortunately, however, advocates of social security benefits are not toiling on various fronts in order to reduce public works projects, or to cut personnel expenses (see Table 8). While they are saying that public works projects should be cut, they are not going to do their duty when it comes to making some sort of move to cut them. As such, they are not actually backing these reductions. Since people such as the road construction lobby who are designed to protect public works projects remain keen to do so, the situation becomes antagonistic, with talk potentially turning back to shifting the burden onto curbing benefits.

### **Moderate Debate will Lead to Stably Securing the Financial Resources for Social Security**

I believe that in terms of the construction of 9,342 km of road in the plans for road development, the decision has already been made to construct all of it. The mass media was naturally critical of the plan, with voices being raised from the people’s side as well asking why it was necessary to construct so many roads. What can be seen within the words “construct all of it,” shows a lack of moderation on the part of the people aiming to construct the road. In other words, it would be slightly better if they were to say, “This road is necessary, but we don’t need that so we’ll cut it.” But if you insert “we’ll cut that” then you would likely hear the criticism that that is insufficient, but at least it might be possible to see some restraint at work in the sense that it clearly stated “we don’t need that.” But since the road

construction advocates did not say anything like that, it has the blatant appearance that there is no moderation. Social security is different from roads, but it is important that social security demonstrate the fact that it has moderation.

For social security, if you were to say that benefits must be applied to all of the areas requiring them, it would invite suspicion regarding the extent to which curbing such benefits is taking effect. It will be necessary to effectively apply

modulation by saying, “This is necessary, this must absolutely be protected, but if we had a little margin here we would still be able to do the job right.” By demonstrating this, it will become consistent with fiscal reconstruction, and the supporting of social security benefits will become more persuasive (see Tables 9 and 10). It will also make it possible to emphasize that the people will not be saddled with a variety of eccentric burdens.

*JMA Health Policy Symposium on National Finance and Social Security*

## Activities of the Japan Medical Association Research Institute\*<sup>1</sup>

JMAJ 51(2): 113–118, 2008

Yumiko MAEDA\*<sup>2</sup>

### Healthcare Provides Support for the Life Cycle

The following discussion provides an outline of the activities of the Japan Medical Association Research Institute (JMARI), based on our observation and analysis of the National Government's financing.

In discussions of social security costs, particularly healthcare costs, common topics of discussion include insurance premiums, patient's co-payment, and whether public funds should be increased or decreased. Alternatively, attention tends to be focused on whether healthcare costs are too high or too low. However, I would like to emphasize here that healthcare costs should not be discussed within such limitations and that constructive discussion about its funding will be necessary for the future.

Figure 1 shows the human life cycle from birth to death. After birth, individuals have the right and the duty to receive education, to work, and eventually to be supported by a pension after retirement. These elements form the basis of our livelihood. Healthcare supports the entire duration of this life cycle, serving as a fundamental basis of human life. Social security functions to provide comprehensive protection for the basis of livelihood and the basis of life. Because of this function, social security can be compared to national security in peacetime. In this context, a reduction in social security costs as an initial step to improved national finances would seem to be moving in the wrong direction. However,

in actuality, discussion has been ongoing under the government's policy of "expenditure reform without sanctuary," fostering the opinion that social security costs are not exceptional, or, more stringently, that they initially should be reduced.

### Disclosure of Information on National Finances: An unexpected by-product of structural reform by the Koizumi cabinet

The JMARI, which was set up in April 1997, has been active for 10 years now. The Koizumi cabinet governed for a period of 4 years during the history of the institute (Fig. 2). Structural reform by the Koizumi cabinet attempted to initiate various innovations and reforms, under a policy of "expenditure reform without sanctuary" and not excluding social security, under a slogan of "small government." Among such efforts was postal service privatization. Although this would appear to have no direct relation with healthcare, postal privatization involved postal life insurance, a form of simple government insurance. It was an epoch-making event when this simple form of government insurance was opened to the market allowing the participation of foreign funds.

In addition to opening insurance to foreign funds, the cabinet produced a number of independent administrative institutions that had the potential to provide plum jobs to retired bureaucrats. This was one of the more unacceptable aspects of the structural reform, in view of the fact that this meant that the government would officially foster the controversial practice of

\*<sup>1</sup> This is a revised English version of a paper originally published in the Journal of the Japan Medical Association (Separate Vol.135, No.12, 2007, pages 62–68). The article is based on a presentation made at the Health Policy Symposium on National Finance and Social Security hosted by the Japan Medical Association at the JMA Hall on December 1, 2006.

\*<sup>2</sup> Chief Senior Researcher, Japan Medical Association Research Institute, Tokyo, Japan (maeda@jmari.med.or.jp).

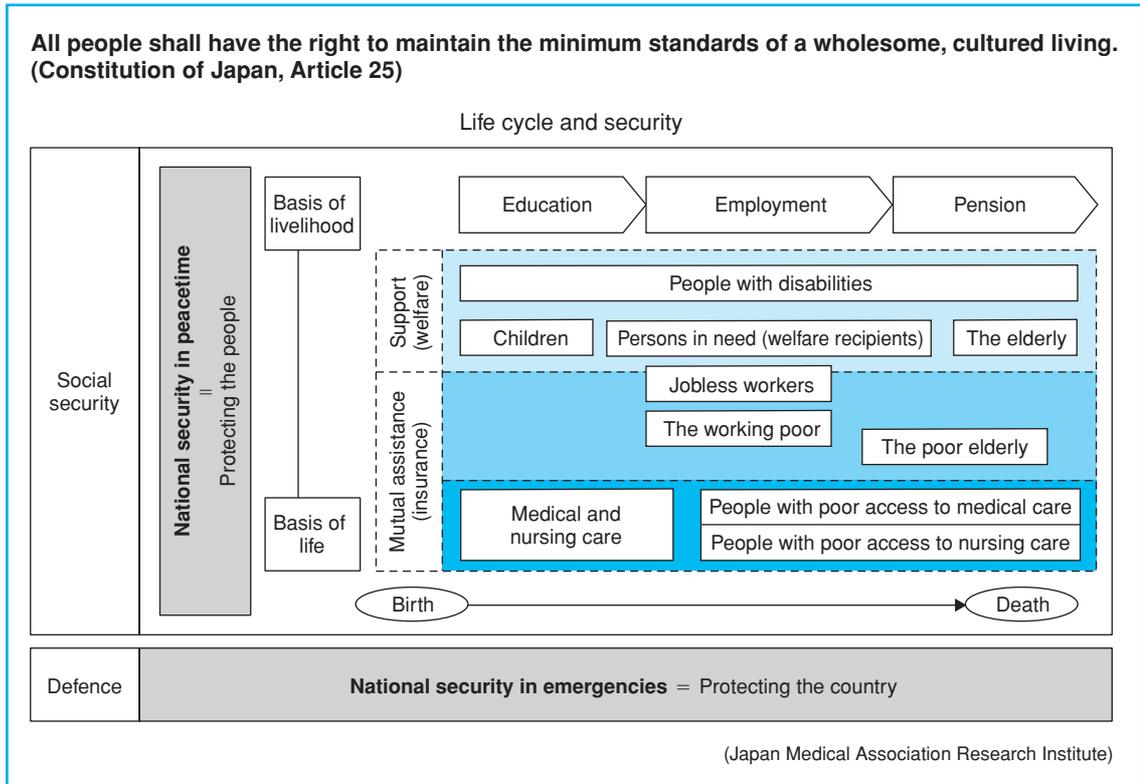


Fig. 1

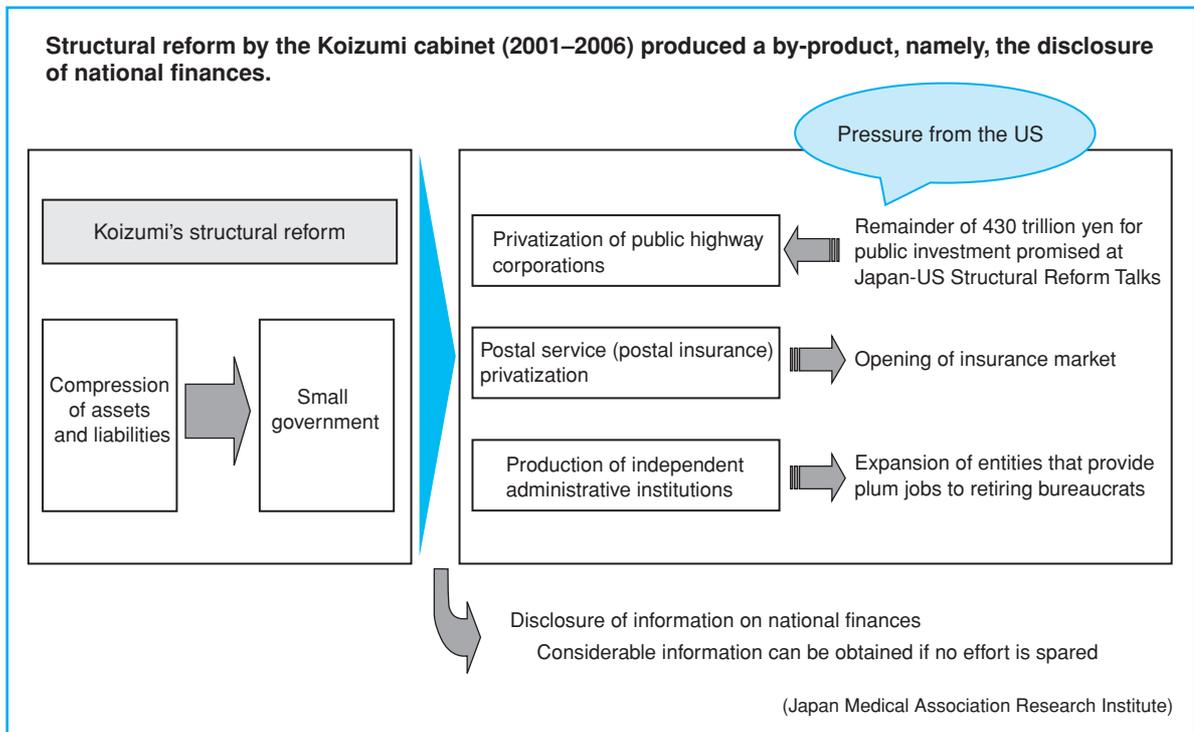


Fig. 2

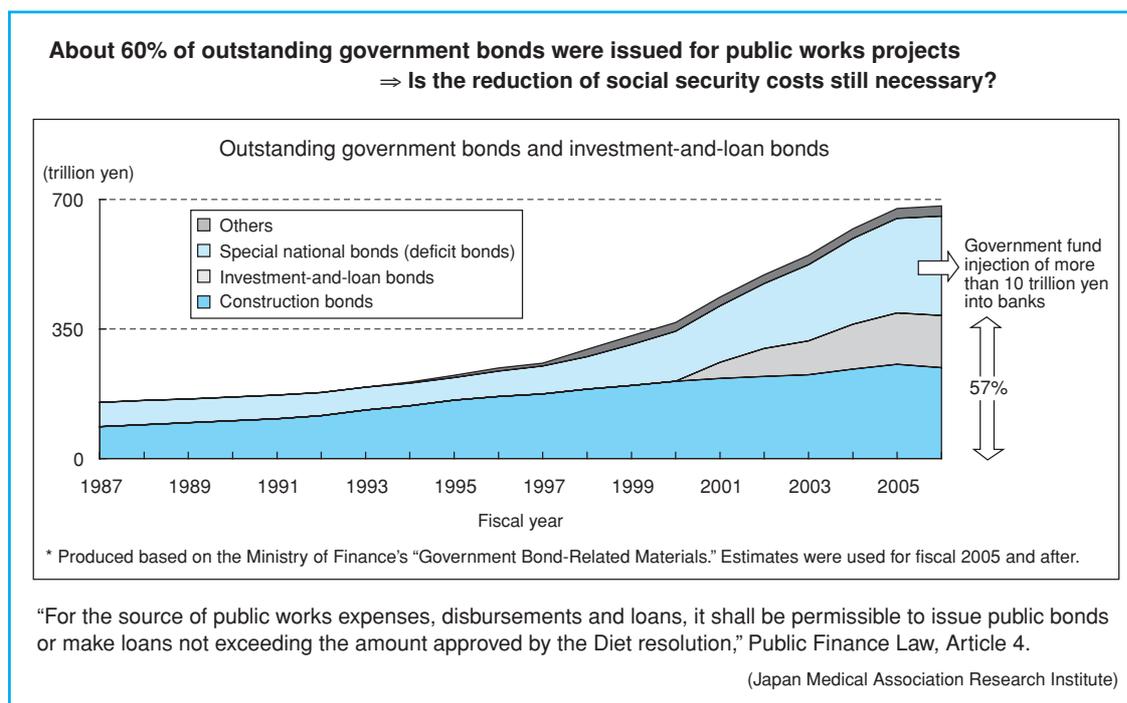


Fig. 3

senior bureaucrats retiring into related private-sector jobs.

However, this process produced unexpected by-products. For instance, bitter dispute arose over the reform of public highway corporations, and structural reform served to a great extent to promote the disclosure of information on national finances. Although government bureaucrats working in vertical administrative structures do not open integrated information to public view, a substantial amount of original and equivalent data has been disclosed to the public. We integrate such data and conduct various analyses of it. Based on such analyses, two aspects of it will be referred to in this communication.

### Public Works Projects Account for 60% of Government Bonds Outstanding

First, I would like to throw doubt on the general view that the national debt has become a major problem because of increasing social security costs. Is this actually true?

Earlier in this session, Dr. Doi quoted material

from the Ministry of Finance that attributed the main portion of recent variations in budgetary expenditure to social security costs. I think that the Ministry of Finance is cleverly manipulating data. The relation with social security costs is a recent issue. Since the rule is that Japanese government bonds are to be redeemed within 60 years, a longer view is necessary. Fifty-seven percent of outstanding government bonds have been issued for public works projects, such as construction bonds and investment-and-loan bonds (Fig. 3).

This 57% is still being used for public works projects. It is a legal requirement that Japanese Government bonds be issued only for public works projects. How then can deficit bonds be issued? Deficit bonds have been issued by manipulating current law or creating a new law every year. We should again bear in mind the fact that the issuance of government bonds is allowed only for public works projects.

To prop up failing Japanese banks, the government spent more than 10 trillion yen (US\$ 83.3 billion)<sup>\*2</sup> of public funds to retire their debt. Con-

\*2 Yen/dollar exchange rate: 1 US dollar = 120 yen.

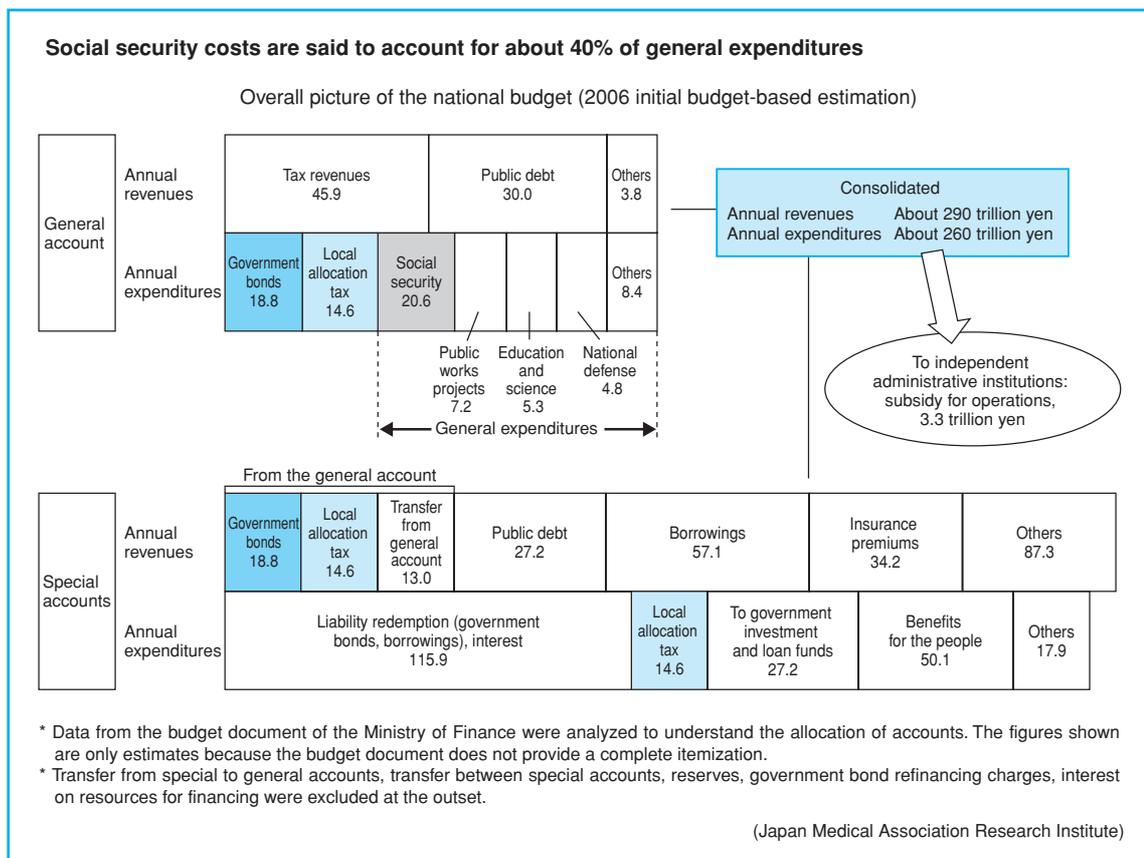


Fig. 4

sidering the actual status of governmental debt, it should be recognized that caution is needed in discussing the issue of reducing social security costs.

### Special Accounts and Purchase of US Government Bonds

The second point I would like to mention is the presence of special accounts (Fig. 4). In Japan, the general accounting budget is 80 trillion yen (US\$ 666.7 billion). The cost of social security is 20 trillion yen (US\$ 166.7 billion), and it is said that this amount is unreasonable because it accounts for about 40% of general operating expenditures, excluding government bonds and tax allocations to local governments. However, Japan has 31 special accounts. When these are combined, the size of consolidated annual expenditures is 260 trillion yen (US\$ 2.2 trillion). This is beyond the scope of a diligent reduction of 20

trillion yen (US\$ 166.7 billion) for social security.

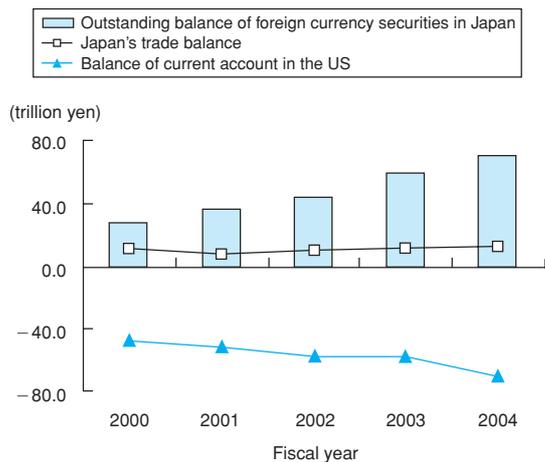
Although it is said that balancing the national budget is difficult to understand, it is possible to obtain such calculations by adding budgetary data and account settlements. The budget document and statement of accounts are as thick as two telephone directories, a size that may indicate bureaucratic wrangling. Such laborious calculations should be avoided if possible, but the result does provide an overall picture of the national budget.

The calculations bring certain issues to light. The consolidated settlement of accounts shows that annual revenue is 290 trillion yen (US\$ 2.4 trillion), and annual expenditure is 260 trillion yen (US\$ 2.2 trillion); this indicates a surplus of 30 trillion yen (US\$ 250 billion). Unfortunately, nothing beneficial seems to come from the presence of such government surpluses. Single-year grant money of 3 trillion yen (US\$ 25 billion) is given as a subsidy for the operation of independent administrative institutions, where retiring

**Japanese debt has substantially benefited business enterprises and the US, yet Japan has no funds for domestic use.**

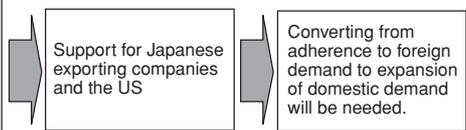
Issuance of foreign exchange fund bills to incur debt → Yen selling and dollar buying → Purchase of US Government bonds

Outstanding balance of foreign currency securities and trade balance of Japan in comparison with balance of current accounts in the US



\* The balance of current accounts in the US was calculated in yen on a calendar year basis by IMF Representative Exchange Rates using data from the Bureau of Economic Analysis. The outstanding balance of foreign currency securities in foreign exchange special accounts were obtained from the statement of accounts issued by the Ministry of Finance.

\* Outstanding balance and the balance of current accounts cannot be compared directly, because the former represents stock and the latter flow, yet there is an interesting relation between these two.



(Japan Medical Association Research Institute)

Fig. 5

bureaucrats of high rank tend to receive high-paying jobs. More than 10 trillion yen (US\$ 83.3 billion) has been invested in these entities that accept retiring bureaucrats. This fact should be borne in mind.

Incidentally, there are interesting data on the relationship with the US (Fig. 5). Japan incurs debt by issuing foreign exchange fund bills, and obtains yen. Using the yen, Japan carries out yen-selling and dollar-buying operations technically for the purpose of stabilizing foreign exchange markets. However, even when dollars are purchased, social security benefits cannot be paid by dollars in Japan. Therefore, US government bonds are purchased. Figure 5 shows both the outstanding balance of foreign currency securities in Japan and the balance of current accounts

in the US. Fiscal economists may disagree about placing them alongside each other in a graph because one is stock and the other is flow. But the relation of these data is interesting. Japan is a major purchaser of US government bonds, which means that the US has current account deficits, but is not short of financing. This situation serves as a support for Japanese exporting companies and the US. Although the exporting companies are supported, they do not receive their earnings in yen; they receive them in dollars.

**Now is the Time to Change from Cutting Expenditures to Enhancing Revenues**

As the baby-boom generation enters retirement

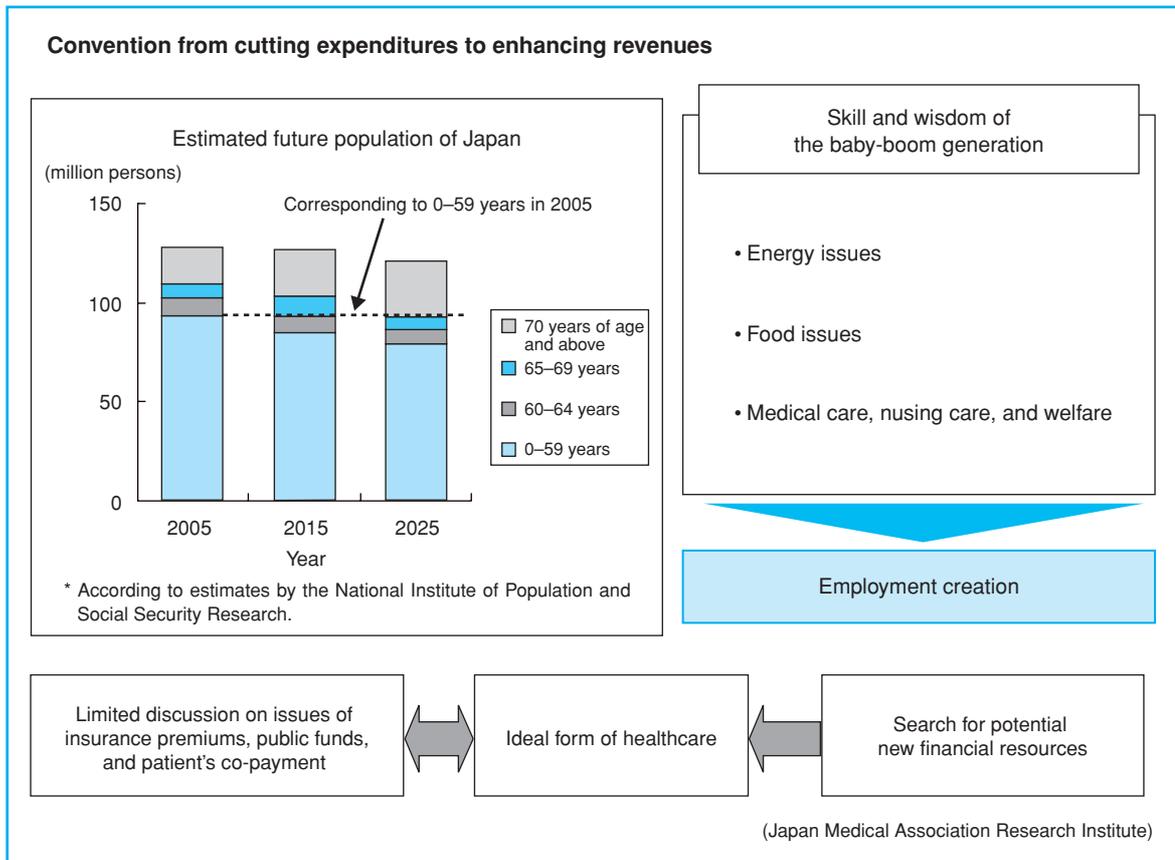


Fig. 6

age, it appears that Japan is facing an opportunity to decrease its adherence to foreign demands while expanding domestic demand (Fig. 6). I believe that the present time, when the baby-boom generation is reaching retirement age, is a favorable opportunity to change from foreign demand to the expansion of domestic demand, and from cutting down expenditures to enhancing revenues. It is generally noted that the number of workers in the labor force is decreasing in Japan. However, senior citizens, particularly those currently aged 65 to 70 years, are very active. If a system for extending retirement to 65 years (already adopted in some major companies) or even 70 years, or for encouraging retirees to start their own businesses, the labor force crisis in Japan could be averted to a certain extent. People of the baby-boom generation in Japan have experienced the period of Japan's high economic growth and have developed high technological skills. Therefore, I would recommend

that their wisdom and skills be utilized to deal with various issues in Japan, including energy, food, medical care, nursing care, and welfare, by extending the retirement age or encouraging new businesses. In this manner, employment could be created and expanded, and this eventually could lead to enhanced revenue.

As mentioned previously, the discussion of revamping healthcare costs tends to be restricted to the contribution of insurance premiums, public funds, or co-payment, and therefore it is difficult to obtain a major breakthrough. However, a more serious discussion of ideal, high-quality healthcare is needed. Healthcare costs and financial resources such as insurance premiums, public funds, and patient's co-payment are critical elements. We intend to further improve our capacity to analyze potential new financial resources. Comments on the prospects of positive and evolving financial resources will be highly appreciated.

# Efforts to Improve Medical Safety in a University Hospital

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Kenji HARADA,\*<sup>1</sup> Ryozo NAGAI\*<sup>2</sup>

## Abstract

In order to facilitate safe medical care, it is necessary to understand that there is a multiple hierarchical structure involving various issues ranging from problems of particular individuals to problems affecting the system of medical care as a whole. To prevent medical malpractice, the manager and staff members at the site of work must recognize the probability of errors and control the accuracy of practice, while recognizing that anyone can make a mistake. Although committing an error is not blameworthy in itself, it is necessary to point out deviations from the rules of daily practice and to offer strict guidance to leaders who disregard such deviations or fail to correct them. Organizational reform to concentrate power within the executive body of the hospital is necessary in order to reconcile the operations of individual departments with the overarching policies of the hospital. It is also necessary to systematize the quality of medical care and improve the hospital environment, including medical equipment. In addition, it is important to provide personnel with frequent training and education to increase their skills and knowledge, utilizing pocket manuals, educational DVD materials on medical safety, e-learning modalities, and mailing lists. The medical field should learn about accuracy and quality control from industry and various other fields.

**Key words** Quality and accuracy control, Organizational reform, Information sharing, Educational videos

## Introduction

As medical care becomes more sophisticated, the background supporting it has become further diversified and more complicated. Collaborative activity and the mutual interdependence of specialized occupations, partially automated and black-box medical devices, drug development, and highly functional information terminals and networks are all serving to enhance efficient medical services on the one hand, but can contribute to mistakes by individuals and to errors in communication on the other.

In order to deal with these issues in medical care, it is necessary to understand that there is a multiple hierarchical structure of problems ranging from those of the medical care system as a

whole to those of particular individuals, as well as to analyze a wide array of medical malpractice cases (Fig. 1).<sup>1</sup> It may be impossible to completely eliminate the occurrence of errors in medical practice, since humans are involved in the system. However, it is possible to decrease the frequency of errors and prevent them from leading to poor outcomes by adopting preventive measures based on the results of factor analyses of medical accidents and an understanding of their patterns.

Ensuring the safety of patients and providing safe medical services are fundamental to re-establishment of social confidence in medical care. This paper introduces some efforts in medical safety currently being performed by the University of Tokyo Hospital, a hospital affiliated with the Faculty of Medicine, the University of Tokyo.

\*1 Director of Medical Safety Management Center, The University of Tokyo Hospital, Tokyo, Japan (kharada-ky@umin.ac.jp).

\*2 Director, The University of Tokyo Hospital, Tokyo, Japan.

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## Recognition of the Required Accuracy of Practice and Examples of the Prevention of Problematic Cases

On a population basis, the number of hospital beds in Japan is three-fold greater than that in the US. However, the mean number of staff members is one per bed, which is only one-quarter the corresponding figure in the US. In particular, the difference between Japan and the US is conspicuous in regard to hospitals that provide

high-level medical care. The shortage of staff members not only causes excessive work and diminished attention, but also expands the discretion of each health care worker and thereby interferes with the standardization of medical care.

On the other hand, an increase in the number of doctors and nurses is likely to produce additional errors owing to miscommunication. Therefore, a simple increase of the number of staff does not ensure medical safety. Moreover, hospitals with a large number of staff require additional safety measures and educational systems that differ from those of smaller hospitals. Although medical malpractice should not exist, it is inevitable in light of human nature.<sup>2</sup> If malpractice is inevitable, the question then is how frequent it is.

For instance, if a health care worker commits simple malpractice at a probability rate of once per 100 years, double checking a medical act by two persons can decrease the frequency of malpractice to as low as once per 10,000 years. As is apparent from the Swiss cheese model (Fig. 2a), if we have a system that incorporates properly combined defense barriers, including the standardization of procedures and the use of safety equipment, the overall frequency of risks, a product obtained by the multiplication of probabilities at all steps, can be lowered substantially.

On the other hand, if there is no relationship between the medical acts of the various health-care workers, the overall frequency of risks is simply the sum of individual frequencies (as in

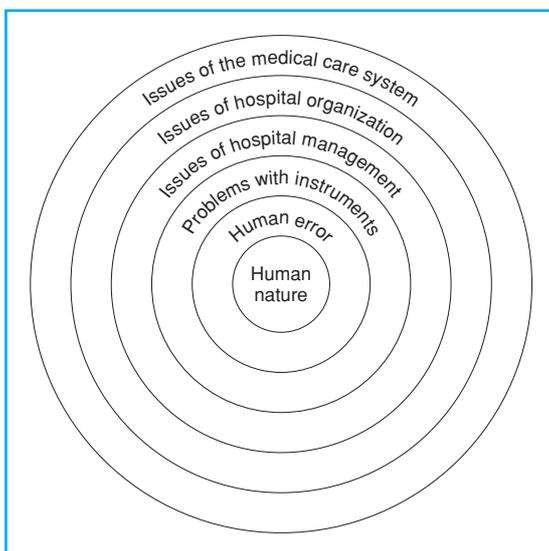


Fig. 1 Background of medical malpractice

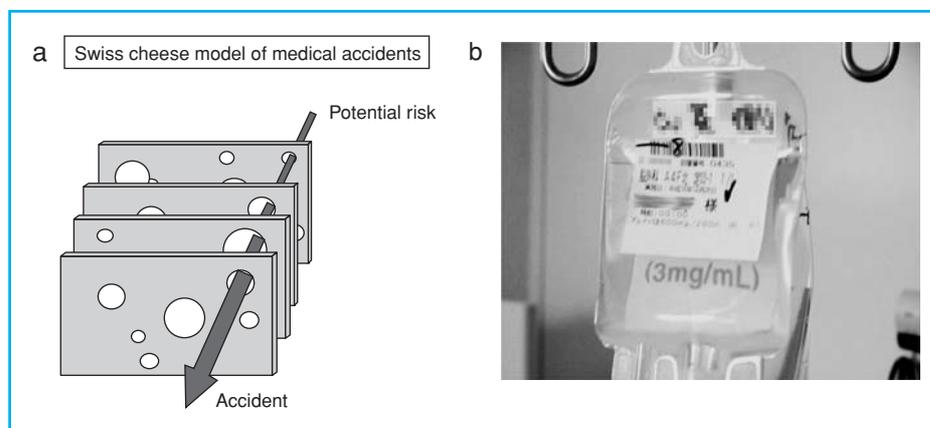


Fig. 2 Awareness of accuracy: the Swiss cheese model of medical accidents (a) and bedside confirmation just prior to the implementation of a medical act (b)

the horizontal lining of Swiss cheese slices). For instance, in order to decrease the overall frequency of malpractice cases in a hospital with 1,000 healthcare workers to a rate of once per 100 years, the frequency of malpractice cases of each healthcare worker should be once per 100,000 years. If a healthcare worker provides medical care independently, confirmation is strictly necessary for each step of a medical act to achieve this accuracy of medical practice. Safety training in large-scale hospitals should also be performed more strictly than in small-scale hospitals.

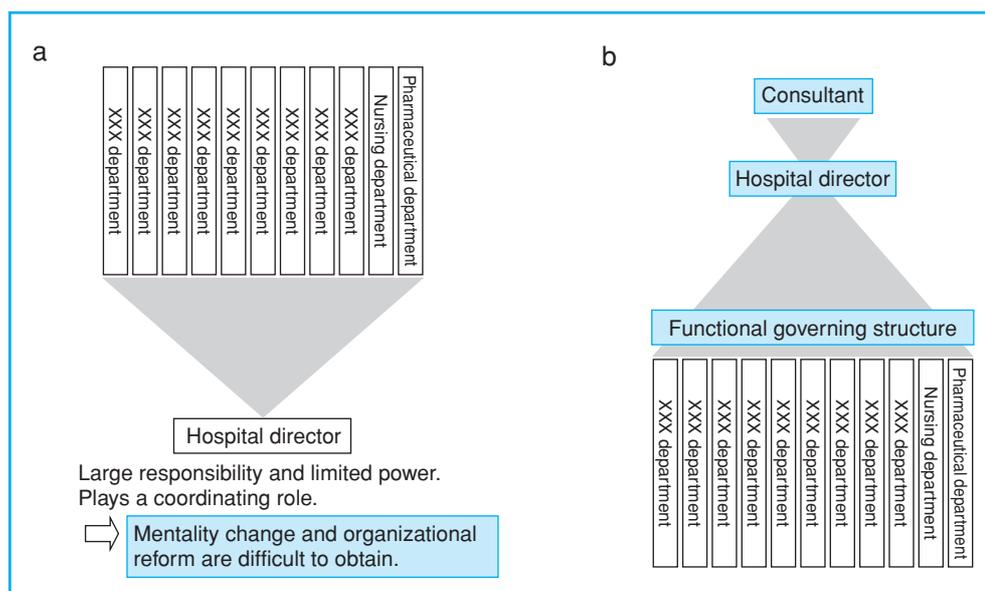
Although personnel shortages are a factor in human error, medical safety measures should not be neglected by reason of personnel shortages. In fact, an increase of staff makes procedures more complicated, leading to the increased occurrence of accidents. Regular revision of the work processes and provision of safety education should be ensured. As a background to malpractice in large hospitals, lack of recognition of these probabilistic issues by the management and workers at the site tends to be involved.

Erroneous dosing of medications or injections is one aspect of malpractice. Confusing one medication prepared for a patient with another medication prepared for a different patient is alarmingly frequent, while confusing one patient with another

may also occur. Confirmation prior to picking up the medication is not enough; final confirmation just prior to administration is essential.

It is important to educate the staff about thorough confirmation and creation of a record of confirmation. The incidence of confusing infusion bags has decreased at the University of Tokyo Hospital since a procedure to check mark the patient's name label on the infusion bag was established (Fig. 2b). The check marks left enable the supervisor to understand how thoroughly the final confirmation procedure has been performed. Furthermore, our hospital has a paperless order execution system. The bar-code on the patient's wristband is checked with the bar-code of the drug at the bedside, and recorded in this system.

Most acts of medical care in a hospital are independent of one another. If a system does not permit us to see whether medical care is performed in accordance with basic procedures, the system is defective. Although staff members alone cannot be blamed for causing accidents, it is necessary to point out deviations from the rules and to give strict guidance to leaders who do not correct erroneous actions even when aware of them. The manager should continue to monitor whether confirmation of the fluid solution or the



**Fig. 3 Organizational reform of a university hospital: conventional structure (a) and structure with enhanced power of the hospital director (b)**

injection drug is in place in everyday practice.

### **Organizational Reform**

University hospitals in Japan have been like aggregates of independent medical departments. Therefore, each doctor has been under the influence of his or her specialty department or office, and has been less aware of issues such as medical safety that require hospital-wide efforts.

Clinical departments of university hospitals are basically set up to correspond to the university's courses of medical education and research. Academic specialties tend not to interfere with other specialties beyond their field. This relationship has been heavily reflected in the management of university hospitals (Fig. 3a). Likewise, there has been insufficient coordination among radiology departments, clinical laboratory divisions, and specialties including the departments of surgery, nursing, pharmaceuticals, and clerical work. It is necessary in pursuing medical safety to prepare a system that is in harmony with the operation of each specialty and with hospital policy by concentrating power within the executive body of the hospital (Fig. 3b).

In the University of Tokyo Hospital, institutional reform was targeted at these issues following the recent change of Japan's national universities into corporate bodies. Previously, the professor of a specialty course in the medical school automatically held the concurrent post of head of the department of that specialty in the university hospital. This custom was abandoned, and replaced by a new system prescribing that the director of the hospital assign the head of the department to a one-year term of office. In addition, the hospital council that corresponds to the clinical professorate was redefined not as a decision-making body but as a consultative body. Furthermore, three clinical executive committees, the inpatient care executive committee, the outpatient care executive committee, and the central clinical executive committee, and four support divisions, the medical auditing, safety, and training division, the personnel division, the planning and management division, and the education and research division, were set up, and it was prescribed that each department comply with the direction of these executive committees and support divisions.

The conventional governing function of each medical department was abandoned, and such

functions were conferred on the above organizations. Under this new system, the medical audit, safety, and training division is in charge of overall control and coordination of outcome evaluation, safety management, staff training, and infection control measures.

In university hospitals, where staff turnover is frequent, training at the time of recruitment is important. In the University of Tokyo Hospital, lectures by the director of the hospital and guidance from the comprehensive training center (including practical matters such as hand-washing) are given periodically. Such a system of hospital management is not only useful in terms of safety, but also is effective for raising the hospital staff's awareness of medical safety.

In many hospitals, attending doctors assume full responsibility for the care of their patients over a 24-hour period. However, the increased burden on the attending doctor necessitated by highly advanced medical care tends to cause medical accidents as well as increasing the doctor's powers of discretion. This situation creates discrepancies in the content of medical care among different doctors, thereby interfering with the standardization of medical care and thorough implementation of safety measures. Adherence to the Labor Standards Law is also required of doctors, and thus a system is needed in which staff members bear some responsibility during their shifts and share in the creation of a medical care team, not placing the entire burden on the attending doctor. The University of Tokyo Hospital has adopted a rotating shift system for attending doctors that aims to provide increased transparency and standardization of medical care.

### **Examples of Quality Control in Medical Care and Measures against Nosocomial Infection**

Medical safety is closely related to the quality control of medical care. Development of indices that reflect the quality of daily medical practice, continuous monitoring of such indices, and implementation of necessary measures and evaluation of outcome are required. In our hospital, periodic surveys are carried out to investigate the following indices and publicize the results: the number of days prior to submission of medical charts after patient discharge, the percentage of discharge summaries prepared, the percentage of medical

charts that carry descriptions given by the supervising doctor, compliance in hand-washing practices when entering the ward, and the time at which consultation at the outpatient clinic began.

Hand-washing practices can decrease the occurrence of nosocomial infection, including MRSA infection. As a result of the aforementioned organizational reform, each department has a staff member who is designated to be in charge of infection control, making this a hospital-wide effort. Unannounced surveillance of adherence to hand-washing practices is also a useful method.

### **Improvement of Medical Instruments**

Unfortunately, medical instruments that lack basic ergonomic safety features<sup>3</sup> such as foolproof<sup>4</sup> and fail-safe designs<sup>4</sup> or those that lack error-free designs involving visibility<sup>5</sup> and affordance<sup>6</sup> are currently in use at medical care facilities.

Intubation of a gastric tube is an example. Errors of intubation and subsequent tube feedings have resulted in many patient deaths from serious pneumonia. Careful confirmation of retention of the tube in the stomach can prevent such accidents. However, when a gastric tube that is coming off is pushed down, it may accidentally enter the bronchus. Since hoarseness or the cough reflex may not occur, the unusual presence of the gastric tube may not be noticed. Although the tip of the gastric tube can be confirmed by X-ray radiography, the development of an apparatus that enables confirmation of the location of the tip without radiography is awaited.

Similarly, it may happen that an infusion pump is disconnected from the infusion line without blocking the drip infusion, resulting in free flow, fully open infusion, of catecholamine, antihypertensive or antiarrhythmic medication, etc. This is also an example of a repeatedly occurring accident. It is vitally necessary to educate allied health personnel in a training program that teaches them to handle infusion apparatuses carefully. However, infusion pumps are used frequently in situations of personnel shortages, and similar accidents may continue to occur in the future. The manufacturers have the responsibility to develop a system that precludes such

accidents. The authorities of the University of Tokyo Hospital are exchanging views with the manufacturers in an effort directed toward the improvement of related apparatuses.

### **Training and Education**

#### **On-site specialty training by medical safety personnel**

The University of Tokyo Hospital has a system of on-site training in which the personnel in charge of medical safety visit each medical department in order to consider countermeasures based on actual cases, and to solicit opinions and proposals from the trainees.

#### **Pocket manual of medical safety**

In 2003 the University of Tokyo Hospital developed a medical safety manual of A4 size and distributed copies to each office and department. In actuality, however, this manual was placed on bookshelves and rarely read. In 2004, a portable pocket manual of medical safety was developed and distributed to all residents. The content of the pocket manual was expanded in 2005, and distributed to all healthcare workers in the hospital. A revised edition of the manual, made smaller in size, was distributed in 2006.

#### **Information sharing**

Currently, the Japan Council for Quality Health Care is preparing a medical accident reporting system. In addition to this, another system is needed to share information on accidents occurring in the hospital or in other medical institutions and to provide the hospital staff with information on internal rules and measures to be taken in case of problems. Our hospital uses a mailing list for all staff members to share such information. The information also can be accessed on the web for hospital staff.

Incident reports are not published. Therefore, the development of systems to share the information contained in incident reports is ongoing. In our hospital, the content of each incident report is summarized in a one-line description, which is then used for database formulation and information sharing.

<sup>3</sup> Foolproof: A mechanism in which no opportunity for error is left for inexperienced persons.

<sup>4</sup> Fail-safe: A mechanism in which no opportunity for harm from error is left. A safe fault occurs if any fault should happen.

<sup>5</sup> Visibility: Display of the current status of the system, how far the operation has proceeded, what can or cannot be done subsequently, etc.

<sup>6</sup> Affordance: The state that the shape and design of a thing prescribes or facilitates the action or operation of a person to the thing.

### Preparation of medical safety DVDs

Medical accidents occur as a result of unexpected communication errors or the faulty operation of medical instruments, which can be overlooked by staff at the work site. Therefore, it has been useful to develop educational videos that provide a visual representation of how medical accidents can occur.

In the University of Tokyo Hospital, two DVDs were prepared to help promote medical safety. One DVD is formulated to show “safe procedures” and was produced in collaboration with the medical equipment manufacturer Terumo Corporation. The other DVD, which focuses on the “psychology of safety,” was developed through joint research with Koichi Okamoto, a social psychologist and professor of human sciences at Toyo Eiwa University. These DVDs have been used for in-house training programs and distributed to participants of the National University Hospital Council of Japan.

### Use of e-learning

Confirming the adequacy of basic knowledge and skills is also important in promoting medical safety. For instance, we sometimes find medical personnel who are not accurate in their dilution of drugs or calculation of the concentrations of drug solutions based on displayed percentages. In our hospital, a self-learning system using an e-learning modality has been established.

In this hospital, an e-learning program designed in the form of a workbook has been developed for hospital staff to utilize fragments of time. In this program, no correct answer but an explanation is displayed when the trainee gives a wrong answer, and then the missed question is repeated on later tests. In this manner, the trainee can learn from reading the explanation while answering the questions.

### Conclusion

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Together with recent medical progress, a number of innovative methods of diagnosis and treatment have been developed. However, if attention is focused only on state-of-the-art medical technology, and quality control in daily practice becomes inadequate, medical accidents may arise from errors in the basics of care, resulting in social distrust of medical services in general, including state-of-the-art medical technology. Like a high-rise building whose groundwork and foundation are neglected, medical care that neglects the basics of the profession is diametrically opposed to the goals of “safety, ease, and compassion.”

In both the medical and industrial fields, the beginning of progress depends on the personal skills of experienced personnel (great physicians, expert workmen). However, it is difficult to obtain consistent results in a system that relies on the superhuman efforts of individuals. In the modernized industrial arena, safe and reliable systems are structured by management techniques including standardization. The medical field should learn about accuracy and quality control from industry and various other fields.

For instance, in the medical field, the incident report is regarded as a tool to prognosticate risk, but it has a drawback: situations that could have been serious accidents are captured only *ex post facto*.

Ex-ante improvement of accuracy by determining checks and risks as well as prognostication activities, which are common practices in the industrial field, should be facilitated in the medical field as well. Furthermore, measures against risks thus anticipated at the site of work should be incorporated in a medical safety system. These are issues that require ongoing effort.

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# Current Status of Otorhinolaryngology and Head and Neck Surgery in Japan

JMAJ 51(2): 125–127, 2008

Toshiaki YAGI\*<sup>1</sup>

## Otology

### 1. Otological Society of Japan

The Otological Society of Japan held its 17th annual meeting in 2007. This society was developed in 1991 through the merger of two related societies, each with more than 30 years of history, namely, the Japan Society of Ear Research (formerly the Japan Society of Inner Ear Biology) and the Japan Society of Clinical Otology (formerly the Japan Oto-Microsurgery).

#### (1) Matters relating to basic otology

##### Genesis of the inner ear:

Research on the genesis of the inner ear has progressed from the morphological aspects to the molecular biological aspects. Specific subjects of research include the preparation of motor protein-expressing outer hair cell lines, the mechanism of differentiation of inner ear precursor cells, and the role of the Notch signal system in the differentiation of inner ear precursor cells into hair cells and supporting cells.

##### Regeneration of the inner ear:

Studies on the regeneration of sensory cells in the inner ear are in progress, especially with regard to the introduction of ES cells. Data are accumulating from studies on the methods of regenerating hair cells, supporting cells, and ganglion cells in cases of inner ear disorder.

##### Pattern of the manifestation of inner ear disorder:

The expression of a neural stem-cell-specific marker, Musashi protein, in cases of inner ear disorder, localization of  $\alpha$ -tectorin (a constituent of the non-collagen matrix of the tectorial membrane), and the relationship between variations

in Connexin 26 and the degree of hearing loss all have been studied.

##### Aging process of the inner ear:

The prevention of age-related hearing loss through calorie restriction has been studied in mice. Studies on the protective function of the neurotrophin receptor P75 and the prevention of inner ear aging through the use of antioxidants are also underway.

#### (2) Matters relating to clinical otology

##### Inner ear surgery:

The method of evaluating the results of tympanoplasty for hearing improvement has been revised, and standardized evaluation based on the revised method has become common. Navigation surgery is being employed for the treatment of outer and middle ear anomalies such as atresia of the ear canal.

##### Artificial eustachian tube and cochlear implant:

Artificial eustachian tubes have been developed for the treatment of patulous eustachian tube. Most children who have undergone cochlear implant surgery attend ordinary elementary schools, and thus the importance of coordination with school education is increasing.

##### Guidelines for the diagnosis and treatment of acute otitis media:

Guidelines for the diagnosis and treatment of acute otitis media were developed through the efforts of the Japan Society for Pediatric ORL, the Otological Society of Japan, and the Japan Society of Immunology & Allergology in Otolaryngology. These are the first guidelines concerning acute otitis media in Japan, and they are expected to have an important impact on future clinical practice.

\*1 Chairman of the Board of Directors, Oto-Rhino-Laryngological Society of Japan. Professor, Nippon Medical School, Tokyo, Japan (t.yagi@nms.ac.jp).

## 2. Japan Audiological Society

The Japan Audiological Society is an academic society with a history of over 50 years. The following areas of clinical practice and research have received particular focus in recent years.

### (1) Sensorineural deafness

A number of reports on sudden deafness and low-tone sensorineural deafness have been presented, particularly from the aspects of clinical epidemiology and treatment modality.

### (2) Evoked response

In addition to auditory brainstem response (ABR) testing using click stimuli, ABR measurement devices with frequency response have been introduced and are currently in wide use.

### (3) Hearing aids

The preference of hearing aid users is shifting from analog to digital types, and research on such hearing aids is progressing rapidly.

### (4) Neonatal hearing screening

Neonatal hearing screening has become more common. In cooperation with the Oto-Rhino-Laryngological Society of Japan, the Japan Audiological Society accredits facilities available for further intensive hearing testing, and thereby facilitates the formulation of a care system for neonates with hearing impairment.

### (5) Hearing loss and genes

Several types of genetic abnormalities common in Japan have become apparent.

## 3. Japan Society for Equilibrium Research

The Japan Society for Equilibrium Research is an academic society with a history of more than 50 years since its founding. As a society that deals with equilibrium, this society is unique from a global standpoint in view of its large membership and extensive activities, outlined below.

### (1) The benign paroxysmal positional vertigo (BPPV) clinical trial project led by this society

In order to determine the clinical efficacy of physical therapies for BPPV, this society has taken a leading role in undertaking randomized controlled trials to investigate the efficacy of

treatment in patients enrolled via the Internet.

### (2) Publication of a CD-ROM guide for equilibrium testing in daily clinical practice

A CD-ROM guide for equilibrium testing has been published and is being distributed to JSER members, providing an easily accessible aid for equilibrium testing in outpatient clinics.

### (3) Vestibular evoked myogenic potential (VEMP) in otolith function test

VEMP evoked by acoustic stimulation and its clinical application have been studied in depth.

### (4) Video images and the three-dimensional analysis of eye movements

Studies to elucidate the origin of nystagmus by the three-dimensional analysis of video-recorded eye movements (slow phase of nystagmus) and by calculation of the axis of eye movements are in progress. It has become apparent that BPPV lesions are not necessarily located in the posterior semicircular canal.

## Rhinology

Rhinology-related academic societies include the Japan Rhinologic Society and the Japan Society of Immunology & Allergology in Otolaryngology. The former covers research and the clinical care of inflammation, allergy, trauma, tumor, and other diseases of the nose and nasal sinus. The latter society was established to cover allergies in all areas of otorhinolaryngology. This society, however, currently deals with diseases related to the nose and nasal sinus in most cases, excluding some exceptional cases, and therefore is referred to under the category of rhinology.

### (1) Intractable sinusitis

The results of treatment for chronic sinusitis have improved markedly by virtue of the long-term administration of 14-membered ring macrolide antibiotics developed in Japan and the spread of endoscopic intranasal sinus surgery. Nevertheless, cases of intractable sinusitis that do not respond to treatment are increasing. Patients with this condition are divided into the combined type, in which allergic inflammation is present, and the conventional uncombined type. Nasal discharge in combined-type cases contains abun-

dant IL5 and leukotriene, whereas IL-1, TNF, and IL-8 are predominant in the conventional cases. It has been pointed out that high concentrations of IL5 are involved in the migration and activation of eosinophils and have a strong relation with the manifestation of eosinophilic sinusitis.

### (2) Nasal allergy

Topics related to the treatment of nasal allergy, a condition that is practically a national affliction, include anti-IgE antibody therapy, gene therapy, and oral hyposensitization therapy. Most of these therapies have been developed in other countries, and additional large-scale clinical trials are needed to address racial differences and other issues. The Japan Society of Immunology & Allergology in Otolaryngology is promoting the establishment of standards to be used in the diagnosis and treatment of nasal allergy by developing guidelines for the diagnosis and treatment of this condition.

### (3) Smell disorder

Experimental studies of the efficacy of nasal steroid therapy in patients with smell disorder have been carried out. A comparison of the conventional suspended head position and the supine position in instillation has revealed that the steroid drop can adequately reach the olfactory mucosa in the supine position.

## Head and Neck Surgery

Academic societies related to head and neck surgery include the Japan Society for Head and Neck Surgery and the Japan Society for Head and Neck Cancer. The former consists of otorhinolaryngologists, whereas members of the latter society includes many dentists. This is different from corresponding academic societies in other

countries, and some reform would be desirable to clarify this issue.

The sensory organs responsible for vision, smell, hearing, equilibrium, and taste are present in the head and neck region, and are involved in masticating and swallowing functions in the upper digestive tract, and in respiratory, phonetic, and language functions in the upper airway. The face and features represent the personality of the individual, and their damage creates a serious situation for the patient. Therefore, treatment of this region, particularly that of malignant tumors, requires comprehensive selection of the treatment modality, taking into account the patient's rehabilitation into society after the end of treatment, although vital prognosis is the first priority.

Recent topics in this field include multiple head and neck cancer, diagnosis and treatment of early oropharyngeal cancer, larynx preservation, chemoradiotherapy, and super-selective arterial infusion chemotherapy. However, at present, otorhinolaryngologists who wish to become head and neck surgeons are not common. A variety of efforts will be necessary in the future to increase the number of otorhinolaryngologists in this field.

## Others

Other academic societies related to the Oto-Rhino-Laryngological Society of Japan include the Japan Broncho-Esophagological Society, Japan Society of Logopedics and Phoniatrics, Japan Society for Pediatric ORL, Society of Practical Otolaryngology, Japan Society of Stomato-Pharyngology, Japan Laryngological Association, and the Society of Swallowing and Dysphagia of Japan. In addition to the above-described academic activities, each of these societies is engaged in important activities.

*The Takemi Program in International Health at Harvard School of Public Health*

## Preliminary Findings: Problems and further improvement of maternal care in Senegal

JMAJ 51(2): 128–130, 2008

Mayumi SHIMIZU\*<sup>1</sup>

The Takemi Program in International Health at Harvard School of Public Health (HSPH) is an interdisciplinary research program, supported by the Japan Medical Association, that provides mid-career public health professionals from around the world with the opportunity to carry out research for one year, under the supervision of a faculty member at the university. Fellows are also able to study broadly beyond their field of research by attending Takemi seminars, courses, and other activities relevant to their interests at HSPH, throughout Harvard University, and at other universities in the Boston area. This valuable program provides an excellent environment for those involved in global health, and it also facilitates the creation of networks among fellows as well as with research supervisors and other university faculty. I have been engaged as a research fellow in the Takemi Program since September 2007. Prior to that, I worked on numerous projects with Japan International Cooperation Agency (JICA) concerning public health, maternal and child health, and healthcare worker training in countries such as Brazil, Cambodia, Indonesia, and Senegal.

Before coming to Harvard, I was also involved in the JICA Project on the Development of Human Resources in Health in the role of Chief Advisor in Senegal. Working together with the Senegal Ministry of Health and Medical Prevention, the project carried out activities to strengthen basic and continuing education for nurses and midwives, and to increase their numbers. While these efforts have achieved a certain measure of success, we are keenly aware of the need to improve the quality of basic healthcare,

especially for normal labor and delivery in public health care facilities, because strengthening basic and continuing education alone cannot improve the quality of care. For example, the percentage of deliveries in health facilities in Dakar, Senegal's capital, is 92% (81.8% for public facilities; 10.2% for private facilities), which is much higher than the national average of 61.8%.<sup>1</sup> However, the estimated maternal mortality rate (MMR) for all of Senegal, which is 410 deaths per 100,000 live births, remains a major challenge.<sup>1</sup>

My research topic during my Takemi fellowship is "Routine Maternity Care for Normal Labor and Delivery at Public Health Centers in Senegal," and my objectives are to clarify the current situation and problems in maternity care for normal labor and delivery at public health care facilities, and to identify potential areas for improvement. I gathered my data by interviewing postpartum women and observing maternity care in health centers in Dakar in July 2007 and March 2008. My preliminary findings are as follows.

First, some health care workers provided inappropriate care that could harm women and babies during labor and delivery. For example, a male janitor was enlisted to apply fundal pressure; some women underwent numerous vaginal examinations by multiple health care workers; inadequately sterilized disposable urinary catheters were used repeatedly (Fig. 1); the same scissors used in an episiotomy were used to cut the umbilical cord; and newborn infants were washed using cold water directly from the tap.

Second, some women were not only neglected by health care workers, but were verbally and

\*1 International Medical Center of Japan, Tokyo, Japan. Takemi Program, Department of Population and International Health, Harvard School of Public Health, Boston, USA (m-shimizu@it.imcj.go.jp).



Fig. 1 Disinfection of medical instruments by chlorine



Fig. 2 A delivery room in one of the health centers

physically abused. For example, a woman reported that she gave birth at a health center without assistance; some health care workers scolded women when they cried out because of labor pain; and some of the women were even slapped by health care workers.

Third, health centers faced problems due to insufficient facilities (Fig. 2) and staff. The number of beds available was inadequate, and two or more women often had to share a bed during labor and/or after delivery. Necessary equipment such as scissors and forceps were in short supply, and as a result were often not properly sterilized. The labor and delivery rooms lacked toilets, so women in the labor room had to walk to the delivery room and use the plastic bedpan on the floor, in front of all those present. In addition, the number of health care workers on duty was often inadequate, and they were struggling with heavy workload under the poor working conditions.

The history of success in reducing maternal and newborn mortalities demonstrates that immediate and effective skilled professional care during and after childbirth can make the difference between life and death for both women and their newborns.<sup>2</sup> For example, Sweden halved its MMR between the 19th century and early in the 20th century as a result of a national policy favoring professional midwifery care for all births, and by establishing standards for quality of care.<sup>3</sup>

To achieve the Millennium Development Goal 5 of reducing maternal mortality, the

Senegalese government has given priority to the provision and enhancement of maternity care by skilled birth attendants (SBAs) such as doctors, midwives, and nurses. However, the preliminary results suggest that the risk of infection, which is the second cause of global maternal death,<sup>4</sup> might occur among deliveries assisted by SBAs in health facilities. In addition, this may be the case not only in Senegal but in other countries as well. To function effectively, SBAs are largely dependent on the wider environment, including access to equipment, drugs, and supplies; transportation for referral; and partnerships with other SBAs.<sup>5</sup> In other words, improving the quality of care by SBAs in Senegal will require steady, long-term support to strengthen the health system, as has been pointed out in discussions about global health policy more generally.<sup>6</sup> This in turn will require further research with large samples across the country, to determine the current state of maternity care, the working environment, and adverse events after delivery at health facilities. Only through these measures will the health of mothers and newborns be able to improve.

#### Acknowledgements

I would like to thank all women and staff of the participating health centers in Senegal; the Senegal Ministry of Health and Medical Prevention; Michael Reich, Marc Mitchell, and Donald Halstead of Harvard School of Public Health; the Japan Medical Association; and International Medical Center of Japan.

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# Child Health Promotion Activities by the Shizuoka Medical Association

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Masamori HARA\*<sup>1</sup>

This paper discusses the activities of regional medical associations to discuss several activities undertaken by the Shizuoka Medical Association in conjunction with the Shizuoka Education Commission and the prefecture's Health and Welfare Department in a school healthcare program—in other words, on behalf of the healthy physical and mental development of children.

### Activities of the School Health Department

In 2006 the Shizuoka Medical Association progressively disbanded its School Healthcare Subcommittee, reorganized it as the School Healthcare Department with a view to greater coordination with regional healthcare programs embracing maternal and child healthcare and to smooth program management, and established a new School Healthcare Measures Committee within the School Healthcare Department. Dr. Mikio Okada, President of the Shizuoka Medical Association and other Association board members tried to actively involve in school healthcare not only school physicians, but also teachers of special needs education and other school staff active on the front lines and public health workers and nurses who administer the maternal and child healthcare programs engaged in child care support in towns and cities.

The organizational structure of the reorganized School Healthcare Department is described as follows. The new School Healthcare Measures Committee was established as an advisory body to the President in place of the School Healthcare Subcommittee; the School Cardiac, School



Nephritic, School Spinal, School Ophthalmologic and School Otolaryngologic Specialist Examination Committees, School Psychiatric Healthcare Specialist Committee and Adolescence Response Specialist Committee as working groups; and we are working on recommendations based on the smooth implementation of school examination programs and the analysis of their results and on studies of measures in response to issues of children's mental well-being and of adolescent issues, including sexually transmitted diseases.

The following is a report on, among these activities, the Children's Mental Health Counseling Program conducted by the School Psychiatric Healthcare Specialist Committee.

### Composition of the School Psychiatric Healthcare Specialist Committee

The committee that studies psychiatric healthcare at school was established in 1998. While its original objective was to create space for the exchange of opinions in order to build collaborative relationships in the psychiatric field, where coordination with school healthcare and school physicians had

\*<sup>1</sup> Board Member, Shizuoka Medical Association, Shizuoka, Japan (nakayama@jim.shizuoka.med.or.jp).

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been sparse, now that smooth collaboration in the field of child psychiatry is growing, the committee is shifting towards a role in exploring the construction and management of specific systems to support teachers of special needs education under pressure on the ground in schools and to support children suffering from troubled mental well-being.

Seeking the assistance of child psychiatrists and pediatricians engaged enthusiastically in children's mental well-being, the Committee comprises a total of eight members, including two board members of the Association's School Healthcare Department and two doctors each from the prefecture's eastern, central and western districts who play leading roles in their home districts.

### **Children's Mental Health Counseling Program**

The Children's Mental Health Counseling Program was organized in 2002 for implementation by the School Psychiatric Healthcare Committee at the direction of President Okada, who was then Vice President for mental health issues.

Its activities policy consists of seeking due coordination, through school physician liaison, between the attending physicians of children suffering problems of mental well-being and "registered consulting physicians," consisting primarily of psychiatric and pediatric specialists registered with the Shizuoka Medical Association, where homeroom teachers, teachers of special needs education, school headmasters or other school personnel directly involved with such children seek specialist advice or guidance in understanding and responding to these children's problems, and so seeking a resolution of their problems.

In concrete terms, the aim is the construction of a system in which (1) homeroom teachers, teachers of special needs education and other school personnel first of all coordinate closely with the school physician, (2) on this basis they coordinate also with the attending physician and after due consideration determine the specific symptoms, and (3) on this basis they consult with a registered consulting physician appropriate to

the symptoms for advice and guidance with a view to resolving the problem.

The list of doctors registered as consulting physicians originally contained some 70 names, and when school physicians expressed, with respect to the list of registered consulting physicians, a wish that interest be taken in children's mental well-being as well as their physical health, it was decided to provide this information solely to school physicians via city-level medical associations and for this list and system to be employed in sufficient coordination with school physicians on the ground at schools. This approach remains in place without functioning sufficiently. In 2006 however we engaged in an operational review in light of strong requests from school locales to provide information pertaining to registered consulting physicians.

The review focused on two outcomes: (1) The list of registered consulting physicians would be distributed to teachers of special needs education and other personnel directly involved locally at schools, who would contact registered consulting physicians to seek advice and guidance only in due coordination with their school physicians, and (2) consulting physician lists would be updated four years after registration and, when doing so, the disorders (symptoms) and age groups the consulting physicians are capable of handling would also be confirmed and that information provided.

In future it is planned to create a space for the exchange of opinions with the prefectural Education Commission, the teachers of special needs education subcommittee and other persons concerned, to publicize and ensure the smooth operation of the revised new system, to form a liaison council made up of registered consulting physicians and to conduct an exchange of opinions, at the request of the School Psychiatric Healthcare Specialist Committee, on the relationship between consulting physicians and school physicians.

We hope that this system will function effectively with the understanding and cooperation of those concerned and that it will contribute to the healthy physical and mental development of the children who embody the future of Shizuoka prefecture.

# A New Approach to Continuing Medical Education

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Yuichi ORITA\*<sup>1</sup>

It appears that in the last years of the Meiji era (1868–1912) local physicians in Shiga Prefecture began to advocate for continuing medical education (CME) through unified cooperation among those who were similarly concerned. The circumstances in those days were described in detail in 1990 in Vol.103, No.7, of the *Nihon Ishikai Zasshi* (*Journal of Japan Medical Association*) by Yusuke Yamashiki, Executive Board Member of the Shiga Medical Association at that time. Dr. Yamashiki also referred to the situation of CME in the Shiga Medical Association at the time the above article was written. Currently, after more than a decade, CME programs are being offered under similar titles, but the content of each program has changed with the times. Some examples are described below.

### Medical Education Programs (Japan Medical Association CME Programs)

In the past 7 or 8 years, the Shiga Medical Association has been providing semiannual medical education programs concerning two separate themes recommended by the Japan Medical Association (JMA), namely, issues of “basic medical care” and “medical science.” An example is the provision of a set of lecture courses entitled “Frequency and characteristic features of hematologic disorders in Japan” and “Communication techniques for the sympathetic physician.” In addition, in a highly regarded lecture given under the title “Quality daily medical records,” the lecturer reviewed samples of daily medical records offered by volunteers among the member physicians of our association. The author also considered that the



issue of medical license renewal and the relationship between specialists and general physicians would become, in the near future, social issues not restricted to physicians alone. More specifically, such issues would include the quality and competency required for a physician and how a true specialist should be appraised. Therefore, the interest of the planners of the CME programs at that time focused on the adoption of “basic medical care subjects” that reflected the code of medical ethics.

However, training programs related to medical care and medical science have been increasing to the extent that training programs, particularly those provided by pharmaceutical companies, currently are available on an almost weekly basis. Although this may cause some misunderstanding, it can be said that medical association members are satiated with ordinary training programs. The CME programs provided by our association also fall into this trend. In this connection, we, as persons in charge of CME in this prefectural medical association, have considered what the ideal state of future CME programs provided by the Shiga Medical Association should be. In the

\*1 Board Member, Shiga Medical Association, Otsu, Japan (cli-ori@hottv.ne.jp).

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previous training programs, those in charge of planning CME programs used to plan lecture courses for the members. As a result the participating trainees absorbed the information rather passively. Although they might consider what they would do if they happened to be in the situation in question, there was no way to validate their decisions. What needed to be done to correct this situation is described below.

The medical course provided in June 2005 dealt with the entire process from disease recognition to patient discharge and resumption of daily life as well as the issue of medical expenses for an association member with myocardial infarction. Since this program was also linked to a JMA CME program, an analyzer was available for participants for detailed explanation. The program proceeded while confirming the views of the participants as to the pivotal points of disease course, e.g., the site of infarction, its clinical implications, and treatment choice (PCI or bypass surgery). A questionnaire survey carried out after the workshop demonstrated that the theme of this workshop program was perceived as a deep issue for the participants themselves, not only for patients, and the program was highly valued as a participatory training program. In the medical education program given in 2005, equipment and personnel were provided by manufacturers who provide spirometers in Japan, to allow each participant to try spirometry and learn more about it, while referring to his or her individual test results. This program was also popular with the participants. Some members indicated that the chance to receive spirometry was an inducement to attend the program. Both programs were participatory workshop programs.

### **Training Programs**

The Shiga Medical Association has long been providing training programs specific to health professionals. In preparing for the 2005 program, questionnaires were sent to health professionals. Based on the results of the questionnaire, the training program was provided in the form of three meetings. The program was highly regarded, and some participants expressed in the post-event questionnaire that they wished they could have attended all three of the section meetings. We intend to improve our training programs in light of these reviews.

The prevention of medical mishaps is a matter of great importance, and one that deserves much attention not only from practicing physicians but also from medical students. In this connection, the Shiga Medical Association has been offering a course called “A Training Program for the Prevention of Medical Accidents” in the Shiga University of Medical Science since 2002. With the cooperation of the university, this program is a compulsory subject for fifth-year medical students. Thirty percent of the participants are medical association members. We consider that learning about medical safety with medical and nursing students is of major significance. After the lecture, participating members have the opportunity to question and consult with doctors in their chosen specialty. In addition, the Shiga University of Medical Science offers a program of practical training in clinics for several days, entitled “contemporary GP,” for fifth-year medical students. In response to a request from the university for cooperation in this program, about 100 clinics in Shiga Prefecture are accepting medical students. These clinics account for about 15% of all clinics in the prefecture. The author’s clinic also accepts medical students for this training program. Clinics may need to alter their view of the ethical and practical aspects of clinical care when accepting medical students. Therefore, this program may serve as one of the best opportunities for CME.

### **WATCH in Shiga 2007 (Welcome & Training Conference Held in Shiga)**

This section introduces “WATCH in Shiga 2007.” This was a 2-day camp session scheduled for the first weekend of June 2007 for all medical interns who would begin clinical training in Shiga Prefecture. JMA considers the value of the clinical training system to be the nurturing of junior physicians by senior physicians. Based on this JMA principle, the program was developed over the course of 3 years by the Shiga Medical Association, a group of senior physicians, to provide valuable advice for junior physicians newly entering clinical practice. The first day of the session focused on “becoming a good clinician.” Dr. Nobuya Hashimoto, a previous JMA executive board member, was scheduled to speak about “basic issues in medical care,” and Dr. Yoshio Gyoten was slated to speak about “desired characteristics of clinicians: the weight

of a medical license in society.” Two hours were allowed between the two presentations for intensive role-playing exercises with senior physicians acting as patients. President Yoshiko Tsujimoto from the Consumer Organization for Medicine & Law (COML) was asked to review the role-plays. A welcome party for new physicians was held in the evening on a boat in Lake Biwa. The prefectural governor was invited to this party and asked to shake hands with the participants together with the president of Shiga University of Medical Science and the president of the Shiga Medical Association, to encourage them in their work.

The second day was dedicated to learning the “tasks of health insurance physicians.” The lecture was designed for group learning, beginning with an explanation of regulations related to the health insurance system and proceeding to how to use the so-called blue book—*Interpretation of Healthcare Score Table* (issued by Shakai Hoken Kenkyujo [Social Insurance Research Institute])—and the red book (*Drugs in Japan*), as well as

how to prepare simple medical records and medical fee receipts, and how to write prescriptions valid anywhere and free from misunderstanding. Since the participants were unlikely to have learned about these topics in their university years, this seems to have been useful for the new physicians. These curricula were accepted by each training hospital and by the administrative authorities of the prefecture.

This camp session was designed to accept as many medical association members as possible, if they wished to attend the camp. It is our belief that this program is in good accordance with the principles of JMA.

The Shiga Medical Association has other programs that are related to CME. We hope to improve these programs gradually through a scrap-and-build method according to the requirements of the time. It is necessary for physicians to consider what is required in the area of their clinical practice and to train themselves to be ready to respond to the need. This point of view is necessary as a fundamental principle of CME.

## Life-long Medical Education— National and international level

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Jaroslav BLAHOS\*<sup>1</sup>

The quality medical education is of fundamental significance for quality health care. There are several main questions how to achieve a most efficient way of education and also how to find most suitable common systems which would be acceptable internationally.

The first problem: Who should provide the education and how. First of all it seems unreasonable to adopt a national prescriptive detailed system. However some basic rules should be given which would fit with global trends. In the Czech Republic the postgraduate and continuing medical education is obligatory during the whole professional life. The Czech Medical Association (CzMA) has a long experience with postgraduate and continuing medical education. It consists in evening symposia or conferences organized by its 104 specialities. In 2007 more than 600 lectures were carried out lasting from several hours to 2 days. Some of the lectures were sponsored by pharmaceutical industry under strict ethical conditions. The CzMA includes also the regional medical clubs which also organize educational activities for doctors and/or nurses working in the region. Participants of the conferences get certificates (or credits) confirming their attendance. The CzMA is a benevolent organization and consists of about 90% of Czech doctors. There are, however, several societies which do not belong to the CzMA and which are authorised by the Ministry of Health to provide the education as well. The authorisation is given to well known and scientific sound societies in order to avoid scientifically and educationally insufficient groups which could provide the education under the denomination of “scientific societies.” Educational events organized by the industry are not granted accreditation but there may

be exceptions (in case that no product of the industry is recommended not even as a hidden publicity). There is an agreement between the CzMA and other institutions which have the accreditation for postgraduate and continuing education, namely the universities and medical schools, professional medical chambers and the Institute for postgraduate education of physicians and pharmacists.

First attempts for e-learning and teleeducation have started recently but are still not easily accepted among the elderly.

Medical research, scientific publications and/or controlled individual education are optional modes of education. An aid to education represents also the tests published in some journals edited by the CzMA.

One of the problems which remain to elaborate is how to incorporate and to what extent the education of medicine—related issues which are universally known as continuous professional development (CPD) which embraces not only CME, but also the development of non—medical competences, such as management, finances, personal and social skills and other proficiencies (CME/CPD). One of the most important tasks is the communication skill between the health worker and the patient. There is a certain danger of dehumanization of medicine due to the progress in technologies. The doctor or nurse may thus communicate more with the computer or other devices than with his or her patient. The “technical attitude” toward the patient concerns especially the younger doctors. Some of them could be even called “engineers of medicine” rather than doctors. Medical ethics and communication skill has been introduced therefore into the CME/CPD.

Contrary to CME, which can be provided

\*1 President, Czech Medical Association, Prague, Czech Republic (czma@cls.cz).

directly by the educational bodies, the postgraduate (specialization) education concerning major medical specialities (e.g. internal medicine, surgery, gynecology-obstetric, pediatrics) is provided by accredited departments of the faculties, hospitals or regional hospitals. Some of the newly established private hospitals without sufficient training facilities are not able to ensure quality and the education might thus be more or less a matter of business.

At present, guidelines are being discussed concerning immigrating doctors from some countries to the Czech Republic and wishing to practice there.

We have been well acquainted with the standards in medical education and the attention to quality assurance and accreditation of medical education institutions and programs outlined by the World Federation of Medical Education (WFME) as well as by the Union Européenne de Médecins Spécialistes (UEMS), European Accreditation Council for CME (EACCME) and Association for Medical Education in Europe (AMEE). However, individual systems of CME/CPD should be tailored for local conditions, tradition, culture, priorities etc.

The second fundamental problem is the financing of postgraduate medical specialization in accredited institutions. The greatest burden

remains on the state (Ministry of health and partly Ministry of educations). The discussion remains on whether the financing should go to the institution or whether it should follow the resident. Both suggestions have their pros and contras. At present the residents are paid from the budget of the hospital or by the regional state authorities and they must sign a contract for 5 years to work in the hospital.

Our CME program includes guidelines for payment of individual educational activities. The payment either sponsored or non-sponsored by pharmaceutical industry includes administrative fees to the Czech Medical Association, Universities, Medical chamber, or the Institute for postgraduate education of physicians and pharmacists. The fees are relatively low compared with those required by authorities of the European Union. This remains the main obstacle to rationalise the mutual recognition of national and European CME. The fees for the local educational program meet the needs of local doctors. They are much lower than the price of the European authorities.

The CME will certainly play a major role in the life of doctors everywhere in the world. Therefore, the endeavour to identify suitable global fundamental standards and harmonized core curriculum of CMP/CPD is well justified.

## Strengthening the Working between the World Medical Association and Confederation of Medical Associations of Asia and Oceania\*<sup>1</sup>

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Nachiappan ARUMUGAM\*<sup>2</sup>

I would like to thank the President and Council of the Confederation of Medical Associations in Asia and Oceania (CMAAO) for inviting me to the 25th CMAAO Congress and Assembly and for giving me an opportunity to share my experience as the president of the World Medical Association (WMA). My thanks also to The Medical Association of Thailand and the organising committee of this conference especially Dr. Wonchat Subhachaturas for making all the necessary arrangements.

The warm, enthusiastic, and friendly welcome, that all of you gave me through out the term as president of the WMA will always be cherished by me. I would also like to place on record my appreciation to many of you for making the special arrangements and for your support.

CMAAO since its inception has come a long way in building a strong and harmonious network among the medical associations in the region. It has organised many conferences and has debated many issues of common interest and drawn up guidelines benefiting the members. CMAAO is not only an important organisation in the region but also is one of the better organised regional associations in the world. I am confident that the newly installed president Dr. Somsri Pausawasdi will further strengthen the work of the association.

The Japan Medical Association which has been one of the prime movers of CMAAO is also one of the important members of the WMA. The Japan Medical Association has always shown

commitment towards the work of the WMA and in recent years has taken on a greater role. It has helped to co-organise a regional meeting of the WMA in Tokyo and has played a major role in representing the interests of the region. Other members of CMAAO, being smaller organisations, have in the past only been able to play a limited role in the activities of the WMA. It is an encouraging and welcome development in recent years, to see more interest by these smaller associations in the activities of the WMA.

One of my main tasks as the president of the WMA was to emphasise the work of the association and make its work more visible to the members and the public at large. An important way to achieve this would be by visiting the National Medical Associations (NMAs) and meeting the presidents, office bearers and the members of the associations. As president I have visited many national and regional organisations, participated in their annual meetings, presented the work and views of the WMA and explored the various possibilities of increasing the working relationship between National Medical Organizations.

Most of us are aware of the many challenges facing the profession. Many of them are similar in many countries while some problems and challenges are peculiar to certain regions. One of the main concerns of the profession in many countries currently seem to be the increasing regulations and administrative requirements by governments and administrators, which seem to have diverted and reduced the time for clinical

\*<sup>1</sup> This article is based on a presentation made at the 25th CMAAO Congress and Assembly Meeting in Pattaya, Thailand on November 19, 2007.

\*<sup>2</sup> Immediate-Past President, World Medical Association. Past-President, Malaysian Medical Association, Kuala Lumpur, Malaysia (mma@tm.net.my).

work. Though this would seem to be a local and service issue, some of these have been stifling the daily practice of medicine and it is worth for different medical associations to share their experiences in order to reach a workable solution.

Medical practice has long been a fine balance between science and art, guided by ethics, but in recent years this balance has been increasingly infringed by commercialisation and politics. The politicising of healthcare, the emergence of convoluted reimbursement systems employing many third party payers, and the increasing needs and demands of the patients, with the pervasive presence of medical litigation have caused much apprehension among doctors throughout the world. The profession, in many countries is demoralised and find many of the systems thrust upon it by the authorities and governments daunting. The profession and NMAs are faced with unenviable task of negotiating favourable and workable healthcare systems benefiting all.

The WMA has continued to maintain and develop the relationship with the World Health Professional Alliance made of doctors, dentists, nurses and pharmacists. A meeting between the presidents of these various organisations was held in Geneva during the period of the assembly of the WHO. The main points of interest discussed at the meeting this year were healthcare personnel migration and the effect of task shifting in various countries. Though there has been progress in these discussions with the health alliance group, there are areas of differences which need to be ironed so that our combined energy could result in a greater impact.

Among the many advocacy issues the WMA champions, smoking and prevention of obesity are important ones. At many forums and media meetings I have drawn attention to the alarming rate of the increasing percentage of the population becoming obese and sometimes grossly overweight. The need to address this looming epidemic is urgent. The WMA with the national organisations should pressurise government agencies and relevant authorities to improve

early education of good nutrition in schools and address the quality of food sold to children especially in schools. As healthy eating is the cornerstone in maintaining a healthy weight and thus health, it is good sense to know what one is eating and there must be attention and effort taken to label food especially by the catering industry. Though many authorities recognise the ominous danger of obesity, their priority to act seems to low and thus persuasive and persistent reminders are indispensable.

I was able to visit many CMAAO member countries during my term as president of WMA. I had the opportunity to address—The Mid-Term CMAAO Council meeting in Singapore, The MASEAN meeting in Malaysia, The Annual General Meeting of the Indonesian Medical Association, The 100 year celebrations of the Philippines Medical Association, The Annual General Meeting of the Australian Medical Association and The Annual Delegates Meeting in India. It has given me immense satisfaction to be able to meet with the leaders and members of these associations and to get to know the various issues affecting them and to discuss approaches which could be employed to overcome them.

CMAAO as a regional organisation is made up of countries with different healthcare systems and varying healthcare standards. In the beginning it was hard for the organisation to have a cohesive policy to follow. Over the years the areas of common interest have gradually emerged and the activities of the association are becoming more relevant to the participating countries. The WMA recognises the need for strong regional partners in order to help in the work of the WMA. I am sure that CMAAO will be able to use its leadership role to enhance advocacy for the profession and the patients in formulating improved healthcare policies for those in the region and for the world.

I would once again like to thank you for the opportunity to address the Congress and lets us all work together to achieve the best for the patient, the profession and healthcare.

### DoH 2008 Workshop in Helsinki

The Declaration of Helsinki (DoH) plays a quite important role in providing guidance to physicians and researchers involved in medical research concerned with clinical trials for new drugs. With the aim of updating the DoH, the WMA brought together more than 50 participants consisting authorities and concerned parties throughout the world as well as WMA Working Team members at the DoH 2008 Helsinki Workshop at the Finnish Medical Association Headquarters on 10–11 March 2008. There were frank discussions about the DoH ranging from general concept to detailed wording, an approach which was appreciated by all participants as a very democratic and open procedure considering the importance of this declaration. The workshop participants were all able to understand that the DoH was created and is continually revised responsibly by the WMA through the appropriate procedures. The members of the DoH Working Team, including the JMA, recognized that completing the entire revision process would be a valuable and rewarding task.

It was also a great pleasure for me to be able to attend a Schubert piano recital at the Sibelius Academy Concert Hall performed by Prof. Risto Lauriala. It was a mightily impressive performance of piano pieces by Franz Schubert giving a sense of Nordic mythology. Moreover, the concert provided valuable indications that such features were primary ingredients of the nature of Schubert's music.



Ainola—the home of Finland's greatest composer, Jean Sibelius

In Finland, I was able to observe actual scenes which have been depicted in musical form by Jean Sibelius. It was the season of the thawing of snow and was much warmer than we have been told it would be, reflecting recent climate changes occurring in Europe. Thus, walking around in the city area of Helsinki I enjoyed taking in the scenery, from historical monuments to traditional pubs. The city also stands on the seashore, carved deeply into the rocky landscape and fronting a magnificent natural harbor.

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Masami ISHII, Executive Board Member, Japan Medical Association (jmaintl@po.med.or.jp), Secretary General, Confederation of Medical Associations in Asia and Oceania (CMAAO), Council Member, World Medical Association.